# Agenda

West Dunbartonshire
Health & Social Care Partnership

# West Dunbartonshire Health & Social Care Partnership Board

**Date:** Wednesday, 2 October 2019

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**Time:** 10:00

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**Venue:** Civic Space, Council Offices, 16 Church Street, Dumbarton

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**Contact:** Gabriella Gonda, Committee Officer
Tel: 01389 737183 Email: gabriella.gonda@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**

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

**Non-Voting Members**

Barbara Barnes
Beth Culshaw
Jo Gibson
Jonathan Hinds
Chris Jones
John Kerr
Helen Little
Diana McCrone
Anne MacDougall
Kim McNab
Peter O'Neill
Selina Ross
Julie Slavin
Val Tierney

Senior Management Team – Health & Social Care Partnership

Date of issue: 23 September 2019

**WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD**

**WEDNESDAY, 2 OCTOBER 2019**

**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 MEETINGS 5 - 11**

Submit, for approval as a correct record the Minutes of Meeting of the Health & Social Care Partnership Board held on 7 August 2019.

**4 VERBAL UPDATE FROM CHIEF OFFICER**

The Chief Officer will provide a verbal update on recent business of the Health & Social Care Partnership.

**5 DRUG-RELATED DEATHS WEST DUNBARTONSHIRE 13 –18**

Submit report by the Head of Mental Health, Addictions and Learning Disability:-

(a) providing an update on the drug related deaths within the West Dunbartonshire Council area; and

(b) outlining current and planned service response.

**6 THEMATIC REVIEW OF SELF-DIRECTED SUPPORT IN SCOTLAND; WEST DUNBARTONSHIRE LOCAL PARTNERSHIP REPORT 19 –42**

Submit report by the SDS Lead Officer updating on progress relating to the Improvement Plan which was agreed following the Care Inspectorate Thematic Review of self-directed support in West Dunbartonshire.

**7/**

**7 INSPECTION OF JUSTICE SOCIAL WORK SERVICES: UPDATE ON ACTIONS** **43 - 46**

Submit report by the Head of Children's Health, Care and Criminal Justice/Chief Social Work Officer updating on actions taken forward following the publication of the inspection of criminal justice social work services by the Care Inspectorate and local action plan.

**8 SCOTPHO ANNUAL SUICIDE STATISTICS LOCAL AUTHORITY LEVEL – WEST DUNBARTONSHIRE** **47 - 53**

Submit report by the Head of Mental Health, Addictions and Learning Disability providing details of ScotPHO Annual Suicide Statistics at both a national and local authority level.

**9 GP OUT OF HOURS SERVICES AND DEVELOPMENT OF URGENT CARE RESOURCE HUB** **55 – 104**

Submit report by the Head of Health and Community Care outlining the outcomes of work that has been underway across NHS Greater Glasgow and Clyde to improve the availability of primary care services outside of office hours.

**10 MINUTES OF MEETINGS FOR NOTING** **105 – 136**

Submit for information, the undernoted Minutes of Meetings:-

(a) Minutes of Meeting of the WD HSCP Board Audit Committee held on 19 June 2019;

(b) Minutes of Meeting of the Clinical and Care Governance Forum held on 17 July 2019;

(c) Minutes of Meeting of WD HSCP Health and Safety Committee held on 30 July 2019; and

(d) Minutes of Meeting of the Joint Staff Forum held on 10 July 2019.

# WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

At a Meeting of the West Dunbartonshire Health & Social Care Partnership Board held in the Council Chamber, Clydebank Town Hall, Clydebank on Wednesday, 7 August 2019 at 2.00 p.m.

**Present:** Bailie Denis Agnew and Councillors Marie McNair and John Mooney, West Dunbartonshire Council; Allan MacLeod, Rona Sweeney and Audrey Thompson, NHS Greater Glasgow and Clyde Health Board.

**Non-Voting Members:** Beth Culshaw, Chief Officer; Barbara Barnes, Co-Chair of the WD HSCP Public Engagement Network for the Alexandria & Dumbarton area; Wilma Hepburn, Professional Nurse Advisor; Helen Little, MSK Physiotherapy Service Manager; Diana McCrone, NHS Staff Side Co-Chair of Joint Staff Forum; Anne MacDougall, Co-Chair of WD HSCP Public Engagement Network for the Clydebank area; Kim McNab, Service Manager, Carers of West Dunbartonshire; Peter O'Neill, WDC Staff Side Co-Chair of Joint Staff Forum and Selina Ross, Chief Officer – WD CVS.

**Attending:** Serena Barnatt, Head of People and Change; Jo Gibson, Head of Health & Community Care; Jonathan Hinds, Head of Children's Health, Care & Criminal Justice Services; Wendy Jack, Interim Head of Strategy, Planning & Health Improvement; Jennifer Ogilvie, HSCP Finance Manager; Julie Lusk, Head of Mental Health, Learning Disability & Addictions; Val Tierney, Chief Nurse; Nigel Ettles, Principal Solicitor; Craig Stewart and Gabriella Gonda, Committee Officers.

**Also Attending:** Peter Hessett, Strategic Lead, Regulatory and David Williams, Director of Delivery, Health & Social Care Integration, Scottish Government.

**Apologies:** An apology for absence was intimated on behalf of Julie Slavin, Chief Financial Officer.

**Mr 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.

## MINUTES OF PREVIOUS MEETINGS

It was noted that the Minutes of The Special Meeting of the Health & Social Care Partnership Board held on 28 March 2019 had already been approved as a correct record at the meeting of the Board held on 8 May 2019.

The Minutes of the Health & Social Care Partnership Board held on 8 May 2019 were submitted and approved as a correct record.

## VERBAL UPDATE FROM CHIEF OFFICER

The Chief Officer provided a verbal update on recent business of the Health & Social Care Partnership and the position was noted in relation to:-

- The work being carried out to tackle summer challenges in providing key services;
- How the Partnership will focus on continuous improvement, sharing good practice, how they work together as a team on existing operational issues and finding the right approach to take forward future challenges;
- The Strategic Plan and consideration of how good practices in other areas could be implemented in West Dunbartonshire;
- The pressures on the Health Board arising from unscheduled care;
- Update on how management is dealing with possible industrial action by employees in the Children and Families service, recruitment of additional staff, regular reports and monitoring activity, future meetings planned with staff and the concern expressed by WDC staff side Co-Chair of Joint Staff Forum over lack of progress; and
- Update on the implementation of the action plan developed following the inspection of Castle View Care Home, the upcoming Strategic Planning Group meeting.

Note: David Williams, Director of Delivery, Health & Social Care Integration, Scottish Government arrived during the above item.

At this point the Chair, Mr MacLeod welcomed David Williams, Director of Delivery, Health & Social Care Integration, Scottish Government to the meeting. Mr Williams gave an introduction on the work he had previously been involved in as the Chief Officer of the Glasgow City Health & Care Partnership and thanked the Board for the opportunity to sit in and observe proceedings.

## FINANCIAL PERFORMANCE AND UPDATE REPORT – PERIOD 3 (30 June 2019)

A report was submitted by the Chief Financial Officer:-

(a) providing an update on the financial performance as at period 3 to 30 June 2019 and a projected outturn position to the 31 March 2020; and

(b) seeking approval for the financial framework being developed to support the implementation of the Five Year Adult Mental Health Strategy across Greater Glasgow and Clyde.

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

(1) to note the updated position in relation to budget movements on the 2019/20 allocation by WDC and NHSGGC and direction back to our partners to deliver services to meet the strategic priorities approved by the HSCP Board;

(2) to approve the proposed financial framework (as shown in sect 4.8 – 4.13 of the report) which would support the implementation of the Five Year Adult Mental Health Strategy;

(3) to note that the revenue position for the period 1 April 2019 to 30 June 2019 was reporting an overspend of -£0.235m (-0.59%);

(4) to note the projected outturn overspend position of -£0.954m (-0.60%) for 2019/20 and the potential impact on the reserves position if demand was not managed within existing resources and an agreed recovery plan;

(5) to approve the use of general, unearmarked reserves to underwrite the additional costs of addressing the Children and Families collective grievance;

(6) to note the update on the capital position and projected completion timelines; and

(7) that officers would bring regular updates to the Board on West Dunbartonshire Council's Budget Allocation to the HSCP Board and on earmarked reserves.

## ANNUAL REPORT AND ACCOUNTS 2018/2019 PROCESS

A report was submitted by the Chief Financial Officer updating on the progress on the 2018/19 Annual Accounts process and requesting approval for the next stages.

After discussion and having heard the HSCP Finance Manager in further explanation of the report, the Board agreed:-

(1) to note that the 2018/19 draft Annual Report and Accounts were approved by the 19 June Audit Committee and passed to external audit; and

(2) to delegate authority to the Audit Committee to formally approve the audited accounts on 25 September 2019, prior to submission to the Accounts Commission by 30 September 2019, in line with the approved Terms of Reference.

## MEMBERSHIP OF THE PARTNERSHIP BOARD

A report was submitted by the Interim Head of Strategy, Planning and Health Improvement nominating new non-voting members to the Partnership Board.

After discussion and having heard the Head of Strategy, Planning & Health Improvement in further explanation of the report, the Board agreed to appoint the undernoted nominated non-voting members to the Partnership Board:

- Helen Little
- Val Tierney

## APPOINTMENT OF A STANDARDS OFFICER

A report was submitted by the Chief Financial Officer on the appointment of a Standards Officer as required by the Ethical Standards in Public Life (Scotland) Act 2000 (Register of Interests) Regulations 2003.

After discussion and having heard the Strategic Lead, Regulatory in further explanation of the report, the Board agreed:-

(1) to note the duties and responsibilities of the Standards Officer as detailed in Appendix 1 to the report;

(2) to approve the appointment (subject to the approval of the Standards Commission for Scotland) of the Strategic Lead, Regulatory as the Standards Officer for the West Dunbartonshire Integration Joint Board; and

(3) to remit the Chief Officer to seek the Standards Commission's approval of the appointment.

Note: Peter Hessett, Strategic Lead, Regulatory left the meeting at this point.

## STRATEGIC RISK REGISTER

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

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

(1) to approve the updated Strategic Risk Register as attached to the report; and

(2) to note the update by officers on the current Social Care Partnership's Risk Management Strategy and Policy for presentation to the 11th December 2019 meeting of the Audit Committee.

## COMMISSIONING AND MARKET FACILITATION PLAN 2019 - 2022

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement seeking approval to publish the draft Commissioning and Market Facilitation Plan and start the implementation process for the plan.

After discussion and having heard the Interim Head of Strategy, Planning & Health Improvement, in further explanation of the report and in answer to Members' questions, the Board agreed to approve the draft HSCP Commissioning and Market Facilitation Plan 2019 – 2022 and that an update report be presented to the Board meeting in March 2020.

## ANNUAL PUBLIC PERFORMANCE REPORT 2018/19

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement presenting the fourth Annual Public Performance Report for the Health & Social Care Partnership, including a complaints management overview for that full year.

A presentation was then given by the Interim Head of Strategy, Planning & Health Improvement; Head of Children's Health, Care & Criminal Justice Services; Head of Health & Community Care; Head of Mental Health, Learning Disability & Addictions; the Chief Nurse and the MSK Physiotherapy Service Manager on the above.

Following questions from Members, the Chair, Mr MacLeod thanked everyone for their informative presentation and for their hard work in 2018/19.

The Board then agreed to approve the Annual Public Performance Report for publication and thanked officers for all their excellent work. It was noted that a further report would be presented to the Board meeting in November.

## WEST DUNBARTONSHIRE HSCP ANNUAL CLINICAL AND CARE GOVERNANCE REPORT 2018-2019

A report was submitted by the Chief Nurse providing an overview of the Annual Clinical and Care Governance Report.

After discussion and having heard the Chief Nurse in further explanation of the report and in answer to Members' questions, the Board agreed to note the content of the

report and the impact of achievements around quality assurance and quality improvement.

## ADJOURNMENT

Having heard the Chair, Mr MacLeod, it was agreed to adjourn for a short period. The Committee reconvened at 4.25 p.m. with all Members listed in the sederunt in attendance.

## THEMATIC REVIEW OF SELF-DIRECTED SUPPORT IN SCOTLAND; WEST DUNBARTONSHIRE LOCAL PARTNERSHIP REPORT

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement presenting the Report from the Care Inspectorate Thematic Review of self-directed support in Scotland; and the West Dunbartonshire local partnership report.

After discussion and having heard the Interim Head of Strategy, Planning & Health Improvement in further explanation of the report, the Board agreed:-

(1) to note the content of the report;

(2) to note the Improvement Plan which had been shared with the Care Inspectorate;

(3) to seek regular reporting on the local response to the recommendations within the report; and

(4) that officers would bring regular updates on the progress being made in implementing the Improvement Plan.

## INSPECTION OF JUSTICE SOCIAL WORK SERVICES

A report was submitted by the Head of Children's Health, Care and Criminal Justice (Chief Social Work Officer):-

(1) advising on the recent inspection of criminal justice social work services by the Care Inspectorate, which focused on how well community payback orders (CPOs) were being implemented and managed; and

(2) outlining key themes of the improvement action plan, informed by the inspection report.

Members were asked to note that the Inspection Report was only published on 6 August 2019 and copies of the report had been made available for circulation at the meeting.

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

(1) to note the contents of the report;

(2) to note the report and recommendations from the Care Inspectorate at Appendix A to the report;

(3) to note the plan outlining improvement actions being undertaken to address the recommendations at Appendix B to the report;

(4) that further reports would be presented to future meetings of the Partnership Board on the progress against the actions being undertaken to address the issues raised within the report.

**MINUTES OF MEETINGS FOR NOTING**

The undernoted Minutes of Meetings were submitted and noted:-

(1) Minutes of Meeting of the WD HSCP Board Audit Committee held on 19 June 2019;

(2) Minutes of Meetings of the Local Engagement Network Events held on 6 June 2019;

(3) Minutes of Meeting of WD HSCP Health and Safety Committee held on 30 April 2019;

(4) Minutes of Meeting of the Clinical and Care Governance Forum held on 15 May 2019; and

(5) Minutes of Meeting of the Joint Staff Forum held on 7 May 2019.

The meeting closed at 5:05 pm

**WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD**

**Date of Meeting: 2 October 2019**

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**Subject: Drug Related Deaths West Dunbartonshire**

## 1. Purpose

**1.1** To provide the Partnership Board with:-

- An update on the drug related deaths within the West Dunbartonshire Council area.
- To outline current and planned service response.

## 2. Recommendations

**2.1** For members to note these changing trends in drug related deaths in West Dunbartonshire and across Scotland.

## 3. Background

**3.1** The report, Drug Related Deaths in Scotland in 2018, was published on 16 July 2019, by the National Records of Scotland (NRS). This continues the annual drug related death (DRD) reporting framework of those vulnerable individuals who lose their lives to controlled drugs.

**3.2** In addition, as part of the Scottish Governments drug strategy "Road to Recovery", the National Drug Related Death Database (NDRDD) report published by NHS National Services Scotland, Public Health Intelligence (PHI) Division, provides more detailed information on a wider variety of data specific to each death. This report provides a summary of the key characteristics of those who died in 2018 within NHS Greater Glasgow & Clyde (NHSGGC).

## 4. Main Issues

**4.1** Key points

Those who died of a drug related death in NHSGGC were most likely to be:-

- Male (71.3%), Aged between 35-44 (24.6%; Median=43, Range18-75).
- It should be noted that in 2018 there was a significant increase in deaths in those aged under 25 (125% increase), although with small numbers again caution should used when interpreting this change. The rise is consistent in males and in females, though with fewer numbers in females.
- It should also be noted that whilst male deaths outnumber female deaths, the rate at which female deaths are increasing is more than that of males.
- There is continuing evidence that there is an increase in polypharmacy. It was most common for 3 drugs to be implied in the cause of death (27.7%).

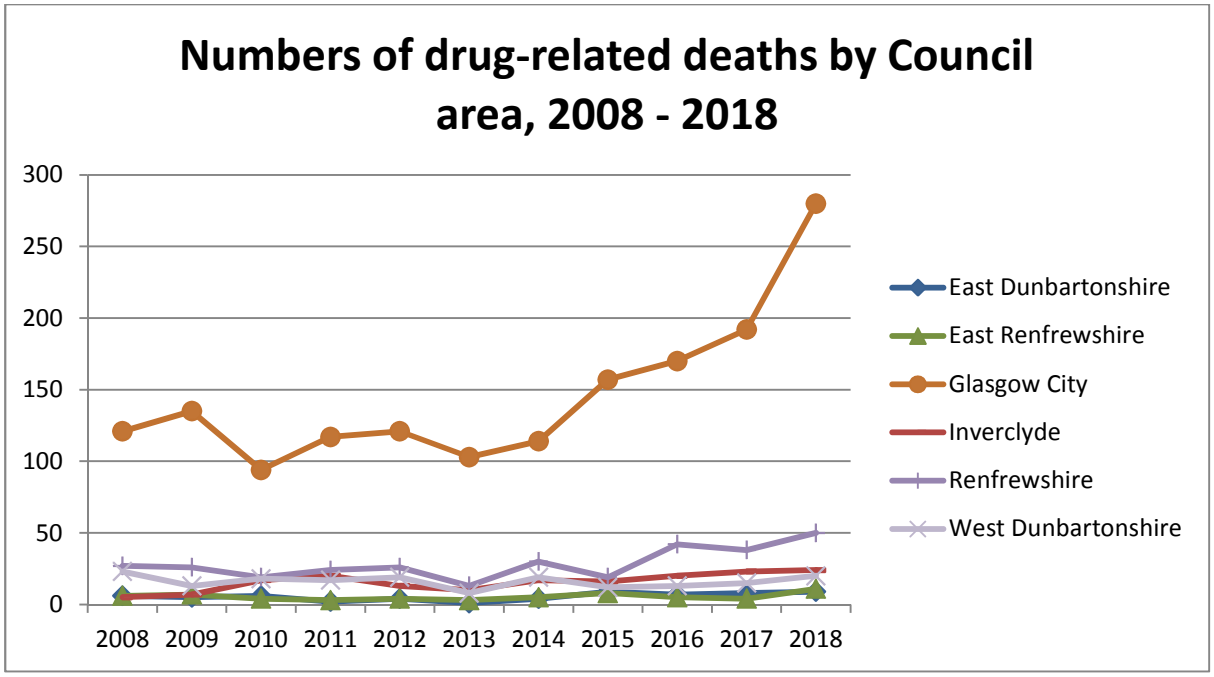
In addition in 2018 there was also an increase in those who also had an underlying health condition such as chronic obstructive pulmonary disorder (COPD) or ischaemic heart disease which contributed to their death (24.6%).

- With regards to opiate drugs, there were decreases in the incidence of Heroin/ Morphine, Methadone and Tramadol, although there was a slight increase in the incidence of Buprenorphine. There were also a very small number of deaths which had Fentanyl present (1.3%).
- With regards to Benzodiazepines, there has been a large increase making this family of drugs the most commonly found implicated in drug related deaths (70.6%), which is mainly driven by the drug Etizolam (60.2%).
- There were slight increases in the incidence of both Gabapentin (14.7%) and Pregabalin (8.4%) at toxicology, whilst there was also a slight increase in deaths involving alcohol.
- There continues to be no incidence of stimulant type NPS drugs within NHSGGC, whilst analysis of other stimulant type drugs indicates a small rise in Cocaine deaths (2017-17.1%; 2018-20.8%) but reductions in those involving Ecstasy (1.5%) and
- Amphetamines (2.0%). In contrast, to previous years there was also a significant decline in the number of individuals who were on Opioid Replacement Therapy at the time of death (39.6% compared with 51.2% in 2017.

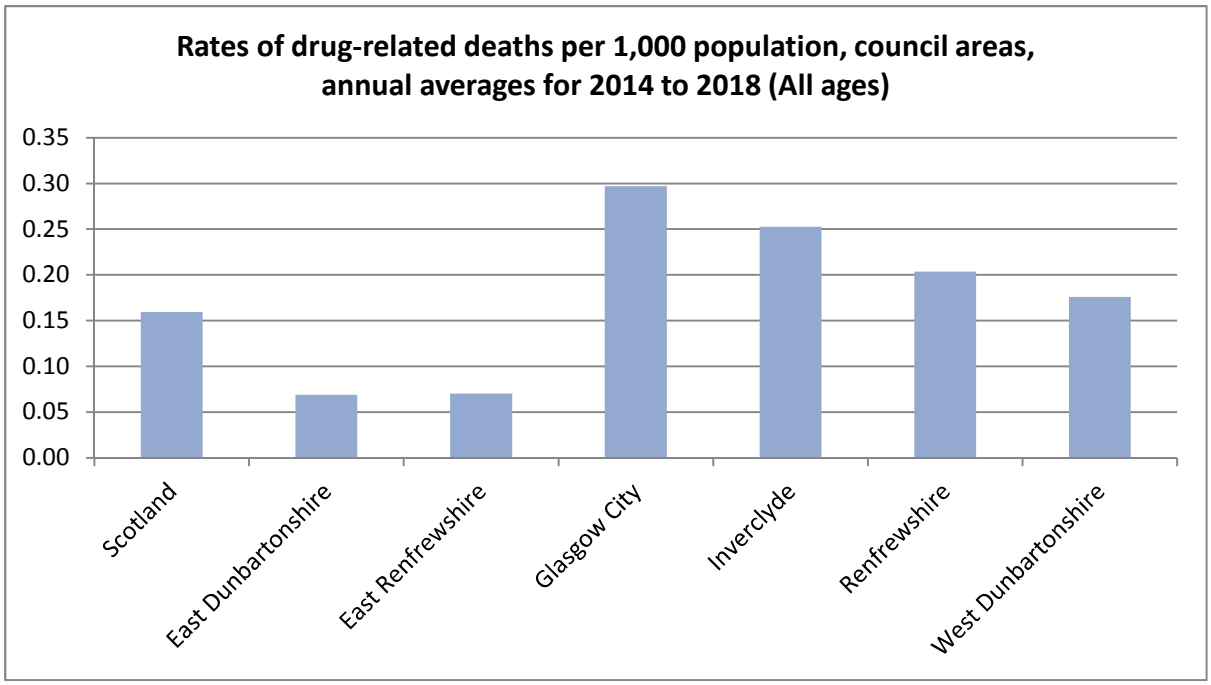
**4.2** Drug Related Deaths

There has been a sharp rise in drug related deaths in NHS GG&C between 2017 and 2018. Within West Dunbartonshire there was an increase of 15.8% against GGC as a whole which was 40.7%.

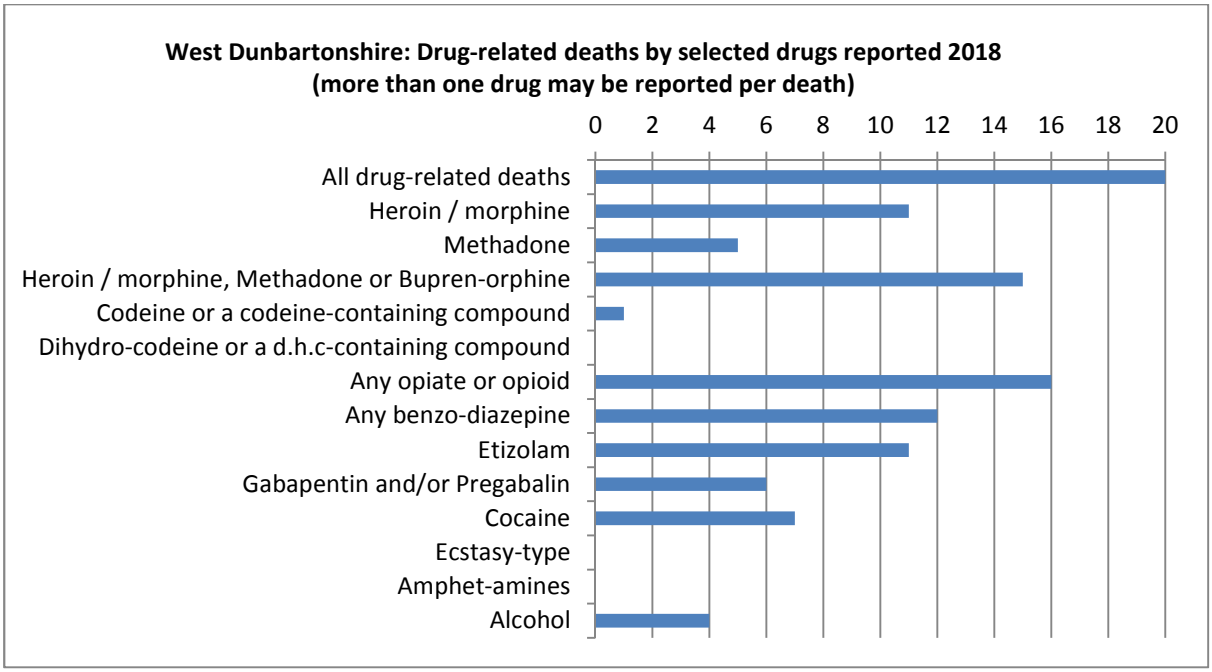
Actual numbers of drug related deaths in comparison to other council areas in NHSGGC are shown in the figure below.




The drug related death rate per 1,000 population for West Dunbartonshire is 0.18. This compares to 0.16 nationally and is higher than East Dunbartonshire and East Renfrewshire but lower than Glasgow City, Inverclyde and Renfrewshire.




The main drug implicated in drug related deaths in West Dunbartonshire are shown in the chart below




Analysis by Health Scotland suggests that the increase in drug related deaths was due to a combination of factors including:

- Increasing numbers of drug users
- Aging population of drug users
- Harmful patterns of use (i.e. combinations of depressant drugs such as heroin, benzos and alcohol)

**Current and Planned Activity**

There is already a comprehensive Community Planning West Dunbartonshire Substance Use Prevention Strategy 2018-2027 and a report on the first year of activity will be presented to the CPWD Safe DIG

.

Work is already underway to develop a 5 year strategy for the West Dunbartonshire Alcohol and Drug Partnership (ADP).

Reducing the number of deaths due to alcohol and drugs was identified as a priority at the ADP planning workshop in January 2019 and has subsequently been confirmed as an ADP Ministerial Priority.

It has been noted that for the first time the number of drug related deaths registered in Scotland in 2018 (n=1,187) was higher than the number of alcohol specific deaths registered for the same year (n=1,136). This is not true for West Dunbartonshire where the number of drug related deaths registered for 2018 (n=20) was lower than the number of alcohol specific deaths for 2018 (n-34).

There is a shared commitment to continued delivery of high quality services based on evidence of effectiveness to treat and support service users;

increasing reach to those who are harder to engage. There are already a range of actions undertaken which include the following:

- West Dunbartonshire Drug Deaths Review Group
- Assertive Outreach Model
- 'Did Not Attend' Policy
- Increased number of Home Visits
- Enhanced Multi-Disciplinary Team (e.g. Psychologist, OT, CBT Therapist)
- Targeted Naloxone Programme
- Injecting Equipment Provision
- Local Hepatitis C treatment
- Housing and Addictions Protocol
- Mental Health and Addictions Protocol

**5. Options Appraisal**

**5.1 Not applicable.**

**6. People Implications**

**6.1 Not applicable**

**7. Financial and Procurement Implications**

**Not applicable**

**8. Risk Analysis**

**8.1 The Addictions Service will continue to work with partners to offer services and training in the delivery of Naloxone as a preventative measure to opiate overdose.**

**9. Equalities Impact Assessment (EIA)**

**9.1 Not applicable**

**10. Environmental Sustainability**

**10.1 Not applicable**

**11. Consultation**

**11.1 Not applicable**

**12. Strategic Assessment**

**12.1 Not applicable**

**Julie Lusk**
Head of Mental Health, Addictions and Learning Disability, WDHSCP
Date:

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|---|---|
| **Person to Contact:** | Julie Lusk, Head of Mental Health, Addictions and Learning Disability |
| **Appendices:** | None. |
| **Background Papers:** | None. |
| **Wards Affected:** | All |

With thanks to Tony Martin (Glasgow Addiction Services) for some of the statistics in this report.

**WESTDUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD**

**Health and Social Care Partnership: 09/09/2019**

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**Subject: Thematic review of self-directed support in Scotland; West Dunbartonshire local partnership report**

## 1. Purpose

**1.1** To update the Partnership Board on progress relating to the Improvement Plan which was agreed following the Care Inspectorate Thematic Review of self-directed support in West Dunbartonshire.

## 2. Recommendations

**2.1** The Partnership Board is recommended:

- to note the content of the Report;
- to note the Improvement Plan which has been presented to the Care Inspectorate;
- Regular reporting on the local response to the recommendations within the Report.

## 3. Background

West Dunbartonshire was one of six local authority areas chosen as a pilot area for a review of the implementation of the principle of Self-Directed Support (SDS) and personalisation which were enshrined in legislation and came into effect in Scotland in 2014.

Since then, success in implementing the legislation has varied across Scotland.

Competing priorities, the financial climate and custom & practice have impacted on the roll out of SDS in West Dunbartonshire as evidenced in the recent Care Inspectorate report, published in June 2019.

## 4. Main Issues

In West Dunbartonshire HSCP, commissioning, procurement and resource allocation have historically been modelled on deficits in the capability of the individual, and tied up in block contracts which offered limited choice and control.

Effective implementation of SDS must be underpinned by systems and processes which allow for choice and control for the individual: allowing them

to work towards an agreed outcome, which maximises their independence and sustains their recovery.

The Care Inspectorate recognised areas of good practice within learning disability and acquired brain injury services however felt that this had not been rolled out to wider adult and older people's services.

The Care Inspectorate reported that HSCP staff were struggling to work to the principles of choice and control within the current systems and processes. In addition, workers were unable to capture where individuals had been signposted to community supports.

Inspectors felt that good practice around early intervention and sign-posting was not being captured by current documentation systems which are aimed at care management and existing care options and not focussed on asset building and personalised support.

**4.1** The HSCP SMT has established an SDS Programme Board to oversee the delivery of the local Improvement Plan and to provide a focus and monitoring processes for the delivery of SDS. The group is chaired by the Chief Social Work Officer with representation from service managers across all operational services; managers from finance and planning and third sector partners.

**4.2** In addition, the SMT have identified dedicated Senior Manager resource to support the SDS Programme Board and the delivery of the Plan. Regular reports will be provided to SMT on progress and to the Care Inspectorate to reassure on the progress against their recommendations. The SDS lead will coordinate the implementation of the detailed improvements with support from four short-life working groups: consisting of operational staff, representatives of partner organisations and service users. These groups will look at: 1.Financial Governance, 2.Staff Training, 3.Community Engagement and 4.Data, Documentation and Performance.

## 5. People Implications

**5.1** A programme of staff training for trainers and the re-establishment of the SDS champions group will aide dissemination of SDS principles and informed practice across the HSCP. This will be coordinated by the SDS Lead, reporting into the SDS programme board. It is anticipated that all staff within the HSCP and commissioned services will be trained by December 2019.

## 6. Financial and Procurement Implications

**6.1** A review of SDS in the context of charging, free personal care, Carers' legislation, respite provision is being undertaken as part of the improvement plan.

## 7. Risk Analysis

**7.1** The HSCP Partnership Board has a duty to implement recommendations from Care Inspectorate therefore there is an organisational risk for the HSCP if actions are not undertaken.

## 8. Equalities Impact Assessment (EIA)

**8.1** No specific implications associated within this report.

## 9. Environmental Sustainability

**9.1** It has been confirmed that there is no requirement for a Strategic Environmental Assessment.

## 10. Consultation

**10.1** Both on-going engagement with partners in the development of the Improvement Plan and this reflects ongoing participation and engagement to update activities and programmes of work. A programme of staff engagement will also be undertaken by the SDS lead and SDS officers to support the training programme and embed the culture of SDS principles. Service users and partner agencies are represented in both the Programme board and the working group.

## 11. Strategic Assessment

**11.1** The Strategic Plan 2019 – 2022 sets out how the Partnership Board will plan and deliver services for the West Dunbartonshire area using the integrated budgets under its control.


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| **Author:** | Marie Rooney SDS Lead Officer |
| **Date:** | 09/09/2019 |
| **Person to Contact:** | Marie Rooney<br>Marie.rooney@ggc.scot.nhs.uk<br><br>01389 776864 |
| **Designation** | West-Dunbartonshire HSCP<br>Self Directed Support Lead |
| **Appendix:** | HSCP Improvement Plan for Care Inspectorate Self Directed Support |
| **Wards Affected:** | All council Wards. |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|

2. SUPPORTED PEOPLE EXPERIENCE POSITIVE PERSONAL OUTCOMES THROUGH THE IMPLEMENTATION OF SELF-DIRECTED SUPPORT

| CARE INSPECTORATE RECOMMENDATIONS<br><br>The partnership should seek to ensure that supported people across all service groups and all unpaid carers consistently experience positive personal outcomes and take action to ensure that it is able to record, measure and report on these<br><br>The partnership should take steps to analyse and understand its local and national performance information and use this to inform and drive improvement in Self-directed Support. | | | | |
|---|---|---|---|---|
| Pilot refreshed asset based SDS Assessment Tool (records good conversations and measures personal outcomes) | Chief Social Work Officer<br><br>Assessors from across adult, older people, learning disability and mental health services<br><br>Carers of West Dunbartonshire | SDS assessment tool is asset based, identifies individual budgets, measures personal outcomes, embedded in all services | Pilot to be completed by August 2019<br><br>New SDS Care Manager Guidance has been agreed by Senior Management Team.<br><br>New SDS assessment tool has been developed with Operational Managers and Integrated Operations Managers based on SDS and ACP to support a person centred assessment based on outcomes and wider social supports. This has been agreed by SMT for piloting and roll out.<br><br>Work is underway with Carers of WD linked to procurement of services including support for carers seeking SDS options. | To be piloted July – August 19<br><br>To be rolled out by November 2019 across all adult services. |
| As part of the pilot – collate and report to SMT on numbers of people with personal outcomes | Chief Social Work Officer<br><br>Assessors from across | Performance team from CareFirst recordings can collate and report figures to | Pilot to be completed by August 2019<br><br>Recording using the new assessment tool will provide information on personal outcomes as | Monthly reporting will begin during August using |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | adult, older people, learning disability and mental health services | monthly SMT during the pilot period | well as improved data linked to choice and control within the SDS options. | data from the pilot and use of new assessment tool. |
| Work with Advocacy Services, Shop-Mobility and Carers of West Dunbartonshire to establish a service user SDS experience focus group | Public Involvement officer | Establish focus group.<br><br>Work-plan to include how to include them in SDS development, increasing innovative options, and identification and reporting on improving outcomes. | Group to be established by August 2019.<br><br>Work is already underway with partners who have been able to access independent funds to support good and accurate local information on SDS.<br><br>HSCP and partner agency SDS workers have established bi-monthly meetings to share information and ensure collaborative working.<br><br>Partners have established a local group of service users as a reference group for SDS across all partners. There is an established programme of awareness and training for local people delivered by third sector partners. | Work stream established and ongoing with partners. |
| Complete an audit of personal outcomes as part of the case file audit process | Chief Social Work Officer<br><br>Public Protection Co-ordinator | As part of the ongoing case file audit process across all adult services include an audit of outcomes | Quarterly reporting to SMT from May 2019.<br><br>A review of case file audit tool underway using the learning from the SDS Review process; this is informing audit in response to SDS as well as public protection within an SDS context. | Work underway by the Public Protection Co-ordinator as part of the local audit |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | | Involve all services in audit<br><br>Adapt case file audit template to measure SDS processes and outcomes. | | processes. |
| As part of the pilot – collate and report to SMT on numbers of people accessing all four options of SDS | Assessors from across adult, older people, learning disability and mental health services<br><br>Performance Team | All assessments include discussions linked to four options of SDS and recorded on CareFirst.<br><br>Quarterly reporting from Performance Team to SMT on %age of adults using direct payments or personalised budgets to identify change and progress. | Quarterly reporting to SMT from May 2019.<br><br>Recording using the new assessment tool will provide information on personal outcomes as well as improved data linked to choice and control within the SDS options. | Monthly reporting will begin during August using data from the pilot and use of new assessment tool.<br>First report 21st August: W Jack/ M. Rooney |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|

3. SUPPORTED PEOPLE ARE EMPOWERED AND HAVE CHOICE AND CONTROL OVER THEIR SOCIAL CARE AND SUPPORT

| CARE INSPECTORATE RECOMMENDATIONS<br><br>The partnership should develop appropriate pathways for individuals to access advocacy and/or independent brokerage if and when they need it to support decision-making around Self-directed Support options, choice and control.<br><br>Where people are signposted to early intervention and preventative services the partnership should take steps to measure the effectiveness of these supports in reducing the need for more formal services and supports. | | | | |
|---|---|---|---|---|
| Work with all advocacy services, Shop-Mobility and Carers of West Dunbartonshire to establish a service user SDS experience focus group | Public Involvement officer | Establish focus group<br><br>Work-plan to include how to include them in SDS development, increasing innovative options, and identification and reporting on improving outcomes | Group to be established by August 2019.<br><br>Work is already underway with partners who have been able to access independent funds to support good and accurate local information on SDS.<br><br>HSCP and partner agency SDS workers have established bi-monthly meetings to share information and ensure collaborative working.<br><br>Partners have established a local group of service users as a reference group for SDS across all partners. There is an established programme of awareness and training for local people delivered by third sector partners. | Work stream established and ongoing with partners. SLWGs to be established September 2019 with agreed terms of reference and2 month turnaround period. |
| Review commissioned services linked to advocacy to ensure fit for purpose | WDC Procurement team | Reviewing the current commissioned services will ensure | Review to be completed by September 2019<br><br>HSCP commissioners are working with WDC | Work stream is underway with Council's |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | Mental Health Integrated Operations Manager. | advocacy is available across all service areas<br><br>Work with all advocacy services to widen their eligibility criteria. | Procurement colleagues to review contracting arrangements within the Procurement Pipeline to ensure Best Value and effective access to advocacy services across all service areas within the HSCP. | procurement. SDS lead to meet Finance/ Procurement staff September 2019 to progress incremental review/change process. |
| Details of signposting to be recordable within the SDS assessment. | Integrated Operations Managers across all adult services<br><br>Information Team | Integrated Operations Managers agree how this will be recorded and ensure within the SDS assessment.<br><br>Develop reportable signposting questions within initial contact forms; details as to who, when and where individuals are signposted and how this is recorded within CareFirst.<br><br>Details of signposting are reportable to ensure measurement of effectiveness of | To be recordable by September 2019.<br><br>As part of the new SDS assessment tool there is a specific pathway for assessors to record where a client is signposted; this also includes specific recording within care at home services where clients are referred directly to LinkUp (local co-productive adult and older people advice and signposting service). | Work stream established and ongoing with partners. SDS working group will develop reportability on signposting within initial contact documentation : deadline October 2019. |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | | signposting. | | |
| Review SDS information on HSCP website and create consistent community information | Planning and Improvement Manager<br>Carers of West Dunbartonshire<br>Shop-mobility<br>CVS | Develop easily shared and accessible information with partners. | Review to be completed by September 2019.<br><br>As part of the development of HSCP web-migration of the website; all information is being reviewed. This information is being duplicated within the NHS Inform Scotland National Directory to ensure consistency of information and messages across West Dunbartonshire and beyond.<br><br>As part of the work with local partners there is a review of all SDS public information; reflects the training and awareness programme with local people. | Work stream established and ongoing with partners. Working group SLWG will review information and update in collaobaration with partners and service-users. Deadline October 2019 |
| Ensure all assessors and care managers have knowledge of LinkUp and wider community supports | All staff across adult, older people, learning disability and mental health services<br><br>Public Protection Co-ordinator<br><br>CVS Third Sector interface | Survey use of alternative community supports as part of casefile audit process | To be reportable by September 2019.<br><br>As part of the new SDS assessment tool there is a specific pathway for assessors to record where a client is signposted; this also includes specific recording within care at home services where clients are referred directly to LinkUp (local co-productive adult and older people advice and signposting service).<br><br>As part of the work with local partners there is a review of all SDS public information; reflects the training and awareness programme with | Work stream established and ongoing with partners. |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | | | local people. | |
| Work with Third Sector to ensure communities have wide range of information available to them about community supports and on developing peer advocacy and independent brokerage | Planning and Improvement Manager<br>Carers of West Dunbartonshire<br>Shop-mobility<br>CVS | Work with Third Sector to inform workers about community supports and survey workers about their use of community supports.<br><br>Development of co-productive peer advocacy<br>Development of independent brokerage. | Review to be completed by September 2019.<br><br>As part of the new SDS assessment tool there is a specific pathway for assessors to record where a client is signposted; this also includes specific recording within care at home services where clients are referred directly to LinkUp (local co-productive adult and older people advice and signposting service).<br><br>As part of the work with local partners there is a review of all SDS public information; reflects the training and awareness programme with local people. | Work stream established and ongoing with partners. As above: to be in place by October 2019. |
| Work with Advocacy Services, Shop-Mobility and Carers of West Dunbartonshire to establish a service user SDS experience focus group | Public Involvement officer<br>Carers of West Dunbartonshire<br>Shop-mobility<br>CVS | Establish focus group<br><br>Work with service users and those with lived experience to measure quality and frequency of signposting and the ongoing access to early intervention and informal supports<br><br>Establish “secret | Group to be established by August 2019.<br><br>Work is already underway with partners who have been able to access independent funds to support good and accurate local information on SDS.<br><br>HSCP and partner agency SDS workers have established bi-monthly meetings to share information and ensure collaborative working.<br><br>Partners have established a local group of service users as a reference group for SDS | Work stream established and ongoing with partners. First meeting of group schedules for September 2019. |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | | shopper" approach to SDS signposting | across all partners. There is an established programme of awareness and training for local people delivered by third sector partners. | |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|

4. STAFF FEEL CONFIDENT, COMPETENT AND MOTIVATED TO PRACTICE IN AN OUTCOME FOCUSSED AND PERSON LED WAY

| Care Inspectorate Recommendations<br><br>The partnership should take action to measure the impact of learning and development and practice processes on staff competence, confidence and motivation. | | | | |
|---|---|---|---|---|
| Social work assessors to use Social Work Forum to develop their SDS CPD | Public Protection Co-ordinator | Monitored through supervision/Be the Best conversations and practice groups<br><br>All practice groups include SDS CPD | To be reportable by September 2019 | SDS lead to liaise with Public Protection Officer to agree appropriate forum for sharing good practice and embedding SDS ethos. |
| Additional SDS programme of training around asset based approaches | Self Directed Services support workers<br><br>SDS Policy Officer | Training offered to each service area via Integrated Operation Managers. | Training to be delivered May – July 2019<br><br>A working group of CSWO and senior managers from across the HSCP has been established to oversee the delivery of this Plan, oversight of the pilot and oversight of the delivery of training across all service areas.<br><br>A workshop has been agreed for 8th July to begin the training programme with Integrated | Work stream established and ongoing. SDS lead meeting with SDS officers August 2019 to agree training programme. |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | | | Operational Managers. | |
| Review Area Resource Groups across all areas of practice to ensure processes to include financial assessments, planning and commissioning | Chief Social Work Officer<br><br>Integrated Operations Managers<br><br>Procurement Team | Review ARG processes within Adults/Older people; learning disability; mental health and addictions. | Completed by January 2020. | SLWG within SDS working group to look at harmonising resource allocation processes across HSCP services. |
| Embed SDS within individual supervision/Be the Best conversations/TURAS | All Managers from Integrated Operations Managers to senior social workers | Develop assessors skills through supervision and identified training needs | To be reportable by August 2019.<br><br>A workshop has been agreed for 8th July to begin the training programme with Integrated Operational Managers. | Work stream established and ongoing.SDS lead to agree methodology with IOMS and professional leads. Deadline November 2019. |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|

5. KEY PROCESSES AND SYSTEMS CREATE CONDITIONS THAT ENABLE SUPPORTED PEOPLE TO HAVE CHOICE AND CONTROL

| CARE INSPECTORATE RECOMMENDATIONS<br><br>The partnership should embed a Self-directed Support ethos and approach across all key processes and systems. It should progress the planned changes to tools and processes and to the business system to ensure these support asset-based and outcomes focussed practice.<br><br>The partnership should ensure that they can demonstrate that good decisions are made in relation to positive risk taking. This should be monitored and evaluated to inform ongoing risk management and risk enablement.<br><br>The partnership should ensure that supported people are better informed about and more involved in key processes regarding their support. | | | | |
|---|---|---|---|---|
| Embed new SDS assessment process following pilot | All Managers from Integrated Operational Managers to senior social workers / AHPs/ clinicians | New assessment tool rolled out to all adult teams | Completed by November 2019 | Work stream established and ongoing. Deadline as above. |
| Regular reports on new SDS assessment in place on Carefirst for reporting | Information Team | Monitor and evaluate assets based assessments<br><br>Record good conversations<br><br>Evaluate ASP risk assessment tool for SDS | Completed by November 2019<br><br>New SDS Care Manager Guidance has been agreed by Senior Management Team.<br><br>New SDS assessment tool has been developed with Operational Managers and Integrated Operations Managers based on SDS and ACP to support a person centred assessment based on outcomes and wider social supports. This has been agreed by SMT for piloting and roll out. | Work stream established and ongoing. Deadline November 2019. |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | | | Work is underway with Carers of WD linked to procurement of services including support for carers seeking SDS options.<br><br>A newly draft Contributions Policy is being developed which references the Carers' Act and updates the HSCP approach to SDS and charging. | |
| Review Area Resource Group processes | Integrated Operations Managers from all services | Review and streamline processes in line with commissioning and procurement as well as co-production and sign posting. | Completed by January 2020 | |
| Develop new case file audit template which incorporates SDS | Public Protection Co-ordinator | Review case file audit template and monitor and evaluate risk assessment and management plans | New template in place August 2019.<br><br>A review of case file audit tool underway using the learning from the SDS Review process; this is informing audit in response to SDS as well as public protection within an SDS context. | Work stream established and ongoing. |
| As above focus group and local engagement groups to develop and evaluate impact of new approach to SDS | Planning and Improvement Team | Review how people engage in planning their own support<br><br>Inform people about SDS processes | Evaluation of new approach completed by April 2020<br><br>HSCP and partner agency SDS workers have established bi-monthly meetings to share information and ensure collaborative working. | Work stream established and ongoing. |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | | | Partners have established a local group of service users as a reference group for SDS across all partners. There is an established programme of awareness and training for local people delivered by third sector partners. Benchmarking against other partners by SDS lead August/September 2019. | |
| As above develop CPD training on SDS approaches | Chief Social Work Officer<br><br>Integrated Operations Managers across all adult services | Include positive risk taking<br><br>Include asset based approaches<br><br>Include SMART and personal outcomes training. | Evaluation of new approach completed by April 2020. Benchmark against other HSCPs and Scot Government Framework by SDS lead September 2019. | |
| Use supervision to develop workers skills in attending ARGs | Chief Social Work Officer<br><br>Integrated Operations Managers across all adult services | Embed SDS within supervision process. | In place by September 2019. To be include in training and | |
| Work with Carers Centre to review carers support plans | Carers of West Dunbartonshire | Report on numbers, outcomes and reviewing of plans. | In place by March 2019.<br><br>Carers assessment are already reporting as part of the Carers' Census. | |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | | | Work is underway with Carers of WD linked to procurement of services including support for carers seeking SDS options. | |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|

6. THE PARTNERSHIP COMMISSIONS SERVICES THAT ENSURE SUPPORTED PEOPLE HAVE A RANGE OF CHOICE AND CONTROL OVER THEIR SOCIAL CARE AND SUPPORT.

| CARE INSPECTORATE RECOMMENDATIONS<br><br>The partnership should engage with supported people, carers and frontline staff to inform the development of new models of care focussed on delivering positive outcomes.<br><br>The partnership should take steps to increase local choice of provider and flexibility in the delivery of services to ensure people have genuine choice and control over how their support is delivered. | | | | |
|---|---|---|---|---|
| HSCP Board report on progress to refresh SDS approach | Chief Social Work Officer | Progress on activities outlined above | Presented HSCP Board November 2019 | |
| HSCP Commissioning Plan developed in partnership with partners | Planning and Improvement Team | Commissioning Plan aligned to Strategic Plan | Plan to be presented HSCP Board August 2019.<br><br>A draft Plan is with SMT for discussion and agreement. | Work stream established and ongoing. |
| Commissioning Consortium reviewed to better consider SDS with Third and independent sectors | Planning and Improvement Team | Commissioning Consortium commitment to quarterly meetings with partners<br><br>Increase range of service providers alongside Council Procurement Team | Presented HSCP Board November 2019<br><br>HSCP and partner agency SDS workers have established bi-monthly meetings to share information and ensure collaborative working.<br><br>Partners have established a local group of service users as a reference group for SDS across all partners. There is an established programme of awareness and training for | Work stream established and ongoing. |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | | | local people delivered by third sector partners. | |
| As above accurately record SDS options through the new SDS tools | Information Team | SDS assessment tool embedded into CareFirst for ease of recording and reporting. | In place by November 2019 | Work stream established and ongoing. |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|

7. THE PARTNERSHIP EMPOWERS AND SUPPORTS STAFF TO DEVELOP AND EXERCISE APPROPRIATE SKILLS AND KNOWLEDGE.

| Care Inspectorate Recommendations<br><br>The partnership should take a strategic approach to the development and delivery of Self-directed Support training for staff at all levels across the partnership.<br><br>The partnership should consider the training and development needs of all partners. | | | | |
|---|---|---|---|---|
| As above embed SDS CPD training for workers | Chief Social Work Officer<br><br>Self Directed Services Support Workers | Formal training provided for assessors<br><br>Embed SDS within supervision processes<br><br>Re-establish SDS Support Workers across all services. | Completed by March 2020.<br><br>New SDS Care Manager Guidance has been agreed by Senior Management Team.<br><br>New SDS assessment tool has been developed with Operational Managers and Integrated Operations Managers based on SDS and ACP to support a person centred assessment based on outcomes and wider social supports. This has been agreed by SMT for piloting and roll out. | |
| Develop SDS training through Third Sector interface | Third Sector Interface<br>Shop-Mobility<br>Carers of West Dunbartonshire | Formal training provided for assessors | Completed by March 2020.<br><br>HSCP and partner agency SDS workers have established bi-monthly meetings to share information and ensure collaborative working.<br><br>Partners have established a local group of service users as a reference group for SDS across all partners. There is an established | |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|
| | | | programme of awareness and training for local people delivered by third sector partners. | |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|

## 8. SENIOR LEADERS CREATE CONDITIONS THAT ENABLE SUPPORTED PEOPLE TO EXPERIENCE CHOICE AND CONTROL OVER THEIR SOCIAL CARE AND SUPPORT.

| Care Inspectorate Recommendations<br><br>The partnership should accelerate its progress in embedding Self-directed Support and set clear timelines for full implementation of Self-directed Support across all care groups.<br><br>The partnership should develop a robust strategic plan for Self-directed Support aligned to its other partnership plans. The strategy should be underpinned by detailed action plans setting out how the partnership intends to fully implement Self-directed Support for all care groups across the partnership. | | | | |
|---|---|---|---|---|
| Agree action plan for delivery | Chief Social Worker<br><br>SMT | Action Plan in place for reporting to HSCP Board. | Complete for Audit Committee June 2019 | |
| Accelerate process in embedding SDS | Chief Social Work Officer<br><br>SMT | | | |
| Commissioning Plan in place to reflect SDS and Strategic Plan | SMT<br><br>Planning and Improvement Team | Strategic Plans- suite of overarching plans – Commissioning Plan, Review of Charging Policy and implementation of Carers Strategy<br><br>Implement Commissioning Plan. | | |

| Tasks | Resources | Issues/comments | Timescale | Complete |
|---|---|---|---|---|

**WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP**

**HSCP Board: 2 October 2019**

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**Subject: Inspection of Justice Social Work Services: Update on Actions**

## 1. Purpose

1.1 To update the HSCP Board on actions taken forward following the publication of the inspection of criminal justice social work services by the Care Inspectorate and local action plan.

## 2. Recommendations

2.1 The HSCP Board is asked to:

(i) Note the contents of this report;
(ii) Note actions being taken forward to deliver on the inspection action plan and wider service improvements.

## 3. Background

3.1 Following publication of the Care Inspectorate report on the inspection of Justice social work services in West Dunbartonshire on 6 August 2019, the Chief Social Work Officer presented an improvement action plan to the last meeting of the HSCP Board on 7 August 2019.

3.2 Since then, a number of actions have been progressed as part of this plan and within the wider context of service improvements around criminal justice social work services.

3.3 Engagement with a range of key partners is also taking place to contribute to a sustained improvement in performance and develop practice to more fully reflect legislative developments and local demand.

## 4. Main Issues

4.1 The confidence of our communities, key stakeholders and wider partners in our services is, of course, paramount and is reflected in the robust actions already being taken forward.

4.2 At a meeting in early August 2019 with the Council Chief Executive, HSCP Chief Officer, Chief Social Work Advisor to the Scottish Government, Chief Inspector, Strategic Scrutiny (Care Inspectorate) and Chief Social Work Officer, the improvement action plan was shared. A further meeting will take

place later this year to maintain these helpful links around delivery of the improvement action plan.

4.3 On 8 August 2019, a successful candidate was appointed to a new criminal justice service manager post. This post was created following a review of management arrangements for the service and will be key to implementing the improvement action plan. The new post holder will take up their role in the forthcoming weeks and the Chief Social Work Officer will directly line-manage the post holder to provide additional support and focus around implementing the improvement action plan.

4.4 Progress deliver on improvement actions also forms a standing item on regular meetings between the HSCP Chief Officer and Council Chief Executive.

4.5 An effective partnership approach is key to maintaining the confidence of our communities, key stakeholders and wider partners. The community justice co-ordinator has established a series of meetings with colleagues from Community Justice Scotland to develop a training needs analysis for criminal justice practitioners and managers.

4.6 A meeting with Karyn McCluskey, Chief Executive, Community Justice Scotland**,** has also taken place and the Chief Social Work Officer will convene a further meeting to agree further arrangements for support and assistance to practitioners and managers, including opportunities for piloting professional development opportunities in West Dunbartonshire.

4.7 Joint training with colleagues from across the Justice sector including Police colleagues and the North Strathclyde multi-agency public protection arrangements (MAPPA) unit are being arranged which further reflect a strong collaborative approach to maintaining public confidence.

4.8 The Scottish Government Cabinet Secretary for Justice has also written to the Council Chief Executive, referencing the local improvement action plan and our engagement with the Chief Social Work Advisor and Care Inspectorate. He advised that the National Community Justice Leadership Group will take a close interest in the national implications of issues arising from scrutiny and assurance of community justice. The Scottish Government Community Justice Division will be kept informed of progress in delivering the plan.

## 5. People Implications

5.1 Development needs for practitioners and managers are reflected in the action plan, to support employees to deliver on their responsibilities and ensure compliance with local and national standards. Collaborative work with Community Justice Scotland will enable this to be taken forward.

5.2 The appointment of a criminal justice service manager will provide additional, dedicated leadership around improvement activity.

## 6. Financial Implications

6.1 Any projected costs associated with the action plan will be included within established, regular financial monitoring arrangements.

## 7. Professional Implications

7.1 The provision of criminal justice social work services is a statutory duty upon West Dunbartonshire Council, delivered by the HSCP. Performance, practice and compliance continue to be monitored and reported on.

## 8. Risk Analysis

8.1 Assessing and managing risk by individuals who offend is central to statutory criminal justice social work. Staff must be qualified, trained and experienced to manage offenders whilst managers oversee how individual risk is managed, in partnership with other responsible services as well as anticipating and ensuring the effective provision of services.

8.2 Details and outcomes from inspection activity are reflected in the HSCP Strategic Risk Register.

## 9. Impact Assessments

9.1 There are no issues identified. .

## 10. Consultation

10.1 The action plan for criminal justice social work services has been shared with criminal justice staff and managers as well as the Care Inspectorate and Chief Social Work Advisor to the Scottish Government.

10.2 Professional consultation and support continues to be progressed with key partners as appropriate, including Community Justice Scotland, the Risk Management Authority and the North Strathclyde unit for multi-agency public protection arrangements (MAPPA).

## 11. Strategic Assessment

11.1 Provision of statutory social work services is a core function of the HSCP and supports the Partnership Board and officers to pursue the strategic priorities of the Strategic Plan.

**Jonathan Hinds**
**Head of Children's Health, Care and Criminal Justice**
**Chief Social Work Officer**
**2 September 2019**

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|---|---|
| **Person to Contact:** | Jonathan Hinds – Head of Children's Health, Care and Criminal Justice/Chief Social Work Officer, 16 Church Street, Dumbarton, G82 1QL, Telephone: 01389 737753 e-mail jonathan.hinds@ggc.scot.nhs.uk |
| **Appendices:** | None |
| **Background Papers:** | None |
| **Wards Affected:** | All |

**WEST DUNBARTONSHIRE HEALTH and SOCIAL CARE PARTNERSHIP**

**Report by Strategic Lead – Julie Lusk, Head of Mental, Learning Disabilities and Addictions**

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**Subject: ScotPHO Annual Suicide Statistics Local Authority Level - West Dunbartonshire**

## 1. Purpose

**1.1** To provide the IJB with details of ScotPHO Annual Suicide Statistics at both a national and local authority level.

## 2. Recommendations

**2.1** Members are asked to:

- Note the contents of the report

## 3. Background

### 3.1 Scottish Government – Suicide Prevention Action Plan

The Scottish Government's current Suicide Prevention Action Plan – Every Life Matters sets out ten measures to continue to support the reduction in the country's rate of deaths by suicide. The plan was developed following extensive engagement with mental health and suicide prevention organizations, people affected by suicide, and academics.

**3.2** To implement the plan, the Scottish Government has set up a National Suicide Prevention Leadership Group (NSPLG) with a £3 million innovation fund. Former Deputy Chief Constable Rose Fitzpatrick will chair the group.

Its aim is to reduce suicide rate by **20% by 2022.**

Key actions in the plan include:

- Creating and implementing refreshed mental health and suicide prevention training by May 2019 for Scotland's public and private sectors. The plan requires all NHS staff to receive training
- Developing reviews of all deaths by suicide and ensuring lessons are shared with partners and acted upon, developing innovative ways to use digital technology to prevent suicide
- The government, NSPLG and partners co-ordinating public awareness campaigns

### 3.3 Board/Local Suicide Prevention Action Planning

At present suicide prevention actions are coordinated at both NHS Board and HSCP/CPP level. West Dunbartonshire HSCP (WD HSCP) have officers who attend the NHS Greater Glasgow and Clyde (NHSGGC) Suicide Prevention

Group and the NHSGGC representative on the NSPLG is Dr Michael Smith, Lead Associate Medical Director, NHSGGC, who also chairs the NHS GGC Suicide Prevention Group.

**3.4** This group has recognised that Individual HSCPs will develop their own action plans to reflect local needs and circumstances, and complement board and national approaches.

## 4. Main Issues

**4.1** Annual Suicide Statistics
The annual suicide figures from ScotPHO were released on the 26/06/2019 and show for Scotland that suicides have increased from 2017 to 2018 by just over 13%; 680 to 784 persons in 2018. ScotPHO provides details of the national picture, the picture at Health Board level and also the picture are Local Authority level.

**4.2** West Dunbartonshire trends
Trend data for Suicide Rates in West Dunbartonshire (by five-year rolling average) from 1984-88 to 2014-2018 based on the old coding rules, show the following:

- There is a 41% decrease in the suicide rate in West Dunbartonshire
- Male suicide rates decreased by 47%
- Female rates decreased by 16.1%.

In 2018, 12 suicides were registered in West Dunbartonshire (7 males and 5 females), compared to 6 (3 males and 3 females) in 2017. These numbers comprise deaths coded to 'intentional self-harm' and to 'events of undetermined intent'.

More detailed (see appendix 1) figures on suicides registered in Scotland by local authority (West Dunbartonshire) by year and sex are worthy of review.

**4.3 European age-sex-standardised Suicide Rates per 100,000 Population**
European age-sex-standardised suicide rates per 100,000 Population figures from ScotPHO show that for males, West Dunbartonshire has lower registered rates per 100,000 populations compared to the Scottish average but that the female rates for West Dunbartonshire are slightly higher.

**4.4** It should be noted that West Dunbartonshire suicide data relates to very small numbers and therefore rates based on these small numbers may fluctuate dramatically from year to year.

**4.5 Suicide Prevention in West Dunbartonshire**
Work is ongoing to establish a West Dunbartonshire Suicide Prevention Group which will lead on delivering the local suicide prevention action plan and link into local community planning structures. Initial discussions with the

Head of Mental, Learning Disabilities and Addictions HSCP and key community planning partners Police Scotland are ongoing.

**5. People Implications**

**5.1** Not applicable.

**6. Financial and Procurement Implications**

**6.1** Not applicable

**7. Risk Analysis**

**7.1** Not applicable.

**8. Equalities Impact Assessment (EIA)**

**8.1** Not applicable.

**9. Environmental Sustainability**

**9.1** Not applicable.

**11. Consultation**

**11.1** Not applicable.

**12. Strategic Assessment**

**12.1** Not applicable

**Name** Julie Lusk
Designation Head of Mental, Learning Disabilities and Addictions

Date: 30/08/2019

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**Person to Contact:** Julie Lusk, Head of Mental, Learning Disabilities and Addictions, Church St, Tel: 01389 737321, Julie.lusk@west-dunbarton.gov.uk

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|---|---|
| **Appendices:** | **Appendix 1** ScotPHO Annual Suicide Statistics Local Authority Level - West Dunbartonshire (26th June 2019). |
| **Background Papers:** | None |
| **Wards Affected:** | All |

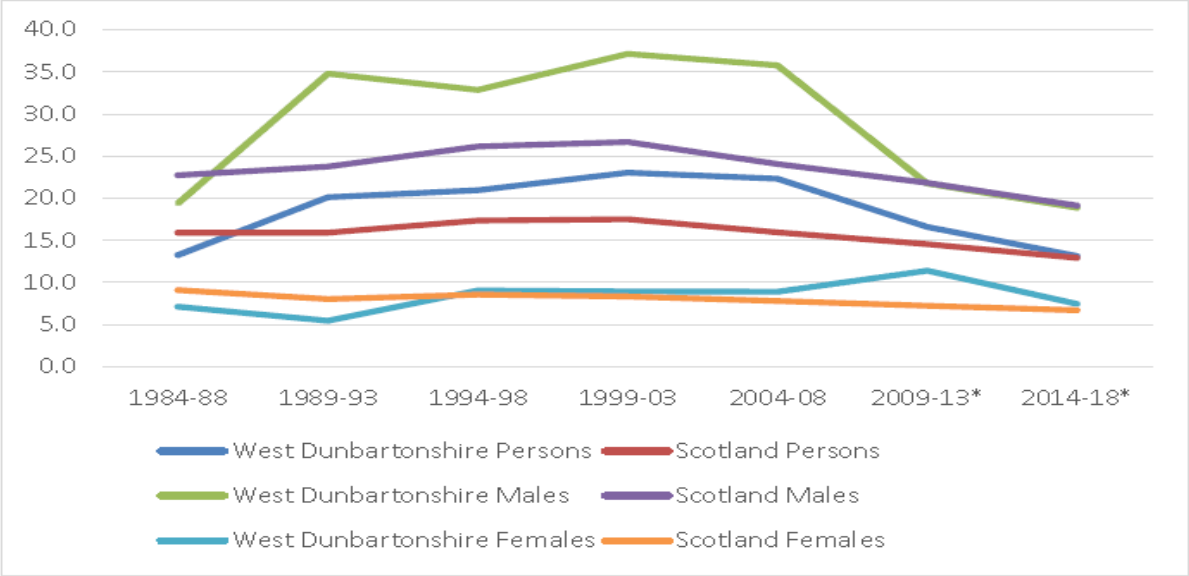
**Appendix 1**
**ScotPHO Annual Suicide Statistics**
**Local Authority Level - West Dunbartonshire**
**(26th June 2019)**

This brief will provide details on ScotPHO Annual Suicide Statistics at both a national and local authority level.

Full Documents available at: ScotPHO: Key Points

**Annual Suicide Statistics**
The annual suicide figures from ScotPHO were released on the 26/06/2019 and show for Scotland that suicides have increased from 2017 to 2018 by just over 13%; 680 to 784 persons in 2018**.** ScotPHO provides details of the national picture, the picture at Health Board level and also the picture are Local Authority level.

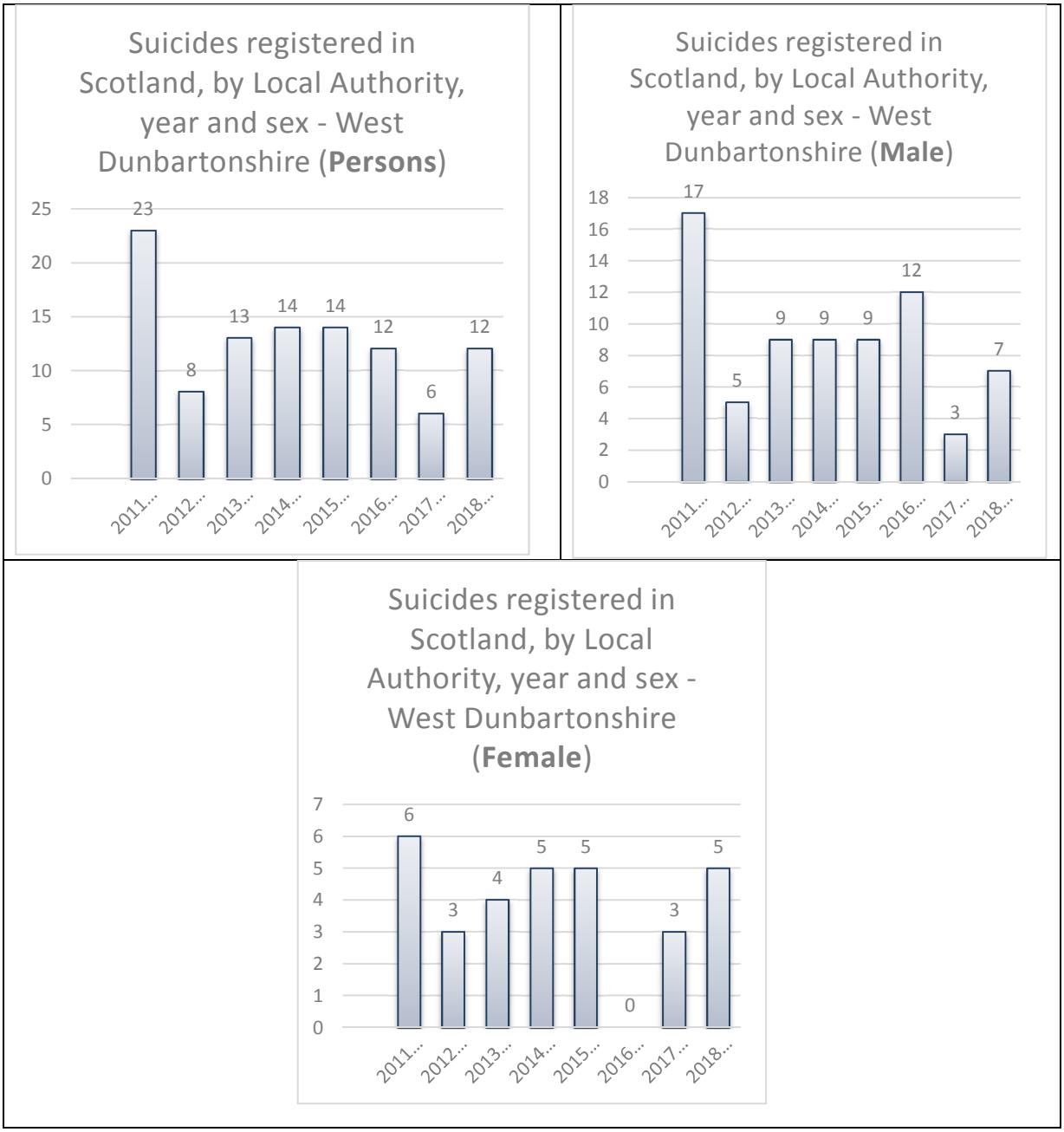
**Suicide: West Dunbartonshire trends**
The chart below shows the trend for Suicide Rates in West Dunbartonshire (by five-year rolling average) from 1984-88 to 2014-2018 based on the old coding rules.




Source: ScotPHO Suicide: Key Points viewed 26/06/2019

The data for 2004-08 to 2014-18 shows:
- There is a 41% decrease in the suicide rate in West Dunbartonshire
- Male suicide rates decreased by 47%
- Female rates decreased by 16.1%.

In 2018, 12 suicides were registered in West Dunbartonshire (7 males and 5 females), compared to 6 (3 males and 3 females) in 2017. These numbers comprise deaths coded to 'intentional self-harm' and to 'events of undetermined intent'. These figures are based on the new coding rules (see Suicide Statistics technical paper) The charts below provide more detailed figures on suicides registered in Scotland by local authority (West Dunbartonshire) by year and sex.




Source: ScotPHO Suicide: by local authority viewed 26/06/2019

The figures show that there has been an increase in registered suicides for both males and females (Persons) from a low of 6 in 2017 to 12 in 2018. The 2018 figure is considerably lower than the high of 23 suicides registered in 2011 and is similar to figures for 4 of the 8 previous years.

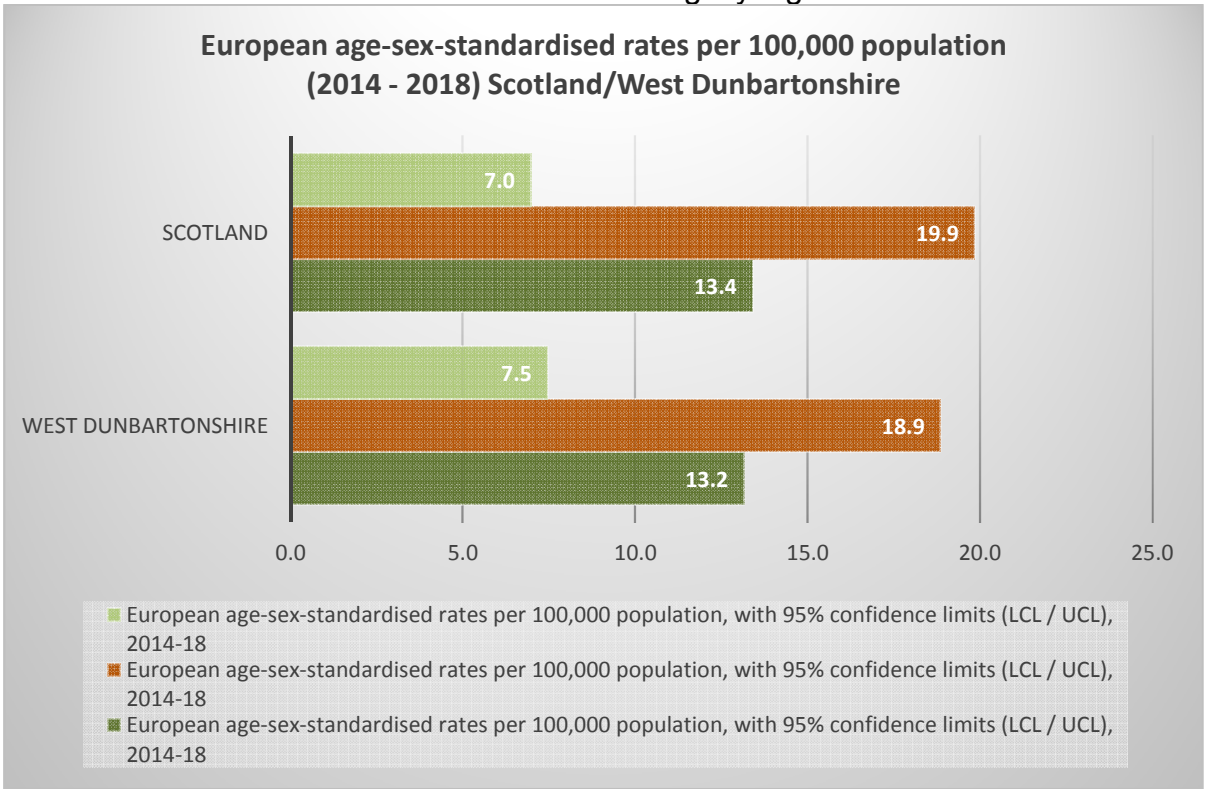
Male registered suicides have increased from 3 in 2017 to 7 in 2018, the 2018 figure is still lower than the high of 17 suicides registered in 2011 and does show a slight continued downward trend.

Female registered suicides have increased from 0 in 2016 to 5 in 2018; this is a noticeable increase but does reflect the range of 3 – 6 registered suicides over the last 8 years.

**European age-sex-standardised Suicide Rates per 100,000 Population**

European age-sex-standardised Suicide Rates per 100,000 Population figures from ScotPHO show that for both Persons and Males, West Dunbartonshire have lower

registered rates per 100,000 populations compared to the Scottish average but that the female rates for West Dunbartonshire are slightly higher.




Source: ScotPHO Suicide: by local authority viewed 26/06/2019

It should be noted that West Dunbartonshire suicide data relates to very small numbers and therefore rates based on these small numbers may fluctuate dramatically from year to year.

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**WESTDUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD**

**2nd October 2019**

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**Subject: GP Out of Hours Services and development of Urgent Care Resource Hub**

## 1. Purpose

**1.1** This paper outlines the outcomes of work that has been underway across NHS Greater Glasgow and Clyde to improve the availability of primary care services outside of office hours.

## 2. Recommendations

**2.1** Board members are asked to note the contents of the paper and support the direction of travel

## 3. Background

**3.1** It is widely recognised that primary care has been experiencing difficulties in delivering a service outside of normal working hours for some time. A Review of Primary Care Out of Hours Services was commissioned by the Cabinet Secretary for Health, Sport and Wellbeing and led by Professor Sir Lewis Ritchie in January 2015. This report, incorporating 28 recommendations, described that a whole system approach is required to enable a service which is:

- Safe
- Sustainable
- Patient centred

3.2 The review recommended a model for out of hours and urgent care in the community that is clinician led but delivered by a multi-disciplinary team

3.3 The review also states that GPs should continue to play a key and essential part of urgent care teams, providing clinical leadership and expertise, particularly for more complex cases.

3.4 A whole system planning process has been established across NHS GGC and lead by a dedicated programme manager, to consider options and develop proposals for how to move forward.

3.5 The attached paper outlines the process to date and the preferred proposals,

## 4. Main Issues

**4.1** The attached paper summarises the current pressures in service delivery, including issues with demand, recruitment, and delays in professionals being able to communicate effectively.

4.2 The proposal, to create an Urgent Care Resource Hub with more direct links to local services, fits well with the current service configuration in West Dunbartonshire and will allow more rapid access to professional opinion and local resources out of hours.

## 5. People Implications

It is not anticipated that the terms and conditions of any staff in West Dunbartonshire will be affected by these proposals.

## 6. Financial and Procurement Implications

Not applicable

## 7. Consultation

7.1 The paper outlines the consultation that has taken place with services users and staff

## 8. Strategic Assessment

8.1 These proposals are in line with HSCP, WDC and NHS GGC objectives

| | |
|---|---|
| **Name** | Jo Gibson |
| Designation | Head of Health and Community Care |
| Date: | 02 September 2019 |

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| | |
|---|---|
| **Person to Contact:** | Jo Gibson<br>Head of Health and Community Care<br>Jo.Gibson@ggc.scot.nhs.uk |


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|---|---|
| **Appendix:** | Appendix |
| **Background Papers:** | None provided |
| **Wards Affected:** | Proposals relate to all council Wards. |

**NHS Greater Glasgow & Clyde**

**Corporate Management Team** **12 September 2019**

**Susanne Millar**
**Interim Chief Officer – Glasgow City HSCP**

**Paper No:**

**Title**

Greater Glasgow and Clyde Review of Health and Social Care OOHs
Comparative Process to determine the option for implementation of Urgent Care Resource Hub(s) Model.

**Recommendation**

CMT to note progress to date and the agreed outcome for the Hub and Spoke implementation of the Urgent Care Resource Hub model and the further phased actions identified by the Review of Health and Social Care Programme Board and Chief Officers.

**Purpose of Paper**

The purpose of this report is to brief GG&C CMT on the progress to date and acknowledge the conclusion of the review phase and proceed with the change and implementation proposals.

**Key Issues to be considered**

The recommendation for change and implementation of the Urgent Care Resource Hub model and the proposed actions set out in a phased set of next steps in the paper.

**Any Patient Safety /Patient Experience Issues**

Any changes to the service to be planned and communicated.

**Any Financial Implications from this Paper**

The financial implications of the proposal will need to be assessed, including the resources required to support the proposed model.

**Any Staffing Implications from this Paper**

To be finalised.

**Any Equality Implications from this Paper**

A baseline EQIA has been undertaken as part of the work and will be revised prior to implementation of the new model.

**Any Health Inequalities Implications from this Paper**

A baseline EQIA has been undertaken as part of the work and will be revised prior to implementation of the new model.

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

Relevant issues will be risk assessed

**Highlight the Corporate Plan priorities to which your paper relates**

**Author:** Kirsty Orr
**Tel No:** 07805763615
**Date:** 26th August 2019

**Greater Glasgow and Clyde Review of Health and Social Care OOHs Comparative Process to determine the option for implementation of Urgent Care Resource Hub(s) Model**

## 1. Purpose

1.1 The purpose of this report is to update GG&C CMT on the work undertaken to date and to note the recommendations from the Health and Social Care OOHs Programme Board and Chief Officers with regards to the Urgent Care Resource Hub (UCRH) Implementation.

1.2 This paper describes the various options to support the implementation of an URCH model and considers: the number of UCRH(s) required for Greater Glasgow and Clyde; where they will be located; confirming the requirements to support service and agency access and pathways to the UCRH; determined the services should be co-located within the UCRH or have virtual links established and how hosted services will be configured within the model.

1.3 The report provides a detailed description of the work carried out during the review: key stakeholder engagement process; public and staff engagement and the operational planning process which has culminated in the recommendation to support the implementation of the UCRH.

## 2. Background

2.1 A Review of Primary Care Out of Hours Services was commissioned by the Cabinet Secretary for Health, Sport and Wellbeing and led by Professor Sir Lewis Ritchie in January 2015, in light of the challenges being faced in delivering services during the out of hours period.

2.2 Professor Sir Lewis Ritchie's Report advised that a whole system approach to enable a safe, sustainable, patient-centered service model to be developed was central to enhanced joint working across health and social care services during the OOHs period. The approach was described through 28 recommendations.

2.3 The review recommended a model for out of hours and urgent care in the community that is clinician led but delivered by a multi-disciplinary team where patients will be seen by the most appropriate professional to meet their individual needs – that might not always be a GP but could be a nurse, or a physiotherapist or social services worker.

2.4 The review also states that GPs should continue to play a key and essential part of urgent care teams, providing clinical leadership and expertise, particularly for more complex cases.

2.5 Following the publication of that report a local review of Health and Social Care Out of Hours provision has been commissioned across the 6 GG&C Health and Social Care Partnerships, led by Glasgow City HSCP. A programme governance structure was agreed to oversee this work and a Programme Manager was appointed in September 2017 to manage and co-ordinate all aspects of the review.

2.6 The OOHs services within that programme scope are:

- GP
- District Nursing
- Community Rehabilitation
- Children's Social Work Residential Services
- Emergency Social Work Services
- Emergency Dental Services
- Homelessness
- Home Care
- Mental Health
- Community Pharmacy
- Optometry

## 3. **Case for Change**

3.1 The present situation for the ongoing provision of Health and Social Care OOHs Services across Greater Glasgow and Clyde is that the current configuration lacks resilience and is probably not sustainable. The reasons for this are multi-factorial and include:

- Lack of work force capacity across parts of the health and social care system as it is challenging to attract and retain staff to work in the OOHs period
- Aging workforce; resulting in the loss of experienced and skilled staff
- Growing numbers of people living with multiple and complex conditions; resulting in an increasing demand on services in an age of austerity which requires us to achieve more through better use of resources
- Expectations of the population in terms of increasing demands for care when convenient rather than a focus on need
- Services needing to work more effectively together in the out of hours period - the current fragmented nature of the health and social care service provision makes communication, day-to-day management and co-ordination of services extremely challenging and resource intensive. The current configuration of provision can result in a number of services working in isolation to provide support to one patient / service user during the OOHs period.

3.2 Within Professor Sir Lewis Ritchie's review, 28 recommendations had been made which have provided us with a clear framework in which to review our current situation and for the provision of consistent urgent OOHs care that is sustainable over time throughout Greater Glasgow and Clyde.

3.3 This report sets out the proposed implementation of Health and Social Care OOHs model in relation to the wider Health and Social Care OOHs. The specific recommendations on the GP OOHs will be the subject of a separate report.

## 4. Process Undertaken to develop an Integrated Health and Social Care OOHs Service Model

4.1 Four half day events were held across May to September 2018 to enable a broad range of staff the opportunity to work through and agree actions and next steps for the proposed new system wide OOHs service model. These events involved members of the Health and Social Care Out of Hours Programme Board, and a range of clinical and managerial colleagues and staff side representatives.

4.2 The central aim of the first three sessions was to develop a finalised position on changes and improvements to the Health and Social Care OOHs models, including changes to the GP OOH model and wider improvements to how other services work together.

4.3 A key output of the sessions was that an Urgent Care Resource Hub (UCRH) approach would be developed to facilitate integrated, person-centred, sustainable, efficient and co-ordinated health and social OOHs services across the GG&C area.

4.4 During these sessions 6 principle elements emerged (for each of the services within the project scope) which required clarity and agreement. These were:

- Service Purpose – defining what the service should do in the OOHs period and defining what patients/carers should expect and what staff can provide;
- Service Access – describing how the service is accessed by a user / patient or other professional service;
- Service Location – confirming the location of service delivery and the numbers of services, sites and staff required;
- Workforce Mix – agreeing the right mix of workers supported with the right training and development to meet the OOH need;
- Service Interfaces – describing and agreeing how services engage and co-ordinate across the health and social care system in hours and out of hours;
- Technology – developing and using technology to enable interfaces and to support care delivery and information sharing across the OOHs Health and Social Care System.

4.5 The fourth session provided the opportunity to robustly test the high level concept of an Urgent Care Resource Hub (UCRH) and the potential to enhance

integration, co-ordination and access to Health and Social Care OOHs services by applying patient, service user and professional focused scenarios.

4.6 This paper describes the high level service model with the detail of the service specifications and description of the operational arrangements that now will be subject to further refinement and clarification to support the local implementation of the UCRH model.

## 5. Outcomes and Enablers of the Urgent Care Resource Hub

5.1 As the work has progressed, it is clear that we already have a number of services working through the out of hours period that are delivering planned care to a number of patients and services users.

5.2 These services include the OOH District Nursing service who work to provide care to a known and defined list of named patients, often patients who are at or near end of life requiring palliative care. Services also delivering planned care include Care at Home services which will provide care and support throughout the OOH period to a number of known service users within a defined assessed care package.

5.3 The creation of an UCRH would primarily have its focus to deliver care coordination and a fast response where care needs change in the OOH period for known patients/service users and provide a response where a patient/service user contacts NHS24 but does not require to see a GP and where their needs can be met through, say a DN intervention and/or by a care at home service or some other intervention from a OOH service delivered through HSCPs. The Hub would also have a role to improve and coordinate the connection of patients/service users back into day time services.

5.4 The UCRH would therefore enable a whole system approach to the provision of scheduled (where planned care needs change and require something beyond what the service can provide) and unscheduled (where a patient/service user contacts NHS24) Health and Social Care. OOHs Care provides a vehicle to enhance and develop integration and co-ordination across a wide range of services.

5.5 This is core to the change required as it has emerged through the review process that the co-ordination of a crisis response, or complex or multi-sectoral urgent planned or unplanned OOHs care for new or known patients from an UCRH is considered to be core to the development of well-led, appropriately supported multidisciplinary health and social care team working.

5.6 The delivery of sustainable OOHs care must also involve close working with Third and Voluntary Sector Providers to continue to meet the population's needs.

5.7 It is essential that the UCRH role would not therefore be to duplicate NHS 24's role and remit; the key outcome for services coordinated within or via the Urgent

Care Resource Hub(s) for GG&C would be to provide patients, carers, service users and professionals with a:

- Single point of access for community settings to co-ordinated support from multiple services, based on need
- Triage / Signposting / Referrals to statutory / non-statutory services, based on need
- Provision of focus on continuity of care and co-ordination of care for individuals with multiple conditions
- Co-ordinated care at crisis / transition points and for those most at risk/with most complex care needs
- Access to specialist advice by phone or in community settings if face to face assessments are required
- Rapid escalation of support / clinical care.

5.8 The development of an UCRH model would also support the development of additional value adding functionality of how services work and add to what is already provided by NHS24 and by existing services working in the OOH period and these should include:

- Electronic Records and Anticipatory Care Plans – secure, appropriate and confidential access to electronic records, including ACPs to support Health and Social Care professionals in their decision making during the OOHs period
- Asset Optimisation – managing demand and capacity across OOHs services by having up to date information about activity and available resources
- Civil Contingencies – supporting coordination of resources during major incidents
- Training and Development – providing a supportive and safe environment to provide training opportunities through rotational posts and Advanced or Extended roles, which will help to develop a flexible and skilled workforce across in-hours and OOHs services.

## 6. An Integrated, Co-ordinated, Patient Centred, Sustainable Health and Social Care OOHs Model for Greater Glasgow and Clyde : The Model

6.1 We used patient, service users, carer and professionals scenarios, to develop the operating principles of the Urgent Care Resource Hub for Greater Glasgow and Clyde. The use of the scenarios enabled us to explore the impact of an UCRH on other parts of the system and services, for example NHS 24 and daytime services.

6.2 The value adding function of the UCRH would be to mobilise and co-ordinate the most appropriate OOHs Health and Social Care response during times of crisis or escalation. The UCRH would support the increase of the number of multi-agency and multi-disciplinary responses which would match patient, service user and

carer's needs, through a wide range of health and social care community based resources.

6.3 In addition the UCRH would provide OOHs practitioners which the facility for professional to professional advice to support management decisions for patients and service users with increasing complexities, thereby reducing the current experiences of communication, day-to-day management and co-ordination of services across the system which are currently extremely challenging and resource intensive.

6.4 Various formats and configurations of the UCRH model were examined and tested prior to the development of the agreed model. This model has been endorsed by the Programme Board, Chief Officers and LMC.

6.5 The preferred model shows a clear patient, service user and carer pathways which would be actioned as required by NHS 24, District Nursing Services and Mental Health Services.

6.6 In this option the service / UCRH interface has been developed to support onward referral for co-ordination of multiple services and complex needs of cases.

6.7 For this model to work effectively a number of critical service enablers for the UCRH have been agreed which include:

- Access to daytime contacts and services to support appropriate information sharing
- Access to ACPs
- Facility to directly transfer to other services

## 7. Process Undertaken to Consult and Engage on the Integrated Health and Social Care OOHs Service Model

7.1 The high level UCRH service model has been endorsed by the OOHs Programme Board members, Chief Officers, NHS Board, LMC and GP Sub.

7.2 We have shared the UCRH model with members of the OOHs Programme Expert Reference Group who endorsed the model and the outcomes that the UCRH should provide across the Health and Social Care OOHs system.

7.3 We have commenced a programme of engagement sessions with a range of service user representative groups with our engagement plan being underpinned by our EQIA process. Specific engagement has been undertaken to ensure that vulnerable and hard to reach groups have been informed about this work which includes face to face sessions with: Mental Health Network, Recovery Communities and Homelessness Services. We have discussed this planned change with existing Community Engagement Forums such as North West and

North East Locality Forums. A video, supported by a project being undertaken by the Mental Health Foundation, has also been recorded to ensure our refugee and asylum seeker populations are informed where possible. Through these face to face engagement sessions undertaken so far we have not received any negative views on the planned change. We will continue to undertake face to face engagement sessions across the NHS Board area.

7.4 We delivered a Greater Glasgow and Clyde system wide Staff, Partner Agencies, Public and Third and Voluntary Sector Engagement Event to share the model to help us identify the opportunities and stress points of the model. We used patient, service user and professional scenarios which spanned across the Health and Social Care system to help test our assumptions and inform our findings. We will continue to undertake and deliver system wide engagement sessions across the NHS Board area. (A summary report of the key themes from this session is detailed in Appendix 1).

7.5 We held a system-wide Operational Planning and Options Development session on the 21 May 2019 to create the list of options for implementation of the UCRH, with board-wide representation from the majority of the key Health and Social Care OOHs service groups. We used collaborative leadership methodology to ensure that the participants were provided with the opportunity to help inform the future model with structured questions covering the following key areas: (A summary report of the key themes from this session is detailed in Appendix 2):

- People
- Processes
- Infrastructure
- Interfaces
- Organisation

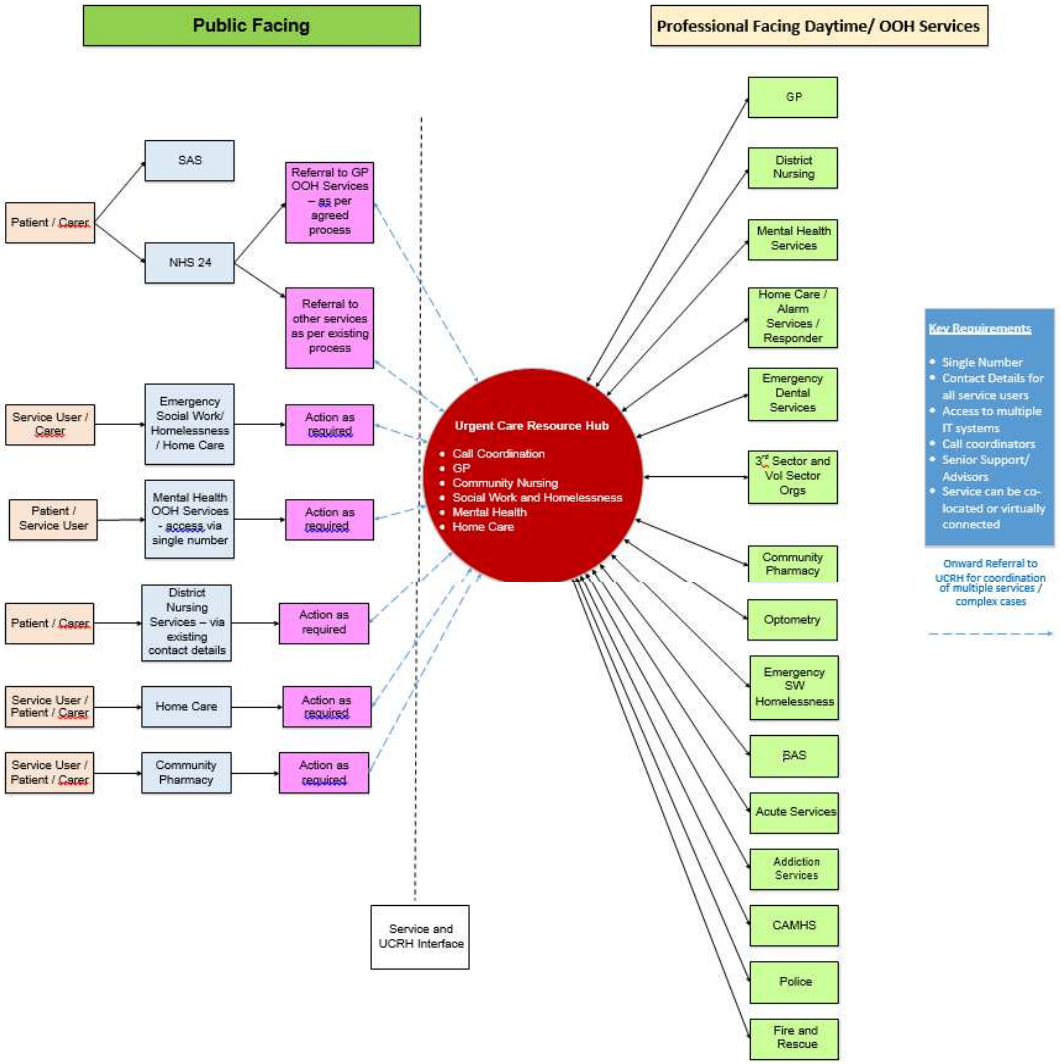
7.6 Whilst the event helped to generate a short-list of options for the UCRH implementation the representatives highlighted a number of key requirements which were critical to the delivery of the UCRH model. These include:

- People – Call Handling function with the appropriate training and development to provide the appropriate level of support and assistance, supported by a Senior Manager with a Health and Social Care background to support decision making within the UCRH
- Processes – review and streamline current service processes and pathways; clarity and confirm service specifications; develop clear pathways/referral criteria for NHS 24, Police and Acute Services to the UCRH

- Infrastructure – access to electronic records, all staff should have access to a device to ensure effective working, adequate resources to support OOHs, expand assessment service during the OOHs to reduce need for admission
- Interfaces – work and build on relationships across the system, ensure frontline staff are further engaged in this work
- Organisation – co-location of District Nursing and Home Care service supported across the board. Co-location of hosted services including Mental Health Services, Emergency Social Work and District Nursing and Home Care Services are also essential. Links to GP OOHs essential but dependent on the outcome of the GP OOHs review.

7.7 A key output of the engagement work was to update the model from the discussions and feedback. The model now includes connections from and to the UCRH with the following services: Addictions; Fire and Rescue; Police Scotland; Child and Adolescent Mental Health Services.
The updated model is detailed below.

## Health and Social Care Services and Urgent Care Resource Hub Interface



Proposed Model - Outcomes of Implementation and Enablers to support implementation

| Outcomes | Enablers to support implementation |
|---|---|
| • Supports Direct Access for professionals to other parts of the system as required, bypassing NHS 24<br>• Maintains existing contact arrangements and process for known patients, service users and carers<br>• Describes NHS 24's relationship with the UCRH and wider Health and Social Care OOHs Services<br>• Clarifies the added value benefits of the UCRH<br>• Highlights the self management aspect of Health and Social Care OOHs Services<br>• Supports integrated and cross system working during the OOHs period and co-ordination between in- hours and OOHs. | • Operational processes, systems and procedures not yet confirmed – this includes determining if services should be virtually or co-located<br>• An UCRH options appraisal requires to be undertaken to determine the number and location(s) of the UCRH(s) |

## 8. The Comparative Process

8.1 The output from the Operational Planning and Options Development Event on the 21 May has helped to create a short-list of options regarding the implementation of the UCRH model.

8.2 The options selected for in-depth decision making includes a status quo as a baseline or benchmark option to assist in the evaluation of the other approaches detailed.

8.3 Some service assumptions have been agreed to be applied when considering the six options. These are:

- A workforce model to ensure the right levels of staff are available to provide a safe Health and Social Care OOHs Service
- Analysis and Evaluation of the agreed option will help to inform any future phases of work
- Work will continue to develop E-Heath Solutions to support decision making across the system

- Work will continue to develop the skill mix across the Health and Social Care system to develop new and sustainable ways of working
- Work will continue to ensure that our service specifications and pathways are reviewed and updated to respond to our populations' needs
- Work will continue on the GP OOHs review, which in the future will determine the number and location of centres from which GP out of hours urgent care is available. The current and future work will also describe the links to an Urgent Care Resource Hub

8.4 List of Options for the Implementation of the UCRH model across NHS Greater Glasgow and Clyde

Table 1 outlines the generated options to achieve the objective

**Table 1: List of Options to achieve the objective**

| No. | Option | Comment |
|---|---|---|
| 1. | **Status quo** | Maintain current Health and Social Care OOHs service provision and considered the consequences of inaction. |
| 2. | **Do Minimum** | Minimum intervention to deliver improvement to existing Health and Social Care OOHs services e.g. extension of the District Nursing Single Point of Access to 8pm. |
| 3. | **IJB Specific Approach for Health and Social Care OOHs Provision:** Each IJB develops their own approach for Health and Social Care OOHs Provision. | Dependant on each HSCP having capacity and capability to provide and deliver the current Health and Social Care OOHs services which are hosted by a HSCP and provided on a board wide basis e.g. Emergency Social Work, Mental Health. |
| 4. | **Implementation of an UCRH within each of the HSCP:** Each HSCP designs, develops and implements an UCRH in response to the 28 Prof Lewis Ritchie recommendations | Dependant on each HSCP having capacity and capability to provide and deliver the current Health and Social Care OOHs services which are hosted by a HSCP and provided on a board wide basis e.g. Emergency Social Work, Mental Health<br>Critically dependent on E-solutions to support sharing of information to support decision making across the system and services. |
| 5. | **Implementation of a Hub and Satellite model – phased approach:** | A phased approach to implementation supports a managed, continuous planning and evaluation which will allows for amendments and |

| | | |
|---|---|---|
| | An UCRH is established in Glasgow City to co-ordinate local and board-wide service provision during the OOHs period with virtual connections to and from local HSCP existing hubs and services. Implementation of the model and co-location of services would take place in a phased approach. | adjustments from an individual service and pathway perspective during the Change and Transformation Phase. The phased approach will help to inform the time, scale and phase of this programme. This will also support the development of further understanding of the presentations of members of the population requiring access to multiple services.<br>Critically dependent on E-solutions to support sharing of information to support decision making across the system and services.<br>Dependant on the support and development of a workforce skill set which will support the complexities of system wide co-ordination of multiple services during periods of escalation and crisis.<br>Dependent of developing good connections and relationships with the HSCP local hubs / services. |
| 6. | **Implementation of a Hub and Satellite model – big bang:**<br>An UCRH is established in one of the HSCPs to co-ordinate local and board-wide service provision during the OOHs period with virtual connections to and from local HSCP existing hubs and services. A go-live date would be agreed for the full implementation of the model and co-location of services | A big bang approach would reduce the opportunity to understand the specific stress points of the implementation of the UCRH.<br>There is a risk that a big bang approach will destabilise the Health and Social Care OOHs system.<br>Dependent on service ownership to facilitate implementation.<br>Critically dependent on E-solutions to support sharing of information to support decision making across the system and services.<br>Dependant on the support and development of a workforce skill set which will support the complexities of system wide co-ordination of multiple services during periods of escalation and crisis.<br>Dependent of developing good connections and relationships with the HSCP local hubs / services |

## 9. Benefits Criteria to support the Comparative Process

9.1 The benefits criteria adopted to support the decision making of the comparative process for implementation are the 8 Health and Social Care OOHs Review Programme Guiding Principles. The content of the criteria also considered the outputs from the OOHs Operational Planning Sessions and were reviewed (with

opportunity for correction or adjustment) by the OOHs Programme Board members and agreed a relevant and sufficiently rigorous to support the right outcome.

9.2 The Programme Guiding Principles are:

- Person-centred: for those who receive and those who deliver services
- Intelligence-led: making the most of what we know about our people and their needs
- Asset-optimised: making the most of all available assets and resources
- Outcomes-focused: making the best decisions for safe and high quality patient care and wellbeing
- Integrated and coordinated: to reduce complexity and duplication which will support the delivery of high quality, safe and effective care
- Sustainable: resilient on a continuous basis
- Equitable: fair and accessible to all
- Affordable: making best use of public funds

| Guiding Principles | Key Features |
|---|---|
| **Person- centred**<br><br>Providing Care that is responsive to the individual persons' preferences, needs and values | A person centred service for Health and Social Care OOHs would ensure:<br>• People are listened to and treated with respect and dignity<br>• Local services and connections are maintained |
| **Intelligence-led**<br><br>Providing informed and joined up care where information is shared across systems and services to support safe decision making | Access to the UCRH will allow us to what we know more about our people and their needs to support:<br><br>• Urgent co-ordination of treatment and / care during times of crisis<br>• An informed co-ordinated response across multiple services and systems is delivered |
| **Asset-optimised** | An efficient service for Health and Social Care OOHs service would therefore provide:<br><br>• A service configured to meet demand<br>• Better utilisation of local services where required<br>• Better utilisation of voluntary and third sector services where appropriate<br>• The available workforce has the range of knowledge and skills responsive to the needs of patients, service users and carers<br>• Informed development of the workforce and |

| | |
|---|---|
| | resources to allow faster access to assessment care and treatment |
| **Outcomes-focused** | An outcomes focused and safe service for Health and Social Care OOHs will provide:<br><br>• The right mix of workforce available to respond to the complexities of OOHs treatment and care<br>• An MDT approach to service delivery providing the right person at the right time and in the right place<br>• Appropriate pathways to support efficient and effective use of these pathways for safe and improved outcomes |
| **Integrated and coordinated** | An integrated and coordinated Health and Social Care OOHs system will help to reduce complexity and duplication which will support the delivery of high quality, safe and effective care by ensuring that there is:<br><br>• Sufficient staff working together in teams across the system to ensure a responsive and flexible service<br>• The range of staff with the right skills available to respond to the demand<br>• Structures and mechanisms in place to utilise and deploy staff and resources effectively |
| **Sustainable** | A sustainable Health and Social Care OOHs system will ensure that:<br><br>• By managing workload we can improve the experiences of our staff<br>• Enhance recruitment and retention by developing an MDT approach to support our population with and being cared for with increasing complexities in the community<br>• Training and staff rotation opportunities are available supported by the UCRH |
| **Equitable**<br><br>Providing care that does not vary in quality because of personal | An equitable service for Health and Social Care OOHs would therefore provide:<br><br>• Equitable access to all who need to access assistance during the OOHs |

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| characteristics such as gender, ethnicity, geographic location or socio-economic status | • Access to a workforce who are suitably qualified, competent and trained to meet the support, care and treatment needs and can reduce any risk of harm and manage the care and treatment sensitively and effectively<br>• Provision of urgent (planned or unplanned) OOHs care does not vary because of geography, location or socio-economic status |
| **Affordable** | An affordable Health and Social Care OOHs will ensure that by:<br><br>• Managing flow and access to the service ensures that the service can be appropriately resourced , financially viable and deliverable on an ongoing basis |

9.3 Preferred Option for UCRH Implementation

The members of the OOHs Programme Board and Chief Officers assessed each of the options 1 – 6, against the criteria, and determined that **Option 5** was the preferred option for the implementation plan of the UCRH model.

## 10. Confirming the Next Steps to finalise Greater Glasgow and Clyde's Review of Health and Social Care OOHs

10.1 The proposed key changes which will support the implementation of an Urgent Care Resource Hub across Greater Glasgow and Clyde have been agreed by members of the Review of Health and Social Care OOHs Programme Board who oversee this work on behalf of the 6 HSCP Chief Officers. It is acknowledged and endorsed from the further work is required prior to support implementation which are described in the following actions with clear responsibility assigned for Phases 1(a) and 1(b).

10.2 The phased actions have been identified as:

<u>Phase 1(a): Immediate actions (June and July 2019) – Programme Function</u>

- Revise and update the Communication and Engagement Strategy which supports the recommendations of the UCRH Comparative process. It is important that this links with all other relevant programmes of work across the NHS Board, for example, Moving Forward Together, Primary Care Improvement Plans, Mental Health Re-design, UCC to ensure consistent key messages are being delivered regarding access and use of services;
- Review and revise the programme governance arrangements to ensure that the final stages of the programme are appropriately supported;
- Agree and assign responsibility of the members of the OOHs Programme Board for the delivery of the communication and engagement to support the Change and Transformation Plan;

- Draft the initial Change and Transformation Plan for each HSCP and the overarching Programme Plan with clear timescales and action owners;
- Develop a risk management framework, which considers all possible consequences of the configuration of an UCRH and work in partnerships with services across the system to describe and establish appropriate mitigation actions;
- Recognising the potential impact of the proposed change of the change for members of the Board's population update the strategic EQIA to ensure that consequences and risks of the change and transformation proposal are agreed and control measures identified;
- Link with Heads of Organisational Development across the system to determine the opportunities to support the Health and Social Care OOHs Change and Transformation;
- Conclude and finalise the work of the OOHs Programme Board and establish an OOHs Implementation Programme Board with detailed infrastructure to support the following phases.

<u>Phase 1(b) Immediate actions (June and July 2019) – HSCPs and Health and Social Care OOHs Services Function</u>

- Assess the service and workforce state of readiness for the change which includes service pathways and service specifications to support the implementation of the UCRH;
- Scope and map the pathway requirements of People with Specific Needs work for the UCRH and determine other work underway across the Board area and how it relates to this;
- Inform the content of the Change and Transformation Plan for each HSCP to support the detail of the programme of work;
- Revisit existing Service Level or Historical arrangements for service provision and determine if there is a need to reconfigure or change these;
- Develop an Integrated Workforce Plan which supports the number of transformation programmes underway across the Board area. By maximising the contribution of our Health and Social Care workforce and challenging the existing boundaries is essential to develop and transform roles to meet the current and future needs of GG&C's health and social care OOHs system. Recognising the intrinsic links between daytime and OOHs a workforce plan which supports the system will help to create and secure a sustainable MDT workforce to meet the immediate and future needs. The workforce planning, recruitment and retention is a high priority to ensure safety and sustainability. We should consider an approach that will help us to develop an enhanced understanding of the specific roles or tasks across the professions or sectors or services to determine where there is an opportunity or a need to do things differently. It will be essential that the future provision of OOHs services is not stilted by existing professional and service boundaries. Developing an

integrated workforce planning approach will allow us to better meet and respond to the needs of local areas and communities;
- Confirm the IT requirements for each service to support sharing of information during the OOHs to inform the UCRH E-Health plan.

Phase 2 – Finalise the Change and Transformation Plan (July and August 2019)

- Members of the Review of Health and Social Care OOHs Programme Board finalise and agree the Change and Transformation Plan(s) which outlines the stage requirements to support the implementation of the UCRH;
- Finalise the E-Health requirements of the UCRH;
- Members of the OOHs Programme Board confirm the shift to operational ownership of the Change and Transformation plan;
- Conclude the review and design work of the Expert Reference Group Members.

Next Steps (date to be determined)

- Develop a proposal for evaluating impact of the UCRH across the Health and Social Care system which takes account that the baseline data from our current system does not capture the complexities of members of the population who access services in the OOHs period and require a response to escalation or crisis.

## 11. Recommendations

11.1 The GG&C CMT are asked to:

a) Note preferred option for UCRH implementation
b) Note the phased actions identified and their alignment to operational and programme ownership

Appendix 1

**System wide OOHs Communication and Engagement Event Key Themes – 7 May 2019**

**Urgent Care Resource Hub: the Proposed Model**

## 1. Purpose

The purpose of this paper is to outline the key themes arising from the system wide event on the 7 May 2019 and outline the points to consider as part on the continued planning process which will in turn inform the detail of the implementation phase.

## 2. The Process

A half day workshop was commissioned by the members of the Health and Social Care OOHs Programme Board with the key objectives agreed as:

- Outlining the Strategic Context of the OOHs Review
- Describing the Greater Glasgow and Clyde Review of Health and Social Care OOHs
- Sharing the Proposed Model – to help us identify the opportunities and stress points

Ninety three participants attended the session and participants comprised of staff from across a range of services within Greater Glasgow and Clyde. The group were allocated to 14 tables with a table facilitator identified ahead of the session.

Two presentations were delivered at the start of the session and covered the following areas:

- Setting the Context
- Sharing the Proposed Model

Following the presentations the remainder of the session comprised of small group discussions. The purpose of the small group discussions was to provide an opportunity for participants to reflect on the detail provided in the presentations and from their own experience in working in or managing or accessing Health and Social Care OOHs Services. Seven scenarios from the perspective of a patient, service user and professional which spanned across the Health and Social Care system were developed to help identify the

opportunities and stress points of the model. Each table was asked to review two scenarios within the context of the proposed model.

The groups were tasked with addressing two key questions during the discussions:

**Facilitated Discussion 1: Exploring the proposed model and identifying the opportunities and possible stress points.**

**Key Questions**

- **What are the opportunities that this model presents for you?**
- **What else would make it work?**
- **What do you think may get in the way of this model?**
- **Are there ways you can suggest to overcome this?**

**Facilitated Discussion 2: Testing the proposed model from the perspective of a patient, carer, service user and member of staff.**

**Key Questions**

- **Explore the scenarios suggested for your table**
- **What do your colleagues say they would do in this scenario and how would the model change this?**
- **What do your colleagues need to make the model work in the scenario?**
- **Who else needs to be involved?**
- **What might be missing?**
- **What connections are crucial to the model and how should we make them?**

**Facilitated Discussion 1 – Key Themes**

| Opportunities? | What else would make it work? |
|---|---|
| • Person-centred, right person at the point of delivery.<br>• Joined up resources<br>• Linked up services<br>• Better picture of overall care needs<br>• Breakdown of the isolated way that we currently work and allow professionals to deliver tasks that they are better placed to do<br>• Reduction duplication through co-location<br>• More efficient and quicker route to understanding people's needs, carers and cared for people<br>• Equity – same standard of care across the Health Board area.<br>• Reduce how often people are removed from their familiar environment<br>• Manage expectations of professionals and service users about service provision / availability<br>• Access to additional resources or expertise<br>• Enhanced professional relations<br>• Improve efficiency - potential to free up time currently spend co-ordinating with other services – avoids long delays<br>• Offers practitioners a handover process via the UCRH<br>• Re-direction - the UCRH could potentially offer alternative | • Access to up to date care plan.<br>• Develop confidence in sharing data<br>• Do awareness raising and training across all partners – "learn together"<br>• Understanding how daytime service impacts on patient / service users and vice versa<br>• More cross over between OOHs and daytime staff<br>• Promote model as an enabling model, not just intervention<br>• Appropriate Risk Management<br>• Capture referrals<br>• Keep it up to date<br>• Ensure similar resources or access to others in larger areas<br>• Essential access to information (i.e. Digital systems / solutions)<br>• Educating the public on the use of OOHs – stop inappropriate OOHs referrals / signposting to other services such as pharmacy<br>• Producing clear guidance for all involved in safe data sharing<br>• Using the UCRH to identify gaps in the OOHs service and push improvement e.g. response times<br>• Inclusion of staff and users in the implementation<br>• Co-location of some services<br>• Telecare<br>• Electronic records |

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| pathways for patients that avoid high demand services and give patients access to the most appropriate service to their needs.<br>• The professional to professional model maintains the clarity for the public using NHS 24 and gives professionals support – fits well with the new GP contract<br>• Improved outcome for patient / service user with improved access / improved communication / story once<br>• Improved working for staff – shared info / communication / dialogue<br>• Continuity of approach in a crisis situation<br>• Directing the patients / service users journey will reduce the need for access to multiple services<br>• Provides one stop shop for carer<br>• Provision of info to help understand risk better<br>• A mechanism of increasing outcomes but we need to be clear what they are | • One number – how to resource and ensure that everyone gets through to a person<br>• Service User / patients need to know what is happening / being arranged in the background from UCRH<br>• Consider alternative communications approaches e,g. Skype / Live chat / Apps<br>• How many UCRHs / Where to cover volume of work e.g. Locality / HSCP?<br>• Ensuring that the same story does not need to be repeated several times for the same episode<br>• Measure patient / service user outcomes and keep monitoring<br>• Managing expectations i.e. Access need and provide appropriate response<br>• Case Management approach – Service User / Patient knows who owns / helps<br>• Increased partnership working<br>• Hub within a Hub approach – local hubs feeding into larger GG&C hub<br>• Crisis and outreach support form 3rd sector org<br>• Workforce development to support an integrated approach<br>• Close links between hub and third sector<br>• Need to build up knowledge of local services and support<br>• Support for stress and distress work as part of the hub<br>• Funding for 3rd sector to compliment model<br>• Streamlined IT and patient notes<br>• Training and support for carers<br>• Funding for 3rd sector to work out of care homes<br>• All agencies set up to work for 24 hours<br>• Role and responsibility of each service<br>• IT / Videoconferencing<br>• Good communication |

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| | • Really robust business support<br>• Person-centred training – needs to be a listening ear<br>• Virtual – need to speak to someone to provide reassurance<br>• Need to learn from what already works |
| **What will get in the way?** | **How can we overcome this?** |
| • SPOA – poor if it affects existing relationships<br>• Patient / Family don't need to know about complexity<br>• GAPS – in communication and non-joined up working resulting in duplication of work<br>• Ageism / compartilisation<br>• Continuity / consistency<br>• Infrastructure / Complexity<br>• Equipment / Suitable<br>• IT<br>• Not understanding all professional roles<br>• Duplication of NHS 24's role<br>• Patient / service user expectations – need to manage<br>• Changing culture around how we currently work<br>• Risk of losing local knowledge of area / patient or service user<br>• Lack of resources i.e GP<br>• Unclear – what existing service offer / then when does the Hub get involved or take over<br>• Continuity of Service – practitioners using the service need to be confident that the services they want the hub to co-ordinate on their behalf are available through the OOHs period | • Listen to feedback from professionals and users of the services<br>• More bringing together of professionals from different services for a collaborative approach<br>• Systems / IT solutions = sensible communication / understanding how the model works<br>• Attract staff to the OOHs role – development opportunity<br>• Multi-disciplinary management<br>• Managing the grey – culture, risk / fear<br>• Clear support for skills development<br>• Make sure promoted and people are aware of service<br>• Communication<br>• Change Management<br>• Clear understanding of the UCRH remit<br>• Funding / Resources<br>• Electronic records<br>• Buy in from Senior Management in each HSCP<br>• Patient / Service User Group for evaluation / monitoring co-produced<br>• Independent researchers / evaluation and ensure objective feedback |

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| • Intersystem working / information sharing – creating a universal process for data sharing and referrals<br>• Maintaining an up to date directory – keeping up with new services, organisations and changes to the service criteria<br>• Service User reluctance to share information across different agencies and organisations<br>• Service User concerns of allowing too much access to personal information<br>• Clarity needed over who has a duty of care once the referral is made e.g If an ED are re-directing someone through the UCRH will the hub manage the potential risk of the patient leaving a "place of safety" for community based care?<br>• Will the UCRH have awareness of acuity and broader risk factors – how will it manage that?<br>• Managing expectations of users<br>• Lack of confidence in service deliver and quality of core staff<br>• Funding and resources to deliver<br>• Adequate staffing during holidays and public holidays<br>• Overwhelming if parameters of service not clearly defined with clear protocols<br>• Start with a few services in the hub – test – then increase<br>• Is there funding to support to support hub and staffing?<br>• Amount of change in system<br>• Education for staff<br>• Could the hub have a central stock of equipment?<br>• Electronic records – lack of knowledge re ACPs<br>• People's access to phone – Communication difficulties<br>• UCRH staff having access to all information - ? use of IT systems<br>• Staff trust / lack of in the system / other professionals<br>• No-one co-ordinating and handover | • Training of staff<br>• Single IT system – portal with information<br>• 24 hour care – improve care pathways and communication<br>• Breaking tradition<br>• Public Education<br>• Public Expectation<br>• Not just health related also crisis related<br>• Individual services need to be fit for purpose before integration<br>• Investment<br>• Knowledge of skills and workforce is really important<br>• More engagement sessions<br>• Public need to understand how it works and what will be shared<br>• Staff need to have training etc to feel confident about what they are doing and support from their organisation<br>• Need to be transparent about process – clear about process for decisions<br>• Knowledge that change takes time and have to keep telling people about changes<br>• Funding for 3rd sector<br>• Independent contractors need to access emergency service for continuity of care<br>• Less bureaucracy to access services<br>• New culture needed to support true person-centred approach and integrated working<br>• UCRH – should adopt an asset based approach to patient care |

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| • System Integration – IT systems<br>• Withdrawal of services without proper engagement<br>• Single point of access – risk of losing local relationships<br>• Withdrawal of services without proper engagement<br>• Single point of access – risk of losing local relationships<br>• Appropriate escalation of calls / contacts<br>• Getting the workforce with the right qualifications and skills<br>• Getting the training of staff right<br>• Response times on the phone<br>• How does the UCRH keep up to date with the changes in the voluntary sector<br>• Model might be a medical model – a broader response is needed for more complex issues<br>• UCRH needs to avoid becoming another “pass to” service that can’t resolve the issues raised<br>• Who will staff the UCRH | |
| **Comments / Feedback** | |
| • Need for adequately trained staff to understand calls<br>• All staff need access to the same info e.g GPs don’t have access to NHS Portal<br>• Systems linking up is a real issue – not sure how to solve<br>• Consideration to logistics of where service is and offering of transport<br>• What is SAS and NHs 24 call volumes?<br>• How many UCRHs and where?<br>• Positive change for system change<br>• GDPR – barrier to sharing information<br>• Better use of technology to meet the needs of the individual<br>• Choice based on needs – ability to use technology<br>• There is an appetite for staff to work differently | |

- The model should offer rapid response and preservation of life
- A streamlined model would assist the teams to prioritise crisis
- There is a need for this type of model

**Facilitated Discussion 2 – Key Themes**

| How would the model change this scenario? | What do your colleagues need to make the model work? |
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| • Proposed model could streamline services accessing patients / service users homes<br>• Proposed model could more easily identify which service visited last<br>• Potentially a better process for dealing with this scenario<br>• Model should facilitate assessment for any ongoing support needed<br>• Direct access via the Hub to GP opposed to NHS 24 / professional line<br>• Review and agree immediate care packages / additional medication / implement initial immediate support and then review next day<br>• Reduces / stops immediate and not required admission<br>• OOHs links to 3rd sector i.e MacMillan<br>• Access to independent prescribing / clinical assessment<br>• Improves better co-ordination / connections for the public i.e. prescribing medication<br>• One contact to the service who continues to co-ordinate<br>• One phone number so quicker and can access the right people – releasing staff to allow them to continue to provide support and care<br>• Model provides a contingency over the weekend re services | • Properly trained staff to carry out a wide range of roles<br>• Clarity on the resource available within the hub<br>• Access to additional resources i.e Third Sector supports and social work<br>• Could there be a medication delivery service – release DNs etc as once prescribed service picks up and delivers<br>• End of life care seamless and optimal as possible<br>• Care plans us up to date – clear of last entry / IT system enable relevant information to be available to assist decision making<br>• Do staff have enough support via the Hub if the person's wishes change<br>• Deeper level of integration between services – to share case work and facilitate the MDT approach<br>• Mapping of pathways and training of staff in the UCRH helps to think more broadly about the services that could support rather than being tagged GP / CPN etc and not appropriate. This might also help to highlight gaps in what we offer.<br>• Seniority / expertise in the UCRH to action/ authorise – packages of care, spot complex cases and liaise with partner organisations. |

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| • Electronic record – all services would have access to information *alert on record*<br>• Dynamic model | • Awareness and use of the new model<br>• Technology – phones, contact details, shared info, follow up care, check-ins<br>• Clarity of routes / access for young adults – particularly Mental Health Services<br>• Knowledge of existing services and how to access them<br>• Communication<br>• Education / parameters of UCRH remit and how to access the UCRH<br>• Knowing what resources are available / can be shared<br>• In hours services need to ensure ACPs in place for services in the OOHs<br>• UCRH have access to ACPs<br>• Access to Advance Statement<br>• Joined up thinking / communication<br>• Need co-ordinator<br>• Collective decision making – with safety priority and plan for next steps<br>• IT system integration<br>• Improve care pathways and communication<br>• Services fit for purpose before integration<br>• Equity of services in local areas<br>• Lack of appropriate resources in current services – services already stretched how are we going to cover this<br>• Another step for existing staff to follow<br>• Communication<br>• Knowledge of services available<br>• Workforce – links to appropriate services<br>• Education / Training<br>• Background re who is involved, background into social care, housing etc |

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| | • Daytime teams need to know background of what was done OOHs<br>• Easier to co-ordinate and could potentially cut down on duplication – could help increase level of quality and support<br>• UCRH should have capacity to put in services without a separate assessment<br>• Better communication between agencies<br>• Model should fast track and reduce steps<br>• Need to have the right people with the right connections |
| **Who else needs to be involved?** | **What might be missing?** |
| • Should 3rd sector be part of the hub rather than connected to the hub<br>• Clear confirmation to daytime services of actions taken in OOHS<br>• How quickly can daytime respond to decisions i.e. Hospice care / 3rd sector supports / provide other supports to grant wishes<br>• Essential 3rd sector involvement to stop hospital admissions<br>• HMPs should be involved / connected<br>• Broadest range of third and voluntary sector services<br>• Police and victim support<br>• Carers and Families<br>• Personal Care Info – re personal package – where would this be held?<br>• Where is the link to school, school counselling and sharing info to provide ongoing joint up support?<br>• Not clear re proactive support | • Police<br>• More effective use of 3rd sector resources – as work in isolation / improved joined up working<br>• Where do Community Treatment and Care Centres sit in this model? esp Weekends and PHs<br>• Mental Health – how does the Hub link to the MH review<br>• Ensure Hub enabled to re-direct stop inappropriate use<br>• Alarm system – auto, IT care systems<br>• Electronic information<br>• Schooling Link<br>• 3rd sector links and awareness<br>• Knowledge of demand on current OOHs services<br>• ? Expand to include other services during the OOHs period<br>• Voluntary Services<br>• Co-ordinator role - lead professional<br>• Assets / strengths approach and should always consider statutory response |

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| • If risk safety then need assessment / co-ordinator for system-wide team<br>• Patient / Service User – key contacts those who can make an impact / difference<br>• 18 months into this project – why are we not discussing finance and staff requirements<br>• Need to ensure that hub does not become a barrier to services<br>• Potential for duplication of services e.g NHS 24<br>• Risk of people being missed out (3rd Sector) not having technology links<br>• UCRH useful info on resources and advice on any other actions<br>• Addiction services | • GP Sub / LMC engagement<br>• 3rd Sector e.g. Woman's Aid<br>• Risk based approach to sharing<br>• Need more collaborative risk assessments<br>• Housing<br>• Advocacy<br>• IT system<br>• Rehab<br>• Fall services – where does this sit in Glasgow |
| **What connections are crucial to the model and how should we make them?** | **Other comments / feedback** |
| • Can people on site update the hub with the situation on what is needed = communication?<br>• Do the patients / service users and carers get updated on what is happening?<br>• Clear confirmation to daytime service of actions taken by OOHs<br>• Demand management – ensure reduces duplication<br>• Careful criteria for use of the Hub that does not create unrealistic expectations<br>• Personal Care packages info<br>• Family involvement | • Ensure effective call handling arrangement to deal with requests / signposting<br>• Change green box from GP to GP team<br>• Language used in presentation – less corporate jargon / needs to be clearer esp for non HSCP attendees<br>• Connecting and sharing of info essential<br>• Availability of Face to Face Assessment if needed<br>• Why should OOHs response be different – need to get right in hours<br>• Concerns re resourcing and getting the person to the right place at the right time |

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| • Inter-professional<br>• Understanding of what each service provides<br>• Referral pathways / protocols<br>• Agreed process from OOHs – Day services / Feedback from UCRH<br>• Connections and planning for transitions to stop crisis<br>• System to get info and discuss and make decisions to plan<br>• Day – Night – Weekend connections<br>• Knowing who to go to<br>• Knowing what services are available | • Concerns re availability of up to date information<br>• Confidentiality and consent<br>• Balance of Health / Physical / Mental<br>• Need prof to prof function for all HSCP professionals<br>• Amount of resource high<br>• Proactive<br>• Admin function is a high priority<br>• Community Link Workers<br>• Alert info<br>• EHealth crucial to model working<br>• DNACPR / VOED available<br>• Function of the Hub – is it a continuation of daytime or a separate service<br>• Co-location of services<br>• Is the intention to pilot a UCRH in one area?<br>• What IT systems are to be used in the UCRH?<br>• Is there scope for Community Connectors or similar to be part of the UCRH to develop knowledge and understanding of what is available in the 3rd sector<br>• We need to be moving to 24/7 services – any OOHs service would need to consider operating hours<br>• We tend to create new services for the existing workforce. If that happens we will just shift the problem. We need to learn from previous service changes<br>• Is this about diverting calls from ED<br>• Adding another layer of complexity without assisting<br>• More needs to be done to describe what is meant by urgent |

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| | care – as this is a broad term which many professionals could interpret differently<br>• How will the activity undertaken by the UCRH team be recorded and captured and understood by other professionals<br>• The more people involved in care the more complicated and uncoordinated it becomes |

Appendix 2

**Review of Health and Social Care OOHs Operational Planning Event – Urgent Care Resource Hub**
**21 ay 2019**

## 1. Purpose

**The purpose of this paper is to outline the key themes arising from the system wide event on the 21 May 2019 and outline the initial recommendations to support the development of the content of the Urgent Care Resource Hub Options Appraisal.**

## 2. The Process

A full day workshop was commissioned by the members of the OOHs Programme Board with the key objectives agreed as:

- Review the proposed model and determine the opportunities and stress points of the model
- Confirm co-location or virtual links for the services connected to the proposed model
- Develop an understanding of the systems, processes and procedures required to operationalise the model

A key output of the session is to:

- Develop understanding to support the content of the Urgent Care Resource Hub options appraisal

Fifty eight members of staff registered for the event with 50 participants attending on the day with all HSCPs represented. There was no representation from the following service groups: Community Pharmacy, GPs and Staff Partnership. The participants comprised of: Heads of Service; Service Managers; Senior Nurses; Team Leaders; Staff working across the Health and Social Care OOHs System. The group were allocated to 8 tables with a table facilitator identified ahead of the session. The participants were allocated by HSCP representatives or Board wide provision or where there were opportunities to consider more integrated working. The event was co-ordinated and lead by the Programme Manager – Review of Health and Social Care OOHs and x 2 Senior Organisational Development Advisors.

It was recognised that some of the attendees had some involvement in the Review of Health and Social Care OOHs programme but many of the attendees had not been part of previous discussions. It was therefore essential that the initial presentations helped to ensure that all participants had a shared understanding of the programme or work. The session was spilt into short presentations followed by small group discussions and covered the following areas:

- Setting the Context – positioning the Professor Lewis Ritchie Review and the Greater Glasgow and Clyde review
- Working Together – getting to know and understand the different way people work
- Sharing the Proposed Model – identifying the opportunities and stress points of the model
- Shaping the Future Together – establishing the key principles to ensure that the service is efficient, effective and user friendly
- Understanding the Human Dimension to support the Change – acknowledging fears, hopes and special requests to support the change

The purpose of the small group discussions was to provide an opportunity for participants to reflect on the detail provided in the presentations and contribute to the group responses prompted by structured questions and templates.

The groups were tasked with addressing two key elements during the exercises:

1) **Exercise 1 – Shaping the Future Together**
   **When developing a revised model we need to establish key principles to ensure that the service is efficient, effective and user friendly within the following aspects:**

   - **People**
   - **Processes**
   - **Organisation**
   - **Interfaces**
   - **Infrastructure**

**2) Exercise 2 – Human Dimension**
**Capture Fears, Hopes and Support Requests**

## 3. Key Themes

**Exercise 1 – Shaping the Future Together**

- **People**
- **Processes**
- **Organisation**
- **Interfaces**
- **Infrastructure**

**Overview / General Comments**

| **Question 1: Describe the "as is" key strengths of the current ways of working which should be maintained within the new model** |
|---|
| Local knowledge – knowing our own "hot spots" – red alerts – people already know<br>Co-location<br>Good robust communication between services / teams<br>Joint assessment / training of patients and carers reduces the level of intervention<br>Communication – discipline to discipline / professional to professional<br>New recruitment practice of open recruitment days<br>Level of expertise already available<br>Specialist response already available if required<br>Specialist knowledge within current system and service<br>Existing and established relationships<br>Opportunity to see what gaps we have<br>DN relationship with GP OOHs Service<br>Different IT systems – access to wider info |

Practitioners do have more access to system – clinical portal is a really positive move
Emergency SW – read only access to other LA areas
Close links with Home Care and access to database
Work going out / opposed to all staff being centralised
Communication – but not across the board
Collaborative approach – trust and openness
Mutual ownership
Managing Risk – least intervention
Access to local knowledge
Differing value bases contributes to decision-making
Agile working maintain / expand touch down spaces
Maintain and maximise face to face contact / reduce travel time
Do not loose direct contact with service users
Do not loose patient choice
DN – Single point of access
Existing SPOA
Local delivery of OOHs services with connections to Board wide

| **Question 1: What improvements or opportunities could a revised model bring – the "to be"** |
| --- |
| Clearer understanding of who the lead professional – right person, right time, right place<br>Need to be locate in the same area in the building<br>Need to consider IT infrastructure – one big system<br>Learning lessons of changes already made<br>Need to consider working patterns and practice through robust improvement<br>Clearer understanding of roles and responsibilities and mutual respect<br>Need more formal arrangements and procedures<br>Streamline access to services for complex care needs<br>Reduce delay to accessing services<br>Sharing specialist knowledge |

Improve opportunities for access to services which frees up specialist skills and services
Co-location
Understanding of roles and processes
Collection of data
Robust IT
Opportunity for development and training
Closer relationships with partners
Easier access
Joined up approach
Reduce duplication and co-ordinated response
Good service day and night (equitable and prioritised OOHs approach)
Triage – more efficient use of staff
Potential to collate data – wider analysis of need and response
Robust IT
Responsiveness and capacity to be flexible – able to blur boundaries
Improved relationships and engagement
Clear pathways and routes into a range of services
Holistic understanding of impact on others involved in process
Improved collaboration
Links with Acute
Re-invigoration of Flagging Alerts
Daytime service i.e. Homelessness and DN – can get a better service OOHs – ensure that doesn't become the norm
Set clear criteria and boundaries – update and review service specification
Clear management and decision making structure – esp if situation escalates
24 hour single point of access for Dns
Better knowledge of what services are provided by what teams – what is appropriate or not
Potential for staff rotations across daytime and OOHs
Education for public re services
Access to more data would be helpful – particularly basic contact info – difficult to access multiple systems
Resolution of existing boundary issues / SLAs / historic arrangements
Resolving front loading of daytime services

**People**

| **Question 2: What staff will be required to support this new model?**<br>**What specific knowledge, experience, skills and training would be required?**<br>**What professional, practice and cultural factors do we need to consider to enable staff buy-in?** |
|---|
| **Board Hub**<br>Needs to be a professional who can give advice, co-ordinate e.g. medical, trained practitioner, SW, MHO, paramedics, DNs, Community Nursing, Home Care, Mental Health.<br>Can access respite (SW and Home Care)<br>Working with independent contractors such as care homes and home care, third sector, practices, transport<br>Having access to all disciplines within the Hub to allow for comprehensive care planning for complex needs<br>Provides a Case Management Service<br><br>**Skill Set**<br>Call Handlers – background in core services with an ability to question, compliance in following a process e.g. algorithm, understanding of professional roles, triage, multidisciplinary, generic support workers or specific service who are able to provide level of support / assistance – as per model<br>Possibility of recruitment from experienced staff – customer care experience and track record of operating in a similar environment<br>Team – knowledge and range of disciplines, Senior Level support to provide accountability and authority, Experimental learning, Financial Understanding, Reputation, Corporate Governance<br>Mental Health – Existing staff with extended hours, additional staff to cover hours, further understanding of all services available<br>Oral Health – Multidisciplinary approach within Hub.<br>Clinical Co-ordinator with sufficient competencies to make decisions and recognised by all disciplines<br>Skill mix – admin for triage / decision / signposting; professional – if escalation / further advice<br><br>**Board wide specific comments:**<br>Escalation in the event of an incident and available competency<br>Multiple guidelines<br>IT<br>Increase in resources or additional to man hub |

Need knowledge – range of services, understanding interdependencies, how they operate, pathways and ability to co-ordinate
Clear of barrier / criteria – not to put stages in process
Give staff permissions to work differently / manage risk differently
Change daytime and – compliment OOHs
Full staff partnership engagement
Professional staff – need to be accessible for advice
Control Hub → Local Hub Responses
Consistent staff covering
Confidence in colleagues
Professional Respect
Teamwork
Acknowledgement of boundaries
Job satisfaction
Feedback to professions in relation to outcome
Need Management Decision makers – who has budget authorisation
Senior Manager on call rota
Senior Decision makers – clinical and social work
Develop existing out of hours resource (HSCP) e.g. residential care facility and telecare service
Up-skill existing staff – facilitate a training needs assessment
Review job roles, descriptions and existing rotas

**Processes**

| **Question 3: What processes would we need to fit in with the new model?**<br>**How do we simplify or improve our processes to ensure patient, service user and staff experience is better?**<br>**How do we do this without adding steps to the process?**<br>**What changes would be required?** |
| --- |
| Review of current processes – ensure no duplication and working well<br>Service Specification required to be clearer of criteria for Urgent Care Resource Hub<br>Reaching limit of professional judgement<br>Threshold in regards to Risk-escalation principles<br>Clarify and remove unnecessary steps e.g. single point of contact<br>Person-centred Care<br>Move to one number<br>Staff will feel more supported with improved process<br>Staff will feel more confident in their decision making – they have back up<br>Need to clarify the OOHs operational support to staff in terms of formal reporting and escalation process – responsibilities, leadership and accountability<br>Do the current referral processes and access processes need reviewed?<br>Reduce the steps for a patient or service user to get access to the appropriate services<br>NHS 24 providing a call handler resource to specific services e.g. mental health<br>Pathways and processes for oral health currently work well, however how do they access other services?<br>Standardised operating procedures for all pathways identified<br>Resource capacity needs to be built in to support / advise for co-ordination. Call Handler identifies who needed to link / connect to prof for advice – need availability to ensure response.<br>Preparation and Planning for Discharges<br>Process of dealing with clients who were not previously known due to limited information<br>Equipment provision access<br>Chronology within system<br>Cultural change |

IT
Information sharing – ensuring client centred
ACP clarification – standardised approach
Electronic discharges
Schedule processes – electronically
Streamline processes – review
Better use of technology
Need robust standardised operating procedures
Need service description – referral process, exclusions and recording system
Need a service specification – is it a co-ordination or doing hub?
Need to understand current processes – updated where needed
Public shouldn't know about the process
Need to reduce duplication
Might not be a reduction is steps but provides the ability for multiple steps / responses to happen at the same time
Consult with patients and service users

**Board wide specific comments:**
Leadership responsibility and support for escalation
Complication of boundaries / different systems / working hours

**Infrastructure**

| **Question 4: What would the infrastructure requirements be and are there any practicalities we need to be aware of in relation to the new model?**<br>**What benefits would there be of co-location of services?**<br>**What roles need to be co-located? What roles could be virtually co-located?**<br>**What would the IT and system requirements be?**<br>**Would services need to access specific equipment or resources?** |
|---|
| Access to electronic records<br>Every staff member should have access to a device, if need to ensure effective working<br>"Tracking" – to support team working (Good examples CM 2000 Inverclyde HSCP)<br>Roles – co-location of Physio and OT<br>Pharmacy – virtually co-located<br>Need small equipment store local hub<br>Need accommodation stock for local hubs and capital funds<br>Dementia Equipment e.g. Tablet<br>All disciplines having access to all systems or one system<br>Services benefiting from co-location – GP; CPNs; Emergency Social Work, DNs, Home Care<br>All OOHs should be able to virtually communicate<br>Being aware of all accessible services in other local authority areas<br>Adequate resources to support the OOHs<br>ACP – continue implementation of ACPs<br>Referral Consideration – SCI gateway, other e.g. Portal<br>Clinical Portal – Assessment, Electronic Document Transfer to services, extend the data set being shared to Portal (extend Adult and include Children), implement GP Summary to portal, extend use of portal to SAS and NHS 24 (Portal to Portal)<br>Information Governance – high level agreement across x 6 HSCPs/ SAS and NHS 24, consider 3rd sector<br>Understand flow to determine appropriate systems<br>Centralised co-ordination point – links to area arrangement s based in field so no additional travel / delays for responding<br>Benefits – standardising / sharing info / expertise / awareness of services or understanding of what we provide<br>Co-locate – definitely Call Handling if full board or hosted plus x 1 rep from MH, SW, Home Care, Homelessness, District Nursing with |

virtual links to alarm centre – which will enable cross referencing / awareness of issues
IT – need system which provides overview from all
Equipment – review and possible extend re delivery services
Barriers due to existing arrangements
IT systems – quality driven
Relevant information sharing
Potential improvement in developing relationships, trust and fast access, benefit of face to face communication
Practicalities of number of HSCPs and distances involved
Communication is vital and relationships can be developed by other means rather than face to face – skype – conference calls
Outcomes more important than co-location or virtual co-location
Digital Network
Robust Phone Systems
IT equipment – updated
Co-location – improve working relationships, key services
Satellite Hubs with virtual links – develop business continuity
Need for change to services e.g. Home Care sitter service ? expansion of Home Care Services – if assessment is available OOHs it could prevent hospital admission
Need to accept that services are different but find away to work better together
Helpful to be co-located as would build relationships and understanding of roles
Easier risk assessments if services are working together
Might need distinction between out of hours and emergency
Needs to have systems available when required
Information Governance

**Interfaces**

| Question 5: What are the key interfaces and links for the service?<br>What are the key relationships and how could these be maintained in the revised model?<br>How would you envisage these being affected and what engagement would be required? |
| --- |
| **Interfaces and Links**<br>Existing OOHs Services in Partnerships<br>Acute Services – Hospital Discharges increasing numbers occurring in the OOHs – needs co-ordinated via Hub<br>Mental Health OOHs Services<br>IT systems – portal<br>NHS 24<br>Mental Health – further internal discussions in regards to OOHs CPNs, Crisis, NHS 24 and Specific role definition<br>GPs<br>Health Visiting<br>Addiction Services<br>Voluntary and Third Sector – directory<br>Pharmacy<br>Fire Service<br>SAS<br>Emergency Departments<br>Community Alarms<br>Patients<br>Families<br>Service users<br>Statutory and non-statutory bodies<br>Elected members |

**Relationships**
Building on existing relationships, connecting people, remove unnecessary duplication
More cohesive working practices
Less silos
Maintaining use of the Hub
Need Service specifications

**Engagement**
Develop sessions with staff across the HSCPs
Building relationships with other stakeholders e.g. Education
Use of staff newsletter, leaflets etc
Induction
Agreed protocols – understand who is out there / who can respond
Communications strategy

**Organisation**

| Question 6: How do we ensure a unified approach given the different organisations?<br>How would you envisage a new model being implemented i.e. full go-live, phased approach, co-location etc?<br>What and who would we need to communicate with both internally and externally? |
| --- |
| Shared Vision<br>Co-location<br>Implementation on a 24 hour basis – not just OOHs<br>Phased roll out, test – no big bang one or two HSCPs first, Pilot or Phased approach<br>Communication Strategy behind this with clear key messages – extend to Scottish Government, SAS, Police, Scottish Fire and Rescue<br>Internally – mental health specific discussions need to be done re specific roles<br>Staffing<br>Central Hub Model with local hubs / connections<br>Create new model – management structure – own identity or expand existing<br>Proof of concept – co-location with phased approach<br>Full Go-live x 2<br>Re-brand Health and Social Care OOHs services and launch<br>Developing relationships<br>Collaborative Working<br>Difficult to achieve a unified approach across each HSCP with different complexities and population needs – East Ren would require links to UCRH for access to Board wide services |

## 4. Key Themes

**Exercise 2 – Human Dimension**
**Capture Fears, Hopes and Support Requests**

| Hopes | Fears | Special Request |
|---|---|---|
| • Involves across all services and staff groups<br>• Improved integrated care<br>• May make job easier with access to more services and to free up capacity<br>• Investment in Future<br>• Fund change<br>• Engagement from other services<br>• Good work environment<br>• Good communication and connection between daytime and OOHs<br>• For opportunities for staff development<br>• For continued sharing of info and building on best practice<br>• Our very positive integrated ways of working continue<br>• Improved services and relationships<br>• Continued support from neighboring HSCPs | • Recruitment and Retention of Staff<br>• Will this bring duplication and more steps?<br>• Staff won't understand the function of the hub<br>• Change is so complex – we can't simplify and not be joined up across service reviews<br>• How do we sustain change and staff?<br>• We have done enough work with first responders, SAS and NHS 24<br>• Doesn't lead to improved patient care<br>• Hub needs resources – will there be capacity to meet demand?<br>• Risk – go through the change and no added value<br>• Different processes<br>• Trust Issues<br>• Timescales<br>• IT infrastructure | • What evaluation? How will we know that it has added value?<br>• More engagement at an operational level<br>• How do you measure success?<br>• How do you future proof<br>• Clear specification – not too prescriptive so not a barrier<br>• Clear processes and procedures<br>• Correct Management structure<br>• Front-line staff impact in change management process<br>• Positive Daytime Services<br>• More sessions needed – lots of operational questions<br>• Consider different working hours e.g 8 – 8<br>• Need to be clearer on definition of urgent and planned care and the benefits of the hub for these |

| | | |
|---|---|---|
| • Clear governance structure and risk identification to support service users<br>• Staff feel less isolated with the Hub – either virtually or co-located<br>• Continuity of care<br>• Support it embed professional respect across all agencies which will support this model<br>• Outcomes to the service user do improve<br>• Deliver required efficiencies and make services sustainable<br>• Change will lead to improvement<br>• The new model will be integrated and multi-professional<br>• Views of current OOHs staff are listened to<br>• Delivers improved service for people | • Resistance of Change<br>• Worried about expectations and ability to deliver changes needed<br>• Autonomy and decision making of services shouldn't be diluted<br>• Difficult to manage a model across all partnerships<br>• Diminishing workforce and succession planning<br>• Ability to attract staff to the OOHs service<br>• Hub would be bypassed if not perceived as adding value<br>• Staff reacting negatively<br>• Add in unnecessary steps<br>• We fear the unknown and the potential destabilization of existing services<br>• Service Users could be lost in the re-design<br>• Service demand increases if the UCRH provides prompt and efficient responses that may differ from in hours<br>• A call handler service may disrupt professional to professional dialogue | • Need baseline of what is working well to evaluate change<br>• We would like help to develop existing out of hours services<br>• We would like help to up-skill staff<br>• We would like help with communication – briefing, newsletters, public engagement<br>• Not everyone is at the same stage of integration – need to consider this<br>• This service re-design would benefit from increased OOHs resources to ensure services are responsive enough<br>• Availability of data sharing<br>• Public behavior<br>• Large geographic service areas<br>• Maintain what works locally<br>• Do not apply a model for Glasgow City to everyone<br>• Investment in the future<br>• Location of the Hub<br>• Management structures / reporting frameworks |

# 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 the Ceremony Room, Clydebank Town Hall, Dumbarton Road, Clydebank on Wednesday 19 June 2019 at 2.05 p.m.

**Present:** Bailie Denis Agnew, Councillor Marie McNair, Mr Allan MacLeod, Ms Rona Sweeney and Ms Audrey Thompson.

**Attending:** Beth Culshaw, Chief Officer; Julie Slavin, Chief Financial Officer; Wendy Jack, Interim Head of Strategy, Planning & Health Improvement; Julie Lusk, Head of Mental Health, Addictions & Learning Disability; Claire Andrews, Internal Auditor; Jo Gibson, Head of Community Health & Care Services; Jonathan Hinds, Head of Children's Health, Care & Criminal Justice Services (Chief Social Work Officer); Serena Barnatt, Head of People and Change; Jennifer Ogilvie, Finance Business Partner and Craig Stewart, Committee Officer.

**Also Attending:** Mr Richard Smith, Senior Audit Manager, and Ms Zahrah Mahmood, Senior Auditor, Audit Scotland.

**Apology:** An apology for absence was intimated on behalf of Councillor John Mooney.

**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 Audit Committee held on 13 March 2019 were submitted and approved as a correct record.

## CHILDREN AND FAMILIES FIELDWORK SERVICES - UPDATE

A report was submitted by the Head of Children's Health, Care and Criminal Justice/Chief Social Work Officer providing information on details of agreement with Trade Union representatives regarding Children and Families Fieldwork Services in response to a Collective Grievance submitted on 6 February 2019.

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

(1) to note the management response to a collective grievance submitted by members of the Children and Families Fieldwork Team, issues identified and actions to be progressed;

(2) to note the terms of the discussion that had taken place in respect of this matter, and approve the proposals being drawn up by officers in relation to the investment of £250,000 across Children and Families and the potential use of general reserves; and

(3) that regular updates would be provided to future meetings of the Committee in relation to this matter.

## INTERNAL AUDIT ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2019

A report was submitted by the Chief Internal Auditor providing the Internal Audit Annual Report for the year ended 31 March 2019 which contains an independent opinion on the adequacy and effectiveness of West Dunbartonshire's Health and Social Care Partnership Board's internal control environment that can be used to inform its Governance Statement.

The Committee agreed to note the contents of the report.

## LOCAL CODE OF GOOD GOVERNANCE REVIEW AND ANNUAL GOVERNANCE STATEMENT

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

(a) the outcome of the self-evaluation undertaken of the Health and Social Care Partnership's compliance with its Code of Good Governance; and

(b) the Annual Governance Statement for inclusion in the HSCP Board's Unaudited Annual Accounts.

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

(1) to note the outcomes of the annual self-evaluation, the issues identified and improvement actions; and

(2) to approve the Annual Governance Statement.

## UNAUDITED ANNUAL REPORT AND ACCOUNTS 2018/19

A report was submitted by the Chief Financial Officer seeking approval of the 2018/19 unaudited annual report and accounts covering the period 1 April 2018 to 31 March 2019, subject to audit approval.

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

(1) to approve the 2018/19 unaudited annual report and accounts; subject to audit review; and

(2) to note that the Audit Committee would be recommended to formally approve the audited accounts at its meeting on 25 September 2019, prior to submission to the Accounts Commission, in line with the approved Terms of Reference.

## AUDIT PLAN PROGRESS REPORT

A report was submitted by the Chief Internal Auditor:-

(1) providing an update on the planned programme of audit work for the year 2018/19 in terms of internal audit work undertaken at West Dunbartonshire Council and NHS Greater Glasgow and Clyde that may have an impact upon the West Dunbartonshire Health & Social Care Partnership Board;

(2) providing an update on the progress on the agreed actions from the review of the Partnership Board's Code of Good Governance; and

(3) providing an update on the progress on the agreed actions arising from the Annual Report to the Integrated Joint Board and the Controller of Audit for financial years ended 31 March 2017 and 31 March 2018 from the External Auditors.

The Committee agreed to note the progress made in relation to the Audit Plan for 2018/19 and in progressing other action plans.

## SELF EVALUATION OF INTEGRATION ARRANGEMENTS 2019

A report was submitted by the Interim Head of Strategy, Planning & Health Improvement providing an update on the Health and Social Care Partnership Board progress under integration as required by the Scottish Government.

The Committee agreed:-

(1) to note the content of the Self Evaluation Review of Integration completed with partners; and

(2) to note that the improvements identified would be developed into an action plan following a local workshop with HSCP Board members and the SMT, supported by colleagues from Scottish Government.

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

A report was submitted by the Interim Head of Strategy, Planning and Health Improvement providing an update on the most recent Care Inspectorate inspection reports for nine independent sector support services operating within the West Dunbartonshire area.

After discussion and having heard the Interim Head of Strategy, Planning and Health Improvement and the Head of Mental Health, Addictions & Learning Disability in further explanation of the report and in answer to Members' questions, the Committee agreed to note the contents of the report.

**CASTLE VIEW CARE HOME – ADULT SUPPORT & PROTECTION LARGE SCALE INVESTIGATION**

A report was submitted by the Head of Community Health & Care Services providing information on:-

(a) the recently conducted Adult Support & Protection Large Scale Investigation relating to Castle View Care Home; and

(b) progress made in relation to the resultant Improvement Plan.

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

(1) to note the contents of the report;

(2) to note the terms of the discussion that had taken place in respect of this matter; and

(3) that this item becomes a standing item of business on the agenda until such time as the Partnership was satisfied that matters had been satisfactorily addressed in the Improvement Plan.

The meeting closed at 3.55 p.m.

**West Dunbartonshire Health & Social Care Partnership**

**Meeting:** **Clinical and Care Governance**

**Date:** **17th July 2019**

**Time:** **1.30pm**

**Venue:** **Denny Meeting Room**

**Draft Minute**

**Present:** Beth Culshaw, Chief Officer (Chair)
Helen Little, MSK Physio Lead
Philip O'Hare, Clinical Risk Coordinator
Julie Lusk, Head of Mental Health
Wendy Jack, Interim Head of Strategy & HI
Jonathan Hinds, Head of Children's Health, Care & Criminal Justice Services, CSWO
Val Tierney, Chief Nurse

Apologies: Jo Gibson, Head of Health & Community Care

In Attendance: David Sawers, IOM Retinal Screening
Lorna Fitzpatrick (Minute)

| Item | Description | Action |
|---|---|---|
| 1. | Welcome and Introductions | |
| 2. | Minute of Previous Meeting - attached<br><br>The Minute was accepted as an accurate record. | |
| 3. | Matters Arising<br><br>Val Tierney will ask Marie Rooney to provide details of the ongoing professional audits which take place throughout services regarding rapid alerts.<br><br>There has been a debate about whether to include members of the public in Child and Adult Protection Forms. The policy was discussed at Primary Care Clinical and Care Governance. The Chair, a GP from Renfrewshire was very positive but overall there was a mixed reception.<br><br>East Renfrewshire governance forum also had a discussion but no final decision made yet.<br><br>Agreed to ask Heather Irving to follow up and look at the guidance and policy. | VT |

Val Tierney will check out whether the overarching Clinical Governance forum as a public rep. VT

After discussion, it was agreed that public representation, with appropriate support, can provide a valuable contribution and that any thoughts around this should be fed back to Heather Irving within four weeks to allow a report to come to the next Clinical and Care Governance meeting. VT

It was agreed that Val Tierney would share some learning with Jo Gibson around a visit from the health visitor where the number of children in the family was unclear from notes. VT

CPR information has been shared with the SMT.

**Governance Leads Update**

4. Lead Report – Mental Health, Addictions and Learning Disability

Julie Lusk presented the lead report on mental health, addictions and learning disability which includes an appendix on the strategic action plan to address concerns surrounding Living Ambition's Supported Living Service in Jamestown. There was a discussion around where to provide an update and this was agreed to go to next Audit Committee. (Added to forward planner.)

There was some discussion around an appropriate template and the need for reports to be balanced across clinical and care governance.

Consider adjusting the template to be slightly less clinical.

It was a very comprehensive report.

When we reference audits, it would be helpful to know what the results are. The reports should also describe hot spots.

HR issues should really come through the HR reports rather than through CCG unless there are issues impacting on services.

Agreed to an amendment to mention that review care packages are being reviewed in line with client requirements. J Lusk

5. Specialist Children's Services Report J

Specialist Children report noted.

6. Children's and Families Services

Jonathan Hinds presented the report and advised that the partnership is in the process of reviewing (externally) our high risk offenders.

Report on CJ will be presented on 6th August and an improvement plan will be put in place. The inspection focused on our ability to deliver community payback orders as an alternative to custody.

Agreed to provide some high level professional support around high risk offenders.

In terms of breaches will include that in the planned report.

SCS – There are some particular pressures in terms of achieving waiting list targets. Some delays are seasonal but the board-wide target of 18 weeks is not being met.

Blairvaddach report showed some shortcomings and there is a commitment to look at what alternatives might look like. Perhaps focus around older young people who are getting ready to leave care and who will require ongoing access to services. Challenge is whether or not we can replace it at all or try to reduce accommodated children population.

Community children's services – UNICEF Gold accreditation has been revalidated and it was noted that this is a very positive outcome. Mags Simpson has accepted a new job with NHS Lanarkshire. This is a huge loss for the partnership but a very positive move for Mags herself. Recruitment is moving ahead.

ASD referrals – why is there a spike from GPs. It could be about awareness or just be reflective of local practices. Similar trends across other GGC areas. Jonathan Hinds will keep under review. JH

7. Health & Community Care

David Sawers presented the report and commented on the development of the Focused Intervention Team.

8. MSK Physiotherapy Report

The content of the report was noted.

9. Strategy Planning and Health Improvement

No exception report.

## Safe Care/Risk Management

10. GDPR and Data Breaches:

Michael Butler attended to update the group on the current activity around data breaches. Most of these relate to administration processes – wrongly addressed letters for example.

A process of continuing to ensure that all staff are GDPR trained is in place.

Beth Culshaw asked about whether disciplinary action had been taken in relation to breaches across the council. Michael Butler advised that this does not currently happen.

There have been a number of further issues since the report was prepared.

There was a discussion around the use of email and the sensitivity of the information. Consideration could be given to using encrypted memory sticks to share sensitive information.

Val Tierney asked that there has to be some sort of fairness and proportionality in the reporting. Data breaches are monitored across the Council as a whole. In terms of scale, the partnership performs well but the nature of the information breached will tend to be more sensitive.

It was confirmed that all breaches should be recorded on Datix.

Managers were asked to take the report back to their teams. Philip O'Hare advised that the information for the NHS was contained in the Clinical and Care Governance Report. HoS

Key message is to remind teams about standard procedures and Kirsteen McLennan's paper will be routinely shared once fully developed. J Gibson

11. NHS Quality Strategy – please follow link

https://www.gov.scot/publications/healthcare-quality-strategy-nhsscotland/

The presentation is attached to this Minute and emphasises the three main quality ambitions:

- Mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision making.

- There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.

- 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.

Excellence in Care is about developing core indicators across all nursing families.

Eight posts were ring-fenced for nursing but only one of them was taken up.

There is a lot of activity going on gathering clients' views and some bigger exercises which have more public involvement.

We publish a resource library and all of our good practice is contained in that. The two policy assistants collate and analyse that information. This can be mapped against the indicators we are being measured against.

Val and Helen will have a discussion to try to feed back clinical and care governance information to that process. VT & HL

12. Mental Welfare Commission for Scotland Report: Vale of Leven, Fruin and Katrine Wards

The report has been submitted and another inspection will be undertaken in due course. This will be monitored.

**Reducing Harm From Medicines**

13. No items

**Clinical Effectiveness/Quality Improvement**

14. Clinical and Care Governance Annual Report

Val Tierney advised of work undertaken for the report which has now been submitted and will be

presented at the HSCP Board.

Datix – of 149 incidents, almost a third are reported as under "other". Philip O'Hare

15. Chief Social Work Officer Report — JH

There are elements of overlap and this offers a chance to review the content.

If there is anything in terms of social work practice, then provide feedback to Jonathan Hinds. There are also questions about how we look ahead and how do we reinvigorate processes. Consider what changes to make to practices to improve.

There is a lot of information around our regulatory services available from Dana and Brian.

That will need to go to

16. Health & Social Care Standards

Comments have to go to Val Tierney and then back to Fiona McKay. Information to Val by 30th July.

**Person Centred Care**

17. Chief Medical Officer 2017-2018 Annual Report – Personalising Realistic Medicine.

The report can be accessed via the Scottish Government website: https://www.gov.scot/publications/personalising-realistic-medicine-chief-medical-officer-scotland-annual-report-2017-2018

Align to the Quality Strategy – review all these issues at the next Clinical and Care Governance meeting. — VT HL

Include Board Quality Strategy at next agenda. — VT

18. Safe Staffing

Sandra Blades at the Board is leading on safe staffing and has offered to present at this group or to the extended SMT.

19. Value Improvement Fund – papers attached

Share information with Anna Crawford and Fiona Rodgers. Would be good to get a bid in – hopefully relating to FIT. How does this look like to Claire Ritchie around near patient testing. Talk to Lynne Ross in diagnostics. — VT

20. Clinical Incident Report

Philip O'Hare presented the paper which informs the CCG meeting of the nature and range of patient clinical incidents that have been reported through the DATIX system across all services during April to June 2019.

Reports are taking too long to complete. A doctor doesn't have to lead the investigation as long as it is led by someone who has received appropriate training.

They go to local governance groups and then to the board. Routinely, the board doesn't look at how may outstanding cases they have.

When Val and Helen go to the overarching Primary Care group, mention that it ought to be escalated and highlighted at Glasgow meeting. VT HL

21. Castleview LSI

The voluntary moratorium has been lifted and monitoring continues.

22. Person Centred Visiting – How To Guide – attached

It was noted that the partnership is already compliant with the advice contained in the guide.

**Vulnerable Children and Adults**

23. SCI Policy and Procedures

Protocol - There was some discussion around the language used and it should be considered not to use the term "Child Protection".

This protocol has been in place for five years or so. If, following the initial Significant Case Review, you would also do a Significant Case Investigation where there has been a health element of the care is a question Val will clarify with Mags. There was a question about this at the Chief Nurse Group about learning and Val Tierney will seek to provide clarity. VT

Item for Next Agenda

**Infection Control**

24. No agenda items.

## Vacancies

25. COPT SLT
Beth will talk to Jo tomorrow as this is cover for sickness absence

26. Physical Disabilities Social Work Assistant
Agreed

27. Burnside
Agreed (2)

28. CAHMS Nurse Therapist
Agreed

## Any Other Business

29. Feedback from Primary Care Clinical Governance Forum

No relevant update.

30. Risk Register

There was a discussion around public protection and the pre- and post-mitigation assessments. After discussion it was agreed not to change now but to keep under review.

External Security. Post-mitigation assessment is straying into green and it should be considered whether this is appropriate or not. JH

31. SDS Review Group

SDS Review Group met on Monday and Wendy has asked Hazel to set up the next meeting of this group. (Complete.)

32. Date of Next Meeting:
18 September 2019

Helen and Val to coordinate on the agenda.

**West Dunbartonshire HSCP Health & Safety Committee**

**Draft Minutes**

**Ballantines Meeting Room, 16 Church Street, Dumbarton G82 1QL**

**Tuesday 30th July 2019, 10:00 a.m. – 12:00 p.m.**

| Item | Subject | Lead/ Action |
|---|---|---|
| 1. | **Welcome & Apologies**<br>Serena Barnatt, (Chair), Head of People and Change<br>Stephen Gallagher, WDC H&S Officer<br>Mags Simpson, Senior Nurse<br>Berny Smith, Interim Integrated Operations Manager – COPT<br>Fraser Downie, Integrated Operations Manager – Mental Health<br>Jacqui McGinn, Health Improvement Manager<br>Helen Little, MSK Service Manager<br>Elaine White, Lead H&S Practitioner<br>Andy McCallion, Unison Rep<br>David Sawers, Service Manager, Retinal Screening<br>Shirley Furie, GMB Rep<br>Hazel Slattery, (minutes) PA, HSCP<br><br>**Apologies**<br>Anne Cameron Burns, NHS Unison Rep<br>Val Jennings, Unison, H&S Rep | **SB** |
| 2. | **Minutes From Previous Meeting**<br>David Sawers was omitted from the minutes, name to be added to minutes.<br><br>Agreed as an accurate reflection of the meeting.<br><br>i) HSCP H&S Committee<br>Minutes of meeting held on 30th April 2019 for noting.<br><br>ii) NHS GGC Board H&S Forum<br>Minutes of meeting held on 17th April 2019 for noting.<br><br>iii) Joint (Corporate) H&S Committee WDC<br>Minutes of meeting held on 7th May 2019 for noting.<br><br>SG confirmed that WDC do not currently report on road traffic accidents involving WDC employees while at work. This will be followed and a possible reporting mechanism put in place. EW advised that NHS keep records and report on figures. | **HS**<br><br>**SG** |
| 3. | **Matters Arising**<br>**Resuscitation Officer**<br>HL advised that the resuscitation officer is now in post. Training dates have been offered. This will now be removed from the agenda. | |

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| | **Stress Survey**<br>Mags Simpson provided an update on work she has been progressing in relation to team stress survey on her return.<br><br>A Stress in the Workplace Implementation Group has now been established which has met twice with terms of reference circulated to this group for information<br><br>The staff stress survey has been issued and results received. Staff have been asked to review results particular to their own team through team meetings. Once results have been reviewed, activities will be drawn up into an action plan. A draft risk assessment is being considered by all teams.<br><br>Overall the staff stress survey were very positive with few areas for consideration for the action plan.<br><br>As part of health and well being the MSK service have organised a health and wellbeing event, HL will provide feedback at the next meeting.<br><br>SB asked JMcG and MS to link up health and well being and healthy working lives and provided a report/presentation at next meeting to share best practice. | **HL**<br><br>**JMcG, MS** |
| **4.** | **HSE Implementation Plan (NHS)**<br>EW spoke through the implementation plan. EW highlighted the new falls policy and procedures. She also asked if regular checks were made in regards to staff training on falls. FD confirmed that this is checked on a regular basis. Staff were reminded that a SCI must be completed when falls take place.<br><br>It was noted that the national consultation on falls is now open for comment. Claire Ritchie is leading on the response from the NHS.<br><br>Managers were reminded to ensure that staff continue to update their skin health and sharps modules. It is imperative that compliance is reached and maintained. This must be auctioned as a matter of priority, | **ALL**<br><br>**ALL** |
| **5.** | **Standing Items – Health and Safety Reports (Datix and Fig Tree)**<br>i) H&S Proforma's<br>Proformas were provided for information from each service area. Mandatory training continues to take place within all services. Managers can now check mandatory training compliance on learn pro.<br><br>MS highlighted a couple of incidents within Children's Services. Two members of staff have been involved with incidents with dogs, both staff members required tetanus injections and follow up at local surgeries. It was agreed that when visiting homes with dogs the worker would phone ahead and ask for the animals to be put in a separate before arrival.<br><br>Discussion took place regarding themes of incidents; themes identified were violence & aggression, slips, trips and falls.<br><br>SG will share draft guidelines with services on incidents to ensure accurate recording. | **SG** |

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| ii) H&S Reports (Figtree)<br>SG circulated HSCP incident report. It was noted that we have taken a positive step forward in the accurate recording of incidents. Members agreed that an overall HSCP report would be provided rather than individual service reports. | **SG** |
| iii) Quarterly H&S Joint Committee Report<br>SG thanked managers for approving incidents promptly. Currently there are no outstanding incidents. HS1 forms are being completed and sent to admin on regular basis. Admin staff are now sending out reminders to managers for completion.<br><br>Senior Managers have now signed off the H&S assessment. However it has not yet been agreed whether the assessments will be allocated to the service or manager.<br><br>Due to an incident regarding the dispensing of medication within young person's care home, SG has recommended that care homes all use the same guidelines to prevent any further incidents in the future. | |
| EW advised that a number of needle stick injuries had been reported in Clydebank Health Centre, she is going to make contact with the centre to ensure that everyone is up to date with training. | **EW** |
| The H&S Management Book Holder must be identified, EW is looking to complete an audit of around 25% of services, she is keen to audit areas that don't currently report any incidences. | **SG, EW** |
| It was agreed that FD will provide a quarterly report on patient fractures. | **FD** |
| iv) Learnpro Needlestick<br>Managers can now pull their own compliance reports from micro strategy.<br><br>The Needlestick Reduction Group have started to review risk assessments and investigate incidents. The group are looking at standardising risk assessments across GG&C, with a view to each HSCP reviewing and reporting their own area. | |
| Members agreed that needlestick injuries would be added to the H&S proforma and included within DATIX reporting. | **SB** |
| v) Datix Group<br>FD advised that this group has disbanded. Short Life Working Groups will take forward any issues that arise. SB will continue to circulate the Datix bulletin and asked managers to ensure that information was disseminated to staff groups. | **ALL** |
| vi) Fire Training & Inspections<br>Fire training module must be completed annually. This is worst area of compliance for the HSCP, if managers can encourage staff to complete.<br><br>Residential staff are the only staff group who require face to face training. | **ALL** |
| Managers can check compliance on micro strategy. NHS managers are unable to log in to the WDC iLearn platform. SG will keep the group updated with any developments. | **SG** |

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| | The Fire Service inspections are ongoing; again SG will keep us updated of progress.<br><br>vii) Update Figtree<br>Development of the Figtree system is now completed. Risk assessments are now up and running. Audio visual clips are available to help complete risk assessments, there is also a video showing managers how to approve risk assessments. SG is hoping to set up a risk assessment team to help support all services to accurately complete the form.<br><br>Managers are automatically being sent emails when assessments require sign off, however managers with a special character in their name are not receiving the email. This issue has been logged with Figtree. SG will keep managers updated. | **SG**<br><br>**SG** |
| **6.** | **Violence and Reduction Group (NHS)**<br>The Violence and Aggression policy is currently being reviewed with CMHT and at Board level. There are some issues with the policy which are still to be resolved, and changes required to some of the forms. The policy is not yet fully approved.<br><br>EW raised the issue of the level of training required for staff to restrain clients. FD has also raised concerns about restraints. He will clarify and provide a further update at the next meeting. | **FD** |
| **7.** | **Health and Safety Protocols**<br>Protocols have been agreed by WDC. A signposting quick reference guide for IOM's has been agreed.<br><br>EW will circulate NHS protocols for comment. | **EW, ALL** |
| **8.** | **Scottish Manual Handling Passport**<br>It is essential that we are up to date with the SMHP. There is a meeting due to take place to move this forward. SB encouraged everyone to attend to ensure that we meet the required standard across the HSCP. It may also be beneficial for trade union representation at the meeting, VJ will be asked to join group. An update will be provided at the next meeting. | **SG, VJ, SF** |
| **9.** | **Risk Assessment Review**<br>Discussed above under Figtree, item 5. | |
| **10.** | **iLearn Modules**<br>Discussed above in item 5. | |
| **11.** | **H&S Group Constitution**<br>EW and SG have been tasked with reviewing the constitution of the group, this will be circulated the group for comment, and will be brought to the next meeting of the group for formal agreement. The group runs well and has produced good pieces of work. | **EW, SG** |
| **12.** | **Any Other Business**<br>SG spoke about the best way to disseminate medical device and safety alerts, it was agreed that SG and FD would meet to discuss processes already in place and if improvements could be made. | **SG, FD** |

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| | JMcG asked if there were systems in place to ensure that compliance with safety alerts are being adhered to, this needs to be monitored. EW will seek advice from the H&S Board Wide Forum. | **EW** |
| **13.** | **Dates of Future Meetings**<br>**Date** **Time** **Venue**<br>22nd October 2019 10 a.m. – 12 p.m. Ballantines Room, 16 Church Street<br><br>**Proposed Meeting Dates**<br>28th January 2020 10 a.m. – 12 p.m. Ballantines Room, 16 Church Street<br>28th April 2020 2 p.m. – 4 p.m. Ballantines Room, 16 Church Street | |

**West Dunbartonshire Health & Social Care Partnership**

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|---|---|
| **Meeting:** | **Joint Staff Forum** |
| **Date:** | **10 July 2019** |
| **Time:** | **1:00 pm (Staffside pre-meeting at 12:00 noon)** |
| **Venue:** | **Ballantines Meeting Room, 16 Church Street, Dumbarton G82 1QL**<br><br>**(Staffside Pre Meeting Burgh Meeting Room, Church Street, Dumbarton)**<br><br>**DRAFT MINUTE** |
| **Present:** | Peter O'Neill, Unison (Chair)<br>Beth Culshaw, Chief Officer<br>Julie Slavin, Chief Financial Officer<br>Gillian Gall, HR<br>Berny Smith, IOM (Acting)<br>Lynne McKnight, IOM, Care at Home<br>Lisa Johnston, Int GM, Oral Health Directorate<br>Una Provan, Unison<br>Andrew McCready, Unite Senior Rep, NHS<br>Susan Walker, Unite Senior Rep, NHS<br>Sandra Goldie, CSP, NHS (MSK Physio)<br>Ian Stevenson, GMB, Home Care<br>Ann Cameron-Burns, Unison, NHS<br>Chris Rossi, Unite<br>Serena Barnatt, Head of People and Change<br>Val Jennings, Unison<br>Jonathan Hinds, Head of C&F and CJ, CSWO<br>David Smith, Unison, WD HSCP<br>Julie Lusk, Head of MH, LD & Addictions<br>Wendy Jack, Interim Head of Strategy & Health Improvement |
| **Apologies:** | Elaine Smith<br>David Scott<br>Jo Gibson<br>Michelle McAloon |

| Item | Description | Action |
|---|---|---|

**1. Welcome & Introductions**

Peter O'Neill welcomed the group and introductions were made.

**2. Minute of Meeting held on 7 May 2019 All**

During ratification of the minutes there was an overall concern around the accuracy of the minutes. Not just on this occasion but also previous minutes. It was requested the review of the Minute should be held under Matters Arising. Susan Walker advised that we cannot move on to Matters Arising without ratification of the minutes. Lengthy discussion took place regarding the minutes and the accuracy going forward.

On page 8 of the Minute under Management Adjustments, it was agreed to change the wording to "Staffside colleagues requested that going forward.... "

Peter O'Neill stated that previously papers shared at finance sessions have been held back and trade unions want to have sight of papers before meetings. It was noted that the finance situation is very fluid and finance papers change frequently. Susan Walker advised that in the NHS, they do have full sight of papers in advance and there needs to be complete transparency to allow full engagement in partnership dicsussions.

Beth Culshaw advised that there is no intention to hide anything and if trade unions want to have an accurate paper then we may have to wait until figures have been finalised before sharing.

Peter O'Neill requested that future updates are provided via a written paper rather than a verbal update.

Beth Culshaw advised again that there is no question that anything is being concealed. The Partnership has tried to present live and changing data before final decisions had been taken.

Val Jennings spoke about management adjustments which she felt were pushed through without proper consultation on everything. It is not possible to look at a screen and remember everything on it and she requested proper consultation. She made particular reference to management adjustments around increases to pendant alarms and stated that she would not have been happy about that.

Susan Walker asked that any presentation should be shared in advance. Beth Culshaw agreed.

David Smith asked that it was noted that there was no suggestion from staffside that they wanted to wait for a final finance paper. NHS get real time information as it happens. The main reason for requesting written updates is that a verbal update can be difficult to take in and doesn't offer the opportunity to discuss and debate and input to decisions.

Andrew McCready advised that East Renfrewshire has an HR sub group where officers can come along and explain to staffside what their plans are. There has only been a few times where the information has been held back. This mostly affects council staff and allows them to report back to members from an informed position. Serena Barnatt advised that the HR sub group has been created as part of an overall review in East Renfrewshire as part of the Fit for the Future Programme which was a restructure of the entire HSCP.

Julie Slavin advised that, very early in the process, it was her role to try and predict where we might be in terms of a financial gap without having full figures and working on the previous year's figures. HOS are asked for their options and how they would fill any gaps. The paper was brought to the group as a presentation and as a handout. When Julie sits with NHS finance colleagues they struggle to get any information around what they are thinking about regarding settlements so would be interested to know what it is that is shared with NHS staff side so we can look at this .

Peter O'Neill talked about appropriate consultation and referred to a previous discussion when it was stated that information was leaked – he asked for it to be recorded that the unions did not leak anything. For trust and transparency, there should be full access to information going forward.

In terms of what has been said, Julie Slavin started to describe that we went through a process over a number of months with two separate finance sessions; one of which concentrated on council finance and another one on health savings. A lot of time was spent talking about new posts coming into the partnership (over 40 posts). So over a period of several months, there was never any question of trying to conceal information.
We made recommendations on the proposals and that was changed as a result of trade unions input.

David Smith asked that it be made clear that the initial point was about the inaccuracy of the minute.

Serena noted that it was two hours that was scheduled for the first finance session and only one NHS rep was present and that was a factor in the decision to have another meeting for NHS savings. Serena noted that she

had a conversation with the one NHS rep that was present at the meeting and he was comfortable to arrange a further meeting.

Peter O'Neill advised that the first meeting ran out of time and that there was never enough time to discuss health savings at the first meeting.

Val Jennings advised that it is essential that there is full consultation around budget process. Proposals were submitted at Council and IJB without staffside involvement. She advised that the partnership must consult appropriately with the trade unions to allow them to feed back to their members.

After discussion the minutes were agreed and ratified.

3. Matters Arising

Serena confirmed she had asked for temporary cover for Diana and asked for an update from NHS staff side .The group welcomed the information from Ann Cameron Burns that hopefully Diana will be back at work within two weeks but in the future a substitute will be sought where necessary.

**4. Review of Public Dental Services – paper attached**

Lisa Johnston attended to present the Oral Health Directorate's Review of the Public Dental Service (PDS) in NHS Greater Glasgow and Clyde. The purpose of the review is to begin the process of ensuring that the services currently provided by the Public Dental Service in NHS Greater Glasgow and Clyde are fit for purpose and that the infrastructure is appropriate to support these services.

Ann Cameron Burns asked about shared care and Lisa Johnstone described the processes in place with clear communication and discharge back to the General Dental Practice on completion of treatment.

The PDS will remain the mainstay for the delivery of NHS dental services to priority groups. However, the PDS must look to modernise how these services are delivered, which is likely to see more development of shared care management arrangements with high street dentists to ensure, wherever possible, people in priority groups receive routine dental care close to home, provided by their own dentists and the PDS would then provide more complex treatments under any shared care arrangements.

**5. Items and Minutes from Other Meetings for noting:**

a) APF Agenda of 22nd May 2019

The Agenda was noted. After discussion, it was agreed to include the Minute with future papers

b) JCF Minute 13th May 2019 and Minute of 14th March 2019

The Minutes were noted.

c) HSCP Health & Safety Committee Minute 30th April 2019

The Minute was noted.

## 6. Finance

Audit Committee Paper 19th June 2019 **JS**

The paper included in the pack is the Unaudited Annual Report and Accounts 2018/19 which was presented to the Audit Committee on 19 June 2019.

Julie Slavin talked to the paper. She advised the extract of our earmarked and un-earmarked reserves is detailed in the paper and the main reason for the increase in earmarked reserves, shown under "transfers in" is due to new funding received from the Scottish Government in 2018/19 not yet fully spent – i.e. Primary Care Improvement; Mental Health Action 15; and Alcohol and Drug Partnership funds.

Julie brought to the attention of the forum that there have been some significant savings from a reduction in the number of high value care packages. There is a £450,000 under spend and a small amount of that will go into general reserves but £435,000 has been requested to be used as a prescribing reserve.

Ann Cameron Burns asked about the increase from health visitors from Band 6 to Band 7 and what would the financial impact of that be. Julie advised that it has a small impact in 2018/19 (just over £20,000) but next year will be £70,000 increasing over the years and we are still waiting for future funding details from the Scottish Government but the HSCP are having to fund internally.

David Smith noted that with increases of charges on the community, it is a real shame that we have a £450,000 under spend and we have imposed a large additional charge on some of the poorest people in our community.

Beth Culshaw advised that in terms of charges, we are monitoring it really closely - particularly around the number of people who are considering cancelling their alarms. Lynne McKnight said that there had been 200 initial requests to cancel but this dropped to 147 and this is similar to the

number who cancelled last year. Usage has been checked and people have been advised that they can come back any time at all to have the alarm reinstalled immediately.

David Smith advised that following the last increase in personal alarm costs one client refused the alarm. That client then fell and lay behind a chest of drawers resulting in a costly hospital admission.

Beth Culshaw advised that this is a detailed written financial update which often comes to this meeting and asked what further information colleagues would like shared.

**7. Service Updates:**

**a) Children's Services and Criminal Justice**

i. Children and Families Fieldwork Update
Jonathan Hinds reported on a broad range of issues that has taken place over the last five months within Children and Families. These focussed mainly on recruitment, laptops and accommodation. Since then there has been a series of actions:

Staffing and equipment. We had identified 6.5 wte vacancies but there were some differing figures from other sources. The establishment will be fully reviewed and the group will include a staffside rep and HR. Posts have been offered to seven new members of staff with four already in post. Some are new social workers and will be able to start immediately they receive their professional awards at the end of the summer.

Agency staff are also in place to make sure wherever possible that caseloads are covered. There was also a commitment to over recruit to the teams and to carry out some demand analysis and caseload reviews. Managers from operational teams are looking at that. It is also being considered whether a third round of advertising is required.

Managers are also looking at the best use of money that was previously paid to a third sector service that has come back into the service.

Jonathan has weekly team meetings with team leaders and is receiving weekly updates.

A group has been established to review the model of duty and to oversee the three separate strands of work; in addition, a Programme Board has been established to support the implementation of all groups.

David Smith stated that the 12.5 vacancies are social workers and the extra money that was identified would be looked at in terms of any other staff that might be required.

Jonathan Hinds advised that if there was an issue in terms of supply or if a different skill mix would be helpful then that would also be considered.

Beth and Jonathan met last week with the Team Leads and started to talk through where we had got to in terms of recruitment. It was felt that we had done reasonably well. Susan Walker asked if we would still use agency workers but it was confirmed that this would reduce as substantive posts are recruited to.

David Smith stated that the industrial action ballot remains live and there is a deadline of 31st August to decide what decision to make going forward. He described the original range of issues in the grievance relating to workload, vacancies and workspace.

ii. HV Skill Mix

Jonathan Hinds advised that there is an intention to bring a paper to a future meeting of this group. This has come about following the health visiting review. Looking at the composition of the health visiting scheme, there is a varied skill mix with one anomalous post in West Dunbartonshire which does not exist in any other partnership. This gives the opportunity for a proper review of the skill mix. In terms of discussing, Mags Simpson has taken this to the Workforce, Recruitment and Retention Meeting. The review will require no additional resource but will clarify roles. Gillian Gall confirmed staff side nominations had been sought.

**b) Health & Community Care Update**

i. CM2000 Compliance

Lynne McKnight described how the CM2000 system works. Workers are required to scan in and out when they visit a client

using a bar code in the care booklet. System was introduced in 2016. There have been previous issues with a variation in the IT skills of people delivering care and appropriate training has been arranged. There has been an improvement in compliance which now sits at 65%; with 17% partial compliance where people either sign in or out. The issue of the importance of compliance has been reinforced across all staff. We have had discussions with trade union colleagues and also started a programme of meetings with local shop stewards and front line staff. She welcomed the fact that there has been good backing from staffside colleagues and broad agreement of the importance of compliance for a number of reasons.

This is in place as accurate information is required by Care Inspectorate, and informs details of continuity of care delivered.

Ann Cameron Burns asked about auditing the time factor of the visit – how often are the times of visits audited? Lynne McKnight advised that this is ongoing and allows a review of the client's requirements as those change. Home carers have an element of flexibility and we trust them to do as required. It is reviewed every week to establish whether enough time is being allocated to a client. There has not yet been a formal audit.

Andrew Macreadieasked about the 18% non-compliant members of staff and Lynne McKnight confirmed that this is being discussed informally with staff to establish reasons. Disciplinary action would be the very last step after establishing that there were no barriers to compliance.

Lynne McKnight updated on programmes of work underway to recruit home carers.Ian Stevenson advised that the length of time disclosures are taking is an issue within West Dunbartonshire where it can take up to four months and can be achieved within a couple of weeks with other agencies. Lynne McKnight advised that this was an external check and the Council cannot control this process given it was undertaken by Disclosure Scotland.

ii. Residential and Day Care Services

Berny Smith advised that the first draft of the restructure paper for Residential and Day Care Services had been shared with trade union colleagues with a further meeting planned for two weeks' time. If it is approved then a period of consultation will be undertaken. This tie in with

the opening of a new care home in Clydebank but is a review of the entire structure.

Ian Stevenson raised an issue about the costs for residents attending the day care centre had been increased from £6 to £10. Berny confirmed that Letters with regards to charging went out last week and there have been six enquiries. She confirmed that this is payable over ten months.

If a client attends more than three times a week, then a discount will be applied. There is also a programme of income maximisation underway with clients.

Sandra Goldie asked about the rationale behind the increases. Beth Culshaw confirmed that we did look long and hard at it before the Council took the decision. Meals and transport are included.

David Smith said that what staff are telling him is that when we had three buildings in the Dumbarton part of the partnership, we had three day care areas and now we have only one. In terms of traditional day care, where you would go for the full day; these changes have led to a massive over subscription and a high waiting list. So people now might go for a two hour session rather than a full day. Are we now offering people to come for a session and getting less day care for an increased price.

Berny advised that there had been changes to day care as part of the residential redesign and we are looking to offer a more accessible service with more choice. The aim is to more towards offering the service over seven days and evenings and weekend.

David Smith advised that there is pessimism amongst the staff group that the only reason that we are moving to this new way of working is because we are moving from three spaces to one. Are we going to charging people £5.50 for a day to charging £10 for a two hour session?

Susan Walker asked about the intention for the staff. Serena advised that we had two day centres and six care homes and the end plan is to have one home at each end of the authority. Staffing model in its entirety is under review and there has been a full consultation process on the original model in accordance with the Council's workforce change policy.

Susan Walker noted that there will be reduced overheads and yet we are charging more for services.

Una Provan asked how service users are given information around the services that are available and Berny Smith confirmed that there is work underway to produce a new leaflet.

**c) Mental Health, Learning Disability and Addictions JL**

i. Action 15 Update

An update was provided at the last meeting and Julie Lusk advised that the two Band 6 Wellbeing Nurses are expected to start in August based in Green Wing and Erskine practices. Working with a partner HSCP who have a very well regarded physical wellbeing health nurse, the profile is being reviewed and will be advertised in July. That is a crucial role as physical health is really important to people who have mental health issues. We have asked Stepping Stones, local third sector partner, to look at recruiting and managing our support worker who will link across services and to Action 15 funding. Once that is in place, the plan for future recruitment will be reviewed.

ii. Meallmore Update

Meallmore have advised that they have some planning issues but they are now on track to build. Once we are aware of what the new development will look like, it will be clearer on what the new service will look like and how they can support us.

Julie provided a further update to confirm that she has recruited to the IOM manager in Addictions with new staff member joining on 19th August.

**d) Strategy, Planning & Health improvement**

No update available.

**8. Standing Items**

a) HSCP Board Meeting
Next meeting is 7th August and papers include:

- Finance
- Annual Performance Report
- Mental Health and Financial Framework
- Risk Register
- Commissioning Plan
- Care Inspectorate Reports
- Membership Report

An informal session will be held at the beginning of the IJB on Children and Families with a session at the next meeting on Carers.

b) HR Reports – attached

Gillian Gall presented the updated Attendance management report. Ann Cameron Burns asked if there were any hot spots. Traditionally, the main hot spot was around mental health inpatient services but that has abated following an intensive piece of work last year.

Susan Walker asked if any HSE work-related stress surveys had been completed. A working group has been established and includes a rep from the RCN.

Serena Barnatt pointed out that within the council side, physical illnesses are broken down but all mental health illnesses are just recorded as mental health for NHS which makes it difficult to extract a breakdown for NHS absence.

Serena Barnatt then spoke about absences on the Council side which are reflective on the workforce profile. Susan Walker asked that the last sentence of the report where it talks about the significant increase in long term absence needing to be investigated and should be reworded. Serena agreed wording need to be reworded; intention was to take a closer look at the reasons why this had increased.

**9. JSF Development Session**

Serena Barnatt advised that in order to develop the programme it will be necessary to have a meeting including NHS reps. The idea is to take stock of how the group runs and to bring new members up to date. Peter O'Neil and Andy McCallion had confirmed they will contribute to developing the programme. Serena Barnatt asked if NHS reps could come back to us with

nominations. Once she receives the nominations a meeting will be arranged.

**10. Workforce Plan Update**

The Integrated Workforce Plan has been in place for four years and is due to be updated. Serena provided some background on new National Workforce Planning Guidance and explained this was expected to be published later on in the year. Serena Barnatt sought around nominations from each of the NHS and Council staffside reps to contribute to the updating work. Once the nominations have been agreed, Serena Barnatt will set up the group.

**Action: Provide nominations direct to Serena Barnatt.**

**11. iMatter – paper attached**

We are in the middle of the i Matter run and currently in the middle of action planning which will finish on 9th September and provided I Matter Directorate report for the Forum.

Serena Barnatt and Lynne McKnight reported on a piece of engagement that had taken place for our Care Home team where previous participation had been very low due to staff not routinely having access to computers at work. A new system was put in place allowing them to complete the survey on their phones. This has resulted in a big increase to over 62%. This was part of a national pilot supported by the Scottish Government. Serena Barnatt wanted to thank the homecare team for all of their support in taking this forward.

**12. Staff Governance and Practice Framework**

Gillian Gall advised that it was time to undertake the annual update of the Staff Governance and Practice Framework. Gillian sought trade union nominations. Once these are received the group will be set up.

**Action: Provide nominations direct to Gillian Gall**

**13. Consultation Budget Setting**

Val Jennings referred to the item discussed at the start of the meeting and asked that it be recorded that consultation is important and just showing us something isn't consultation.

**14. Appointment of Management Posts**

Val Jennings asked for more detail about these posts where we are spending over £400,000. Beth referred to page 6 of the Minute from the last meeting where the posts and the processes were described. Val Jennings advised that the job descriptions would normally be shared with staffside.

David Smith referred to previous conversations where the additional people would be in place to drive forward change. What he feels is that the people at the top of the tree are being given a pal to help them do their job, while there has been a struggle to recruit people at the bottom of the ladder to deliver services to our communities. David Smith requested more information on what these posts were doing?

Susan Walker advised that even if it goes through job evaluation it should be shared with staffside. Serena stated there was no issue with sharing job descriptions and highlighted these were new additional posts which were being developed and as such they will go through appropriate Job Evaluation process in both the Council and NHS. Serena advised as outlined in the Strategic Plan that there is a huge amount of transformational change required so it's necessary to have some additional capacity to support this work. The funding is coming from reserves and was agreed at IJB back in March. This recognises that this is about service improvement and using change agents to deal with the challenges. These are not management consultants. In the long term these posts should help us protect how we deliver services. Beth noted that she felt this language was challenging around the establishment of these posts.

Susan Walker advised that we are always keen to get posts in place. You have partnership colleagues who are unhappy and who should have had sight of the job descriptions. We need to have more of a partnership model and this shows a lack of transparency.

Val Jennings advised that we currently have social workers who have voted for strike action because of a lack of staff and yet we are starting more senior managers. Why do we need these four grade 9 posts when we are cutting cleaners?

Val Jennings advised that under collective bargaining you still have a duty to consult with us. She asked for a detailed business plan and the job descriptions with all the relevant information.

Beth Culshaw advised that there is no requirement to prepare a business plan for additional posts.

**15. Information Exchanges – 3 Key Messages for APF**

- i Matters pilot use of phone for staff with no computer access

- Representation from Health for this partnership meeting
- Development Session Agreed

**16. AOCB**

We are struggling to get nominations for staff awards and it is important for nominations to come in from all areas of service and Serena asked for input from all present to encourage applications.

**17. Date of Next Meeting**

16 October 10.00am
With staffside pre-meetings one hour before main meeting