West Dunbartonshire
Health & Social Care Partnership

Supplementary Agenda

West Dunbartonshire Health & Social Care Partnership Board

Date: Thursday, 25 June 2020

Time: 10:00

Venue: Video Conference

Contact: Scott Kelly, Committee Officer
Email: scott.kelly@west-dunbarton.gov.uk

Dear Member

ITEMS TO FOLLOW

I refer to the agenda for the above Meeting of the West Dunbartonshire Health & Care Partnership Board which was issued on 15 June 2020 and now enclose a copy of the undernoted reports which were not available for issue at that time.

Yours faithfully

BETH CULSHAW

Chief Officer of the Health
& Social Care Partnership

Note referred to:-

6 WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP QUARTERLY PEFORMANCE REPORT QUARTERS 3 AND 4 2019-20 **93 – 113**

Submit report by the Head of Strategy & Transformation presenting for consideration performance information reported against the strategic priorities for the periods October to December 2019 (Quarter 3) and January to March 2020 (Quarter 4).

9 UNAUDITED ANNUAL REPORT AND ACCOUNTS 2019/20 **115 – 174**

Submit report by the Chief Financial Officer seeking approval of the unaudited Annual Report and Accounts for the HSCP Board covering the period 1 April 2019 to 31 March 2020.

10 DRAFT UNSCHEDULED CARE COMMISSIONING PLAN **175 – 253**

Submit report by the Head of Health & Community Care providing an update on progress across NHSGGC in developing the strategic commissioning plan for unscheduled care.

Distribution:-

Voting Members

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

Non-Voting Members

Barbara Barnes
Beth Culshaw
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: 19 June 2020

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD

25 JUNE 2020

Subject: West Dunbartonshire Health and Social Care Partnership Quarterly Performance Report Quarters 3 and 4 2019-20

1. Purpose

1.1 The purpose of this report is to ensure the Integration Joint Board (IJB) fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and on the programme of work as set out in the West Dunbartonshire Health and Social Care Partnership (HSCP) Strategic Plan.

1.2 This report presents the HSCP performance information reported against the strategic priorities for the periods October to December 2019 (Quarter 3) (Appendix 1) and January to March 2020 (Quarter 4) (Appendix 2) for the Board's consideration.

1.3 It includes an Exception Report highlighting those indicators which are currently at red status (not meeting local targets and out with tolerances) which can be seen in Appendix 3.

The performance information is presented in order to allow IJB to fulfil its scrutiny function.

2. Recommendations

2.1 It is recommended that the Integration Joint Board (IJB):

i. Comment on the layout, timing and presentation of the Quarterly Performance Indicators;

ii. Comment on the content of the HSCP Quarterly Performance Report Quarters 3 and 4 2019-20 and performance against the Strategic Plan 2019 - 2022 by Exception (Appendices 1, 2 and 3);

iii. Note that due to timing issues and service priorities during the current COVID-19 pandemic this report presents partial Quarter 4 data ahead of the 2019/20 Annual Performance Report;

iv. Note the impact of the COVID-19 global flu pandemic and agree to delay the publication date for the annual performance report until 30 September 2020 in exercise of the power granted to public authorities under the Coronavirus (Scotland) Act 2020 to do so.

3. Background

3.1 The Performance Framework monitors the HSCP's progress against a suite of performance measures, as outlined in the West Dunbartonshire HSCP Strategic Plan.

3.2 Developmental work continues to refine the performance information reported and ensure alignment with local and national developments.

3.3 A key commitment moving forward will be to ensure future reports provide the necessary assurance to the IJB as to how the HSCP is performing, with a focus on the provision of timely information supported by a balanced approach to measurement and reporting.

4. Main Issues

4.1 Performance Report

4.2 The West Dunbartonshire HSCP performance indicators include a suite of challenging targets. To date, targets have been set using local trends and taking into consideration demographic projections. In due course further work will be undertaken to ensure the targets set against each indicator remain appropriate moving forward.

4.3 It should be noted that due to timing issues and service priorities during the current COVID-19 pandemic this report presents partial Quarter 4 data ahead of the 2019/20 Annual Performance Report.

4.4 The HSCP have 43 performance indicators, with 12 indicators in Red Status which is out with target tolerances. These exceptions are detailed in Appendix 3 together with information about improvement actions currently being taken to address these performance issues.

4.5 Ongoing measurement against this suite of indicators provides an indication of how the HSCP is making progress towards the key objectives of integration, in particular how health and social care services support people to live well and independently in their communities for as long as possible.

4.6 Importantly they help to demonstrate how the HSCP is ensuring best value in respect of ensuring good governance and effective management of resources, with a focus on improvement, to deliver the best possible outcomes for the public.

4.7 It is nonetheless recognised that the factors influencing changes in performance can be various and complex. Performance monitoring arrangements continue to be refined and developed to ensure appropriate scrutiny and ownership of the factors and issues affecting performance.

5. Annual Report and Impact of COVID-19

5.1 On the 1 March 2020 the first positive case of COVID-19 was confirmed in Scotland, with the WHO declaring the virus a pandemic on 11 March 2020.

5.2 Although the full impact of the COVID-19 outbreak had yet to be felt at that time, during the final weeks of the 2019/20 financial year the daily routine of service delivery within HSCP was turned upside down in a matter of days.

5.3 The pace of transformation within the HSCP has been exceptional. Large number of staff where quickly equipped to work from home and many teams continued to deliver vital services to our most vulnerable service users. There has been an extremely positive response from staff and service users with many staff redeployed on a voluntary basis to roles dedicated to supporting the most vulnerable within our communities during this very difficult time.

5.4 As we move into 2020/21 and the transition between response and recovery the HSCP will continue to respond positively and plan for the future model of service delivery. It is however recognised that there will be increase in demand for, and backlog of, statutory services all of which will have financial implications.

5.5 With regard to the HSCP Annual Report, there is a new power in para 8 of Schedule 6 to the Coronavirus (Scotland) Act to postpone publication and laying of reports. This gives a formal route to postpone publication of integration authority annual performance reports during the pandemic.

5.6 As outlined above, due to the pandemic, members of staff who contribute to and are responsible for information illustrating our partnership's effectiveness have moved into different roles to support our response and support our communities.

5.7 It is therefore recommended in Section 2 of this report that the IJB agree to delay the publication date for the annual performance report until 30 September 2020 in exercise of the power granted to public authorities under the Coronavirus (Scotland) Act 2020 to do so.

6. People Implications

6.1 There are no personnel issues arising from the recommendations contained within this report.

7. Financial and Procurement Implications

7.1 There are no financial or procurement issues arising from the recommendations contained within this report.

8. Risk Analysis

8.1 There are no risks arising from the recommendations contained within this report.

9. Equalities Impact Assessment (EIA)

9.1 An equality impact assessment is not required as the recommendations contained within this report do not have a differential impact on any of the protected characteristics.

10. Environmental Sustainability

10.1 A Strategic Environmental Assessment (SEA) is not required as the recommendations contained within this report do not have an impact on environmental sustainability.

11. Consultation

11.1 Monitoring Officers within Finance and Regulatory Services have been consulted in the preparation of this report and are satisfied that the report complies with the Scheme of Governance and complies with all legislative requirements.

MARGARET-JANE CARDNO
Head of Strategy and Transformation

17 June 2020

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Appendices:
Appendix 1: Performance Report Quarter 3
Appendix 2: Performance Report Quarter 4
Appendix 3: Exceptions Report Quarters 3 and 4

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health and Social Care Partnership
Performance Report 2019/20: Quarter 3 October – December 2019

PI Status	
	Alert
	Warning
	OK
	Unknown
	Data Only

Long Term Trends	
	Improving
	No Change
	Getting Worse

Short Term Trends	
	Improving
	No Change
	Getting Worse

Early Intervention

Ref	Performance Indicator	Q3 2019/20				Q2 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
1	Percentage of Measles, Mumps & Rubella (MMR) immunisation at 24 months	88.1%	95%			94.4%	
2	Percentage of Measles, Mumps & Rubella (MMR) immunisation at 5 years	98.6%	95%			98.2%	
3	Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%			100%	
4	Percentage of child protection investigations to case conference within 21 days	90%	95%			88.57%	
5	Number of referrals to the Scottish Children's Reporter on care and welfare grounds	64	N/A			61	
6	Number of referrals to the Scottish Children's Reporter on offence grounds	45	N/A			47	
7	Number of delayed discharges over 3 days (72 hours) non-complex cases	11	0			9	
8	Number of bed days lost to delayed discharge 18+ All reasons	1,185	860			1,320	
9	Number of bed days lost to delayed discharge 18+ Complex Codes	180	N/A			148	
10	Number of acute bed days lost to delayed discharges (inc Adults With Incapacity) Age 65 years & over	793	596			1,015	

Ref	Performance Indicator	Q3 2019/20				Q2 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
11	Number of acute bed days lost to delayed discharges for Adults with Incapacity, age 65 and over	76	N/A			56	
12	Number of emergency admissions 18+	2,462	2,156			2,519	
13	Number of emergency admissions aged 65+	1,273	979			1,197	
14	Emergency admissions aged 65+ as a rate per 1,000 population	76.1	58.5			71.5	
15	Number of unscheduled acute bed days 18+	17,516	15,850			17,623	
16	Unplanned acute bed days (aged 65+)	12,004	11,077			11,980	
17	Unplanned acute bed days (aged 65+) as a rate per 1,000 population	717.5	662			716	
18	Number of attendances at Accident and Emergency (Emergency Departments and Minor Injuries Units)	8,324	5,587			8,571	
19	Percentage of people aged 65+ admitted twice or more as an emergency who have not had an assessment	22.6%	25%			26%	
20	Number of clients receiving Home Care Pharmacy Team support	245	233			257	
21	Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	28%	90%			38%	
22	Percentage of carers who feel supported to continue in their caring role when asked through their Adult Carer Support Plan	94%	90%			98.5%	
23	Percentage of clients waiting no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	97.5%	90%			96.8%	
24	Percentage of Adult Support and Protection clients who have current risk assessments and care plan	100%	100%			100%	
25	Number of people receiving Telecare/Community Alarm service - All ages	2,121	N/A			2,111	

Access

Ref	Performance Indicator	Q3 2019/20				Q2 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
26	Number of people receiving homecare - All ages	1,522	N/A			1,439	
27	Number of weekly hours of homecare - All ages	11,096	N/A			10,708	

Ref	Performance Indicator	Q3 2019/20				Q2 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
28	Total number of homecare hours provided as a rate per 1,000 population aged 65+	568.2	570			566.4	
29	Percentage of people aged 65 and over who receive 20 or more interventions per week	37%	35%			36.9%	
30	Percentage of homecare clients aged 65+ receiving personal care	97.4%	95%			97.1%	
31	Percentage of identified patients dying in hospital for cancer deaths (Palliative Care Register)	32.7%	30%			16.7%	
32	Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)	33.8%	32%			38.2%	
33	Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	78%	98%			91%	
34	Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.	66%	80%			69%	
35	Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	54%	80%			70%	

Resilience

Ref	Performance Indicator	Q3 2019/20				Q2 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
36	Child and Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	55.7%	90%			58%	
37	Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services	18	18			14	
38	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	53.3%	90%			62.8%	

Assets

Ref	Performance Indicator	Q3 2019/20				Q2 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
39	Prescribing cost per weighted patient	£162.69	Annual average across NHSGGC	To follow		£163.13	
40	Compliance with Formulary Preferred List	78.7%	78%			79%	

Inequalities

Ref	Performance Indicator	Q3 2019/20				Q2 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
41	Balance of Care for looked after children: % of children being looked after in the Community	91.4%	90%			92.4%	
42	Percentage of looked after children being looked after in the community who are from BME communities	72.22%	N/A			80%	
43	Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	100%	75%			50%	

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health and Social Care Partnership
Performance Report 2019/20: Quarter 4 January – March 2020

Due to timing issues and service priorities during the current COVID-19 pandemic we are presenting partial Quarter 4 data ahead of the 2019/20 Annual Performance Report

PI Status	
Alert	
Warning	
OK	
Unknown	
Data Only	

Long Term Trends	
Improving	
No Change	
Getting Worse	

Short Term Trends	
Improving	
No Change	
Getting Worse	

Early Intervention

Ref	Performance Indicator	Q4 2019/20				Q3 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
3	Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	100%			100%	
4	Percentage of child protection investigations to case conference within 21 days	64.7%	95%			90%	
5	Number of referrals to the Scottish Children's Reporter on care and welfare grounds	78	N/A			64	
6	Number of referrals to the Scottish Children's Reporter on offence grounds	39	N/A			45	
7	Number of delayed discharges over 3 days (72 hours) non-complex cases	11	0			11	
8	Number of bed days lost to delayed discharge 18+ All reasons	1,638	860			1,185	
9	Number of bed days lost to delayed discharge 18+ Complex Codes	559	N/A			180	
10	Number of acute bed days lost to delayed discharges (inc Adults With Incapacity) Age 65 years & over	1,208	596			793	
11	Number of acute bed days lost to delayed discharges for Adults with Incapacity, age 65 and over	405	N/A			76	
18	Number of attendances at Accident and Emergency (Emergency Departments and Minor Injuries Units)	7,026	5,587			8,324	

Ref	Performance Indicator	Q4 2019/20				Q3 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
20	Number of clients receiving Home Care Pharmacy Team support	273	233			245	
21	Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	21%	90%			28%	
22	Percentage of carers who feel supported to continue in their caring role when asked through their Adult Carer Support Plan	95%	90%			94%	
24	Percentage of Adult Support and Protection clients who have current risk assessments and care plan	100%	100%			100%	
25	Number of people receiving Telecare/Community Alarm service - All ages	2,110	N/A			2,121	

Access

Ref	Performance Indicator	Q4 2019/20				Q3 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
26	Number of people receiving homecare - All ages	1,247	N/A			1,522	
27	Number of weekly hours of homecare - All ages	9,141	N/A			11,096	
28	Total number of homecare hours provided as a rate per 1,000 population aged 65+	461.3	570			568.2	
29	Percentage of people aged 65 and over who receive 20 or more interventions per week	33.1%	35%			37%	
30	Percentage of homecare clients aged 65+ receiving personal care	96.5%	95%			97.4%	
31	Percentage of identified patients dying in hospital for cancer deaths (Palliative Care Register)	32.7%	30%			16.7%	
32	Percentage of identified patients dying in hospital for non-cancer deaths (Palliative Care Register)	33.8%	32%			38.2%	
33	Percentage of Criminal Justice Social Work Reports submitted to court by noon on the day prior to calling.	69%	98%			78%	
34	Percentage of Community Payback Orders attending an induction session within 5 working days of sentence.	80%	80%			66%	
35	Percentage of Unpaid work and other activity requirements commenced (work or activity) within 7 working days of sentence.	56%	80%			54%	

Resilience

Ref	Performance Indicator	Q4 2019/20				Q3 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
36	Child and Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	40.5%	90%			55.7%	
37	Mean number of weeks for referral to treatment for specialist Child and Adolescent Mental Health Services	21	18			18	
38	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	43.6%	90%			53.3%	

Assets

Ref	Performance Indicator	Q4 2019/20				Q3 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
39	Prescribing cost per weighted patient	£165.07	Annual average across NHSGGC	To follow		£162.69	
40	Compliance with Formulary Preferred List	78.58%	78%			78.7%	

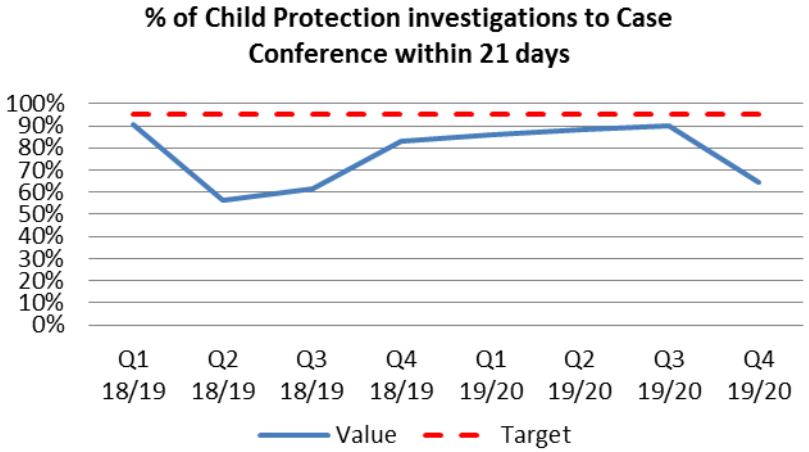
Inequalities

Ref	Performance Indicator	Q4 2019/20				Q3 2019/20	Trend
		Value	Target	Status	Short Trend	Value	
41	Balance of Care for looked after children: % of children being looked after in the Community	91%	90%			91.4%	
42	Percentage of looked after children being looked after in the community who are from BME communities	73.68%	N/A			72.22%	
43	Percentage of 16 or 17 year olds in positive destinations (further/higher education, training, employment) at point of leaving care	100%	75%			100%	

West Dunbartonshire Health and Social Care Partnership
Exceptions Reporting: Quarters 3 and 4, October 2019 – March 2020

Performance Area: Child Protection Case Conferences

Quarter	Value	Target
Q1 18/19	90.50%	95%
Q2 18/19	56.25%	95%
Q3 18/19	61.76%	95%
Q4 18/19	83.33%	95%
Q1 19/20	85.71%	95%
Q2 19/20	88.57%	95%
Q3 19/20	90.00%	95%
Q4 19/20	64.70%	95%



Key Points:
Performance in this area can fluctuate around the conclusion of police investigations to allow an Initial Case Conference (ICC) to take place with all of the required information.

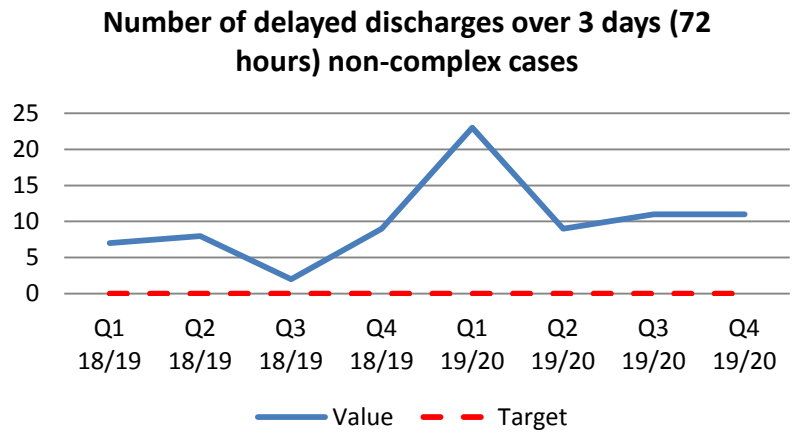
In addition there is a system aspect where duplication of an approved CP1 for siblings associated with the child being considered at ICC may be duplicated and signed off after the ICC thus looking like a delay against some children where there is none. Similarly, pre birth decisions to move to an ICC post birth may (due to the date of actual birth of the child) be well outwith timescales for this reason.

Improvement Actions:
Exceptions will now be tracked to allow specific reporting against individual cases, tracking themes and areas for improvement.

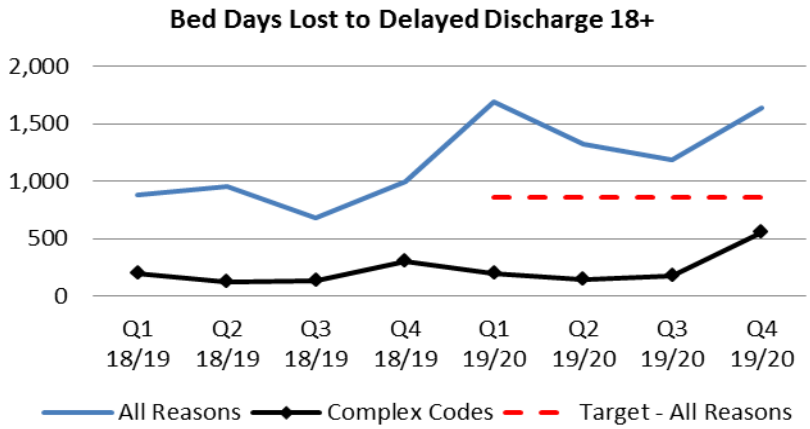
Cases are now routinely placed in service managers' diaries at the point of investigation meaning that if no ICC is required it can be removed with timescales being met in most cases, however exceptions will always apply.

Performance Area: Delayed Discharge

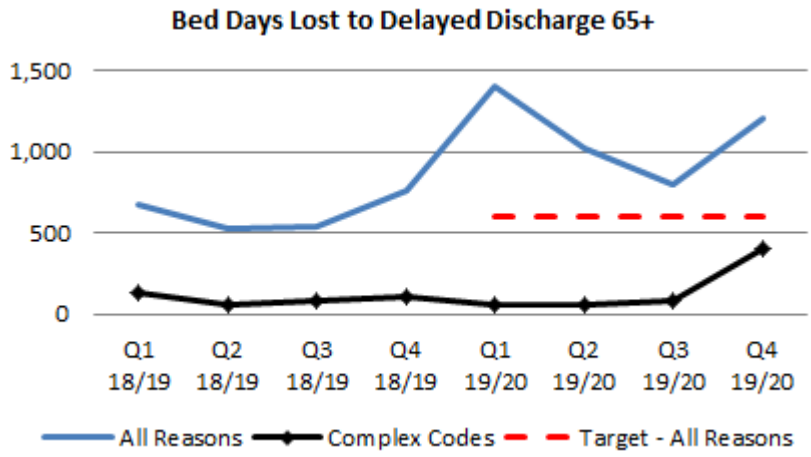
Quarter	Value	Target
Q1 2018/19	7	0
Q2 2018/19	8	0
Q3 2018/19	2	0
Q4 2018/19	9	0
Q1 2019/20	23	0
Q2 2019/20	9	0
Q3 2019/20	11	0
Q4 2019/20	11	0



Quarter	All Reasons	Complex Codes
Q1 18/19	879	200
Q2 18/19	952	125
Q3 18/19	682	137
Q4 18/19	999	304
Q1 19/20	1696	201
Q2 19/20	1320	148
Q3 19/20	1185	180
Q4 19/20	1638	559



Quarter	All Reasons	Complex Codes
Q1 18/19	674	134
Q2 18/19	525	59
Q3 18/19	544	81
Q4 18/19	759	113
Q1 19/20	1401	60
Q2 19/20	1015	56
Q3 19/20	793	76
Q4 19/20	1208	405



Key Points:
Numbers of delayed discharges have remained consistent over Quarter 4 and reflect the large number of Adults with Incapacity (AWI) cases being progressed. In addition to this, two very complex housing cases impacted significantly on the bed days lost to delayed discharge.

Improvement Actions:
Early identification of cases where adults lack capacity, and early social work allocation to start the guardianship process sooner and further upstream, prior to a patient being medically fit for discharge from hospital. The good practice guides highlight that the guardianship process from application to powers being granted should be 10-12 weeks . A recent audit has identified that most delays sit with the courts.

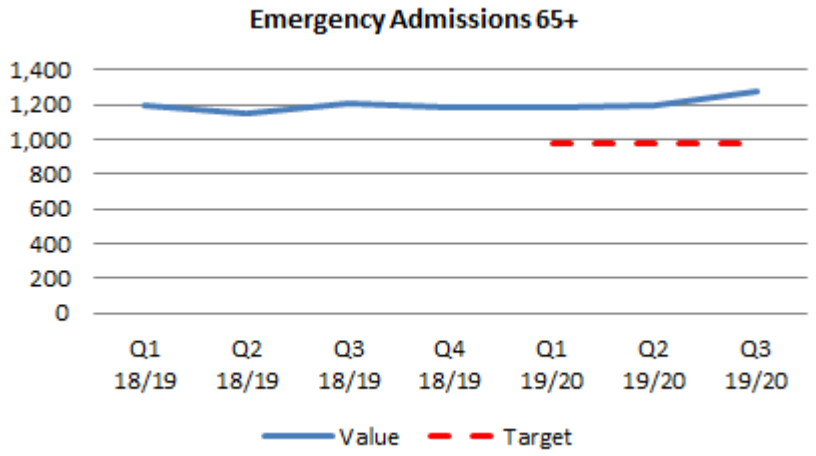
On-going review of the use of Section 13za of the Social Work (Scotland) Act throughout the guardianship process, as this can lead to much quicker progress.

Development of a hoarding policy alongside housing and mental health is underway with the aim of providing early assessor input to ensure the condition of an individual's home is of a habitable standard to return to.

Development of a Housing/Homelessness policy with housing colleagues to ensure those who cannot return to previous accommodation are picked up sooner, reducing the time spent in hospital awaiting more appropriate housing.

Performance Area: Emergency Admissions to Hospital

Quarter	Value	Target
Q1 18/19	1192	
Q2 18/19	1144	
Q3 18/19	1212	
Q4 18/19	1186	
Q1 19/20	1180	979
Q2 19/20	1197	979
Q3 19/20	1273	979



Key Points:
The Ministerial Steering Group (MSG) for Health and Community Care is closely monitoring the progress of HSCPs across Scotland in delivering reductions in: delays in hospital discharge; unnecessary hospital admissions; attendances at accident and emergency (A&E); and shifting the balance of care from hospital to community settings. In light of the integration of health and social care services significant improvements in ways of working and efficiencies are expected.

Emergency admissions for people aged 65 and over have increased by almost 3% during April to December 2019 on the same period in 2018. Data for January to March 2020 is not yet available due to data completeness issues at Health Board level.

Improvement Actions:
Continue to develop the Focussed Intervention Team (FIT) with a view to 7 day access. This is a rapid response team based in the community with a primary focus of preventing and avoiding admission to hospital where possible. This is achieved by visiting and assessing the person referred in their home or homely setting within 2 hours for those with an immediate need, and within 24 hours for those whose presenting situation requires rapid but not urgent intervention.

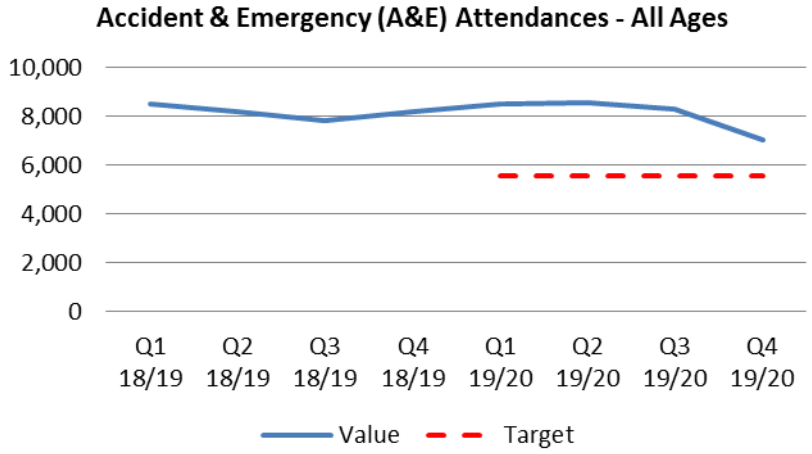
Launched in August 2019 the team accept referrals from all GP Practices and care homes across West Dunbartonshire as well as other HSCP Community teams, and from front door services at the Queen Elizabeth and Vale of Leven Hospitals. Between 19th August 2019 and 10th June 2020 FIT received 737 referrals. These were all referrals that previously would have required further GP Practice input, input from other HSCP teams, or possibly admission to hospital.

Work towards opening referrals to FIT to the Royal Alexandra Hospital is ongoing.

Continue to work closely with Scottish Ambulance Service to encourage appropriate referrals from ambulance crews.

Performance Area: Attendances at Accident and Emergency (A&E)

Quarter	Value	Target
Q1 18/19	8541	
Q2 18/19	8214	
Q3 18/19	7844	
Q4 18/19	8219	
Q1 19/20	8497	5587
Q2 19/20	8571	5587
Q3 19/20	8324	5587
Q4 19/20	7026	5587



Key Points:
Unnecessary attendances at Accident and Emergency (A&E) are part of the MSG's focus to reduce unscheduled care. During 2018/19 there were over 1.5 million A&E attendances across Scotland. During April to December 2019 there were 793 more attendances than in the same period in 2018, however the impact of the COVID-19 pandemic can clearly be seen in the January to March figures with a drop of 15% in 2020 and the total attendances for 2019/20 was 400 less than in 2018/19.

Improvement Actions:
The Vulnerable Adults Multi-Agency Forum (VAMAF) meets weekly and examines relevant presentations to services and repeat attenders at Emergency Departments. Following discussion, a lead agency is then agreed and tasked with following up the assertive outreach to that person. A track is kept of their engagement/progress and their cases is reviewed four weeks after initial presentation to assess the need for further input of required. If a case is of particular concern, the lead agency will organise a multi-agency case discussion and agree care plan/risk management and review schedule. This group, which includes Mental Health, Addictions, Learning Disabilities, Police, Adult Care and Public Protection staff, was formed following a request from the Safer Delivery and Improvement Group and as part of the Greater Glasgow & Clyde multi- agency Distress Collaborative. It also complements other HSCP work on the MSG targets around unscheduled care.

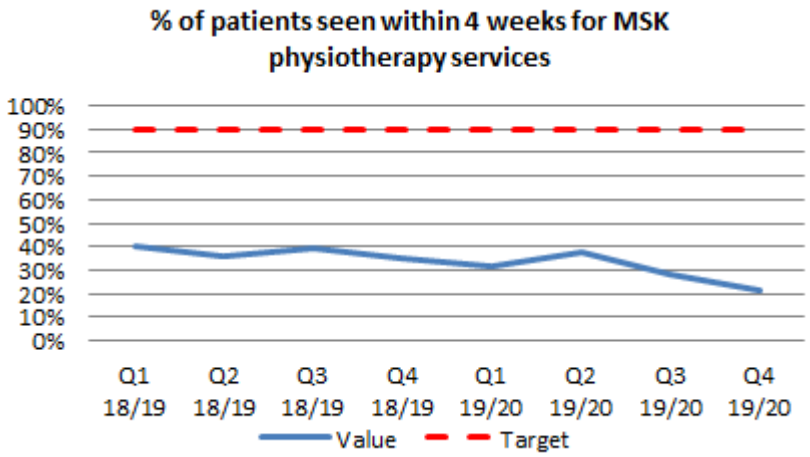
Work is being carried out with the Scottish Ambulance Service (SAS) to increase awareness of our Focussed Intervention Team and their role in preventing A&E attendance and admission. Training has been delivered at ambulance stations, catching crews between responses and tying in with other SAS in-house training delivery.

The Hope Café in Clydebank was opened in December 2019 as part of our response to the significant number of people with mental health and/or addiction problems being among those with the highest levels of attendance. Unfortunately the COVID-19 pandemic resulted in the temporary closure of the service.

Continued monthly analysis of Frequent Attender data.

Performance Area: Musculoskeletal Physiotherapy (MSK) Waiting Times

Quarter	Value	Target
Q1 18/19	40%	90%
Q2 18/19	36%	90%
Q3 18/19	39%	90%
Q4 18/19	35%	90%
Q1 19/20	32%	90%
Q2 19/20	38%	90%
Q3 19/20	28%	90%
Q4 19/20	21%	90%



Key Points:
Referrals during April 2019 to December 2019 were 3.6% higher than in the same period in 2018. During 2019 the expansion of Advanced Practitioner posts in Orthopaedics, Emergency Department and within GP practices led to an unprecedented level of vacancy especially of the senior clinician roles within the MSK Physiotherapy Service. This was replicated nationally.

The waiting list in October to December 2019 was artificially elevated by the Referral Management Centre changing processes in December relating to opt-in letters sent to patients and a delay in removing patients from the waiting list. This was rectified early in Quarter 4: all urgent referrals were seen within target.

The current pandemic response has resulted in the deployment of MSK staff to support colleagues in Acute sites and all routine appointments were cancelled Mid-March resulting in a large number returning to the waiting list.

Improvement Actions:
A Waiting times project was commenced in January 2020 to explore innovative approaches to the waiting list using Quality Improvement methodology. Unfortunately the 3 month timeframe for the project limited the approaches explored and the current emergency footing limited the project developing further.

Remobilisation plans are in development for the service but capacity is greatly reduced due to current service restrictions.

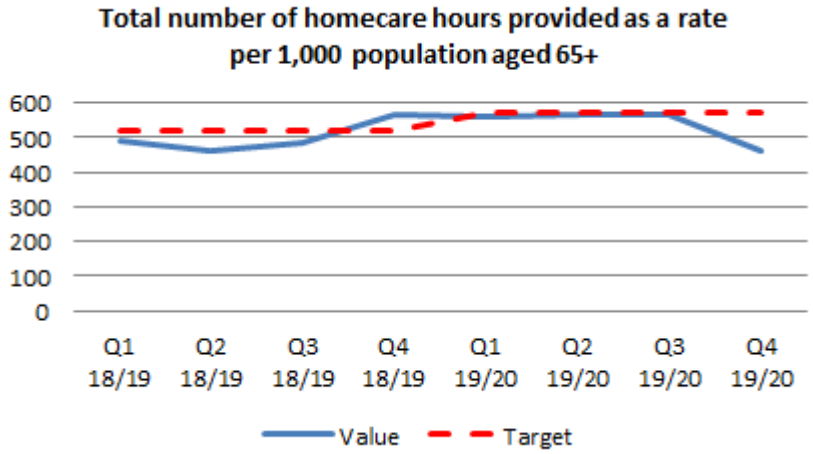
Enhanced Supported self management resources are being developed to facilitate improved patient agency.

Waiting list revalidation process is in development and NHS Near Me and telephone consultations are being evaluated to support waiting times management.

The recruitment process is progressing for vacancies.

Performance Area: Homecare

Quarter	Value	Target
Q1 18/19	490.3	518
Q2 18/19	463.4	518
Q3 18/19	482.6	518
Q4 18/19	566.5	518
Q1 19/20	557.3	570
Q2 19/20	566.4	570
Q3 19/20	568.2	570
Q4 19/20	461.3	570



Key Points:
The number of targeted hours of homecare and the numbers of people receiving homecare had been steadily increasing until the current COVID-19 pandemic.

As part of the HSCP's initial response to the pandemic the Care at Home Service identified all those who required critical and urgent care. Less essential tasks were put on hold which resulted in a reduction of

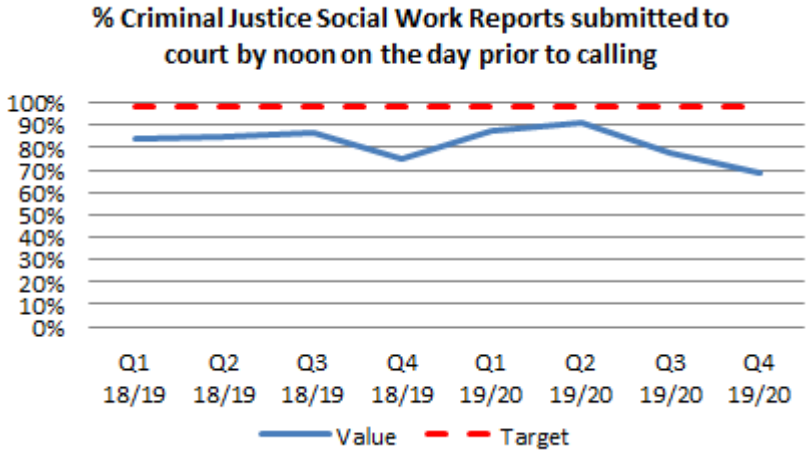
hours delivered. Where possible, family members were asked to provide some of the care for their loved one to enable Care at Home to focus on those whose needs were critical and could not be met elsewhere. In addition to family support, volunteers provided basic practical support e.g. shopping and meal deliveries to clients, and over 160 clients opted to receive wellbeing calls over this period, in order to identify if their needs changed over time.

Improvement Actions:
Due to the nature of the COVID-19 pandemic the Care at Home Service is continually adapting its response in line with the current Government guidance, levels of need and staffing/absence levels due to illness, shielding or self-isolation.

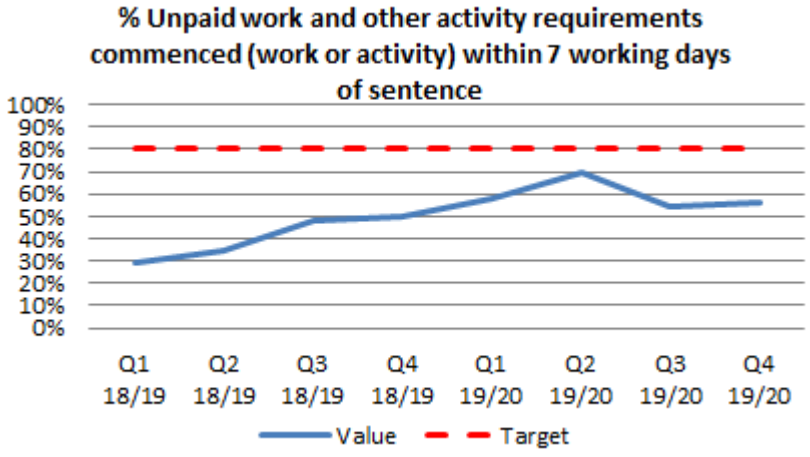
During this current phase of easing of the lockdown, we are looking at ways to increase service levels as staff absence declines however the unpredictable nature of the virus means that we will be sensitive to all changes and developments and react quickly and appropriately.

Performance Area: Criminal Justice Social Work

Quarter	Value	Target
Q1 18/19	84%	98%
Q2 18/19	85%	98%
Q3 18/19	87%	98%
Q4 18/19	75%	98%
Q1 19/20	88%	98%
Q2 19/20	91%	98%
Q3 19/20	78%	98%
Q4 19/20	69%	98%



Quarter	Value	Target
Q1 18/19	29%	80%
Q2 18/19	35%	80%
Q3 18/19	48%	80%
Q4 18/19	50%	80%
Q1 19/20	58%	80%
Q2 19/20	70%	80%
Q3 19/20	54%	80%
Q4 19/20	56%	80%



Key Points:
The increasing numbers of Criminal Justice Social Work Reports required has been a significant factor in meeting timescales. Staff absence in February and March increased pressure on the service and a social worker was re-allocated to full-time court report writing, while others were asked to prioritise court reports.

Although performance in relation to Unpaid Work Orders commencing within timescale has dipped during October 2019 to March 2020, the trend is still improving on the poor performance at the beginning of 2018/19.

Improvement Actions:
Designated Social Worker for Criminal Justice Social Work Reports has returned to full time work, increasing capacity for report writing.

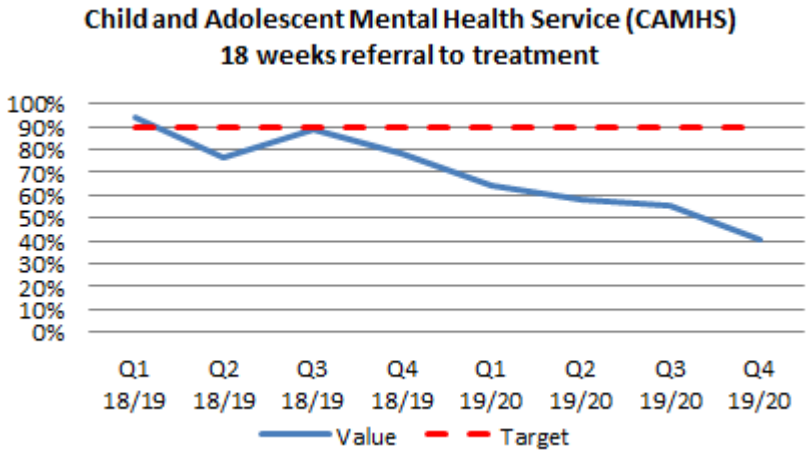
A scoping exercise is being undertaken to determine the re-alignment of caseloads to further increase capacity for completion of reports.

Management action has been taken to ensure staffing complement does not drop below 50% during peak times for leave.

A change in recording practice of duplicate Unpaid Work Orders has been made.

Performance Area: Child and Adolescent Mental Health Services (CAMHS)

Quarter	Value	Target
Q1 18/19	94.2%	90%
Q2 18/19	76.1%	90%
Q3 18/19	89.1%	90%
Q4 18/19	78.5%	90%
Q1 19/20	64.0%	90%
Q2 19/20	58.0%	90%
Q3 19/20	55.7%	90%
Q4 19/20	40.5%	90%



Key Points:
Accepted referrals for CAMHS increased by 22.3% between 2018 and 2019. In addition to this increased demand, significant staffing difficulties due to recruitment, retention and long term sickness absence have impacted on the service's ability to meet timescales. In September 2019, due to staffing levels, there were 130 open cases without a case manager. As a result, urgent new referrals and high risk open cases were prioritised.

In August 2019, new funding from the Scottish Government allowed us to recruit a full time band 5 nurse and 3 sessions Child and Adolescent Therapists. The HSCP also funded a temporary Band 5 nurse. This staffing has allowed the service to minimise the risks by prioritising urgent and high risk cases however, due to other core staff absences, it has resulted in waiting times for routine cases becoming longer over an extended period of time.

Improvement Actions:
CAMHS leadership have launched an Operational Working Group where West Dunbartonshire CAMHS are represented. A large range of strategic projects are underway designed to improve efficiency of the patient flow and effectiveness of service delivery. The following improvement actions are in progress to address the demands on the service:

Regular updates with CAMHS management and teams to ensure the most effective use of clinical capacity for the waiting list and open caseload throughout the COVID-19 Pandemic.

Waiting lists are being analysed to identify cohorts of patients and match these to clinical skill i.e. children awaiting treatment for anxiety.

Brief intervention and online Cognitive Behavioural Therapies are being developed. Attend Anywhere has been implemented across Greater Glasgow and Clyde CAMHS teams and drop in clinics are being considered. Solutions for virtual group clinics are also being sought to increase numbers of children seen.

Planning within HSCP with integrated planning partners to utilise Scottish Government funding for community mental health and wellbeing supports.

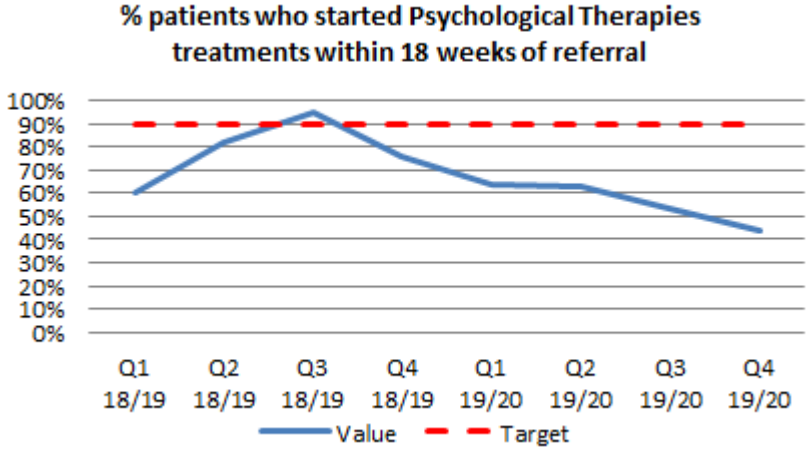
Analysing the demand for CAMHS and availability to meet this.

Development of integrated care pathway for Neuro Development referrals.

Increase the time available for clinicians to provide help and treatment at first contact.

Psychological Therapies

Quarter	Value	Target
Q1 18/19	59.9%	90%
Q2 18/19	82.2%	90%
Q3 18/19	94.7%	90%
Q4 18/19	75.9%	90%
Q1 19/20	63.6%	90%
Q2 19/20	62.8%	90%
Q3 19/20	53.3%	90%
Q4 19/20	43.6%	90%



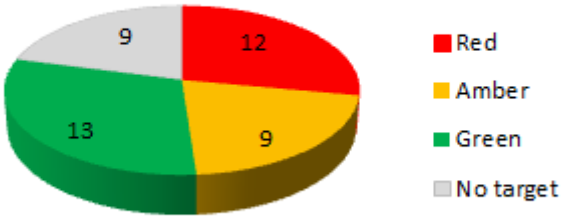
Key Points:
Reduction in available practitioners through vacancy and absence has had a negative impact with the number of patients waiting rising. Primary Care Mental Health Team returned to full treatment capacity in December 2019, the lag effect of working through assessments should show positive upward future trend.

Improvement Actions:
Increase the number of psychologists across West Dunbartonshire, Helensburgh and Lomond by reconfiguring vacant Mental Health Practitioner (MHP) posts. This will support increased numbers of patients being seen within Adult Community Mental Health Teams that will help offset any change in staffing numbers due to absence loss. This requires Argyll and Bute HSCP agreement due to MHP being part funded by them. In progress.

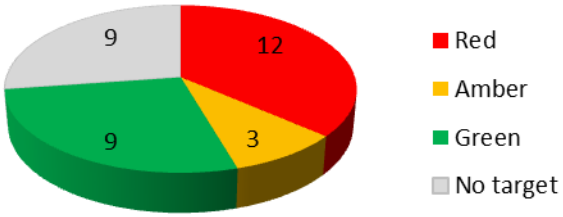
Rollout of Wellbeing Mental Health Nurse service across all GP practices. Currently in 3 practices. End of rollout April 2021.

Summary of Indicators

Quarter 3: October to December 2019



Quarter 4: January to March 2020 (Partial data)



WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

25 June 2020

Subject: Unaudited Annual Report and Accounts 2019/20

1. Purpose

1.1 To request the approval of the unaudited Annual Report and Accounts for the HSCP Board covering the period 1 April 2019 to 31 March 2020.

1.2 Once approved the unaudited Accounts and associated working papers will be passed to our external auditors for their review. Their report on the Accounts will be submitted to a future meeting of the Audit & Performance Committee for consideration (as per the Terms of Reference) prior to being presented to the HSCP Board for final approval.

2. Recommendations

2.1 Members are asked to:

(a) Approve the 2019/20 unaudited Annual Report and Accounts;
(b) Note that the audited Accounts should be presented for final approval no later than 30 November 2020 (subject to confirmation as detailed in section 4.10), prior to submission to the Accounts Commission; and
(c) Note the extension of the current external audit appointments detailed in section 4.12

3. Background

3.1 Integrated Joint Board's are legal entities in their own right and are required by law to produce a draft Statement of Accounts for audit by 30 June each year and publish audited accounts by 31 October each year. The provisions contained within the Coronavirus (Scotland) Act 2020 allow for a reasonable extension to these dates with the view of the Scottish Government being that the audited accounts should be published no later than 30 November 2020.

3.2 Integration Joint Boards are specified in legislation as a "section 106" body under regulations of the Local Government (Scotland) Act 1973 and as such is expected to prepare annual accounts in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

3.3 The Local Authority Accounts (Scotland) Regulations 2014 came into force on 10 October 2014, revoking the Local Authority Accounts (Scotland) Regulations 1985. The regulations therefore apply to the HSCP Board's 2019/20 annual accounts.

4. Main Issues

4.1 The annual accounts for the HSCP Board (Appendix 1) have been prepared in accordance with appropriate legislation and guidance. An overview of the process is set out below.

4.2 **Financial Governance & Internal Control;** the regulations require the Annual Governance Statement to be approved by the HSCP Board or a committee of the HSCP whose remit include audit & governance. This will assess the effectiveness of the internal audit function and the internal control procedures of the HSCP Board.

4.3 The HSCP Board's Audit and Performance Committee would have undertaken this review at the planned 17 June meeting, however this was replaced by a formal member's session on the HSCP's draft COVID-19 Recovery and Renewal process. Therefore the HSCP Board have been recommended to approve the 2019/20 Annual Governance Statement as a separate item on the agenda.

4.4 **Unaudited Accounts;** the regulations state that the unaudited accounts are submitted to the External Auditor no later than 30th June immediately following the financial year to which they relate. The provisions contained within the Coronavirus (Scotland) Act 2020 allow for a reasonable extension to this date; however this has not been required.

4.5 Scottish Government guidance states that best practice would reflect that the HSCP Board or committee whose remit includes audit and governance should consider the unaudited accounts prior to submission to the external auditor. The HSCP Board annual accounts for the year ended 31 March 2020 (Appendix 1) will be considered at this meeting of 25 June 2020.

4.6 **Right to Inspect and Object to Accounts:** the public notice period of inspection should start no later than 1st July in the year the notice is published. This will be for a period of 3 weeks and will follow appropriate protocol for advertising and accessing the unaudited accounts.

4.7 **Approval of Audited Accounts**: the regulations require the approval of the audited annual accounts by the HSCP Board or a committee of the HSCP whose remit include audit & governance. This will take account of any report made on the audited annual accounts by the "proper officer" i.e. Chief Financial Officer being the Section 95 Officer for the HSCP Board or by the External Auditor by the 30th September immediately following the financial year to which they relate. In addition any further report by the external auditor on the audited annual accounts should also be considered.

4.8 Owing to the ongoing Coronavirus pandemic and the impact associated restrictions may have in terms of allowing the audit of the accounts to

progress, additional flexibility in terms of the approval process for the audited accounts has been provided under the Coronavirus (Scotland) Act 2020. In essence, each Council and IJB may set its own timetable for approval of the audited accounts; however, Scottish Ministers have indicated in Finance Circular 10/2020 that they consider audited accounts should be published no later than 30 November 2020.

4.9 Our external auditor (Audit Scotland) will endeavour to complete the audit process in line with these timescales (Appendix 2) and an update will be provided to the HSCP Board on progress with the audit at the earliest possible stage. The external audit report on the Accounts and the proposed audit certificate (ISA 260 report) will be made available to all members and will be submitted to a meeting of the Audit and Performance Committee for consideration prior to the meeting of the HSCP Board where the audited accounts are considered.

4.10 **Publication of the Audited Accounts:** the regulations require that the annual accounts of the HSCP Board be available in both hard copy and on the website for at least five years, together with any further reports provided by the External Auditor that relate to the audited accounts.

4.11 The annual accounts of the HSCP Board must be published by 31st October and any further reports by the External Auditor by 31st December immediately following the year to which they relate. As detailed above, the impact of the ongoing Coronavirus pandemic means that this date may also be subject to delay.

4.12 **Key Documents:** the regulations require a number of key documents (within the annual accounts) to be signed by the Chair of the HSCP Board, the Chief Officer and the Chief Financial Officer, namely:

Document	**Signatory**
Management Commentary	Chair of the HSCP Board Chief Officer
Statement of Responsibilities	Chair of the HSCP Board Chief Financial Officer
Remuneration Report	Chair of the HSCP Board Chief Officer
Annual Governance Statement	Chair of the HSCP Board Chief Officer
Balance Sheet	Chief Financial Officer

Draft Annual Report and Accounts (Appendix 1)

4.13 The draft annual report and accounts reflect the financial position reported to the HSCP Board throughout 2019/20. On 4 June 2020, through a targeted communication, members were provided with the interim Period 12 position which detailed the projected position to the 31 March 2020 of a £0.933m (0.57%) underspend. This figure was reflective of planned increase in reserves. This report has been published on the

HSCP website under the original planned meeting date of 20 May 2020 which was cancelled as a consequence of the Coronavirus pandemic.

4.14 The final year end position for 2019/20 as reflected in the draft annual report and accounts (attached at Appendix 1) has only marginally changed from the May report to £0.883m underspend, as detailed in the table below.

Extract from 2019/20 Unaudited Annual Report and Accounts

West Dunbartonshire Integrated Joint Board **Consolidated Health & Social Care**	**2019/20 Annual Budget £000**	**2019/20 Net Expenditure £000**	**2019/20 Underspend/ (Overspend) £000**
Older People, Health and Community Care	45,855	44,207	1,648
Physical Disability	2,949	2,748	201
Children and Families	22,131	24,898	(2,767)
Mental Health Services	10,156	9,317	839
Addictions	2,820	2,859	(39)
Learning Disabilities	16,560	16,258	302
Strategy, Planning and Health Improvement	1,850	1,301	549
Family Health Services (FHS)	27,427	27,427	0
GP Prescribing	19,305	19,432	(127)
Hosted Services - MSK Physio	6,492	6,370	122
Hosted Services - Retinal Screening	800	824	(24)
Criminal Justice - Grant funding of £2.1m	0	0	0
HSCP Corporate and Other Services	6,279	6,100	179
IJB Operational Costs	281	281	0
Cost of Services Directly Managed by West Dunbartonshire HSCP	**162,905**	**162,022**	**883**
Set aside for delegated services provided in large hospitals	28,389	28,389	0
Assisted garden maintenance and Aids and Adaptions	661	661	0
Total Cost of Services to West Dunbartonshire HSCP	**191,955**	**191,072**	**883**

4.15 The main reason for the movement of £0.050m is due to the creation of a provision in relation to an insurance claim that has now been settled.

4.16 The draft accounts under "Final Outturn Position 2019/20" provides details of the key messages which are reflective of the significant variances and pressures reported in the May report. These include overspends within social care for children's community and residential placements offset by lower than anticipated spend in older people services within care homes (reflective of our demographic and social needs) and other adult services in learning disabilities and mental health as well as the application of social care funding earmarked for service redesign and transformation. For health care the main budget pressure of GP prescribing was offset by additional income from Highland

Health Board for their use of West Dunbartonshire mental health in-patient beds and underspend within Adult Community Services due to part year impact of service redesign, including introduction of Focussed Intervention Team and cessation of purchased step up/step down Care Home beds.

4.17 As covered in the last financial performance report the draft accounts (under Note 12. "Useable Reserve: General Fund") details the opening reserves balance, transfers in and out and the proposed final balance for both unearmarked and earmarked reserves. To support the Medium Term Financial Plan the transfers include an increase in unearmarked reserves of £0.352m which brings the balance to £2.809m, reflecting the Reserves Policy target of 2% (£2.8m) to be held to "create a contingency to cushion the impact of unexpected events or emergencies". An extract is provided below:

Balance as at 31st March 2019 £000	Total Reserves	Transfers Out 2019/20 £000	Transfers In 2019/20 £000	Balance as at 31st March 2020 £000
(4,723)	Total Earmarked Reserves	2,185	(2,716)	(5,254)
(2,457)	Total Unearmarked Reserves	0	(352)	(2,809)
(7,180)	Total General Fund Reserves	2,185	(3,068)	(8,063)
	Overall Movement			(883)

4.18 The remaining 2019/20 surplus of £0.531m (shown as the total of "transfers out" and "transfers in" above) has been transferred to earmarked reserves. The main highlight to note within earmarked reserves is the un-earmarking of reserves no longer required and the creation of new reserves for unscheduled care and the anticipated increase in demand for a number of HSCP services as we move from Covid-19 response phase into the recovery and renewal phase. The GP Prescribing reserve has also been increased to address the risk of volatility in the supply and cost of medicines that remains as the full impacts of the Covid-19 pandemic and the transitional arrangements of the United Kingdom leaving the European Union have yet to be fully understood.

4.19 The financial outlook for Scotland, the UK and the rest of the world as it emerges from the Coronavirus pandemic is likely to be one of a depressed economy with significant public sector debt, high unemployment and a reduction in private sector investment against. The people of West Dunbartonshire have already been disproportionally impacted by the virus than some of its neighbouring local authority areas, which will almost certainly have a knock-on impact on an increase in demand for health and social care services. Therefore the requirement for strong financial management has never been more critical. The final outturn position for 2019/20 as reflected in these accounts provide the HSCP Board with an opportunity to underwrite and element of the ongoing financial risk, with the proviso that the Scottish Government provide sufficient funding to public sector bodies to cover the unfunded costs of responding the pandemic.

4.20 The Chief Financial Officer would like to extend sincere thanks to colleagues across the HSCP, in particular the finance team; and partner organisations acknowledging the detailed work required in the 2019/20 year end closure

process, a year that has been like no other as we continued to work collegiately while abiding by “lockdown” conditions to support the health and wellbeing of all.

Extension of Audit Appointments

4.21 The COVID-19 pandemic has resulted in significant disruption for public bodies and their capacity for financial reporting, and to auditors of the public sector. In light of this the Auditor General for Scotland and the Accounts Commission for Scotland intend to extend the current audit appointments by one year in the first instance. This is in line with provisions in the current contracts that allow for extensions of up to two years. These appointments were for the audit of public bodies for the financial years of 2016/17 to 2020/21 inclusive. The intended extension would be through to the audit of the 2021/22 year. The Auditor General and the Commission will confirm both the extension and the time period in Autumn 2020.

4.22 In addition the Code of Audit Practice was due to be renewed this year and in place from the start of the 2021/22 audits. In light of the difficult circumstances, the current code will apply to the extended appointments. Earlier this year Audit Scotland carried out a public consultation on the new draft code. This has now closed, and later this year they will engage further with stakeholders on aspects of the draft code with the aim of finalising the new code in early 2021.

4.23 Extension of the current audit appointments will create the best opportunity to maintain high-quality audit services to the public sector in Scotland and provide a degree of clarity and certainty during a time of significant and fast-moving change.

5. People Implications

5.1 There are no people implications.

6. Financial Implications

6.1 There are no financial implications other than those detailed in the report.

7. Professional Implications

7.1 None

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 No risk analysis was required.

10. Impact Assessments

10.1 None

11. Consultation

11.1 This report was prepared in conjunction with NHSGGC and WDC colleagues.

12. Strategic Assessment

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

12.2 The report is in relation to a statutory function and is for approving.

12.3 This report links to the strategic financial governance arrangements of both parent organisations.

Julie Slavin – Chief Financial Officer
Date: 18 June 2020

Person to Contact:	Julie Slavin – Chief Financial Officer, Church Street, Dumbarton e-mail : julie.slavin@ggc.scot.nhs.uk
Appendices:	Appendix 1: Draft Unaudited Annual Accounts 2019/20 Appendix 2: Letter from Audit Scotland re 2019/20 Annual Audit timelines
Background Papers:	31 May 2020 HSCP Board: 2019/20 Financial Performance Report Audit and Performance Committee Terms of Reference
Wards Affected:	None

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Integration Joint Board

Commonly known as

West Dunbartonshire Health and Social Care Partnership Board

Annual Accounts 2019/20

DRAFT

TABLE OF CONTENTS

MANAGEMENT COMMENTARY

INTRODUCTION

This publication contains the financial statements for the West Dunbartonshire Integration Joint Board (IJB), hereafter known as the Health and Social Care Partnership Board (HSCP Board) for the year ended 31 March 2020.

The Management Commentary aims to provide an overview of the key messages in relation to the HSCP Board's financial planning and performance for the 2019/20 financial year and how this has supported the delivery of its strategic priorities as laid out in its Strategic Plan. The commentary also outlines the future challenges and risks which influence the financial plans of the HSCP Board as it delivers high quality health and social care services to the people of West Dunbartonshire.

In early February when initial year end preparations began for the closure of the 2019/20 financial year the impact of a new virus named Coronavirus Disease or COVID-19 on the population of Scotland and the rest of the world was only beginning to reveal itself.

Within weeks the world was in the grip of a global pandemic and life changed for everyone as governments reacted and mobilised services to fight this public health crisis. For many it may have felt like the world paused or slowed down but for all involved both in the delivery and receipt of health and social care services the pace and scale of activity undertaken to keep safe, treat and support has been extraordinary.

While more than 11 months of the facts and figures referred to in this review of the 2019/20 financial year are not impacted by the HSCP's response to the COVID-19 pandemic, it must be acknowledged that at the time of writing, this "Business as Usual" position for health and care services, delivered to the citizens of West Dunbartonshire, will not reflect current service delivery models set out in both local and national mobilisation plans.

Going forward over the next year and beyond, the HSCP Board together with its partners and stakeholders will move through this crisis into recovery and renewal phases with the overarching strategic intent of *delivering better services **with** the residents of West Dunbartonshire, improving health and reducing inequalities*.

The attached annual accounts have been prepared in accordance with current regulations and guidance.

Our Partnership Vision Statement is:

Improving lives with the people of West Dunbartonshire

WEST DUNBARTONSHIRE HSCP BOARD - REMIT and VISION

The Public Bodies (Joint Working) Act (Scotland) 2014 sets out the arrangements for the integration of health and social care across the country. The West Dunbartonshire IJB, commonly known as the HSCP Board was established as a "body corporate" by Scottish Ministers' Parliamentary Order on 1st July 2015.

The HSCP Board's Integration Scheme details the body corporate arrangement by which NHS Greater Glasgow and Clyde Health Board (NHSGGC) and West Dunbartonshire Council (WDC) agreed to formally delegate all community health and social care services provided to children, adults and older people, criminal justice social work services and some housing functions. This way of working is referred to as "Health and Social Care Integration". The full scheme can be viewed here (see Appendix 1, 1).

The 2014 Act requires that Integration Schemes are reviewed within five years of establishment; the current scheme was revised during 2019/20 and this was reviewed by the HSCP Board at its 19 February 2020 meeting however the final approval processes have been delayed as the HSCP Board, NHSGGC and WDC respond to COVID-19. The Scottish Government has confirmed that the Act does not require the Health Board and Local Authority to produce a successor scheme, it requires a ***review***. "This review can note anything that requires further work between the partners and set out plans for the completion of that work at a later date, once the current very challenging situation passes, including the production of a successor scheme. Meantime, the current Integration Scheme will remain in force".

The HSCP Board's primary purpose is to set the strategic direction for the delegated functions through its Strategic Plan. It is responsible for strategic commissioning (either by direct service delivery or external providers), service delivery and performance for those integrated services delegated to it (except for NHS acute hospital services, which are managed directly by the Health Board). The HSCP Board discharges these responsibilities through its operational delivery arm, which is West Dunbartonshire HSCP. Staff who work within the management of the HSCP continue to be employed by either NHSGGC or WDC, retaining their respective terms and conditions.

COVID-19 PANDEMIC IMPACT AND RESPONSE

On the 1 March 2020 the first positive case of COVID-19 was confirmed in Scotland, with the World Health Organisation (WHO) declaring the virus a pandemic on 11 March 2020. Although the full impact of the COVID-19 outbreak had yet to be felt at that time, during the final weeks of the 2019/20 financial year the daily routine of service delivery within HSCP moved into emergency response mode, implementing Business Continuity Plans as Scotland went into "lockdown" on the 23 March 2020. A Local Mobilisation Plan (supported by a detailed financial tracker) was produced based on Scottish Government guidance and fed into the collective NHSGGC response together with our five partner HSCPs in the Glasgow Board wide area.

On the 25 March 2020 the HSCP Board convened its scheduled meeting through the use of telephone conferencing as all required to take part phoned in from their homes. The Board

agreed to implement "Temporary Decision Making Arrangements" delegating authority to make operational demand decisions, normally requiring HSCP Board approval to the Chief Officer in consultation where necessary with the Board Chair, Vice Chair and Chief Financial Officer.

On the 6 April the Coronavirus (Scotland) Act 2020 received Royal Assent. This Act of the Scottish Parliament made provisions to ease many regulations in sectors that may struggle to meet their statutory requirements, such as the NHS, Local Authorities, Social Security Scotland and the Scottish Courts and Tribunals Service.

The pace of service response and transformation within the HSCP has been exceptional. The health, safety and wellbeing of service users and the wider population of West Dunbartonshire is at the heart of everything that we do and reflected in our phase one response. To comply with physical distancing measures and shielding requirements of vulnerable groups all non-critical health and care services stopped and capacity focussed on the COVID-19 response. The public's use of hospital emergency departments has significantly reduced and there has been an extremely positive response from staff and service users with many staff redeployed on a voluntary basis to roles dedicated to supporting the most vulnerable within our communities during this very difficult time. For example, Community Justice Officers were actively redeployed to support those on the Shielding list.

The pandemic has provided an opportunity for enhanced partnership working and significant efforts have taken place to support the mental health and wellbeing of the workforce. Collaboration between the HSCP and local government colleagues to effectively procure and distribute PPE across the HSCP and ensured confidence in the supply of PPE has been particularly successful, with the West Dunbartonshire approach being recognised as best practice across the Greater Glasgow and Clyde area.

Perceived barriers in areas such as information governance have been quickly removed and the push for real time data has significantly enhanced the effective response to the crisis.

Large numbers of staff were quickly equipped to work from home and many teams continued to deliver vital services to our most vulnerable service users, notably vulnerable children and families, those in care homes and those requiring care at home.

The use of technology enabled staff to maintain contact with service users and was also utilised creatively to support contact between children and their families.

As we move into 2020/21 and the transition from response to recovery it is recognised that there will be an increase in demand for, and backlog of, statutory services all of which will have wide ranging resource implications, primarily staffing and financial. The current Strategic Plan clearly sets out the scale of the challenge around effective delivery of health and social care services in West Dunbartonshire in particular tackling multi-morbidity, poverty, addiction, domestic violence and mental health. As the full impact of the health, social and economic consequences of the COVID-19 pandemic reveal themselves the HSCP Board will continue to respond positively and plan for the future new model of service delivery.

STRATEGIC PLANNING FOR OUR POPULATION

West Dunbartonshire lies north of the River Clyde encompassing around 98 square miles of urban and rural communities across the two localities of Clydebank and Dumbarton/Alexandria. The area has a rich past, shaped by its world famous shipyards along the Clyde, and has significant sights of natural beauty and heritage from Loch Lomond to the iconic Titan Crane as well as good transport links to Glasgow. However the area has challenges in addressing deprivation, ill health and inequality, within the local population across the age categories, and has the Scottish average in many key health and social care indicators e.g. income deprivation, employment and life expectancy. It has the joint third highest number of data zones in the 20% most deprived in Scotland and the gap between the most deprived areas compared to the least deprived areas is widening.

Successful and strong integration of health and social care services will address the challenges faced by the people of West Dunbartonshire by ensuring that people have access to the services and support they need, so that their care feels seamless to them, and they experience good outcomes and high standards of support. The local community response to the COVID-19 pandemic runs parallel to the strategic planning intention of the Partnership and we must continue to work with our partners and communities to consider how services can be focused on not only early intervention and prevention but on how we are able to support people to maintain their independence and to be as independent as possible. Working with our local communities to consider how we can better support and embed capacity building within localities is a key objective.

The HSCP Board approved its third Strategic Plan, covering the three year period 2019 – 2022, which can be viewed here (see Appendix 1, 2.) in March 2019. The Plan, developed by the Strategic Planning Group formed in early 2018, describes how we will use our resources to continue to integrate services in pursuit of national and local outcomes.

The Strategic Planning Group took an innovative approach to the development of the new strategic plan by working in partnership with the national Burden of Disease Team (Appendix 1, 3.), by evidencing the case for change through a Strategic Needs Assessment that took a population view using an epidemiological approach. This internationally recognised approach is used to quantify the difference between the ideal of living to old age in good health and the situations where a healthy life is shortened by illness, injury, disability and early death.

Change in the provision of health and social care services is necessary as demand is rising significantly whilst financial and staffing resources are stretched. The demographic profile has been well documented, and while life expectancy may be below the Scottish average, West Dunbartonshire population projections indicate that the age groups of 65+ and 75+ will increase up to the year 2037 with other age bands decreasing. A continued increase in the older age population will have a significant impact on the dependency ratio. The dependency ratio measures the proportion of the population seen as economically dependent upon the working age population. A strong economy and thriving community needs a finely balanced population mix.

The Strategic Plan identified **five key Strategic Priorities** aligned to HSCP Board's vision and Strategic Outcomes as follows:

- **Early Intervention** – clear pathways to support, anticipatory care planning, social prescribing, carers support, rehabilitation and re-ablement
- **Access** – primary care, self directed support, community link support
- **Resilience** – recovery groups, wellbeing support to staff and service users
- **Assets** – staff training and support, carers, partners, community
- **Inequalities** – locality groups, carers support, tackling poverty, employment opportunities

The **Strategic Outcomes** are embedded in our commitment to:

- Children and young people reflected in Getting It Right for Every Child;
- Continual transformation in the delivery of services for adults and older people as reflected within our approach to integrated care;
- The safety and protection of the most vulnerable people within our care and within our wider communities;
- Support people to exercise choice and control in the achievement of their personal outcomes; and
- Manage resources effectively, making best use of our integrated capacity.

PERFORMANCE HIGHLIGHTS 2019/20

The HSCP Board receives a Quarterly Public Performance Report at each meeting, which provides an update on progress in respect of key performance indicators and commitments. These can be viewed here (see Appendix 1, 4).

The Joint Bodies Act also requires all IJBs to produce an Annual Performance Report, no later than four months after the end of that year i.e. 31 July. The report content is governed by the 2014 Act and must cover the HSCP Board's performance against the nine national outcomes and 23 national indicators.

The Coronavirus (Scotland) Act 2020 referred to above has made provision under Schedule 6 (para.8) to allow an extension to the publication deadline until 30 September 2020. Therefore some of the data included in this report may be subject to change. The latest version of the quarterly performance report was presented to the HSCP Board on the 25 June and covered both quarter 3 for publication and quarter 4 in draft. The presentation of performance data has been refreshed to categorise the statutory key performance indicators under the five strategic priorities as detailed above. The report can be viewed here (see Appendix 1, 5).

Some key areas of performance (as defined by the Scottish Government) over the past year are detailed below. Subject to final verification - Quarter 4 data was used where available, if not Quarter 3 is noted and will be revised for audited accounts.

KEY

PI Status	
	Alert
	Warning
	OK
	Unknown
	Data Only

Short Term Trends	
	Improving
	No Change
	Getting Worse

Extract from Performance Report 2019/20

Strategic Priority and associated Performance Indicators	2018/19 Value	2019/20 Value	2019/20 Target	Status	Short Trend Qtr3 to Qtr4
Early Intervention					
Number of acute bed days lost to delayed discharges (including AWI) aged 65 years and over	2,502	**4,417**	596		
Percentage of children on the Child Protection Register who have a completed and current risk assessment	100%	**100%**	100%		
Percentage of carers who feel supported to continue in their caring role	98%	**95%**	90%		
Percentage of patients seen within 4 weeks for musculoskeletal physiotherapy services - WDHSCP	39%	**21%**	90%		
Access					
Percentage of people aged 65 and over who receive 20 or more interventions per week	36.90%	**33.10%**	35%		
Percentage of Community Payback Orders attending an induction session within 5 working days of sentence	59%	**80%**	80%		
Resilience					
Child and Adolescent Mental Health Service (CAMHS) 18 weeks referral to treatment	78.50%	**40.50%**	90%		
Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	77.4%	**43.60%**	90%		

Extract from Performance Report 2019/20 (cont.)

Strategic Priority and associated Performance Indicators	2018/19 Value	2019/20 Value	2019/20 Target	Status	Short Trend Qtr3 to Qtr4
Assets					
Prescribing cost per weighted patient	£167.87	**£165.07**	TBC		
Inequalities					
Balance of Care for looked after children: % of children being looked after in the Community	91.5%	**91%**	90%		
Percentage of looked after children being looked after in the community who are from BME communities	86%	**73.68%**	N/A		

PERFORMANCE CHALLENGES

The table above provides only a small extract of some strong and improving performance and the 2019/20 Annual Performance Report, when published, will bring this performance to life with real examples of how HSCP services positively impact on our service users and their families.

It also highlights areas for improvement and as part of the HSCP Board's expectation of continuous improvement and demonstration of best value, each area will revisit its service delivery plans and develop action plans to address this. The quarter 4 data has been significantly impacted by the COVID-19 lockdown arrangements, especially around provision of health services that are traditionally clinic based; however there have been some longer term workforce recruitment issues in particular services as well as increases in demand.

MSK Physio Service recruitment and vacancy levels continue to be impacted by staff transferring Primary Care, Acute and Orthopaedics to take up Advanced Practitioner posts. Demand is also up 3.6% in the year to December 2019 bringing new referrals to just fewer than 57,000 patients. The service is undertaking a waiting list revalidation exercise and "NHS Near me" and telephone consultations are being evaluated.

CAMHS accepted referrals increased by 22.3% between 2018 and 2019. In addition to this increased demand, significant staffing difficulties due to recruitment, retention and long term sickness absence have impacted on the service's ability to meet timescales. As a result, urgent new referrals and high risk open cases were prioritised. The funding for two additional Band 5 Nurses was identified and this will continue into 2020/21. The service is also extending online Cognitive Behavioural Therapies (CBT) and "Attend Anywhere" has been rolled out.

Psychological Therapies have been impacted by a reduction in available practitioners through vacancy and absence which has had a negative impact with the number of patients

waiting rising. Primary Care Mental Health Team returned to full treatment capacity in December 2019, the lag effect of working through assessments should show positive upward future trend.

COVID-19 will be an on-going threat until either a vaccine is found or immunity levels increase across the general population. The threat of a second wave is still a possibility, therefore the continued need for social distancing, shielding the vulnerable and the as yet unknown impact of "Test and Protect" on the workforce could have significant impacts on a whole range of services and their targets.

The HSCP remains ambitious for the communities of West Dunbartonshire and, during this period of transition, recovery plans are an opportunity to build better services as part of the journey of continuous improvement. Over the next 18 months, HSCP will work in partnership with its staff, trade union colleagues and citizens, and will deliver better services with the people of West Dunbartonshire to improve health and reduce inequalities.

The strategic intent of the HSCPs COVID-19 Recovery and Renewal Plan "Keep Building Better – A Journey of Continuous Improvement" is: "Over the next 18 months, driven by our staff and citizens, we will deliver better services to the people of West Dunbartonshire improving health and reducing inequalities."

The HSCP Senior Management Team have developed a set of overarching strategic principles as a framework for our approach to recovery and renewal, these are:

- Arrangements must be adaptable to increased volatility
- Staff and Service User Safety must be paramount
- Adoption of People Centred Service Design Principles
- Development of Self-Efficacy and Personal Agency
- Strong Employee Engagement
- Reduce Inequalities
- Hybridised Work – Integrate Physical With Virtual
- Real Time Data Push
- Focus on Automation
- Focus on Climate Change and Sustainability
- Ensuring there is longevity in its services
- Clear access point for all services

The HSCP Board considered the early groundwork for the "COVID-19 Recovery and Renewal Plan" during a member's session on 17 June 2020. The stages of the plan will be aligned to the:

- Scottish Government's "COVID-19 – Framework for Decision Making"
    - Scotland's Route Map Through and Out of the Crisis; and
    - Re-mobilise, Recover, Re-design: The Framework for NHS Scotland" and
- West Dunbartonshire Council's COVID-19 Recovery Plan

Positive Performance in Action

While the impacts and response to the COVID-19 pandemic will dominate the HSCP service delivery in 2020/21 and beyond, there are many examples of positive performance in 2019/20 some examples of which are detailed below:

- Our **Health Visiting team** has achieved re-accreditation of the UNICEF Gold Award in recognition of their ongoing work to promote maternal infant nutrition;
- The inspection of our **Throughcare Team's Housing support service** was rated as 'very good' or 'excellent' for support, leadership and how young people's health benefits from our support;
- The Care Inspectorate report on the inspection of **Justice Social Work Services** (August 2019), while highlighting a number of areas for improvement, recognised the commitment of staff and the positive relationships with individuals who offend. A new post of Justice Service Manager was created and now provides dedicated leadership to the team, as well as leading on delivery of the improvement action plan;
- On-going recruitment to social worker vacancies and an additional six **social worker posts** has been further augmented by six support worker posts for two years which will strengthen the service's ability to support contact between children and their families as well as providing intensive support to young people, their carers and their families;
- The new SCI Gateway referral system for **Carers** went live in November 2019. This allows GPs to make direct care referrals to our 3rd sector partners;
- The **Focussed Intervention Team** (primarily designed to avoid and prevent hospital admission by providing quick access to a multi-disciplinary team of nurses, physiotherapists, occupational therapists, pharmacy support and social care staff) has been in operation since August 2019. Of the 759 referrals to date 492 hospital admissions were avoided.
- **Mental Health Wellbeing Nurses** - registered mental health nurses located within GP practices have been incredibly well received with 246 patients attending in the first 3 month period. Customer experience rated the services as 70% excellent, 18% very good and 12 % as good. Individuals are able to contact the nurse directly through GP receptionist rather than having to see their GP in the first instance. This 30 minute consultation service supports people with emotional wellbeing and mental health needs that in the first instance do not require a medication review.
- **Primary Care** - The HSCP Primary Care Improvement Plan was approved in July 2019. Since then the HSCP has worked in collaboration with our partners to increase delivery of a number of workstreams. We have increased our **Pharmacotherapy team, Advance Practice Physiotherapists, Treatment Room Service, including Phlebotomy service**. We have supported the pilot of the Childhood Immunisation Programme which will be rolled out further in 2020. We have also extended our contract with West Dunbartonshire Community Volunteering Service across 5 GP Practices to supply **Community Link Workers** to help patients with signposting to other support.
- **Alcohol and Drugs Partnership (ADP)** – To support Ministerial Priorities including a "Education, Prevention and Early Intervention" – The Health Improvement Team has made a clear impact on influencing the Licensing Board Policy Statement and working in partnership to raise health issues at the Licensing Forum.

Positive Performance – COVID-19 Response

As covered briefly in the section "COVID-19 Pandemic Impact and Response" the HSCP had to adapt quickly some further detail is provided below:

- Personal Protective Equipment (PPE) for Health and Social Care Staff – two PPE HUBS were established in Clydebank and Dumbarton, with the support of our WDC Procurement and Asset Teams. A centralised PPE stock control model was developed to assess demand and track supply from both council and National Services Scotland procurement routes. These HUBS not only provide essential equipment to HSCP staff but also to a wide range of our social care providers, carers and personal assistants;
- Testing and Assessment – Under the direction of our Senior Nurse Adult Care a testing team was established to undertake enhanced outbreak investigation in all care homes where there are cases of COVID-19;
- Community Assessment Centres – were established in Clydebank and Renton for people concerned about potential COVID-19 symptoms. Led by our Clinical Directors, premises were adapted, new cleaning regimes implemented and local GPs and nurses assessed those referred;
- Focussed Intervention Team – provided a Secondary Respiratory Response Service to provide follow up support for post-COVID patients and community respiratory patients;
- Health and Social Care Community Services – a Local Management Response Team was established and met via tele-conference at least weekly, led by the Chief Officer with the membership from all the senior management team, community pharmacy, West Dunbartonshire CVS (Community Volunteer Service), Scottish Care representative, human resources and staff representatives; and

- Community Response – the community response from volunteers from the local community and from staff within the HSCP, WDC and NHSGGC has been incredible. From weekly support phone calls to those shielding, supporting carers to delivering food parcels and essential medication this community mobilisation response validates the strategic vision of working ***with*** the people of West Dunbartonshire will improve lives.

FINANCIAL PERFORMANCE 2019/20

The Statement of Accounts contains the financial statements of the HSCP Board for the year ended 31 March 2020 and has been prepared in accordance with The Code of Practice on Local Authority Accounting in the United Kingdom (the Code).

Financial performance is an integral element of the HSCP Board's overall performance management framework, with regular reporting and scrutiny of financial performance at meetings of both the HSCP Board and its Audit and Performance Committee. The full year financial position for the HSCP Board can be summarised as follows:

SUMMARY FINANCIAL POSITION 2019/20

1 April 2019 to 31 March 2020	West Dunbartonshire Council £000	Greater Glasgow & Clyde Heath Board £000	Total £000
Funds Received from Partners	(68,244)	(123,711)	(191,955)
Funds Spent with Partners	67,835	123,237	191,072
Surplus in Year 2019/20	(409)	(474)	(883)

The Comprehensive Income and Expenditure Statement (CIES) on page 36 details the cost of providing services for the year to 31 March 2020 for all health and care services delegated or hosted by the HSCP Board.

The total cost of delivering services amounted to £191.072m against funding contributions £191.955m, both amounts including notional spend and funding agreed for Set Aside of £28.389m, (see Note 4 “Critical Judgements and Estimations” page 41). This therefore leaves the HSCP Board with an overall surplus (including planned transfers to earmarked reserves) on the provision of services of £0.883m, the composition of which is detailed within Note 12 “Usable Reserve: General Fund” page 44.

The HSCP Board’s 2019/20 Financial Year

The HSCP Board approved the 2019/20 revenue budget on 28 March 2019. This clearly set out the funding offers from our partners WDC and NHSGGC as well as specific funding streams from the Scottish Government for Primary Care Improvement, Mental Health Strategy (Action 15), Alcohol and Drug Partnership, Free Personal Care (under 65), Carers Act, Scottish Living Wage and Investment in Integration.

While there were budget gaps identified the HSCP Board accepted recommendations to balance the budget by the application of new funding streams, the release of funds from previously agreed savings programmes and additional resource transfer funds. Unlike 2018/19 there was no public consultation as there was no additional savings programmes impacting on service delivery.

The format of the financial performance reports was revised to provide members with a detailed analysis of progress of savings programmes, significant variances and reserves activity. The first quarter’s financial performance report projected an overspend of £0.954m (0.60% of total budget), primarily as a consequence of the cost of children and young people community placements and residential schools, as was the case in the latter part of 2018/19. In line with the requirements of the Integration Scheme, and as part of the financial governance framework, a recovery plan was developed and reported to the Board in

October 2019 based on actual financial performance to 31 August 2019. The recovery plan included:

- Review of Care at Home activity to include client charging and maximisation of service provision based on identified need;
- Continued scrutiny of implementation of attendance management policy to reduce current absence levels;
- Increased focus on recruitment of local foster carers to reduce spend on external placements;
- Capitalisation of staff costs in relation to various ICT projects; and
- Application of continuing care funding from Health to Social Care to support the costs of supporting older people in their home.

The recovery plan, mainly through the capitalisation of staff costs and the application of continuing care funding and significant tracking work by HSCP budget holders and the finance team, resulted in the overspend projection diminishing with each financial performance report before starting to report an underspend for the period ending 31 December 2019.

Final Outturn Position 2019/20

The final Financial Performance Report (see Appendix 1, 6.) issued to the HSCP Board on 31 May 2020, projected an underspend of £0.933m (1.4%) for the financial year ended 31 March 2020. This figure excluded transfers to/from earmarked reserves with the components parts of this underspend (further explained below) being £0.474m for health care and £0.459m for social care.

The financial statements contained within these annual accounts finalise the outturn position for 2019/20 as at 31 March 2020. Again as above, excluding planned transfers to/from reserves and after accounting for all known adjustments, the recorded position is an underspend of £0.883m, a very minor reduction to the underspend of £0.050m reported to the HSCP Board on 31 May 2020. This £0.050m is related to the creation of a provision as detailed in the balance sheet.

The Comprehensive Income and Expenditure Statement (CIES) on page 36 is required to show the surplus or deficit on services and the impact on both general and earmarked reserves. The final position for 2019/20 was an overall surplus of £0.883m with £0.352m transferred to general reserves and £0.531m transferred to earmarked reserves. Earmarked reserves are detailed in Note 12 of these accounts on page 44 coupled with some additional information detailed below in the “Key messages”.

While the CIES provides actual expenditure and income values for services in 2019/20 and their comparison to the previous financial year, it does not highlight the reported budget variations as the HSCP Board would consider them. Therefore the table below is presented to provide additional detail and context to the key financial messages listed below.

2019/20 Final Outturn against Budget

West Dunbartonshire Integrated Joint Board Consolidated Health & Social Care	2019/20 Annual Budget £000	2019/20 Net Expenditure £000	2019/20 Underspend/ (Overspend) £000
Older People, Health and Community Care	45,855	44,207	1,648
Physical Disability	2,949	2,748	201
Children and Families	22,131	24,898	(2,767)
Mental Health Services	10,156	9,317	839
Addictions	2,820	2,859	(39)
Learning Disabilities	16,560	16,258	302
Strategy, Planning and Health Improvement	1,850	1,301	549
Family Health Services (FHS)	27,427	27,427	0
GP Prescribing	19,305	19,432	(127)
Hosted Services - MSK Physio	6,492	6,370	122
Hosted Services - Retinal Screening	800	824	(24)
Criminal Justice - Grant funding of £2.1m	0	0	0
HSCP Corporate and Other Services	6,279	6,100	179
IJB Operational Costs	281	281	0
Cost of Services Directly Managed by West Dunbartonshire HSCP	**162,905**	**162,022**	**883**
Set aside for delegated services provided in large hospitals	28,389	28,389	0
Assisted garden maintenance and Aids and Adaptations	661	661	0
Total Cost of Services to West Dunbartonshire HSCP	**191,955**	**191,072**	**883**

Detailed explanations and analysis of budget performance against actual costs is laid out in the 31 May 2020 Financial Performance Report (link above) however the main highlights are:

- Strategy, Planning and Health Improvement report an underspend of £0.549m due to a recharge of staff costs to capital and a delay in recruitment of vacant posts, timing of service redesign for Smoking Cessation and delivery of core priorities within existing team, releasing discretionary/non recurring funding to bottom line.
- Children and Families report a collective overspend of £2.767m mainly due to:
    - Overspend of £1.767m within residential care due to the increasing pressure of high cost packages including £0.490m related to children placed within residential schools due to emotional, behavioural or physical disabilities. This is an extremely volatile budget and secure placements can cost in excess of £0.2m per child; and
    - Overspend of £0.857m within community placements due to the number of kinship and external foster placements since the start of the financial year.

In recognition of the pressure being reported in these areas in late 2018/19, additional investment of £1.042m (6.3%) was added to the 2019/20 budget. While the overall number of community and residential placements at 31 March 2020 increased by 5.5% compared to numbers at 31 March 2019 the increase in cost can be attributed to the timing of placement

in year and the disproportionate increase in the number of high costs placements within residential care. The Head of Children and Families is committed to reviewing the reasons, processes and outcomes of these placements and is a main focus of the projects being supported by our Service improvement Leads.

- Internal and External Residential Accommodation for Older People report an underspend of £1.287m due to reducing demand for care home/nursing beds arising from shorter stays, supporting people at home for longer and the impact of the moratorium on admissions in a local nursing home .
- Adult Community Health Services report an underspend of £0.457m mainly due to part year impact of service redesign, including introduction of Focussed Intervention Team (phased rollout from October) and cessation of purchased step up/step down Care Home beds.
- Mental Health – Adult Community and Elderly Services report an underspend of £0.579m, mainly due to additional income due from NHS Highland under the terms of the Service Level Agreement for access to in-patient beds. This is based on a 3 year rolling average.
- All other adult services including learning and physical disability and mental health and addiction services collectively underspent by £0.628m, mainly due to an ongoing review of client packages and a number of vacant posts remaining unfilled as the impact of Action 15 recruitment across Scotland and NHSGCC is rolled out.
- Other Services including spend on hosted services, primary care improvements and resources for social care funding from Scottish Government contributed £0.277m to the outturn position. This was due to a number of short term benefits from delays in recruitment of service improvement leads and Scottish Government funding for investment in integration allocated to partially offset various overspends reported elsewhere. This was tracked throughout the financial year and adjusted for as part of the 2020/21 budget setting exercise.
- Within GP Prescribing the volatility of drug costs has been highlighted as the main risk factor on the overall financial performance of this £19.3m budget. The outturn position is an overspend of £0.127m including costs of £0.345m related to a 25% spike in GP prescribing activity in March as additional medications were issued in preparations for the anticipated COVID-19 lockdown.
- The movement in earmarked reserves is an overall increase of £0.531m, bringing the closing balance to £5.254m. There were a number of significant drawdowns and additions amounting to £2.185m and £2.716m respectively as detailed in note 12.
- The movement in un earmarked, general reserves is an overall increase of £0.352m, bringing the closing balance to £2.809m and satisfies the 2% target as set out in the Reserves Policy.

Key Risks, Uncertainties and Financial Outlook

The HSCP Board Financial Regulations reflect the recommendations of the national Integrated Resources Advisory Group which confirms the responsibility of the Chief Officer to develop a local risk strategy and policy for approval by the Partnership Board. The HSCP Board Financial Regulations can be viewed here (see Appendix 1, 7.). The planned review has been delayed due to the response to COVID-19; however this will be undertaken over the next couple of months.

The HSCP Board approved its Risk Management Strategy & Policy at its August 2015 meeting, which can be viewed here (see Appendix 1, 8.) The Strategic Risk Register is

reviewed by the Audit and Performance Committee before consideration by the HSCP Board. The latest review was February 2020 and the full report can be viewed here (see Appendix 1, 9.).

The key risks are summarised below and the full Risk Register Report details scoring and mitigating actions:

- Financial Sustainability/Constraints/Resource Allocation (covered in more detail below);
- Procurement and Commissioning;
- Performance Management;
- Information and Communication;
- Public Protection;
- Outcomes of external scrutiny; inspection recommendations;
- Delayed Discharge and Unscheduled Care;
- Workforce Sustainability;
- Waiting Times; and
- Brexit

There will be a full review of the Strategic Risk Register to account for the impact of the COVID-19 pandemic. The HSCP Senior Management Team developed an extensive COVID-19 Risk Register of 65 key risks for consideration and to inform the Local Mobilisation Plan. These ranged from the impact of staff absence across individual service areas, increase in demand and waiting times, financial sustainability and delays in statutory deadlines. Mitigating actions included, daily assessment of HSCP staff resource requirements and the assessment of a minimum staffing level to provide critical services, sufficient PPE, emergency day centre provision for vulnerable clients, introduction of telephone services and additional financial monitoring processes put in place and detailed financial tracking of additional costs to the Scottish Government.

Reserves

The HSCP Board has the statutory right to hold Reserves under the same legal status as a local authority, i.e. "*A section 106 body under the Local Government (Scotland) Act 1973 Act, and is classified as a local government body for accounts purposes..., it is able to hold reserves which should be accounted for in the financial accounts and records of the Partnership Board".* Reserves are generally held to do three things:

- create a working balance to help cushion the impact of uneven cash flows and avoid unnecessary temporary borrowing – this forms part of general reserves;
- create a contingency to cushion the impact of unexpected events or emergencies; and
- provide a means of building up funds, often referred to as earmarked reserves, to meet known or predicted liabilities.

Reserves are a key component of the HSCP Board's funding strategy. It is essential for the medium to longer term financial stability and sustainability of the board that sufficient useable funds are held for the reasons detailed above and to earmark specific funding to deliver on Scottish Government priorities.

The HSCP Board's Reserves Policy, which can be viewed here (Appendix 1, 10.) recommends that its aspiration should be a general reserves level of 2% of its net expenditure (excluding Family Health Services). This would equate to approximately £2.8m, and for 2019/20 the final position is £2.809m (see Note 12: Usable Reserve: General Fund) meeting the recommended target.

The overall movement in reserves is covered above in the "2019/20 Final Outturn against Budget" section. Detailed analysis of the movements in earmarked reserves is available at Note 12 Useable Reserves – General Fund.

Our earmarked reserves are mainly from the Scottish Government to support health and social care policy commitments and statutory duties including Primary Care Improvement, Mental Health Action 15, Alcohol and Drugs Partnership, Scottish Living Wage, Carers and Free Personal Care (under 65). The flow of funding for some of these policy commitments is linked to quarterly returns detailing the activity and cost of various programme strands.

We started the year with £4.723m earmarked reserves and during the year we allocated £2.185m. The main areas of spend were:

- £0.742m – to support the various workstreams of the Primary Care Improvement Plan as laid out in the Memorandum of Understanding.
- £0.283m – to support the work of the West Dunbartonshire Alcohol and Drug Partnership;
- £0.329m – to support the HSCP service re-design and transformation agenda, including additional staffing resource; and
- £0.500m – reallocation of previously earmarked reserves for Integrated Care Fund and Delayed Discharge into a new reserve to support the work around Unscheduled Care.

We also added £2.716m to earmarked reserves throughout the year for, the main areas being:

- £0.486m – to increase the current GP Prescribing reserve to reflect the COVID-19 activity, i.e. increase in community prescribing during and early intelligence on global short supply of some medicines;
- £0.515m – to support the HSCP COVID-19 Recovery and Renewal Plan, in particular anticipated increase in demand for mental health, addictions and community based services;
- £0.485m – the 2020/21 revenue budget includes £1.705m of approved savings and efficiencies targets through service improvement plans. There is an increased element of risk around some of these savings due to the impact of the COVID-19 response; and
- £0.171m – to support CAMHS (Child and Adolescent Mental Health Services) waiting times performance by increasing clinical posts for a fixed period.

Financial Outlook – Medium Term Financial Plan

The review of the 2019/20 financial statements and the strategic risks highlights the financial pressures and uncertainties facing the HSCP Board. These pressures have been factored into the 2020/21 budget where appropriate and also considered across the medium to longer terms.

The 2020/21 revenue budget was approved on 25 March as Scotland entered "lockdown" but the identified budget gaps and actions taken to close these gaps, to present a balanced budget, are pre COVID-19 service impacts, the full report can be viewed here (Appendix 1, 11.).

The HSCP Board revenue budget for 2020/21 to deliver our strategic priorities is £196.086m, including £28.694m relating to set aside (notional budget allocation). As stated above under "Reserves" this balanced position includes a number of approved savings programmes equating to £1.705m that requires to be delivered on, including a review of learning disability services, a reduction in external care home places and care at home scheduling efficiencies.

During the 2020/21 budget setting exercise the single biggest threat to the United Kingdom and the Scottish Economy was the uncertainties of Britain's exit from the European Union. To this now is added the emerging worldwide response to halting the spread of the Covid-19 pandemic and its devastating impact on families, jobs, business, education and health and social care services including disruption to the medicines supply chain and global markets. All current predictions on economic growth, plans for taxation both in a national context and devolved tax raising powers of the Scottish Government will require significant revision.

Since mid-March the HSCP has had to respond to the COVID-19 pandemic and make significant service changes to protect the needs of our service users and wider population. As referenced throughout this report, the HSCP response was detailed in the Local Mobilisation Plan (LMP) and the associated costs through the financial tracker returns to the Scottish Government. While the LMP was approved by the Cabinet Secretary on 9 April and a commitment to fund all reasonable costs, there are many individual elements of the plan which are difficult to accurately cost at this stage. The last submission to the Scottish Government in late May estimates a potential cost to the HSCP of £9.6m in 2020/21.

To date the greatest elements of actual expenditure incurred have been on PPE and staff absence and overtime at a cost of £1.1 million. However the most significant cost yet to be fully understood is the cost of financial support to externally commissioned services, including residential care, especially for older people and social care support across all client groups. The Scottish Government has committed to support the social care sector throughout this pandemic to help the longer term sustainability of the sector. The HSCP Board currently commission approximately £47m with external providers and that this stage the level of support and how long it will have to continue are difficult to predict, however approximately £4.2m has been included in the financial tracker. To date the Scottish Government have provided funding to the HSCP in support of the LMP of £0.898 million. There is a significant financial risk that the collective cost of the public sector response

cannot be fully funded by the Scottish and UK Governments and the HSCP Board has to consider this in the context of the available 2020/21 budget and across the medium term.

The risk of financial sustainability has long been identified as a key strategic risk of the HSCP Board and the pandemic adds a further layer of risk to its stability going forward. Using 2020/21 as the baseline a Medium Term Financial Plan 2020/21 – 2024/25 was drafted and approved by the HSCP Board in March 2020, and can be viewed here (Appendix 1, 12.). It should be noted that the financial analysis and projections were written before the COVID-19 pandemic hit the United Kingdom, although there was time to reference this within the economic outlook:

"The uncertainties of Britain's exit from the European Union weigh heavily on the economic outlook and while predictions vary, until there is a clear understanding of the UK's future trading relationship with Europe and the rest of the world, forecasts for growth remain fragile. Add to this the emerging worldwide response to halting the spread of the Covid-19 pandemic and its devastating impact on families, health and social care services including disruption to the medicines supply chain and global markets, all current predictions on economic growth, plans for taxation both in a national context and devolved tax raising powers of the Scottish Government will require significant revision."

The plan sets out the main cost pressures and funding assumptions for the partnership and presents these under "Best", "Likely" and "Worst" Case scenarios using 2020/21 as the baseline, see below:

Extract from Medium Term Financial Plan

Table 10 – Best, Likely and Worst Case Budget Gaps from 2021/22 to 2024/25

Indicative Budget Gap	2021/22 £000's	2022/23 £000's	2023/24 £000's	2024/25 £000's
Best	(55)	(1,510)	(3,190)	(4,812)
Likely	(1,492)	(2,995)	(4,725)	(6,397)
Worst	(5,184)	(6,790)	(8,626)	(10,408)

The medium term financial plan is centred on financial sustainability and service redesign. The scale of the financial challenge is influenced by a number of key cost drivers including:

- Pay inflation and pension costs – uncertainty around pay settlements for public sector workers and additional investment in pension schemes;

- Demographics – reflecting the increases in over 65+ and over 75 years population often coping with a range of health conditions against a challenging social and economic climate;

- Scottish Government Priorities - improvements in primary care and support for mental health and addictions;

- Contractual price increases – commitment to adhering to the National Care Home Contract and to deliver Scottish Living Wage to adult social care workers employed by our third sector and private providers; and

- Prescribing Costs – inflationary increases, short supply issues and treatment of complex health conditions.

The HSCP Board will address these challenges going forward by considering:

- Better ways of working – integrating and streamlining teams including the benefits of information technology to deliver services more efficiently will release financial savings and protect front line services;

- Community Empowerment - support the vision for resilient communities with active, empowered and informed citizens who feel safe and engaged to be a main contributor to service change across health and social care;

- Prioritise our services – local engagement and partnership working are key strengths of the HSCP. We must think and do things differently and find new solutions to providing support to those who need it; and

- Service redesign and transformation – build on the work already underway redesigning support to people to remain or return to their own homes or a homely setting for as long as possible. This will be across all care groups including older people, learning, physical and mental disabilities and children and families, in partnership with Housing services, third sector and local providers.

Also for 2020/21 the HSCP Board will closely monitor progress on the delivery of its approved savings programmes, through robust budget monitoring processes and savings trackers. As part of its commitment to a strong governance framework around regular and robust budget and performance monitoring and on-going assessment of risk, the HSCP Board and its senior officers will monitor such developments and will take appropriate action as required.

Agreeing a mechanism to transfer actual funding from the notional set aside resource must be progressed, but there is a risk that it will come with a savings target attached. The further development of the Unscheduled Care Commissioning Plan across the six partnerships with NHSGGC will address this risk.

Conclusion

In 2019/20 the West Dunbartonshire Health and Social Care Partnership Board has continued to demonstrate its commitment to strong financial governance while delivering on its strategic priorities. With its acceptance of the Medium Term Financial Plan the Strategic Plan was to be refreshed in 2020/21 and this has become even more essential in the midst of the COVID-19 response. What has been clear throughout the pandemic, is some geographical areas have suffered at different rates, and at this stage there appears to have

been a greater impact in some areas where deprivation is more prevalent, such as West Dunbartonshire and some of its neighbouring partnerships. In the medium to longer term, we will ensure that our plan will be adaptable to respond to the uniqueness of the population we serve.

Allan MacLeod Date: 25 June 2020
HSCP Board Chair

Beth Culshaw Date: 25 June 2020
Chief Officer

Date: 25 June 2020

Julie Slavin CPFA
Chief Financial Officer

STATEMENT OF RESPONSIBILITIES

Responsibilities of the Health and Social Care Partnership Board

The Health and Social Care Partnership Board is required to:

- Make arrangements for the proper administration of its financial affairs and to secure that the proper officer of the board has responsibility for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973). In this partnership, that officer is the Chief Financial Officer.
- Manage its affairs to secure economic, efficient and effective use of resources and safeguard its assets.
- Ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland Act 2003).
- Approve the Annual Accounts.

I confirm that these Annual Accounts were approved for signature at a meeting of the HSCP Board on 25 June 2020.

Signed on behalf of the West Dunbartonshire Health & Social Care Partnership.

Allan MacLeod
HSCP Board Chair

Date: 25 June 2020

Responsibilities of the Chief Financial Officer

The Chief Financial Officer is responsible for the preparation of the HSCP Board's Annual Accounts in accordance with proper practices as required by legislation and as set out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (the Accounting Code).

In preparing the Annual Accounts, the Chief Financial Officer has:

- selected suitable accounting policies and then applied them consistently
- made judgements and estimates that were reasonable and prudent
- complied with legislation
- complied with the local authority Code (in so far as it is compatible with legislation)

The Chief Financial Officer has also:

- kept proper accounting records which were up to date; and
- taken reasonable steps for the prevention and detection of fraud and other irregularities

I certify that the financial statements give a true and fair view of the financial position of the West Dunbartonshire Health and Social Care Partnership Board as at 31 March 2020 and the transactions for the year then ended.

Julie Slavin CPFA
Chief Financial Officer

Date: 25 June 2020

REMUNERATION REPORT

Introduction

The Local Authority Accounts (Scotland) Regulations 2014 (SSI No. 2014/200) require local authorities and IJB's in Scotland to prepare a Remuneration Report as part of the annual statutory accounts.

It discloses information relating to the remuneration and pension benefits of specified WDHSCP Board members and staff. The information in the tables below is subject to external audit. The explanatory text in the Remuneration Report is reviewed by the external auditors to ensure it is consistent with the financial statements.

The HSCP Board does not directly employ any staff. All staff working within the HSCP are employed through either NHSGGC or WDC; and remuneration for senior staff is reported through those bodies. This report contains information on the HSCP Board Chief Officer and Chief Financial Officer's remuneration together with details of any taxable expenses relating to HSCP Board voting members claimed in the year.

Membership of the HSCP Board is non-remunerated; for 2019/20 no taxable expenses were claimed by members of the partnership board.

Health and Social Care Partnership Board

The six voting members of the HSCP Board were appointed, in equal numbers, through nomination by Greater Glasgow and Clyde Health Board and West Dunbartonshire Council. Nomination of the HSCP Board Chair and Vice Chair post holders alternates, every 3 years, between a Councillor from WDC and a NHSGGC Health Board representative.

The HSCP Board does not pay allowances or remuneration to voting board members; voting board members are remunerated by their relevant nominating organisation.

The HSCP Board does not have responsibilities, either in the current year or in future years, for funding any pension entitlements of voting members. Therefore, no pension rights disclosures are provided for the Chair or Vice Chair. For 2019/20 no voting member received any form of remuneration from the HSCP Board as detailed in the table over.

Voting Board Members 2019/20	Organisation
Allan MacLeod (Chair)	NHS Greater Glasgow & Clyde Health Board
Marie McNair (Vice Chair)	West Dunbartonshire Council
John Mooney	West Dunbartonshire Council
Denis Agnew	West Dunbartonshire Council
Rona Sweeney	NHS Greater Glasgow & Clyde Health Board
Audrey Thompson	NHS Greater Glasgow & Clyde Health Board

Senior Officers

The HSCP Board does not directly employ any staff. All staff working within the HSCP are employed through either NHSGGC or WDC; and remuneration for senior staff is reported through those bodies.

Chief Officer

Under section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 a Chief Officer for the HSCP Board has to be appointed and the employing partner has to formally second the officer to the HSCP Board. The employment contract for the Chief Officer will adhere to the legislative and regulatory framework of the employing partner organisation. The remuneration terms of the Chief Officer's employment are approved by the HSCP Board.

Ms Culshaw is employed by WDC, and holds an honorary contract with NHSGGC.

Chief Officer and Chief Financial Officer posts funding is included equally in the partner contributions.

Other Officers

No other staff are appointed by the HSCP Board under a similar legal regime. Other non-voting board members who meet the criteria for disclosure are included below.

Total Earnings 2018/19 £	Senior Officers	Salary, Fees & Allowance £	Compensation for Loss of Office £	Total Earnings 2019/20 £
108,300	B Culshaw Chief Officer	113,721	-	113,721
74,524	J Slavin Chief Financial Officer	78,352	-	78,352

In respect of officers' pension benefits the statutory liability for any future contributions to be made rests with the relevant employing partner organisation. On this basis there is no pensions liability reflected on the HSCP Board balance sheet for the Chief Officer or any other officers.

The HSCP Board however has responsibility for funding the employer contributions for the current year in respect of the officer time spent on fulfilling the responsibilities of their role on the HSCP Board. The following table shows the HSCP Board's funding during the year to support officers' pension benefits. The table also shows the total value of accrued pension benefits which may include benefits earned in other employment positions and from each officer's own contributions.

Senior Officers	In Year Contributions		Accrued Pension Benefits		
	For Year to 31/03/2019 £000	For Year to 31/03/2020 £000		For Year to 31/03/2019 £000	For Year to 31/03/2020 £000
B Culshaw Chief Officer	21	22	Pension Lump Sum	4 -	6 -
J Slavin Chief Financial Officer	11	12	Pension Lump Sum	4 -	5 -

The officers detailed above are all members of the NHS Superannuation Scheme (Scotland) or Local Government Scheme. The pension figures shown relate to the benefits that the person has accrued as a consequence of their total public sector service, and not just their current appointment. The contractual liability for employer pension's contributions rests with NHS Greater Glasgow & Clyde and West Dunbartonshire Council. On this basis there is no pension liability reflected on the HSCP Board balance sheet.

Disclosure by Pay Bands

As required by the regulations, the following table shows the number of persons whose remuneration for the year was £50,000 or above, in bands of £5,000.

Remuneration Band	Number of Employees 31/03/2019	Number of Employees 31/03/2020
£70,000 - £74,999	1	
£75,000 - £79,999		1
£105,000 - £109,999	1	
£110,000 - £114,999		1

Allan Macleod
HSCP Board Chair

Date: 25 June 2020

Beth Culshaw
Chief Officer

Date: 25 June 2020

ANNUAL GOVERNANCE STATEMENT

Introduction

The Annual Governance Statement explains the HSCP Board's governance arrangements as they meet the requirements of the "Code of Practice for Local Authority Accounting in the UK" (the Code) and reports on the effectiveness of the HSCP Board's system of internal control, including the reliance placed on the governance frameworks of our partners. It is included within the HSCP's financial statements to assure stakeholders on how the HSCP directs and controls its functions and how it relates to communities in order to enhance transparency and scrutiny of the HSCP's activities.

This statement lays out the governance arrangements in place for more than eleven months for the year ended 31 March 2020, and where significant, any changes to those arrangements as a consequence of local, national and international responses to the global Coronavirus (Covid-19) Pandemic. Further detail is provided below under "Governance Issues 2019/20 - Impact of Covid-19 Response on Governance Arrangements".

Scope of Responsibility

The HSCP Board is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively. It also has a statutory duty to make arrangements to secure best value under the Local Government in Scotland Act 2003.

To meet this responsibility the HSCP Board continues to have in place robust arrangements for the governance of its affairs and the effectiveness of its functions, including the identification, prioritisation and the management of risk. It has an established Audit and Performance Committee to support the board in its responsibilities for issues of risk, control and governance and associated assurance through a process of constructive challenge and promoting a culture of continuous improvement in performance.

In discharging this responsibility the Chief Officer has put in place arrangements for governance which includes a system of internal control. The system is intended to manage risk to a reasonable level and to support the delivery of the HSCP Board's policies, aims and objectives. Reliance is also placed on Greater Glasgow and Clyde Health Board and West Dunbartonshire Council's systems of internal control that support compliance with both partner organisations' policies and promotes the achievement of each organisation's aims and objectives, as well as those of the HSCP Board.

The Chief Internal Auditor reports directly to the HSCP Board's Audit and Performance Committee on all audit matters, with the right of access to the Chief Officer, Chief Financial Officer and Chair of the Audit and Performance Committee on any matter.

The Governance Framework and Internal Control System

The governance framework is comprised of systems and processes and cultures and values by which the HSCP is directed and controlled. It is not static and is updated to reflect new legislative requirements and best practice. This has never been more apparent as the HSCP Board, its partner organisations and numerous stakeholders have had to adapt to respond to the impact of the Covid-19 in the latter part of March 2020.

The system of internal control is based on an ongoing process designed to identify, prioritise and manage the risks facing the organisation. It enables the HSCP Board to monitor and evaluate the achievements of the strategic objectives laid out within its Strategic Plan and consider whether these have been delivered in an appropriate and cost effective manner.

The HSCP Board adopted governance arrangements are consistent with the Chartered Institute of Public Finance and Accounting (CIPFA) and the Society of Local Authority Chief Executives (SOLACE) framework "Delivering Good Governance in Local Government". Based on the framework's seven core principles a Local Code of Good Governance is in place which is reviewed annually and evidences the HSCP Board's commitment to achieving good governance and demonstrates how it complies with the recommended CIPFA standards. A copy of the code is available here (Appendix 1, 13.) on the HSCP website.

The main features of the HSCP Board's governance framework and system of internal control is reflected in its Local Code, with the key features summarised below:

- The HSCP Board is the key decision making body, comprising of a Chair, five other voting members and a number of professional and stakeholder non-voting members;
- The HSCP Board is formally constituted through the Integration Scheme which sets out the local governance arrangements, including definition of roles, workforce, finance, risk management, information sharing and complaints;
- A register of interests is in place for all Board members and senior officers;
- The HSCP Board has two governance sub-committees; Audit and Performance Committee (previously known as Audit Committee) and the Strategic Planning Group;
- Reports considered by the HSCP Board and the Audit and Performance Committee are published on the HSCP website;
- The scope, authority, governance and strategic decision making of the HSCP Board and Audit and Performance Committee is set out in key constitutional documents including the HSCP Strategic Plan 2019 – 2022, terms of reference, code of conduct, standing orders and financial regulations;
- The Terms of Reference for the updated Audit and Performance Committee Terms were agreed by the HSCP Board in November 2019 and included the additional of two additional members to the Committee drawn from the Strategic Planning Group. The full report can be found here (Appendix 1, 14.);
- The Performance Management Framework commits to regular performance and financial reporting to the HSCP Board and Audit and Performance Committee, enhanced by a programme of development sessions, enabling members to interrogate performance and policy in greater detail;

- Clinical and Care Governance Group – provide oversight and scrutiny of all aspects of clinical and care risk and effectiveness as well as how patient centred care is delivered.
- The Risk Management Strategy, including the risk management policy and strategic risk register (underpinned by operational risk registers), are scrutinised at least annually by the Audit and Performance Committee with level of risk, its anticipated effect and mitigating action endorsed before being referred to the HSCP Board;
- The Reserves Policy is reviewed as part of the annual budget setting process and has identified a reasonable level of both general and earmarked reserves;
- A performance appraisal process is in place for all employees and staff who are also required to undertake statutory and mandatory training to reinforce their obligations to protect our service users, including information security; and
- Effective scrutiny and service improvement activities are supported by the formal submission of reports, findings, recommendations and associated action plans by Audit Scotland, Ministerial Strategic Group, our external and internal auditors and the Care Inspectorate.

The governance framework described, operates within the system of internal financial controls, including management and financial information, financial regulations, administration (including segregation of duties), management supervision and a system of delegation and accountability. Development and maintenance of these systems is undertaken by the Council and the Health Board as part of the operational delivery arrangements of the HSCP. In particular these systems include:

- Financial regulations and codes of financial practice;
- Procurement regulations which recognise the complexities of health and social care services for vulnerable service users;
- Comprehensive budgeting systems;
- Clearly defined capital expenditure guidelines;
- Programme of internal audits; and
- Senior officer led joint working groups, planning groups and project boards.

Compliance with Best Practice

The HSCP Board's financial management arrangements conform to the governance requirements of the CIPFA statement *"The Role of the Chief Financial Officer in Local Government (2010)"*. To deliver these responsibilities the Chief Financial Officer must be professionally qualified and suitably experienced and lead and direct a finance function that is resourced and fit for purpose.

The HSCP Board complies with the requirements of the CIPFA Statement on *"The Role of the Head of Internal Audit in Public Organisations 2010"*. The HSCP Board's appointed Chief Internal Auditor has responsibility for the internal audit function and is professionally qualified and suitably experienced to lead and direct internal audit staff. The Internal Audit service generally operates in accordance with the CIPFA *"Public Sector Internal Audit Standards 2013".*

The HSCP Board's Audit and Performance Committee operates in accordance with CIPFA's *"Audit Committee Principles in Local Authorities in Scotland"* and *"Audit Committees: Practical Guidance for Local Authorities (2018)"*. In November 2019, to align with the review of the terms of reference, the Chief Internal Auditor and the Chair of the committee considered the CIPFA's 2018 guidance and carried out a:

- Self-assessment of Good Practice; and
- An evaluation of the Effectiveness of the Committee

The report concluded that the committee "largely complies with CIPFA good practice and thereby can assess its performance as generally meeting the CIPFA requirements". The full report can be found here (Appendix 1, 15.).

Review of Adequacy and Effectiveness

The HSCP Board is committed to continuous improvement and is responsible for conducting at least annually, a review of its governance framework including the system of internal control. The review of the effectiveness of the framework is informed by the work of the Chief Officer and the Senior Management Team who have the responsibility for the development and maintenance of the governance environment and the work of internal and external audit and other review agencies including the Care Inspectorate.

The HSCP Board adopted "The Code of Practice for Local Authority Accounting", recommendation that the local code is reviewed each year in order that it can inform the Governance Statement. For the June 2020 review the 25 June HSCP Board agreed that there were no areas assessed to be non-compliant and more than three quarters were considered fully compliant.

Also supporting the review of the HSCP Board's governance framework are the processes of internal controls of West Dunbartonshire Council and Greater Glasgow and Clyde Health Board.

Within the council each member of the Corporate Management Team (including HSCP Heads of Service) completes a checklist to assess compliance levels against each aspect of the council's local code. These are considered by the Chief Internal Auditor and inform each Strategic Director's Certificate of Assurance as well as the Council's Governance Statement. An extract of the Improvement Areas identified for HSCP Senior Managers in relation to their Strategic Lead roles within the Council are detailed below:

- Complaints timescales;
- Incorporate service user feedback into Service Delivery Plans; and
- Improve governance around action plan/audit recommendation deadlines;

Within the health board a similar process is in operation which required the Chief Officer to complete a "Self Assessment Checklist" covering all the key areas of the internal control framework.

Other reviews to support continuous improvements and the control environment include the work undertaken by WDC & NHSGGC internal audit teams. Any specific control issues emerging from these audits are considered through each organisation's own Audit Committee and recommendations on improvements agreed. However any audits impacting on HSCP services are also considered by the HSCP Audit and Performance Committee for information and impact on delivering on strategic priorities.

In 2019/20 three social care audits were undertaken by WDC internal audit team:

- CM2000 Functionality Review – CM2000 is used by Care at Home services for the electronic scheduling and optimisation of visits. The audit found that the systems examined were generally working effectively. It also identified five actions to strengthen controls and support best value including increasing staff clocking in and out compliance and using this data to authorise overtime claims. These actions will be delivered in the coming financial year.
- Social Care Attendance Management Review – final recommendations have still to be finalised.
- Social Care Case Management Review – final recommendations have still to be finalised.

There were no health care based audits carried out by NHSGGC that directly impacted on HSCP service priorities.

Update on Previous Governance Issues

The 2018/19 Annual Governance Statement set-out a number of Improvement Actions based on the annual review of the Local Code and Areas for Improvement by each Head of Service. These are updated below with further expansion of two key areas.

Improvement Action 2018/19	Lead Officer	Due Date	Update
Develop a robust Commissioning Plan driven by new Strategic Plan 2019 – 2022.	Head of Strategy and Transformation	August 2019	Date revised to late 2020 after update report to Feb HSCP Board. Progress made to date with the Strategic Planning Group, procurement pipeline priorities and agreed service improvement programmes.
Increase the % of spend with 3rd party social care providers being compliant with Financial Regulations (incorporating procurement regulations) and have robust service specifications and contract monitoring arrangements in place.	Chief Financial Officer & Head of Strategy and Transformation	April 2020	Ongoing – but significant progress made – further expanded below.

Update on Previous Governance Issues (Cont'd)

Improvement Action 2018/19	Lead Officer	Due Date	Update
Improve case recording and assessment for Children & Families who receive statutory social work services.	Head of Children's Health, Care and Criminal Justice	On-going	Work to improve case recording is continuing – include changes to capture activity for the Scottish Govt. National Covid-19 dataset. Review of Care First case recording system by Information Team to be scheduled following lockdown. Improvement activity around assessments and supported by monthly meetings with the Area Locality Reporter. Case sampling for children on the child protection register will report to the Child Protection Committee after June 2020.
Improve sickness Absence Rates	All Heads of Service	On-going	Ongoing - analysis of absence data shows a downward trend from the start of this performance year. New Supporting Employee Wellbeing Policy for WDC launched last year, with master classes rolled out.
Ministerial Strategic Group Review on the Progress of Integration Action Plan – from May 2019 Self Evaluation	Chief Officer	Full agreement required from partners	Ongoing. The Scottish Government accepted the HSCP Action Plan. Ownership and delivery of actions across the HSCP Board, WDC, NHSGGC and the Scottish Government.
Strengthen the budget setting arrangements with WDC & NHSGGC and work on producing a robust medium term financial plan.	Chief Financial Officer	November 2019	Chief Financial Officers of WDC, NHSGGC and HSCP work together and align budget processes where possible. Medium Term Financial Plan presented and approved by the 25 March 2020 HSCP Board. Covid-19 pandemic and recovery plans will impact on scenario planning.

Progress continues around the formalisation of "Set Aside" budgets with agreement across the Scottish Government, the health board and the six HSCP's on robust data sets to allow for calculation and comparison of actual activity and associated costs. This has been reflected in these annual accounts including a restatement of the 2018/19 set aside amount within the Comprehensive Income and Expenditure Statement (page 36). Prior to the Covid-19 outbreak the Glasgow HSCPs had developed a draft Commissioning Plan on Unscheduled Care which was due to be presented to all IJBs March – June. This will need revision to reflect Covid-19 Recovery Plans.

Compliance with financial regulations in the area of procurement of social care services is a key priority area for the HSCP Board in evidencing best value in a climate of financial challenge and was referenced in both the Council's and HSCP Board's 2018/19 Annual Governance Statements.

Significant progress has been made throughout 2019/20 with a number of procurements being approved by the WDC Tendering Committee or under Delegated Authority. In financial year 2019/20, HSCP procurement expenditure was £47.4 million. The procurement spend that is compliant with the Financial Regulations was £37.6 million (79.2%). This takes account of "partial compliance" i.e. spend where contracts were awarded during the year and in turn increased the compliance rate. In comparison, financial year 2018/19 HSCP procurement spend was £40.2m with £5.2m (13%) spend that was compliant with the Financial Regulations. The HSCP's Senior Management Team will revisit the Procurement Pipeline Priorities and align to Recovery and Renewal Plans (further detail below).

Governance Issues 2019/20

The 2019/20 Internal Audit Annual Report for the HSCP Board identifies no significant control issues. As stated above the HSCP Board must also place reliance on the Council and Health Board's internal control framework. The Council's Internal Audit Annual Report has concluded that the Council's control procedures in key areas are operating as expected during 2019/20. The Health Board's internal auditor has yet to release their annual report opinion (expected September 2020), however based on in-year reports the opinion is expected to be one of reasonable assurance can be placed on the adequacy and effectiveness of the current governance and control systems and processes.

Impact of Covid-19 Response on Governance Arrangements

From mid-March 2020 as the effects of the Covid-19 pandemic began to impact on daily life in Scotland, the response of those charged with the delivery of public services especially health and social care services had to be rapid. To adapt services to meet the challenge of the pandemic there had to be appropriate and transparent amendments to current governance frameworks.

An urgent item - Temporary Decision Making Arrangements (Appendix 1, 16.) was considered by the 25 March 2020 HSCP Board which recommended:

- Approve the suspension of normal governance arrangements during the Covid-19 pandemic and accept the alternative Board meeting arrangement outlined at section 4 of this report ; and
- Approve delegation of authority to the Chief Officer, in consultation with the Chair and Vice Chair of the HSCP Board and the Chief Financial Officer, be enacted "if required", to meet immediate operational demand on decisions normally requiring Board approval;

This is managed through weekly telephone conferences and a decisions log/approval tracker which captures the timeline and any action sheets or final reports are published on the HSCP website. There are also weekly Chief Officer Briefings issued to all board members which update on key service impacts of Covid-19 and the interpretation of national guidance on local services.

All members of the HSCP Senior Management Team and key stakeholders are participants in a variety of HSCP specific Covid-19/Business Continuity response groups as well as WDC, NHSGGC and Scottish Government Strategic Resilience and Tactical Groups. In mid-March the Clinical and Care Governance Group stepped down and a Local Management Response Team (LMRT) was established to respond to the Covid-19 pandemic. Membership included the HSCP SMT, our newly appointed Clinical Directors, staff side union and third sector representatives. The initial meeting took place on 17 March and at least weekly thereafter. This remains in place, however the Clinical and Care Governance Group has re-established its 6 weekly meeting cycle effective from 1 June 2020.

A comprehensive Covid-19 Impact Risk Register was developed covering all aspects of service delivery ranging from risk to service delivery from staff absence, system failure, insufficient PPE, Complaints, Freedom of Information Requests, Carer illness and increased demand for emergency support for various vulnerable individuals and families.

By the 3 April the Scottish Government required each HSCP to submit a Local Mobilisation Plan (LMP) and associated Financial Cost Tracker, which set out the high level service response across all delegated health and social care services. These were approved in principle by the Cabinet Secretary for Health and Sport on 9 April with ongoing follow-up to understand the impact on service delivery and associated costs.

The LMP set out how existing services could be impacted and their response as well as considering new service areas that required to be established to support health and care services in this public health emergency. This included the opening of two Covid-19 Hubs on 2 April to distribute the necessary Personal Protective Equipment (PPE) and two Community Assessment Centres (Clydebank and Renton) to support the clinical assessment and testing of people referred with potential Covid-19 symptoms.

Business as Usual Governance Issues

As referred to under "Review of Adequacy and Effectiveness" above the Local Code was reviewed at the 25 June HSCP Board. The overall assessment was that there were improvements in overall compliance with the principles of the code, due to the completion or

significant progress of a number of the Improvement Actions identified in last year's review, including:

- The Development of a Medium Term Financial Plan - presented and approved by the 25 March 2020 HSCP Board. Impact of Covid-19 pandemic and recovery plans will impact on scenario planning; and
- Evaluating the effectiveness of the Audit Committee.

The Local Code review also included the HSCP Board's Improvement Actions for 2020/21. This included those 2019/20 actions not fully complete plus one new action detailed below:

Improvement Action	Lead Officer	Due Date
Review and revise the format of HSCP Board Reports to reflect the new guidance on Statutory Directions issued by the Scottish Government in January 2020.	Chief Financial Officer and Head of Strategy and Transformation	September 2020

Recovery and Renewal

While some service areas are still in response mode the HSCP senior management in partnership with key stakeholders are shifting focus to the "Recovery and Renewal" phases.

The Clinical and Care Governance Group has re-established its 6 weekly meeting cycles and at its 1 June meeting it began its review of the governance arrangements for services developed and responses to key police directives introduced as a consequence of Covid 19 to provide assurance around compliance with these requirements. This included:

- HSCP Covid Community Assessment Centres;
- Provision of enhanced care assurance visits to local authority and independent and care homes;
- Testing in Care Homes – and all current guidance; and
- Legislative powers introduced as result of Coronavirus Act and with respect to any impact on service quality.

Reflective Learning will be a key element of recovery as well as building on the enhanced partnership working and collaboration required to creatively adapt services to meet service user needs in line with strategic priorities.

The "new normal" will have an impact on service demand and the financial consequences of this will have to be clearly laid out within the current performance reporting framework.

Conclusion and Opinion on Assurance

Overall the Chief Internal Auditor's evaluation of the control environment concluded that; based on the audit work undertaken, the assurances provided by the Chief Officers of the HSCP Board, West Dunbartonshire Council and Greater Glasgow and Clyde Health Board*, the review of the local code and knowledge of the HSCP Board's governance, risk management and performance monitoring arrangements:

*"As the presentation of the Annual Internal Audit Report for *NHSGG&C has been deferred until September, this means that the IJB's Chief Internal Auditor is unable to conclude the IJB's Annual Audit Report and provide an assurance opinion at this time. However, based on in year reports, Officers are confident that the overall opinion will be that reasonable assurance can be placed upon the adequacy and effectiveness of systems of governance, risk management and internal control in the year to 31 March 2020 but this is not confirmed at this time. The final accounts will include the view once this is available in September.*

Covid-19
The significant incident in late March tested how well the HSCP Board's risk management, governance and internal controls framework is operating. It will be important for the HSCP Board, at the appropriate time, to carry out a post-incident review and highlight any lessons learned."

Assurance and Certification

Whilst recognising that improvements are required, as detailed above, it is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the HSCP Board's system of governance.

We consider the internal control environment provides reasonable and objective assurance that any significant risks impacting on our principal objectives will be identified and actions taken to mitigate their impact and deliver improvement.

Allan Macleod Date: 25 June 2020
HSCP Board Chair

Beth Culshaw Date: 25 June 2020
Chief Officer

COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

This statement shows the cost of providing services for the year according to accepted accounting practices.

2018/19 Gross Expenditure Restatement £000	2018/19 Gross Income Restatement £000	2018/19 Net Expenditure Restatement £000	West Dunbartonshire Integrated Joint Board Health and Social Care Partnership	2019/20 Gross Expenditure £000	2019/20 Gross Income £000	2019/20 Net Expenditure £000
Consolidated Health & Social Care						
53,165	(8,157)	45,008	Older People Services	52,265	(8,058)	44,207
3,270	(263)	3,007	Physical Disability	2,963	(215)	2,748
23,618	(1,107)	22,511	Children and Families	26,121	(1,223)	24,898
11,554	(2,605)	8,949	Mental Health Services	12,081	(2,764)	9,317
2,730	(162)	2,568	Addictions	3,494	(635)	2,859
17,266	(611)	16,655	Learning Disabilities services	16,884	(626)	16,258
26,824	(1,086)	25,738	Family Health Services (FHS)	28,484	(1,057)	27,427
19,383	0	19,383	GP Prescribing	19,432	0	19,432
6,447	(193)	6,254	Hosted Services - MSK Physio	6,572	(202)	6,370
763	(8)	755	Hosted Services - Retinal Screening	824	0	824
2,120	(2,120)	0	Criminal Justice	2,170	(2,170)	0
4,069	(826)	3,243	Other Services	8,171	(770)	7,401
270	0	270	IJB Operational Costs	281	0	281
171,479	**(17,138)**	**154,341**	**Cost of Services Directly Managed by WD HSCP**	**179,742**	**(17,720)**	**162,022**
29,522	0	29,522	*Set aside for delegated services provided in large hospitals	28,389	0	28,389
577	0	577	Assisted garden maintenance and Aids and Adaptations	661	0	661
201,578	**(17,138)**	**184,440**	**Total Cost of Services to WD HSCP**	**208,792**	**(17,720)**	**191,072**
	(185,478)	(185,478)	Taxation & Non-Specific Grant Income (contribution from partners) **Note 7**	0	(191,955)	(191,955)
201,578	**(202,616)**	**(1,038)**	**(Surplus) or Deficit on Provisions of Services**	**208,792**	**(209,675)**	**(883)**

*NHSGGC are now in a position to report the set aside figures based on actual expenditure which has resulted in the restatement of 18/19 figures which were previously based on a notional budget figure. The notional budgets for set aside were based on NRAC activity and information from the cost book and were very high level. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

MOVEMENT IN RESERVES STATEMENT

This statement shows the movement in the year on the HSCP Board's reserves. The movements which arise due to statutory adjustments which affect the General Fund balance are separately identified from the movements due to accounting practices.

Movement in Reserves During 2019/20	Unearmarked Reserves Restatement Balance £000	Earmarked Reserves Restatement Balance £000	Total General Fund Reserves £000
Opening Balance as at 31 March 2019	(2,457)	(4,723)	(7,180)
Total Comprehensive Income and Expenditure (Increase)/Decrease 2019/20	(352)	(531)	(883)
Closing Balance as at 31 March 2020	(2,809)	(5,254)	(8,063)

Movement in Reserves During 2018/19	Unearmarked Reserves Restatement Balance £000	Earmarked Reserves Restatement Balance £000	Total General Fund Reserves £000
Opening Balance as at 31 March 2018	**(1,706)**	**(4,436)**	**(6,142)**
Total Comprehensive Income and Expenditure (Increase)/Decrease 2018/19	(751)	(287)	(1,038)
Closing Balance as at 31 March 2019	**(2,457)**	**(4,723)**	**(7,180)**

BALANCE SHEET

The Balance Sheet shows the value of the HSCP Board's assets and liabilities as at the balance sheet date. The net assets of the HSCP Board (assets less liabilities) are matched by the reserves held by the HSCP Board.

2018/19 Restatement £000		Notes	2019/20 £000
7,180	Short Term Debtors	9	8,113
7,180	**Current Assets**		**8,113**
0	Short Term Creditors	10	0
0	Provisions	11	(50)
0	**Current Liabilities**	**-**	**(50)**
7,180	**Net Assets**	**-**	**8,063**
(2,457)	Usable Reserves: General Fund	12	(2,809)
(4,723)	Usable Reserves: Earmarked	12	(5,254)
(7,180)	**Total Reserves**	**-**	**(8,063)**

The unaudited accounts were issued on 25 June 2020 and the audited accounts were authorised for issue on Date to be confirmed.

Julie Slavin CPFA
Chief Financial Officer

Date: 25 June 2020

NOTES TO THE FINANCIAL STATEMENTS

1. Significant Accounting Policies

1.1 General Principles

The Financial Statements summarises the HSCP Board's transactions for the 2019/20 financial year and its position at the year-end of 31 March 2020.

The HSCP Board was established under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a joint venture between West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board.

The HSCP Board is a specified Section 106 body under the Local Government (Scotland) Act 1973 and as such is required to prepare their financial statements in compliance with the Code of Practice on Local Authority Accounting in the United Kingdom 2019/20, supported by International Financial Reporting Standards (IFRS), unless legislation or statutory guidance requires different treatment.

The accounts are prepared on a going concern basis, which assumes that the HSCP Board will continue in operational existence for the foreseeable future. The historical cost convention has been adopted.

1.2 Accruals of Income and Expenditure

Activity is accounted for in the year that it takes place, not simply when settlement in cash occurs. In particular:

- Expenditure is recognised when goods or services are received and their benefits are used by the HSCP Board.
- Income is recognised when the HSCP Board has a right to the income, for instance by meeting any terms and conditions required to earn the income, and receipt of the income is probable.
- Where income and expenditure have been recognised but settlement in cash has not taken place, a debtor or creditor is recorded in the Balance Sheet.
- Where debts may not be received, the balance of debtors is written down

1.3 Funding

The HSCP Board is primarily funded through contributions from the statutory funding partners, WDC and NHSGGC. Expenditure is incurred as the HSCP Board commission's specified health and social care services from the funding partners for the benefit of service recipients in West Dunbartonshire and service recipients in Greater Glasgow and Clyde, for services which are delivered under Hosted arrangements.

1.4 Cash and Cash Equivalents

The HSCP Board does not operate a bank account or hold cash and therefore has not produced a cashflow statement for these annual accounts Transactions are settled on behalf of the HSCP Board by the funding partners. Consequently the HSCP Board does not present a 'Cash and Cash Equivalent' figure on the balance sheet. The funding balance due to or from each funding partner, as at 31 March 2020, is represented as a debtor or creditor on the HSCP Board's Balance Sheet.

1.5 Employee Benefits

The HSCP Board does not directly employ staff. Staff are formally employed by the funding partners who retain the liability for pension benefits payable in the future. The HSCP Board therefore does not present a Pensions Liability on its Balance Sheet.

The HSCP Board has a legal responsibility to appoint a Chief Officer. More details on the arrangements are provided in the Remuneration Report. The charges from the employing partner are treated as employee costs. Where material the Chief Officer's absence entitlement as at 31 March is accrued, for example in relation to annual leave earned but not yet taken.

Charges from funding partners for other staff are treated as administration costs.

1.6 Provisions, Contingent Liabilities and Contingent Assets

Provisions are liabilities of uncertain timing or amount. A provision is recognised as a liability on the balance sheet when there is an obligation as at 31 March 2020 due to a past event; settlement of the obligation is probable; and a reliable estimate of the amount can be made. Recognition of a provision will result in expenditure being charged to the Comprehensive Income and Expenditure Statement and will normally be a charge to the General Fund.

A contingent liability is a possible liability arising from events on or before 31 March 2020, whose existence will only be confirmed by later events. A provision that cannot be reasonably estimated, or where settlement is not probable, is treated as a contingent liability. A contingent liability is not recognised in the HSCP Board's Balance Sheet, but is disclosed in a note where it is material.

A contingent asset is a possible asset arising from events on or before 31 March 2020, whose existence will only be confirmed by later events. A contingent asset is not recognised in the HSCP Board's Balance Sheet, but is disclosed in a note only if it is probable to arise and can be reliably measured.

1.7 Reserves

The HSCP Board's reserves are classified as either Usable or Unusable Reserves.

The HSCP Board's only Usable Reserve is the General Fund. The balance of the General Fund as at 31 March 2020 shows the extent of resources which the HSCP Board can use in later years to support service provision or for specific projects.

1.8 Indemnity Insurance

The HSCP Board has indemnity insurance for costs relating primarily to potential claim liabilities regarding HSCP Board member and officer responsibilities. Greater Glasgow and Clyde Health Board and West Dunbartonshire Council have responsibility for claims in respect of the services that they are statutorily responsible for and that they provide.

Unlike NHS Boards, the HSCP Board does not have any 'shared risk' exposure from participation in CNORIS. The HSCP Board's participation in the CNORIS scheme is therefore analogous to normal insurance arrangements.

Known claims are assessed as to the value and probability of settlement. Where it is material the overall expected value of known claims taking probability of settlement into consideration is provided for in the HSCP Board's Balance Sheet.

The likelihood of receipt of an insurance settlement to cover any claims is separately assessed and, where material, presented as either a debtor or disclosed as a contingent asset.

1.9 VAT

VAT payable is included as an expense only to the extent that it is not recoverable from Her Majesty's Revenue and Customs. VAT receivable is excluded from income.

2. Prior Year Re-Statement

Within the Comprehensive Income and Expenditure Statement the set aside figure for 2018/19 has been restated. This figure was previously based on a notional budget figure based on NRAC activity and information from the cost book and were very high level. Actual figures are now based on a much more detailed approach including actual spend and activity for each. See Note 4. Critical Judgements and Estimation Uncertainty below.

3. Accounting Standards Issued Not Yet Effective

The Code requires the disclosure of information relating to the expected impact of an accounting change that will be required by a new standard that has been issued but not yet adopted.

The HSCP Board considers that there are no such standards which would have significant impact on its Annual Accounts.

4. Critical Judgements and Estimation Uncertainty

The set aside resource for delegated services provided in large hospitals is determined by analysis of hospital activity and cost information. For 2019/20 the set aside value is now based on a detailed approach including actual spend and activity levels. The 2018/19 value has been re-stated after recalculation for its value using the 2019/20 calculation method.

5. Events After the Reporting Period

The Annual Accounts were authorised for issue by the Chief Financial Officer on 25 June 2020. Events taking place after this date are not reflected in the financial statements or notes. Where events taking place before this date provided information about conditions existing at 31 March 2020, the figures in the financial statements and notes have been adjusted in all material respects to reflect the impact of this information.

6. Expenditure and Income Analysis by Nature

2018/19 £000	West Dunbartonshire Integrated Joint Board Health & Social Care Partnership Consolidated Health & Social Care Services	2019/20 £000
67,444	Employee Costs	70,609
894	Property Costs	1,062
1,507	Transport	1,472
6,560	Supplies and Services	4,985
47,019	Payment to Other Bodies	51,615
23,294	Prescribing	24,014
22,728	Family Health Services	23,773
1	Capital Charges	0
2,007	Other – Direct Payments	2,185
25	Audit Fee	27
577	Assisted Garden Maintenance and Aids and Adaptations	661
29,522	Set Aside for Delegated Services Provided in Large Hospitals	28,389
(17,138)	Income	(17,720)
(185,478)	Taxation and non specific grant income	(191,955)
(1,038)	**Surplus on the Provision of Services**	**(883)**

There are no statutory or presentational adjustments which reflect the WDHSCP Board's application of the funding received from partners. The movement in the General Fund balance is therefore solely due to the transactions shown in the Comprehensive Income and Expenditure Statement. Consequently an Expenditure and Funding Analysis is not provided in these annual accounts.

7. Taxation and Non-Specific Grant Income

The funding contribution from the NHS Greater Glasgow and Clyde Health Board shown below includes £18.210m in respect of 'set aside' resources relating to acute hospital and other resources. These are provided by the Health Board which retains responsibility for managing the costs of providing the services. The HSCP Board however has responsibility for the consumption of, and level of demand placed on, these resources.

2018/19 Restatement £000	Taxation and Non-Specific Grant Income	2019/20 £000
(91,061)	NHS Greater Glasgow and Clyde Health Board	(95,322)
(64,318)	West Dunbartonshire Council	(67,583)
(29,522)	NHS GGCHB Set Aside	(28,389)
(577)	Assisted garden maintenance & Aids and Adaptations	(661)
(185,478)	**Total**	**(191,955)**

8. Hosted Services

Consideration has been made on the basis of the preparation of the 2018/19 accounts in respect of MSK Physiotherapy, Retinal Screening and Old Age Psychiatry Services hosted by West Dunbartonshire HSCP Board for other IJBs within the NHSGGC area. The HSCP Board is considered to be acting as a "principal", with the full costs of such services being reflected in the 2018/19 financial statements. The cost of the hosted services provided to other IJBs for 2018/19 is detailed in the table below:

2018/19 £000 Net Expenditure of Other IJB Activity	Host Integrated Joint Board	Service Description	2019/20 £000 Net Expenditure of Other IJB Activity
5,366	West Dunbartonshire	MSK Physiotherapy	5,845
689	West Dunbartonshire	Retinal Screening	746
73	West Dunbartonshire	Old Age Psychiatry	64
6,128		**Cost to GGC IJBs for Services Hosted by WD**	**6,655**

Similarly, other IJBs' within the NHSGGC area act as the lead manager (or host) for a number of delegated services on behalf of the WD HSCP Board. The table below details those services and the cost of providing them to residents of West Dunbartonshire, based on activity levels, referrals and bed days occupied.

2018/19 £000 Net Expenditure by WD HSCP	Host Integrated Joint Board	Service Description	2019/20 £000 Net Expenditure by WD HSCP
617	East Dunbartonshire	Oral Health	625
570	East Renfrewshire	Learning Disability	846
0	East Renfrewshire	Augmentative and Alternative Communication	4
286	Glasgow	Continence	283
563	Glasgow	Sexual Health	560
1,431	Glasgow	Mental Health Services	1,257
1,048	Glasgow	Addictions	1,046
763	Glasgow	Prison Healthcare	806
189	Glasgow	Health Care Police Custody	188
5,003	Glasgow	General Psychiatry	4,552
0	Inverclyde	General Psychiatry	13
521	Renfrewshire	Podiatry	535
298	Renfrewshire	Primary Care Support	306
11,289		**Cost to WD for Services Hosted by Other IJBs**	**11,021**

9. Debtors

2018/19 Restatement £000	Short Term Debtors	2019/20 £000
0	NHS Greater Glasgow and Clyde Health Board	0
7,180	West Dunbartonshire Council	8,113
7,180	**Total**	**8,113**

10. Creditors

2018/19 £000	Short Term Creditors	2019/20 £000
0	NHS Greater Glasgow and Clyde Health Board	0
0	West Dunbartonshire Council	0
0	**Total**	**0**

11. Provisions

A provision has been established in relation to the insurance excess value payable as a result of an claim arising from Employer's Liability Insurance Claim

2018/19 £000	Provisions	2019/20 £000
0	Insurance Claim	(50)
0	**Total**	**(50)**

12. Useable Reserve: General Fund

The HSCP Board holds a balance on the General Fund for two main purposes:

- To earmark, or build up, funds which are to be used for specific purposes in the future, such as known or predicted future expenditure needs. This supports strategic financial management.
- To provide a contingency fund to cushion the impact of unexpected events or emergencies. This is regarded as a key part of the HSCP Board's risk management framework.

Balance as at 31 March 2019 £000	Total Reserves	Transfers Out 2019/20 £000	Transfers In 2019/20 £000	Balance as at 31 March 2020 £000
(6)	GIRFEC Council	6	0	0
(71)	Criminal Justice - Transitional Funds	0	(24)	(95)
(183)	Carers Funding	0	0	(183)
(773)	Social Care Fund - Living Wage	95	0	(678)
(971)	Service Redesign & Transformation	329	0	(642)
(420)	Integrated Care Fund	420	0	0
(103)	Delayed Discharge	103	0	0
0	Unscheduled Care Services	0	(500)	(500)
(99)	GIRFEC NHS	27	0	(72)
(174)	DWP Conditions Management	5	0	(169)
(146)	TEC (Technology Enabled Care) Project	24	0	(122)
(260)	Primary Care Transformation	260	0	0
(125)	Physio Waiting Times Initiative	0	(122)	(247)
(60)	Retinal Screening Waiting List Grading	36	0	(24)
(68)	GP Premises Improvement Funding	68	0	0
(369)	Prescribing Reserve	0	(486)	(855)
(123)	Mental Health - Action 15	47	0	(76)
(482)	Primary Care Improvement Plan	482	0	0
(290)	Alcohol & Drug Partnership	283	0	(7)
0	CAMHS	0	(171)	(171)
0	Primary Care Board wide MDT	0	(27)	(27)
0	Child Health Weight (Henry Programme)	0	(15)	(15)
0	Infant Feeding PFG Funding	0	(30)	(30)
0	Clydebank Health & Care Centre	0	(250)	(250)
0	COVID-19 Recovery/Increased Demand	0	(515)	(515)
0	Un achievement of Savings	0	(485)	(485)
0	PCIP Premises	0	(91)	(91)
(4,723)	**Total Earmarked Reserves**	**2,185**	**(2,716)**	**(5,254)**
(2,457)	**Total Un-earmarked Reserves**	**0**	**(352)**	**(2,809)**
(7,180)	**Total General Fund Reserves**	**2,185**	**(3,068)**	**(8,063)**
	Overall Movement			**(883)**

13. Related Party Transactions

The HSCP Board has related party relationships with the Greater Glasgow and Clyde Health Board and West Dunbartonshire Council. In particular the nature of the partnership means that the HSCP Board may influence, and be influenced by, its partners. The following transactions and balances included in the HSCP Board's accounts are presented to provide additional information on the relationships.

Both NHSGGC and WDC provide a range of support services to the HSCP Board which includes legal advice, human resources support, some financial services and technical support. Neither organisation levied any additional charges for these services for the year ended 31 March 2020.

Transactions with Greater Glasgow and Clyde Health Board

2018/19 Restatement £000		2019/20 £000
(120,583)	Funding Contributions Received from the NHS Board	(123,711)
119,754	Expenditure on Services Provided by the NHS Board	123,237
(829)	**Net Transactions with NHS Board**	**(474)**

Transactions with West Dunbartonshire Council

2018/19 £000		2019/20 £000
(64,895)	Funding Contributions Received from the Council	(68,244)
64,416	Expenditure on Services Provided by the Council	67,554
270	Key Management Personnel: Non Voting Members	281
(209)	**Net Transactions with West Dunbartonshire Council**	**(409)**

14. External Audit Costs

In 2019/20 the HSCP Board incurred external audit fees in respect of external audit services undertaken in accordance with the Code of Audit Practice:

2018/19 £000		2019/20 £000
25	Fees Payable	27

INDEPENDENT AUDITOR'S REPORT

For Draft Accounts – this page is left intentionally blank

APPENDIX 1: LIST OF WEBSITE LINKS

1. http://www.wdhscp.org.uk/media/1215/wdhscp-integration-scheme-may-2015.pdf
2. http://wdhscp.org.uk/media/2158/hscp-strategic-plan-2019-2022.pdf
3. https://www.scotpho.org.uk/comparative-health/burden-of-disease/overview
4. http://www.wdhscp.org.uk/about-us/public-reporting/performance-reports/
5. http://www.wdhscp.org.uk/media/2323/document-pack-hscp-board-25-06-20.pdf
6. http://www.wdhscp.org.uk/media/2310/2019-20-financial-performance-update.pdf
7. http://www.wdhscp.org.uk/media/2018/wd-hscp-board-financial-regulations-feb-2018.pdf
8. http://www.wdhscp.org.uk/media/1874/wdhscp-risk-policy-and-strategy-august-2015.pdf
9. http://www.wdhscp.org.uk/media/2286/document-pack-erratum-notice-bookmarked-hscp-board-19022020.pdf
10. http://www.wdhscp.org.uk/media/2305/reserves-policy-april-2020.pdf
11. http://www.wdhscp.org.uk/media/2298/supplementary-document-pack-hscp-250320-3.pdf
12. http://www.wdhscp.org.uk/media/2299/appendix-8-wdhscp-draft-medium-term-plan-202021-to-202425.pdf
13. http://www.wdhscp.org.uk/media/1793/wdhscp-local-code-of-good-governance.pdf
14. http://www.wdhscp.org.uk/media/2276/audit-committee-tor-revised-october-2019.pdf
15. http://wdhscp.org.uk/media/2281/audit-committee-papers-11-december-2019.pdf
16. http://wdhscp.org.uk/media/2300/urgent-item-temporary-decision-making-arrangements.pdf

4th Floor, South Suite
The Athenaeum Building
8 Nelson Mandela Place
Glasgow G2 1BT

18 June 2020

Julie Slavin
Chief Financial Officer
West Dunbartonshire Health & Social Care Partnership
Council Offices
16 Church Street
Dumbarton
G82 1QL

Dear Julie

West Dunbartonshire Integration Joint Board 2019/20 Annual Audit

1. Further to my recent email, I am writing to confirm the implications of the COVID-19 crisis on the audit of the 2019/20 accounts.

2. On 21 May 2020, The Scottish Government issued Local Government Finance Circular 10/2020, covering the format and publication timetables for the 2019/20 accounts, that apply to this year only. I know that you are still planning to issue the unaudited accounts for audit and public inspection by 30 June. If you subsequently find you are unable to meet this deadline, and plan to take advantage of the timetable extension in the circular we will work with you on a flexible approach to the audit.

3. The circular includes the following reference to timelines relating to the publication of audited accounts:

   Timelines

   5. Local authorities, in their discussions with auditors around such timescales, should strive to work to as early a date as practicable for both parties.

   6. Scottish Ministers consider it reasonable that a local authority publishes its audited Annual Accounts no later than 30 November 2020.

4. The impact of the COVID-19 crisis on the work of Audit Scotland is now becoming clearer. Audit Scotland staff are not considered essential workers in the current COVID-19 lockdown and our offices remain closed and all staff are required to work from home. We know that the council is taking action to protect the health of staff and Audit Scotland is also prioritising the health of our staff in the current crisis. Audit Scotland has published 'COVID-19: the impact on public audit in Scotland', which explains that our approach to audit during these circumstances will be pragmatic, flexible and consistent.

5. The Scottish Government COVID-19 Routemap indicates that it will be some time until we can resume office based audit work. Under these restrictions, our teams have been progressing the audits, looking for opportunities to revise the scope of our work and to realise any efficiencies we

can, whilst responding to the changing audit risks. Our original hope was that audits could be concluded on time, however our experience to date is that remote audit tasks are often taking longer than when our staff are on site. Some of our staff are also facing illness and caring responsibilities alongside their work, which impacts on the time taken to complete work.

6. Audit Scotland normally recruit additional temporary auditors over the summer months to support our permanent audit teams when we are auditing local authority accounts. We have not recruited these extra staff in 2020 as we do not feel we can appropriately supervise temporary staff remotely, to assure the audit quality required. This is impacting on the audit resources available to work on all of our audits.

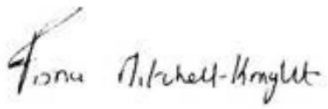
7. We intend to start the audit of your accounts when they are submitted to us with the working papers, and to conclude our work as quickly as possible. However due to the above issues we are unable to guarantee completing the audit by the timetable described in our 2019/20 Annual Audit Plan, of 30 September 2020.

8. We appreciate that any delay in the sign off has wide implications for you alongside your COVID-19 response and due to the committee timetable. However we feel that it is best to let you know that a delay in the audit is a possibility, in which case we would work with you towards a sign off and publication of the accounts by 30 November 2020 at the latest.

9. Audits in all sectors are subject to delays, and Audit Scotland teams are taking this approach with all IJBs. If once we start the audit we find progress is being made more quickly than anticipated we will work with you on earlier sign off, if it is practical to do so.

10. We will work with you to update the audit timetable to minimise the impact on you. Please call me if you wish to discuss any aspects of the audit.

Yours sincerely



Fiona Mitchell-Knight

Audit Director

WESTDUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

25 June 2020

Draft Unscheduled Care Commissioning Plan

1. Purpose

1.1 The purpose of this report is to update the IJB on progress across NHSGGC in developing the strategic commissioning plan for unscheduled care.

2. Recommendations

2.1 The Integration Joint Board is asked to:

- approve the draft commissioning plan for unscheduled care attached;
- note the further work underway to finalise the plan, including the planned engagement process; and,
- receive a further update with a finalised plan in November 2020.

3. Background

3.1 Work has been undertaken by all six HSCPs in NHSGGC to develop a system wide strategic commissioning plan in partnership with the NHS Board and Acute Services Division and in line with the IJB's Strategic Plan. The draft plan attached builds on the GG&C Board wide Unscheduled Care Improvement Programme and is integral to the Board-wide Moving Forward Together programme.

3.2 The draft plan is being presented to all six IJBs for consideration recognising that further work is required on key aspects as outlined below. The plan aims to ensure that what works well and has the greatest evidence base, is what we do, recognising that that does not necessarily require uniformity.

3.3 One key aspect of that work is learning from the pandemic which has seen a dramatic fall in unscheduled care activity. While the bulk of the draft plan itself is still relevant, the learning from what has worked well during the pandemic will be incorporated in the key actions in the final version. This learning is outlined below.

4. Main Issues

4.1 The purpose of the plan is to outline how we aim to respond to the continuing pressures on health and social care services in NHSGGC and meet future demand. The draft explains that with an ageing population and changes in how and when people chose to access services, we need to change services so that we can meet patients' needs in different ways with services that are more clearly integrated and with the public understanding better how to use them.

4.2 The draft plan explains that simply providing more of what we have (e.g. more emergency departments) is not possible within existing resources, nor does this fit with our longer term ambition of providing care closer to where patients live and reducing our reliance on hospitals. The direction of travel is to meet people's needs in community settings with primary care as the corner stone of the health and social care system.

4.3 The draft outlines how we plan to support people better in the community and develop alternatives to hospital care so that we can safely reduce the over-reliance on unscheduled care services. The draft describes the delivery of an integrated system of health and social care services that we believe will better meet patients' needs. While this is a strategic plan outlining improvements for patients to be implemented over the next five years, the plan also includes some immediate actions that can be delivered in the short term in response to current imperatives. Indeed, with some aspects of the plan, we have already began to work in this way, such as in the establishment of FIT (Focussed Intervention Team – supporting people at home and avoiding hospital admission) and our assertive in-reach approach to accelerating hospital discharge.

4.4 The programme outlined in the plan is based on evidence of what works and our estimate of patient needs in GG&C. The programme is focused on three key themes:

- **early intervention and prevention** of admission to hospital to better support people in the community and includes actions on:
  - implementing anticipatory care plans within specific patient groups; e.g. COPD, residential care home clients etc.;
  - working with GPs through the national frailty collaborative, and building on the strong foundation of frailty work in West Dunbartonshire to better manage frailty within the community;
  - work with care homes to reduce hospital admissions;
  - work with the Scottish Ambulance Service (SAS) to reduce the number of falls conveyed to hospital as part of a wider falls prevention strategy;
  - continue to develop the palliative care fast track service; and,
  - extending the community respiratory service to provide a service over weekends through the FIT Team.

- **improving hospital discharge** and better supporting people to transfer from acute care to community supports and includes actions on:
  - expansion of the hospital discharge team;
  - intermediate care improvement programme designed to reduce length of stay and improve the number of people returning home; building on the early impact of FIT
  - additional intermediate care capacity introduced as part of the winter planning arrangements;
  - additional Red Cross transport capacity purchased to assist with hospital discharge; and,
  - continued robust performance management of delays.

- **improving the primary / secondary care interface** jointly with acute to better manage patient care in the most appropriate setting and includes actions on:
  - reviewing acute assessment unit referrals discharged on the same day to explore scope for managing this activity as part of planned care;
  - reducing the number of frequent A&E attenders by looking at the scope for early intervention approach to reduce attendances;
  - introducing a re-direction policy;
  - introducing a test of change involving consultant geriatricians and GPs to better manage care home patients; and,
  - introducing consultant connect to improve GP to consultant liaison.

4.5 The changes proposed will not take effect immediately or all at the same time. Some need testing first and others need time to bed in. Change will be gradual but should be fully implemented by 2022/23. While the challenge is to change to respond to current and future demand, it is also to maintain the direction outlined in the plan over the longer term so that we can better meet the needs of the people we serve.

4.6 We also need to communicate more directly with patients and the general public to ensure people know what service is best for them and can access the right service at the right time and in the right place.

4.7 Progress on these actions is reported regularly to *the* HSCP's Unscheduled Care Group.

5. Learning from the pandemic

5.1 Unscheduled care services have seen dramatic changes as a result of the pandemic. As well as there being an unprecedented drop in A&E attendances, emergency admissions and delays, has also been significant changes in primary and secondary care services. These changes include the opening of Community Assessment Centres (CACs), GPs operating by telephone triage and 'Attend anywhere' and new Covid pathways introduced in secondary care. These changes together with the lockdown measures and a strong public messaging and information campaign have impacted on unscheduled care activity. It is important therefore going forward that we learn lessons from what has worked well during the pandemic and might be followed through as part of our system wide approach to improving patient services and better managing demand.

5.2 What has also been clear throughout the pandemic, is different areas have suffered at different rates, and at this stage there appears to have been a greater impact in some areas of deprivation such as West Dunbartonshire and Inverclyde. However, in the medium to longer term, we are unsure as to whether this will continue and therefore our plans must be adaptable to respond to the uniqueness of the population we serve.

5.3 Alongside the programmes detailed in NHSGGC's Unscheduled Care Commissioning Plan, to which we contribute, West Dunbartonshire already has a range of local developments to further shift the balance of care, and support people with effective alternatives to attending hospital.

These include:

a) Full roll out of the Focussed Intervention Team (FIT) across West Dunbartonshire. FIT was established in August 2019 and provides rapid, multi-disciplinary and intensive care at home, where conditions escalate and where hospital attendance may become likely.

b) Agreement has been reached with the Scottish Ambulance Service that referrals with be redirected to FIT as an alternative pathway to conveying residents of West Dunbartonshire to acute (when presenting with a fall or breathing difficulties.) Monthly audits suggest this will amount to approximately 30 referrals per month. A joint HSCP /SAS programme of training and awareness raising with Paramedic crews is underway and these new pathways went live on 4th November 2019.

c) Work with the Vale of Leven Hospital to ensure best use of day hospital and clinic capacity for people who are suffering from frailty and who would benefit from hospital services.

d) Detailed regular analysis of those frequently attending A&E, and proactive contact with these individuals to develop more appropriate supports

e) A proactive approach to ensuring high vaccination rates for influenza for both staff and vulnerable patient groups.

f) Very proactive in-reach work with acute sites, using an electronic dashboard to monitor all emergency hospital admissions by residents of West Dunbartonshire, ensuring early contact with the patient, and the ward, to start planning for an effective and timely discharge.

g) Better communication and networks across all parts of our local unscheduled care system. The HSCP hosted an unscheduled care event for local stakeholders on 21st October 2019, looking to develop pathways, build relationships, find solutions and promote a fully integrated approach.

5.4 Key examples of what has worked well and, subject to further testing, could be included in our unscheduled care plan include:

- the introduction of the NHSGGC wide community respiratory service to better manage COPD in the community and reduce hospital admissions;
- building on our approach to shielding to improve community support to vulnerable patients with specific conditions including working with the third sector, and integrating this with our approach to ACPs;

- embedding actions to improve delays so this becomes standard practice across NHSGGC e.g. discharge to assess;
- learning from the operation of the CACs to introduce an appointment based model in GP assessment units with same day and next day appointments;
- aligned to this, accelerating the introduction of appointment based "hot clinics" for specific conditions as part of an integrated primary / secondary care pathway; and,
- refreshing and updating our re-direction protocol to coincide with the re-opening of Minor Injuries Unitds and a wider public awareness raising campaign on unscheduled care services.

5.5 These and other actions will also be included in the NHS Board's Turnaround plan as part of the performance escalation reporting process with Scottish Government.

6. Next Steps

6.1 Key next steps include:

- engagement on the draft with key partners and stakeholders;
- further work to finalise the financial framework; and,
- the key impact measures to be used in reporting on progress.

6.2 Originally the plan was to be subject to a period of engagement with key stakeholders and clinicians in primary and secondary care in the spring. Key stakeholders include SAS, NHS24, the third and independent sectors, GPs and other primary care contractors, acute clinicians and staff and neighbouring HSCPs / NHS Boards. The intention was that the draft would be discussed at various events and fora across NHSGGC and while the draft was being considered by the six IJBs. Due to the pandemic, this engagement has been postponed and will now be extended into the summer. A period of public / patient engagement is also planned co-ordinated with other public engagement exercises to ensure a joined up and consistent message is given publicly. This is now likely to be towards the autumn.

6.3 Further work is also required on the financial framework to support delivery of the plan – see section 8 of the draft. The draft identifies a number of key actions that could require financial investment to deliver. A finalised financial plan will be incorporated in the final plan to be reported to the IJB in November 2020. Until this is complete only aspects of the plan which can be funded within existing budgets will be progressed.

6.4 Work is also in hand on the key impact measures to be used to demonstrate improvements in performance – see section 9 of the draft. Among the indicators to be used will be:

- emergency admissions;
- acute unscheduled hospital bed days;

- A&E attendances; and,
- bed days lost due to delayed discharges

Person to Contact: Jo Gibson – Head of Health and Community Care

NHS GREATER GLASGOW AND CLYDE
HEALTH AND SOCIAL CARE PARTNERSHIPS

D R A F T

Moving Forward Together

The challenge is change

D R A F T

Strategic Commissioning Plan for Unscheduled Care Services in Greater Glasgow & Clyde 2020-2025

March 2020

SUMMARY

- **Unscheduled care services in Greater Glasgow & Clyde are facing an unprecedented level of demand**
- **The wider health and social care system, including primary and social care, has not seen such consistently high levels of demand before**
- **While we are performing well compared to other health and social care systems nationally, and the system is relatively efficient in managing high levels of demand we are struggling to meet key targets consistently and deliver the high standards of care we aspire to**
- **We need major change if we are to meet the challenge of rising demand**
- **This draft plan charts a way forward over the next five years to 2025**
- **Essentially it aspires to patients being seen by the right person at the right time and in the right place**
- **For hospitals that means ensuring their resources are directed only towards people that require hospital-level care**
- **At present, an unsustainable number of people are accessing hospital resources on an unplanned basis when their needs can and should be met in a different way**
- **Therefore the emphasis in this strategy is on seeing more people at home or in other community settings when it is safe and appropriate to do so**
- **The plan includes proposals for a major public awareness campaign so that people know what services to access when, where and how**
- **We will work with patients to ensure they get the right care at the right time**
- **Analysis shows that a significant number of patients who currently attend emergency departments could be seen appropriately and safely by other services. A number of services could be better utilised by patients**
- **We also need to change and improve a range of services to better meet patients' needs**
- **Not all the changes in this plan will take effect at the same time. Some need to be tested further and others need time to be fully implemented. That is why this is a long term plan with some short term actions we need to take soon**
- **The challenge is change**
- **A summary of the key actions in this plan and timescales are shown on the next page. Work to measure the overall impact of the programme is in hand**

KEY ACTIONS

Below is a summary of the key actions in the plan and the timescale for implementation.

Key Actions	Timescale
Communications plan (page 26)	
1) We will take forward a major campaign across a range of media to better inform the public about which service to access for what and when. The campaign will also raise awareness about issues such anticipatory care plans, and key health promotion initiatives. The aim will be to have a more informed public consumer of health and care services.	**Through 2020/21 and updated for future years**
Prevention & early intervention (pages 30-37)	
2) We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions	**2020/21**
3) We will work with the Scottish Ambulance Service (SAS) and patient groups to develop a care pathway to safely manage the care of patients who have had a fall but do not need to be seen in an A&E department.	**2020/21**
4) We will through the frailty collaborative develop an integrated frailty pathway with secondary care, GPs and community teams to provide alternatives to hospital or to reduce length of stay for patients admitted with frailty and that contributes to a reduction in emergency admissions.	**2021/22**
5) We will increase support to carers as part of implementation of the Carer's Act	**2020/21 and ongoing**
6) We will increase the number of community links workers working with primary care to 50 by the end of 2020/21	**2020/21**
7) We will develop integrated pathways for the top six conditions most associated with admission to hospital with the aim of better supporting patients in the community	**By end 2020**
8) We will develop a range of alternatives to admission for GPs such as access to consultant advice, access to diagnostics and "hot clinics" e.g. community respiratory team advice for COPD and promote consultant connect – that enable unscheduled care to be converted into urgent planned care wherever possible.	**By end 2020**
9) We will further pilot access to "step-up" services for GPs as an alternative to hospital admission.	**By end 2020**
10) We will continue the work with the independent sector, GPs and others to further reduce avoidable emergency department attendances and admissions from care homes.	**2020/21**
11) We will explore extending the care home local enhanced service to provide more GP support to care homes	**By end 2020**
Primary and Secondary care interface (pages 38-52)	
12) We will develop and apply a policy of re-direction to ensure patients see the right person, in the right place at the right time.	**2020/21**

Key Actions	Timescale
13) We will test a service in emergency departments that offers patients who could be seen elsewhere advice and assistance in getting the most appropriate service.	**2020/21**
14) To improve the management of minor injuries and flow within emergency departments and access for patients, separate and distinct minor Injury Units (MIUs) will be established at all main acute sites.	**2020/21**
15) We will incentivise patients to attend MIUs rather than A&E with non-emergencies through the testing of a 2 hour treatment targets	**2020/21**
16) We will explore extending MIU hours of operation to better match pattern of demand	**2020/21**
17) We will assess the feasibility of opening an MIU on the Gartnavel site	**By the end of 2020**
18) We will continue to improve urgent access to mental health services	**2020/21**
19) We will reduce the number of A&E attendances accounted for by people who have attended more than five times in the previous twelve months equivalent to 2% of total attendances	**2020/21**
20) We will reduce the number of people discharged in the same day from GP assessment units through the implementation of care pathways for high volume conditions such as deep vein thrombosis and abdominal pain. To enable this we will review same day discharges and signpost GPs to non-hospital alternatives that can be accessed on a planned basis.	**2020/21**
21) We will develop hospital at home approaches that strengthen joint working between consultant geriatricians and GPs in order to better support patients in the community at most risk of admission to hospital. Specific populations will be prioritised, including care home residents and people living with frailty.	**2020/21**
Improving hospital discharge (pages 53-61)	
22) We will work with acute services to increase by 10% the number of hospital discharges the number of discharges occurring before 12.00 noon and at weekends and during peak holiday seasons, including public holidays.	**By end of 2020**
23) Working closely with Acute Teams, HSCP staff will proactively begin care planning as soon as possible after a patient is admitted to hospital with the aim of expediting discharge at the earliest opportunity once the person is medically fit	**2020 / 21**
24) We will undertake a programme of continuous improvement in relation to HSCP intermediate care and rehabilitation and re-ablement services in an effort to optimise efficient and effective use of these resources which are critical to the overall acute system performance.	**2020/21**
25) We will reduce delayed discharges so that the level of delays accounts for approximately 2.5%-3.00% of total acute beds, and bed days lost to delays is maintained within the range of 37,000 – 40,000 per year.	**2020/21**

CONTENTS

List of tables and figures

1. INTRODUCTION

1.1 The health and social care system in Greater Glasgow & Clyde (GG&C) – the largest in Scotland – is facing unprecedented levels of demand. Demand for acute hospital services continues to rise and has increased by 4.3% since 2017/18 and shows no sign of reducing. Whilst the whole system is working hard to deliver more quality care to people than ever before, our performance against some key performance targets has deteriorated in line with this increased demand for example, the percentage of patents seen within 4 hours at emergency departments at currently at 90%, and bed days lost due to delayed discharges has increased by 9,323 since 2017/18. There is also evidence that people are using A&E services more now than they used to in the past.

1.2 Despite this the health and social care system in GG&C performs well compared to other systems nationally, and is relatively efficient in managing high levels of demand and dealing with complexity. However, an over-reliance on unscheduled care services can indicate that a health and social care system is not performing optimally in helping people to know where to go to for help.

1.3 The health and social care system can be confusing for patients, and complicated to navigate for clinicians, staff and the general public. It is often not clear to patients and families which service should be accessed for different needs, how and when. This is an inherent challenge when there are such a broad range of needs, specialisms, professional groups and varying levels of health literacy amongst the general population.

1.4 We must adapt our service model in response to an ageing population, and changes in how and when people choose to access services, so that we can meet patients' needs in different ways, ensure services are more clearly integrated and that the public understand better how to use them. The challenge is change.

1.5 Providing more of what we currently have (e.g. more emergency departments) is neither possible within the resources we have nor does it fit with our longer term ambitions of providing care closer to where patients live, and reducing our reliance on hospitals. We believe people's needs should be met in community settings whenever possible with primary care as the corner-stone of the health and social care system.

1.6 This draft strategy outlines how we as Health and Social Care Partnerships (HSCPs) in Greater Glasgow & Clyde, in partnership with secondary care colleagues and other partners plan to support people better in the community, developing alternatives to hospital care that ensure hospitals are utilised only by those that require that level of medical care. This plan describes the delivery of an integrated system of health and social care services that we believe will better meet patients' needs. While this is a strategic plan outlining improvements for patients to be implemented over the next five years, we also include some immediate actions that can be delivered in the short term in response to current imperatives.

1.7 We will require patients and the wider public to share responsibility for achieving the improvement in service performance and experience we all want to see over the next 5 years. A key element of that will be working with the public to increase general knowledge and understanding of which services to access for what and when.

1.8 In developing this strategy we recognise that the health and social care system operates in a wider social and economic context which often drives demand for health and care support. This plan has been developed at a time when significant changes are taking place in the population we serve, and in society as a whole, that will have an impact on health and social care services. According to the National Records Office "In recent years … increases in life expectancy have stalled"[1], and the Institute for Fiscal Studies has reported that "average household income [in the UK] growth stalled in 2017-18 and is still only 6% above its pre-recession levels"[2].

1.9 Both these factors, and others, will influence the shape and pattern of demand over the next few years. Therefore whilst we make estimates of the potential impact of our programme, it is impossible to provide guarantees of future impact. There are many complex and unpredictable factors involved in being able to predict future impacts with certainty, particularly into the long term. The estimates of potential impact should therefore be viewed with this qualification in mind.

What is unscheduled care?

1.10 Unscheduled care has been defined as:

"… any unplanned contact with health and / or social work services by a person requiring or seeking help, care or advice. Such demand can occur at any time, and services must be available to meet this demand 24 hours a day. Unscheduled care includes urgent care and acute hospital emergency care."[3]

Integration Joint Boards' responsibilities

1.11 As part of the legislation on health and social care integration, Integration Joint Boards were given a statutory duty for the strategic planning of unscheduled care services. The integration scheme for Integration Joint Boards includes the following statement and which forms the statutory basis for our strategic planning responsibilities:

"The Integration Joint Board will assume lead responsibility jointly with the five other Health and Social Care Partnerships within the Greater Glasgow and Clyde area for the strategic planning of the following:

- accident and emergency services provided in a hospital.

[1] Life Expectancy in Local Areas 2015-17, National Records for Scotland, December 2018,
[2] Institute for Fiscal Studies, March 2019, Briefing note: No growth in household incomes in the last year – for only the fourth time in the last 30 years
[3] *Commissioning a new delivery model for unscheduled care in London,* Healthcare for London, 2016

- in-patient hospital services relating to the following branches of medicine:
i. general medicine;
ii. geriatric medicine;
iii. rehabilitation medicine;
iv. respiratory medicine; and
- palliative care services provided in a hospital."

National picture

1.12 Audit Scotland in their recent report on the NHS in Scotland stated that:

> "***The healthcare system faces increasing pressure from rising demand and costs, and it has difficulty meeting key waiting times standards. Without reform, the Scottish Government predicts that there could be a £1.8 billion shortfall in the projected funding for health and social care of £18.8 billion by 2023/24. So far, the pace of change to address this, particularly through the integration of health and social care, has been too slow."***[4]

1.13 Audit Scotland recommended that the Scottish Government in partnership with health boards and integration authorities should:

> ***"develop a new national health and social care strategy to run from 2020 that supports large-scale, system-wide reform, with clear priorities that identify the improvement activities most likely to achieve the reform needed"***[5]

1.14 In 2015 Scotland's Deputy First Minister in his budget speech stated that:

> ***"The nature and scale of the challenges facing our NHS – in particular the challenge of an ageing population – mean that additional money alone will not equip it properly for the future. To be blunt, if all we do is fund our NHS to deliver more of the same, it will not cope with the pressures it faces. To really protect our NHS, we need to do more than just give it extra money - we need to use that money to deliver fundamental reform and change the way our NHS delivers care."***[6]

This draft plan

1.15 The purpose of this draft plan is to set out the six NHSGG&C HSCPs' collective response to Audit Scotland's recommendation, and how we aim to fulfil the statutory requirement for strategic planning of unscheduled care services laid down in Integration Joint Boards' integration schemes.

[4] NHS IN Scotland 2019, Audit Scotland
[5] Op cit
[6] John Swinney, MSP, Deputy First Minister, Budget Speech, December 2015

1.16 The draft plan looks at where we are now, assesses the demographics and needs of our population, and current trends in unscheduled care activity in Greater Glasgow & Clyde. We then move on outline our vision for unscheduled care services to respond to the pressures and demands within the health and social care system. We go on to outline specific changes we wish to introduce working with acute colleagues, GPs and others and the estimated impact these changes might have, together with the benefits for patients. Finally we outline the resource framework that will support this work and the implementation arrangements to ensure success.

1.17 This plan should be read together with other plans being taken forward by the NHS Board and Health and Social Care Partnerships including:

- the wider Moving Forward Together programme[7] ;
- our digital and eHealth programme[8];
- our local primary care improvement plans[9] ;
- our Board-wide adult mental health strategy and older people's mental health strategy [in development];
- our redesign of out of hours services[10] ;
- our wider programme of integration of health and social care services[11] ; and,
- our partners' plans such as the Scottish Ambulance Service, NHS24, Strategic Housing Investment Plans and Community Planning plans.

1.18 Before we move on we need to clarify who we are serving when describing the changes we want to see. HSCPs are responsible for delivering health and social care services for their resident populations. Acute services in GG&C however serve a much larger population than those who live in GG&C – approximately 10% of the total acute service activity in GG&C comes from out with the Board area. So while some changes in this plan will affect the wider population e.g. minor injury services, others will only affect HSCPs' resident population e.g. anticipatory care plans. In the main we use Health Board data as it relates to our resident population and where we use data that relates to the totality of activity in GG&C serving the wider catchment population we will explain this in the appropriate section. For any national comparisons that are used we will use national data.

1.19 This plan is a draft because we want to hear your views. We will outline separately how comments may be made as part of our engagement process.

[7] https://www.movingforwardtogetherggc.org/
[8] https://www.nhsggc.org.uk/about-us/digital-as-usual/digital-strategy-outlook-2018-2022/
[9] https://www.nhsggc.org.uk/media/250803/item-12-primary-care-improvement-plans-18-49.pdf

[10]
https://glasgowcity.hscp.scot/sites/default/files/publications/IJB%2026%2004%202017%20Item%20No%2011%20-%20Out%20of%20Hours%20Reform%20Update.pdf
[11] https://glasgowcity.hscp.scot/strategic-and-locality-plans

2. WHY WE NEED CHANGE

Introduction

2.1 In this section we look at where we are now, current and projected needs and demand for unscheduled care services. A comprehensive needs analysis was undertaken to inform NHSGG&C's *Moving Forward Together* programme, including a literature search of the available evidence on best practice and system wide change. This analysis is not repeated here and can be found at[12] .

Changes in Demand

2.2 The health and social care system in Greater Glasgow & Clyde is experiencing a period of sustained high demand. The reasons for this are considered to be changes in patient expectations and behaviour (see page 46 below), and changes in our population with an increase in the number of people aged over 75 (see page 13 below) and increases in levels of deprivation[13]. Some of this demand is also due to advances in treatments and technology. A key factor in looking at the pattern of demand in GG&C appears to be an over-reliance by some patients on emergency departments (EDs) for non-urgent conditions. This is sometimes associated with adverse life circumstances and ageing.

2.3 At a headline level in 2018/19 there was:

- a continued growth in emergency department attendances at all main acute sites (a 4.3% increase on 2017/18);
- which creates difficulties in meeting the national 4 hour waiting time target on a consistent basis (at the time of writing performance was at 80.9%[14]). During 2018/19 in emergency departments in GG&C the percentage of patents seen within 4 hours at main sites was 88% compared to the national value of 90%;
- a slight decrease in GP referrals to assessment units year on year (-1.3%) with no change in the percentage of patients discharged on the same day (45%-48%);
- a slight increase emergency admissions (0.5%) and a decrease in emergency admission bed days (-1.2%);
- an increase in delayed discharges with, in 2018/19, 36,968 acute hospital bed days lost due to delays; and,
- heightened levels of activity in all services over the winter period and on public holidays.

[12] https://www.movingforwardtogetherggc.org/media/248682/mft-top-100-transformational-articles.pdf

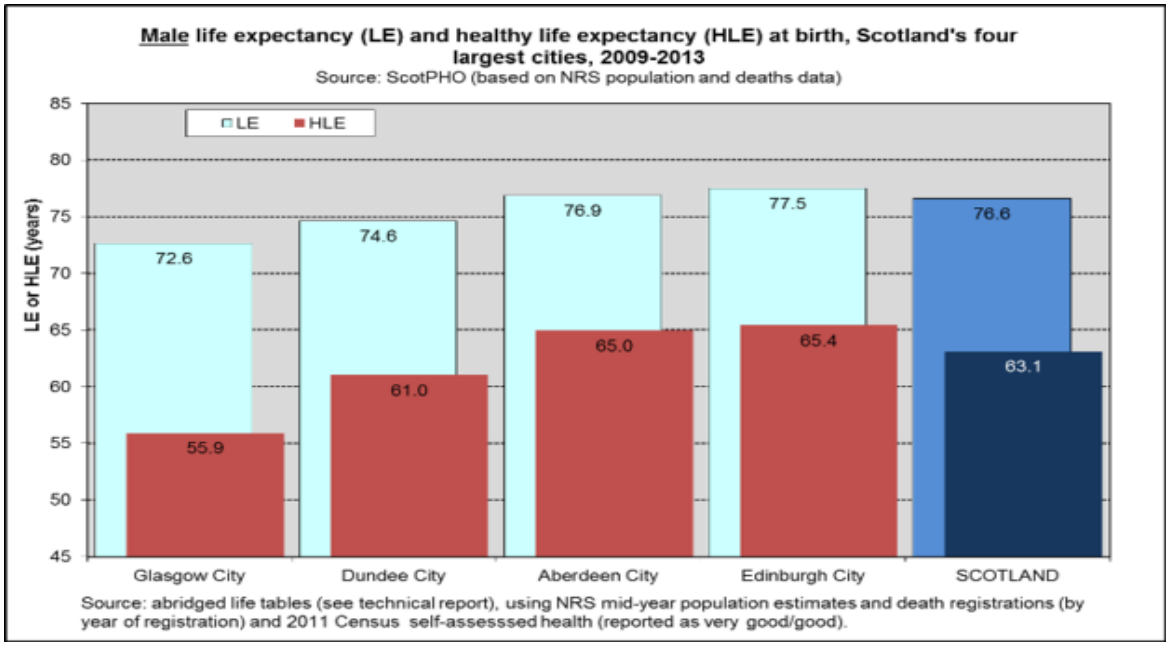
[13] https://www.gov.scot/publications/scottish-index-multiple-deprivation-2020/

[14] https://www.nhsperforms.scot/hospital-data?hospitalid=20

Changes in our population

2.4 Coupled with these changes in demand we have also seen changes in our population. We are now seeing for the first time a reversal in the increase in life expectancy for women and men; due it is thought to social and economic reasons[15] . People are still living longer than they were but when looking at healthy life expectancy (life expectancy adjusted to take account of health) we see that for many this is significantly lower than life expectancy (see figure 1)[16].

Figure 1: Male life expectancy and healthy life expectancy at birth 2009-2013

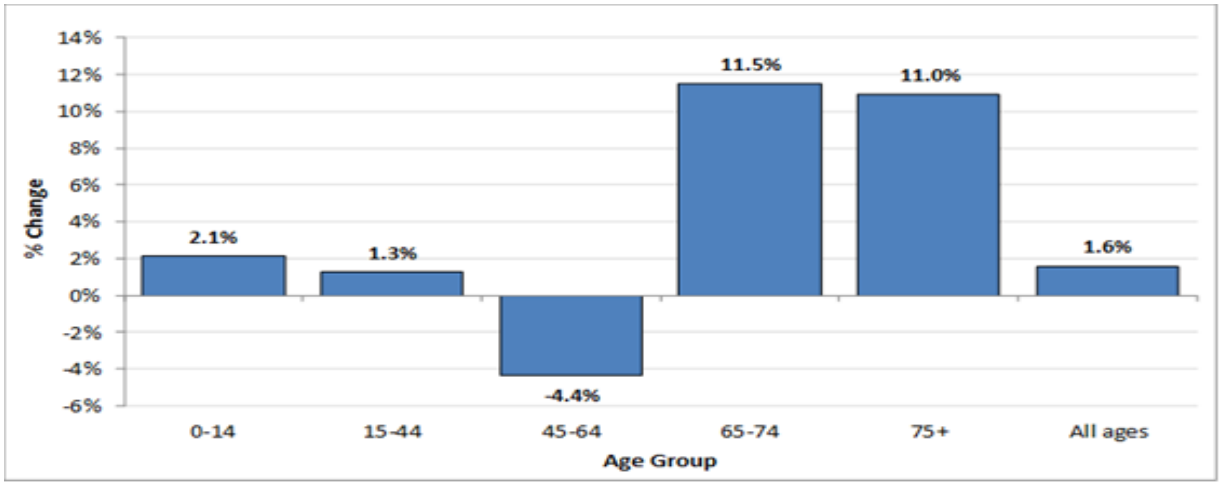


2.5 In addition it is projected that over the next ten years to 2030 in Greater Glasgow & Clyde we will see a 24% increase in the number of people aged over 65 and a 32% increase in the number of people aged over 90. There are also more immediate increases over the next five year with a projected 11% increase in those aged over 75 (see figure 2 below).

[15] *Mortality and Life Expectancy trends in the UK: stalling progress,* The Health Foundation, November 2019 *https://www.health.org.uk/publications/reports/mortality-and-life-expectancy-trends-in-the-uk*

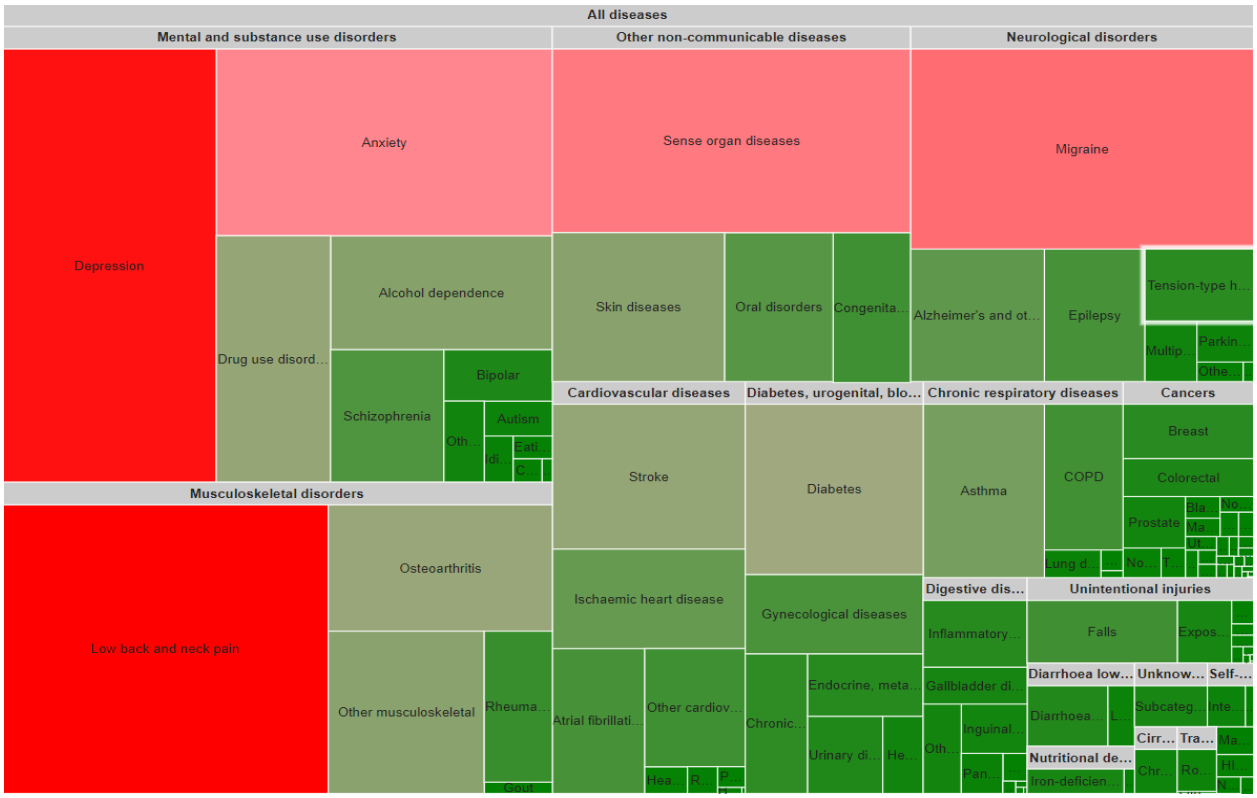
[16] http://www.understandingglasgow.com/indicators/health/trends/male_healthy_life_expectancy/scottish_cities/males

Figure 2: Projected GG&C population change 2019 to 2025



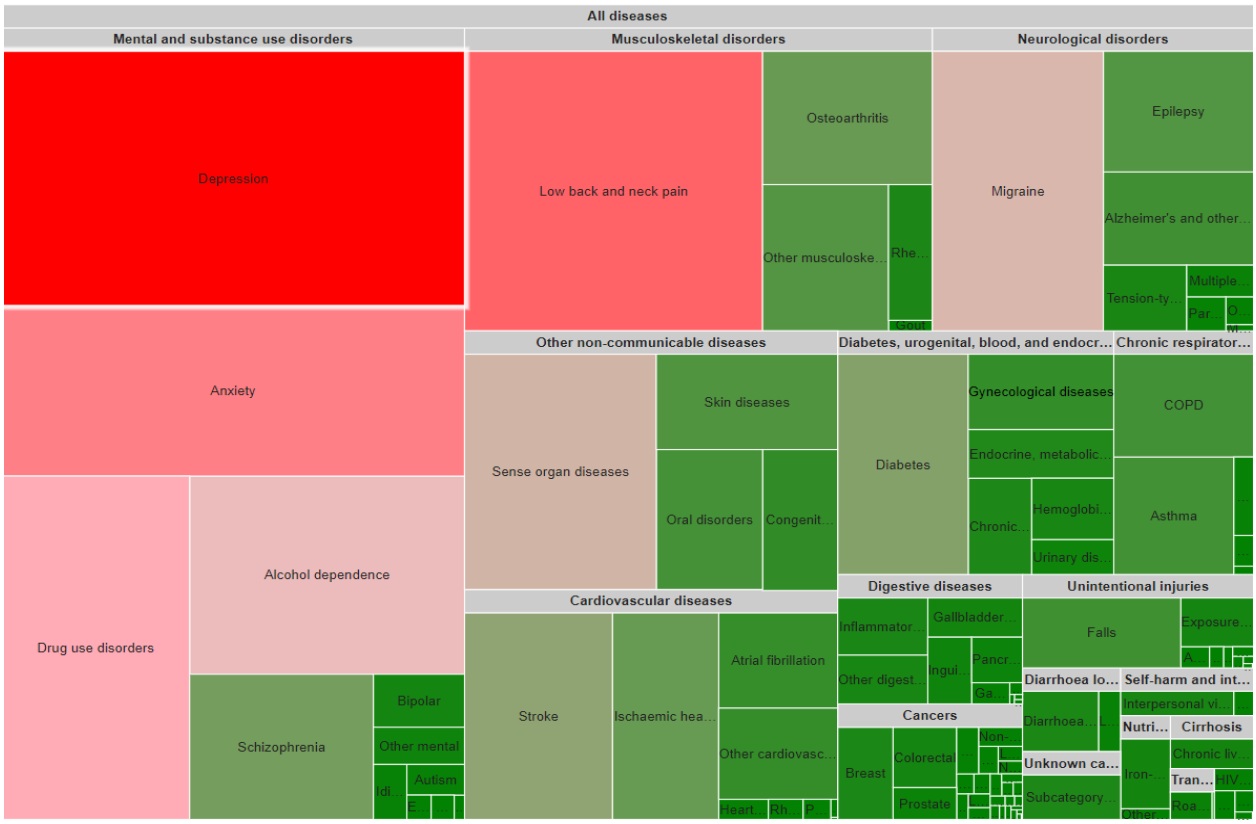
2.6 We can also look at the profile of disease in our population and while this shows considerable changes in the causes of ill health from ten years ago, it also shows differences within our population. The figure 3 below shows the burden of chronic illness and disability in the population as a whole in Scotland and figure 4 shows the picture for the poorest 10% of the population.

Figure 3 – Chronic illness and disability all Scotland



Source: ISD

Figure 4 – Chronic disease and disability Scotland poorest 10%



Source: ISD

2.7 For more information on the health population of Greater Glasgow & Clyde see https://www.nhsggc.org.uk/your-health/public-health/the-director-of-public-health-report/dph-report-2017-2019/

Understanding Current Trends[17]

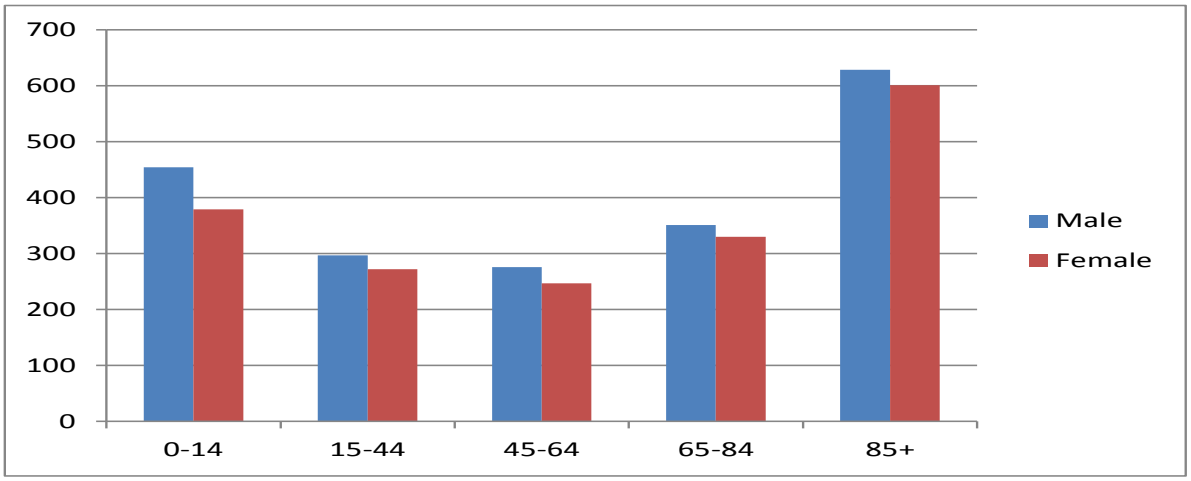
2.8 The current levels of unscheduled care activity in GG&C are unprecedented, and have been driven by demographic changes and the health of our population.

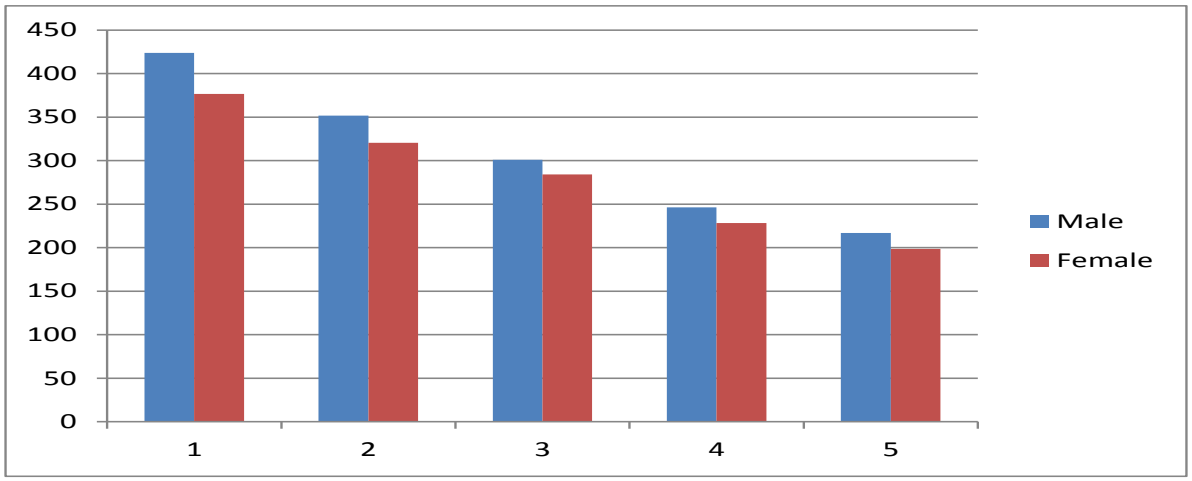
2.9 In 2018/19 there were a total of 517,730 unscheduled care attendances in secondary care. This includes attendances at emergency departments (EDs), GP assessment units (AUs) and minor injury units (MIU). This is a 4.3% increase on total attendances in 2017/18. Of these attendances 448,803 were GG&C residents (87%). The overall attendance rate per 1,000 residents for GGC was 338.2 compared to 285.7 nationally. The rate of attendance varies greatly by age, with higher rates among the young and older age groups. Furthermore attendance rates are higher for those who live in the most deprived areas when compared with the least deprived (see figures 5a and 5b below).

[17] Thanks to John O'Dowd for most of this analysis

This pattern is similar to other parts of the UK but is a particular factor in NHSGGC given the relatively high levels of deprivation in our communities.

Figure 5a. Rates of unscheduled care at hospitals for males and females by age-band. (2018/19). 5b. Rates of unscheduled care for males and females by SIMD quintile for deprivation, (2018/19), where 1 is most socio-economically deprived.





2.10 Of the total number of acute hospital attendances the proportion that requires admission is relatively low at 24% of all hospital attendances. When analysed by source of referral, this varies from 55% of attendances coming via 999 calls, to 37% from GP out of hour's calls, 15% from NHS24 calls, and 11% of patients who self-refer. Of unscheduled care attendances the majority of patients who attend self-refer (66% of all attendances). Of those who do attend emergency departments in GG&C analysis has shown that a significant number could been safely seen and treated elsewhere.

2.11 Based on current trends, and using ISD data, if nothing else changes we can expect a 14.6% increase in ED attendances (see figure 6 below) and a 4.8% increase in emergency admissions over the next five years (see figure 7 below) – this is essentially a do minimum option as it does not take into account the impact of population changes.

Figure 6: Projected total number of emergency department attendances 2020/21 to 2025/26

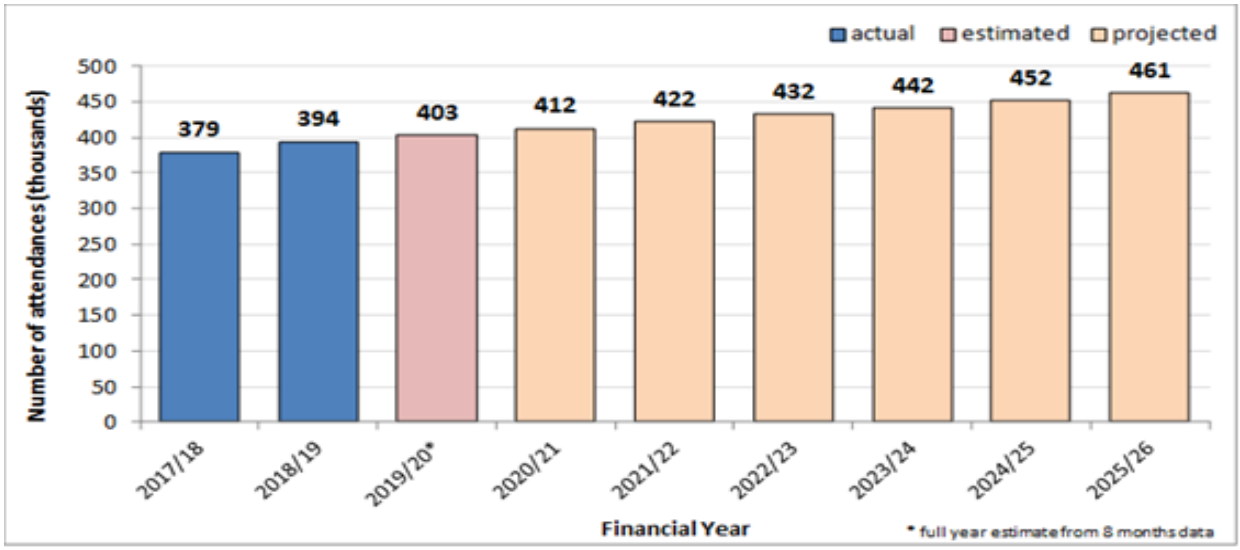
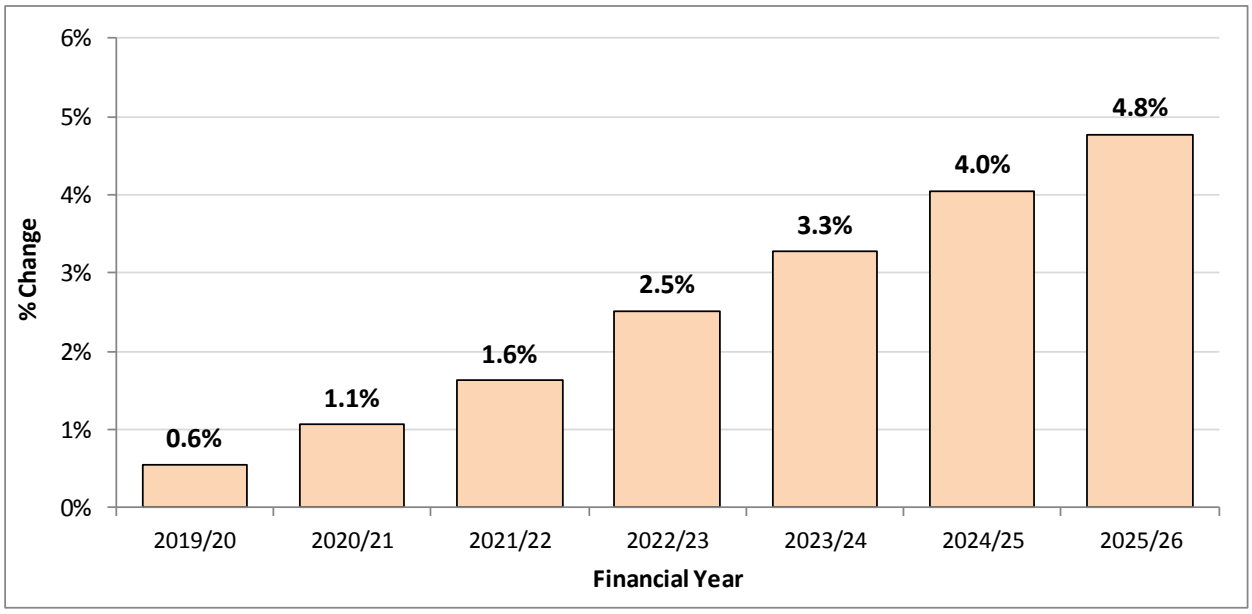


Figure 7: Projected percentage increase in emergency admissions from latest year 2018/19



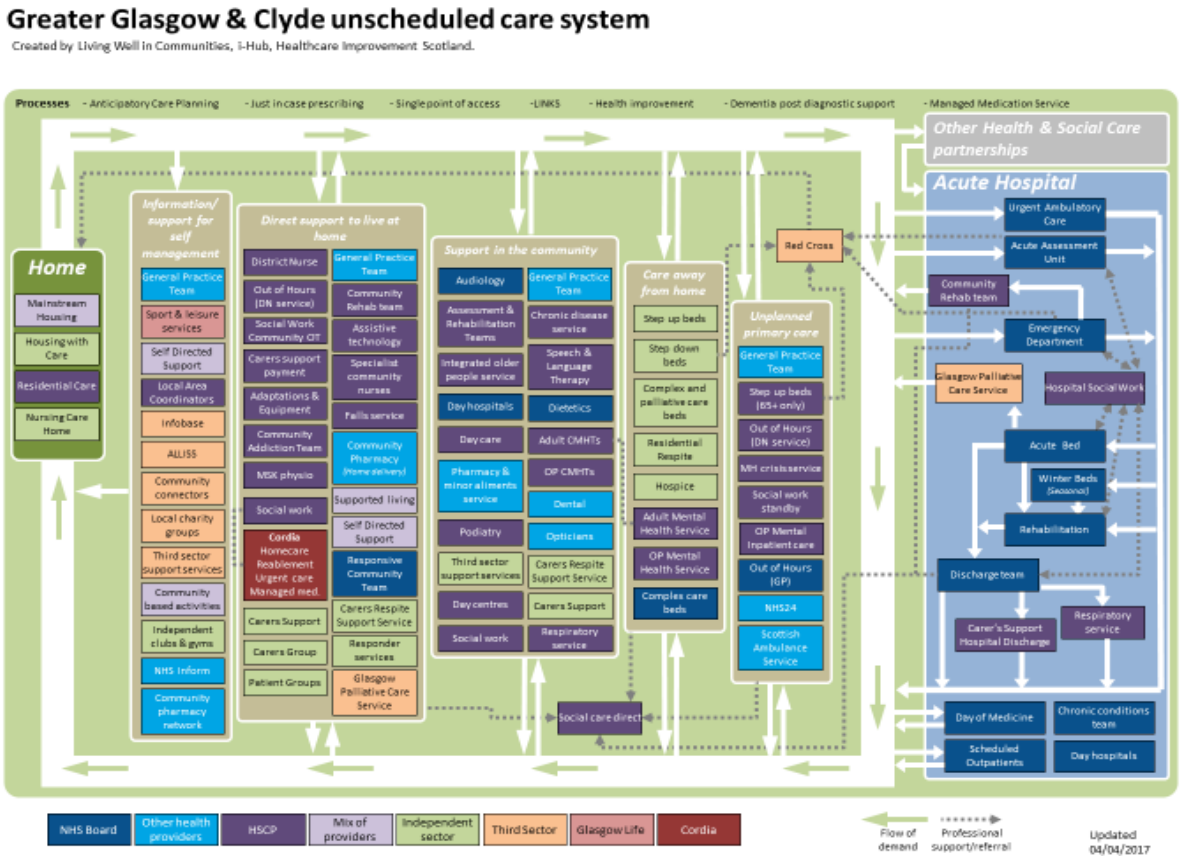
2.12 Unscheduled care is not just a secondary or acute care issue. Unscheduled care attendances also occur within primary care although data on this is not as readily available. We do however have data on GP out of hours activity (OOH). In 2018/19 there were 219,985 OOH consultations, at a rate of 187.2 per 1,000 residents. In hours

consultations can be estimated using English data[18], which shows consultation rates vary from 3.64 to 9.88 consultations per patient per annum nationally. This equates to a range of 4.69 to 12.74 million consultations per annum. The most reliable estimate is considered to be 6.33 million consultations per year. A significant proportion of this in hours work will also be urgent, though it is not yet possible to ascertain the proportion. Most GP practices will have provision for urgent same day appointments, and GPs will be called out to attend patients urgently at home. The Primary Care Improvement Plans have proposals to provide support to unscheduled care in primary care such as advanced practice based physiotherapy and advanced nurse practitioners.

Unscheduled care system

2.13 As explained in the introduction, the current unscheduled care health and social care system is complex (see figure 8). There are many entry and exit points and many interacting services provided by different organisations but all serving the patient. It is also clear that there is a wide range primary care and community based services actively working to support patients.

Figure 8 – Greater Glasgow & Clyde unscheduled care system
[19]



[18] https://www.kingsfund.org.uk/publications/pressures-in-general-practice

[19] Chart produced by iHub and reproduced with thanks

2.14 Our ambition is to change this so that this complex system operates in a more integrated way, supported by new technology. We aim to make it a more straight forward system to navigate for patients and clinicians alike. We will plan a major public awareness campaign to support patients access the right service for their needs, and which enables people to use services wisely. We also plan a co-ordinated approach to health and healthcare literacy skills as this will help people make informed choices about their care.

Primary Care

2.15 Significant changes are taking place in primary care too. GPs have a new contract that came into force in 2018/19 and aims to substantially improve patient care by maintaining and developing the role of primary care as the 'cornerstone of the NHS system'. The essence of the contract is to create conditions that enable GPs to operate as expert medical generalists by diverting from them work that is capable of being carried out by others, thereby allowing GPs more time to spend on more complex care for vulnerable patients and as senior clinical leaders of extended primary care teams.

2.16 The new contract outlines a range of changes that should take place between now and 2021. In the first phase the key priorities include changes in:

- vaccination services;
- pharmacotherapy services;
- community treatment and care services;
- urgent care services;
- additional professional services, including acute musculoskeletal physiotherapy services, community mental health services; and,
- community link worker services.

2.17 While there is limited data on activity within primary care, analysis in GG&C has estimated that there were 3.77 million face to face consultations with GPs and 1.77 million consultations with practice nurses, or 5.55 million face to face consultations in general practice in 2012/13 (the year the analysis was done). The King's Fund has reported a 13% increase in face to face contacts within general practice over the past five years[20]. If this change is reflected across Scotland, and applies equally to GPs and practice nurses, this equates to 4.26 million contacts with GPs and 2.0 million contacts with practice nurses, a total of 6.26 million face to face contacts per annum.

2.18 Changes are taking place in community pharmacy services too with the introduction of pharmacy first[21]. The new NHS Pharmacy First Service will be available from all community pharmacies in Scotland from April 2020. The service will promote community pharmacies as the first port of call for patients seeking care and support on self-limiting

[20] https://www.kingsfund.org.uk/publications/pressures-in-general-practice

[21] https://www.nhsggc.org.uk/patients-and-visitors/know-who-to-turn-to/pharmacist/pharmacy-first/

illnesses and stable long term conditions utilising the ease of access to clinical expertise within this setting available over extended hours of opening.

2.19 Pharmacy First has the potential to become an integral part of the local service provision as the first point of entry to health and social care provision for the majority of residents within a locality. Changes are required to be developed within the community pharmacy network to allow the service to progress due to new ways of working. This service development will lay the foundations for further extensions to local and potential national services and could lead to delivery of other services e.g. treatment of common clinical conditions, shingles, COPD, skin infections etc. It will be important to align these future developments with the demand coming from the GP practices, out of hours, emergency departments etc. to assist with identifying unscheduled care requirements

Out of Hours Redesign

2.20 Following the publication of the Professor Lewis Ritchie report[22] a local review of health and social care out of hour's provision was agreed by all six NHSGG&C Health and Social Care Partnerships, led by Glasgow City HSCP. The Review commenced in September 2017 and was completed in June 2019. A key output of the review process was that an Urgent Care Resource Hub (UCRH) model would be developed to facilitate integrated, person-centred, sustainable, efficient and co-ordinated health and social OOHs services throughout GG&C.

2.21 We plan to implement an Urgent Care Resource Hub model in the summer of 2020 in Springburn, Glasgow. Other hubs in GG&C will follow in a phased approach. This will enable a whole system approach to the provision of scheduled (where planned needs change and require something beyond what the service can provide) and unscheduled (where a patient / service user contacts NHS 24) Health and Social Care. The UCRH will provide a vehicle to enhance and develop integration and co-ordination across a wide range of services. The hub will also have a role to improve and co-ordinate the connection of contacts back into day time services and vice versa. The UCRH provides a single point of access across the health and social care system to support co-ordinated support from multiple services based on need.

2.22 There are currently many access points to out of hour's services including NHS 24, SAS and GPs. The UCRH will provide a whole system response via a single point of access.

2.23 Following the implementation of the UCRH model for the OOHs period we will evaluate the impact of the resource and determine which further opportunities could be considered to support the system, e.g. expand the hours of operation of the UCRH to cover daytime hours.

GP Out of Hours (OOHs)

[22] https://www.gov.scot/publications/main-report-national-review-primary-care-out-hours-services/pages/0/

2.24 GP OOHs services in Greater Glasgow and Clyde are currently facing a number of challenges which impact on delivering a sustainable service. These include:

- ensuring that that there are appropriate levels of GPs and other staffing across the service to respond safely to current demand;
- recruiting and retaining staff to work in the OOHs period;
- current workload and demand pressures in day time practice adversely impact on recruitment to work in OOHs;
- ensuring that the public are aware of how and when to use the service; and,
- reinforcing that GP OOHs is not an extension of in-hours general practice when patients are struggling to / do not attempt to obtain an appointment.

2.25 The service sees a significant number of patients every year in eight primary care emergency centres in GG&C and a home visiting service is also provided for patients who are unable to come to a centre – this is usually frail older people or people at the end of their lives. Centres are closed when the service has insufficient staff and patients are directed by NHS 24 to their nearest available centre. A home visiting service is always provided and transport is provided if people do not clinically require a home visit and do not have transport.

2.26 During 2017/18 and 2018/19 a series of key stakeholder engagement events, were undertaken which included a wide ranging exploration of the challenges faced by the service and identification of the opportunities which helped to shape a programme of work. The key changes are outlined below:

- **developing a sustainable workforce** – ongoing recruitment of GPs (including salaried GPs, ANPs and Primary Care Nurses to support the service);
- **developing professional to professional support** – another health professional working in the out of hours period, who required to speak directly to a GP who is working in the out of hours service require to contact via NHS 24. District Nurses can now contact the GP OOHs service direct during weekend days. There are plans, when resources allow, to extend this facility to cover the OOHs period.
- **frequent attenders** - it is recognised that there are people who frequently attend the GP OOH service. Some of these may also attend in hour's services and the Emergency Departments. Others may have made no effort to contact their GP or NHS 24. Details of these patients are provided to the HSCPs to incorporate into their work on people who frequently attend Emergency Departments.
- **self-referrals** - the service has always seen patients who arrive at a centre even if they have not called NHS 24 – self referrals or "walk-ins". Services elsewhere in Scotland do not provide this option. An element of this will be appropriate – patients who are experts in their own condition, who recognise their deterioration and know that it needs action. However, some could be given advice from NHS 24 and do not needed to not be seen, some could wait to see their own GP the next day and some could be seen by another service such as community pharmacy, dentistry or optometry. An implementation plan to support people to call NHS 24 has been

developed with the aim that the service will not see people unless they have called NHS 24 or have been directed by another heath professional such as the Emergency Department or Community Pharmacy.

2.27 The impact of this work will lead to a revised profile of demand on the service. Therefore further development work has been identified to:

- determine the number and location of centres from which GP out of hours urgent care is available. The hours of operation of these centres and the implementation of an appointment system to support the management of patient flow to the service. The workforce model of the GP OOHs service also needs to be considered as part of this work. This work will also describe the links to the Urgent Care Resource Hub (UCRH) through which links to other out of hours health and social care services may be available. The patient transport service should also be considered as part of this work;
- the changes that will be delivered in the six HSCP Primary Care Implementation Plans through to March 2021 and beyond will bring a clear focus on ensuring the use of day time, planned care services are maximised;
- develop a communication and engagement strategy which supports the recommendations of the site options appraisal and the service re-branding;
- develop a risk management framework, as part of a site options appraisal which considers all possible consequences of reconfiguration of GP OOHs services, e.g. increased attendances at Emergency Departments and work in partnerships with services across the system to describe and establish appropriate mitigation actions; and,
- work collaboratively with neighbouring NHS Boards/HSCPs to better understand how to reduce demand for Greater Glasgow and Clyde GP OOHs service from outside NHSGG&C.

Public Health Strategy

2.28 The Public Health strategy *"Turning the Tide through Prevention"*[23] sets the strategic direction for public health in Greater Glasgow and Clyde to improve public health outcomes through collaboration. The aim of the strategy is that NHS Greater Glasgow and Clyde (GGC) "becomes an exemplar public health system which means there would be a clear and effective focus on the prevention of ill-health and on the improvement of well-being in order to increase the healthy life expectancy of the whole population and to reduce health inequalities". The aim of the strategy is that by 2028, NHSGGC healthy life expectancy (HLE) should be equal to the rest of Scotland with a narrowing of the inequality in life expectancy within GGC.

2.29 The strategic objectives of the strategy are to:

[23] https://www.nhsggc.org.uk/media/251914/item-8-paper-18_59-update-on-turning-the-tide-through-prevention-board-paper-final-version.pdf

- reduce the burden of disease through health improvement programmes and a measureable shift to prevention;
- reduce health inequalities through advocacy and community planning;
- ensure the best start for children with a focus on early years to prevent ill-health in later life;
- promote good mental health and wellbeing at all ages;
- use data better to inform service planning and public health interventions; and,
- strengthen the Board and the Scottish Government's ability to be Public Health Leaders

Summary

2.30 The key points from this section are:

- there has been a continued growth in attendances at emergency departments in GG&C in recent years;
- we have also seen changes in our population with a projected increase of 11% in those aged over 75 over the next five years;
- if we do nothing it is projected that emergency admissions will increase by 4.8% over this period;
- our unscheduled care system is complicated to navigate both for patients and clinicians, and we need to change this so it is more integrated and straight forward;
- unscheduled care is not just an acute hospital issue as primary care and community services are facing increased demand too;
- changes are planned in GP services, community pharmacy and out of hours services to better meet patients' needs; and.
- our public health strategy aims to address the longer term issues of healthy life expectancy, tackling inequalities and reducing the burden of disease.

3. OUR VISION

3.1 Our ambition is to improve the health of our population, and meet people's health and social care needs better, by improving access to health and social care support when and where they need it. In order to do this we must transform the way we deliver health and social care services and work collaboratively with key partners in the third and independent sectors, SAS, NHS24, housing, GPs and other primary care contractors, our staff, and users and carers. Each Partnership has published a strategic plan that describes the specific programmes we plan to take forward to realise these ambitions over the next three years.

3.2 The *Moving Forward Together* programme[24] was launched in 2017 as a wide range transformation programme in response to changes in needs and demands, advances in technology and changes in the way health care is delivered. The programme culminated in a report published in June 2018 that set out a strategic direction for health and care services over to next five to eight years. That report stated that in respect of unscheduled care:

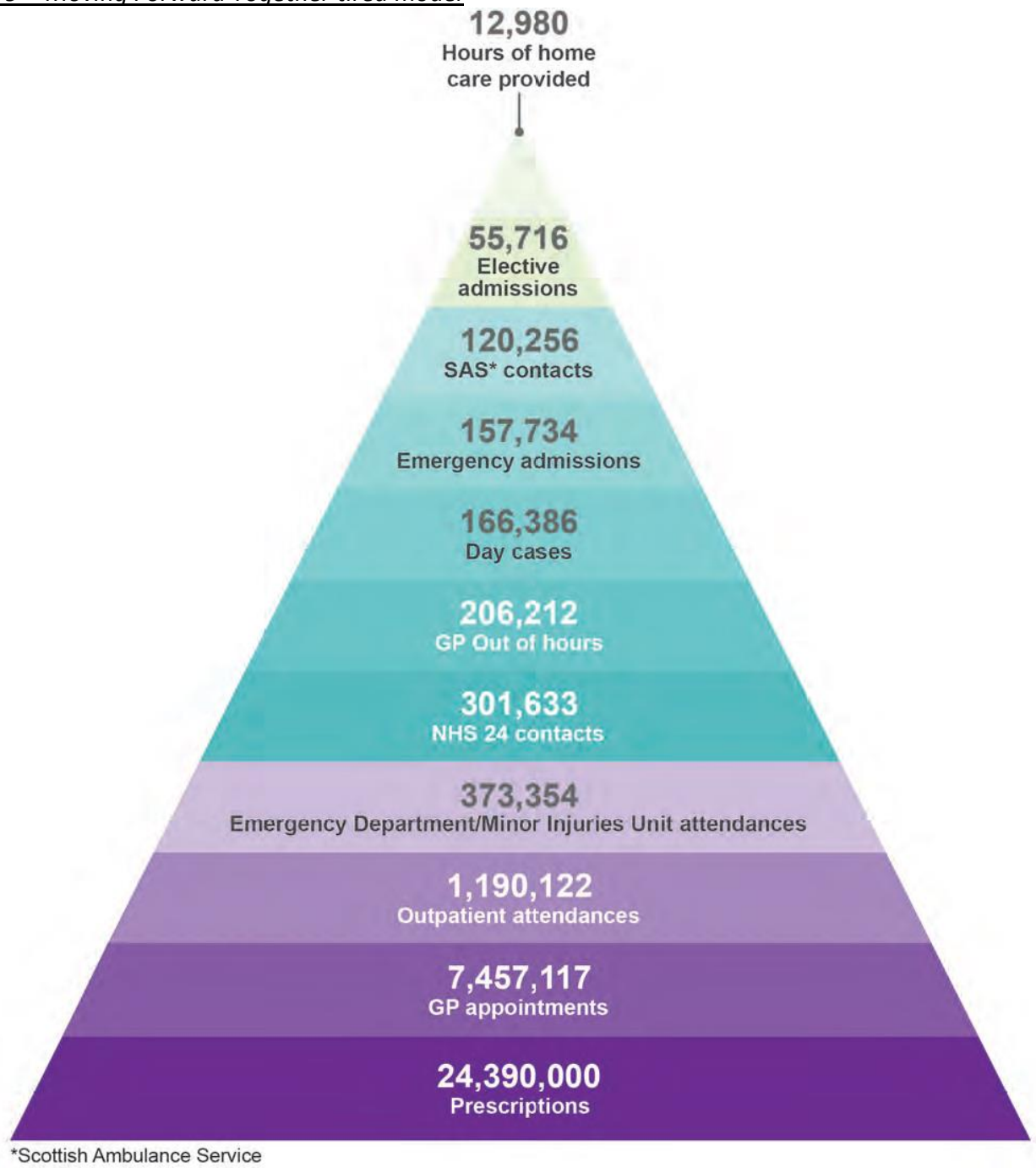
> ***"Our approach … should ensure people are admitted to hospital only when it is not possible or appropriate to treat them in the community. Admissions should be reduced whenever alternatives could provide better outcomes and experiences.***
>
> ***We should develop our system wide approach to unscheduled care in which:***
>
> - ***people have access to a range of alternatives to attendance at their GP surgery or local hospital emergency department;***
> - ***care is better coordinated between community and hospital services at crisis/transition points;***
> - ***services are tiered to provide an appropriate level of care;***
> - ***some specialist services are provided on fewer sites in order to achieve a higher volume of cases and better outcomes;***
> - ***local access to emergency care is at a level that is clinically safe and sustainable;***
> - ***the enhancement of community-based services provide a more appropriate alternative to hospital care;***
> - ***IT systems enable the rapid exchange of up-to-date information between services and support integrated working;***
> - ***ambulatory care services reach out into the community-based networks with jointly designed and delivered pathways across the whole system with specialist support and diagnostic services provided when required;***
> - ***there is better connectivity with community services and participation in agreed ambulatory care pathways across the whole system, involving also NHS 24, GP out of hours services and the [Scottish Ambulance Service, to ensure the***

[24] https://www.movingforwardtogetherggc.org/

most appropriate care for individuals by the most appropriate person or service at the right time and in the right place."

3.3 This can be illustrated in the model shown below.

Figure 9 – Moving Forward Together tired model



3.4 In step with this approach is the maximising independence programme being developed by Glasgow City HSCP which has echoes in approaches by other HSCPs for example compassionate Inverclyde. The maximising independence programme proposes a step change in individual, family and community independence from statutory support, a focus

on prevention and early intervention approaches in partnership with local community organisations and third, independent and housing sector partners. This assets based approach is in recognition that the tolerance of the health and social care system to absorb increasing demand is limited and change is needed[25]

3.5 Our vision is that self-care and prevention is prioritised, so that a greater proportion of needs are met in a planned way. This approach involves a number of elements working together to maximum effect including:

- health education and promotion at both a population level and individual level;
- strengthened community-based services to respond to urgent care needs in-hours and out of hours; and
- a sophisticated ongoing public awareness campaign advising patients which service to turn to when.

[25] https://glasgowcity.hscp.scot/publication/item-no-19-maximising-independence-glasgow-city

4. CHANGING THE BALANCE OF CARE

Introduction

4.1 If we are to respond to the current increases in demand and pressures across the health and social care system described above, and to better meet patients' needs, we need to make some changes. In this section we focus on the key improvements we plan to take forward over the next five years.

4.2 In our view it is highly improbable that the health and social care system can absorb continuous year on year increases in demand without making some fundamental key changes. More importantly we would not be acting in patients' best interests, and getting the best from the resources we have available, if we did nothing to change the services we deliver and commission. The challenge is change.

Long term direction

4.3 We need to present these changes as part of a much longer term strategic direction of travel for the whole health and social care system. *Moving Forward Together* [26] describes the strategic direction for health and social care is to move away from hospital based or bed based services to providing more support to patients in community settings. And to work with primary care, NHS24, the Scottish Ambulance Service, the third and independent sectors, including housing, to develop preventative approaches. This is coupled with an approach that seeks to manage patient care so that patients are seen by the right person, in the right place at the right time.

4.4 This means that each part of the health and social care system should focus on what it does best, and the links and connections between services should be as smooth and efficient as possible so patients receive care when and where they need it. For example emergency departments will function best if they are to focus on accidents and emergencies, and primary care will function best if GPs are supported by other community based professionals to be expert medical generalists.

4.5 There is evidence that a significant proportion of patients may be attending secondary care unnecessarily and could be seen safely and more appropriately elsewhere. For many, their care could be better treated through scheduled care approaches in the community or through supported self-care or care and treatment as outpatients. A number of different explanations for the use of unscheduled care for non-urgent problems have been identified in the literature. These relate to lack of knowledge of healthcare use or confidence in accessing this in the community, and barriers to using in hours care due to work or stigma.

[26] https://www.movingforwardtogetherggc.org/

4.6 To achieve such changes means that we must develop both short term and longer term responses, and test new approaches on the way to see what might work best. In order to support these changes we will develop a major public awareness campaign the purpose of which will be to inform patients and professionals on how best to access the right service at the right time. A consistent message we receive when we engage with the public is that people do not know what service to turn to for what and when. We need to do more to support people become aware of what service to access and when.

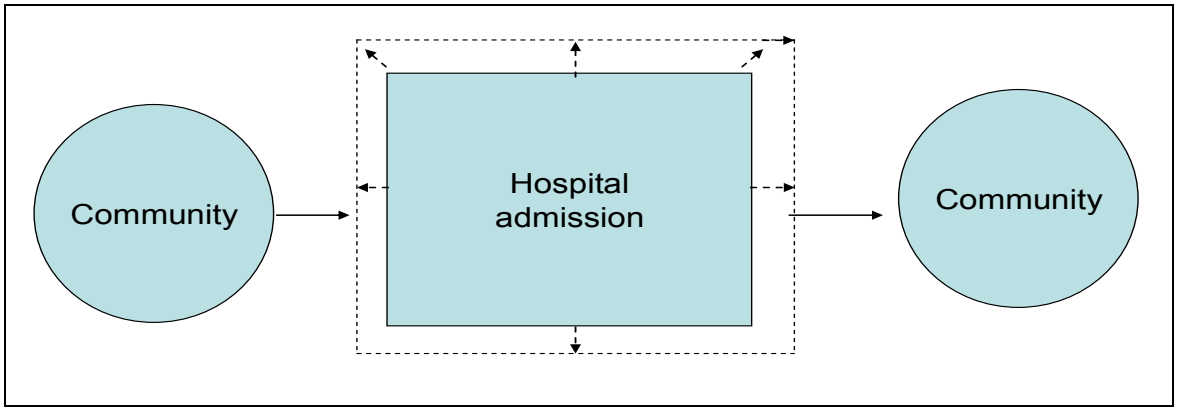
Our priorities

4.7 What follows is our plan to do this by focusing on three key areas each with their distinct but linked programmes of activity:

- ***prevention and early intervention*** to better support people receive the care and treatment they need at or close to home and to avoid hospital admission where possible;
- so that our health and social care system works more smoothly and efficiently in patients' interest we aim to ***improve the interface between primary and secondary care services***; and,
- for people who are admitted to hospital for whatever reason we aim to ***improve hospital discharge*** and better support people to transfer from acute care to appropriate support in the community.

4.8 This reflects the patient pathway as shown in figure 10, below, and is based on the best available evidence of what works – this is described in the 2017 Nuffield Trust report[27] on shifting the balance of care and is summarised in annex A.

Figure 10 – current system of care



[27] *Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), Shifting the balance of care: great expectations. Research report. Nuffield Trust.*

4.9 Prevention and early intervention, and improving hospital discharge, involve programmes that are in the main led by HSCPs working closely with other partners such as GPs, the third and independent sectors and the Scottish Ambulance Service. The primary / secondary care interface programme is a joint endeavour between HSCPs, acute hospitals and clinicians working in primary and secondary care, to test and introduce improvements and will therefore require specific arrangements to take these forward.

4.10 In presenting our programme we have identified the short term actions we intend to take over the period to 2022, in response to current pressures (see section 2 above) and the longer term actions we will work towards up to 2029 to fulfil our vision and the ambitions set out in *Moving Forward Together*. Examples are given of where some of these initiatives are already underway in GG&C or elsewhere.

4.11 In section eight we outline the financial framework to support these changes, and in section nine we identify the impact and outcomes of our programme.

5. PREVENTION AND EARLY INTERVENTION

Introduction

5.1 In this section we outline the actions we have in place to better support people receive the care and treatment they need at or close to home and to avoid hospital admission where possible. We include here our early intervention and prevention strategies and their impact on reducing unscheduled care activity and managing patients in the community. This programme also forms part of the broader early intervention and prevention agenda that is key to delivering the ambitions in the Board's public health strategy outlined in section 2 above.

5.2 The programme is based on the conclusions drawn from a review of the evidence (summarised in annex A), and with reference to the recent iHub review [28] and the framework for community health and social care integrated services published by Health and Social Care Scotland[29]. It is important to note that the reviews of the evidence base are not conclusive about what works in reducing admissions to hospital although they do give us a valuable base from which to plan our programmes. That said the iHub review report stated that:

> ***"It is not possible to draw firm conclusions or recommend implementation of specific interventions for NHS Scotland based on this review [of the evidence] but there was at least some moderate evidence of effectiveness relating to broad groups of interventions***."

Anticipatory care planning

5.3 Anticipatory care plans (ACPs) are key to supporting people with specific needs in the community, including those with long term conditions. A national model for ACPs was introduced in 2017 (www.myacp.scot). In GG&C HSCPs have developed a standardised approach to ACPs that involves a summary of the patient led ACP being completed by community teams and shared with GPs (with the patients' consent) so that relevant information can be included in the Key Information Summary (KIS). The KIS is vital information that is seen by out of hours services, SAS and A&E and crucial to support decision making should a patient attend emergency services.

5.4 By 2021/22 we plan that all people in Greater Glasgow and Clyde over 65 with a chronic condition, who would benefit from an ACP because of a high risk of admission to hospital, will have been introduced to anticipatory care planning and asked to consent to a summary of their ACP being shared with their GP and other relevant care providers via Clinical Portal and KIS. There will be a far greater number of people, families and carers who have been introduced to ACPs and may take up an ACP at a later stage. ACPs are still

[28] https://ihub.scot/improvement-programmes/evidence-and-evaluation-for-improvement/review-of-literature-and-evidence-summaries/reducing-unplanned-admission-to-hospital-of-community-dwelling-adults/
[29] https://hscscotland.scot/resources/

a new concept for the most people and it will take time for the message about the benefits of ACPs to be widely understood. ACPs will be promoted as part of our wider communications strategy to support this plan.

5.5 Through this programme we estimate that over a number of years the take up of ACPs will contribute to a reduction in emergency admissions for those aged over 65. In future years we will further extend this programme to other patients groups (e.g. care home residents) targeting those who may be at risk of admission or re-admission.

Example – Glasgow City HSCP
Glasgow City HSCP is leading on the development of an electronic ACP tool in Riverside Residential Care Home and other care homes to support timely information sharing in decision making in residential care settings.

Falls prevention

5.6 In 2018/19 there were 8,948 people aged over 65 who attended hospital because of a fall. There is a strong link between falls and frailty, although not everyone who experiences a fall is frail. Frailty can contribute to falls and result in a person making a slower or poorer recovery following a fall, and a fall can trigger or accelerate the progression of frailty. Most people who attend hospital because of a fall are aged 85 and over.

5.7 The Scottish Government has launched a new draft *"Falls and Fracture Prevention Strategy"*[30] . In Greater Glasgow and Clyde we have taken action to prevent falls working with other agencies such as the Scottish Fire & Rescue Service, housing and leisure services on early risk identification and promotion of positive messages about physical activity and bone health. We support all staff to be aware of the risk factors and where appropriate to assess patients for falls risk or start a conversation with individuals that could identify that risk. We also work with Scottish Care to support care homes in falls prevention strategies and promoting physical activity, reducing sedentary behaviour to improve strength and balance. We also promote strength and balances classes through our rehabilitation teams and by the community falls team.

5.8 We also aim to work with the Scottish Ambulance Service to reduce the number of people who have had a fall needing to be conveyed to hospital. Not all falls need to attend hospital as other alternatives are available. We are working with the SAS and patient groups to develop a care pathway to safely manage the care of patients who have had a fall but do not need to be seen in an A&E department.

Frailty

[30] https://www.gov.scot/publications/national-falls-fracture-prevention-strategy-scotland-2019-2024/

5.9 Supporting people living with frailty is an increasingly urgent issue for health and social care services. Approximately 10 per cent of people aged over 65 years, and 25 to 50 per cent of those aged over 85 years, are living with frailty. Frailty (see definition below[31]) is associated with age. Older people living with frailty are often at risk of adverse outcomes following a relatively minor event and often fail to recover to their previous level of health.

5.10 Hospitals admit older people more frequently than other age groups and so an ageing population creates additional demand for health and social care services. These admissions are often unplanned and older people who are frail are more susceptible to healthcare associated infections, falls, delirium and difficulties in maintaining good nutrition, hydration, and skin care. As a result frail older people often have longer hospital stays, higher readmission and mortality rates, and are more likely to be discharged to residential care.

5.11 Frailty identification and management to support people is therefore an important part of our early intervention and prevention strategy. There are 23 GP practices in GG&C who have joined the national frailty collaborative to better identify and support people living with frailty[32] . By the end of 2020/21 we aim to have identified all patients whose frailty score has changed from 'moderate to severe' and develop an ACP with information uploaded onto KIS. As a result we estimate that people who are frail will:

- spend more time living in the community with fewer moments of crisis;
- experience fewer incidents of unplanned care, including GP home visits; and,
- be more involved in decisions about their care through ACPs.

5.12 We will also develop, as part of the collaborative, an integrated frailty pathway with secondary care so that there is a seamless service for those patients who require admission to hospital. We will also manage frailty more proactively for those admitted and to optimise pre hospital management where appropriate for this patient group

Carer support

5.13 Carers play a crucial and important role in supporting people at home or other community settings. Carers are key to any strategy that aims to shift the balance of care towards more support and intervention in the community. It is vital therefore that this plan recognises and supports carers in their caring role. Each Partnership has its own carer's strategy as required by the Carers Act 2017[33]

[31] "a geriatric syndrome of decreased reserve and resistance to stressors, resulting from cumulative declines across multiple physiologic systems, causing vulnerability to adviser health outcomes including falls, hospitalisation, institutionalisation and mortality" Fried, 2018

[32] https://ihub.scot/news-events/new-living-and-dying-well-with-frailty-collaborative/

[33] https://www2.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation/Carers-scotland-act-2016

5.14 In total we estimate that Partnerships will support each year, through one means or another, over 4,000 new carers in their caring role.

Primary care based community links workers

5.15 Links workers support people through strengthening connections between community resources and primary care services. Links workers work with patients to identify issues and personal outcomes and then support patients to overcome barriers to addressing these by linking with local and national support services and activities. Links workers support GP practice teams to become better equipped to match support services to the needs of individuals attending primary care. They will also build relationships between the GP practice and community resources, statutory organisations, other health services and voluntary organisations to better support patients. Links workers can therefore play a vital role in the community based network of support to prevent people needing to access hospital services.

5.16 In Greater Glasgow and Clyde we aim to have over 50 link workers in post by the end of 2020/21 focused on GP practices with the most deprived patient populations. In total we estimate that by the end of 2020/21 links workers will have supported 17,500[34] people registered with GP practices in the most deprived areas of GG&C.

5.17 These new posts will be aligned with other similar roles such as community connectors, Local Area Co-ordinators and the community orientated primary care initiative. Community connectors, Local Area Co-ordinators, and others also help people access community supports to improve well-being.

Avoidable admissions[35]

5.18 Ambulatory Care Sensitive Conditions (ACSCs) also known as Primary Care Sensitive Conditions (PCSCs) have been used as a way of assessing what proportion of hospital admissions could potentially be avoided through other interventions, including stronger community management and early intervention / prevention. The thrust of this plan is to better support people at home or in community settings. So if we can do more to prevent hospital admissions and provide care and treatment in the community we should do so, particularly where there is an evidence base to support such an approach. We need to avoid circumstances where decisions to admit a patient to hospital are taken for largely social reasons rather than clinical reasons

5.19 In 2018/19 in GG&C the main reasons for admission to hospital were:

- COPD & pneumonia
- sepsis
- cerebral infarction

[34] Calculated on the basis that each worker receives 350 referrals per annum based on caseload in East Ren
[35] Thanks again to John O'Dowd for this analysis

- fracture of femur, and
- other disorders of the unitary system

Table 1 – main reasons for hospital admission 2018/19

2018-19 non elective inpatient activity		
Reason for admission	**Occupied Bed days**	% of Total OBD
Pneumonia	**43,776**	4.5%
Sepsis	**43,742**	4.5%
Cerebral Infarction	**37,102**	3.8%
Fracture of Femur	**36,465**	3.7%
COPD	**34,518**	3.5%
Other Disorders of Urinary System	**33,125**	3.4%
TOTAL	**228,728**	**23.5%**

Notes:
1. Discharges of Non elective IP only
2. Excludes other HSCP
3. Includes all ages

5.20 Of these COPD & Pneumonia accounts for 8% of total occupied bed days following an emergency admission. We will continue to develop our community respiratory services across GG&C that have proven effective in supporting people with COPD in the community and prevent admission to hospital. In this way we estimate that in 2020/21 we will have avoided a significant percentage of these admissions.

5.21 In 2020/21 we will also introduce a revised model of care for heart failure utilising the skills of the specialty nurse practitioners and other professionals within a multi-disciplinary team construct to develop alternatives to admission.

5.22 For the other conditions we will develop new care pathways with primary care to ensure that wherever possible patients can avoid attending hospital. Our aim will be to start patient pathways in primary care and community services supported by access to diagnostics and secondary care clinical advice as an alternative to an overnight stay in hospital.

Example – Glasgow Community Respiratory Service
The Community Respiratory Team is a nationally unique service that supports the needs of people living with COPD in their own home and is made up of physiotherapists, respiratory nurses, pharmacists, occupational therapists, dieticians and rehabilitation support workers. GPs refer to the service as an alternative to patients going into hospital by accessing the specialist service to support the patient in their own home. The service also facilitates early discharge from hospital by closely linking with secondary care colleagues and providing responsive follow

up and support.

The ethos of the service is to provide a personalised approach to care, enabling self-management by those affected by COPD including:

- *increasing their own knowledge of their condition.*
- *knowing what to do when they are unwell.*
- *improving knowledge of inhaled therapies.*
- *knowing how to clear secretions from their chest.*
- *increasing their physical activity and independence through the provision of home pulmonary rehabilitation and equipment.*

An evaluation has shown a reduction in the impact of disease, an improvement in quality of life and a reduction in hospital admissions.[36]

Hospital at Home

5.23 Hospital at Home is being promoted as an innovative initiative to support older people with frailty who would ordinarily require admission to hospital to receive treatment in their home[37]. The i hub guidance points out however that while the evidence base identifies potential benefits from this approach there are "areas of uncertainty". Further work is needed to test the benefits of introducing this model in GG&C alongside existing services such as the FIT team in West Dunbartonshire and the Glasgow Community Respiratory Team. Glasgow City HSCP is developing a trial of the Hospital at Home model within a care home in the North East of the City. A number of GP practices in HSCPs are also involved in the frailty collaborative (see above).

Alternatives to admission

5.24 We also need to look at potential alternatives to admission so that GPs have a range of options available to manage patient care in the community. There are five specific measures we wish to test with acute clinicians and GPs to assess the impact on patient care. These are:

- **GP access to consultant advice:** the facility for GPs to obtain direct and timely consultant or senior clinical advice on an individual patient's care has the potential to reduce the need for patients to attend hospital and thus avoid the transport and other arrangements that might need to be put in place in enable this to happen. Consultant Connect piloted at the QEUH has shown some benefits in this respect, and it is now been rolled out to other specialities and hospitals. Experience in Tayside has shown that this also has benefits for emergency departments and GP assessment units. We plan to further test its benefits in

[36] CRT final evaluation report, 2018
[37] https://ihub.scot/project-toolkits/hospital-at-home/hospital-at-home/

2020/21.

- **GP direct access to diagnostics:** access to diagnostic tests is crucial in determining a patient's treatment and care plan. Currently GPs have to refer patients to GP assessment units or ambulatory care clinics for an acute clinician to then order the appropriate tests and review the results. If GPs had access directly to an agreed range of tests and the results, such as CT and MRI, with the facility to discuss the results with a senior acute clinician if need be, then patients may not need to be referred and care and treatment could be managed within primary care. We wish to test this approach with acute diagnostics and evaluate its potential impact on GP referrals and acute activity.

- **next day outpatient appointments:** GP direct access to next day out patient appointments or "hot clinics" in line with an agreed care pathway, supported by patient transport, would provide GPs with a further alternative to referral to GP assessment units. Here we would be seeking the freeing up of an agreed number of appointments to allow GPs to book these direct instead of referring a patient to an assessment unit and potentially being admitted overnight. Essentially this would move some unscheduled care activity to being dealt with in a more planned way. A test of change to evaluate this should be set up involving acute clinicians on the main acute sites.

- **referral for assessment:** the ability for GPs to refer for assessment via SCI gateway with a view to preventing admission is another potential alternative that could be explored. We will set up a test of change to evaluate the potential for such a facility to be introduced across GG&C.

- **step-up care:** we have piloted step up care in care homes that GPs can access for patients who are unwell and need nursing care and observation but don't need to be admitted to hospital. The GPs who use these beds find them helpful in providing patients with care in a community setting for a short period of time before they go home again. If these beds were not available it is highly likely that such patients would have been admitted to hospital via a GP assessment unit (see below). In 2020/21 we will work with GPs and others to review this service as part of a wider review of intermediate care (see below) to determine if this is something we should develop further.

Example – West Dunbartonshire Focused Intervention Team (FIT)
West Dunbartonshire introduced the FIT team in July 2019 with the aim of providing an integrated community based service to support people to remain at home or homely setting as an alternative to hospital admission. The team provide a rapid response service to avoid admission, a care home liaison service to support care homes and COPD. It is estimated that to date, of the referrals received by the team nearly 60% have avoided a hospital admission.

Reducing admissions from care homes

5.25 In 2017/18 across Greater Glasgow and Clyde care homes accounted for 5,900 emergency admissions – 5% of total emergency admissions. Since then Partnerships have developed programmes with care homes to reduce emergency admissions by:

- providing training;
- support to GP practices covering care homes;
- introducing anticipatory care planning; and
- implementing the red bag scheme to safely transfer patients to and from hospital.

5.26 We have also in our residential care homes in Glasgow introduced advanced nurse practitioners covering approximately 550 beds who have already made an impact on both reducing GP call outs and admissions to Hospital.

5.27 By further developing this whole programme we estimated that by the end of 2020/21 we will have reduced emergency admissions from care homes by 2.5% from the level it was in 2018/19.

Summary

5.28 The aim of our prevention and early intervention programme is to reduce emergency hospital admissions particularly for those aged over 65, and support more patients in the community. Our programme based on the evidence of what works includes:

- extending anticipatory care plans;
- falls prevention strategies;
- work to manage frailty in the community;
- link workers to support GPs;
- support to carers;
- developing more integrated patient care pathways for the top key conditions that result in admission;
- assessing Hospital at Home;
- providing GPs with alternatives to admission and more options and support to manage patient care in the community; and,
- work with care homes to reduce admissions to hospital.

5.29 This is an extensive programme and will take time to be fully implemented in its entirety across GG&C. In section 9 we give an indication of the potential impact of the programme on the system as a whole.

6. PRIMARY AND SECONDARY CARE INTERFACE

Introduction

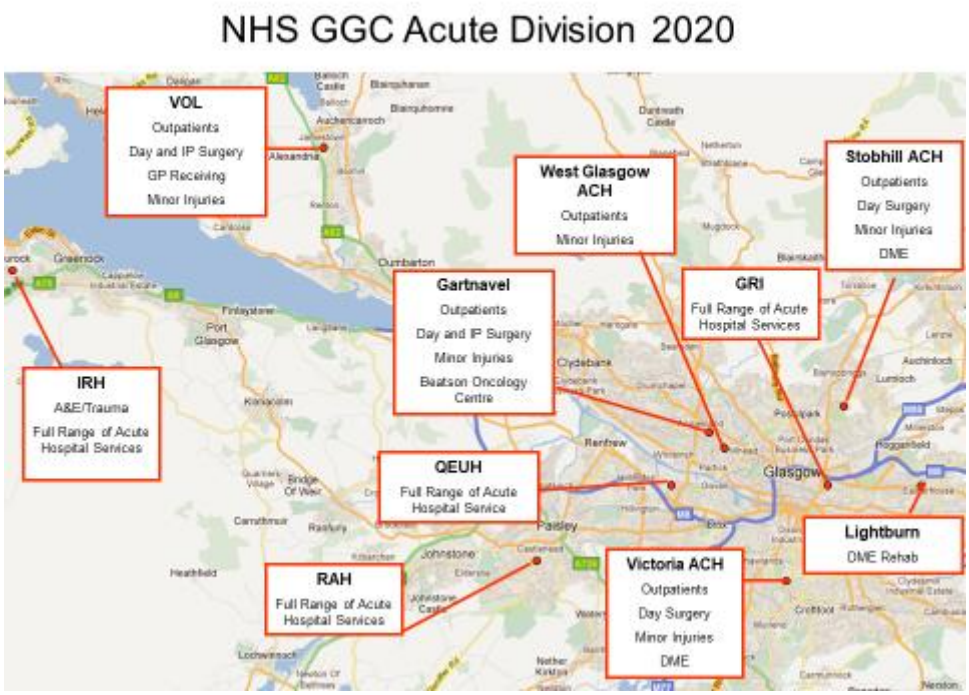
6.1 The interface between primary care, where most patients are seen, and secondary or acute hospital care, where patients attend for specialist treatment and investigations, is important in delivering a quality service to patients. It is in everyone's interest that the communications and links between primary and secondary care work smoothly and efficiently so that patients receive the right care in the right place at the right time.

6.2 In this section we focus on our priorities to improve the interface between primary and secondary care, including actions to reduce demand on our emergency departments as these have seen a significant growth in attendances in recent months (see section 2 above). Actions to address pressures in primary care are included in each HSCPs' Primary Care Improvement Plan.

6.3 Our proposals here focus on what has emerged from our analysis of the population's health and the balance of care, key issues highlighted by GPs and secondary care clinicians, and are set within the context of the strategic direction outlined in *Moving Forward Together*.

6.4 Patients in Greater Glasgow & Clyde access acute emergency and unscheduled care services at the four main acute hospitals – GRI, IRH, QEUH and the RAH (see figure 11 for location of acute hospital services including other hospitals).

Figure 11 – main acute hospital sites in GG&C



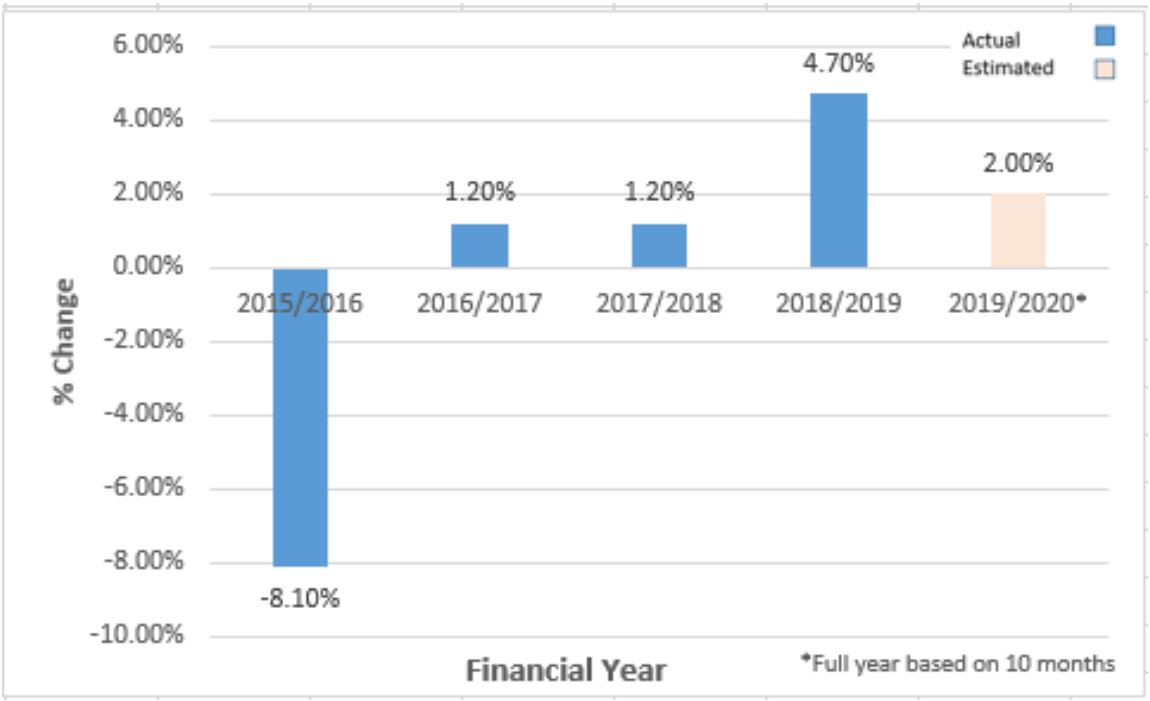
Information sharing

6.5 Information sharing between clinicians and primary and secondary care is vital in reaching decisions about patient care. Great strides have been made in improving information sharing between GPs and secondary care and the eHealth strategy outlines further developments[38] planned in the future. At a micro level improving access to EMIS for secondary care clinicians and the role of ECAN nurses pulling together patient information to inform decision making can make a difference. HSCPs are also encouraging GPs to update the Key Information Summary with summary ACPs to assist managing patients who attend emergency services.

Emergency department attendances

6.6 Emergency department (ED) attendances (see figure 12) have risen steadily in recent years and all EDs in GG&C have struggled recently to achieve the national 95% target for four hour waits (see figure 13). During 2018/19 in emergency departments in GG&C the percentage of patents seen within 4 hours at main sites was 90% against the national target of 95%.

Figure 12: Percentage change in ED attendances from previous year, 2015/16 to 2019/20



[38] https://www.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/

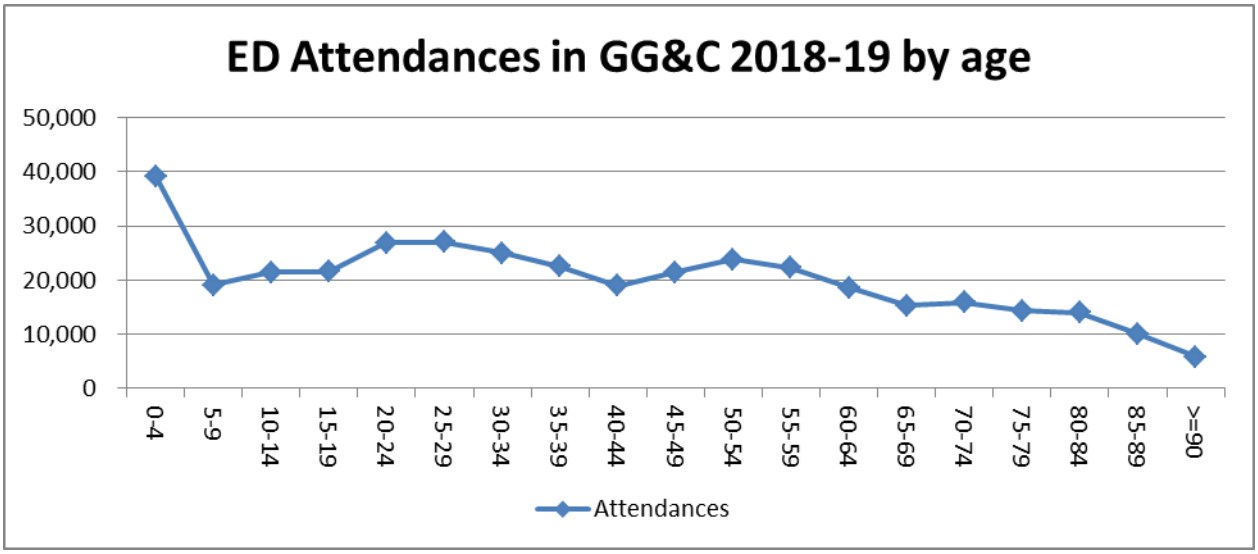
Table 2 – Emergency attendances and 4 hour target – GG&C

Year	% Compliance
2014/2015	87.7%
2015/2016	92.3%
2016/2017	91.9%
2017/2018	89.7%
2018/2019	90.0%
2019/2020 (to February)	85.2%

6.7 Analysis also shows that:

- the highest proportion of emergency department attendances were very young children and those in their twenties;

Figure 13 – ED attendances in GG&C 2018/19 by age



- in 2018/19 there were more than 300 attendances at the four main emergency departments for every 1000 people aged over 65;

Table 3 – Total attendances at 4 major emergency departments in NHS GG&C (2018/19) and rate per 1,000 population

Age	Number of attendances	2018 Population Estimate	Rate per 1,000 population
Age 65+	65,546	181,637	360.9
All attendances	265,514	1,174,980	226.0

- the proportion of attendances for over 65s at the main emergency departments has increased. One in 4 attendances at main emergency departments are over 65;

Table 4 - Attendances at 4 major emergency departments in NHS GG&C (2018/19) by age

Age	Attendances	% attendances
65+	65,546	24.7%
All Attendances	265,514	100.0%

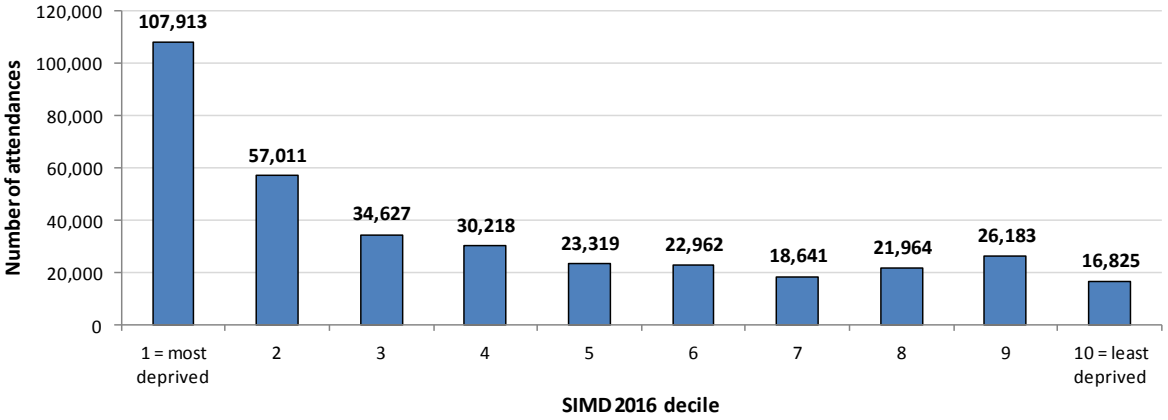
- in 2018/19, on average 58% of attendees referred themselves to ED while 8% were referred by a GP;

Table 5 - Attendances at all emergency departments in NHS GG&C (2018/19) – source of referral

Source of referral	Attendances	% attendances
GP	37,200	8%
Self-referral	256,803	58%
All attendances	440,007	100%

- a patient living in one of the most deprived areas in GG&C is more than six times likely to attend ED than a patient one of the least deprived areas (see figure 14);

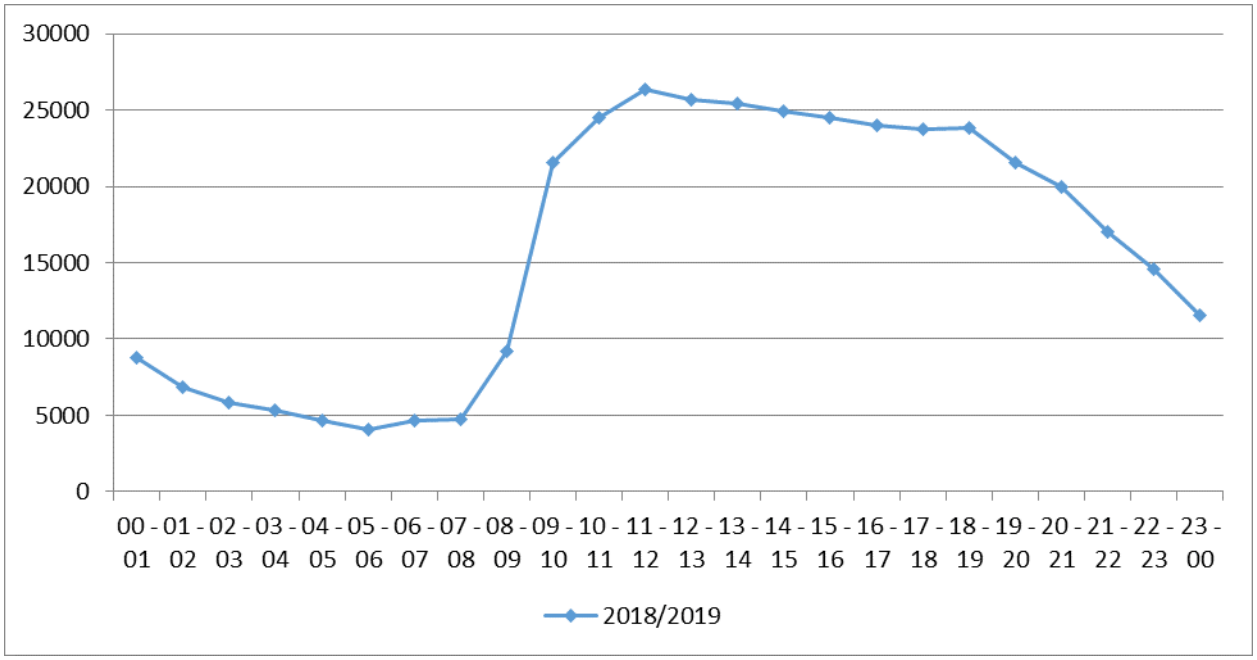
Figure 14 - attendances at all emergency departments in NHS GG&C (2018/19) by SIMD



- users of mental health services were more than twice as likely to have attended ED as non-users. They were also likely to attend more frequently;

- the pattern of arrival time by hour of day has remained consistent over the past five years with most attendances occurring between the hours of 10:00 and 18:00 (see figure 17 below);

Figure 15 - attendances at all emergency departments in NHS GG&C by time of day (2018/19)



- more than one in four of all ED attendances ended with admission to hospital.

Table 6 - attendances at all emergency departments in NHS GG&C (2018/19) percentage admitted

Discharge Destination	Number of attendances	Proportion of all attendances
Admitted	105,126	28.5%
All attendances	368,993	100%

- over half of all ED attendances for people aged over 65 ended with admission to hospital. Compared to nearly one in three for people aged under 10.

Table 7 - attendances for those aged 65+ at all emergency departments in NHS GG&C (2018/19)

Discharge Destination	Total attendances (all ages)	% of attendances (all ages)	Total attendances (64+)	% of total attendances (64+)
Admitted	87,848	23%	35,250	47%
All attendances	383,298	100%	75,390	100%

Table 8 - attendances for those aged under 10 at all emergency departments in NHS GG&C (2018/19)

Discharge Destination	Number of attendances (65+)	Proportion of all attendances (65+)
Admitted	92,715	31.0%
All attendances	299,540	100%

6.8 Further analysis of attendances also shows that approximately 51% of self-presentations are as a result of a minor illnesses or ailments[39]. It is possible then that a significant proportion of self-presentations at emergency departments could be treated by other services such as primary care, pharmacy or minor injuries units[40]. Currently there are no national or GG&C policies in place to support front line staff to direct patients to other services, therefore all individuals who attend ED are seen and assessed. We wish to develop a policy of re-direction to support patients accessing the right service in the right place at the right time.

Public attitudes to A&E

6.9 In putting such a policy in place we need to understand why some people attend ED instead of other services. Recent research[41] into public attitudes to accident and emergency services found that:

- **People living in deprived areas** are more likely to prefer A&E departments over their GP to get tests done quickly, find it more difficult to get an appointment with their GP and think A&E doctors are more knowledgeable than GPs;
- **Parents with children under 5** are most likely to have used A&E in the last year, to think it is hard to get an appointment with their GP, less likely to trust their GP but are also more likely to use the internet to try to decide what the problem might be; and,
- **Men** are less knowledgeable about how to contact a GP out of office hours and less likely to use the internet to research a health problem.

6.10 The study also found that in the main people believe that A&E is overused, and a clear majority (86%) think that too many people unnecessarily use A&E services. This increases to 94% for people aged 65 to 74 years old and drops to 79% for those aged 18 to 24 years.

[39] Demand and Capacity Model for NHS Greater Glasgow and Clyde, Final Report and Recommendations, NECS, 2019

[40] Richardson M, Khouja C, Sutcliffe K, Hinds K, Brunton G, Stansfield C, Thomas J (2018). Self-care for minor ailments: systematic reviews of qualitative and quantitative research. London: EPPI-Centre, Social Science Research Unit, UCL Institute of Education, University College London.

[41] National Centre for Social Research (August 2019)

When asked whether they had actually accessed A&E services in the previous 12 months for themselves or others, 32% of the public and more than half of parents with a child under 5 (54%) report they have done so at least once. 29% of those without young children in the household say they have visited A&Es in the same period.

6.11 Around half (51%) the population agrees that it is hard to get an appointment with a GP. Those with children under 5 (65%) and those living in the most deprived areas (59%) are most likely to agree. While over one third (36%) of the public report that they prefer NHS services where they do not need to make an appointment, those living in the most deprived areas (48%) and those with no educational qualifications (48%) are most inclined to say so. Only 27% of people living in the least deprived areas and 30% of graduates express this sentiment.

6.12 17% prefer A&Es to GPs because they can get tests done quickly. The figure rises to 29% when looking at people in the most deprived areas. This view is held by just 11% of people who live in the least deprived areas. By the same token those with no qualifications are twice as likely (26%) as degree holders to prefer A&Es to GPs to get tests done quickly (13%).

6.13 65% of the total population have confidence in GPs, while 11% state they do not have much confidence. This compares to 18% of those living in the most deprived areas, 16% of people with no qualifications and 20% of parents with a child aged under 5 who do not have much confidence. In contrast, 10% of those without young children and 8% of degree holders and 8% of those living in the least deprived areas feel the same.

6.14 Overall just 19% agree that doctors at A&Es are more knowledgeable than GPs. However, this jumps to a third for those without any qualifications (32% compared with 14% of graduates) and 28% of those in the most deprived areas (compared with 15% living in the least deprived areas).

6.15 58% of people with internet access say they would look online to help understand a health problem, while 47% would use the internet to decide what to do about it. Nevertheless, substantial gaps between demographic groups exist. Young people aged 18 to 24 are twice as likely (62%) to research health problems online than those aged 75 and over (30%). Those without children under 5 (56% compared with 72% of those with young children) and people with no qualifications (42% compared with 71% of graduates) and men (54% compared with 62% of women) are less likely to turn to the internet for health advice.

6.16 When it comes to awareness and confidence to access the right NHS services, most people (90%) report being confident that they know when to see a doctor regarding a health problem. Men (76% compared with 85% of women) and young people (64% compared with 79% of those 75 and over) emerged as the groups least confident in knowing how to contact a GP out of hours. And while 85% of people say they could rely on family and friends to care for them in the case of a non-life-threatening health

problem, this drops to 76% for those in the most deprived areas and rises to 91% for those living in the least deprived areas.

The challenge is change

6.17 So taking public attitudes into account and looking at our performance and recent trends shown above it is clear we need to do two things - change services to meet rising demand and change public awareness and attitudes. The data shows (see figure 6 above) that if emergency departments continue to operate as it stands they will not be able to cope with annually increasing demand[42]. If we do not change either, and ideally both, then primary and secondary care services are going to struggle to keep pace with demand and we will not be able to deliver the best we can for patients.

6.18 We outline our plans to raise public awareness and change attitudes in section 3. The challenge is change.

Patient advice - right service right place

6.19 From the analysis presented above it is possible some patients who are not an accident or an emergency could in theory be seen appropriately by other services rather than having to wait to be seen in A&E. We will test the potential for a service in emergency departments that offers patients who could be seen elsewhere advice and assistance in getting the most appropriate service. This could operate at peak periods and assist in easing pressure on emergency departments and ensuring patients are seen by the most appropriate professional.

6.20 As part of a comprehensive whole-system strategy for unscheduled care, helping patients with minor ailments navigate to alternative sources of support can also be an important change. There is evidence from other health and social care systems that supporting patients who attend A&E and who could more appropriately and safely be seen in primary care can work; e.g. Tayside. Such a policy has been implemented at GRI for certain conditions; e.g. COPD. Patients triaged are provided with information on alternative sources of community support for their condition. The policy has relatively modest aims and follows guidance from the Royal College of Emergency Medicine[43].

6.21 It is important we look at what can be done to guide patients safely and smoothly to alternative services where we can. We wish to work with acute clinicians to test re-direction arrangements at all the main acute sites so that emergency departments can focus on treating patients who need acute care. We will discuss with primary care how this might be done to ensure appointment slots are available timeously for patients re-directed from emergency departments. We estimate the impact of such a policy, supported by a public awareness campaign, the use of Consultant Connect and improved

[42] Demand and Capacity Model for NHS Greater Glasgow and Clyde, Final Report and Recommendations, NECS, 2019

[43] https://www.rcem.ac.uk/docs/SDDC%20Intial%20Assessment%20(Feb%202017).pdf

pathways, could be that potentially in a full year in GG&C 8,000 attendances could be seen within primary care either by GPs or community pharmacies (see table 9). For GP practices this could mean an additional two appointments per week.

Table 9 – potential impact of re-direction

	Total
Non Urgent - 80%	8,711.2
Standard - 10%	9,332.9
Total	**180,44.1**

Note estimate based on 2018/19 data and assumes a reduction of 80% of activity triaged as "non-urgent" and around 10% of "standard" activity.

Minor injuries

6.22 Minor injuries units offer a safe and effective service to patients. The units at Stobhill and the New Victoria see a large number of patients year on year and regularly achieve the four hour waiting time target (see table 10 below). They offer a good model for how we can serve patients better. We think that there should be similar dedicated minor injury units at the main acute hospital sites in addition to those at Stobhill and the New Victoria. Such units would relieve pressure on busy emergency departments and improve the flow within A&E departments and access for patients, separate and distinct MIUs should be established at all main acute sites

Table 10 – MIU attendances

Year	**Total attendances**	**No. under 4 hours**	**% Compliance**
2018/2019	46,575	108	99.8%
2019/2020 (to February)	44,215	129	99.7%

6.23 We will test developing further the MIU service model to deliver shorter waiting times consistently and reliably to increase attendances, and encourage patients to attend MIUs for appropriate cases instead of A&E e.g. patients seen and treated within 2 hours at MIUs versus the 4 hour A&E target. We will also test a change in the hours of operation to better match pattern of demand with MIUs open to 11.00 pm at weekends and Bank Holidays. We also wish to explore the costs and benefits of opening an MIU at Gartnavel.

6.24 If minor injuries were seen in dedicated units rather than being seen in emergency departments we estimate this could significantly reduce A&E attendances with no detrimental impact on patient safety.

Frequent attenders at Emergency Departments

6.25 In 2018/19 there were 1,188 patients who had attended an A&E department in Greater Glasgow and Clyde more than ten times. In total these patients accounted for 17,918 A&E attendances – 3.5% of the total attendances in GG&C. Each Partnership has a programme of work with GPs and other services such as mental health and addictions, to review individual cases to see what early intervention or preventative measures can be taken to support these patients.

6.26 Through this programme we estimated that by the end of 2020/21 the number of A&E attendances accounted for by people who have attended more than ten times in the previous twelve months will have reduced by 2.5%. Through further extension of this programme beyond 2020/21 we estimate will reduce the number of frequent attenders as a percentage of total A&E attendances from the current level to approximately 2%.

Example – Inverclyde HSCP
Data suggests that in Inverclyde the largest group of frequent attenders either have Alcohol & Drugs issues or poor mental wellbeing. Inverclyde HSCP set a target to reduce number of frequent attenders the aim being to work with individuals on a partnership basis to reduce attendances with the provision of appropriate community services. Alcohol and Drugs Recovery Service implemented a test of change in September 2019, involving an MDT and assessment and care management approach.

Mental Health

6.27 Individuals with mental health problems have been identified nationally to be as likely to breach the four-hour emergency access target as those with any other presentation. Action 13 of the national mental health strategy highlights the unnecessary delays experienced and aims to streamline care pathways irrespective of the patient's mental health problem. The recommended model for all unscheduled care services is one part of the *Moving Forward Together* programme matching demand to a prompt and effective response. 2020 sees the proposed implementation for a more standardised approach to maximise effectiveness and efficiency. The identified actions include:

- psychiatry liaison services – rolling out a single adult mental health liaison service across NHSGGC, with designated teams working into each acute hospital during working hours and a coordinated out of hours response via a single point of access to emergency departments 24/7. Services will operate to defined response and accessibility criteria. The ability to provide a 24 hour timeous response will be coordinated across liaison and out of hours Community Psychiatric Nursing services.
- Acute Psychiatric Liaison for Older People will commence enhancing capacity of older people's liaison services to the acute sector and to care homes. This will be implemented by Liaison Services using a range of low level interventions and support for people suffering with dementia. These will target people who access

services and their families/carers at an earlier stage, help people live longer in the community and reduce attendance at emergency departments.

- Crisis Resolution and Home Treatment - enhanced Board-wide access to crisis resolution and home treatment teams as an alternative to hospital admission. The service will implement intensive home treatment coordinated across Crisis and OOH CPN services, close an identified gap in response to Emergency Departments and will be available from 8am to 11pm, 7 days a week and will offer home-based care visits up to three times daily.
- Out of Hours – Implementing in 2020 a single point of access that will coordinate care across all unscheduled activity arising outside normal working hours. This will include provision of CRHT (Crisis Resolution & Home Treatment Teams) and Liaison Services to Emergency Departments as well providing access for emergency and urgent care assessment for people presenting in distress. A senior clinician will be available to offer telephone advice to referrers and to coordinate responses from Community Mental Health Teams and Crisis Resolution & Home Treatment Teams (CRHTs) as needed. Access as identified has also been increased to OOH CPNs from 5.00pm to 9.00am which will improve accessibility and be connected to the broader OOH review.
- Mental Health Services and emergency departments have established a standardised response time to EDs from point of referral to Mental Health Services. Both Mental Health Services and EDs are promoting a supportive joint working ethos and shared responsibility to ensure that people with a mental health presentation get the most appropriate care treatment response. The standard target response time is to carry out a face to face mental health assessment within one hour from point of receipt of referral (time of initial telephone call). Prioritisation of all referrals are based on individual patient risk factors, current demand/activity within the service, current risk factors within Emergency Departments, medical fitness, ability to engage in psychiatric assessment due to substance intoxication or availability of interpreting services.

6.28 The focus of implementation during 2020 will be on the following:

- GGC wide approach to Crisis Resolution and Home Treatment (CRHT) service 8am-11pm x 7 days. HT up to 3 x visit/treatment daily;
- Provide single point of Out of Hours access co-ordinated across all unscheduled care services arising outside normal working hours;
- One coordinated single board wide adult mental health liaison service;
- Dedicated liaison teams working in to each of the 5 acute hospital sites GRI; VOL; QEUH; RAH & IRH;
- Coordinated Out of Hours response to 4 x Emergency Departments 24/7;
- Implement an SOP describing input to the EDs and inpatient wards;
- Development in partnership with third sector, a tender for Safe Haven Crisis outreach model to provide an alternative response to people in distress (away from EDs);

- Evaluating pathways and safe response models as an element of a partnership with a commissioned 3rd Sector Safe Haven hub approach across Glasgow City to support distressed people to access care and prevent attendance at accident and Emergency Units; and,
- Test the concept of new health and social care assessment model for older adults.

GP assessment units

6.29 At each main hospital site in GG&C there are assessment units located close to emergency departments where GPs can refer patients to be assessed. Such referrals are usually unplanned and made on the same day when a patient has been seen by a GP, and a decision taken that they need assessment in secondary care. These units provide an essential service to patients and support to GPs and are extremely busy departments. Prior to these units being introduced referrals such as these would be made straight to emergency departments. The current rate of referral to assessment units is shown in table 12.

Table 11 – GP referrals to assessment Units

	2017/2018	2018/2019	2019/2020 (to February)
GP referrals	13,030	12,587	10,040
Total attendances	55,705	56,709	49,152
% GP referrals	23%	22%	20%

6.30 There is a variation across the main hospital sites in the ratio of attendances at assessment units and the number of admissions. We will work with assessment units and GPs to explore the reasons for this variation with a view to improving overall ratios and in particular reduce the number of people discharged in the same day by the development of care pathways for such conditions such as DVT and abdominal pain (see above). Providing alternatives to admission as described above will assist in achieving such improvements.

Table 12 – GP Assessment Units - ratio of attendance to admission

	2017/2018	2018/2019	2019/2020 (to February)
Total admissions	31,106	31,022	25,929
Total attendances	55,705	56,709	49,152
% admissions	56%	55%	53%

6.31 A significant proportion (45-48%) of GP referrals to AUs are discharged on the same day and not admitted. Most attendances occur between the 4pm and 6 pm with same day discharges often taking place in the evening. As well as being inconvenient for patients and their families there is a risk that patients are admitted overnight because of

difficulties in getting patients home safely. Work will be undertaken to review same day discharges and what alternatives could be offered to GPs on a planned basis, and what the impact might be if discharge to assess was scaled up. It is also suggested that the contact telephone number of the consultant in charge should be shared to encourage GPs to contact the consultant to seek advice before making a referral.

6.32 We will look at potential alternatives for GPs for this group of patients where advice and or tests are needed and can be managed the next day. The potential here might be we give GPs the ability to book patients directly into next day clinics for advice and treatment. This would alleviate pressure on assessment units and give patients and GPs assurance that they will be seen quickly and on a more planned basis.

6.33 Initial analysis indicates that the effect of such a programme could be a significant reduction in admissions from assessment units although clearly some of this activity would be converted into planned activity in other services such as diagnostics.

Advice to secondary care clinicians

6.34 In seeing patients who attend emergency departments it is important secondary care clinicians can access support and advice in order to make decisions about the next steps. Currently emergency departments can access advice from CPNs, community rehab, hospital discharge teams and others for support in managing patients. HSCPs will review these arrangements with acute clinicians to see what improvements can be made to respond to an increase in the numbers attending. We are conscious that in a busy ED department when decisions about a patient need to be taken quickly it can be confusing to know who to turn to in HSCPs for advice and support.

Day of care survey

6.35 A national Day of Care survey was carried in October and May 2019 out to provide an overview of in-patient bed utilisation across NHS Scotland. In GG&C the survey involved 3,038 patients in 3,216 beds and an overall occupancy level of 94.7%. The results of the survey were that:

- 13.8% of in-patients did not meet survey criteria for acute hospital care;
- the main three reasons identified for patients not being discharged were:
  - awaiting social work allocation/assessment/completion of assessment;
  - awaiting consultant decision/review; or,
  - legal or financial reasons.

6.36 The audit also concluded that the older the patients were, the less likely they were to meet the criteria for acute care.

6.37 These numbers compare well with previous audits although the number of patients and beds surveyed, and occupancy levels were higher than in May 2019 when the last survey was conducted.

6.38 HSCPs are keen to work with the NHS Board and the acute division to take forward the results of the survey. Our programme to improve discharge and our proposals to provide GPs with alternatives to admission should positively impact on these results going forward. We would wish to see an improvement in performance from current 14% of bed days not meeting the acute care criteria to 10% in 2022/23.

Length of stay

6.39 One area highlighted in the day of care survey that impacts on patient flow within the acute hospital system is the length of time patients spend in a hospital bed. There are variations in length of stay across specialties and hospital sites. When comparing GG&C hospitals performance there is significant variation (see table 9 below).

Table 13 – length of stay by specialty by hospital compared with Scotland – general, geriatric & respiratory medicine 2018/19

Hospital	All specialties	General Medicine	Geriatric Medicine	Respiratory Medicine
Glasgow Royal Infirmary	5.2	3.3	10.8	7.4
Inverclyde Royal Hospital	7.2	5.9	20.6	*2.6
Queen Elizabeth University Hospital	6.3	5.1	12.2	5.9
Royal Alexandra Hospital	6.1	6.1	16.1	*1.9
Vale of Leven General Hospital	6.6	4.5	14.7	*1.1
NHS Greater Glasgow & Clyde	**6.2**	**4.9**	**15.5**	**6.1**
NHS Scotland	**6.3**	**4.9**	**16.7**	**5.9**

* - denotes small number of spells

Source: NSS Discovery dashboard

Notes:

Description: Analysis of the variation in LOS based on Total LOS and number of spells

Numerator: Total LOS (days)

Denominator: Number of spells

6.40 There is a need for fast access to investigation, diagnostic services and pharmacy services to shorten lengths of stay and prevent potentially avoidable admissions. We need also to optimise bed use given demand pressures generated by scheduled and unscheduled care needs, and delivery of waiting time targets. Implementation of the NHS Board's 2017 unscheduled care improvement programme is key to this and the following should contribute to delivering these improvements for patients.

Consultant geriatricians and GPs

6.41 Considerable progress has been made in joint working between HSCPs, GPs and consultant geriatricians. Further development of these links is desirable to better support patients in the community. Particular areas of focus for the next stage of this work would be:

- geriatrician support to GPs who cover care homes potentially utilising Attend Anywhere for MDTs;
- defining the geriatrician's role in anticipatory care planning, the management of complex cases and involvement in MDTs;
- introducing telephone or virtual clinics between GPs and geriatricians including advising GPs before referrals to AUs;
- considering the role of day hospitals in the provision of community based older people's services including the potential for the urgent / rapid review of patients referred by GPs; and,
- improving the management of frailty in the community as part of the frailty collaborative and the development of an integrated primary / secondary care frailty pathway.

6.42 Consultant geriatricians currently undertake a number of sessions in the community at a day hospital or other community setting. These sessions are important in supporting patients in the community after discharge or preventing potential future hospital admission and providing integrated care with community based services including GPs. As part of this plan we would like to explore the potential for more community sessions as part of developing an integrated approach to managing frailty within community settings, working with the third and independent sectors, including housing. We will work with consultant geriatricians to explore the opportunities to take further steps to develop more integrated care pathways.

Summary

6.43 In this section we have focused on our priorities to improve the interface between primary and secondary care, including actions to reduce demand on our emergency departments. This programme requires a whole system approach to make progress, and further discussion particularly at a clinical level between GPs and secondary care clinicians to move these proposals forward. Improving links between primary and secondary care is a long term agenda recognising the changes taking place within general practice and the scale and size of the health and social care system in GG&C. Nevertheless some important key steps can be made early to impact on emergency care such as:

- introducing dedicated minor injury units at each emergency department to improve flow and performance against the four hour target;
- introducing a re-direction policy to support patients access appropriate emergency services;
- reducing the number of frequent attenders at A&E;
- improving the proportion of patients seen on a planned basis as an alternative to attendance at GP assessment units;
- improving length of stay; and,
- improving links between GPs and consultant geriatricians.

7. IMPROVING HOSPITAL DISCHARGE

Introduction

7.1 The plan is about taking a 'whole system approach' to unscheduled care and outlines a range of community alternatives to hospital admission. We recognise that hospitals provide valued and essential assessment, treatment and care and patients are often admitted because the necessary care and treatment they need cannot be provided safely and effectively at home or in the community. It is important that all potential options are explored with patients and their carers before a decision is taken to admit someone to hospital. Anticipatory care plans have a role to play here.

7.2 A prolonged stay in hospital however is often not associated with a good outcome so we must do as much as we can to speed up the discharge process. Being in hospital can disconnect people from their family, friends and social network and can result in a sense of isolation, loss of confidence and depression. Visiting hospital for a long period may heighten an already stressful situation for family carers. Older people experience functional decline as early as 72 hours after admission and are more likely to have an episode of delirium or infection. The risk of a poor outcome increases every time a frail patient is moved from ward to ward.

7.3 Every unnecessary day in hospital increases the risk of an adverse outcome for the individual, drives up the demand for institutional care and reduces the level of investment that is available for community support.

Improving discharge

7.4 Achieving safe, timely and person centred discharge from hospital to home is therefore an important indicator of quality and a key measure of effective and integrated care. Once a patient is fit for discharge it is in their best interest that this takes place as quickly as possible so that they can settle safely and comfortably at home or other appropriate setting. For those patients who need further support in the community from health and / or social care it will often be the HSCPs' discharge teams that make sure that support is in place. For most patients discharge will be followed up by community services and / or their GP. We want to ensure that people get back into their home or community environment as soon as appropriate and with minimal risk of re-admission to hospital.

7.5 On a typical day there are over 250 discharges from acute hospitals in GG&C. Most of these discharges occur during the hours of 14.00 and 17.00. The pattern of discharges varies during the week with most discharges occurring towards the end of the week. Ideally we would like to see this pattern spread more evenly throughout the week, including weekends, and increase the number of discharges occurring before 12.00 noon and at weekends as this easies pressure on home care, community services and others who follow up patients in the community.

7.6 We will aim to routinely discharge patients home from hospital in days not weeks. We believe that when a patient no longer requires to remain in hospital, they should be discharged home and their post hospital rehabilitation, care and support needs met by the local community services. If return home is not possible in the short term, they should transfer to a step down bed in the community for a period of Intermediate care and rehabilitation.

Example - Home for Me, East Dunbartonshire
In East Dunbartonshire Home for Me is working closely with orthopaedics to support early discharge with follow up rehabilitation and home care re-ablement

Example – Home First, Inverclyde
In Inverclyde Home First tracks patients in hospital and once a discharge date is agreed early referral is made so patients can be discharged to assess with an appropriate risk assessment. The Home1st team brings together ACM, reablement, in reach team and discharge team to move the emphasis of discharge planning from hospital to community provision. Discharge planning begins in the community and assessments completed in the service users home. The discharge to assess approach, when an individual is medically fit to be discharged they return home where an assessment for future needs is completed by the Home 1st (Reablement) Team. In this way Inverclyde ensure a smooth patient pathway, early referral for social care assessment and reduce duplication. Care Home Liaison Nurses are also involved in supporting care homes to maintain residents in community and avoid hospital admission

Discharge process

7.7 We will begin care planning as soon as possible after a patient is admitted to hospital and involve the appropriate members of the multi-professional team at the earliest opportunity. Planning for discharge with clear dates and times reduces a patient's length of stay, potential re-admission and therefore pressure on acute hospital beds. The multi-disciplinary team should meet ideally within 12 hours of a patient's admission to consider the patient's discharge plan so that patients can be discharged safely onto the next appropriate area of care.

7.8 Key to a successful discharge is:

- specifying an estimated date and/or time of discharge and discharge planned from the point of admission (or before) with the norm being discharge within hours and days of readiness rather than weeks;
- identifying early what a patient's discharge needs are and how they will be met;
- taking a personal outcomes approach that tackles every delay, every day and uses data to examine performance and challenge causes of variation;
- active participation by patients and their carers ensuring that they understand and are able to contribute as appropriate to care delivery and discharge planning;

- identifying a named person with responsibility for co-ordinating all stages of discharge planning throughout the patient's journey including engagement with housing where appropriate;
- an acute hospital bed is not the best place for assessing an individual's need for long term care and support so, unless unavoidable, no-one should move directly from an acute bed to a long-term care home placement; and,
- most importantly we will adopt of a culture of 'Home First' as a default position - wherever possible and safe, patients should return to the home they were admitted from and only explore alternatives if this is not possible.

Discharges before 12.00 noon

7.9 This plan proposes more discharges before 12.00 noon – currently less than 10% of discharges are before midday. Earlier in the day discharges would be better for patients allowing them time to settle beck at home or other setting, and also ease pressure on wards. We propose an improvement of 10% over the next 12 months.

Intermediate care

7.10 Intermediate care acts as a bridge between hospital and home for those deemed medically fit for discharge but who are delayed in hospital. In this way it ensures that acute hospital capacity is used appropriately and individuals achieve their optimal outcome and has been shown to be effective[44] .

7.11 There are a number of intermediate care places in GG&C commissioned by HSCPs from the independent care sector. The function of this service is to create a stable non-acute environment where individuals being discharged from hospital with enduring complex care needs can have their long-term social care assessments undertaken.

7.12 Most intermediate care resources are of this 'step down' type of provision for patients transferred from an acute hospital. However, the model also lends itself to 'step up' intermediate care where a patient might be referred to avoid a potential hospital admission. This aspect of the model needs further development and has the potential to offer GPs another option for patients even in an emergency or urgent situation. We will explore this further with GPs and the independent care sector and how this service might operate.

Adults with Incapacity (AWI)

7.13 At the time of writing there were 57 patients in acute hospital beds who have been identified as AWI patients within the definition of the Act[45]. AWI patients typically have a

[44] Implementing a step down intermediate care service, Kate A. Levin, Martine A. Miller, Marion Henderson, Emilia Crighton, Journal of Integrated Care, ISSN: 1476-9018, 10 October 2019

[45] https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/delayed-discharges/delayed-discharges-in-nhsscotland-monthly/

longer length of stay than other patients and therefore consume more acute bed days than other patients. In 2018/19 AWI patients accounted for 10,037 bed days in GG&C – over a quarter of all bed days. HSCPs will bring a dedicated focus and resources to monitoring and expediting guardianship process as far as their authority extends

7.14 Following a legal challenge to the Health Board policy on AWI by the Equalities and Human Rights Commission we have ceased admitting AWI patients to specific care home places. Currently alternative pathways are being explored. In the interim the number of AWI delays in acute hospital beds is likely to rise.

Improving Delayed Discharges

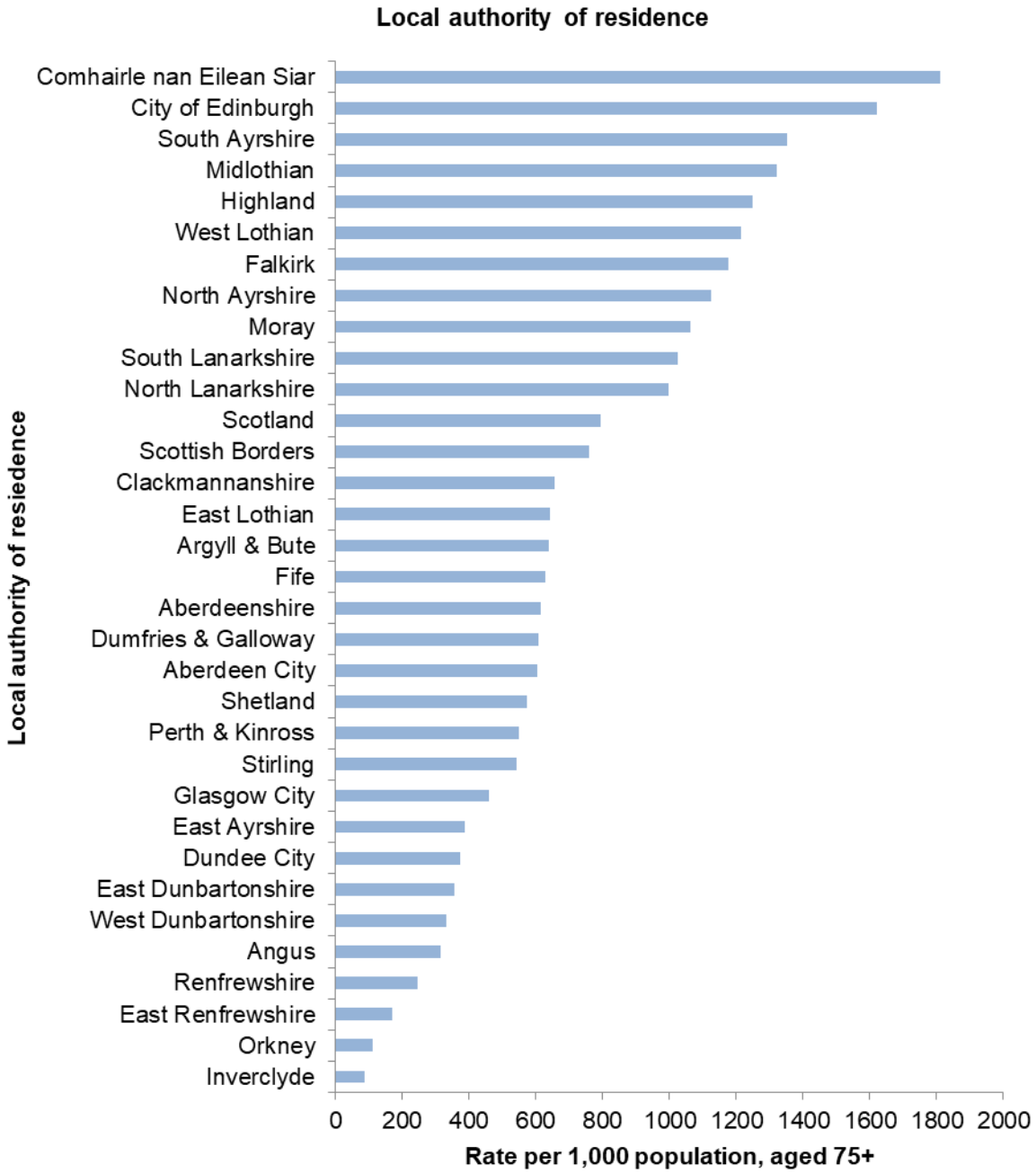
7.15 HSCPs have performed well in recent years in managing delayed discharges which have been on a downward trajectory since 2016. However, reflecting pressures in the wider health and social care system our performance has declined over the past 12 months. While this mirrors a trend nationally, GG&C performance as a whole continues to compare favourably with other Health Boards. HSCPs and the Acute Services Division have robust processes in place to manage delays on a day-to-day basis, and a range of actions are currently being implemented designed to improve hospital discharge arrangements and patient outcomes.

7.16 It is widely acknowledged that delays in patients being discharged from hospital can be detrimental to patient care. No patient ideally wants to remain in hospital any longer than they need to. A long delay can often lead to a patient falling ill again, or losing vital life skills, independence or mobility. It could ultimately result in the patient having to be admitted to a care home due to the deterioration in their health and mobility. There is clear evidence that an unnecessary, prolonged stay in hospital can be detrimental to a person's physical and mental wellbeing.

7.17 In GGC acute patients who are declared fit for discharge are immediately recorded as such and "the clock starts ticking" with reports generated daily on the number of delayed patients in the health and social care system and into which category they fall e.g. AWI, mental health etc. The discharge planning process will begin much before this date, and this is now further improved with the introduction of the Estimated Date of Discharge on admission to an acute ward, and availability to HSCPs of inpatient data via dashboards.

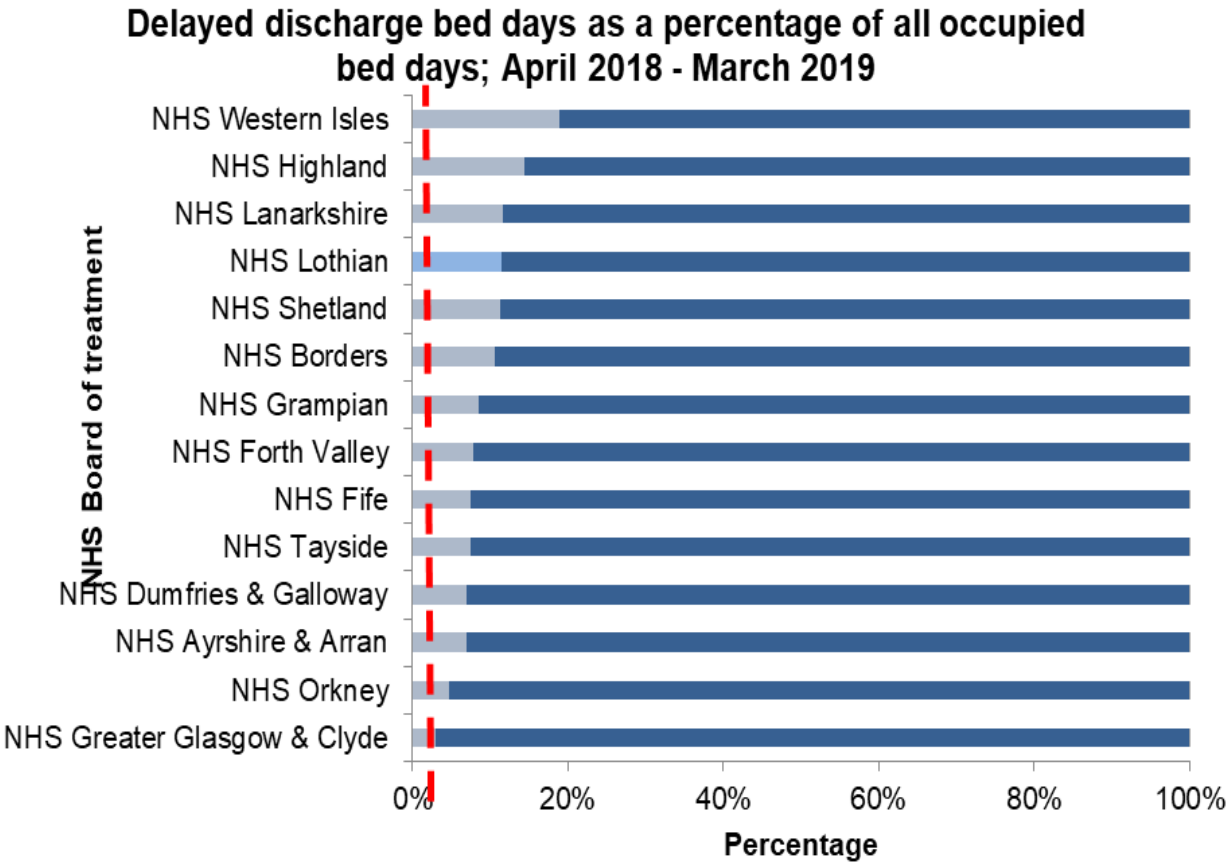
7.18 The current rate of delays (i.e. all delays) for all patients aged 75 plus per head of population by HSCP for 2018/19 is shown in figure 24 below and illustrates that the performance of GG&C HSCPs compares favourably with other HSCPs nationally.

Figure 16 – Delayed discharges per 1,000 population aged over 75 by HSCP – April 2018 to March 2019



7.19 This is further illustrated when considering the percentage of acute beds in GG&C (3.1%) occupied by people who were delayed in their discharge (see figure 17 below);

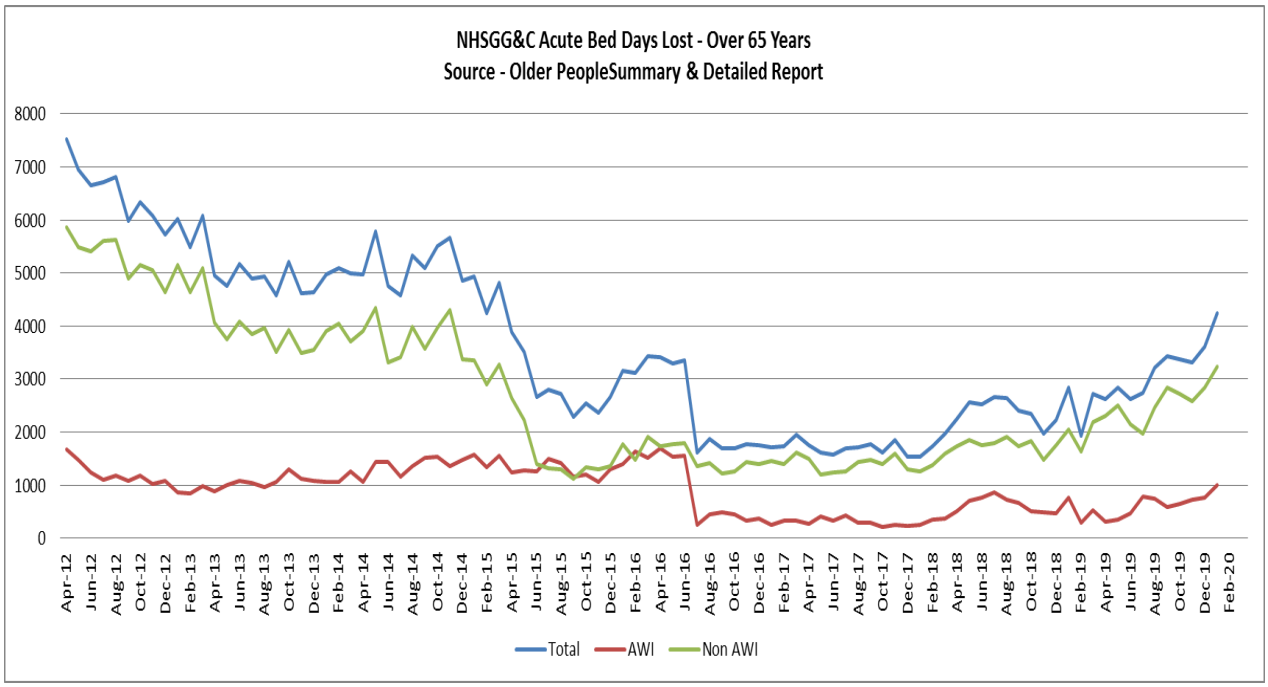
Figure 17 – delays as a percentage of acute beds – 2018/19



7.20 The number of delayed discharges in GG&C and the associated bed days due to delays has increased in recent months:

- the number of acute delays for patients aged over 65 in GG&C has risen from 352 in January 2019 to 472 in January 2020 – the highest since 2012/13;
- total acute delays for all ages in GG&C has risen from 342 in September 2018 to 527 in January 2020 (this is the highest it has been for some years);
- in 2018/19 there were 36,968 bed days occupied by people delayed in their discharge, and of these 29,072 were occupied by people aged 65 years and over (see figure 26 below); and,
- there has been an increase of 9,323 in delayed discharge bed days between 2017/18 and 2018/19.

Figure 18 – Acute hospital bed days lost due to delays – over 65 – AWI and none AWI - April 2012 to February 2020



7.21 The main reasons for delay in GG&C are:

- awaiting place availability (28.4%);
- awaiting completion of care arrangements (22.4%);
- complex delay reasons (21.5%);
- awaiting community care assessment (20.6%); and,
- other reasons including funding, transport, patient and family related reasons (6.8%).

7.22 Recent analysis has shown that there is a significant variation across hospital sites in the timing of referrals to social work services as part of the discharge process. This variation creates an added challenge to respond effectively to the assessment of individuals in a time sensitive manner. There is a clear relationship between early referral to social work and a reduction in delays. Where referral occurs earlier in the patient pathway, the data shows that delays are mitigated or reduced. The average delay following same day referral to social work for those who become delayed discharges is eight days. A third of referrals were made with less than three days of the patient being reported as 'Ready for Discharge' (RFD). The average length of stay for those referred on the same day was 26 days at the point of referral. This would suggest that for many people, there could be opportunities for earlier signposting of patients in areas of high activity in advance of referral and for referrals to be made earlier in the patient stay.

7.23 All HSCPs have action plans in place to reduce delays (see annex B). Additional staffing is being recruited to Glasgow City HSCP's hospital discharge team. East Dunbartonshire

have substantiated the Social work resource within the Home for Me service to improve relationships, communication and consistency within the wards. Inverclyde HSCP has additional assessment staff for the Home1st Assessment and Rehabilitation Service. West Dunbartonshire HSCP are re-aligning staff within the Hospital Discharge Team to place greater emphasis on in-reach/ early assessment. In addition, West Dunbartonshire's new Focussed Intervention Team is responding to referral where a hospital admission is being considered, and through intense support, avoid these admission in 60% of cases.

7.24 The aim of these actions at a GG&C level is to reduce delays so that they account for approximately 2.5% to 3% of total acute beds, and that bed days lost due to delays (non AWI patients) are maintained within the range of 37,000 to 40,000 per year. In summary these actions include:

- increased intermediate care capacity;
- discharge teams linked more closely to acute wards;
- estimated date of discharge planning;
- direct access to home care or same day response to care packages;
- increased support within hospital discharge teams; and,
- improvements to the process for managing AWI patients

Managing capacity at peak times – seasonal planning

7.25 The health and social care system experiences peaks of demand at certain periods during the year usually over the winter period and at bank holidays, and also when conditions such as flu affect large sections of the population. It is essential that we review the capacity of the system to meet these peaks in demand and ensure patients continue to receive a consistently high quality service throughout the year. We must plan additional supports during these key points of the year, and scale up services quickly where we need to. In doing so we will be guided by our strategic direction to manage patient care in the community and avoid the need for hospital admission. Each year we will develop a capacity plan informed by the latest projections of future demand.

7.26 We also need to consider managing services on a 52 week annual cycle. At present we scale services down for several days over annual holiday periods. As demand is 24/7 all year round we do put strain on the system by managing 52 weeks demand over a 51-50 week year. We fully recognise that staff need a break and are entitled to annual leave, but we do need to look at ways we can deliver services throughout 52 weeks of the year.

7.27 Our aim is that we have a coherent system wide plan capable of adapting to seasonal or system pressures so we can flex capacity and service responses as needed. Traditionally our response has been to open additional beds over the winter period the consequence of which is to place additional demands on other parts of the health and social care system. Our aim starting in 2020/21 will be not to open any additional beds in line with our overall approach in this plan to prevent admission and build capacity within community services. As part of our seasonal planning we will continue to:

- proactively manage a flu immunisation campaign both to staff and the general public to encourage increased uptake, including capitalising on the role of community pharmacies;
- proactively deliver a public awareness campaign on what services to access for what over the holiday period and alternatives to accident and emergency such as minor injuries;
- implementation of the re-direction protocol in emergency departments to advise patients on appropriate services;
- seven day working to support improving weekend discharges and discharges earlier in the day;
- introducing "hot clinics" for quick access for GPs for specific conditions such as abdominal pain; and,
- take forward actions to improve communication between GPs and secondary care clinicians e.g. consultant connect for GP to consultant advice

Summary

7.28 In this section we have outlined our priorities for improvements in unscheduled care services to ensure patients receive the right care in the right location and at the right time. We have outlined proposals we intend to test with secondary care clinicians and primary care to provide GPs with alternatives to admission and other actions that can be taken to better respond the changes in demand that can yield further improvements in our health and care system.

7.29 In summary the key actions to improve the discharge process planned are:

- take a personal outcomes approach and encourage the active participation by patients and their carers in the discharge planning process;
- identify a named person with responsibility for co-ordinating all stages of discharge planning;
- as early as possible following admission, including agreeing an estimate date of discharge;
- adopt a home first default position;
- better managing community capacity by increasing the number of discharges earlier in the week, before 12.00 noon and at weekends;
- improving our management of delays; and,
- better manage capacity over the winter period and at other times of the year.

8. RESOURCING THE CHANGES

Introduction

8.1 In this section we outline the financial framework to support delivery of the plan. A number of the proposals in this plan are already funded in HSCPs or the Acute Services Division. Others will need additional or a shift in resources to support implementation.

Financial Framework

8.2 This commissioning plan represents the first step in moving towards delegated hospital budgets and set aside arrangements within Greater Glasgow and Clyde. In 2019/20 unscheduled care is estimated to cost Greater Glasgow and Clyde £438.7m. With a budget of £409.3m identified by Greater Glasgow and Clyde Health Board. This is a shortfall in funding of £29.4m and represents a significant financial risk to Greater Glasgow and Clyde Health Board and the six IJB's with strategic responsibility for this area.

8.3 This budget shortfall impacts on the IJB's ability to strategically plan for unscheduled care. Nationally there is an expectation that IJB's, through commissioning plans, can improve outcomes and performance in relation to unscheduled care, which in turn will support the release of resources to support investment in primary care and community services. This was reiterated in the Scottish Government's Medium Term Financial Plan[46] which assumes that 50% of savings released from the hospital sector will be redirected to investment in primary, community and social care service provision. The ability to achieve this in Greater Glasgow and Clyde is hindered by the existing financial position outlined at 8.3 above.

8.5 The commissioning plan identifies a number of key actions and investments which require financial investment to deliver. Work is in hand with all HSCPs and the acute division to identify the level of resource needed across the life of the plan. Until this is complete only projects which can be funded within existing resources will be progressed.

Acute Inpatient Beds Plan

8.6 There is a requirement that this Commissioning Plan outlines an inpatients beds plan for the specialities included in the set aside arrangements (see 1.11 above). Annex C shows the changes in inpatient beds across the main acute hospital sites in GG&C since 2010. These numbers show that the potential to significantly reduce further acute beds capacity in NHSGGC is limited given the current and projected future demand for acute hospital care.

[46] https://www.gov.scot/publications/scotlands-fiscal-outlook-scottish-governments-medium-term-financial-strategy-2019/

8.7 Further the acute system in NHSGGC already benchmarks favourably with the rest of Scotland in terms of its efficiency KPIs, reflected in average length of stay (ALOS) and day of care audit data (see table 14).

Table 14 – acute inpatient beds benchmarks 2019

Indicator	Pan-Scotland Acute (28 Sites) Oct 2019	Pan-Scotland Acute (29 sites) May 2019	NHSGG&C Oct 2019	NHSGG&C May 2019
Bed Occupancy %	**96%**	95%	94.7	96.29
Day of Care - criteria not met %	**19%**	21%	13.8	14.12

8.8 NHSGGC has also given effect to the Scottish Government's Hospital Based Complex Clinical Care (HBCCC) guidance from May 2015, which saw all acute continuing care capacity in the Board area phased out over the past 3 years (see annex c).

8.9 As the scope to deliver a further significant reduction in future acute inpatient bed capacity is limited we will take action to support the acute hospital system to manage growing demand without having to expand bed capacity (the thrust of the actions in section 5) and specifically we will work with the acute system to reduce the requirement to open additional winter beds over the winter period to zero over the lifetime of this plan (see annex D).

8.10 As per the set aside arrangements, this would require funds to be directed towards community alternatives to hospital, in line with the programme detailed in this plan. The ability to do this will be dependent on the level of funds available for investment over the life of the plan and represents a risk to delivery.

9. MEASURING IMPACT AND PROGRESS

Introduction

9.1 In this section we look at the potential impact of the programme outlined in this draft plan and the key measures we will use to monitor progress.

9.2 In a large and complex system such as GG&C with many moving parts estimating and forecasting the impact of specific interventions is not an exact science. There are many external factors that can influence the impact of any given intervention – some of which are not in our control. Forecasting or estimating impact is even more difficult when looking into future years. The numbers presented below should therefore be viewed with caution and should not be considered as a firm guarantee of future impact; they are a guide and our best estimate based on what the evidence says and our knowledge of the health and social care system in GG&C. These numbers will also need regular review and updating following implementation.

Key Measures

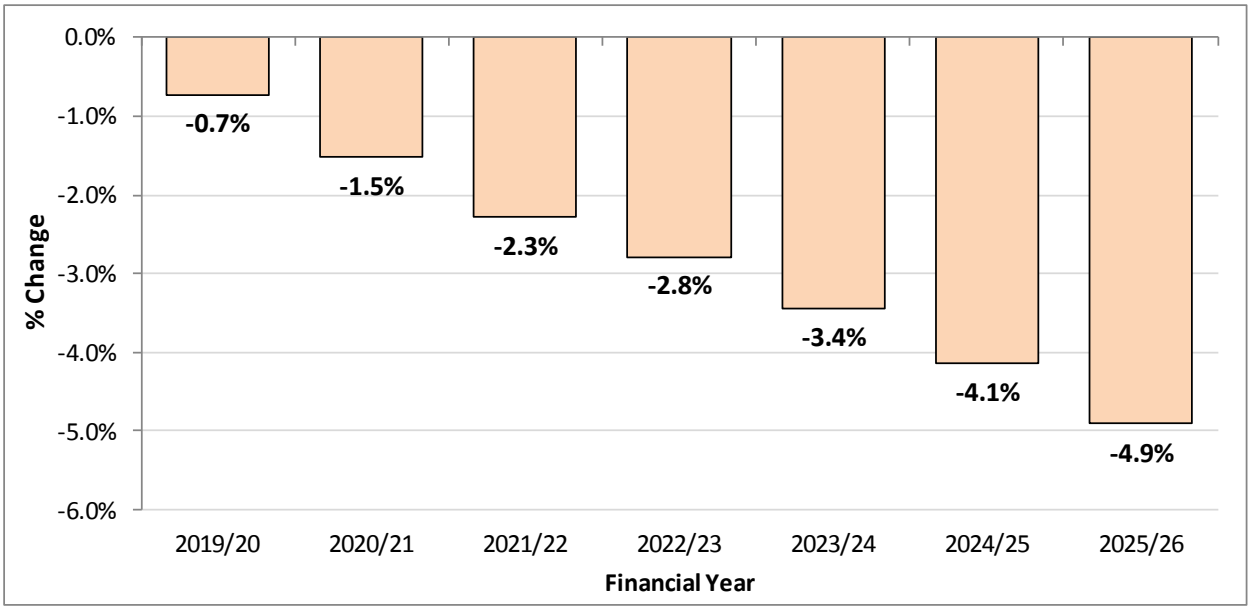
9.3 The key indicators we propose to use to measure the impact of our programme are:

- emergency departments attendances:
  - delivery of the four hour target
  - total attendances by age, sex and deprivation
  - total attendances per head of population
  - rates of admissions and discharges
  - frequent attenders
- minor injury units attendances:
  - delivery of the four hour target
  - total attendances by age, sex and deprivation
  - total attendances per head of population
  - rates of admissions and discharges
- GP assessment units attendances:
  - total attendances by age, sex and deprivation
  - total attendances per head of population e.g. 65-74, 75+
  - rates of admissions and discharges
  - GP referral rates
- emergency hospital admissions:
  - admissions by age, sex and deprivation
  - rates per head of population e.g. 65-74, 75+
  - length of stay
  - rates per GP practice
- acute unscheduled care bed days
  - rates per head of population e.g. 65-74, 75+
- acute bed days lost due to delayed discharges

- rates by age e.g. e.g. 65-74, 75+
- AWI and non AWI rates
- bed days lost as % of total acute beds

9.4 In assessing the impact of the programme outlined in section 5 to prevent admissions, and based on current rates of admission per head of population and for different age groups (e.g. 65-74, 75 plus) we estimate that the full implementation of this programme will likely result in a reduction in the rate of emergency admissions for over 65s by 4.9% by 20205 (see figure 19 below). This estimate takes into account the demographic changes forecast over this period.

Figure 19 – projected percentage change in emergency admissions (based on 2018/19 data)



9.5 An important caveat to these projections is that other changes in the population e.g. changes in life expectancy, wider society and the economy highlighted in section 1, will affect these numbers in ways that are difficult to predict at the present time.

9.6 Work is underway to identify the potential impact of all the actions outlined in this draft plan. Through this further work we aim to demonstrate that if plans are delivered in full by 2021/22 as envisaged this will not only enable increases in demand anticipated from changes in our population to be met, it will also result in a reduction in current costs.

10. CONCLUSION

10.1 The purpose of this plan is to outline how the six NHSGG&C HSCPs in partnership with Acute Division and other partners aim to respond to the continuing pressures on health and social care services in Scotland's largest Health Board. For a number of reasons health and social care services are stretched and we are struggling to meet key targets. In a large system such as GG&C a large number of patients are seen by health and social care professionals in a variety of different settings on a daily basis. When looking to the future we can see that demand will increase as the number of people aged over 75 is forecast to rise over the next five years. We need to change therefore if we are to both meet current and future demand.

10.2 The challenge is change. We need to do somethings differently (e.g. out of hours services) and we need to change some services (e.g. mental health services) to respond better to patients. We need to scale up some of what we are already doing (e.g. anticipatory care planning) and we need to try new things (e.g. "hot clinics" for GPs). We also need to look at putting new additional services in place (e.g. minor injury units) and changing how emergency departments operate more effectively.

10.3 We also need to communicate more directly with patients and the general public to ensure people know what service is best for them and can access the right service at the right time and in the right place.

10.4 The programme outlined in this plan is based on evidence from elsewhere of what works and our estimate of patient needs in GG&C. We believe it is the right way forward. The changes proposed will not take effect immediately or all at the same time. Some need testing and others need time to bed in. Change will be gradual but should be fully implemented by 2022/23. While the challenge is change to respond to current and future demand, the challenge is also maintaining the direction outlined in this plan over the longer term so that we can better meet the needs of the people we serve.

Annex A

SUMMARY OF THE EVIDENCE[47]

Redesigning elective care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Improved GP access to specialist expertise
Mixed evidence, particularly on overall cost reduction	• Peer review and audit of GP referrals • Shared decision-making to support treatment choices • Shared care models for the management of chronic disease • Direct access to diagnostics for GPs
Evidence of potential to increase overall costs	• Consultant clinics in the community • Specialist support from a GP with a special interest • Referral management centres

Redesigning urgent and emergency care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Ambulance/paramedic triage to the community
Emerging positive evidence	• Patients experiencing GP continuity of care
Evidence of potential to increase overall costs	• Extending GP opening hours • NHS 111 (NHS24 in Scotland) • Urgent care centres including minor injury units (not co-located with A&E)

Avoiding hospital admission and accelerating discharge

Relative strength of evidence of reduction in activity and whole-system costs	Initiative

[47] *Imison C, Curry N, Holder H, Castle-Clarke S, Nimmons D, Appleby J, Thorlby R and Lombardo S (2017), Shifting the balance of care: great expectations. Research report. Nuffield Trust.*

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence Emerging positive evidence	• Condition-specific rehabilitation • Senior assessment in A&E • Rapid access clinics for urgent specialist assessment
Mixed evidence, particularly on overall cost reduction	• Intermediate care: rapid response services • Intermediate care: bed-based services • Hospital at Home

Managing 'at risk' populations

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Additional clinical support to people in nursing and care homes • Improved end-of-life care in the community • Remote monitoring of people with certain long-term conditions
Emerging positive evidence	• Extensive model of care for high risk patients
Mixed evidence, particularly on overall cost reduction	• Case management and care coordination • Virtual ward

Support for patients to care for themselves and access community resources

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Support for self-care
Emerging positive evidence	• Social prescribing

Annex B

HSCP DELAYED DISCHARGE ACTION PLANS
SUMMARY

Each HSCP, working closely with the acute services division, has a number of actions in train to improve outcomes for patients and current performance. Progress on actions plans and performance is routinely reported to IJBs. Key actions being taken by HSCPs are summarised below.

East Dunbartonshire:

- Linked Mental Health Officer to Hospital Assessment Team to lead improvement in relation to AWI focusing on timeous completion of reports, local authority guardianship applications etc.;
- Dedicated Intermediate Care Unit;
- Palliative and Complex Care beds;
- Hospital attached Social Workers linked to wards who proactively engage with discharge co-ordinators and MDT discussions;
- Proactive use of unplanned inpatient activity dashboard to identify those who have been inpatient for 10 days+ and those with an EDD of 1 month+ to facilitate early referral and allocation of case;
- Same day response to care packages

East Renfrewshire:

- continued use of the inpatient dashboard to identify at earliest point East Renfrewshire residents in acute wards to support early referral;
- continue to strengthen relationships between our Hospital to Home Social Work Assistants aligned to acute sites, staff in acute wards and discharge co-ordinators;
- Proactive planning by Hospital to Home multidisciplinary team to support safe, early discharge collaborating with Care @ Home services and wider RES team;
- Further development of Intermediate bed capacity model as a result of Local Authority Care Home refurbishment over the winter period;
- Unscheduled Care daily huddles to identify those at risk of admission and planned discharges; and,
- Implementation of pan Greater Glasgow & Clyde AWI approach.

Glasgow City:

- a continuing programme of improvement in relation to intermediate care with a focus on reducing average length of stay;
- additional capacity recruited to the HSCP hospital social work team;
- for under 65s, a named Adult Service Manager in each locality to hold accountability and ensure progress with complex adult delays daily;

- improved links with complex wards to improve early referral and effective communication;
- the sharing of estimated day of discharge information to a give early indication of potential future discharges; and,
- a management focus on everyday activities, including:
    - a reduction in same day (as fit for discharge) referrals from Acute – which automatically generate delays;
    - more assiduous prioritisation of delays by HSCP community staff – these are marginal, as most cases are held by the hospital-facing Home Is Best team; and,
    - improved communication arrangements between ward staff and the hospital discharge team around individual patients i.e. single points of contact, more effective networks.

Inverclyde:

- 7 Day Service - we will continue to work in partnership with local Care Homes to accept safe weekend and evening discharges for new admissions;
- Following last Winter's successful Pilot we wish to again increase capacity in our Home care Service to cover 175 hours per week to focus upon evening and weekend discharges for new service users as well as restarting existing packages;
- Test of Change Care Coordination - Coordination of Emergency Department Frequent Re-Attenders will utilise existing Locality Meetings to identify people at risk of hospital re-attendance and implement review and development of appropriate support to address unnecessary presentation. This will be across Health and community Care (including OPMHT) and have similar process in place to address frequent attendances of people known to Alcohol and Drugs Service and Community Mental Health Team;
- Day Care Services - a further Test of Change is to utilise Day Care Services to prevent Unscheduled Attendance's at Hospital This will identify 10 Frailty Day Places which will help to address Isolation and Anxiety amongst Older People which we have identified as a factor for some attendance's and admissions. These will be short term placements with clear link to reablement and accessing community supports;
- Assessment and Care Coordination at Emergency Department - we also intend to support the strengthening decision making at Emergency Department with greater knowledge of community resources and services to allow safe return home rather than admit. To support this we are requesting funding for 6 months to cover a Care Management post who would link directly to IRH Emergency Department complete assessments and return people home with necessary support thus avoiding unnecessary admissions;
- Choose the right Service - we have also extended our local Choose the Right Service campaign to cover attendance at emergency department and families with children.
- Purchase of step up beds on call off basis to prevent inappropriate admissions and also short term placements to facilitate discharge as required.

Renfrewshire:

- Discharge Coordinator post created from November 2019. This dedicated role solely focuses on working with Families, Acute and HSCP Services to manage the discharge process;
- when available, beds at Hunterhill Care Home are used for the reablement of delayed discharged patients;
- Hospital discharge protocol to be finalised and implemented;
- Acute and HSCP meet 3 times a day to discuss discharge planning and review active cases/delayed discharges and agree appropriate actions;
- Hospital Social Work Team attending daily huddle including bank holidays; and
- Weekly meetings with the Care at Home Service Delivery Team Manager; Acute; and the Royal Alexandra Hospital Social Work Team to discuss delayed discharges

West Dunbartonshire:

- Full use of inpatient dashboard to identify patients with admissions of 10 days+
- Dedicated early assessment cohort (Social Care, Nursing, OT) undertaking assertive in reach in wards
- Continuing programme of robust review in relation to use of s13za for AW patients.
- Refresh of hospital discharge homeless policy in conjunction with WDC Housing to ensure streamlined approach
- Refinement of engagement by colleagues in mental health and learning disability services to support safe and timely discharge

Annex C

Acute Inpatient Beds Totals by Hospital site 2010-2025

2010	Beds	2015	Beds	2020	Beds	Projected 2025	Beds
Southern General	900	QEUH campus	1450	QEUH campus	1400	QEUH campus	1400
Victoria Infirmary	370	New Victoria	60	New Victoria	60	New Victoria	60
Western Infirmary	500						
Stobhill Hospital	440	Stobhill ACH	60	Stobhill ACH	60	Stobhill ACH	60
Glasgow Royal	930	Glasgow Royal	910	Glasgow Royal	870	Glasgow Royal	870
Gartnavel General	450	Gartnavel G	360	Gartnavel G	360	Gartnavel G	360
RHSC Yorkhill	230	RHC	215	RHC	215	RHC	215
RAH	650	RAH	550	RAH	550	RAH	550
IRH	320	IRH	300	IRH	300	IRH	300
VOL	90	VOL	80	VOL	80	VOL	80
Total	**4880**		**3985**		**3895**		**3895**

2008 – publication of QEUH business case
2015 – opening of QEUH/ closure of Victoria Infirmary, Southern General Hospital, Western Infirmary, conversion of Stobhill Hospital to ACH
2020 – year 1 of Joint Unscheduled Care Commissioning Strategy – figures include additional winter beds
2025 – year 5 of Joint Unscheduled Care Commissioning Strategy (will be the same as 2020 minus the winter beds)

Notes:

All numbers are rough estimates. Bed numbers fluctuate seasonally and for other operational pressures
2010 figures include total bed numbers in the catchments of each hospital, including continuing care beds, e.g. Drumchapel, Blawarthill, etc.
QEUH campus includes QEUH, Institute of Neurological Sciences, Maternity & Gynaecology, and the Langlands building. RHC shown separately
GRI numbers exclude Lightburn
Gartnavel campus is GGH and BWOSCC only

Annex D

Proposed Reduction of Use of Additional Winter Beds

	2019/20	2020/21	2021/22	2022/23	2024/25	2025/26
South	**88**					
North	**51**					
Clyde	**89**					
Total GG&C	**228**	**200**	**175**	**100**	**75**	**0**