For meeting on
6 OCTOBER 2016

Agenda *2016*

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

NHS
Greater Glasgow and Clyde

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

A meeting of the East Dunbartonshire Health and Social Care Partnership Integration Joint Board will be held within the **Committee Room, 12 Strathkelvin Place, Kirkintilloch G66 1XT** on **Thursday, 6 October 2016** at **9.30 am** to consider the undernoted business.

(Sgd) Councillor Rhondda Geekie
Chair, East Dunbartonshire Health and Social Care Partnership Integration Joint Board

12 Strathkelvin Place
KIRKINTILLOCH
Glasgow
G66 1XT

Tel: 0141 201 4217
Date: 29 September 2016

AGENDA

Sederunt and apologies

Any other business - Chair decides is urgent

Signature of minute of meeting HSCP Board held on 11 August 2016

SEMINAR – Children's Services – Paolo Mazzoncini

STANDING ITEMS			
Item No.	**Contact officer**	**Description**	**Page Nos**
1	Martin Cunningham	Minute of HSCP Board – 11 August 2016. (Copy herewith).	1 - 14
2	Karen Murray	Chief Officers Report.	15 - 92
3	Jean Campbell	Finance Report – Month 5 Outturn & Forecasting to year end.	93 - 100
4	Fiona McCulloch	Performance Report 2016/17 – Quarter 1	101 - 114
5	AndyMartin	Delayed Discharges – Performance Update	115 - 136
ITEMS FOR DISCUSSION			
6	Tom Quinn / Sharon Bradshaw	Appointment of Interim Chief Officer	137 - 140
7	Andy Martin	Review of Complex & Continuing Hospital Care	141 - 144

Item No.	Contact officer	Description	
8	Jean Campbell	The “Living Wage” – Implementation – progress update	145 - 148
9	Andy Martin	Intermediate Care Model - Update	149 - 170
10	Sandra Cairney	Winter Plan 2016-17	171 - 180
11	Jean Campbell	Commissioning and Contract Management Framework (CMF)	181 - 186
12	Paolo Mazzoncini	Draft Interim Integrated Children’s Services Plan 2016-17	187 - 244
13	Karen Murray	ED HSCP Clinical Governance Report	245 - 266
ITEMS FOR NOTING			
Item No.	**Contact officer**	**Description**	**Page Nos**
13	Paolo Mazzoncini	Progress on Community Justice Work stream	
14	Tom Quinn/Sharon Bradshaw	HSCP Management Structure – Phase 2 Update	
15	Fiona Borland	Presentation on proposed HSCP Logos	
		Date of next meeting Thursday, 1 December 2016 at 09.30am, Council Committee Room, Southbank Marina	

Minute of meeting of the Health & Social Care Partnership Board held within the Committee Room, 12 Strathkelvin Place, Kirkintilloch on **Thursday, 11 August 2016.**

Voting Members Present: EDC Councillors **GEEKIE, MCNAIR & O'DONNELL**

NHSGGC Non-Executive Director **TRISHA McAULEY**

Non Voting Members present:

M. **Brickley**	HSCP Service User Representative
J. **Campbell**	HSCP Chief Finance and Resources Officer
K. **Murray**	Chief Officer - East Dunbartonshire HSCP
G. **Thomson**	HSCP Voluntary Sector Representative
W. **Hepburn**	HSCP Professional Nurse Adviser
P. **Mazzoncini**	Chief Social Work Officer
C. **Shepherd**	HSCP Carer Representative

Rhondda Geekie (Chair) presiding

Also Present:	M. **Devlin**	EDC Finance Manager
	A. **Martin**	HSCP Head of Adult & Primary Care Services
	F. **McCulloch**	HSCP Planning & Performance Manager
	L. **McKenzie**	EDC Team Leader – Democratic Services
	L. **Williams**	HSCP Clinical Lead Representative

APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of I. Fraser, R. Finnie, S. Cairney, G. Morrison, A. McCready and J. Duffy.

CHAIR'S REMARKS

Councillor Geekie welcomed everyone to the meeting and thereafter everyone, in turn, introduced themselves. Councillor Geekie advised that Lisa Williams was in attendance as a substitute for Graham Morrison.

1. MINUTE OF MEETING – 26 MAY 2016

There was submitted and noted minute of the meeting of the HSCP Board held on 26 May 2016.

With reference to Page 4, Trisha advised that both she and Ross Finnie had raised the issue of Auditing of Accounts by external auditors which she confirmed would be for one year only. It was agreed that this be recorded within the minute.

2. CHIEF OFFICER'S REPORT

The Chief Officer submitted a Report HSCP 2016/17-02, copies of which had previously been circulated, which summarised the national and local developments in relation to the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 since the May meeting of the Partnership Board. The report advised HSCP Board

members that Ministerial approval had been granted for the revised Scheme of Integration to include the additional Children's Services and Criminal Justice Social Work Services functions delegated to the HSCP.

In particular, the Chief Officer highlighted the following: 2016/17 Financial Allocation to East Dunbartonshire Health & Social Care Partnership; and Health Board Budget Setting.

She further highlighted the Annual Review and NHS Board Meeting with the Cabinet Secretary and Team. NHS Board Members, Corporate Directors and Chief Officers had been invited to a private meeting with the Cabinet Secretary at the conclusion of the public meeting and there had been a commitment from the Cabinet Secretary to meet more regularly with the NHS Board. Discussion had taken place regarding the lack of alignment between the processes and timescales for budget setting between Councils and Health Board and it had been noted that this issue would be looked at. The Chief Officer also highlighted: the Scrutiny of IJBs; Reform Agenda; level of resources allocation; and delayed discharges which were all discussed.

It was noted that CoSLA had agreed to develop a briefing note for elected members who were not members of HSCP Boards. It had been agreed that elected members be provided with a Briefing Note, when it is made available by CoSLA.

The Chief Officer advised that the process for appointing her replacement had been agreed. The date of the interviews had still to be confirmed. Discussion had taken place between the Chief Executives of the Health Board and Council over interim cover arrangements. An officer led process will recommend the appointment of an Interim Chief Officer and the recommendation from this process will be ratified by voting HSCP Board members at the meeting of the Board on 6th October 2016.

There followed discussion, during the course of which the Chief Officer confirmed that the IJB had no capital funding or assets. Both the Health Board and Council retained responsibility and liability for their own respective premises. If the HSCP, through its strategic planning process, identifies a business requirement for capital investment then a business case would be developed to seek capital funding via one or both of the constituent bodies.

Following further consideration, the Board:

a) welcomed the Ministerial Approval for the Revised Scheme of Integration, granted on 5th July 2016;

b) noted the letter from NHS GGC to the Chief Officer confirming the Health Board approval of the 2016/17 financial plan and the opening NHS budgets for 2016/17 allocated to East Dunbartonshire HSCP;

c) noted the updates on local integration progress; and

d) noted the updates on national guidance issued and the requests for information from Scottish Government.

3a. 2015/16 FINANCIAL ACCOUNT S FOR THE HSCP BOARD

Report HSCP 2016/17-03(i) by the Chief Finance and Resources Officer, copies of which had previously been circulated, presented to the Board the Unaudited Accounts for the East Dunbartonshire Health and Social Care Partnership for the period from the 3rd September 2015 – 31st March 2016. The Accounts were contained as Appendix 1 to the Report.

The Chief Finance and Resources Officer provided further detail on the content of the Report. It was noted that the finalised accounts would be submitted to the Audit Committee at the end of September and that, currently, officers were working with the Auditors. Comments had been made and these had been incorporated in the accounts appended to the Report. It was also noted that the accounts were for a partial year from 3 September onwards.

There then followed discussion during the course of which the Chief Finance and Resources Officer confirmed that there would be discussion regarding Financial planning and a reserves budget.

Councillor Geekie identified that there was a half our presentation/workshop on the budget arranged as part of the HSCP Board Development session arranged for the 18th August and encouraged board members to attend.

Following further consideration, the Board:

a) noted the unaudited accounts for 2015/16; and

b) noted the financial position for the HSCP and agreed to maintain the carry forward balance as a reserve to meet priorities set out in the Strategic Plan and provide resilience for future financial challenges.

3b. FORECAST OUTTURN HSCP BUDGETS 2016/17 (ADULT SERVICES) AT MONTH 3

Report HSCP 2016/17-03(ii) by the Chief Finance & Resources Officer, copies of which had previously been circulated, updated the Board on the projected financial outturn for the Health & Social Care Partnership for 2016/17.

The Chief Finance & Resources Officer provided further detail on the content of the Report and steps being taken to identify recurrent savings/solutions. Any proposals would require to be considered by the Partnership Board and Health Board.

Following further consideration, the Board noted the projected outturn position for the HSCP for 2016/17 and that uncertainty existed in both funding and operational costs of demand sensitive areas.

4. DELAYED DISCHARGES PERFORMANCE UPDATE

The Head of Adult & Primary Care Services presented Report HSCP 2016/17-04, copies of which had previously been circulated, advising the Board on the progress being made in relation to the Delayed Discharges Action Plan.

The Head of Adult & Primary Care Services advised that Appendix 1 formed part of a larger report, copies of which could be circulated to members on request. He advised further on the two specific cases contained within the Report, and the progress that had been made, he also highlighted the success of the Power of Attorney Campaign and the Hospital Assessment Team and Care Home pressures. There then followed discussion and it was noted that issues raised were being forwarded to the relevant service as part of the feedback cycle. The Chief Officer advised that, Chief Officers across NHS GGC were in dialogue with the NHS Board about delayed discharge targets and the commissioning of acute unscheduled care by HSCPs. This work is still in early stages and would be further discussed at the NHS Board Whole System Planning meeting on 22 August.

Thereafter the Board noted the contents of the Report.

5. PERFORMANCE REPORT QUARTER 4 (2015-16)

The Planning & Performance Manager submitted Report HSCP 2016/17-05, copies of which had previously been circulated, presenting a summary of the agreed HSCP targets and measures, relating to the delivery of the strategic priorities, for the period January - March 2016 (Quarter 4).

The Planning & Performance Manager advised of a typographical error in respect of Page 1, Paragraph 2.2, which should read "21, 19,4,11 and 2". She was heard further on the content of the Report. She further advised that consideration was being given to revising the Report presentation and that Children and Criminal Justice would be added to future Reports.

There then followed discussion on screening and national media campaigns and whether there was any increase in uptake. It was noted that more people had presented at GPs, however, there was no increase in cancer identification. Councillor Geekie suggested that local publicity be examined in further detail. It was considered that the Mens' Shed Initiative could be a good local opportunity for the promotion of bowel screening.

There also followed full discussion on issues such as delay in submission of consent forms, percentage uptake of bowel screening programme and referral to alcohol and drug treatment during the course of which officers were heard in response to questions.

Following further consideration, the Board noted the content of the performance report and the progress against targets.

6. ED HSCP INTEGRATION SCHEME: DELEGATION, DIRECTION AND STRATEGIC PLANNING OF ADDITIONAL FUNCTIONS AND SERVICES

The Chief Officer submitted Report HSCP 2016/17-06, copies of which had previously been circulated, notifying the HSCP Board of the formal approval of the East Dunbartonshire Health and Social Care Integration Scheme by the Cabinet Secretary for Health and Sport on 5th July 2016 and seeking approval for the commencement of the delegation of the additional functions set out in the Scheme on 11 August 2016, subject to a number of technical processes, as set out in the Report.

During the course of consideration, Councillor Geekie intimated that she wished to record her thanks to Alan Cairns for all his work on the preparation of the Scheme.

Following consideration, the Board agreed to:

a) note the formal approval of a revised Integration Scheme with extended functional scope for the HSCP Board, in areas of NHS Community Children's Services, Social Work Children's Services and Social Work Criminal Justice (Appendix 1);

b) note the separate process of HSCP Board empowerment of these new functions, and agrees an "integration start day" of 11 August 2016;

c) that the overarching Strategic Plan for integrated services pursuant to the delegated functions relating to Health and Social Care Children's Services would be the East Dunbartonshire Children's Services Plan. This plan would be supported by subordinate improvement action plans that will collectively meet the full strategic planning requirements of the Public Bodies (Scotland) (Joint Working) Act 2014;

d) ratify the improvement planning framework that comprises current plans as described at 3.1(c) and detailed in report 2016/17_6, collectively as the HSCP Board's initial Strategic Plan for integrated Health and Social Care Children's Services;

e) ratify the Argyll, Bute and East and West Dunbartonshires' Criminal Justice Social Work Partnership Strategy Map and Operational Action Plan 2014-17 as detailed within Appendix 2, as the HSCP Board's initial Strategic Plan for these delegated functions;

f) direct the Council and Health Board to carry out the new functions delegated to the HSCP Board, in accordance with Section 26 of the Public Bodies (Joint Working) (Scotland) Act 2014, and that these should be delivered in line with the Strategic Plan and pursuant to the functions delegated respectively by them, unless otherwise specified in the Integration Scheme or by subsequent agreement;

g) the financial allocations that accompany its direction to the Parties to deliver services pursuant to the newly delegated functions, would be exactly the same in amount and origin to those that accompany the delegation of functions for 2016/17 by the Parties to the HSCP Board, and that any amendment to these arrangements in subsequent years was carried out in line with the terms of the Report;

h) place the Chief Officer at the disposal of the Chief Executives of the Council and the Health Board to operationally manage these services and the employees engaged in their delivery;

i) request that the Chief Officer work with officers of the Corporate Management Teams of both the Council and the Health Board to establish an arrangement

for the provision of support services in terms as proposed at paragraph 2.13 of the Report;

j) note the Good Practice Guidance on content and practice with respect to IJB statutory direction to constituent bodies at Appendix 3 of the Report and request that a report is brought to a future HSCP Board meeting on proposals for local implementation; and

k) that the incumbent Chief Officer's duties be extended to incorporate these additional functional areas, pending appointment of a new Chief Officer with a suitably amended job description.

7. RATIFICATION OF CURRENT STRATEGIC PLANS FOR EXTENDED FUNCTIONS

The Chief Officer presented Report HSCP 2016/17-07, copies of which had previously been circulated, requesting that the HSCP Board members agree the ratification of current NHS and Social Work Children's Services and Criminal Justice Social Work Plans in order that the HSCP Board would assume responsibility for existing strategic business plans for new areas of functional delegation from 11th August 2016.

It was noted that the existing Plans would be adopted as a starting point. There would be a role for the CPPB in conjunction with the IJB. The Chief Social Work Officer confirmed that he had started the process and draft plans were out for consultation. The plans would be finalised and all plans would be brought together

Following further consideration, during the course of which it was noted that the matter would be reported to the CPPB, the Board:-

a) approved the proposal to assume responsibility for existing strategic business plans for new areas of functional delegation; and

b) instructed the Chief Officer to work with key partners towards the development of new integrated transformational plan(s) for these additional functions.

8. CHILDREN'S HEALTH, CHILDREN'S SOCIAL WORK & CRIMINAL JUSTICE SERVICES OPENING BUDGET 2016/17

Report HSCP 2016/17-08 by the Chief Finance & Resources Officer, copies of which had previously been circulated, presented the opening budget for 2016/17 for Children's Social Work & Criminal Justice Services and Children's Health Services.

The Chief Finance & Resources Officer provided members with further detail on the contents of the Report. She specifically highlighted Paragraph 4.4 which detailed the totality of budgets. She confirmed that that the Criminal Justice budget was ring-fenced. In response to a question from T McAuley, the Chief Finance & Resources Officer confirmed that the integration of children and adult budgets could be looked at as the funding followed the individual concerned from childhood through to adulthood. With reference to Page 159, Criminal Justice Risks, the Chief Finance & Resources Officer advised that these could be in the region of £30,000 to £50,000 and that the scale was not considered as great. There followed discussion on the costs associated with children in secure accommodation and measures that were being taken by all partners to ensure

that all other suitable alternatives were being used where this is possible and ensures the best outcome for the child. With reference to Page 161, recurring solutions, the Chief Finance & Resources Officer advised that they were trying to embed the principles of GIRFEC. It was noted that the North Strathclyde Criminal Justice Authority and Scottish Prisons are represented at the CPPB. The Scottish Government and CoSLA are also working through the implications of the planned changes to Criminal Justice Services.

Following further consideration, the Board noted the opening budget position for Children's Health, Children's Social Work & Criminal Justice Services for the HSCP for 2016/17.

9. REVISIONS TO HEALTH & SOCIAL CARE PARTNERSHIP ADMINISTRATIVE SCHEME - SCHEME OF DELEGATION TO OFFICERS; AND CODE OF CONDUCT FOR MEMBERS OF EAST DUNBARTONSHIRE HSCP BOARD

Report HSCP 2016/17-09 by the Chief Officer, copies of which had previously been circulated, advised the HSCP Board of the potential impact of the revised Integration Scheme on the HSCP's Administrative Scheme, sought approval of matters that required attention and updating and advised advise the HSCP Board that Scottish Government, supported by the Standards Commission, required each IJB to produce their own Code of Conduct and submit this to the Scottish Government for approval.

The Chief Officer confirmed that members would be required to update their register of interests and copies of the form were tabled.

Following consideration, the Board:-

a) approved the revised East Dunbartonshire Code of Conduct and requested that the Chief Officer submit the Code to Scottish Government for approval;

b) to review individual member registration of interests as a consequence of the HSCP Board now assuming delegated responsibility for a range of new functions as set out in the revised Integration Scheme, and to update their annual declaration. Members were asked to raise any such matters directly and individually with the Chief Officer;

c) asked the Chief Officer, after approval was received from Scottish Government, to publish the Code of Conduct for the HSCP Board and the Register of Members' Interests; and

d) to approve the changes proposed for the Scheme of Delegation to Officers.

10. CHIEF SOCIAL WORK OFFICER: GOVERNANCE AND ACCOUNTABILITY PROTOCOL - REVISION AND CONSULTATION

Report HSCP 2016/17-10 by the Chief Officer, copies of which had previously been circulated, requested that the Shadow IJB consider an updated draft Governance and Accountability Protocol that set out the provisions and limitations to permit the Chief Social Work Officer role to operate across the Council and the Health and Social Care Partnership in East Dunbartonshire.

The Chief Social Work Officer provided members with further detail on the report and confirmed that the protocol would be similar to as the one for adults. He highlighted the role of the Chief Social Work Officer, reporting aspect, statutory obligation and Limitations. It was also noted that this paper would be submitted for approval to the Social Work Committee on 1 September 2016.

Following further consideration, the Board considered and commented on the amended draft Chief Social Work Officer Governance and Accountability Protocol set out at Appendix 1 of the Report and agreed that it should be submitted to Social Work Committee for approval.

11. ANNUAL PERFORMANCE REPORT (2015-16)

Report HSCP 2016/17-11 by the Chief Officer, copies of which had previously been circulated, provided the HSCP Board with the Annual Performance Report 2015-16.

The Planning & Performance Manager advised that all HSCPs will be required to produce an Annual Report to be submitted to the Scottish Government for 2016/17, there is no requirement for the East Dunbartonshire HSCP to submit an annual report for 2015/16 as the partnership has not been live for the full year. We have however, developed the report as a learning exercise in preparation for meeting the requirement from 2016/17 onwards and we will provide a copy to Scottish Government colleagues and ask for feedback.

The Planning & Performance Manager provided further detail on the indicators detailed within the Report which covered the period 3 September 2015 to 31 March 2016.

With reference to Page 249, Councillor McNair requested a larger copy of the Locality Boundaries Map. With reference to Page 245, 2.8, it was noted that the data relates to NHS staff only and is collected through the annual NHS Staff Survey. In 2016/17 the NHS annual staff survey is being replaced by the introduction of a team based staff engagement system (iMatter) which we hope to use for both NHS and Social Work staff throughout the HSCP In East Dunbartonshire HSCP the plan is to commence the work on iMatter in November 2016.

Thereafter, the Head of Adult & Primary Care Services provided further detail on the work of the Rapid Assessment Link Team in reducing emergency hospital admissions. The Board noted that there was typographical error in Page 240, Table, Option 2,

Following further consideration, the Board:-

a) noted the content of the Report; and

b) approved the Annual Performance Report 2015-16.

12. STRATEGIC PLAN – ONE YEAR PROGRESS AND UPDATE 2016/17

Report HSCP 2016/17-12 by the Chief Officer, copies of which had previously been circulated, provided the HSCP Board with two reports that, together, provide a comprehensive description of the Year 1 progress achieved against the agreed priorities

set out in the East Dunbartonshire Strategic Plan 2015-18, and the proposed priorities for 2016-17.

The Planning & Performance Manager provided information on the Report and highlighted that Appendix 1 set out progress for 2015/16 and Appendix 2 set out priorities for 2016/17.

There followed discussion during the course of which it was noted that, as a result of the timescale for preparing the Report, the 2016/17 priorities were light in detail in respect of Children's Services and Criminal Justice because formal ministerial approval for the delegation of these functions was not granted until 5th July 2016. The Chief Social Work Officer confirmed that work was already progressing to augment these sections. Councillor Geekie requested that an updated report be brought back to the next meeting of the Board. The Chief Social Work Officer confirmed that he could submit a draft copy to the next meeting. There followed discussion on the Place Projects and it was agreed that further detail be included within the priorities for 2016/17. The Board also discussed the provision of new care homes in Lennoxtown and Milngavie & Bearsden and the potential impact on GP workload and the steps that care home managers could take to mitigate the impact by training staff to address specific needs. It was also highlighted that the Plan should recognise the strength and diversity of the voluntary sector.

Following further consideration, the Board:

a) noted the content of the Strategic Commissioning Plan Progress Report; and

b) approved the HSCP priorities for 2016-17.

13. STRATEGIC ACUTE SERVICE PLANNING

Report HSCP 2016/17-13 by the Chief Officer, copies of which had previously been circulated, allowed early consideration of NHS GGC Board's proposed approach, how the IJB wishes to engage in the proposed process and proposed a response to the NHS Board's request that early engagement in the process be established through the HSCPs patient and public engagement arrangements.

The Chief Officer advised that the Board was getting early sight of the proposals and an update report was being submitted to the Health Board on Tuesday. Councillor Geekie confirmed that members would be provided with regular feedback on the proposals.

Following further consideration, the Board:-

a) considered and approved the process proposed by NHS Greater Glasgow and Clyde to develop a strategic plan for acute services; and

b) considered and approved the approach to engage with the HSCP.

14. HSCP COMPLAINTS PROCEDURE

Report HSCP 2016/17-14 by the Chief Officer, copies of which had previously been circulated, provided the Board with a copy of the integrated Health & Social Care Partnership (HSCP) Complaints Procedure that covered confidentiality, anonymity and

data protection; complaint handling; detailed algorithm and tools; and learning from complaints.

The Board noted that the procedure would create a single pathway for complaints, process and point of response. Staff would be provided with one document and user would be provided with a single leaflet. Councillor Geekie requested that a report on complaints be submitted to the Board. The Chief Officer confirmed that that it was intended to report twice per year as part of clinical and care governance reports to the Board.

Following further consideration, the Board considered and approved the HSCP Complaints Procedure.

15. HSCP MANAGEMENT STRUCTURE PROGRESS REPORT

Report HSCP 2016/17-15 by the Chief Officer, copies of which had previously been circulated, provided an update to the HSCP Board on progress in taking forward phase 2 of the Senior Management Structure for the HSCP.

The Chief Officer advised that this was an update on the top level management structure. It did not included Children's Services and Community Justice and it was noted that the matter was being taken forward by appropriate officers of the Health Board and Council. With regards to the roles detailed within the Report it was noted that matters were being progressed quickly and that Trades Unions were also involved in the process. In response to a question form Councillor McNair, the Chief Officer advised that the process would be cost neutral or better. The Chief Officer and Head of Adult and Primary Care Services provided further detail on the recruitment process. There was still work to be done before Tier 3 posts were considered and there would be on-going engagement with NHS and Council Trades Unions.

Following further consideration, the Board approved Phase 2 of the Senior Management Structure.

16. AUDIT COMMITTEE – REVISED TERMS OF REFERENCE

Report HSCP 2016/17-16 by the Chief Officer, copies of which had previously been circulated, sought approval for the terms of reference for the Audit Committee for the East Dunbartonshire Health & Social Care Partnership.

Following consideration, the Board approved the revised Terms of Reference for the Audit Committee.

17. EAST DUNBARTONSHIRE HSCP FINANCIAL RESERVES POLICY

Report HSCP 2016/17-17 by the Chief Officer, copies of which had previously been circulated, sought approval for the Reserves Policy for the HSCP.

Following consideration, the Board approved the Reserves Policy attached as Appendix 1 of the Report.

18. UPDATE REPORT ON IMPLEMENTATION OF THE LIVING WAGE

Report HSCP 2016/17-18 by the Chief Finance & Resources Officer, copies of which had previously been circulated, updated the Board on the implementation of the Living Wage commitment to all care workers in adult social care from the 1st October 2016.

The Chief Finance & Resources Officer provided further detail on the Report. She highlighted the timescales and Scottish Government contribution detailed within Paragraph 2.2. She also highlighted the collaborative approach and good practice. In response to a question from Councillor Geekie regarding the implications for next year, the Chief Finance & Resources Officer confirmed there would be pressures. Any full year effect pressures will be quantified once local implementation has been completed.

Following further consideration, the Board noted the updated position regarding implementation of the Living Wage locally.

19. ALCOHOL AND DRUG PARTNERSHIP UPDATE REPORT

Report HSCP 2016/17-19 by the Chief Officer, copies of which had previously been circulated, updated the Board on actions taken by the Alcohol and Drug Partnership to take forward recently agreed reductions in its budgetary allocation from the Scottish Government.

The Head of Adult & Primary Care Services provided further detail on the Report. He highlighted the budget reductions detailed within Paragraph 4.1 and advised that there had been engagements with all the Organisations. With regard to ARC, meetings were going forward with regard to the decommissioning proposal. Councillor Geekie advised that she had offered to meet with ARC to discuss ways of finding alternative sources of support for ARC's clients. The Head of Adult & Primary Care Services advised that a Technical Note was being prepared which would update elected members on progress.

Following further consideration, the Board noted the content of the Report.

20. UPDATE ON INTERMEDIATE CARE

Report HSCP 2016/17-20 by the Chief Officer, copies of which had previously been circulated, updated the HSCP Board on the service developments of an intermediate care facility within East Dunbartonshire.

The Head of Adult & Primary Care Services provided members with further detail on the pilot and the contents of the Report and appendices. He confirmed that he had been in discussion with GPs. There then followed discussion at the conclusion of which Councillor Geekie advised that there would further reports to the Board.

Following further consideration, the Board noted the content of the Report

21. MENTAL WELFARE COMMISSION REPORT ON EMERGENCY DETENTION CERTIFICATES

Report HSCP 2016/17-21 by the Chief Officer, copies of which had previously been circulated, advised the HSCP Board of a recent report by the Mental Welfare

Commission (MWC) which highlighted the growing numbers of Emergency Detention Certificates issued without the consent of a Mental Health Office (MHO) and its implications for the partnership.

The Head of Adult & Primary Care Services highlighted the findings of the MWC investigation. He confirmed that there had been no incidents within East Dunbartonshire of patients detained without MHO involvement. He also highlighted the local problems with retaining trained Mental Health Officers.

Following further consideration, the Board:-

a) noted the content of the Report and Appendices; and

b) requested that HSCP officers work with Council officers develop a strategic MHO Recruitment and Retention plan.

22. COMMUNICATIONS OBJECTIVE CREATING A BRAND

Report HSCP 2016/17-22 by the Communications Adviser, copies of which had previously been circulated, sought approval for the branding that would be used to identify the East Dunbartonshire Health and Social Care Partnership (HSCP).

There followed discussion on the examples of potential branding as detailed within the report. Of those representing the user and carer groups, they confirmed that they had been asked indicate a preference from the final designs. During further consideration, members expressed the view that were looking for a logo that represented the different organisations coming together to provide integrated, person centred services.

Following consideration, the Board agreed that that more ideas be produced and submitted to the Board for initial consideration. Thereafter the designs would be the subject of wider consultation.

23. PAG MINUTES – 16TH DECEMBER 2015 AND 16TH MARCH 2016

Following consideration, the Board note the contents of the minutes.

24. DRAFT MINUTE OF THE HSCP AUDIT COMMITTEE – 20TH JUNE 2016

Following consideration, the Board note the contents of the minute.

25. HSCP BOARD DEVELOPMENT UPDATE

Following consideration, the Board noted the Programme for the Development Sessions on 18th August and 5th October 2016.

Councillor Geekie suggested that other possible visits include the respite provision in Bishopbriggs and Twechar, the Children's Unit at Ferndale and the Tilly Care Flat.

26. HSCP RECORDS MANAGEMENT PLAN

Report HSCP 2016/17-26 by the Chief Officer, copies of which had previously been circulated, provided the HSCP Board with an update on the future arrangements required in relation to the development of an ED HSCP Records Management Plan.

The Chief Officer confirmed that a further Report would come to the Board.

Following consideration, the Board noted the contents of the Report and the timeframes applicable for the implementation of the actions which would be informed by National Records Scotland.

27. DATE OF NEXT MEETING – 6TH OCTOBER 2016, 9.30 – 12.30

The Board noted that the next meeting would be held on Thursday, 6 October 2016 at 9.30 am and be held within the Committee Room at the Corporate & Civic Headquarters, 12 Strathklvin Place, Kirkintilloch.

The Board also noted that the topic of the presentation would be "Understanding the additional scope of HSCP services, NHS, Children &Families, Children's Social Work & Criminal Justice Social Work"

28. DATE OF HALF DAY SEMINAR – 18TH AUGUST 2016, 9.30 – 12.30

The Board noted that a half day Seminar would be held on Thursday, 18 December 2016 between 9.30 am and 12.30 pm and be held within the Seminar Room 3, ACH Stobhill and the subject would be "Improving the understanding of assessing continuous improvement, performance management systems and performance data."

29. VALEDICTORY REMARKS

Councillor Geekie advised that Trisha McAuley and Ross Finnie will be replaced as Non-Executive Board Members on the Health & Social Care Partnership Board with effect from 1st September 2016. She thanked them for their valuable contribution to the Board.

Councillor Geekie also advised that this was Karen Murray's last meeting of the Board. She wished Karen all the best for the future and recognised her contribution to East Dunbartonshire, the IJB and the Community Planning Partnership Board (CPPB).

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 2

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**6th October 2016**
Report Number	**2016/17_ 02**
Subject Title	**Chief Officer Update Report**
Report By	**Karen Murray, Chief Officer East Dunbartonshire Health and Social Care Partnership**
Contact Officer	**Karen Murray, Chief Officer** **East Dunbartonshire Health and Social Care Partnership** **0141 201 4212** **Karen.Murray@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 This is the highlight report to the Health and Social Care Partnership Board on national and local developments in respect of integration of health and social care since the August meeting of the Board. This month the report advises on;

- Changes to the NHS Non Executive Director membership of the HSCP Board;
- Confirmation of arrangements for NHS Non Executive substitute members and proxy voting for HSCP Board meetings;
- Advises of the appointment of an Interim Chief Officer, subject to ratification by the HSCP Board;
- Advises of the appointment of the new Chief Executive and Chair for the national body, Community Justice Scotland;
- Requests HSCP Board members complete and return their updated Register of Interests forms as soon as possible;
- Updates members on requests for information and national publications received by the HSCP.

2.0 SUMMARY

National Update

2.1 There has been significant activity nationally in respect of the Scottish Government and CoSLA requesting information on progress with the implementation of the Living Wage from 1st October 2016.

2.2 Scottish Care and CoSLA have published the results of two surveys undertaken to gather information on the experiences of independent sector providers and HSCP Chief Officers in respect of the National Care Home Contract.

2.3 The Care Inspectorate issued a summary report to each local authority area on the social work activity and spend for the years 2006/7 to 2014/15. These reports were previously provided by the Office of the Chief Social Work Adviser, this is the first time the Care Inspectorate has published this information.

2.4 The Health and Sport Committee issued to all HSCPs a survey requesting information on three key areas in relation to integration authorities:

- Budget setting
- Delayed Discharges
- Social and community care workforce

Local Update

2.5 The Chairman of NHS GGC Board wrote to the HSCP Chair on 11th August to advise of the changes to NHS Non Executive Director HSCP Board membership with effect from 1st September 2016. A copy of the letter is attached as an appendix.

2.6 Paul Cannon, Deputy Head of Administration for NHS GGC wrote to HSCPs on 26th August to confirm the arrangements that have been put in place from 1st September 2016 in relation to NHS Board Non Executive Director substitute members and proxy voting for HSCP board members. A copy of the correspondence is attached as an appendix.

2.7 Report 2016/17_13, Strategic Acute Service Planning, presented at the August 11th meeting of the HSCP Board advised that an updated report was to be presented at the NHS GGC Board meeting on 16th August. A paper on the proposed next steps, following the NHS Board meeting is attached as an appendix to update HSCP Board members and advise there needs to be further work undertaken on agreeing the role of HSCPs in the strategic planning for acute services.

2.8 Report 2016/17_14 on the board agenda provides an update on progress with implementation of the Phase 2 HSCP management structure, agreed at the last HSCP Board meeting.

2.9 Report 2016/17-06 advises of the appointment of an Interim Chief Officer, by secondment, for ratification by the Board at today's meeting. This secondment is to cover the gap until the substantive vacancy for the Chief Officer is filled, following interviews held on 3rd October 2016. An update on the outcome from the substantive recruitment process will be provided at the meeting.

3.0 RECOMMENDATIONS

3.1 The HSCP Board are asked

a) to ratify the appointment of James Hobson as Interim Chief Officer;
b) to note the contents of the report;
c) to return updated and completed register of interest forms to the HSCP Head of Administration as soon as possible;
d) to note that any issues arising from discussion of the Chief Officer's report will be progressed by the Interim Chief Officer.

4.0 MAIN REPORT

4.1 The Health and Sport Committee survey response, submitted by East Dunbartonshire HSCP is attached for information. The response provides the detail of 2016/17 budget allocations provided by the Health Board and the Council and the amount allocated as a notional set aside budget for acute hospital care. The response also provides the detail of how East Dunbartonshire HSCP's share of the £250M allocated for adult social care will be utilised in 2016/17. Our response also highlights the challenges experienced during the budget setting processes for 2016/17 and our responses to these challenges. The response provides three examples of how we expect integration to facilitate shifts in use of resource over the period of the Strategic Plan. Our response highlights the addition of Children's Services and Criminal Justice Social Work as delegated functions to the HSCP during 2016/17. The response also provides the detail of the indicators we have adopted to monitor performance against the nine national outcomes and detailed responses to specific questions asked by the Health and Sport Committee in respect of delayed discharges.

The response submitted from East Dunbartonshire is attached as **Appendix 1.** The Health and Sport Committee Chair, Neil Findlay MSP passed on his and the Committee's appreciation and thanks to Chief Officers across Scotland for a 100% response to the questionnaire.

4.2 Both CoSLA and Scottish Government continue to request information on progress in each HSCP area on the implementation of the Living Wage from 1st October 2016. An update paper on local progress has been provided by the Chief Finance Officer for the HSCP Board. The most recent correspondence from Scottish Government is attached at **Appendix 2.** Feedback from Chief Officers to Scottish Government is likely to reflect the challenge of being able to reach agreement with all local providers to ensure implementation is achieved by 1st October 2016.

4.3 The Care Inspectorate have issued a summary report to each Local Authority area which describes Social Work activity and expenditure from 2005/06 to 2014/15. The report is attached for information at **Appendix 3**. The report shows a shift in spend nationally from older people's services to children's services. In East Dunbartonshire the shift has been from children's services into adult services, particularly in to older people's services, which might be expected because of our demographic profile. The report shows East Dunbartonshire "mid table" when comparing total gross social work spend per head of population in 2015/16 across Scotland. East Dunbartonshire has maintained a lower rate of children looked after away from home than the rate for Scotland over the period of the report. The report also shows East Dunbartonshire spends £2071 per head of population on older people's services in 2014/15, compared to a national spend per head of £1853. The report identifies that East Dunbartonshire has moved from a rate of 35.1 per 1000 of the population aged 65+ in 2005/2006 to 28.3 per 1000 in 2014/15. The average rate in Scotland moved from 38.4 per 1000 to 31.2 per 1000 over the same period. The report shows that in 2014/15 East Dunbartonshire provides the highest rate of home care hours per 1000 population aged 65+ across Scotland. We are also second highest provider of intensive home care (10 hours+ per week). Our rate of older people receiving intensive home care has increased from 8.3 per 1000 population in 2005/06 to 28.4 per 1000 in 2014/15. This report will be useful as a baseline to monitor change over time and the impact of integration on the indicators used in the report.

4.4 Scottish Care and CoSLA have published the results of two surveys undertaken to gather information on the experiences of independent sector providers and HSCP Chief Officers in respect of the National Care Home Contract. The reports were provided to the national Chief Officers Health and Social Care Scotland group and discussed at their August meeting. The reports are provided for information at **Appendix 4.**
The responses from the independent sector provider survey indicated that as many respondents were unhappy with the current contract as the number of respondents happy with the contract. Only 45% of HSCPs responded to the survey (East Dunbartonshire provided a response). Of those who participated 95% indicated that the National Care Home Contract worked well for their area. Both surveys highlighted that respondents consider

funding to be the most significant challenge for the future.

4.5 The Cabinet secretary for Justice announced on 18th September 2016 that two appointments had been made for the new national body, Community Justice Scotland. Karyn McCluskey has been appointed as Chief Executive. Karyn is currently Director of the Scottish Violence Reduction Unit. Jean Couper has been appointed as Chair of the new national body from Jean Couper has extensive governance experience and has contributed to the efficient and accessible operation of Scotland's justice system in senior non-executive roles. She has held a number of Board appointments in the Public, Private and Voluntary sectors and has been awarded a CBE in June 2006 for services to the administration of justice.

4.6 The NHS Board undertook a review of the membership of the NHS Board Standing Committees and HSCPs as a result of the establishment of two new NHS Board Standing Committees and to take account of the appointment of eight new Non Executive members who joined the Board from 1st July 2016. A copy of the letter from the NHS Board Chair to the HSCP Board Chair is attached at **Appendix 5** and provides the details of the new members. The letter also advises that each HSCP has appointed a Non Executive Lead to the HSCP Board and a Deputy.

4.7 Paul Cannon, Deputy Head of Administration for the NHS Board wrote to HSCP Non Executive members on 26th August to confirm the arrangements for substitute members and proxy voting for HSCP Board meetings. A copy of the correspondence is attached at **Appendix 6.**

4.8 Report 2016/17_13 Strategic Acute Service Planning was presented at the HSCP Board meeting on 11th August and the report advised that a further report was to be considered at the NHS Board meeting held on 16th August 2016. The paper presented to the NHS Board on 16th August is attached at **Appendix 7** to update HSCP Board members on the proposed next steps. You will see from the paper that there are several strands of work that will require significant engagement and collaboration with and between HSCPs and Acute Service planning staff. The paper highlights that there is further work to be done to agree the processes which require HSCP leadership or involvement.

4.9 Report 2016/17_06 advises the HSCP Board of the appointment of an Interim Chief Officer for the HSCP and requests ratification of the appointment by voting members at today's HSCP Board meeting. The interim appointment has been made to ensure there is Chief Officer cover until the appointment process for the substantive vacancy can be completed and the selected candidate takes up post. The Chair of the HSCP Board will provide an update on the progress with the substantive recruitment process.

Chief Officer report – appendix 1

Health and Sport Committee Integration Authorities Survey 2016

Integration authorities will be a key area of interest for the Health and Sport Committee over the course of the five year parliamentary session. The Committee has recently agreed its work programme for autumn 2016. The Committee is keen to explore three key areas in relation to integration authorities:

- Budget setting
- Delayed discharges
- Social and community care workforce

The following questions are designed to allow the Committee to understand each of these aspects. Integration authorities are encouraged to supplement answers to increase committee understanding. The Committee will follow up answers which are unclear.

It would be much appreciated if your integration authority could respond to the questions detailed in this survey by **Wednesday 17 August 2016**. Please can responses be emailed to **HealthandSport@parliament.scot.**

If you require any further information regarding this survey please contact:

Rebecca Macfie, Senior Assistant Clerk, Health and Sport Committee, Tel: 0131 348 5247 rebecca.macfie@parliament.scot

Budget Scrutiny: Integration Authorities

The Committee has chosen to consider the integration of health and social care as part of its consideration of the Scottish Government's budget. The following questions are designed to explore the budget setting process for 2016-17 and how budget allocation reflects the priorities set out in the performance framework.

1. Which integration authority are you responding on behalf of?

   East Dunbartonshire Health and Social Care Partnership

2. Please provide details of your 2016-17 budget:

	£m
Health board	78,573,000
Local authority	40,500,000
Set aside budget	16,560,000
Total	135,633,000

3. Please provide a broad breakdown of how your integration authority budget has been allocated across services, compared with the equivalent budgets for 2015-16.

£m	**2015-16***	**2016-17**
Hospital	9,570,000	16,560,000
Community healthcare	13,152,000	35,543,000
Family health services & prescribing	25,355,000	43,030,000
Social care	24,661,000	40,500,000
Total	**72,738,000**	**135,633,000**

**Represents part year only as partnership went live on the 3rd September 2015.*

4. The 2016-17 budget allocated £250m for social care. Please provide details of the amount allocated to your integration authority and how this money has been utilised.

£4.31m

50% of the funding is to be utilised to fund the implementation of the Living Wage in line with Scottish Government commitment to the living wage being paid to care staff in care homes, care at home providers and housing support for Adult social care services. The remaining 50% is allocated to Adult services to fund social care "growth" in respect of current social care cost pressures, (ie pay and increments, contract prices) non-residential charging thresholds to raise the buffer from 16.5% to 25%, additional care places, increase in costs for National Care Home Contract.

Budget setting process

5. Please describe any particular challenges you faced in agreeing your budget for 2016-17
   - Differences in timescales for setting respective partnership budgets – LA set their budget by 31st March and Health Board did not set their budget until 28 June.
   - Ambiguity in budget savings allocations from parent bodies and the share for the partnership.
   - Delays in SG spending review had an impact on Council budget setting timescales, not known until March.
   - The legislation provides that "money loses its identity" in delivery of priorities set out in the strategic plan, however the SG spending review process undermines this intent by ring-fencing monies such as the £250m to Adult social care services only.
   - SG reductions in bundled funding to Health Boards impact on Alcohol and Drug Partnerships (ADP) as Health Board finances in 16/17 will not allow for ADP bundled funding to be supplemented from mainstream allocations to Health Boards without this impacting on other critical services
   - HSCP need absolute autonomy to agree funding allocation. In the early years there is a general lack of understanding across the board which requires wider awareness raising.
   - Partnership going live part way through the year.

6. In respect of any challenges detailed above, can you describe the measures you have put in place to address these challenges in subsequent years?
   - Earlier discussion and indicative budgets to be provided at an earlier stage to support partnership financial planning – this is outwith the control of the HSCP
   - The legislation provides that "money loses its identity" in delivery of priorities set out in the strategic plan, however the SG spending review process undermines this intent by ring-fencing monies such as the £250m to Adult services only .
   - Reliance on Audit Scotland and wider body of knowledge for shared learning to support implementation.

7. When was your budget for 2016-17 finalised?
   28th June 2016

8. When would you anticipate finalising your budget for 2017-18?

   End June 2017 – will get indicative budgets earlier but reliant on NHS Board approval timescales.

Integration outcomes

9. Please provide up to three examples of how you would intend to shift resources as a result of integration over the period of your Strategic Plan:

   - Delayed Discharges – reduce use of acute services and invest more into intermediate care models within the community
   - Increase in investment in community nursing which allows older people to die in their own homes as opposed to a hospital setting.
   - Local Enhanced Services (LES) for primary care which increases funding to GP's to better support care homes to maintain individuals in a homely setting, preventing admission to hospital.

10. What efficiency savings do you plan to deliver in 2016-17?

    £1.3m in community based health services. Still awaiting allocation from Council towards procurement and efficiencies in resourcing staffing.

11. Do you anticipate any further delegation of functions to the integration authority? (If so, please provide details of which services and anticipated timescales)

    Yes – the original Scheme of Integration approved for adult services in July 2015 has been revised to include the delegation of NHS Children's Services and Children's Social Work & Criminal Justice functions and services. The revised Scheme of Integration received Ministerial Approval on 5th July 2016 and the additional delegated functions will be implemented following the HSCP Board meeting on the 11th August 2016.

Performance framework

12. (a) Please provide details of the indicators that you will use to monitor performance and show how these link to the nine national outcomes

(b) If possible, also show how your budget links to these outcomes

National Outcome	Indicators	2016-17 budget
People are able to look after and improve their own health and wellbeing and live in good health for longer.	Number of successful smoking quits at 12 weeks in 40% most deprived areas	
	Percentage of respondents receiving intervention from the Alcohol & Drug Service, who indicated an increase in their well-being as a result of their treatment, care and recovery	
	Number of alcohol brief interventions delivered	
	drug related deaths (per 100,000 pop)	
	alcohol related deaths (per 100,000 pop)	
	Percentage of clients will wait no longer than 3 weeks from referral to alcohol treatment	
	Uptake of Cancer Screening Programmes: Bowel	
	Percentage uptake of Bowel screening SIMD 1	
	Uptake of Cancer Screening Programmes: Cervical	
	Update of Cancer Screening Programmes: Cervical SIMD 1	
	Percentage uptake of Cancer Screening: Breast	
	GP 48hr Access	

National Outcome	Indicators	2016-17 budget
	GP Advance Booking	
People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	Number of rapid response referrals from GP to RR Team and GP to Homecare	
	Number of emergency admissions 75+ rate per 1,000 pop	
	Rate of unplanned acute bed days 75+ (per 1,000 pop)	
	Number of emergency admissions 75+ rate (per 1,000 pop)	
	Number of acute bed days lost to delayed discharge	
	Number of delayed discharges for Adults with Incapacity (Acute Beds)	
	Reduce bed days consumed by delayed discharge for AWIs (aged 65+)	
	Number of acute bed days lost to delayed discharge (inc AWI)	
	Long Term Conditions - Bed days per 100,000 pop (Total)	
	Number of acute bed days lost to delayed discharges for AWI (65+)	
	Falls rate per 1,000 pop in over 65 years	
	Access to Psychological Therapies: % of patients who started treatments within 18wks of referral	

	Suicide rate (per 100,000 population)	
	Waiting times to PCMHT: Referral to first appointment (4 weeks)	
	Waiting times to PCMHT: referral to treatment (9wks)	
	Rate of alcohol related admissions (per 1,000 pop rolling year)	
	People with a diagnosis of dementia on the QOF Register	
	Number of newly diagnosed people with dementia in receipt of one year's post diagnostic support	
	Number of people 65+ with anticipatory care plans in place	
	GP	
	District Nursing	
	Waiting times between request for a housing adaptation, assessment of need and delivery of any required adaptation	
	Home care costs for people aged 65 or over per hour	
	Self-directed support spend for people aged over 18 as a % of total social work spend on adults	
	Net residential costs per capita per week for Older Adults 65+	
	Percentage of people 65 or over with intensive needs receiving care at home	
	Number of people 75+ with a telecare package	

	Percentage of customers completing re-ablement with a reduction in homecare	
	Number of new permanent admissions to care homes for 65+	
	Number of people aged 65+ in permanent care home placement	
	Number of clients receiving care and repair services 75+	
	The percentage of EDC homecare customers aged 65+ receiving a service during evenings or overnight	
	The percentage of EDC homecare customers aged 65+ receiving a service at weekends	
	As a proportion of home care clients aged 65+, the number receiving personal care	
	The number of homecare hours per 1,000 population age 65+	
	Increase the number of people (65+ per 1,000 population) with high levels of care needs who are cared for at home	

People who use health and social care services have positive experiences of those services, and have their dignity respected.	Percentage of Adults with a direct payment in the month who use this as personal care	
	Percentage of all adults receiving homecare on the last week of the month who receive personal care as part of this service	
	Percentage of customers (65+) meeting the target of 6 weeks from completion of community care assessment to service delivery	
	Percentage of adults needing care receiving personal care at home or direct payments for personal care	
	Percentage of adults satisfied with social care or social work services	
	Percentage aged 18+ receiving personal care at home	
	Numbers receiving self directed support package of a direct payment per 1,000 population 65+	
	The number of homecare hours per 1,000 pop age 65+	
	Percentage of people 65+ indicating satisfaction with their social interaction opportunities	
	Percentage of respondents receiving intervention from the Alcohol and Drug Service, who indicated an increase in their well-being as a result of their treatment, care and recovery	
	Percentage of service users / clients satisfied with the quality of care provided	
	Percentage of adults supported able to look after their health very well or quite well.	

	Percentage of adults supported at home who agree that they are supported to live as independently as possible	
	Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	
	Percentage of adults receiving any care or support who rate it as excellent or good	
	Percentage of social care providers who are compliant with the terms of their contract	
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Percentage of people 65+ indicating satisfaction with their social interaction opportunities	
	Percentage of service users satisfied with their involvement in the design of their care packages	
	Percentage of service users / clients satisfied with the quality of social care provided	
Health and social care services contribute to reducing health inequalities.	Death rates (per 100,000 pop)	

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.	Number of carers who feel supported and capable of continuing in a caring role	
People who use health and social care services are safe from harm.	Percentage of adults supported at home who agreed that they felt safe	
	% of complaints received & responded to within organisational timeframe (currently Health only)	
	Reported Incidents & remedial actions	
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Percentage of sickness / absence	
	Percentage of sickness / absence - Short Term	
	Percentage of sickness / absence - Long Term	
	Percentage of staff with standard induction training completed	
	Percentage of staff with mandatory induction training completed within the deadline	
	Percentage of staff who would recommend their workplace as a good place to work (NHS Staff survey)	
Resources are used effectively and efficiently in the provision of health and social care services.		

Delayed Discharges

In relation to delayed discharge the Committee is interested in three areas. The extent to which the IJB is able to direct spending, how much money is available to tackle delayed discharge and how well it is being spent to eradicate the problem.

1. As an Integrated Authority what responsibility do you have for tackling the issue of delayed discharges?

   The partnership has primary responsibility for tackling delayed discharges.

2. What responsibility do you have for allocating expenditure including additional sums allocated by the Scottish Government to tackle delayed discharges?

   The partnership has primary responsibility for allocating expenditure.

3. How much was spent in 2015-16 on tackling delayed discharges? If necessary this answer can be based on your shadow budget for 2015-16.

   This information is not held in this format across the partnership, however an estimation of the spend within specific budget lines including Social Work assessment, care home, care at home is provided, delayed discharge allocation - £16.9m

4. What is the total funding (in 2016-17) you are directing to address the issue of delayed discharges? Please provide a breakdown of how much money has been received from each of the following for this purpose:

   As above

   a. NHS board £510K
   b. Local authority £17.3m
   c. Other (please specify)

5. How was the additional funding allocated by the Scottish Government to tackle delayed discharges spent in 2015-16? How will the additional funding be spent in the current and next financial years?

   In 2015/16 – funding spent on additional Social Worker capacity to support assessment and discharge and solicitor capacity to support legal processes for adults with incapacity

   In 2016/17 – funding allocated to intermediate care model of care to facilitate early discharge.

6. What impacts has the additional money had on reducing delayed discharges in your area?

   Bed days lost reduced during 2015/16.

7. What do you identify as the main causes of delayed discharges in your area?

   Lack of early referrals from hospital, a lack if an intermediate care model, complexity of care needs for population being discharged from hospital and availability of specialist places within the community to support complex needs.

8. What do you identify as the main barriers to tackling delayed discharges in your area?

   Lack of early referrals from hospital, a lack if an intermediate care model, complexity of care needs for population being discharged from hospital and availability of specialist places within the community to support complex needs.

9. How will these barriers to delayed discharges be tackled by you?

   Development of an intermediate care model, re-engineering homecare, whole system planning across acute and primary care.

10. Does your area use interim care facilities for patients deemed ready for discharge?

    Yes for AWI patients.

11. If you answered yes to question 10, of those discharged from acute services to an interim care facility what is their average length of stay in an interim care facility? Approx. 40 days

12. Some categories of delayed discharges are not captured by the integration indicator for delayed discharges as they are classed as 'complex' reflecting the fact that there are legal processes which are either causing the delay (e.g. application for guardianship orders) or where there are no suitable facilities available in the NHS board area. Please provide the total cost for code 9 delayed discharges for 2015-16? What is your estimate of cost in this area in the current and next financial years? Approx. £60k

Social and Community Care Workforce

In relation to the social and community care workforce the Committee is interested in the recruitment of suitable staff including commissioning from private providers and the quality of care provided.

1. As an Integrated Joint Board what are your responsibilities to ensure there are adequate levels of social and community care staff working with older people?

Responsibility to risk assess and put in place plans to mitigate risks, adhere to care inspectorate ratios and monitor waiting list times and the risks associated with and impact on service delivery.

2. Are there adequate levels of these social and community care staff in your area to ensure the Scottish Government's vision of a shift from hospital based care to community based care for older people is achieved? If not, please indicate in what areas a shortage exists.

No - difficulties recruiting sufficient numbers of band 6 nursing staff, physios, OT's and other AHP's and some geographical issues within homecare.

3. Other than social and community care workforce levels, are there other barriers to moving to a more community based care?

Capital investment in facilities to accommodate more staffing locally, building community capacity, managing expectations and pressures on acute services to effectively support the required change in the model and lack of agreement nationally on the closure of hospital beds to release funding to invest in communities.

4. What are the main barriers to recruitment and retention of social and community care staff working with older people in your area?

Relatively affluent population locally in better paid opportunities out with health and social care sector. Next door to much bigger local authority employers.

5. What mechanisms (in the commissioning process) are in place to ensure that plans for the living wage and career development for social care staff, are being progressed to ensure parity for those employed across local authority, independent and voluntary sectors?

Modern apprentice schemes, provider forums to share good practice and deliver cross sector training, Provider liaison officer, liaison with the care inspectorate supported by a memorandum of understanding.

6. What proportion of the care for older people is provided by externally contracted social and community care staff? 60/40

7. How are contracts monitored **by you** to ensure quality of care and compliance with other terms including remuneration?

Monitoring returns required of all providers, service reviews during lifetime of contract including review of cost breakdown. Comprehensive Contract Management Framework which captures; regular monitoring, audit and service review information - including analysis of individual service budget(s) to help determine on-going compliance

Chief officer report - Appendix 2

Health and Social Care Integration Directorate
Geoff Huggins, Director

T: 0131-244 3210 F: 0131-244-2042
E: geoff.huggins@gov.scot

To: Chief Officers, Integrated Joint Boards

Copy:Living Wage in Care National Partners Group

13 September 2016

Dear Chief Officer

LIVING WAGE

Last week the Scottish Government launched its Programme for Government for 2016/17. The Programme for Government restates the shared commitment to deliver the Living Wage of £8.25 per hour from 1 October to care workers delivering social care services to vulnerable adults.

In introducing the Programme for Government to the Scottish Parliament, the First Minister, Nicola Sturgeon MSP said.

"I am also delighted to confirm that, with effect from the start of next month, all adult social care workers will be paid the real Living Wage."

I spoke with a number of you last week and know that while there continue to be challenges, you are working hard through local negotiations with providers to ensure the commitment is delivered by October the 1st. From a Scottish Government perspective, I am meeting and speaking regularly with colleagues from COSLA, CCPS, Scottish Care and the STUC through the Living Wage in Care National Partners Group to ensure that we collectively have the best knowledge and understanding in respect of progress.

We will continue to have this dialogue with partners but would ask that should you identify significant local challenges to delivering the commitment that you share those with mself or my colleague, Eilidh Smith (Eilidh.smith@gov.scot) and as appropriate Paula at COSLA, at the earliest opportunity.

Geoff Huggins

Geoff Huggins
Director of Health and Social Care Integration

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

αβχδε αβχ α

Next SDT agenda.
Chief officer report appendix 3

McMartin, Geraldine

From: ACraig@careinspectorate.com
Sent: 07 September 2016 11:14
To: gerry.cornes@eastdunbarton.gov.uk
Cc: keith.gardner@eastdunbarton.go.uk; Murray, Karen
Subject: Social Work Expenditure and Activity
Attachments: East Dunbartonshire Council.pdf

Follow Up Flag: Follow up
Flag Status: Flagged

Categories: Print please

Dear Mr Cornes

Summary report on Social Work Spend and Activity for your Local Authority Area - 2006/07 - 2014/15

Please find attached, for information, a summary report on the social work spend and activity for your local authority area for the years 2006/7 to 2014/15. The report also includes information on the national picture.
These reports were previously provided by the Office of the Chief Social Work Adviser, and this is the first time the Care Inspectorate has published this information.

These individual reports enable each area to gain an understanding of their social work spend and activities and of the national picture. All of the data contained in the database is taken from publically available sources such as the annual Local Government Finance Statistics. We have published a Scotland-wide report in the Publications and Statistics section on our website along with the data for each local authority areas which will be published over the course of the next week.

The Care Inspectorate regularly publishes its findings about the availability and quality of care, most recently "Inspecting and improving care and social work in Scotland" and the " Joint Inspections of Services for Adults" and the "Joint Inspection on Services for Children and Young People" which you can find in the publication section of our website:

http://www.careinspectorate.com/index.php/publications-statistics/53-public/reviews
http://www.careinspectorate.com/index.php/publications-statistics/28-inspection-reports-local-authority/inspection-reports-joint-inspections-of-children-s-services
http://cinsp.in/jointinspectionsofadultservices

We welcome your views on this data publication, and on its future given the significant changes in the move to integrated health and care. If you or your staff have any views about the future of this report, please let us know by filling out our short consultation survey here https://www.surveymonkey.co.uk/r/GYK266F

If you have any queries regarding these summary reports please contact :

Ingrid Gilray
Intelligence and Analysis Manager
Analysis and Business Planning
Care Inspectorate
tel: 01382 207179 mob: 07766 133205
email: ingrid.gilray@CareInspectorate.com

Kind regards

Karen Reid

Select Council: East Dunbartonshire

East Dunbartonshire Council

Social Work Expenditure and Activity (2005/06 to 2014/15)

Select Council: East Dunbartonshire

Overall Gross Social Work Spend*

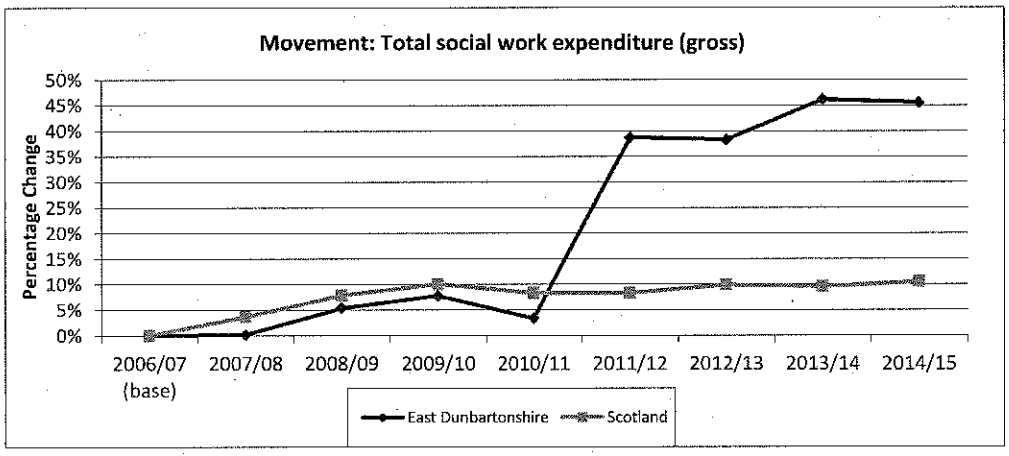
In real terms, spend on social work services in East Dunbartonshire has moved from £53million in 2006/07 to £78million in 2014/15, as shown in Figure 1.

Figure 1

	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
East Dunbartonshire (£'000)	53,432	53,523	56,281	57,577	55,203	74,114	73,868	78,080	77,750
Year on Year Move	-	0%	5%	2%	-4%	34%	0%	6%	0%
Move over the Period	46%								
Scotland (£'000)	3,447,102	3,572,869	3,716,888	3,791,310	3,732,201	3,732,142	3,785,476	3,776,318	3,808,461
Year on Year Move	-	4%	4%	2%	-2%	0%	1%	0%	1%
Move over the Period	10%								

As can be seen from the above, the gross spend on Social Work Services in East Dunbartonshire has moved by 46% over this period, at a time when the total spend across Scotland has moved by 10%. The annual movements are shown at Figure 2.

Figure 2 - East Dunbartonshire and Scotland total social work expenditure



Note:

**The analysis in this document is based on actual (gross) spend data as published by the Scottish Government in the annual 'Local Government Finance Statistics' (based on financial returns made by Local Authorities throughout the financial year).*

Throughout this report, all expenditure figures are expressed in real terms (calculated using the GDP deflator from HM Treasury).

Select Council: East Dunbartonshire

Breakdown of Social Work Spend

East Dunbartonshire's spend shown in Figure 1 above can be further analysed as follows:

Figure 3

	£'000s								
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Total SW Expenditure	**53,432**	**53,523**	**56,281**	**57,577**	**55,203**	**74,114**	**73,868**	**78,080**	**77,750**
Children & Families	**10,885**	**9,555**	**9,500**	**10,894**	**10,276**	**11,529**	**10,353**	**10,649**	**10,189**
All Adults	**41,515**	**42,607**	**42,701**	**42,875**	**43,437**	**61,218**	**62,259**	**66,436**	**67,019**
- Older People	23,391	23,581	24,213	24,525	25,351	36,637	37,443	40,944	44,004
- Learning Disability	10,784	11,147	11,085	11,421	11,052	16,171	15,958	15,903	14,700
- Mental Health	3,063	3,723	3,446	2,897	2,529	3,201	3,095	3,570	3,084
- Other needs*	600	591	676	627	583	888	1,006	1,068	904
- Other Adult Groups*	3,677	3,566	3,282	3,405	3,921	4,322	4,757	4,951	4,328
Miscellaneous	**1,031**	**1,361**	**4,080**	**3,808**	**1,490**	**1,367**	**1,256**	**995**	**542**
- Service Strategy	1,031	1,361	4,074	3,797	1,487	1,360	1,253	992	539
- Children's Panel	0	0	7	11	3	6	3	3	3
- Asylum Seekers	0	0	0	0	0	0	0	0	0

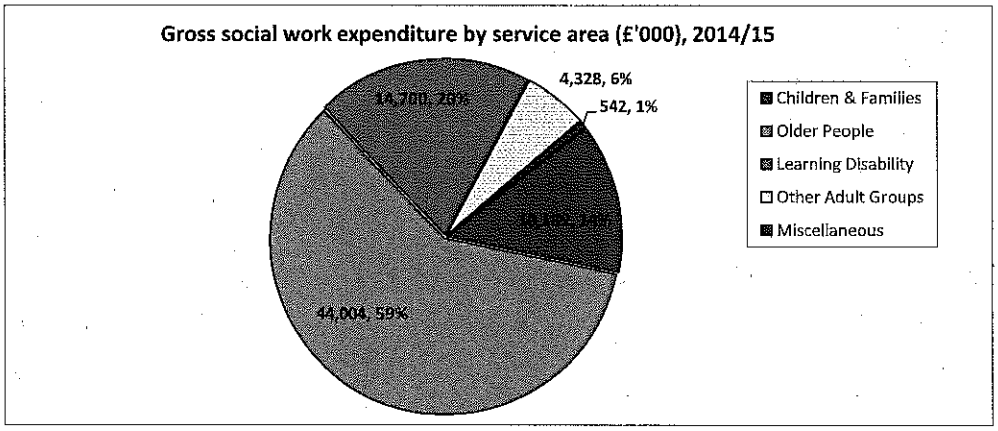
*From 2012/13, Addictions was renamed as "Other needs" and expanded to also include expenditure on HIV/AIDS (moved from "other adult groups") and asylum seekers

Nationally, we have observed a shift in spend from older people's services to childrens services over the period from 2006/07 to 2014/15. The position in East Dunbartonshire is shown below.

Figure 4

	East Dunbartonshire			Scotland		
	2006/07	2014/15	Movement	2006/07	2014/15	Movement
Children's Services	20.4%	13.1%	-7.3	21.3%	22.4%	1.1
All Adults	77.7%	86.2%	8.5	77.6%	76.6%	-1.0
- Older People	43.8%	56.6%	12.8	45.2%	44.5%	-0.7
- Learning Disability	20.2%	18.9%	-1.3	16.8%	17.7%	0.9
- Other Adult Groups	6.9%	5.6%	-1.3	15.6%	14.5%	-1.2

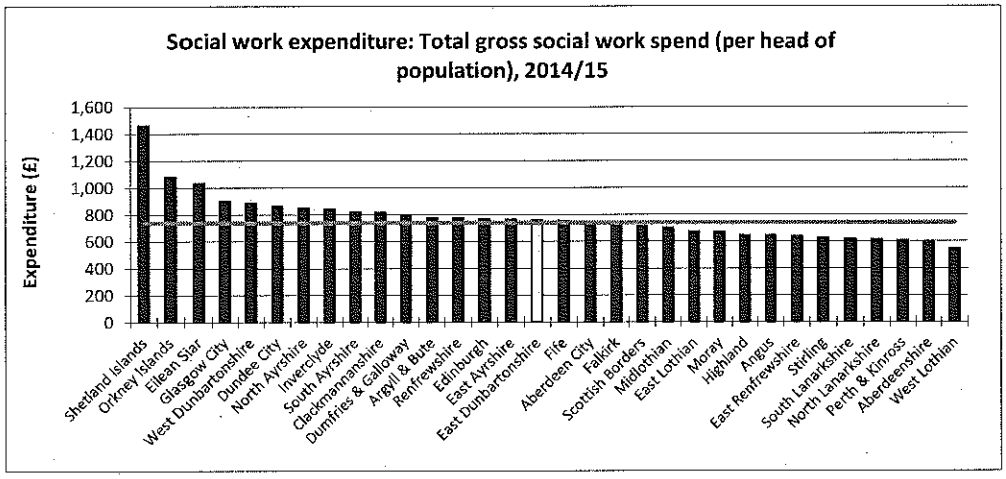
Figure 5- East Dunbartonshire expenditure by service area



Further detail on individual care groups is shown in more detail over the following pages.

Select Council: East Dunbartonshire

Figure 6 - Total social work spend per head across Scotland

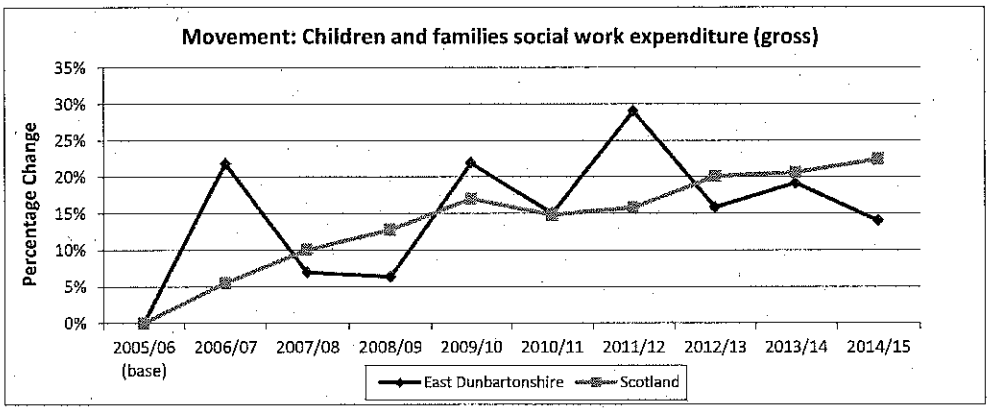


- This spend equates to £754 per head of population in East Dunbartonshire in 2014/15
- The average spend per head nationally in 2014/15 was £738 (represented by the horizontal line)
- The range of spend per head in 2014/15 was £544 to £1463

Select Council: East Dunbartonshire

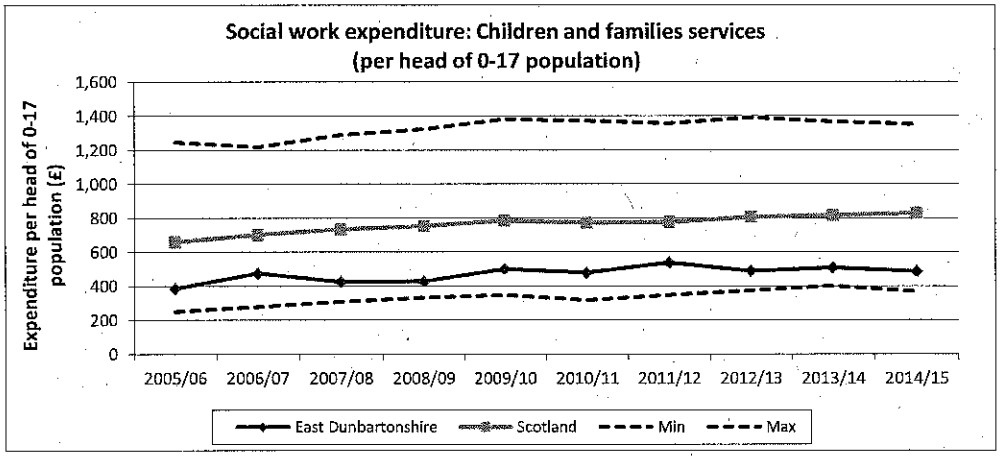
Children and Families (C&F)

Figure 7 - East Dunbartonshire and Scotland's movement in children and families social work expenditure



- Over the period, spend has moved from £8.9 million to £10.6 million (in real terms)
- This represents a move of 14%
- Nationally, spend has moved by 22%
- C&F accounts for 13.1% of council social work spend in 2014/15 (20.4% in 2005/06)
- As a proportion of total spend nationally, C&F accounts for 22.4% (21.3% in 2005/06)

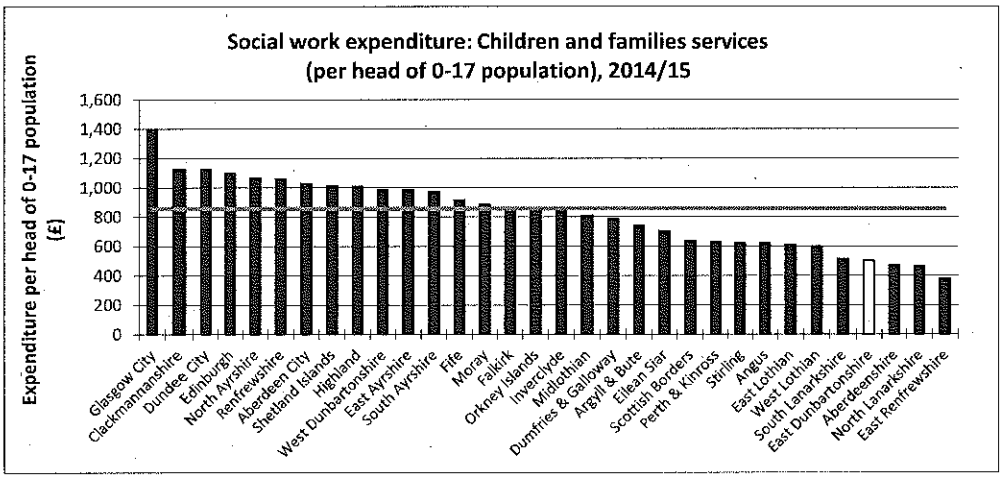
Figure 8 - East Dunbartonshire and Scotland's children and families social work expenditure



- Per head of population aged 0-17 in 2014/15:
  - The spend per head in East Dunbartonshire has moved from £384 to £484
  - The average spend per head across Scotland has moved from £658 to £826

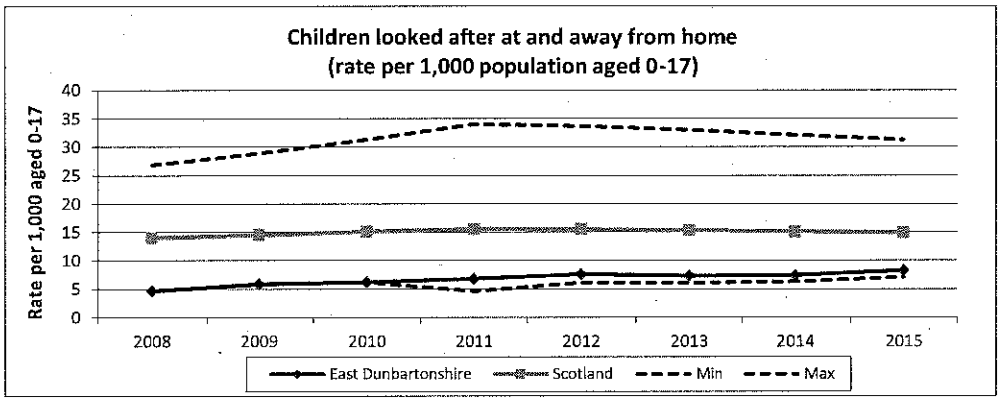
Select Council: East Dunbartonshire

Figure 9 - Children and families social work spend per head across Scotland



- Council spend equates to £501 per head of 0-17 population in 2014/15
- The average spend per head, nationally, in 2014/15 was £856
- The range of spend per head in 2014/15 was £380 to £1397

Figure 10 - East Dunbartonshire and Scotland's rate of children aged 0-17 looked after away from home



- At July 2015 in East Dunbartonshire there was a rate of 8.2 children looked after per 1,000 population aged 0-17

- The average rate, nationally, was 14.9 per 1,000 population aged 0-17
- The rates ranged from 7.0 to 31.2 per 1,000 population aged 0-17 as of July 2015

Select Council: East Dunbartonshire

Figure 11 - East Dunbartonshire's children aged 0-17 looked after away from home (age breakdown)

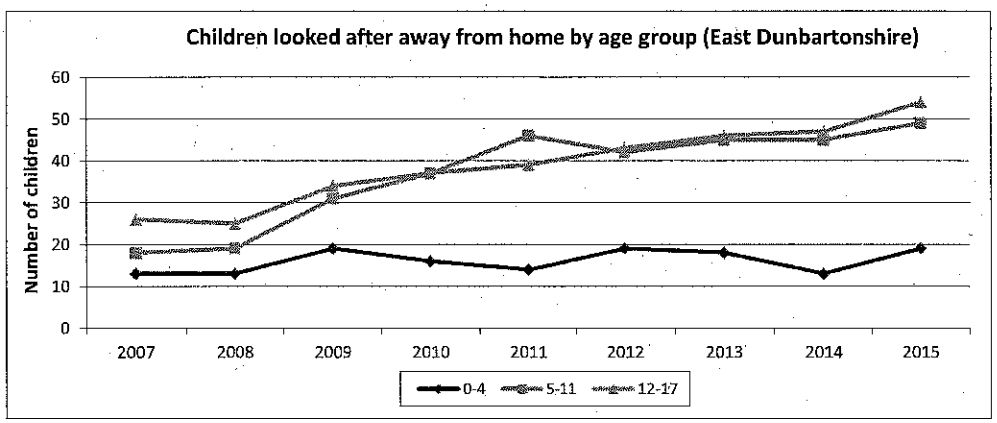
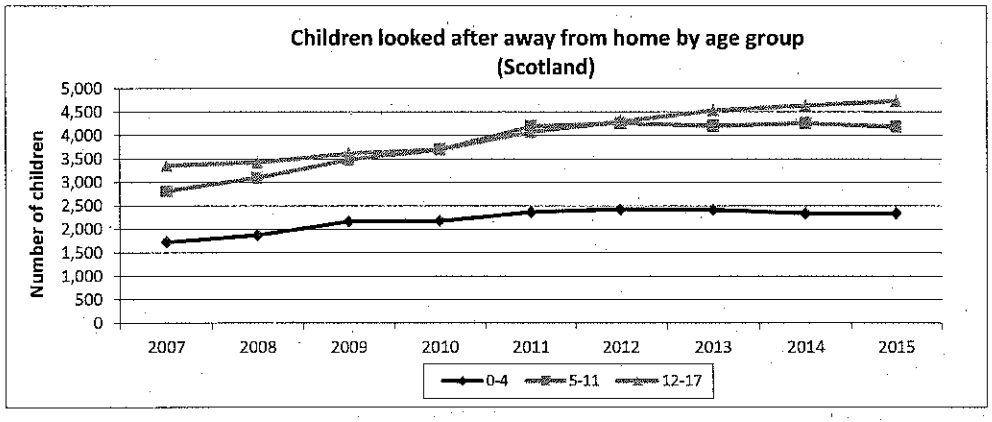


Figure 12 - Scotland's children aged 0-17 looked after away from home (age breakdown)



- At 31 July 2015, in East Dunbartonshire, there were 19 children looked after away from home aged 0-4, this was greater than the 2007 figure of 13 (a change of 46%). In Scotland over the same period there was an increase of 35%

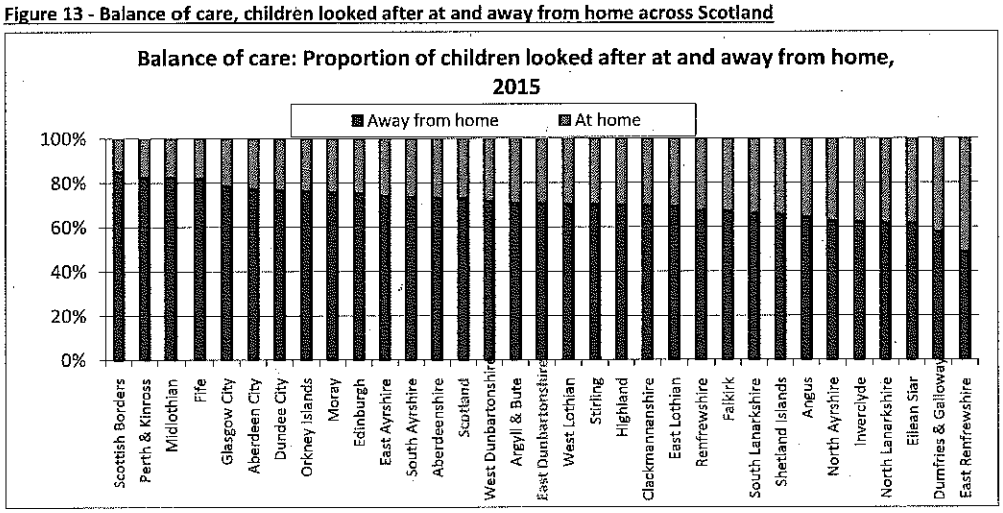
- At 31 July 2015 in East Dunbartonshire there were 49 children looked after away from home aged 5-11, this was greater than the 2007 figure of 18 (a change of 172%). In Scotland over the same period there was an increase of 49%

- At 31 July 2015 in East Dunbartonshire there were 54 children looked after away from home aged 12-17, this was greater than the 2007 figure of 26 (a change of 108%). In Scotland over the same period there was an increase of 41%

Please note that numbers of children looked after away from home in the Island councils and small council areas are based on small numbers and in these areas exercise caution when interpreting percentage changes.

Select Council: East Dunbartonshire

Figure 13 - Balance of care, children looked after at and away from home across Scotland

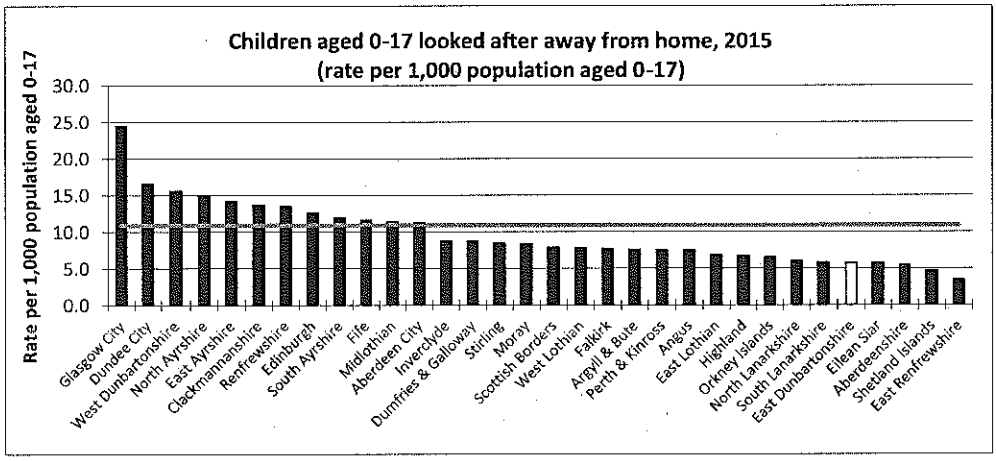


- At July 2015, balance of children looked after at and away from home as a rate per 1,000 population aged 0-17 was as follows:

- In East Dunbartonshire there were 5.8 children looked after away from home per 1,000 which was equal to 71% of children looked after aged 0-17 (in Scotland 73% of children were looked after away from home).

- In East Dunbartonshire there were 2.4 children looked after at home per 1,000 which was equal to 29% of children looked after aged 0-17 (in Scotland 27% of children were looked after at home).

Figure 14 - Rates of children aged 0-17 looked after away from home across Scotland



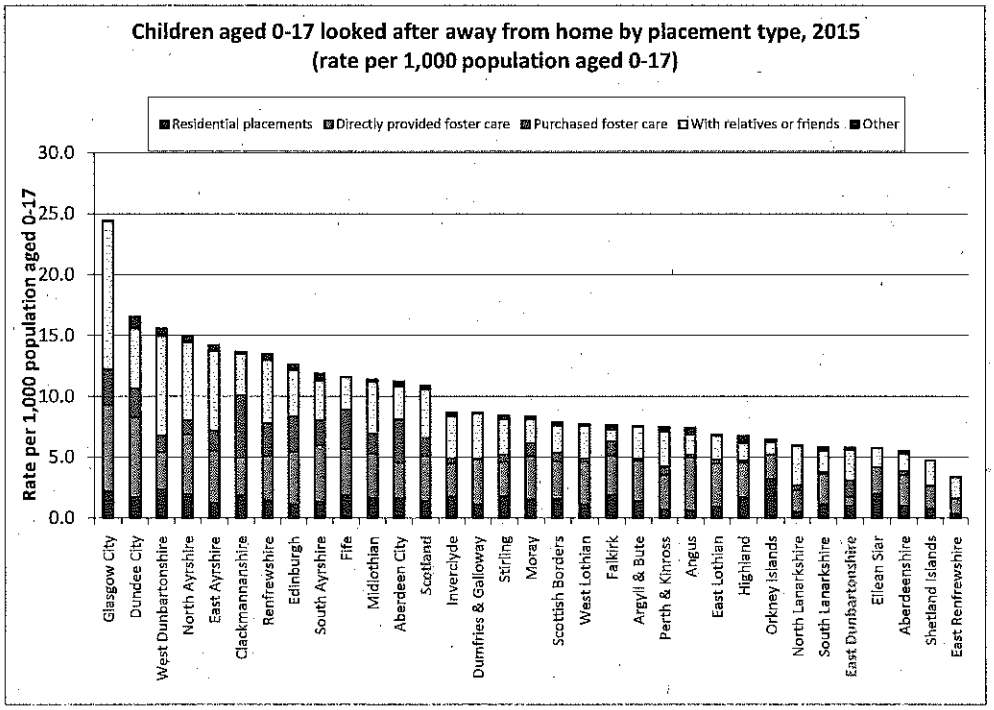
- As of July 2015, in East Dunbartonshire, the rate of children looked after away from home was 5.8 per 1,000 population aged 0-17

- The rate, nationally, of children looked after away from home was 10.9 per 1,000 population aged 0-17 (represented by the horizontal line)

- Rates of children looked after away from home in Scotland ranged from 3.4 to 24.5 per 1,000 population aged 0-17

Select Council: East Dunbartonshire

Figure 15 - Children aged 0-17 looked after away from home by placement type in 2015

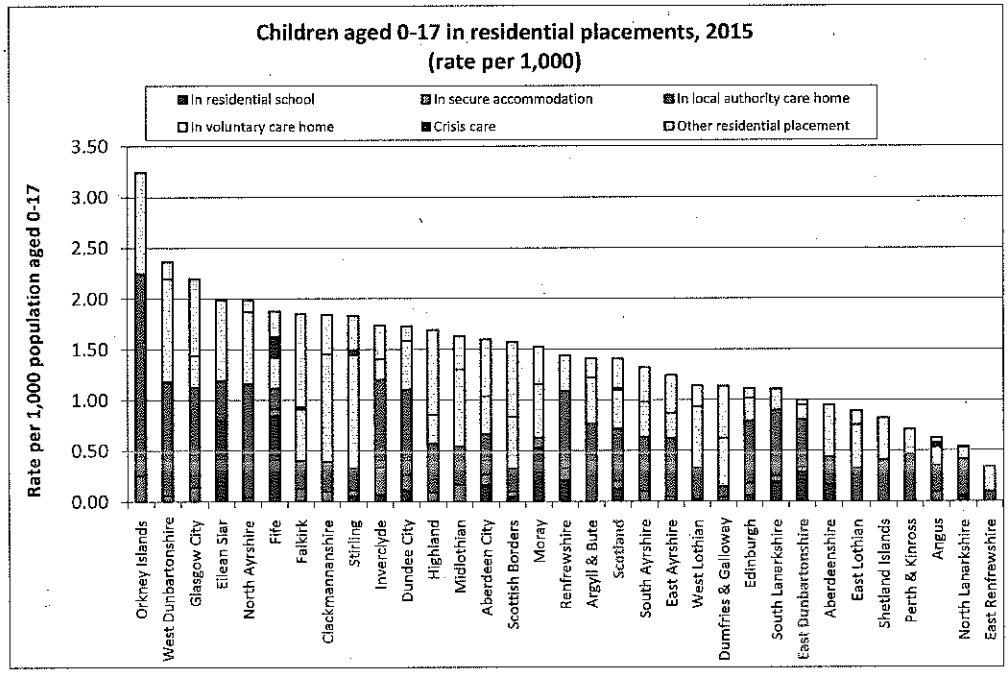


- At July 2015, in East Dunbartonshire, placements for children looked after away from home per 1,000 population aged 0-17 were as follows:
  - 17% (1.0 per 1,000) in residential placements. Scotland's rate was 13% (1.4 per 1,000)
  - 12% (0.7 per 1,000) in directly provided foster care. Scotland's rate was 34% (3.7 per 1,000)
  - 24% (1.4 per 1,000) in directly purchased foster care. Scotland's rate was 14% (1.5 per 1,000)
  - 43% (2.5 per 1,000) with relatives or friends. Scotland's rate was 37% (4.0 per 1,000)
  - 3% (0.2 per 1,000) population in an other placement. Scotland's rate was 3% (0.3 per 1,000)

Note: Other includes with prospective adopters, supported accommodation/semi-independent living, supported tenancy, own tenancy/independent living, hostel, "Leaving Care Services", placed with carers from adult services, and "throughcare and aftercare".

Select Council: East Dunbartonshire

Figure 16 - Breakdown of children looked after in residential placements across Scotland



- At July 2015, in East Dunbartonshire, rates of children looked after aged 0-17 in residential placements per 1,000 population were as follows:
  - 29% (0.29 per 1,000) in residential schools. Scotland's rate was 9% (0.12 per 1,000)
  - 5% (0.05 per 1,000) in secure accommodation. Scotland's rate was 5% (0.08 per 1,000)
  - 48% (0.48 per 1,000) in local authority homes. Scotland's rate was 37% (0.52 per 1,000)
  - 14% (0.14 per 1,000) in voluntary homes. Scotland's rate was 27% (0.38 per 1,000)
  - 0% (0.00 per 1,000) in crisis care. Scotland's rate was 1% (0.02 per 1,000)
  - 5% (0.05 per 1,000) in another residential placement. Scotland's rate was 21% (0.29 per 1,000)

Note: Other residential includes close support unit, intensive support unit, residential units outwith the local authority, homeless unit, private or NHS home, emergency accommodation, hospital, Spark of Genius, Quarriers, residential home, and other specific residential establishments and purchased placements

Select Council: East Dunbartonshire

Older People

Figure 17 - Older people population data - % change 2012-2017 & Projections 2017-2027

Local Authority Area	% change 2012-17 (65-74)	% change 2012-17 (75-84)	% change 2012-17 (85+)	Projection 2017-27 (65-74)	Projection 2017-27 (75-84)	Projection 2017-27 (85+)
Aberdeen City	14%	-1%	18%	17%	28%	27%
Aberdeenshire	17%	13%	17%	11%	45%	52%
Angus	13%	8%	20%	4%	37%	44%
Argyll & Bute	8%	11%	15%	-4%	31%	47%
Clackmannanshire	17%	14%	24%	7%	50%	62%
Dumfries & Galloway	9%	9%	21%	2%	27%	48%
Dundee City	6%	-3%	13%	12%	15%	23%
East Ayrshire	11%	8%	22%	9%	32%	48%
East Dunbartonshire	8%	9%	33%	13%	23%	58%
East Lothian	11%	10%	20%	18%	33%	46%
East Renfrewshire	11%	5%	19%	20%	27%	36%
Edinburgh	15%	0%	14%	19%	31%	25%
Eilean Siar	10%	9%	17%	5%	29%	41%
Falkirk	13%	11%	17%	12%	34%	53%
Fife	13%	9%	14%	7%	39%	46%
Glasgow City	5%	-5%	10%	28%	10%	18%
Highland	15%	11%	24%	9%	42%	52%
Inverclyde	10%	2%	17%	12%	26%	33%
Midlothian	15%	12%	23%	7%	44%	58%
Moray	10%	11%	23%	5%	29%	52%
North Ayrshire	10%	12%	21%	6%	32%	53%
North Lanarkshire	10%	11%	21%	16%	28%	56%
Orkney Islands	6%	24%	24%	5%	32%	73%
Perth & Kinross	11%	9%	23%	7%	33%	45%
Renfrewshire	9%	7%	20%	16%	25%	46%
Scottish Borders	13%	10%	15%	8%	39%	47%
Shetland Islands	16%	18%	21%	12%	44%	63%
South Ayrshire	10%	8%	14%	5%	31%	44%
South Lanarkshire	11%	8%	25%	18%	29%	48%
Stirling	9%	12%	20%	11%	30%	55%
West Dunbartonshire	11%	2%	11%	19%	27%	32%
West Lothian	13%	20%	30%	16%	42%	74%
Scotland	**11%**	**7%**	**18%**	**13%**	**31%**	**43%**

Sources:

Projected Population of Scotland (2012-based) (NRS)

Select Council: East Dunbartonshire

Figure 18 - East Dunbartonshire and Scotland's ten year and twenty year projected percentage change of older people (aged 65-74, 75-84 and 85+) - 2012 based estimates

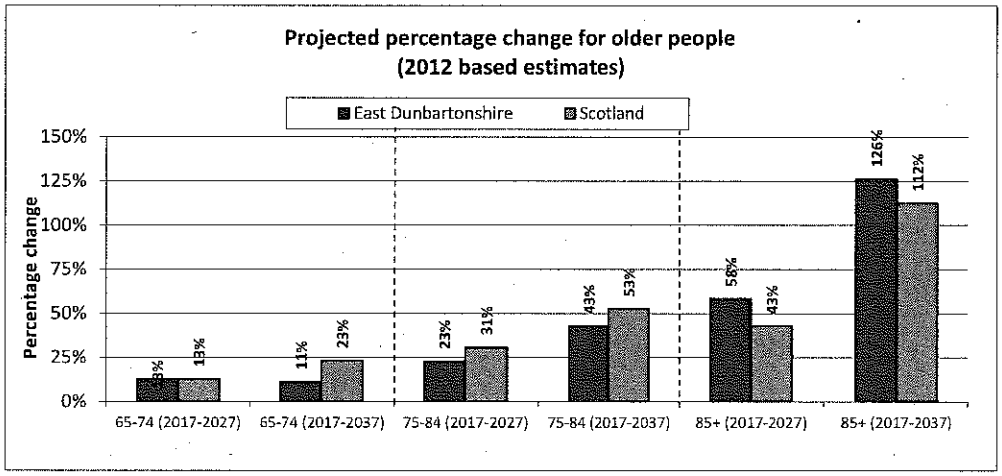
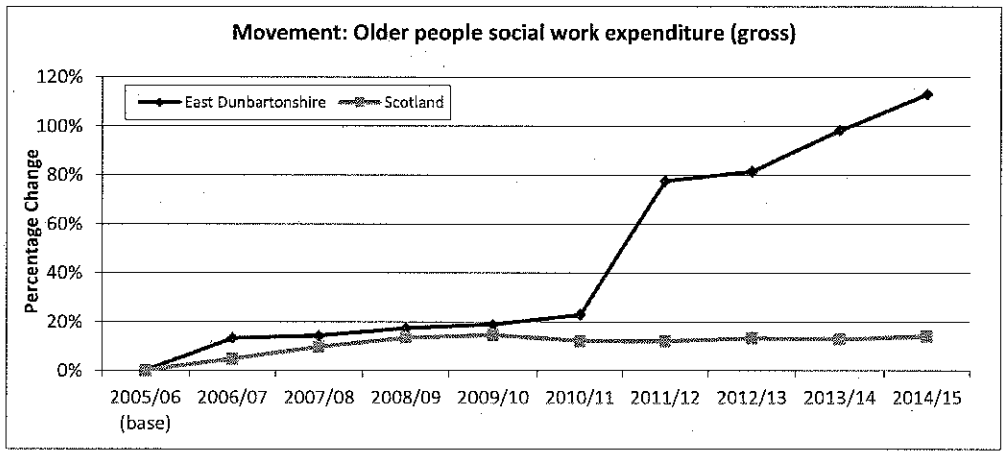


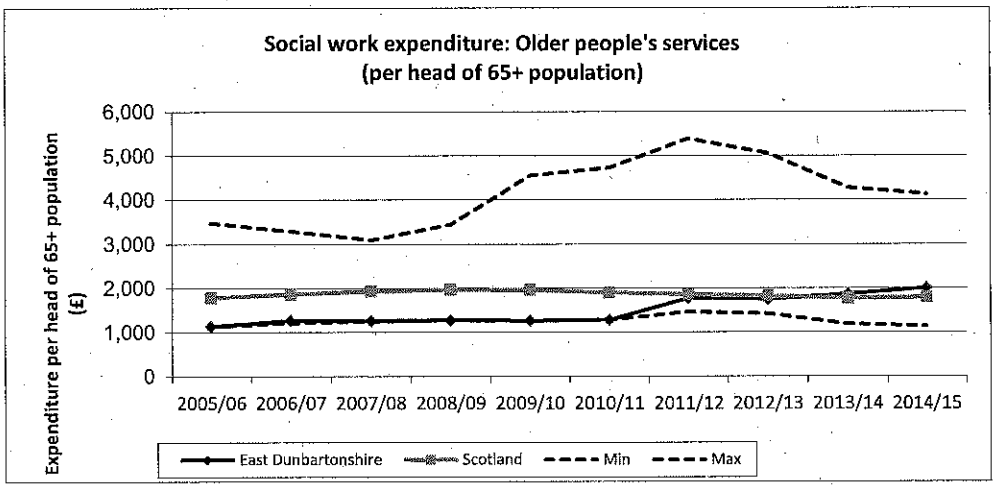
Figure 19 - East Dunbartonshire and Scotland's movement in older people's social work expenditure



- Over the period, spend has moved from £20.6 million to £44 million (in real terms)
- This represents a move of 113%
- Nationally, spend has moved by 14%
- As a proportion of total social work spend in East Dunbartonshire, this accounts for 57% (2005/06 44%)
- As a proportion of total social work spend, nationally, this accounts for 44% (2005/06 45%)

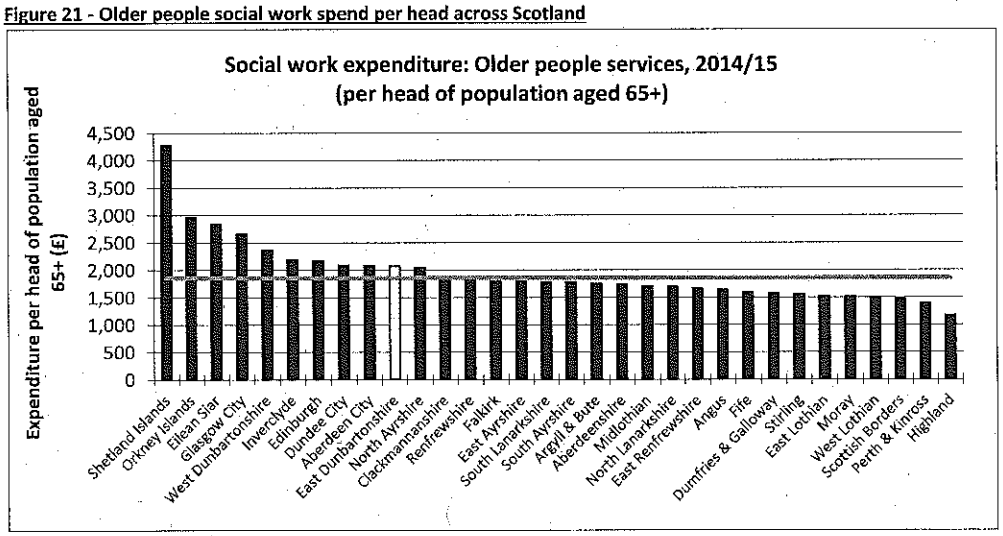
Select Council: East Dunbartonshire

Figure 20 - East Dunbartonshire and Scotland's older people's social work expenditure



- The spend per head of population aged 65+ in 2014/15:
  - In East Dunbartonshire has moved from £1128 to £2000
  - The average spend per head across Scotland has moved from £1783 to £1789

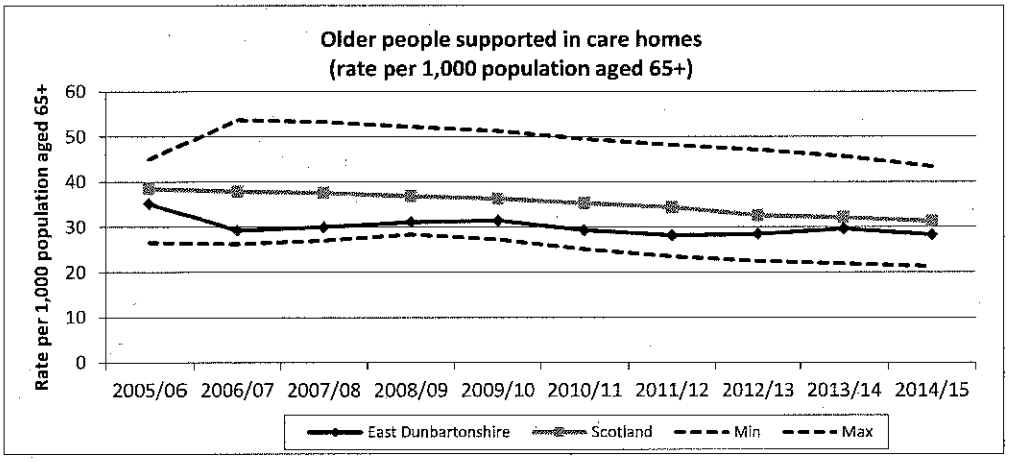
Figure 21 - Older people social work spend per head across Scotland



- This spend equates to £2071 per head of population in East Dunbartonshire in 2014/15
- The spend per head nationally in 2014/15 was £1853 (represented by the horizontal line)
- The range of spend per head in 2014/15 was £1172 to £4278

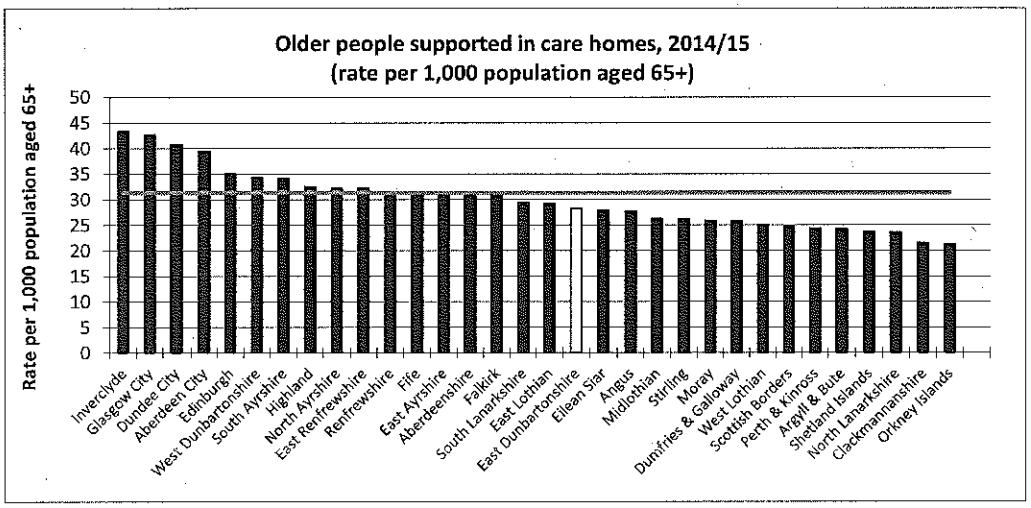
Select Council: East Dunbartonshire

Figure 22 - East Dunbartonshire and Scotland's rate of older people supported in care homes



- The rate of older people supported in care homes per 1,000 population aged 65+:
  - In East Dunbartonshire has moved from 35.1 to 28.3
  - The average rate in Scotland has moved from 38.4 to 31.2 per 1,000 population

Figure 23 - Rates of older people supported in care homes across Scotland



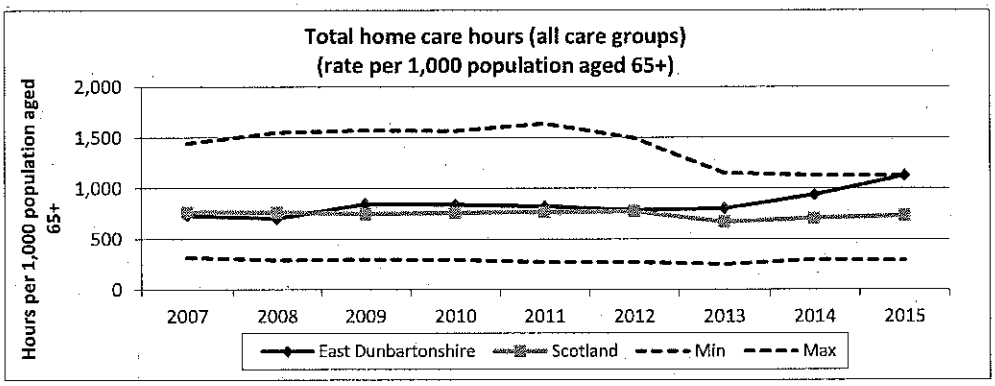
- In 2014/15 in East Dunbartonshire the rate of older people supported in care homes was 28.3 per 1,000 population

- The average rate in Scotland in 2014/15 was 31.2 per 1,000 population (represented by the horizontal line)

- In 2014/15 rates of older people supported in care homes ranged from 21.2 to 43.3 per 1,000 population aged 65+

Select Council: East Dunbartonshire

Figure 24 - East Dunbartonshire and Scotland's rate of total home care hours provided

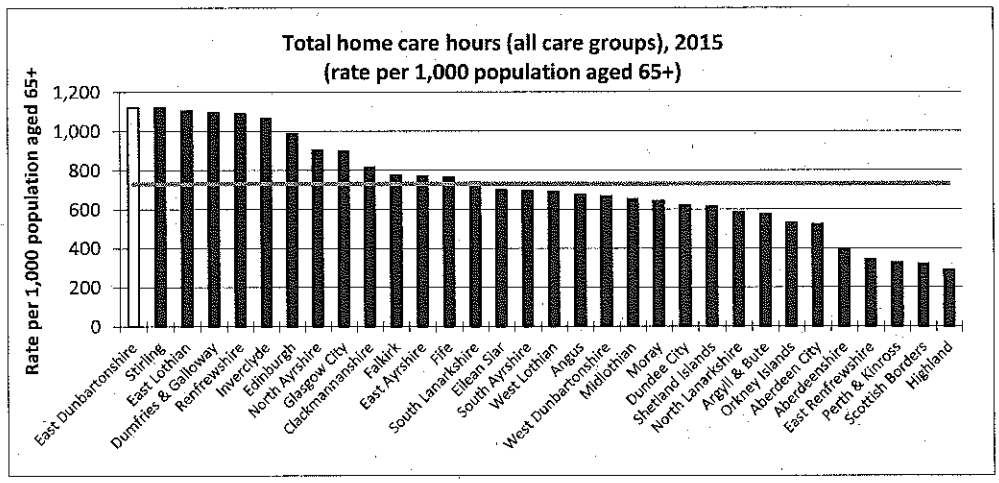


- Between 2007 and 2015, the total rate of home care hours (all care groups) provided per 1,000 population aged 65+:

  - In East Dunbartonshire had moved from 727.0 in 2007 to 1122.7 per 1,000 population in 2015

  - The average rate in Scotland has moved from 762.8 in 2007 to 729.0 per 1,000 population in 2015

Figure 25 - Total rates of home care hours provided across Scotland



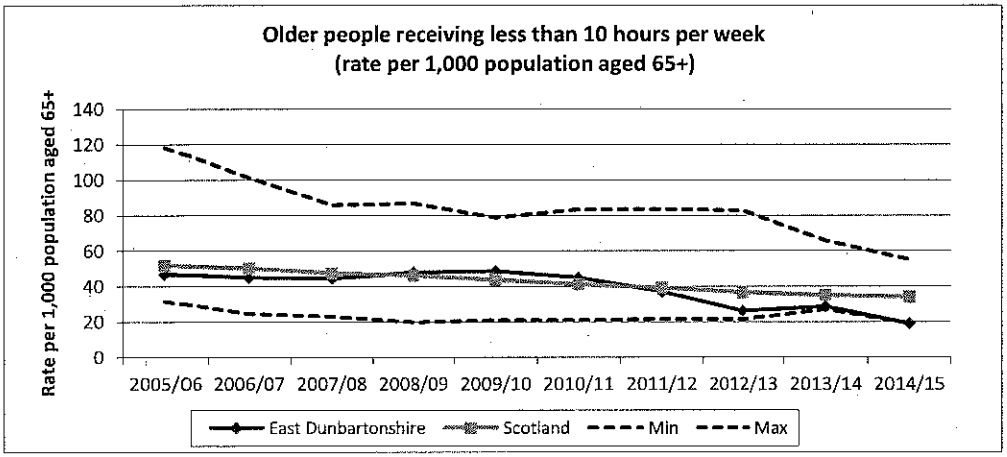
- At March 2015, the total rate of home care hours provided by East Dunbartonshire was 1122.7 hours per 1,000 population aged 65+

- The average rate in Scotland in 2015 was 729.0 hours per 1,000 population (represented by the horizontal line)

- In 2015 rates of total home care hours provided ranged from 289.5 to 1122.7 per 1,000 population

Select Council: East Dunbartonshire

Figure 26 - East Dunbartonshire and Scotland's rate of older people receiving less than 10 hours of home care per week

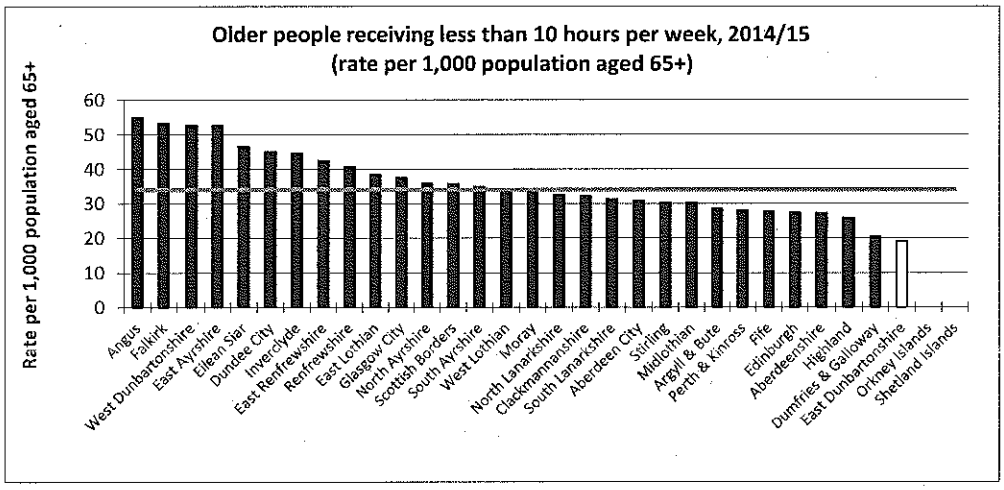


- Between 2005/06 and 2014/15, the rate of older people receiving less than 10 hours per week per 1,000 population aged 65+:

  - In East Dunbartonshire has moved from 46.8 in 2005/06 to 19.0 per 1,000 population in 2014/15

  - The average rate in Scotland has moved from 51.7 in 2005/06 to 33.9 per 1,000 population in 2014/15

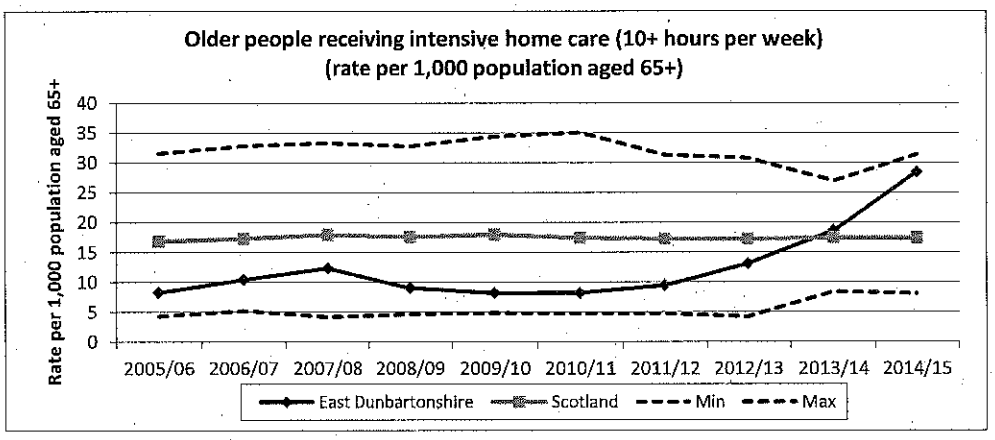
Figure 27 - Rates of older people receiving less than 10 hours of home care per week across Scotland



- Over 2014/15, in East Dunbartonshire, there was a rate of 19.0 people per 1,000 population aged 65+ receiving less than 10 hours per week
- The national rate was 33.9 per 1,000 population aged 65+ (represented by the horizontal line)
- Rates in 2014/15 ranged from 19.0 to 55.0 per 1,000 population aged 65+

Select Council: East Dunbartonshire

Figure 28 - East Dunbartonshire and Scotland's rate of older people receiving intensive home care (10+ hours per week)

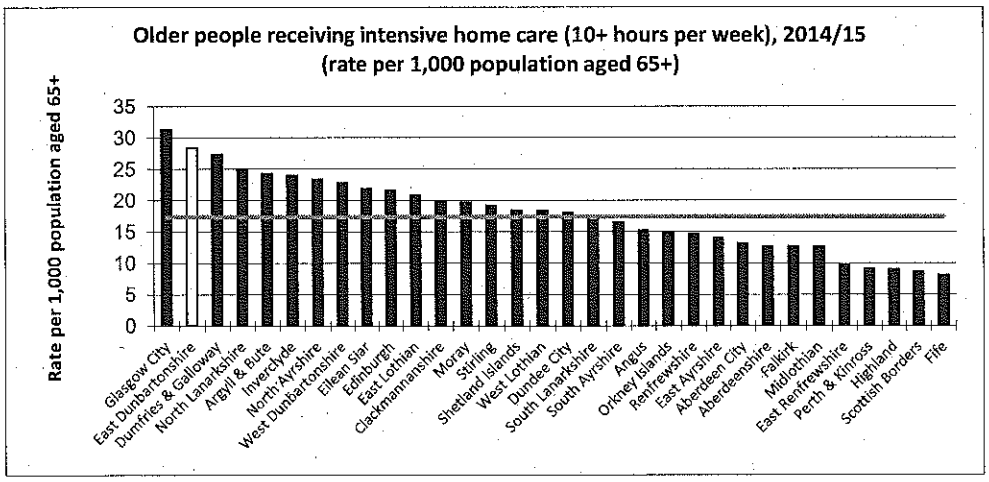


- Between 2005/06 and 2014/15, the rate of older people receiving intensive home care per 1,000 population aged 65+:

  - In East Dunbartonshire has moved from 8.3 in 2005/06 to 28.4 per 1,000 population in 2014/15

  - The average rate in Scotland has moved from 16.8 in 2005/06 to 17.4 per 1,000 population in 2014/15

Figure 29 - Intensive home care provided across Scotland

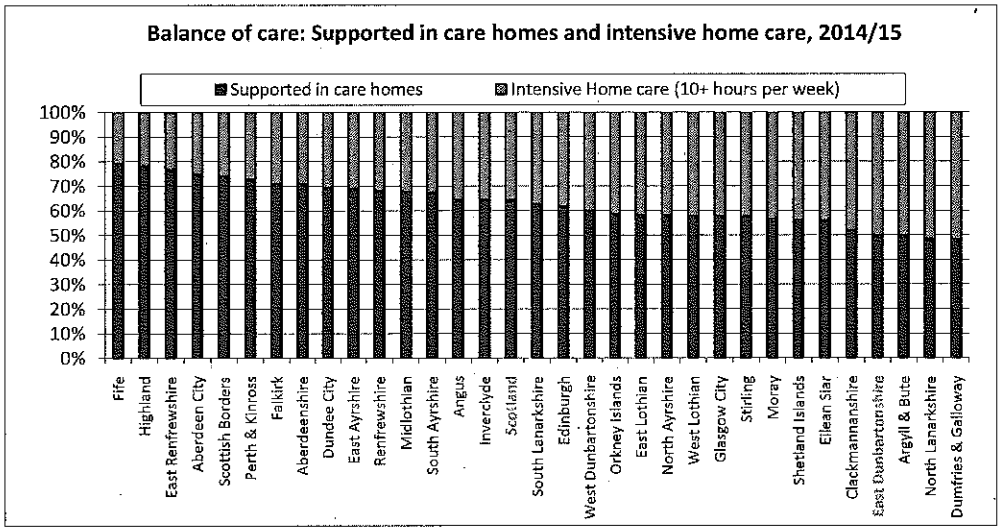


- Over 2014/15, in East Dunbartonshire, there was a rate of 28.4 people per 1,000 population aged 65+ receiving intensive home care (i.e. 10+ hours per week)
- The national rate was 17.4 per 1,000 population aged 65+ (represented by the horizontal line)
- Rates in 2014/15 ranged from 9.0 to 31.3 per 1,000 population aged 65+

Select Council: East Dunbartonshire

Figure 30 - Balance of care (supported in care homes / intensive home care) across Scotland

Figure 30 shows the wide variation across authorities in Scotland in the balance of care.



- During 2014/15, the balance of care in East Dunbartonshire can be broken down as follows:

Intensive home care:

-28.4 people per 1,000 population (or 50%) aged 65+ were receiving intensive home care.

- Scotland's rate was 17.4 per 1,000 (or 36%)
- Rates across Scotland ranged from 21% to 50%

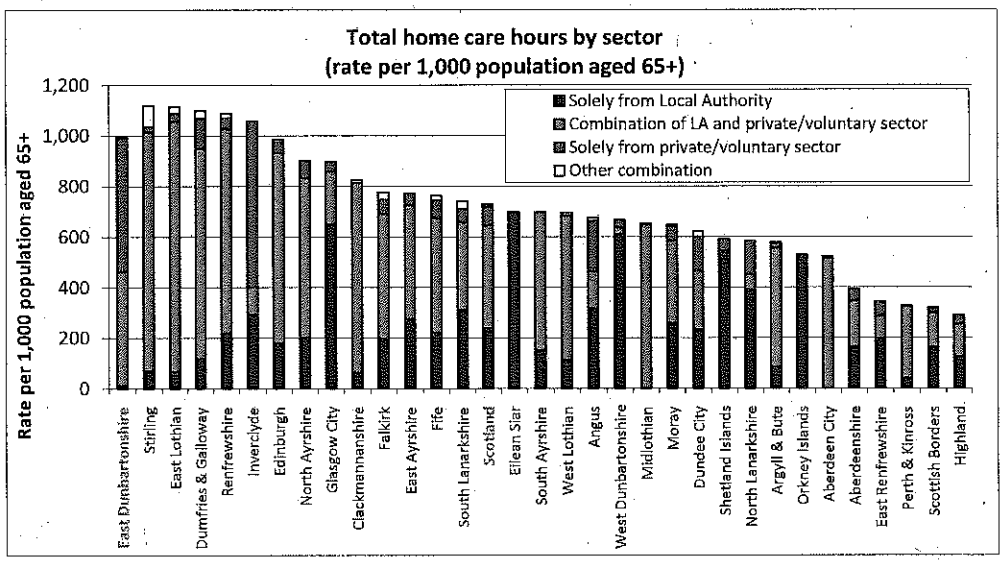
Care homes:

-28.3 per 1,000 population (or 50%) aged 65+ were supported in care homes.

- Scotland's rate was 31.2 per 1,000 (or 64%)
- Rates across Scotland ranged from 50% to 79%

Select Council: East Dunbartonshire

Figure 31 - Total rates of home care hours provided by sector across Scotland



- At March 2015, in East Dunbartonshire, a total of 1122.7 home care hours were provided per 1,000 population. The breakdown of home care provision is given as follows:

-13.3 home care hours per 1,000 population (or 1% of the total) provided solely from local authority (Scotland's rate was 239.1)

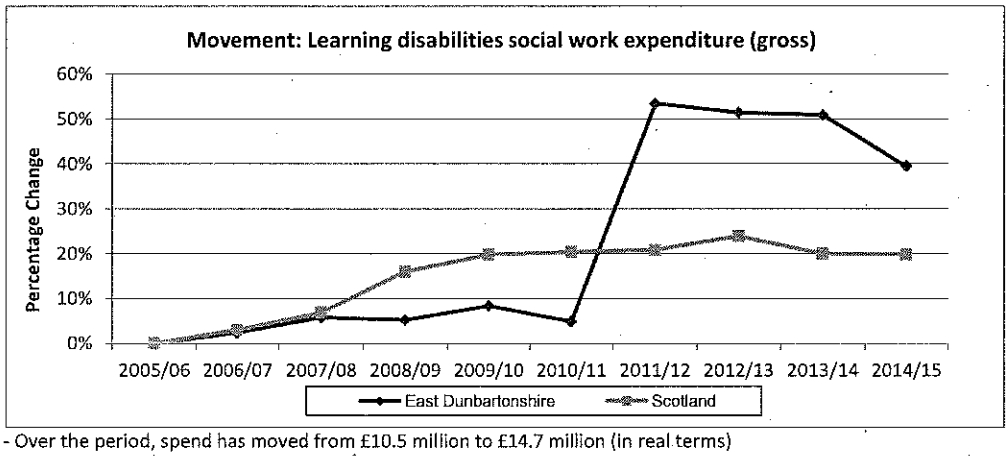
-450.8 hours per 1,000 population (or 40% of the total) was provided from a combination of sectors (Scotland rate 74.5)

-526.0 home care hours per 1,000 population (or 47% of the total) provided solely from private/voluntary sector (Scotland's rate was 405.5)

Select Council: East Dunbartonshire

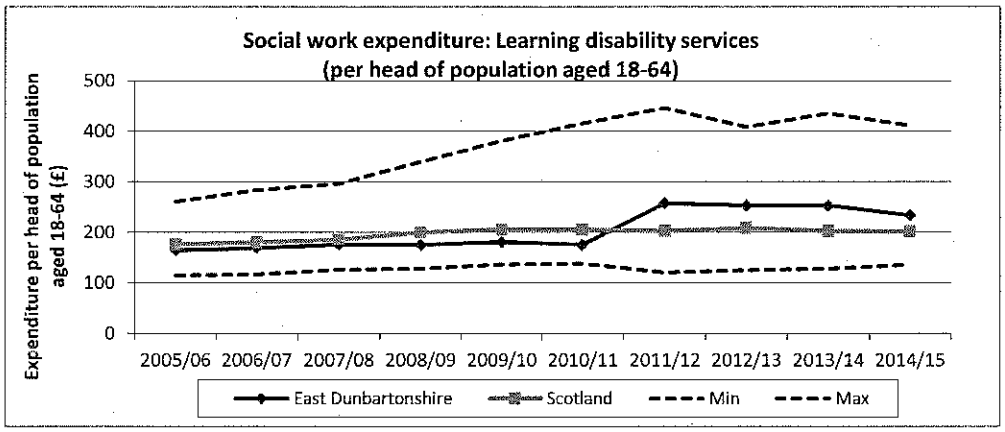
Learning Disabilities

Figure 32 - East Dunbartonshire and Scotland's movement in learning disability social work expenditure



- Over the period, spend has moved from £10.5 million to £14.7 million (in real terms)
- This represents a move of 39%
- Nationally, spend has moved by 20%

Figure 33 - East Dunbartonshire and Scotland's per head expenditure on learning disability services



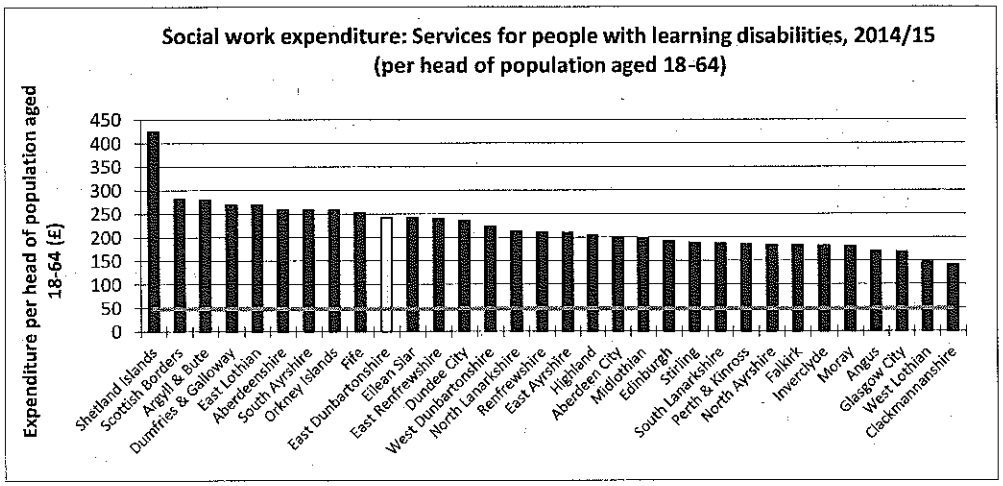
- Per head of population aged 18 to 64 in 2014/15:
  - The spend per head in East Dunbartonshire has moved from £164 to £233 (real terms)
  - The average spend per head across Scotland has moved from £176 to £201

Note:

Due to the wide variation in the numbers of adults with learning disabilities known to and recorded by councils, this report uses spend per head of population aged 18-64 as a proxy to allow us to make some comparison of relative spend.

Select Council: East Dunbartonshire

Figure 34 - Learning disability per head spend across Scotland

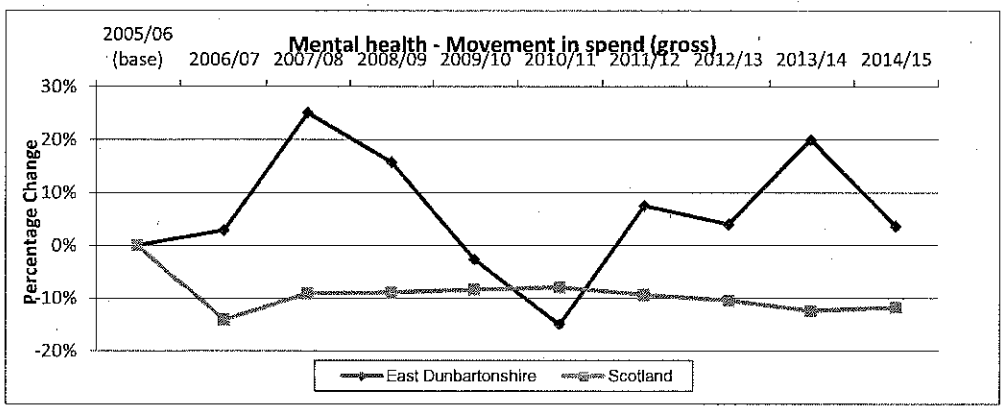


- This spend equates to £241 per head of population in East Dunbartonshire in 2014/15
- The average spend nationally in 2014/15 was £48 (represented by the horizontal line)
- The range of spend per head in 2014/15 was £140 to £425

Select Council: East Dunbartonshire

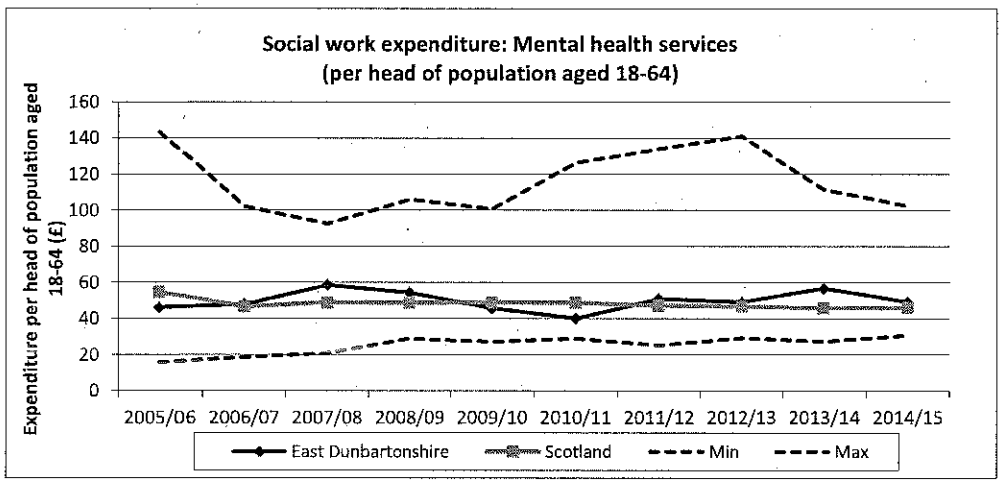
Mental Health

Figure 35 - East Dunbartonshire and Scotland's movement in mental health social work expenditure



- Over the period, spend has moved from £3 million to £3.1 million (in real terms)
- This represents a move of 4%
- Nationally, spend has moved by -12%

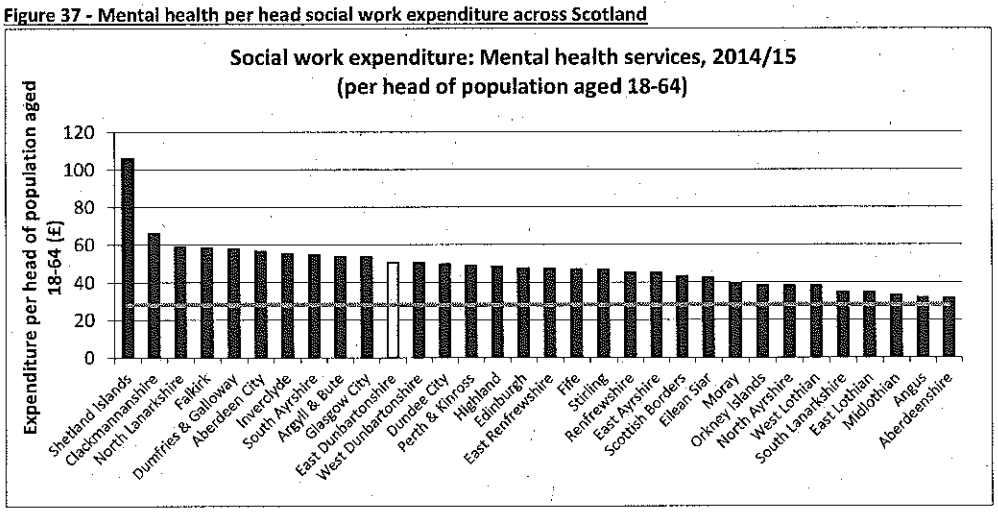
Figure 36 - East Dunbartonshire and Scotland's mental health social work expenditure



- Per head of population aged 18 to 64 in 2014/15:
  - The spend per head in East Dunbartonshire has moved from £46 to £49 (real terms)
  - The average spend per head across Scotland has moved from £55 to £46

Select Council: East Dunbartonshire

Figure 37 - Mental health per head social work expenditure across Scotland

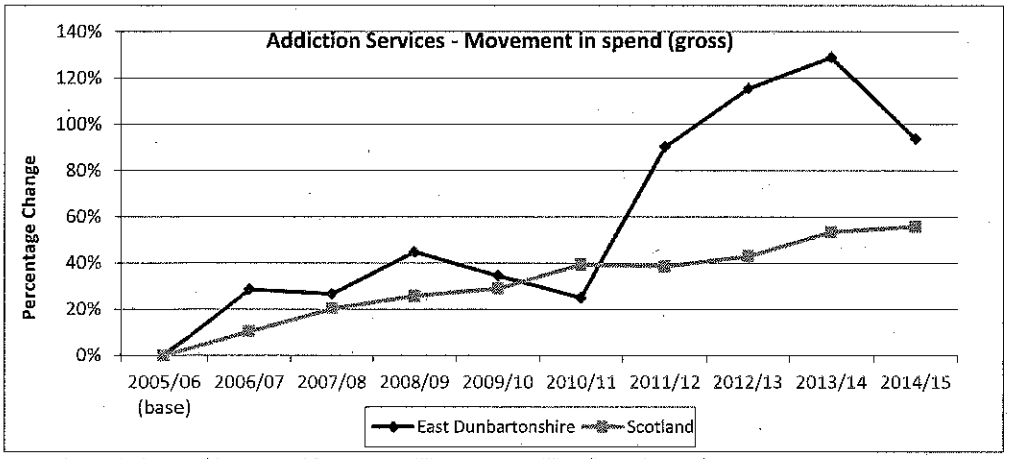


- This spend equates to £51 per head of population in East Dunbartonshire in 2014/15
- The average spend nationally in 2014/15 was £28 (represented by the horizontal line)
- The range of spend per head in 2014/15 was £32 to £106

Select Council: East Dunbartonshire

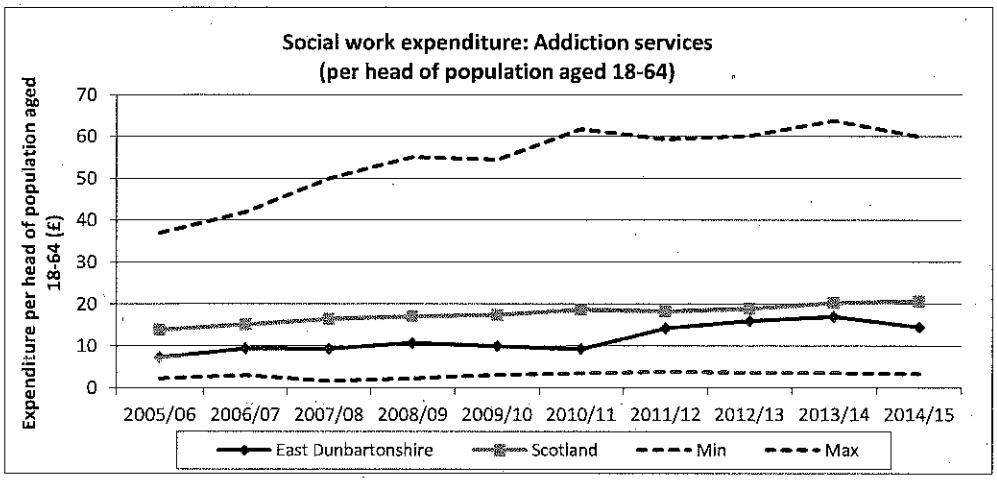
Addiction Services

Figure 38 - East Dunbartonshire and Scotland's movement in addictions/substance misuse social work expenditure



- Over the period, spend has moved from £0.5 million to £0.9 million (in real terms)
- This represents a move of 94%
- Nationally, spend has moved by 56%

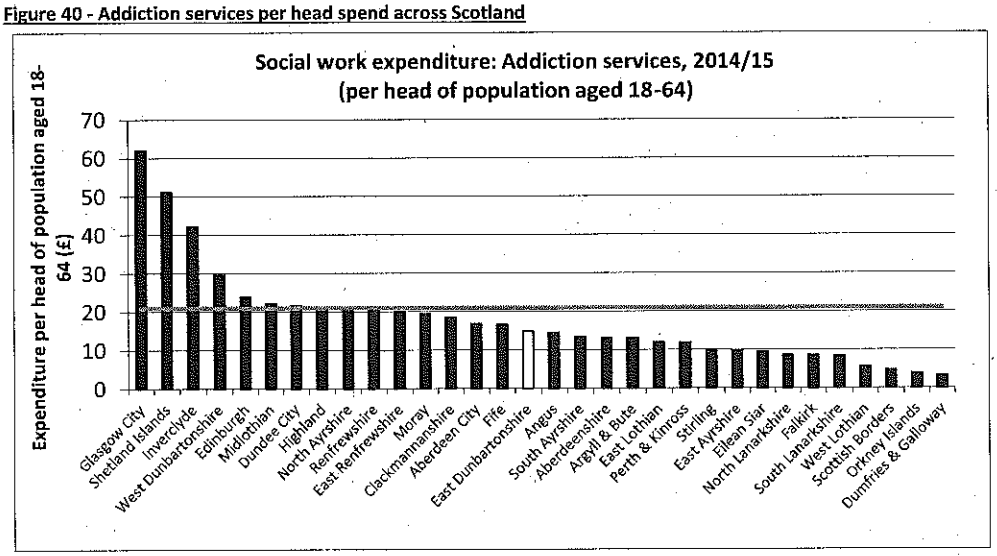
Figure 39 - East Dunbartonshire and Scotland's addiction services per head spend



- Per head of population aged 18 to 64 in 2014/15:
  - The spend per head in East Dunbartonshire has moved from £7 to £14 (real terms)
  - The average spend per head across Scotland has moved from £14 to £21

Select Council: East Dunbartonshire

Figure 40 - Addiction services per head spend across Scotland



- This spend equates to £15 per head of population in East Dunbartonshire in 2014/15
- The average spend nationally in 2014/15 was £21 (represented by the horizontal line)
- The range of spend per head in 2014/15 was £3 to £62

chief officer report - Appendix 4

McMartin, Geraldine

From: Fitzpatrick, Lorna
Sent: 18 August 2016 12:19
To: Adams, Debbie (Rob McCulloch-Graham's PA); Arthur, Julie (Janice Hewitt's PA); Baird, Jan; Bell, Nicki (Robert Packham's PA); Bokor Ingram, Simon; Cassidy, Patricia; Coldwells, Adam; Colvin, Iona; Culley, Ron; Elliott, Kerry (Sandy Riddell's PA); Eltringham, Tim; Fitzpatrick, Lorna; Forrest, Jim; Fraser, Eddie; Gilbert, Barbara (David Small's PA); Gillan, Eileen (Tim Eltringham's PA); Gowans, Pamela; Hamer, Nicki (Simon Boker Ingram's PA); Hewitt, Janice; Irons, Vicky; Johnson, Beverley (Judith Proctor's PA); Johnston, Stephanie (PA to Caroline Sinclair); Kellet, Michael; Leese, David; Lennox, Karen-Anne (Jan Baird's PA); Lynch, David; Manion, Susan; McCulloch-Graham, Rob; McHugh, Eibhlin; McVicar, Gill; Merchant, June (Adam Coldwells' PA); Moore, Brian (INV); Murray, Julie (ERC); Murray, Karen; Packham, Robert; Pinkman, Sandra (Eibhlin McHugh's PA); Plenty, Linda (Gill McVicar's PA); Proctor, Judith; Redpath, Keith; Riddell, Sandy; Robbie, Margaret (Shiona Strachan's PA); Ross, Katrina (Jim Forrest's PA); Sinclair, Caroline; Small, David; Smith, Annette (Pa to Patricia Cassidy, Falkirk); Strachan, Shiona; West, Christine; White, Julie; Whyte, Isla (PA to Pam Gowans); Williams, David
Subject: COHSCS Meeting Friday 19 August
Attachments: NCHC Providers Questionnaire - Overall Summary.docx; NCHC IJB Questionnaire - Overall Summary.docx

Follow Up Flag: Follow up
Flag Status: Flagged

Categories: Print please

Colleagues

Please find an additional two papers for discussion under the business session on the agenda – "National Care Homes Contract".

Kind regards.

Lorna

Lorna Fitzpatrick
PA to Keith Redpath, Chief Officer
West Dunbartonshire HSCP
01389 737526
lorna.fitzpatrick@ggc.scot.nhs.uk
www.wdhscp.org.uk

West Dunbartonshire Council
NHS Greater Glasgow and Clyde
West Dunbartonshire Health & Social Care Partnership
Chief Officer: Keith Redpath

Scottish Care
Voice of the independent care sector

National Care Home Contract Reform: Results of Independent Sector Provider Survey July 2016

Context and survey information

In June-July 2016, Scottish Care undertook a survey of its care home membership to ascertain their experiences of the current National Care Home Contract and their views on what should inform the development of a new contract and negotiation process.

It is intended that the results of this survey can help to inform the work of the National Care Home Contract Technical Group and wider discussions on how all health and social care partners can ensure that Scotland has a high quality, sustainable, fit for purpose care home sector that can best support the complex and changing needs of Scotland's elderly population.

From the survey 135 responses were collected covering a spectrum of service sizes and locations, ranging from very small care homes (less than 25 beds) to those with over 100 beds, and from inner-city services to those in rural locations. Given that 10% of responses are attributed to corporate organisations, it can be reasonably estimated that the number of services accounted for in the survey is significantly higher than 135.

60% of responses came from nursing home services, with a further 25% from residential homes. The remaining 15% were attached to care homes delivering both residential and nursing care.

Assessment of the current NCHC

Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
13.33%	23.33%	26.67%	34.44%	2.22%

It is interesting to note that an identical number of respondents are unhappy with the current National Care Home Contract as are happy with it. Scottish Care believes this is reflective of the range of experiences of the contract both in how it relates to providers' local circumstances and elements perceived to be both helpful and unhelpful in its annual national negotiation.

In particular, 53% of respondents found the fee rates set as part of the current contract to be largely unhelpful, and 50% saw the lack of flexibility it offers in relation to different models of care provision

to be detrimental at present. Nearly 60% of responses stated funding as the most challenging element of the contract, in terms of:

- how the current rates fail to reflect the 'true cost' of care
- the difference between residential and nursing rates and how this impacts on placements and the ability for a service to meet changing resident needs
- the relationship between public rates (set through the NCHC) and self-funder rates, which many deem to be unfair to those paying for their own care
- staff wages and differentials
- differences between in-house provision rates and those set for externally purchased services

The issue of funding was closely related to lack of flexibility in responses, predominantly in terms of how the 'one size fits all' approach that is currently adopted negatively impacts on providers' ability to address personalisation, changing dependency, geographical factors and different models of care such as dementia provision.

In terms of helpful elements, 44% perceived the terms and conditions of the contract to be positive and 42% supported the model of annual negotiation currently in place. Providers value the consistency and stability offered by the current model, whereby the contract is negotiated by one body (namely Scottish Care) in a way that unifies providers and protects against a model of local negotiations whereby providers feel they risk being "picked off" by Local Authorities.

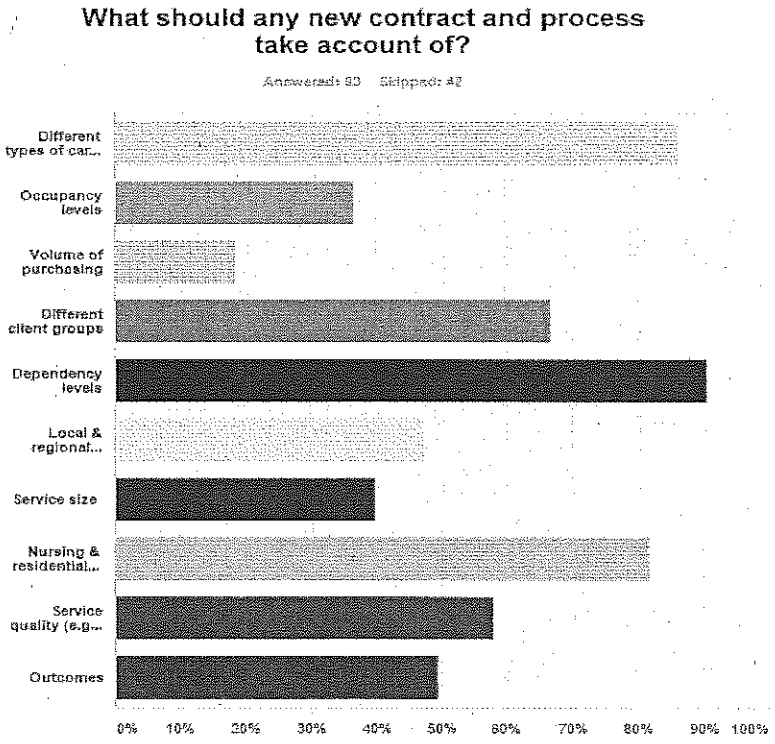
This information indicates that the general model for negotiating the contract (that being Scottish Care and COSLA leading the process on behalf of their members) and the finer detail of the contract remain satisfactory for providers and therefore don't require significant reform. Instead, providers feel that the focus of the NCHC reform process should be the 'in-between' section – the factors on which a new care home contract is premised and the process, calculations and information by which any contract is arrived at by Scottish Care and COSLA.

More specifically, respondents felt a reformed approach should be premised on:

- Timely negotiation & implementation of any agreed contract
- More regular and meaningful engagement with providers
- Flexibility in relation to resident needs
- Recognition of dependency levels
- Reflection of true costs (including staffing costs)

Looking ahead

Overwhelmingly, respondents considered that dependency levels, different types of care provision and nursing and residential definitions need to be accounted for in a new contract, with 90%, 86% and 82% of responses indicating these factors respectively. In relation to the latter factor, providers stressed the need for a 'rethinking' of the nursing and residential distinction, with some believing that the terms are no longer meaningful or relevant in the current care climate.



Interestingly, more local variables and commissioning options such as volume of purchasing, occupancy levels and service size were less popular. This highlights that providers concerns are more closely aligned to ensuring their services can deliver what's needed for residents, rather than on filling beds or making significant returns.

It may also be indicative of providers' uncertainties about moving towards negotiating locally on certain elements and how willing or able they feel to do this. This stresses the importance of getting any future national-local balance right and ensuring sufficient support is available if an element of local negotiation was to be introduced. However, further engagement with providers would be needed around this area before any conclusions could be drawn.

What needs to be different

In order for a re-envisioned care home contract to be successful, there were a number of other factors that providers perceived important to get right. Many of these are wider than the contract itself, but equally require a partnership approach to their reform.

1. ***Procurement and commissioning practice***
   Respondents were keen to see a reformed approach to commissioning and procurement practice which isn't only about recognising costs in a fair way, but is about relationships. Openness, transparency, respectfulness and honest dialogue were acknowledged as crucial to future commissioner- provider relationships. Providers recognised the challenges faced by commissioners, but stressed the ongoing need to communicate these clearly and fairly to providers in order that local partners can work together towards the best outcomes. This includes the need for fair placement practise, timely payment of rates, an understanding of the 'true cost' of care delivery and clarity in relation to future service requirements in a partnership area.

2. ***Regulation***

Throughout the survey, respondents stressed the need for the Care Inspectorate to be much more engaged in the reform process as a key partner, and that they must be more aware of agreements made through the national contract. It was felt that the regulatory body must be much more flexible, facilitative and light-touch in how they implement registration and regulation of services, in order that they enable rather than impede innovative approaches to service delivery. At present, providers feel the Care Inspectorate are too far removed from the contract and the challenging realities of service commissioning and delivery, and therefore risk making unrealistic demands of services in relation to costs, improvement and staffing. There needs to be much more tangible, consistent linking of commissioning, delivery and regulation and what can be expected through each, without in any way compromising quality or the importance of continuous improvement.

3. ***Supporting innovation and new models of care***

Respondents detailed a number of factors which are currently creating barriers to innovating current service provision and developing new models of care from their perspective. These were:

a. Finance – over a third of respondents listed a lack of funding as the main barrier
b. Workforce – the current recruitment issues facing many providers, particularly in relation to nursing staff, is a common barrier
c. Environment – some providers felt unable to innovate within their current environment, with issues such as old premises being a barrier
d. Lack of support from partners – respondents felt that a reluctance from partners to treat the sector as equal partners and part of the solution, coupled with a failure to communicate what is required locally, was preventing providers from implementing new ideas and approaches
e. Care Inspectorate – again, the rigid application of the regulatory framework was hindering those with enthusiasm and imaginative solutions from trying them out.

It is important to note that many respondents detailed plans they had for innovation and new models of care. If some of these inhibiting factors aren't addressed in a partnership-based, solution-focused way, there is a real risk that the health and social care sector will lose the entrepreneurial spirit and flexible approach that the independent sector can offer.

The uncertain future and the need to get it right

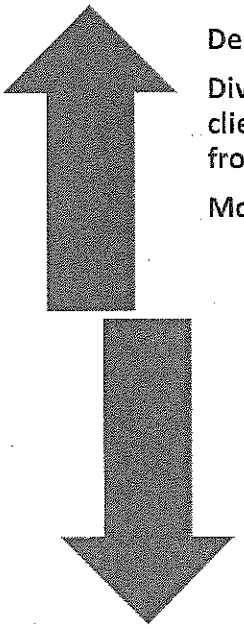
Financial investment & service development

85% of respondents anticipated that they will require significant financial investment (capital, revenue or both) in their services in the near future if they are to remain fit for purpose.

Most respondents attributed this to increased staffing costs (including wage rises) and the need to upgrade facilities. In fact, many respondents detailed ways in which they hoped to improve their services through investment with most recognising the need to make changes in the next few years.

However, real concerns were expressed in relation to whether this would be possible. Even those with funding arrangements in place were cautious about whether they could invest at this time, with others indicating that their precarious viability at the present time would make obtaining financial investment impossible and others still admitted they were looking at closing services. The most significant barrier to investment for providers, other than a straightforward inadequacy of funding, was the uncertainty surrounding the care home sector and elderly care more generally in Scotland. This is making business planning and investment from the banks extremely difficult and has really concerning implications for what care home provision there will be and how fit for purpose it is in the coming years.

A fairly bleak picture was painted when respondents were asked about how they saw their services developing in the next five years:



Dementia services

Diversification of client groups (away from elderly)

More self funders

Surviving, not developing

Developments on hold

Anxiety in relation to CI

Not sure if still here

Those considering service development tended to express a desire to diversify their services into more specialist provision, other client groups or to predominantly focus on self-funding residents.

Others stressed the need to 'batten down the hatches' and focus on maintaining high quality care for their residents. Some detailed service developments they had been planning, but which they intended to put on hold given the current uncertain climate.

A further group expressed some real anxieties in relation to the future of their care provision and whether they would still be operational within five years. Some clearly stated their intention to exit the market, whilst others felt they would be driven towards those decisions involuntarily if significant changes weren't made to funding and regulation.

Serious consideration must be given as to whether this is an acceptable future vision for care home provision, and what it might result in for the growing number of elderly people with complex needs who may require support in a care home setting. Even those with a more positive outlook seem to be considering moving away from elderly care specifically, at a time when we are likely to need more positive options for elderly care and not less.

Self-funders

A significant outcome of the survey was the information it provides about the self-funding market:

- 1-25% of an average service's residents are self-funding
- 61% of services see the self-funding market as increasingly important
- Respondents indicated a heavy focus and reliance on self-funders, as they are seen as crucial to the viability of their services

- A significant number of respondents support a move towards increased harmonisation of public and self-funding rates, which is seen as unfair at present, but only if this was realised in the form of a significant upward revision of public rates

The reform of the National Care Home Contract, whilst separate from self-funding rates, must ensure the links between public and self-funding rates and the impact of one upon the other are fully understood. If significant progress isn't made on the reform agenda, we are at real risk of unintentionally promoting a two-tier care home system, whereby innovative services that are regularly invested in and improved are only available to those who can pay for their own care. This is absolutely not the direction Scottish Care or its members want to see the sector developing in.

Summary

Scottish Care and its members hope the information obtained through this survey will be helpful in informing the reform of the National Care Home Contract. It is crucial that we get this work right, and this can only be achieved through meaningful engagement with those affected by the contract and by taking their views and experiences on board. This survey exercise was a first step in capturing information from providers, and Scottish Care is happy to undertake any further engagement exercises that may be required over the coming months.

NCHC REFORM – IJB CHIEF OFFICERS SURVEY RESPONSES SUMMARY

Is the NCHC *Working Well?*

- 45% of IJBs participated in the survey. Of those who participated, 95% think the NCHC works well in their area. Reasons given include the fairness, consistency and transparency of a standardised approach to terms and conditions, specification and price; the fact that the specification and prices are agreed without a disproportionate amount of local negotiation work; and the idea that the current arrangements do much to support a consistent level of care standards across the country. Overall, while the majority of respondents recognise the need to move towards new arrangements which better support local commissioning, the majority wish to keep a core suite of nationally agreed contract components and have asked that any new approach build on the solid foundations of the existing arrangement.

Existing Challenges

- Looking at the current negotiation process, two-thirds of respondents agree it has worked well, but future arrangements will need to better reflect the role of IJBs in the decision-making process. Many respondents noted that the annual settlement round was unhelpful in relation to supporting strategic planning and budget setting, committee reporting and financial assessment. Returning to the question of cost every 12 months is seen as an unhelpful burden on local providers and their lenders and is stifling innovation. Additionally, the lateness of the process in the financial year doesn't lend itself to individual council budgeting timescales and leaves little time for meaningful preparation. A few respondents also highlighted that it was unclear whether the existing arrangements have actually raised quality. Despite these criticisms, many respondents highlighted the financial stability of a national contract in terms of supporting in-year planning and related communication.
- Most respondents agreed that the traditional residential / nursing care home model is no longer relevant to the range of people who currently use care homes and that new models are needed. In time, consideration should be given to extending any new arrangements to encompass all adult care places.
- A few respondents suggested that a return to local negotiation (even in part) could risk providers in their area seeking a significant increase in rates at a level that would be unaffordable and unsustainable. A number of respondents requested that a move to some form of local negotiation be phased / staged in line with emerging developments in strategic commissioning.

Future Arrangements

- Ensuring the new arrangements support different types of care provision, are outcomes focused and support service quality were identified as key deliverables. Over 80% of respondents believe there are existing barriers to innovation and pointed to a need for changes in relation to Care Inspectorate registration categories to make them more flexible, especially in relation to workforce matters. Many respondents pointed to the need for a new enabling approach through a formalised relationship with the Care Inspectorate in relation to innovation and creativity. It was suggested by some respondents that future contracting arrangements should rely less on numerical grading when assessing quality and focus more on qualitative data around continuous improvement.
- In terms of commissioning, a number of respondents confirmed that arrangements are still being developed and it will take the next 12-18 months before IJBs can present their local

markets with a detailed picture of their needs. A few respondents suggested the timeline may be longer – perhaps two years. Overall, respondents suggested that the next 5 years will see an increased demand for more flexible and diverse services tailored to individual needs, with more third sector and independent sector collaboration. This transformational change will be phased and involve a gradual move from "traditional" models of care to more flexible arrangements capable of reacting quickly to changing needs.

- Looking ahead, the vast majority of respondents see budgets as the greatest challenge. There is simply not enough resource to make the improvements needed as a result of increasing demographic demand and the lack of standardised rates for specialist services (such as older adults with learning difficulties and dementia). This is making it hard to match increased demand to budget settlements. This challenge has been made more difficult by the ambitions of introducing the living wage. Local pressures include scarce labour markets, rurality and delivering personalised services which match the needs of an ageing population. Respondents were split 60/40 against the idea of harmonising the rates for publicly funded and self-funded residents.
- In terms of raising quality, respondents highlighted the need for investment in dementia training and sharing learning from the SDS pilots. They also encouraged providers to share and promote discussions around recruitment challenges and to work with them to explore more holistic, neighbourhood solutions. Many respondents suggested a big push was needed in relation to the 'environmental offer' to residents beyond the traditional room and common area towards a richer homely setting. Other themes suggested for exploration include the role of extra care housing / nurse advisers and dementia specialists / videoconferencing to support upskilling / pharmacy support / and new models of partnership involving multi-disciplinary teams.

Conclusion

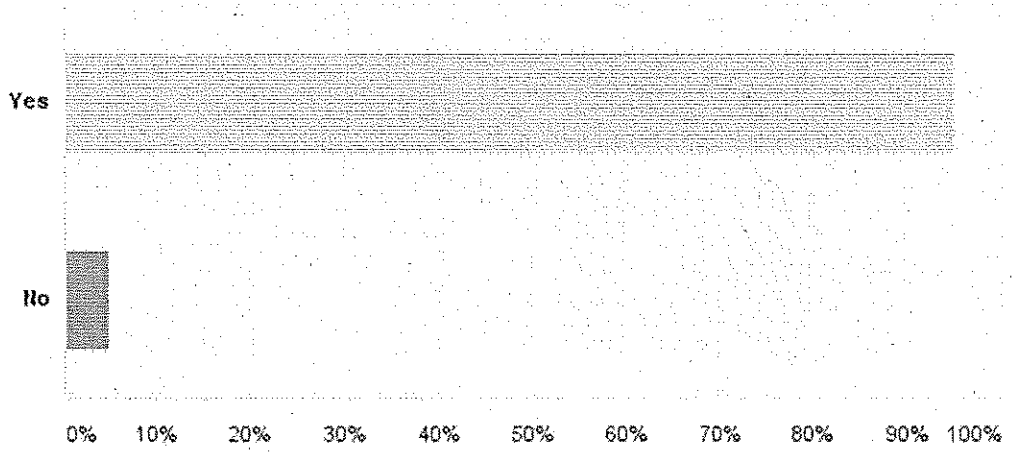
- Overall, there was broad consensus amongst respondents that any future contracting arrangement will not, by themselves, address everything that needs to be done in the sector. Any new contracting arrangement for adult residential care needs to be set within a wider strategic context for managing all care demand and be developed alongside a range of options that provide real choice and see care homes as part of a continuum of provision.

COSLA
18 August 2016

TABLES

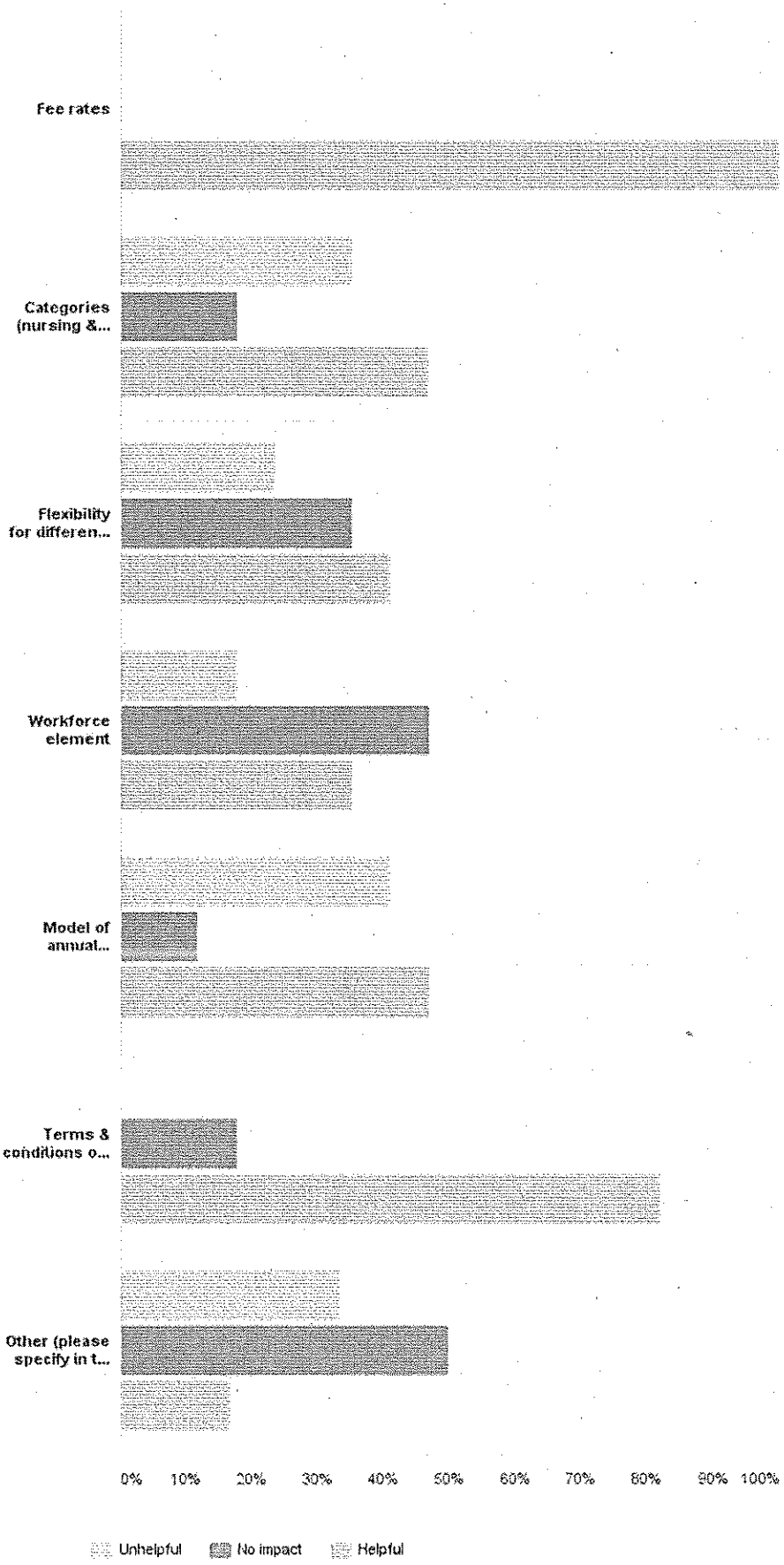
Q2 Do you think the current National Care Home contract works well for your area

Answered: 21 Skipped: 0



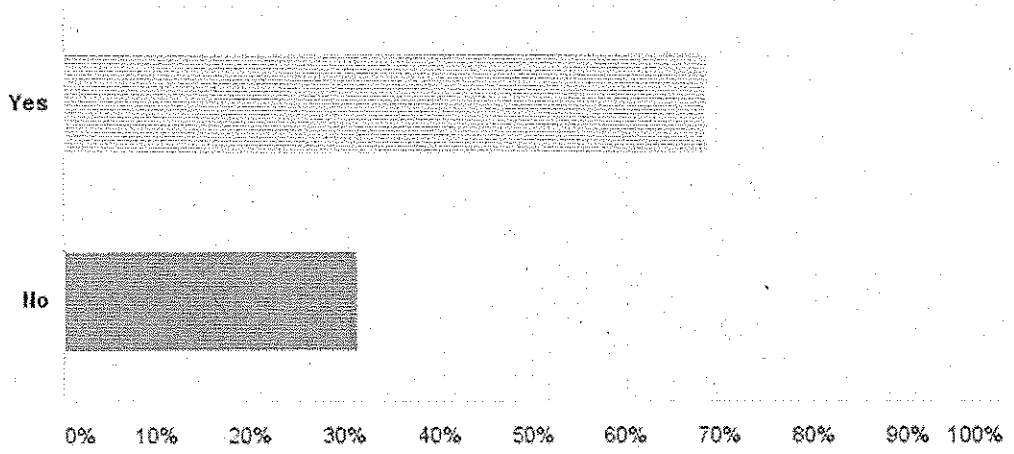
Q4 How would you assess the impact of the following elements of the NCHC

Answered: 17 Skipped: 4



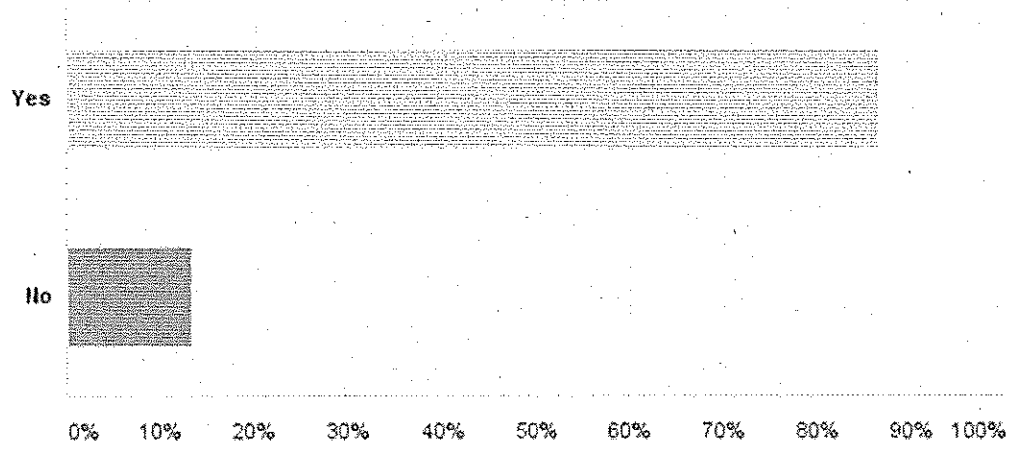
Q7 Do you think the current negotiation process works well

Answered: 16 Skipped: 5



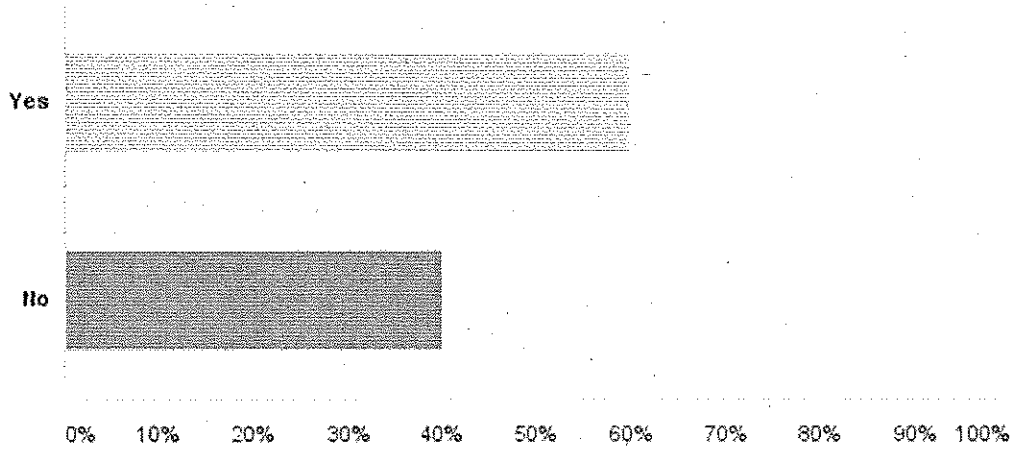
Q9 Do you think there are barriers to innovation e.g. premises, workforce etc.

Answered: 15 Skipped: 6



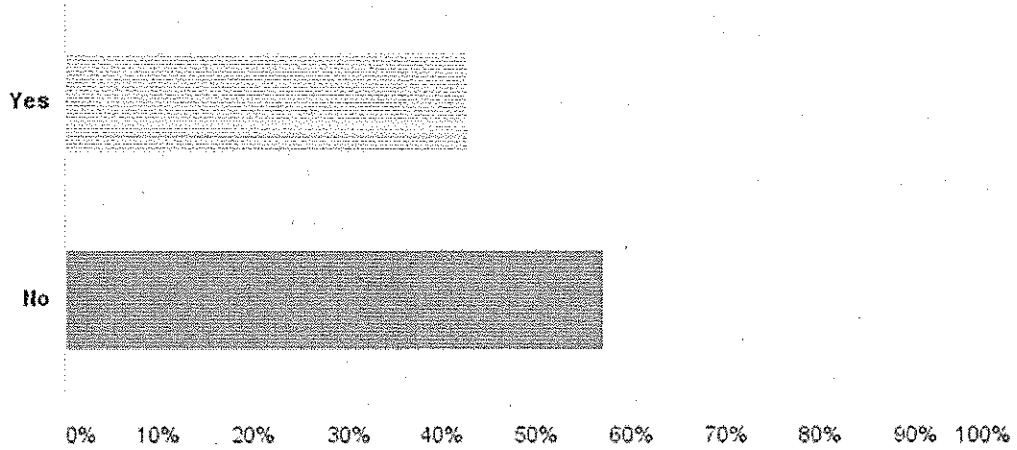
Q11 Do you have the right mix of residential and nursing provision to meet your current commissioning needs

Answered: 15 Skipped: 6



Q15 With these financial barriers in mind, should there be a move towards harmonising the rates for publicly funded and self-funded residents

Answered: 14 Skipped: 7



chief officer report - appendix 5

Greater Glasgow and Clyde NHS Board

JB Russell House
Gartnavel Royal Hospital
1055 Great Western Road
GLASGOW
G12 0XH
Tel. 0141-201-4444
Fax. 0141-201-4601
Textphone: 0141-201-4479
www.nhsggc.org.uk

Councillor Rhondda Geekie
Council Leader
East Dunbartonshire Council
12 Strathkelvin Place
Kirkintilloch
Glasgow
G66 1TJ

Date: 11 August 2016
Our Ref: JB/RB – Rhondda Greekie

Enquiries to: John Brown
Direct Line: 0141-201-4410
E-mail: JJBrown@ggc.scot.nhs.uk

Dear Councillor Geekie

I wanted to alert you to the content of a paper that will be presented to our NHS Board next week (Tuesday 16 August 2016) that will have an impact on the membership of the East Dunbartonshire Health & Social Care Partnership (HSCP) Board.

We have been reviewing the membership of NHS Board Standing Committees and HSCPs as a result of the Board deciding to establish two new Standing Committees, and to take account of the eight new Non Executive members who joined the NHS Board from 1 July 2016.

The NHS Board on 16 August 2016 will be asked to consider the revised membership of the HSCPs; this letter sets out below what the proposed membership will be and some additional information.

Non Executive Lead
Ian Fraser

Non Executive Deputy Lead
John Legg

Non Executive Membership
Ian Ritchie

It is intended that these new arrangements take effect from 1st September 2016; however if local circumstances dictate that as particular arrangements have been made for specific meetings or events, then local discretion can be applied by the Chief Officer of the HSCP to the effective date.

You will see that the opportunity has also been taken to appoint a deputy Lead Non Executive Member for each HSCP. The arrangements for substitute members for HSCP meetings will be communicated shortly to our Non Executive members.

I hope you find this helpful and John Hamilton, Head of Administration, will ensure that the HSCP Chief Officer is provided with contact addresses for your new Non Executive members.

Yours sincerely

JOHN BROWN CBE
Chairman

Cc Gerry Cornes, Council Chief Executive
Karen Murray, HSCP Chief Officer

CO report to HSCP Board Appendix 6

McMartin, Geraldine

From: Cannon, Paul
Sent: 26 August 2016 15:19
To: Brimelow, Susan [Board]; Brown, Morag [Board]; Cameron, Heather; Carr, Simon [Board]; Cowan, Alan [Board]; Finnie, Ross [Board]; Forbes, Jacqueline [Board]; Fraser, Ian [Board]; Legg, John [Board]; Lyons, Donald (Board); Macleod, Allan [Board]; Matthews, John [Board]; McAuley, Trisha (Board); Monaghan, Anne-Marie [Board]; Reid, Robin [Board]; Ritchie, Ian [Board]; Sweeney, Rona [Board]; McErlean, Dorothy
Cc: Renfrew, Catriona; Brown, John; Calderwood, Robert; Gordon, Shirley; Williams, David (GCC); Moore, Brian (INV); Murray, Karen; Murray, Julie (ERC); Redpath, Keith; Leese, David
Subject: IJB guidance for NHS Members

Follow Up Flag: Follow up
Flag Status: Flagged

Categories: Print please

Dear Members of IJBs/HSCPs,

my apologies for the delay in writing to you about substitute / proxy voting arrangements.

NHSGGC has a responsibility for providing a replacement Non Executive member anytime a Non Executive member is unable to attend a formal IJB Board meeting. Local Authorities have made provision for their proxy members; however this is something we are only now able to do with the arrival of the additional Non Executive Members on the NHS Board.

The relevant Regulations state -

Proxies
12.
(1) If a voting member is unable to attend a meeting of the integration joint board the constituent authority which nominated the member, is to use its best endeavours to arrange for a suitably experienced proxy, who is either a councillor or, as the case may be, a member of the Health Board, to attend the meeting in place of the voting member.
(2) If a member who is not a voting member is unable to attend a meeting of the integration joint board that member may arrange for a suitably experienced proxy to attend the meeting.
(3) A proxy attending a meeting of the integration joint board by virtue of paragraph (1) may vote on decisions put to that meeting.
(4) If the chairperson or vice chairperson is unable to attend a meeting of the integration joint board, any proxy attending the meeting may not preside over that meeting.

I am therefore writing to confirm the arrangements that we are putting in place from 1 September 2016 in relation to substitute members and proxy voting for IJB meetings. I have also included additional guidance in relation to liability, and flagged some further guidance that will be circulated shortly on a role descriptor for Non Executive Members on IJBs.

If any NHS GG&C Non Executive member is unable to attend an IJB meeting, could you please contact (by email) myself and Shirley Gordon, we will then canvas for an alternative member to attend.

Once a substitute member has been identified we will provide the agenda and papers to that member directly. We are taking steps to have all IJB agendas and papers routinely sent to the Board so that we have these in the event that these are required to be passed on to another member urgently. We will also confirm with the relevant IJB secretariat that a substitute member will attend from the NHS Board, if this is necessary.

I will shortly be writing to all members with a template which describes the role of IJB Members / Leads which we thought might also be helpful, not just for newly appointed Non Executive colleagues.

In terms of liability, please note that all Councils have confirmed that they have put in place appropriate liability cover for members, through the same scheme used by the Board, known as CNORIS (Clinical Negligence & Other Risks Indemnity Scheme).

CNORIS is a risk transfer and financing scheme for the NHS and integrated health and social care Boards in Scotland and was first established in 1999 by the Scottish Government Health Directorates. A CNORIS Steering Group was established to assist in the administration and management of the Scheme, with membership drawn from senior staff of member organisations, as well as Scottish Government. Paul Cannon, Deputy Head of Administration, is a member of the Steering Group, representing NHS Board interests.

I hope this is helpful.

If you have any queries about the substitute member / proxy arrangements, please let me know.

Kind Regards.

Paul Cannon
Deputy Head of Administration
NHS Greater Glasgow & Clyde
JB Russell House
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow G12 0XH

0141 211 0246
07850 741090
paul.cannon@ggc.scot.nhs.uk

Chief officer report appendix 7

1. Strategic Planning for Acute services: next steps

The Board agreed in June to establish a process which would deliver a strategic plan for acute services. The purpose of this section, with the full Board paper below, is to set out the programme we need to deliver to be able to publish 2017/18 service change proposals for patient and public engagement set in the context of a longer term strategic plan by the end of the calendar year. The first milestone is to deliver an overview for Board members at the October Board seminar. It is proposed that this will be delivered with a similar structure which we will use to frame the public document; a first iteration of this is set out below. The aim would be to describe from these strands of work a strategic shape of our services and sites.

1.1 **National Clinical Strategy (NCS):** an outline of the NCS and how it has framed our approach to shaping our strategic plan, this will include our thinking on developing work on realistic medicine;

1.2 **Regional service Planning:** We will describe the regional planning work programme, and it's likely further development, potentially beginning to shape populations required for planning of different services.

1.3 **Clinical Service Strategy:** a restatement of the clinical strategy as follows:-

http://www.nhsggc.org.uk/media/233577/clinical-services-strategy.pdf

- Population health analysis: we need to develop this with a focus on usage and demand and linked to analytical work being done by IJBs around service usage. Needs to give us an informed forward look at population and other changes which will require service transformation;
- Drivers for change; the drivers for change remain valid, we would include narrative to relate them to the NCS;
- Future clinical models; again this largely remains valid, there are some areas of new thinking including separating emergency and elective, development of regional hub and spoke. There are areas where our work is has developed with HSCPs, we need a particular focus on cross system frail older peoples care as a major driver of acute use and one where there is significant potential for change;
    - Frail older people process.....workshop HSCPs
    - Progress on implementation;
    - A joint appraisal with IJBs of the implications of their strategic commissioning plans for the delivery of acute services;
    - Analysis of service changes emerging from regional and national planning to deliver the National clinical strategy;

1.4 **2017/18 service changes:** these will be framed by the Divisional Delivery Plan process both completing work outlined in the 2016/17 plan, we have detailed reviews underway in a wide range of clinical areas, and the work to establish the 2017/18 delivery plan. For the Board seminar we would outline likely areas of change, the Divisional delivery event at the end of October 2016 is the opportunity to discuss the detail.....areas for change include:

- Orthopaedics and trauma
- Stroke
- Gynaecology
- Breast surgery
- Urology

We also have a major review of unscheduled care and on capacity and demand for scheduled care, both of which need to be shaped to inform the plan.

1.5 **IJB commissioning/strategic directions:** We have discussed with HSCPs the need for these to be clear about proposed changes to acute services and critically the development of the interface services which are a critical element of delivering the Clinical Services Strategy shift in the balance of care and enabling acute hospitals to focus on delivering acute care. We need the intentions to have a shared focus on demand reduction.

1.6 **Financial Framework:** a realistic view of our current spending and what is affordable, plus costed impact of HSCP commissioning intentions and shift in balance of care. Key issue is what are our additional proposals to reduce acute cost? This envelope for acute can be developed from our 2016/17 position and what we already know about the gap for 2017/18.....for years beyond that we should have an outline agreed developed with HSCPs of changing spend on acute services.

1.7 **Strategic service appraisal for each site:** narrative on any service issues for each site including development aspirations, which would include major trauma, BOC and cardiac surgery for QEUH.....we need to engage with GJNH about future shape of services there.

1.8 **Estate appraisal of our hospital sites:** We have a statement on each site which needs to be developed to offer a forward view on the future configuration of each site. At headline level this would be expanded acute facilities at our three major acute sites with development of ambulatory care.

1.9 **Clinical engagement:** this will be through a number of routes:-

- Restatement of CSR outlined above;
- Work underway for Divisional delivery plan has strong clinical focus;
- Division wide event end October 2016 will enable us to have senior clinical input to the emerging vision and shape the detailed thinking on specific sites and services;
- HSCPs and GPs: suggest shaping event in each HSCP November 2016;
- Discussion of this paper through Clinical Advisory structures and MSAs:

1.10 **IJBs:**

- COs have been given a version of the Board paper to be considered by their IJBs with the recommendation that IJBs engage in the process and that their PPFs become directly involved in the early stages, we need to agree further IJB process.

1.11 **Communication:** below initial thoughts

- **Staff:** core brief to staff during September;
- **Patient panel and IJB PPFs:** suggestion is that after the initial briefing on the process in September, we should be establishing these in late October;
- **Wider patient and public engagement:** should have programe in place from January 2017

1.12 **Timetable**

- **September whole system Directors:** this paper would go out to COs now for comment and engagement but for detailed discussion at that meeting and final shaping of Board seminar.
- **October Board seminar:** structure would follow the headings as outlined above
- **End October:** divisional development/planning event
- **Mid November:** first draft paper to Acute Services Committee
- **Mid December:** Final draft paper to Board meeting prior to public process

Board Paper Strategic Service Planning

1. Background and Purpose

1.1. This paper proposes a process for the strategic planning for acute services. The approach outlined will enable:-

- Coordination of our planning with the developing regional and national approaches.
- The wide engagement of our clinical staff in strategic planning;
- Integration of planning for acute services with the planning led by IJBs for community and primary care services;
- The shaping of acute services to respond to IJBs Strategic Commissioning Plans.
- The further development of our existing extensive planning;
- The delivery of early patient and pubic engagement;

1.2. This purpose of the paper is to enable the Board to contribute at this early stage to shaping the strategic planning process, informing the further development of the process.

2. Planning Roles and Responsibilities

2.1. Responsibility for strategic service planning is now shared between the Health Board and Integration Joint Boards.

2.2. The Health Board is responsible for the overall planning for acute services, working with IJBs on planning the delivery of unscheduled care and on the shaping of the primary care and community services which are critical to the delivery of acute care.

2.3. The IJB's are responsible for strategic planning for the health and social care services for which they are responsible and for the strategic commissioning of unscheduled care services;

3. Strategic direction and principles for planning

3.1. The Board already has a clear strategic direction which sets out our purpose as:

"Deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities."

3.2. That purpose is amplified with five strategic priorities, these are:

- Early intervention and preventing ill-health.
- Shifting the balance of care.
- Reshaping care for older people.
- Improving quality, efficiency and effectiveness.
- Tackling inequalities.

3.3. In planning for 2016/17 the Board also developed a series of principles to establish a clear framework for planning. These principles, set out below continue shape our approach to planning, particularly our approach to the assessment of available resources and how they should be deployed.

- Make financial decisions which are in line with and enable us to move in coherence with our purpose, strategic direction and related strategies all of which are focussed on ensuring our services are focussed on the needs of patients.
- Continue to play our part in trying to reduce the inequalities which affect our population and have a strong focus on equality impacts in making our decisions.
- Ensure that our decisions do not have unintended consequences such as unplanned transfers of pressures, responsibilities or costs to other parts of the system.
- Aim to continue to deliver the key Scottish Government targets.
- Focus first on changes which make clinical and service sense and increase efficiency and productivity and reduce our unit costs.
- Ensure that where we propose to restrict access to services or stop planned developments we will have a clear framework for prioritisation of patient care linked to clinical benefit.
- Shift the balance of care and resources but also recognise the pressures on acute services.
- Test all new national initiatives and proposals which have financial implications against our strategy and report to Board for decision.
- Underpin our decision making with evidence about what delivers the safest, highest quality and most cost effective healthcare.
- Explicitly consider risks and benefits in making decisions.
- Remain committed to the importance of innovation and research to shape changes in the way we deliver care.
- Work across boundaries with other Health Boards and public bodies to identify ways in which we can deliver services more efficiently.
- Take a whole system approach not localised savings targets, that approach driven by:
  - cost scrutiny in every part of the organisation, led by the local teams; and
  - a whole system programme of change to deliver cost reduction.
- Commitment to engagement with patients and the wider public.

- Commitment to fully engage with our staff and their representatives in shaping, planning and delivering the changes to services which will be required

3.4. The Strategic Direction, strategic priorities and principles will underpin our approach to strategic planning for acute services.

4. Current position on strategic planning for acute services

4.1. This section describes the local, regional and national position on planning for acute services, which set the context within which this next phase of our planning will be developed.

4.2. At **national level,** there are a series of programmes of work which will inform our strategic planning. These include:-

- The work of the Transformation Board which is overseeing a range of reviews including for planning for seven day services, the review of out of hours services and the current maternity and neonatal services review.
- Service strategies including for cancer;
- Planning being established for future scheduled care capacity;

4.3. In addition to these elements of national direction, the National Clinical Strategy (NCS) was published in February 2016 following an extensive programme of development and engagement. The Strategy sets out a framework for the development of health services across Scotland for the next 10-15 years. It gives an evidence-based high level perspective of why change is needed and what direction that change should take. The Strategy sets out the case for:-

- Planning and delivery of primary care services around individuals and their communities;
- Planning hospital networks at a national, regional or local level based on a population paradigm;
- Providing high value, proportionate, effective and sustainable healthcare;
- Transformational change supported by investment in e-health and technological advances.

The full strategy can be found at http://www.gov.scot/Publications/2016/02/8699 The programe to establish the framework, which will enable implementation of the strategy, bringing together Scottish Government Directors with Board Chief Executives, is currently being established.

4.4. A final a critical part of the national scene is the work to develop a new GP contract which needs to provide the platform to enable the transformation of primary care.

4.5. At **Regional level,** there are well established planning arrangements which set the direction for a number of our services which are provided to populations beyond the Board area. The Regional Planning Group is discussing how to extend the range and depth of planning done at regional level to respond to the NCS and the growing reality that a wider range of services need to be planned for larger populations and that we need to create clinical networks for service delivery beyond Board boundaries.

4.6. At our **Board level** we have a comprehensive Clinical Services Strategy approved by the Board in January 2015 and since endorsed by the IJBs.

4.7. The key aims of the strategy are to ensure:

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

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

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

4.9. We have also developed a delivery plan for the Acute Division which focuses on resolving short term challenges but also describes a series of strategic service issues which we need to address.

4.10. IJBs have published their first Strategic Commissioning Plans, these highlight the need for Partnerships to establish a real focus on changing the way their populations use hospital services in their future planning.

5. Developing our Strategic Plan: proposed process

5.1. We know from our planning for 2016, and from the material outlined in the previous section, that it is imperative that we reshape acute services in the short, medium and longer term. Our proposed approach is to bring together those three horizons for planning into an integrated process so that we develop and describe the changes we need to make in 2017/18 in the context of describing a longer term strategic change programe.

5.2. To begin this process it is proposed that we complete a series of strands of work for consideration by a Board seminar in October 2016. The proposed strands are:-

An update of the key elements of the Clinical Services Review including:-

- Population health analysis;
- Drivers for change; realistic medicine programe national clinical stragey regionalistaion
- Future clinical models; separate emergency and elective
- Frail older people process.....workshop HSCPs
- Progress on implementation;
- An informed forward look at population and other changes which will require service transformation;
- A joint appraisal with IJBs of the implications of their strategic commissioning plans for the delivery of acute services;
- Analysis of service changes emerging from regional and national planning to deliver the National clinical strategy;

- An outline of proposed service changes for 2017/18 from the Acute Division's clinical planning processes, which are focussed on delivering high quality, safe and sustainable care;
- A strategic service and estate appraisal of our hospital sites;

Cardiac surgery

Elective which can be done elsewhere

BOC elements which needs to be done elsewhere

Major trauma

5.3. We also need to produce an initial forward financial framework for acute services, developed with the Integration Joint Board's;

5.4. The development of each of these strands will include extensive clinical engagement and engagement with wider stakeholders including other Boards and Scottish Government

5.5. The Acute services Committee will receive regular updates as this work develops to ensure continuing Non Executive input. Following the October Seminar, enabling the Board to consider and shape this material, there would be further discussion with IJBs with the aim that this work can be finalised to enable the Board to approve for publication, and public engagement, proposed service changes for 2017/18 set in the context of a longer term strategic plan.

6. Conclusion

6.1. Subject to the Board discussion the Board Executive team will work with IJB Chief Officers to establish the required processes to develop the material outlined in this paper.

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 3

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**6th October 2016**
Report Number	**2016/17_03**
Subject Title	**Month 5 Outturn report & Forecasting to year end**
Report by	**Jean Campbell, Chief Finance & Resources Officer East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Jean Campbell, Resource and Finance Officer, EDHSCP 0141 201 4210 Jean.Campbell@ggc.scot.nhs.uk**

1. PURPOSE

1.1. The purpose of this report is to update the Board on the projected financial outturn for the Health & Social Care Partnership for 2016/17 and to update on the IJB Budget 2016/17.

2. SUMMARY

2.1 The financial performance in relation to the forecast outturn for the Health & Social Care Partnership is based on the period 5 reporting cycle for the period to 31st August 2016 (dates vary between NHS and Council reporting cycles which do not align). This is still early in the financial year and the position can vary significantly based on unknown demand pressures (particularly throughout the winter period) and the volatile nature of Social Work budgets.

2.2 The current position indicates a surplus for the Health & Social Care Partnership as a result of capacity within the Integrated Care Fund and delayed discharge monies as developments are underway which will improve performance and there is also a positive impact from monies allocated to deliver the living wage which will not incur a full year cost in 2016/17. This is offsetting pressure in relation to care home placements. This position takes account of the full extent of savings agreed as part of the NHS GG&C Board savings agreed within their financial plan for 2016/17.

2.3 There are monies available to meet any ongoing demographic pressures and there is partnership reserves of £1.388m carried forward from 2015/16 to provide some additional resilience in 2016/17. However, reserves are non-recurring monies and will therefore require measures in place to manage any budget pressures on an ongoing basis.

2.4 There continue to be risks to the projected outturn position in respect of monies allocated by East Dunbartonshire Council. The Council's 2016/17 Revenue Budget was balanced by recognising that savings will accrue from a number of Transformation Work streams that are currently progressing. Improved financial efficiency will arise and the Partnership will be advised once these are determined.

2.5 In addition, Children's Social Work and Criminal Justice Services formally moved into the partnership on the 11th August 2016 and this is also an area subject to levels of volatility across budgets albeit there is currently a projected surplus on budget due to the level of staff vacancies offsetting pressures in respect of residential school expenditure.

3 RECOMMENDATIONS

It is recommended that the Board:-

a) Notes the projected outturn position for the HSCP for 2016/17 and that uncertainty exists in both funding and operational costs of demand sensitive areas;

b) Agrees net revenue budgets of £78.6m to NHS GG&C and £52.1m to East Dunbartonshire Council and direct that this funding be spent in line with the strategic plan;

c) Agree the "set aside" budget for prescribed acute services of £17.4m.

4.0 MAIN REPORT

4.1 East Dunbartonshire Health & Social Care Partnership (HSCP) was established on the 3rd September 2015 and 2016/17 represents the first year that budgets will be fully aligned for Adult Services. The incorporation of Children's Social Work and Criminal Justice Services on the 11th August 2016 will further increase the budgets, responsibilities and reporting requirements for the partnership.

4.2 The table below shows the year to date variance and estimated out –turn forecast for the HSCP.

Partnership Expenditure	Annual Budget £000	YTD Budget £000	YTD Actual £000	YTD Variance £000	Out-turn Forecast £000
NHS Community Budgets	25,221	8,127	8,242	(115)	600
Oral Health	10,301	4,214	4,171	43	0
FHS & Prescribing	43,037	17,932	17,932	0	0
Adult Social Care	40,500	13,768	10,412	3,356	900
Children & CJ Services	11.630	4,423	3,785	638	0
SUB-TOTAL	**130,689**	**48,464**	**44,543**	**3,921**	**1,500**
Acute Set Aside	17,381	7,242	7,242	0	0
TOTAL	**148,070**	**55,706**	**51,785**	**3,921**	**1,500**

HSCP Budget Outturn

4.3 The overall projected out turn for the HSCP is indicating a surplus position for 2016/17 of £1.5m. This is an accumulation of surplus available from monies allocated to deliver on the living wage (£1.4m - part year only for 2016/17) and surplus on the Integrated Care Fund and delayed Discharge monies (£600k).There continue to be pressures on Older People services and in particular care home placements (£500k), however these are being offset by

the monies available through the Social Care Fund allocation. There are also reserves carried forward at the end of 2015/16 to provide some in year resilience if required.

NHS Budget Outturn

4.4 The table below shows a detailed breakdown of the partnerships NHS budgets for the 5 month period to the 31st August 2016

NHS Expenditure £000	Annual Budget £000	YTD Budget £000	YTD Actual £000	Variance £000
Addictions – Community	701.5	292.3	328.1	(35.8)
Adult Community Services	4,297.8	1,790.6	1,717.2	73.4
Integrated Care Fund	1,200.0	142.2	142.2	0
Child Services – Community	1,367.4	573.5	525.8	47.8
Learning Disability – Community	306.7	160.6	129.2	31.4
Mental Health – Adult Community	1,248.7	518.2	477.7	40.5
Mental Health – Elderly Services	636.6	262.9	255.2	7.7
Other Services*	5,772.6	352.4	632.5	(280.1)
Planning & Health Improvement	745.6	255.7	255.7	0
Resource Transfer to Local Authority	8,884.6	3.701.5	3.701.5	0
Total Integrated Budgets	**25,221.4**	**8,127.4**	**8,242.5**	**(115.1)**
Family Health Services – Prescribing	18,807	7,836.3	7,836.3	0
Family Health Services – GMS	12,793	5,330.4	5,330.4	0
Family Health Services – Other	11,437	4,765.4	4,765.4	0
Total Ring-fenced NHS Budgets	**43,037**	**17,932.1**	**17,932.1**	**0**
Total Directly Managed NHS Budget	**68,258.4**	**26,059.5**	**26,174.6**	**(115.1)**
Oral Health – Public Dental Service (Hosted)	10,301	4,423	4,172	42
Acute Set Aside	17,381	7,242	7,242	0
Total IJB Health Budget	**95,940.4**	**37,724.5**	**37,588.6**	**(115.1)**

- *Current pressure relates to phasing of savings allocation. An adjustment to allocate this to relevant expenditure line will be done for future reports.*

4.5 The projected year end out turn for NHS budgets for 2016/17 is that of a surplus of £600k. This relates primarily to capacity within the Integrated Care Fund where monies are yet to be allocated to deliver on strategic priorities, delayed discharges monies where the implementation of the Intermediate Care proposal will only incur a part year spend in 2016/17, delays in filling vacancies and management costs and development monies

unallocated. There are a number of budget pressures in relation to Addictions, a consequence of the effect of the savings allocated in respect of the ADP allocation which will be resolved through adjustment to the level of Resource Transfer to the Council, and Other Services, in relation to accommodation charges for KHCC. However, these are offset by surpluses in a number of other areas including Adult Community Services relating to vacancies within District Nursing and Rehab and under spend on management costs within Adult and Mental Health services. The latter will form part of the structure considerations as these are further developed.

4.6 GP Prescribing costs are not available until two months after the month in which prescriptions are dispensed which means that only April - June expenditure is available, therefore actual is assumed to be on budget at this stage. There remains a risk sharing arrangement in place for 2016/17 across the GG&C board area and this will be managed within the NHSGGC board budgets.

4.7 The Public Dental Service hosted by ED HSCP is projected to achieve a breakeven position. There are a number of savings plans incorporated with the 16/17 budget which are yet to deliver but are expected to be achieved over the course of the current year.

Social Work Budget Outturn

4.8 The table below shows the partnerships Social Work budgets for the 5 month period to the 31st August 2016:-

SW Expenditure	Annual Budget £000	YTD Budget £000	YTD Actual £000	Variance £000
Adult SW Services	40,500	13,768	10,412	3,356
Children & CJ Services	11.630	4,423	3,785	638
TOTAL SW Budgets	**52,130**	**18,191**	**14,197**	**3,994**

4.9 The projected out turn for Adult Social Work services shows continued pressure in relation to care home placements, predominantly from a hospital setting in achievement of delayed discharge targets, however these are currently being managed from surpluses across other Adult Social Work budgets and monies available through the SG allocation to the Social Care Fund (£4.31m for East Dunbartonshire). The projected outturn at this point in the financial year is that of a surplus of £900k.

4.10 The projected out turn for Children's SW & CJ services is showing a breakeven position with positive variation in payroll as a result of vacancies within the service and pressure on residential school placements which requires further analysis. The projected outturn at this point in the financial year is projected to be breakeven.

Budget Setting 2016/17

4.11 The NHS GG&C Board approved the 2016/17 Financial Plan on the 28th June 2016. The proposed budget (£78.6m) and detailed breakdown for Health Services is detailed in paragraph 4.4 and includes a savings target of £1.368k for East Dunbartonshire of which £1.022k had previously been identified as a contribution to the £20m partnership savings allocation. The full extent of savings has now been identified for 2016/17.

Plans Identified to Date	£m	Status
Primary Dental Service Reduction In Dental Bundled Funding Reduction in allocation for Primary Dental Service	 0.228 0.263	Plans identified and detailed PIDs in development.
Sub Total		
NHS Community Services Integrated Care Fund Reduction in Drug / Alcohol allocations	 0.250 0.125	Plans identified and detailed PIDs in development.
Sub Total		
Collective Schemes Identified – Payroll Uplift Funding	0.156	Plans identified
Integrated Care fund Unallocated Development monies unallocated	0.300 0.046	Review of In Year Variances
Total Indicative Savings Target	**1.368**	

4.12 The health board has agreed a "set aside" budget for a range of in scope hospital based services for unscheduled care. The budget for Set Aside services for East Dunbartonshire is £17.4m (attached as **Appendix 1**).

4.13 The Council approved its budget for 2016/17 on the 17 March 2016 and the corresponding contribution to the IJB of £40.5m in line with the integration scheme. A further £11.6m was approved as the contribution to the IJB in respect of Children's SW & CJ Services giving a total of £52.1m.

4.14 The Council's 2016/17 Revenue Budget was balanced by recognising that savings will accrue from a number of Transformation Work streams that are currently progressing and these have still to be allocated to the HSCP.

Financial Risks

4.15 The most significant risks that will require to be managed during 2016/17 are;

- **Prescribing Expenditure** –Prescribing cost volatility represents the most significant risk within the NHS element of the partnership's budget. At this stage of the year it is now possible to make an informed assessment of the in year position against budgets and to estimate the likely out-turn for 2016/17, however based on previous year experience this will require close ongoing monitoring.
- **Achievement of Savings Targets** – Local NHS savings targets of £1.368m have been identified in part and there may be some non-recurring relief to meet any savings shortfall, however the release of this will be the subject of further discussions throughout the year. Recurring solutions will have to be identified going forward. Similarly, there are elements of savings targets for Total Resourcing and procurement, within the Council, which have yet to be allocated out which may present in year pressure.
- **Demographic Pressures** – Increasing numbers of older people is placing significant additional demand on a range of services including Home Care. In addition achieving the required reductions in delayed discharges is creating increased demand for care home places and resulting in increased levels of self directed support payments. These factors

increase the risk that overspends will arise and that the partnership Board will not achieve a balanced year end position.

- **Children's Services** – managing risk and vulnerability within Children's Services is placing significant demand pressures on residential placements which will increase the risk of overspend which may impact on achieving a balanced year end position.

5.0 IMPLICATIONS

5.1 This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document. The implications for the Council are as undernoted.

5.2 Financial – Information collated and reported within the HSCP has been done in discussion with the relevant partnership bodies and is consistent with their reporting requirements.

Comparison of 2016/17 Notional Set Aside Budgets with NRAC Share

APPENDIX 1

	2013/14			2014/15				Average Activity			2014/15	2015/16	2016/17	NRAC		NRAC Variance
Inpatients	Activity SMR Discharges	Activity OBD	A&E Attendances	Activity SMR Discharges	Activity OBD	A&E Attendances	£000	Activity SMR Discharges	Activity OBD	A&E Attendances	£000	£000	£000	%	£000	£000
East Dunbartonshire	11,442	53,266		12,896	59,490		14,453	12,169	56,378		15,106	15,257	15,410	8.00893	14,869	(541)
East Renfrewshire	8,337	52,025		9,462	56,112		12,223	8,901	54,068		12,243	12,365	12,489	6.74132	12,516	27
Glasgow City	79,039	409,653		83,896	417,000		99,670	81,470	413,326		101,866	102,885	103,914	54.97557	102,064	(1,849)
Inverclyde	10,277	62,133		10,504	61,284		15,896	10,393	61,709		13,835	13,974	14,114	7.24021	13,442	(672)
Renfrewshire	19,295	100,344		20,539	106,456		24,290	19,918	103,400		24,490	24,735	24,982	14.96838	27,789	2,807
West Dunbartonshire	10,937	59,062		12,488	63,181		15,465	11,714	61,122		14,455	14,600	14,746	8.06559	14,974	228
	139,327	736,483	0	149,785	763,522	0	181,996	144,565	750,003	0	181,996	183,816	185,654	100	185,654	(0)
A&E Outpatients																
East Dunbartonshire			19,975			20,417	1,949			20,196	1,932	1,952	1,971	8.00893	2,417	446
East Renfrewshire			21,022			21,445	2,035			21,234	2,032	2,052	2,072	6.74132	2,034	(38)
Glasgow City			173,476			172,612	16,484			173,044	16,556	16,722	16,889	54.97557	16,590	(299)
Inverclyde			23,458			24,191	2,315			23,825	2,279	2,302	2,325	7.24021	2,185	(140)
Renfrewshire			47,148			47,102	4,504			47,125	4,509	4,554	4,599	14.96838	4,517	(82)
West Dunbartonshire			23,556			23,987	2,295			23,772	2,274	2,297	2,320	8.06559	2,434	114
	0	0	308,635	0	0	309,754	29,583	0	0	309,196	29,583	29,878	30,177	100	30,177	(0)
Total																
East Dunbartonshire	11,442	53,266	19,975	12,896	59,490	20,417	16,402	12,169	56,378	20,196	17,038	17,209	17,381	8.00893	17,286	(95)
East Renfrewshire	8,337	52,025	21,022	9,462	56,112	21,445	14,258	8,901	54,068	21,234	14,274	14,417	14,561	6.74132	14,550	(11)
Glasgow City	79,039	409,653	173,476	83,896	417,000	172,612	116,154	81,470	413,326	173,044	118,422	119,606	120,803	54.97557	118,654	(2,148)
Inverclyde	10,277	62,133	23,458	10,504	61,284	24,191	18,211	10,393	61,709	23,825	16,115	16,276	16,439	7.24021	15,627	(812)
Renfrewshire	19,295	100,344	47,148	20,539	106,456	47,102	28,794	19,918	103,400	47,125	28,999	29,289	29,582	14.96838	32,306	2,725
West Dunbartonshire	10,937	59,062	23,556	12,488	63,181	23,987	17,760	11,714	61,122	23,772	16,730	16,897	17,066	8.06559	17,408	342
Total Budget	139,327	736,483	308,635	149,785	763,522	309,754	211,578	144,565	750,003	309,196	211,578	213,694	215,831	100	215,831	0

Notes

1 2014/15 Notional Budget is based on the average of 2013/14 and 2014/15 activity

4 Cost based on PLICS applied to activity by ISD reconciled to 2014/15 Cost Book

3 1% annual uplifts applied to 2014/15 budgets to derive 2016/17 budgets

4 NRAC shares for 2016/17 used as a comparison

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 4

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**6th October 2016**
Report Number	**2016/17_04**
Subject Title	**Quarter 1 Performance Report**
Report By	**Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Fiona McCulloch, Planning & Performance Manager,** **East Dunbartonshire Health & Social Care Partnership** **0141 201 9705** **Fiona.mcculloch@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to present a summary of the agreed HSCP targets and measures, relating to the delivery of the strategic priorities, for the period April to June 2016 (Quarter 1).

2.0 SUMMARY

2.1 The Health & Social Care Partnership Board agreed to receive and consider Quarterly Performance Reports on progress of an agreed suite of measures and targets against the priorities set out in the Strategic Plan. During 2015/16, the reports focused only on adult services.

2.2 Following the agreed integration Children's Services and Criminal Justice, the 2016/17 quarterly performance reports will also include measures and targets for Children's Services and Criminal Justice for which the HSCP has responsibility.

2.3 Therefore, the Quarter 1 Performance Report sets out:

- Positive Performance (on target) improving (19 measures)
- Positive Performance (on target) declining (1 measure)
- Negative Performance (below target) improving (6 measures)
- Negative Performance (below target) declining (7 measures)

There are 5 measures for which data are not available.

A summary of the performance indicators for the reporting period is provided in **Section 1.** The full list of measures and targets are then provided. **Section 2** lists the Adult Services data. The performance measures are set under the relevant National Health & Wellbeing Outcome to assist in the scrutiny of the HSCP's progress against these outcomes. **Section 3** provides the Children's Services data and **Section 4** provides the Criminal Justice data.

2.4	Each section concludes with the relevant exception reports that provide a brief review of performance and actions to be taken to address deficits. They include the percentage variance from target and, if available, the actual numbers. The exception reports are ordered from greatest to least percentage variance.
3.0	**RECOMMENDATIONS**
3.1	It is recommended that the Health & Social Care Partnership Board: • Notes the content of the Quarter 1 Performance Report and monitors progress against these targets

SECTION 1 Performance Summary

Key	
Positive Performance (on target) improving / declining	
Negative Performance (below target) improving / declining	

 **Positive Performance (on target & improving) is reported in:**

Ref		
2.1.2	Sustain and embed alcohol brief interventions in three priority settings (primary care, A&E, Antenatal) and broaden delivery in wider settings	
2.2.1	Rate of unplanned acute bed days 75+ (per 1.000 pop) (rate at quarter end)	
2.2.2	Number of emergency admissions 75+ rate (per 1,000 pop) (rate at quarter end)	
2.2.3	Number of delayed discharges for Adults with Incapacity (Acute Beds)	
2.2.4	Number of acute bed days lost to delayed discharges for patients 65+ (Inc AWI)	
2.2.5	Number of acute bed days lost to delayed discharges for Adults with Incapacity (65+)	
2.2.6	Delayed Discharge >14 days	
2.2.9	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	
2.2.13	Number of people with a new or additional telecare package (at quarter end)	
2.2.16	Percentage of EDC homecare customers 65+ receiving a service at weekends	
2.6.1	Number of carers who feel supported and capable of continuing in a caring role (Social Care only)	
3.1	18 weeks referral to treatment for specialist Child and Adolescent Mental health Services	
3.4	Percentage of parents receiving 1:1 parenting support within the first 6 weeks following birth	
3.5	As a proportion of parents who attend a Triple P group – the percentage of parents completing the Triple P programme	
3.7	Percentage of child care Integrated Assessments (ICA) for SCRA completed within target timescales (20 days)	
3.9	Percentage of first Child Protection review conferences taking place within 3 months of registration	
3.12	Percentage of Social Work reports submitted to Child Protection Case Conference	
4.1	Percentage of Court report requests allocated to a Social Worker within 10 days	
4.3	Percentage of CJSW reports submitted to Court by due date	

Positive Performance (on target but declining) is reported in:

Ref		
2.2.14	Percentage of people 65 or over with intensive needs receiving care at home (% at quarter end)	

Negative Performance (below target but maintaining/improving) is reported in:

Ref		
2.2.7	Percentage of people newly diagnosed with dementia accessing a minimum of one year's post-diagnostic support	
2.2.8	Number of people aged 65 years+ with an anticipatory care plan in place (DNs only)	
2.2.10	Primary Care Mental Health Team Waits % of patients referred to 1st appointment offered <4wks	
2.2.12	Number of people aged 65+ in permanent care home placements	
3.8	Percentage of Initial Child Protection Case Conferences taking place within 21 days from receipt of referral	
3.10	Balance of care for Looked After Children: Percentage of children being looked after in the community	

Negative Performance (below target and declining) is reported in:

Ref		
2.2.11	Primary Care Mental Health Team Waits % of patients referred to 1st appointment offered <9wks	
2.2.15	Percentage of EDC homecare customers 65+ receiving a service during evenings or overnight	
2.3.1	Percentage of service users / clients satisfied with the quality of care provided (Social Care only)	
2.4.1	Percentage of people 65+ indicating satisfaction with their social interaction opportunities (Social Care only)	
2.4.2	Percentage of service users satisfied with their involvement in the design of their care packages (Social Care only)	
3.11	Percentage of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated	
4.2	Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order	

Indicators with no current data available

Ref.	
2.1.1	Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas (Cumulative quarterly)
2.1.3	Percentage of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery
3.2	Uptake of MMR 24 months
3.3	Uptake of MMR 5 years
3.6	Number of parents receiving planned 1:1 parenting support

SECTION 2 Adult Performance Quarterly Measures 2016-17

Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer

			Quarter				
Ref.	**Measure**	**Status**	**Q2 2015/16**	**Q3 2015/16**	**Q4 2015/16**	**Q1 2016/17**	**2016/17**
			Value	**Value**	**Value**	**Value**	**Target**
2.1.1	Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas (Cumulative quarterly)	-	**6**	**12**	**20**	**Not available**	**6**
2.1.2	Sustain and embed alcohol brief interventions in three priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings. (Cumulative quarterly)		**342**	**498**	**625**	**207**	**122**
2.1.3	Percentage of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	-	**91.6%**	**99%**	**91.6%**	**Not available**	**91.5%**

SECTION 2 Adult Performance Quarterly Measures 2016-17

Outcome 2: People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

			Quarter				
Ref.	**Measure**	**Status**	**Q2 2015/16**	**Q3 2015/16**	**Q4 2015/16**	**Q1 2016/17**	**2016/17**
			Value	**Value**	**Value**	**Value**	**Target**
2.2.1	Rate of unplanned acute bed days 75+ (per 1,000 pop) (rate at quarter end)	✓	**302**	**401**	**372**	**343**	**345**
2.2.2	Number of emergency admissions 75+ rate (per 1,000 pop) (rate at quarter end)	✓	**29**	**35**	**33**	**28**	**29**
2.2.3	Number of delayed discharges for Adults with Incapacity (Acute Beds)	✓	**5**	**2**	**0**	**0**	**0**
2.2.4	Number of acute bed days lost to delayed discharges for patients 65+ (inc AWI)	✓	**670**	**916**	**843**	**527**	**622**
2.2.5	Number of acute bed days lost to delayed discharges for Adults with Incapacity (65+)	✓	**128**	**41**	**0**	**0**	**0**
2.2.6	Delayed Discharge >14 days	✓	**5**	**1**	**2**	**0**	**0**

SECTION 2 Adult Performance Quarterly Measures 2016-17

Ref.	Measure	Status	Quarter				
			Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	2016/17
			Value	Value	Value	Value	Target
2.2.7	Percentage of people newly diagnosed with dementia accessing a minimum of one year's post-diagnostic support.	✗	72%	81%	90%	95%	100%
2.2.8	Number of people aged 65 years+ with an anticipatory care plan in place (DNs only)	✗	51	62	63	65	70
2.2.9	Percentage of patients who started Psychological Therapies treatments within 18 weeks of referral	✓	99.5%	99%	98.4%	100%	85%
	Primary Care Mental Health Team Waits						
2.2.10	% of patients referred to 1st appointment offered <4 wks	✗	100%	100%	99.2%	99.6%	100%
2.2.11	% of patients referred to 1st treatment appt offered <9wks	✗	100%	100%	100%	88%	100%
2.2.12	Number of people aged 65+ in permanent care home placements (at quarter end)	✗	690	Data not available	674	669	640
2.2.13	Number of people with a new or additional telecare package (at quarter end)	✓	Not available	Not available	Not available	64	60
2.2.14	Percentage of people 65 or over with intensive needs receiving care at home (% at quarter end)	✓	38.5%	38%	38.1%	37.33%	32%
2.2.15	Percentage of EDC homecare customers 65+ receiving a service during evenings or overnight	✗	55%	52.7%	50.9%	49.9%	50%
2.2.16	Percentage of EDC homecare customers 65+ receiving a service at weekends	✓	90.2%	89.4%	90.2%	90.4%	84%

Outcome 3 People who use health and social care services have positive experiences of those services, and have their dignity respected							
			Quarter				
Ref.	Measure	Status	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	2016/17
			Value	Value	Value	Value	Target
2.3.1	Percentage of service users/clients satisfied with the quality of care provided (Social Care only)		98%	96%	100%	91%	99%

Outcome 4 Health and social care services are centered on helping to maintain or improve the quality of life of people who use those services.							
			Quarter				
Ref.	Measure	Status	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	2016/17
			Value	Value	Value	Value	Target
2.4.1	Percentage of people 65+ indicating satisfaction with their social interaction opportunities (Social Care only)		97.5%	92%	100%	83%	95%
2.4.2	Percentage of service users satisfied with their involvement in the design of their care packages (Social Care only)		100%	96%	100%	91%	95%

SECTION 2 Adult Performance Quarterly Measures 2016-17

Outcome 6 People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.							
			Quarter				
Ref.	Measure	Status	Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	2016/17
			Value	Value	Value	Value	Target
2.6.1	Number of carers who feel supported and capable of continuing in a caring role (Social Care only)	✓	100%	88%	100%	100%	94%

SECTION 2 Exception Reports - Adult Performance Quarterly Measures 2016-17 (descending order of variance from target)

Ref.	Performance below Target	Exception Report	Action(s) to improve	Variance from target
2.4.1	Percentage of people 65+ indicating satisfaction with their social interaction opportunities (social care only)	The figure is based on the number of older people community care reviews undertaken in the first quarter. Due to the low number of reviews the variance has occurred due to the dissatisfaction pertaining to a small number of older people (3) living in the community or residential care. Dissatisfaction can occur for a variety of reasons including situations where health and physical frailty can contribute to the person's ability to participation in social interactions.	The practitioners and support staff will continue to work closely with this small number of individuals to ensure that the most appropriate person centered approach is undertaken.	12%
2.2.11	Primary Care Mental Health Team Waits: % of patients referred to 1st treatment appt offered <9wks	The percentage in June 2016 is noted as low. This is due to the migration to EMIS in July. The data reported includes only information from PiMS.	Data will be monitored.	12%

Ref.	Performance below Target	Exception Report	Action(s) to improve	Variance from target
2.3.1	Percentage of service users/clients satisfied with the quality of care provided (Social Care only)	The variance has occurred due to a very small number of individuals stating dissatisfaction with the quality of their care. If a person has not been satisfied with their involvement in the design of their care, they may also be dissatisfied in the quality of care received. This can be attributed to reasons such as emergency care being provided while ongoing assessment takes place and decisions taken in the best interests of the person by their guardians/power of attorney.	Practitioners will continue to work with individuals to ensure the support arranged is personalised to that customer's needs and outcomes.	**8%**
2.4.2	Percentage of clients satisfied with their involvement in the design of their care packages (social care only)	The variance has occurred due to a very small number of individuals stating dissatisfaction with their involvement in the design of their care package. This dissatisfaction can stem from a variety of reasons in particular where decisions regarding support are made by the legal power of attorney or guardian and are in the best interests of the cared for person. The setting up of care and support in an emergency/crisis situation can also put limitations on choice, control and involvement in the design of the care package.	Practitioners will continue to work with individuals to ensure that decisions taken by legal guardians continue to be in the best interests of the cared for person. In relation to emergency care, once crises have been averted focus can shift to the longer term personalised care package for individuals.	**4%**
2.2.15	Percentage of EDC Homecare customers 65+ receiving a service during evenings or overnight	The Out of Hours Homecare Service was introduced to prevent vulnerable older people being admitted to Nursing Care. This was intended for people with complex needs and palliative care whose choice was to be supported to stay at home for as long as possible respecting and facilitating their wish to die at home with dignity.	The service is currently staffed to meet the needs of 50 Home Care customers. A further 2 staff members to be recruited to increase capacity.	**0.2%**

SECTION 3 Children's Performance Quarterly Measures 2016-17

Ref.	Measure	Status	Quarter				
			Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	2016/17
			Value	Value	Value	Value	Target
3.1	18 weeks referral to treatment for specialist Child and Adolescent Mental health Services	✓	Not available	Not available	Not available	100%	100%
	Uptake of MMR						
3.2	24 months	-	98%	96.8%	95.3%	Not available	95%
3.3	5 years	-	97.1%	98%	97.5%	Not available	95%
3.4	Percentage of parents receiving 1:1 parenting support within the first 6 weeks following birth	✓	100%	100%	100%	100%	100%
3.5	As a proportion of parents who attend a Triple P group - the percentage of parents completing the Triple P programme	✓	80%	10%	71%	74%	70%
3.6	Number of parents receiving planned 1:1 parenting support	-	19	37	65	Not available	40
3.7	Percentage of child care Integrated Assessments (ICA) for SCRA completed within target timescales (20 days)	✓	100%	100%	75%	100%	75%
3.8	Percentage of Initial Child Protection Case Conferences taking place within 21 days from receipt of referral	✗	88%	91%	88%	89%	90%
3.9	Percentage of first Child Protection review conferences taking place within 3 months of registration	✓	83%	78%	78%	100%	95%

Ref.	Measure	Status	Quarter				
			Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	2016/17
			Value	Value	Value	Value	Target
3.10	Balance of care for Looked After Children: Percentage of children being looked after in the community		89%	87%	87%	88%	89%
3.11	Percentage of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated		100%	100%	100%	88%	100%
3.12	Percentage of Social Work reports submitted to Child Protection Case Conference		100%	100%	100%	100%	100%

SECTION 3 Exception Reports - Children's Performance Quarterly Measures 2016-17 (descending order of variance from target)

Ref.	Performance below Target	Exception Report	Action(s) to improve	Variance from target
3.11	Percentage of first Looked After & Accommodated reviews taking place within 4 weeks of the child being accommodated	There were 8 first LAAC Reviews held during quarter 1, 7 of these took place within the target timescale. One Review did not take place within timescale, the child was subject to CP registration and continued to be reviewed under CP processes until a LAAC Review was arranged		12%

SECTION 4 Criminal Justice Performance Quarterly Measures 2016-17

Ref.	Measure	Status	Quarter				
			Q2 2015/16	Q3 2015/16	Q4 2015/16	Q1 2016/17	2016/17
			Value	Value	Value	Value	Target
4.1	Percentage of Court report requests allocated to a Social Worker within 10 days		100%	100%	100%	100%	100%
4.2	Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order		83%	81%	72%	72%	80%
4.3	Percentage of CJSW reports submitted to Court by due date		98%	100%	97%	100%	95%

SECTION 4 Exception Reports – Criminal Justice Performance Quarterly Measures 2016-17 (descending order of variance from target)

Ref.	Performance below Target	Exception Report	Action(s) to improve	Variance from target
4.2	Percentage of individuals beginning a work placement within 7 days of receiving a Community Payback Order	23 out of 32 individuals started an unpaid work placement within the agreed timescales. Of those individuals who did not; 4 were undertaking paid employment, 3 were currently on an Order, 1 individual was ill, 1 transferred from another Local Authority and 2 were the result of service based error.	Service based error was within the mail system and has since been corrected.	10%

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number:5

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**6th October 2016**
Report Number	**2016/17_05**
Subject Title	**Delayed Discharges Action Plan Update**
Report by	**Karen Murray, Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Andy Martin, Head of Adult & Primary Care Services,** **East Dunbartonshire Health & Social Care Partnership** **0141 201 4209** **Andy.martin@eastdunbarton.gov.uk**

1.0 PURPOSE OF REPORT

1.1 To advise the HSCP Board on the progress being made in relation to the Delayed Discharges Action Plan.

2.0 SUMMARY

2.1 The Scottish Government provided an allocation of £510,000 to East Dunbartonshire HSCP to support improvement in reducing Delayed Discharges. A report was presented to the HSCP in December 2015 outlining the proposed allocation of this funding, and the Action Plan to support progress.

2.2 This report provides a brief narrative outlining the progress made against the priorities set out in the Action Plan.

2.3 Current performance data included in the report provide comparatives with Greater Glasgow and Clyde Partnerships, and are taken from the NHSGG&C Older People's Monitoring Report and the ISD Delayed Discharge Census for January 2016.

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

(a) Notes the content of this report

4.0 BACKGROUND

4.1 Due to changes in the way that information is held across the partnership the NHS Greater & Glasgow & Clyde Corporate Older Peoples monitoring report is currently being revised and is not available. A local count taken from the EDISON discharges management data system indicates that East Dunbartonshire's Bed Days Lost to Delayed Discharges total was 206 days in July, continuing the overall downward trend.

4.2 Equally encouraging is the ongoing maintenance at zero of bed days lost to delayed discharges for Adults with Incapacity (AWI). This rose briefly to 10 in the month of

December 2016 but has been maintained at zero since.

5.0 ACTION PLAN UPDATE

5.1 POA Campaign

East Dunbartonshire is participating in the wider national Power of Attorney awareness campaign. This has already begun to demonstrate impact, both nationally and within East Dunbartonshire. The most recent comparative table from the office of the Public Guardian showing the relative uptake of POA's across a range of Scottish partnerships is attached as **Appendix 1**. The figures are lower than actual. The OPG has informed that there is a current backlog of POA's waiting to be processed of around 12,000. East Dunbartonshire will participate in a Christmas campaign to drive uptake.

5.2 Patients with Complex Needs

Patient K was admitted to hospital on the 7th June 2014 due to progressive muscle weakness. He was diagnosed with Guillain-Barré syndrome, a rare condition of the peripheral nervous system that can cause acute neuromuscular paralysis. As a result of his condition, K has no meaningful function in his trunk and upper and lower limbs (near paralysis). K is ventilator dependent with a tracheostomy. He is catheterised and incontinent of bowel. K requires daily trache care and in the community will require the constant presence of two ventilator and trache trained staff to meet his respiratory needs and specifically deal with any emergency that should arise in relation to the ventilator or tracheostomy.

Pulse Community Healthcare Ltd has been commissioned to ensure a timely discharge from the Queen Elizabeth University Hospital. Support Staff from Pulse Community Healthcare are undertaking comprehensive training to ensure that all the patients support team are clinically competent to meet his healthcare needs. Competency in all areas will be assessed during training by nursing staff from the Community Ventilation Team.

The anticipated discharge date is November 2016.

5.3 Clinical Portal – Impact

Social work staff within the Hospital Assessment Team has had access to the shared portal since July 2016. This has established much greater ease of access to patient information, reduced wastage of staff time, and allowed social worker staff responsible for meeting delayed discharge targets to have access to real time information regarding patient pathways. It has promoted significant improvement and efficiency in information sharing and its use has been embraced and adopted across the Hospital Assessment Team.

5.4 Intermediate Care Pilot

As part of our strategic and delayed discharge planning, East Dunbartonshire Health and Social Care Partnership are introducing an eight bedded intermediate care unit. This unit will provide an opportunity for social work and health staff to work in partnership with service users, carers, families, care home staff and third sector stakeholders during the service user's transition from a hospital based setting to long term care or a return to their own home environment. The 'Intermediate Care' project, although a time limited intervention, will transition service users from the hospital setting, when medically fit for discharge, to a homely environment giving the service user time for additional recovery and to receive a comprehensive assessment of their longer term health and social care support needs. The aim of the Project is to facilitate the care management and rehabilitation of service users in the integrated care unit by delivering person centred care with focus on personal outcomes for the service user.

Discharge will be planned from the time of admission to the unit. Service user goals will be set and regularly reviewed throughout the individual's stay.

5.5 RAL Update

The RAL (Rapid Assessment Link), service focuses on GP admission avoidance referrals, urgent rehab and out of hours(OOH'S) referrals. OOH's is for patients attending A&E out of hours who are deemed able to return home on the proviso they are followed up at home the following day. Referrals continue to demonstrate increasing demand:–

- **Referrals 2014 – 99**
  2015 – 187
  2016 – 148 (until end Aug 2016)

Admissions remain at less than 30% with main reasons being requirement for IV antibiotics, fractures or acute illness. All patients admitted are followed up in acute via a phone call to the ward advising of service and referral back to team at point of discharge as appropriate.

Any known admissions from either RAL or the Rehab Team are highlighted as part of the weekly delayed discharge meeting to enable early intervention and forward planning as appropriate.

6.0 IMPLICATIONS

6.1 This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document. The implications for the Council are as undernoted.

6.2 Financial – Information collated and reported within the HSCP has been done in discussion with the relevant partnership bodies and is consistent with their reporting requirements.

Glasgow

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	751
Quarter 2 (2013)	01/04/2013 - 30/06/2013	703
Quarter 3 (2013)	01/07/2013 - 30/09/2013	604
Quarter 4 (2013)	01/10/2013 - 31/12/2013	643

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	928
Quarter 2 (2014)	01/04/2014 - 30/06/2014	448
Quarter 3 (2014)	01/07/2014 - 30/09/2014	892
Quarter 4 (2014)	01/10/2014 - 31/12/2014	1,344

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	1,165
Quarter 2 (2015)	01/04/2015 - 30/06/2015	868
Quarter 3 (2015)	01/07/2015 - 30/09/2015	1,178
Quarter 4 (2015)	01/10/2015- 31/12/2015	946

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	747
Quarter 2 (2016)	01/04/2016 - 30/06/2016	765
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

Aberdeenshire

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	633
Quarter 2 (2013)	01/04/2013 - 30/06/2013	638
Quarter 3 (2013)	01/07/2013 - 30/09/2013	473
Quarter 4 (2013)	01/10/2013 - 31/12/2013	589

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	765
Quarter 2 (2014)	01/04/2014 - 30/06/2014	480
Quarter 3 (2014)	01/07/2014 - 30/09/2014	674
Quarter 4 (2014)	01/10/2014 - 31/12/2014	947

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	1,038
Quarter 2 (2015)	01/04/2015 - 30/06/2015	732
Quarter 3 (2015)	01/07/2015 - 30/09/2015	1,050
Quarter 4 (2015)	01/10/2015- 31/12/2015	712

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	616
Quarter 2 (2016)	01/04/2016 - 30/06/2016	656
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

Edinburgh

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	1,176
Quarter 2 (2013)	01/04/2013 - 30/06/2013	1,142
Quarter 3 (2013)	01/07/2013 - 30/09/2013	849
Quarter 4 (2013)	01/10/2013 - 31/12/2013	1,102

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	1,355
Quarter 2 (2014)	01/04/2014 - 30/06/2014	616
Quarter 3 (2014)	01/07/2014 - 30/09/2014	1,161
Quarter 4 (2014)	01/10/2014 - 31/12/2014	1,602

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	1,600
Quarter 2 (2015)	01/04/2015 - 30/06/2015	1,194
Quarter 3 (2015)	01/07/2015 - 30/09/2015	1,417
Quarter 4 (2015)	01/10/2015- 31/12/2015	1,118

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	1055
Quarter 2 (2016)	01/04/2016 - 30/06/2016	1075
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

FORTH VALLEY

FALKIRK

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	324
Quarter 2 (2013)	01/04/2013 - 30/06/2013	271
Quarter 3 (2013)	01/07/2013 - 30/09/2013	206
Quarter 4 (2013)	01/10/2013 - 31/12/2013	272

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	352
Quarter 2 (2014)	01/04/2014 - 30/06/2014	133
Quarter 3 (2014)	01/07/2014 - 30/09/2014	312
Quarter 4 (2014)	01/10/2014 - 31/12/2014	493

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	387
Quarter 2 (2015)	01/04/2015 - 30/06/2015	326
Quarter 3 (2015)	01/07/2015 - 30/09/2015	421
Quarter 4 (2015)	01/10/2015- 31/12/2015	359

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	270
Quarter 2 (2016)	01/04/2016 - 30/06/2016	262
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

STIRLING

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	270
Quarter 2 (2013)	01/04/2013 - 30/06/2013	180
Quarter 3 (2013)	01/07/2013 - 30/09/2013	160
Quarter 4 (2013)	01/10/2013 - 31/12/2013	264

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	85
Quarter 2 (2014)	01/04/2014 - 30/06/2014	105
Quarter 3 (2014)	01/07/2014 - 30/09/2014	312
Quarter 4 (2014)	01/10/2014 - 31/12/2014	411

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	121
Quarter 2 (2015)	01/04/2015 - 30/06/2015	267
Quarter 3 (2015)	01/07/2015 - 30/09/2015	368
Quarter 4 (2015)	01/10/2015- 31/12/2015	249

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	227
Quarter 2 (2016)	01/04/2016 - 30/06/2016	242
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

CLACKMANNANSHIRE

QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	105	Quarter 1 (2014)	01/01/2014 - 31/03/2014	85	Quarter 1 (2015)	01/01/2015 - 31/03/2015	121
Quarter 2 (2013)	01/04/2013 - 30/06/2013	82	Quarter 2 (2014)	01/04/2014 - 30/06/2014	47	Quarter 2 (2015)	01/04/2015 - 30/06/2015	108
Quarter 3 (2013)	01/07/2013 - 30/09/2013	77	Quarter 3 (2014)	01/07/2014 - 30/09/2014	87	Quarter 3 (2015)	01/07/2015 - 30/09/2015	154
Quarter 4 (2013)	01/10/2013 - 31/12/2013	75	Quarter 4 (2014)	01/10/2014 - 31/12/2014	110	Quarter 4 (2015)	01/10/2015- 31/12/2015	119

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	111
Quarter 2 (2016)	01/04/2016 - 30/06/2016	111
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

LANARKSHIRE

North Lanarkshire

QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	445	Quarter 1 (2014)	01/01/2014 - 31/03/2014	576	Quarter 1 (2015)	01/01/2015 - 31/03/2015	718
Quarter 2 (2013)	01/04/2013 - 30/06/2013	399	Quarter 2 (2014)	01/04/2014 - 30/06/2014	250	Quarter 2 (2015)	01/04/2015 - 30/06/2015	550
Quarter 3 (2013)	01/07/2013 - 30/09/2013	352	Quarter 3 (2014)	01/07/2014 - 30/09/2014	525	Quarter 3 (2015)	01/07/2015 - 30/09/2015	694
Quarter 4 (2013)	01/10/2013 - 31/12/2013	395	Quarter 4 (2014)	01/10/2014 - 31/12/2014	786	Quarter 4 (2015)	01/10/2015- 31/12/2015	514

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	421
Quarter 2 (2016)	01/04/2016 - 30/06/2016	527
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

South Lanarkshire

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	707
Quarter 2 (2013)	01/04/2013 - 30/06/2013	569
Quarter 3 (2013)	01/07/2013 - 30/09/2013	481
Quarter 4 (2013)	01/10/2013 - 31/12/2013	568

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	763
Quarter 2 (2014)	01/04/2014 - 30/06/2014	396
Quarter 3 (2014)	01/07/2014 - 30/09/2014	782
Quarter 4 (2014)	01/10/2014 - 31/12/2014	1,165

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	1,077
Quarter 2 (2015)	01/04/2015 - 30/06/2015	792
Quarter 3 (2015)	01/07/2015 - 30/09/2015	1,002
Quarter 4 (2015)	01/10/2015- 31/12/2015	786

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	733
Quarter 2 (2016)	01/04/2016 - 30/06/2016	640
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

TAYSIDE

Angus

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	264
Quarter 2 (2013)	01/04/2013 - 30/06/2013	300
Quarter 3 (2013)	01/07/2013 - 30/09/2013	226
Quarter 4 (2013)	01/10/2013 - 31/12/2013	276

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	313
Quarter 2 (2014)	01/04/2014 - 30/06/2014	220
Quarter 3 (2014)	01/07/2014 - 30/09/2014	286
Quarter 4 (2014)	01/10/2014 - 31/12/2014	409

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	529
Quarter 2 (2015)	01/04/2015 - 30/06/2015	430
Quarter 3 (2015)	01/07/2015 - 30/09/2015	553
Quarter 4 (2015)	01/10/2015- 31/12/2015	412

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	321
Quarter 2 (2016)	01/04/2016 - 30/06/2016	340
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

Dundee City

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	321
Quarter 2 (2013)	01/04/2013 - 30/06/2013	308
Quarter 3 (2013)	01/07/2013 - 30/09/2013	264
Quarter 4 (2013)	01/10/2013 - 31/12/2013	306

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	329
Quarter 2 (2014)	01/04/2014 - 30/06/2014	217
Quarter 3 (2014)	01/07/2014 - 30/09/2014	292
Quarter 4 (2014)	01/10/2014 - 31/12/2014	365

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	478
Quarter 2 (2015)	01/04/2015 - 30/06/2015	334
Quarter 3 (2015)	01/07/2015 - 30/09/2015	439
Quarter 4 (2015)	01/10/2015- 31/12/2015	405

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	329
Quarter 2 (2016)	01/04/2016 - 30/06/2016	319
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

Perth & Kinross

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	576
Quarter 2 (2013)	01/04/2013 - 30/06/2013	488
Quarter 3 (2013)	01/07/2013 - 30/09/2013	408
Quarter 4 (2013)	01/10/2013 - 31/12/2013	452

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	543
Quarter 2 (2014)	01/04/2014 - 30/06/2014	299
Quarter 3 (2014)	01/07/2014 - 30/09/2014	551
Quarter 4 (2014)	01/10/2014 - 31/12/2014	668

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	767
Quarter 2 (2015)	01/04/2015 - 30/06/2015	590
Quarter 3 (2015)	01/07/2015 - 30/09/2015	818
Quarter 4 (2015)	01/10/2015- 31/12/2015	577

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	486
Quarter 2 (2016)	01/04/2016 - 30/06/2016	475
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

Argyll & Bute

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	306
Quarter 2 (2013)	01/04/2013 - 30/06/2013	274
Quarter 3 (2013)	01/07/2013 - 30/09/2013	224
Quarter 4 (2013)	01/10/2013 - 31/12/2013	226

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	347
Quarter 2 (2014)	01/04/2014 - 30/06/2014	141
Quarter 3 (2014)	01/07/2014 - 30/09/2014	298
Quarter 4 (2014)	01/10/2014 - 31/12/2014	423

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	359
Quarter 2 (2015)	01/04/2015 - 30/06/2015	312
Quarter 3 (2015)	01/07/2015 - 30/09/2015	432
Quarter 4 (2015)	01/10/2015- 31/12/2015	319

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	264
Quarter 2 (2016)	01/04/2016 - 30/06/2016	206
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

West Dunbartonshire

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	220
Quarter 2 (2013)	01/04/2013 - 30/06/2013	181
Quarter 3 (2013)	01/07/2013 - 30/09/2013	111
Quarter 4 (2013)	01/10/2013 - 31/12/2013	124

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	174
Quarter 2 (2014)	01/04/2014 - 30/06/2014	112
Quarter 3 (2014)	01/07/2014 - 30/09/2014	147
Quarter 4 (2014)	01/10/2014 - 31/12/2014	234

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	218
Quarter 2 (2015)	01/04/2015 - 30/06/2015	202
Quarter 3 (2015)	01/07/2015 - 30/09/2015	257
Quarter 4 (2015)	01/10/2015- 31/12/2015	202

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	133
Quarter 2 (2016)	01/04/2016 - 30/06/2016	142
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

East Dunbartonshire

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	404
Quarter 2 (2013)	01/04/2013 - 30/06/2013	335
Quarter 3 (2013)	01/07/2013 - 30/09/2013	267
Quarter 4 (2013)	01/10/2013 - 31/12/2013	301

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2014)	01/01/2014 - 31/03/2014	455
Quarter 2 (2014)	01/04/2014 - 30/06/2014	217
Quarter 3 (2014)	01/07/2014 - 30/09/2014	415
Quarter 4 (2014)	01/10/2014 - 31/12/2014	549

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2015)	01/01/2015 - 31/03/2015	582
Quarter 2 (2015)	01/04/2015 - 30/06/2015	396
Quarter 3 (2015)	01/07/2015 - 30/09/2015	580
Quarter 4 (2015)	01/10/2015- 31/12/2015	404

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	414
Quarter 2 (2016)	01/04/2016 - 30/06/2016	343
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

Renfrewshire

QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	450	Quarter 1 (2014)	01/01/2014 - 31/03/2014	439	Quarter 1 (2015)	01/01/2015 - 31/03/2015	486
Quarter 2 (2013)	01/04/2013 - 30/06/2013	324	Quarter 2 (2014)	01/04/2014 - 30/06/2014	177	Quarter 2 (2015)	01/04/2015 - 30/06/2015	478
Quarter 3 (2013)	01/07/2013 - 30/09/2013	310	Quarter 3 (2014)	01/07/2014 - 30/09/2014	466	Quarter 3 (2015)	01/07/2015 - 30/09/2015	553
Quarter 4 (2013)	01/10/2013 - 31/12/2013	346	Quarter 4 (2014)	01/10/2014 - 31/12/2014	643	Quarter 4 (2015)	01/10/2015- 31/12/2015	397

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	344
Quarter 2 (2016)	01/04/2016 - 30/06/2016	381
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

East Renfrewshire

QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	282	Quarter 1 (2014)	01/01/2014 - 31/03/2014	364	Quarter 1 (2015)	01/01/2015 - 31/03/2015	406
Quarter 2 (2013)	01/04/2013 - 30/06/2013	276	Quarter 2 (2014)	01/04/2014 - 30/06/2014	164	Quarter 2 (2015)	01/04/2015 - 30/06/2015	341
Quarter 3 (2013)	01/07/2013 - 30/09/2013	237	Quarter 3 (2014)	01/07/2014 - 30/09/2014	314	Quarter 3 (2015)	01/07/2015 - 30/09/2015	445
Quarter 4 (2013)	01/10/2013 - 31/12/2013	242	Quarter 4 (2014)	01/10/2014 - 31/12/2014	464	Quarter 4 (2015)	01/10/2015- 31/12/2015	301

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	315
Quarter 2 (2016)	01/04/2016 - 30/06/2016	279
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

Inverclyde

QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	144	Quarter 1 (2014)	01/01/2014 - 31/03/2014	194	Quarter 1 (2015)	01/01/2015 - 31/03/2015	230
Quarter 2 (2013)	01/04/2013 - 30/06/2013	158	Quarter 2 (2014)	01/04/2014 - 30/06/2014	91	Quarter 2 (2015)	01/04/2015 - 30/06/2015	199
Quarter 3 (2013)	01/07/2013 - 30/09/2013	105	Quarter 3 (2014)	01/07/2014 - 30/09/2014	149	Quarter 3 (2015)	01/07/2015 - 30/09/2015	272
Quarter 4 (2013)	01/10/2013 - 31/12/2013	155	Quarter 4 (2014)	01/10/2014 - 31/12/2014	310	Quarter 4 (2015)	01/10/2015- 31/12/2015	199

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	201
Quarter 2 (2016)	01/04/2016 - 30/06/2016	169
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

All Scotland

QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED	QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2013)	01/01/2013 - 31/03/2013	12,175	Quarter 1 (2014)	01/01/2014 - 31/03/2014	13,820	Quarter 1 (2015)	01/01/2015 - 31/03/2015	17,141
Quarter 2 (2013)	01/04/2013 - 30/06/2013	11,192	Quarter 2 (2014)	01/04/2014 - 30/06/2014	6,753	Quarter 2 (2015)	01/04/2015 - 30/06/2015	13,168
Quarter 3 (2013)	01/07/2013 - 30/09/2013	9,116	Quarter 3 (2014)	01/07/2014 - 30/09/2014	12,697	Quarter 3 (2015)	01/07/2015 - 30/09/2015	17,584
Quarter 4 (2013)	01/10/2013 - 31/12/2013	10,876	Quarter 4 (2014)	01/10/2014 - 31/12/2014	18,028	Quarter 4 (2015)	01/10/2015- 31/12/2015	13,202

QUARTER	DATE REGISTERED	NO REGISTERED
Quarter 1 (2016)	01/01/2016 - 31/03/2016	11,552
Quarter 2 (2016)	01/04/2016 - 30/06/2016	11,214
Quarter 3 (2016)	01/07/2016 - 30/09/2016	
Quarter 4 (2016)	01/10/2016 - 31/12/2016	

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 6

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**6th October 2016**
Report Number	**2016/17_06**
Subject Title	**Appointment of Interim Chief Officer**
Report By	**Tom Quinn, Head of HR, East Dunbartonshire Health & Social Care Partnership** **Sharon Bradshaw, HR Business Partner, East Dunbartonshire Council**
Contact Officer	**Tom.quinn@ggc.scot.nhs.uk 0141 201 4217** **Sharon.bradshaw@eastdunbarton.gov.uk 0141 574 5609**

1.0 PURPOSE OF REPORT

1.1 This paper advises of the process undertaken to secure, by officer selection, the appointment of an Interim Chief Officer for the HSCP Board to cover the vacancy created by the retirement of the previous Chief Officer from 1st October for a period of approximately 4 months, or until the vacancy can be filled on a substantive basis.

1.2 The HSCP Board voting members are required to ratify the appointment of the Interim Chief Officer, seconded from either NHS GGC or East Dunbartonshire Council, following the jointly agreed officer lead appointment process.

2.0 SUMMARY

2.1 The Chief Officer for the HSCP retired from service on 30th September 2016. The recruitment process to replace the Chief Officer has been agreed jointly between the two constituent bodies and has been progressed through internal and external advertising, shortlisting of candidates and interviews were scheduled to be held on 3rd October 2016.

2.2 In light of the date of interviews there will be a gap between the Chief Officer leaving her post and the substantive appointment being selected and being able to take up post. There will be an anticipated 3 month minimum gap to take account of the expected notice period required by the current employer for any substantive appointment selected on 3rd October.

2.3 From 1st October to 7th October the Head of Strategic Planning has been asked to cover the responsibilities of the Chief Officer, as would be the case if the Chief Officer was taking leave.

2.4 The main report details the process undertaken to attract internal applications from NHS GGC and East Dunbartonshire Council staff to the 4 month secondment opportunity.

3.0 RECOMMENDATIONS

3.1 The HSCP Board are asked to ratify the recommendation made by the officer panel to appoint, by secondment, of James Hobson to the post of Interim Chief Officer and to agree to the successful candidate taking up post on 7th October 2016 until the substantive Chief Officer appointment is completed and the successful candidate can take up post.

4.0 MAIN REPORT

4.1 The Chief Executives of the Council and the Health Board agreed that the Chief Officer should progress an officer led appointment process for the secondment of a senior officer, with appropriate qualifications and experience, from either NHS GGC or East Dunbartonshire Council to the post of Interim Chief Officer for East Dunbartonshire HSCP.

4.2 The secondment will be for a period of approximately 4 months or until the substantive appointment is made and the selected candidate is able to take up post.

4.3 The opportunity for secondment was advertised internally within both the Council and the NHS Board to a jointly agreed cohort of senior managers within both organisations.

4.4 There were a number of expressions of interest but only one formal application for the secondment.

4.5 The agreed interview panel included Human Resources advisers from both East Dunbartonshire Council and NHS GGC, the Chief Officer for East Dunbartonshire HSCP and the Chief Officer for East Renfrewshire HSCP as an external assessor.

4.6 Appendix 1, shows the Secondment Advertisement that was circulated to Chief Officers and Directors in NHS GGC and Deputy Chief Executives in the Council for distribution to senior managers within their departments.

4.7 The appointment panel met on 19th September and agreed that the applicant, James Hobson, is recommended to the HSCP Board as a suitable candidate to be seconded to the post of Interim Chief Officer for the HSCP.

Appendix1

East Dunbartonshire Health & Social Care Partnership
Short term secondment opportunity: 4 Months starting 7th October 2016
Post: Interim Chief Officer

East Dunbartonshire Health & Social Care Partnership is seeking to appoint on secondment, an Interim Chief Officer to provide leadership, support and continuity until the appointment of a substantive post holder. The Partnership is looking to appoint an experienced manager with the following key attributes:

- Board level experience
- National involvement in policy or service development
- Good people management skills
- Ability to provide guidance and support to senior NHS and Social Work managers in operational aspects of their role
- Knowledge of the Public Bodies (Scotland)(Act 2013)
- Experience of partnership working across organisations and with Trades Unions and Professional Organisations
- Understanding of Primary Care Services

- Understanding of Community Planning
- Good strategic financial management skills

Expressions of interest:
In the first instance, East Dunbartonshire Health & Social Care Partnership would welcome expressions of interest enclosing a current CV to:
Karen Murray, Chief Officer, (Karen.murray@ggc.scot.nhs.uk) by Friday 9th September 2016
Interviews are scheduled for Monday 19th September 2016.
For informal discussion please contact:
Karen Murray (Karen.murray@ggc.scot.nhs.uk)
Pauline Halligan (Pauline.Halligan@eastdunbarton.gov.uk)
Tom Quinn (tom.quinn@ggc.scot.nhs.uk)

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 7

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**6th October 2016**
Report Number	**2016/17_07**
Subject Title	**Review of Complex and Continuing Hospital Care**
Report By	**Interim Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Andy Martin, Head of Adult & Primary Care Services** **East Dunbartonshire Health & Social Care Partnership** **0141 201 4209** **Andy.martin@eastdunbarton.gov.uk**

1.0 PURPOSE OF REPORT

1.1 The purpose of the report is to inform the Board of the ongoing review of Complex and Continuing Hospital Care provision across NHS Greater Glasgow & Clyde, highlighting its impact on East Dunbartonshire and outlining actions being undertaken to implement the initial phases of the review and to plan for its later phases.

2.0 SUMMARY

2.1 In light of the change of Guidance governing eligibility for hospital based complex care, a review of this provision has been initiated by NHS Greater Glasgow& Clyde. This involves all 6 Health and Social Care Partnerships and the Acute Division.

2.2 A rationalization of current provision is being taken forward with a scaled down provision being considered to meet the reduced number of patients eligible for NHS Complex and Continuing Care going forward.

2.1 The report sets out:

- the shape of current provision which is based on hospital sites and in commissioned establishments;
- the emerging model of proposed future provision;
- an outline financial framework which will form the basis of any resource transfer

3.0 RECOMMENDATIONS

3.1 It is recommended that the Board:-

a) Notes the content of the report and the potential impacts on Community Care provision and costs for East Dunbartonshire as this change is progressed.

4.0 BACKGROUND

4.1 Revised Guidance was issued by the Scottish Government in June 2015 establishing a single criterion for eligibility for hospital based complex care.

4.2 The only test that now applies to considering appropriate care arrangements for a patient is: *'Can the individual's care needs be properly met in any setting other than a hospital?'* If the answer to this question is yes then the patient should be discharged from NHS care.

4.3 NHS Greater Glasgow & Clyde has established a cross-Partnership Working Group to take forward a review of the current provision of hospital-based complex and continuing care, initially concentrating on provision for Frail Elderly, then moving eventually to Older People Mental Health. This report refers to the first phase of consideration: Frail Elderly provision.

4.4 Currently there are 312 beds provided across 8 sites as outlined in **table 1** below. The sites are a mix of NHS hospitals and commissioned provision in care homes.

4.5 Patients placed in Continuing Care prior to the introduction of the revised guidance in June 2015 have the interim right to remain within the provision, but their cases will be subject to ongoing review to ensure that they meet the criterion outlined above on an ongoing basis.

Table 1

Location	Total No Beds on Site	Use of Non- NHSCC beds	Ward Name	No of NHSCC beds
Fourhills **(Barchester)**	120	60 GCC care home beds – NCHC & FPC: some self funders	Firhill Maryhill **Subtotal**	30 30 **60**
Greenfield Park (HC-One)	120	5 HSCP step up beds: 4 HSCP intermediate care beds; 10 GCC ABI beds; 30 GCC care home beds – NCHC & FPC; 8 GCC YPD beds currently being decommissioned; remaining approx. 10 beds private care home	Findlay Oakley **Subtotal**	30 20 **50**
Drumchapel	56	28 DME rehab beds	Tiree	28
St Margarets	60	30 palliative Care Beds		30
Mearskirk (Walker Healthcare)	72	All beds for NHSCC	Lanrig Millbrae **Subtotal**	36 36 **72**
Rutherglen (BUPA)	120	54 MH NHSCC beds: 42 beds private care home		24
RAH	28	Beds for NHSCC, DME rehab and delays in discharge	Ward 36	28
IRH	24	Beds for NHSCC, Palliative Care and delays in discharge	Larkfield wards 1A	20
TOTAL				**312**

4.5 Bed occupancy across this estate fluctuates and not all patients currently occupying beds are placed for continuing care. Some beds have been used to extend rehab capacity and some have been traditionally used to accommodate delayed discharges. The number of patients from East Dunbartonshire within this provision is small, fewer than 10 patients.

4.6 As stated previously, this phase of the Complex and Continuing Hospital Transition Programme concerns provision for Frail Elderly only. The next phase – Older People Mental Health provision - will see many more East Dunbartonshire patients involved, including those currently placed in Birdston care home in Milton of Campsie, where the Continuing Care facility(56 beds) is due to close in 2017.

5.0 LOCAL ACTION PLAN

5.1 A group of officers from Older Peoples Social Work, Rehab and Commissioning have been meeting to develop a local Action Plan to take forward the Frail Elderly Transition, both in terms of addressing the issue of current patients and the impact of the absence of the current provision on future options for complex patients. The main work streams include:

- Scoping numbers and locations of patients, pre- and post-June 2016
- Establish a programme of allocation and assessment to inform transfer to care homes
- Participate in the development of patient / carer information materials
- Engage Ceartas Advocacy for the cohort of patients and their families affected by the change
- Scope collaborative procurement for complex patients, eg tracheostomy
- Investigate commissioning options re. enhanced dementia provision

6.0 FINANCIAL FRAMEWORK

6.1 An outline Financial Framework has been developed across the programme. This scopes the estimated amount of resource, including staffing, deployed within the current model of provision. This is set out as **table 2.**

Table 2 - Financial Framework Summary - NHS Continuing Care/Hospital Based Complex Clinicial Care

Location	Sector	Beds	Budgeted WTE	Pays Budgets (£000)	Non-Pays (£000)	Total Resource (£000)
Mearnskirk	Acute - South Sector	72	59.91	2,043	106	**2,149**
Mearnskirk	Corporate - Facilities			423	1,081	**1,504**
Ward 36	Acute - South Clyde Sector	28	27.83	869	61	**930**
Larkfield Ward 1A	Acute - South Clyde Sector	24	25.61	678	59	**737**
St. Margaret of Scotland	Corporate	30			1,582	**1,582**
Greenfield Park	Corporate	60			2,183	**2,183**
Greenfield Park	Acute - North Sector		0.79	46	117	**163**
Fourhills	Corporate	60			1,989	**1,989**
Fourhills	Acute - North Sector		1.27	78	98	**176**
Rutherglen	Mental Health Partnerships	24			858	**858**
		298				**12,270**

6.2 It is important to state that the resource outlined does not constitute the final total which may be available as resource transfer to partnerships once the transition programme is progressed.

Contract arrangements with external providers which have varying lengths to run mean that some facilities will continue to operate under different models and rather than the resource being cashed-in, it might be available, for example, as bed spaces potentially to be used for intermediate care.

6.3 A collective commitment to develop an enhanced model of provision able to meet the needs of this complex patient group is being developed and will be piloted initially in Glasgow North East, thereafter to be extended to other partnerships. It is unlikely that the resource transfer available once the transition programme is complete will be sufficient to cover the full cost of the new enhanced model.

7.0 IMPLICATIONS

7.1 This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document. The implications for the Council are as undernoted.

7.2 Financial – Information collated and reported within the HSCP has been done in discussion with the relevant partnership bodies and is consistent with their reporting requirements.

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number:8

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	6th October 2016
Report Number	2016/17_08
Subject Title	Implementation of the Living Wage Commitment
Report By	Jean Campbell, Chief Finance & Resources Officer East Dunbartonshire Health & Social Care Partnership
Contact Officer	Gillian Healey, Team Leader, Planning & Service Development East Dunbartonshire Council 0141 777 3000 Gillian.healey@eastdunbarton.gov.uk

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to update members on the Living Wage Commitment and to seek approval on the preferred delivery approach as outlined within this report.

2.0 SUMMARY

2.1 As part of the Scottish Government's 2016/17 local government financial settlement, £250 million was allocated to integrated authorities for social care via the Health budget. East Dunbartonshire's Health and Social Care Partnership (HSCP) share equates to £4.3 million.

2.2 Part of the £4.3 million is to be used to help deliver on the Living Wage Commitment which is applicable from 1st October 2016. The commitment includes all staff that currently works in the Care at Home, Housing Support and Care Home markets and provides direct care and support.

2.3 National guidance was circulated to help inform local decision making. The guidance entails four delivery options along with the potential associated risks - all of which have been fully explored. Option 2: *Apply a differing percentage increase per provider, though individual negotiation based on their particular costs* - is considered the best approach for delivering the local commitment. Key determining factors include overall affordability and time constraints.

2.4 The estimated total cost of implementing the commitment in 16/17 is £1,061,208 based on half year costs. The full year impact (17/18) is estimated to be £2,122,416 million. A full breakdown of costs is detailed within section 4 of this report.

3.0 RECOMMENDATIONS

3.1 Members are asked to note the contents of this paper and approve the approach identified in 2.3 to deliver the living wage commitment in 16/17.

4.0 MAIN REPORT

4.1 As part of its 2016/17 settlement, the Scottish Government allocated, via the Health budget, £250 million to integrated authorities for social care services. There were specific requirements attached to the allocation which include; £125 million to support the expansion of social care to help achieve the objectives of integration and £125 million to meet a range of existing health and social care costs in the context of reducing budgets.

4.2 The Scottish Government's and COSLA's joint aspiration to deliver the Scottish Living Wage (£8.25) across social care workers is included within the latter provision.

4.3 On the basis that preparatory work is required to scope costs, an implementation date of 1st October 2016 was agreed.

4.4 To help support local implementation, the Scottish Government, in conjunction with COSLA, CCPS and Scottish Care, developed and issued guidance which outlined four potential delivery options. After extensive discussions/consultation with legal and procurement colleagues and providers, Option 2: *Apply a differing percentage increase per provider, though individual negotiation based on their particular costs* - has been identified as the best approach for delivering on the commitment. Key determining factors include overall affordability and time constraints.

4.5 This commitment is not, as of yet, a commitment to the National Living Wage as an on-going benchmark for wages, but to the delivery of £8.25 per hours from 1st October 2016. Any further commitments would be subject to spending review negotiations for 2017/18 and beyond.

4.6 Annual negotiations on the fee uplift within the National Care Home Contract (NCHC) settlement for 2016/17 were agreed earlier this year and include: 2.5% uplift from 11st April 2016 and a further uplift of 3.9% applicable from 1st October 2016 (resulting in a cumulative uplift of 6.4%). The 3.9% uplift is to meet the living wage commitment across the residential and nursing sector.

4.7 The total estimated cost of implementing the Living Wage Commitment in 16/17 is £1.061m and is predicated upon on increased basic pay of £8.25 across all hours worked including sleepovers. Personalised budgets and Direct Payment uplifts are also included.

4.8 The estimated total cost is broken down as follows:

- Increase to Care at Home and Housing Support services: £541,492
- Increase to Direct Payments: £150,000
- Increase to Care Home (Residential) services £369,716 (expected to be met from Council reserves for 16/17)
- Total: £1,061,208 (half year costs)
- Total: £2.122,416 million (full year costs 17/18)

4.9 The estimated costs do not at this point include any on-costs or cost differentials. This is primarily due to overall affordability but also takes into account provider's current business

models and their ability to make a contribution. Importantly, on-costs and cost differentials were not considered or included within the original funding allocation (£125 million).

4.10 Whilst local plans for delivery of the commitment are progressing in line with requirements, an imminent announcement pertaining to timescales and sleepovers is expected from the Scottish Government. Intelligence to date (via COSLA) suggests that a possible relaxation around timescales may be granted as well as the removal of sleepovers from consideration - at least until such times as more work has been undertaken to determine the full impact - particularly in light of the recent EU ruling on this matter.

4.11 As implementation of the living wage progresses, further updates will be submitted to the Board including actual costs and timescales.

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 9

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**6th October 2016**
Report Number	**2016/17_09**
Subject Title	**Update on the Intermediate Care Model**
Report by	**Interim Chief Officer,** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Andy Martin, Head of Adult & Primary Care Services** **0141 201 4209** **Andy.martin@eastdunbarton.gov.uk**

1.0 PURPOSE OF REPORT

1.1 The purpose of the report is to update the HSCP Board on the service developments of an intermediate care facility within East Dunbartonshire

2.0 SUMMARY

2.1 East Dunbartonshire HSCP is in the process of commissioning an intermediate care facility within a nursing home in East Dunbartonshire. This service will include a model of GP provision, care management, rehabilitation and home care support.

2.2 The intermediate care project will transition service users from the hospital setting, when medically fit for discharge, to the facility giving the service user time for additional recovery and the opportunity to receive a comprehensive assessment of their longer term health and social care support needs.

2.3 A multi disciplinary project group has been established to take forward agreed actions to the proposed implementation date of October 2016. A wider governance reporting structure is being developed. A programme of engaging with stakeholders in underway to help shape and develop the model. All of these priorities are set out within an overarching Project Plan which is attached as **Appendix 1.**

2.4 A service policy and procedure document been produced to set out pathways, roles and responsibilities, to assist with communication, to focus on working through challenges, review priorities and evidence blockages and resolutions. This is attached as attached as **Appendix 2.**

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

a) Note the content of the report

4.0 BACKGROUND

4.1 GP Service – Currently a GP practice is delivering a local enhanced service to the care home. There has been an initial discussion with the practice to ascertain their interest in undertaking a clinical service to the intermediate care home unit. Whilst the GP demonstrated an interest, she requires to discuss this with partners.

4.2 AWI patients – Service users who have been deemed to lack capacity and do not have the appropriate legal powers in place currently remain in hospital until the assessment has taken place and appropriate use of Section 13ZA of the Adults with Incapacity Act has been utilised to transfer the individual to a long term residential/nursing care home.

Whilst the legislation does not stipulate that the individual may only be subjected to one accommodation move under Section 13ZA, Court Sheriffs have deemed it to be good practice which should be followed. It is acknowledged that health services are not subject to this legislation when transferring an AWI patient from an acute hospital to a continuing care or long stay facility. We have therefore asked our colleagues from East Dunbartonshire Council's legal services to explore the viability of transferring AWI patients to the Intermediate Care Unit. This will only affect those service users who do not have the appropriate legal powers in place (Power of Attorney or Guardianship) and have been deemed to lack capacity.

In the meantime those service users falling into this category will remain in hospital for their assessment period and be transferred, where appropriate, using Section 13ZA to their final destination care home.

4.3 Transport – Negotiations are taking place with the Red Cross and Glasgow Health and Social Care Partnership (GHSCP) with a view to expanding the intermediate care transport service they deliver to GHSCP. ED HSCP's requirement for transport is on a much smaller scale than GHSCP and the Red Cross has advised that it would not be viable to operate a separate, dedicated transport service for our intermediate care unit in East Dunbartonshire. Members of the Intermediate Care Project Team will continue discussions with these organisations exploring proposed costs, contract requirements and the logistics of delivering the transport service within East Dunbartonshire.

It is highly unlikely that contracted arrangements for transportation will be in place prior to the commencement date of the intermediate care facility. While negotiations are ongoing transport will be arranged via a variety of routes. Hospital transportation will be utilised to transport service users from hospital to the intermediate care facility. Thereafter transport requirements will be met via families, care at home services, Westerton Care Home and final destination care homes. There may also be requirements to utilise ambulance services where there are complex needs in relation to moving and assistance.

5.0 IMPLICATIONS

5.1 This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document. The implications for the Council are as undernoted.

5.2 Financial – Information collated and reported within the HSCP has been done in discussion with the relevant partnership bodies and is consistent with their reporting requirements.

APPENDIX 1

Project plan - Intermediate care bed project							
	June	**July**	**August**	**Sept**	**Oct**	**Lead**	**Comments**
Intermediate Care model							
Workshop to agree ethos, criteria, pathways, roles & responsibilities						GN	Following workshop, policy document developed (in draft)
Plan how project embeds into current teams delivery						DA/SMcD/FM	Teams require to prioritise project within current service delivery
Project Leads and Care Home manager to discuss agreed service model. Actions to be added to project plan							Model agreed with care home
Pull together/develop policies, procedures and protocols relevant for implementation						KG/GN	Formal sign off in Sept of document
Arrange for an AWI workshop						GN	Awaiting formal response from lawyer
Hold pathways event for relevant clinical staff						GN/FM/LM	Stakeholder event planned for 4th Nov
Accommodation							
Site visit with ops managers to ascertain functionality of accommodation							All operational mangers have now visited site
Communication							
Develop a communication strategy						GN	Comms dept developed comms plan
Develop service user information sheet						GN/LM	Draft to be discussed at project team meeting (6th Sept)
Governance							
Establish governance framework/sign off at SDT						GN	Finalise once care home tender and GP contract finalised.
Develop regular briefing to OMG/SDT						AM/GN	On going
Develop a project risk register						GN	Discussed and reviewed at every project team meeting
Tender process							
Negotiated tender to EDC Committee						MF	Visit to care manager to sign off tender 8th Sept
Develop service specification						MF	See above

APPENDIX 1

GP negotiations/contract							
Scope out arrangements in Glasgow city. Discuss with Primary Care Support & Clinical Director						AM/GN/CF	Meeting took place on 20/7/16
Meet with current LES GP						AM/GN	Initial meeting on 25/07/16
Establish contract						AM/MF	Awaiting formal response from GP
Technology/Report writing							
Access to Smart working within Care home						KG/GN	Lap tops ordered
Evaluation							
Establish evaluation framework to be implemented at implementation						GN/KG	Meeting with performance team 8/09/16
Agree performance outcomes						KG/GN/MF	Meeting with performance team 8/09/17
Financial							
Review costs in line with service/model developments						AM/GN	Awaiting information on transport scoping and cost of GP clinical sessions
Agree financial arrangements with GP/Care Home						AM/MF	Aim to finalised contract with GP in Sept
Agree financial evaluation model						JH/GN	Initial meeting cancelled 2nd Sept, to be rescheduled

Key	
Andy Martin	AM
Gillian Notman	GN
Kelly Gainty	KG
Margaret Friel	MF
Fiona Munro	FM
David Aitken	DA
Lisa Miller	LM
James Hobson	JH
Carolyn Fitzpatrick	CF

EAST DUNBARTONSHIRE
HEALTH AND SOCIAL CARE PARTNERSHIP

INTERMEDIATE CARE
OPERATIONAL PROCEDURES

AUGUST 2016

Introduction

Over the next few years in East Dunbartonshire our overall population is predicted to decrease by 0.5%, while the 85 years + age group will increase by 17.8%. Increasing age has an impact on the likelihood of developing one or more long term conditions and increase the demand for health and social care provision. In-service user care will always be an important part of the provision of care for people who require medical needs. Reducing unscheduled hospital admissions and bed usage is a key priority for the Health and Social Care Partnership. Our services are working in partnership to facilitate early discharge. Discharge planning for people with complex support needs takes longer and may require further assessment and recovery in the right setting. These people may benefit from the provision of intermediate care provided at home or in a homely setting.

Local data suggests that the majority of our delayed discharge cohort of service users have long term conditions which have impacted on their functionality to such a degree that rehabilitation/enablement may not be an option and that emphases on intermediate care would mainly be about focusing on transitions into a care home. There should however still be an opportunity for the promotion of rehabilitation, re-ablement and self-management for those with identified needs.

As part of our strategic and delayed discharge planning, East Dunbartonshire Health and Social Care Partnership are introducing an eight bedded intermediate care unit. This unit will provide an opportunity for social work and health staff to work in partnership with service users, carers, families, care home staff and third sector stakeholders during the service user's transition from a hospital based setting to long term care or a return to their own home environment.

The 'Intermediate Care' project, although a time limited intervention, it will provide appropriate integrated community services within an alternative setting that can support older people and adults with long term conditions during their time of transition in their health and support needs.

Mission Statement

To facilitate the care management and rehabilitation of service users in the integrated care unit by delivering person centred care with focus on personal outcomes for the service user. Discharge will be planned from the time of admission to the unit. Service user goals will be set and regularly reviewed throughout the individual's stay.

Aims and Objectives

The intermediate care project will transition service users from the hospital setting, when medically fit for discharge, to a homely environment giving the service user time for additional recovery and to receive a comprehensive assessment of their longer term health and social care support needs. This transition will be

instrumental in determining the service user's future care in the form of a personalised support plan.

The outcomes of the Project are:

- To bridge the gap by supporting people with a timeous, smooth discharge from hospital to home with appropriate community supports or into a homely setting within a residential/nursing care home;
- To maximise the service user's ability for rehabilitation and reablement;
- To reduce the number of people delayed in hospital when they have been declared medically fit for discharge;
- To respond flexibly to the needs of service users through implementation of an agreed outcome focused person centred support plan;
- To support carers in their role and promote their assistance in the rehabilitation and socialisation process.
- To provide a source of professional expertise;
- To support the individual and their carers on re-integration and socialisation in the assessment and decision making process in respect of moving back into the community or into long term residential/nursing care;
- To improve outcome for service users, upon discharge from the intermediate care project, to their own home or an alternative homely setting. These outcomes would include feeling safe; being listened to; being party to decisions about their long term support; and having choice.

Relevant Legislation and Policies

The Public Bodies (Joint Working) (Scotland) Act 2014 – this Act sets the framework for integrating adult health and social care, to ensure a consistent provision of quality, sustainable care services for the increasing numbers of people in Scotland who need joined up support and care, particularly people with multiple, complex, long-term conditions.

The Social Work (Scotland) Act 1968 – This is the primary Act detailing the general social work function of the local authority. There have been a number of subsequent Acts that have inserted amendments in respect of revised or additional duties.

The Community Care and Health (Scotland) Act 2002 – This Act details a range of provisions in respect of community care services.

The Mental Health (Care and Treatment) (Scotland) Act 2003 – This Act is about protecting the rights of people with a mental disorder. Its primary objective is to make sure people with a mental disorder can receive effective care and treatment.

Adult Support and Protection (Scotland) Act 2007 – This Act details measures to identify, support and protect adults who may be at risk of harm or neglect and who may not be able to protect themselves.

Adults with Incapacity (Scotland) Act 2000 – This Act provide ways to help safeguard the welfare and finances of people who lack capacity.

East Dunbartonshire Council Eligibility for Social Work Services – The Eligibility Criteria policy ensures that those in the greatest need receive the highest priority and that there is a fair distribution of resources across different groups of adults requiring care or assistance.

East Dunbartonshire Council Assessment and Support Management Procedures – These procedures provide a focus on enabling practitioners to provide a fair and consistent approach to assessing and planning support for the individuals and families with whom they work.

The Social Care (Self Directed Support) (Scotland) Act 2013 – The Act makes legislative provisions relating to the arranging of care and support ("community care services" and "children's services") in order to provide a range of choices to individuals as to how they are to be provided with their support.

East Dunbartonshire Health and Social Care Partnership's Strategic Plan 2015 – 2018 – East Dunbartonshire's Health and Social Care Partnership's strategic plan to contribute to its vision of working with people and partners to build strong communities with equity of opportunity for wellbeing and access to care and support when required.

NHS Scotland, Everyone Matters: 2020 Workforce Vision – this document sets out the aim of Scotland's Health Services to provide safe, effective and person-centred care and that everyone, by 2020, is able to live longer, healthier lives at home or in a homely setting.

Scottish Government, Maximising Recovery, Promoting Independent: An Intermediate Care Framework for Scotland - The document provides a Framework for local health and social care partnerships to review and further develop Intermediate Care within their area. It identifies the common and key components that should make up these services, however they may be configured.

Target Audience

This policy is targeted at the following stakeholders:

Social Work and Health staff within East Dunbartonshire Health and Social Care Partnership;

Service Users, Carers and Families;

The GP attached to the care home and other GPs within the locality;

Geriatricians and other clinical staff from the acute sector;

Westerton Care Home;

Housing staff;

Relevant third sector organisations;

These are the main stakeholders; however this list is not exhaustive.

Intermediate Care Location and Facilities

The Intermediate Care facility will be housed in Westerton Care Home in Bearsden. This will provide a comfortable and homely, self-contained, appropriately staffed unit of eight beds, all in single rooms, within a modern, accessible care home. The facility will include:

- Six beds for the purpose of assessing service users who have been deemed as requiring further assessment with a view to admission in the longer term to a residential or nursing home care environment;
- Two beds for the purpose of providing a 'step down' function whereby the service user can receive intensive rehabilitation and re-ablement provision from care home; care at home and community health services with a view to returning to their own home.

There requires to be ongoing flexibility and review of the functionality of the unit in relation to the beds during this pilot so that opportunities for rehabilitation/respite can be maximised.

Eligibility Criteria for Intermediate Care Unit

- The service user must be an adult (aged 65 and over) and live within East Dunbartonshire;
- The service user must be an in-service user of a hospital setting. Exceptions to this must be agreed by East Dunbartonshire's Chief Officer;
- The service user must be medically stable, fit for discharge and deemed appropriate for intermediate care;
- The service user must have capacity to consent to engage in the process or have the appropriate legal powers in place which could include the utilisation of Section 13ZA of the Adults with Incapacity Act;
- The service user must be allocated to a Lead Professional who will co-ordinate the assessment and care management;
- The service user must be able to have their needs met safely in the intermediate care facility;
- The service user and any other relevant persons must be party and in agreement to the decision to move to the intermediate care facility;

- The service user and any other relevant persons must be made aware of the intermediate care process. This may take the form of a legal contract

- The service user and any other relevant persons accept that this is a four week time limited facility – up to one week and no longer than four weeks;

- The service user is identified with a clear pathway for moving on from the Intermediate Care facility.

Exclusions from the Intermediate Care facility

- Any service users requiring end of life/palliative care;

- Any service users not deemed medically fit for discharge;

- Any service users referred directly from the Accident and Emergency Units within the hospital environment.

Charging

The placement time within the intermediate care facility is limited to four weeks. During the assessment period, the intermediate care service will be free of charge, however, if the service user remains beyond the assessment period, through no fault of East Dunbartonshire Health and Social Care Partnership, residential care charges will apply. The charges that will be applied are consistent with the normal terms for care home provision. It is expected that service users will supply their own sundries i.e. toiletries, clothing etc.

Referral Process

The utilisation and co-ordination of the assessment beds within the intermediate care facility will remain the responsibility of the Senior Practitioner within the Hospital Assessment Team.

Following agreement by the responsible Consultant that the service user is medically fit for discharge, referrals will be made to the Hospital Assessment Team via currently arranged routes. The acute sector is encouraged to make early referrals where ever possible. Early referrals and SMAT forms are accepted by the Hospital Assessment Team Monday to Friday from 9.00am to 5.00pm excluding public holidays.

Hospital Assessment Team Duty Telephone Number: 0141 355 2228

Hospital Assessment Fax Number: 0141 355 2416

As the early stage of assessment goes forward, the Lead Professional will triage the referral and the service user will be directed down one of three potential sub-pathways:

- Step Down with Advanced Rehabilitation;
- Enhanced Care at Home;
- Intermediate Assessment and onward placement.

Medical Investigations

Prior to discharge to Intermediate Care, service users should have undergone all necessary investigations relating to their in-patient admission. Should further investigations be required following discharge to Intermediate Care, service users will need to attend the relevant hospital on an out-patient basis and the unit will be responsible for organising transport and escort for this purpose.

Protocol to be followed in the event of no capacity in the Intermediate Care Unit

If there is no available capacity in the Intermediate Care Unit at the time of referral, the service user's name will be placed on a waiting list held by the Hospital Assessment Team Senior Practitioner; however the responsibility for the service user remains with the referring agent. Where the facility is running at full capacity the service user will remain in hospital until the assessment is complete and placement has been arranged.

Roles and Responsibilities

Hospital Assessment Team/Allocated Social Work Practitioner:

The responsibility for the co-ordination of and the management of admission, discharge and through-put to the intermediate care facility will rest with the Senior Practitioner within the Hospital Assessment Team.

Initial assessment must be commenced within three days of the service user's admission to the intermediate care facility identifying and agreeing collaborative goals/outcomes for the service user and carer.

The allocated social work practitioner role will be primarily directed towards assessment and care management including financial assessment and care placement.

The standing processes currently in place within the weekly Delayed Discharges Planning Group will continue to provide management oversight and support and a multi-disciplinary forum to plan care and agree resource deployment.

The Senior Practitioner will be responsible for prioritising and allocating the beds within the intermediate care facility.

Referring Hospitals:

Hospital staff, through clinical MDT discussions and the completion of SMAT forms will identify potential services users for intermediate care. The lead Consultant is an essential part of this process. However, final decision will remain with the Senior Practitioner within the Hospital Assessment Team, taken in consultation with all appropriate health and social care professionals. Referring teams are responsible for forwarding up to date assessments, medical forms and treatment plans as well as ensuring that the service user is transferred with a supply of current medications, dressings, continence products etc.

Community Rehabilitation Team:

The Community Rehab Team (CRT) currently provides a range of enhanced clinical interventions to service users returning from hospital to the community. These interventions will be provided via the Rapid Assessment Link (RAL) utilising core rehabilitation services as required. Where there is an ongoing or potential rehabilitation need for any service user who is discharged to the intermediate care facility or their own home with an intensive home care package, this will be provided by the Community Rehab Team. The services required will predominantly consist of physiotherapy and occupational therapy. Staff from the team will be responsible for assessing and developing a person centred treatment plan, monitoring and evaluating progression with therapy and care staff within the unit. They will support staff within the Unit to adopt a rehabilitative approach.

Enhanced Model of Home Care:

There will be a provision of intensive care at home support as an option for service users with complex needs who may have the potential to return from hospital and establish a degree of independence at home with the help of an initial intensive support period. This will be in line with the agreed support plan outlining the assessed needs and outcomes. This service will be available within the eligibility and charging criteria proposed for the intermediate care facility as appropriate and thereafter could be delivered within the service user's home, or using the Telecare Smart Flat in Auchinairn as a base to commence the rehab journey. After the period of reablement at home has been completed, the service will review the service user's assessed needs and outcomes and agreed a continued support package (where required) taking account of the service user's chosen self-directed support option.

Care Home:

The intermediate facility is a registered nursing home and will be responsible for delivering all the clinical competencies that are contracted within that function. The home has appointed a Team Leader qualified at SVQ Level 3 who will have access at all times to the Registered Nursing Staff located within the home. The nominated person is responsible for all aspects of the role in respect of both assessment and intermediate beds such as reablement tasks and will encompass a wider preventative role, aiming to promote confidence building and social inclusion.

GP Services:

Garscadden Burn Medical Practice is contracted for primary medical care for the Unit. The Unit will have temporary registration for service users whilst they are receiving intermediate care. The GP Practice will provide an initial review within 48 hours of admission to the Unit. The GP will attend the unit twice per week in addition to providing telephone advice. They will provide discharge prescriptions and (electronic) transfer summaries to receiving GPs within 48 hours of discharge from the Unit.

Carers:

Where there are identified carers of those service users being considered for intermediate care, the carer/s will have the opportunity to be fully involved in the intermediate care process and will be offered a Carer's Assessment.

Pharmacy:

After discharge from hospital with an initial supply of medication, the community pharmacist, attached to the care home, will be responsible for supplying the service user with any further medications required. It is anticipated that all medications will be individually labelled unless a compliance aid is requested. The Intermediate care Unit will adhere to the NHS Safe and Secure Handling of Medications Policy and all staff must familiarise themselves with this. Self-administration of medications will be encouraged where appropriate. All staff must adhere to policies specific to medication within the Unit.

Phlebotomy:

This will be carried out as required. The Anticoagulation Service will attend the Unit for service users who are on Warfarin and are stable.

General Information

Case Records: A copy of the service user's discharge will be transferred to the Intermediate Care Unit and will be stored in a non-service user area with secure access. Medical records will be stored as per the relevant policies for Records Strategy and Management Policy.

These standards of good clinical practice will be followed:

- Any change in treatment (e.g. initiating, discontinuing or modifying) should be clearly documented in notes;
- A written record of clinical meetings, assessments and case conferences should be kept mentioning by name all staff concerned;
- In the event of a death, the information recorded on the death certificate should also be listed in the case notes;

- When called out to see a service user at night or over the weekend it is particularly important to ensure that there is a record in the medical notes of any change in management e.g. drugs or any discussions with relatives.

When advice is given over the telephone this will be recorded in the service user's medical notes and reference to it made in the service user's care pathway communication sheet by the practitioner making the call. If a GP is called to see a service user it must be recorded in the service user's medical notes.

The medical practice providing clinical services will continue to use its GP IT systems for recording information within the service user record and will send copies to the Unit, which will then form part of the medical record.

The Lead Professional will ensure that assessments, case notes, support plans and reviews are recorded appropriately and kept up to date using existing IT systems.

On discharge from the Unit a transfer summary should be sent to the named GP.

Team Meetings/Briefings: The full team will meet on a weekly basis to discuss all cases and more frequently if a service user's condition requires it. Informal discussions will be ongoing. Appropriate multi-agency and multi-disciplinary staff must be present to facilitate problem solving using a multi-disciplinary model. Daily team briefings will take place within the Unit to share relevant information, update information and discuss changing plans as required.

Service User Confidentiality: All Health and Social Care Partnership staff will adhere to their records management and confidentiality policies and procedures.

Incidents: All incidents occurring and related to health and social care services within the Unit or affecting a service user or staff member in the Unit will be reported on Datix and recorded in all necessary IT systems. The relevant Service Manager will verify incidents within 72 hours and will communicate any learning outcomes as a result of the investigation. Local adverse event reviews will be conducted in partnership between Health and Social care staff, GP practice and Care Home staff (as appropriate).

Complaints: The Unit will implement and maintain a complaints procedure which is consistent with the Health and Social Care Partnership's existing complaints procedures. Any complaints made by the service users or their representatives will be dealt with via the most appropriate complaints system (i.e. if the complaint is concerning the Home, then this will be progressed via the Home's complaint process; if the complaint concerns Health and Social Care Services this will be progressed via the relevant complaints processes). The Unit Manager and the HSCP will keep each other fully informed regarding the resolution of any such complaint. The HSCP may refer the same to the Care Inspectorate for investigation at any time.

Infection Control: Infection control policies will be available within the Unit complying with the NHS and Care Inspectorate standards. At all times policy must

be adhered to in relation to infection control. It is the responsibility of staff to familiarise themselves with the policies.

Equipment: Equipment required as part of the integrated care process will be subject to existing protocols.

Escalation: Any issues or concerns that require to be escalated urgently should follow the process outlined below:

If the issue/concern relates to the Intermediate Care Unit (staff, facilities, services etc) contact should be directed to the Care Home Manager based at Westerton Care Home on 0141 942 5834.

If the issue/concern relates to the service user and/or health and social care services contact should be directed to the allocated Lead Professional on 0141 355 2200.

Evening and Weekend Arrangements: The following arrangements are in place for any issues that arise during the evenings or weekends:

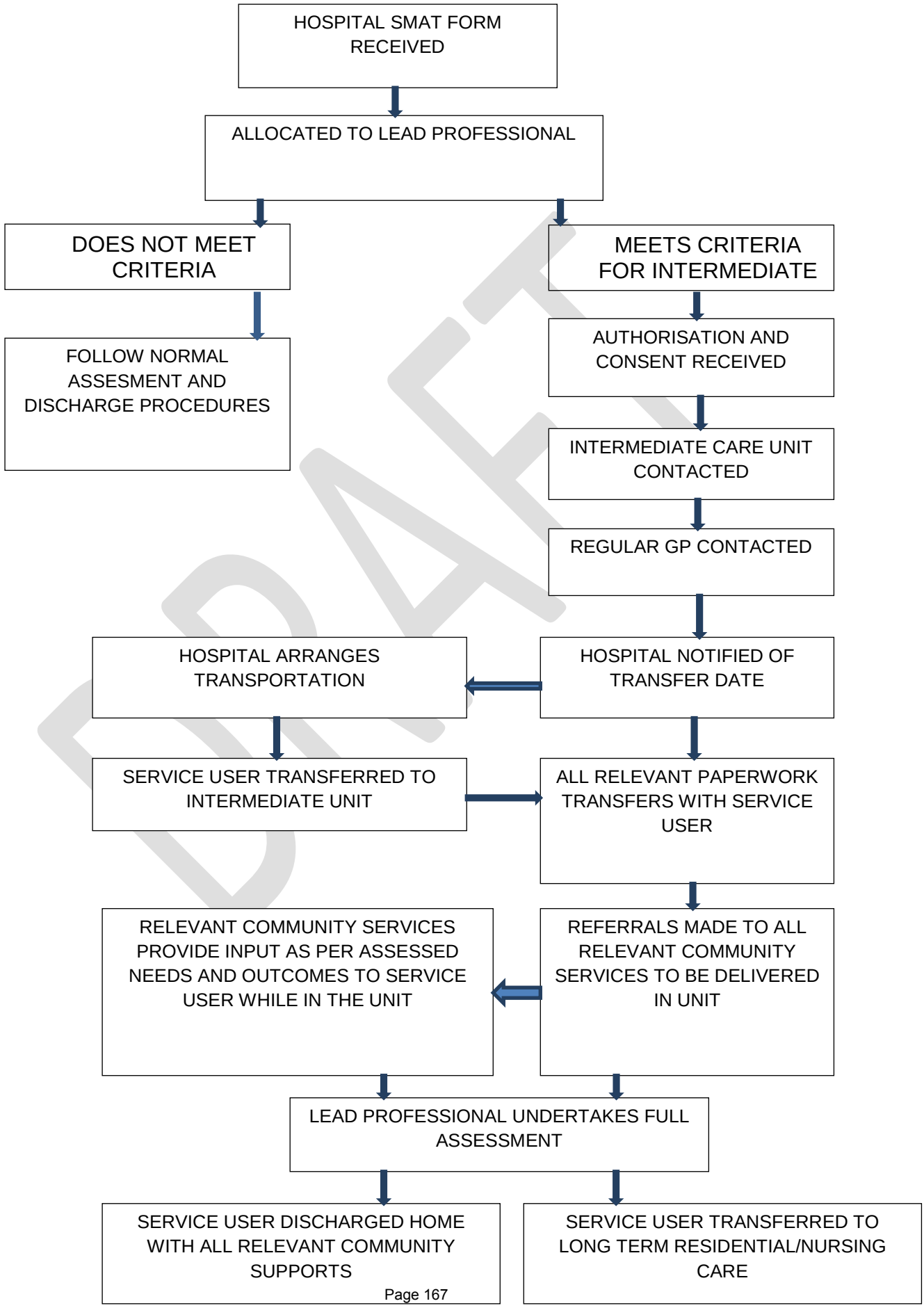
Greater Glasgow Out of Hours Social Work Service (Social Work Standby)	0800 811505	5.00pm to 9.00am (Mon to Thur) 5.00pm (Fri) to 9.00am (Mon)	Deal with crises and emergency care including child and adult protection and preventing admissions.
NHS 24	08454 242424	Open 24 hours, 7 days per week	Online and telephone access.
Garscadden Burn Medical Practice	0141 211 6100	Mon to Friday: 8.00am to 1.00pm 2.00pm to 6.00pm	Regular GP services.
Care at Home – Out of Hours Service	0141 578 2101	Mainstream service until 10.30pm. Nightshift service from 10.30pm to 8.00am.	Deals with planned cases which includes palliative care, responding to community alarm call outs and preventing admissions.
Transport			Issues re planned transport arrangements made for evenings and weekends.

Evaluation:

The service evaluation will utilise a variety of quantitative and qualitative approaches to measure effectiveness against planned outcomes. These will include:

- Data related to bed days, admissions/readmissions, delays and throughput within the Unit;
- Service user; carer and staff perceptions of the Intermediate Care Unit
- Outcomes in relation to the customer's final destination following discharge from the Unit;
- Financial Evaluation;
- Health and Social Care staff activity within the Unit.

Referral Pathway



PROCEDURE FOR ADMISSION TO AND DISCHARGE FROM INTERMEDIATE CARE UNIT

1. Following a multidisciplinary initial assessment has identified that a service user is appropriate to move to the Intermediate Care Unit, the Lead Professional will discuss the availability of a bed with the Senior Practitioner within the Hospital Assessment Team.

2. The Lead Professional will discuss the intermediate care facility with the service user and their carer/family (where appropriate) and provide them with the appropriate information leaflets and gain consent for transfer.

3. The Lead Professional will contact the service user's regular GP to receive up to date medical information.

4. Once authorisation has been given the Lead Professional will proceed with the transport and admission arrangements.

5. The Lead Professional will contact the Intermediate Care Unit to advise of impending admission and provide them with the initial assessment screening tool.

6. The service user will be transferred within 72 hours of their 'fit for discharge' date to the intermediate care facility following the agreed transportation protocol.

7. The discharging hospital ward, upon notification from the Lead Professional, will arrange transport following the agreed transportation protocol.

8. Prior to discharge from hospital and admission to the Intermediate Care Unit, the hospital will ensure that:

    - All medical and nursing documentation is completed;
    - A medical discharge summary is completed;
    - A seven day supply of medication is provided.

9. Prior to transfer to the intermediate care unit the following must accompany the service user:

    - A discharge summary of current in-service user stay;
    - A seven day supply of current medications;
    - All relevant medical notes – SCI Transfer;
    - All relevant Nursing and AHP Notes – access to clinical portal;
    - A completed SMAT must have been received by the HAT
    - A completed transfer information sheet;

10. The Lead Professional will provide the Intermediate Care Unit with an initial care plan for the service user.

11. The Care Home nurse will be responsible for checking in the service user's medication with the Senior Support Worker upon arrival at the Unit.

12. The Intermediate Care Unit will contact the GP practice to advise of the service user's admission.

13. The GP will visit and assess the service user within 48 hours of admission. The GP will also arrange for further medication supplies.

14. The discharging hospital/lead professional will make appropriate referrals to the RAL.

15. Where the service user will be in receipt of enhanced home care re-ablement services, the lead professional will contact the relevant Home Care Organiser to make referral.

16. The Enhanced Home Care service will establish a programme of reablement, based on the assessed needs and outcomes, which will commence within the intermediate care unit and transfer to the service user's home when discharged.

17. The RAL will arrange to visit the service user within the intermediate care unit to establish a rehabilitation support plan where appropriate.

18. The lead professional will carry out the full assessment involving all stakeholders.

19. If the outcome of the assessment is that the service user will return to their own house in the community, the lead professional will ensure appropriate community services are in place for discharge.

20. If the outcome of the assessment is that the service user will require to move to long term residential/nursing home care, the lead professional will be responsible for following all procedures/protocols associated with this activity i.e. completion of FA1 financial form; confirming care home choices with service user and/or family; submission of papers to RSG for authorisation

21. When discharge arrangements have been agreed the Lead Professional will ensure necessary transport as per the transportation protocol.

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number:10

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**6th October 2016**
Report Number	**2016/17_10**
Subject Title	**Winter Plan 2016-17**
Report By	**Sandra Cairney, Head of Strategy, Planning and Health Improvement** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Fiona McCulloch, Planning & Performance Manager** **East Dunbartonshire Health & Social Care Partnership** **0141 201 9705** **Fiona.mcculloch@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 To provide a report on;
The East Dunbartonshire Health and Social Care Partnership Winter Plan 2016-17

2.0 SUMMARY

2.1 The East Dunbartonshire HSCP Winter Plan addresses the twelve key critical areas set out in the Scottish Government guidance *Preparing for Winter 2016/17* (DL (2016) 18) and the 6 Essential Actions

2.2 The Winter Plan sets out the local issues across primary care and community health and social care services for which the HSCP is responsible, to support the NHSGG&C whole system planning.

2.3 A rolling action log will be discussed and maintained by the operational managers at the OMG meetings throughout the winter period, September 16 – March 17. In addition, situation reports (SITREPs) will be escalated as appropriate.

2.4 A report analysing the activity, performance and pressures during the winter will be provided for the HSCP Board at the end of the winter period

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

a) Approve the Winter Plan 2016-17

East Dunbartonshire
Health & Social Care Partnership

Winter Plan

2016/17

4.0 MAIN REPORT

4.1 Introduction

Health and Social Care Partnerships have a critical role in the wider service system which enables the delivery of effective unscheduled care. It has been agreed through the NHSGG&C whole system planning group that each HSCP will produce an operational unscheduled care plan with a particular focus on the winter period. These plans will cover:

- The community service aspects of the 6 essential actions (Appendix 1)
- Delayed discharge
- Measures to reduce admissions and attendances
- Delivery of key service features including single point of access, Care Home support and Anticipatory Care
- Continuity and resilience
- Developing an agreed set of indicators to monitor performance
- Planning with GPs for the two long bank holidays

This Winter Plan identifies and addresses the local issues across the primary care and community services for which East Dunbartonshire Health and Social Care Partnership is responsible, to support the NHSGG&C whole system planning as detailed above.

4.2 Winter Planning Arrangements

Winter Planning arrangements have been established through the fortnightly Operational Managers' Group, with Winter Planning being a standing agenda item throughout the winter period. This ensures that all HSCP service leads are represented in discussing the delivery of the Winter Plan and identifying any issues that require to be addressed, or escalated, to enable appropriate actions to be put in place and ensure that service users receive safe, person centred, effective care to minimise unscheduled hospital admissions and reduce delays in discharges throughout the winter, and in particular, the festive period.

4.3 Key Themes

The Scottish Government guidance *Preparing for Winter 2016/17* (DL (2016) 18) has identified twelve key critical areas, outcomes and indicators which are considered key to effective winter planning and the bedrock on which winter plans are built. The indicators underpin the processes to achieving the outcomes described.

The HSCP local planning arrangements are set out under the headings of the 12 critical areas identified. In addition, the planning arrangements described have integrated the relevant essential actions as outlined in the Scottish Government *6 Essential Actions to Improving Unscheduled Care Performance*

i. Business continuity plans tested with partners.

Business Continuity Plans (BCP) for both Health and Social Care Services have been harmonised into a single BCP and will be tested during the winter season. Each service has completed a Departmental Service Plan and these were tested in February 2016. Service

leads have been asked to update and review their individual Departmental BCP service plans by November 2016.

Links have been established with East Dunbartonshire Council's winter planning arrangements to support the continuity of all partnership services throughout the winter period.

GP Practices and Pharmacies have BCPs in place that include a 'buddy system' should there be any failure in their ability to deliver essential services. The HSCP met with Practice Managers in September 2016 and asked that they reaffirm their arrangements.

ii. Escalation plans tested with partners.

Escalation plans will be prepared and shared across services to ensure a whole system approach to implementing actions that minimise potential issues.

The Hospital Discharge team will provide a reduced staff rota during the week between the public holidays, with a minimum of two staff on duty. Additional capacity to respond to particular increases in service demand can be resourced from other social work teams if required.

Commissioned services have emergency arrangements are in place and the Independent Sector Integration Lead has agreed to act as a link between the HSCP, the commissioning team , and Care Homes to share information and identify any issues that require to be escalated.

iii. Safe & effective admission / discharge continue in the lead-up to and over the festive period and also in to January.

(a) Admission Avoidance

Teams have systems in place to predict or identify vulnerable patients at risk of admission so that the necessary support can be given to avoid unnecessary admissions and help people remain in their own homes:

- The Community Nursing teams have a *Patient Status at a Glance* Boards that are updated daily. The board displays details of vulnerable patients as well as patients with changing needs. The nursing teams have daily meetings to identify vulnerable patients and those at risk of admission. The nurses will link with GPs to identify patients who may potentially be vulnerable during the long bank holidays.
- The Social Work team maintain a register of vulnerable people known to them living in the community. The Social work out of hours Standby Services have a copy of the information regarding these individuals to ensure appropriate supports can be provided if required outwith office hours, including weekends and Public Holidays.
- The Community Rehabilitation team and Older Adults Mental Health team maintain a list of patients at risk of admission to assist in daily scheduling of visits during adverse weather periods.
- The Rapid Assessment Link within the rehabilitation team offer same day access to service for patients referred by the GP before 4pm who are at risk of admission.

- Community and Acute Services will be asked to predict service users who will be discharged and require Homecare services during the two long weekends as Homecare will stop accepting referrals 48 hours prior to each Public Holiday.
- The Older Adults Mental Health Team has an in-hours duty system in place to provide urgent advice and input as appropriate. Out of hours referrals are directed to the Crisis Team
- Social Work Occupational Therapy is staffed daily and can respond to prevent escalation leading to potential admission. This provision is maintained across the holiday period with the exception of the public holidays.
- Contacts with private providers of Homecare services include monitoring their capacity for delivering services as commissioned.
- The HSCP Older People's Programme Board will continue to work in partnership, with GPs, Acute services, Independent Sector including links with Care Homes, and Third Sector organisations including Older People's Access Line, Carers Link, Ceartas, Marie Curie, Befriending Plus and the Red Cross, to help people remain in their own homes, or homely setting, when it is safe to do so.

(b) Anticipatory Planning and Care

There are a number of anticipatory actions established across all health and social care teams. In particular,

- Local intelligence and SPARRA information is used to identify patients at risk of admission. These patients are offered assessment and support from the Community Nursing service. Complete anticipatory care plans are uploaded by GP practices onto their electronic information system, eKIS. Work is underway with local GP colleagues to extend this over the winter period to include specific long term conditions.
- Anticipatory structures within Social Work Older People's services seek to identify those considered to be potentially most at risk across this time and information provided to Social Work Standby Services is regularly updated by social work staff.
- All patients with palliative and end of life care needs have an anticipatory care plan and electronic palliative care summary completed within EMIS which is shared with acute and the Scottish Ambulance Service.
- Community teams will ensure that people are reminded to order and collect their repeat prescriptions in advance of the festive period.
- A predictive stock order of essential equipment from EQUIPU, wound dressings, pharmacy, and syringe drivers will be submitted early December to ensure availability of supplies for the Community Nursing and Rehabilitation teams during the holiday period.
- Homecare services have access to 4x4 vehicles in the event of severe weather to ensure that they can reach vulnerable service users.
- The East Dunbartonshire Council Roads Department has agreed that an HSCP service manager can inform them of remote vulnerable service users who cannot

be reached by car or foot during severe weather and actions will be taken to clear the road and enable access, thereby preventing a potential avoidable hospital admission.

- Public information which directs people to appropriate services will be made available to direct them to appropriate services through website links on the HSCP, East Dunbartonshire Council, and relevant Third Sector websites. This will include "Know who to turn to" and NHSGG&C winter website link.

(c) Expediting Discharge from Hospital

A weekly operational discharge meeting has been established to review all individual hospital delayed discharge cases and ensure that the collective resources are appropriately directed to create improved joined up working that will minimise and reduce future delays.

There are a number of activities that the group explore and enact including:

- Promotion of legal powers in relation to adults with incapacity;
- Further exploration of the use of 13ZA under 'deprivation and liberty' Mental Health (Scotland) Act;
- Weekly discussions regarding those people currently in hospital and the issues that require to be resolved;
- Access to Trakcare to assist early identification of admissions known to social care services;
- Anticipatory AWI meetings;
- A dedicated process for allied health professionals and home care organisers to identify and highlight issues to the Team Manager, Older People's Team, regarding individuals, living in the community, who lack capacity and legal powers.
- The use of delayed discharge monies to employ a Resource Worker role that will support the Joint Delayed Discharges group by arranging meetings; gathering and comparing information across various systems (Trakcare, Carefirst etc); analysing case notes and highlighting issues that could prevent discharge;
- The use of delayed discharge monies to fund care placements in the short term while financial disputes are settled;
- The use of delayed discharge monies to fund the services of a solicitor (via Citizens Advice Bureau) to undertake a short term episode of processing power of attorney applications

iv. Strategies for additional surge capacity across Health & Social Care services

The HSCP will respond where possible to support Acute services in managing surge capacity. The GP practices will be informed of any acute pressures to assist in considering possible alternatives to admission, where appropriate. This will be supported by the Rapid Assessment link Team, and the Hospital Assessment Team will provide a reduced staff rota the week between the public holidays with a minimum of two staff on duty to support

surge activity. Additional capacity to respond to particular increases in service demand can be resourced from the wider local social work teams if required.

v. Whole system activity plans for winter: post-festive surge / respiratory pathway

The HSCP will continue to contribute to the whole system activity planning and ensure representation at winter planning groups.

Links will be maintained with Acute and Partnership Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action.

The HSCP Planning Manager attends the North Sector UCC Winter Planning Group meetings to share planning arrangements and discuss issues with the North Sector Acute Services and East Dunbartonshire HSCP.

Situation reports (SITREPs) will be shared between the Community and Acute services to inform escalation pressures.

vi. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

The actions set out in this Winter Plan will be monitored and analysed to identify and potential improvements to inform future predictive modelling and planning.

Particular measures that will be monitored include;

- Bed days lost to delayed discharge
- Bed days lost to delayed discharge for AWIs
- Emergency admissions age 75yrs+
- Percentage uptake of flu vaccinations by staff
- Percentage uptake of flu vaccinations by GP population
- Referrals to Rapid Response and Rapid Assessment Link team
- Referrals to Hospital Assessment Team
- Demand and capacity (including GP practices)

vii. Workforce capacity plans & rotas for winter / festive period agreed by October.

Service leads will be responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity during the festive period, and immediately following the four day holiday periods. This will be confirmed through the Operational Management Group in October.

viii. Discharges at weekend & bank holidays.

The Community Nursing service and Homecare service are the only HSCP community teams which provide a service 24 hours, 365 days per year inclusive of bank public holidays. These teams, in partnership with Acute and Out of Hours services, will support safe and effective hospital discharges during weekends and holidays.

ix. The risk of patients being delayed on their pathway is minimised.

Anticipatory structures have been supported to ensure that potential areas of need, particularly in respect of the adults with incapacity (AWI) are best met and AWI delays minimised**.** The Integrated Care Fund has supported additional capacity, including Mental Health Officers and

a part time Solicitor, to facilitate the process around Power of Attorney and Guardianship orders to minimise delays for AWIs.

There is ongoing work at the primary secondary care interface within rehabilitation services to improve the sharing of information and reduce need for reassessment at points of transition that could lead to a delay in the patient's pathway.

x. Communication Plans

To ensure that staff and Primary Care colleagues and partner agencies are kept informed, the HSCP will;

- Ensure information and key messages are available to staff through communication briefs, team meetings and electronic links
- Circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices
- Collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues and NHSGG&C Board.
- Information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices. The Clinical Director will re-enforce these messages to GP Practices.

xi. Preparing effectively for norovirus.

Information distributed to Care Homes will be shared by the Independent Sector Integration Lead

xii. Delivering Seasonal Flu Vaccination to Public and Staff

All health and Homecare staff will be reminded to encourage elderly and vulnerable groups to attend their GP flu vaccination sessions. The Community Nursing service will vaccinate those who the GPs identify as being housebound and consent to receiving the flu vaccination

Health staff are actively encouraged to be vaccinated and local peer vaccination sessions will be provided. Homecare staff will be advised as to how they can receive the vaccination if they so choose.

4.4 Governance

A detailed rolling action log will be maintained and updated at the Operational Management Group, and a report analysing the activity, performance and pressures will be provided at the end of the winter planning period.

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 11

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**6th October 2016**
Report Number	**2016/17_11**
Subject Title	**Commissioning and Contract Management Framework**
Report By	**Jean Campbell, Chief Finance & Resources Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Gillian Healey** **Team Leader, Planning & Service Development** **East Dunbartonshire Council** **0141 777 3000** **Gillian.healey@eastdunbarton.gov.uk**

1.0 PURPOSE OF REPORT

1.1 To provide a summary of the Commissioning and Contract Management Framework (CMF) and ask members to note and agree underpinning procedures required to support effective delivery of this function.

2.0 SUMMARY

2.1 Commissioning is a strategic function which involves identifying priorities and allocating resources to ensure care and support services are provided effectively to meet the needs of the local population. It is the process of translating aspirations and needs into services by making the best use of resources to deliver the best possible individual outcomes for service users and their carers.

2.2 Commissioning is a complex and often challenging process driven by legislation, regulation and policy frameworks which inevitably conflict. It is considered a cross-cutting activity which links strategic and financial planning with the care management function.

Commissioning activities include:

- Agreeing strategic priorities and outcomes;
- Analysing market intelligence and forecasting needs;
- Awareness & application of key strategic drivers underpinning respective client groups;
- Understanding factors which impact on market supply and demand;
- Developing commissioning strategies in accordance with identified needs and resources;
- Procuring services in line with EU Procurement Regulations & Council Standing Orders;
- Contingency and Risk Management planning;
- Facilitating effective engagement/consultation with providers, services users and carers;
- Contract Management/monitoring and evaluating commissioned services;
- Developing exit strategies for services which no longer meets needs or delivers best value

2.3 Commissioning activity should be fluid and cyclical in nature and is best demonstrated within the

widely acclaimed Institute of Public Care (IPC) model as illustrated in **Appendix 1.** A key principle of this model is that commissioning activity is equitable, transparent and open to influence from all stakeholders via on-going dialogue with people who use services, their carers and providers.

3.0 RECOMMENDATIONS

3.1 Members are asked to note and agree the procedures underpinning the Contract Management Framework (CMF)

4.0 MAIN REPORT

4.1 Commissioning - Contract Management Framework (CMF)

Contract Management forms an essential part of the commissioning function. This is where contracts are executed and monitored to ensure on-going compliance. Given the level of commissioned spend across the market, circa £39.4m for Adults and £6.6m for Children and Families, it is imperative that contracts are managed within a robust framework.

A comprehensive Contract Management Framework (CMF) was established in 2008 (by the Planning & Service Development Team) and proves effective in terms of monitoring provider/service performance and compliance. The CMF is built across four key areas:

Level 1: Accreditation/Risk Assessment

Accreditation - An Initial Information Request (IIR) form is issued to providers to capture baseline information including contact, service, policy, insurance and care inspectorate registration details. Following receipt, the IIR is checked and recorded onto the CMF database.

Risk Assessments – Services are risk assessed to help determine the level/intensity of monitoring/scrutiny required. Higher risk services attract more intensive monitoring requirements. Key factors used to determine risk levels include: volume, cost, type of service/mode and client group. The level of risk is categorised as High, Medium and Low. High risk services usually require monthly monitoring returns and more frequent visits, whilst low risk services require six monthly monitoring returns along with an annual visit.

Level 2: Baseline Monitoring

Commissioned providers are required to submit service type specific monitoring returns on a monthly, quarterly or six monthly basis - determined by the level of risk (as above). Each return is analysed and recorded onto the CMF database - effectively building up a picture of provider/service performance. If/where service deficits/issues arise, providers are contacted in the first instance to discuss further, however, and dependent on the severity of the deficit/issue, Level 3 Audit and/or Level 4 Service Review activity may be invoked.

Other information sources including; Notification forms, Care Commission Inspection Reports, Pre-evaluation and Self-Assessment Returns and regular contact/feedback with care managers is also used to inform baseline monitoring.

Level 3: Audits

A service will be audited at least once a year and more often if/where concerns arise. An audit involves visiting a service to check service performance and compliance. Information held on the CMF database obtained from monitoring returns and other sources is used to inform the audit. The outcome of an audit is recorded onto the CMF database and dependent on the findings, may result in closer monitoring/scrutiny, improvement action plans or possibly, if deemed significant and/or serious, escalated to service review level. Care managers, the Care Inspector and other agencies are involved accordingly.

Level 4: Service Reviews

The purpose of a Service review is to evaluate a provider's overall performance and ensure compliance with the following criteria: service "fits" strategically (aligned to national and local key drivers), delivers best value and is outcomes focussed. Typically, a service is reviewed at least a year before the contract is due to expire, however, an earlier review could be triggered if/where recurring and/or significant concerns arise. Information collated to date via monitoring and audit activity is used to help to inform service reviews along with information provided by a number of key stakeholders including: Provider, service users, carers, social work and health colleagues and the Care Inspectorate.

The key findings of a service review and any subsequent recommendations are articulated within a draft Service Review Report which is forwarded to the Strategic Development Team (SDT) for final approval. The outcome of a service review will generally result in the re-awarding of a contract (subject to minor changes and/or improvements) or, de-commissioning of the service. The latter is instigated where a provider/service is deemed to be non-compliant with one or more of the above criteria and/or fundamental changes are required, for example, a change of service model to meet current and future needs.

Once approved via the SDT, the provider is notified of the review outcome. Where a contract is to be awarded - subject to minor changes/improvements, an Action Plan will be implemented and monitored for compliance. Once completed, a new contract is executed.

However, if/where a decision is taken to decommission a service, the following occurs:

- Provider notified of the review outcome and subsequent decision to decommission the service;
- Notice period agreed in line with contract/service requirements;
- Meetings scheduled throughout the notice period to help support and guide the provider through the de-commissioning process;
- Identify existing service users, current & future needs and possible alternative services;
- Develop new spec/tender and issue in line with Procurement/Standing Orders;
- Consider facts which might impinge new service delivery including TUPE, suitable accommodation, Self-Directed Support;
- Evaluate and award new contract - ensure smooth transition from existing to new service;
- Contract monitor new service to ensure compliance

A Service Review "Decision Making Process" flow chart is illustrated on **Appendix 2.**

Notwithstanding the above, the Council is required and expected to re-provision services regularly in order to comply with EU Regulations and Standing Orders. The re-provisioning of services will also help to secure Best Value and promote healthy competition across the market.

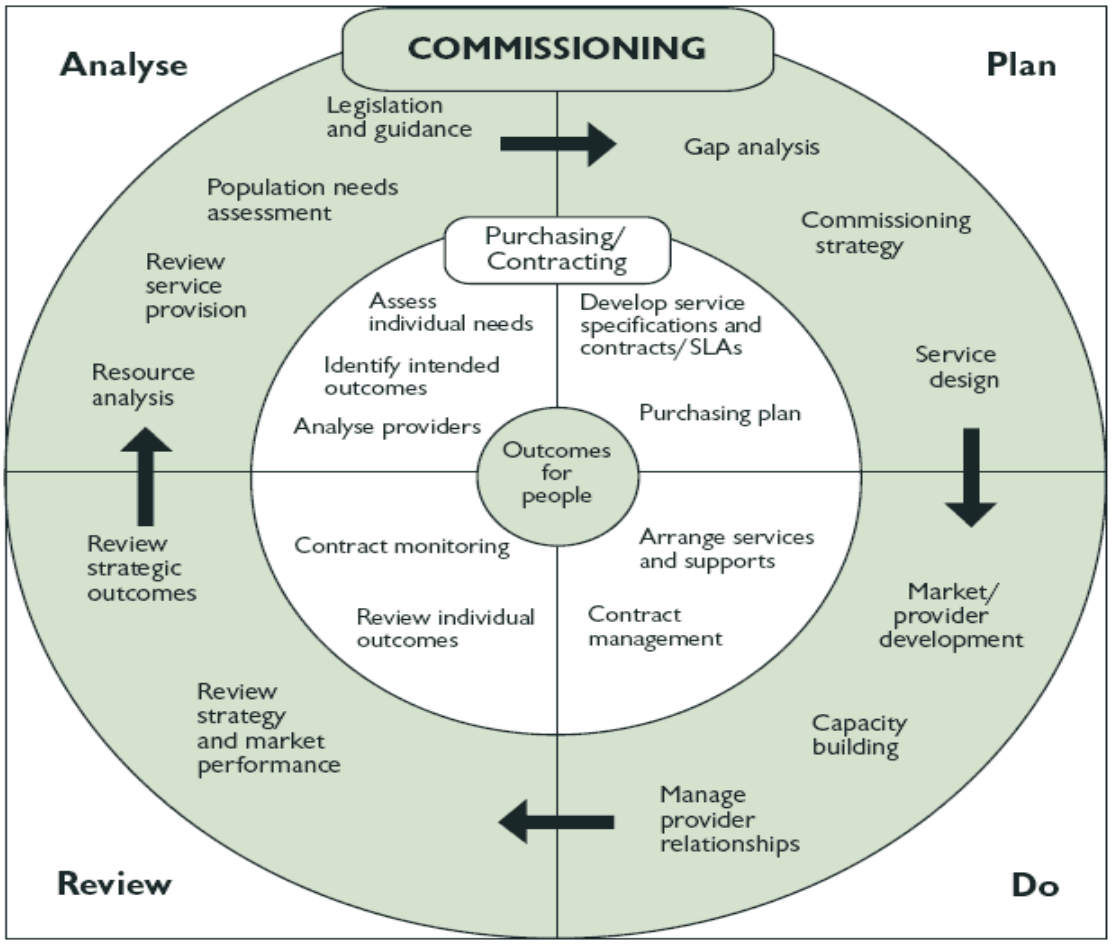
5.0 IMPLICATIONS

5.1 This report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document. The implications for the Council are as undernoted.

5.2 Financial – Information collated and reported within the HSCP has been done in discussion with the relevant partnership bodies and is consistent with their reporting requirements.

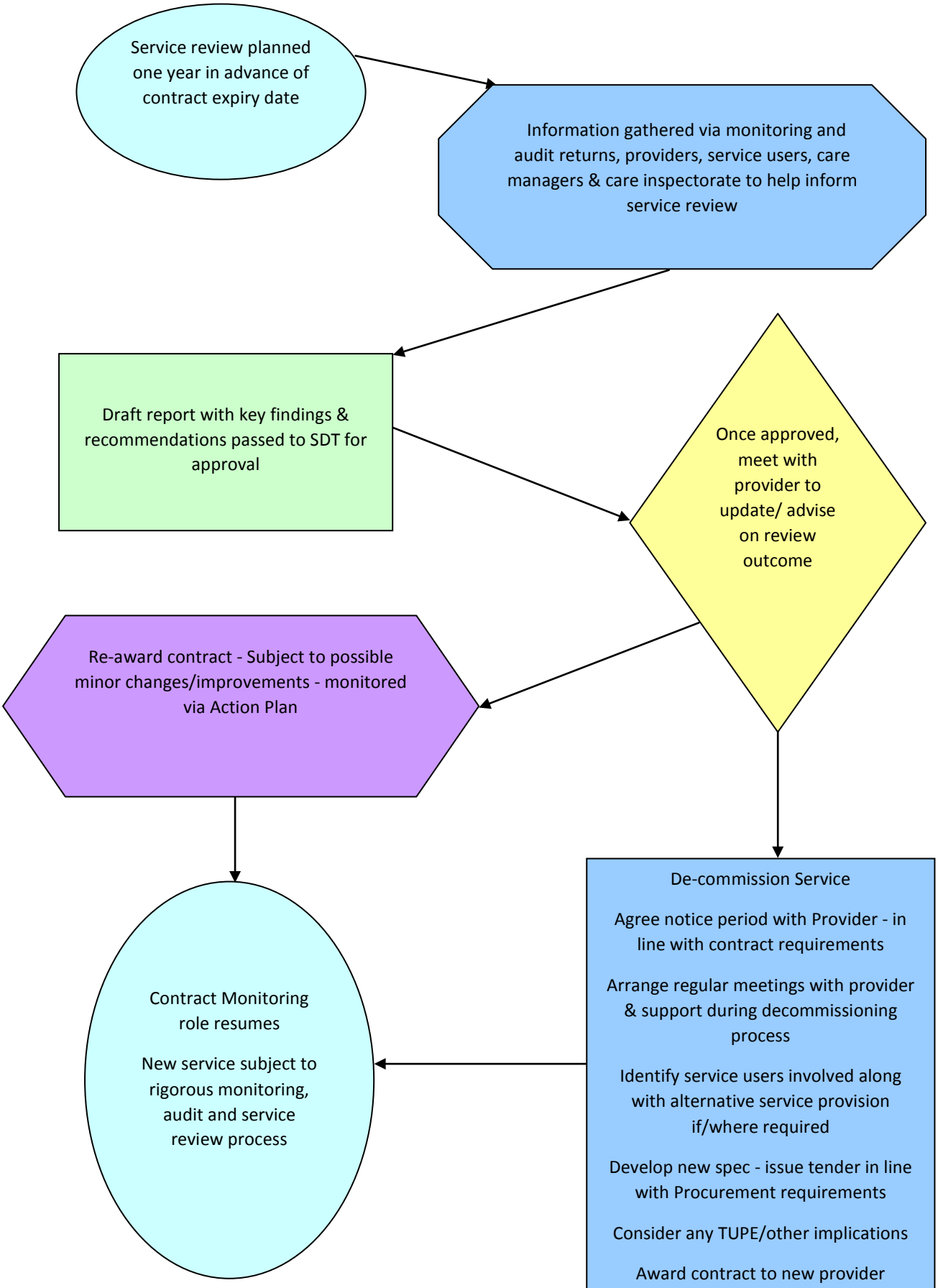
Appendix 1

INSTITUTE OF PUBLIC CARE - COMMISSIONING MODEL



Appendix 2

SERVICE REVIEW DECISION MAKING PROCESS FLOW CHART



Agenda Item Number: 12

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**6th October 2016**
Report Number	**2016/17_12**
Subject Title	**Draft Interim Integrated Children's Services Plan 2016/17**
Report By	**Interim Chief Officer** **East Dunbartonshire Health and Social Care Partnership**
Contact Officer	**Paolo Mazzoncini, Chief Social Work Officer** **East Dunbartonshire Health & Social Care Partnership** **0141 578 8039** **Paolo.mazzoncini@eastdunbarton.gov.uk**

1.0 PURPOSE OF REPORT

1.1 This report provides Board members with an update on the work being done to deliver an Integrated Children's Services Plan for East Dunbartonshire Council.

2.0 SUMMARY

2.1 The Children and Young People (Scotland) Act 2014 places a duty on local authorities and health boards to jointly prepare a Children's Services Plan (CSP) for the area of the local authority covering a 3 year period and to jointly publish an annual report, detailing how the provision of children's services, both universal and targeted and related services in that area have been provided in accordance with the CSP. This is Part 3 of the Act, and CSPs for the period 2017-20 are expected to be in place by April 2017.

2.2 Part 1 (sections 2 and 3) of the Act also places duties on public authorities, as defined at Schedule 1 to the Act, to report every 3 years on the steps they have taken in that period to secure better or further effect of the United Nations Convention on the Rights of the Child. Part 1 (section 2 and 3) will commence in April 2017, with 2020 as the date of first reporting.

2.3 The East Dunbartonshire Community Planning Partnership provides the overarching Strategic Planning and Performance Framework that brings together local partners to address the range of complex issues that face some of our communities. East Dunbartonshire has well-established arrangements for community planning with a Board, Chief Officers Group, six Local Outcome multi-agency planning groups and other satellite groups covering cross-cutting priorities such as equality.

2.4 East Dunbartonshire's Delivering for Children and Young People Partnership (DCYPP) is the main strategic body responsible for addressing the broad range of issues affecting children and young people living in East Dunbartonshire. The DCYPP leads on Local Outcome 3 '*Our children and young people are safe, healthy and ready to learn'*.

2.5 The DCYPP has been working on an Integrated Children's Services Plan recently and produced the attached interim draft (**Appendix 1**). This is the common agreed plan for 2016/17. However, DCYPP partners agree that this plan is a temporary document and that it will require to be revised to meet the requirements of the Children and Young People (S) Act 2014 and our three year planning cycle for 2017-20.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Health and Social Care Partnership Board:

a) Notes the content of the report.

4.0 MAIN REPORT

4.1 The membership of the Delivering for Children and Young People Partnership (DCYPP) includes representatives from local and national organisations and services (e.g. Police Scotland, the Reporter's Department, Education, and Children's Services etc.) across East Dunbartonshire. The Partnership works hard to ensure that the people who can contribute to outcome focused planning are involved in the group.

4.2 This Plan has been developed by the DCYPP and covers the period 2016 – 2017, setting out how partners will work together to develop and provide services during this period. Our objective is two-fold. Firstly, partners are seeking to improve universal service provision for all our children, while enhancing targeted services to those children, young people and their families who need additional support to achieve their full potential.

4.3 The Plan focuses on three key areas that partners agree are integral for the coming period: Our children and young people are (1) safe; (2) healthy; and (3) ready to learn. There are improvement actions specific to each area that support our overall aim that our children and young people's services will:

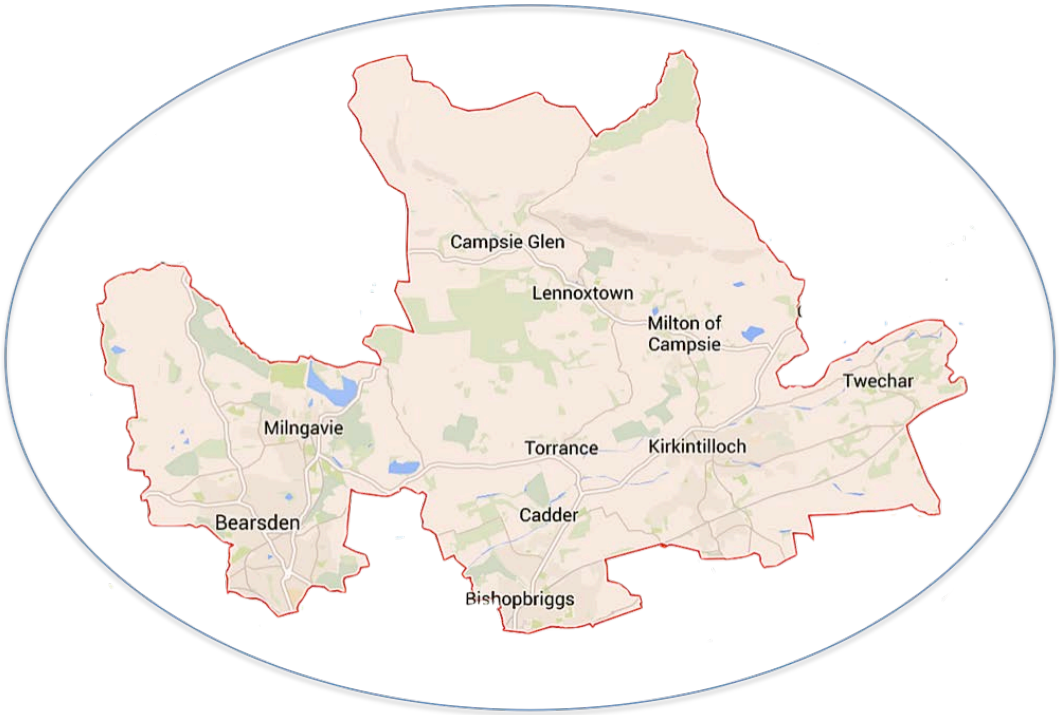
- safeguard, support and promote wellbeing;
- ensure that action is taken at the earliest opportunity;
- take appropriate action to prevent need;
- be integrated from the point of view of service users;
- constitute the best use of available resources.

4.4 The Plan provides information on the progress that has been made in East Dunbartonshire with respect to the areas above, and also outlines the arrangements that are in place for performance management and quality assurance.

4.5 Partners are committed to developing systems that help us listen to and act upon the views of children and young people in East Dunbartonshire.

East Dunbartonshire Community Planning Partnership

Integrated Children's Services Plan (2016/17)



sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

East Dunbartonshire
Health & Social Care Partnership

NHS
Greater Glasgow & Clyde

EAST DUNBARTONSHIRE
INTEGRATED CHILDREN SERVICE'S PLAN

CONTENTS

			Page
1.	**OUR STRATEGIC VISION AND APPROACH**		
	1.1	East Dunbartonshire Community Planning Partnership – Our Golden Thread	3
	1.2	Understanding the Needs of Our Children and Young People	6
	1.3	Planning for PLACE neighbourhoods	8
	1.4	Getting It Right for Every Child, Young Person and Family	14
2.	**EQUALITY AND DIVERSITY**		
	2.1	Our Commitment to Meeting Equality Duties & Reducing Inequality	15
	2.2	Corporate Parenting Approach	16
	2.3	Strengthening the Voice of our Children, Young People and their Families	16
3.	**OUR PARTNERSHIP APPROACH**		
	3.1	How we Work Together	17
	3.2	Multi-agency Workforce Development	19
4.	**PERFORMANCE MANAGEMENT**		
	4.1	Monitoring and Evaluation	20
	4.2	External Audits, Inspections and Scrutiny	21
5.	**IMPROVEMENT PLANNING**		
	5.1	Our Improvement Plan	22
	5.2	Our Children and Young People are Safe	24
	5.3	Our Children and Young People are Healthy	32
	5.4	Our Children and Young People are Ready to Learn	39
6.	**APPENDICES**		
	6.1	Our Corporate Parenting Action Plan	46

1. OUR STRATEGIC VISION AND APPROACH

1.1 East Dunbartonshire Community Planning Partnership - The Golden Thread

The East Dunbartonshire Community Planning Partnership provides the overarching Strategic Planning and Performance Framework that brings together local partners to address the range of complex social, community, physical, economic, health and wellbeing issues that face some of our communities. We have well established arrangements for community planning in East Dunbartonshire with a Board, Chief Officers Group, 6 Local Outcome multi-agency planning groups and other satellite groups covering cross-cutting priorities such as equality.

The Community Planning Partnership's Vision

'Working together to achieve the best with the people of East Dunbartonshire.'

Long-term Outcomes:

- 'We have reduced inequality and disadvantage across East Dunbartonshire.'
- 'Our communities are more engaged in the design and delivery of services.'

We will work towards our vision and long-term outcomes through Local Outcomes which we have agreed through the analysis of our community profile and feedback from local people and communities. Our strategic direction and long term priority is to reduce inequality between our most and least deprived communities.

Six Local Outcomes:

1. East Dunbartonshire has an expanding economy with a competitive and diverse business and retail base
2. Our people are equipped with knowledge, skills and training to enable them to progress to employment
3. Our children and young people are safe, healthy and ready to learn
4. East Dunbartonshire is a safe and sustainable environment in which to live, work and visit
5. Our people and communities enjoy increased physical and mental wellbeing and health inequalities are reduced
6. Our older population is supported to enjoy a high quality of life and our more vulnerable citizens, their families and carers benefit from effective care and support services.

Our Community Planning approach is inherently linked to a broader framework of related plans, strategies and outcomes, both national and local. Ensuring that there is a co-ordinated and robust approach to achieving good outcomes for children and young people is a key part of the work undertaken by the Delivering for Children and Young People Partnership (DCYPP). We are committed to the continued delivery of high quality and effective services, which help address the wide range of issues our children and young people face.

While the strategy is relevant to a number of national outcomes, the most relevant are contained within the National Performance Framework:

Our children and young people:

- *are successful learners, confident individuals,*
- *are effective contributors and responsible citizens*
- *have the best start in life and are ready to succeed*
- *have improved the life chances and those of families at risk.*

East Dunbartonshire's DCYPP is the main strategic body responsible for addressing the broad range of issues affecting children and young people living in East Dunbartonshire and as such, leads on Local Outcome 3 Our children and young people are safe, healthy and ready to learn'.

The membership of the DCYPP includes both national and local organisations and services involved in the strategic and operational provision across the authority. This ensures the Partnership has the right people 'around the table' who can contribute to outcome focused planning. This Plan has been developed by the DCYPP and covers the period 2016 – 2017, setting out how we will work together to develop and provide services during this period. Our focus is two-fold. We seek to improve universal services to all our children, while improving targeted services to those children, young people and their families who need additional support to achieve their full potential.

Other groups also make a significant contribution to planning services for children, young people and families, for example the Child Protection Committee and Empowered, the Violence Against Women and Girls Partnership. Furthermore, given that all of our Local Outcome Delivery Groups plan for services which impact all members of our communities, including children and young people, their work too will indirectly or directly contribute to Local Outcome 3.

The Child Protection Committee has responsibility for progressing our Child Protection Business Plan, while some of our other work with children, young people and their families is described in the following documents:

- Our approach to Getting It Right For Every Child (GIRFEC)
- Empowered Violence Against Women and Girls Strategy and Action Plan
- Curriculum for Excellence Strategic Plan;
- Developing the Young Workforce Strategic Plan;
- Additional Support Needs (ASN) Strategic Plan;
- East Dunbartonshire Community, Learning and Development Plan;
- Early Years Strategy;
- Kinship Care Strategy, and
- Parenting Support Strategy.

Table 1: This table demonstrates the 'Golden Thread' approach we have used within our strategic planning and sets out our vision, priorities, improvement objectives, aims and long-term outcomes at a glance.

WORKING TOGETHER WE WILL ACHIEVE THE BEST WITH THE PEOPLE OF EAST DUNBARTONSHIRE		
Our priorities	**Our Improvement Objectives**	**Our aim**
Children and young people are...	**Children & Young People's Services seeks to ensure...**	**Children and young people's services will ...**
Safe	▪ Staff and volunteers across all services and agencies utilise child protection guidance and adhere to agreed procedures	... best safeguard, support and promote wellbeing; ...ensure that action is taken at the earliest opportunity; ... take appropriate action to prevent need; ... be integrated from the point of view of service users; ... constitute the best use of available resources
	▪ All children and young people are afforded timely protection and support	
	▪ The public and civil society understand how to protect children and young people and keep them safe	
	▪ Children and young people have the knowledge and skills to keep themselves safe	
Healthy	▪ Policies, strategies and plans promote and improve the health and wellbeing of children, young people and their families	
	▪ Children, young people and their families live in health promoting environments	
	▪ Effective community action empowers children, young people and their families to be involved in improving their own health and wellbeing	
	▪ Children, young people and their families are supported to improve their health through developing personal and social skills	
	▪ NHS Children's Services support children, young people and their families to improve health and wellbeing	
Ready to learn	▪ Attainment and wider achievement for all children and young people is raised	
	▪ The quality and provision of early learning and child care is improved	
	▪ Issues of inequality and discrimination are addressed	
	▪ Parents are empowered to feel confident in supporting their children's development	
We will develop systems that help us listen to, and act upon the views of children and young people in East Dunbartonshire		
This will mean	**1.We have reduced inequality and disadvantage across East Dunbartonshire** **2.Our communities are more engaged in the design and delivery of services**	

Strategic Planning and Performance Framework

Due to new duties placed upon the Community Planning Partnership by the Community Empowerment (Scotland) Act 2015, East Dunbartonshire CPP is currently preparing to launch a revised Strategic Planning and Performance Framework; Local Outcome Improvement Plan and Locality Plans for areas which are experiencing poorer outcomes compared with others within the authority. Where appropriate, the DCYPP has taken account of these emerging developments and has incorporated elements of the revised Framework within this Integrated Children's Services Plan. This is most notably referenced within the 'Understanding and Planning for Place' section. A review of this document will take place subsequent to the Framework being launched in October 2017 with a revised version being published no later than April 2018. This is in keeping with all Local Outcome Delivery Groups.

1.2 Understanding the Needs of Our Children and Young People

East Dunbartonshire is an area of both urban and rural communities. It is recognised as one of the best places to live in Scotland. This is based on statistical evidence regarding health outcomes, life expectancy, levels of employment and the performance of our children and young people in school.

Most recent population studies predict that by 2037, there will be a 7% decrease in the area's overall population. This is as a result of natural change (that is the difference between the number of births and the number of deaths) and migration which is the movement of people from one place to another. Between 1995 and 2011 more people left the area than moved in, but since then this trend has reversed. While migration can be difficult to predict, recent forecasts suggest this more recent situation will continue.

While children under the age of 16 years presently account for 17% of the area's population, this is figure is predicted to fall to 16% by 2037. During this period, the most significant increase will be in the number of residents aged 65 years or over, with this group accounting for a third of the total population.

There is an11.6 years variance in life expectancy between our most and our least deprived communities. Additionally, almost 18% of children aged up to 15 years are living in our three most deprived datazones. This means that a significant percentage of our children are living in areas of multi-deprivation with poor economic activity and low life expectancy.

Despite this, attainment in secondary schools as measured in SQA examinations is among the highest nationally. The Audit Scotland report in 2014 acknowledged that East Dunbartonshire Council had the highest level of improvement of any Council in Scotland for pupils in S4 in the last ten years. It is also reported that the Council was the best performing authority for the lowest 20%.

The "East Dunbartonshire Schools Health & Wellbeing Survey – 2014" was conducted in our secondary schools, with a total of 2,901 young people, aged between 11 and 18 years, taking part (52% were male, 48% were female and 89% described their ethnicity as 'white'). Overall, the survey found that our young people are adopting positive, healthy behaviours. This is evidenced through the following key findings from the survey:

- 87% cleaning their teeth twice a day or more;
- 84% having visited the dentist in the previous six months' period;
- 83% having received sexual health and relationships education at school;
- 75% expecting to go on to further education or training;
- 56% never drinking alcohol;
- 52% walking or cycling to school;
- 48%eating five or more portions of fruit or vegetables in a day;

- 44% meeting the physical activity target of taking 60 minutes or more of moderate physical activity on five or more days per week; and
- 31% having nine or more hours of sleep per night.

However, the survey also presents findings which demonstrate where children and young people are not reporting positive health and well-being behaviours:

- 54% reported being exposed to environmental tobacco smoke;
- 50% had engaged in anti-social or risk-taking behaviours in the previous year;
- 22% had been bullied in the previous year;
- 18% have more than eight hours of screen based activity on a school day;
- 15% admitted to bullying others in the previous year;
- 12% had taken illegal drugs;
- 10% have a limiting illness or disability; and
- 8% were current smokers.

As the child population is decreasing, we are experiencing an increase in the numbers of children in need of care and protection. This is demonstrated in a number of ways, including:

- a rise in the number of children on the child protection register;
- an increased number of children who are looked after; and
- more children being referred to Social Work.

Since 2010, the number of child protection investigations has risen by 10%, alongside a 25% increase in the number of children whose names have subsequently been placed on the child protection register. Parallel to this, has been a rise in the number of case conferences convened. Between 2010 and 2015, there was a 42% increase in new referrals to the social work duty service and a 60% increase in open case referrals. This combined with a 25% rise in the number of children who are looked after, present challenges for the DCYPP.

At a national level, we know the risks experienced by children and young people are becoming increasingly more complex, evidenced by the growing number of children where multiple risk factors are recorded at child protection case conferences. This is also reflected in local statistics.

In the 154 child protection investigations undertaken during 2014/15, physical abuse was the most common area of concern identified, followed by neglect and parental mental health. The highest area of concern recorded for children on the Child Protection Register at 31 March 2015 was neglect, followed by non-engaging families and parental mental health. Between 1 May and 31 July 2015:

- 57 of our children and young people were referred to the Children's Reporter;
- Child Protection Orders were granted for 3 of our children and young people;
- 24.5% of all non-offence referrals were taken to a hearing by the Reporter;
- A total of 94 Children's Hearings were held;
- 11 Pre Hearing Panels were held; and
- At the end of the quarter, 132 children and young people had a Compulsory Supervision Order in place.

Since 2011, we have made significant progress in shifting our balance of care from children and young people being looked after in residential homes towards more children and young people remaining in the community and being looked after by either their parents, friends or family, foster carers or prospective adoptive parents. To date, we have achieved some success with 40% more children now being supported in community based placements.

Our economic activity and employment rates are high. 96% of our school leavers go onto a positive destination when they leave school. This breaks down as 60.9% who go to university, 16.3% who go to college, 16.6% who find employment and 2.2% who go into training. Our continuing success here places us in top position nationally.

While East Dunbartonshire is an area that traditionally experiences low levels of crime, Police Scotland continue to engage with local communities to ensure that issues of most concern are identified and addressed. These annual community consultation surveys inform our policing priorities which currently include tackling: violence, including domestic abuse and hate crime; disorder and anti-social behaviour.

1.3 Planning for PLACE

Despite the positive aspects of living in East Dunbartonshire, analysis of data and consultation with local communities tells us that there are areas where the quality of life for some residents falls well below the national average and that issues they experience are complex and often compounding. Our Community Planning Partnership Board recognises this and in response, launched our 'PLACE' approach in the community of Hillhead in 2012. Since then, the approach has been developed further and is now being embedded in Lennoxtown and Auchinairn.

PLACE aims to increase and improve partnership working, make the most effective use of our resources and engage our communities in the design and delivery of services. This is a coordinated approach which actively seeks to address the wide ranging challenges experienced by our communities with the poorest outcomes across our authority. Through PLACE, we are strongly focussed on reducing inequality and disadvantage and building the capacity and resilience of our communities. This is a particular way of working with communities which moves away from providing services to tackling local issues with tailored solutions, making local people central to the process.

On the whole, East Dunbartonshire performs very well when compared to other local authorities but this high performance, when considered at an authority level can hide the inequality gaps which exist between communities. Being committed to a PLACE approach to planning, means we look beyond the performance of our authority as a whole, and focus our resources at a neighbourhood level where we know our communities experience poorer outcomes.

The Outcome Indicators in Table 2 demonstrate the inequality experienced in PLACE and other communities where inequality exists by showing the inequality gap between these communities and East Dunbartonshire as a whole. It also shows how these communities fair from a National perspective, where in some instances our communities are performing 'statistically significantly worse.'

Table 2: Outcome Indicators

Outcome Indicator	Hillhead	Lennoxtown	Auchinairn	Twechar & Harestanes East	Harestanes	East Dunbartonshire
Children living in Poverty (2012 August snapshot - HMRC) ***Definition:*** The percentage of dependent children under the age of 20 in families that receive Child Tax Credits (<60% median income) or income support/Jobseekers Allowance. The total number of children in the area is produced using Child Benefit data held by HMRC which covers around 96% of children. All of the estimates are independently rounded to the nearest 5, therefore aggregating the individual estimates may not sum to the given totals for an area. The estimates are based on the finalised awards tax credits data, and as such are derived from a full set of administrative records rather than a sample.	28.6% Statistically **significantly worse** than the National average.	13.4% Statistically **not significantly** different from the National average.	15.2% Statistically **not significantly** different from the National average.	19.1% Statistically **not significantly** different from the National average.	17.3% Statistically **not significantly** different from the National average.	7.8% Performs **significantly better** than the National average.
	The National Average for this Indicator is 15.3%					
Working age population claiming Out of Work benefits (2014 May snapshot - DWP) ***Definition:*** Percentage of working age population claiming 'key out of work benefits.' This is a combined count of claimants on Jobseekers	23.8% Statistically **significantly worse** than the National average.	11.7% Statistically **not significantly** different from the National average.	14.1% Statistically **significantly worse** than the National average.	12.5% Statistically **not significantly** different from the National average.	15.3% Statistically **significantly worse** than the National average.	7.6% Performs **significantly better** than the National average.

Outcome Indicator	Hillhead	Lennoxtown	Auchinairn	Twechar & Harestanes East	Harestanes	East Dunbartonshire
Allowance (JSA), Employment and Support Allowance (ESA), Incapacity Benefit (IB) or Severe Disablement Allowance ('incapacity benefits'), Income Support with a child under 16 or no partner Lone parent and other Income Support (including IS Disability Premium) or Pension Credit with each person being counted only once.	The National Average for this Indicator 12.5%					
Population Income Deprived (2014 Calendar year – SIMD, Scottish Government) ***Definition:*** for income and employment deprived: percentage of a total population classified as income deprived or working age population (defined as 16-64 year olds) classified as employment deprived within SIMD income domain.	24.1% Statistically **significantly worse** than the National average.	12.8% Statistically **not significantly** different from the National average.	16.3% Statistically **significantly worse** than the National average.	13.8% Statistically **not significantly** different from the National average.	16.4% Statistically **significantly worse** than the National average.	7.7% Performs **significantly better** than the National average.
	The National Average for this Indicator 13.1%					
Working age population employment Deprived (2014 Calendar year – SIMD, Scottish Government) ***Definition:*** A count of the working age population claiming relevant benefits (Job Seekers Allowance, Incapacity Benefit, Employment and Support Allowance, or Severe	22.1% Statistically **significantly worse** than the National average.	11.7% Statistically **not significantly** different from the National average.	14.2% Statistically **significantly worse** than the National average.	14.7% Statistically **significantly worse** than the National average.	15.8% Statistically **significantly worse** than the National average.	8.2% Performs **significantly better** than the National average.
	The National Average for this Indicator 12.2 %					

Outcome Indicator	Hillhead	Lennoxtown	Auchinairn	Twechar & Harestanes East	Harestanes	East Dunbartonshire
Disablement Allowance).						
The following Indicators are specific to Local Outcome 3.						
Low birth weight (2012/13 to 2014/15 financial year; 3-year aggregates – ISD Scotland) ***Definition:*** Low weight (<2500g) live full-term births; 3-year rolling average number and percentage of all live singleton births	5.6% Statistically **not significantly** different from the National average.	0.0% Statistically **not significantly** different from the National average.	1.2% Statistically **not significantly** different from the National average.	1.6% Statistically **not significantly** different from the National average.	0.0% Statistically **not significantly** different from the National average.	1.5% Statistically **not significantly** different from the National average.
	The National Average for this Indicator is 2.0%					
Child obesity in Primary 1 (2014/15 academic year – CHSP – S) ***Definition:***Primary 1 children whose BMI is within the top 5% of the 1990 UK reference range for their age and sex.	11.1% Statistically **not significantly** different from the National average.	7.1% Statistically **not significantly** different from the National average.	9.1% Statistically **not significantly** different from the National average.	3.4% Statistically **not significantly** different from the National average.	5.7% Statistically **not significantly** different from the National average.	6.6% Performs **significantly better** than the National average.
	The National Average for this Indicator is 9.8%					
Average Tariff Score of all pupils on the S4 roll (2012/13 academic year – SNS/SG) ***Definition:*** Average tariff score (pupil attainment in national exams of all	174 No significance can be calculated	191 No significance can be calculated	219 No significance can be calculated	219 No significance can be calculated	207 No significance can be calculated	225 No significance can be calculated

pupils enrolled in fourth year of publicly funded secondary schools (S4).	The National Average for this Indicator is 193					
Mothers smoking during pregnancy (2012/13 – 2014/15 financial years; 3-year aggregates – ISD Scotland) ***Definition:*** Mothers with a known smoking status at first postnatal booking appointment (Health Visitor first review) who are recorded as a 'current smoker;' 3-year rolling average of all women with a known smoking status at booking (those with a smoking status of unknown have been excluded).	37% Statistically **significantly worse** than the National average.	14.2% Statistically **not significantly** different from the National average.	13.2% Statistically **not significantly** different from the National average.	29.3% Statistically **not significantly** different from the National average.	18.4% Statistically **not significantly** different from the National average.	11.1% Performs **significantly better** than the National average.
	The National Average for this Indicator is 18.5%					
Babies exclusively breastfed at 6-8 weeks ***Definition:*** Number of babies reported by parent to being exclusively breastfed at 6-8 week review; 3-year rolling average number and percentage of total number of babies receiving a 6-8 week review.	13.2% Statistically **significantly worse** than the National average.	16.1% Statistically **not significantly** different from the National average.	17.7% Statistically **not significantly** different from the National average.	13.8% Statistically **not significantly** different from the National average.	19.1% Statistically **not significantly** different from the National average.	32.6% Performs **significantly better** than the National average.
	The National Average for this Indicator is 26.8%					

PLACE Based Engagement and Recommendations

Hillhead

Eight of East Dunbartonshire's 127 data zones are in the 25% most deprived in Scotland. Five of these eight form a cluster around Hillhead in Kirkintilloch, with two of the data zones falling within the most deprived 5% in Scotland.

Hillhead was the first area of East Dunbartonshire to be targeted using a PLACE approach. From initial workshops held with partners, and conversations with parents at Hillhead Primary School, it was agreed tha ,to begin with, resources should be dedicated to creating a Family Centre. This brought together services to engage with families through nursery and school using family learning and opportunities for parents to up-skill themselves in parenting strategies, personal development, managing family budgets and reducing stress. A steering group took this approach forward resulting in increased engagement with formal learning settings and increase confidence in parenting. The PLACE approach is a key element of the Early Years Collaborative, ensuring more integrated ways of service planning and delivery across local communities.

Building on the success of the family centre, which was located within Hillhead Primary School and nursery, community and practitioner feedback resulted in the development of an innovative Family Learning pilot, Little Explorers' Nurture Day, within Hillhead Community Centre. It is targeted towards children and families, pre-birth to 8 years of age and runs once a week. A wide range of activities from a variety of services and support and advice to parents has been developed in response to identified need. This initiative has been positively evaluated, with attendance increasing over the course of the programme. It has helped to develop secure parent/child attachment through promoting nurturing approaches and family life, and includes playing, talking and reading together.

Community and practitioner feedback has also informed the decision to concentrate on building the capacity of parents and carers to take ownership of their provision and services. The focus in Hillhead is providing and building services in partnership with parents and carers, and volunteering is a key element to making this approach sustainable. Efforts to support and promote volunteering should continue to underpin the work with children and families in Hillhead. This will encompass parenting and health and well-being as a focus and should build on the success of the family learning approach and the support to parents as champions within the nurseries. There will also be support for parents to engage in activities to promote their own personal development, such as by providing community based affordable childcare tied in with opportunities for parents and carers to learn and develop their employability skills.

Lennoxtown

Lennoxtown has one datazone which falls into the 25% most deprived in Scotland. Aworkshop involving services delivering provision within Lennoxtown was held in 2014 and the resulting ideas for working with children, young people and families were then taken to the community for feedback. It was agreed by practitioners and the community that there was a need to support the development of pre and post school provision for children and that the extension of the hours of Lennoxtown Nursery provision would be very beneficial. Community members also felt that employability services and support to parents and carers could be coordinated with this provision. Community members reported that there was a lot of childcare support provided by grandparents and that more could be done to support people in this role. It was also noted that solutions should be kept local and within the village.

The creation of a co-ordinated Early Years Facility catering for early years provision including nursery, family learning, family support and community led playgroups is

underway. Local groups will be supported to build their capacity to provide out of school services and that family learning approaches consider the needs of relatives, such as grandparents, where appropriate. It is also vital that services look to join up support to families who are most vulnerable and that suitable integration of support to parents is considered in areas outwith parenting, such as health promotion and building skills in employability

Auchinairn

Auchinairn has one datazone which falls into the 25% most deprived in Scotland. A multi-agency workshop was held in February 2015 to look at Auchinairn and develop locally tailored solutions. Profile information was provided and services contributed their own knowledge and experience to the process. Suggestions for work-streams were then presented in a well attended community workshop and feedback was used to shape these into recommendations. These recommendations did not look at children and families as a work-stream in their own right but rather elements of work with this group were considered as part of other themes ; namely community safety, employability and health and well being. Since this workshop, considerable consultation has taken place with local groups and individuals on the development of a new community and early years facility in the place of the primary school which will close in 2017.

It is widely acknowledged that Auchinairn lacks suitable facilities from which to support the local delivery of activities for children, young people and families. It is also worth noting that there are several key individuals within the community who work positively in partnership with services to provide pre and after school activities. Over the period 2016-2017 it will be essential to continue dialogue with the community about what can be put in place in the new community facility to support existing groups, such as the Auchinairn Breakfast Club and Families of Auchinairn Coming Together, as well as to develop new provision to meet their needs. Consideration for alternative venues for this provision will have to be considered as part of these conversations, particularly when the school closes in 2017 and the already stretched resource of the community centre will feel the pressure. From the feedback to date, it is likely that the suggested services will include parenting advice and support to families accessing the new early years facility, after school activities for children and a suitable evening youth provision. Consideration will be given to how the school merger will open up opportunities for widening the pool of volunteers to support community based activities. Capacity building, including support with child protection policies and procedures for community groups, should be provided as part of the package of support in developing new services for children, young people and families. Support to parents and carers will also include up-skilling opportunities and volunteering will be considered as part of this. It will be challenging to continue to build and provide services while the creation of the new facility is underway and all service providers will have to plan for this carefully in partnership.

As the Local Outcome Delivery Group for Local Outcome 3, DCYPP is committed to adopting a PLACE approach to their strategic planning. This is demonstrated within our Strategic Plan.

1.4 Getting It Right for Every Child, Young Person and Family

GIRFEC is the Scottish Government's approach to improving the services that support the wellbeing of all children and young people in Scotland. It has several principles at its core:

- It puts the wellbeing of the child or young person at the heart of decision making;
- It takes a holistic approach to the wellbeing of a child or young person;
- It works with children, young people and their families on ways to improve wellbeing;

- It advocates preventative work and early intervention to support children, young people and their families; and
- It believes professionals must work together in the best interests of the child.

The approach underpins the recent Children and Young People (Scotland) Act 2014, the Early Years Framework, Curriculum for Excellence and a range of programmes to support improvements in services. GIRFEC is being threaded through all existing policy, practice, strategy and legislation affecting children, young people and their families. The Act provides a framework for information sharing between professionals to support the functions of the Named Person and the operation of the Child's Plan.Additionally, the Act embodies some key aspects of the GIRFEC approach to improve how services can support the wellbeing of children and young people:

- It sets out what is meant by 'wellbeing', a holistic understanding of what makes a child or young person well;
- It formalises the role of the Named Person, already widely used across Scotland, ensuring that a Named Person will be available for every child from birth to 18 (or older if still in school); and
- It makes provision for a statutory Child's Plan to coordinate support for those children who may require additional help.

All of our work with children, young people and their families is underpinned by the GIRFEC principles. We have the main components in place and we are continuing to strengthen and further develop this approach, reviewing and updating all aspects of our work to ensure compatibility ahead of the new Act coming into force in August 2016.

Some of the services we provide are universal, like schools and health visiting. This means they are available to all children and young people. However, some children and young people have additional needs, which require further support. In these circumstances, the individual child or young person's needs will be assessed and addressed through the provision of more targeted interventions.

2. EQUALITY AND DIVERSITY

2.1 Our commitments to Meeting Equality Duties and Reducing Inequality

DCYPP is committed to valuing diversity and promoting good relations between different groups of children and young people. As a result, all partners will ensure that discriminatory practices, either direct or indirect, are removed from their functions, and that attitudes and beliefs are consistent with the fairness and respect that anyone would expect to receive. This Integrated Children's Services Plan aims to take cognisance of characteristics which compound children and young people's experiences of inequality. DCYPP appreciates that all children and young people may be vulnerable to discrimination or inequality of opportunity due to the characteristics they identify with. This may be on the grounds of their gender identity, ethnicity, skin colour or language(s) spoken, a disability or long term health condition, whether they are pregnant or have recently given birth, religion or belief or their sexuality. Indeed it is essence of the GIRFEC framework, which underpins this Plan, that children and young people are '**included'** by having help to overcome social, educational, physical and economic inequalities and being accepted as part of the community in which they live and learn.

In the implementation of this Plan and where it is within the scope of DCYPP, we will have due regard to the need to:

- Eliminate discrimination, harassment and victimisation;

- Advance equality of opportunity between children and young people who share a characteristic and those who do not;
- Foster good relations between different groups.

To further this commitment, DCYPP will adopt the following working principles:

- Promote service uptake and participation from proportionately under-represented groups of children and young people;
- Acknowledge the differential impact our services may have according to children and young people's individual characteristics, and respond effectively;
- Seek to better understand the access barriers associated with individual characteristics.

An Equality Impact Assessment has been undertaken for this Children's Plan and the results have been taken into consideration in its development and subsequent monitoring arrangements.

2.2 Corporate Parenting Approach

In 2014, six Heads of Service championed seven looked after children as part of the Corporate Parenting initiative. This programme demonstrated a positive impact on the individual children's lives and helped to improve their outcomes. It also helped to improve the council's procedures and policy reviewing processes, by raising awareness of the challenges, faced by care experienced children and the services that support them, across all council responsibilities.

Due to the success of the Corporate Parenting approach, the existing Corporate Parenting Action Plan (Appendix 1) is currently in development, building on the strengths and lessons learned, and will be extended to cover years 4-6. It will target inequality by providing support to help care experienced children and young people overcome the additional obstacles they face. The Corporate Parenting Champions programme is one aspect of this and is now in its third year. The following comments come from two of our Corporate Parenting Champions and demonstrate the impact this experience has had on their own learning and understanding:

> "*Being a Children's Champion has given me a greater exposure to the work of colleagues in education and social work and an appreciation of their commitment and professionalism in dealing with our looked after young people. I've also had the experience of the learning from other champions through our joint meetings and feedback sessions and would encourage that these continue with future champions.*
>
> Thomas Glen, Depute Chief Executive - Place, Neighbourhood & Corporate Assets
>
> *It gave me a greater understanding of the adverse challenges that this group of children and young people have to face in their daily lives and relationships. Also how important the team around the child is to these children who would otherwise have a limited network of support.*
>
> Grace Irvine, Director of Neighbourhood Services

2.3 Strengthening the Voice of our Children, Young People and their Families

One of the long-term outcomes of the Community Planning Partnership is:

- our communities are more engaged in the design and delivery of services

We are keen to listen to children and young people, both to help shape future service delivery and to involve our next generation as "citizens" in their local communities. We are doing this in a number of ways; our long standing tradition of Pupil Councils which operate in our primary and secondary schools and in our more specialist education provision; the establishment of our Youth Council with representatives from across the area; and through our Members of the Scottish Youth Parliament who are elected to represent parliamentary constituencies.

Separate arrangements are in place to ensure that our children and young people who are looked after have their voice heard too. On an individual basis this is done through children and young people having the opportunity to raise issues at their reviews and being surveyed on the support they receive. In addition, groups of children and young people with care experience participate in focus groups on more specific topics.

3. OUR PARTNERSHIP APPROACH

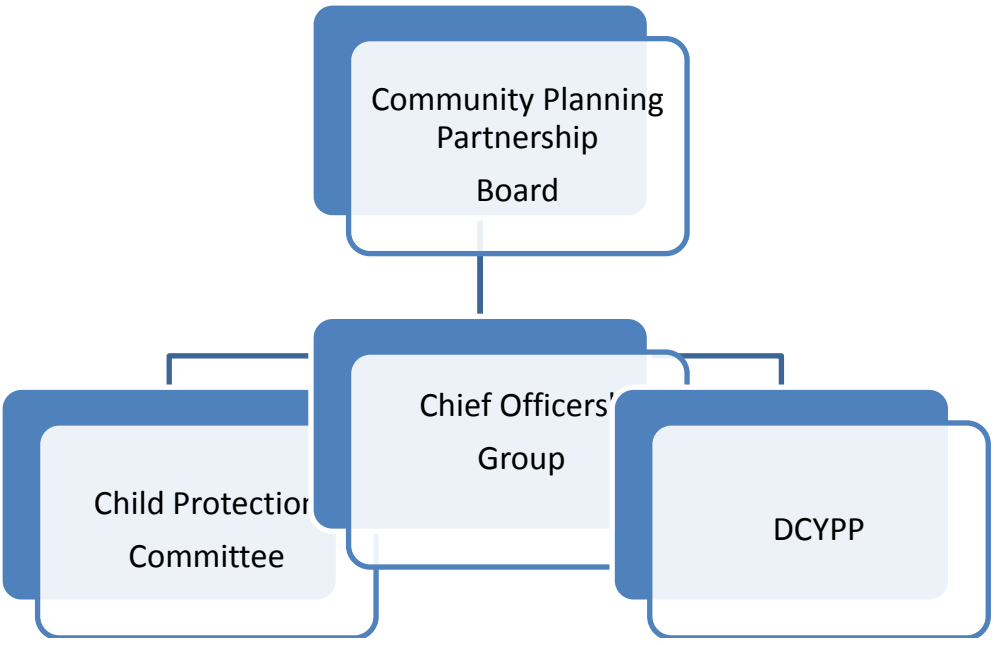
3.1 How we Work Together

For many years, partners have worked together to plan and deliver services for children, young people and their families. Some years ago, after a review of our community planning structures, partners agreed to merge our joint planning group for children's services and our child protection committee. For a period of time this worked well, but in the light of further organisational changes, a more recent review was undertaken between 2014 and 2015. This review recommended that the planning and the child protection groups separate to ensure more effective attention to all areas of responsibility. Our new arrangements came into effect in June 2015 and will be independently evaluated in 2016.

There are now two key strategic groups that lead on children's service planning:

- Delivering for Children and Young People's Partnership (DCYPP); and
- Child Protection Committee (CPC).

Both of these groups report to a Chief Officers' Group which in turn, is directly responsible to the Community Planning Partnership Board (CPPB).



Adopting this approach ensures our service planning for children, young people and their families is co-ordinated and a joint approach is in place for policy development and service planning. The DCYPP and CPC provide leadership and scrutiny for agreed strategic priorities, including those serving our most vulnerable and at risk children, young people and families.

This partnership approach strengthens effective planning and delivery and helps ensure services are co-ordinated and informed by local needs. We are therefore confident that our services make a positive difference. Partnership working is well established within our community planning arrangements. Our direction of travel is towards the integration of services and this is reflected in the recent agreement by NHSGGC and EDC to extend the functional responsibilities of the East Dunbartonshire Health & Social Care Partnership Board to include NHS Community Children's Services, alongside Social Work Children Services and Criminal Justice services. This additional delegation of functions necessitated revision to the current HSCP Integration Scheme and the process was formally approved by the Cabinet Secretary on the 5th July 2016.

Over the years, partners have combined resources to enable the development of new interventions and strengthen existing provision. Examples include:

- Strengthening earlier partnership commitment by establishing a local Parenting Steering Group in 2012, to develop and deliver a comprehensive joint strategy. The Parenting Strategy (2016/19) articulates a shared understanding of our overarching approach and commitment to improving the co-ordination, integration and delivery of parenting support. The parenting model consists of four defined areas of support from preconception to teenage years. This brings together a range of parenting interventions provided by Health, Social Work and Education Services and spans both universal and targeted approaches. Within each of the key support areas there is a suite of specific programmes to meet the needs of individual parents. The intensity of the support families receive depends on and is tailored around individual circumstances and needs.
- Joint planning of family learning programmes covering a wide range of topics and engaging parents in both their own learning and that of their children.
- Building on a dedicated home care and family support previously developed by partners, the Community Support Team was established to ensure the assessed needs of vulnerable children and their families are met. Service users include:
  - Vulnerable children and young people who may need some additional and targeted support at different times in their lives;
  - their parents, carers and families; and
  - children and young people considered to be at risk of harm or in need due to their individual circumstances.

  Support is provided by both family support workers and social work assistants to vulnerable children, young people and their families both at home, and where the child or young person is accommodated. Parenting capacity assessments can also be undertaken during supervised contact to enable practical parenting support to be provided, as appropriate. As children may have a range of additional support requirements, such as physical or learning disabilities, in some instances, personal care may be required.

  The key objectives of the service are to ensure vulnerable children and young people are given the opportunity to reach their potential in a safe, nurturing environment;

provide supports which meet assessed needs; contribute to child centred care planning within the principles of safe, healthy, active, nurtured, achieving, responsible, respected, included; promote a performance driven culture of team work and flexibility; and provide a range of practical, personal and emotional support.

- Campus Police Officers/ School Link Officers, which were fully established in 2015, with a third officer now in place to extend this service throughout the area. These officers provide a single point of contact for all our high schools and associated primary schools. The officers deliver a variety of inputs through PSE classes covering topics such as internet safety, anti-bullying and gang/ knife culture. They also attend pupil support groups and are well placed to address any issues identified by either the local community or school, through presentations at school assemblies. Following the introduction of School Link (Police) Officers, there has been a consistent decrease in the level of crime involving young people aged under 16 years.
- Continued commitment from partners to implement a Whole System Approach (WSA).This approach is part of the Getting it Right for Every Child (GIRFEC) agenda and specifically relates to children involved in offending behaviours. Currently this approach is applicable to children and young people aged between 8 and 18 years. However it may be impacted upon by the present Scottish Government consultation on raising the age of criminal responsibility. All agencies involved are committed to preventing and intervening early to ensure young people are diverted from statutory systems of intervention. This ideology is embedded in the Early and Effective Intervention (EEI) and Diversion from Prosecution Services and commits partners to the safe management of high risk young people in the community, reducing the use of secure accommodation and custody. Staff use evidence based risk assessment tools such as Asset, SAVRY and AIM2 are applied to this group of high risk young people; and a Care and Risk Management (CARM) structure is employed to manage them safely in the community.

  We believe the effectiveness of this approach can be measured by: a continued reduction in the numbers of young people aged 8-15 years being referred to the Scottish Children's Reporter's Administration (SCRA) due to involvement in offending behaviours; an increase in the number of young people referred to diversion from prosecution schemes; an increase in the number of young people aged 16-17 years whose case is remitted from the court to the Children's Hearing for Advice; sustaining/or increasing the number of young people who are retained on supervision post 16 years; and a reduction in the use of and time spent in secure accommodation

3.2 Multi-agency Workforce Development

East Dunbartonshire CPP is committed to sharing the skills, knowledge and experience of our joint-workforce. To strengthen this commitment, the CPP Board has embedded 'Integrated Workforce Development' as an Improvement Area in each version of the Partnership Development Programme since 2013; a working document which sets out a range of improvement activity to underpin the strategic direction of the CPP. It should be made clear that 'Integration' in this context is not in relation to the integration of the health and social care services of the Council and the Health and Social Care Partnership but rather, refers to using a multi-agency/partnership approach to workforce development.

'Integrated Workforce Development' is known by many other names and guises; multi-agency learning and development, joint learning/training, and shared learning/development. Regardless of how it is known, they all share a common goal; to improve our ability to work together through the sharing of learning and development.

Many of our colleagues across Community Planning engage with the same people and communities and often, they have a shared learning and development need. To take forward this improvement action, the Partnership Workforce Development Programme (PWDP) was introduced to support and foster a systematic and qualitative approach to multi-agency learning and development. DCYPP is committed to this Programme and as such promote a learning culture across our partnership. Over the life of this Plan, our multi-agency workforce development priorities are:

- **Child Protection**: Developing our Child Protection training at all levels, from raising the awareness of staff across all services to more specialist training for those colleagues who carry out specific functions
- **GIRFEC**: Continuing to equip staff with the necessary knowledge and skills to carry out their new statutory responsibilities, ahead of the legislation coming into force;
- **Parenting Programmes**: Continuing to develop the skills of frontline practitioners across a continuum of programmes, targeted at addressing a range of needs; and
- **Health Improvement**: Delivering opportunities to build practitioners' capacity to support behaviour change; influence built and socio- economic environments; and engage meaningfully with communities.

These will be addressed through a range of learning methods and will be complemented with more role specific training, delivered by individual services and agencies.

4. PERFORMANCE MANAGEMENT

4.1 Monitoring and Evaluation

Single service and multi-agency performance, self-evaluation and audit frameworks operate across the Partnership. This helps us to review how well our services are meeting needs and to help identify areas of strength and those areas for continued improvement.

This is undertaken in a variety of ways and includes:

- Interrogation of statistical and performance information, presented quarterly at DCYPP and CPC meetings. This involves comparing current practice with our own previous achievements, and analysis with national trends. The CPC's Performance Management and Practice Improvement Subgroup gathers and reviews available data in relation to Child Protection activity, across the key partners and provides a cogent analysis of this, in report form, to the CPC. The group has a chair from Police Scotland and vice-chair from the Scottish Children's Reporter Administration (SCRA). This information is made available to the DCYPP as required;
- Quarterly reporting by Lead Officers on the progress of our Improvement Objectives and Strategies Plans and agreement of remedial action, should any issues have been identified; and
- Twice yearly reporting to the CPPB through the Council's business improvement planning (BIP) process. This Plan essentially forms the partnership action plan for Local Outcome 3 and as such is reported as part of the Education Service's Business Improvement Plan (BIP).
- Yearly self-evaluation of DCYPP as a Local Outcome Delivery Group using the CPP 'How Good is Our Partnership' self-evaluation framework

This activity is supplemented by the routine monitoring and evaluation arrangements within each partner organisation.

4.2 External Audits, Inspections and Scrutiny

External inspections by the Care Inspectorate and Education Scotland provide additional scrutiny of our services. This helps us build on existing good practice and drive further improvement to ensure we deliver high quality, effective services.

The most recent joint children's services inspection in 2013 was positive, identifying a number of key strengths including:

- Very widely available and highly effective services to support parents;
- Good quality assessment and care planning for children and young people;
- High quality early years services and schools to support children and young people in their learning and educational achievement;
- The strong, proactive approach to involving individual children in important decisions about their lives; and
- Highly committed and motivated staff who have a very positive impact on the lives of children, young people and families.

5. IMPROVEMENT PLANNING

5.1 Our Improvement Plan

Areas for Improvement	Improvement Activity	Timescale	Governance	Wellbeing Indicator	C&YPSP Aim
We have effective governance	Evaluate DCYPP and EDCPC structures	Dec '16	Community Planning Partnership DCYPP HSCP	Respected; Included	... best safeguard, support and promote wellbeing; ... be integrated from the point of view of service users; ... constitute the best use of available resources
	Develop a children's rights strategy and ensure its compliance across the community planning partnership				
Our GIRFEC approach is strengthened and further developed.	Develop and implement a GIRFEC Strategic Plan	Aug '16	DCYPP HSCP	Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible; Included	.. best safeguard, support and promote wellbeing;
The voices of our children, young people and their families inform service delivery and development; and shape the future of our communities	Further develop strategies to engage children and young people in local decision making	Aug '17	Community Planning Partnership DCYPP	Respected; Included	.. best safeguard, support and promote wellbeing; ... be integrated from the point of view of service users;
	Parents and carers are supported to engage in service development and delivery				
	Develop strategies to ensure young people , who are in more vulnerable		DCYPP Corporate Parenting		

	circumstances, are represented		Group		
Disadvantage and inequality is reduced	Develop our Financial Inclusion programmes Develop Our Place approach in Hillhead; and extend it to Lennoxtown and Auchinairn Review and update our Corporate Parenting Plan Establish better mechanisms to identify and support young carers	Aug '17	Community Planning Partnership DCYPP Health Improvement Strategy Group Corporate Parenting Group PLACE Steering Group	Safe; Healthy; Achieving; Nurtured; Active Respected; Responsible; Included	... constitute the best use of available resources
Our monitoring and evaluation is robust	Review our current monitoring and evaluation arrangements to ensure they are effective and fit for purpose. Undertake a risk assessment of our monitoring and evaluation systems, and address any potential risks identified.	Aug '17	DCYPP CPC	Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible; Included	...ensure that action is taken at the earliest appropriate time; ... take appropriate action to prevent need; ... constitute the best use of available resources

5.1 Our Children & Young People Are Safe

What we do?

We are committed to ensuring that all of East Dunbartonshire's children and young people are protected from abuse, neglect and harm: at home, in school and in the community. Our support ranges from information on road safety, accident prevention, internet safety and who to contact when a child is at risk, through to intensive intervention in serious instances of abuse or vulnerability.

"Fatal child pedestrian accident rates for 10 to 14 year olds in Scotland are amongst the highest in Europe. The poorest children are four times more likely to be killed in a road accident than the wealthiest. At home the poorest children are 9 times more likely to die in a fire." (For Scotland's Children, 2001)

To help prevent accidents in the home, safety advice and packs are provided to families with new babies. While as part of our approach to promoting road safety, our school link and local community police officers deliver programmes in schools and are involved in developing road traffic action plans, targeted at helping to keep children and young people safe. They also deliver internet safety training as part of personal and social development programmes.

From working with expectant mothers to ensure the wellbeing of their babies from the outset, we provide support to children of all ages, up to and including young people who are leaving a 'care' setting. For example, when young people are moving on to their own independent accommodation, we provide a range of support that is tailored to meet the individual's assessed needs. This can take the form of an intensive package of 24 hour care for young people with either complex needs or as a direct alternative to secure care, and is usually provided by a combination of services working together. These include East Dunbartonshire's Through-care Team, our Residential Outreach Service and other external providers such as Stepdown, Barnardo's, Quarriers and Care Visions.

This work is also supported by the Community Safety Partnership who are the Local Outcome Delivery Group for Local Outcome 4 and by Empowered, who lead on preventing and eliminating all forms of Violence Against Women and Girls (VAWG) in East Dunbartonshire.

Empowered recognises that all children and young people may be victims of child sexual abuse, including child sexual exploitation. As well as adult women, girls and young women are at an increased risk of violence and abuse precisely because they are female. There are a number of specific issues prevalent in the lives of girls and young women, for example sexting and non-consensual sharing of intimate images (also known as 'revenge porn'). Young women disproportionately experience intimate partner violence in relation to young men, and report much greater negative impacts as a result[1]. The prevalence of and easy access to pornography is a constant presence in the lives of young people that contributes to reinforcing the gender norms that perpetuate VAWG.

In order to address these specific experiences of young people, Empowered coordinate multi-agency activities aimed at prevention and intervention. Empowered partner agencies deliver workshops and learning throughout the school calendar, often maximising the opportunity to mark national gender-based violence campaigns such as 16 Days of Action.

[1] https://www.nspcc.org.uk/globalassets/documents/research-reports/partnerexploitation-violence-teenage-intimate-relationships-report.pdf

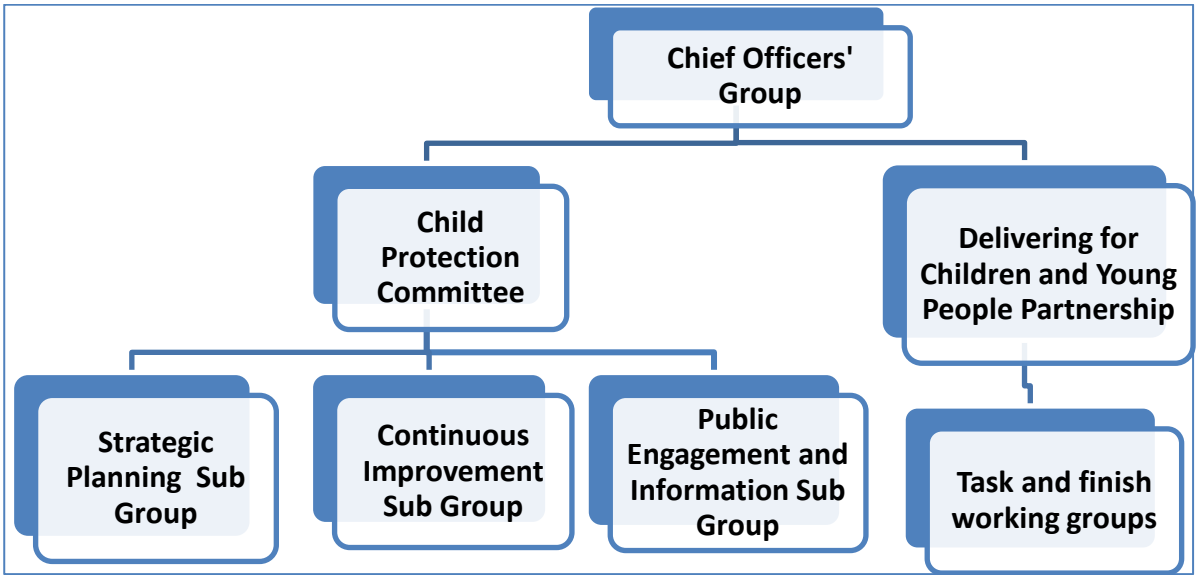
The CEDAR (Children Experiencing Domestic Abuse Recovery) Project involves therapeutic group work for children and young people in recovery from domestic abuse. CEDAR is based on and responds to evidence about the impact of trauma on child development; evidence about what helps to protect children; evidence about resilience development; and how abuse used against women can significantly undermine their relationships with their children. The Empowered Partnership supports CEDAR in-kind through in a number of ways.

From 2016 onwards Empowered also supports the Mentors in Violence Prevention Programme in Secondary schools. MVP adopts a bystander intervention approach to gender-based harmful attitudes and behaviours, ultimately aiming to tackle harassment, intimidation and abuse in young relationships and inspire leadership.

Throughout the life of its five-year Strategy, Empowered places girls and young women at the fore of its activities in preventing and eliminating Violence Against Women and Girls.

Child Protection

Child protection is a key priority in East Dunbartonshire. A Chief Officers' Group (COG) oversees the work of the Child Protection Committee (CPC) and is located within the Community Planning Executive Group. This relationship is demonstrated in the schematic below:



The purpose of the CPC is to provide strategic leadership, on an inter-agency basis for the design, delivery and evaluation of child protection policy and practice. It also operates as a "task force" should an emergency arise. The CPC draws its members from Education, Health, Housing, Police Scotland, Procurator Fiscal's Office, Scottish Children's Reporter Administration, Social Work and the voluntary sector.

How well we do it?

Over the years, we have improved our performance in respect of the assessment of, and early response to, the needs of our more vulnerable children and young people. We have successfully progressed a challenging agenda which involved improving professional practice, strengthening partnership working and redesigning services, in order to better meet the needs of our most vulnerable children and young people. We have developed a range of responses, interventions and services to promote, support and safeguard

children's wellbeing, both at present and in the longer term, with the intention of improving their life chances.

As previously mentioned, our most recent joint children's services inspection was positive, with this picture being reinforced in the results of other inspections carried out by the Care Inspectorate. The Fostering Service and the Adoption Service were both awarded grades of "Good" across all areas inspected. Ferndale Children's Residential Unit was awarded grades of "Very Good" across all areas; evidencing continuous improvement in these key areas.

We recognise that the ability to meet children and young people's needs, and reduce risk, is based on good assessment and have, therefore, focussed attention on further developing this. Taking forward this agenda has involved securing improvements in the quality of assessments and risk assessments, coupled with the development of effective risk management arrangements. The introduction of evidenced based approaches supported by training has helped us achieve success in this regard. This has enabled us to identify and respond to the needs and risks of vulnerable children and young people, at the earliest possible time.

We have improved training and staff support arrangements and strengthened our performance management systems. Alongside this, we have introduced a range of evidence based approaches to improve our risk management practices and provide our staff with the necessary frameworks they need. Our partnership working has helped develop local services which are flexible and able to respond to the changing needs of vulnerable families. We have taken appropriate steps to ensure our staff are clear on their roles and responsibilities; and that those children and young people who are in need of care and protection, get the help they need when and for as long as they need it.

A range of responsive services are in place that can, if needed, provide 24 hour care for vulnerable children. An outreach service is delivered by highly trained residential staff operating from our children's Unit. This service supports both children at risk of being looked after and accommodated, and those returning home after periods in care. The central aim is to deliver flexible and responsive care at times of crisis and avoid, where possible, a child becoming looked after.

Our approach to keeping children and young people safe includes a shift from crisis intervention to methods that seek to prevent harm from arising in the first place. Performance information already evidences success in relation to this, particularly in respect of services for: children living in situations where there is domestic abuse; young people involved in offending behaviours; and vulnerable pregnant women.

Effective joint working has been a key feature of practice. This has been based on the GIRFEC approach which has ensured that all factors are taken into account when examining the circumstances of vulnerable children. A range of documents provide guidance for staff and assists them to analyse complex information so that they can make better decisions.

The introduction of the National Risk Management Framework provides staff with a range of tools to help them structure complex information and identify the risks to vulnerable children and young people. The launch of the framework has been supported by a comprehensive programme of training.

Improved arrangements are in place to measure and evaluate services. These help ensure that our services continue to improve. We use both quantitative and qualitative information to help us allocate resources more effectively and to develop services to meet new and changing needs.

The following summarises the nature of the information used.

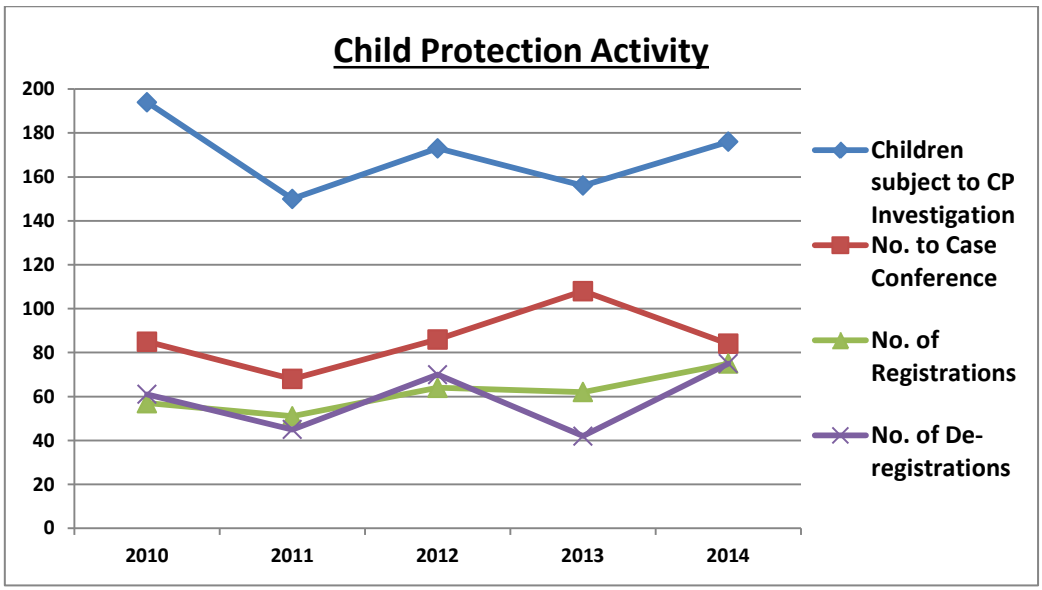
- Statistical data highlighting patterns and trends;
- Outcomes from quality assurance activity;
- The outcome of case file audits – both thematic and case specific;
- Consultation activity involving service users and carers;
- Benchmarking activity; and
- The outcomes of external inspections by the Care Inspectorate.

A culture of self-evaluation and continuous improvement has been fostered within the partnership and informs improvement planning across child protection services. Statistical data highlights the following patterns and trends over the last five years:

- An increase in the number of referrals received by our Social Work Service. including concerns regarding the immediate safety of children;
- A steady rise in the number of children subject to child protection processes. This equates to a 10% increase in child protection investigations undertaken;
- A 25% increase in child protection registrations;
- Children remain on the child protection register for appropriate periods of time with the vast majority of children being de-registered between 6 months and one year;
- Small numbers of children being re-registered within a short period indicating that decision making in this area is good;
- A positive shift in the balance of care figures, demonstrated by a 40% increase in community based placements for children; and
- A reduction in the number of days that children remain in secure accommodation.

The statistical information suggests increased awareness across both the planning partnership and the community about child protection with growing confidence in the way responses are delivered. The statistical data, coupled with the results from quality assurance processes, confirm the increased numbers of case conferences and subsequent registrations are appropriate and necessary. Close examination of the investigation and decision making process as part of our quality assurance confirms investigations and interventions are of a good standard and the latter are proportionate and informed. Children remain on the child protection register for appropriate periods of time, with the vast majority being de-registered between 6 months and a year. There are also very few re-registrations within a short period indicating good decision making in this area. We are therefore able to conclude that children are receiving the help they need at the time they need it.

This positive picture is further reinforced by successful planning, in response to increasing numbers of children who are looked after. The local picture mirrors what is happening nationally with increasing numbers of vulnerable children coming to the attention of partners. The statistical data demonstrates an improving balance of care. Services have been developed which now support more children at home or in community settings, with our figures confirming that fewer children are placed in residential care settings. In addition to this, our children and young people spend less time in secure care. Our approach is informed by research in this field indicating that children do better in community settings.



This available data helps us understand local needs and identify key themes that require more focused consideration, for example:

- In the 154 child protection investigations undertaken during 2014/15, physical abuse was the most common area of concern identified, followed by neglect and parental mental health. This information has led to the development of improved protocols between children and families' and mental health services. A joint working group has delivered training and staff briefings and managers from both services meet on a regular basis to discuss complex cases. Neglect has also featured high on our training agenda to ensure that our staff are skilled and knowledgeable in this key area;
- Children on the Child Protection Register are categorised under areas of concern and can have multiple concerns recorded. The highest area of concern recorded for children on the Child Protection Register at 31 March 2015 was neglect, followed by non-engaging families and parental mental health. Training has now been delivered in respect of working with non-engaging families while staff briefings have addressed the issue of 'disguised compliance' which features in a number of significant case reviews;
- In 2013/14, 5 children were the subject of Child Protection Orders granted by the sheriff;
- Of the 22 unborn children referred to Social Work during 2014/15, 8 were placed on the Child Protection Register; and
- Of the 98 children who were the subject of an Initial Child Protection Case Conference, 68 were placed on the Child Protection Register.

Key Developments

- Good and improving quality of assessment and risk assessment reports as evidenced in performance management and quality assurance reports to CPC;
- Effective and timely information sharing to ensure decisions regarding children are informed. This is evidenced in the outcome of our child protection quality assurance systems;
- Positive engagement with children and young people ensuring their views and wishes are taken into account. The views of children are one aspect that is tested via quality

assurance processes for child protection and looked after children. The outcome is positive with the majority of children articulating their views;

- The introduction of Prevention and Early Intervention approaches such as whole school initiatives designed to promote children's well-being;
- Effective, integrated working that ensures comprehensive information is secured when examining the circumstances of children and young people as evidenced in our self-evaluation arrangements, particularly the outcome of audits of case files and quality assurance processes;
- Good understanding of the needs of local communities which was identified by inspectors in our joint children's services inspection;
- Reviewed and reconfigured our services to ensure improved flexibility to meet the changing needs of children, young people and families;
- Accessible and effective services to support parents. The outcome of our inspection of Community Support Services and our Outreach Service at Ferndale provides evidence of this;
- A strong, proactive approach to involving individual children and young people in important decisions about their lives. This was positively commented on by the joint inspection of children's services; and
- Highly committed and motivated staff that have a positive impact on the lives of children, young people and families. This was positively commented on throughout the inspection process.

Going forward - Our Plan to keep our children and young people safe and protected

We recognise the need to maintain our track record of continuous improvement and aim to further embed an outcome focussed approach to assessment and planning into our practice. Further improving risk assessment and risk management processes will be a key feature of our approach.

Our Improvement Objectives going forward are:

Staff and volunteers across all services and agencies have access to child protection guidance and procedures
All children and young people are afforded timely protection and support
The public and civic society understand how to keep children and young people safe
Children and young people have the knowledge and skills to keep themselves safe

OUR C&YP ARE SAFE

Improvement Objectives	Strategies	Timescale	Governance	Wellbeing Indicator	C&YPSP Aim
Staff and volunteers across all services and agencies have access to child protection guidance and procedures	Embed new CPC structures and processes Review and improve multi-agency information management processes Plan and coordinate a programme of self-evaluation Identify and address gaps and risks Deliver a range of single and multi-agency training based on local need	2016/17	CPC	Safe	Safeguarding, supporting and promoting wellbeing
All children and young people are afforded timely protection and support	Develop targeted services for assessment and intervention Review early intervention screening groups for: unborn babies; domestic violence; young people who offend Implement the staged model of intervention Address the needs of children and young people affected by issues of mental health and/or addiction Develop a systematic approach to identifying and meeting local need Further develop risk assessment and risk management Further develop parenting capacity assessments, including affects of parental addiction and mental	2016/17	CPC DCYPP	Safe Healthy Respected	Safeguarding, supporting and promoting wellbeing Ensure that action is taken at the earliest appropriate time Where appropriate action is taken to prevent need Be integrated from the point of view of service users Constitute the best use of available resources

Improvement Objectives	Strategies	Timescale	Governance	Wellbeing Indicator	C&YPSP Aim
	health issues				
The public and civic society understand how to protect children and young people and keep them safe	Re-establish the CPC Communication Information & Engagement Group	2016/2017	CPC Community Safety Partnership	Safe Respected Responsible Included	Safeguarding Supporting and promoting wellbeing Be integrated from the point of view of service users
	Develop a communications strategy				
	Develop approaches for gathering the views of children and young people in Child Protection processes				
	Continue to deliver Road Safety and Home Safety initiatives				
	Continue implementation of parenting strategy				
	Develop our advocacy services for children and young people				
	Provide children and young people with age appropriate information on drug and alcohol use				
	Provide children and young people with age appropriate information to keep themselves safe on line				

5.2 Our Children & Young People Are Healthy

What we do?

There is clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and young people. Early intervention can promote good health; and reduce ill-health and premature death for children and young people. Adopting healthy behaviours in childhood and the teenage years set patterns for later life.

We acknowledge that improving health is not just the responsibility of the health sector. Improving the health of children and young people needs to go beyond healthy life-styles and health care to encompass multi-faceted collaborative action across all sectors. The role of other public sector organisations and third sector agencies in supporting children and young people's knowledge and understanding of health issues is vital in equipping them to be able to grow up taking responsibility for their own health.

Our recent Health & Wellbeing Survey (2014) demonstrates that local people are adopting more positive health behaviours. It suggests they are significantly more active, eating more healthily, smoking and drinking less. In addition, local residents report increased positive mental health and feelings of belonging within their family and community. Whilst these findings are moving in the right direction, they are not universal and there remain inequalities across the area. Sustained action by all planning partners and local communities is required to continue, to not only improve universal health but also reduce the inequality gap.

The five key components of the Ottawa Charter for Health Promotion (WHO 1986 & 2005) have been utilised as a recognised framework to articulate the actions required to improve the health of the East Dunbartonshire population over the life course.

1. Build Healthy Public Policy;
2. Create Health Promoting Environments;
3. Strengthen Community Actions;
4. Develop personal and social skills; and
5. Re-orient Health Services.

Building Healthy Public Policies and Plans

Building strong local health alliances is an effective way to deliver joint health improvement priorities and reduce inequalities. In response to the Scottish Government's *A Fairer Healthier Scotland, (NHS Health Scotland's strategy 2012-2017)* the multi-agency Health Improvement Strategy Group takes responsibility for setting the overarching strategic priorities which are articulated through the Joint Health Improvement Plan (JHIP). The JHIP describes a range of universal and targeted actions across all sectors that promote health, prevent ill health and address inequalities in health outcomes. Key strategic alliances and a suite of joint policies and plans are linked through the JHIP.

Some examples include:

- Health Improvement Strategy Group - *Joint Health Improvement Plan;*
- Sexual Health Strategy Group - *Sexual Health Action Plan; Sexual Health & Relationship Education Policy; Sexual Health Protocol for Sexually Active Young;*
- *People (Under 16 years); and Sexual Health Protocol for Children & Young People who are Looked After at Home & away from Home;*
- East Dunbartonshire Tobacco Alliance - *Tobacco Strategy;*
- *Welfare Reform Steering Group - Financial Inclusion Strategy;*
- *Promotion, Prevention & Inclusion Group - Mental Health Improvement Plan; and*
- *Prevention, Education, Promotion and Control Group - Substance Misuse Plan.*

Creating Health Promoting Environments

It is widely accepted that living in poverty is particularly harmful to health and wellbeing. Having an adequate income is essential if families are to maintain a decent standard of living, eat properly, heat their homes adequately and be able to afford to socialise. Community planning partners have developed a Financial Inclusion Strategy which outlines services that aim to address health and socio-economic inequalities.

Education establishments, with the involvement of partners, are playing a significant role in creating supportive environments in which children and the wider school community are supported and empowered to develop their health and wellbeing and are protected from factors which threaten good health.

Being a volunteer has positive health benefits, including increasing self-confidence and self-esteem, and developing a more positive outlook on life. Community planning partners work with local communities to plan and deliver a range of volunteering opportunities that enable people to develop and practice skills, meet new people, gain valuable experiences and improve their own health, as well as contributing to the health of their communities.

A healthy community is one that creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and develop to their fullest potential. We recognise the value of having a variety of settings that are safe and pleasant and in which children and families can work, play, learn and relax. A wide range of programmes that promote health and wellbeing within the home and local communities is being planned and implemented.

Strengthening Community Actions

Community planning partners have developed a range of interventions and approaches, aimed at building community capacity and strengthening social networks. The intention is to connect children, young people and their families to their communities to better support access to information, advice and services; as well as encouraging them to play their full part in contributing to improving the health and wellbeing of their families and communities. Partners have combined their resources to support the Third Sector Interface to develop and coordinate community participation, engagement and capacity building approaches across East Dunbartonshire but with a specific focus on ‘PLACE’ areas. This approach aligns to the *Healthier Happier Communities Partnership* which is driving forward key priorities that focus on prevention, protection and support, and on health inequality and its effects.

Developing Personal and Social Skills

Stopping smoking is one of the most important lifestyle changes to improve health and wellbeing. Tobacco is highly addictive with most smokers starting as teenagers and continuing to smoke well into their adult life. Evidence shows that young people are at higher risk of starting to smoke if they live with parents or siblings who smoke. They are also influenced by their peers and role models, as well as by other factors such as marketing. Exposure to second hand smoke increases the risk of respiratory problems in babies and children and can cause heart disease and lung cancer in non-smoking adults. The East Dunbartonshire Tobacco Control Alliance is a coalition of partners who are working together to systematically reduce tobacco related harm in our communities and the Tobacco Strategy consists of aspirations and targets to be achieved through Prevention & Protection; Education; Cessation; Control; and Enforcement.

Physical activity is a key protective asset for children and young people’s health and wellbeing. There are clear health benefits including promoting healthy weight, enhanced cardio-metabolic and bone health and improved psychological wellbeing. There are

particular benefits to young people living in lower socio-economic backgrounds. The national report *Start Active, Stay Active* (2011) included, for the first time, physical activity guidelines for children under 5. At present physical activity opportunities are developing across a range of settings.

Eating patterns established during childhood and adolescence may remain throughout the life course. Optimising nutritional intake, alongside the development of healthy eating and activity patterns during these early years is vital for building resilience and protecting against chronic disease in adulthood. Universal and targeted action to promote health weight and improve oral health are planned and delivered across agencies and settings.

Breastfeeding makes an important contribution to the health of mothers and children in the short and long term. East Dunbartonshire recognises the need to promote and invest in services which aim to support all mothers so that they can breastfeed as long as is desirable.

Children and young people's mental and emotional health, resilience, self esteem and confidence lie at the heart of improving their ability to manage risk. The Youth Multi-agency Group develops and implements joint strategic approaches across a number of key national and local mental health improvement policy drivers for children and young people. Joint mental health improvement action is delivered by a range of organisations across different settings.

Sexual health is important to both individuals and communities and relates to other public health issues such as safeguarding, equalities, child poverty and educational attainment. The Sexual Health Strategy Group is responsible for the development, delivery and monitoring of sexual health improvement outcomes.

Re-orienting Health Services

The Early Years have a profound impact on an individual's future experience of health and wellbeing. Evidence demonstrates the importance of prevention, early identification and intervention throughout the early years of life. Health Visitors and School Nurses have, and always have had, a significant public health role in relation to individuals, families and communities, by providing appropriate support to all children. A public health approach is adopted when responding to the needs of all families. There is also an emphasis on reducing inequalities by improving access to appropriate interventions and prioritising vulnerable groups. It is important that Health Visitors and School Nurses are in the right place, with the right support available to them to deliver a quality assured service.

Introducing the legislative functions of the 'Named Person' on behalf of the Health Board will be responsive to parents and promote, support and safeguard the wellbeing of children. This role formalises the activities organisations are undertaking routinely in their day-to-day work.

The *Getting It Right for Every Child* National Practice Model is being implemented in East Dunbartonshire. This provides a framework for Midwives, Health Visitors and School Nurses to gather, structure, and analyse information in a consistent way to help identify and understand the child or young person's wellbeing needs, the strengths and pressures on them and their carers, and consider what support is required.

A healthy pregnancy and the first three years of life are vital to a child's development, life chances and achievement. Healthy mothers tend to have healthy babies and a mother who receives high quality maternity care throughout pregnancy is well placed to provide the best possible start for her baby. Therefore the care and support provided for mothers and babies during pregnancy, childbirth and the postnatal period has a significant effect on children's healthy development and their resilience to problems encountered later in life

(DH, 2004). Maternity and health visiting services are working in partnership with women and other professionals to respond to their needs, in order to ensure the best possible outcomes for mother and child. A range of universal and targeted NHS interventions are provided to support children, young people and their families, particularly those identified as having complex needs.

Facilitate appropriate access to specialist children's services for children and young people who have mental health issues or life-long or life limiting health problems. Services include speech & language; eating disorders; autism; alcohol & drugs misuse; learning disabilities; community paediatrics; and Child & Adolescent mental health services (CAMHS).

Going forward – Our Plan to ensure our children and young people are healthy

We recognise the importance of continuously addressing the health needs of our younger population and have developed a plan to progress this.

Our Improvement Objectives going forward are:

Policies, Strategies and Plans promote and improve the health and wellbeing of children, young people and their families
Children, young people and their families live in health promoting environments
Effective community action empowers children, young people and their families to be involved in improving their own health and wellbeing
Children, young people and their families are supported to improve their health through developing personal and social skills
NHS Children's Services support children, young people and their families to improve health and wellbeing

OUR CHILDREN ARE HEALTHY

Improvement Objectives	Strategies	Timescale	Governance	Wellbeing Indicator	C&YPSP Aim
Policies, Strategies and Plans promote and improve the health and wellbeing of children, young people and their families	Build strong local health alliances as an effective way to deliver joint health improvement priorities and reduce inequalities Develop and implement a suite of joint health promoting policies and plans	April 2016 to March 2019	DCYPP Health Improvement Strategy Group	Healthy Safe Nurtured Active	Safeguarding, supporting and promoting wellbeing Appropriate action taken to prevent need Action taken at the earliest appropriate time Integrated from the point of view of service users
Children, young people and their families live in health promoting environments	Improve access to financial inclusion services Schools and the wider community are supported to promote health and wellbeing Plan and deliver a range of volunteering opportunities Develop and deliver initiatives that promote healthy homes, workplace and	April 2016 to March 2019	DCYPP Health Improvement Strategy Group	Healthy Healthy Safe Nurtured Active Healthy Active Included Healthy Safe	Safeguarding, supporting and promoting wellbeing Appropriate action taken to prevent need Action taken at the earliest appropriate time

Improvement Objectives	Strategies	Timescale	Governance	Wellbeing Indicator	C&YPSP Aim
	communities			Nurtured Active	
Effective community action empowers children, young people and their families to be involved in improving their own health and wellbeing	Develop a range of interventions and approaches aimed at building community capacity and strengthening social networks	April 2016 to March 2019	DCYPP Health Improvement Strategy Group	Healthy Safe Nurtured Active Included	Safeguarding, supporting and promoting wellbeing
Children, young people and their families are supported to improve their health through developing personal and social skills	Work together to systematically reduce tobacco related harm in communities	April 2016 to March 2019	DCYPP Health Improvement Strategy Group	Healthy	Safeguarding, supporting and promoting wellbeing Appropriate action taken to prevent need Action taken at the earliest appropriate time Integrated from the point of view of service users
	Develop and deliver a range of physical activity opportunities across a range of settings			Healthy Active	
	Develop and deliver universal and targeted action to promote healthy weight and improve oral health			Healthy Active	
	Promote and invest in services which aim to support all mothers to breastfeed as long as they wish			Healthy Nurtured	
	Develop and implement mental health improvement action by a range of organisations across different settings			Healthy Safe Nurtured	
	Develop, deliver and monitor sexual health interventions and services			Healthy	

Improvement Objectives	Strategies	Timescale	Governance	Wellbeing Indicator	C&YPSP Aim
				Safe	
NHS Children's Services support children, young people and their families to improve health and wellbeing	Implement the Universal Pathway which offers a core health visiting programme to all families	April 2016 to March 2019	DCYPP Health Improvement Strategy Group	Healthy Safe Nurtured	Safeguarding Supporting and promoting wellbeing Appropriate action taken to prevent need Action taken at the earliest appropriate time Integrated from the point of view of service users
	Implement the legislative functions of the 'Named Person' within the health visiting service			Healthy Safe Nurtured	
	Implement the National Practice Model within health visiting and school nursing services			Healthy Safe Nurtured	
	Implement the national childhood immunisation programme for children and young people			Healthy Safe	
	Identify and address the needs of vulnerable pregnant women			Healthy Safe Nurtured	
	Facilitate appropriate access to Specialist Children's Services			Healthy Safe Nurtured	

5.3 Our Children & Young People Are Ready To Learn

What we do?

We want all of our children and young people to be prepared for life, work and learning and to have the highest standards of attainment and achievement. Children growing up in families that have low incomes are most likely to be living in our most disadvantaged communities. The effect of poverty on a child's ability to achieve their potential is well documented and includes: higher incidence of behavioural problems; lower education attainment and fewer qualifications. We also know that failure to achieve potential at school can have a negative impact on a child's whole life experience. So we work towards to ensuring equity and to provide support to children and families who require it. This is done in a variety of ways and by working with partner agencies. The PLACE approach in Hillhead, Lennoxtown and Auchinairn is enabling and empowering parents to be more involved in their child's development.

In East Dunbartonshire, our children and young people attain high levels of educational attainment. Our schools remained focused on raising attainment and monitoring young people's progress carefully. At a national level, East Dunbartonshire continues to be ranked among the best in Scotland in terms of young people achieving Highers in S5. Our schools have the best performance in Scotland for young people in the lowest 20% in S4.

The School Leaver Destination Return published in December 2015 showed that the percentage of East Dunbartonshire school leavers in 2014-15 entering a positive destination was 97.6%. This has been an increasing trend over the last three years and resulted in East Dunbartonshire being in first place nationally for positive destinations.

The Education Service is working with the Council's Skills for Life, Learning and Work Team to support schools to implement the Council's Strategic Plan in response to the national report, Developing Scotland's Young Workforce. This supports schools to build on the good practice that already exists to provide a range of more flexible pathways for young people. This requires close partnership working with colleges, businesses and Skills Development Scotland.

Early Years

To make sure that all of our children have the best start in life, we provide a range of early years' services through local authority early learning and childcare centres and commissioned places in partnership centres in the private and voluntary sector. We provide parents and carers of eligible two, three and four year olds with flexibility and choice of models of early learning and childcare. In response to the views of parents and carers, we have expanded the number of extended day places within our local authority centres. In addition to this, and in line with our new legal responsibilities under the Children and Young People (Scotland) Act 2014, we also provide a range of support throughout the area, to more vulnerable two year olds. The day-care child-minding service provides a nurturing, home environment for some of our most vulnerable families.

There are currently five extended day and year centres and five extended day centres which provide early learning and childcare from 08:00 to 18:00. There are also eight sessional early learning and childcare centres. Where we cannot provide places within the local authority, we procure places from partner providers.

As quality provision is of crucial importance, we provide support to local authority centres and partner providers. Our aim is to continue to reflect and improve the quality of provision within East Dunbartonshire, to provide flexibility and choice to parents and carers of eligible children.

Parenting and Nurture Approaches

In 2012, the *East Dunbartonshire Parenting Support Strategy / Tripartite Partnership Agreement* was updated in line with national policy and current evidence of effective parenting interventions. This Strategy aims to improve outcomes for children, young people and their families.

We recognised the need to improve the co-ordination, integration and delivery of our parenting support programmes and their accessibility to families living throughout our area. Consequently, an innovative "Parenting Pathway" has been developed to ensure all families can access help when they need it, including those families with additional needs and/or who are living in disadvantaged circumstances.

To ensure that our multi-agency practitioners are delivering a common shared message when working with children and families in our area, we agreed to adopt the "Triple P" parenting programme which empowers and promotes a self-efficacy approach to positive parenting through:

- Building positive relationships with their children;
- Providing praise and encouraging behaviours they like;
- Teaching children new skills;
- Setting rules and giving instructions their children will follow;
- Responding to misbehaviour immediately, consistently and decisively;
- Using discipline strategies that work; and
- Taking care of themselves as parents and carers.

In all local authority early learning and childcare centres, there is a trained Family Champion who provides a friendly and approachable point of contact, where parents can seek timely and appropriate advice around a range of issues, including parenting. This preventative approach is key to intervening early to prevent common everyday issues escalating. Through this approach we are building the confidence and capacity of staff to provide positive, preventative interventions.

Family Champions are mentored by Early Years Supporting Families' team members, to increase their confidence and ensure that high quality appropriate advice is offered. For more complex situations, the Supporting Families Workers can provide one-to-one interventions, tailored to the needs of individual families, either in their own homes or in agreed community settings.

All local authority early learning and childcare centres provide an environment which nurtures, encourages and promotes child development in the crucial early years' stage. This approach raises our children's self-esteem and resilience. Some centres have an identified nurture room, where targeted interventions are delivered. This has been part of the work of the Early Years Collaborative and tests of change have evidenced positive impact on children's development.

Our Schools

Most of our children and young people attend one of our 36 primary schools and 8 secondary schools where we provide additional support for those who require it.

Support is provided to children, with additional needs, by staff within the school, many of whom have additional training and qualifications. They are provided with advice from the central team, including the Psychological Service.

The Primary School Improvement Programme is continuing. The new Lairdsland Primary School opened in May 2015 and the new school in Lenzie, Lenzie Meadow will open in August 2016. It will also have an extended day and year early years centre. The new

schools in Bishopbriggs and Kirkintilloch are on schedule to open in 2016/17. The new school in Bearsden and Milngavie to replace St Andrew's and St Joseph's Primary Schools will open in 2017/18.

However, we also have two special educational schools: Merkland and Campsie View which cater for children and young people who have more complex needs. Both schools provide a high standard of provision for children with a range of additional support needs.

Young people, who find mainstream education difficult, benefit from individualised learning programmes in the Primary Wellbeing Service including the base within Oxgang Primary and the Secondary Wellbeing Service in Kirkintilloch. Both of these services provide advice and support to staff, children and young people, as well as full time places for those who require it. They work with a range of agencies, including Positive Achievements which supports young people, who are either due to leave school or are post school, to achieve a range of qualifications.

Ahead of new legal responsibilities, that will come into force in August 2016, all our primary school head teachers and a member of the senior management team in our secondary schools have taken on the role of Named Person. For young people who have left school but have not reached the age of 18 years a senior officer within the authority carries this responsibility.

Our Communities

We recognise that learning takes place in both formal and informal settings and are committed to promoting learning opportunities within the community such as family learning and achievement awards.

The Duke of Edinburgh Award is delivered in all 8 secondary schools as well as 2independent Open Award Centres. East Dunbartonshire Council is within the top 5 Local Authorities nationally.

We are committed to preventative and early intervention approaches and have piloted a number of these, as part of the PLACE approach in Hillhead. The Little Explorers' Nurture Day involves a wide range of agencies providing programmes to parents and families. The uptake has increased each week and the programme continues to be a success within the community. Initial evaluation demonstrates positive impact on the families who have participated.

How well we do it?

Our schools and learning communities are evaluated extremely positively by Education Scotland. Across two primary and one special school inspections in 2014, 93% of the evaluations of the five quality indicators were 'good' or better. There were no HMI inspections of nurseries or secondary schools during this period. The three year average for inspections in the primary sector is just below 'excellent'.

Since 2010, there have been three Learning Community Inspections with all being evaluated at "Very Good" or "Excellent".

In the last year, the Care Inspectorate inspected 13 nurseries of which 4 were local authority provision and 9 were partnership centres. Of the local authority nurseries assessed, all were evaluated as 'good' or higher on every measure. 83% of evaluations of partner provider measures were 'good' or higher.

Going forward - Our Plan to ensure our children and young people are ready to learn

While our education services are considered among the best nationally, there is no room for complacency.

Our Improvement Objectives going forward are:

Attainment and wider achievement for all children and young people is raised
Improve the quality and provision of early learning and child care
Address issues of inequality and discrimination
Empower parents to feel confident in supporting their child’s development

OUR CHILDREN & YOUNG PEOPLE ARE READY TO LEARN

Improvement Objective	Strategies	Timescale	Governance	Wellbeing Indicator	C&YPSP Aim
Attainment and wider achievement for all children and young people is raised	Support children to achieve age appropriate levels of literacy and numeracy Develop the range and access to wider achievement for all children and young people Continue to raise levels of attainment in the Senior Phase Implement the Developing the Young Workforce Strategic Plan	2016/17	DCYPP	Achieving Respected Responsible Included	Safeguarding, supporting and promoting wellbeing Action is taken at the earliest appropriate time; Where appropriate action is taken to prevent need; Be integrated from the point of view of service users
Improve the quality and provision of early learning and child care	Implement increased entitlement to early learning and child care Improve staff knowledge and confidence in effective practice within early years in line with Building the Ambition. Implement national play strategy	2016/17	DCYPP	Achieving Respected Responsible Included	Safeguarding, supporting and promoting wellbeing Action is taken at the earliest appropriate time Where

Improvement Objective	Strategies	Timescale	Governance	Wellbeing Indicator	C&YPSP Aim
	Improve the quality of leadership in local authority and partner providers				appropriate action is taken to prevent need; Be integrated from the point of view of service users;
Address issues of inequality and discrimination	Raise attainment in literacy and numeracy in areas of high deprivation	2016/17	DCYPP	Achieving Respected Responsible Included	Promoting wellbeing Action is taken at the earliest appropriate time; Where appropriate action is taken to prevent need; Be integrated from the point of view of service users;
	Improve attainment for the lowest 20%				
	Implement the strategic Plan for ASN				
	Implement GIRFEC in line with the requirements of the Children and Young People's Act				
Empower parents to feel confident in supporting their child's development	The PLACE approach and other locality developments are extended to geographical areas of need	2016/17	DCYPP	Achieving Respected Responsible Included	Safeguarding, supporting and promoting wellbeing Action is taken at
	Further develop services and support for Young Carers				

Improvement Objective	Strategies	Timescale	Governance	Wellbeing Indicator	C&YPSP Aim
	Develop support to children and young people who are looked after at home or away from home				the earliest appropriate time; Where appropriate action is taken to prevent need; Be integrated from the point of view of service users;
	Develop and implement Rights Based Learning				
	Develop the use of nurture approaches from early years to secondary schools				
	Implement the parenting strategy				
	Develop and deliver universal and targeted parenting support				

6. Appendix 1.

SOA Outcome 3 – Our children are safe , healthy and ready to learn
Corporate Parenting Action Plan – 2016 -2019

Improvement Actions	Improvement Activities	Progress To Date	Indicators	Timescale
HEALTH IMPROVEMENT 2016 - 2019				
Promote health improvement and healthy lifestyle options	Ensure all LAC/LAAC and young people have a personal health plan that ensures continuity of care and regular check-ups etc	Specialist Children's Services in NHS Greater Glasgow & Clyde are currently undergoing re-design, and includes the CEL 16 agenda around provision of LAC at home health assessments. The LAC Health Nursing Team, based centrally, currently delivers the health assessments, reviews and care for LAC away from home supported by Paediatricians. The gap in service provision for LAC at home has been filled by recruiting a Band 6 nurse who will undertake health assessments for this population in East Dunbartonshire. The nurse commenced post in October 2013, completing a Specialist Children's Services and local induction, ready to commence health assessments from the beginning of January 2014. This nurse will also provide a health service to the local residential unit, completing health assessments and reviews. The LAC Nurse is required to commence the health assessment process for LAC at home	% of LAC / LAAC children and young people with a personal health plan This is an on-going process. LAAC Nurse attends Ferndale at least once a fortnight and on request, if required.	On going Fortnightly

Improvement Actions	Improvement Activities	Progress To Date	Indicators	Timescale
		children and young people. The LAC nurse is also the named nurse for the local authority residential unit. Referral will be through social services, with the expectation a health assessment, summary and action plan, with consent, will be shared with families and professions involved in the child or young person's care. All children from East Dunbartonshire should be registered with a GP who has responsibility to look after their primary health needs.		
	Extend Passport to Leisure for LAC/LAAC	This provides access to health and leisure facilities at a reduced cost. It is currently used within Ferndale. Staff costs are met by the Council. The approach within Ferndale places an emphasis on healthy lifestyles and encourages young people to participate in local amenities and supports inclusion. An agreement with the Trust has been reached for young people leaving the care system to access leisure activities free. Mark Grant provided the EDLT Board with a report recommending full access memberships for Leisure Centres available to all children and young people in Throughcare and Residential services. This will go live by 1April 2014. All young people in Ferndale have obtained passport to leisure cards. To date eleven young people from Throughcare services have obtained	Passport to Leisure extended	2013-2016 April 2014 April 2014

Improvement Actions	Improvement Activities	Progress To Date	Indicators	Timescale
		leisure cards and arrangements are in place to support the remaining young people to access the service. Membership cards have also been made available for staff who are accompanying young people. This has been a successful opportunity for young people and another three Throughcare young people have recently obtained passport to leisure cards. The free passport to leisure has been extended to young people living in Action for Children's Canal Project for homeless young people, supported in partnership by EDC. Consideration should be given to extending passport to leisure to Young People in kinship care placements.		Dec 2015 June 2016
KEEPING SAFE				
Prioritise housing solutions for LAC/ LAAC	Develop good quality, affordable and supported housing options for care leavers	Estimated completion date would probably be October now as progress cannot be made until the outcome of the Canal Project's inspection review is known and any findings are actioned. An outstanding issue remains in respect of the funding required to take this service forward. The Canal project will deliver residential group living for 6 young people with additional 2 bedsit flats attached to the building that have external access.	% of eligible LAC / LAAC young people securing supported housing option	Oct 2015

Improvement Actions	Improvement Activities	Progress To Date	Indicators	Timescale
		Support will be available to young people 24 hours a day where required. Waking night shift staff will be incorporated into the new structure based within the Canal project base and will: ▪ Meet the care and housing support needs of the 8 young people residing within the Canal Service residential base, including direct access to two of those places through the Throughcare and Aftercare routes. ▪ Provide follow on outreach support for up to 3 months for young people leaving the Canal service. ▪ Funding for the Canal Project will be via Action for Children budget. ▪ New tendering process for service to deliver support has taken place. The draft delegated decision for the negotiated tender to procure the Throughcare flats went through Legal and Procurement. Legal raised several queries including the issue of whether it was 1 or 2 bedroom flats to be procured and also re the costs. These queries have now all been responded to. A number of properties have been viewed (all two bedroomed). Uncertainty around additional funding requirement to purchase property to ensure rent will remain at local housing level. This requires clarity from Clyde Valley. Further		Dec 2015

Improvement Actions	Improvement Activities	Progress To Date	Indicators	Timescale
		meeting necessary with Housing, Planning and Development and Social Work to discuss options re moving forward. These will include acquiring additional funding, buying the property ourselves or looking at cheaper options. The support Y/P will receive when moving on to independent accommodation is varied and based on assessed needs. This can range from an intensive package of support such as 24hr support for a Y/P with either complex needs or as a direct alternative to secure care. The support networks we can access are: ▪ EDC Throughcare Team ▪ EDC Residential Outreach Service ▪ Stepdown (independent provider) ▪ Barnardo's (independent provider) ▪ Quarriers (independent provider) ▪ Care Visions (independent provider) We will also shape a Y/Ps support plan whereby they can receive on-going support from their residential provider where appropriate, such as the agencies mentioned above and allowing for consistency and continuity of the team around the child. Where it is evident Y/P require less intensive support it is still important that they are aware who they can contact if and when they are in a		

Improvement Actions	Improvement Activities	Progress To Date	Indicators	Timescale
		crisis situation. All of the above support needs will be captured in the Y/Ps Pathways Plan.		
READINESS TO LEARN				
Involve partners in developing a comprehensive range of supports to enhance learning opportunities	Corporate Parenting Champions Programme	We currently have 11 Champions for children or young people who are looked after away from home. The ages range from 5-18 and some live out with EDC. Next steps: ▪ to include some kinship care children in the Champions programme for 2016/17 To expand the champions from EDC senior managers to include our corporate parenting planning partners, under the C&YPs Act 2014.	Number of Champions with a kinship care child. Number of Champions from corporate parenting planning partners.	Report annually Report annually
	Who Cares? Scotland Corporate Training – "Corporate Parenting and You"	Plans and preparation are in progress for this training event to take place this year, 2016. Developed by Who Cares? Scotland and Scottish Government to fully equip new corporate parents named in the Children and Young People (Scotland) Act 2014, to meet the needs of the young people in their care.	Number of corporate parents who attend the training programme.	September 2016
	Improve school the well-being of looked after children, through monitoring and tracking	All schools regularly monitor the well-being, outcomes and attendance of looked after children at their Pupil Support Groups (PSG). EDC recommends that looked after children remain as	% of looked after children who have ASN, or none and/or a CSP.	Report 6 monthly

Improvement Actions	Improvement Activities	Progress To Date	Indicators	Timescale
	at school pupil support groups using a GIRFEC approach.	a standing item on the agenda of each school's PSG. This is to ensure regular monitoring and tracking of the education of their looked after children. All looked after children are considered to have additional support needs (ASN), unless evidenced through a multi-agency meeting such as a PSG or otherwise. All LAC will be considered for a Coordinated Support Plan (CSP), where the additional support needs meet the criteria for a CSP. Consultation will take place with designated managers for looked after children in EDC schools to look at where we can improve on the support for looked after children at home. CELCIS has produced the document "Looked After and Learning – Improving the learning journey of looked after children" and offers a tool kit "How good is your provision?" This will be shared with designated managers for looked after children in schools.	% attendance of children looked after at home Audit use of tool kit in schools.	Dec 2016
	Increase targeted family learning opportunities	Early Years Team and PT - ASN Team developed a test of change pilot project with children and parents/carers who were part of the Dolly Parton Imagination Library scheme. EDC were the first LA in Scotland to sign up to this scheme, which provides a free book per month for LAC from 0 – 5years. The pilot project involved a book group for children and	Test of change results Test of change results	May – Sep 2015 Dec 2016

Improvement Actions	Improvement Activities	Progress To Date	Indicators	Timescale
		parent/carers led by artist in residence Alison Irvine. The focus was on the impact the books have in relation to active reading and on the level of engagement of parent/carer on reading with their children.(May 2015 – August 2015) A plan is in place to extend the initial pilot project to work with 4 additional vulnerable families of looked after at home children. A funding application has been submitted by Alison Irvine to Creative Scotland to work collaboratively with EDC. EDC and Alison Irvine are currently submitting a revised bid as advised by Creative Scotland and plan to begin the extended project when funding is secured in 2016.	indicating level of engagement of families.	
	Ensure learning friendly residential and community based care settings	Residential - A plan is in place to continue with information sessions for staff on a yearly basis. This year's actions include accessing a catalogue of opportunities available to school leavers and to look at introducing online learning resources for the young people. ▪ Ferndale now operates a weekly job club. with Margaret Harkins, Opportunities for All coordinator for the school leavers who reside in Ferndale. ▪ Ferndale key workers send a monthly educational report to PT – ASN team, which contains the children's progress and views on their education from a home perspective.	% of LAC residential and community based care settings which are learning friendly % Positive destinations of Ferndale school leavers % School Attendance of Ferndale residents.	Report annually Report termly

Improvement Actions	Improvement Activities	Progress To Date	Indicators	Timescale
		▪ PT - ASN team & the Manager (acting) at Ferndale have a monthly GIRFEC education review meeting to discuss the progress, any educational supports required and views of all the children in Ferndale. This provides ideas for information sessions for children/carers and for Ferndale's education action plan. ▪ Ferndale plan to further develop how they seek the views of the children and young people that they care for. The aim is increase the level of engagement of children and young people views in their education and care planning. It is hoped that this could make up part of a contribution to the Corporate Parenting Steering Group of EDC children and young people's views.	Number of participants contributing their views on a yearly basis Engagement of LAC young people in Corporate Parenting Programme	Monthly Dec 2016
	Develop a range of Dynamic Youth Awards and accredited peer educator programmes, specifically relevant for LAC/LAAC at National 4 level	Opportunities for young people to gain Dynamic Youth Awards for some continue to be developed in schools this is now part of a the Study Leave Programme for young people on National 4 level or sitting few or no National 5 exams.	% LAC / LAAC at National 4 level participating in Dynamic Youth Awards.	Report annually
READY TO LEARN - POSITIVE POST SCHOOL OUTCOMES 2016 - 2019				
Improve strategic approach to	Support LAAC young people to move from school into a positive	Considerable progress has been made in working with Social Work to ensure that LAAC young people are aware of Activity Agreements if they	% of LAAC young people entering positive destination	Reported annually

Improvement Actions	Improvement Activities	Progress To Date	Indicators	Timescale
proactively ensuring LAC/LAAC achieve positive post school destinations	destinations.	have not moved into or sustained a positive post school destination. Although many young people are participating in Activity Agreements, it has proved difficult to engage with some of these young people. The Opportunities for All co-ordinator is working closely with Social Work and attends case conferences etc to identify what activities would be appropriate and relevant.	after leaving school.	
	Support LAAC (16-18) and Through and Aftercare (16-25) young people into education/training/employment.	New system will be developed to report on current employment/ training/education position of LAAC (16-18) young people and Through and Aftercare (16-25) young people every 6 months.	Number of young people in training, employment and /or education.	Reported 6 monthly
	Increase volunteering opportunities	Require to revise actions in this area – discuss with EDVA	% of eligible LAC / LAAC young people engaged in volunteering activities	

Other Formats & Translations

This document can be provided in large print, Braille or on CD and can be translated into other community languages. Please contact the Council's Corporate Communications Team by calling **0300 123 4510** or emailing **corpcommumicatons@eastdunbarton.gov.uk**

本文件可按要求翻譯成中文，如有此需要，請電 0300 123 4510。

اس دستاویز کا درخواست کرنے پر (اردو) زبان میں ترجمہ کیا جا سکتا ہے۔ براہِ مہربانی فون نمبر 0300 123 4510 پر رابطہ کریں۔

ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਮੰਗ ਕਰਨ ਤੇ ਪੰਜਾਬੀ ਵਿੱਚ ਅਨੁਵਾਦ ਕੀਤਾ ਜਾ ਸਕਦਾ ਹੈ। ਕਿਰਪਾ ਕਰਕੇ 0300 123 4510 ਫ਼ੋਨ ਕਰੋ।

Gabhaidh an sgrìobhainn seo cur gu Gàidhlig ma tha sin a dhìth oirbh. Cuiribh fòin gu 0300 123 4510

अनुरोध करने पर यह दस्तावेज हिन्दी में भाषांतरित किया जा सकता है। कृपया 0300 123 4510 पर फ़ोन कीजिए।

East Dunbartonshire
Health & Social Care Partnership

Agenda Item Number: 13

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	6th October 2016
Report Number	2016/17_ 13
Subject Title	ED HSCP Clinical Governance Report
Report By	Interim Chief Officer East Dunbartonshire Health and Social Care Partnership 0141 201 4212
Contact Officer	Lisa Williams, Associate Clinical Director, East Dunbartonshire Health and Social Care Partnership 0141 201 4217 Lisa.williams@nhs.net

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to share with the HSCP Board the annual clinical governance report that the HSCP requires to be submitted annually to NHS GGC Clinical Governance Support Unit, to provide assurance to the Health Board, in respect of HSCP health services provided under direction by the Health Board, and operationally managed by the HSCP Chief Officer.

2.0 SUMMARY

This report covers activities for the calendar year from January 2015 to the end of December 2015 and relates, in the main, only to health clinical governance and clinical effectiveness activities. Community Health Partnerships were removed from statute on 31st March 2015. The Shadow HSCP Board was established in October 2014, prior to the removal of CHPs. The period of this report therefore covers 8 months of Shadow HSCP activity and 4 months of activity from the HSCP being established for adult services from September 2015.

The HSCP went live or adult services on 3rd September 2015 and the existing health only Clinical Governance Sub has progressed work on transformation into a Clinical and Care Governance Group over the last quarter of the period of this report. Future reports to the HSCP Board will cover both clinical and care governance activities and will reflect the additional delegated functions and services given ministerial approval in July 2016.

A key milestone in taking forward an integrated approach to developing HSCP clinical and care governance policies and processes has been the development of the integrated Complaints process approved by the HSCP Board at the August meeting.

The report contains the details of achievements made in improving quality of services, many of which are based on service user feedback, and recognises areas of good practice.

The report will be shared will all service teams so that the good practice in the report can be used by all service teams to continue to develop and improve the patient experience of our services.

3.0 RECOMMENDATIONS

3.1 The HSCP Board are asked:

a) To note the contents of the Clinical Governance Annual Report;

b) To commend the efforts of the members of the Clinical and Care Governance Group to ensure scrutiny and assurance of services has been maintained during a period of significant organisational change;

c) To request an update on the further development of Clinical and Care Governance arrangements to reflect the delegation of additional functions for children's health services, children's social work services and criminal justice social work services in six months time.

4.0 MAIN REPORT

4.1 The Clinical Governance Annual Report for 2015 reflects a period of significant change in governance arrangements as the HSCP moved from shadow arrangements to the implementation of integrated arrangements for adult services from September 2015.

4.2 The annual report highlights and emphasises the involvement of service users, carers and staff in our clinical governance activities over the last year and the importance of using patient experience and service user feedback to inform our quality improvement work.

4.3 The annual report sets out the context in which clinical governance activities have been progressed during 2015 and the specific quality improvement initiatives undertaken by our service teams. It also sets out initiatives to support the focus on person centred care, the implementation of the NHSGGC Learning Disability Redesign – Strategy for the Future, Adult Protection and Child Protection activities, complaints and incident reporting, some key achievements for 2015 and finally an appendix showing those clinical quality improvement projects which delivered service improvements in 2015.

East Dunbartonshire Council
www.eastdunbarton.gov.uk

NHS
Greater Glasgow and Clyde

East Dunbartonshire

Shadow Health & Social Care Partnership/Health & Social Care Partnership

Clinical Governance Annual Report

CONTENTS

	Page
Introduction	4
Service Context	5
Quality Improvement Initiatives	6
Learning Disability	6
➢ Weight Management Clinic	6
➢ Art Therapy Group	6
➢ Development of Dementia Care Pathways	6
Mental Health	6
➢ Improving access & productivity	6
➢ Low Level Psychological Therapy	7
➢ Introduction of Electronic CORE system	7
Older Adults Mental Health	7
➢ Post Diagnostic Support (PDS)	7
Community Rehabilitation	8
➢ Rapid Assessment Link (RAL)	8
Community Nursing	8
➢ End of life care monitoring	8

Children & Families..... 9

- Immunisation Service Rota..... 9
- First Steps Group..... 9

Person Centred Care..... 10

- #hellomynameis..... 10
- Implementation of GG&C Learning Disability Redesign – Strategy for the Future..... 10

Adult Protection..... 11

Child Protection..... 11

Patient Rights (Scotland) Act 2011..... 12

Complaints..... 12

Incident Reporting..... 13

Risk Register..... 14

Quality Improvement Overview..... 14

Key achievements 2015..... 15

Key challenges 2016 onwards..... 16

Chief Officers Concluding Remarks..... 17

.

Introduction

NHS Greater Glasgow & Clyde's Clinical Governance Support Unit requires the HSCP to provide a report to assess the current position in relation to clinical governance activity. This report relates to the period from January 2015– December 2015 and so largely relates to health related clinical governance activities.

The purpose of this report is to provide a summary of clinical effectiveness activity throughout this period. It highlights and recognises areas of good practice and is reflective of achievements for the last year. During this year the HSCP entered its shadow year of becoming a fully fledged integrated Health and Social Care Partnership, with full integration becoming active as of 3rd September 2015, when adult Social Work Services became part of the HSCP.

Throughout this period the HSCP has strived to deliver safe, effective and person-centred care. This report aims to highlight some of the work on-going within our teams, and how we ensure standards of care are maintained and improved upon.

With the agreement of the new Chief Officer and the Chief Social Work Officer, the Clinical Governance Group has become an HSCP Clinical and Care Governance group, with new Terms of Reference, and a revised membership to reflect the new Governance structure within the organisation (reflecting the national Clinical and Care Governance Framework published by the Scottish Government).

Throughout the transition period, there has been ongoing development of primary care services, with excellent continued engagement with our 17 GP practices, close links with Optometry and Community Pharmacy, and closer working with our Social care colleagues.

As always we should not underestimate the importance of involving service users, carers and staff from the frontline in our governance work, and learning from feedback, both positive and negative is essential in order to improve the quality of care we deliver. We have had continued support from local third sector and voluntary groups and their input and services remain highly valued.

Many thanks to all of those who contributed to this report, which demonstrates our commitment to delivering quality care to the people of East Dunbartonshire.

Service Context

Geographical Area

East Dunbartonshire has a large geographic area which covers Bearsden, Milngavie, Lennoxtown, Kirkintilloch, Torrance, Lenzie, Auchinloch, Milton of Campsie, Lennoxtown and Bishopbriggs.

Population

The 2015 population for East Dunbartonshire is 106,960, an increase of 0.2% from 106,730 in 2014. The population of East Dunbartonshire accounts for 2% of Scotland's total population.

In East Dunbartonshire 15.5% of the population are aged 16 to 29 years. This is less than Scotland where 18.2% are aged 16 to 29 years. Persons aged 60 and over make up 28% of East Dunbartonshire's population. This is greater proportion than Scotland where 24% are aged 60 or over.

The 2011 Census showed 5.4% of East Dunbartonshire's population were from a minority ethnic group, an increase of around 2% since the last census in 2001, with the Asian population constituting the largest minority ethnic group.

Services

The Shadow HSCP/HSCP works closely with East Dunbartonshire Council, hospitals, community and voluntary groups to help improve the health and wellbeing of East Dunbartonshire residents. The HSCP provides the following NHS Services in East Dunbartonshire: -

- Community Nursing
- Children and Family Services, including School Nursing
- Community Rehabilitation Team
- Health Improvement and Inequalities Team
- Community Alcohol & Drug Service
- Community Learning Disability Service
- Community Mental Health Services and Primary Care Mental Health Services
- Primary Care Contractors e.g. GP's. Dentists, Community Pharmacists and Opticians
- Older Peoples Mental Health Service at Woodlands Centre
- Continence Services
- Diabetes Services

The Shadow HSCP/HSCP also hosts the Oral Health Directorate. Although the Directorate has its own operational structure this is monitored through the Shadow

HSCP/HSCP governance structure and the Interim Chief Officer/HSCP Chief Officer has overall management responsibility. Other hosted services include Podiatry, Physiotherapy, Speech and Language and
Dietetics.

Quality Improvement Initiatives

Throughout 2015 there has been numerous and varied quality improvement initiatives carried out by East Dunbartonshire HSCP Services. Below are some examples of these, and the teams involved:

Learning Disability

The Joint Learning Disabilities Team has introduced a number of initiatives to improve service user experience and outcomes:

Weight Management Clinics

There was an unmet health care identified, with a need to offer proactive advice and support to a vulnerable group in relation to weight management. The proposal was to improve outcomes in relation to weight problems for people with learning disabilities. An evaluation on this service has noted the attendance rates have increased since 2013 by 10%. Positive feedback has been received from service users stating that the clinic provides a useful source of health monitoring, especially for some individuals with more complex needs. The clinic also provides the opportunity to signpost more able service users to other services such as Waist Winners or Live Active.

Art Therapy Group

This was developed to provide a positive experience for users to promote and develop new skills. The aim was to improve personal outcomes for individuals with learning disabilities and to increase self-esteem and mental well being. Positive feedback has been received from both service user and carers

Development of Dementia Care Pathway

The local Joint Learning Disabilities Team have a leading role within the NHSGG&C boardwide group for improving services and access for people with a learning disability who have dementia. The pathway is to be introduced and evaluated at a local level and will contribute to NHSGG&C boardwide delivery of the service.

Mental Health

Improving Access & Productivity

The Primary Care Mental Health Team (PCMHT) identified a need for Out Of Hours (OOH) appointments for service users who were unable or struggling to attend appointments during normal daytime working hours. Patient feedback indicated that some service users were finding it difficult to request time off work to attend appointments due to:

- Work commitments
- Stigma and difficulty in disclosing mental health problems to employers

- Being short staffed and under pressure at work to avoid taking time off
- Work-related stress being the main issue requiring mental health support

It was therefore decided to offer OOH appointments for a period of 6 months as a pilot project, and to conduct an audit thereafter. Due to the nature of the service, it was not possible to have the end of the pilot (appointments offered) and the data collection for the audit to coincide with each other, as the outcome of the audit would dictate future appointments for current service users attending OOH appointments. Therefore the audit results were made available for discussion, before the end of the pilot period.

The Audit results supported that the OOH service has been a very positive development for the PCMHT, with service users giving overwhelmingly positive feedback about the service and it was recommended that the service should continue.

Low level psychological therapy

This was introduced to improve recording of data and raise awareness to increase the numbers and recording of identified cases. This has resulted in better data recording. Primary Care Mental Health staff now offer one to one low level psychological intervention supervision with Psychology. All staff within Health and Social Work offer low level group sessions along with Psychology. Monitoring reports have been established to ensure that staff are recording appropriate and meaningful data and there has been a noted improvement in recording systems

Introduction of Clinical Outcome Routine Evaluation (CORE)

The above system was introduced to enable early interventions. CORE reports outcomes for service users. Service users are encouraged to participate throughout the process to attend. There has been an extremely low non attendance rate and the Primary Care Mental Health Team have received positive feedback from Service Users.

To enable flexibility for Service Users, staff have changed their work patterns to accommodate early and late appointments. Early appointments have also been offered at satellite clinics throughout East Dunbartonshire to facilitate easier access and attendance.

Older Adults Mental Health

Post Diagnostic Support

In 2010 the Scottish Government launched the National Dementia Strategy which identified improving Post Diagnostic Support (PDS) as one of two key improvement areas. From this stemmed the PDS HEAT target: *"everyone diagnosed with dementia from April 2013 is entitled to a minimum on one year's worth of post diagnostic support coordinated by a link worker"*.

The PDS guarantee has enabled the delivery of an inclusive, equitable service to those newly diagnosed with dementia in East Dunbartonshire. Prior to 2013 those diagnosed with dementia types not suitable for a cognitive enhancer, and with no

behavioural and psychological symptoms of dementia (BPSD) were routinely discharged. This accounted for approximately 50% of patients, with those with vascular dementia disproportionately affected.

The positive impact of this model of service cannot be underestimated. With this cohort now accessing PDS, services can be tailored to deal with what is effectively a terminal diagnosis, and work by supporting people through the immediate stages following diagnosis, and the anticipatory care planning beyond. More meaningfully they are able to "look after and improve their own health and wellbeing and live in good health for longer".

Positive feedback has been received from both service users and carers and this has been a rich source of qualitative feedback demonstrating the impact of the service.

"Thanks for all your help with our Mum. We now have a better understanding of her illness and feel we can cope better"

Community Rehabilitation

Rapid Assessment Link (RAL)

The Rapid Assessment Link is a multi-disciplinary service within the Community Rehabilitation Team. The team was established to provide GPs with a rapid response and intervention within the community, for people who might otherwise require be admitting or re-admitting to hospital as a result of becoming unwell, or developing additional needs.

The team provide a holistic assessment of need and provide input as required, with the aim of preventing an avoidable admission to secondary care. They can make onward referrals and signpost users to the Third or Independent sector.

Success of the service has been demonstrated by a 25% rise in GP referrals since 2013. Data also shows that although 28% of referrals do go on to require admission, 72% are able to be supported and managed within the community, who otherwise may have needed to be referred into an acute bed.

Community Nursing

Palliative Care

This project commenced in 2014 and was aimed at improving the District Nursing services that 'End-of-Life Patients' receive and to develop services around 'End-of-Life patients' needs.

At the time of initiating the project there was uncertainty over the use of the Liverpool Care Pathways and recognition that patients' and carers' views had not routinely been sought about end-of-life care. This piece of work was one of a number of initiatives to improve palliative and end of life care with the aim to increase the number of patients

who died in their preferred place of care and reduce the number of patients with palliative care needs who die in hospitals.

A 'How are we doing?' questionnaire was developed and is now given to all relatives of patients who have been on the palliative care register and received care from the District Nurse regardless of final place of care.

The first annual questionnaire results highlighted frustrations accessing District Nursing services for unplanned visits, particularly with regards to the use of voicemail. In response to this, District Nurses provided a mobile telephone number to carers for direct contact Monday – Sunday 08.30 – 1630hrs. A key message from year 1 and year 2 has been the gaps in provision of the District Nursing service in the early morning and evening hours. Board wide work is currently underway to ensure 24hr provision of service.

Children & Families

Immunisation Service Rota

The Immunisation Service Rota was established to ensure equal distribution of clinic commitments for all band 5 staff nurses across the HSCP. The completion of a time management audit identified a significant variation of between 20-50 % of their time spent on the delivery of 0-5 year immunisation programme on a monthly basis. The rota system was introduced in May 2015 and has been successful in accomplishing the aim of equal time distribution on this task with all staff now spending an equal 20% of their monthly working hours delivering the programme.

First Steps Group

The First Steps Group is a service provided by East Dunbartonshire Children & Families team to promote maternal wellbeing, positive parenting and child development. The group was established in March 2015 and provides new parents with an opportunity to receive additional support from a health professional while enjoying the social interaction of a peer group. Service users benefit from the social interaction that peer support provides, this has been evidenced to promote positive mental health and wellbeing.

The service is currently provided within 3 areas of East Dunbartonshire: Milngavie, Kirkintilloch and Bishopbriggs. The programme is delivered in one hour sessions over a four week period. Each session covers the following topics:

Session 1 - Supporting your partner & being a parent
Session 2 - Sleep patterns & crying
Session 3 - Play & book-bug
Session 4 - Promoting development.

Pre and post programme questionnaires are used for evaluation purposes. To date the programme has been evidenced to increase maternal confidence in relation to; parenting, positive parent child attachment and promoting child development.

The Long term goal is to see a reduction in the number of mothers who require additional support with mental health issues, positive parent child attachment and a reduction in the number of children requiring additional support to meet their developmental milestones.

Person Centred Care

#hellomynameis

On Wednesday 9th December, Karen Murray, Chief Officer for East Dunbartonshire HSCP sent the inaugural tweet to @GrangerKate pledging East Dunbartonshire HSCP Health Teams support to the #hellomynameis campaign.

#hellomynameis was founded by Dr Kate Granger, a Consultant Geriatrician with Mid-Yorkshire NHS Trust who was living with terminal cancer. Whilst in hospital being treated for post-operative sepsis Kate became a "keen observer" of her own care and was struck when she noted that many of the staff caring for her did not introduce themselves. She was also deeply affected by those who did take time to introduce themselves and connect with her. This led her to reflect on the importance of therapeutic communication and how much 'the little things' could make a profound difference to a patient when they are at their most vulnerable.

From these observations Kate came up with the "ingeniously simple" premise that introducing yourself and connecting with the patient is the "first rung on the ladder of compassionate care". From this a movement was born.

The campaign has been successfully introduced within a number of secondary care settings throughout the UK. To the best of our knowledge, East Dunbartonshire is one of the first health and social care partnerships to introduce the campaign, and certainly the first within the Health Board area.

Implementation of the NHSGG&C Learning Disability Redesign – Strategy for the Future

The 'Strategy for the Future' document outlines aspirations to provide a future service which focuses on providing good outcomes for people with a learning disability and to support people to live healthy, happy, independent lives within the community. This vision is underpinned by human rights, fairness and equality and demonstrates our intent and obligation to provide opportunities which enable people with a learning disability to access good quality healthcare which is knowledgeable and sensitive to their specific needs and aspirations.

The intention is to enable individuals with a learning disability to access the right healthcare, at the right place, at the right time and to support our mainstream colleagues to understand and better cater for the needs of people with a learning disability

People with a learning disability continue to experience significant inequalities; this strategy aims to address these by creating a fairer system which listens to what

people with learning disabilities want and need from specialist services and to develop better ways of supporting our mainstream services.

Engagement with people with learning disabilities has defined what people expect from NHS / Social Care Services such as less reliance on bed based services, greater meaningful participation, more control and an ability to access the service which best meets their needs regardless of the presence of a learning disability.

Adult Protection

The HSCP continue to work in partnership with our Social Work colleagues on identified cases.

A report on multi-agency ASP activity is submitted to the Scottish Government on a biennial basis. Locally, performance and improvement is reported regularly via internal and community planning structures. 2014-15 saw a real reduction in referrals from Police Scotland thanks to the introduction of the iVPD system (Vulnerable Person Database) which distinguishes between 'adult at risk of harm' referrals and 'adult concerns'. 2014-15 also saw referrals from provider agencies overtake those from Police Scotland for the first time, resulting in provider agencies becoming the largest single source of adult protection referrals in East Dunbartonshire.
Self-harm was the most common cause of ASP referrals in 2013-14 and was identified as a priority for strategic improvement by the Committee during 2014-15. The links between psychological trauma and repeat self-harm are established, and developing effective multi-agency responses which recognise these links formed the theme of the Adult Protection Committee's annual conference in March 2015.

The table below outlines the provision of Adult Support and Protection Services in 2014-15:

Nature of Activity	Number
Duty to Inquire	451
Referrals with child present/child care responsibilities	manual count pending
Planning meetings	15
Investigations	25
Case conferences	12
Review case conferences	28
Protection plans initiated in 2014-15	8
Temporary Banning Orders	0
Banning Orders	1

Child Protection

The HSCP has had child protection activities at the forefront of its agenda. This is a priority activity for social work and health services.

Social work services continue to investigate and manage child protection matters, liaising with other partners as required. The HSCP continues to fully participate in East Dunbartonshire's Child Protection Committee, the NHSGG&C Child Protection Forum, the NHSGG&C Child Protection Operational Group and the West of Scotland Child Protection Consortium Chairs meeting. The information gained from these meetings ensures services in East Dunbartonshire are in line with local, national and NHSGG&C recommendations.

Patient Rights (Scotland) Act 2011

In response to the Patient Rights (Scotland) Act 2011, East Dunbartonshire HSCP invites service users and carers to submit any feedback, comments or concerns they had in relation to Healthcare services.

Each health service has an established mechanism to gain feedback from their service users. As well as these systems, a web-based system was also established to gather feedback. These comments are also collated and reported, on a quarterly basis to the NHSGG&C Board. East Dunbartonshire welcomes all feedback received from their service users and carers and use this to improve services throughout East Dunbartonshire.

The Act requires that all Independent Contractors i.e. GP Practices, Dental Practitioners, Optometrists & Community Pharmacists, provide a submission to the Health Board regarding complaints they have received. A compilation of these complaints and outcomes are provided to the Clinical & Care Governance Sub Group for review on a quarterly basis.

Complaints

EAST DUNBARTONSHIRE HSCP
SUMMARY BY QUARTER FOR 2015 for all FORMAL COMPLAINTS RECEIVED

From 1 January 2015 to 31 December 2015		**% of complaints meeting 20 day target**
Number of complaints received	**5**	**75%**
Number of complaints received and completed within 20 days	**3**	
Number of complaints completed	**4**	
Upheld	**1**	
Partially upheld	**3**	
Not upheld	**0**	
Consent not received	**1**	

Breakdown by Service	Total number to date
East Dunbartonshire Alcohol & Drug Service	1
Community Mental Health Team	2
Primary Care Mental Health Team	1
Management of care	
Community Mental Health Team	**3**
Staff Attitude	
East Dunbartonshire Alcohol & Drug Service	**1**

Analysis of complaints (see table 1) for 2015 shows a total of 5 complaints with 75% of complaints responses completed within the 20 day target period. There was 1 complaint upheld, 3 partially upheld and 1 where no consent was received which means this complaint was not progressed and closed. The 4 complaints related to:

Management of Care – The following measures have been implemented to;

- Ensure sufficient time is allocated when assessing new patients to allow dialogue and provide patients with information relating to prescribed medication.
- Ensure effective notice is given in relation to cancellations of appointments.
- Improve recording issues and discussions between staff to improve on outcomes for the service user

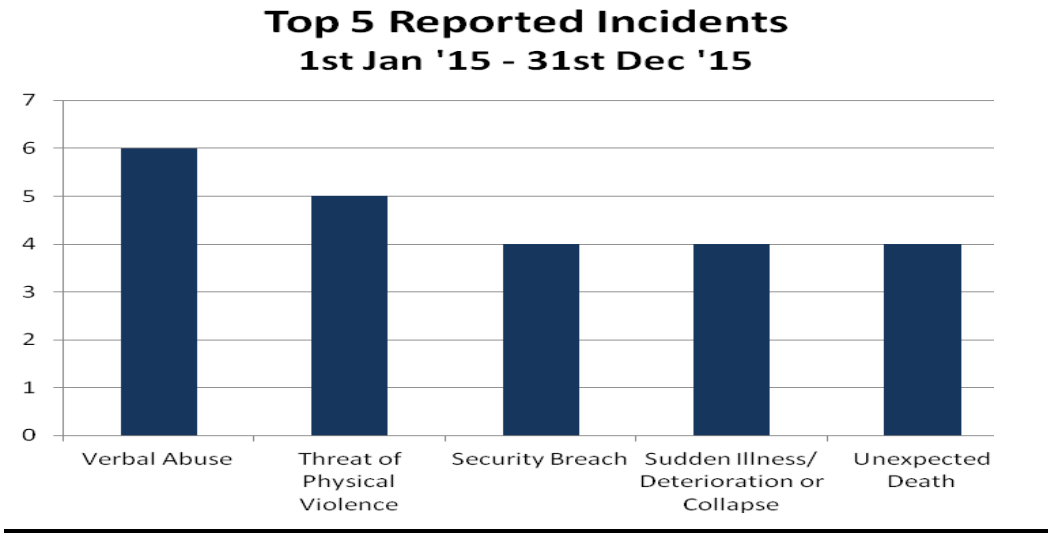
Staff Attitude

- All staff have are reminded to respect and support peoples rights whilst ensuring the needs of the users are being met.

Incident Reporting

The reporting of incidents is recognised as a means of improving the quality of patient care and minimising risk. The open reporting of even minor incidents allows weaknesses to be identified in the system, customs and practices changed and retraining of staff where necessary.

Analysis of incidents in East Dunbartonshire HSCP shows that in 2015 there were some 127 incidents recorded onto the DATIX recording system. The graph below shows the top incident categories during 2015.



Datix recording system is currently available for reporting of incidents for health. The Clinical and Care Governance Group will consider how to ensure incidents for social care are reported, analysed and the learning used to inform future practice.

Outcomes of incident reporting

As detailed in the diagram above, the top categories reported within the HSCP during 2015 were verbal abuse and a threat of physical violence towards our staff. The HSCP are sympathetic towards our Service Users, however, NHS Greater Glasgow & Clyde have a zero tolerance policy against this behaviour and on each of these occasions staff involved have escalated each incident and have been supported by their Line Manager.

Risk Register

East Dunbartonshire HSCP acknowledges that sound and effective implementation of risk management is considered best business practice at a corporate and strategic level, as well as a means of improving operational activities. The continuing development of a comprehensive Risk Register is a core part of risk management activity. The Risk Register is used as a systematic and structured method of recording all risks: clinical, financial and organisational, that threatens the objectives of the organisation. This process is an integral part of day-to-day practices and culture, utilising a single co-ordinated approach to the identification, assessment and management of all types of risk.

All operational teams compile a Risk Register and these are routinely reviewed and updated. Identified risks are addressed through systems/meetings, i.e. Clinical Governance Sub Group, Health & Safety and Healthy Working Lives.

An overall Clinical Governance Risk Register is kept by the Clinical and Care Governance Sub Group and this is reviewed and updated on a 6 monthly basis. Risk Registers are a standing item on the Clinical and Care Governance Sub Group

agenda. Clinical Governance Risks are reviewed regularly and included as appropriate in the overall HSCP Risk Register, which feeds in to the Board's corporate risk processes.

Although risks are ever present, with appropriate review we can ensure that risks are not increasing, and that current control measures are sufficient to ameliorate risks. The HSCP is confident that risk levels are minimised where possible by the control measures in place.

Quality Improvement Work Overview

An overview of quality improvement work carried out over 2015 can be found in **Appendix 1.**

Key Achievements for 2015

Transition to HSCP

East Dunbartonshire proceeded successfully through a transition process with a shadow integration period, to a fully operational Integrated HSCP for Adult Services by September 2015. The process was led by the Interim Chief Officer, Karen Murray whose enthusiasm and hard work was in no small part responsible for the successful transition to integration. There was full support from the Chief Social Work Officer, Council members, and Senior Health Team Managers, to facilitate the move to integration.

Development of locality planning groups

Part of the integration process required the development of locality planning groups, to help drive and develop local services for our population, with representation from General practices, Community teams, Social work, Housing, Homecare, Third sector and service users. East Dunbartonshire has two Locality Planning Groups, and they are beginning to develop their role and function with time.

Lennoxtown Hub

The Lennoxtown Hub opened in February 2016. This was a substantial investment within the local area. The building brings together a range of Council and Health services under one roof.

The building contains three levels being two stories high fronting Main Street in the middle of Lennoxtown village.

- The lower ground floor will contain an entrance foyer and employee facilities with level access to the parking area to the rear of the building.
- The ground floor will contain the main entrance, library, a Learning Disability

complex needs facility, Council Customer Services and offices.

- The first floor with have office space, two treatment rooms and two interview rooms for staff. Health Visitors and District Nurses who work within the Lennoxtown area will use these premises as their base. There will also be some clinical sessions from Physiotherapy and Podiatry. Peel View Medical Centre and Lennoxtown Medical Practice will also be based within this floor. In time, they plan to extend their clinical services

Opportunities will be available for other Teams to utilise the facilities within the new Hub to deliver services within the local area.

A series of engagement events have taken place within the local community. Feedback from these sessions helped to change and adapt the plans for the building.

Key Challenges 2016 onwards

Development of Integration

The continued development of an integrated HSCP will require ongoing commitment from all involved, with a need for openness to learn from colleagues and adapt to new ways of working. With appropriate management and leadership this should prove a successful time for East Dunbartonshire. The addition of Children's NHS Sevices, Social Work Children's Services and Criminal Justice Social Work Services from July 2016 as delegated functions of the HSCP will extend the scope of the remit of the Clinical and Care Governance Group beyond adult services in 2016.

Ageing Population

The demographic within East Dunbartonshire continues to change, with an increasing population of over 60 years, and rapidly increasing numbers of residents over the age of 70 and 80 years. This increases demand on the resources available and will require new ways of working and innovative practice to meet this growing need.
Many of these patients have complex health needs, with long-term conditions and social needs. It will require close working between health and social care to best manage their needs within the available resource.

Introduction of Intermediate Care Beds

Plans to develop a number of intermediate care beds within the locality will be closely monitored and managed, and will need audited and reviewed to ensure the beds are utilised appropriately.

Opening of Care / Nursing Homes within East Dunbartonshire

A number of new care homes continue to be opened within East Dunbartonshire, and this causes challenges with regards to resourcing care within existing budgets, provision of primary care services, and ensuring residents are cared for equitably in all homes.

Staff site move from Stobhill to KHCC

Plans to move all HSCP staff to one site at KHCC will be challenging due to space constraints, and will need carefully managed to ensure a smooth transition with no adverse effect on services.

Service User / Carer Feedback

Each service within the HSCP gathers feedback from their service users and carers. Since integration in September 2015, the Health & Social Care Partnership established a short life working group to scope and implement a system where the feedback can be obtained to gain an overall picture of service user / carer experiences. This work is continuing and will aim to allow a more streamlined and comparative feedback process.

Chief Officer Concluding Comments

I would like to thank and acknowledge all NHS and Social Work Staff working in the HSCP during 2015 for their significant Contribution to Clinical and Care Governance activities in the 2015 reporting year. Our focus on Clinical and Care Governance is essential if we are to achieve our aspiration for continuing improvement in patient and service user safety and putting people and service user experience at the heart of what we do to develop and improve service provision and outcomes for patients and service users.

During 2016 we will continue to develop and conclude the arrangements required to fully implement the Public Bodies (Joint Working) Scotland legislation for the substantive integration of both Adult and Child Health and Social Care Services. This will mean accelerating the progress being made on developing and implementing joint “Clinical and Care” governance in integrated adult, children’s and criminal justice health and social care service.

We need to continue our focus on maintaining and improving the standards of care provided and the outcomes achieved for our patients and service users, and ensure that best practice is firmly embedded in all of our services. Effective systems of clinical and care governance are essential if we are to provide the public with assurance about their services and confidence in the HSCP.

APPENDIX 1

EAST DUNBARTONSHIRE HSCP CLINICAL GOVERNANCE ANNUAL REPORT 2015: DRAFT CONTRIBUTION FROM THE CLINICAL GOVERNANCE SUPPORT UNIT (CGSU): CLINICAL QUALITY IMPROVEMENT PROJECTS WHICH RECORDED SERVICE IMPROVEMENTS IN 2015

ADULT MENTAL HEALTH

Primary Care Mental Health Team (PCMHT): Service User Satisfaction Survey

This survey aimed to identify whether service user satisfaction re waiting times and after hours appointments had increased following changes made since the previous survey in 2013. The improvements service users identified were as follows:

- Referral Process: improvement in the waiting times for call back. Service users commented on the positive manner in which call back had been conducted.
- Waiting Times were reduced, with 75% of service users stating that they thought the waiting times were reasonable in comparison to the 65% that thought it was reasonable in 2013.
- Other areas of improvement included the helpfulness of the self-help material and service users feeling more involved in decisions made about their treatments. The number of service users using tools and techniques suggested by practitioners also increased.
- Satisfaction with interventions provided: there was an increase in the percentage of service users who felt that their health had improved since attending the service and that they were more in control of their symptoms since the survey in 2013. 94% of service users were satisfied with their experience of using the service in comparison to 87% in 2013.

Primary Care Mental Health Team (PCMHT): Monitoring and Improving Clinical Outcomes

This project aims to align with the citywide operation policy on recording of patients clinical outcomes; to ensure all patients' clinical outcomes are recorded at every psychological intervention; and to improve data quality within the PCMHT. Improvements to date are: 1. All staff are utilising technical equipment during interventions to record clinical outcomes. 2. For all psychological interventions CORE net has been utilised and the information recorded. 3. All Staff have received additional support and training around CORE/CORE net.

Primary Care Mental Health Team (PCMHT): Tackling Inequalities: Employability

The aim is to carry out a pilot to assess and monitor the out of hours working for individual treatment. The target groups are people who are in employment or students who are unable to attend appointments during the day. To date tests have been carried out of telephone assessments and groups out with working hours.

Primary Care Mental Health Team (PCMHT): Tackling Inequalities: Positive Ageing Group

This is a specialised group targeting older people who have mild to moderate mental health issues. To date the PCMHT have carried out approximately 4 positive ageing groups, evaluated the groups at the completion of each and adjusted the content

depending on the feedback from services users. The groups have also utilised many useful community services for older people.

Community Mental Health Team: Improving Access and Productivity

The aim of this project is to improve service users' attendance at clinics - service users are now reminded of appointments 48 hours beforehand. To date, attendance rates have improved, DNA Rates have fallen, and cancellation appointments have been utilised as notice has been given by service users.

ADULT NURSING:

District Nursing Survey of Relatives and Carers of End-of-Life Patients: Baseline Evaluation

Relative and Carer feedback was predominately positive in relation to the appropriateness, timeliness and person-centredness of care provided by the DN service in East Dunbartonshire. The qualitative feedback described excellent person centred and holistic care which supported both patients and families. Actions on areas for improvement were as follows:

- As part of a DN review, scoping work to reduce gaps in DN service provision, including sharing of the survey report with the review group to ensure consideration of carers' views.
- All DNs in hours to provide an estimate of visit time to patients and carers.

CHILDREN AND FAMILIES

Triple-P Parenting Tip Sheets

The aim is to ensure the parenting tip sheets are used and recorded accurately to reflect the level of working undertaken with the families. This has now been achieved.

0-5 Baby Drop-In Staff Skill Mix

This project worked towards a new skill mix resource in the Children and Families Team with the team taking ownership of the 0-5 Baby Drop in Service, allowing Staff Nurse resources to be re-directed. The role and remit of staff is now clearer.

Immunisation Service Rota

The aim was to introduce an immunisation rota for staff nurses in all three bases to ensure equal distribution of workload. This has now been achieved.

Support for All System

The aim is to ensure staff are informed of any support for all meetings, aware of the staff rota and any information required for and from the meetings. Clearer processes and sharing of information has been achieved, with a better shared understanding for health and early education services.

COMMUNITY REHABILITATION (EDCRT)

Team Effectiveness Work Stream

This quality improvement work aims to build effective Team processes and pathways, to ensure the most effective use of time at work and increase patient-facing time. To date it has resulted in pathway improvements, triage guidance and a new checklist which is working well for the service.

East Dunbartonshire Health & Social Care Partnership Board

Distribution List:

Name	Designation	
Councillor Rhondda Geekie	Chair - EDC - Elected Member	1
Councillor Anne McNair	EDC - Elected Member	1
Councillor Michael O'Donnell	EDC - Elected Member	1
Ian Fraser	Non-Executive Board Member	1
John Legg	Non-Executive Board Member	1
Ian Ritchie	Non-Executive Board Member	1
James Hobson	Interim Chief Officer - East Dunbartonshire HSCP	1
Paolo Mazzoncini	Chief Social Work Officer	1
Jamie Robertson	Chief Internal Auditor HSCP	1
Karen Donnelly	EDC Chief Solicitor & Monitoring Officer	1
Martin Cunningham	Corporate Governance Manager	3
Andy Martin	Head of Adult & Primary Care Services	1
Sandra Cairney	Head of Strategy, Planning & Health Improvement	1
Fiona McCulloch	Planning & Performance Manager	1
Jean Campbell	Chief Finance & Resources Officer, HSCP	1
Linda Tindall	Organisational Development Lead, HSCP	1
Graham Morrison	Clinical Lead Representative	1
Adam Bowman	Acute Services Representative	1
Wilma Hepburn	Professional Nurse Advisor - NHS	1
Gordon Thomson - Ceartas	Voluntary Sector Representative	1
Martin Brickley	Service User Representative	1
Chris Shepherd	Carers Representative	1
Andrew McCready	Trades Union Representative	1
John Duffy	Trades Union Representative	1
Fiona Borland	HSCP Communications	1
		27

For Information (Substitutes):

Name	Designation
Councillor Ashay Ghai	EDC - Elected Member
Councillor Gillian Renwick	EDC - Elected Member
Councillor Manjinder Shergill	EDC - Elected Member