For meeting on
26 MAY 2016

Agenda *2016*

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

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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, 26 May 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: 19 May 2016

AGENDA

Sederunt and apologies

Any other business - Chair decides is urgent

Signature of minute of meeting HSCP Board held on 31 March 2016

SEMINAR – Health Improvement Key Deliverables and the specific contribution to PLACE Communities

STANDING ITEMS			
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ITEMS FOR NOTING			
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		Date of next meeting Thursday, 11 August 2016 at 09.30am, Council Committee Room, Southbank Marina	

East Dunbartonshire
Health and Social Care Partnership

HEALTH IMPROVEMENT KEY DELIVERABLES 2013-16

Presentation to
HSCP Board meeting 26th May 2016

Sandra Cairney – Head of Strategy, Planning & Health Improvement
David Radford – Health Improvement & Inequalities Manager

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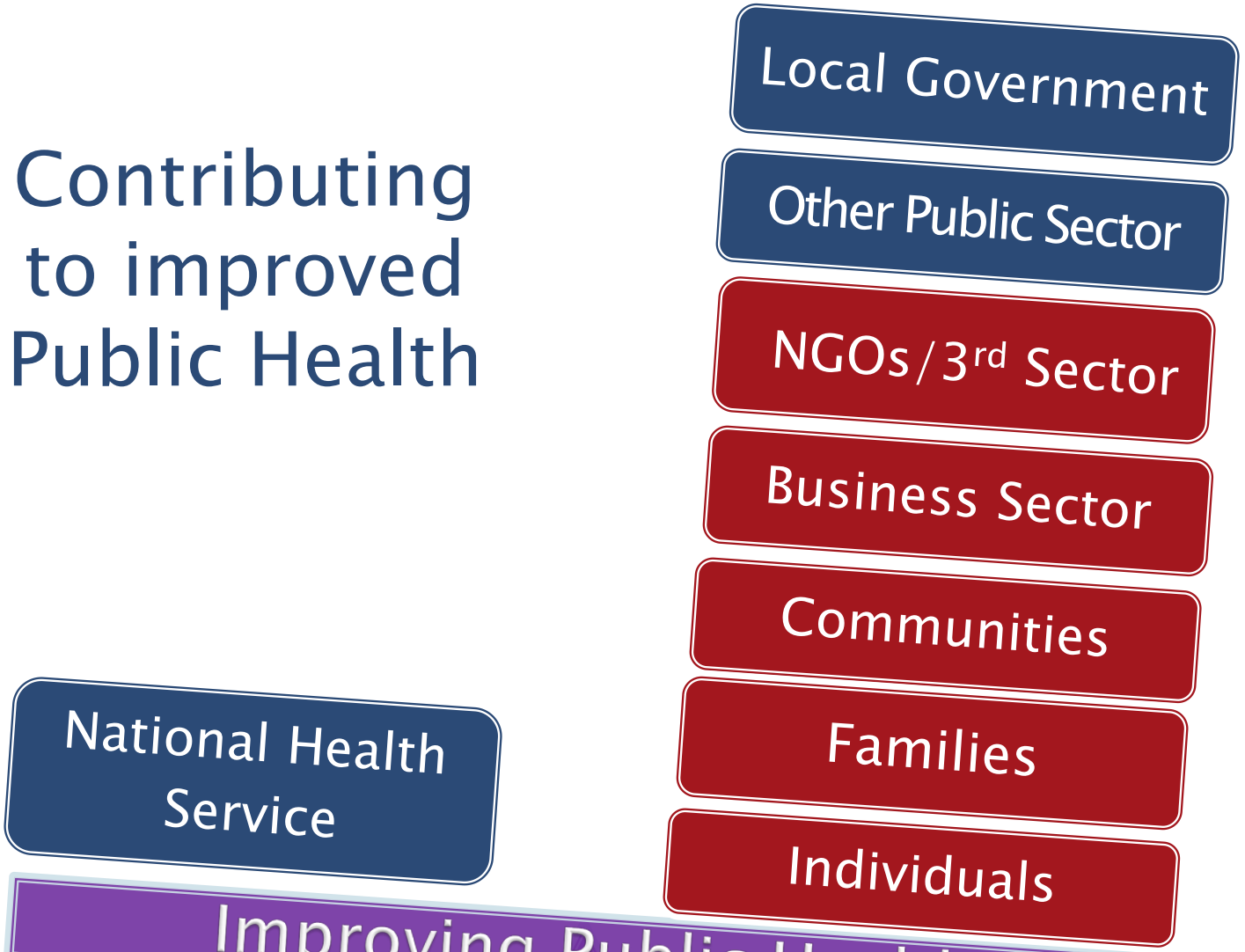
Overview

- Local Outcomes Framework
- International Framework for Action
- Local Health Improvement in Action
- HSCP contribution to PLACE
- Role of the Specialist Public Health workforce
- Questions

Who makes a significant contribution to improving public health?

Contributing to improved Public Health



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Local Outcomes Framework

CHILDREN AND YOUNG PEOPLE ARE HEALTHY & HAVE THE BEST START IN LIFE

ADULTS LIVE HEALTHY ACTIVE LIVES

OLDER PEOPLE REMAIN ACTIVE AND INDEPENDENT

PEOPLE EXPERIENCE IMPROVED LIFE CIRCUNSTANCES

The Ottawa Charter – Global Charter for achieving Health Improvement (1986)

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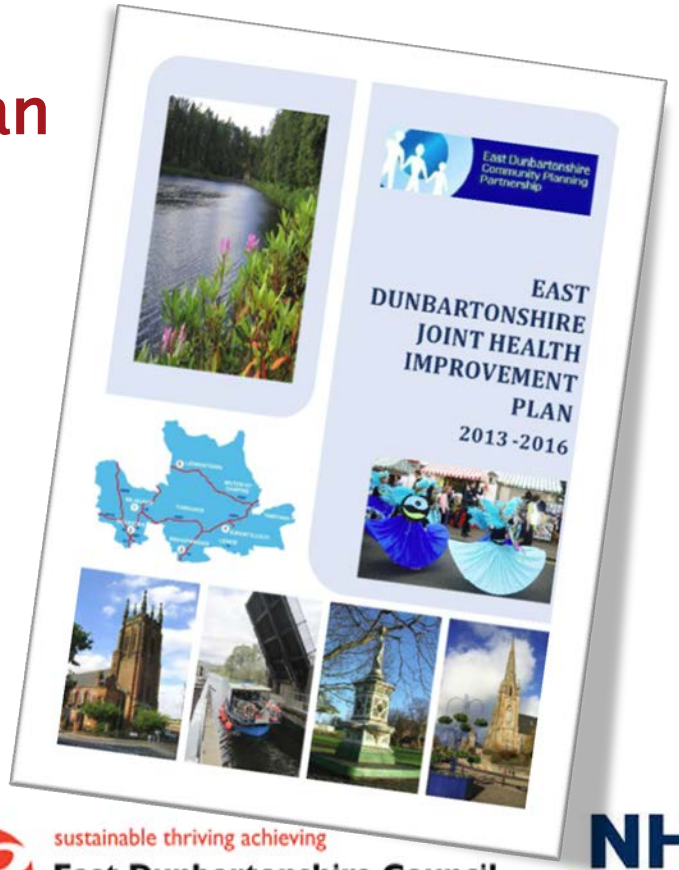
Build Healthy Public Policy

Health promotion policy combines diverse but complementary approaches and involves coordinated action that leads to policies that foster greater equity

- **Joint Health Improvement Plan**
- Tobacco Control Strategy
- Sexual Health Action Plan
- Financial Inclusion Strategy
- Mental Health Improvement plan
- PLACE



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Create Health Promoting Environments

Socio-ecological approach to health improvement which generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

- Community Asset map
- Smoke Free Play Parks
- Healthy Working Lives
- Children's & Older People's Welfare Benefit service
- 'Flourishing Schools' self-evaluation toolkit
- Walking & Arts Learning Knowledge (WALK)
- PLACE

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Strengthen Community Action

The process of empowering of communities lead to improved health through effective community action in setting priorities, making decisions, planning and implementing strategies to achieve better health.

- Happier, Healthier Communities
- Community Asset Map Champions Programme
- 'Volunteering is Good for your Health' programme
- 'Men's Sheds'
- Community Food Programme
- OPAL
- PLACE

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Developing personal and social skills

Supporting personal and social development enables people to exercise more control over their own health.

- 'Trade Winds' and 'Smoke free 4 Me' Programmes delivered in primary and secondary schools
- 'Going for Gold' physical activity in early years
- 'Active Choices' healthy weight programme
- 'ChildSmile' tooth brushing in early years and schools
- UNICEF Baby Friendly Accreditation
- Self-Harm 'On Edge' School Pack
- Sexual health workshops for parents
- PLACE

Self harm pack Pic

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Reorient health services

smokefree SERVICES

Health services need to embrace the promotion of health & prevention of illness

- 'Early Booking Service' for pregnant women
- 'Universal Pathway' offering a core home visiting programme to all families
- Comprehensive immunisation programme for children and young people
- Stop smoking community and pharmacy services
- Comprehensive sexual health services
- Comprehensive public health screening programmes
- PLACE

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HSCP targeted HI in PLACE Communities

- Breast feeding Baby Cafe
- Baby drop-in sessions
- Parenting support
- Buggy Walks
- Community Walks
- Community food programmes
- Waist Winners programme
- ACES/Active Choices programmes
- Resident led Food Coop
- Stop smoking services
- Second Hand smoke prevention
- Stop smoking/Start Saving incentive service

Triple P
Positive Parenting Program
for every parent

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Cont...

- Community asset development
- Cancer screening promotion
- Alcohol Brief Intervention programme
- Free Condom service and Parent sexual health workshops
- Safe Talk and Self Harm community workshops
- Commissioned 3rd Sector community capacity building programmes
- Resourced structural changes to the Family room within Hillhead Primary School to increase community access and usage.

What is the Specialist Public Health role?

Questions

- What stood out from the presentation?
- How can we sustain the good progress to date?
- What do you think the specific role of the HSCP Board is?

Minute of meeting of the Health & Social Care Partnership Board held within the Committee Room, 12 Strathkelvin Place, Kirkintilloch on **Thursday, 31 March 2016.**

Voting Members Present:		EDC Councillors **GEEKIE & O'DONNELL**
		NHSGGC Non-Executive Directors **R. FINNIE, I. FRASER, & TRISH McAULEY**
Non Voting Members present:		
	K. **Murray**	Chief Officer - East Dunbartonshire HSCP
	M. **Brannigan**	Director of Nursing Partnerships
	M. **Brickley**	HSCP Service User Representative
	A. **Bowman**	HSCP Acute Services Lead Representative
	J. **Duffy**	Trade Union / Employees Representative – EDC
	A. **McCready**	Trade Union / Employees Representative - NHS
	G. **Morrison**	HSCP Clinical Lead Representative

Rhondda Geekie (Chair) presiding

Also Present:	S. **Cairney**	HSCP Head of Strategy, Planning & Health Improvement
	J. **Campbell**	Shared Services Manager - EDC
	M. **Cunningham**	Corporate Governance Manager - EDC
	J. **Hobson**	HSCP Interim Chief Finance Officer
	G. **Mackintos**h	Housing Manager
	F. **McCulloch**	Planning & Performance Manager
	L. **Tindell**	Organisational Development Lead NHSGGC
	J. **Robertson**	Audit & Risk Manager - EDC / HSCP Chief Internal Auditor

APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Councillor McNair, A. Martin, W.Hepburn, C.Shepherd and G. Thomson

1. MINUTE OF MEETING – 11 FEBRUARY 2016

There was submitted and noted minute of meeting of the HSCP Board held on 11 February 2016. Linda Tindall agreed to examine dates for future development sessions based on responses received in relation to:- the Mental Health Team and the work of Silver Birch – a local mental health employer producing soil feed and plants; a future seminar on HSCP activiites integrating with the "Place" model being used for community engagement across East Dunbartonshire.

2. CHIEF OFFICER'S REPORT

The Chief Officer submitted a Report HSCP/013/16/KM, 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 February meeting of the Shadow Integration Joint Board.

In particular the Chief Officer highlighted the following:-

Local Implementation – Progress Update:-

Following discussion and agreement at the HSCP Board Meeting on 11th February the Chief Officer notified the Community Planning Partnership of the decision made by the HSCP Board on the proposal for joint resourcing of community police officers in Place areas. At the request of the HSCP Board the HSCP Head of Strategy was asked to prepare a paper to be brought to a future meeting of the HSCP Board which identifies the current levels of HSCP support and activity provided in "Place" areas.

The NHS GGC Review of Complex and Continuing NHS Care is on-going. The HSCP Head of Adult and Primary Care is involved in the group undertaking this work and will bring a report to the HSCP Board when proposals have been developed for the future service provision, the report will set out for the HSCP Board the impact of the proposals on local service provision.

Following discussion at the HSCP Board meeting in February, Linda Tindall has circulated to Board members suggested development sessions and visits and is collating feedback so that dates for these sessions can be agreed and organised.

Interviews for the Chief Finance and Resources Officer took place on Thursday 23rd March; the Chief Officer provided a verbal update on the outcome of the interviews at the HSCP Board meeting on 31st March – Jean Campbell former Shared Services manager and accountant with EDC..

The annual external audit plan for the HSCP Board is currently in draft and issued to officers for comment. The final plan will be submitted to the next meeting of the HSCP Audit Committee.

The Standards Commission, Scotland, has written to all HSCP Chief Officers in March 2016 to advise that the Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003 requires the Standards Commission to approve the Standards Officer of devolved public bodies, where that body has no employees. This applies to Health and Social Care Integration Joint Boards. The Chief Officer has provided the Standards Commission with information requested by them in order that the Standards Commission can consider granting approval of the Chief Officer as the nominated Standard's Officer for the HSCP Board.

At a Special Meeting of East Dunbartonshire Council held on Thursday 17th March 2016 the Council agreed a proposal for the incorporation of Children's Social Work and Adult Criminal Justice Services into the delegated functions of the HSCP Board. A copy of the report (CST/027/16/AD) is attached at Appendix 1. The next report on the agenda provides an outline of the process by which the current HSCP Scheme of Integration for Adult services will be revised to include delegation of NHS Children's Services functions, as previously agreed and consulted on during February 2016, and Children's Social Work and Adult Criminal Justice Services functions. The Council and the Health Board must approve the revised draft Scheme of Integration and the HSCP Board must undertake a further consultation process with the statutory stakeholders on the revised Scheme before it can be submitted to the Scottish Government for Parliamentary approval.

A formal transition plan will be developed and a report submitted to the HSCP Board detailing the transition arrangements to be established until the Parliamentary approvals process for the revised Scheme has been completed.

National Implementation Progress Update.

Scottish Government is currently consulting on draft refreshed guidance, following work in collaboration with Social Work Scotland and the Chief Social Work Officers Group, with a view to publishing finalised guidance in March 2016. COSLA members have been invited to endorse the guidance, with the proviso that any substantive changes, following consultation, would result in the guidance being brought back to the COSLA Executive Group meeting in June 2016. A copy of the draft guidance was attached at Appendix 2.

A National Clinical Strategy was published in February 2016 which sets out a framework for the development of health services across Scotland for the next 15 years. The Strategy does not give prescriptive details; it is designed to give an evidence-based, high-level perspective of why change is needed. It is intended that the National Clinical Strategy will provide a unifying direction to the range of complex service reviews currently underway in Scotland. The National Clinical Strategy can be accessed at http://www.gov.scot/Publications/2016/02/8699

Scottish Government (Integration and Reshaping Care Division) issued draft guidance for Health and Social Care Partnerships on Performance Reporting for comment during February 2016. A copy of the draft guidance was attached at Appendix 3. Partnerships are required to have regard to this guidance when preparing performance reports. The HSCP Head of Strategy will review the guidance and ensure that the HSCP annual performance report meets the minimum statutory requirements for the annual report whilst developing a report which best suits local needs. Scottish Government has offered to provide further support to Partnerships to help them develop their own report.

A final version of Good Practice Note on Directions from Integration Authorities to Health Boards and Local Authorities was issued by Scottish Government on 11 March and was attached at Appendix 4. At the inaugural meeting of the HSCP Board on 3rd September 2015, the HSCP Board agreed the recommendations in paper IJB/018/15/KM which set out the delegation and direction of functions and services to the HSCP Board, in compliance with the guidance.

Attached at Appendix 5 was the summary and recommendations from the most recent in the health and social care series of reports produced for the Accounts Commission by Audit Scotland, published in March 2016. The full report can be accessed at http://www.audit-scotland.gov.uk. The majority of the recommendations in the report are for Scottish Government. The recommendations identified for NHS Boards, Councils and Integration Authorities, working together in the first year of integration, will be considered by HSCP officers as part of our on-going planning and service redesign work.

The Director of Health Finance for the Scottish Government issued a letter to NHS Board, and Council Chief Executives and the HSCP Chief Officers on 14 March 2016, confirming that NHS Boards are required to delegate the full £250 million allocated in the December Spending Review to their Integration Authorities. A copy of the letter

was attached at Appendix 6. The finance paper for the HSCP Board meeting on 31st March 2016 identifies East Dunbartonshire HSCP share of the £250 million as £4.31 million and sets out the detail of how the allocation will support funding of social care.

Scottish Social Services Council published their annual report, A trusted, skilled and valued social service workforce, in March 2016. A copy of the report can be accessed athttp://www.sssc.uk.com. The report provides an up to date picture of social service workforce regulation and workforce improvement. SSSC intend to produce an annual update which delivers facts and figures that will help identify trends, challenges and opportunities for the social care workforce.

There have been a number of communications from Scottish Government during February and March setting out more detail on the various funding streams announced for Primary Care and on the Transitional Quality Arrangements for the 2016/17 General Medical Services (GMS) Contract. NHS GGC is developing a coordinated approach across all 6 HSCPs in response to these communications, which were attached at Appendix 7.

In addition to the Primary Care Transformation Fund the Cabinet Secretary for Health announced an additional package of measures at the BMA annual Scottish Conference of Local Medical Committees on 11 March 2016. A copy of the press release was attached at Appendix 8 and set out additional funding support for GPs worth £20 million over the next year. The funding is intended to provide short term support to General Practice while work is on-going on long term, sustainable change.

Following consideration, the Board agreed to:

a) Note the decision made by East Dunbartonshire Council on the further delegation of social work functions;
b) Note the progress made with local implementation of integration plans;
c) Note the information provided on national strategy and guidance relevant to health and social care integration; and
d) Welcome confirmation of the £4.31 million allocation to East Dunbartonshire HSCP to support social care pressures, Fair Wage proposals and reform of services.

3. SCHEME OF INTEGRATION

Report HSCP/014/16/KM by the Chief Officer, copies of which had previously been circulated, advising the HSCP Board that in addition to the agreement by the Council and the Health Board to revise the Scheme of Integration to include delegation of the functions of local NHS Children's services, the Council, at the Special Council Meeting held on 17th March 2016, has proposed that Children's Social Work Services and Adult Criminal Justice Services functions are also delegated to the HSCP. This will require a further revision of the Scheme of Integration and statutory consultation on the revised Scheme and Scottish Parliamentary approval of the revised Scheme.

Following consideration, the Board agreed to:

a) Note the agreement by the Council on the 17th March 2016 to the proposal to incorporate Children's Social Work Services and Adult Criminal Justice Services as delegated function to the HSCP;
b) Request that the Chief Officer, with support from Council and NHSGGC officers, develop a transition plan which secures approval of a revised Scheme of Integration extending the delegated functions of the HSCP Board, for approval by the Council and GGC Health Board; and
c) Requests that the Chief Officer submits the detailed transition plan to the next HSCP Board meeting.

4. FINANCE REPORT

Report HSCP/015/16/KM by the Interim Chief Finance Officer, copies of which had previously been circulated, updating the Board on the HSCP's likely out-turn for 2015/16 and the opening position and outlook for 2016/17. The Board noted the HSCP would generate a surplus in 2015/16 which could be carried forward as a reserve into 2016/17 for investment or as transitional finance to provide relief for any slippage in the savings plan.

Following consideration, where members highlighted the conflicting timetables for year-end processes for the Health Board, the Council and the HSCP, the Board agreed to:

a) note the expected out-turn for 2015/16;
b) the Council's contribution to the HSCP and note the allocation of Integration funding; and
c) note the current position in respect of finalising the NHS component of the HSCP budget for 2016/17 and progress towards identifying plans against the indicative savings target for 2016/17.

5. STRATEGIC PLAN – 2015/18 - ANNEXES 1 – 4

Report HSCP/016/16/KM by the Chief Officer, copies of which had previously been circulated, presented the Board with a suite of annexes that informed and supported the delivery of the East Dunbartonshire HSCP Strategic Plan 2015-18. Members noted that the four Annexes were as follows: Annex 1 – Strategic Commissioning Plan; Annex 2 – Joint Strategic Needs Assessment; Annex 3 – Market Position Statement; and Annex 4 – Housing Advice Note.

Following consideration, the Board noted the increasing levels of bureaucracy from Scottish Government rather than a focus on the outcomes from IJBs. Therreafter the Board agreed to approve each of the four Annexes to the East Dunbartonshire HSCP Strategic Plan 2015-18.

6. DELAYED DISCHARGES ACTION PLAN UPDATE

The Chief Officer presented Report HSCP/017/16/KM, copies of which had previously been circulated, advising the Board on the progress being made in relation to the Delayed Discharges Action Plan. Members noted 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 the funding and the Action Plan to support progress.

Thereafter the Board noted the contents of the Report.

7. PERFORMANCE REPORT – QUARTER 3 – 2015/16

The Chief Officer submitted Report HSCP/018/16/KM, 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 October - December 2015 (Quarter 3). Members noted the Board agreed to receive and consider quarterly performance reports on the progress of an agreed suite of measures and targets against the priorities set out in the Strategic Plan.

Following consideration, the Board agreed to consider the performance report and monitor progress.

8. CARE OF GARDENS SCHEME

The Chief Officer presented Report HSCP/019/16/KM, copies of which had previously been circulated, providing the Board with an overview of the Care of Gardens Scheme. Members noted that 'The Public Bodies (Joint Working) (Scotland) Act 2014' requires Health Boards and Local Authorities to integrate certain adult health and social care services.

Delegated functions include the provision of gardening assistance for the disabled and the elderly. Within East Dunbartonshire the Care of Gardens Scheme is currently operated by Neighbourhood Services Streetscene, with administrative functions carried out by the Council Shared Services Team.

Following consideration, the Board agreed to:

a) Note the content of the Report;
b) Approve the continued charging policy and service subsidy; and
c) Approve the development of a garden sizing exercise to allow a more reflective charging policy to be applied to either the subsidised or full costs recovery service.

9. AIDS & ADAPTATIONS – DELEGATED FUNCTIONS

Report HSCP/020/16/KM by the Chief Officer, copies of which had previously been circulated, advised the Board of the procedures and working practice for implementation and monitoring of Aids and Adaptations for both EDCl owned and privately owned properties. This Report was complemented with a presentation by Grant Mackintosh, EDC Housing Manager. Members noted there were different processes in place for the provision of Aids and Adaptations to council owned properties and privately owned properties. The Council's Housing Strategy Team is responsible for the budget monitoring but the process for works is carried out by various cross departmental teams.

Following consideration, the Board agreed to:

a) Note the information within the paper; and
b) the process for on-going monitoring.

10. EQUALITY PLAN MAINSTREAMING POSITION STATEMENT

Report HSCP/021/16/KM by the Chief Officer, copies of which had previously been circulated, provided the Board with a draft copy of the Equality Plan Mainstreaming Position Statement 2016/17 for approval. Members noted the HSCP was directly accountable for developing a set of measurable equality outcomes with associated performance reports which ensured all new policies and practices were reviewed and would mainstream the Equality Act General Duty.

Following consideration, the Board agreed to the Equality Plan Mainstreaming Position Statement 2016/17.

11. EAST DUNBARTONSHIRE TOBACCO ALLIANCE – ASH SMOKE FREE CHARTER

Report HSCP/022/16/KM by the Chief Officer, copies of which had previously been circulated, presented a summary of actions towards the implementation of an East Dunbartonshire Smoke Free Charter. Members noted that the Scottish Government aspiration was for a tobacco-free Scotland by 2034. A 'tobacco-free' Scotland would be where smoking prevalence amongst adults would be 5% or lower.

Following consideration, the Board agreed to:

a) Note the contents of the Report; and
b) Support the Smoke Free Charter.

12. PUBLICATION OF THE REVIEW OF PUBLIC HEALH IN SCOTLAND

Report HSCP/023/16/KM by the Chief Officer, copies of which had previously been circulated, presented the Board with the findings and recommendations outlined in the Review of Public Health in Scotland and implications for East Dunbartonshire. Members noted that Scottish Ministers announced in November 2014 that they had asked for a review of public health in Scotland and had established an expert group to take this forward.

The Review Group was asked to examine: 1 - public health leadership and influence both within the health sector and more widely; 2 - how public health featured in community planning and health and social care integration; and 3 - workforce planning and development, succession planning and resourcing.

Following discussion the Board noted the focus on process and bureaucracy and the lack of strategic direction of Public Health as an organisation and its relevance to patients. Thereafter the Board agreed as follows:

a) Note the Public Health Review Report and the implications for the HSCP; and
b) Support the actions already being progressed across Community Planning through the Joint Health Improvement Plan.

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 2

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**Chief Officer Update Report**
Report by	**Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Karen Murray, Chief Officer, East Dunbartonshire Health & 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 & Social Care Partnership Board on national and local developments in respect of the Public Bodies (Joint Working) (Scotland) Act 2014, since the March 2016 meeting of the Partnership Board.

2.0 SUMMARY

2.1 The local implementation progress update highlights key activities that have been undertaken within the HSCP since the March meeting of the HSCP Board.

2.2 The national progress update identifies national guidance and correspondence, relevant to the activities and r esponsibilities of the HSCP Board issued since the March board meeting, for information. T his report aims to provide members with information to allow them to access reports and publications of relevance to the HSCP Board. There has been very little information issued from Scottish Government in the period from 1st April to the time of preparation of this report because of the Scottish Parliamentary elections.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Health & Social Care Partnership Board:

a) Notes the progress on local implementation activities
b) Requests a future report on the local implementation of the Living Wage Commitment to Care at Home and Housing Support.

4.0 MAIN REPORT

Local Implementation Update

4.1 NHS GGC Chief Executive wrote to East Dunbartonshire Council Chief Executive on 29th April 2016 to acknowledge and welcome the Council's decision to delegate Children's Social Work and Criminal Justice Social Work functions to the HSCP Board and to confirm that the NHS Board will work with the partnership and the Council to achieve the necessary steps to agree a revised Scheme of Integration.

4.2 The Chief Finance and Resources Officer, Jean Campbell was appointed following interview on 31st March 2016 and took up post on Monday 9th May 2016.

4.3 The HSCP Communication Officer, Fiona Borland has been in post since 11th April and is currently working with senior officers to develop a comprehensive communication strategy for the HSCP, which will include engagement with stakeholders to develop the HSCP identity and logo and an HSCP website that meets the needs of internal and external stakeholders.

4.4 A fixed term Project Officer has been appointed to the HSCP to revise the Scheme of Integration to include the additional functions delegated to the HSCP Board by the NHS Board and the Council. The Project Officer took up post on 12th May and is currently progressing revision of the Scheme and development of a detailed transition plan for the additional delegated functions.

4.5 The March report for older people's bed days lost to delayed discharge showed a continuation in the improving trend seen from December 2015 and the total bed days lost for 2015/16 was 3635, just within the 50% target reduction set for the Partnership from the 2009/10 outturn. A report on future plans to improve performance on delayed discharge is on the agenda.

4.6 The Chair and the Chief Officer of the HSCP Board and the Chief Executives of the Council and the Health Board met with representatives of the Scottish Government Directorate for Health and Social Care Integration on 21st April 2016. This meeting was described as a Partnership engagement meeting with Scottish Government colleagues, to provide an opportunity to discuss support for implementing integration. Scottish Government colleagues requested sight of specific documents prior to the meeting, Strategic Commissioning Plan, Directions and Financial Statement and in advance of the meeting provided some slides to provide context for discussions at the meeting. A copy of the slides is attached at **Appendix 1** and a copy of the letter received from Scottish Government following the meeting is attached at **Appendix 2**. We have provided feedback on the meeting to inform the content of future Partnership Engagement Meetings, as the majority of the discussion on 21st April was very health related. The partnership received largely positive feedback from Scottish Government colleagues on the progress made to date, acknowledging the pragmatic approach taken with the first iteration of our strategic plan because the partnership required to complete the plan to achieve the planned early go live date for the partnership in September 2015. The Strategic Needs Assessment presented to the HSCP Board in March was acknowledged as excellent and we are encouraged to translate the findings from the needs assessment into the next update of the strategic plan and link investment to improved outcomes. Scottish Government recognized that all partnerships are facing similar challenges in respect of strategic planning and they intend sharing learning from the initial plans to improve future iterations. Scottish Government intends to continue partnership engagement meetings and expect to meet with representatives from the HSCP Board and the Chief Executives of NHS Board and Council every 9 months.

4.7 Work is ongoing to progress the development of the next level of the management structure for the HSCP. The process is being undertaken in partnership between the

two employing organisations and their trades union and staff partnership representatives.

4.8 HSCP Board members should have received a communication from the NHS Board, issued on 6th May to advise of the engagement processes being undertaken on the proposal to move the GP Out of Hours Service, which currently serves people living in the Bearsden and Milngavie areas of East Dunbartonshire. An information leaflet has been issued to community groups, community councils and elected members in the areas affected by the proposed change. Information sessions are being held about the proposed change on 31st May 2016, one session in Drumchapel Hospital at 12.30pm and a later session at Gartnavel Royal Hospital at 5pm on the same date.

4.9 The Chief Officer for the HSCP has intimated to the Chief Executive of the NHS Board, the Chief Executive of the Council and the Chair of the HSCP Board, her intention to retire from the service on 30th September 2016. The Chief Executive of the NHS Board has requested the Director of HR for the NHS Board agrees the process and timetable for recruitment to the post to be taken forward, jointly with the Council. The Director of Human Resources for the NHS Board has made contact with East Dunbartonshire Council to commence the recruitment process.

National Implementation Progress Update

4.10 The Scottish Parliamentary elections were held on Thursday 5th May, and in the run up to the elections there has been very little national guidance issued.

4.11 On 9th May 2016, a guidance document, informed and agreed by Scottish Government, COSLA, CCPS and Scottish Care, was issued to support the delivery of the Living Wage Commitment to Care at Home and Housing Support. A copy of the guidance is attached at **Appendix 3**. The guidance acknowledges that implementing the Living Wage commitment will present a number of challenges and each local authority will need to undertake their own risk assessment to identify the best local solutions for implementation. This will be a significant piece of work for officers to undertake in partnership with colleagues in council legal and procurement services. An update paper on implementation of the Living Wage will be submitted to a future meeting.

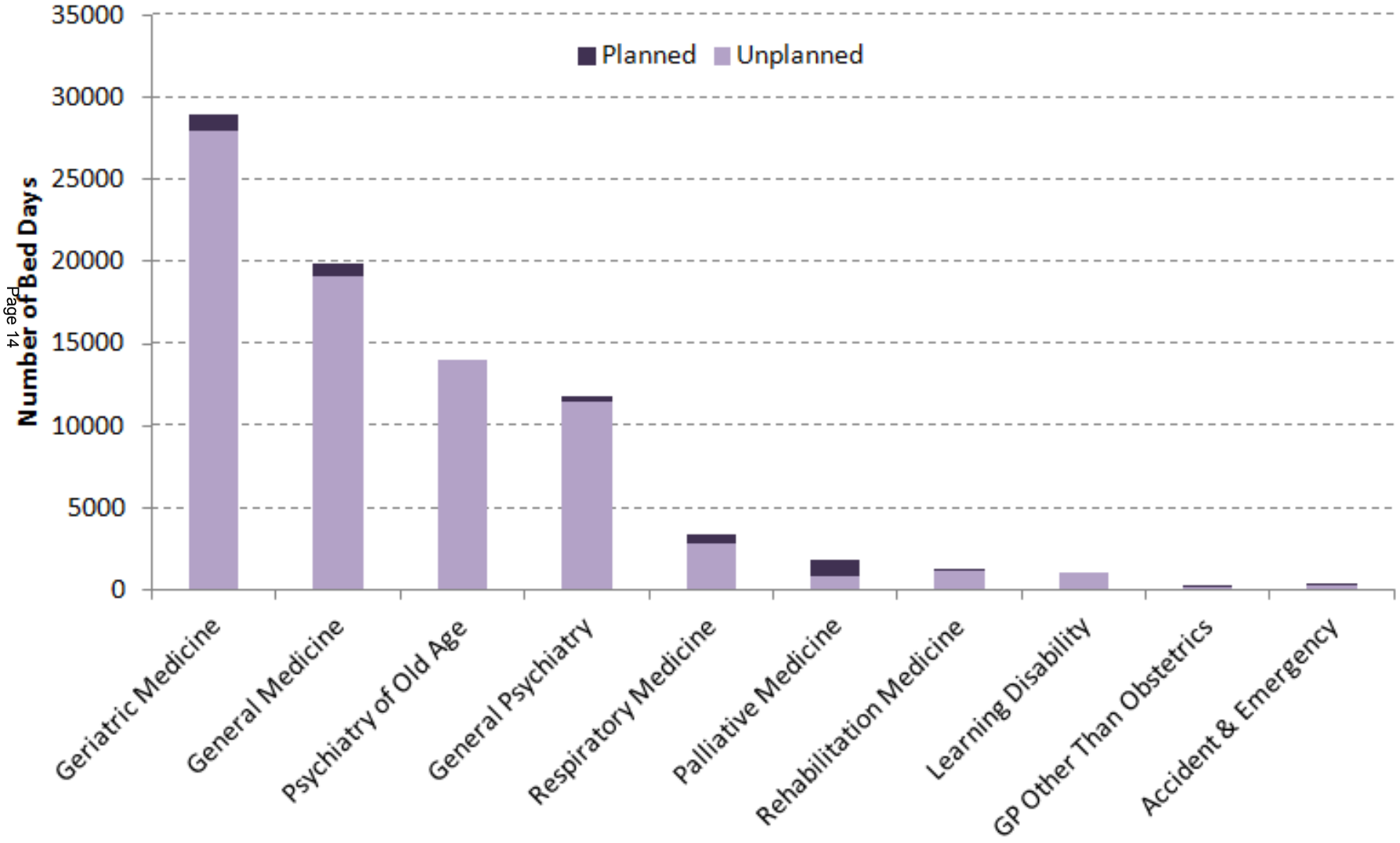
4.12 On 17th May the HSCP Chief Officer received a letter from Health Improvement Scotland (HIS) indicating that Ruth Glassborrow, Director of Safety and Improvement for HIS has been assigned to be the key point of contact with East Dunbartonshire HSCP to facilitate the linkage between local priorities for improvement support and the national and tailored support programmes on offer from HIS. Ruth Glassborrow will be in contact to arrange to discuss how HIS can help the partnership in service improvement and service redesign. Letter is attached at **Appendix 4.**

4.13 On 13th May the Director of Public Health and Intelligence for National Services Scotland (NSS) wrote to the HSCP Chair to confirm that NSS has secured funding to continue the support the HSCP has received in 2015/16 from the Information and Statistics Division (ISD) Local Intelligence and Support team for 2016/17. The ISD local intelligence and support team have provided valuable input to the preparation of our local Joint Strategic Needs Assessment, which was considered at the HSCP Board meeting in March. The ISD team have also provided the analysis of high resource individuals for health and social care and analysis of delayed discharges to help inform our plans.

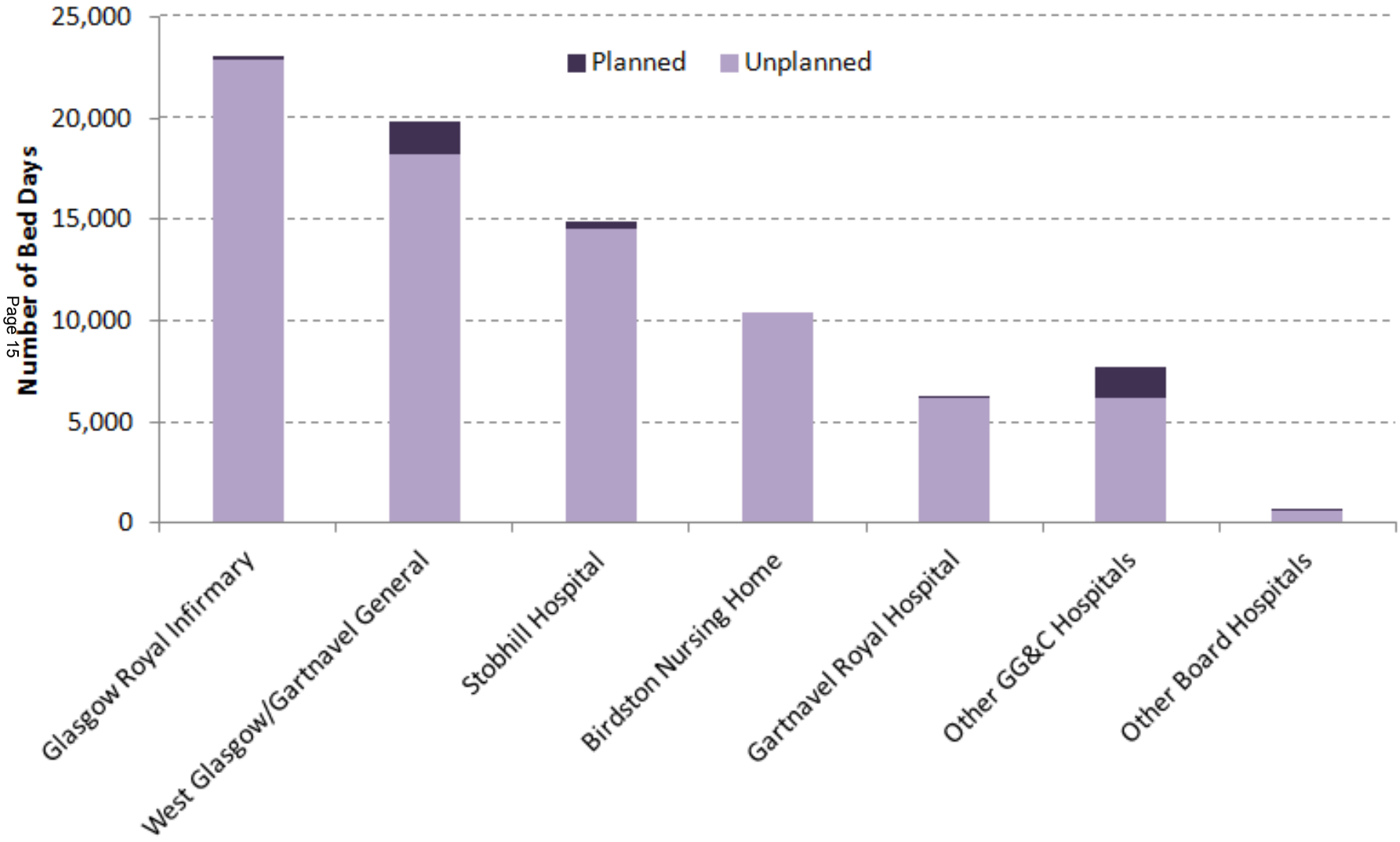
Appendix 1

East Dunbartonshire Partnership

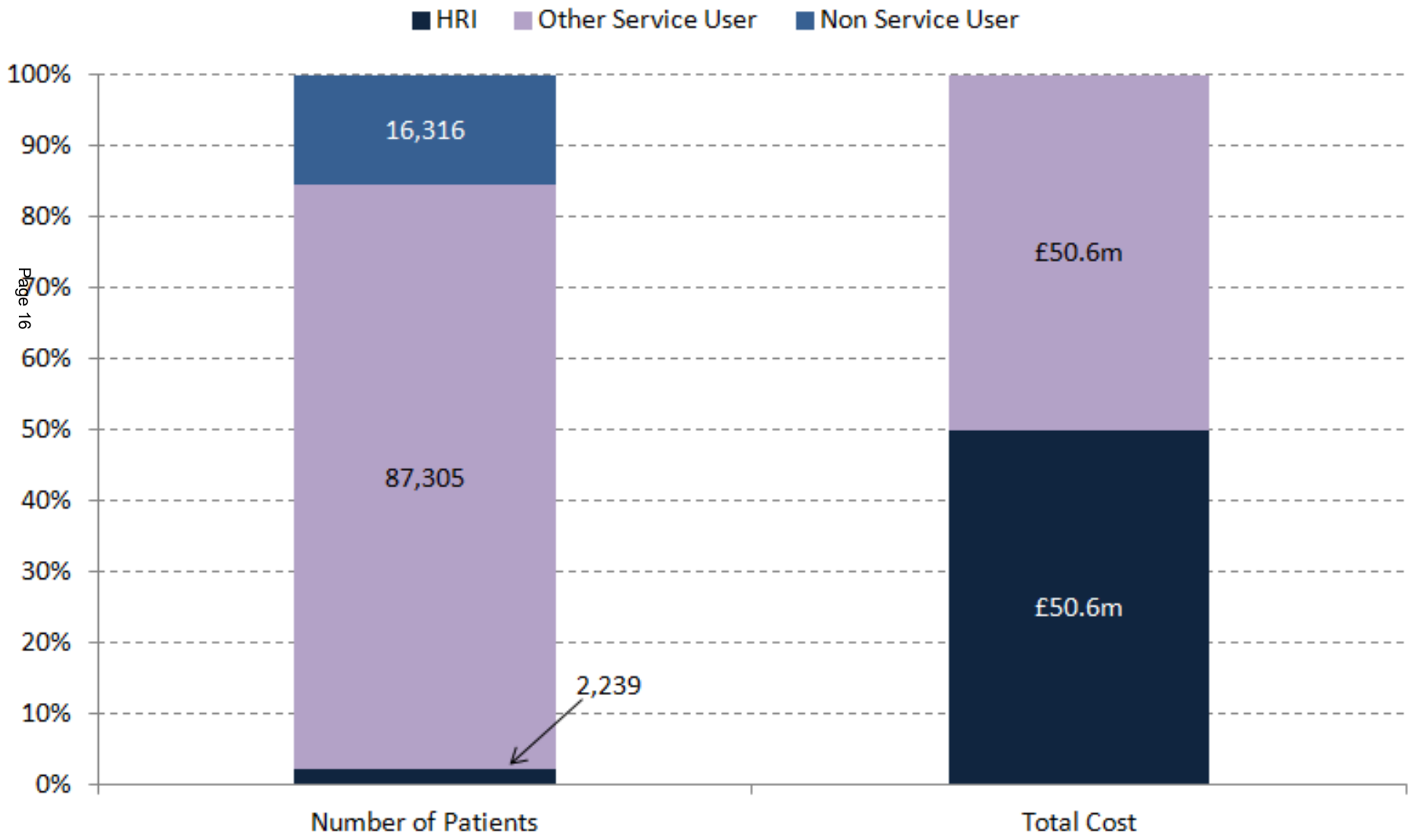
Hospital Services by Delegated Specialty



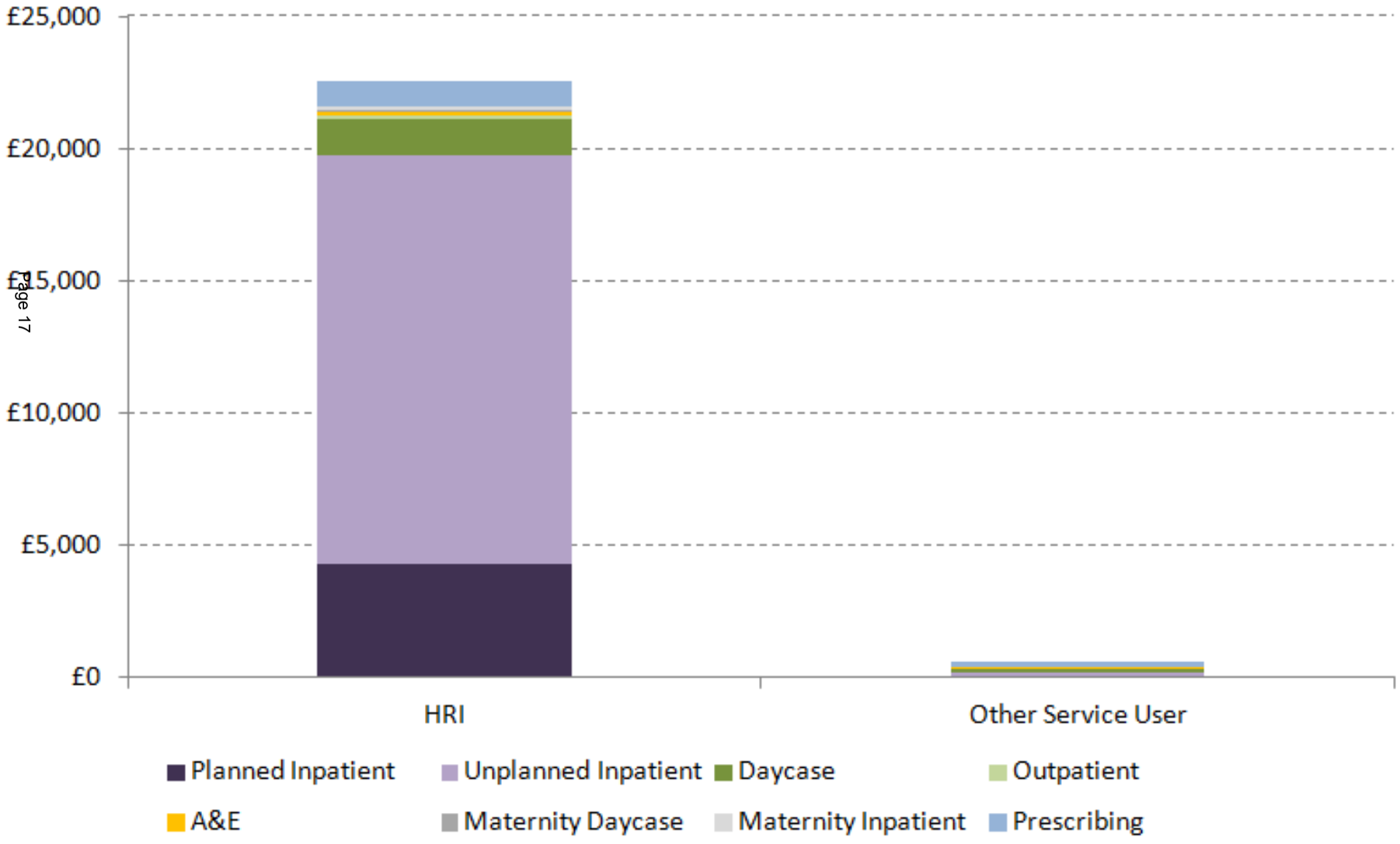
Hospital Services by Location



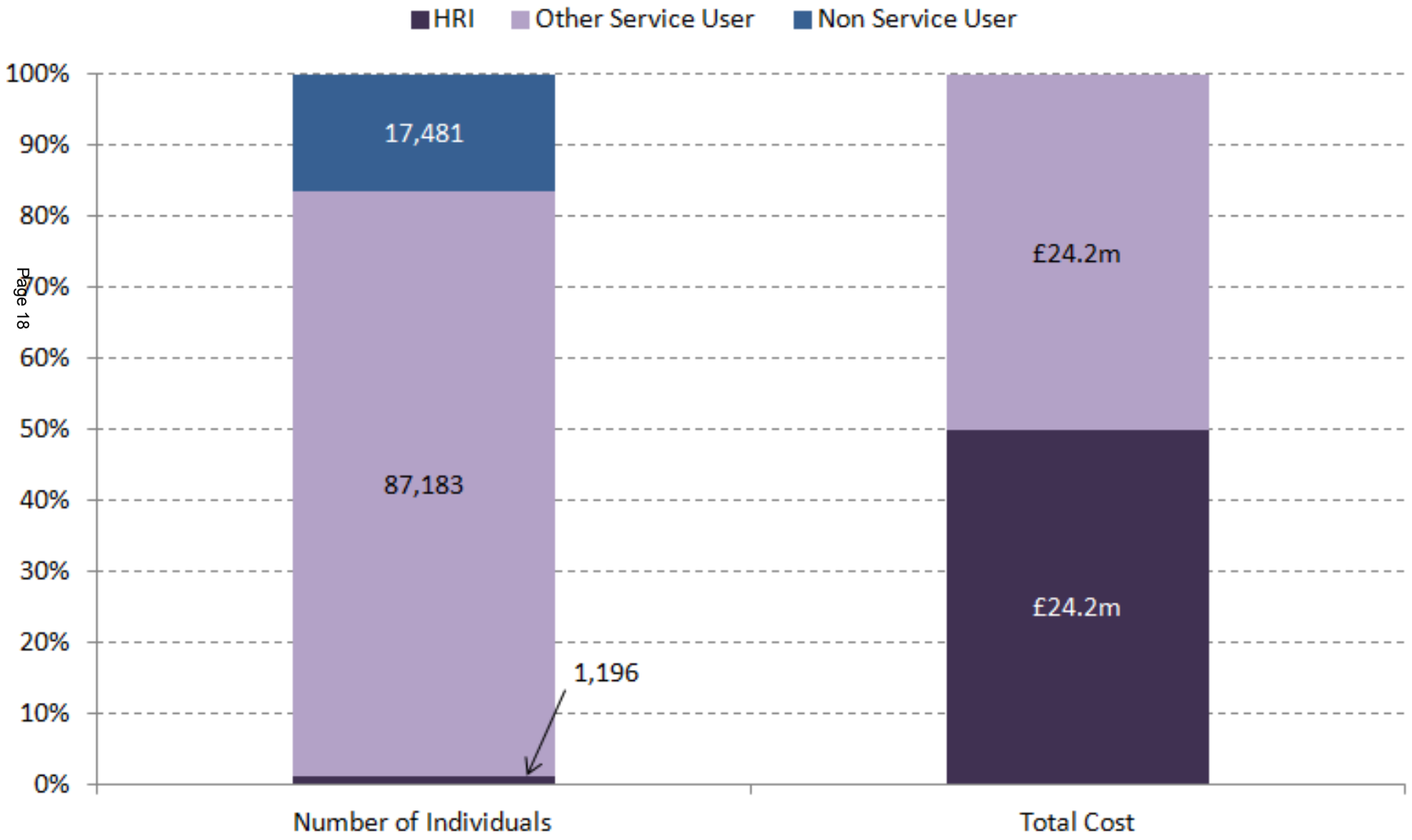
High Resource Individuals
All Specialties



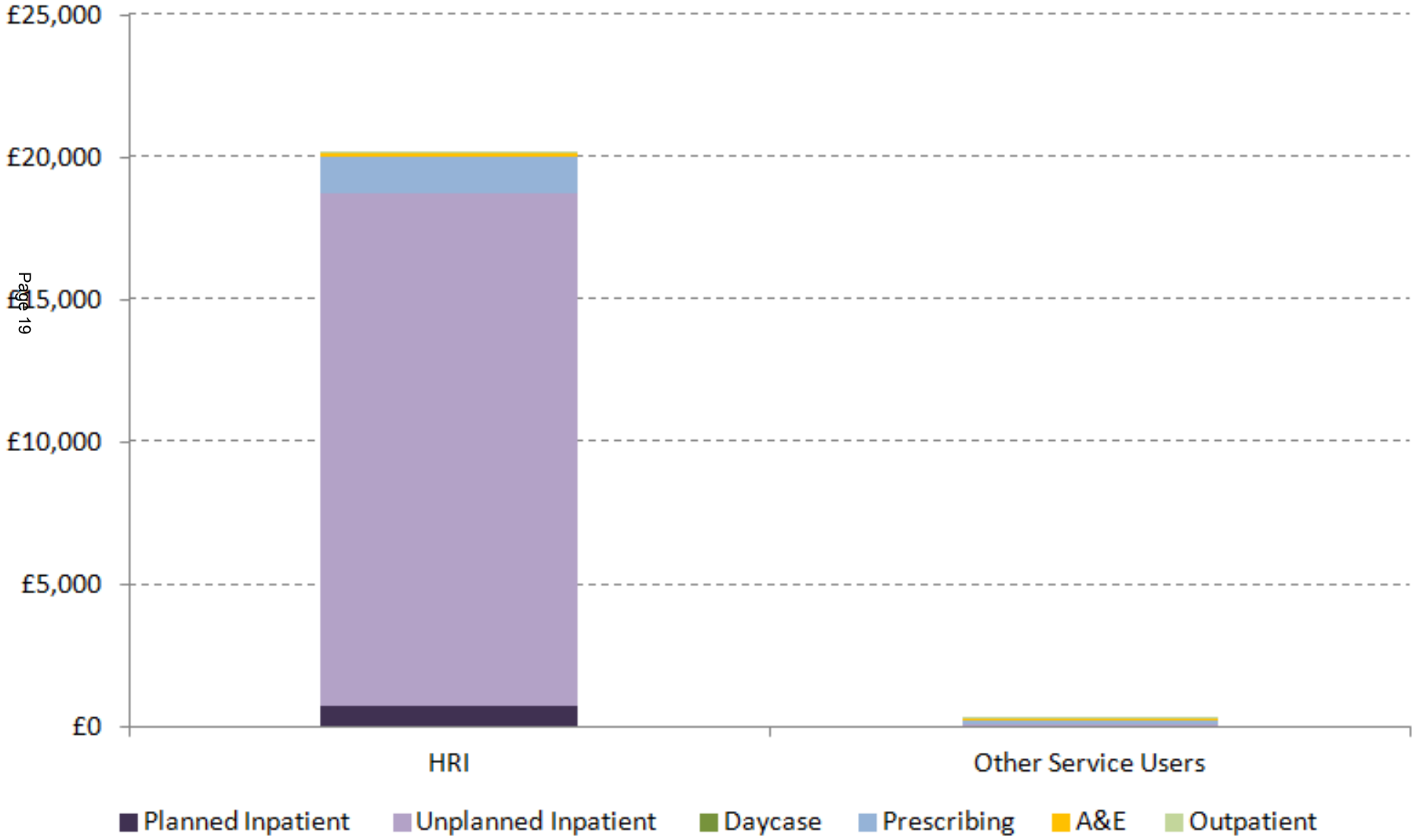
HRI Average Cost
All Specialties



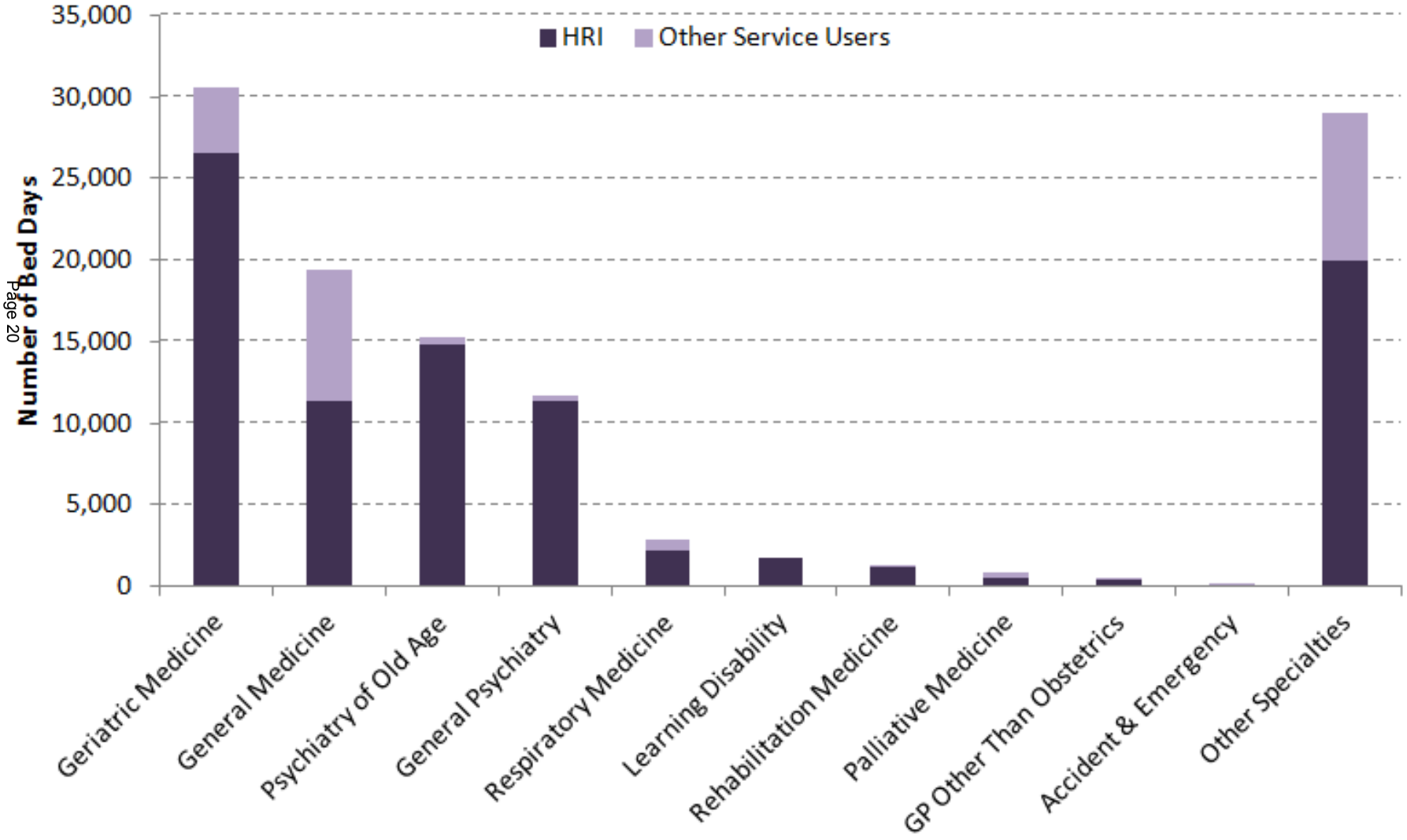
High Resource Individuals Delegated Specialties



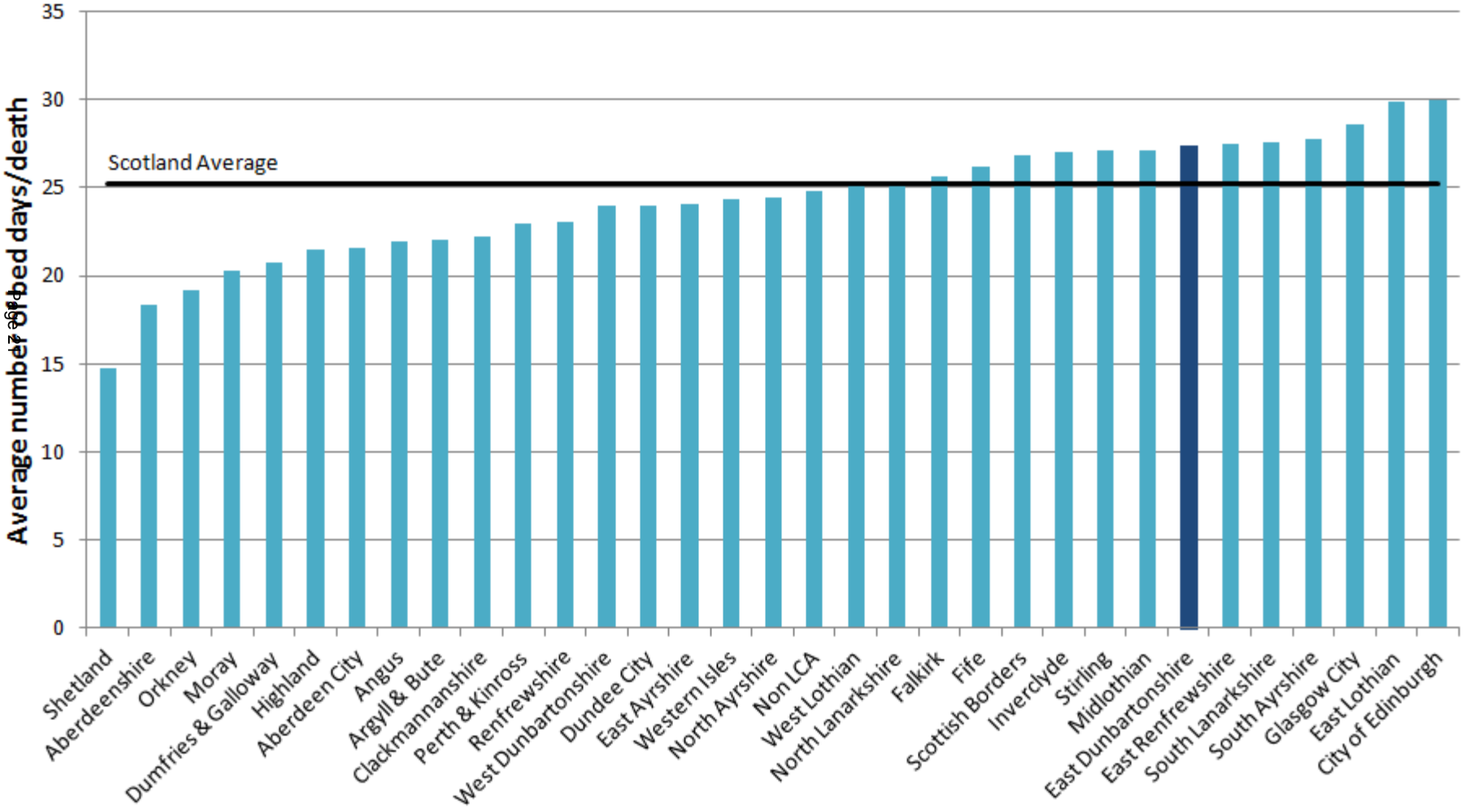
HRI Average Cost Delegated Specialties



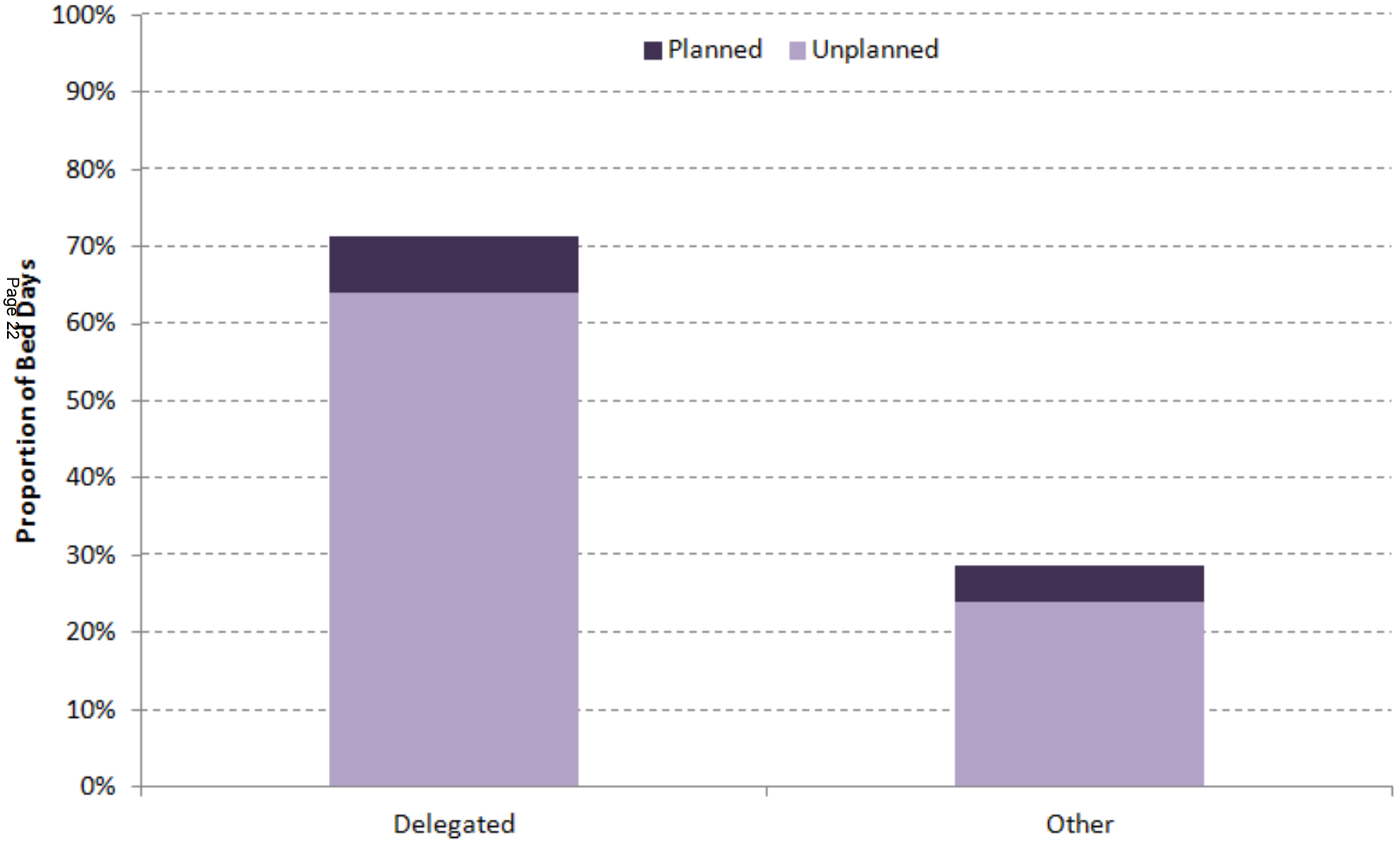
Unplanned Bed Days



Unplanned bed days in last six months of life



Bed days in last six months of life



Health and Social Care Integration Directorate

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The Scottish Government
Riaghaltas na h-Alba

Councillor Rhondda Geekie, Chair, East Dunbartonshire IJB

Ms Karen Murray, Chief Officer, East Dunbartonshire Health and Social Care Partnership

Mr Gerry Cornes, Chief Executive, East Dunbartonshire Council

Mr Robert Calderwood, Chief Executive, NHS Greater Glasgow & Clyde

22 April 2016

Dear Colleagues

Thank you for taking the time to meet with us yesterday to discuss integration of health and social care in East Dunbartonshire. We are finding this first sequence of meetings with senior colleagues from Health and Social Care Partnerships, which we intend to complete over the next two months, consistently helpful and informative. I hope you found the meeting useful too.

Karen outlined the strong progress you have already made locally, noting your recent decision to add children's social care services and criminal justice social work to the IJB's responsibilities. I explained that the process for amending the Integration Scheme to accommodate these changes should not take long once revisions have been agreed, as revised Schemes are approved by the Cabinet Secretary and do not need to be laid in Parliament. Karen also advised that she is in the process of finalising her senior management structure, and that delegated budgets were agreed on time for 2016/17 following fair and transparent discussions.

We noted your excellent Strategic Needs Assessment and discussed the challenges of translating its findings into a strategic plan that links investment to improved outcomes; your approach has been pragmatic in the first year, not least because the partnership went live early, in September last year. We noted that all partnerships share similar challenges in relation to strategic planning, and that we will be sharing learning from the first year's plans so that future iterations can be more detailed and ambitious. We also said we are about to begin a review of the national indicators, to ensure over time that they properly reflect partnerships' responsibilities; we noted Karen's observation that the key priority must be to ensure that the indicators we develop contribute to our understanding of people's wellbeing.

We discussed what support you might find helpful, and were pleased to hear that you have found your work with NSS's Local Information Support Team very valuable. The partnership previously worked quite closely with the Joint Improvement Team, and Karen indicated that it will be important to ensure that the support on offer from Healthcare Improvement Scotland, under the new iHub arrangements, is clearly articulated to local systems.

Having successfully tackled delayed discharge, we heard that you continue to experience challenges regarding care of people who lack capacity and as a consequence remain in hospital when other forms of care would be more appropriate to their needs. You noted that, in response, you have appointed additional Mental Health Officers and have improved local procedures, including availability of advocacy support. I outlined the work my team is taking forward nationally and promised to keep the partnership in touch with this.

Finally, we had an interesting discussion about the challenges you are experiencing in terms of bringing together local decision-making responsibilities, under the IJB, with the wider governance of the Health Board, which covers six partnerships. We agreed that these are important points that we will return to in due course, not least because they will offer wider learning for integration across Scotland.

We agreed that it would be useful to meet approximately every nine months. We will be in touch to arrange the next date and specific items for discussion.

Yours sincerely

Alison Taylor

ALISON TAYLOR
Head of Integration Partnerships

Guidance to support delivery of the Living Wage Commitment to Care at Home and Housing Support

1. Introduction

This guidance is a tripartite document informed and agreed by Scottish Government, COSLA, and CCPS and Scottish Care on behalf of providers. Its purpose is to support local authorities and providers in their local decision making to help implement the Living Wage commitment as part of a positive approach to fair work practices. The Living Wage commitment was agreed between Scottish Government and Local Government as part of the Local Government Settlement. Moving forward, a tripartite approach is being taken to delivery with the full involvement of providers.

The guidance deals with the particular issue of implementing the commitment to pay all care workers in adult social care regardless of age, £8.25 per hour from October 1st 2016. The guidance does not direct a particular route or mechanism for delivery but rather supports a consistent understanding of the risks that need to be balanced in taking local decisions when implementing the commitment and a description of some of the options which could be used to support the delivery of the commitment.

It is at the same time important to keep in mind when considering options for implementation that the purpose behind this commitment is to value and improve the quality of care. It is an opportunity to invest in social care as a career of choice by addressing one aspect of the recruitment and retention challenge in the sector. However it would be counter to the aim and intention of the investment if this were achieved for example at the expense of fair work practices more generally, including training, development, and broader terms and conditions etc. which influence and underpin social care as a quality career option.

These discussions are an opportunity to ensure that a focus on the quality of care and support and the drive towards continuously improving outcomes for people continues to be at the heart of this agenda. This process may also represent an opportunity in the longer term for Integrated Joint Boards and local authorities in collaboration with partners, to review models of care and revise commissioning, procurement and contract monitoring policies and processes which can support and drive improved and innovative services.

It should be noted that every local authority will need to take a range of local advice in deciding a way forward including legal, financial and professional advice in addition to this guidance. This reflects the fact that the risks present in each local authority will differ due to local circumstance and local employment and market dynamics.

2. Background

The Living Wage commitment made by Scottish Government and Local Government as part of the 16/17 settlement is to ensure that the Living Wage of £8.25 per hour from October 1st 2016 is paid to care workers providing direct care and support to adults in care homes, care at home, and housing support (as per the Scottish Social Service Sector report on Workforce Data). This covers all purchased services, including specialist support services such as those for people with physical disabilities, learning disabilities, mental health difficulties and substance misuse issues. The new rate applies for all hours worked and therefore encompasses sleepovers, travel time and holiday pay and should be achieved as part of a positive approach to fair work practices.

Personal assistants employed via Self-Directed Support (Option 1 – Direct Payment) were not explicitly included in the commitment to deliver the Living Wage of £8.25 per hour for adult social care workers. However, Local Authorities may be at risk of challenge with regards to principles of equal treatment and discrimination if allowances aren't sufficient to pay a personal assistant the Living Wage of £8.25. The Scottish Government will make arrangements to ensure that people supported under the Independent Living Fund are also enabled in this way. We will work with Self-directed Support Scotland, Centres for Inclusive Living and Personal Assistant Employers Network to encourage the payment of Living Wage to all personal assistants. Local authorities will not be accountable for ensuring Living Wage is paid to personal assistants directly employed by an individual.

The Scottish Government and Local Government have provided resources to contribute to this commitment for 2016/17 within the £250m Health and Social Care monies. However, it will be important to bear in mind that as well as the increase to basic pay, employers will incur additional costs including National Insurance contributions, employer pension contributions and adjustment of pay differentials with the organisation. This will affect the total cost of the commitment. Costs are also likely to vary locally depending on local markets including employment, provider business models and on the implementation method adopted.

The agreement to pay £8.25 per hour to adult social care workers from 1st October 2016 is part of an overall Local Government settlement. Within the terms of the 2016/17 settlement, councils are required by the Scottish Government to deliver on a package of commitments. If a council does not deliver on these commitments, including the Living Wage commitment, then the Scottish Government has stated that it reserves its position to take action to remove access to, or recover, the specific funding identified in the settlement letter. This settlement agreement between Scottish Government and Local Government was predicated on providers making a contribution to the overall cost of the Living Wage commitment. Providers were not party to this formal agreement.

The scale and timeframe for implementing the Living Wage means that a collaborative approach between commissioners and providers will be critical. Local authorities will need to engage care providers in negotiations to reach a voluntary agreement and this will be facilitated by a funding process that is fair, transparent and collaborative, and achieves 'buy-in' from providers. This approach in itself should reduce the risk of challenge and increase the likelihood of compliance and a successful voluntary agreement.

It is also important to keep in mind that this commitment is not, as of yet, a commitment to the Living Wage as an ongoing benchmark for wages, but to the delivery of £8.25 per hour from October 1st 2016. Any further commitments would be subject to spending review negotiations for 2017/18 and beyond. However, in implementing this year's commitment local authorities may wish to be cognisant of the potential for further commitments to the Living Wage as these may be driven by local decisions and prioritisation as well as national ones.

3. Implementation

We acknowledge that implementing this commitment will present a number of challenges - some to do with matters of legality around procurement and state aid and others relating to adhering to social care policy legislation and principles. However, these need not be prohibitive and there are a number of options which should be considered so as to minimise any risks which may be present. Some of these are described below although this cannot be taken as universal legal advice and the application of this guidance will need to be judged on a case by case basis by each local authority according to their specific local circumstance. **There is no single answer which will work for all care arrangements and local authorities are best placed to undertake a risk assessment to help them identify the best local solution.**

In this guide we seek to highlight some of the areas of particular vulnerability. The risks associated with procurement and state aid are of particular importance but so too are wider social care policy and principles.

Partners should therefore ensure that their selected mechanism:

- Supports the intention of improving the quality of care by investing in the workforce;
- Supports the recruitment and retention of the right people to support and promote stability and continuity of care and support for the user;
- Prioritises choice and control for people supported by care services;

In addition, the delivery mechanism should take into account the key considerations that a contracting authority should have before and when procuring care and support services, including the key principles of fairness; transparency; and collaboration with partners, those with an interest and those affected. Further details are provided in supporting guidance. It is worth noting that having considered and evaluated these risks transparently before making a decision about which mechanism to choose is in itself a protective measure which, done in collaboration between authorities and providers, is likely to limit the potential for challenge and the risk of a successful challenge to the decisions taken.

While cost is not the only, nor necessarily the dominant factor in commissioning services, affordability will be a key question to address when considering the delivery mechanisms for implementation. It is suggested that if they have not already done so, local authorities formally establish the breadth of the current wage rates paid to care workers by providers in their local area as well as any other costs associated with a minimum wage rate of £8.25. Understanding the full cost of this commitment as thoroughly as possible will help with the immediate implementation and the costing of any future commitments.

4. Procurement and fair work, including the Living Wage

The Scottish Government has obtained clarification from the European Commission on the application of the Living Wage in procurement processes. This confirms that contracting authorities are unable to make the payment of any specified wage rate above the legal minimums enshrined in law a mandatory requirement as part of a competitive procurement process. In the UK, this is the National Minimum Wage and National Living Wage, dependant on age. It is, therefore, not possible to reserve any element of the overall tender score specifically to the payment of the Living Wage.

However, where relevant to the delivery of the contract, it is possible for a contracting authority to take account of a bidders approach to fair work practices which includes, for example, the payment of £8.25 per hour, and to evaluate this as part of the procurement process. Fair work practices will be particularly relevant to consider where the quality of the service being delivered is directly affected by the quality of the workforce engaged in the contract. The Scottish Government has issued statutory guidance on this issue.[1]

Evaluation criteria in a tender process must be relevant and proportionate to the subject matter of the contract being let and it is for contracting authorities to determine the balance that meets their requirements for the service. In a sector such as care services, where quality and continuity of service and low staff turnover are likely to be closely related to fair work practices such as recruitment, remuneration and other terms of engagement, the weighting being given to fair work practices will be particularly significant in contributing to the desired outcome for quality of service. A contracting authority therefore does have a significant discretion to set evaluation criteria in a way that recognises the impact of fair work practices on the quality of the services, and therefore a higher percentage weighting for fair work practices, including the payment of £8.25 per hour, is likely to be justified. Where a contract is let in compliance with the relevant legislation, there is limited scope for a tenderer to challenge the weighting which is assigned to evaluation criteria.

When evaluating fair work practices as part of a procurement exercise contracting authorities must consider a bidder's overall approach to fair work and all bids must be treated equally. This should include consideration of all relevant evidence, including (but not limited to) recruitment, remuneration, terms of engagement, skills utilisation and job support and worker representation. A bidder's approach to fair work practices may vary depending on the bidder's size and the scope of the contract and the contracting authority must take a measured and balanced approach based on this.

The statutory guidance states that any decision to include a question on fair work practices should be made on a case by case basis taking into account commitments set out in the contracting authority's procurement strategy. The question should be framed in a way that is consistent with the principles deriving from the Treaty on the Functioning of the European Union: transparency, equality of treatment and non-discrimination.

[1] http://www.gov.scot/Resource/0048/00486741.pdf

A commitment to pay £8.25 per hour to adult social care workers would be a strong indication of a positive approach to fair work practices. Payment of the Living Wage is not the only indicator of fair work, however, and it should be emphasised that whilst failure to pay the Living Wage would be a strong negative indicator it does not mean that the employer's approach automatically fails to meet fair work standards. The question should ask bidders to describe the package of measures which demonstrates their positive approach to fair work practices in delivering the public contract. This context further demonstrates the need to progress this commitment as far as possible in collaboration and through the voluntary agreement of providers.

5. State Aid

Entering into a contract following an open and transparent procurement procedure which complies with the relevant legislation would be unlikely to raise any state aid risks. Similarly, varying a contract in a way that is compatible with procurement legislation should not constitute an award of unlawful state aid. Where there are doubts as to the state aid position, additional support to undertakings should be given in a manner that is compliant with state aid requirements.

The state aid position will always depend on the particular factual (local) matrix at hand and there will inevitably be cases where the state aid position is not clear. Where there is a risk that a measure constitutes state aid, appropriate mitigation measures should be taken. This may include awarding uplifts under the general de minimis regulation[2].

Local authorities will inevitably need to form their own view on the state aid compatibility of any particular locally applied measure.

6. Best Value and Procurement

Generally Scottish Government policy requires that contracts are awarded through a genuine and effective competition which also enables local authorities to evidence best value. However, in relation to contracts for health or social services, the Procurement Reform (Scotland) Act 2014 (Section 12) makes provision for authorities to award contracts without competition where their value is lower than the EU threshold of €750,000 (the relevant guidance provides further detail). Those contracts or framework agreements with a value greater than, or equal to €750,000 can all apply 'light-touch' provisions (described in regulations 74-76 of The Public Contracts (Scotland) Regulations 2015).

Below the EU-regulated procurement threshold the European Commission has confirmed that these services will 'typically not be of interest to providers from other Member States, unless there are concrete indications to the contrary, such as Union financing for cross-border projects' [3]. However, it is for a contracting authority to assess whether there is cross-border interest. As such a public body should decide on a case-by-case basis whether or not to seek offers in relation to proposed contracts or framework agreements with a value of £50,000 or more, but less than €750,000. It is important to highlight that the Treaty on the Functioning of the

[2] Commission Regulation 1407/2013, OJ L352/1, 24.12.2013

[3] EU Directive 2014/24/EU, Recital, 114

European Union fundamental principles should always be considered where relevant.

Public bodies should secure best value by balancing quality and cost and having regard to efficiency, effectiveness, economy, equal opportunities and sustainable development. Public bodies should determine the appropriate quality/cost ratio. When procuring care and support services, greater emphasis should be placed on quality rather than cost as far as practicable.

7. Monitoring

Scottish Government will be assured of the use of the allocated contribution via the Integration section 95 officer sign-off process. Local Government will be responsible for ensuring that this commitment is delivered through local contracts and agreements. The settlement agreement between Scottish Government and Local Government was predicated on providers making a contribution to the overall cost of the commitment.

Given that a council cannot direct or stipulate that the Living Wage of £8.25 per hour is paid as part of a procurement process, any agreement to do so would need to be voluntary and agreed in partnership with providers. Where, following a compliant procurement process, a provider emerges as the preferred bidder, they cannot be disqualified on the basis that they do not commit to the Living Wage. However, the main scope for mitigating this risk lies in the contracting authority's ability to take account of a bidder's approach to fair work practices as part of the evaluation criteria as detailed above and working collaboratively and in partnership with providers to seek a voluntary agreement.

Once agreed, the monitoring of that commitment can be a condition of contract and be a part of the contract management process. Effective contract management and monitoring should also ensure that wider fair work practices, as agreed within the contract, continue to be applied throughout the duration of the contract, e.g. by requesting information on the pay, terms and conditions of workers involved in the delivery of the contract. In the longer term, this should also help to monitor the outcomes and impact of increased wages on the quality of services which people receive.

8. Delivery mechanisms - Identifying and assessing risk

The mechanism used to deliver the Living Wage commitment is a matter for local authorities to decide and will depend upon a local assessment of the risks presented by each of the options.

No option is entirely risk free. How the procurement rules apply; what local financial regulation and local standing orders say; and the benefits and risks to service users of each approach will need to be individually assessed according to local circumstance. All these options are equally applicable to self-directed support, including Direct Payments.

The key risks that will need to be considered and weighted against the overall objective include:

1. Social care outcomes
2. Impact on the quality of care
3. Proportionality of the mechanism
4. The impact on local trade and the local market
5. Compliance with state aid and procurement rules
6. Best value
7. Impact on market continuity

(a) Modification / contract variation

There are a number of relevant factors to take into account when determining whether modification of a particular contract is permissible and authorities should take advice in relation to specific contract variations.

Local authorities will need to consider the particular context for each proposed variation and look to provisions of regulation 72 of the Public Contracts (Scotland) Regulations 2015, which provide further detail of the circumstances in which a contract can be varied. The provisions of regulation 72 only apply in a strict sense to contracts valued at €750,000 or above. Contracts below this value are less likely to be of interest to operators in the rest of the EU and contracting authorities are not bound by the restrictions in these cases where there is no evidence of cross border interest [4].

However, when calculating whether the 10% threshold referred to in regulation 72(5) of the Public Contracts (Scotland) Regulations 2015 has been exceeded, the element which is taken into consideration is that which relates to the monies paid by the contracting authority: any contribution by the provider does not form part of the contract sum. In this context we also draw authorities' attention to regulation 72(1)(5)(a) which requires that any modifications under regulation 72(1)(5) are also below the regulation 5 threshold.

Varying a contract in a way that is compatible with the relevant legislation should not constitute an award of unlawful state aid. Where there are doubts as to the state aid position, additional support to undertakings should be given in a manner that is compliant with state aid requirements.

There are a number of ways that a council can vary the contract in order to pay the Living Wage of £8.25 per hour. These are detailed below, and it may be necessary to adopt a range of approaches or take a staged approach and implement the commitment using one mechanism while considering another mechanism for a longer term approach if required.

[4] Scottish Government has recently published Guidance on the Procurement of Care and Support Services 2016 (Best-Practice). Public bodies should take account of this guidance which provides further advice on the amending of care contracts below the value of €750,000, in particular see Sections 8.12, S9.9, S9.18, S9.20, S9.26 and S9.63

The main risks of these example approaches are highlighted but should be considered within the wider context of a complete risk assessment and in particular in the context of social care outcomes.

- **Apply a percentage increase across the board: uplift all contract values/hourly rates by uniform amount on condition that providers volunteer to pay £8.25 to care workers.** This approach would be relatively easy to administer and would remove any competitive disadvantage between providers who may or may not already have invested in workforce wages. However Local Authorities will need to satisfy themselves as to the overall affordability of this option (depending on local circumstance and against their allocated resource) and be content that there would not be others interested in the terms of this contract, if this had been the basis of the original tendering process.

- **Apply a differing percentage increase per provider, through individual negotiation based on their particular costs.** This may be a more bureaucratic process dependent upon how many contracts and providers there are in each council. There may also be issues around the overall transparency of the process which, as noted, will be important for provider 'buy-in' to this initiative. It would however target the resources available to the purpose of addressing low pay and delivering the Living Wage commitment. If this approach were pursued then Local Authorities would need to be clear that in order to comply with state aid, providers could not be treated inequitably.

- **Set a standard rate for each local authority within which the £8.25 per hour wage for care workers is affordable.** To deliver this approach the rate would have to be set at a level adequate to cover all costs, not just the Living Wage commitment. The desirability and affordability of this approach would need to be assessed on a case by case basis. More generally this option can be insensitive to the fact that costs may legitimately vary depending on level of need, service model, skill mix of staff, quality of service and would also be insensitive to other justified variation of cost within local authorities where rurality and employment market dynamics impact on viable business models. This option may also include state aid and procurement issues around the equitable treatment of providers which would need to be assessed locally.

- **Set a suite of rates.** This option, whilst addressing the issue raised (above) regarding legitimate variation in service costs, goes beyond the requirement to implement the Living Wage commitment. The desirability and affordability of this approach would need to be assessed locally and in line with longer term commissioning agendas. Negotiating and implementing such an approach across Local Authorities, particularly if supported by service specifications, could be lengthy and so consideration on whether this is deliverable by October the 1st would also be required.

(b) Undertake a new procurement of services in line with new statutory and best practice guidance on social care and 'Fair Work Practices'

Generally, entering into a contract following an open and transparent procurement procedure which complies with the relevant legislation would be unlikely to raise any state aid risks. Retendering may therefore be an option for some Local Authorities – particularly for those who were otherwise expecting to need to tender for adult social care services regardless of this commitment and depending on the assessed risk of a challenge to the other models of contract variation. However this mechanism has to be balanced against the time, expense and potential disruption (to providers and clients) that a retendering process could bring. Additionally, bearing in mind that the overarching intention of this initiative is to invest in and value the workforce, the potential impact of retendering on that workforce will need to be carefully considered before proceeding.

9. Definitions

The National Minimum Wage: is a legal minimum wage for 21-24 year olds. This means that all employers must pay all of their staff that are between 21 and 24 a minimum of £6.70 per hour.

The National Living Wage: is an enhanced legal minimum wage for over 25's. This means that all employers must pay all of their staff that are over 25 a minimum of £7.20 per hour.

Age group	Nationally defined legal minimum wages
25 and over	£7.20
21 - 24	£6.70
18 - 20	£5.30
16 – 17	£3.87
Apprentices	£3.30

The Living Wage: set by the Living Wage Foundation is currently £8.25 per hour. This is up-rated annually and a new rate will be announced in November.

The Living Wage commitment: agreed as part of the 2016/17 Local Government settlement is to pay all adult social care workers the current Living Wage rate of £8.25 per hour from October 1st 2016. There is no requirement on local authorities as part of this agreement to increase wages to the new Living Wage rate when it is announced in November.

Adult social care workers: This commitment specifically applies to care workers providing direct care and support to adults in care homes, care at home and housing support settings (as per the Scottish Social Service Sector report on Workforce Data). This covers all purchased services, including specialist support services such as those for people with physical disabilities, learning disabilities, mental health difficulties and substance misuse issues.

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17 May 2016

Karen Murray
karen.murray@ggc.scot.nhs.uk

Dear Karen

Support for Quality Improvement in Health and Social Care Partnerships

With Heath and Social care integration now a reality across Scotland I write to update you on the improvement support available to partnerships and NHS Board's through Healthcare Improvement Scotland's new Improvement Hub (ihub) which was formally launched on 1st April 2016.

The HIS Improvement Hub (ihub) has been created from the merger of three national integration resources, HIS (Safety and Improvement Directorate), JIT and QuEST, to provide improvement support for everyone engaged in the delivery of integrated health and social care across Scotland including health and social care partnerships, third sector organisations, the independent care sector and housing organisations; as well as providing ongoing national support for NHS boards.

The next 12 months will serve as a transitional year for the ihub as we integrate the support offerings of the three national teams. This will include working closely with Health and Social Care Partnerships and NHS boards to better understand the current priorities for national improvement support and adjusting our programme in light of this.

Details of our current 2016/17 work programme can be found by accessing the following link *http://ihub.scot/about/work-programme/* This includes over 30 programmes of work that support improvement in aspects of care delivery services and the development of infrastructures and cultures which enable the work of improvement.

Our newly created Tailored and Responsive Improvement Support Team is also available to provide flexible improvement support to help NHS boards and Health and Social Care Partnerships address local priorities. Additionally a small grants-making arm has been

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introduced that will provide resources for organisations to test and develop approaches to improving health and social care services. We aim to have this up and running in the latter half of this year.

Going forward the HIS ihub's focus will be twofold; supporting services improve what they are already doing and aiding transformational redesign. In doing so we are able to draw on a broad range of resources, theories and techniques to facilitate this journey of improvement; combining technical and relational approaches which focus on effective system and process design as well as essential person centered issues in change processes.

As part of this offer the HIS ihub has identified a number of senior 'ihub account managers' with a specific remit to act as a key point of contact with the 31 Health and Social Care Partnerships to facilitate the linkage between local priorities for improvement support and our national and tailored support programmes.

I will undertake this role for your partnership and my PA will be in contact shortly to agree a suitable date and time to discuss your improvement support priorities and how the ihub can assist you in addressing these.

I look forward to working with you and your colleagues in supporting health and social care organisations design and deliver services that better meet the changing needs of people in Scotland and which reflect the aspirations of individuals, families and communities that access care.

In the meantime should you have any immediate queries in respect of the HIS ihub and our improvement offer please do not hesitate to contact me, using the details listed above.

Yours sincerely

Ruth Glassborow
Director of Safety and Improvement
Healthcare Improvement Scotland

ihub supporting health and social care

NHS SCOTLAND

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 3i

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**Finance Report – Outturn 2015/16**
Report by	**Jean Campbell, Chief Finance and Resources Officer**
Contact Officer	**Jean Campbell, Chief Finance and Resources Officer** **0141 201 4210** **Jean.campbell@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to update the Board on the financial outturn for the Health & Social Care Partnership for 2015/16.

2.0 SUMMARY

2.1 The final position in relation to the outturn for the Health & Social Care Partnership is known with some degree of certainty subject to any final year adjustments. This will form the basis of the Unaudited Accounts to be presented to a future HSCP Board / Audit Committee.

2.2 As previously reported, NHS budgets have attained a breakeven position and the outturn for Social Work budgets has delivered a more favourable position than that previously reported with a final year overspend of £557k (previously reported as £709K) which the Council have committed to fund in the first year from its contingency reserves.

2.3 Overall the HSCP has generated a surplus in 2015/16 which will be carried forward as a reserve into 2016/17 for investment into the strategic priorities outlined in the Strategic Plan and to provide some resilience for on-going pressure and slippage in savings plans.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Board:-

a) Notes the final outturn position for the HSCP for 2015/16.

4.0 MAIN REPORT

4.1 East Dunbartonshire Health & Social Care Partnership (HSCP) was established on the 3rd September 2015 and is considered a "live" partnership for the purposes of health and social care integration. This status allows the HSCP to retain any surplus funds and carry them forward for use in future years as a reserve. This is potentially a significant development and allows significant greater flexibility for financial planning and management in particular for NHS services.

NHS Budget Outturn

4.2 In terms of the final position for NHS budgets, there was a surplus generated across community NHS budgets of £400k in relation to Adult Community Services (Rehab Team and District Nursing) - £200k, Learning Disability - £50k, Mental Health - £110k and Addictions - £40k. In addition there was planned slippage of £400k against the HSCP's delayed discharge funding allocation. This was transferred to the Council to carry forward as a reserve into 2016/17 leaving a breakeven position at 2015/16.

4.3 GP Prescribing costs are projected to overspend by £4m across NHSGGC of which £400k relates to East Dunbartonshire. However the risk sharing arrangement in place means that this will be managed within the NHSGGC board budgets.

4.4 The Public Dental Service hosted by ED HSCP achieved a breakeven position as projected.

Social Work Budget Outturn

4.5 In terms of the final position for Social Work services, there was an increase in expenditure in relation to care home placements over and above projections as a result of the impact of winter pressures, year-end accruals and conclusion of the financial assessment processes. This has been offset by a number of recurring carry forwards written off where there are no expenditure commitments and removal of liabilities in respect of bad debt provision and employee severance which will absorbed by the Council. This gives a final outturn of £557k, an improvement of £152k based on previous projections of £709k. As previously agreed with the Council's Director of Finance, this deficit will be funded from Council Contingency Reserves.

HSCP Budget Outturn

4.6 The overall position for the HSCP is that of a breakeven in 2015/16 and reserves of £1.4m carried forward to 2016/17. A number of the carry forwards are required to meet on-going commitments, however there will be a surplus to meet the priorities set out in the Strategic Plan, and to provide some resilience for on-going pressure and slippage in savings plans.

Budget Setting 2016/17

4.7 The final position in relation to NHS board budgets is yet to be determined, however as previously reported there is an indicative savings target of £1.236m for East Dunbartonshire HSCP. Given the year end position has now been confirmed, work will be concluded on identifying the balance of savings to be achieved of £366k and will be reported to the next Board meeting.

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

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 3ii

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**Overview of the Preparation of Annual Accounts for the Integration Joint Board**
Report by	**Jean Campbell, Chief Finance & Resources Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Jean Campbell, Chief Finance & Resources Officer** **0141 201 4209** **Jean.campbell@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to update the Board on the preparation of the Annual Accounts for the IJB to ensure compliance with the legislative requirements and to seek approval to remit the approval of the annual accounts to the Audit Committee.

2.0 SUMMARY

2.1 The IJB is specified in legislation as a "section 106" body under the terms of the Local Government Scotland Act 1973 and as such is expected to prepare annual accounts in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

2.2 The report outlines the legislative requirements in respect of the governance and reporting considerations and the key stages in the preparation of the IJB Accounts.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Board:-

- Notes the contents of this report
- Remit the approval of the annual accounts to the Audit Committee.

4.0 MAIN REPORT

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 was passed by the Scottish Parliament on 25 February 2014 and received Royal Assent in April 2014. This established the framework for the integration of Health & Social Care in Scotland.

4.2 The IJB is a legal entity in its own right, created by Parliamentary Order, following Ministerial approval of the Integration Scheme. NHS Greater Glasgow and Clyde (NHSGGC) and East Dunbartonshire Council have delegated functions to the IJB which has the responsibility for strategic planning, resourcing and ensuring delivery of all integrated services.

4.3 The IJB is specified in legislation as a "section 106" body under the terms of the Local Government Scotland Act 1973 and as such is expected to prepare annual accounts in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

4.4 LASAAC [The Local Authority (Scotland) Accounts Advisory Committee] has produced additional guidance on accounting for the integration of health and social care.

4.5 The annual accounts for the IJB will be prepared in accordance with appropriate legislation and guidance. An overview of the process is set out below:

4.6 **Financial Governance & Internal Control;** the regulations require the Annual Governance Statement to be approved by the IJB or a committee of the IJB whose remit include audit & governance. This will assess the effectiveness of the internal audit function and the internal control procedures of the IJB. The Audit Committee meets this requirement.

4.7 **Unaudited Accounts;** the regulations state that the unaudited accounts are submitted to the External Auditor no later than 30th June immediately following the financial year to which they relate. The IJB or committee whose remit includes audit and governance must meet to consider the unaudited annual accounts as submitted to the external auditor no later than the 31st August immediately following the financial year to which the annual accounts relate. The IJB annual accounts for the year ended 31st March 2016 will be considered at the Audit Committee on 20th June 2016.

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

4.9 **Approval of Audited Accounts**: the regulations require the approval of the audited annual accounts by the IJB or a committee of the IJB whose remit include audit & governance. This will take account of any report made on the audited annual accounts by the "proper officer" i.e. Chief Financial Officer being the Section 95 Officer for the IJB or by the External Auditor by the 30th September immediately following the financial year to which they relate. In addition any further report by the external auditor on the audited annual accounts should also be considered. The Audit Committee will consider for approval the External Auditors report and proposed audit certificate (ISA 260 report) and the audited annual accounts at its meeting in September 2016.

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

4.11 The annual accounts of the IJB must be published by 31st October and any further reports by the External Auditor by 31st December immediately following the year to which they relate.

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

Management Commentary / Foreword	Chair of the IJB Chief Officer
Statement of Responsibilities	Chair of the IJB Chief Financial Officer
Annual Governance Statement	Chair of the IJB Chief Officer
Remuneration Report	Chair of the IJB Chief Officer
Balance Sheet	Chief Financial Officer

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.

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 4

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**East Dunbartonshire Health & Social Care Partnership Winter Plan 2015/16**
Report by	**Karen Murray, Chief Officer,** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Fiona McCulloch, Planning & Performance Manager,** **0141 201 9705** **Fiona.mcculloch@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 To provide a final report on the East Dunbartonshire Health and Social Care Partnership Winter Plan 2015/16

2.0 SUMMARY

2.1 The East Dunbartonshire HSCP Winter Plan was presented to the HSCP Board on 22nd October 2015, and a progress report was presented on 11th February 2016.

2.2 This report reviews the delivery of the East Dunbartonshire Winter Plan 2015/16 and provides the actions undertaken to ensure services were prepared for all possible adverse events during the winter period.

2.3 There were no disruptions reported by HSCP services during the winter period.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Health and Social Care Partnership Board:

- Notes the content of the report

4.0 MAIN REPORT

4.1 Introduction

The East Dunbartonshire Winter Plan 2015/16 set out the East Dunbartonshire Health and Social Care Partnership planning arrangements to ensure the delivery of services during the winter period. The Plan described the HSCP arrangements under the twelve key themes set out in the Scottish Government *National Unscheduled Care Programme:Preparing for Winter 2015/16* (DL (2015) 20). The Plan also took cognisance of the *6 Essential Actions to Improving Unscheduled Care Performance.*

The plan also contributed to the NHSG&C whole system planning arrangements to enable the delivery of effective unscheduled care.

4.2 Winter Planning Progress

The Winter Planning Group was established and met on a monthly basis between September 2015 and March 2016 to discuss the delivery of the East Dunbartonshire Winter Plan. A rolling Action Log **(Appendix 1)** set out the actions required to ensure services were appropriately prepared for any winter pressures. The function of the Action Log was to support the continuation of service delivery, minimise unscheduled hospital admissions and reduce delays in discharges.

The HSCP regularly monitored available data in relation to delayed discharges and unscheduled admissions through the Weekly Operational Delayed Discharge meeting in order to expedite discharge and identify potential improvements that could inform future predictive modelling and planning.

During 2015/16 winter period all NHS staff were encouraged to receive a flu vaccination at the sessions provided across GG&C. A total of 301 HSCP NHS staff, (including Oral Health) and 11 frontline social work staff received a flu vaccination, of which 140 attended the HSCP peer vaccination sessions.

A report is awaited from Public Health detailing the total uptake of patient vaccinations at GP surgeries. Local data indicated that the Community Nursing service vaccinated 662 housebound patients.

There were no disruptions reported by HSCP services during the winter period. However, in January 2016, the Acute sector advised that they were experiencing a surge in admissions. In response, the HSCP circulated information to all services, including GP Practices, highlighting the pressures in the Acute sector. GPs were asked to consider signposting patients to Minor Injury facilities, and to use the local Community Rehabilitation Team and Rapid Assessment Link service as appropriate.

Appendix 1

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE SERVICES WINTER PLAN 2015/16 ACTION LIST

Last Updated: 9th March 2016

ROLLING ACTION LOG

Winter Planning Group Arrangements

Action	Progress	Lead	Status
Establish monthly Winter Planning Group and regular meetings. • Monthly multidisciplinary meetings arranged from September 15 – March 16 • Meetings will increase up to daily meetings if required as part of the escalation process.	Monthly multidisciplinary meetings arranged from September 15 – March 16. Meetings to be re-established in September 2016. Process agreed to increase meetings if required	Fiona McCulloch / Service Leads	Ongoing throughout winter period

Admission Avoidance

Action	Update	Lead	Status
Systems in place to ensure community teams are able to provide rapid response for vulnerable older people at risk of hospital admission/readmission over Winter period:	Process in place for ▪ DN Patient status at a glance board in place ▪ DN Daily meetings in place chaired by named Band 6 on duty ▪ GPs reminded of same day Rapid Response service by CRT in hours ▪ 24hr Homecare available to support people in	All HSCP Service Leads Processes complete.	Ongoing throughout winter period

	their homes ▪ Urgent advice from OPMH available in hours ▪ SW OT will respond to prevent escalation in hours		

Anticipatory Planning and Care

Action	Update	Lead	Status
Progress Anticipatory Care Planning and upload onto eKIS in advance of the winter period to ensure continuity of care and avoid unnecessary emergency admissions / attendances, including patients with palliative and end of life care needs	Process for identifying patients requiring ACPs now developed and shared with GP colleagues. District Nursing ACPs inform and add to GP information for eKIS to promote continuity of patient centered care and avoid unnecessary interventions	Fraser Ross	Embedded as standard practice
Facilitate services, including GPs, to utilise local intelligence and predictive modeling tools such as SPARRA to identify patients at risk of admission and endeavor to put plans in place for those individuals over the winter period.	New DN / GP ACP model utilising local intelligence and SPARRA to identify patients at risk of admission implemented in Practice.	Fraser Ross / Graham Morrison	Embedded as standard practice
4x4 vehicles available for essential HSCP care services during severe weather	Agreed access to 4x4 vehicles during severe weather and also access to mini buses to transport staff if required.	Stephen McDonald	**Completed**
Agree with Roads Department gritting procedures to assist access to vulnerable patients	Confirm gritting policy with Roads Department.	Stephen McDonald	**Completed**
Progress predictive modeling for home care packages & increase in service demand over	Homecare service stopped taking referrals as of	Stephen	**Completed**

the winter (especially festive) period.	23rd December 2015. Communication was sent to all hospitals on the14th December 2015. Homecare wrote to families to estimate the amount care packages required over festive period. There was reduced staffing levels on Public Holidays. Normal working resumed Tuesday 29th December.	McDonald	
Patients reminded to re-order repeat prescriptions in advance of the festive period particular emphasis on methadone prescriptions.	All GPs received letters from LMC in regards to this. Addictions Team Lead has confirmed that systems were in place for Methadone Prescribing over the festive period, and that nursing staff were on duty along with a medical back up team from North Community Addiction Team.	HSCP Operational staff & GPs Kirsteen Jack	**Completed**
Patients reminded to arrange for Prescriptions to be collected from pharmacy in advance of public holidays	Opening hrs of pharmacies circulated for public holidays.	HSCP Operational staff & GPs	**Completed**
Supply of emergency equipment from EQUIPU, McKinley syringe drivers and essential pharmacy, wound dressings, continence products etc in each base.	Bulk ordering from EquipU deadline is 1st December 2015. All relevant staff have been made aware of this	Fraser Ross	**Completed**
Winter Planning page on ED HSCP websites to share public information. Share links across HSCP	Winter information available on both Health and Local Authority websites.	Dianne Rice	**Completed**
Ensure public facing website links are included in both HSCP and relevant Third Sector websites including “Know who to turn	Information placed on Website	Dianne Rice	**Completed**

to" & NHSGG&C winter website link			

Expediting Discharge from Hospital

Action	Update	Lead	Status
Support timely discharges to avoid delays	Weekly Discharge Planning meetings established to avoid delays and plan for discharges, particularly at weekends, and over festive holiday period. People who are delayed are discussed by all service leads to expedite discharge. Ongoing process in relation to available care home placements. Issues around finance / funding in relation to community care arrangements.	David Aitken HSCP Service Leads	Embedded as standard practice

Workforce Capacity Plans & Rotas for Winter / Festive period

Action	Update	Lead	Status
HSCP staff rotas over the festive period to be completed by end October and leads to confirm community capacity and availability particularly OOHs including overnight, weekends and Homecare specifics.	All service leads have submitted assurance emails to confirm they have completed their staff rotas to ensure staff coverage over festive period including post holiday surges.	All HSCP Service Leads	**Completed**
Planned leave is coordinated to ensure adequate cover during anticipated peaks and demands for services including post holiday surges.			

Whole system activity plans for winter: post-festive surge

Action	Update	Lead	Status
Provide representation at Acute North Winter Planning UCC Group to share planning arrangements.	Planning manager attends North Glasgow UCC meetings. The East Dunbartonshire HSCP Winter Plan has been presented to the group. Head of Planning for North Glasgow is a member of the HSCP Winter Planning Group.	Fiona McCulloch	UCC established as a regular meeting
Maintain links with EDC winter planning meetings and arrangements	Stephen McDonald will attend EDC Winter Planning meetings and provide a link between the groups.	Stephen McDonald	**Completed**
Complete SITREP reports as required and share with community and acute services to inform escalation pressures.	Service leads to ensure SITREP reports are completed as appropriate. Example of report circulated. No SITREP reports required to be completed during winter period.	All HSCP Service Leads	**Completed**
Inform Head of Service SMT of local escalation pressures	Service leads to ensure Head of Service is informed of escalation pressures.	All HSCP Service Leads	**Completed**
Inform Chief Officer on performance issues and escalation arrangements which require action	Head of Service leads to ensure Chief Officer is informed of escalation pressures and required actions.	Heads of Service	Ongoing throughout winter period

Strategies for additional winter beds and surge capacity

Action	Update	Lead	Status
Ensure links are in place between community teams, hospital teams, third sector and independent sector to ensure services work together to cover peaks in demand	Links with partners established through Older Peoples Programme Board and also Acute UCC meetings. Links to be developed with Third sector through established engagement groups.	All HSCP Service Leads	Ongoing throughout winter period
Identify and put in place processes to respond to acute additional winter beds and surge capacity	Process in place to provide increased social work support as required	David Aitken	**Complete**

The risk of patients being delayed on their pathway is minimised

Action	Update	Lead	Status
Explore processes to minimise the risk of patients being delayed on their pathway	Ongoing work to improve information sharing of assessments. Additional resources provided and utilised to facilitate PoA and minimise AWI delays	HSCP Service Leads	Continues to be developed

Discharges at weekend & Bank Holidays

Action	Update	Lead	Status
Ensure Community Nursing and Homecare, in partnership with Acute and OOHs services are able to support hospital discharges during weekends and holidays	24 hr Homecare provided 7 days per week including public holidays Community Nursing provided 7 days per week	Stephen McDonald / Fraser Ross	**Completed**

	including public holidays W/b 21/12/16 seen a rise in discharges from Acute. This was predicted and planned for.		

Escalation plans tested with partners

Action	Update	Lead	Status
Explore the introduction of an early alert system to enable GP practices to highlight unexpected increases in demand for appointments; increase in specific illness or viruses, causing strain on their services	GPs alerted of surges via email and reminded of available community services which can respond to prevent admissions.	Graham Morrison	**Completed**

Business Continuity Plans tested with partners

Action	Update	Lead	Status
Robust business continuity management arrangements in place which describe escalation arrangements in anticipation of rising demand and increased pressure with suitable contingencies, including managing key disruptive risks such as the impact of severe weather.	All services to complete the Departmental/Service specific business continuity plans by 18th January 16. Departmental /Service BCPs to be tested on 10th February 2016. Draft HSCP Business Continuity Plan out for consultation January 16. Planning Manager will circulate draft Business Continuity Plan to the group for comment.	Fiona McCulloch / Service Leads Fiona McCulloch	**Completed**

Ensure GP and pharmacy BCPs and buddy systems are in place	All practice managers and pharmacies will be contacted in January 16 to confirm systems are in place.	Fiona McCulloch	**To be completed through BCP arrangements**

Preparing effectivel for norovirus

Action	Update	Lead	Status
Establish robust links with Care Homes and Independent contractors to identify any issues that require escalation	Independent Liaison Officer will share winter planning information with Care Homes. Contract arrangements address potential business continuity issues requiring escalation	Gillian Healey / Janice Cameron	**Completed**

Delivering Seasonal Flu Vaccination to Public and Staff

Action	Update	Lead	Status
Staff encourage uptake of flu vaccines to elderly and vulnerable groups	Flu vaccination sessions undertaken by GP practices. DNs completing vaccinations for housebound patients	All HSCP Service Leads	**Completed**
Encourage all HSCP staff to receive flu vaccination	All NHS staff invited to attend peer vaccination sessions Sessions provided for frontline EDC staff Through peer led clinics 129 health staff and 11 frontline social work staff were vaccination. District	All HSCP Service Leads	**Completed**

	Nursing service also provided vaccinations to housebound patients. Public Health will release full breakdown of staff vaccinations.		

Communication to Staff & Primary Care Colleagues

Action	Update	Lead	Status
Briefing of HSCP staff on local planning arrangements including HR policies regarding severe weather. Key winter planning messages to be communicated to staff.	EDC included key messages for staff within newsletters. Service leads discussed at team meetings NHS Policies available on staffnet	All HSCP Service Leads	**Completed**
Ensure information on District Nursing OOH bases, telephone/mobile phone /fax numbers are available for NHSGG&C GP OOHs and across HSCP services	List of OOH bases, contact details updated and circulated.	Dianne Rice	**Completed**
Inform GP Practices of availability of HSCP community services and clinics over festive season.	Template completed and circulated to GPs December 2015	Dianne Rice	**Completed**
Inform patients of GP Practices availability over festive season, including service on 24th Dec and 31st Dec.	GPs advised to provide information on opening hours for patients	Graham Morrison	**Completed**

Effective analysis to plan for and monitory winter capacity, activity, pressures and performance

Action	Update	Lead	Status
Rolling action log to be submitted monthly to the HSCP Senior Management Team	Action updated and agreed at each Winter Planning meeting and included in papers for HSCP Senior	Fiona McCulloch	Ongoing throughout

meetings.	Development Team meetings.		winter period
Report on activity, performance and pressures will be provided at end of winter planning period.	Planning Manager to provide end of season report.	Dianne Rice	End of season update report to HSCP Board Mar 16.
Include Fieldwork Manger, Older People to distribution list for Team Brief for information	Team Brief circulation list updated.	Dianne Rice	**Completed**

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 5

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**Delayed Discharges – Action Plan Update**
Report by	**Karen Murray, 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 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 to support improvement in reducing Delayed Discharges. A report was presented to the HSCP Board 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 provides comparatives with other Greater Glasgow and Clyde Partnerships and is taken from the NHS GG& C Older Peoples Monitoring Report for March 2016. (**Appendix 1**)

2.4 East Dunbartonshire has achieved good performance for rate of bed days occupied for people aged 75+ compared to other HSCPs.

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

a) Notes the content of this report
b) Notes the achievement of the 50% target reduction of bed days lost to delayed discharge in 2015/16

4.0 BACKGROUND

4.1 The NHS Greater Glasgow & Clyde Corporate Older Peoples monitoring report for March 2016 is attached as **Appendix 1.** It shows an improving picture for East Dunbartonshire over the past three months after the rise in bed days lost which peaked in December 2015. Both February and March figures for bed days lost have come within the 50% reduction target of 307 per month, being respectively 276 and 220.

4.2 As a result of this improvement in performance, which has continued into the month of April, the Partnership has achieved the 50% reduction target for year 2015-16. The annual total bed days lost to delayed discharges was 3635 against the target of 3680.

4.3 The AWI performance continues to be encouraging. Delays of AWI patients have remained at zero throughout 2016.

4.4 The structural and service shortcomings that have contributed to the relatively poor performance comparative with other partnerships remain, but the development of intermediate provision is expected to commence soon. It is anticipated that once this resource comes on stream the scale and pace of performance improvement will increase, comparable to neighbouring partnerships.

4.5 **Appendix 2** attached shows recently released national data from Information and Statistics Division of National Services Scotland which shows East Dunbartonshire HSCP to have the 5th lowest rate of acute bed days per 1000 population aged 75+ occupied by delayed discharges. East Dunbartonshire occupied bed day rate for delayed discharge patients aged 75+ is 379 bed days per 1000 population compared to a Scottish average of 915 bed days per 1000 population.

5.0 ACTION PLAN UPDATE

5.1 Intermediate Care Proposal

A short life working group was commissioned to scope options for an intermediate care resource that would enable patients deemed *fit for discharge* to be discharged within the 72 hour target to a locus from which further rehabilitation or assessment could be carried out. The report from that group is being presented to the Board on today's agenda with a comprehensive proposal for a model of intermediate care to be funded for 1 year from Delayed Discharge monies. If the proposal receives approval, it is envisioned that such a resource will be operational by October of this year. Performance targets relating to this model and timescale are included within the report.

5.2 Patients with Complex Needs

Two patients with complex needs have been delayed throughout the period covered by this report. These two patients, between them account for more that 30% of the total bed days lost. A proposal to commission a specialist service to enable the discharge home of patient KS, who remains paralyzed and dependent on artificial ventilation is being presented to the Board on today's agenda. A patient with complex co-morbidity of learning disability and metal illness remains placed in the specialist Blythswood Learning Disability Acute Unit. Discussions are continuing to secure a robust

community placement for this patient who presents very challenging behaviour and who has experienced a number of placement breakdowns in the community.

Older People's Bed Days Lost to Delayed Discharge Monthy Monitoring Report - March 2016

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

(patients aged 65 & over on day of admission)

HSCP	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16 Apr Actual	May Actual	June Actual	July Actual	Aug Actual	Sept Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Actual
East Dunbartonshire	7,359	6,883	6370	5534	2686	4,916	462	458	287	308	216	146	283	254	379	347	276	220
East Renfrewshire	4,829	4,799	4,093	5171	2445	2,896	164	84	112	100	155	105	163	170	170	123	156	178
Glasgow City	**53,110**	**56,635**	**64,865**	**43,185**	**39,929**	**38,152**	**2204**	**2106**	**1513**	**1571**	**1668**	**1417**	**1563**	**1484**	**1566**	**2020**	**2028**	**2148**
Inverclyde	6,724	5,497	5578	3744	3010	3,462	138	97	80	142	167	192	116	99	90	169	143	127
Renfrewshire	16,207	14,319	19792	12,698	5835	5,325	529	482	436	423	284	262	198	172	153	217	207	270
West Dunbartonshire	7,638	8,644	8611	6050	4925	5,802	396	284	230	263	242	157	219	187	301	280	301	485
GGC(All above areas	**95,867**	**96,777**	**109,309**	**76,382**	**58,830**	**60,553**	**3,893**	**3,511**	**2,658**	**2,807**	**2,732**	**2,279**	**2,542**	**2,366**	**2,659**	**3,156**	**3,111**	**3,428**

HSCP	Number of Beds Consumed Annually 2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	Monthly Number of Beds Consumed Apr Actual	May Actual	June Actual	July Actual	Aug Actual	Sept Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Actual
East Dunbartonshire	19.2	17.9	16.6	14.4	7.0	12.8	15	14	9	9	7	5	9	8	12	11	9	7
East Renfrewshire	12.6	12.5	10.7	13.5	6.4	7.5	5	3	4	3	5	3	5	5	5	4	5	5
Glasgow City	**138.2**	**147.4**	**168.8**	**112.4**	**103.9**	**99.3**	**70**	**65**	**48**	**48**	**51**	**45**	**48**	**47**	**48**	**62**	**66**	**66**
Inverclyde	17.5	14.3	14.5	9.7	7.8	9.0	4	3	3	4	5	6	4	3	3	5	5	4
Renfrewshire	42.2	37.3	51.5	33.0	15.2	13.9	17	15	14	13	9	8	6	5	5	7	7	8
West Dunbartonshire	19.9	22.5	22.4	15.7	12.8	15.1	13	9	7	8	7	5	7	6	9	9	10	15
GGC(All above areas	**249.5**	**251.9**	**284.5**	**198.8**	**153.1**	**157.6**	**123**	**108**	**84**	**86**	**84**	**72**	**78**	**75**	**81**	**97**	**102**	**105**

AWI identified by code "51X"

Edison extract as at 29th April 2016

Older People's Bed Days Lost to Delayed Discharge Monthy Monitoring Report - March 2016

Appendix 1

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

(patients aged 65 & over on day of admission)

							2015/16												2015/16	2015/16
CH(C)P	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	Apr Actual	May Actual	June Actual	July Actual	Aug Actual	Sept Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Actual	Cumulative Actual	Year End Forecast
East Dunbartonshire	7,359	6,883	6370	5534	2686	4,916	462	458	287	308	216	146	283	254	379	347	276	220	3,636	3,416
East Renfrewshire	4,829	4,799	4,093	5171	2445	2,896	164	84	112	100	155	105	163	170	170	123	156	178	1,680	1,502
Glasgow City	**53,110**	**56,635**	**64,865**	**43,185**	**39,929**	**38,152**	**2204**	**2106**	**1513**	**1571**	**1668**	**1417**	**1563**	**1484**	**1566**	**2020**	**2028**	**2148**	**21,288**	**19,140**
Inverclyde	6,724	5,497	5578	3744	3010	3,462	138	97	80	142	167	192	116	99	90	169	143	127	1,560	1,433
Renfrewshire	16,207	14,319	19792	12,698	5835	5,325	529	482	436	423	284	262	198	172	153	217	207	270	3,633	3,363
West Dunbartonshire	7,638	8,644	8611	6050	4925	5,802	396	284	230	263	242	157	219	187	301	280	301	485	3,345	2,860
GGC(All above areas)	**95,867**	**96,777**	**109,309**	**76,382**	**58,830**	**60,553**	**3,893**	**3,511**	**2,658**	**2,807**	**2,732**	**2,279**	**2,542**	**2,366**	**2,659**	**3,156**	**3,111**	**3,428**	**35,142**	**31,714**
North Lanarkshire			1,561	793	677	1,244	104	89	83	117	100	168	159	56	21	52	99	34	820	1,048
South Lanarkshire			4,101	3,922	4851	5,812	301	383	329	295	355	255	252	249	280	348	264	355	2,170	3,311
All other area's			2,042	2,288	**2,985**	**3,750**	267	330	229	167	223	158	180	225	245	168	217	246	1,554	2,409
All area's			**117,013**	**83,385**	**67,343**	**71,359**	**4,565**	**4,313**	**3,299**	**3,386**	**3,410**	**2,860**	**3,133**	**2,896**	**3,205**	**3,724**	**3,691**	**4,063**	**39,686**	**38,482**

Bed Days Lost to Delayed Discharge for AWIs - Acute

(patients aged 65 & over on day of admission)

							2015/16												2015/16	2015/16
CH(C)P	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	Apr Actual	May Actual	June Actual	July Actual	Aug Actual	Sept Actual	Oct Actual	Nov Actual	Dec Actual	Jan Actual	Feb Actual	Mar Actual	Cumulative Actual	Year End Forecast
East Dunbartonshire	3,200	2,075	1351	63	15	1,185	210	154	63	62	36	30	31	0	10	0	0	0	596	596
East Renfrewshire	1,219	829	60	386	31	213	0	0	7	31	19	30	61	60	47	31	51	90	427	337
Glasgow City	**18,704**	**13,319**	**19,188**	**9,341**	**8,936**	**8,987**	**556**	**638**	**752**	**890**	**1033**	**831**	**811**	**751**	**934**	**1059**	**1292**	**1168**	**10,715**	**9,547**
Inverclyde	300	582	352	53	108	31	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Renfrewshire	2,128	1,190	1647	2,050	2288	4,301	351	402	321	370	217	180	148	131	108	124	151	121	2,624	2,503
West Dunbartonshire	931	3,160	1798	1,872	1547	2,127	124	93	111	137	120	82	153	128	200	178	146	145	1,617	1,472
GGC(All above areas)	**26,482**	**21,155**	**24396**	**13,765**	**12,925**	**16,844**	**1,241**	**1,287**	**1,254**	**1,490**	**1,425**	**1,153**	**1,204**	**1,070**	**1,299**	**1,392**	**1,640**	**1,524**	**15,979**	**14,455**
North Lanarkshire			0	0	0	90	30	31	30	60	23	0	0	0	0	0	0	0	174	174
South Lanarkshire			756	268	975	1,188	91	111	60	8	0	0	0	0	0	4	29	60	270	303
All other area's			322	385	365	**634**	5	0	0	0	0	0	0	0	0	26	0	0	5	31
All area's			**25,474**	**14,418**	**14,265**	**18,756**	**1,367**	**1,429**	**1,344**	**1,558**	**1,448**	**1,153**	**1,204**	**1,070**	**1,299**	**1,422**	**1,669**	**1,584**	**16,428**	**14,963**

AWI identified by code "51X"
Edison extract as at 29th April 2016

Forecast figures based on a year to date average

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

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

Appendix 1

NHSGGC SUMMARY INDICATORS

Ref No	Performance Measures	2009/10 Baseline	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Actual	2015/16 Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	2015/16 Cumulative Actual
1	Number of acute bed days lost to delayed discharges (inc AWI)	95,867	96,777	109,309	76,382	58,830	60,553	3,893	3,511	2,658	2,807	2,732	2,279	2,542	2,366	2,659	3,156	3,111	3,428	35,142
2	Number of acute bed days lost to delayed discharges for Adults With Incapacity	26,482	21,115	24,396	13,765	12,925	16,844	1,241	1,287	1,254	1,490	1,425	1,153	1,204	1,070	1,299	1,392	1,640	1,524	15,979
3	Number of acute delayed discharges (within period)	2,360	2,674	2,850	N/A	N/A	N/A	363	347	321	279	282	236	274	285	300	323	351	354	N/A
	Delayed Discharges (at census)	N/A	N/A	N/A	N/A	N/A	N/A	102	112	67	82	90	102	103	98	84	100	100	122	N/A
	Delayed Discharge > 14 days	N/A	N/A	N/A	N/A	N/A	N/A	37	23	13	10	15	13	14	18	7	6	15	27	N/A
	Delayed Discharge < 3 days (72 hours)	N/A	N/A	N/A	N/A	N/A	N/A	n/a	30	5	12	13	13	16	12	10	19	6	7	N/A
	Delayed Discharge > 14 days exception codes	N/A	N/A	N/A	N/A	N/A	N/A	65	56	49	60	60	75	71	67	66	70	79	87	N/A
	Delayed Discharge < 3 days (72 hours) exception codes	N/A	N/A	N/A	N/A	N/A	N/A	n/a	3	0	0	2	1	2	1	1	5	0	1	N/A
5a	Unplanned acute bed days (65 +)	673,143	685,043	658,865	650,071	593,078	619,237	49,542	47,854	45,191	45,833	44,666	42,186	47,692	46,252	48,326	54,361	49,141	53,344	574,388
	Unplanned acute bed days 65 + rate / 1,000 pop	3,814	3,863	3,687	3,565	3,215	3,357	265	256	242	245	239	226	255	247	258	291	263	285	3,071
5b	Unplanned acute bed days (75 +)	498,460	512,137	497,526	484,039	439,984	462,111	36,892	35,377	33,391	34,155	33,213	31,757	35,156	34,474	35,806	41,006	36,751	39,199	427,177
	Unplanned acute bed days 75 + rate / 1,000 pop	6,065	6,134	5,878	5,658	5,108	5,365	422	405	382	391	380	364	403	395	410	470	421	449	4,891
6	Number of emergency admissions 65+	49,257	51,873	52,928	53,831	52,348	54,250	4,405	4,512	4,554	4,626	4,304	4,252	4,464	4,460	4,986	4,919	4,603	5,083	55,168
	Emergency admissions 65+ Rate /1,000 pop	279	293	296	295	284	294	24	24	24	25	23	23	24	24	27	26	25	27	295
7	Number of unplanned admissions by SIMD:																			
	SIMD Quintile 1	12,348	12,765	12,515	12,332	12,439	12,117	1,012	1,011	1,058	1,070	993	997	1,009	1,026	1,170	1,126	1,076	1,143	12,691
	SIMD Quintile 2	11,988	12,561	12,960	12,874	12,712	12,622	987	1,076	1,066	1,045	963	994	1,052	1,010	1,102	1,153	1,041	1,164	12,653
	SIMD Quintile 3	10,511	10,624	10,508	10,561	10,228	11,454	914	957	931	983	896	876	947	931	1,058	1,029	962	1,032	11,516
	SIMD Quintile 4	7,456	7,908	8,050	8,420	8,274	9,151	757	728	757	771	753	710	746	789	859	840	801	877	9,388
	SIMD Quintile 5	6,954	7,930	8,496	9,094	8,356	8,906	735	740	742	757	699	675	710	704	797	771	723	867	8,920

EAST DUNBARTONSHIRE HSCP

Ref No	Performance Measures	2009/10 Baseline	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Actual	2015/16 Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	2015/16 Cumulative Actual
1	Number of acute bed days lost to delayed discharges (inc AWI)	7,359	6,883	6,370	5,534	2,686	4,916	462	458	287	308	216	146	283	254	379	347	276	220	3,636
2	Number of acute bed days lost to delayed discharges for Adults With Incapacity	3,200	2,075	1,351	63	15	1,185	210	154	63	62	36	30	31	0	10	0	0	0	596
3	Number of acute delayed discharges (within period)	N/A	N/A	N/A	N/A	N/A	N/A	35	35	39	28	22	13	24	35	41	34	31	24	N/A
	Delayed Discharges (at census)	N/A	N/A	N/A	N/A	N/A	N/A	6	10	6	5	6	4	3	5	2	3	2	4	N/A
	Delayed Discharge > 14 days	N/A	N/A	N/A	N/A	N/A	N/A	0	1	0	2	2	1	0	1	0	1	0	1	N/A
	Delayed Discharge < 3 days (72 hours)	N/A	N/A	N/A	N/A	N/A	N/A	n/a	3	2	1	3	2	2	3	2	0	0	1	N/A
	Delayed Discharge > 14 days exception codes	N/A	N/A	N/A	N/A	N/A	N/A	6	6	4	2	1	1	1	1	0	2	2	2	N/A
	Delayed Discharge < 3 days (72 hours) exception codes	N/A	N/A	N/A	N/A	N/A	N/A	n/a	0	0	0	0	0	0	0	0	0	0	0	N/A
5	Unplanned acute bed days (65 +)	59,883	59,192	54,865	63,051	52,633	58,944	4,379	4,877	4,305	4,677	4,412	3,949	4,733	4,623	5,034	5,566	4,641	5,137	56,333
	Unplanned acute bed days 65 + rate / 1,000 pop	3,039	2,936	2,661	2,938	2,392	2,679	194	216	190	207	195	175	209	204	223	246	205	227	2,490
6	Unplanned acute bed days (75 +)	46,369	46,382	43,358	48,377	41,715	47,106	3,353	3,557	3,295	3,675	3,482	3,225	3,676	3,664	4,290	4,475	3,688	3,980	44,360
	Unplanned acute bed days 75 + rate / 1,000 pop	5,198	5,021	4,544	4,843	4,043	4,566	314	333	308	344	326	302	344	343	401	418	345	372	4,148
7	Number of emergency admissions 65+	4,547	4,910	4,736	5,105	4,901	5,463	435	443	423	445	474	448	453	406	504	495	460	547	5,533
	Number of emergency admissions 65+ rate / 1,000 pop	231	244	230	238	223	248	19	20	19	20	21	20	20	18	22	22	20	24	245
	Number of emergency admissions 75+					3,288	3,823	292	289	287	302	322	308	292	272	369	346	307	351	3,737
	Number of emergency admissions 75+ rate / 1,000 pop					319	371	27	27	27	28	30	29	27	25	35	32	29	33	349
8	Number of unplanned admissions by SIMD																			
	SIMD Quintile 1	58	61	0	0	17	67	6	8	6	5	5	4	12	1	7	12	9	9	84
	SIMD Quintile 2	258	241	133	128	156	194	15	14	20	10	16	18	20	20	18	24	7	16	198
	SIMD Quintile 3	1126	1,078	912	935	1,054	1,263	89	95	78	104	107	101	105	75	114	94	114	124	1,200
	SIMD Quintile 4	778	902	875	965	974	1,128	99	92	77	88	106	101	79	85	96	105	97	134	1,159
	SIMD Quintile 5	2327	2,620	2,782	3,033	2,668	2,811	226	234	242	238	240	224	237	225	269	260	233	264	2,892
9	Number of delayed discharges for Adults with Incapacity (Acute Beds)	47	33	51	5	1	50	8	7	3	2	2	1	1	0	1	0	0	0	25
10	Reduced ALOS for over 75s in mental health beds	176	144	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Appendix 1

EAST RENFREWSHIRE HSCP

Ref No	Performance Measures	2009/10 Baseline	201/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Actual	2015/16 Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	2015/16 Cumulative Actual
1	Number of acute bed days lost to delayed discharges (inc AWI)	4,829	4,799	4,093	5,171	2,445	2,896	164	84	112	100	155	105	163	170	170	123	156	178	1,680
2	Number of acute bed days lost to delayed discharges for Adults With Incapacity	1,219	829	60	386	31	213	0	0	7	31	19	30	61	60	47	31	51	90	427
3	Number of acute delayed discharges (within period)	N/A	N/A	N/A	N/A	N/A	N/A	20	16	17	15	26	9	15	16	14	13	18	16	N/A
	Delayed Discharges (at census)	N/A	N/A	N/A	N/A	N/A	N/A	2	3	1	2	1	3	2	4	2	2	1	4	N/A
	Delayed Discharge > 14 days	N/A	N/A	N/A	N/A	N/A	N/A	2	0	0	0	0	0	0	0	1	0	0	0	N/A
	Delayed Discharge < 3 days (72 hours)	N/A	N/A	N/A	N/A	N/A	N/A	n/a	2	0	0	0	1	0	1	0	1	0	2	N/A
	Delayed Discharge > 14 days exception codes	N/A	N/A	N/A	N/A	N/A	N/A	0	1	1	2	1	2	2	3	1	1	1	2	N/A
	Delayed Discharge < 3 days (72 hours) exception codes	N/A	N/A	N/A	N/A	N/A	N/A	n/a	0	0	0	0	0	0	0	0	0	0	0	N/A
5	Unplanned acute bed days (65 +)	42,174	45,067	42,102	44,986	39,754	44,733	3,797	3,564	3,000	3,117	2,808	2,670	2,710	2,660	2,747	3,373	3,551	3,761	37,758
	Unplanned acute bed days 65 + rate / 1,000 pop	2,649	2,788	2,573	2,661	2,303	2,591	215	201	170	176	159	151	153	150	155	191	201	213	2,135
6	Unplanned acute bed days (75 +)	33,915	36,371	33,435	35,228	30,471	36,066	3,131	2,831	2,324	2,493	2,119	2,127	2,195	2,155	2,152	2,789	2,890	3,117	30,323
	Unplanned acute bed days 75 + rate / 1,000 pop	4,457	4,665	4,194	4,326	3,693	4,372	370	335	275	295	251	252	260	255	255	330	342	369	3,588
7	Number of emergency admissions 65+	3,130	3,437	3,592	3,911	3,541	3,878	313	323	305	311	251	275	295	301	332	311	324	351	3,692
	Emergency admissions 65+ Rate /1,000 pop	197	213	220	231	205	225	18	18	17	18	14	16	17	17	19	18	18	20	209
8	Number of unplanned admissions by SIMD:																			
	SIMD Quintile 1	12	36	121	169	108	28	2	3	2	5	1	1	3	3	0	2	1	3	26
	SIMD Quintile 2	224	214	215	258	261	321	19	32	17	21	20	22	18	23	33	25	25	28	283
	SIMD Quintile 3	515	392	227	212	325	560	42	45	44	46	42	37	41	42	45	58	46	41	529
	SIMD Quintile 4	599	714	756	827	657	693	61	69	62	54	49	53	64	52	73	50	74	69	730
	SIMD Quintile 5	1780	2,078	2,243	2,410	2,168	2,276	189	174	180	185	139	162	169	181	181	176	178	210	2,124

GLASGOW CITY HSCP

Ref No	Performance Measures	2009/10 Baseline	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Actual	2015/16 Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	2015/16 Cumulative Actual
1	Number of acute bed days lost to delayed discharges (inc AWI)	53,110	56,635	64,865	43,185	39,929	38,152	2,204	2,106	1,513	1,571	1,668	1,417	1,563	1,484	1,566	2,020	2,028	2,148	21,288
2	Number of acute bed days lost to delayed discharges for Adults With Incapacity	18,704	13,319	19,188	9,341	8,936	8,987	556	638	752	890	1,033	831	811	751	934	1,059	1,292	1,168	10,715
3	Number of acute delayed discharges (within period)	N/A	N/A	N/A	N/A	N/A	N/A	227	222	181	161	171	154	181	179	189	201	222	216	N/A
	Delayed Discharges (at census)	N/A	N/A	N/A	N/A	N/A	N/A	66	79	43	52	63	77	76	70	61	72	78	91	N/A
	Delayed Discharge > 14 days	N/A	N/A	N/A	N/A	N/A	N/A	35	22	13	8	12	11	13	15	5	5	15	23	N/A
	Delayed Discharge < 3 days (72 hours)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	22	2	9	7	10	11	8	8	15	4	1	N/A
	Delayed Discharge > 14 days exception codes	N/A	N/A	N/A	N/A	N/A	N/A	31	32	28	35	42	55	50	47	48	48	59	66	N/A
	Delayed Discharge < 3 days (72 hours) exception codes	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3	0	0	2	1	2	0	0	4	0	1	N/A
5	Delayed Discharges - Non complex needs cases - Included codes:																			
	< = 3 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	22	2	9	7	10	11	8	8	15	4	1	
	4 days to < 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	N/A	15	18	15	16	7	11	10	11	13	16	13	
	> 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	N/A	22	13	8	12	11	13	16	5	5	15	23	
6	Delayed Discharges - Complex & AWI:																			
	< = 3 days	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3	0	0	1	1	0	0	0	4	0	1	
	4 days to < 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	N/A	4	3	9	5	4	3	0	4	2	4	4	
	> 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	N/A	29	26	32	39	48	41	35	37	37	51	56	
7	Older People's Mental Health:																			
	Total number of OPMH bed days lost to DDs	N/A	N/A	N/A	N/A	N/A	N/A	738	485	520	419	434	484	786	797	553	427	533	777	N/A
	No.of OPMH bed days lost to DDs for AWI patients	N/A	N/A	N/A	N/A	N/A	N/A	161	73	156	179	220	255	217	227	210	141	132	138	N/A
8	DDs for OPMH patients - Included codes:																			
	< 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	6	5	6	5	3	8	10	6	4	8	4	6	
	> 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	12	8	7	0	2	0	6	7	3	2	4	8	
9	DDs for OPMH patients - Excluded codes:																			
	< 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	0	0	1	0	1	2	1	0	0	0	0	1	
	> 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	5	5	3	5	5	8	9	9	10	2	6	5	
10	Unplanned acute bed days (65 +)	369,715	377,603	360,428	354,632	318,653	325,545	26,561	25,082	23,963	24,412	23,759	22,358	25,352	24,774	25,534	28,438	25,860	28,229	304,322
	Unplanned acute bed days 65 + rate / 1,000 pop	4,469	4,584	4,382	4,275	3,830	3,913	318	300	287	292	284	268	303	297	306	340	310	338	3,643
13	Unplanned acute bed days 75+	269,581	281,899	269,959	261,427	235,267	235,488	19,323	18,479	17,796	17,901	17,568	16,528	18,100	18,197	18,576	21,281	18,920	20,401	223,070
	Unplanned acute bed days 75+ (per 1,000)	6,849	7,082	6,762	6,561	5,925	5,930	487	466	448	451	443	416	456	458	468	536	477	514	5,619
11	Number of emergency admissions 65+	26,202	27,463	27,432	27,839	26,436	26,237	2,172	2,265	2,353	2,353	2,143	2,098	2,250	2,274	2,517	2,520	2,349	2,597	27,891
	Emergency admissions 65+ Rate /1,000 pop	317	333	334	336	318	315	26	27	28	28	26	25	27	27	30	30	28	31	334
12	Number of unplanned admissions by SIMD:																			
	SIMD Quintile 1	9771	9,830	8,607	8,871	8,808	9,252	803	813	840	824	771	761	796	797	943	904	861	907	10,020
	SIMD Quintile 2	7292	7,807	8,439	8,228	7,757	7,096	547	629	670	609	555	562	618	576	628	672	614	683	7,363
	SIMD Quintile 3	4742	5,048	5,341	5,438	4,912	4,844	401	405	419	458	372	379	440	436	473	459	422	470	5,134
	SIMD Quintile 4	2954	3,212	3,494	3,637	3,459	3,345	273	281	298	309	310	266	273	330	328	347	309	346	3,670
	SIMD Quintile 5	1443	1,531	1,400	1,466	1,366	1,700	148	137	126	153	135	130	123	135	145	138	143	191	1,704

Appendix 1

14	Emergency admissions 75+	16,225	17,261	17,589	17,734	16,742	16,530	1,389	1,458	1,462	1,508	1,405	1,347	1,416	1,503	1,598	1,623	1,495	1,640	17,844
	Emergency admissions 75+ (per 1,000)	412	434	441	445	422	416	35	37	37	38	35	34	36	38	40	41	38	41	450
15	Reduction in hospital lengths of stay (65+ emergency admissions)	14.2	13.9	14.0	13.3	12.4	12.9	13.4	12.4	11.5	10.1	10.8	11.0	10.8	11.8	10.7	11.6	11.0	11.2	136.2
	Reduction in hospital lengths of stay (75+ emergency admissions)	16.9	17.2	16.2	15.3	14.5	14.7	15.2	14.2	13.5	11.4	12.3	12.6	12.4	13.0	12.0	13.8	12.7	12.6	155.9
21	Reablement																			
i	% of service users referred to re-ablement home care service (inc non-complex and community	N/A	N/A	N/A	N/A	N/A	N/A	47.9%			43.5%			50.6%						N/A
22	Telecare																			
i	number in receipt of basic telecare	N/A	N/A	N/A	N/A	N/A	N/A	6,839			6,949			6,894						N/A
ii	number in receipt of advanced telecare	N/A	N/A	N/A	N/A	N/A	N/A	1,271			1,276			1,273						N/A
iii	proportion of people aged 75+ with a telecare package	N/A	N/A	N/A	N/A	N/A	N/A	6678 82%			5918 72%			6894 71%						N/A
23	Carers																			
i	number of new older carers identified in the period	N/A	N/A	N/A	N/A	N/A	N/A	147			N/A			152						N/A
ii	% of carers feeling supported in their caring role	N/A	N/A	N/A	N/A	N/A	N/A	1			N/A			89%						N/A
24	Admissions to long term care																			
i	total admissions to nursing homes	N/A	N/A	N/A	N/A	N/A	N/A	412			228			258						N/A
ii	total admissions to residential care	N/A	N/A	N/A	N/A	N/A	N/A	99			90			104						N/A
iii	total admissions to respite	N/A	N/A	N/A	N/A	N/A	N/A	N/A			120			90						N/A
iv	total admissions to all long term care	N/A	N/A	N/A	N/A	N/A	N/A	511			438			362						N/A
v	Admissions by age:																			
	18-64	N/A	N/A	N/A	N/A	N/A	N/A	28			19			22						N/A
	65-74	N/A	N/A	N/A	N/A	N/A	N/A	71			47			28						N/A
	75-84	N/A	N/A	N/A	N/A	N/A	N/A	184			163			122						N/A
	85+	N/A	N/A	N/A	N/A	N/A	N/A	228			209			190						N/A
vi	Admissions by sex:																			
	Male	N/A	N/A	N/A	N/A	N/A	N/A	194			157			135						N/A
	Female	N/A	N/A	N/A	N/A	N/A	N/A	317			281			227						N/A
vii	Source of admission:																			
	Community	N/A	N/A	N/A	N/A	N/A	N/A	N/A			N/A			N/A						N/A
	Hospital	N/A	N/A	N/A	N/A	N/A	N/A	N/A			N/A			N/A						N/A

INVERCLYDE HSCP

Ref No	Performance Measures	2009/10 Baseline	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Actual	2015/16 Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	2015/16 Cumulative Actual
1	Number of acute bed days lost to delayed discharges (inc AWI)	6,724	5,497	5,578	3,744	3,010	3,462	138	97	80	142	167	192	116	99	90	169	143	127	1,560
2	Number of acute bed days lost to delayed discharges for Adults With Incapacity	300	582	352	53	108	31	0	0	0	0	0	0	0	0	0	0	0	0	0
3	Number of acute delayed discharges (within period)	N/A	N/A	N/A	N/A	N/A	N/A	18	15	13	23	23	23	17	22	17	23	25	24	N/A
	Delayed Discharges (at census)	N/A	N/A	N/A	N/A	N/A	N/A	0	1	1	0	2	2	4	2	2	4	4	2	
	Delayed Discharge > 14 days	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	0	0	0	0	0	
	Delayed Discharge < 3 days (72 hours)	N/A	N/A	N/A	N/A	N/A	N/A	n/a	1	1	0	2	0	2	0	0	2	2	0	
	Delayed Discharge > 14 days exception codes	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	2	2	2	2	2	2	2	
	Delayed Discharge < 3 days (72 hours) exception codes	N/A	N/A	N/A	N/A	N/A	N/A	n/a	0	0	0	0	0	0	0	0	0	0	0	
5	Unplanned acute bed days (65 +)	56,840	53,533	49,528	50,735	50,064	50,559	4,063	4,042	3,689	3,628	3,991	4,237	4,472	3,850	3,957	4,200	3,954	4,726	48,809
	Unplanned acute bed days 65 + rate / 1,000 pop	3,902	3,649	3,338	3,338	3,245	3,277	259	258	235	231	254	270	285	245	252	268	252	301	3,111
6	Unplanned acute bed days (75 +)	41,741	39,109	36,610	37,066	35,317	38,254	3,188	3,058	2,608	2,569	3,075	3,244	3,448	2,871	2,762	3,128	3,050	3,481	36,482
	Unplanned acute bed days 75 + rate / 1,000 pop	6,224	5,773	5,334	5,293	4,976	5,389	441	423	361	355	425	449	477	397	382	433	422	482	5,048
7	Number of emergency admissions 65+	4,045	4,309	4,328	4,455	4,493	4,828	373	367	357	370	369	394	387	359	406	383	365	412	4,542
	Emergency admissions 65+ Rate /1,000 pop	278	294	292	293	291	313	24	23	23	24	24	25	25	23	26	24	23	26	289
8	Number of unplanned admissions by SIMD:																			
	SIMD Quintile 1	1215	1,332	1,577	1,592	1,398	1,121	76	83	86	99	75	106	85	92	92	87	84	108	1,073
	SIMD Quintile 2	1091	1,119	896	893	1,069	1,349	106	110	94	105	107	117	115	98	113	106	93	113	1,277
	SIMD Quintile 3	537	535	482	470	555	789	44	53	50	38	56	56	46	49	64	49	48	50	603
	SIMD Quintile 4	941	926	813	858	914	1,092	103	78	91	95	92	81	89	87	88	105	102	100	1,111
	SIMD Quintile 5	261	392	522	615	536	477	44	43	36	33	39	34	52	33	49	36	38	41	478
9	Reduction in unplanned admissions for people aged over 75	2,562	2,541	2,758	2,831	2,807	3,131	246	235	213	231	252	254	253	221	253	250	236	260	2,904
10	Reduction in unplanned admissions for EMI patients	121	123	57	54	46	33	4	5	3	5	6	5	8	3	3	5	6	5	58
11	Older People's Mental Health:																			
	Total number of OPMH bed days lost to DDs	N/A	N/A	N/A	N/A	N/A	N/A	23	25	24	5	18	29	19	56	29	7	0	37	N/A
	No.of OPMH bed days lost to DDs for AWI patients	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	18	0	0	0	0	N/A
12	DDs for OPMH patients - Included codes:																			
	< 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	1	0	0	0	1	0	0	0	0	0	0	0	
	> 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	0	0	0	0	0	
13	DDs for OPMH patients - Excluded codes:																			
	< 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	1	0	0	0	0	
	> 2 weeks	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	0	0	0	0	0	

14	Numbers of people accessing self directed support	N/A	22	19	24	N/A	N/A	47	N/A	N/A	1,103	1,103	N/A	1,188						47
15	Increase in care at home services - number of individuals over 65 years per 1,000 population	N/A	77.4	79.3	83.9	N/A	N/A	79.2	79.0	78.0	78.0	N/A	N/A	N/A						79.2
16	Number of people aged 65 years+ in care home placements	N/A	563	611	569	N/A	N/A	586	572	587	587	588	591	587						586
17	Number of new admissions to care homes for people aged 65 years+	N/A	184	210	207	N/A	N/A	14	14	10	19	25	11	16						14
18	Number of new admissions to care homes by SIMD																			
	SIMD Quintile 1	N/A	N/A	N/A	N/A	N/A	N/A	6	8	5	10	9	2	3						6
	SIMD Quintile 2	N/A	N/A	N/A	N/A	N/A	N/A	1	0	2	2	6	2	2						1
	SIMD Quintile 3	N/A	N/A	N/A	N/A	N/A	N/A	3	1	0	3	4	1	3						3
	SIMD Quintile 4	N/A	N/A	N/A	N/A	N/A	N/A	2	2	2	3	3	5	2						2
	SIMD Quintile 5	N/A	N/A	N/A	N/A	N/A	N/A	2	3	1	1	3	1	6						2
19	Number of new admissions to care homes by:																			
	Male	80	48	73	70	N/A	N/A	8	8	3	7	6	4	7						8
	Female	161	136	137	137	N/A	N/A	6	6	7	12	19	7	9						6

Appendix 1

RENFREWSHIRE HSCP

Ref No	Performance Measures	2009/10 Baseline	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Actual	2015/16 Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	2015/16 Cumulative Actual
1	Number of acute bed days lost to delayed discharges (inc AWI)	16,207	14,319	19,792	12,698	5,835	5,325	529	482	436	423	284	262	198	172	153	217	207	270	3,633
2	Number of acute bed days lost to delayed discharges for Adults With Incapacity	2,128	1,190	1,647	2,050	2,288	4,301	351	402	321	370	217	180	148	131	108	124	151	121	2,624
3	Number of acute delayed discharges (within period)							29	29	45	28	20	22	20	18	19	28	21	39	
	Delayed Discharges (at census)	N/A	N/A	N/A	N/A	N/A	N/A	21	15	13	17	14	13	12	9	9	9	7	7	
	Delayed Discharge > 14 days	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	1	1	1	2	1	0	0	0	
	Delayed Discharge < 3 days (72 hours)	N/A	N/A	N/A	N/A	N/A	N/A	n/a	0	0	0	0	0	0	0	0	1	0	0	
	Delayed Discharge > 14 days exception codes	N/A	N/A	N/A	N/A	N/A	N/A	21	15	13	17	13	12	11	7	8	7	7	7	
	Delayed Discharge < 3 days (72 hours) exception codes	N/A	N/A	N/A	N/A	N/A	N/A	n/a	0	0	0	0	0	0	0	0	1	0	0	
5	Unplanned acute bed days (65 +)	93,485	96,646	96,766	84,919	86,333	90,129	7,267	6,986	7,209	6,874	6,528	6,185	7,484	6,559	7,416	8,441	7,495	7,640	86,084
	Unplanned acute bed days 65 + rate / 1,000 pop	3,247	3,321	3,265	2,778	2,778	2,901	229	220	227	216	206	195	236	207	234	266	236	241	2,711
6	Unplanned acute bed days (75 +)	68,888	69,536	72,549	62,627	64,120	68,567	5,408	5,053	5,283	5,239	4,622	4,504	5,464	4,675	5,309	6,218	5,529	5,511	62,815
	Unplanned acute bed days 75 + rate / 1,000 pop	5,386	5,331	5,388	4,575	4,613	4,933	379	354	370	367	324	315	383	327	372	435	387	386	4,399
7	nber of emergency admissions 65+	7,386	7,501	8,358	8,601	9,004	9,472	777	793	786	807	762	784	789	768	872	851	757	834	9,580
	Emergency admissions 65+ Rate /1,000 pop	257	258	282	281	290	305	24	25	25	25	24	25	25	24	27	27	24	26	302
8	Number of unplanned admissions by SIMD:																			
	SIMD Quintile 1	771	927	1,570	1,652	1,520	1,134	77	74	84	93	83	96	78	88	95	89	78	76	1,011
	SIMD Quintile 2	2066	2,084	2,156	2,288	2,390	2,330	204	193	175	185	175	185	203	177	204	201	200	207	2,309
	SIMD Quintile 3	2090	1,989	1,891	1,864	1,964	2,323	216	212	213	218	215	212	205	202	218	235	196	221	2,563
	SIMD Quintile 4	1415	1,299	1,162	1,138	1,485	2,175	167	168	168	180	151	171	179	178	212	177	160	181	2,092
	SIMD Quintile 5	1044	1,170	1,446	1,487	1,524	1,510	113	146	146	131	138	120	124	123	143	149	123	149	1,605
9	Reduce A&E attendances (65+)	N/A	12,756	13,550	13,625	13,544	14,023	1,150	1,127	1,114	1,120	1,162	1,126	1,152	1,050	1,161	1,210	1,083	1,174	13,629
10	Reduce readmissions (65+)	1,534	1,583	1,770	1,947	2,032	2,432	215	200	194	219	177	218	199	197	231	199	189	211	2,449
11	Number of respite hours	10,954	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	N/A		N/A
12	Number of individuals supported at home with a telecare safety package	142	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	N/A		N/A
13	Number of admissions to care homes 65 years+	424	476	386	392	391	416	50	47	37	25	34	20	N/A	N/A	N/A	NA	N/A		213
14	Number of new purchased admissions to care homes	TBC	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	N/A		N/A
15	Number of new admissions to care homes by SIMD																			
	SIMD Quintile 1	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	N/A		N/A
	SIMD Quintile 2	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	N/A		N/A
	SIMD Quintile 3	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	N/A		N/A
	SIMD Quintile 4	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	N/A		N/A
	SIMD Quintile 5	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	N/A		N/A
16	Number of new admissions to care homes by:																			
	Male	TBC	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	N/A		N/A
	Female	TBC	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	30	N/A	N/A	NA	N/A		
17	Number of care home beds (residents 65+ in placements provided by Council)	1,019	1,030	1,057	1,030	1,034	983	1,000	1,017	1,017	1,003	1,013	1,013	1,027	N/A	N/A	NA	N/A		7,090
18	Number of Standard Shareable Assessments (65 yrs+)	N/A	N/A	1,109	1,317	3,209	3,273	292	261	280	228	295	303	282	N/A	N/A	NA	N/A		1,941
19	Number of carers reporting they are better supported in their caring role	TBC	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	NA	N/A		N/A

Appendix 1

WEST DUNBARTONSHIRE HSCP																							
Ref No	Performance Measures	2009/10 Baseline	2010/11 Actual	2011/12 Actual	2012/13 Actual	2013/14 Actual	2014/15 Actual	2015/16 Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	2015/16 Cumulative Actual
1	Number of acute bed days lost to delayed discharges (inc AWI)	7,638	8,644	8,611	6,050	4,925	5,802	396	284	230	263	242	157	219	187	301	280	301	485	3,345
2	Number of acute bed days lost to delayed discharges for Adults With Incapacity	931	3,160	1,798	1,872	1,547	2,127	124	93	111	137	120	82	153	128	200	178	146	145	1,617
3	Number of acute delayed discharges (within period)							34	30	26	24	20	15	17	15	20	24	34	35	
	Delayed Discharges (at census)	N/A	N/A	N/A	N/A	N/A	N/A	7	4	3	6	4	3	6	8	8	10	8	14	
	Delayed Discharge > 14 days	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0	0	0	0	0	0	3	
	Delayed Discharge < 3 days (72 hours)	N/A	N/A	N/A	N/A	N/A	N/A	n/a	2	0	2	1	0	1	0	0	0	0	3	
	Delayed Discharge > 14 days exception codes	N/A	N/A	N/A	N/A	N/A	N/A	7	2	3	4	3	3	5	7	7	10	8	8	
	Delayed Discharge < 3 days (72 hours) exception codes	N/A	N/A	N/A	N/A	N/A	N/A	n/a	0	0	0	0	0	0	1	1	0	0	0	
5	Unplanned acute bed days (65 +)	51,046	53,002	55,176	51,748	45,641	49,327	3,475	3,303	3,025	3,125	3,168	2,787	2,941	3,786	3,638	4,343	3,640	3,851	41,082
	Unplanned acute bed days 65 + rate / 1,000 pop	3,458	3,567	3,681	3,389	2,942	3,179	221	210	192	199	201	177	187	241	231	276	231	245	2,610
6	Unplanned acute bed days (75 +)	37,966	38,840	41,615	39,314	33,094	36,630	2,489	2,399	2,085	2,278	2,347	2,129	2,273	2,912	2,717	3,115	2,674	2,709	30,127
	Unplanned acute bed days 75 + rate / 1,000 pop	5,582	5,687	6,054	5,712	4,827	5,343	356	343	298	326	336	305	325	417	389	446	383	388	4,312
7	Number of emergency admissions 65+	3,947	4,253	4,482	4,398	3,973	4,372	335	321	330	340	305	253	290	352	355	359	348	342	3,930
	Emergency admissions 65+ Rate /1,000 pop	267	286	299	288	256	282	21	20	21	22	19	16	18	22	23	23	22	22	250
8	Number of unplanned admissions by SIMD:																			
	SIMD Quintile 1	521	579	640	588	588	515	48	30	40	44	58	29	35	45	33	32	43	40	477
	SIMD Quintile 2	1057	1,096	1,121	1,079	1,079	1,332	96	98	90	115	90	90	78	116	106	125	102	117	1,223
	SIMD Quintile 3	1501	1,582	1,655	1,642	1,418	1,675	122	147	127	119	104	91	110	127	144	134	136	126	1,487
	SIMD Quintile 4	769	855	950	995	785	718	54	40	61	45	45	38	62	57	62	56	59	47	626
	SIMD Quintile 5	99	139	103	83	94	132	15	6	12	17	8	5	5	7	10	12	8	12	117
9	Reduction in ALOS delay for AWI patients	98	122																	
10	Number of EMI delayed discharges	17	6	63	47	33	37	4	5	1	1	0	1	5	1	1	2	1	1	23
11	Number of bed days lost to EMI delayed discharges	1,140	730	1,514	611	710	522	87	36	3	26	0	8	25	12	3	10	1	14	225
12	Number of people in care home placements in the month	449	N/A	505	533	563	535	542	549	564	552	565	565	551	552	547	546	542	544	6,619
13	% of people aged 65 years+ admitted twice or more, as an emergency, who have not had an assessment	0	N/A	37.52%	34.16%	41%	39.2%	39.2%	39.2%	29.4%	29.4%	29.4%	29.4%	35.4%	35.4%	35.4%	35.8%	35.8%	35.8% (prov)	33.5%
14	Number of patients in anticipatory care programmes	N/A	N/A	N/A	N/A	1,024	1,645		1,601			1,634			1,624			1,821		1,670
15	% of people aged 65 years+ with intensive care needs receiving care at home.	0	N/A	42.8%	42.4%	40.8%	39.3%	40.2%	40.2%	38%	38.5%	38.0%	38.0%	38.6%	38.5%	38.7%	38.8%	38.9%	38.8% (prov)	39.0%
16	Number of new admissions to care homes (65 years+)	N/A	N/A	197	210	198	186	17	15	17	9	17	18	11	15	13	14	22	19	187

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

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

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Bed Days Occupied by Delayed Discharge Patients

General:

These tables report on the number of bed days occupied by all patients experiencing a delay. They are collected as part of national reporting requirements recommended by the Delayed Discharge Expert group and agreed by the Cabinet Secretary.

A delayed discharge occurs when a patient, who is clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available, for example to purchase a care home place.

Information is presented on delays where the standard maximum delay period applies (referred to as 'standard') and Code 9 delays, from April 2012 to the present. Data is available at Scotland, NHS Board (of Treatment) and Local Authority (of Residence) levels, and is broken down by Delay Type (standard and code 9) and calendar month.

NOTES:

October 2015 - Since the move to monthly publishing of delayed discharge figures in June 2015, ISD have been made aware of a number of instances where local recording practices have changed, resulting in additional 1-3 day delays being recorded where previously none were, or the numbers were incomplete. ISD are looking to establish the position of the other geographic health boards in relation to their recording of 1-3 day delays, and assess the impact of this on interpreting delayed discharge and associated bed days data. In the meantime, explanatory notes have been added to the data tables for boards who have informed us of any change in recording practice.

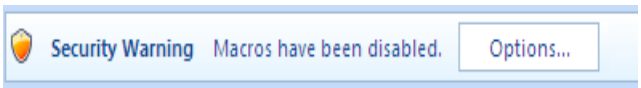
The workbook includes the following information:

Glossary	Contains explanation of technical terms used in this workbook
Tab 1	Number of Bed Days Occupied by Delayed Discharge Patients by Month, Financial Year, Delay Type and Health Board of Treatment/Local Authority of Residence.
Tab 2	Chart showing the number of Bed Days Occupied by Delayed Discharge Patients by Month, Financial Year, Delay Type and Health Board of Treatment/Local Authority of Residence.
Tab 3	Chart showing the number of Bed Days Occupied by Delayed Discharge Patients by Delay Type, March 2014 - March 2016
Tab 4	Number of Bed Days Occupied by Delayed Discharge Patients by Age Group, Delay Type, Health Board of Treatment and Local Authority of Residence
Tab 5	Percentage Standard and Code 9 Bed Days Occupied by Delayed Discharge Patients by Age Group and Health Board of Treatment/Local Authority of Residence
Tab 6	Bed Days Occupied by Delayed Discharge Patients - Rate per 1,000 population aged 75+ by Local Authority of Residence. Chart showing a timeline of the number of Bed Days Occupied by Delayed Discharge Patients. Available by Health Board of Treatment/Local Authority of Residence. ***Note: This data is updated annually.***

Problems with drop down lists

Excel 2003 users - If the drop down lists are not working please ensure that Macro security settings are set to medium. To do this, go to 'Tools' menu and select 'macro'. Then select 'Security' and ensure that the security setting is set to either 'Medium' or 'Low' (Medium is the recommended option). If your settings were set to 'High' you should reset the level when you have finished working with the template. Also when opening the file you will be asked whether you wish to "enable" or disable" macros. You must select "Enable macros", otherwise the template will not function correctly.

Excel 2007 & 2010 users - need to enable macros via the Options button on the pop-up menu below which will appear below the main Ribbon menu.



Help with workbook

If you need any help accessing these tables or have any comments, suggestions or questions, please email nss.delayeddischarges@nhs.net

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Glossary

Contains explanation of any technical terms used with this publication

Bed Days Occupied

The number of bed days occupied is gathered for all patients (aged 18 years and over) who have met the criteria for a delayed discharge for each month.

In order to ensure consistency, a 'midnight bed count' approach is applied to each delay episode to determine which particular days should contribute to the bed day count. The 'ready for discharge' date (RDD) is not counted, as the first midnight occurring in the delay episode is attributable to the day after the RDD. The discharge date (the date the delay ended) is counted as the assumption is that the patient was delayed at 00:00 on that day. The following applies to calculating bed days occupied for delayed patients:

- Count all days that occur between the 'ready for discharge' date (RDD) and the discharge date (the date the delay ended)
- Do not count the 'ready for discharge' date (RDD)
- Do count the 'discharge date' (the date the delay ended)

For example, if the RDD of a patient was on the 1st of the month and the delay ended on the 5th, the number of days delayed is 4 and the days counted in this delay are the 2nd, 3rd, 4th and 5th.

The number of bed days occupied by some patients delayed under the 'Adults with Incapacity Act' (AWIs, code 9/51X) was undercounted for 3 quarterly reporting periods (Apr-Jun, Jul-Sep, Oct-Dec 2012) because of a technical problem with the system used to record delayed discharges. The affected the number of bed days attributed to specific Code 9/51X delays only where the ready for discharge date has been updated during the reporting period. This issue has now been resolved. The estimated undercount for each quarterly period affected is less than 2% of the total quarterly number of bed days.

Delayed Discharge

A delayed discharge is experienced by a hospital inpatient who is clinically ready to move on to a more appropriate care setting but is prevented from doing so for various reasons. The next stage of care covers all appropriate destinations within and out with the NHS (patient's home, nursing home etc). The date on which the patient is clinically ready to move on to the next stage of care is the ready for discharge date which is determined by the consultant/GP responsible for the inpatient care in consultation with all agencies involved in planning the patient's discharge, both NHS and non-NHS (Multi-Disciplinary Team). Thus the patient is ready-for-discharge, but the discharge is delayed due to:

- Social care reasons
- Healthcare reasons
- Patient/Carer/Family-related reasons.

Delay Types

Standard: Information is presented on delays where the standard maximum delay period applies (referred to as 'standard' delays). Partnerships have previously worked towards discharging patients from hospital within a maximum time period of 6 weeks, reducing to 4 weeks then 2 weeks from April 2015.

Code 9: It is recognised that there are some patients whose discharge will take longer to arrange and therefore the standard maximum delay is not applicable (see paragraph above for maximum standard delay periods). These cases are classified as 'Code 9s' and would include patients delayed due to awaiting place availability in a high level needs specialist facility and where an interim option is not appropriate, patients for whom an interim move is deemed unreasonable or where an adult may lack capacity under adults with incapacity legislation.

Code 9 cases are reported separately in this report to differentiate them from those cases where the standard maximum delay applies.

Health Board of Treatment

NHS Health Board of Treatment refers to one of the 14 Territorial Health Boards.

Further Information

Information on the recording and use of this code within the Delayed Discharges Census can be found in the Delayed Discharges Data Definitions and Recording Manual (link below:)
http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed-Discharges/Guidelines/

These data are for management purposes only and please treat the material and any indication of the results as restricted until public release by ISD.

Tab 1 - Bed Days Occupied by Delayed Discharge Patients - April 2015 to March 2016: All Delays; Age Group: All

Please select yearly period: 2015/16 **Please select age group:** All **Please select Delay Type:** All

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
NHS Board area of treatment [1]	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**	**Total**
Scotland	**47,476**	**46,890**	**45,356**	**47,797**	**48,526**	**48,091**	**50,945**	**47,862**	**46,878**	**47,827**	**43,896**	**46,309**
Ayrshire & Arran	2,087	2,399	2,164	1,914	1,652	1,510	1,705	2,121	2,336	2,270	2,026	2,118
Borders	509	460	550	686	517	506	650	775	889	786	575	605
Dumfries & Galloway	638	846	807	527	581	1,167	1,455	773	882	920	646	845
Fife	2,614	3,074	3,406	4,237	4,358	4,596	5,123	4,992	3,737	3,859	3,254	3,164
Forth Valley	1,300	1,656	1,767	1,983	2,086	2,441	2,362	2,358	2,132	1,969	1,768	1,937
Grampian	7,790	7,352	7,186	7,201	7,330	6,581	6,731	6,339	6,160	6,472	5,924	6,280
Greater Glasgow & Clyde	7,840	6,857	5,342	5,391	5,661	5,406	5,879	5,366	5,457	6,102	6,093	7,143
Highland	3,869	4,200	4,017	3,999	4,156	4,099	4,681	4,449	4,541	4,444	3,833	4,247
Lanarkshire	4,718	3,648	4,671	6,605	6,848	6,597	6,992	6,755	6,982	7,165	6,926	6,793
Lothian	11,622	12,175	10,973	11,055	11,017	10,595	10,496	9,322	9,128	9,295	8,055	8,019
Orkney	39	124	60	55	88	72	92	42	129	83	73	159
Shetland	184	234	120	45	68	113	105	126	150	127	136	137
Tayside	3,509	2,971	3,388	3,215	3,334	3,670	3,906	3,618	3,781	3,846	4,059	4,349
Western Isles	757	894	905	884	830	738	768	826	574	489	528	513
Local Authority of residence [1]												
Scotland	**47,476**	**46,890**	**45,356**	**47,797**	**48,526**	**48,091**	**50,945**	**47,862**	**46,878**	**47,827**	**43,896**	**46,309**
Aberdeen City	4,382	4,162	4,203	3,934	3,872	3,498	3,729	3,238	3,326	3,463	2,953	3,184
Aberdeenshire	2,786	2,549	2,529	2,716	2,859	2,409	2,147	1,885	1,782	2,323	2,228	2,080
Angus	621	567	579	552	442	334	517	509	491	642	628	610
Argyll & Bute	776	809	754	599	681	682	699	825	859	793	608	772
City of Edinburgh	8,109	8,523	7,796	8,454	8,171	7,871	7,807	6,865	6,488	6,762	5,534	5,441
Clackmannanshire	172	173	217	351	403	443	373	347	214	256	199	228
Comhairle nan Eilean Siar	766	903	905	884	830	738	768	826	574	489	533	518
Dumfries & Galloway	638	846	807	527	581	1,167	1,455	773	882	920	646	845
Dundee City	1,070	1,121	1,302	971	1,087	1,632	1,574	1,249	1,256	1,122	1,333	1,333
East Ayrshire	642	641	591	501	452	480	575	515	371	491	368	416
East Dunbartonshire	581	590	473	440	300	172	327	386	457	476	349	287
East Lothian	2,081	2,075	1,770	1,087	1,155	1,177	1,347	1,146	1,058	967	885	1,081
East Renfrewshire	236	119	145	181	208	173	236	283	215	162	184	224
Falkirk	729	929	997	1,034	1,125	1,365	1,053	1,238	1,381	1,181	1,018	1,256
Fife	2,821	3,188	3,566	4,374	4,522	4,747	5,246	5,171	3,966	4,071	3,419	3,313
Glasgow City	4,621	4,019	2,785	2,858	3,128	3,145	3,441	3,150	2,997	3,505	3,667	4,266
Highland	3,323	3,556	3,558	3,558	3,630	3,531	4,068	3,855	3,876	3,840	3,365	3,620
Inverclyde	177	176	111	171	257	303	221	249	208	266	217	232
Midlothian	649	909	897	782	771	631	475	534	595	644	655	626
Moray	628	638	443	572	640	674	913	1,180	1,054	703	723	967
North Ayrshire	387	866	499	399	337	419	557	739	830	714	767	604
North Lanarkshire	1,726	1,673	1,828	2,949	3,259	3,205	3,523	3,347	3,315	3,416	2,989	3,026
Orkney	39	145	90	82	91	101	92	47	129	83	73	159
Other	14	17	-	18	34	29	15	30	31	31	55	42
Perth & Kinross	1,612	1,144	1,293	1,470	1,607	1,560	1,719	1,690	1,791	1,845	1,891	2,249
Renfrewshire	780	688	615	624	600	551	498	341	337	397	301	367
Scottish Borders	533	488	585	767	579	589	739	843	986	848	639	680
Shetland	184	234	138	61	68	113	105	126	150	127	142	168
South Ayrshire	1,096	1,070	1,177	1,102	1,000	701	716	976	1,278	1,138	978	1,253
South Lanarkshire	3,551	2,577	3,494	4,194	4,224	3,982	4,100	3,886	4,172	4,364	4,632	4,558
Stirling	418	535	502	596	510	642	842	683	514	502	541	408
West Dunbartonshire	605	340	261	377	261	256	349	292	460	471	458	702
West Lothian	723	620	446	612	842	771	719	638	835	815	918	794

1 Health Board figures are based on NHS board area of treatment. Local Authority figures are based on Local Authority of residence. There are a small number of patients experiencing a delay in discharge who are residents of local authorities outwith the NHS Board Areas in which they are being treated. This may mean that the NHS board area of treatment is not responsible for the patient's post hospital discharge planning. This also means that the combined figures for local authorities within a particular NHS board area might not be equal to the corresponding total for that NHS board area.

2. Occupied bed days information is available up to March 2016

3. Due to a change in local practices, NHS Lanarkshire have provided a more accurate and complete bed days occupied by delayed discharges figure for July 2015. However this means that NHS Lanarkshire's bed days occupied are not comparable to previous years with effect from July 2015

Source: ISD Scotland

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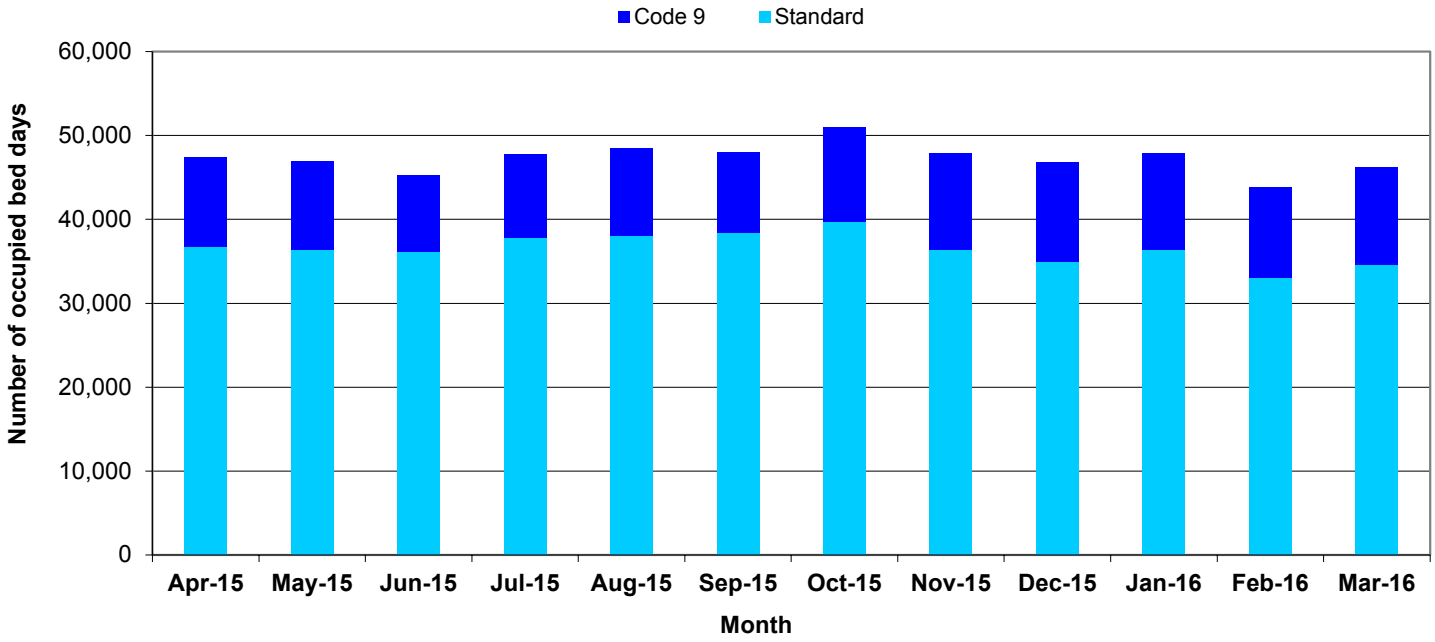
Tab 2 - Bed Days Occupied by Delayed Discharge Patients by Delay Type: Scotland, April 2015 to March 2016

Please select financial year: 2015/16

Please select an NHS Board or Local Authority: Scotland



1. Occupied bed days information is available up to March 2016

Source: ISD Scotland

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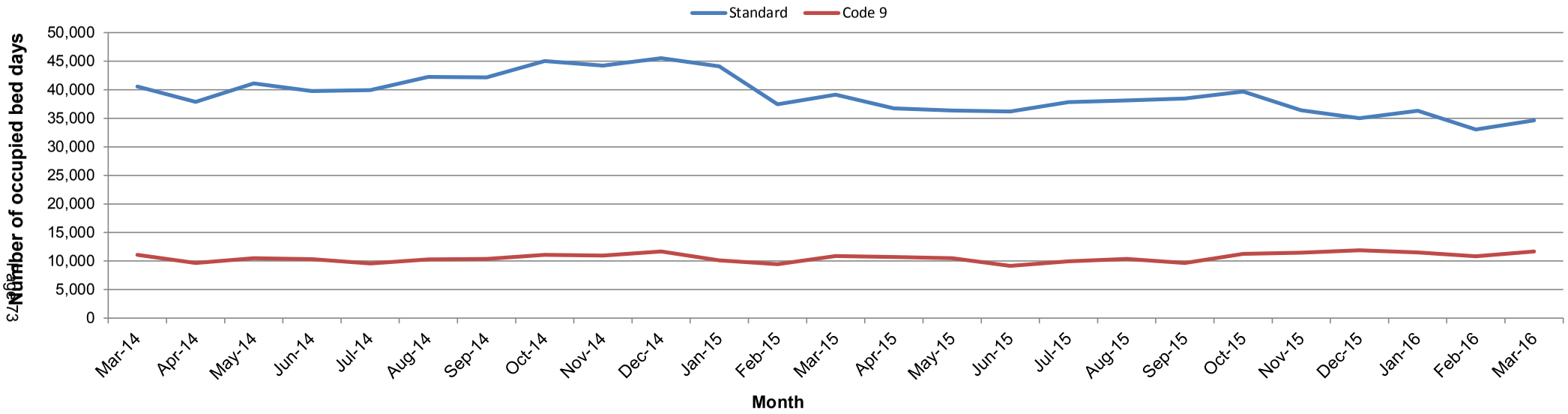
Tab 3 - Bed Days Occupied by Delayed Discharge Patients, by Delay Type: Scotland, March 2014 to March 2016

Please select an NHS Board or Local Authority: Scotland



1. Occupied bed days information is available up to March 2016

Source: ISD Scotland

Tab 4a - Bed Days Occupied by Delayed Discharge Patients per Health Board - by Age Group and Delay Type: March 2016

Please select month/year: -2016 Mar

	All Ages					18 - 74 years					75 + years				
NHS Board area of treatment [1]	**Total**	**Standard**	**%**	**Code 9**	**%**	**Total**	**Standard**	**%**	**Code 9**	**%**	**Total**	**Standard**	**%**	**Code 9**	**%**
Scotland	**46,309**	**34,628**	**74.8**	**11,681**	**25.2**	**13,698**	**9,313**	**68.0**	**4,385**	**32.0**	**32,611**	**25,315**	**77.6**	**7,296**	**22.4**
Ayrshire & Arran	**2,118**	**1,409**	66.5	**709**	33.5	**466**	**286**	61.4	**180**	38.6	**1,652**	**1,123**	68.0	**529**	32.0
Borders	**605**	**380**	62.8	**225**	37.2	**204**	**119**	58.3	**85**	41.7	**401**	**261**	65.1	**140**	34.9
Dumfries & Galloway	**845**	**652**	77.2	**193**	22.8	**124**	**62**	50.0	**62**	50.0	**721**	**590**	81.8	**131**	18.2
Fife	**3,164**	**2,640**	83.4	**524**	16.6	**899**	**777**	86.4	**122**	13.6	**2,265**	**1,863**	82.3	**402**	17.7
Forth Valley	**1,937**	**1,271**	65.6	**666**	34.4	**531**	**236**	44.4	**295**	55.6	**1,406**	**1,035**	73.6	**371**	26.4
Grampian	**6,280**	**5,009**	79.8	**1,271**	20.2	**1,902**	**1,339**	70.4	**563**	29.6	**4,378**	**3,670**	83.8	**708**	16.2
Greater Glasgow & Clyde	**7,143**	**4,273**	59.8	**2,870**	40.2	**2,854**	**1,524**	53.4	**1,330**	46.6	**4,289**	**2,749**	64.1	**1,540**	35.9
Highland	**4,247**	**2,537**	59.7	**1,710**	40.3	**842**	**485**	57.6	**357**	42.4	**3,405**	**2,052**	60.3	**1,353**	39.7
Lanarkshire	**6,793**	**6,010**	88.5	**783**	11.5	**1,810**	**1,455**	80.4	**355**	19.6	**4,983**	**4,555**	91.4	**428**	8.6
Lothian	**8,019**	**6,834**	85.2	**1,185**	14.8	**2,634**	**2,307**	87.6	**327**	12.4	**5,385**	**4,527**	84.1	**858**	15.9
Orkney	**159**	**68**	42.8	**91**	57.2	**92**	**22**	23.9	**70**	76.1	**67**	**46**	68.7	**21**	31.3
Shetland	**137**	**137**	100.0	**-**	-	**23**	**23**	100.0	**-**	-	**114**	**114**	100.0	**-**	-
Tayside	**4,349**	**3,105**	71.4	**1,244**	28.6	**1,290**	**665**	51.6	**625**	48.4	**3,059**	**2,440**	79.8	**619**	20.2
Western Isles	**513**	**303**	59.1	**210**	40.9	**27**	**13**	48.1	**14**	51.9	**486**	**290**	59.7	**196**	40.3

Please see footnotes

Tab 4b - Bed Days Occupied by Delayed Discharge Patients per Local Authority - by Age Group and Delay Type: March 2016

Please select month/year: -2016 Mar

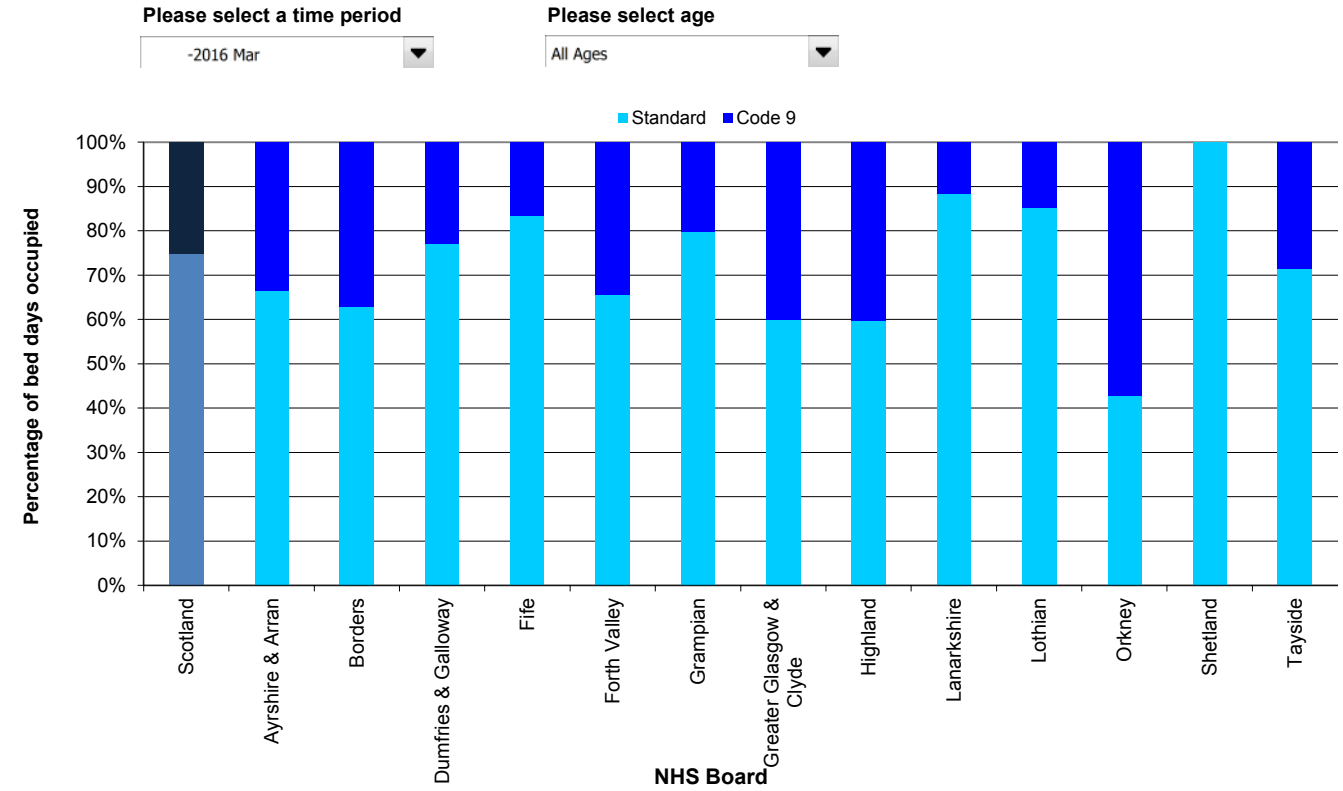
	All Ages					18 - 74 years					75 + years				
Local Authority of residence [1]	**Total**	**Standard**	**%**	**Code 9**	**%**	**Total**	**Standard**	**%**	**Code 9**	**%**	**Total**	**Standard**	**%**	**Code 9**	**%**
Scotland	**46,309**	**34,628**	**74.8**	**11,681**	**25.2**	**13,698**	**9,313**	**68.0**	**4,385**	**32.0**	**32,611**	**25,315**	**77.6**	**7,296**	**22.4**
Aberdeen City	**3,184**	**2,699**	84.8	**485**	15.2	**1,143**	**802**	70.2	**341**	29.8	**2,041**	**1,897**	92.9	**144**	7.1
Aberdeenshire	**2,080**	**1,646**	79.1	**434**	20.9	**436**	**291**	66.7	**145**	33.3	**1,644**	**1,355**	82.4	**289**	17.6
Angus	**610**	**425**	69.7	**185**	30.3	**239**	**148**	61.9	**91**	38.1	**371**	**277**	74.7	**94**	25.3
Argyll & Bute	**772**	**558**	72.3	**214**	27.7	**114**	**37**	32.5	**77**	67.5	**658**	**521**	79.2	**137**	20.8
City of Edinburgh	**5,441**	**4,603**	84.6	**838**	15.4	**1,700**	**1,499**	88.2	**201**	11.8	**3,741**	**3,104**	83.0	**637**	17.0
Clackmannanshire	**228**	**53**	23.2	**175**	76.8	**65**	**3**	4.6	**62**	95.4	**163**	**50**	30.7	**113**	69.3
Comhairle nan Eilean Siar	**518**	**308**	59.5	**210**	40.5	**32**	**18**	56.3	**14**	43.8	**486**	**290**	59.7	**196**	40.3
Dumfries & Galloway	**845**	**652**	77.2	**193**	22.8	**124**	**62**	50.0	**62**	50.0	**721**	**590**	81.8	**131**	18.2
Dundee City	**1,333**	**718**	53.9	**615**	46.1	**551**	**241**	43.7	**310**	56.3	**782**	**477**	61.0	**305**	39.0
East Ayrshire	**416**	**113**	27.2	**303**	72.8	**98**	**21**	21.4	**77**	78.6	**318**	**92**	28.9	**226**	71.1
East Dunbartonshire	**287**	**225**	78.4	**62**	21.6	**92**	**30**	32.6	**62**	67.4	**195**	**195**	100.0	**-**	-
East Lothian	**1,081**	**988**	91.4	**93**	8.6	**365**	**334**	91.5	**31**	8.5	**716**	**654**	91.3	**62**	8.7
East Renfrewshire	**224**	**128**	57.1	**96**	42.9	**34**	**27**	79.4	**7**	20.6	**190**	**101**	53.2	**89**	46.8
Falkirk	**1,256**	**991**	78.9	**265**	21.1	**299**	**206**	68.9	**93**	31.1	**957**	**785**	82.0	**172**	18.0
Fife	**3,313**	**2,789**	84.2	**524**	15.8	**933**	**811**	86.9	**122**	13.1	**2,380**	**1,978**	83.1	**402**	16.9
Glasgow City	**4,266**	**2,442**	57.2	**1,824**	42.8	**1,937**	**1,101**	56.8	**836**	43.2	**2,329**	**1,341**	57.6	**988**	42.4
Highland	**3,620**	**2,087**	57.7	**1,533**	42.3	**784**	**489**	62.4	**295**	37.6	**2,836**	**1,598**	56.3	**1,238**	43.7
Inverclyde	**232**	**170**	73.3	**62**	26.7	**87**	**25**	28.7	**62**	71.3	**145**	**145**	100.0	**-**	-
Midlothian	**626**	**562**	89.8	**64**	10.2	**259**	**228**	88.0	**31**	12.0	**367**	**334**	91.0	**33**	9.0
Moray	**967**	**584**	60.4	**383**	39.6	**299**	**191**	63.9	**108**	36.1	**668**	**393**	58.8	**275**	41.2
North Ayrshire	**604**	**423**	70.0	**181**	30.0	**191**	**129**	67.5	**62**	32.5	**413**	**294**	71.2	**119**	28.8
North Lanarkshire	**3,026**	**2,604**	86.1	**422**	13.9	**1,113**	**936**	84.1	**177**	15.9	**1,913**	**1,668**	87.2	**245**	12.8
Orkney	**159**	**68**	42.8	**91**	57.2	**92**	**22**	23.9	**70**	76.1	**67**	**46**	68.7	**21**	31.3
Other	**42**	**42**	100.0	**-**	-	**31**	**31**	100.0	**-**	-	**11**	**11**	100.0	**-**	-
Perth & Kinross	**2,249**	**1,840**	81.8	**409**	18.2	**431**	**242**	56.1	**189**	43.9	**1,818**	**1,598**	87.9	**220**	12.1
Renfrewshire	**367**	**155**	42.2	**212**	57.8	**173**	**47**	27.2	**126**	72.8	**194**	**108**	55.7	**86**	44.3
Scottish Borders	**680**	**455**	66.9	**225**	33.1	**225**	**140**	62.2	**85**	37.8	**455**	**315**	69.2	**140**	30.8
Shetland	**168**	**168**	100.0	**-**	-	**54**	**54**	100.0	**-**	-	**114**	**114**	100.0	**-**	-
South Ayrshire	**1,253**	**1,028**	82.0	**225**	18.0	**214**	**173**	80.8	**41**	19.2	**1,039**	**855**	82.3	**184**	17.7
South Lanarkshire	**4,558**	**3,983**	87.4	**575**	12.6	**997**	**726**	72.8	**271**	27.2	**3,561**	**3,257**	91.5	**304**	8.5
Stirling	**408**	**198**	48.5	**210**	51.5	**144**	**20**	13.9	**124**	86.1	**264**	**178**	67.4	**86**	32.6
West Dunbartonshire	**702**	**323**	46.0	**379**	54.0	**211**	**66**	31.3	**145**	68.7	**491**	**257**	52.3	**234**	47.7
West Lothian	**794**	**600**	75.6	**194**	24.4	**231**	**163**	70.6	**68**	29.4	**563**	**437**	77.6	**126**	22.4

1. Health Board figures are based on NHS board area of treatment. Local Authority figures are based on Local Authority of residence.
There are a small number of patients experiencing a delay in discharge who are residents of local authorities outwith the NHS Board Areas in which they are being treated. This may mean that the NHS board area of treatment is not responsible for the patient's post hospital discharge planning.
This also means that the combined figures for local authorities within a particular NHS board area might not be equal to the corresponding total for that NHS board area.
2. Occupied bed days information is available up to March 2016

Source: ISD Scotland

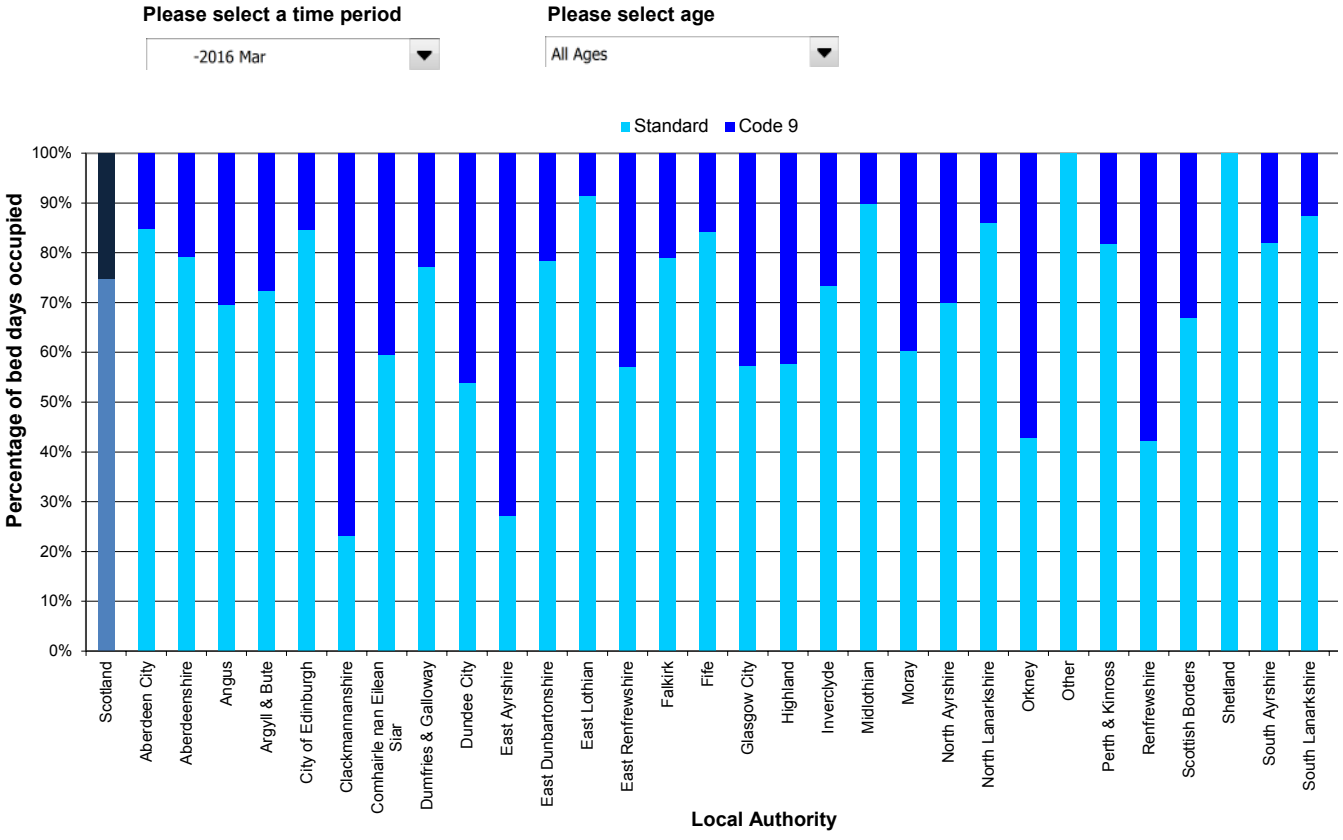
These data are for management purposes only and please treat the material and any indication of the results as restr until public release by ISD.

Tab 5a - Standard and Code 9 Delayed Discharge Bed Days by Health Board: March 2016, All Ages



Please see footnotes

Tab 5b - Standard and Code 9 Delayed Discharge Bed Days by Local Authority: March 2016, All Ages

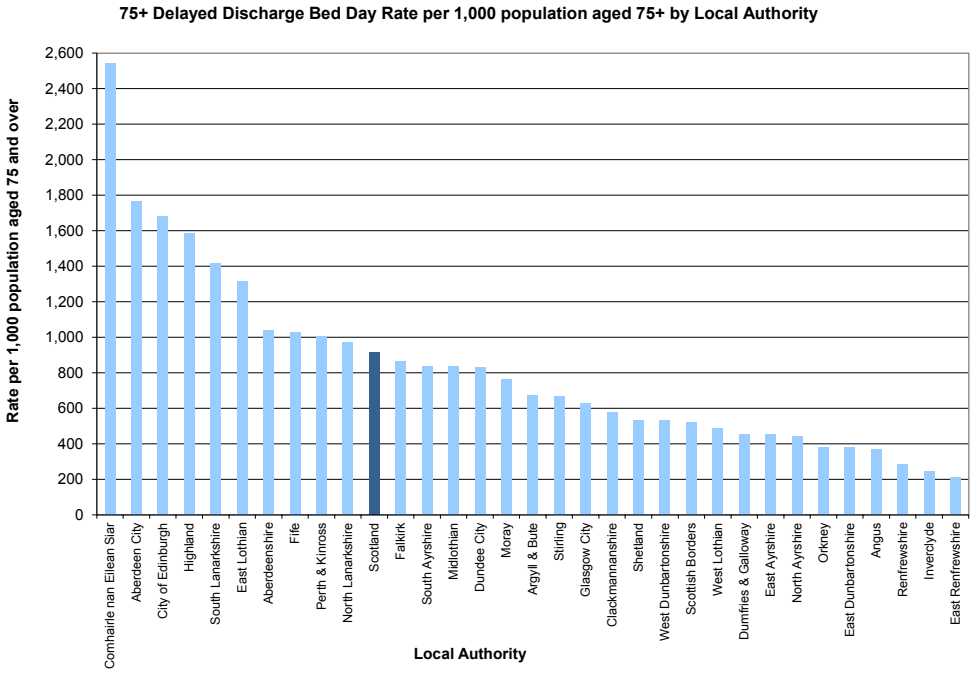


These data are for management purposes only and please treat the material and any indication of the results as restricted until public release by ISD.

PLEASE NOTE THAT THESE TABLES WILL BE UPDATED ON AN ANNUAL BASIS.

Tab 6 - Bed Days Occupied by Delayed Discharge Patients per 1000 Population aged 75+ by Local Authority, April 2015 - March 2016

Local Authority of Residence	Annual 75+ years Delayed Discharge bed day rate per 1,000 population aged 75+
Scotland	**915**
Aberdeen City	**1,765**
Aberdeenshire	**1,037**
Angus	**368**
Argyll & Bute	**673**
City of Edinburgh	**1,679**
Clackmannanshire	**579**
Comhairle nan Eilean Siar	**2,540**
Dumfries & Galloway	**454**
Dundee City	**832**
East Ayrshire	**451**
East Dunbartonshire	**379**
East Lothian	**1,314**
East Renfrewshire	**209**
Falkirk	**864**
Fife	**1,030**
Glasgow City	**627**
Highland	**1,585**
Inverclyde	**244**
Midlothian	**835**
Moray	**764**
North Ayrshire	**443**
North Lanarkshire	**973**
Orkney	**382**
Perth & Kinross	**1,005**
Renfrewshire	**287**
Scottish Borders	**522**
Shetland	**534**
South Ayrshire	**838**
South Lanarkshire	**1,416**
Stirling	**670**
West Dunbartonshire	**530**
West Lothian	**485**



Source: ISD Scotland
Based on 2015 Mid-year population estimates (Council Area of Residence)

APPENDIX 2

Predictive Bed Day Figures for 2016/17

Model A
A methodological approach was taken to predict the number of bed days that would be lost to delayed discharges for those aged 65+yrs. The methodology has been utilised in other HSCPs across Scotland.

- Monthly figures for the past four years were used to calculate a four year average number of bed days.
- The crude rate per 1,000 population (based on 2012 NRS projections) was then applied to calculate the monthly projected figures for 2016/17

The model assumes that all things remain equal, there is no downward trajectory and no improvements are made.

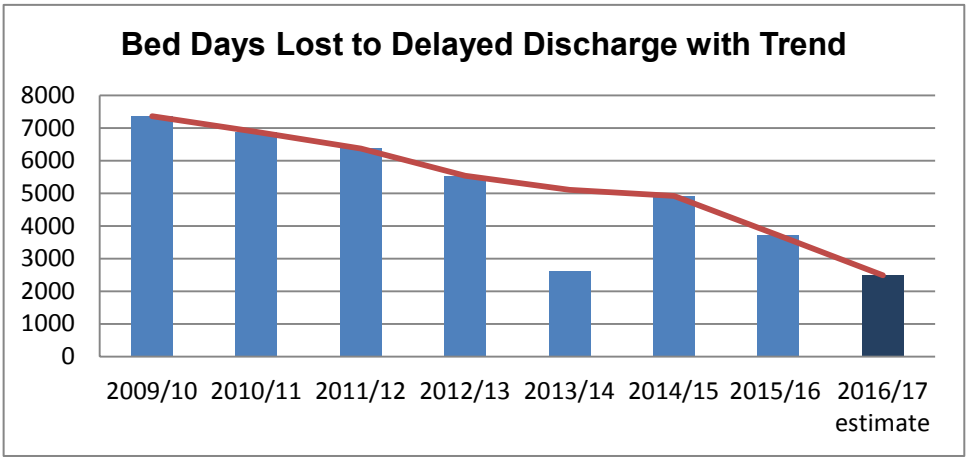
This modelling predicted that the total number of bed days lost during 2016/17 would be **4501**

Model B
Non-methodological, based on trend data. The nominal figure of 300 bed days has been added for March to provide 2015/16 total bed days lost figure.

The overall downward trend has reduced since 2012, and older population predictions have increased, therefore, this model assumes that all no improvementwill be realised and delayed discharges for 2016/17 would remain at would be**3716**

Performance Improvement Assumptions

1 Current Improvement trend will continue on a similar trajectory



FMcC 22/4/16

2 Intermediate Care (I.C.) beds will be operational by 1st October (6 months =182.5 days). Therefore:

- 8 I.C. beds =1,460 bed days
- 6 I.C. beds = 1,095 bed days

3 Performance improvement (e.g. through anticipatory care planning, telecare options, encouraging all service users to consider putting in place PoAs) will reduce beds lost by a further **5%**

	Predicted bed days lost 2016/17	
	Model A (downward trend not included)	**Model B (downward trend included)**
Predicted bed days lost(no change made)	4501 = 12 acute beds approx.	3716= 10 acute beds approx.
8 Intermediate Beds**+**5% improvement	2,888 = 8 acute beds approx.	2,143 = 6 acute beds approx.
6 Intermediate Beds**+**5% improvement	3,234 = 9 acute beds approx.	2,490 = 7 acute beds approx.

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 6

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**Intermediate Care Model**
Report by	**Karen Murray, 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 set out for the Board's consideration and approval a range of proposed service developments designed to further reduce delays of patients from East Dunbartonshire in hospital.

2.0 SUMMARY

2.1 The report proposes a number of service developments, including the commissioning of an intermediate facility in a local care home, an associated model of GP provision, community clinical and home care support, and a process of proactive care management to ensure that patients from East Dunbartonshire are discharged within the Scottish Government's target of 72 hours from being declared fit for discharge.

2.2 Within these developments it is intended that patients with complex needs, identified as fit for discharge, will be transferred by their fit for discharge date to the commissioned intermediate facility where the ongoing work to discharge them to their final destination, be that home or another care setting, will be taken forward and concluded.

2.3 It is proposed that patients will be able to stay within this provision for up to 4 weeks free of charge. Thereafter, standard charging processes will apply. Patient and carer processes of engagement, including publicity leaflets for families and hospital staff will be developed.

2.4 To resource the above proposals, the report seeks the Board's approval to allocate the Partnership's Delayed Discharge funding allocation as outlined.

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board:

i. Notes the content of the report;

ii. Approves the recommendations made by the Multidisciplinary Delayed Discharges Planning Group of the HSCP to move to implementation of Option 1 and Option 4;

iii. Approves the financial and commissioning proposals associated with implementation of Option 1 and Option 4;

iv. Requests a report to the Board after 6 months of the pilot's implementation to monitor progress and impact of the pilot on delayed discharges.

4.0 MAIN REPORT

4.1 Background

One of the key priorities for the Scottish Government is to reduce the number of people waiting to be discharged from hospital. Funding has been made available to health boards and local authorities to deliver good quality care for people at home or in a homely setting. There is a commitment to discharge patients within 72 hours of clinical readiness, so this funding should be used as a catalyst to help partnerships redesign services and create an even greater focus on supporting people to live independently at home or in a homely environment. East Dunbartonshire Health & Social Care Partnership's Delayed Discharge allocation is £510,000 per annum

4.2 Within the HSCP, a multidisciplinary Delayed Discharges Planning Group has been established which discusses all patients whose discharge is delayed, or likely to be so. Information from this group has identified that consistently the median number, calculated over the past 4 years, of delayed discharges at any one time is around 8. This number has been used to cost out the various models described in this report.

4.3 Local data suggests that we have an increasing number of older people living over 85. The majority of our delayed discharge cohort of patients have long term conditions which have impacted on their functionality to such a degree that rehabilitation/enablement may not be an option and that the main emphasis of intermediate care would be about focusing on transition into a care home.

4.4 Commissioned Intermediate Facility

On behalf of the Delayed Discharges Planning Group, a short-life working group has scoped options for intermediate care and rehabilitation, and specifically options to commission a provision of beds that would provide a locus for a range of intermediate and step-down functions that would enable all (or the vast majority of) patients with complex needs from East Dunbartonshire to be discharged from acute hospital settings by, or within 72 hours of their *fit for discharge* date. A copy of the report produced by that working group is attached as **Appendix 1.**

4.5 Based on the findings of the working group it is proposed that a year-long contract is agreed with the identified Care Home A, at the terms outlined, and for the reasons detailed. It is envisaged that this process will be taken forward via a 'restricted' tender which will be compliant with procurement regulations. This is possible due the shorter term 'pilot' nature of the service procured.

4.6 This will provide a comfortable and homely, self-contained, appropriately staffed unit of 8 beds, all in single rooms, within a modern, accessible care home which receives consistently high Care Inspection grades to be the chief intermediate locus within the model we propose. The year-long contract would enable this to be taken forward as a pilot, with a view to review, taking into consideration bed activity, management of voids, performance, and the availability and cost of other beds – especially as the restructure of NHS GG&C Complex & Continuing Care provision goes forward. This restructure may provide opportunity to source alternative intermediate care bed options at a lower cost.

4.7 Assessment and Care Management

Currently patients with complex needs, i.e. those who are unlikely to be able to be discharged back home without significantly enhanced support, if at all, are assessed and have their future care planned agreed and arranged whilst remaining as acute in-patients. Under this model, it is proposed that these patients will be transferred within 72 hours of their *fit for discharge* date to the intermediate facility where these processes, as well as ongoing rehabilitation, will be carried out.

4.8 The responsibility for the coordination of these processes, as well as the management of admission, discharge and through-put to the intermediate facility will rest with the Team Manager - Hospital Assessment. 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 concentration of these patients in a single locus as opposed to a number of discrete hospital sites should enable more efficient deployment of social worker time.

4.9 Within a revised Adults & Primary Care structure, the Hospital Assessment Team (HAT) will have its staffing resources consolidated from current temporary funding sources (ICF, Delayed Discharge fund) as these funds are assumed into the Health & Social Care Partnership's base budget. This strengthening of the social work team will enable the speed and intensity of engagement required to make this model of intermediate intervention effective and sustainable. It is vital that sufficient social work resources are present at all times to ensure that timescales do not stretch, patients do not linger within the system effectively still blocking beds, and that voids do not undermine the financial viability of the model.

4.10 A standard pathway process has been devised which will identify patients whose complexity suggests that their discharge might not be achieved within the 72 hour target unless special measures are put in place. As the early stage of assessment goes forward, these patients will be directed down one of three potential sub-pathways

- Step Down with Advanced Rehab
- Enhanced Care at Home
- Intermediate Assessment and Onward Placement

4.11 The HAT social worker role will be primarily directed towards assessment and care management, including financial assessment and care placement. The community rehab and clinical processes and the enhanced care at home arrangements are set out below. There may be circumstances where the lead in case management is taken by a health professional or a homecare organiser. This will only be the case where the plan is for the patient to return home.

4.12 Rehab and Clinical Support

The intermediate facility we propose to commission is a registered nursing home and will be expected to deliver all the clinical competencies that are contracted within that function. In addition it will be a basic premise that all patients passing through these processes are *fit for discharge*, i.e. they are not acutely unwell and do not require the concentration of skills and resources and the intensity of treatment characteristic of the hospital setting.

4.13 The Community Rehab Team (CRT) currently provides a range of enhanced clinical interventions to patients returning from hospital to the community, via its core service and also through the Rapid Assessment Link. Where a patient is discharged to the intermediate facility or home with an intensive homecare package, where there is ongoing rehab need and potential, this will be provided by the CRT. It is envisaged that this support will be required by up to 30% of complex patients discharged, an average of 2-3 patients at any one time. The service required will predominantly be physiotherapy and OT. It is assumed that this will be provided from currently existing resources. However, this will be kept under review as the pilot progresses.

4.14 Enhanced Model of Homecare

Through the recent Strategic Review of Homecare, resources have been developed to allow the provision of intensive, round-the-clock care at home as an option for individuals 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 service will be available within the eligibility and charging criteria proposed for the intermediate facility, and could be delivered within the patient's home, or using the Telecare Smart Flat in Auchinairn as a base to commence the rehab journey.

4.16 GP Services

The nursing home selected to be the locus of the intermediate facility, Care Home A, already participates in a Local Enhanced Service (LES) relationship with a GP practice. It is intended to seek an extension to this contracted service of 2 x GP sessions in order that the full range of medical cover is available to patients moved to this setting.

4.17 Patient and Carer Support inc. Advocacy

Patients and their families will need to agree to be voluntarily discharged into any of the intermediate arrangements being developed. A range of information materials will be developed outlining the processes involved, timescales, conditions, charging etc. It is important that the temporary nature of these interventions does not add to the distress and confusion sometimes experienced by older people who reach a point where they are no longer able to live safely at home. A person-centred approach must be maintained at all times. Care Home A has been chosen in part because of its excellent track record in this regard. An expanded bespoke advocacy service has already been

commissioned as a one year pilot to work with patients being discharged from hospital and their families. This will be continued, and advocacy will have a consistent presence in the intermediate unit within the home. Advocacy arrangements will be evaluated and reviewed as part of the wider review of the pilot.

4.18 Adults with Incapacity (AWI)

It is important to emphasise that in order to participate in any of the intermediate arrangements proposed, patients will need to be discharged from hospital. This means that individuals delayed in hospital who do not have capacity and who do not meet the criteria which would permit them to be moved under Sect. 13 ZA of the Social Work (Scotland) Act cannot be moved to the intermediate unit. It is therefore vital that the range of proactive, preventative work that is currently being undertaken to prevent AWI delays continues and strengthens. Current arrangements that enable the transfer of AWI patients to commissioned care settings supported by Acute clinicians will continue.

4.19 Practical Arrangements, e.g. transport

It is expected that hospital Patient Transport arrangements will continue to be the primary means of transporting individuals to their next location at point of discharge. Patients moving on from intermediate care will have their transport coordinated by the care manager. With regard to family and carer contact, financial assistance with transport costs will be provided in any circumstances of hardship. In some cases this will involve the practical arranging and funding of taxis. This will also be coordinated by the care manager.

4.20 Financial Assessment and Charging

All of the intermediate options proposed will be made available for up to 4 weeks free of charge while the patient's next move is being considered and planned. In cases where the patient cannot return home and a care home is the destination being worked towards, then the normal financial assessment process will be undertaken. It is likely that, from time to time, disputes will arise with individuals and their families with respect to eligibility for public funding and ongoing care home fees. It is vital that such disputes do not interrupt the process of moving patients on to their final destination. It must be emphasised from the outset that 4 weeks is the maximum length of stay and that patients (and their families) will be liable for the full cost of whichever intermediate arrangements they are subject to should they stay beyond this limit.

4.21 Performance Management

The substantial funding proposed to support these intermediate arrangements is predicated upon their having significant impact on the partnership's Delayed Discharge performance. Work has been carried out, using a standard methodology employed across NHS Greater Glasgow & Clyde, to set a target level of bed days lost for year 2016-17. This work, which is set out within **Appendix 2**, factors in the impact of these proposals from an estimated start date of 1st October 2016. It sets a target for 2016-17 of 2143 bed days. This represents a further reduction of bed days lost of > 50% as compared to current performance. Model A as outlined in the Appendix 2 predicts the use of approximately 10 acute beds by delayed East Dunbartonshire patients at any one time. With the provision of intermediate beds, this falls to just under 6 beds at any one time – a saving of 4 acute beds.

4.22 Financial Framework

The total costs of the proposals for intermediate provision in the pilot phase are detailed below. The partnership's allocation of Delayed Discharge funding is £510k per annum. All of these costs will be dr awn from this funding. At this stage no further funding is sought for extra staffing resources. It is calculated that the social work, rehab and homecare contributions assumed will come from within existing resources.

Table 1

Cost	**Funding**
Commission 8-bedded unit at Care Home A for 1 year	£345,280
Extend GP LES contract x 2 sessions	£21,840
Fees relating to the registration of Auchinairn Smart Flat	£4,000
Carer Transport Costs	£5,000
TOTAL	**£376,120**

APPENDIX 1 Options Report re. Intermediate Care Provision

1.0 PURPOSE

1.1 The purpose of the report is to allow the multi-disciplinary Delayed Discharges Working Group to consider the attached proposal which describes a range of service options for intermediate care to support delayed discharges in East Dunbartonshire and to make recommendations to the Health & Social Care Partnership Board.

2.0 SUMMARY

2.1 Local data suggests that we have an increasing number of older people living over 85. The majority of our delayed discharge cohort of patients have long term conditions which have impacted on their functionality to such a degree that rehabilitation/enablement may not be an option and that the main emphases on intermediate care would be about focusing on transitions into a care home. Within the HSCP, a multidisciplinary delayed discharge meeting has been established which discuss all delayed discharge clients. Modelling of the service use of acute beds for delayed discharges suggests that in order to meet the 72 hour target for discharge, 8 intermediate beds will be required. This number has been used to cost out the various models described in this paper.

2.2 The range of options considered were:-

Option 1. An 8 bedded unit in a care home within East Dunbartonshire. Costs provided on four care homes within our locality. The proposed functionality of unit would be:-

- 6 beds - for intermediate care assessment only
- 2 beds for step down function

Option 2. Information on a unit in Glasgow City. Bed function ratio as above.
Option 3. Sheltered housing complex - a mixed model of service delivery
Option 4. SMART flat - steps down/step up unit in conjunction with an Intermediate Care at Home model

3.0 RECOMMENDATIONS

3.1 The Delayed Discharges Working Group recommend for approval by the HSCP Board that Option 1 and Option 4 are funded, as a pilot for 12 months and evaluated before the model is continued.

4.0 BACKGROUND

4.1 One of the key priorities for the Scottish Government is to reduce the number of people waiting to be discharged from hospital. Funding has been made available to health boards and local authorities to deliver good quality care for people at home or in a homely setting. There is a commitment to discharge patients within 72 hours of clinical readiness, so this funding will be used as a catalyst to help partnerships redesign services and create an even greater focus on supporting people to live independently at home or in a homely environment.

4.2 Over the next few years in East Dunbartonshire our overall population is predicted to decrease by 0.5%, while the 85+ 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-patient 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 HSCP. 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.

4.3 Local data suggests that the majority of our delayed discharge cohort of patients 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 focusi on transitions in to a care home. There should however still be an opportunity for the promotion of rehabilitation, reablement and self management for those with identified potential to return home. This paper will therefore provide options to create a mixed intermediate care model to reflect the diversity and needs of our local population

4.4 Within the HSCP, a multidisciplinary delayed discharge meeting has been established which discusses all delayed discharge clients and those who potential could be delayed. Modelling of the patterns of available data of acute bed use suggests the number of delayed discharges is around 8. This number has been used to cost out the various models described in this paper.

4.5 Options to be considered

Option 1. An 8 bedded unit within a care home within East Dunbartonshire locality

- 6 beds - for intermediate care assessment only
- 2 beds for step down function

Option 2. A unit within the wider function of a Glasgow City care home. Bed function ratio as above.

Option 3. Sheltered housing complex - a mixed model of service delivery

Option 4. SMART flat - steps down/step up unit in conjunction of an intermediate Care at Home model

4.6 Broad Aims of Intermediate Care

The broad aims of an integrated care bed unit/service to support people with complex needs are:-

- To support people to live independently at home or be placed within a homely setting (care home or sheltered housing) in their community.
- To improve outcomes for older people. Elements for the service should include the promotion of prevention, early intervention, diversion from hospital and institutional care and earliest possible discharge from hospital.
- To reduce the number of older people delayed in hospital when they are fit for discharge
- To reduce the number of older people moving into care or to provide alternative options within the community

4.7 Charges

Placement time limited to 4 weeks. During the assessment period, the intermediate care service will be free of charge however if the service user remains beyond the assessment period, residential care charges will apply. It is expected that service users would pay for sundries.

4.8 Option 1 – Intermediate Care Beds

Function of unit

- Opportunity for further social work assessment following discharge from hospital predominately for placement in to a care home
- A rehabilitation and enablement approach within the step down element of the unit where:-
  - All relevant clients assessed to determine their level of function
  - Focused rehabilitation and goal planning
  - Undertake home visits including environmental and Telecare assessment to maximise opportunities to return home.
  - Anticipatory care planning

Community Rehabilitation Team (CRT)

The CRT would provide the rehabilitation skill mix for the service. Whilst this would predominantly be undertaken by Physio's and OTs, there is good interface and crossover with other members of the CRT so there may be times when those professions like Dietiticians and CPN would be utilised to deliver this service.

Costing options

1. For additional AHP/Social Work staff
2. Provision of service to be consumed within current service delivery.

Option 1a Care Home A (West)

Care Home A	Option 1	Option 2	Comments
Cost of unit for 1 year - £830 / wk	345,280	345,280	
GP Cover	21,840	21,840	Based on 2 sessions weekly on top of LES. This may be reduced
1 Band 6 AHP	43,000		Skill mix from OT and Physio within CRT
1 Band 4 RSW	27,300		
0.5 Social Worker	21,757		
Total	**459,177**		

Advantages:

- Self-sufficient unit currently existing within care home
- LES GP well established in Care home
- Close to railway station

Risks:

- Poor access for service users living in East locality
- Care home will not negotiate costs from the quote they have provided

Option 1b Care Home B (East)

Care Home B	Option1	Option 2
Cost of unit for 1 year - £649 / wk	312,000	312,000
Staff costs as above	92,057	
GP Cover	21,840	21,840
Total	**383,881**	**291,824**

Advantages:

- The location would serve a wider geographical catchment
- Adequate public transport

Risks:

- Continued concerns regarding service quality and leadership
- Poor Care Inspectorate reports
- Current challenges re. the operation of GP LES

Option 1c Care Home C (East)

In this model the Care Home would allocate a 15 bedded unit to the HSCP, so this facility would incorporate a mixed care group / multi functional purpose unit. For the purpose of this report, this has been costed pro-rata for 8 beds, 2 of which would be step down beds.

Care Home C	Option 1	Option 2
Cost of unit for I year - £750 / wk	312,000	312,000
Staff cost as above	92,057	
GP cover	21,840	21,840
Total	**425,897**	**333,840**

Advantages:

- New facilities with up to date technology
- Potential to work with care home staff from the point of opening of unit

Risks:

- Untried business model. Potential financial risk until service has been established
- No Care Inspectorate information available
- No identified GP cover as yet

Option 1d Care Home E (West)

Care Home E	Option 1	Option 2
Cost of unit for 1 year - £649 / wk	269,984	269,984
Staff cost as above	92,057	
GP cover	21,840	21,840
Total	**383,881**	**291,824**

Advantages:

- Care Home can identify 8 beds at the COSLA rate
- Large modern home, popular in its locality

Risks:

- Concerns expressed by Care Inspectorate
- Travel links adequate, but poor access from East locality

4.9 Option 2 – Outwith East Dunbartonshire

Option 2 Care Home E (Glasgow City)
Currently 60 beds of this 120 bedded care home have an NHS Continuing Care provision. This is being reviewed following the revised guidance on Hospital-Based Complex Clinical Care. The contract for this service will formally move to Glasgow City HSCP in July 2016. there is an opportunity to have wider discussion with partners on the developing functionality of these premises.

Care Home E	Option 1	Option 2	Comments
Cost of unit for 1 year	Unknown as yet		Still waiting for cost per bed
Staff cost as above	92,057		
GP cover	21,840	21,840	
Total			

Advantages:

- There is already a skill base and ethos established within the care home for delivery of expertise of continuing care
- Although in Glasgow City, very accessible from both sides of East Dunbartonshire

Risks

- LES GP element may need to be established, currently RMO function performed by geriatricians
- Outwith East Dunbartonshire

4.10 Option 3 – Sheltered Housing Model

Potential model would be to revamp a 20-bedded sheltered housing accommodation and utilize 8 beds for intermediate care / step down with the additional beds used for supported living placement for learning disability clients. 24 hour wardens would undertake personal care tasks. A three shifts pattern necessary to cover 24/7. Additional home care necessary to complement the delivery of personal care tasks.

Based on 8 Flats			
	WTE		**Comments**
Warden (Dayshift) x 5 days (Mon to Fri)	1.0	27,300	
Warden (Backshift) x 5 days (Mon to Fri)	1.0	36,309	
Warden (Nightshift) x 5 days (Mon to Fri)	1.0	29,047	
Warden(Dayshift) x 2 days (Sat and Sun)	1.0	10,920	
Warden (Backshift) x 2 days (Sat and Sun)	1.0	14,523	
Warden(Nightshift) x 2 days (Sat and Sun)		21,786	
Homecarer (Mon to Fri) (8am to 1 pm)	1.0	33,022	
Homecarer(Mon to Fri) (4pm to 6.30pm)	1.0	16,514	
Homecarer(Mon to Fri) (8pm to 11pm)	1.0	13,174	
Homecarer(Sat and Sun) (8am to 1 pm)	1.0	13,208	
Homecarer(Sat and Sun) (4pm to 6.30pm)	1.0	6,604	
Homecarer(Sat and Sun) (8pm to 11pm)	1.0	5,268	
AHP Band 6	1.0	43,000	
RSW Band 4	1.0	27,300	
Social Worker	0.5	21,757	
TOTAL STAFFING COSTS		**£319,732**	
Electricity and Gas		20,800	£50 per week
Rent		166,400	£400 per month
Telecare		4000	£500 one off spend
Total Cost		**£510,932**	

NB – These costs are for the whole unit – would be pro-rata for 8 intermediate beds

Advantages:

- A multifunctional residential unit providing accommodation for older people and disabled adults
- Warden costs would resource the support of all clients not just intermediate care
- Assessment would be carried out in a homely environment allowing service users to explore sheltered housing as a long term option

Risks:

- Location not particularly accessible
- Complete remodeling of role and function of wardens and other staff
- Considerable, although one-off, investment required to upgrade premises

4.11 Option 4 - SMART Flat- step down / step up unit

Two bedded flat fitted out with Telecare would be supported by the intermediate care at home service. This facility would be tightly controlled / monitored with placements lasting up to one week. The unit could be prioritized for situations where a carer was in crisis, as an alternative to respite. A phased approach could be deployed in conjunction with a step down facility.

Advantages:

- Existing facility not currently used to full capacity and function
- Would encourage more uptake of Telecare

Risks:

- Would need to be considered as part of a wider package as this option may need to be used in conjunction with rehabilitation and intermediate care at homes service if required.

Cost of care commission registration	4,000
Total	**4,000**

This option would require in-reach / out-reach support as below:

The intermediate care at home model would be a resource for complex clients who following discharge from hospital:

- Could be supported at home with a personal care package over a 24 hour period
- Require further assessment within the home environment to ascertain a longer term placement.

Pathway

- A discharge planning meeting (coordinated by HAT) would identity those clients who would benefit from this service.
- The intermediate care at home service would use an multi agency approach to determine which care at home package would be appropriate
- Package would be in place at point of discharge for up to four weeks

Three pathway options available:-

- Standard care at home package
  Delivery of personal care tasks identified from assessment
- Intermediate care at home service
  Initial settling in visit would support safe transfer in to the home environment. This may include purchasing the provision of groceries, heating the property etc. Coordinated interface with relevant voluntary organisations to provide a coproduction model to deliver community support.

- Intermediate Smart flat with clients existing care at home package to support individual's reablement/rehabilitation goals through time specific placements within this environment.

Cost
Consumed within the current service delivery.

Summary
This paper provides high level information on the potential options for an intermediate care service within East Dunbartonshire. These services aim to support people to live independently at home or be placed within a homely setting (care home or sheltered housing) in their community whilst also addressing delayed discharges using a timely and coordinated service delivery model.

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 7

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**Commissioning Proposals regarding the discharge of patient with complex needs**
Report by	**Andy Martin, Head of Adult and Primary Care Services**
Contact Officer	**Gillian Healey, Planning & Service Development Manager** **0141 777 3074** **Gillian.healey@eastdunbarton.gov.uk**

1.0 PURPOSE OF REPORT

1.1 To inform the HSCP Board of the steps undertaken to identify an appropriate service to support the safe discharge home of a patient with complex needs, and to seek approval to commission the identified service by a negotiated route and at the terms proposed.

2.0 SUMMARY

2.1 Patient KS has been designated *fit for discharge* since November 2015. He has complex needs including the requirement to be ventilated via a tracheostomy.

2.2 A range of potential support packages to allow him to be discharged from hospital have been explored, thus far without success.

2.3 Patient, who has capacity, has insisted that he wishes to be discharged to his home in Bearsden.

2.4 A provider, Pulse Community Healthcare, has been identified who can arrange and provide a comprehensive package of care, including tracheostomy management, which will enable Mr. Smith to be discharged home. Costs and conditions relating to this proposal are detailed below.

2.5 Because of the scale and costs of the proposed package, standard European Union procurement conditions will apply to the commissioning of this support service ongoing. This is likely to require a process of some length.

2.6 In order to secure patient's earliest discharge home, it is proposed to engage with the provider identified on the basis of a restricted tender for a period of one year, pending a full tendering exercise.

3.0 RECOMMENDATIONS

3.1 The HSCP Board are asked to note:

a) The progress on securing an appropriate care package for this patient with complex needs to be discharged home

b) Note that HSCP Strategic Development Group approved the proposal to commission the service for one year

c) Further work is being undertaken by the commissioning team with support from Council Procurement and Legal departments the development of a framework for commissioning of complex care packages.

1.0 BACKGROUND

1.1 Patient, KS, has been cared for within the Intensive Treatment Unit of the Queen Elizabeth University Hospital since August of 2015. Prior to this he was cared for within a similar unit at the Western Infirmary. He has been diagnosed as suffering from Guillaume-Barre's disease which renders him paralysed from the neck down and reliant on artificial ventilation delivered via a tracheostomy. He was been designated *fit for discharge* on 27th November 2015. The current and rising delay of his discharge amounts to 146 days.

1.2 Over a period of nearly 2 years since its onset, there has been no improvement or remission in the patient's condition and his prognosis is that he will remain paralysed for the rest of his life. Despite this, the patient's general health remains reasonably good.

1.3 Discussions have taken place with NHS Greater Glasgow & Clyde Acute leads as to the possibility of the patient being considered for Complex and Continuing hospital care. He has not been agreed as falling within the eligibility for consideration of this option because, contrary to the criterion set out in the revised Guidance, his condition can be managed and treated outwith hospital. In any case, the patient has stated, and continues to state, his profound wish to be discharged home. The patient retains full capacity.

1.4 Anticipating that there was likely to be a significant cost attaching to the patient's support upon discharge, regardless of which type of package was eventually put in place, an alert was put into the Cost of Current Level of Service (CCLS) Budgetary planning process for 2016-17. This resulted in £150,000 being provided within this year's budget. It was always anticipated that this sum would fall considerably short of the full financial resource required.

1.5 A number of options involving using an interim locus for the patient to be discharged to have been explored. These have included a nursing home close to his home in Beardsen and a local respite facility. None of these have proved viable due to the reluctance of the patient and his family to agree them and the reticence of providers to participate in a régime of care as complex as the one required. All of these options would still have required the bulk of funding necessary to support the delivery of his tracheostomy management and care.

1.6 Pulse Community Healthcare is an experienced national provider of complex health care with a track record in delivering tracheostomy care to patients in the community.

They have indicated that they would be able to provide a comprehensive, round-the-clock support service to the patient delivered within his home at a cost of **£6,655 per week (annual cost of £346,107)**.

1.7 These figures reflect very high staffing costs stemming from a staff/management/on-call team who are highly skilled/trained and span social care/general health/clinical specialism. Pulse, for this tariff, would recruit, train and deploy a team of 12-14 carers working a rota around the clock to provide seamless cover within the family home, with speedy access to external management support and relief cover from within Pulse's wider resources. It is envisaged that in addition to this specialist team there will be significant call upon HSCP staffing resources including District Nursing, Rehab AHP and Homecare to enable patient to be safely and sustainably discharged.

1.8 If commissioned, Pulse indicate that they could recruit, train and be ready to deploy the care team within 8 – 12 weeks. They are already in the process of training carers for similar tasks within the ITU in the Queen Elizabeth University Hospital where KS is currently a patient.

1.9 Clearly a commission of this scale going forward will require to be delivered through a tendering process that complies with European Union Procurement Regulations. This process is likely to take a protracted period of time adding to the already considerable delay that has attended the patient's discharge. It is therefore proposed to engage Pulse on the basis of a negotiated tender and to contract with them on that basis for 1 year pending the delivery of a fully EU Regulations-compliant tendering process.

Pulse
Community Healthcare

Pulse Community Healthcare Overview

Andy Martin, Commissioner

East Dunbartonshire Council

Quality | Choice | Independence

We work as a trusted partner with over 200 commissioners, supporting people with a variety of specialist care and clinical needs. Enabling our clients to live the life they want and offering each empowerment and choice, which is at the heart of everything we do.

Working in close partnership with our clients and their families, friends, carers, commissioners, local organisations and hospital teams, we provide safe and effective healthcare services to people in their own homes and communities. We have a proven track record of supporting a wide range of short and long term complex care conditions and a reputation for delivering excellence across all aspects of case management. We also have experience in developing and implementing large-scale, managed service care provision.

Our local presence means we understand local communities and this has been hugely beneficial for our clients. You can be confident that our quality assurance and clinical governance procedures are robust and not only meet, but exceed UK legal requirements.

Areas of specialism include:

- Learning disabilities
- Mental health
- Acquired brain injury
- Spinal injury
- Paediatrics
- Palliative/End of life
- Neurological
- Physical disabilities

Continuity of Care

Through careful recruitment we aim to ensure that throughout the provision of each package of care, individuals receive the benefit of a sustained support team, with key individuals providing all support on a regular basis. We recognise that this aids in effective care provision, and ensures minimal disruption to individuals, especially where they require a stable support team to ensure they feel safe and familiar with their team of staff.

We recruit teams of support workers specific to each individual client, and encourage the client and their family to participate in the recruitment process, enabling choice and control over their care by choosing their own support team. This includes introducing potential workers to a client and their family via ‘meet and greet’ sessions, in addition to encouraging the individual/their family to interview each worker.

Finding the right support team takes time and planning and this process ensure that all involved get to know one another, build trust and familiarity, and has proved to increase the stability of the care team. We adopt the ethos of recruiting support staff locally to ensure they have the local knowledge to access community services.

To ensure consistency and continuity of care at all times, we identify and train a back up support team, who are familiar with the client and their full support needs, meaning that in the event of any absence (planned or unplanned) of the clients regular support team, the

back-up team are able to step in and ensure continuity in the quality of support. In addition, all members of the teams are introduced and selected by the individual/family as detailed above.

Obtaining the right skills to support a client

Before any support worker can commence working with the client, they must complete all mandatory and any specialist training required to support the client. (e.g. specific behavioural training or training to maintain specialist equipment and emergency procedures). Our dedicated Community Nurse will observe practice to ensure their clinical competence before they can work with the client on a 1:1 basis. In some cases we will identify a specialist nurse to work with the client, alongside our specialist support workers to provide the most appropriate environment for the client.

To provide a quality and bespoke care service to clients following a full assessment of the client, and detailed discussions with the wider multi disciplinary team, a bespoke training plan will be agreed taking into consideration the client's social, behavioural, physical and mental well being needs. We recognise the importance of ensuring the support team have the necessary observational skills and can identify how to support the client socially in an appropriate context dependent upon the client's needs and capabilities. We offer assessment, education and support to be able to understand how the client's condition affects the individual, their family and the people supporting them.

Our internal training specialists will provide the care team with personalised training, covering all of the client's identified health needs. This will be delivered prior to us becoming involved in their support package; the Community Nurses will observe practice to ensure their clinical competence before they can work with the client on a 1:1 basis. Our mandatory and specialist training to support a client will include (but not limited to):

- Induction Day
    - Understand the principles of delivering personal care to clients through a person-centred approach
    - Understand best practice and legal requirements for record keeping and documentation
    - Understand the importance of good communication
    - Have the knowledge to apply equality and diversity to all aspects of the role
    - Recognise and maintain professional boundaries
    - Understand the process and rationale for gaining informed consent
    - Understand the principles of the MCA / Adults with Incapacity Act and associated assessments
    - Be confident in the recognition and reporting of incidents and complaints
    - Be informed of any updates in relation to the legal framework and other relevant Acts

- Moving and Handling
    - Define the term 'Manual Handling'
    - Understand the relevant pieces of legislation relating to Manual Handling
    - Outline employers and employees responsibilities according to the Manual Handling Operations Regulations 1992

- Cite the core principles of safe handling of people/loads
- Apply these principles to various handling situations
- Carry out adequate risk assessments relating to Manual Handling
- Follow the correct procedure for reporting of accidents/incidents

- First Aid and Basic Life Support
  - Awareness of the legalities surrounding Basic Life Support & First Aid
  - Recognise injury and /or accident and provide immediate first aid.
  - Demonstrate the principles of basic life support and their role as candidate in providing resuscitation effectively.
  - Provide a level of competency to meet the Resuscitation Council guidelines 2010.
  - Explain the use of associated equipment and techniques of improvising in the home.

- Management of Medicines
  - Have a clear understanding of the legal issues in relation to controlled drugs and show an awareness for types & routes of medication
  - Show a clear and basic understand of medication calculation.
  - Recognise acceptable terminology and abbreviations used in medicines management
  - Understand the difference between how to administer and assist medication
  - Know how and why to recognise and report errors

- Refresher Day (Meds, BLS, M&H) is undertaken every 12 months by all staff
  - Define the term 'Manual Handling'
  - Understand the relevant pieces of legislation relating to Manual Handling
  - Outline employers and employees responsibilities according to the Manual Handling Operations Regulations 1992
  - Cite the core principles of safe handling of people/loads
  - Apply these principles to various handling situations
  - Carry out adequate risk assessments relating to Manual Handling
  - Follow the correct procedure for reporting of accidents/incidents
  - Awareness of the legalities surrounding Basic Life Support & First Aid
  - Demonstrate the principles of basic life support and their role in providing resuscitation effectively.
  - Provide a level of competency to meet the Resuscitation Council guidelines 2010.
  - Explain the use of associated equipment and techniques of improvising in the home.
  - Have a clear understanding of the legal issues in relation to controlled drugs and show an awareness for types & routes of medication
  - Recognise acceptable terminology and abbreviations used in medicines management
  - Understand the difference between how to administer and assist with medication
  - Know how and why to recognise and report errors and near misses.

- Paediatric Basic Life Support
  - Demonstrate the principles of basic life support in babies and young children and their role as candidate in providing resuscitation
  - Provide a level of knowledge to meet the Resuscitation Council guidelines 2010
  - Explain the use of associated equipment and of techniques used to improvise in the home
  - Understand the candidates role in relation to Pulse Policies & Procedures

Client Specific Training

Supporting a client with Gullian-Barre syndrome can present different challenges depending on the severity and symptoms. Clients are known to experience paralysis or unsteady on their feet, double vision, difficulty chewing or swallowing (sometimes needing to be PEG fed), difficulty with bladder control and digestion and they can also experience difficulty with their speech.

We have extensive experience of supporting people with complex care needs and realise these cover a very broad spectrum of conditions, and only once a full assessment is complete can a bespoke plan be formulated, the core basis of support should take into consideration:

- Fall Prevention
  - Specific strategies for each individual client and their home environment.

- Involuntary movement
  - Understanding these movements and how best to manage these.

- Communication
  - Strategies to assist the support worker to maximise their communication with the client breaking down questions into smaller steps and try to ask closed questions, speaking slowly and clearly.
  - We would work alongside dieticians and SALT to agree a care plan, documenting the clients' nutrition and language plan which will be available to everyone involved in the clients care and a copy will be kept within their home.

- Weight loss
  - Strategies to minimise weight loss

- Choking/Swallowing disorder
  - Strategies for ensuring that meals are enjoyed in a safe way and minimise the risk of choking.

- Clinical observations
  - Understand the relationship between the clients clinical observations and the clients state or condition
  - Demonstrate the ability to take and record the following observations: Temperature, blood pressure, pulse, respirations and oxygen saturations

- Bladder management
  - Understand the anatomy and physiology of the urinary tract
  - Understand and apply the impact of health and well-being in relation to bladder management
  - Demonstrate a knowledge of the principles of conveen and suprapubic and urethral catheter care

- Personal care
  - Understand what personal care involves

- Know how to provide comprehensive personal care to a client, whilst maintaining their choice and independence

– Pressure area management
  - Understand and demonstrate a knowledge of the skin and underlying tissues
  - Identify and take necessary precautions to prevent pressure sores
  - Understand the recommendations for treating pressure sores
  - Know the correct reporting procedures

We provide care within the NICE guidelines and ensure we work in partnership the wider multi disciplinary team to provide a full holistic care plan, which may include:

- Neurologists
- Physiotherapists
- Speech and Language therapist
- Occupational therapist
- Psychologist
- Specialist MS nurses

Other specialist courses

- Management of a spinal cord injury (In addition to this course we would expect candidates to attend the bladder, PAC and bowel course, so they attend a second 7.5 hour teaching day)

- Have a knowledge and understanding of the anatomy and physiology of the normal spine and the nerve pathways
- Understand the different sites, types and complications of spinal injuries
- Demonstrate a knowledge of the care and management of a spinal client through a person-centred approach
- Understand the condition autonomic dysreflexia, including recognition of symptoms, prevention and treatment
- Demonstrate the ability to accurately monitor, interpret and record a clients Temperature and Blood Pressure

– Acquired Brain Injury

Our workers are thoroughly competent in supporting people with Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI) and associated conditions and can provide enabling care. We offer short or long term specialist services for clients with a variety of needs such as support with:

- Daily living skills -
- Social interaction
- Confidence building
- Emotional support -
- Advocacy

– Huntington ’s Disease

All care workers supporting someone with Huntington’s disease will undertake specialist Awareness Training, which is delivered by an external Huntington’s Community Nurse Specialist.

- Introduction to cerebral palsy
    - Demonstrate a knowledge and understanding the disease and associated disability
    - Recognise the signs and symptoms of a worsening condition
    - Know the principles of maintaining independence in relation to the activities of daily living
    - Demonstrate an understanding of the appropriate care and management of the clinical interventions

- Epilepsy awareness
    - To have a basic understanding of epilepsy - the condition, seizure types, diagnosis, and treatment
    - Understand the theoretical care of a client with epilepsy, including emergency
    - Seizure first aid and the administration of buccal midazolam and rectal diazepam

- Tracheostomy and ventilation course
    - Know of the anatomy and physiology of the respiratory tract
    - Understand the various types of tracheostomies
    - Understand the indications and complications associated with tracheostomies
    - Know the theory of caring for and managing a client with a tracheostomy, including the cleaning, changing and suctioning of tracheostomies
    - Know the anatomy and physiology of the respiratory tract
    - Be able to describe the mechanics of breathing
    - Understand the indications and complications for invasive ventilation
    - Know the basics behind the 8 main modes of ventilation (VCV, PCV, CPAP, BPAP, SIMV, PS)
    - Know the theory of managing an invasively ventilated client, including the care of the machine, use of oxygen, nebulisers, manual bagging, tracheal suctioning, humidification (active and passive) and adjunctive therapies

- Multiple Sclerosis
    - Multiple Sclerosis is a complex disorder that can impact on many aspects of life in varying degrees, depending on whether the person has relapsing, secondary or primary MS. People with MS may experience visual problems, muscle spasm, neuropathic or musculoskeletal pain as well as mobility and cognitive problems.

- Oral and nasal suctioning
    - Have a comprehension of the anatomy and physiology of the respiratory tract
    - Recognise the clinical indications for suctioning
    - Demonstrate knowledge and recognition of associated complications of suctioning
    - Know the theory of performing oral and nasal suctioning techniques

- Cough assist and assisted cough
    - The ‘normal’ cough process
    - The theory of performing the assisted cough including its indications and complications
    - The theory of performing the cough assist including its indications and complications

- An Introduction to motor neurones disease (In addition to this course we would expect candidates to attend the NIV and gastrostomy course. So they attend a 7.5 hour teaching day)

- Know and understand motor neurone disease and its associated disabilities
- Recognise the signs and symptoms of motor neurone disease
- Know the principles of maintaining the client's independence in relation to the activities of daily living
- Understand the treatment and symptom control available for someone with motor neurone disease

- Non-invasive ventilation
  - Know the anatomy and physiology of the respiratory tract
  - Be able to describe the mechanics of breathing
  - Understand the indications and complications for non invasive ventilation (NIV)
  - Know the basics behind the two main modes of ventilation (CPAP, BPAP)
  - Know the theory of managing a client receiving non invasive ventilation, including the care of the machine, use of oxygen, nebulisers and oral and nasal suctioning

- Specialist medication (Including rectal medication and subcutaneous injections)
  - Understand the legal requirements for the administration of medication
  - Understand the requirements for medication administration
  - Know the process for administrating rectal preparations and subcutaneous injections

- Gastrostomy care and management
  - Understand the anatomy and physiology of the gastrointestinal tract
  - Understand the indications and complications of gastrostomy and jejunostomy tube insertion
  - Demonstrate knowledge and understanding in the care, management and monitoring of the gastrostomy and jejunostomy tubes
  - Demonstrate a knowledge of drug and feeding administration through gastrostomy and jejunostomy

- Enteral feeding tube care and management
  - Understand the anatomy and physiology of the gastrointestinal tract
  - Understand the different types of enteral feeding tubes, including naso-gastric, gastrostomy and jejunostomy tubes
  - Understand the indications and complications of enteral feeding tube insertion
  - Demonstrate knowledge and understanding in the care, management and monitoring of the enteral feeding tubes
  - Demonstrate a knowledge of drug and feeding administration through enteral feeding tubes bowel management
  - Understand the anatomy and physiology of the large & small intestine
  - Understand and apply the impact of health & wellbeing in relation to bowel management (constipation and diarrhoea)
  - Demonstrate a theoretical knowledge of the principles of bowel management and practice insertion of a suppository and digital rectal stimulation and manual evacuation of faeces

- Nasogastric tubes
  - Understand the anatomy and physiology of the upper gastrointestinal tract
  - Understand the indications and cmplication for nasogastric tube insertion

- Demonstrate knowledge and understanding in the care, management and monitoring of the nasogastric tube
- Demonstrate knowledge of drug and feeding administration through nasogastric tube.

- Stoma management
  - Have a knowledge and understanding of the anatomy and physiology of the digestive tract
  - Understand the reasons for the creation of a stoma, including urostomies, colostomies and ileostomies
  - Demonstrate a theoretical knowledge in the management and care of a stoma, including the application, emptying and removal of stoma bags

- Diabetes mellitus
  - Know and understand normal insulin production and types of diabetes
  - Have an awareness of different treatment plans and the issues surrounding them
  - Understand and demonstrate how to safely administer appropriate medication, including subcutaneous injections
  - Recognise signs, symptoms and treatments for hypo/hyperglycaemia
  - Demonstrate an understanding in the monitoring, recording and reporting of a client's blood sugars

- Introduction to mental health
  - Know and understand various mental health disabilities and their associated conditions, including dementia, alzheimer's and depression
  - Know the principles of support and treatment for someone with mental ill-health
  - Utilise appropriate communication methods and recognise barriers to communication

- An Introduction to challenging behaviour
  - Understand what is meant by the term 'challenging behaviour'
  - Know what influences and impacts challenging behaviour
  - Understand the potential consequences of challenging behaviour
  - Understand how to support an individual who experiences challenging behaviour through a person-centred approach
  - Understand what positive behaviour support is
  - Understand how to apply positive behaviour support to improve an individual behaviour and quality of life
  - Understand what may trigger a 'critical incident' of challenging behaviour
  - Recognise and manage the different stages of emotional arousal during a 'critical incident'
  - Be able to identify some techniques for de-fusing situations of emotional arousal
  - View 'critical incidents' as learning opportunities.

- Introduction to learning disabilities
  - Know and understand various learning disabilities and their associated conditions
  - Know the principles of supporting someone with a learning disability
  - Utilise appropriate communication methods and recognise barriers to communication

- Care planning and risk assessment
    - To understand what the aims and purpose of a care plan are
    - Know there responsibility and accountability when it comes to care plans and risk assessment
    - Demonstrate an ability to recognise weak care plans and produce a 'gold standard' care plan.

Monitoring of the client's support package would be tailored to their individual personal outcomes as well as taking into account the safety and general management elements of the package of care. For our most complex clients a clinical review would initially be carried out every two weeks by our Community Nurse, our Case Manager would carry out a social review every four weeks.

Expertise to provide a specialist service within clients own homes

As a leading provider of community-based, outcome-focused health and social care services, we have extensive experience and expertise in providing specialist services to individuals with a wide range of complex needs in their own homes. We have a demonstrable track-record in providing the required support services and would welcome the opportunity to discuss in more detail, and provide evidence if required.

We consider the individual goals, wishes and needs of each individual, forming the basis of each care plan we create. Our person-centred, outcome-focused care planning takes in to account all applicable legislative and best-practice guidelines.

We undertake clinical and environmental risk assessments and put a number of controls in place to manage risks, complying fully with regulatory outcomes and standards from the Care Inspectorate and other professional/regulatory bodies.

Creation of the support plan

Our service provision is person-centred and will focus on the client's needs at all times in a way that respects their right to privacy, choice, safety and independence as well as considering their equality, cultural and ethical needs.

Once a support plan has been identified, we would endeavour to employ and recruit the most appropriate support team to meet the clients' specific health and social care needs. We recruit and develop our workforce around each individual, at a local level and involve the clients' in the recruitment, selection and management of their support team, ensuring that the client is empowered to exercise choice and control. This may in some cases involve a registered nurse being recruited to support the specific needs of the client.

We work in conjunction with all stakeholders to ensure that the care package provides support and does not undermine any existing personal and social relationship/desires that the client and their family have and the individual support staff that are selected are fully trained in clients care plan and service delivery from the outset.

Care plan reviews

Pulse Community Healthcare recognises the importance of monitoring and reviewing any service provision in order to ensure the quality, on-going effectiveness and development of

our services to the individual, whilst aiming to maintain an all-inclusive approach and recognising that each individual is unique, with unique outcomes and desires.

Monitoring of the client's support package would be tailored to their individual personal outcomes as well as taking into account the safety and general management elements of the package of care. A clinical review would initially be carried out every two weeks by our Community Nurse and our Case Manager would carry out a social review every four weeks.

Further reviews would be agreed at regular 2 or 4 weekly to suit the client and their requirements. These reviews are to ensure that the package as a whole is progressing and meeting the client's needs and offers the opportunity to try and develop new activities (where applicable).

Our core values, principles and ethos are aligned with objectives as set out in the various initiatives, white papers and best practice guidance that influences community-based care and support, allowing us to provide all-inclusive, robust and holistic support to the client and their family within their own home and in the community.

Recruitment

If we do not already have staff available with the required range of skills to meet the client's care requirements PCH will recruit and train suitable support workers or registered nurses where appropriate, ensuring they have the right skills and attitude to work with the client. We would encourage the client and individuals the client wishes to be included, to be involved in the recruitment and selection of their support team.

The office team would undertake the initial screening of staff and to eliminate the candidates that do not meet Pulse Community Healthcare minimum recruitment criteria. These include:

- At least six months experience of providing care, within the last two years, preferably working with individuals with complex care needs.
- Evidence of references for the past 24 months
- Successful completion of a competency based questionnaire at interview
- Successful completion of a competency based interview
- An enhanced PVG for both adults and children, that meets our criteria
- Successful completion of our mandatory and specialist training courses
- Competency based assessment carried out by our Community Nurse to ensure that the candidate is safely follow company policies and procedures. Competencies are re-checked every 12 months to ensure that they have maintained their standards
- Where a registered nurse is being recruited, their registration, qualifications and experience would be assessed by an experienced member of our clinical team.

Support & supervision of staff

Staff are invited to regular staff meetings to share information and discuss matters in relation to the support packages they support and we encourage the staff team to be proactive and discuss matters that have arisen. Each support worker has supervision every

two months to discuss their personal development and identify any training needs they may have or require.

If staff go longer than two months without a review meeting, without good reason, then this will affect them being able to continue working. We also undertake a full appraisal every twelve months with each Support Worker. The purpose of these regular supervisions is to facilitate a positive working relationship with the office team and encourage the support workers to feel able to raise issues and discuss any concerns they have. On a less formal basis we encourage all staff to contact the office with any concerns or to keep us informed about what is happening – whether this is about the package of care or on a more personal basis. This helps us to monitor how the staff are feeling, whether they getting enough hours of work, if they have issues with their travel, if they have concerns about their client or whether their personal circumstances changed in a way that will impact upon their work.

We have a charter in place called 'Boomerang' which encourages staff to report concerns to our Managing Director, if they are dissatisfied with their treatment or to report concerns. Every member of staff is given an email address that enables them to communicate any feedback or concerns directly to the MD who takes rapid action as and when required.

When we undertake the client reviews, we ask for feedback about the staff and the team. We seek nominations on an annual basis from clients to recognise support workers who they believe to provide exceptional support to them. Within the local branch we also nominate staff, who have been exceptional in some way. This information is shared with the rest of the support workers in the branch.

Our on call team includes a Critical Care Nurse with experience of complex care to provide support and advice to support workers out with office hours. This is to ensure that our staff have clinical support 24 hours per day, wherever possible to avoid unnecessary hospital admissions.

Rotas

We would discuss with the client and their family, how best to run the staff rota for the client's support, taking into account how things have run in the past and what was successful or less successful. We would aim to have a 'rolling rota', to enable staff to know in advance what shifts they are working and this facilitates the staff to plan their lives around their shifts. This tends to minimise the rate of absence and enables the team to ensure a better work life balance. These are usually produced 4-6 weeks in advance.

Safeguarding

Pulse Community Healthcare promotes a 'fair blame' culture, encouraging the reporting of near misses to support quality improvement by learning from all incidents, occurrences and complaints. This open and frank culture provides the opportunity to share working practices, knowledge and experiences. Incident and complaints data is reported to the governance Committee and Board monthly as well as outcomes, lessons and risks being reported to the governance committee to ensure investigations and outcome and lesson are, as appropriate, disseminated across the group.

All adverse/serious and/or safeguarding incidents are reported to the governance - committee/board and the Care Inspectorate. We electronically log everything on our 'Datix' - system and have an open book policy. -
Incidents are investigated using a root cause analysis tool kit and lessons learned are - distributed company-wide by way of alerts and monthly governance newsletters.

Where applicable, action plans are instigated and monitored by the governance committee and used to regularly develop service delivery and provide high quality care at all times.

We operate a comprehensive clinical governance framework, which is the assurance framework through which we structure the clinical accountability of our organisation ensuring direct accountability to our Board. The Clinical Governance Report includes:

- Policies and procedures
- Professional leadership
- Health and safety
- Occupational health
- Risk management
- Incidents and complaints handling

All of our operations are delivered with appropriate clinical input which ensures that our services to individuals in receipt of care and support from Pulse Community Healthcare remain safe, effective, and of high-quality, in line with contractual requirements.

At all times, our clinical effectiveness can be measured by our performance within each individual package of care and support, and we have implemented processes to ensure that feedback from each individual package is fed in to our clinical governance framework to influence our corporate risk register as applicable.

Incident management and analysis using DATIX

We have implemented the DATIX risk management software to support the management of incidents, issues, feedback and complaints. This system provides a comprehensive platform to facilitate the effective management of identified issues and risks to agreed protocols. The system consists of five modules:

- Incidents
- Complaints
- Risk
- Claims
- Safety alerts

Our DATIX system is fully auditable, and affords us the opportunity to report and analyse issues and risks holistically. It also enables us to offer bespoke reporting capabilities in order to work in conjunction with commissioning authorities in delivering consistent, safe services to individuals at all times.

Policies and procedures (covering patient safety, clinical effectiveness & patient experience)

We have invested in robust, comprehensive clinical governance arrangements, which are designed to ensure clinical effectiveness. Our governance and clinical leadership structure provides a framework of appropriate clinical protocols to follow for all clinical aspects of the service delivery. Good governance and clinical leadership provide the environment for continual quality improvement and high quality care. This is evidenced by client outcomes and supports our ability to manage clinical issues effectively, whilst offering the structure through which we ensure clinical improvements are implemented based on evidence, changing legislation and best practice.

The safety and effectiveness of our service is governed by our Care Inspectorate registration and we have a suite of clinical policies to ensure safe best practice is adhered to at all times, these include a risk management strategy, clinical risk policy and clinical governance policy all ratified by the clinical governance committee which is a direct sub-committee of the main board. Further details on individual policy and procedures are highlighted below:

Management of adverse/serious incidents and safety alerts

Pulse has a comprehensive system in place for recording, investigating and reporting accidents and incidents. We have an Accident & Emergency Policy & Process in place to protect service users and our workers which complies with Standard 15 of the National Minimum Standards for Domiciliary Care & the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). Full details and training are provided to workers at induction, before commencing any package of care.

We also utilise the DATIX risk management software for incidents and risk/safety alerts to further-enhance the management of issues/incidents, highlighting areas for improvement and development. It also allows us to report on client safety data monthly, quarterly and annually, both internally and to external organisations, as applicable.

Working in partnership

Our current experience of multi-agency working with other support providers, as well as the wider healthcare community, has proved invaluable in providing high quality, seamless holistic support and resulted in the success and development of our service delivery to individuals and seeing our service provision develop across the UK as a result. Where a Multi Disciplinary Team (MDT) can be established and work seamlessly together, we have found that the achievement of the desired outcomes of any holistic package of support can be reached with the greatest efficiency. Close working relationships have been developed to the point of autonomous decisions being made by the Pulse Community Healthcare team, such as support plan updates and reviews, often with telephone permission from commissioners and other related professionals as required.

We would seek to work in collaboration with the client, nominated individuals and Multi Disciplinary teams for co-ordination of service provision and to monitor and assess quality on an on-going basis to ensure that the clients support plan is responsive to their changing needs. We believe that in doing this, we not only increase the pool of knowledge and

expertise of our own support teams and those of other stakeholders, but that this also aids in the realisation of individual outcomes and an improved quality of service throughout.

Additional Information

Should you wish to know more about Pulse and review a selection of case studies and our client blogs please visit our website www.pulsecommunityhealthcare.co.uk and out client blogs at www.pulsecommunityhealthcare.co.uk/blog/ and our recent care awards at www.pulsecommunityhealthcare.co.uk/blog/category/pulse-community-care-awards-2015/

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East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 8

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	26th May 2016
Report Number	
Subject Title	Oral Health Directorate and East Dunbartonshire Health and Social Care Performance Reports
Report by	Karen Murray, Chief Officer, East Dunbartonshire Health and Social Care Partnership
Contact Officer	Frances McLinden, General Manager, Oral Health Directorate, 0141 201 4271, Frances.McLinden@ggc.scot.nhs.uk

1.0 PURPOSE OF REPORT

1.1 To report the performance of the Oral health Directorate (OHD) in respect of national waiting times (access) targets and guarantees.

1.2 To update the HSCP Board on the progress of capital works across OHD premises

1.3 To update on progress with delivery of the current Oral Health Improvement and Prevention strategies across GG & C

1.4 To report on oral health activity/performance specific to the residents of East Dunbartonshire HSCP.

2.0 SUMMARY

The Oral Health Directorate includes responsibility for the management of waiting times for acute dental services provided from Glasgow Dental Hospital (GDH) and other acute sites across NHSGG&C. The HSCP Board has no governance or accountability for the delivery of acute access targets as these are not delegated function to the partnership from the NHS Board. However, East Dunbartonshire's residents will access services at Glasgow Dental Hospital and other acute hospital sites across GGC from where acute and specialist dental services are provided so board members may have an interest in the acute performance data.

There is an ongoing capital programme of works at GDH and an update on recently completed projects and on the current stage of works is provided to board members for interest.

Through the Scottish Dental Action Plan we provide a wide range of services across the Board area to address the health improvement and prevention agenda. East Dunbartonshire HSCP "hosts" delegated dental services (General Dental Services (GDS), Public Dental Services (PDS) and oral health improvement services provided for all of the partnerships in NHS GGC. Individual performance reports on these hosted services are provided to each of the other HSCP boards in NHS GGC so that each HSCP Board can retain oversight of the delivery of these in-scope services delivered by the host HSCP to its population.

The first report attached provides current performance data in respect of outpatient and inpatient/daycase waiting times for secondary dental care services, by specialty. It also provides performance data in respect of Oral Health Improvement services provided across the whole of NHS GGC, for example Childsmile programmes for fluoride varnish application, tooth brushing programmes in schools and nurseries and oral health improvement services for vulnerable groups, for example services to care homes, prisons, homeless and looked after children

3.0 RECOMMENDATIONS

3.1 The Board is asked to note the information provided and acknowledge the maintenance of the acute access waits across all specialties;
3.2 The Board is asked to note the progress on the capital projects;
3.3 The Board is asked to note the health improvement programmes and performance;
3.4 The Board is asked to note the oral health activity and performance data specific to residents within East Dunbartonshire HSCP

Oral Health Directorate Performance Summary

The oral health directorate is responsible for the provision of secondary care dentistry for Greater Glasgow and Clyde (GG&C) and the West of Scotland Boards. This serves a population of circa 3 million people.

This service is provided from Glasgow Dental Hospital and School and 7 acute sites across GG & C. The following reports outline our performance in relation to;

- 12 week Scottish Government Outpatients waiting time
- 12 Week Treatment Time Guarantee (TTG)
- 18 week Referral to treatment target (90%)
- DNA / FTA rates (Did Not Attend/Fail To Attend)

Outpatient Waiting Times

True OPWL at 20th April 2016

GDH

Specialty	Weeks Waited						
	0-4	4-6	6-7	7-8	8-9	9-10	Total
Oral Surgery	529	295	136	120	107	64	1251
Oral Medicine	451	200	99	90	86	18	944
Orthodontics	141	45	34	46	4	2	272
Restorative	638	327	150	145	122	48	1430
Paediatrics	424	156	83	75	55	59	852
Total	**2183**	**1023**	**502**	**476**	**374**	**191**	**4749**

GRI

Specialty	Weeks Waited						
	0-4	4-6	6-7	7-8	8-9	9-10	Total
Oral Surgery	27	20	0	0	0	0	47
Total	**27**	**20**	**0**	**0**	**0**	**0**	**47**

Clyde

Orthodontics	Weeks Waited						
	0-4	4-6	6-7	7-8	8-9	9-10	Total
RAH	11	5	5	0	0	0	21
IRH	12	0	0	0	0	0	12
Total	**23**	**5**	**5**	**0**	**0**	**0**	**33**

18 Week RTT Outcome Compliance

GDH New and Return Activity, March 2016

Specialty	Booked	DNA F/A	DNA No F/A	Total Outcome	Blank	No Form	Comp. Mar %	Var.	Comp. Feb %
OM	719	9	124	702	10	7	98	↓	99
OS	1454	100	154	1361	48	45	94	↑	93
PD	878	133	58	843	13	22	96	↑	93
OD	1360	110	58	1282	40	38	94	↑	91
RS	335	12	24	294	21	20	88	↓	90
TOTAL	**4746**	**364**	**418**	**4482**	**132**	**132**	**94**	↑	**93**

The above table summarises each specialties percentage of compliance with the RTT outcomes in March 2016 across the Oral Health Directorate. Waiting List Co-ordinators (WLAC) manage and work with clinical staff to ensure that this target is met and maintained. 18 Week RTT outcome compliance is the methodology used to ensure that information is collected about every patient from the date of receipt of their referral through outpatient attendance and on to inpatient or day case treatment to ensure that all patients are seen and admitted, where necessary within the 18 week standard set by Scottish Government.

DNA Rates

Did not attend rates for oral health services are above the National target of 10%. Despite engaging with patients to attend and confirmation of attendance by telephone contact, we continue to see high levels of DNA throughout the services. The Directorate is about to commence a text Reminder service which is in the final stages of testing, with expected rollout towards the end of July 2016. DNA reports are shared with Lead Clinicians monthly.

	January 2016			**February 2016***		
	No. pts Attended	No. pts DNA	DNA **%**	No. pts Attended	No. pts DNA	DNA **%**
New Patients	1270	346	27.24	1550	374	24.12
Return Patients	5631	903	16.04	5525	743	13.44
Total	**6901**	**1249**	**18.09**	**7075**	**1117**	**15.79**

*March DNA figures not available at time of preparing report.

Inpatient/Day Case Waiting Times

True IPWL at 20th April 2016

Specialty	**Weeks Waited**								
	0-4	**4-6**	**6-7**	**7-8**	**8-9**	**9-10**	**10-11**	**12**	**Total**
Community Dentistry	24	17	4	7	4	0	0	0	56
Oral Surgery	52	26	6	6	14	13	8	0	125
Total	**76**	**43**	**10**	**13**	**18**	**13**	**8**	**0**	**181**

True IPWL at 20th April 2016

Royal Hospital for Children	**Weeks Waited**								
Specialty	**0-4**	**4-6**	**6-7**	**7-8**	**8-9**	**9-10**	**10-11**	**12**	**Total**
GA Comprehensive Care	75	40	41	40	20	10	9	8	243
Extraction	132	93	50	56	74	12	10	12	439
Total	**207**	**133**	**91**	**96**	**94**	**22**	**19**	**20**	**682**

Dental Extraction Kelvin Suite and General Anaesthetic (GA) Comprehensive Care

We continue to maintain the national targets for in patients and day case surgery. Our theatre utilisation remains above the target of 81% at over 95% for children's care and 89% for Adult care. We continue to work with patients to avoid GA where possible to deliver their treatment.

Capital Plans

The Directorate was allocated approx £1m capital funding for 2015/2016 by the Board Capital Planning Group.

This year the focus was to refurbish level 3 of Glasgow Dental Hospital to provide permanent, fit for purpose accommodation for Oral Surgery, Oral Medicine, Radiology and Photography Services and move Health Records to a new location on level 2. This allowed us to bring clinical modalities for imaging and diagnostic services into a single area. This project was successfully completed and on 31 August 2015, the new Oral Surgery Department on level 3 opened its doors to patients for the first time. In addition to this, work was completed in relation to the re decoration and new carpeting for the Board room. Telephone and video conferencing and new furniture were also installed.

In addition to the level 3 upgrading, the project also included the refurbishment of the Oral medicine area on level 4. Work commenced on 27 January and has just been completed and handed over for clinical use. This area now provides dedicated and fit for purpose rooms to enable consultation and treatment services for patients who present with oral medicine concerns.

Moving forward to 2016/17 capital funding is allocated to support the infrastructure work required to allow further upgrading of the student teaching areas and the laboratories within the Dental Hospital and School. Further upgrading or refurbishment of clinical and teaching areas cannot be undertaken before work on buildings infrastructure has been completed.

Health Improvement

The Oral Health Directorate reviews and supports all General Dental Services provided by independent contractors (high street dental practices`) and the Public Dental Service, with the monitoring and recording of Childsmile activity. Childsmile is a national programme aimed at improving the oral health of children in Scotland and reducing inequalities in oral health; ensuring access to dental services for every child across the country. Childsmile involves tooth brushing programmes in nurseries and schools, application of fluoride varnish and assistance with dental registration and participation.

The following tables represent performance across GG & C in relation to the Childsmile programme.

Practice & PDS

Date	No. of GDP Practices in GG&C (as at timeline)	Fluoride Varnish Applications (FVAs) (2-6 yrs)
GDS	262	4241
PDS	19	118

Timeline	No. of GDP's reporting Childsmile Practice Activity	% from Total number of GDP practices
Date (3 months)	228	87 %

Fluoride Varnish Activity

Class Type	Targeted Children	Children with Consent		Children with validated consents		Children receiving at least one FVA				Children receiving two or more FVAs			
	T	C	% of T	V	% of T	n	% of T	% of C	% of V	n	% of T	% of C	% of V
nursery	8661	7327	84.6%	7128	82.3%	5865	67.7%	80.0%	82.3%	2935	33.9%	40.1%	41.2%
p1	5735	5070	88.4%	4956	86.4%	4549	79.3%	89.7%	91.8%	2582	45.0%	50.9%	52.1%
p2	5582	5079	91.0%	4997	89.5%	4601	82.4%	90.6%	92.1%	2885	51.7%	56.8%	57.7%
p3	5291	4861	91.9%	4800	90.7%	4480	84.7%	92.2%	93.3%	2950	55.8%	60.7%	61.5%
p4	5151	4729	91.8%	4654	90.4%	4339	84.2%	91.8%	93.2%	2816	54.7%	59.5%	60.5%
p5	95	14	14.7%	12	12.6%	2	2.1%	14.3%	16.7%	1	1.1%	7.1%	8.3%

Tooth brushing Activity

Additional Support Needs Schools

At the end of December 2015, 100 % (34) of ASN schools are participating in the tooth brushing programme.

Mainstream Schools

At the end of February 2016, 235 mainstream schools are participating out of 299 (79%), the table below details the SIMD profile of the 66 schools **not participating**

Schools not participating in Tooth brushing by SIMD					
Area	**SIMD 1**	**SIMD 2**	**SIMD 3**	**SIMD 4**	**SIMD 5**
GLASGOW CITY	14	15	12	7	4
EAST DUN		2	1	1	3
RENFREWSHIRE					
WEST DUN	2				
EAST REN					
INVERCLYDE					
TOTAL					

Next Steps;

- SIMD 1 Engagement with thriving community committees to influence participation in daily tooth brushing and good oral health habits in areas of most need.

- Liaising with Health Improvement (HI) colleagues within HSCP teams to identify additional forums to promote daily tooth brushing and good oral health habits.

- Mapping of HI activity opportunities to reduce inequalities within each HSCP area to integrate oral health promotion.

- Facilitate volunteer programme to provide tooth brushing monitors for primary schools as required

Antenatal Activity

Midwives and Dental Health Support Workers (DHSW) continue to provide oral health advice and resources at a number of antenatal booking clinics.

Next Steps;

- Engagement with children and families directorate to integrate oral health into existing maternity services programmes.

Priority Groups

Caring for Smiles is a National programme delivered within care homes to train care home staffing to provide a high standard of oral health care for people in a residential setting. The National target is 100% of care homes provided with training and 30% of staff trained in the programme.

The table below reflects the activity to 15th April 2016

Area	No. of Care Homes	No. of Care Homes Participating	% of CH Participating	% Staff Trained in participating Care Home	% participating in monitoring programme
East Renfrewshire	16	16	100%	43.6%	**100%**
East Dunbartonshire	13	13	100%	41.2%	**93.8%**
West Dunbartonshire	13	13	100%	61.6%	100%
Renfrewshire	23	23	100%	38.4%	100%
Inverclyde	18	18	100%	58.1%	100%
NE Glasgow	24	24	100%	44.4%	95.8%
NW Glasgow	21	21	100%	48.9%	95.2%
South Glasgow	31	31	100%	46.7%	100%
Total	**159**	**159**	**100%**	**46.5%**	**98.1%**

Total number staff trained to date since the commencement of the programme – 4254

Currently all homes have been provided with training and 3 homes in April were not participating in the monitoring programme at present. Dialogue with the care homes continues.

- Centralised training has commenced within all HSCP areas. There are currently 11 centralised venues across the health board area. Oral Health Educators and the DHSW's promote training in all areas.

- Deliveries of the new Caring For Smiles resource which gives care home residents and their families a guide to dental costs are continuing across the health board area.

- 100% (increase of 5%) of care homes have had an oral health visit in the month of February 2016.
- 61% (increase of 5%) of care home residents with NHS GG&C have been seen by a dentist within the last year.
- The Oral Health Training Officers gather registration data and monitor dental registration levels within all care homes participating in the monitoring of the programme.

Homeless & Prisons

- Toothbrush packs are distributed to Homeless Centres across NHS GG&C. From January 2016 - March 2016, 500 toothbrush packs have been distributed.
- Smile4life programme is now the responsibility of the Health and Social Partnership (North East Sector). Support will be provided from OHD as required for training and education materials.
- North East Sector and Health Improvement (Prisons) are working in partnership to ensure through care for prisoners on release.

Looked After and Accommodated Children (LAAC)

The OHD directorate has been working within the LAAC facilities for a number of months. Our recent survey of the areas has identified issues to address across all LAAC areas.

- 85% of staff have never received any formal oral health training
- 50% of the children/young people in the establishments do not brush teeth daily
- LAAC training proposal currently being compiled for consideration across all areas within the board

Special Care Needs

- Currently organisations requesting training are being offered Caring for Smiles training sessions while a dedicated training programme is developed nationally.
- The health improvement teams are working across all HSCPs to support the development of training for vulnerable young adults and families to improve their oral health

AD HOC

Throughout the year adhoc requests are submitted from criminal justice partners, homeless shelters and health improvements teams to seek advice and or support for groups of people who would benefit from oral health advice and support.

Modern Apprentice

Oral Health has been successful in recruiting 10 modern apprentices. The Modern apprentice scheme in Greater Glasgow and Clyde allows for people aged 16 to 24 to start a programme of training which may eventually lead to a career in the health service. The programme provides an entry opportunity for staff to the health service and can often lead to an entry point to study for a professional qualification in different disciplines. This group of staff are the largest within the board and add to our wide variety of occupations within the Oral Health Directorate services.

The 10 Modern Apprentices who began work in September 2015 within the Oral Health Directorates' Health Improvement Department are now a fully integrated addition to the Health Improvement Department.

They have already completed their Childsmile qualification delivered by NES and are currently all working towards achieving their SVQ Level 3 in Healthcare Support (Non Clinical) provided in partnership with Clyde College.

Over the past 6 months they have been gaining practical experience in a range of placements within nursing homes, schools and nurseries and working as part of the multidisciplinary teams in each area. They have been providing assistance, under supervision, within various National Programmes including Childsmile fluoride varnish, Childsmile school tooth brushing and Caring for Smiles.

By May 2017 the apprentices will be fully qualified dental health support workers and will all be given the opportunity to apply for vacant suitable substantive posts if available.

East Dunbartonshire Health and Social Care Partnership Performance Report

General Dental Services

There are 24 independent contractor practices providing NHS dentistry in East Dunbartonshire. These practices provide general dental services (GDS) and in addition 3 practices provide sedation services. East Dunbartonshire has 2 practices that provide only orthodontic services meaning no patients are registered with them for GDS.

Data available from ISD (September 2015) shows the proportion of patients registered in East Dunbartonshire are:

- 89.6% Children (compared to 93.4% Scotland; 93.9% GG&C)
- 89.1% Adults (compared to 88.4% Scotland: 92.3% GG&C)

Registrations with NHS dentists for East Dunbartonshire are consistently lower than the data for GG&C and for Scotland. There are possible explanations for the data. A number of patients (particularly adults) will be registered with non-NHS dentists, or may travel outside of East Dunbartonshire for dental treatment. As data is not collected for non-NHS practices, it is not possible to determine numbers of patients seeking treatment outside of the NHS.

This explanation may not hold as robustly for children, as dentists may hold list numbers with NHS GG&C to provide NHS dental registration and treatment for children, whilst providing non-NHS treatment for parents.

The Oral Health Improvement Team will seek to determine if there is a risk that more affluent children are being overlooked in oral health improvement programmes which are targeting more vulnerable, or deprived children.

The most recent quarterly data available for Childsmile Practices activity demonstrates that 3 practices recorded no Childsmile activity during the quarter October – December 2015.

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Practice Name	Address	Postcode	Date of Combined Practice Inspection	Date of Sedation Practice Inspection	Orthodontic Practice	Sedation Practice	No Practice Childsmile Activity	0 yr -2 yrs, 11 months	3 yrs-5yrs, 11 months	6 yrs-12yrs, 11 months	13 yrs-17 yrs,11 months	18 yrs - 64 yrs, 11 months	65 yrs and over	Grand Total
Milngavie Orthodontics	13 Main Street, Milngavie	G62 6BJ	10/02/16		√									
Kirkintilloch Orthodontic Clinic	22 West High Street, Kirkintilloch	G66 1AA	11/08/14		√									
Kessington Dental Practice	53 Milngavie Road	G61 2DW	02/10/14				√	89	185	523	372	3454	912	**5535**
Boclair Dental Practice	91 Milngavie Road	G61 2EN	13/12/13					54	114	181	96	1169	253	**1867**
Dental FX	84 Drymen Road	G61 2RH	10/12/13				√	18	48	140	90	1023	172	**1491**
Park Cottage Dental Practice	8a Roman Road	G61 2SW	31/10/14					69	135	325	220	1424	312	**2485**
Chartwell Dental Practice	148-150 Drymen Road	G61 3RE	03/07/14					40	88	316	326	931	50	**1751**
Bearsden Dental Care	8-12 Ledi Drive	G61 4JJ	28/05/14	23/05/14		√		165	255	675	440	3935	1383	**6853**
Milngavie Dental Care	Suite 6, Douglas House 42 Main Street	G62 6BU	23/07/14				√	4	18	83	64	306	218	**693**
Allander Dental Care	7 Stewart Street	G62 6BW	16/12/14					102	230	694	618	6469	2434	**10547**
Jennings Dental Care	4 Station Road	G62 8AB	10/12/14					65	133	352	259	2801	1259	**4869**
Woodhill Dental Practice	176 Woodhill Road	G64 1DH	04/07/14					39	96	283	292	1040	181	**1931**
Oaktree Dental Centre	180 Woodhill Road	G64 1DH	08/01/14					43	96	273	181	1974	369	**2936**
Bishopbriggs Dental Care	17 Arnold Avenue	G64 1PE	07/05/15					86	169	432	283	3260	1113	**5343**
Dental Care by Claire Tierney	Unit 1, 122 Kirkintilloch Rd	G64 2AB	24/02/15					33	58	174	136	1107	209	**1717**
The Dental Professionals	171 Kirkintilloch Road	G64 2LS	29/10/14					56	136	341	327	3771	1120	**5751**
FJ Murphy	4 Morar Crescent	G64 3DQ	06/08/14					53	76	201	166	1505	675	**2676**
Torrance Dental Practice	22 Main Street	G64 4EL	21/08/14					22	48	172	129	1122	270	**1763**
Cowgate Dental Surgery	11 Cowgate	G66 1HW	06/02/15					44	139	301	211	2631	725	**4051**
Kirkintilloch NHS Dental Care	14-16 Townhead	G66 1NL	04/02/16					64	140	319	208	2289	609	**3629**
Hazel Hiram Dental Care	26 Townhead	G66 1NL	11/02/14					32	61	153	106	1229	287	**1868**
Alasdair MacKenzie Dental	69 Townhead	G66 1NN	02/09/14	07/05/15		√		60	142	430	355	3797	1053	**5837**
Marina Dental Care	South Bank Marina, Southbank Road	G66 1XQ	27/10/15					108	243	590	402	4989	1673	**8005**
Mark Gallacher Dental Surgery	95 Hillhead Road	G66 2JA	23/09/14					17	64	171	158	828	409	**1647**
Millersneuk Dental Surgery	112 Kirkintilloch Road	G66 4LQ	26/02/14	13/11/15		√		97	153	457	332	1242	198	**2479**
Campsie Dental Practice	127 Main Street, Lennoxtown	G66 7DB	21/08/13					51	93	217	160	1824	435	**2780**
								1411	**2920**	**7803**	**5931**	**54120**	**16319**	**88504**

Table 1 - GDS Dental Practices in East Dunbartonshire with NHS Activity

PUBLIC DENTAL SERVICE

The Public Dental Service provides comprehensive dental care and oral health education to priority group patients, including those with special needs, adult and paediatric learning disabilities, medically compromised and all groups of children. Treatment is provided in clinics, schools and nurseries, care homes, out patient daycentres, hospital units and domiciliary visits, prisons and undergraduate outreach clinics.

Locations/Services	**Paediatric Dentistry**	**Special Care Dentistry**	**Adult Special Care – General Anaesthetic Assessment**	**Adult Special Care – General Anaesthetic**	**Adult Special Care – Intravenous Sedation**	**General Dental Services**	**Oral Hygiene Services**	**Domiciliary Care**
Kirkintilloch Health Centre	√						√	√
Low Moss Prison						√		

Table 2 - Public Dental Services in East Dunbartonshire, with Locations and Services

DENTAL PUBLIC HEALTH

The oral health of children in NHS Greater Glasgow and Clyde has improved significantly over the last 20 years. A major contributing factor in this has been the implementation of the Childsmile programme. Children in East Dunbartonshire have generally demonstrated better levels of oral health than the average for GG&C and Scotland, supported by data from the National Dental Inspection Programme **(Tables 3 & 4)**.

% of Primary 1, with no obvious decay experience		
	2012	**2014**
Scotland	67.00%	68.20%
NHSGGC	63.20%	65.30%
East Dunbartonshire	78.90%	75.60%

Pr 1 Mean dmft for Children With dmft>0		
	2012	**2014**
Scotland	4.10	3.97
NHSGGC	4.38	4.10
East Dunbartonshire	3.1	3.6

Table 3 - NDIP Data for Primary 1 (Detailed Inspections 2012/14)

% of Primary 7, with no obvious decay experience		
	2013	**2015**
Scotland	72.8%	75.3%
NHSGGC	67.8%	72.5%
East Dunbartonshire	77.0%	81.4%

Pr 7 Mean dmft for Children With dmft>0		
	2013	**2015**
Scotland	2.24	2.16
NHSGGC	2.33	2.27
East Dunbartonshire	2.2	1.9

Table 4 - NDIP Data for Primary 7 (Detailed Inspections 2012/15)

The proportion of children who do not have obvious dental decay is higher in East Dunbartonshire than in GG&C and Scotland for both P1 and P7 children. Where children have decay experience, the dmft (number of decayed, missing or filled teeth) is lower in East Dunbartonshire than the average for GG&C and Scotland.

Comparison of data between 2012 and 2015 suggests a steady improvement in oral health at a local and national level, with the exception of P1 detailed inspection data between 2012 and 2014 w here a s mall decrease is suggested in East Dunbartonshire. It is not clear what has caused this effect in the data.

Analysis of detailed inspection date at HSCP level may have less precision than data at a NHS Board or national level (as it is from a sampled population). However, the detailed data still supports the position that the oral health of children in East Dunbartonshire is better than the average for GG&C and Scotland as a whole and is generally supportive of continued improvement.

The NDIP programme also reports on all children attending state schools in P1 and P7 at a more basic level. This provides an overall assessment of oral health. Data are reported as three categories:

- Category A- (High Risk) – severe decay and should seek immediate dental care; or
- Category B- (Medium Risk) – some decay experience and should seek dental care in the near future; or
- Category C- (Low Risk) – no obvious decay but should continue to see the family dentist on a regular basis

School level data for P1 and P7 Basic NDIP for East Dunbartonshire (2014/15) is illustrated below. A summary of the totals (and proportions) of each category letter is also displayed, together with corresponding summaries for the years 2012-2014 for comparison.

Letter A : child should seek immediate dental care on account of severe decay or abscess
Letter B : child should seek dental care in the near future due to one or more of the following: presence of decay, a broken or damaged front tooth, poor oral hygiene or may require orthodontics
Letter C : no obvious decay experience but child should continue to see the family dentist on a regular basis

School	Class	Letter A (n)	Letter B (n)	Letter C (n)	Not Inspected (n)	Poor Oral Hygiene (n)
Auchinairn	P1	1	16	19	3	0
Baldernock	P1	0	2	2	1	0
Baljaffray	P1	2	4	27	2	0
Balmuildy	P1	4	7	35	1	2
Bearsden	P1	0	5	52	1	0
Castlehill	P1	1	3	19	0	0
Clober	P1	2	2	26	1	0
Colquhoun Park	P1	1	14	25	1	0
Craigdhu	P1	0	1	24	1	0
Craighead	P1	2	10	19	4	0
Gartconner	P1	1	7	8	0	0
Harestanes	P1	1	5	21	1	0
Hillhead (Kirkintilloch)	P1	5	10	9	0	0
Holy Family	P1	0	9	42	0	0
Killermont	P1	2	3	33	4	0
Lairdsland	P1	2	5	34	1	0
Lennoxtown	P1	1	4	21	1	0
Lenzie	P1	1	5	29	4	0
Lenzie Moss	P1	2	9	36	1	0
Meadowburn	P1	1	3	36	2	0
Millersneuk	P1	2	6	37	1	1
Milngavie	P1	1	6	26	2	0
Mosshead	P1	0	5	38	4	0
Oxgang	P1	2	4	24	1	0
St Agatha's	P1	2	7	7	0	0
St Andrew's (Bearsden)	P1	0	7	39	1	0
St Flannan's	P1	5	3	19	2	0
St Helen's	P1	3	14	45	1	0
St Joseph's (Milngavie)	P1	0	6	16	0	0
St Machan's	P1	2	2	18	2	0
St Matthew's	P1	4	9	33	0	1
Torrance	P1	0	3	12	1	0
Twechar	P1	1	0	4	1	0
Wester Cleddens	P1	1	3	18	0	0
Westerton	P1	0	8	30	2	0
Woodhill	P1	0	12	37	0	0

Number of NDIP Schools	36	
Total number of P1's on Roll	1238	
Total number of P1's not receiving NDIP	47	
Number (%) Children Inspected: Letter A	52	4.4%
Number (%) Children Inspected: Letter B	219	18.4%
Number (%) Children Inspected: Letter C	920	77.2%

Number (%) with Poor Oral Hygiene	4	0.3%

Summary of Basic NDIP Programme 2014/15

	2012		2013		2014	
Number of NDIP Schools	36		36		36	
Total number of P1's on Roll	1172		1191		1268	
Total number of P1's not receiving NDIP	57		53		40	
Number (%) Children Inspected: Letter A	81	7.3%	67	5.9%	80	6.5%
Number (%) Children Inspected: Letter B	220	19.7%	203	17.8%	241	19.6%
Number (%) Children Inspected: Letter C	814	73.0%	868	76.3%	907	73.9%
Number (%) with Poor Oral Hygiene	27	2.4%	6	0.5%	9	0.7%

Corresponding data from Basic NDIP Programme 2012-2014

Letter A : child should seek immediate dental care on account of severe decay or abscess
Letter B : child should seek dental care in the near future due to one or more of the following: presence of decay, a broken or damaged front tooth, poor oral hygiene or may require orthodontics
Letter C : no obvious decay experience but child should continue to see the family dentist on a regular basis

School	Class	Letter A (n)	Letter B (n)	Letter C (n)	Not Inspected (n)	Poor Oral Hygiene (n)	Letter B Only Needs Ortho Assess. (n)
Auchinairn	P7	1	13	11	1	0	1
Baldernock	P7	0	1	5	0	1	0
Baljaffray	P7	0	14	31	5	3	5
Balmuildy	P7	1	19	23	5	6	2
Bearsden	P7	0	35	20	3	15	11
Castlehill	P7	0	5	9	1	1	3
Clober	P7	0	13	17	2	0	4
Colquhoun Park	P7	0	19	14	0	2	8
Craigdhu	P7	0	27	16	1	7	13
Craighead	P7	2	16	15	5	10	2
Gartconner	P7	0	8	11	1	4	0
Harestanes	P7	1	9	17	2	1	1
Hillhead (Kirkintilloch)	P7	2	10	9	2	1	0
Holy Family	P7	0	16	35	3	1	1
Killermont	P7	0	11	29	0	0	0
Lairdsland	P7	0	12	19	2	1	2
Lennoxtown	P7	0	4	9	2	0	0
Lenzie	P7	0	14	19	1	7	1
Lenzie Moss	P7	0	19	26	4	4	2
Meadowburn	P7	0	4	27	7	3	0
Millersneuk	P7	1	9	29	2	3	0
Milngavie	P7	0	30	18	4	11	16
Mosshead	P7	0	13	29	0	0	0
Oxgang	P7	0	12	13	1	2	0
St Agatha's	P7	0	8	2	1	1	0
St Andrew's (Bearsden)	P7	0	7	33	4	1	0
St Flannan's	P7	0	12	9	2	1	0
St Helen's	P7	0	19	33	2	2	2
St Joseph's (Milngavie)	P7	0	8	3	2	3	4
St Machan's	P7	0	12	15	0	5	0
St Matthew's	P7	0	17	31	2	4	1
Torrance	P7	0	6	26	2	0	1
Twechar	P7	0	4	8	1	1	0
Wester Cleddens	P7	0	8	14	2	5	0
Westerton	P7	1	6	31	1	0	0
Woodhill	P7	0	18	30	5	0	3

Number of NDIP Schools	36	
Total number of P7's on Roll	1231	
Total number of P7's not receiving NDIP	78	
Number (%) Children Inspected: Letter A	9	0.8%

Number (%) Children Inspected: Letter B	458	39.7%
Number (%) Children Inspected: Letter C	686	59.5%
Number (%) with Poor Oral Hygiene	106	9.2%
Number (%) Letter B - Ortho Only	83	7.2%

Summary of Basic NDIP Programme 2014/15

	2012		2013		2014	
Number of NDIP Schools	36		36		36	
Total number of P7's on Roll	1187		1179		1107	
Total number of P7's not receiving NDIP	67		76		72	
Number (%) Children Inspected: Letter A	20	1.8%	16	1.5%	13	1.3%
Number (%) Children Inspected: Letter B	579	51.7%	537	48.7%	438	42.3%
Number (%) Children Inspected: Letter C	521	46.5%	550	49.9%	584	56.4%
Number (%) with Poor Oral Hygiene	95	8.5%	171	15.5%	98	9.5%
Number (%) Letter B - Ortho Only	74	6.6%	61	5.5%	72	7.0%

Corresponding data from Basic NDIP Programme 2012-2014

The data for Basic NDIP is supportive of the Detailed NDIP findings – the oral health of children in East Dunbartonshire is steadily improving. However, the Basic NDIP data for P1 does reflect the small decrease in 2014 found in the Detailed NDIP sample. The P1 Basic NDIP data for 2015 returns to a projection of improvement in oral health. Closer examination of the data at a school level suggests whilst the overall picture of oral health in East Dunbartonshire is good, there are areas where oral health is poor. There are a number of schools in localities where higher numbers of category A and B letters were issued. This is reflected in both the P1 and the P7 data. Caution should be used when interpreting this data as the sample sizes are low and comparisons between schools may not be robust. However, the data are suggestive there are areas of East Dunbartonshire where closer scrutiny of population oral health may be needed. Deprivation can be linked to an increased risk of dental decay, but there are schools located in more affluent areas where the prevalence and severity of dental decay is higher than expected.

Dental Extraction under General Anaesthetic

The extraction of teeth is an end-point for dental decay experience. For young children this procedure is usually performed under general anaesthetic – a traumatic experience presenting a risk to children, loss of school time (work time for parents) and resource intensive for NHS GG&C. Data are available for the numbers of referrals of children for extraction of teeth under general anaesthetic and can assist in building a more comprehensive knowledge of population oral health. The numbers of referrals of children for dental extractions under general anaesthetic is shown in **Table 5**.

Postcode	2013	2014	2015	Total	Pop^{n} Rate (per 1000) in 2015
G61 1	2	7	4	13	
G61 2	3	2	5	10	
G61 4	10	3	5	18	

G62 7	5	4	7	16	
G64 1	**9**	**17**	**15**	**41**	
G64 2	3	2	9	14	
G65 9	4	11	3	18	
G66 1	9	1	4	14	
G66 2	**13**	**13**	**20**	**46**	
G66 3	**5**	**7**	**10**	**22**	
G66 4	1	7	5	13	
G66 7	**5**	**9**	**12**	**26**	
G66 8	2	6	7	15	
Total East Dun	71	89	106	266	7
Total GG&C	2339	2340	2413	7092	15

Table 5 - Referrals for dental extractions under general anaesthetic for children in East Dun (rates calculated from mid 2014 population estimates ages 3-16)

As with data for dental caries, the numbers of referrals for extractions under general anaesthetic are lower in East Dunbartonshire than for other localities in GG&C. It should be noted the data rows in **Table 5** are raw data and not weighted by population. Nevertheless, the data illustrates there has been a slight increase in the number of children referred in East Dunbartonshire, with numbers of referrals higher in certain localities. The population rate in 2015 for East Dunbartonshire for referrals for extraction under general anaesthetic is 7/1000, compared to 15/1000 for GG&C. This demonstrates the better oral health of children in East Dunbartonshire compared with GG&C as a whole.

The localities with higher numbers of referrals for general anaesthetic extractions demonstrate a correlation with schools and localities where NDIP outcomes are poorer.

Overall, the oral health of children in East Dunbartonshire is better than the average for GG&C and for Scotland. However, it is not without its challenges. There remain pockets of significant dental decay in some localities. A major challenge in East Dunbartonshire will be to sustain improvements in oral health. The Childsmile programme has contributed to rapid improvements in oral health since 2006. In East Dunbartonshire the baseline for child oral health is high and as a consequence additional improvements will be more difficult to achieve.

Greater use of dental public health intelligence and collaboration is facilitating the development of more effective partnership working for the Oral Health Improvement Team and the HSCPs. Data intelligence is assisting in the targeting of interventions to the most vulnerable groups in East Dunbartonshire in order to improve oral health outcomes.

ORAL HEALTH IMPROVEMENT

The Oral Health Directorate work to support improvement in oral health sees an important link is established between Health Visitors & Dental Health Support Workers (DHSW) and dental practices. Assistance is provided in locating and visiting

a dentist for new parents. **Table 6** outlines the patient contacts for Childsmile practice staff providing home visit support.

SIMD	CHILDREN WITH (AT LEAST ONE) KEPT DHSW APPOINTMENT	CHILDREN WHOSE FAMILIES REFUSED CHILDSMILE	'FAMILY COULD NOT BE CONTACTED'	FAMILIES WITH OUTCOME 'FTA / NOT AT HOME' (FURTHER CONTACT REQUIRED)
1	3010	85	20	546
2	1168	48	5	215
3	741	41	1	100
4	598	42	1	82
5	669	45	2	50
Total	6457	276	29	1041
Unknown	271	15	0	48

Table 6 - Children Successfully Contacted and Not Contacted by DHSW, and Families Who Refused Childsmile 2015/2016

The data in Table 6 demonstrates the uptake of dental contacts as well as the challenges to address in making the process more effective for the more vulnerable groups in SIMD quintiles 1 & 2.

Childsmile Core: Toothbrushing Activity 1st April 2015 – 31st March 2016

Childsmile Core Tooth brushing programme was established within the East Dunbartonshire area in 2006.

There are currently 30/36 mainstream schools and 2/3 ASL schools taking part in the programme.

The non-participating schools are contacted on a regular basis to review interest in participation and offered support to implement Childsmile. This is done in a variety of ways and involves education staff.

Oral Health Educator's (OHE's) have established effective partnership working with HSCP health improvement colleagues in East Dunbartonshire.

The OHE/Team attends the Oral Health Network established by the Health Improvement team in East Dunbartonshire. The OHE/Team Lead will chair this group during the next academic year, looking at future planning, event organisation and partnership links.

OHE's have attended several health events in primary schools, delivering Oral health advice related to toothbrushing, diet and dental attendance. OHE's have also worked with school nurses to identify vulnerable children who require 1-1 advice along with their parents and support in addressing their individual needs to be registered with a dentist. Support has been offered to children who have a fear around going to the dentist by offering acclimatisation sessions before their dental appointment.

OHE's are also involved in the annual Canal Festival where they promote Childsmile and offer advice and resources alongside the Smoking Cessation, Addictions, Antenatal and Weight Management teams.

Summary of OHE Activity

Area	Health Days	OH Session	Induction Days	ED HSCP Events	School Nurse Referral/ School	NSM Talk/Event	Training
East Dunbartonshire	22	25	20	2	3	26	15

Table 7

OHE's along with 2 Modern Apprentices (DHSW) assisted ED HIT with Childsmile Nursery Core Toothbrushing programme to achieve the completion of Toothbrushing standards for Nursery Tooth-brushing.

East Dunbartonshire Establishments Participating in Tooth-brushing 2015/2016

SIMD	Nurseries	Playgroups	Primary Schools	Total (N+P+S)	Special Education Establishments
1	2	0	2	4	1
2	4	0	3	7	0
3	8	0	7	15	0
4	7	0	4	11	1
5	28	0	14	42	0
Total	49	0	30	79	2

Table 8

East Dunbartonshire Children with Tooth-brushing Consents 2015/2016

Class Year / Age Group	Children on Class List (n)	Children with positive toothbrushing consent (n)
Nursery under 3 year old	103	101
Nursery 3-4 year old	888	879

Nursery Special Education	1	1
Nursery Other	800	795
P1	1185	1179
P2	1237	1209
P3	892	884
P4	19	18
P6	16	15
P7	20	14
Total	5031	4965

Table 9

Caring for Smiles Activity 1st April 2015 – 31st March 2016

The Caring for Smiles Programme has been operational within the East Dunbartonshire area since February 2013. There are 13 care homes within the HSCP and all care homes have been signed up to participate in the Caring for Smiles Programme. One care home (Antonine House) has received training; however, this establishment is not currently active within the programme.

HSCP	Number of Care Homes	Number participating in CFS Training	Number participating in CFS Monitoring	Total number of Residents	Number registered & seen by a dentist within last 12 months	% of residents seen & registered with a dentist within last 12 months
East Dun	13	13	12	276	163	59%

Table 10

The National standard for training asks that 30% of care home staff have been trained in the caring for smiles dental programme. Between 1st April 2015 and 31st March 2016 a total of 26 staff have been trained, however, the overall number of staff trained since programme commenced is Outlined in Table 11 below.

Care Home	Total Number of staff	Number of WTE	Number of WTE trained	% of WTE trained	Number of staff trained
Canniesburn Care Home	101	69.0	23.6	34.2%	26
Abbotsford House	20	15.0	6.2	41.4%	8

Buchanan House	52	37.0	15.2	41.0%	18
Buchanan Lodge	30	26.6	22.4	84.3%	34
Mavis Bank	45	35.2	26.6	75.6%	32
Campsie View	125	90.0	31.1	34.5%	43
Campsie House	17	14.0	6.1	43.2%	8
Whitefield Lodge	41	36.0	16.2	45.0%	18
Lillyburn	80	42.3	16.7	39.6%	20
Westerton Care Home	77	66.0	27.7	42.0%	31
Antonine Care Home	42	33.0	13.6	41.1%	14
Whitehill Court Care Home (respite)	7	6.0	3.8	63.8%	8
Mugdock House	54	44.0	22.3	50.6%	26

Table 11

Centralised training, provided at KHCC and Westerton Care Home is offered to all care homes every 10 - 12 weeks to maintain the minimum 30% WTE staff trained in all establishments.

All establishments are visited by an OHE on a monthly basis to provide advice and support and feedback registration numbers and any issues with dental access or support.

East Dunbartonshire was the second HSCP area to adopt The Caring for Smiles Programme; therefore the programme is currently in a consolidating and maintenance phase supported by the OHTOs and OHE Team.

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 9

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**Alcohol and Drug Partnership Funding**
Report by	**Karen Murray, 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 advise the Board of recent reductions in the budgetary allocation made to East Dunbartonshire Alcohol & Drug Partnership and to outline to the Board the proposed revisions to funding across the ADP's activities.

2.0 SUMMARY

2.1 A reduction of approximately 23% in the allocation given to Health Boards to fund to Alcohol & Drug Partnerships across Scotland was announced as part of the Scottish Government's budgetary settlement for 2016-17.

2.2. Health Boards were given the opportunity by the Government to make good the resulting shortfall to ADP's from other sources. In the case of NHS Greater Glasgow & Clyde this option was considered but declined, and the full reduction has been passed to all ADP's.

2.3 Following on from this reduction, East Dunbartonshire ADP has conducted a revision of its local spending priorities in order to achieve a balanced budget for financial year 2016-17.

2.4 A recurring saving of £124,751 has been identified. This is within an overall previous annual budget (2015-16) of £488,238.27. This leaves a remaining budget for year 2016-17 of £358,487.

2.5 Whilst the cut in funding is regrettable, the ADP believes that the core and detail of our Alcohol & Drug Strategy will not be significantly affected by the decommissioning of certain services and the reduction of some budget lines.

2.6 Further detail regarding those elements of funding which have been discontinued or reduced is contained in the Background section of this report.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Health and Social Care Partnership Board:

a) Notes the recommendations from the Alcohol and Drug Partnership to deliver a reduction in expenditure of £124,757 per annum to ensure delivery of services within the reduced ADP funding allocation for 2016/17.

Budget Type	2015/16	Amount
Voluntary Organisations		
	Scottish Association for Mental Health (The Foundry)	£118,000.00
	Addiction Recovery Centre (ARC)	£72,751.00
	Glasgow Council on Alcohol	£40,000.00
	Addaction - Families Plus	£25,000.00
	Scottish Families Affected by Alcohol and Drugs	£27,487.27
	Scottish Drugs Forum	£15,000.00
	Positive Achievements - Young People	£11,500.00
	Carr-Gomm Rosebank Allotments - Mental Health and Substance misuse	£40,000.00
	Turning Point - Housing First Service	£14,000.00
	Group Recovery Aftercare Community Enterprise - GRACE	£10,000.00
Training and Conferences	Substance misuse conferences, courses and training	£10,000.00
Befriending	East Dunbartonshire Befriending Service	£3,000.00
Treatment and Recovery	Treatment and Recovery Sub Group - including recovery café	£7,500.00
PEPC	Prevention, Education, Protection and Controls Sub Group	£7,500.00
ABI Sub group	Alcohol Brief Interventions Sub Group	£7,500.00
ADP Post	Alcohol and Drug Partnership Coordinator post	£54,000.00
ROSC	Development Funding ROSC	£25,000.00
Total spend		**£488,238.27**
ADP Budget total		**£488,496.00**
Uncommitted	Outstanding amount not committed	**£257.73**

4.0 BACKGROUND

4.1 The current funding allocations made in 2015-16 by the ASP are detailed above.

The ADP Budget 2016-17 Savings amount required is £125,367

Proposed Savings

£72,751	Decommission ARC
£10,000	Training and Conferences
£11,500	Positive Alternatives
£3,000	EDC Children's Befriending
£7,500	PEPC sub group of ADP
£7,500	Treatment and Recovery
£7,500	Alcohol Brief Intervention Strategy Group
£5,000	ROSC Development
£124,751	**Total**

4.2 Apart from Addiction Recovery Centre (ARC) the budget savings identified would shield front line services. Below are listed anticipated impacts of removal of funding and planned action in mitigation:

4.3 **ARC** is an organisation which is based upon a mutual aid model. East Dunbartonshire is the only ADP where a service of this nature is funded as mutual aid groups are provided free of cost in other areas and tend to remain at arm's length from statutory services. It is fair to say that ARC does work in a disengaged way which has become more apparent through the development of our local Recovery Orientated System of Care Model.

4.4 Whilst there would be an initial impact on service users, this could be managed due to the wide range of services which now exist in East Dunbartonshire which would offer alternative choice and support alongside a wide range of Self-Management and Recovery Training (SMART), and Alcoholics and Narcotics Anonymous groups which now exist across East Dunbartonshire. Increasingly ARC's ethic and practice is not consistent with our Recovery Oriented System of Care (ROSC) approach.

4.5 As more services have developed over the last 3 years, service users are rightly exercising choice and utilising a range of providers to support their recovery journey and so are less dependent on one provider. There are a small number of service users of this service who are over-dependent on the service. The East Dunbartonshire Alcohol and Drug Service (EDADS) Team are aware of these individuals and would facilitate the necessary extra support these service users may require in an interim measure.

4.5 The monies allocated to **Positive Alternatives** are historic. This project is now substantially funded from mainstream sources and is no longer dependent on ADP monies to enable frontline provision.

4.6 The allocation made to **EDC Children's Befriending** was to fund work with children living in families affected by drugs and alcohol. This work is now being taken forward on a wider, more strategic basis by the Addaction Families Plus, and Scottish Families Affected by Alcohol & Drugs services, both of which have sustainable funding in place.

4.7 The other savings are monies which have been attributed to **Training and Conferences**. Access to internal training would continue, access to any free training would be facilitated alongside e-learning opportunities. The existing

and developing wider training and OD strategies being developed to support the partnership's Strategic Plan will be refocused to take cognisance of any training gaps identified.

4.8 With respect to the monies which were allocated to **ADP sub-groups (PEPC, Treatment & Recovery, ABI)** to fund local small projects aimed at early intervention and prevention, it is the conviction of the ADP that the removal of these smaller allocations will not affect front line provision and there are other funding streams which can be tapped into for initiatives like these e.g. Community Safety Partnership funding. There are other funding bodies which the ADP Coordinator is in contact with which could help supplement or replicate the work which this funding has hitherto enabled. These options will be pursued ongoing.

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 10

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**HSCP Information Governance Plan**
Report by	**Karen Murray, Chief Officer,** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Louise Martin - Head of Administration** **0141 201 3351** **Louise.martin2@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 To update the HSCP Board on the progress to date with regard to a number of strategic information governance plans required to be in place by the 31st March 2017.

2.0 SUMMARY

2.1 The Public Records (Scotland) Act 2011 (Section 1(1) requires the HSCP Board to prepare a Records Management Plan setting out the organisation's proper arrangements for the authority's public records.

2.2 Under the Freedom of Information (Scotland) Act, the HSCP Board is required to develop a F reedom of Information Publication Scheme to be approved by the Scottish Commissioner.

2.3 Both documents are in the early stages of development and will be presented to the HSCP Board early 2017 for approval.

3.0 RECOMMENDATIONS

The HSCP Board are asked to note the contents of this report and progress to date.

4.0 BACKGROUND

4.1 Records Management Plan & Memorandum of Understanding

The Public Records (Scotland) Act 2011 (Section 1(1) requires HSCP Boards to prepare a Records Management Plan setting out the organisation's proper arrangements for the authority's public records. The Plan will be subject to approval by the Keeper of the Records of Scotland. Once approved, the HSCP Board is required to ensure that its public records are managed in accordance with the plan as agreed with the Keeper. For the purpose of the Act (Section 3(1)) "public records" means:-

(a) records created by or on behalf of the authority in carrying out its functions,

(b) records created by or on behalf of a contractor in carrying out the organisation's functions,

(c) records created by any other person that have come into the possession of the authority or a contractor of the authority in carrying out the authority's functions.

The Public Records (Scotland) Act 2011 ("PR(S) Act 2011") specifically requires a Records Management Plan to make provision for the archiving and destruction or, other disposal, of any HSCP Board public records.

The Keeper has prepared a Model Records Plan which contains 14 elements the Keeper would expect a Scottish public authority to consider when creating its Records Management Plan. The 14 elements are:

1. Senior management responsibility
2. Records manager responsibility
3. Records management policy statement
4. Business classification
5. Retention schedules
6. Destruction arrangements
7. Archiving and transfer arrangements
8. Information security
9. Data protection
10. Business continuity and vital records
11. Audit trail
12. Competency framework for records management staff
13. Review and assessment
14. Shared information

The Model Records Plan and the NHHGGC Records management Plan will inform the development of the East Dunbartonshire Records Management Plan. The NHSGG&C Records Management Plan can be viewed using the link below.

http://live.nhsggc.org.uk/about-us/nhs-board/finances-publications-reports/records-management-plan

:

4.2 Freedom of Information Publication Scheme

Under the Freedom of Information (Scotland) Act, the HSCP Board is required to develop a Freedom of Information Publication Scheme to be approved by the Scottish Commissioner. The Freedom of Information Publication Scheme sets out the HSCP Board's responsibilities in relation to Information Governance and specifically under the;

1) Freedom of Information(Scotland) Act 2002
2) Environmental Information (Scotland) Regulations 2004
3) Public Records (Scotland) Act 2011
4) Data Protection Act 1998

The HSCP Board is required to have:

- a Publication Scheme – Section 23 Freedom of Information (Scotland) Act 2002 requires that all Scottish public authorities subject to the Act maintain a Publication Scheme,
- policies and procedures in place on how the organisation responds to request for information,
- internal review/appeals process to consider cases where an applicant is dissatisfied with a respond to a request for information, or there has been a failure to respond,
- arrangements in place to make staff and the public aware of the procedures to follow and to distinguish appropriately between requests that should be processed by the Council/Health Board rather than the HSCP Board.

The Scottish Information Commissioner has produced and approved a Model Publication Scheme to aid HSCP Board's in developing their specific Freedom of Information Publication Schemes.

5.0 LOCAL PROGRESS

5.1 A draft Records Management Plan and a draft Freedom of Information Publication Scheme are in the early stages of development.

5.2 These documents will seek the views of the Professional Advisory Group, the Clinical Governance Group and the Strategic Development Team to inform final drafts.

5.3 Both documents will be presented to the HSPC Board for final approval early 2017 for implementation by the 1st April 2017.

Agenda Item Number: 11

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**Health & Social Care Partnership Risk Management Register**
Report by	**Karen Murray, Chief Officer** **0141 201 3553**
Contact Officer	**Sandra Cairney, Head of Strategy, Planning & Health Improvement** **0141 201 3301** **Sandra.cairney@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 To provide the Board with a copy of the Health & Social Care Partnership (HSCP) Risk Management Register, that covers risk policy, procedure, process, systems, risk management roles and responsibilities (attached)

2.0 SUMMARY

2.1 The HSCP Risk Management Register enables the HSCP to take an effective approach to managing risk in a way that both addresses significant challenges and enables positive outcomes.

2.2 The aim is to provide safe and effective care and treatment for patients and clients, and a safe environment for everyone working within the HSCP and others who interact with the services delivered under the direction of the HSCP Board

2.3 Appropriate application of good risk management will prevent or mitigate the effects of loss or harm and will increase success in the delivery of better clinical and financial outcomes, objectives, achievement of targets and fewer unexpected problems

2.4 The HSCP will be required to prepare a Risk Management Strategy by 1st April 2017

3.0 RECOMMENDATIONS

3.1 It is recommended that the Health and Social Care Partnership Board:

- Considers and approves the HSCP Risk Management Register
- Instructs officers to progress the HSCP Risk Strategy

Risk Reference	Risk Event	Cause	Effect	Category of risk	Control Measures	Residual Likelihood	Residual Impact	Rank (Equals L*I)	Priority	Strategy for Risk	Risk Management Actions	Acceptable Likelihood	Acceptable Impact	Rank (Equals L*I)	Priority	Risk Owner
HSCP01	Failure to rebalance care from hospital to community settings in line with the Strategic plan	Lack of resource(Housing, Care Home,Personnel,Community Packages) Increased demand in Acute Sector Carer and Service user expectations	Delays in discharging patients to appropriate settings. Cost implications Quality of Life	Service User	Strategic plan with accompanying Financial plan and Performance Management Framework.	4	4	16	2	Tolerate	N/A	4	4	16	2	Chief Officer
HSCP02	Inability to effectively manage demand on financial capacity.	Demographics;OP, LD, Children's service and Criminal Justice Increasing number of vulnerable children identified and referred to social work Policy context, SDS, Carers legislation, Children and Young Person (Scotland) Act Criminal Justice redesign Lack of provision/alternative services Enhanced early identification/diagnosis i.e. autism Expectations in society built up over 20-30years Increased cost of services Savings realisation year on year. Inadequate Infrastructure Insufficient Resource Ineffective communication with Service Users and Carers Relaxed requirements around SDS training and registration of carers Raised expectations Changes in legislation/Statutory demands	Budgetary restriction elsewhere in Social Work or Council Reduced ability to maintain Service Levels Reduction in jobs Budgets overcommitted Political implications Reputational damage Policy changes Inadequate care arrangements for vulnerable adults and children Financial impact due to double funding requirements through service default Potential exploitation of Service users Deconstruction of In-house provision Litigation Demoralised workforce (poor staff morale) Absence levels Increased scrutiny Injury to service users	Financial	Financial Regulations Eligibility criteria Internal Budget controls/Management systems Internal Audit Policy and Procedure guides Budget Management processes Training and Awareness for managers Resource Screening groups	4	4	16	2	Treat	Practice Review Homecare Review Introduction of CM 2000 Learning Development Programme Infrastructure being developed Staff training - including forthcoming policy and legislation Children Services Strategic Review	3	3	9	3	Chief Officer
HSCP03	Failure of protection procedures for vulnerable adults	Disjointed communication Lack of clarity around roles and responsibilities Inadequate training	Death or Injury to Service user Reputational damage Litigation	Health and Safety	Work plan in place for audit, training & development. Inter agency referral framework launched. East Dunbartonshire Adult Protection Committee now in place.	3	5	15	2	Tolerate	N/A	3	5	15	2	Chief Officer
HSCP04	Inability to effectively manage Data Protection Standards	Structural changes require new and more sophisticated forms of data management. Lack of understanding and awareness of Data Protection rules Increasing demand and competing priorities cause workers to have decreased awareness and lessened regard for Information Security. Inadequate training for staff and use of technologies. New duties incorporated within the Children and Young Person (Scotland) Act - in particular the named person	Breach of Information management legislation. Financial impact Increased external scrutiny Reputational damage Litigation	Data Protection	Information sharing protocols Codes of Practice Guidance - Information Commissioners Office External Scrutiny systems - (Care Inspectorate) Procedures are in place on all sites for use/release of data, including Multi-Agency Public Protection Arrangements (MAPPA) related information, monitoring of Information Governance Standards and Security Policy, Caldicott Guardian responsibilities, Information Sharing Protocols, NHSGGC-wide Information Governance Steering Group. All laptops (now including University equipment) encrypted. Information Sharing Protocol (endorsed by the Information Commissioner) in place. New information governance policies approved. New e-mail policy in place. Extended use of electronic records. A programme of work re the systematic audit of access to electronic records is being extended beyond the Emergency Care Summary. Access is controlled via a role based access protocol signed off by senior clinicians	3	4	12	2	Tolerate	N/A	3	4	12	2	Chief Officer
HSCP05	Medication errors	Errors in patient information Errors in drug information Poor or inadequate communication Inadequate medication storage, stock, standardization, and distribution Drug device acquisition, use, and monitoring Environmental factors	Death or Injury to Service user Reputational damage Litigation Poor Staff morale	Health and Safety	Regular training for employed staff, educational events for contractors, complaints handling procedures within Partner Organisations Monitoring by Clinical Governance Group.	4	3	12	2	Tolerate	N/A	4	3	12	2	Chief Officer
HSCP06	Failure to comply with requirements of Patient Rights (Scotland) Act 2012	Failure to prepare staff to implement New Ways Failure to raise patient awareness of rules	Reputational damage Litigation Regulatory censure	Regulatory	Implementation of the RTT Guarantee and complaints aspects of the Act Group established to lead on implementation measures in ASD Regular reports to be provided to SMG	4	3	12	2	Tolerate	N/A	4	3	12	2	Chief Officer
HS	Failure to effectively identify children at risk.	Disjointed communication Lack of clarity around roles and responsibilities Inadequate training Inconsistent assessment and application of Child Protection procedures.	Death or Injury to Service user Reputational damage Litigation Poor Staff morale Legislative requirements not being	Health and Safety	Robust policies and procedures are in place and have been communicated throughout all Partner organisations. An on-going comprehensive training programme is in place. Monitoring systems are established and all adverse events investigated and reported	3	4	12	2	Tolerate	N/A	3	4	12	2	Chief Officer
HSCP08	Inability to maintain continuity of service due to catastophic events e.g. Pandemic Flu)	Poor/ineffective Civil contingencies planning, Lack of suitably trained resource, Disjointed partnership working.	Death or Injury to Service user Reputational damage Litigation Poor Staff morale Legislative requirements not being complied with.	Health and Safety	Development of local action plan, current overall NHS Board action plan in place	3	4	12	2	Tolerate	N/A	3	4	12	2	Chief Officer
HSCP09	Failure to secure the annual revenue budget allocation to support delivery of the Strategic Plan.	Deterioration in Financial Settlements from Scottish Government and Constituent Bodies that are worse than currently reflected in the Financial Planning Assumptions; Delays to budgeted savings and planned cost efficiencies are delayed or not fully deliverable.	Overspends within individual financial years; Depletion of Contingency & Prudential Reserves; Requirement to make unplanned reactive savings and service reduction with a short	Financial	Robust financial planning to predict areas of future cost pressure and factoring all variables in assumptions with sensitivity testing of varying scenarios. Detailed scoping of business cases to determine and give assurance on the	3	4	12	2	Tolerate	N/A	3	4	12	2	Chief Officer
HSCP10	Failure to secure effective service delivery from Support and Hosted services	Increasing demands on staff Shared electronic systems Limited resources to implement CareFirst Reliance on multiple/obsolete systems Competing Priorities Poor Communication Lack of clarity around roles and responsibilities	Failure to accurately assess and respond to risk Failure to effectively and securely store and retrieve records Inability to effectively and timeously share SDS information Inability to be effective in electronic management and communication (e.g.	Service Delivery	Staff Training Technology Infrastructure	3	3	9	3	Tolerate	N/A	3	3	9	3	Chief Officer
HSCP11	Inability to recruit, retain and appropriate numbers of trained staff to meet requirements resulting in reduction in service.	The reduction in numbers of specialty trainees as part of the Government's Reshaping the Medical Workforce policy could make some rotas in acute specialties difficult to staff. When added to the risks of failure to recruit enough adequately qualified medical staff, increasing numbers of trainee staff involved in out of hours work, less than full time work and maternity and paternity leave, this could lead to a reduction in available doctors for direct	Unable to provide/arrange care services Inability to meet statutory requirements/duties Service is reduced Fragmented services Increased complaints Service user detriment Reputational damage	Service Delivery	Recruitment Processes National Procedures/negotiations Workforce Planning Continue to review with the Deanery the implications of junior doctor vacancies. Work with Medical Staffing to monitor high risk rotas. Report to Head of Medical Staffing Regional Workforce Director and SGHD on high risk rotas if necessary.	3	3	9	3	Tolerate	N/A	3	3	9	3	Chief Officer
HSCP12	Failure of contract compliance framework.	Ineffective monitoring of contract management services. Failure to follow established procedures for commissioning	Limited monitoring of auditing of contracts/services across adult services Failure to meet legal & inspection requirements. Failure to satisfactorily measure quality of	Governance	Performance and management scrutiny by the planning and commissioning via the contract management framework Workload prioritisation by P & D team Partnership working with care providers in Care Inspectorate	3	3	9	3	Treat	Internal Audit Action plan	2	3	6	3	Chief Officer
HSCP13	Failure of external provider to maintain delivery of services	Collapse of Care Provider; care homes and practice failures	Unable to provide/arrange care services Inability to meet statutory requirements/duties Service is reduced Fragmented services Increased complaints Service user detriment Reputational damage	Service Delivery	Financial Monitoring system Contingency planning arrangements Contract Management Framework Regulation/Inspection Performance improvement Internal Audit Service user feedback mechanisms - including complaints procedures	3	3	9	3	Tolerate	N/A	3	3	9	3	Chief Officer
HSCP14	Failure of infection Control	Failure to comply with national patient safety programmes; audits and inspections Lack of suitably trained resource, Disjointed partnership working.	Death or Injury to Service user Reputational damage Litigation Poor Staff morale Legislative requirements not being complied with.	Health and Safety	Development of local action plan, current overall NHS Board action plan in place Implement the Patient Safety Programme and prescribing audits	3	3	9	3	Tolerate	N/A	3	3	9	3	Chief Officer

Risk Reference	Risk Event	Cause	Effect	Category of risk	Control Measures	Residual Likelihood	Residual Impact	Rank (Equals L*I)	Priority	Strategy for Risk	Risk Management Actions	Acceptable Likelihood	Acceptable Impact	Rank (Equals L*I)	Priority	Risk Owner
HSCP15	Significant IT failure impacting on Service delivery	Lack of or ineffective contingency planning Outdated or unreliable IT systems Lack of trained resource	Loss of or disruption to service Reputational damage Litigation Unforeseen costs	Service Delivery	Business Continuity Planning	3	3	9	3	Tolerate	N/A	3	3	9	3	Chief Officer
HSCP16	Failure to implement performance management systems to measure,analyse,interpret and report on national and local outcome indicators and targets.	Lack of clarity around roles and responsibilities Inadequate training Incompatible IT systems Lack of clarity around the totality of Performance Requirements	Inability to accurately measure Service Delivery Inability to effectively benchmark Ineffective resource allocation	Strategic	Develop and implemet a robust performance management framework to inform progress against Strategic Plan priorities	3	3	9	3	Tolerate	N/A	3	3	9	3	Chief Officer
HSCP17	Inability to secure capital funds to meet the priorities in the Strategic Plan.	Deterioration in Financial Settlements from Scottish Government and constituent bodies that are worse than currently reflected in the Financial Planning Assumptions. Conflicting Priorities. Lack of appropriate future planning to meet capital needs.	Inability to deliver aims of the Strategic plan.	Financial	Local Authority and Health Board capital Planning Groups	3	3	9	3	Tolerate	N/A	3	3	9	3	Chief Officer
HSCP18	Inability to meet new and existing duties/ Statutory requirements	Substantial and multiple legislative changes across a range of disciplines within the same time period. Increased complexities of risk which require to be managed Cross cutting issues that are complex(e.g. mental health addictions) at a time when there is significant structural changes (Integration) Staffing issues (Inadequate , Staff turnover) Lack of experienced staff.	Service users sustain increased levels of harm Reputational damage Increased litigation Demoralised workforce Poor staff morale Public protection compromised	Service Delivery	Multi-agency planning forums (e.g. DCYPP) Multi-agency training Policies and Procedures Capacity Planning Eligibility Criteria Equality Impact Assessments	2	4	8	3	Tolerate	N/A	2	4	8	3	Chief Officer
HSCP19	Failure to meet regulatory and inspection requirements	Pattern of increasing demand against reducing resource base. Increased national expectations. Inability to meet training requirements Physical environment Underinvestment	De-registration Inability to deliver core services Increased scrutiny Adverse publicity Low staff morale	Regulatory	Training Care Inspectorate Preparation. Care Inspectorate Improvement action plans in place. LAN Corporate Reporting Internal Quality Assessment	2	4	8	3	Tolerate	N/A	2	4	8	3	Chief Officer
HSCP20	Failure to effectively manage levels of violence to staff	Increasing levels of resistance to interventions by service users New Risk connected to Social networking - web usage Public expectation/Changes to Service Delivery Technology moving more quickly in wider population	Staff stress levels increasing Increased absence levels Lack of interaction Defensive Reputational damage Physical and Emotional Harm to staff	Health and Safety	Violence against Staff Policy (Under Review) Lone Working policy (Under Review) Enhanced use of technology within EDC (CCTV,Buzzers,Panic alarms, Mobile phones) Staff supervision Staff briefings Warning Management system - Carefirst	2	4	8	3	Tolerate	N/A	2	4	8	3	Chief Officer

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 12

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**Transition Plan for transfer of local NHS Children's Service functions, Children's Social Work functions and Criminal Justice Social Work functions to East Dunbartonshire HSCP**
Report by	**Karen Murray, Chief Officer, East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Alan Cairns, Integration Project Manager, East Dunbartonshire Health & Social Care Partnership 0141 201 4270 Alan.cairns@ggc.scot.nhs.uk**

1. PURPOSE OF REPORT

1.1 The purpose of this report is to seek HSCP Board approval for a detailed Transition Plan that sets out the preparatory processes and approvals for the delegation of certain additional functions pertaining to NHS local children's services, and Council Social Work Children and Criminal Justice services.

2. SUMMARY

2.1 On the 30th April 2015 East Dunbartonshire Council agreed to the request by NHSGGC Board to extend the functional responsibilities of the East Dunbartonshire Health & Social Care Partnership Board to include local Children's Community Health Service functions.

2.2 On 7 April 2016, NHSGGC agreed to the request by the Council to extend the functional responsibilities of the East Dunbartonshire Health & Social Care Partnership Board to include Social Work Children and Criminal Justice service functions.

2.3 As reported to the HSCP Board at its meeting on 31 March 2016 (Report No. HSCP/014/16/KM), this additional delegation of functions will necessitate revision to the Integration Scheme, for approval by the Council, the Health Board and by the Cabinet Secretary.

2.4 In addition to revision to the Integration Scheme, a range of other organisational, procedural and governance instruments that support the constitution and operation of the HSCP will also require elements of review, updating and replacement, to reflect the extension of the HSCP's proposed scope of functional responsibility.

2.5 In order to ensure a systematic approach is applied to this process, a detailed Transition Plan has been prepared for approval at **Appendix 1**. A similar approach was successfully used to guide and support the original delegation of adult health and social care functions to the HSCP.

2.6 Overall timescales for the delegation of the additional functions are set out below. These may be subject to variation due to Scottish Government approval processes:

- Amended Integration Scheme to be finalised and through public consultation by 21 June 2016;
- Simultaneous liaison with Scottish Government on changes to ensure compliance with regulations and guidance;
- Approval of the Scheme by NHSGGC on 21 June 2016 and by Council on 28 June 2016;
- Submission of the Scheme to the Scottish Government on 29 June 2016 for Cabinet Secretary approval;
- Organisational, financial, governance and other procedural supporting detail to be updated, as necessary, by 28 July 2016;
- A go-live date of 11 August 2016, which is (provisionally) the first HSCP Board meeting after the recess.

3. RECOMMENDATIONS

3.1 The HSCP Board is asked to:

a) Approve the Transition Plan at **Appendix 1**;

b) Note the outline timescales for the proposed delegation of the additional health and social care functions, and;

c) Request that the Chief Officer provides regular updates on the progress of actions contained within this Transition Plan.

4. BACKGROUND AND CONTEXT

4.1 The scope of integration must be set out in an Integration Scheme, agreed between the Council and the Health Board and approved by the Scottish Parliament. The East Dunbartonshire Integration Scheme was approved by Parliamentary Order on 27 June 2015. The agreement reached between the Council and the Health Board was for the integration of adult services.

4.2 With both the Council and the Health Board wishing to now extend the scope of delegation to the HSCP, a revised Integration Scheme must be prepared and approved. This process also requires that any revision to the Integration Scheme be subject to public and stakeholder consultation, as prescribed in regulations.

4.3 The regulations state that the following people or groups of people must be jointly consulted on the development of the Integration Scheme:

- Health and Social Care professionals and staff of the Health Board and Council who operate within the boundaries of the proposed integration authority;
- Users of health and/or social care and their carers who reside within the boundaries of the proposed integration authority;
- Third sector bodies carrying out activities related to health and/or social care who operate within the boundaries of the proposed integration authority;

- Commercial and non-commercial providers of health and social care who operate within the boundaries of the proposed integration authority;
- Local authorities or integration authorities who operate within the geographic boundaries of the same Health Board;
- Non-commercial providers of social housing who operate within the boundaries of the proposed integration authority**.**

4.4 After the conclusion of the consultative process, the Health and Social Care Partnership's Chief Officer will prepare a final draft revised Integration Scheme for consideration by the Council and Health Board and thereafter, if approved, for submission to the Scottish Government for approval by the Cabinet Secretary.

4.5 In addition to revisions to the Integration Scheme, a range of other organisational, financial and governance procedures must be updated to reflect the proposed increase in functional responsibility delegated to the HSCP. These are also set out in the Transition Plan set out at **Appendix 1**, with associated actions, timescales and officer allocations.

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE TRANSITION PLAN Appendix 1

- Extension of delegation to HSCPB to include NHS and Council Children's Functions and Council Criminal Justice Functions (Provisional "go-live" date of 11 August 2016)

Version 13/05/16

	WORKSTREAM	LEAD OFFICER(S)	WORKING / REFERENCE GROUP	INDICATIVE COMMENCEMENT DATE	INDICATIVE COMPLETION DATE	PROGRESS	COMMENTS
1	Council and NHSGGC to agree in principle to extend scope of delegation to HSCP to include NHS Children's Functions and Council Social Work Children and Criminal Justice functions.	CEOs EDC and NHSGGC	n/a	n/a	7 April 2016	**COMPLETED**	Completed via correspondence.
2	Agree detail of extended delegation of statutory functions, and associated services that will fall within scope.	Karen Murray Gordon Currie Catriona Renfrew Alan Cairns	n/a	Dec 2015 (for NHS Children's functions)	31 May 2016 (for all extended functions)	In progress	
3	Obtain Council and NHSGGC approval to proceed with delegation of additional functions to the HSCP.	Catriona Renfrew Ann Davie	n/a	n/a	17 March 2016	**COMPLETED**	
4	Formal notification to HSCP Board by Council and NHSGGC to intimate intended additional delegation of functions.	Karen Murray	n/a	n/a	17 March 2016	**COMPLETED**	
5	Establish Joint Communication Strategy for staff, stakeholders and the general public.	Sandra Cairney Alan Cairns	Sandra Cairney Angela Fegan Fiona Borland Alan Cairns	20 May 2016	3 June 2016	Awaiting commencement	

AC 130516

- Extension of delegation to HSCPB to include NHS and Council Children's Functions and Council Criminal Justice Functions (Provisional "go-live" date of 11 August 2016)

Version 13/05/16

	WORKSTREAM	LEAD OFFICER(S)	WORKING / REFERENCE GROUP	INDICATIVE COMMENCEMENT DATE	INDICATIVE COMPLETION DATE	PROGRESS	COMMENTS
6	Draft amendments to Integration Scheme and re-consult. Content can be informed by GGC Partnerships with similar scope.	Alan Cairns	Karen Murray Catriona Renfrew Gordon Currie Paulo Mazzoncini Karen Donnelly Alan Cairns	12 May 2016	21 June 2016	In progress	
7	Work with SG to amend Scheme as necessary to meet their requirements (contact: Alison Taylor).	Alan Cairns	Karen Murray Alan Cairns	20 May 2016	21 June 2016	Awaiting commencement	
8	Obtain Council and NHSGGC approval of revised Integration Scheme	Karen Murray	Karen Murray Alan Cairns	1 June 2016	21 & 28 June 2016	Awaiting Commencement	
9	Revised Integration Scheme to be submitted for Cabinet Secretary approval.	Karen Murray	Karen Murray Alan Cairns	n/a	29 June 2016	Awaiting Commencement	
10	Develop revised HSCP high level organisational structures.	Karen Murray	Karen Murray Pauline Halligan Tom Quinn	7 April 2016	30 June 2016	In progress	
11	Review IJB Standing Orders and update if necessary.	Alan Cairns	Karen Murray Legal and governance leads – EDC and GGC Jean Campbell	27 May 2016	30 June 2016	Awaiting commencement	

- Extension of delegation to HSCPB to include NHS and Council Children's Functions and Council Criminal Justice Functions (Provisional "go-live" date of 11 August 2016)

Version 13/05/16

	WORKSTREAM	LEAD OFFICER(S)	WORKING / REFERENCE GROUP	INDICATIVE COMMENCEMENT DATE	INDICATIVE COMPLETION DATE	PROGRESS	COMMENTS
12	Review and update financial monitoring and governance arrangements, if necessary.	Jean Campbell	Karen Murray Ian Black NHSGGC finance lead	20 May 2016	30 June 2016	Awaiting commencement	
13	Review HSCP's Scheme of Delegation to Officers and update if necessary.	Alan Cairns	Karen Murray Legal and governance leads – EDC and GGC Jean Campbell	27 May 2016	30 June 2016	Awaiting commencement	
14	Review Council's and NHS's Schemes of Delegation to Officers and update if necessary.	Legal and governance leads – EDC and GGC	n/a	10 June 2016	28 July 2016	Awaiting commencement	
15	Review impact on Criminal Justice partnership arrangements and clarify governance protocols.	Paolo Mazzoncini	Paolo Mazzoncini Keith Gardener Gerard McCormack	23 May 2016	30 June 2016	Awaiting commencement	
16	Revise Chief Social Work Protocol.	Paolo Mazzoncini	Karen Murray EDC legal lead Pauline Halligan Alan Cairns	23 May 2016	30 June 2016	Awaiting commencement	
17	Decide on Council's governance structures – i.e. whether retention of Social Work Committee or incorporation into other Committee.	Gerry Cornes	Karen Donnelly Karen Murray Andy Martin Paolo Mazzoncini	tbc	28 July 2016	Awaiting commencement	

- Extension of delegation to HSCPB to include NHS and Council Children's Functions and Council Criminal Justice Functions (Provisional "go-live" date of 11 August 2016)

Version 13/05/16

	WORKSTREAM	LEAD OFFICER(S)	WORKING / REFERENCE GROUP	INDICATIVE COMMENCEMENT DATE	INDICATIVE COMPLETION DATE	PROGRESS	COMMENTS
18	Agree revised budgets for delegation to HSCPB to reflect extended functional responsibility.	Jean Campbell	Karen Murray Ian Black NHS finance lead	20 May 2016	28 July 2016	Awaiting commencement	
19	Agree approach to extension of HSCP's Chief Officer's remit, revised role profile and appointment.	Tom Quinn	EDC and GGC HR leads	tbc	tbc	Awaiting commencement	
20	Agree date for empowerment of HSCP Board with extended delegation of functions and budgets.	Karen Murray	CEOs EDC and GGC	tbc	28 July 2016	Awaiting commencement	
21	Provide HSCP Board members with OD support on new responsibilities, associated obligations and current priorities.	Paolo Mazzoncini	Linda Tindall Ceri Paterson	18 July 2016	19 August 2016	Awaiting commencement	
22	Extend remit of statutory Strategic Planning Group to incorporate new functional areas.	Sandra Cairney	Strategic Planning Group Fiona McCulloch	6 June 2016	28 July 2016	Awaiting commencement	

Version 13/05/16

	WORKSTREAM	LEAD OFFICER(S)	WORKING / REFERENCE GROUP	INDICATIVE COMMENCEMENT DATE	INDICATIVE COMPLETION DATE	PROGRESS	COMMENTS
23	Agree approach to Strategic Planning – i.e. incorporation of Children's and Criminal Justice functions into Adult Services Strategic Plan, or separate Strategic Planning streams.	Sandra Cairney	Strategic Development Team	6 June 2016	28 July 2016	Awaiting commencement	
24	Agree approach to degree of financial flexibility to move resources between adult / children / criminal justice functional and service areas.	Jean Campbell	Karen Murray Ian Black NHS finance lead	20 May 2016	28 July 2016	Awaiting commencement	
25	Review and update terms of reference for HSCP's Audit Committee to reflect extended functional HSCPB responsibility, if necessary.	Jean Campbell	Karen Murray Ian Black NHS finance lead	20 May 2016	28 July 2016	Awaiting commencement	
26	Develop revised Performance Management arrangements for HSCP, Council and NHSGGC to reflect extended functional HSCPB responsibility.	Sandra Cairney	EDC and NHS performance management leads	20 May 2016	28 July 2016	Awaiting commencement	

Version 13/05/16

	WORKSTREAM	LEAD OFFICER(S)	WORKING / REFERENCE GROUP	INDICATIVE COMMENCEMENT DATE	INDICATIVE COMPLETION DATE	PROGRESS	COMMENTS
27	Update Integrated Care Governance Framework and Action Plan, including joint risk register to incorporate new functional responsibilities.	Karen Murray	Clinical and Care Governance Group	6 June 2016	28 July 2016	Awaiting commencement	
28	Finalise implementation and go-live date and obtain Council and NHSGGC approval. Address any interim accountability gaps.	Karen Murray	Karen Murray Gordon Currie Paolo Mazzoncini	tbc	21 & 28 June 2016	Awaiting commencement	NHSGGC Board meeting 21 June. EDC Council meeting 28 June.
29	Formal notification to HSCP Board by Council and NHSGGC to confirm go-live date for delegation of additional functions.	Karen Murray	tbc	tbc	11 August 2016	Awaiting commencement	Awaiting HSCP Board meeting date confirmation – prov 11/8/16.
30	Formal Direction by HSCPB to Council and NHSGGC to deliver services associated with the HSCPB's new areas of strategic responsibility.	Karen Murray	tbc	tbc	11 August 2016	Awaiting commencement	Awaiting HSCP Board meeting dates.
31	Confirmation to all staff of new organisational arrangements.	Karen Murray	Karen Murray Tom Quinn Pauline Halligan Fiona Borland	tbc	11 August 2016	Awaiting commencement	

Agenda Item Number: 13

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**25th May 2016**
Report Number	
Subject Title	**Strategic Planning Group & Locality Planning Groups Update**
Report by	**Karen Murray, Chief Officer,** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**Fiona McCulloch, Planning & Performance Manager,** **0141 201 9705** **Fiona.mcculloch@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 To inform the Board of the actions undertaken and agreed by the Strategic Planning Group (SPG) and Locality Planning groups

2.0 SUMMARY

2.1 It has been agreed that the HSCP Board receive the action notes and updates from the Strategic Planning Group (SPG) and the two Locality Planning groups.

2.2 The meeting of the Strategic Planning Group on 15th March focussed on t hree priorities within the Strategic Plan, namely

- Supporting People with Mental Health in their Community
- Self Management / Long Term Conditions
- Preventing People Being Admitted to Hospital Unnecessarily

The group discussed what they know about each of the priorities, and suggested the approaches or actions which should be considered in taking these priorities forward. The main points of discussion were noted are provided in **appendix 1**. Future meetings of the SPG will continue to inform and focus on HSCP priorities and consider progress made.

2.3 The West Locality had its first meeting on 20th January. At this meeting an overview of the Locality was presented. The Terms of Reference were discussed and are provided in **appendix 2**. The group appointed Dr John McPherson as Chairperson. The next meeting will focus on both dementia and mental health. The action notes from the meeting are provided in **appendix 3**

2.4 The East Locality had its first meeting on 27th January. This meeting followed the same format as the West Locality meeting, with an overview of the Locality being presented and the Terms of Reference, including the comments from the West Group, discussed. A chairperson was not appointed at the meeting, but the Group have subsequently agreed the appointment of Dr Diane Meek. The next meeting will focus on health inequalities. The action notes from the meeting are provided in **appendix 4**.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Health and Social Care Partnership Board:

- Note the contents of this report

Strategic Planning Group Meeting 15th March 2016

Notes from Priorities Workshop

1. Supporting People with Mental Health in their Community

What do you know about approaches to supporting people with mental health in their community	Approaches / Actions that should be considered
• Recovery oriented approaches • GP / CPNs / local mental health service provision • Service provision a bit random • Psychological therapies • Breathing Space • Asset map • NHS specialist services • Advocacy / 3rd sector organisation involvement • Support to young carers of people with mental health • Negative impact of welfare reforms • Suicide intervention collaboration across providers	• Anti stigma in schools • Introduce building emotional/well being in schools • Raise profile of mental health • Explore Scottish Recovery Network research on non chemical / non clinical approaches • Better communication between providers in response to crisis • Self management/recovery focussed approaches • Suite of treatments/therapies available • Stepped approach to care and treatment • Review housing allocation policy • Local services should be 'trauma-informed' • Review existing services to deliver a more coordinated approach • Join up information sharing to support services • Local support groups • Opportunities for counselling before crisis

2. Self Management / Long Term Conditions

What do you know about Self Management approaches	Approaches / Actions that should be considered
• Managed Clinical Networks • Peer support groups • Patient education programmes • Asset map • Well being recovery action programme (addictions) • GP based reviews • VOX voices of experience • Health improvement programmes • Local service uses testimony / experience • LTC Alliance	• Written plans to manage condition • Education / Information about condition and what you can do to help yourself • Improve befriending • Improved awareness and involvement of 3rd sector • Support groups / targeted groups • Identify from research what can be introduced in HSCP • Task PSU&C forum to bring big ideas to strategic planning processes

3. Preventing People Being Admitted to Hospital Unnecessarily

What do you know about approaches to preventing hospital admissions	Approaches / Actions that should be considered
• Self management • Palliative care gold standards • Anticipatory Care Plans • Improved communication • Safe discharge from A&E • Keeping people healthier longer / Walking groups • Emergency care plans for carers • Rapid assessment / prompt response and coordination of services • Carer support and training • GP Care Home contracts	• Services based around people's home • Improved services out of hours • Shift resources from Acute to Community • Dementia friendly communities • Equipment & adaptations in the home • Visual impairment awareness • Befriending services • Public education • Crisis standards agreed and implemented by all providers • Target specific groups

East Dunbartonshire Health & Social Care Partnership

West Locality Planning Group

TERMS OF REFERENCE

The East Dunbartonshire "West Locality Planning Group" is established in accordance with the Sections 29(3)(a) Public Bodies (Joint Working) (Scotland) Act 2014. These Terms of Reference are the procedures of the Locality Planning Groups as determined by the East Dunbartonshire Health and Social Care Board in accordance with the Act.

The West Locality is defined as including the towns and villages of:

- Bearsden
- Milngavie
- Bardowie
- Baldernock

1. ROLE

The West Locality Planning Group represents local stakeholder groups in relation to health and social care services to inform HSCP service planning.

The West Locality Planning Group is required to provide views on the development, implementation and review of the East Dunbartonshire Health and Social Care Partnership Board (HSCPB) strategic plans.

The West Locality Planning Group will be a k ey partner in developing and supporting engagement, communicating and sharing information locally to deliver the national health and wellbeing outcomes in East Dunbartonshire.

To fulfil its role, the West Locality Planning Group will aim to:

- be involved in assessing the needs of the Locality population / community;
- support a proactive approach to capacity building in communities
- contribute to the HSCPB's strategic proposals, policy documents, plans and services by giving due consideration and views to draft materials;
- support GPs and stakeholders to work together and better co-ordinate services with and for local communities
- support the delivery of HSCP outcomes as set out within the Strategic Plan
- support the principles that underpin collaborative working to ensure a strong vision for service delivery
- forge links with other Localities to share learning and good practice

2. MEMBERSHIP

The West Locality Planning Group consists of the following members:

- General Practitioners
- Health & Social Care Partnership Manager
- Health Professionals
- Social Care Professionals
- Acute Services - Planning Manager
- Third sector body carrying out activities related to health and social care
- Persons who uses local health and social care services
- Carers of a persons who uses local health and social care services
- Nominee representing housing

The Chair will be nominated and agreed by the group. The Chair will reappointed annually, and will serve no more than a maximum three years.

Established 'networks' and/or stakeholder groups will be invited to nominate relevant representation, including proxy representation, to the West Locality Planning Group.

In addition, the West Locality Planning Group may invite contributions from other relevant stakeholders that it considers will add value to its operations. This input may be on a one-off, for the duration of a defined piece of work/agenda item or on recurring basis and will be arranged at the discretion of the Chair in agreement with the individual(s) invited.

A representative from the West Locality Planning Group will represent the interests of the Locality at the Strategic Planning Group.

3. ROLE OF MEMBERS

Members are expected to:

- attend meetings regularly and consistently;
- link with stakeholders through agreed networks to ensure the interests of their stakeholder group are represented;
- actively contribute to the discussions of the West Locality Planning Group;
- act in such a way that safeguards the Health and Social Care Partnership's public reputation.

4. OPERATING PROCESSES

4.1 Meetings

On an annual basis at the first meeting of each year, the West Locality Planning Group will agree a schedule of meetings sufficient to deliver local priorities. Meetings will be no less than three per calendar year. In addition, information may be provided and sought on a virtual basis, communicated via email.

4.2 Quorum

Quorum for the West Locality Planning Group will be one third of the members, at least 2 of whom will be non-statutory partner representatives. If inquorate, agenda items may be discussed but decision/recommendations will not be agreed until such times as a quorum of members have acceded to them. The Chair will be responsible for obtaining the agreement of enough members to achieve a quorum outwith scheduled meetings, in order to make representations to the HSCP Board.

4.3 Administration

Support will be provided to the West Locality Planning Group and will include arranging meetings; producing meeting agendas; recording action notes and rolling action log; and circulating papers to members.

West Locality Planning Group members are expected to submit their apologies in advance of any meeting they are not able to attend, and arrange for their proxy to attend on their behalf.

The Health and Social Care Partnership will offer members reasonable support, including appropriate expenses, to enable them to attend meetings and fulfil their duties (GGC Volunteer Policy).

4.4 Review of Terms of Reference

These Terms of Reference will be reviewed at least annually, at the first meeting of the West Locality Planning Group each year, or at any time the HSCP Board considers a review to be necessary in the light of experience or emerging issues.

East Dunbartonshire
Health and Social Care Partnership

Meeting:	**West Locality Planning Group**		**Meeting called by:**	Fiona McCulloch	
			Date:	20/1/16	
Attendees:			**Apologies:**	Rita Pitts Alison Blair, Jean Powell	
Cara Bottomley, Catherine Davison, Fiona McCulloch, Flora Thomson, Gillian Notman, Gordon Cox, Graham Morrison, Ishbel Wright, Alistair Taylor John McPherson, Jon Berry, Lynne Milne, Marjorie Johns, , Rona Wotherspoon, Tina Boyle, Anne Hinselwood			**Next Meeting:**	11/5/16 **Time**	1.30pm
			Venue:		

	Discussion Points			
	➢ Welcome & Introductions ➢ Role and purpose of group outlined and discussed ➢ Draft Terms of Reference discussed ➢ Appointment of Chair – Dr John McPherson ➢ Possible topics for discussion: Dementia - diagnoses/cognitive impairment and map of services ➢ Mental Health services ➢ Understanding Physiotherapy pressures ➢ Voluntary organisations and the Asset map			
Item	**Action**	**Timescale**	**Owner**	**Progress**
1	Terms of Reference final version to be circulated to group		FMcC	Circulated
2	Strategic Plan and Localities Guidance to be circulated		FMcC	Circulated
3	Dates for meetings for the year to be circulated		CB	
4	Feedback from 'Rich Picture' event		FMcC	
5	Invite Dr Eric Jackson to next group		J McP	
	Focus of Next Meeting			
	Dementia - diagnoses/cognitive impairment, map of services Mental Health services			

East Dunbartonshire
Health and Social Care Partnership

East Dunbartonshire
Health and Social Care Partnership

Meeting:	**East Locality Planning Group**		**Meeting called by:**	Fiona McCulloch	
			Date:	19/1/16	
Attendees:			**Apologies:**		
Simon Beardsley; Mari Brady; Emma Carberry; Simon Chiswell; Elizabeth Elder; David Gilmore; Karen Heath; Paul Lyons; Margaret McCracken; Catherine McCrae; Fiona McCulloch; Diane Meek; Gillian Notman; Lorraine Pollock; David Radford; Pamela Ralphs; Jamie Sokolowski; Clair Taylor; Michael Foley; Lisa Williams; Valerie Berg; Mary McGuire; Connie Williamson.			**Next Meeting:**	18/5/16 **Time**	1.30pm
			Venue:		

	Discussion Points			
	➢ Welcome & Introductions ➢ Role and purpose of group outlined and discussed ➢ Draft Terms of Reference discussed ➢ Appointment of Chair – no Chair appointed. Lisa Williams agreed to chair next meeting if no Chair identified ➢ Possible topics for discussion: dementia; depression; deprivation; health literacy; inequalities			
Item	**Action**	**Timescale**	**Owner**	**Progress**
1	Terms of Reference final version to be circulated to group		FMcC	Circulated
2	Strategic Plan and Localities Guidance to be circulated		FMcC	Circulated
3	Chair to be agreed by group.		LW	Dianne Meek agreed by group as Chair 3/2/16
	Focus of Next Meeting			
	Health Inequalities – David Radford will present Health & Well Being Survey			

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs. Karen E. Murray

Agenda Item Number: 14

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**Public, Service Users and Carers' Network -Update**
Report by	**Karen Murray; Chief Officer** **East Dunbartonshire Health & Social Care Partnership**
Contact Officer	**David Radford Health Improvement and Inequalities Manager,** **0141 355 2391** **David.radford@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to inform the Health & Social Care Partnership Board (HSCP) of the activity undertaken by the Public, Service Users and Carers Network (PSU&CN) for the period between December 2015 and March 2016.

2.0 SUMMARY

2.1 Mechanisms to achieve meaningful engagement with the public, service users and their carers have been established in accordance with section 32 of the Public Bodies (Joint Working) (Scotland) Act 2014.

2.2 The PSU&CN has held one workshop in each of the two locality areas, the last meeting was the 10th March 2016 in Kirkintilloch.

2.3 The PSU&CN developed and agreed a draft Terms of Reference (Appendix1).

2.4 PSU&CN participants agreed and undertook a process to nominate future public, service users and carer representation to each of the following groups;

- HSCP Board;
- Strategic Planning Group;
- Locality Groups.

2.5 The PSU&CN members completed an Equalities Impact Assessment on their representation (Appendix 2).

2.6 The HSCP Board will receive update reports from the PSU&CN on a twice yearly basis. Future reports will be presented by the 'User' representative of the HSPC Board.

3.0 RECOMMENDATIONS

It is recommended that the Health & Social Care Partnership Board:

- notes the activities undertaken by the Public, Service User and Carer Network.
- Approve the PSU&CN Terms of Reference. (Appendix 1)
- Agree the improvement actions outlined in the EQIA (Appendix 2)

PUBLIC, SERVICE USER & CARERS NETWORK (PSU&CN)
DRAFT TERMS OF REFERENCE (March 2016)

1. BACKGROUND

The Public Bodies (Joint Working) (Scotland) Act 2014 and associated regulations and guidance requires the Health & Social Care Partnership (HSCP) to establish mechanisms to take account of the particular needs of communities, service-users and carers in different parts of the authority and to engage them in shaping health & social care services.

2. ROLE

The East Dunbartonshire Public Service User & Carers Network (PSU&CN) has been established with the aim of:

- supporting and empowering service-users, carers and the wider public specifically through their participation in the Health & Social Care Partnership Board (HSCP), the Strategic Planning Group and the Locality Planning Groups.
- taking account of the views of service users, carers and the wider public in the decision-making process.

The PSU&CN acts as a key mechanism for developing and facilitating effective engagement with individuals, groups and communities. The PSU&CN will:

- communicate in the most effective way with the public to understand and articulate their views on matters relating to health & social care services,
- be involved in assessing the needs of the population/communities,
- through their representative role on the HSCP Board, the Strategic Planning Group and the Locality Planning Groups, support the HSCP to consider the needs and views of the public in planning and shaping of local services
- produce briefings for the HSCP Board, highlighting key messages and outputs from the work of the Public Service User & Carers' Network

3. MEMBERSHIP

Membership is open to members of the public, service users and carers who live within East Dunbartonshire.

4. ROLE OF MEMBERS

Members are invited to:

- actively contribute to discussions & activities through quarterly workshops,
- link with others through agreed networks to ensure the interests of wider groups are represented,

- agree mechanisms to secure representation on HSCP Board, Strategic and Locality Planning Groups.
- establish short-life working groups to progress specific interests or work on behalf of the PSU&CN.

5. OPERATING PROCESSES

- The PSU&C Network will be supported to take part in participatory workshops not less than 4 times per year.
- Workshops will be promoted and open to anyone living in East Dunbartonshire.
- Participants will determine and agree an annual schedule of activity, relevant to the priorities articulated in the HSCP Strategic Plan.
- Additional communication methods will be developed to increase the reach of the PSU&CN
- All participants have the right to feel physically and emotionally safe; be treated with respect; and have the opportunity to voice their views and be listened to

6. SUPPORT TO THE PSU&CN

The HSCP will provide the following support.

- Organising workshops; recording action notes; circulating information to participants; and supporting shared learning opportunities.
- Offering members reasonable support, including appropriate expenses, to enable them to attend meetings (GGC Volunteer Policy).

7. COMMITMENT TO EQUALITY AND DIVERSITY

The PSU&CN will seek to secure and monitor community participation in relation to those:

- living in areas of deprivation
- with protected characteristic groups defined within *The Equality Act (2010)* and the additional Scottish Statutory Instrument *The Equality Act (2010) (Specific Duties) (Scotland) Regulations 2012*.

8. REVIEW OF TERMS OF REFERENCE

These Terms of Reference will be reviewed at least annually or at any time the Health and Social Care Partnership Board considers a review to be necessary in the light of experience or emerging issues.

East Dunbartonshire

Health and Social Care Partnership

Equality Impact Assessment

East Dunbartonshire Public, Service Users & Carers Network

March 2016

Organisation:	Health & Social Care Partnership
Service:	Public, Service Users & Carers Network
Function being assessed:	Network membership
Is this a proposed or existing function?	New

Officer responsible for assessment:	David Radford
Lead manager responsible for assessment:	Sandra Cairney
Date of Relevance Assessment:	March 2016
Date of Sign Off:	

1. PURPOSE OF THE ANALYSIS

The purpose of this Equality Impact Assessment (EQIA) is to analyse the information gathered on the Public, Service Users & Carers Network, to test it for potential relevance to equality.

2. ABOUT THE SERVICE

Equality OUTCOME 3 People who use health and social care services have positive experiences of those services, and have their dignity respected.

2.1 Service user involvement in the planning, development and monitoring of services is a priority for the HSCP. A development programme will provide support to service users and carer representatives to effectively fulfil their role as members of the HSCP Board, the Strategic Planning Group, and Locality Planning Groups. A Service User and Carer Network has been established and supported to secure wider involvement of local people in contributing to maintaining and improving high quality, efficient, safe and effective services. In addition, links with existing networks will be strengthened to promote access to marginalised groups. The H&SCP commitment is outlined in the Strategic Plan – 2015/2018.

2;2 **T**he Public Service User & Carers Network (PSU&CN) is open to members of the public, service users and carers who live within East Dunbartonshire and has been established with the aim of:

- supporting and empowering service-users, carers and the wider public specifically through their participation in the Health & Social Care Partnership Board (HSCP), the Strategic Planning Group and the Locality Planning Groups.
- taking account of the views of service users, carers and the wider public in the decision-making process.

2.3 The PSU&CN acts as a key mechanism for developing and facilitating effective engagement with individuals, groups and communities. The PSU&CN will:

- communicate in the most effective way with the public to understand and articulate their views on matters relating to health and social care services

- Communicate in the most effective way with the public to understand and articulate their views on matters relating to health & social care services
- be involved in assessing the needs of the population/communities
- through their representative role on the HSCP Board, the Strategic Planning Group and the Locality Planning Groups, support the HSCP to consider the needs and views of the public in planning and shaping of local services
- produce briefings for the HSCP Board, highlighting key messages and outputs from the work of the Public Service User & Carers' Network

3. EQIA : METHODOLOGY

The Equality Act (2010) describes these groups of people as having legally 'Protected Characteristics'. The legally protected characteristics that must be considered by an EQIA are:

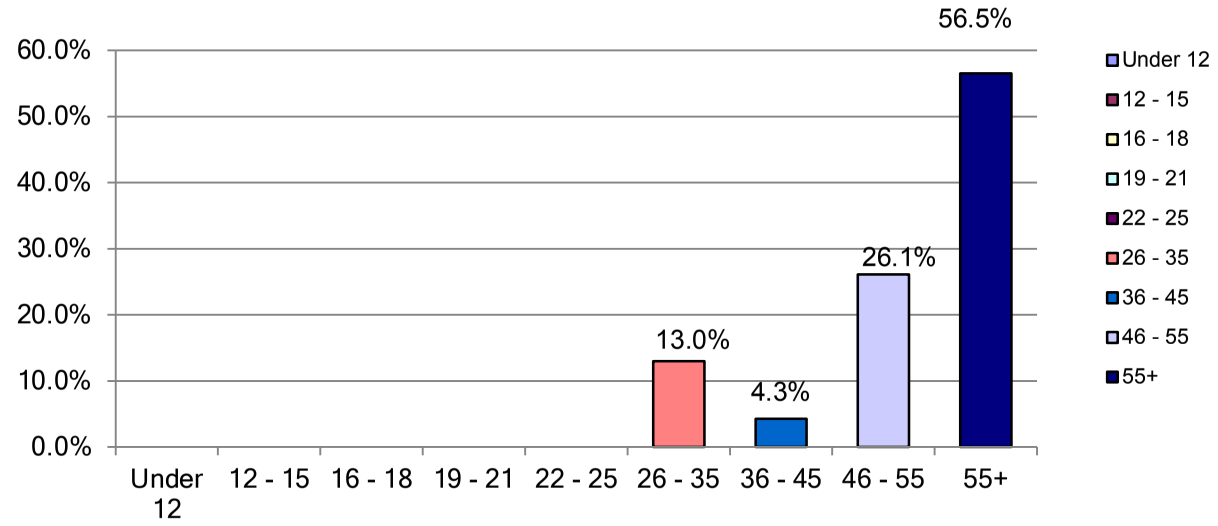
1. Age
2. Disability
3. Gender Reassignment
4. Marriage and Civil Partnership
5. Pregnancy and Maternity
6. Race (including ethnicity and nationality)
7. Religion and Belief
8. Sex
9. Sexual Orientation

In addition to the legally defined protected characteristics, NHS Greater Glasgow and Clyde includes social class and socio-economic status as an additional characteristic to be considered.

East Dunbartonshire H&SCP in association with East Dunbartonshire Voluntary Action (EDVA) carried out an Equality Impact Assessment. The aim is to assess the diversity of Network membership, communities of interest and marginalised groups from across the locality who is sufficiently well involved in their community to be able to represent the views of different groups from the protected characteristics listed. A survey was undertaken with those members who attended the development event on the 10th of March 2016. This involved 26 members of the Network, 23 of those present completed the survey (88% of attendee's). The survey was a confidential / anonymous and only the information pertaining to the protected characteristics and socio-economic status was asked for.

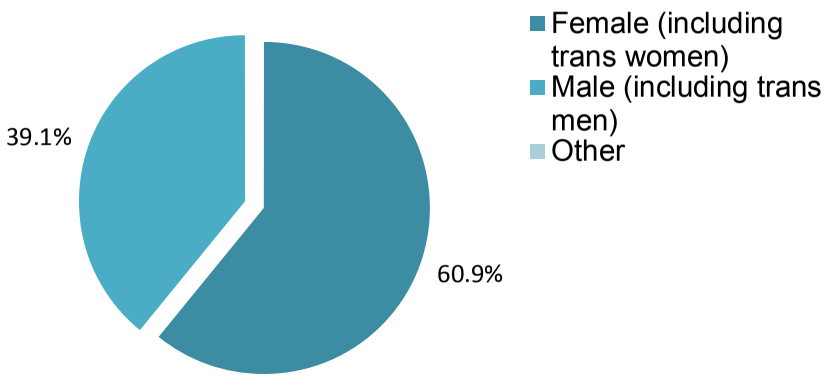
4. EQIA : FINDINGS

4.1 Age of members

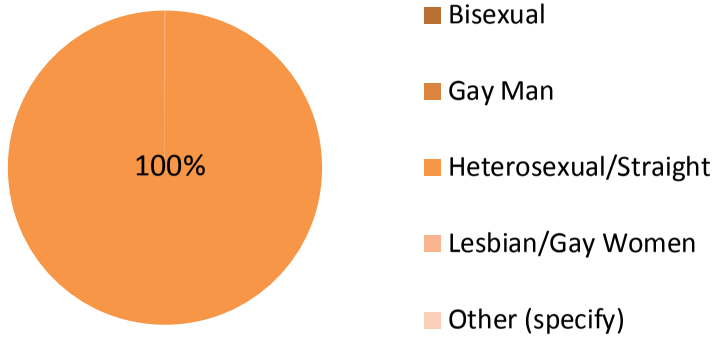


- Over 55% of the members are above 55yrs.
- 26% of those present are between 46 – 55yrs old.
- Just over 17% of the forum is between 26 & 45 yrs.
- There are no members under 35yrs of age.

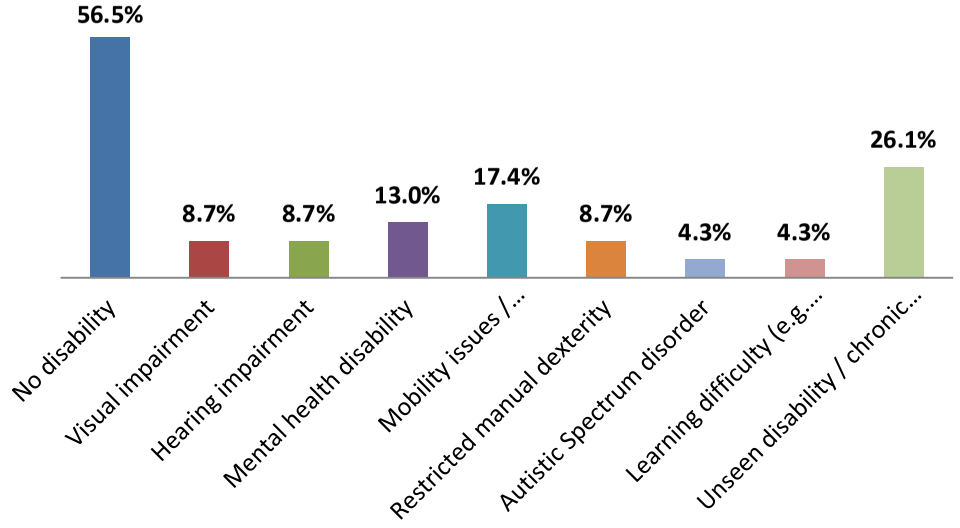
4.2 Gender



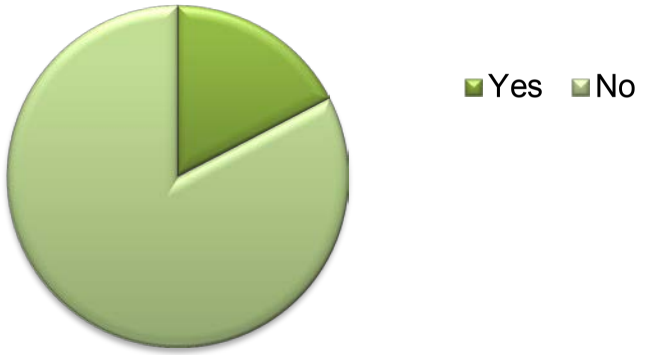
4.3 Best describes Sexual Orientation



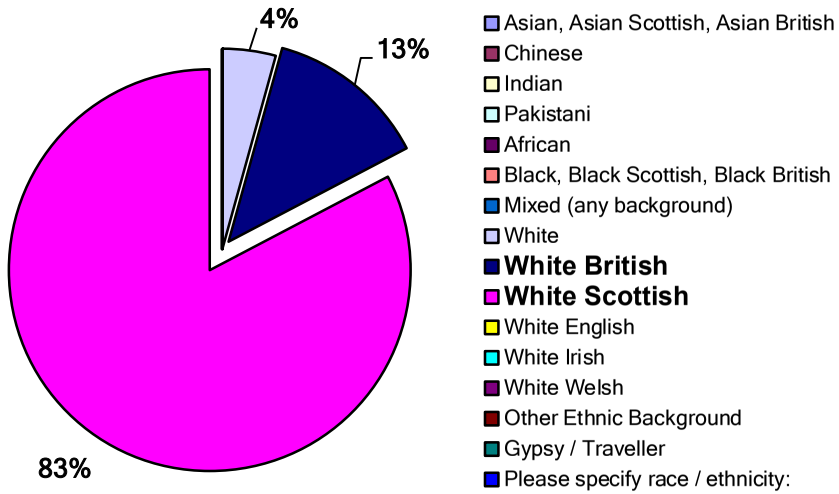
4.4 Members with a disability



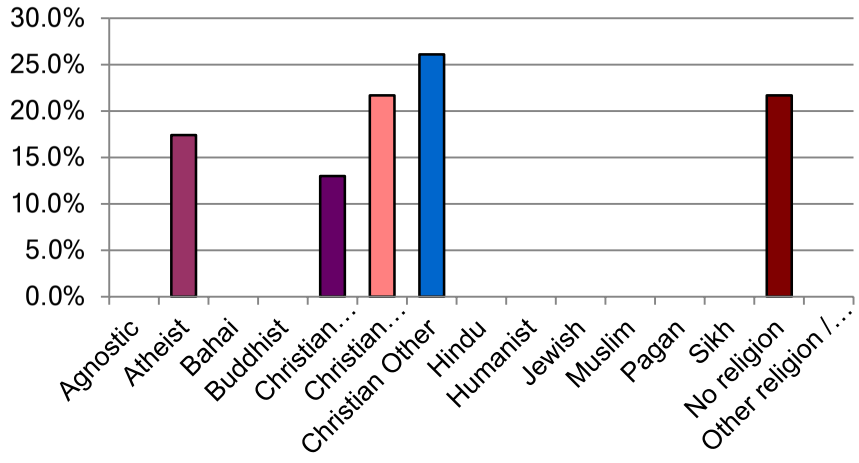
4.5 Those with a disability, who have a support / case worker i.e. Social Work / Job Centre or NHS?



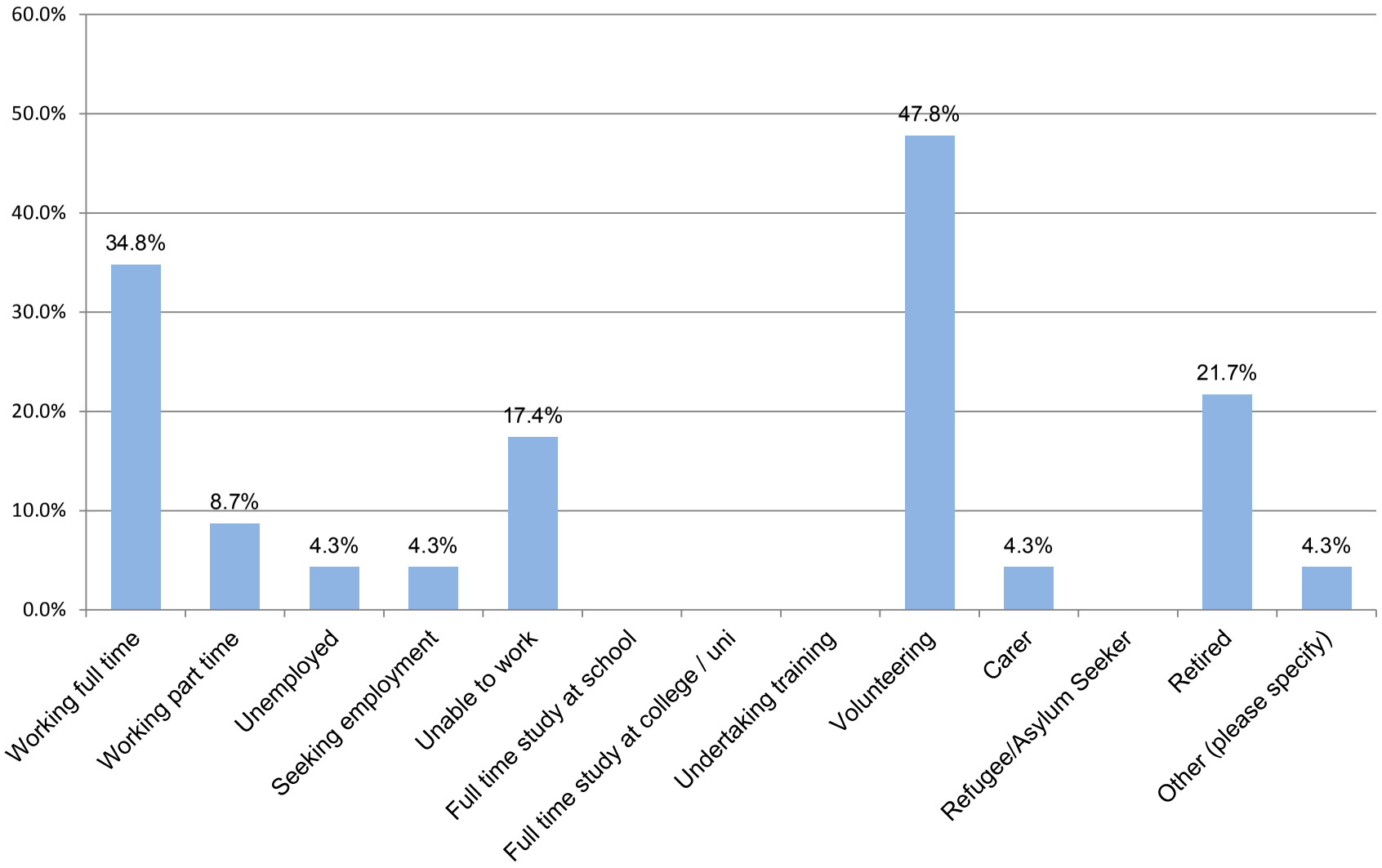
4.6 Best describes race or ethnic group



4.7 Religion or Belief



4.8 Current employment / education / training



5. RELEVANCE ASSESSMENT FINDINGS

This analysis has demonstrated relevance to equality with regard to:

5.1 Protected Characteristics
Age☒ Disability ☒ Race ☒Sex ☒Gender includes gender reassignment) ☒ Pregnancy and maternity) ☒ Sexual Orientation☒ Religion or Belief (or lack of)☒ Marriage or Civil Partnership ☒
5.2 Aims of the Equality Duty (with relevance measures) ▪ Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act (i.e. the function removes or minimises disadvantages suffered by people due to their protected characteristics)☒ ▪ Advance equality of opportunity between those who share a protected characteristic and those who do not (i.e. the function takes steps to meet the needs of people from protected groups where these are different from the needs of other people)☒ ▪ Foster good relations between people who share a protected characteristic and those who do not (i.e. the function encourages people from protected groups to participate in public life or in other activities where their participation is disproportionately low) ☒

6. CONCLUSIONS

6.1 Relevance Ranking

The function shows a **high** degree of relevance to one or more protected characteristic and / or one or more aim of the general equality duty
The relevance assessment has identified a **high** or **medium** relevance ranking and a Stage 2 Equality Analysis (Equality Impact Assessment) is required

7. ACTION AND MONITORING

Age: Identify and construct a process of enrolment that will include membership from all 16+ age groups in East Dunbartonshire. Especially recommend increased enrolment from the under 35yrs age demographic.
Disability: Increased enrolment from service users and providers of disability services that have not participated thus far, by identifying service users and individuals not represented thus far.
Race: Conduct further enquiry to groups and organisations that represent ethnic minorities, harder to reach groups and individuals, i.e. travellers, ethnic minority groups.
Sex / Gender reassignment: Further enquiries around good practice required around lesbian, gay, bi-sexual people and transgender people and identify further engagement with these groups and individuals.
Social class and socio-economic status Further investigation required to have engagement across all post code areas of East Dunbartonshire, especially from areas that fall into the SIMD datazones of the most deprived areas of Scotland.

East Dunbartonshire
Health and Social Care Partnership

Chief Officer: Mrs Karen E. Murray

Agenda Item Number: 15

EAST DUNBARTONSHIRE
HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Date of Board Meeting	**26th May 2016**
Report Number	
Subject Title	**Development Programme for the HSCP Board for 2016/17**
Report by	**Karen Murray, Chief Officer, East Dunbartonshire Health and Social Care Partnership**
Contact Officer	**Linda Tindall, Organisational Development** **07824623633** **Linda.tindall@ggc.scot.nhs.uk**

1.0 PURPOSE OF REPORT

1.1 To invite HSCP Board members to consider and agree the attached proposals for further HSCP Board development.

2.0 SUMMARY

2.1 During the period of transition the Joint Board engaged in two development sessions for members in 2015 (March and August 2015)

2.2 In addition shadow board members were invited to attend induction visits to Kirkintilloch Health & Care Centre and Kelvinbank Resource Centre to introduce members to the services provided by the HSCP and to engage with staff and service users.

2.3 Feedback from the service visits and the development sessions from those participating was positive. It was agreed that there was a requirement for further development activities.

2.4 In December the Scottish Government published a guide supporting the formation of Integration Joint Boards. A number of the identified development exercises in this document have already been discussed in previous development sessions that took place in 2015

2.5 To facilitate further discussions about future development a proposal was put to the HSCP Board meeting held on 11 February 2016. This paper summarised the current position and made a number of recommendations with options for a future development programme for Board members

2.6 A time table of development activities based on the proposal was presented and accepted at the board meeting held on 31 March 2016. It was agreed that a final programme containing relevant details including dates and times of activities would be presented at the board meeting due to take place on 26 May 2016.

3.0 RECOMMENDATIONS

3.1 It is recommended that the HSCP Board considers the programme of development activities contained in Appendix 1 of this report and:

- Agree the dates, times and topics for the development programme as detailed in Appendix 1

4.0 MAIN REPORT

4.1 Following the Board meeting held on 11th February 2016 a proposal containing suggestions about half day development sessions, service visits and topic specific seminars was circulated to Board members. Board members were asked to consider the programme and rate the suggested topics in order of preference. They were also asked to add areas of particular interest not included in the paper

4.2 The feedback from this proposal was taken on board and a summary of options developed. These options were presented to Board members at the meeting held on 31st March 2016

4.3 At this meeting it was agreed that members would be asked to provide their availability, dates would be coordinated and a final paper containing details for Board development for 2016/17 would be presented at the next Board meeting due to take place on 26 May 2016

4.4 Prior to each service visit and half day development session a programme containing practical arrangements for the visit will be circulated to Board members

4.5 Details of the Board development programme are contained in Appendix 1 to this report

APPENDIX 1

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
HEALTH & SOCIAL CARE PARTNERSHIP BOARD
DEVELOPMENT PROGRAMME 2016/17

SERVICE VISITS **(Dates between Board meetings)**	
27 April 2016 ***1.00 - 3.30pm***	**Woodlands Centre** - HSCP Older People Mental Health Team **Silverbirch Garden Centre** - Work experience and skills development for people with learning disabilities
8 June 2016 ***9.30 – 10.30am***	**Milngavie Clinic** - Base for community NHS district nursing, health visiting teams and for podiatry and physiotherapy services
5 ***October 2016*** ***2.00-3.00pm***	**Lennoxtown Community Hub** - Bringing together delivery of existing East Dunbartonshire council services within NHS services
6 December 2016 ***9.30-10.30am***	**Homecare Team** - KHCC
9 February 2017 ***9.30-10.30am***	**Milan Centre** - Ethnic Minority Day Care Centre
TOPIC SPECIFIC SEMINARS * **(every second board meeting lasting between 30 minutes – 1 hour)**	
26 May 2016	Joint Health Improvement Plan Functions and Key deliverables
September 2016	Understanding HSCP Finances, prescribing and prescribing best practice
January 2017	The role of the HSCP board in strategic planning of unscheduled care
March 2017	Introduction to Adults with Incapacity and the role of the Mental Health Officer
HALF DAY DEDICATED DEVELOPMENT SESSION	
18 August 2016 ***9.30 – 12.30pm***	Improve the understanding of assessing continuous improvement, performance management systems, performance data and patient experience information
16 March 2017 ***9.30 – 12.30pm***	Working to support localities and understanding the GP contract

* Dates will be added once HSCP Board dates have been agreed

East Dunbartonshire Health & Social Care Partnership Board
Distribution List

Name	Designation
Councillor Rhondda Geekie	Chair - EDC - Elected Member
Councillor Anne McNair	EDC - Elected Member
Councillor Michael O'Donnell	EDC - Elected Member
Ian Fraser	Non-Executive Board Member
Ross Finnie	Non-Executive Board Member
Trisha McAuley	Non-Executive Board Member
Karen Murray	Chief Officer - East Dunbartonshire HSCP
Ian Black	Director of Finance & Shared Services (Sect95)
Sandra Cairney	CHP Head of Planning & Health Improvement
Fiona McCulloch	CHP Planning & Performance Manager
Keith Gardiner	Acting Chief Social Work Officer
Graham Morrison	Clinical Lead Representative
Adam Bowman	Acute Services Representative
James Hobson	Finance Lead Representative
Andrew McCready	Trades Union Representative
John Duffy	Trades Union Representative
Gordon Thomson - Ceartas	Voluntary Sector Representative
Martin Brickley	Service User Representative
Chris Shepherd	Carers Representative
W. Hepburn	Professional Nurse Advisor - NHS
Martin Cunningham	Corporate Governance Manager (3)

For Information (Substitutes)

Name	Designation
Councillor Ashay Ghai	EDC - Elected Member
Councillor Gillian Renwick	EDC - Elected Member
Councillor Manjinder Shergill	EDC - Elected Member