Municipal Buildings, Greenock PA15 1LY

Ref: SL

Date: 18 June 2020

A meeting of the Inverclyde Integration Joint Board will be held on Tuesday 23 June 2020 at 2pm.

Please note, this meeting is by remote online access only through videoconferencing. The joining details will be issued to participants in advance of the meeting.

Gerard Malone
Head of Legal and Property Services

BUSINESS

1. **Apologies, Substitutions and Declarations of Interest**

ITEMS FOR NOTING

2. **Chief Officer's Report**
   Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership

ITEMS FOR ACTION

3. **Minute of Meeting of Inverclyde Integration Joint Board of 17 March 2020**

4. **Minute of Meeting of Inverclyde Integration Joint Board of 12 May 2020**

5. **Rolling Action List**

6. **Inverclyde Integration Joint Board (IJB) and IJB Audit Committee – Proposed Dates of Future Meetings**
   Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership

7. **2019/20 Draft Annual Accounts**
   Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership

8. **COVID-19 Inverclyde HSCP Transition to Recovery Planning**
   Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership

9. **Support to Care Homes COVID-19**
   Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership

10. **Unscheduled Care Commissioning Plan**
    Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership

11. **Champions Board/Proud 2 Care**
Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership

12. **District Nursing Workforce**
Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership

ITEM FOR NOTING

13. **COVID Mortality Report June 2020**
Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership

The documentation relative to the following items has been treated as exempt information in terms of the Local Government (Scotland) Act 1973 as amended, the nature of the exempt information being that set out in paragraph 6 of Part I of Schedule 7A of the Act as are set out opposite the heading to each item.

14. **IJB Risk Register** **Para 6**
Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on the status of the IJB Strategic Risk Register in light of the current COVID-19 pandemic

Please note that because of the current COVID-19 (Coronavirus) emergency, this meeting will not be open to members of the public.
The papers for this meeting are on the Council's website and can be viewed/downloaded at https://www.inverclyde.gov.uk/meetings/committees/57

In terms of Section 50A(3A) of the Local Government (Scotland) Act 1973, as introduced by Schedule 6, Paragraph 13 of the Coronavirus (Scotland) Act 2020, it is necessary to exclude the public from this meeting of the Integration Joint Board on public health grounds. It is considered that if members of the public were to be present, this would create a real or substantial risk to public health, specifically relating to infection or contamination by Coronavirus.

Enquiries to - **Sharon Lang** - Tel 01475 712112

AGENDA ITEM NO: 2

Report To:	**Inverclyde Integration Joint Board**	**Date: 23 June 2020**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/42/2020/LL**
Contact Officer:	**Louise Long**	**Contact No: 712722**
Subject:	**CHIEF OFFICER'S REPORT**	

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board on a number of areas of work.

2.0 SUMMARY

2.1 The report details updates on work underway across the Health and Social Care Partnership.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the items within the Chief Officer's Report and advise the Chief Officer if any further information is required.

Louise Long
Chief Officer

4.0 BACKGROUND

4.1 There are a number of issues or business items that the IJB will want to be aware of and updated on, which do not require a full IJB report, particular with HSCP response to COVID19 by a full report. IJB members can of course ask that more detailed reports are developed in relation to any of the topics covered.

5.0 BUSINESS ITEMS

5.1 Public Protection Dashboard

As the pandemic has progressed, the Scottish Government in collaboration with COSLA, Solace and Chief Officers' Groups have sought additional assurances on a number of areas in respect of public protection. This has resulted in the creation of a public protection dashboard that services, mainly social work and the police, are required to submit to the Scottish Government on a weekly basis .The key areas addressed include:

- Adult and Child Protection
- MAPPA
- Looked after Children
- Young people in receipt of after care
- Suspected drug deaths
- Homelessness

A second set of data incorporating much of the above is also submitted to Solace and this has a wider range of indicators in respect of issues relating to humanitarian responses and wider council functions.

The data requested was not readily retrievable form our existing data collection systems and measures and notice of the data requirements was very short. Despite this we have been able to meet the requirements to a good standard and on time and now have a process in place to meet the ongoing requirements.

Data submitted to government is then collated by Local Authority area with commentary from government analysts. This in turn has been used locally to support the governance of the Adult and Child Protection Committees and the Chief Officers' Group. The data collated is reported weekly on the Scottish Government website.

Separately, locally we have worked to ensure minimum disruption to our key governance mechanisms .The Chief Officers' Group, the Adult and Child Protection Committees, the Alcohol and Drugs Partnership, the Mental Health Programme Board and the Clinical and Care Governance Group are all back in operation albeit with modifications commensurate with the particular needs of each forum. Plans are underway for the subgroup structures that support these mechanisms to be eased back to operational capacity.

The Violence Against Women Partnership and the Community Safety Partnership are not hosted by the HSCP, however we are liaising with partners regarding them meeting.

5.2 Capital Projects

HSCP Capital Projects Programme Boards have now stepped up to ensure that the impact of COVID19 is understood on capital - see information below.

Learning Disability

Approval has been given by Inverclyde Council in the allocation of £7.4 million of funding as part of to the Council's budget-setting process to allow planning for the Inverclyde HSCP's new Learning Disability Resource Hub which will house Learning Disability Day Opportunities Services and the Integrated Community Learning Disability Team.

This process sees the successful decommissioning of the McPherson Centre and the interim use of the Fitzgerald Centre for day services after extensive service user and carer consultation independently supported by The Advisory Group.

Planning is now underway with Property Services in the design of the new hub with cognisance to service user involvement and access to open space within the site to develop our services for Autism with a two year programme of consultation, planning and construction.

This process is managed through a program board chaired by the Health & Community Care Head of Service, with key constituencies from all aspect of Learning Disability Services within both the HSCP and its external key partners.

Greenock Health Centre

At a recent site progress meeting it was noted that the overall works are approximately 8.5 weeks behind on current programme due to the impact of COVID19 with impact on site closure, site restrictions, limited numbers of operatives due to self-isolating, social distancing measures, furlough of subcontractors and material suppliers. The site is currently operating on a reduce workforce of around 50% capacity.

It is anticipated that the completion will be late 2020 early 2021. This will allow all services and GP practices to review their recovery plans in line with the commissioning period.

A meeting has been scheduled with CVS and other voluntary organisations to consider a transport model for the new facility. The design team are working closely with NHSGGC procurement teams to ensure all equipment is in hand and sample rooms are currently being developed. The Project Board, Delivery Group, ICT/Telephony Groups continue to meet regularly to drive the programme forward.

SWIFT

The Scotland Excel tender framework was put on hold in response to the COVID19 pandemic. This has resulted in an inevitable delay to the publication of the revised Invitation to Tender (ITT) on Public Contracts Scotland (PCS-T). At this time the exact timeline for publication of the ITT is not fully agreed but Scotland Excel are now making moves to resume this work and are working back from presenting recommendations to the Executive Sub Committee on 28th August. Assuming approval, regulation 85 letters will be sent out with a two week standstill, so the framework would be accessible in the second half of September. The SWIFT Replacement Project Team have continued to progress preparatory work during the past two months, working primarily on data cleanse tasks and developing a suite of 'As Is' process maps for current SWIFT processes.

IT Portable Work Expansion

Significant work has already taken place around expanding agile and mobile working capacity for all staff in response to COVID19. Investment has been made in additional hardware, software and licences by both Inverclyde Council and NHS GG&C as part of their response to the pandemic. In addition, the HSCP has invested in additional hardware to support video communications with service

users and external agencies. Services are moving to make extended use of software such as Meet Anywhere to support safe stepping up of services using these technologies. Additional investment is being made on upgraded smart phones for staff and more vulnerable service users to ensure digital access to services is maintained. Much of this investment has been by the Council and Health Board as part of their overall ICT response to COVID19 and in addition, the HSCP has invested in some additional service specific equipment. Costs of the HSCP spend are being captured through the mobilisation plans where the projected spend on additional equipment and supplies is estimated at £139.5k in 2020/21.

5.3 **Mobile Testing**

On 19th May 2020, Scottish Government COVID19 Testing capacity was expanded to anyone in Scotland aged 5 or over, who is self-isolating because they are showing symptoms can be tested. Priority for testing appointments will be maintained for key workers and their household members to support them returning to work where it is safe to do so.

The mobilisation of a COVID19 Mobile Testing Unit (MTU) managed by the Army located initially at the Waterfront Leisure Car Park Greenock from Friday 22nd May 2020, moved to St Andrews Church, Auchmead Road, Greenock. Currently operation Monday to Sunday 10.00 a.m. – 6.00 p.m.

Testing is accessed via the government website:

- Citizen Portal https://www.nhs.uk/ask-for-a-coronavirus-test
- Essential Workers self referral https://www.gov.uk/apply-coronavirus-test-essential-workers
- Employers Portal https://coronavirus-invite-testing.service.gov.uk/DaraTestDemand/Login

5.4 **Health & Social Care Staff Testing**

A COVID19 drive through testing centre has been established at Port Glasgow Health Centre for Health & Social care staff and commissioned social care providers with a process which allows staff members to self-refer for testing or members of their family where they are self-isolating. There have now been in excess of 800 staff tested here and whilst the centre is currently running at about half capacity, this spare capacity has been used for care home staff mass testing allowing for a further 120 tests to take place on site. The centre moved from Port Glasgow to Greenock Health Centre on Monday 15th June. It operates in the morning Monday to Friday.

5.5 **COVID19 Care Home Testing for Residents and Staff**

As per Scottish Government guidelines, COVID19 testing for Residential and Nursing Care Homes has been established to test symptomatic residents via their GP and via Port Glasgow test centre for symptomatic staff. In addition to this, from 7th May 2020 testing of non- symptomatic staff and residents will take place within individual residential and nursing care homes and will be undertaken by the outreach testing service. This will be co-ordinated from the Port Glasgow testing site.

As from 25th May, all adult residential care homes will have had all residents and staff tested who have agreed to the test.

Care homes who do not wish for large numbers of staff to enter the premises and have been carrying out their own tests with support from the HSCP Care Home Liaison Nurses where requested.

5.6 **COVID Assessment Centre**

The Inverclyde HSCP COVID19 Assessment centre opened on Monday 30th March 2020. This is based at Wings H and I of the Greenock Health Centre. This was in response to the National UK / Scotland wide COVID19 assessment requirements and was part of the Greater Glasgow and Clyde response. Inverclyde was the second centre to open after GGC Barr Street HUB.

Inverclyde CAC centre is open Monday to Friday 9-5pm with capacity to see 20 symptomatic patients per day. Across pandemic usage has reduced.

On 15th June the CAC moved to afternoon operating with the testing centre moving to Greenock Health Centre to support testing in the morning.

5.7 **Annual Performance Report being delayed due to COVID**

Schedule 6 to the Coronavirus (Scotland) Act, paragraph 8 provides for the postponement of the publication and laying of reports, including publication of integration authority annual performance reports during the pandemic. Officers are still working on the data that is available to them and it is anticipated that the Annual Performance Report will come to the IJB for consideration and approval in November.

5.8 **Wellbeing**

Regular briefings have been sent to all staff. Wellbeing Champions have been working with Staffside to create a plan that supports staff through COVID19.

The HSCP Local Resilience Management Group requested that CVS lead the work to bring together services funded by the HSCP and Council to look at how they could use all their collective resources to support communities.

Initially linked to having processes/support in place for those on the Shielded list, providers have come together to expand this and to provide extraordinary response to the communities needs.

A range of support is provided through Your Voice and Compassionate Inverclyde and have delivered 3533 keeping in contact calls to support people by being neighbourly and reducing social isolation. In addition, Mosaic have supported keyworkers with mental health support.

Together Your Voice, Compassionate Inverclyde, Salvation Army and Mind Mosaic have offered support to those who have experienced loss through bereavement.

5.9 **iDEAS Project**

The iDEAS Project is a Lottery funded financial inclusion service which worked with the people of Inverclyde to alleviate financial difficulties and help reduce inequalities. Within Inverclyde this was a £2.327m contract over 3 years which was due to end in June 2020. The I:DEAS project was delivered through work that was sub contracted to 6 external partners and 2 internal partners. Progress on successfully processing provider claims through the project has been slow nationwide, with compliance issues being the main barrier. To address this and reduce the risk of providers not being funded for work completed due to claim compliance issues, the Lottery have offered additional funding to extend current staffing around the project to the end of August 2020 in order to allow time for all claims against the scheme to be properly verified, submitted and approved within set compliance requirements. For Inverclyde this relates to 2 temporary staff members whose contracts would extend by 2 months to allow completion of the project. This will be fully funded by the Lottery and on that basis, the Council and HSCP have agreed to the temporary extension of these staff contracts to support

this.

5.10 **Strategic Plan Progress Report**

Overall, progress has been positive and achievements have been outlined in a progress report that went to the Strategic Planning Group on 8th June. The report highlighted process to date and plans to continue transformational change during the forthcoming year, noting that due to COVID19, progress in some areas will inevitably be slower than planned. Big Actions 1-4 are ranked green and actions are progressing as planned. Big Actions 5 and 6 are ranked amber. For Big Action 5 - reducing harm from alcohol, tobacco and drugs, some progress has been made. With regard to the pace of change in terms of the Addictions Review, however, this has not been as fast as we had hoped and Addictions is still a significant issue within Inverclyde. Performance in national KPIs is still poor so this is a real area of concern and there will be an ongoing area of focus on these areas through 20/21. Big Action 6 is also ranked amber, in terms of community engagement this has been very positive throughout the pandemic with large numbers of new volunteers and new community initiatives springing up. This work is being overseen by CVS. There have also been a number of awards won in relation to work in this area, however progress has been slow in relation to getting the localities up and running properly. Focus will be on these areas through 20/21. There are plans being developed to pick up the pace of transformational change, where possible, during the forthcoming year. Once a semblance of normality resumes, the pace of change will continue with the aim of ensuring the Strategic Plan is delivered in full by March 2024.

5.11 **Clinical and Care Governance**

Given the ongoing pressures presented in managing the challenge of COVID19, it has not been possible to maintain the normal range of clinical and care governance and functions. The NHS Strategic Executive Group approved adaptations to the arrangements for governance of healthcare quality. This includes suspension of the strategically supported Quality Improvement programmes, revisions to processes for clinical guidelines, audit and clinical incident management. NHS Acute, Partnership and Board Clinical Governance Forums which had been suspended are now being reconvened with the Primary Care and Community Clinical Forum holding a virtual meeting on 17th June.

Within Inverclyde HSCP there has been a temporary suspension of our clinical and care governance meetings. However it is important to note that the legal duty of quality and the requirement to maintain health and care quality continue to be standing obligations, therefore where local arrangements cannot be sustained, operational oversight of healthcare quality and clinical governance have been maintained by embedding the following essential functions in the local management arrangements:

- Responding to any significant patient feedback
- Responding to any significant clinical incident
- The approval and monitoring of any clinical guidelines or decision aids that are required for the COVID19 pandemic emergency
- Responding to any significant concerns about clinical quality

Plans are now in place to re-establish our governance arrangements. Inverclyde HSCP Clinical and Care Governance Group reconvened on 26th May. Governance arrangements for Significant Case Reviews (SCRs) and MAPPA remain in place. This also applied to Significant Clinical Incident (SCIs) in accordance with issued guidance. A number of SCIs continue to be progressed, with a limited number suspended at present due to the social distancing guidelines currently in place preventing reviews from carrying out face-to-face interviews with family and staff.

Plans are now in place to re-establish our governance arrangements. Inverclyde

HSCP Clinical and Care Governance Group reconvened on 26th May. Governance arrangements for Significant Case Reviews (SCRs) and MAPPA remain in place. This also applied to Significant Clinical Incidents (SCIs) in accordance with issued guidance. A number of SCIs continue to be progressed, with a limited number suspended at present due to the social distancing guidelines currently in place preventing reviews from carrying out face-to-face interviews with family and staff.

The Annual Report for Clinical and Care Governance reflects the work of the Clinical and Care Governance Group and preparations to develop and submit the report to the NHS GGC Clinical and Care Governance Forum have been paused due to the current crisis. We anticipate that the annual report will continue to be required. A draft report has been prepared for circulation to relevant colleagues for their contribution.

6.0 IMPLICATIONS

FINANCE

6.1

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

LEGAL

6.2 There are no legal implication within this report.

HUMAN RESOURCES

6.3 There are no specific human resources implications arising from this report.

EQUALITIES

6.4 Has an Equality Impact Assessment been carried out?

	YES
X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

6.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	Tracking impact on services through data dashboard.

Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	Maintain levels of services for people who are vulnerable.
People with protected characteristics feel safe within their communities.	Increased risk on mental health wellbeing due to COVID19 impact due to isolation.
People with protected characteristics feel included in the planning and developing of services.	Survey being undertaken with community and those using services.
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	The paper is based on Inverclyde's response to COVID19.
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	Learning disability hub is maximising opportunities for those with learning disabilities.
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

6.5 There are no clinical or care governance implications arising from this report.

6.6 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	Mobile Testing Unit and Assessment to ensure early access in Inverclyde.
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	Link Learning Disability Hub.
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Undertaking surveys with people to understand their experience.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Focus on centred care throughout Covid-19.
Health and social care services contribute to reducing health inequalities.	Access to services in Inverclyde to all groups to reduce inequalities.
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None.
People using health and social care services are safe from harm.	Services to vulnerable people monitored through dashboard.
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Engaged with staff in developing services in response to COVID19.
Resources are used effectively in the provision of health and social care services.	Costs contained within mobilisation plan.

7.0 DIRECTIONS

7.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	X

8.0 CONSULTATION

8.1 The report has been prepared by the Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

9.0 BACKGROUND PAPERS

9.1 None.

INVERCLYDE INTEGRATION JOINT BOARD – 17 MARCH 2020

Inverclyde Integration Joint Board

Tuesday 17 March 2020 at 2pm

Present: Councillors J Clocherty, L Quinn, L Rebecchi and E Robertson, Mr S Carr, Dr D Lyons (by telephone), Mr A Cowan, Ms D McErlean, Dr H MacDonald, Dr D McCormick, Ms L Long, Ms S McAlees, Ms L Aird, Ms G Eardley, Ms D McCrone, Ms C Boyd and Mr S McLachlan.

Chair: Councillor Clocherty presided.

In attendance: Mr A Stevenson, Head of Health & Community Care, Ms J Allan, Service Manager (Older People's Services), Ms V Pollock (for Head of Legal & Property Services), Ms S Lang (Legal & Property Services) and Ms K McCready, Corporate Policy Officer.

22 Apologies, Substitutions and Declarations of Interest **22**

Apologies for absence was intimated on behalf of Mr H MacLeod and Ms C Elliott.

Declarations of interest were intimated as follows:

Agenda Item 9 (Hard Edges Scotland Report) – Mr S Carr.
Agenda Item 24 (Reporting by Exception – Governance of HSCP Commissioned External Organisations) – Ms C Boyd.

23 COVID-19 Emergency **23**

Prior to the commencement of business, the Chief Officer provided an update to the Board on the work currently being undertaken across the Greater Glasgow & Clyde area and within Inverclyde in response to the COVID-19 pandemic.

Councillor Clocherty asked that the Board's appreciation be passed on to all staff at this difficult time.

24 Minute of Meeting of Inverclyde Integration Joint Board of 28 January 2020 **24**

There was submitted the minute of the Inverclyde Integration Joint Board of 28 January 2020.
Decided: that the minute be agreed.

25 Rolling Action List **25**

There was submitted a rolling action list of items arising from previous decisions of the Integration Joint Board.
The Chief Officer advised the Board that in light of the COVID-19 situation, only essential decision-making was currently being undertaken and accordingly, implementation of a number of actions was likely to be delayed.
Decided: that the rolling list be noted.

26 Financial Monitoring Report 2019/20 – Period to 31 December 2019, Period 9 **26**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership on the Revenue and Capital Budgets, other Income Streams and Earmarked Reserves position for the current year and the detailed position as at Period 9 to 31 December 2019.

Decided:

(1) that the current Period 11 forecast position for 2019/20 and the Period 9 detailed report contained in appendices 1 to 3 of the report be noted;

(2) that the proposed budget realignments and virement as set out in appendix 4 be approved and that authority be granted to officers to issue revised Directions to the Council and/or Health Board as required on the basis of the revised figures set out in appendix 5;

(3) that approval be given to the planned use of the Transformation Fund as set out in appendix 6;

(4) that the planned use of the Integrated Care Fund and Delayed Discharge monies as set out in appendix 7 be noted;

(5) that the current Capital position as set out in appendix 8 be noted; and

(6) that the current Earmarked and Unearmarked Reserves position as set out in appendix 9 be noted.

27 Scottish Index of Multiple Deprivation (SIMD) 2020 **27**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership (1) providing a detailed analysis of the results of the SIMD 2020, (2) advising of the work which was currently being progressed in connection with this and (3) requesting the Integration Joint Board to consider its unique contribution to addressing deprivation.

During the course of discussion on this item, the role in the decision-making process of members of the community with first-hand experience of the issues involved was acknowledged and it was noted that their involvement was addressed through the locality planning arrangements which had been the subject of a report to the Alliance Board.

Decided:

(1) that it be agreed to note the analysis which had been carried out on the SIMD 2020 and that this work was ongoing through the SIMD data group;

(2) that it be agreed to support the Alliance Board to create a multi-agency plan; and

(3) that it be agreed that an annual report be submitted to the Integration Joint Board on the outcomes of this work and that a joint session be arranged between the Integration Joint Board and the Alliance Board in 2020.

28 Indicative Inverclyde IJB Budget 2020/21 **28**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership requesting agreement of an indicative budget for the Inverclyde Integration Joint Board for 2020/21 in line with the Strategic Plan.

Decided:

(1) that the report be noted;

(2) that the confirmed funding of £52.289m from Inverclyde Council be accepted;

(3) that the confirmed funding of £115.554m from Greater Glasgow & Clyde (GG&C) Health Board, including £23.956m for the Set Aside budget be accepted;

(4) that agreement be given to net revenue budgets of £52.289m to Inverclyde Council and £115.554m, including the Set Aside budget, to NHS Greater Glasgow & Clyde and it be directed that this funding be spent in line with the Strategic Plan;
(5) that officers be authorised to issue related Directions to the Health Board and Council;
(6) that the proposals relating to the IJB Reserves as set out in appendix 5 be noted and approved;
(7) that approval be given to the updated five year Financial Plan contained within the Annual Financial Statement in appendix 6;
(8) that the ongoing work in relation to the Set Aside budget be noted; and
(9) that on completion of the Joint Commissioning Plan for Unscheduled Care, a report be submitted to the Integration Joint Board showing the relationship between the Plan and the Set Aside budget.

29 GP Out-of-Hours Service **29**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership appending the report on GP Out-of-Hours Service resilience which had been submitted to the NHS GG&C Board on 25 February 2020 for discussion.
(Dr MacDonald entered the meeting during consideration of this item of business).
Ms Susan Manion, Interim Chief Officer, GP Out-of-Hours was present by telephone for this item.
The Integration Joint Board discussed the change to the service model as set out in the paper to the Health Board and the concerns which had been expressed regarding the implications for local residents as a result of the decision to withdraw temporarily the GP Out-of-Hours
Decided:
(1) that the decision of Greater Glasgow & Clyde Health Board on 25 February 2020 in relation to GP Out-of-Hours provision within Inverclyde be noted; and
(2) that it be noted that the Health Board had agreed for a report to be submitted to the September meeting of the Integration Joint Board on the Equality Impact Assessment undertaken following the Health Board's decision, together with the implications in terms of equity of access.

Dr MacDonald left the meeting at this juncture.

30 Inverclyde Integration Joint Board Audit Committee Membership **30**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership requesting the agreement for the appointment of a voting member of the Integration Joint Board (IJB) to the IJB Audit Committee.
Decided:
(1) that the resignation of Councillor Lynne Quinn as a voting member of the IJB Audit Committee be noted; and
(2) that it be agreed to appoint Councillor Luciano Rebecchi to serve on the IJB Audit Committee.

Mr Carr left the meeting at this juncture.

31 Inverclyde Alcohol and Drug Recovery Development Update **31**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership (1) providing an update on the progress of the Inverclyde Alcohol and Drug Partnership recovery development workstream and (2) requesting the use of underspends to develop further local recovery communities.
(Mr Carr returned to the meeting during consideration of this item of business).
Decided:
(1) that agreement be given for recruitment to a recovery post for 12 months to support the establishment of a recovery approach, including commissioned services within Inverclyde, and to support the development of recovery concepts within communities;
(2) that agreement be given to the approach to commission four tests of change, as outlined in the report, to test the model and to learn from the tests; and
(3) that it be agreed to allocate £825,000 across three years from the Transformation Fund to support the development of a commissioned community recovery hub, if no confirmation of future funding from the Scottish Government to Inverclyde Alcohol and Drug Partnership was received.

32 Hard Edges Scotland Report **32**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership (1) informing the Integration Joint Board of the main findings of the Hard Edges Scotland report (2) setting out the key messages from recent Inverclyde events and (3) requesting the Board to approve funding for two care navigator posts.
Mr Carr declared a financial interest in this item as he had been commissioned as an independent contractor by IHub at Health Improvement Scotland to research and report on (1) a national and local data review of adults who faced severe and multiple disadvantage and (2) a national and local review of housing-related delayed discharges. He also formed the view that the nature of his interest and of the item of business did not preclude his continued presence at the meeting or his participation in the decision-making process.
It was clarified in relation to the financial implications within the report, that of the £100,000 allocated from the Transformation Fund, £81,600 was for the cost of the posts with the remainder being used to support the activities of the care navigators.
Decided:
(1) that the Hard Edges Scotland report be noted; and
(2) that approval be given for funding for the appointment of two care navigators as set out in the report and that it be agreed that an evaluation report be submitted to the Integration Joint Board later in 2020.

33 Continuing Care **33**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on the work being progressed to reduce the pressures associated with the provision of continuing care whilst ensuring corporate parenting duties were fulfilled in respect of young people's rights to continuing care.

Decided:
(1) that approval be given to the costs associated with the provision of continuing care as set out in paragraph 6.1 of the report;
(2) that the adaptations to each of the children's houses to increase the number of bedrooms from six to seven be endorsed; and
(3) that the development of hybrid core and cluster accommodation linked to residential services be endorsed.

34 Tailored Moving and Handling Solutions **34**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership (1) advising the Integration Joint Board of the initial outcomes of an IHub funded project and (2) proposing a "spend to save" model for changing practice around complex moving, handling and care solutions.
(Mr Cowan left the meeting during consideration of this item of business).
Decided:
(1) that agreement be given to implement the roll-out of tailored moving and handling solutions beyond the project timeline; and
(2) that agreement be given to support the funding of one WTE I Grade Occupational Therapist (for 18 months initially) to sustain the focus of the work and drive it forward and also to share capacity to support reviews around moving and handling.

35 Inspection of Children's Residential Care Homes **35**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership on the outcome of the Care Inspectorate inspection of The View and Kylemore Children's Residential Care Homes.
The report advised that in respect of Kylemore Children's Residential Care Home, grades of 6 (excellent) had been received for both quality indicators, How Well Do We Support Children and Young People's Wellbeing? and How Well is our Care and Support Planned? In relation to The View Children's Residential Care Home, grades of 5 (very good) had been received for the same quality indicators.
(Mr Cowan returned to the meeting during consideration of this item of business).
Decided:
(1) that the outcome of the inspections of The View and Kylemore Children's Residential Care Homes be noted; and
(2) that the Board's congratulations be extended to all those involved in the service provision.

36 Update on Significant Case Review **36**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on the actions taken to initiate the Significant Case Review in respect of Ms Margaret Fleming, deceased.
Decided:
(1) that the formal commencement of the Significant Case Review in respect of the death of Ms Margaret Fleming, chaired by Professor Jean MacLellan OBE be noted; and
(2) that it be noted that the outcome of the Significant Case Review would be reported to the Council's Health & Social Care Committee in public and to the Integration Joint Board as soon as practicable.

37 Non-Voting Membership of the Integration Joint Board – Change to Named Proxy **37**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership advising of a change to the named proxy for the service user representative, Mr Hamish McLeod.

Decided: that it be noted that Ms Margaret Moyes had been confirmed as the proxy member for Mr Hamish McLeod for meetings of the Integration Joint Board.

38 Minute of Meeting of the Inverclyde Integration Joint Board (IJB) Audit Committee of 28 January 2020 **38**

There was submitted the minute of the Inverclyde Integration Joint Board (IJB) Audit Committee of 28 January 2020.

Mr Alan Cowan, Chair of the IJB Audit Committee, provided a brief feedback on the main issues discussed at the Committee held earlier in the day. These were:

Internal Audit Progress Report

The regular progress report had been presented and it was noted in particular that new statutory guidance had been received in relation to IJB Directions, with a revised date of 30 June having been set for the update of the policy, including issues identified in the previous audit review.

Internal Audit Annual Plan 2020 – 21

Mr Cowan confirmed for the Board that the report had given assurance regarding the systematic audit approach which matched audit activity with the risk register. Two advisory reviews would be undertaken by Internal Audit in 2020-21 including (1) IJB Directions and (2) the risk management process.

The Committee had also asked for a report to be submitted to its September meeting on the criteria used to define the various categories of reserves with further detailed information being provided in respect of smoothing and earmarked reserves. Future detailed reports covering the other types of reserves would be provided as required.

External Audit Annual Audit Plan 2019/20

The 2019/20 Plan had been noted. The annual report to the IJB and Controller of Audit for the financial year ended 31 March 2020 was due for submission to the IJB Audit Committee in September.

Decided:

(1) that the minute of the Inverclyde Integration Joint Board Audit Committee of 28 January 2020 be noted; and

(2) that the feedback provided by the Chair in respect of the meeting of the IJB Audit held earlier in the day be noted.

39 Immunisations and Screening Report **39**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership on the position of Inverclyde Health & Social Care Partnership in relation to the uptake of immunisations, vaccinations and the national cancer screening programme.

Decided:

(1) that the data contained within the report to measure uptake in respect of immunisations, vaccinations and key screening programmes be noted; and

(2) that a report be submitted to the Integration Joint Board on the work being carried out locally to increase both immunisations and screenings uptake by people with a learning disability.

40 ADRS CORRA Project – New Pathways for Service Users **40**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on the progress to date with regard to the Inverclyde Alcohol and Drug Partnership's successful bid to the Scottish Government's CORRA Challenge Fund to support activities which tackle problem alcohol and drug use in Scotland.
Decided: that the progress to date and actions being taken with regard to the CORRA-funded New Pathways for Service Users Project be noted.

41 Chief Officer's Report **41**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on a number of activities undertaken across the Inverclyde HSCP.
The Board was advised that the Adult Protection Inspection was not being progressed at the present time due to the COVID-19 situation.
Decided: that the report be noted.

It was agreed in terms of Section 50(A)(4) of the Local Government (Scotland) Act 1973 as amended, that the public and press be excluded from the meeting for the following items on the grounds that the business involved the likely disclosure of exempt information as defined in the paragraphs of Part I of Schedule 7(A) of the Act as are set opposite the heading to each item.

Item	Paragraph(s)
IJB Risk Register	**6**
Review of Health & Social Care Out-of-Hours Services	**1**
Inverclyde HSCP Alcohol and Drug Service Redesign Workforce	**1**
Learning Disability Redesign – Preferred Site for New LD Community Hub	**6, 8 and 9**
Reporting by Exception – Governance of HSCP Commissioned External Organisations	**6 and 9**
Social Care Case Management – Mini Competition	**1**

42 IJB Risk Register **42**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership appending the IJB Risk Register as agreed by the IJB Audit Committee in January 2020.
Decided: that the report be noted.

43 Review of Health & Social Care Out-of-Hours Services **43**

There was submitted a replacement report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update in relation to the review of the Out-of-Hours District Nursing, Technology Enabled Care and Home Care services.

Decided: that the outcome of the review be noted and approval be given to the new posts required within an integrated service as detailed in paragraph 3.1 of the report.

Councillor Robertson and Mr McLachlan left the meeting at this juncture.

44 Inverclyde HSCP Alcohol and Drug Service Redesign Workforce **44**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership (1) providing an update on the progress of the Inverclyde HSCP Review of Alcohol and Drug Services and (2) seeking approval to proceed with the workforce plan.

Decided:

(1) that the progress made in terms of the review of the HSCP Alcohol and Drug Service be noted; and

(2) that agreement be given to the proposed workforce plan being progressed in line with both NHS and Council HR organisational review procedures.

45 Learning Disability Redesign – Preferred Site for New LD Community Hub **45**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership on the conclusion of the site investigation works undertaken relative to two potential sites for the new Learning Disability (LD) Community Hub

Decided:

(1) that the work undertaken by officers to identify two potential sites for the new LD Community Hub be noted; and

(2) that it be noted that the former Hector McNeil Baths site was the preferred site for the new LD Community Hub.

46 Reporting by Exception – Governance of HSCP Commissioned External Organisations **46**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on matters relating to the HSCP governance process for externally commissioned social care services.

Ms Boyd declared a non-financial interest in this item as a Director of Inverclyde Carers' Centre. She also formed the view that the nature of her interest and of the item of business did not preclude her continued presence at the meeting or her participation in the decision-making process.

Decided:

(1) that the governance report for the period 23 November 2019 to 24 January 2020 be noted; and

(2) that Members acknowledge that officers regard the control mechanisms in place through the governance meetings and Managing Poorly Performing Services Guidance within the Contract Management Framework as sufficiently robust to ensure ongoing quality and safety and the fostering of a commissioning culture of continuous improvement.

47 Social Care Case Management – Mini Competition **47**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership (1) updating the Integration Joint Board on the proposal to move forward with replacing the current Social Care Case Management Solution (SWIFT) and (2) seeking approval for a portion of the proposed Capital funding of £243,000 being paid for by the Board through the Transformation Fund.
Decided: that support be given to the replacement of the current Social Work Information System subject to the Council approving Capital funding of £600,000 and that agreement be given to the provision of £243,000 from the Transformation Fund.

48 Future Meeting Arrangements **48**

In light of the ongoing COVID-19 crisis, it was agreed to review the arrangements for future meetings at an appropriate time, it being noted that the Chief Officer would utilise her delegated powers as set out in the Scheme of Delegation to officers, in consultation with the Chair and Vice Chair, to deal with matters of an urgent nature.

Inverclyde Integration Joint Board

Tuesday 12 May 2020 at 2pm

Present: Councillors J Clocherty and E Robertson, Mr S Carr and Mr A Cowan (both by telephone), Ms L Long and Ms L Aird.

Chair: Councillor Clocherty presided.

In attendance: Ms V Pollock (for Head of Legal & Property Services) and Ms S Lang (Legal & Property Services).

49 Apologies, Substitutions and Declarations of Interest **49**

No apologies for absence or declarations of interest were intimated.

Prior to the commencement of business, Ms Long referred to a number of questions and comments submitted by Members of the Integration Board (IJB) in relation to the items of business to be considered at the meeting.

It was agreed that these submissions, together with Ms Long's written responses, be circulated to all Members of the IJB in due course.

50 Inverclyde Integration Joint Board – Temporary Meeting and Decision-Making Arrangements **50**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an overview of the interim governance arrangements for the Inverclyde Integration Joint Board during the COVID-19 pandemic.

Decided:

(1) that the contents of the report be noted;

(2) that it be noted that the scheduled meeting of 19 May 2020 is cancelled; and

(3) that it be agreed to continue with the current temporary meeting and decision-making arrangements for a further month and to review the position thereafter with a view to holding a full meeting of the Integration Joint Board on the scheduled date of 23 June 2020 using telephone or other remote meeting arrangements as available.

51 COVID-19 Inverclyde Response **51**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on a number of areas of work in relation to Inverclyde's response to the COVID-19 pandemic.

It was clarified that the statistics relating to deaths in paragraph 2.4 of the report covered the period 23 March to 19 April 2020.

HSCP Interim Operating Arrangements

In response to a question from Diana McCrone, NHS Staff Representative regarding implementation of "Attend Anywhere", Ms Long confirmed that a meeting was taking place that afternoon with a view to understanding the learning and determining a clear timeline for rollout.

Following discussion on Ms McCrone's further question regarding the use of IT

equipment to enable expansion of the current remote working arrangements, it was agreed that this should be the subject of a report to the next meeting of the IJB.

Testing

Ms Long referred to concerns intimated to her by Christina Boyd, Carer Representative, including testing for carers and the requirement for key workers to travel to Glasgow Airport for this. She explained that this was a recently-established UK government initiative for key workers in other community settings and those who cannot work from home. Symptomatic HSCP workers, their families and providers including care at home, care homes and the hospice were currently being provided with testing during week days at the Inverclyde staff testing centre based at Port Glasgow Health Centre. The requirement for other key workers to travel to Glasgow Airport was a matter which had been raised at the Council's Policy & Resources Executive Sub-Committee on 5 May when it had been agreed to make representations to the Scottish Government regarding the expansion of local testing provision. To expedite matters, Ms Long had also written to the Director of Public Health regarding the introduction of a mobile testing unit.

Recovery Plan

It was noted also that Councillor Quinn had raised the fact that the proposed recovery structure which was reported to the Policy & Resources Executive Sub-Committee on 5 May did not include provision for IJB Board Members on the HSCP Recovery Group.

Ms Long explained that the draft recovery plan, which would use a risk-based approach, would require to be submitted to the Strategic Planning Group for consideration prior to its submission to the Integration Joint Board which would provide an opportunity for issues such as group membership to be raised and she confirmed she would contact Councillor Quinn regarding this proposed course of action.

Decided:

(1) that the items contained within the report be noted;

(2) that a presentation be made to the Integration Joint Board once the analysis of Inverclyde COVID-19 related deaths, as requested by the Policy & Resources Executive Sub-Committee, has been completed;

(3) that a report be submitted to the next meeting of the IJB on the use of reserves to support funding for Information Technology to allow the extension of portable working for HSCP staff, including the procurement of additional equipment if required, and in the meantime, the Chief Officer progress action in this regard within her delegated powers;

(4) that the HSCP draft digital strategy be submitted to the next meeting of the IJB;

(5) that the Inverclyde HSCP Assessment Centre remain open for at least a further four week period; and

(6) that a report be submitted on the plans to develop the humanitarian work referred to a section 5.10 of the report.

52 COVID-19 Mobilisation Plan **52**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership seeking approval of the COVID-19 Mobilisation Plan which outlines the measures and associated costs being put in place locally to address the emerging impacts of the COVID-19 pandemic.

Ms Aird referred to the report on Support to Care Homes (Item 5) and confirmed that the removal of the additional 50 care home beds at the end of the initial 12 week contract and an increase in Homelessness Temporary Accommodation requirements linked to early prisoner releases would reduce the total cost of the mobilisation plan from £8.854m in the 27 April submission to £7.513m in the 14 May submission.

It was noted that no clarification had been received to date regarding the use of

reserves and the view was expressed by IJB members that it would be unfair to penalise those IJBs holding reserves in terms of funding allocated.

Decided:

(1) that the process for development, review and weekly submission of mobilisation plans be noted;

(2) that the Integration Joint Board note the Scottish Government's agreement in principle of the submission so far and confirmation of the initial £0.785m of funding announced on 12 May;

(3) that approval be given to the actions as outlined in the mobilisation plan on the basis that the £0.450m of the 2019/20 and £7.063m of the 2020/21 COVID-19 costs are expected to be funded through the Scottish Government COVID-19 funding; and

(4) that the Chief Officer be authorised to issue directions to the Chief Executives of the Health Board and Inverclyde Council to implement the updated £7.513m mobilisation plan.

53 Support to Care Homes – COVID-19 **53**

There was submitted a report by the Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership advising the IJB of the preparation and actions taken by the HSCP to support care homes in Inverclyde during the COVID-19 pandemic.

During the course of discussion on this item, the IJB Members expressed the view that the current arrangement to purchase 50 care home beds for 12 weeks until the middle of June 2020 under the National Care Home Contract should not be renewed.

Decided:

(1) that approval be given to the continued implementation of the delayed discharge mobilisation plan to address the pressures presented by the COVID-19 pandemic;

(2) that the removal of the projected costings for an additional 20 care home beds from the mobilisation plan finance return be noted;

(3) that the current arrangement to purchase 50 care home beds for 12 weeks until mid-June 2020 under the National Care Homes Contract be noted and that it be agreed that the contract be not renewed thereafter; and

(4) that it be noted that additional costs relating to these proposals will be covered from a combination of existing budgets and from additional Scottish Government funding linked to the COVID mobilisation returns.

AGENDA ITEM NO. 5

INVERCLYDE INTEGRATION JOINT BOARD

ROLLING ACTION LIST

Meeting Date and Minute Reference	Action	Responsible Officer	Timescale	Progress/Update/Outcome	Status
10 September 2019 (Para 76(3))	Technology Enabled Care (TEC) – Further report on conclusion of feedback from National Workstreams	Allen Stevenson	June 2020	Update Report	Delayed
4 November 2019 Para 94(5)	Mental Health Strategy – Outcome of Peer Recovery Model	Deborah Gillespie	September 2020	Progress on pilot	Delayed
4 November 2019 Para 98(2)	Implementation of Primary Care Improvement Plan Update (May 2020)	Allen Stevenson	May 2020	Update report	Delayed
28 January 2020 Para 8(2)	Criminal Justice Social Work Inspection – Update on Improvement Action Plan	Sharon McAlees	May 2020	Update report	Delayed
28 January 2020 Para 9(3)	Review of Support to Locality Planning Groups (after first year)	Helen Watson	January 2021	Review report	Delayed
28 January 2020 Para 12(2)	Living Well – Proposals to Progress Model	Allen Stevenson	June 2020	Update report	Delayed
17 March 2020 (Para 28(9))	Relationship between Joint Commissioning Plan for Unscheduled Care and Set Aside Budget	Lesley Aird	June 2020	Update report	June 2020
17 March 2020 (Para 29(2))	EIA – GP Out-of-Hours Service and Equity of Access (September 2020)	Allen Stevenson	September 2020	Update report	September 2020

Meeting Date and Minute Reference	Action	Responsible Officer	Timescale	Progress/Update/Outcome	Status
17 March 2020 (Para 32(2))	Hard Edges – Evaluation Report (Later in 2020)	Sharon McAlees	November 2020	Update report	November 2020
17 March 2020 (Para 39(2))	Immunisations and Screenings Uptake by People with a Learning Disability	Allen Stevenson	September 2020	Update report	November 2020
12 May 2020 (Para 51(2))	Presentation on COVID-19 deaths analysis once completed	Lesley Aird	June 2020	Report on agenda	June 2020
12 May 2020 (Para 51(3))	Funding for IT for Portable Work Expansion	Lesley Aird	June 2020	Report on the agenda	June 2020
12 May 2020 (Para 51(4))	HSCP Draft Digital Strategy	Lesley Aird	September	SPG in summer	September 2020
12 May 2020 (Para 51(6))	Plans for Development of Humanitarian Work	Louise Long	September	Meeting has taken place and term of reference agreed	September 2020

AGENDA ITEM NO: 6

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**23 June 2020**
Report By:	**Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership**	**Report No:**	**SL/LP/042/20**
Contact Officer:	**Sharon Lang**	**Contact No:**	**01475 712112**
Subject:	**Inverclyde Integration Joint Board (IJB) and IJB Audit Committee – Proposed Dates of Future Meetings**		

1.0 PURPOSE

1.1 The purpose of this report is to request agreement of a timetable of meetings for both the Inverclyde Integration Joint Board (IJB) and the IJB Audit Committee for 2020/21.

1.2 Members will note from the 2020/21 timetable that it is proposed to hold six meetings of the Integration Joint Board, allowing for an additional meeting in June, and three meetings of the IJB Audit Committee. To tie in with the arrangements for signing off the annual accounts, it is proposed that the September IJB and IJB Audit Committee be moved to later in the month, on 21 September 2020.

1.3 To avoid a potential clash with a number of meetings arranged by NHS Greater Glasgow & Clyde and which are attended by members of the IJB, the meetings in this cycle have been moved from Tuesdays to Mondays.

1.4 As in previous years, meetings of the IJB and IJB Audit Committee are scheduled to begin at 2pm and 1pm respectively. The only exception to this is the IJB Audit Committee on 21 September. It is proposed that on that day, members meet with the External Auditors and Chief Internal Auditor at 12 noon (via video conference) without other senior officers present, as provided for in the Committee's Terms of Reference, and that the usual business of the Committee commence at 1pm.

2.0 RECOMMENDATION

2.1 It is recommended that agreement be given to the timetable of meetings for the Inverclyde Integration Joint Board and IJB Audit Committee for 2019/20 as detailed in the appendix to the report.

2.2 It is recommended that, in the light of the current COVID-19 emergency, the September meetings of the Integration Joint Board and IJB Audit Committee be held via video conferencing and that the arrangements for future meetings be reviewed thereafter, taking account of the public health situation at that time

Corporate Director (Chief Officer)
Inverclyde Health & Social Care Partnership

3.0 BACKGROUND

3.1 The Standing Orders of the Inverclyde Integration Joint Board (IJB) provide for meetings to be held at such place and such frequency as may be agreed by the Board. The proposal in this report is for six meetings to be arranged for the period from September 2020 to June 2021, with all meetings commencing at 2pm. The additional June meeting of the Board has been formalised in the timetable.

3.2 In June 2016, an Audit Committee was established as a Standing Committee of the IJB. The Audit Committee's Terms of Reference provide for the Committee to meet at least three times each financial year and that there be at least one meeting a year, or part thereof, where the Committee meets the External Auditors and Chief Internal Auditor without other senior officers present.

3.3 It is proposed that the IJB Audit Committee meets on three of the six dates on which the IJB meets in September, January and March.

3.4 It is also proposed that, in the light of the current COVID-19 emergency, the September meetings of the Integration Joint Board and IJB Audit Committee be held via video conferencing and that the arrangements for future meetings be reviewed thereafter, taking account of the public health situation at that time

4.0 IMPLICATIONS

Finance

4.1 There are no financial implications arising from this report.

Financial Implications:

One Off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments
N/A	N/A	N/A	N/A	N/A	N/A

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments
N/A	N/A	N/A	N/A	N/A	N/A

Legal

4.2 None.

Human Resources

4.3 None.

Equalities

4.4 There are no equality issues within this report.

4.4.1 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

4.4.2 How does this report address our Equality Outcomes

There are no Equalities Outcomes implications within this report.

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	None
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

Clinical or Care Governance

4.5 There are no clinical or care governance issues within this report.

National Wellbeing Outcomes

4.6 How does this report support delivery of the National Wellbeing Outcomes

There are no National Wellbeing Outcomes implications within this report.

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	None
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	None
Health and social care services contribute to reducing health inequalities.	None
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None

People using health and social care services are safe from harm.	None
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	None
Resources are used effectively in the provision of health and social care services.	None

5.0 CONSULTATIONS

5.1 The Corporate Director (Chief Officer) has been consulted in the preparation of this report.

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	X
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 BACKGROUND PAPERS

7.1 N/A

TIMETABLE 2020/21

IJB/IJB Audit Committee	Submission Date – 9am	Pre-Agenda Date	Issue Agenda	Date of Meeting
IJB Audit Committee	28 August	Monday 7 September – 2.15pm	11 September	**Monday 21 September – 12 noon, then 1pm**
Inverclyde Integration Joint Board	28 August	Monday 7 September – 3pm	11 September	**Monday 21 September – 2pm**
Inverclyde Integration Joint Board	9 October	Monday 19 October – 3pm	23 October	**Monday 2 November – 2pm**
IJB Audit Committee	18 December	Monday 11 January – 2.15pm	15 January	**Monday 25 January – 1pm**
Inverclyde Integration Joint Board	18 December	Monday 11 January – 3pm	15 January	**Monday 25 January – 2pm**
IJB Audit Committee	26 February	Monday 8 March – 2.15pm	12 March	**Monday 22 March – 1pm**
Inverclyde Integration Joint Board	26 February	Monday 8 March – 3pm	12 March	**Monday 22 March – 2pm**
Inverclyde Integration Joint Board	23 April	Tuesday 4 May – 3pm	7 May	**Monday 17 May – 2pm**
Inverclyde Integration Joint Board	28 May	Monday 7 June – 3pm	11 June	**Monday 21 June – 2pm**

AGENDA ITEM NO: 7

Report To:	**Inverclyde Integration Joint Board**	**Date: 23 June 2020**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/47/2020/LA**
Contact Officer:	**Lesley Aird**	**Contact No: 01475 715381**
Subject:	**2019/20 DRAFT ANNUAL ACCOUNTS**	

1.0 PURPOSE

1.1 The purpose of this report is to set out the proposed approach of the Inverclyde Integration Joint Board (IJB) to comply with its statutory requirements in respect of its annual accounts and to present the draft 2019/20 Annual Accounts and Annual Governance Statement.

2.0 SUMMARY

2.1 IJBs are specified as 'section 106' bodies in terms of the Local Government (Scotland) Act 1973, and consequently are expected to prepare their financial statements in compliance with the Local Authority Accounts (Scotland) Regulations 2014 (the regulations) and the Code of Practice on Accounting For Local Authorities in the United Kingdom.

2.2 The Scottish Government introduced the regulations to update the governance arrangements relating to the authorisation and approval of a section 106 body's annual accounts. This report outlines the IJB's approach to comply with the regulations and presents the draft 2019/20 accounts.

2.3 The regulations require the Annual Governance Statement be approved by the IJB or a committee of the IJB whose remit includes audit and governance and require that unaudited accounts are submitted to the auditor no later than 30 June immediately following the financial year to which they relate.

2.4 From March 2020 the context in which the IJB operates was impacted by the Covid-19 pandemic. Schedule 6 to the Coronavirus (Scotland) Act, provides for the postponement of the publication and laying of reports, including publication of integration authority annual accounts and annual performance reports during the pandemic. Despite this the IJB accounts are being produced in line with the normal timelines.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board:

1. Notes the proposed approach to complying with the Local Authority Accounts (Scotland) Regulations 2014;
2. Approves the Annual Governance Statement included within the Accounts; and
3. Agrees that the unaudited accounts for 2019/20 be submitted to the auditor.

Louise Long, Chief Officer **Lesley Aird, Chief Financial Officer**

4.0 BACKGROUND

4.1 On 10 October 2014 the Local Authority Accounts (Scotland) Regulations 2014 came into force. The Scottish Government also provided additional guidance on the application of these regulations.

4.2 These regulations superseded the 1985 regulations and provide clearer definitions of the roles and responsibilities of Board Members and Officers in respect of the authorisation and approval of a section 106 body's annual accounts.

4.3 These regulations apply to any annual accounts with a financial year that begins from 1 April 2014 and therefore govern the preparation of the IJB's 2019/20 annual accounts.

4.4 Schedule 6 to the Coronavirus (Scotland) Act, provides for the postponement of the publication and laying of reports, including publication of integration authority annual accounts and annual performance reports during the pandemic. Despite this, the IJB accounts are being produced in line with the normal timelines.

5.0 ANNUAL GOVERNANCE STATEMENT 2019/20

5.1 The regulations require the Annual Governance Statement be approved by the IJB or a committee of the IJB whose remit includes audit and governance following an assessment of both the effectiveness of the internal audit function and the internal control procedures of the IJB.

5.2 The Audit Committee has considered the performance of internal audit and internal control procedures throughout the year.

5.3 The Integration Joint Board (IJB) is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively. The IJB also aims to foster a culture of continuous improvement in the performance of the IJB's functions and to make arrangements to secure best value.

5.4 In discharging these responsibilities, the Chief Officer has a reliance on the NHS and Local Authority's systems of internal control that support compliance with both organisations' policies and promote achievement of each organisation's aims and objectives, as well as those of the IJB.

5.5 The IJB has adopted governance arrangements consistent where appropriate with the principles of CIPFA and the Society of Local Authority Chief Executives (SOLACE) framework "*Delivering Good Governance in Local Government*". This statement explains how the IJB has complied with the Local Code and also meets the Code of Practice on Local Authority Accounting in the UK, which details the requirement for an Annual Governance Statement.

5.6 The Board of the IJB comprises eight voting members, including the Chair and Vice Chair; four voting members are Council Members nominated by Inverclyde Council and four are Board members of NHS Greater Glasgow and Clyde. There are also a number of non-voting professional and stakeholder members on the IJB Board. Stakeholder members currently include representatives from the third and independent sector bodies and service users. Professional members include the Chief Officer, Chief Finance Officer and Chief Social Worker. The IJB, via a process of delegation from NHS Greater Glasgow and Clyde and Inverclyde Council, and its Chief Officer have responsibility for the planning, resourcing and operational delivery of all integrated health and social care within its geographical area.

5.7 A Local Code of Good Governance has been approved by the Audit Committee and based on this, an assurance assessment template was completed. Initial improvement actions identified through the assurance assessment in 2017 have all been delivered in full.

5.8 The IJB Chief Internal Auditor (CIA) places reliance on the Health Board and Inverclyde Council Internal Audit Annual Reports in order to complete the IJB annual Internal Audit. Unfortunately due to the Covid-19 pandemic, the Health Board report will not be available until after the Health Board Audit Committee meets in September. At this time the CIA has issued a draft Internal Audit Annual Report and opinion which is subject to receiving the final Health Board Internal Audit reports. The Chief Internal Auditor has confirmed that, at this time, there are no additional significant governance issues that require to be reported specific to the IJB.

5.9 Based on the audit work undertaken, the assurances provided by Directors (of Inverclyde Council) and the Senior Management Teams (of services within NHS Greater Glasgow and Clyde), it is the Chief Internal Auditor's interim opinion (subject to receipt of the final NHSGG&C Internal Audit Annual Report for the year) that reasonable assurance can be placed upon the adequacy and effectiveness of the governance and control environment which operated during the reporting period of 2019/20.

5.10 Subject to the above, and on the basis of the assurances provided, we consider that the internal control environment operating during the reporting period provides reasonable and objective assurance that any significant risks impacting upon the achievement of our principal objectives will be identified and actions taken to avoid or mitigate their impact. Systems are in place to continually review and improve the internal control environment.

5.11 The IJB is asked to approve the Annual Governance Statement. The draft statement is enclosed on pages 17-20 of the draft annual accounts within Appendix A.

6.0 UNAUDITED ACCOUNTS

6.1 In normal years the regulations require that the unaudited accounts are submitted to the auditor no later than the 30 June immediately following the financial year to which they relate. Due to the Coronavirus Act this is not applicable for the 2019/20 accounts however despite that, the IJB is still able to adhere to the original deadlines.

6.2 The normal regulations state that the IJB or committee whose remit includes audit and governance, for Inverclyde this is the IJB Audit Committee, must meet to consider the unaudited annual accounts as submitted to the external auditor no later than 31 August immediately following the financial year to which the annual accounts relate. The unaudited accounts are appended to this report for IJB consideration.

6.3 Scottish Government guidance states that best practice would reflect that the IJB or committee whose remit includes audit and governance should consider the unaudited accounts prior to submission to the external auditor.

7.0 RIGHT TO INSPECT AND OBJECT TO ACCOUNTS

7.1 The right to inspect and object to the accounts remains unchanged through these regulations. The timetable for the public notice and period of inspection is standardised with the inspection period starting no later than 1 July in the year the

notice is published.

8.0 APPROVAL AND PUBLICATION OF AUDITED ACCOUNTS

8.1 The regulations normally require that the audited annual accounts should be considered and approved by the IJB or Audit Committee having regard to any report made on the audited annual accounts by the proper officer[1] or external auditor by 30 September immediately following the financial year to which the accounts relate. In addition any further report by the external auditor on the audited annual accounts should also be considered by the IJB or Audit Committee. It is anticipated that the IJB accounts will comply with these dates for this year despite the provision in the Coronavirus Act to defer.

8.2 The Audit Committee will consider the external auditors' report and proposed audit certificate (ISA 260 report) prior to inclusion in the audited annual accounts. Subsequently, the external auditor's Board Members Report and the audited annual accounts will be presented to the IJB for approval and referred to the Audit Committee for monitoring of any related action plan.

8.3 In order to comply with the regulations, it is proposed that the ISA260 and Board Members Report, together with a copy of the audited annual accounts, is considered by the Audit Committee and thereafter referred to the IJB for approval prior to the 30 September in the year immediately following the financial year to which they relate.

8.4 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.

8.5 The annual accounts of the IJB must normally be published by 31 October and any further reports by the external auditor by 31 December immediately following the year to which they relate. However, as a result of Covid-19, Audit Scotland have confirmed that, since they are not considered essential workers, their planned audit timelines for 2019/20 accounts have been impacted. We have been advised that they are unable to guarantee completing the audit by the timetable described in their 2019/20 Annual Audit Plans, of 30 September 2020, and suggest instead working towards sign off and publication of the accounts by 30 November 2020. Officers within the IJB will continue to work to normal yearend timelines and will work with Audit to ensure fieldwork is completed as soon as possible.

8.6 The table below summarises the key required and proposed dates for the 2019/20 annual accounts on the basis of the Audit Scotland advice.

	Required Date	Proposed Date
IJB or Audit Committee to approve Annual Governance Statement	30 June	23 June
Unaudited Annual Accounts to be submitted to external audit	30 June	By 30 June
Publication of Draft Accounts inspection period	1 July	By 27 June
Draft Accounts inspection period	2-20 July	30 June-13 July
IJB or Audit Committee to consider unaudited Annual Accounts	31 August	23 June
IJB or Audit Committee to consider any reports made by the Chief Financial Officer or External Auditor	30 Nov	tbc Nov
IJB to consider and approve the audited annual accounts	Tbc Nov	Tbc Nov

[1] The Proper Officer is set out in Section 95 of the Local Government (Scotland) Act 1973. In Inverclyde IJB this role is fulfilled by the Chief Financial Officer.

Audited Annual Accounts to be published	31 Tbc	Following the Nov IJB
Any further reports by the external auditor to be published	31 Dec	Following the Nov IJB

9.0 2019/20 UNAUDITED ANNUAL ACCOUNTS

9.1 The draft Accounts are being prepared in line with guidance issued by CIPFA and provide an overview of the financial performance of the IJB through the following statements:

- Management Commentary
- Statement of Responsibilities
- Annual Governance Statement
- Remuneration Report
- The Financial Statements
- Notes to the Financial Statements

10.0 IMPLICATIONS

10.1 **FINANCE**

There are no direct financial implications within this report.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

LEGAL

10.2 There are no specific legal implications arising from this report.

HUMAN RESOURCES

10.3 There are no specific human resources implications arising from this report.

EQUALITIES

10.4 There are no equality issues within this report.

10.4.1 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

10.4.2 How does this report address our Equality Outcomes

There are no Equalities Outcomes implications within this report.

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	None
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

10.5 CLINICAL OR CARE GOVERNANCE IMPLICATIONS

There are no governance issues within this report.

10.6 NATIONAL WELLBEING OUTCOMES

How does this report support delivery of the National Wellbeing Outcomes

There are no National Wellbeing Outcomes implications within this report.

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	None
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	None

Health and social care services contribute to reducing health inequalities.	None
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None
People using health and social care services are safe from harm.	None
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	None
Resources are used effectively in the provision of health and social care services.	None

11.0 DIRECTIONS

11.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	X
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

12.0 CONSULTATION

12.1 This report has been prepared by the IJB Chief Financial Officer. The Chief Officer and the Council's Chief Financial Officer and Director of Finance NHSGGC have been consulted.

13.0 BACKGROUND PAPERS

13.1 None

APPENDIX

Inverclyde Integration Joint Board

Unaudited Annual Accounts 2019/20

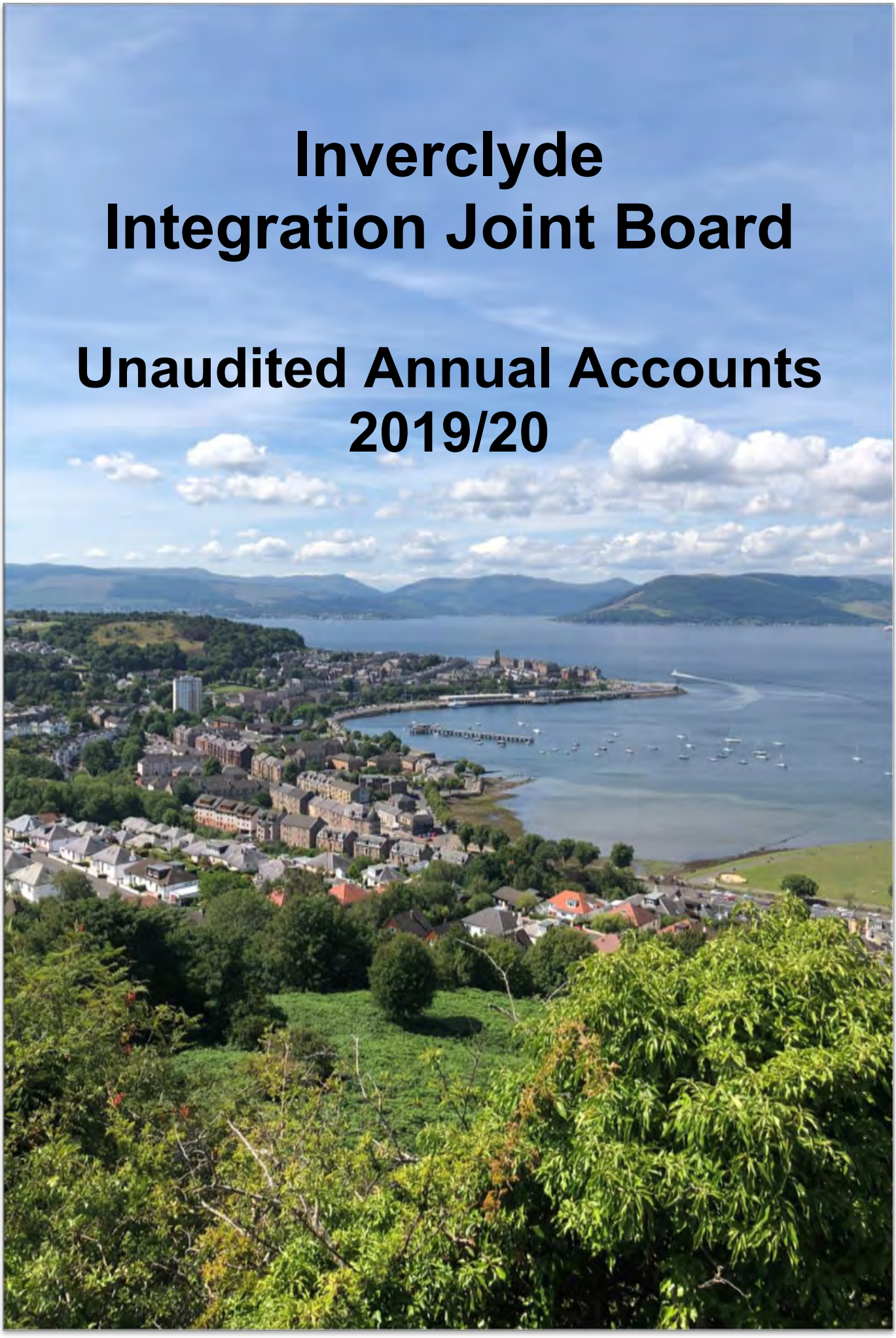


Table of Contents

Management Commentary

Introduction

This publication contains the financial statements for the Inverclyde Integration Joint Board (IJB) for the year ended 31 March 2020.

The Management Commentary outlines the key messages in relation to the IJB's financial planning and performance for the year 2019/20 and how this has supported delivery of the IJB's core objectives. This commentary also looks forward, outlining the future financial plans for the organisation and the challenges and risks which we will face as we strive to meet the needs of the people of Inverclyde.

Inverclyde IJB

In Inverclyde we have an 'all-inclusive' health and social care partnership. The Inverclyde IJB has responsibility for the strategic commissioning (either planning or direct service delivery, or both) of the full range of health and social care services; population health and wellbeing, statutory health and social work/ social care services for children, adults, older people, homelessness and people in the community justice system. The IJB discharges this responsibility through its operational delivery arm, which is the Inverclyde Health and Social Care Partnership (HSCP).

The Inverclyde IJB was established by parliamentary order on 27 June 2015 following approval of the Inverclyde Integration Scheme by the Scottish Ministers. From 1st April 2016, the IJB took formal delegated responsibility from the NHS Greater Glasgow and Clyde and Inverclyde Council for the delivery and/or planning of local health and social care services.

For some services this delegation of responsibility means the IJB taking full responsibility for planning, management and delivery of service provision, while for others, notably hospital based services, this means planning with partners who continue to manage and deliver the services as part of wider structures (e.g. the Greater Glasgow & Clyde Acute Sector).

Inverclyde is located in West Central Scotland along the south bank of the River Clyde. It is one of the smallest local authority areas in Scotland, home to 78,150 people and covering an area of 61 square miles. Our communities are unique and varied.

Covid-19 was declared a pandemic by the World Health Organisation on 12 March 2020. Since then Covid-19 has spread across all areas of the UK. Inverclyde has been particularly hard hit by the virus in its initial phase. Officers worked with Public Health to look at the underlying causes.

Covid-19 is expected to be an ongoing threat requiring continued social distancing until the UK has built up herd immunity through vaccination or natural infection. In the meantime, HSCPs will have to deal with waves of Covid-19 activity (infected individuals and public health measures), and also deliver other health and care services. In this first wave, HSCPs stopped a wide range of activity to create capacity for Covid-19 activity, comply with social distancing requirements and address increased levels of staff absence within the HSCP and the wider provider network.

Interim governance structures were put in place and a recovery plan has been drafted to map out the pathway for services and the IJB over the coming months as the country moves through this pandemic. Throughout this time the HSCP has continued to work to put people at the centre of all that we do and ensure that essential services are delivered safely and effectively and in line with our strategic plan.

The IJB Strategic Plan 2019-24 outlines our vision for the Inverclyde Health & Social Care Partnership as well as our core objectives and services which are delivered through four core teams. The HSCP has worked hard during 2019/20 to deliver the 6 Big Actions contained within the plan.

The IJB Strategic Plan is supported by an operational/implementation plan and a variety of service strategies, investment and management plans which aid day to day service delivery. These plans and strategies identify what the IJB wants to achieve, how it will deliver it and the resources required to secure the desired outcomes. The Strategic Plan also works in support of the Inverclyde Community Planning Partnership's Local Outcome Improvement Plan and the Greater Glasgow & Clyde Health Board Local Delivery Plan. It is vital to ensure that our limited resources are targeted in a way that makes a significant contribution to our objectives.

The Strategic Plan and other key documents can be accessed online at:

https://www.inverclyde.gov.uk/health-and-social-care

The operational HSCP Structure responsible for delivering services is illustrated below.

HSCP Operational Structure

The Annual Accounts 2019/20

The Annual Accounts report the financial performance of the IJB. Its main purpose is to demonstrate the stewardship of the public funds which have been entrusted to us for the delivery of the IJB's vision and its core objectives. The requirements governing the format and content of local authorities' annual accounts are contained in The Code of Practice on Local Authority Accounting in the United Kingdom (the Code). The 2019/20 Accounts have been prepared in accordance with this Code.

The Financial Plan

IJBs need to account for spending and income in a way which complies with our legislative responsibilities.

For 2019/20 the IJB budgeted to deliver Partnership Services at a cost of £157.447m, including £16.857m of notional budget for Set Aside and £0.827m of spend through Earmarked Reserves. During the year funding adjustments and reductions in spend and a restatement of Set Aside budgets resulted in actual spend of £165.907m, including Set Aside (£23.635m) and spend from Reserves, for the year. Funding rose during the year from a budgeted £157.475m to an actual £167.075m, the majority of the additional income was non-recurring or related to the Set Aside restatement. This generated a surplus for the year of £1.168m. The movement in budget vs actual and analysis of the surplus are shown in the tables on pages 7 and 8.

Critical Judgements and Estimation Uncertainty

In applying the accounting policies set out above, the IJB has had to make a critical judgement relating to the values included for Set Aside services. NHS GG&C are now in a positon to report the Set Aside figures based on actual expenditure which has resulted in the restatement of 18/19 figures which were previously based on a notional budget figure. The notional budgets for Set Aside were based on NRAC activity and information

from the cost book and were very high level. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

The IJB also has to make critical judgement relating to services hosted within Inverclyde for other IJBs within the NHS Greater Glasgow & Clyde area. In preparing the 2019/20 financial statements the IJB is considered to be acting as 'principal', and the full costs of hosted services are reflected within the financial statements. The services which are hosted by Inverclyde are identified in the table below. This also shows expenditure in 2019/20 and the value consumed by other IJB's within Greater Glasgow and Clyde.

Host	Service	Actual Net Expenditure 2019/20	Consumed by other IJBs
Inverclyde	General Psychiatry	£6,141,820	£595,336
Inverclyde	Old Age Psychiatry	£3,594,707	£80,615
	Total	**£9,736,527**	**£675,951**

The services which are hosted by other IJB's on behalf of the other IJB's including Inverclyde are identified in the table below. This also shows expenditure in 2019/20 and the value consumed by Inverclyde IJB.

Host	Service	Actual Net Expenditure 2019/20	Consumed by Inverclyde IJB
East Dunbartonshire	Oral Health	£9,834,812	£563,535
	Total	**£9,834,812**	**£563,535**
East Renfrewshire	Learning Disability	£8,478,024	£198,612
	Total	**£8,478,024**	**£198,612**
Glasgow	Continence	£3,876,864	£294,197
Glasgow	Sexual Health	£10,170,910	£422,921
Glasgow	Mh Central Services	£6,871,677	£751,565
Glasgow	MH Specialist services	£10,137,509	£859,200
Glasgow	Alcohol + Drugs Hosted	£16,112,699	£510,160
Glasgow	Prison Healthcare	£7,300,414	£557,839
Glasgow	HC In Police Custody	£2,321,505	£171,791
Glasgow	Old Age Psychiatry	£16,545,390	£23,453
Glasgow	General Psychiatry	£40,074,926	£247,737
	Total	**£113,411,893**	**£3,838,863**
Renfrewshire	Podiatry	£6,732,195	£585,701
Renfrewshire	Primary Care support	£4,144,772	£257,294
Renfrewshire	General Psychiatry	£7,479,719	£19,021
Renfrewshire	Old Age Psychiatry	£6,800,216	£0
	Total	**£25,156,901**	**£862,016**
West Dunbartonshire	MSK Physio	£6,370,000	£436,170
West Dunbartonshire	Retinal Screening	£815,416	£54,737
West Dunbartonshire	Old Age Psychiatry	£1,004,099	£0
	Total	**£8,189,515**	**£490,907**
Total		**£165,071,144**	**£5,953,934**

Performance

The IJB and HSCP tracks change in need and demand, and delivery of the National Wellbeing Outcomes through its performance management arrangements. Every service undergoes a quarterly service review, chaired by the relevant Head of Service. Service use, waiting times and any other pressures are closely reviewed alongside progress against the service's key objectives and delivery of outcomes. Any divergence from the agreed strategic direction is quickly identified and steps are put in place to get the service back on track. If there are notable differences between the service's performance and what has been planned for, then these differences are reported to the IJB along with a summary of the reasons for the divergence, and an outline of the planned remedial action in cases where the divergence is negative. This is reported through Performance Exceptions Reports, and these continue to be produced and published on a six-monthly basis. The legislation requires that we follow a prescribed format of annual performance reporting against the nine outcomes, based on 23 national indicators and a requirement to publish an annual performance report by 31st July. However, following the outbreak of Covid-19 in the UK Scottish Government extended the publication timeline for the Annual Performance Reports. Inverclyde's Annual Performance Report 2019/20 will be published in line with this revised timeline.

The IJB's 2019/20 Performance against the 23 National Indicators is shown in the table below:

↑ ↓	Performance is equal or better than the Scottish average
↑ ↓	Performance is close to the Scottish average
↑ ↓	Performance is below the Scottish average

TABLE TO FOLLOW

The data presented against these National Integration Indicators is the most up-to-date as available from ISD in May 2020. Those marked with an * are taken from the 2017/18 biennial Health and Care Experience Survey (http://www.isdscotland.org/Products-and-Services/Consultancy/Surveys/Health-and-Care-Experience-2017-18/).

During 2019/20 the HSCP achieved a number of successful external inspection reports in: Criminal Justice; Children's Homes, Adoption Services and our Learning Disabilities residential unit. In addition our Advice Service won awards for their work this year including the service team leader winning the Scottish Public Sector Leader of the Year Award.

Successes in other areas include:

- Primary Care Improvement Programme – this investment has already delivered a number of benefits to service users and primary care services. One of the key successes this year is the increased impact of the Advanced Nurse Practitioners who have seen a significant increase in client numbers this year, this helps reduce referrals to Primary Care and provides a better, more easily accessible service for clients.
- Community Connectors – as part of the social prescribing initiative outlined in the Strategic Plan this service has seen a significant growth in demand and impact. During the Covid-19 pandemic this social prescribing and enhanced community support has been even more evident and has had a significant impact on the health and wellbeing of people throughout Inverclyde.
- Early Years Vaccinations – Inverclyde is one of the top performing areas in Scotland for update of these crucial vaccinations.
- Successful pilot of one handed care programme to deliver more efficient service and improved support to service users needing support with personal care.
- Criminal Justice – a recent inspection highlighted the high quality of the unpaid work and supervision provisions within this service.
- Development of a Champions Board and Community Champions.

- Inverclyde's Delayed Discharge performance has remained among the best in Scotland for the third year running. Even throughout the Covid-19 pandemic the service has continued to work well with Acute colleagues to ensure that delayed discharges are minimised.
- Access to rehabilitation – the service saw a significant increase in the number of service users regaining their independence after re-ablement support was provided.
- Successful public awareness campaign on adult protection.
- Alcohol related Accident & Emergency admissions were successfully reduced in year following the appointment of an alcohol liaison nurse based at the local hospital. In addition the service was successful in attracting CORRA funding, matched by IJB funding to support a move to 7 days Addictions services in a drive to reduce Emergency Admissions over the weekend. This work has been paused to some extent as a result of the Covid-19 pandemic but is expected to restart as part of the recovery plan when it is safe to do so.
- Homelessness – in response to Covid-19 the service accelerated the roll out of key aspects of the Rapid Rehousing Transition Plan and successfully set up short term tenancies for around 60 homeless clients within the first few weeks of the outbreak.
- Improvement in breastfeeding performance through additional support in place for local families, in particular targeted support for families in SIMD 1 areas.
- Community Response to Covid-19 – the community response to the pandemic has been incredible. The HSCP has seen significant growth in volunteers, local groups have set up well being support arrangements and food and care parcels are being delivered across the district. This was a key part of the Strategic Plan and the IJB is keen to ensure that the positive growth in social prescribing and community cohesion continues long after the pandemic is over.

Areas the HSCP will be focussing on in the coming year include:
- Health inequality is still a challenge in Inverclyde, even more so with Covid-19 impacts and the anticipated increase in welfare issues for many local people.
- Mental Health referrals are still high locally and again these will also be negatively impacted by Covid-19. The IJB agreed to invest additional money into local services during 2019/20 to support the overall sustainability of the services.
- Looked After Children – a change in legislation means that children have the opportunity to stay in care till they are older. This creates an additional financial and operational pressure on this service. Plans are in place to address that and as part of that initiative existing homes are being adapted to increase bedroom capacity.
- Child Protection registrations grew to an all time high in 2019/20. Officers are looking into underlying reasons for this increase.
- Presentations at Accident & Emergency remained high across the system and within Inverclyde until the Covid-19 outbreak began, since then however A&E attendances have reduced nationwide.
- Unplanned Bed Days – although the Inverclyde bed days are low in comparison with other HSCPs the service is looking at bringing this down further through focus on frequent attenders, re-ablement and continued focus on delayed discharge performance.
- Addictions – the Addictions Review was completed in the year and the service was moving into implementation phase when Covid-19 hit. It is anticipated that some of the new operating models brought in as a response to Covid-19 may be able to be continued longer term as part of the implementation plan.

An Adult Protection Inspection was scheduled for March 2020, however, the Covid-19 outbreak meant that all of non-essential inspections have been postponed for the time being.

Financial Performance

Financial information is part of our performance management framework with regular reporting of financial performance to the IJB. This section summarises the main elements of our financial performance for 2019/20.

(a) Partnership Revenue Expenditure 2019/20

During the year the Partnership again successfully mitigated the full value of the inherited Health baseline budget pressure on Mental Health Inpatient services through a combination of measures, including: improved cost control and tighter absence management arrangements and planned one off underspends in other areas

to offset the remaining budget pressure. Monies were received in year from Scottish Government for Mental Health Action 15, ADP developments and Primary Care Improvement Planning. In addition the IJB agreed to invest additional monies on a non recurring basis to support a number of Mental Health service developments.

Partnership services saw continued demand growth with numbers of service users and cost per service user rising across a number of services. The Partnership was able to effectively manage these budget pressures in year and as a result of the inherent delay in filling vacancies and some additional funding received in year, generate an overall surplus of £1.168m which was carried into Earmarked Reserves.

In previous years certain budgets have experienced a degree of short term volatility in certain demand led budgets. In order to address this any one off underspends on these budgets have been placed in Earmarked Reserves to cover any one off overspends in future years. In 2019/20 a net £0.407m was used from the Adoption, Fostering and Residential fund within Children & Families and £0.300m was added to recreate the previous Prescribing Reserve.

During the year £3.952m of Earmarked Reserves were used to fund specific spend and projects, an additional £5.369m was transferred into Earmarked Reserves and £0.249m of the General Reserve was used, leading to a net increase of £1.168m in Reserves over the year.

Total net expenditure for the year was £165.907m against the overall funding received of £167.075m, generating a revenue surplus of £1.168m. This was made up as follows:

Analysis of Surplus on Provision on Services

	£000
Additional funding for 2019/20 covid costs	400
Older People underspend on continuing care & ethical care monies partially offset by overspends on Respite, Direct Payments and Additional Hours	297
Learning & Physical Disabilities overspends due to increased demand and equipment costs	(315)
Mental Health overspend due to underlying budget pressure	(343)
Planned underspend in Health Central budgets through early delivery of future year savings to offset Mental Health budget pressure	343
Additional in year ringfenced funding for Tier 2 counselling service not spent in year	258
Underspend on various Social Care services due to delay in filling vacancies and additional funding received in year	504
Underspend on prescribing, partially offset by initial impact of covid-19	300
Underspend on various Health services due to delay in filling vacancies, slippage on procurement of external services and early delivery of future year savings	742
Refugee scheme carry forward - change in Council accounting policy - previously handled through accruals not left as underspend and moved to EMR	432
Planned in year use of earmarked reserves	(1,450)
Surplus on Provision of Services	**1,168**

The surplus has been taken to IJB reserves as detailed in note 7.

During the year Health services were projected to underspend by an overall £1.692m due to a combination of factors including slippage on some projects, delays in filling vacancies, early delivery of future year savings and an anticipated underspend on Prescribing costs. The Period 9 monitoring report outlined the detail of this underspend, some of which was against ringfenced funding. The IJB agree to carry the underspend forward for a range of specific projects within Earmarked reserves as detailed in the Period 9 report. Social Care core

services were projecting a £0.065m overspend after transfers to Earmarked Reserves at Period 9. At that time new Earmarked Reserves created in year from a combination of underspends against Health and Social Care core recurrent budgets and some additional external funding were projected to be £3.909m and spend against reserves was projected at £3.811m. This gave a final projected outturn of £0.037m deficit for the IJB and total projected reserves balance of £7.244m.

At year end the actual surplus was comprised of:

- underspend on Health services of £1.042m, variance from the Period 9 projections, £0.650m, decrease in the underspend relates to:
  - final spend on prescribing in year being around £0.390m higher than projected due to an increase in prescribing costs in March 2020 linked to Covid-19, overall prescribing was still underspent by £0.300m.
  - the remainder relates to some vacancies being filled quicker than anticipated leading to reduced slippage on ringfenced projects and underspends on some other core budgets.
- underspend on Social Care services of £1.176m, variance from the Period 9 projection, £1.111m decrease in spend to take it from an overspend to underspend position, relates to:
  - £0.249m overspend on core services due mainly to additional client commitments and increased package costs within Learning Disabilities.
  - £0.432m carry forward for the Refugee Scheme, in previous years the accounting treatment for this funding was through accrual, in 2019/20 the Council changed the accounting treatment in year and this is now reflected as an Earmarked Reserve.
  - Additional in year funding for the tier 2 counselling service carried forward at the year end £0.258m.
  - Net underspend on Older People services £0.297m linked to additional monies received in year, partially offset by small overspends on Respite, Direct Payments and Additional Hours.
  - the remainder relates to delays in filling vacancies and other additional funding received in year which has been carried forward for future year use.
- at the year end a net £1.450m of Earmarked Reserves had been spent on agreed projects.
- a new Earmarked Reserve was created after the year end for Covid-19 to reflect the anticipated income the IJB is due to receive in relation to 2019/20 Covid-19 costs. The costs were not accrued at the year end but instead will be charged to this reserve in 2020/21.

Budget agreed at Period 9 vs Final Outturn

Revised Budget	IJB	Projected Outturn @ P9	Outturn	P9 vs Actual Outturn
73,179	Health Funding	73,179	76,060	2,881
73,179	Health Spend	73,179	76,060	2,881
0	**Contribution**	**0**	**0**	**0**
50,777	Social Care Funding	50,777	50,722	(55)
49,922	Social Care Spend	49,987	49,554	(433)
855	**Contribution**	**790**	**1,168**	**378**
16,662	Resource Transfer Funding	16,662	16,658	(4)
16,662	Resource Transfer Spend	16,662	16,658	(4)
0	**Contribution**	**0**	**0**	**0**
16,857	Set Aside Funding	16,857	23,635	6,778
16,857	Set Aside Spend	16,857	23,635	6,778
0	**Contribution**	**0**	**0**	**0**
(827)	Movement in Reserves	(827)	(0)	827
28	**Surplus/(Deficit) on Provision of Operating Services**	**(37)**	**1,168**	**1,205**

Revised Budget		Projected Outturn @ P9	Outturn	P9 vs Actual Outturn
157,475	IJB Funding	157,475	167,075	9,600
156,620	IJB Expenditure	156,685	165,907	9,222
827	Movement on Earmarked Reserves (Decrease)/Increase	827	0	(827)
28		**(37)**	**1,168**	**1,205**

(b) The Balance Sheet

The Balance Sheet summarises the IJB's assets and liabilities as at 31 March 2020, with explanatory notes provided in the full accounts.

Financial Outlook, Risks and Plans for the Future

The UK economy was showing signs of recovery with inflation and unemployment falling and growth taking place in a number of sectors. The imminent exit from the European Union has created some further, short and longer term, uncertainty and risk for the future for all public sector organisations.

Additional funding of £148m was announced for Integration Authorities across Scotland from 2019/20 to support the delivery of new policy initiatives such as the Carers Act and Free Personal Care for under 65s and to fund general demographic and demand pressures. Despite this, pressure continues on public sector expenditure at a UK and Scottish level with further reductions in government funding predicted. In addition to economic performance, other factors influence the availability of funding for the public sector including demographic challenges that Inverclyde is facing. In response to the Covid-19 pandemic HSCPs are submitting regular financial mobilisation plans to Scottish Government detailing the additional costs being incurred in addressing the pandemic both by HSCPs and their providers. Anticipation is that these costs will be funded centrally. Across Scotland they are expected to equate to around 4-5% of HSCP expenditure budgets over the full year.

The HSCP has a Covid-19 risk register that is reviewed weekly through the Local Resilience Management Team meetings. The IJB risk register was updated in May to reflect the impact of responding to the Covid-19 pandemic. The most significant risks faced by the IJB over the medium to longer term, reflected in the IJB risk register can be summarised as follows:

- Financial sustainability around cost pressures and funding linked to unfunded/ unanticipated/ unplanned demand for services and/or partners being unable to allocate sufficient resources, and
- Financial Implications of Responding to Covid-19 – All costs are being tracked and the IJB is actively engaged with Scottish Government and providing regular updates on associated costs. Governance arrangements are in place re approval and monitoring of costs. The IJB is actively engaging with the third and independent sector in relation to their associated costs

The Inverclyde IJB has responsibility for social care and a range of health services. The IJB is responsible for financial and strategic oversight of these services.

The planning and delivery of health and social care services has had to adapt to meet the significant public health challenge presented by the Covid-19 pandemic. In response to the pandemic the IJB has been required to move quickly and decisively.

There has been significant disruption to how health and social care services across Inverclyde are currently being delivered and experienced by service users, patients and carers and this is likely to continue in the short to medium term. The HSCP has also had to implement new service hubs in response to the pandemic, examples of which have included the establishment of assessment and testing centres to support assessment and testing of potential Covid-19 patients and the creation of a hub to support the distribution of PPE to our

social care services and those delivered by the third and independent sector and personal assistants and carers.

The financial impact of implementing the required changes to services and service delivery models (e.g. to support social distancing requirements, support staff with the appropriate protective equipment, and manage the new and changing levels of need and demand) is significant and likely to be ongoing and evolving. The Governance Statement outlines the governance arrangements which are in place during this challenging time. These accounts have been prepared on the assumption that the Scottish Government will meet the additional costs experienced by the IJB and this is also the assumption which has been made moving forward into 2020/21.

Moving into 2020/21, we are working to proactively address the funding challenges presented while, at the same time, providing effective services for the residents of Inverclyde throughout the Covid-19 pandemic. In March 2020 the IJB agreed a balanced budget which included a savings plan totalling £1.044m for 2020/21 and an updated 5 year budget to 2025. As a result of the Covid-19 pandemic £0.050m of those savings may not be deliverable in year, this has been reflected in the Covid-19 mobilisation plan submitted to Scottish Government. The remaining savings are expected to be delivered in full in 2020/21, in line with the IJB's Medium Term Financial Plan.

The 2020/21 budget remains an indicative budget at this time as the formal funding offer from the Health Board has not yet been agreed. The Health Board's draft financial plan for 2020/21 was presented to the Health Board in February 2020. An updated version was due to be presented at the April meeting however due to the Covid-19 pandemic this was not possible as the full Board did not meet in April as it has been replaced by an Interim Board. The Board's Operational Plan has been suspended and both it and the supporting Financial Plan will require to be reviewed in light of the Covid-19 pandemic. This has led to a delay in IJB's being given their formal 20/21 budget allocation, however, it is anticipated this will be in line with the interim budget offer made in March.

We have well established plans for the future, and the IJB Strategic Plan 2019/20 to 2023/24 and 5 year Financial Plan were approved by the IJB in March 2019 these plans outlined the overarching vision and financial landscape for the coming years.

Following on from our last Strategic Plan we are still committed to "Improving Lives", and our vision is underpinned by the "Big Actions" and the following values based on the human rights and wellbeing of:

- **Dignity and Respect**
- **Responsive Care and Support**
- **Compassion**
- **Wellbeing**
- **Be Included**
- **Accountability**

6 Big Actions

Big Action 1: Reducing Health Inequalities by Building Stronger Communities and Improving Physical and Mental Health	Big Action 2: A Nurturing Inverclyde will give our Children & Young People the Best Start in Life	Big Action 3: Together we will Protect Our Population
Big Action 4: We will Support more People to fulfil their right to live at home or within a homely setting and Promote Independent Living	Big Action 5: Together we will reduce the use of, and harm from alcohol, tobacco and drugs	Big Action 6: We will build on the strengths of our people and our community

Conclusion

In a challenging financial and operating environment the IJB successfully oversaw the delivery of its Strategic Plan objectives and the delivery of all core services while undertaking a significant change programme designed to provide a more person centred model of care, deliver on early intervention and prevention ambitions and free up efficiencies. In 2019/20 there have been many successes within year 1 of the new Strategic Plan, including delivery of significant change and foundations set for more changes in the year ahead. Since Covid-19 emerged as a pandemic and business as usual was no longer an option, services were mobilised into hubs and new operating procedures brought in to respond to the pandemic and ensure the ongoing safety of our staff and service users. Covid-19 will inevitably impact on the next year in terms of delivering the Strategic Plan. As time has moved on the IJB is moving now into the recovery phase where services can begin to be stepped back up in line with national guidance and safety protocols.

The Strategic Plan, associated Implementation Plan and Medium Term Financial Plan will lead the IJB forward over the next 5 years and improve the lives of the people of Inverclyde and the Strategic Plan will be reviewed in response to the pandemic.

Where to Find More Information

If you would like more information please visit our IJB website at:
https://www.inverclyde.gov.uk/health-and-social-care

Louise Long
Chief Officer _____ **Date:** tbc September 2020

Lesley Aird, CPFA
Chief Financial Officer _____ **Date:** tbc September 2020

Councillor Jim Clocherty
IJB Chair _____ **Date:** tbc September 2020

Statement of Responsibilities

Responsibilities of the IJB

The IJB is required to:

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

I confirm that the audited Annual Accounts were approved for signature at a meeting of the IJB on tbc September 2020.

Signed on behalf of the Inverclyde IJB

Councillor Jim Clocherty

IJB Chair _____ **Date:** tbc September 2020

Responsibilities of the Chief Financial Officer

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

In preparing these annual accounts, the Chief Financial Officer has:

- Selected appropriate accounting policies and then applied them consistently;
- Made judgements and estimates that were reasonable and prudent;
- Complied with legislation;
- Complied with the local authority Code (in so far as it is compatible with legislation)

The Chief Financial Officer has also:

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

I certify that the financial statements give a true and fair view of the financial position of Inverclyde IJB as at 31 March 2020 and the transactions for the year then ended.

Lesley Aird, CPFA

Chief Financial Officer _____ **Date:** tbc September 2020

Remuneration Report

Introduction

This Remuneration Report is provided in accordance with the Local Authority Accounts (Scotland) Regulations 2014. It discloses information relating to the remuneration and pension benefits of specified IJB members and staff.
The information in the tables below is subject to external audit. The explanatory text in the Remuneration Report is reviewed by the external auditors to ensure it is consistent with the financial statements.

1 Integration Joint Board

The voting members of the IJB were appointed through nomination by the Health Board and Council.

2 Senior officers

The IJB does not directly employ any staff in its own right. All HSCP officers are employed through either the Health Board or Council and remuneration for senior staff is reported through those bodies. Specific post-holding officers are non-voting members of the Board

Chief Officer

Under section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 a Chief Officer for the IJB has to be appointed and the employing partner has to formally second the officer to the IJB. The Chief Officer, Louise Long, is employed by Inverclyde Council and seconded to the IJB and has been in post since 8 May 2017. The statutory responsibility for employer pension liabilities sits with Inverclyde Council as the employing partner organisation. There is therefore no pension liability reflected on the Inverclyde IJB balance sheet for the IJB's Chief Officer. The remuneration terms of the Chief Officer's employment are approved by the IJB.

Chief Financial Officer

The IJB Chief Financial Officer, Lesley Aird, is employed on a part time basis by NHS Greater Glasgow and Clyde. The Council and Health Board share the costs of this and all other senior officer remunerations.

Other officers

No other staff are appointed by the IJB under a similar legal regime. There are no other non-voting board members who meet the criteria for disclosure and require to be included in the disclosure below.

Salary, Fees & Allowances 2018/19 £	Name and Post Title	Salary, Fees & Allowances 2019/20 £
109,475	Louise Long Chief Officer	116,221
45,500	Lesley Aird (part time 0.5 WTE) Chief Financial Officer	46,217

There were no exit packages paid in either financial year.

3 Remuneration: IJB Chair, Vice Chair and Voting Members

The voting members of the IJB are appointed through nomination by Inverclyde Council and Greater Glasgow & Clyde Health Board. Nomination of the IJB Chair and Vice Chair post holders alternates between a Councillor and Health Board representative.

The IJB does not provide any additional remuneration to the Chair, Vice Chair or any other board members relating to their role on the IJB. The IJB does not reimburse the relevant partner organisations for any voting board member costs borne by the partner. The details of the Chair, Vice Chair and other IJB voting member appointments and any taxable expenses paid by the IJB are shown below.

The IJB does not have responsibilities, either in the current year or in future years, for funding any pension entitlements of voting IJB members. Therefore no pension rights disclosures are provided for voting members.

Voting IJB Members Remuneration Table

Name	Post(s) Held	Nominated By
Councillor Jim Clocherty	IJB Chair	Inverclyde Council
Alan Cowan	IJB Member, Vice Chair Chair Audit Committee	NHS GG&C
Simon Carr	IJB Member	NHS GG&C
Dr Donald Lyons	IJB Member Audit Committee Member	NHS GG&C
Dorothy McErlean	IJB Member	NHS GG&C
Councillor Lynne Quinn	IJB Member Vic Chair Audit Committee (until 17/03/2020)	Inverclyde Council
Councillor Ciano Rebecchi	IJB Member Audit Committee Member (from 17/03/2020)	Inverclyde Council
Councillor Elizabeth Robertson	IJB Member Audit Committee Member	Inverclyde Council

There were no Inverclyde IJB specific expenses recorded for voting members of the IJB during 2019/20. Any expenses claimed by voting members are paid through the relevant IJB partner organisation.

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

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

Senior Employee	In Year Pension Contributions		Accrued Pension Benefits		
	For Year to 31/03/19 £	For Year to 31/03/20 £		Difference from 31/03/19 £	As at 31/03/20 £
Louise Long Chief Officer	21,073	22,328	Pension	2,536	15,970
			Lump Sum	0	0
Lesley Aird Chief Financial Officer	5,342	5,778	Pension	762	2,881
			Lump Sum	0	0

The Chief Financial Officer was previously a member of the Strathclyde Pension Scheme but has opted not to transfer those benefits. The accrued pension benefit disclosed above therefore relates only to this current employment and pension.

Disclosure by Pay Bands

Pay band information is not separately provided as all staff pay information has been disclosed in the information above

Louise Long

Chief Officer _____ **Date:** tbc September 2020

Councillor Jim Clocherty

IJB Chair _____ **Date:** tbc September 2020

Annual Governance Statement

The Annual Governance Statement explains the IJB's governance arrangements and reports on the effectiveness of the IJB's system of internal control.

Scope of Responsibility

The Inverclyde IJB was established by parliamentary order on 27 June 2015 following approval of the Inverclyde Integration Scheme by the Scottish Ministers. It is a body corporate, a legal entity in its own right but it relies on support from officers employed by Inverclyde Council and Greater Glasgow & Clyde NHS Board in relation to the conduct of its business. It is subject to the Public Bodies (Joint Working) (Scotland) Act 2014 and secondary legislation directly relating to the integration of health and social care services, and indirectly in relation to regulatory regimes affecting devolved public bodies in Scotland. The main features of the IJB's governance arrangements are described in the Local Code but are summarised below.

The IJB is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively.

To meet this responsibility the IJB has established arrangements for governance which includes a system of internal control. The system is intended to manage risk to support the achievement of the IJB's polices, aims and objectives. Reliance is also placed on the Inverclyde Council and Greater Glasgow & Clyde Health Board systems of internal control that support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives, as well as those of the IJB.

The system can only provide reasonable and not absolute assurance of effectiveness.

The Governance Framework and Internal Control System

The Board of the IJB comprises voting members, nominated by either Inverclyde Council or Greater Glasgow & Clyde Health Board, as well as non-voting members including a Chief Officer appointed by the Board.

The main features of the IJB's governance arrangements are described in the Local Code but are summarised below:

- The IJB was the key decision making body. The IJB's membership (voting and non-voting), as set by statutory instrument, is fully established. An Audit Committee with detailed remit and powers and clearly defined membership considers all matters in relation to Internal and External Audit and Risk Management;
- Strategic decision-making is governed by the IJB's key constitutional documents including the Integration Scheme, Standing Orders, and Financial Regulations.
- The IJB's purpose and vision are outlined in the IJB Strategic Plan which was approved and published on 19 March 2019 and which links closely to the vision of the Inverclyde Community Planning Partnership and the Single Outcome Agreement and is underpinned by an annual action plan and national statutory performance indicators;
- The Performance Management Strategy focuses very firmly on embedding a performance management culture that measures delivery of improved outcomes rather than systems and processes throughout the IJB. Regular reporting to Board Members takes place;
- The IJB has a Code of Conduct based on the Model Code of Conduct for Integration Joint Boards. The register of members' interests is published and made available for inspection.
- The IJB has in place a development programme for all Board Members. The IJB places reliance on the organisational development activity undertaken through partnership organisations for senior managers and employees;

- The IJB has established 6 localities to reflect the local planning areas that were developed by the Community Planning Partnership (the Inverclyde Alliance) through full public consultation. These provide Board Members with the opportunity to be involved in considering the priorities for each area and outline the role for each Community Planning Partner in meeting these priorities in conjunction with the local communities.
- As a separate Public Body, the IJB is required to publish Equalities Outcomes. These are published on the HSCP website.

The governance framework was in place throughout 2019/20.

The System of Internal Financial Control
The governance framework described operates on the foundation of internal controls, including management and financial information, financial regulations, administration, supervision and delegation. Development and maintenance of these systems is undertaken by the Health Board and Council as part of the operational delivery of the Health and Social Care Partnership. During 2019/20 this included the following:

- Financial regulations and codes of financial practice;
- Comprehensive budgeting systems;
- Regular reviews of periodic and annual financial reports that indicate financial performance against budget and forecasts;
- Setting targets to measure financial and other performance;
- Clearly defined capital expenditure guidelines;
- Formal project management disciplines.

The IJB complies with "The Role of the Head of Internal Audit in Public Organisations" (CIPFA) and operates in accordance with "Public Sector Internal Audit Standards" (CIPFA). The Chief Internal Auditor reports directly to the IJB Audit Committee with the right of access to the Chief Financial Officer, Chief Officer and Chair of the Audit Committee on any matter. The annual programme of internal audit work is based on a strategic risk assessment, and is approved by the Audit Committee.

With regard to the entries taken from the Health Board and Council Accounts, the IJB is not aware of any weaknesses within their internal control systems and has placed reliance on the individual Annual Governance Statements where appropriate.

Review of Effectiveness

Inverclyde IJB has responsibility for conducting, at least annually, a review of the effectiveness of its governance framework including the system of internal control. The review of the effectiveness of the framework is informed by the work of the Senior Management Team who have responsibility for development and maintenance of the governance environment, the annual report by the Chief Internal Auditor and reports from Audit Scotland and other review agencies.

The Internal Audit functions of the Council and Health Board have independent responsibility for examining, evaluating and reporting on the adequacy of internal control. During 2019/20, these services operated in accordance with relevant professional audit standards and the Public Sector Internal Audit Standards. The Chief Internal Auditors prepared annual reports to the relevant Audit Committees, including an assurance statement containing a view on the adequacy and effectiveness of the systems of internal control.

Significant Governance Issues during 2019/20
The Internal Audit Annual Reports 2019/20 for the Council and Health Board identify no significant control issues. Some actions have been agreed within the Council and Health Board Annual Governance statements to further enhance those internal control environments. None of these are considered material enough to have a significant impact on the overall control environment.

The Internal Audit Annual Report and Assurance Statement for 2019/20 concludes: *"Due to Covid-19 the presentation of Annual Internal Audit report for GG&C has been deferred until September. This means the IJB Chief Internal Auditor is unable to conclude the IJB's Annual report and provide an assurance statement opinion at this time. However, based on in year reports, Officers are confident that the overall opinion will be* ***Satisfactory*** *but this is not confirmed at this time. The final accounts will include the view once it is available in September.*

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

Covid-19

From March 2020 the governance context in which the IJB operates has been impacted by the need to implement business continuity processes in response to the significant public health challenge presented by the Covid-19 pandemic. The planning and delivery of health and social care services has had to adapt to meet this challenge and the IJB has had to adapt its governance structures accordingly.

In response to the pandemic and the requirement to move quickly and decisively to manage the subsequent pressures on health and social care services, the IJB approved and initiated temporary decision making arrangements. The temporary arrangements will be in place for as long as is necessary, subject to ongoing review.

Under these temporary arrangements authority is delegated, if required to meet immediate operational demand, to the Chief Officer and the Chief Financial Officer in consultation with the Chair and Vice Chair of the IJB. Interim arrangements were also put in place for the IJB which were formally ratified at the May meeting.

Any decisions made under temporary delegated authority are recorded in the approvals/decision tracker log that captures the approval timeline, with reports shared with IJB Members for information. IJB papers are available through the Inverclyde Council website.

The IJB is working with partners to participate in the wider response to the pandemic at Health Board and national level and is a key participant in the Council and Greater Glasgow and Clyde governance structures, working with other HSCPs to manage the impact of the pandemic.

New service hubs were set up in March to deliver an agile response to the pandemic, this included the establishment of an assessment centre and testing centre to support assessment and testing of potential Covid-19 patients and the creation of a hub to support the distribution of PPE to our social care services and those delivered by the third and independent sector and personal assistants and carers.

With significant disruption to how health and social care services are currently being delivered and experienced by service users, patients and carers likely to continue in the short to medium term, officers within the HSCP are developing plans to capture the extent of the shift from business as usual activity and ensure the IJB can continue to meet need and achieve the strategic priorities set out in the Strategic Plan. Planning activity takes into consideration the learning from the first phase of responding to the pandemic and engaging with and listening to key stakeholders in planning future service provision.

The financial impact of implementing the required changes to services and service delivery models (e.g. to support social distancing requirements, support staff with the appropriate protective equipment, and manage the new and changing levels of need and demand) is significant and likely to be ongoing and evolving. A detailed approval/decision tracker log is being maintained internally and scrutinised by senior management to record the details, including approval routes, of any decisions with financial implications for the IJB. This is supported by a mobilisation plan which has been approved by the Scottish Government, with discussions in relation to funding ongoing.

A vital element of the recovery planning activity being undertaken is learning from the interim changes put in place. The HSCP are actively seeking to understand the impact of the measures implemented and are

engaging with service users to understand which could be retained or adapted to improve services and continue to meet individuals' outcomes. The IJB will consider the learning from the pandemic including the innovative approaches and service alterations put in place out of necessity may present opportunities as we seek to re-start services within the new context in which health and social care services need to be delivered. In doing so the IJB will continue to follow appropriate governance structures and consider equalities and human rights requirements to ensure that from the current crisis emerges a more efficient and effective health and social care system that delivers on the priorities set out in the Strategic Plan.

Action Plan

Following consideration of adequacy and effectiveness of our local governance arrangements the IJB approved a local code of good governance on 20 March 2018. A number of actions were identified to enhance local governance and ensure continual improvement of the IJB's governance, all of those actions have been delivered in full.

Conclusion and Opinion on Assurance

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

We consider that the internal control environment provides reasonable and objective assurance that any significant risks impacting on the IJB's principal objectives will be identified and actions taken to avoid or mitigate their impact.

Systems are in place to regularly review and improve the internal control environment.

Louise Long

Chief Officer _____ **Date:** tbc September 2020

Councillor Jim Clocherty

IJB Chair _____ **Date:** tbc September 2020

The Financial Statements

Comprehensive Income and Expenditure Statement

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

2018/19 Restated*				2019/20		
Gross Expenditure £000	Gross Income £000	Net Expenditure £000		Gross Expenditure £000	Gross Income £000	Net Expenditure £000
3,520	(1,104)	**2,416**	Strategy & Support Services	2,845	(733)	**2,112**
29,302	(2,282)	**27,020**	Older Persons	30,508	(2,101)	**28,407**
12,157	(259)	**11,898**	Learning Disabilities	12,813	(269)	**12,544**
6,862	(150)	**6,712**	Mental Health – Communities	7,225	(124)	**7,101**
9,017	(288)	**8,729**	Mental Health – Inpatients	10,115	(378)	**9,737**
14,353	(615)	**13,738**	Children & Families	15,496	(1,381)	**14,115**
3,376	(259)	**3,117**	Physical & Sensory	3,353	(150)	**3,203**
3,464	0	**3,464**	Addiction/Substance Misuse	3,498	(317)	**3,181**
8,548	(290)	**8,258**	Assessment & Care Management / Health & Community Care	10,408	(427)	**9,981**
4,951	(1,038)	**3,913**	Support / Management / Admin	6,917	(2,845)	**4,072**
1,932	(1,906)	**26**	Criminal Justice / Prison Service	2,163	(2,114)	**49**
1,442	(651)	**791**	Homelessness	1,632	(589)	**1,043**
26,528	(981)	**25,547**	Family Health Services	28,010	(954)	**27,056**
18,591	0	**18,591**	Prescribing	18,359	0	**18,359**
1,133	0	**1,133**	Change Fund	1,044	0	**1,044**
261	0	**261**	IJB Operational Costs (see note 4)	267	0	**267**
145,437	**(9,823)**	135,614	**Cost of Services Directly Managed by Inverclyde IJB**	**154,653**	**(12,382)**	**142,271**
22,632	0	**22,632**	Set Aside	23,635	0	**23,635**
168,069	**(9,823)**	158,246	**Total Cost of Services to Inverclyde IJB**	**178,288**	**(12,382)**	**165,906**
0	(159,731)	**(159,731)**	Taxation and Non-Specific Grant Income (Note 2)	0	(167,075)	**(167,075)**
168,069	**(169,554)**	**(1,485)**	**Surplus on Provision of Services**	**178,288**	**(179,456)**	**(1,168)**
		(1,485)	**Total Comprehensive Income and Expenditure**			**(1,168)**

* The 2018/19 Accounts have been restated to reflect updated Set Aside figures and associated funding based on actual spend rather than notional budgets.

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

Movement in Reserves Statement

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

Movements in Reserves During 2019/20	General Reserves £000	Earmarked Reserves £000	TOTAL Reserves £000
Opening Balance at 31 March 2019	**(1,010)**	**(6,271)**	**(7,281)**
Total Comprehensive Income and Expenditure	249	(1,418)	(1,169)
Closing Balance at 31 March 2020	**(761)**	**(7,689)**	**(8,450)**

Balance Sheet

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

31 March 2019 Restated £000		Notes	31 March 2020 £000
	Current Assets		
7,298	Short term debtors	5	8,467
	Current Liabilities		
(17)	Short term creditors	6	(17)
7,281	**Net Assets**		**8,450**
7,281	Reserves	8	8,450
7,281	**Total Reserves**		**8,450**

The Statement of Accounts present a true and fair view of the financial position of the Integration Joint Board as at 31 March 2020 and its income and expenditure for the year then ended.

The audited financial statements were authorised for issue on tbc September 2020.

Lesley Aird, CPFA

Chief Financial Officer _____ **Date:** tbc September 2020

Notes to the Financial Statements

1. Significant Accounting Policies

1.1 General principles

The Inverclyde Integration Joint Board is formed under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014. It was established by parliamentary order on 27 June 2015 following approval of the Inverclyde Integration Scheme by the Scottish Ministers. The Integration Scheme is a legally binding agreement between Inverclyde Council and NHS Greater Glasgow and Clyde.

Integration Joint Boards (IJB's) are specified as section 106 bodies under the Local Government (Scotland) Act 1973 and as such are required to prepare their financial statements in compliance with the Local Authority Accounts (Scotland) Regulations 2014 and the Code of Practice on Accounting for Local Authorities in the United Kingdom, supported by International Financial Reporting Standards (IFRS). These are issued jointly by CIPFA and the Local Authority (Scotland) Accounts Advisory Committee (LASAAC) and are designed to give a "true and fair view" of the financial performance of the IJB.

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

The Annual Accounts summarise the IJB's transactions for the 2019/20 financial year and its position at the year end of 31 March 2020.

1.2 Accruals of expenditure and income

Activity is accounted for in the year that it takes place, not simply when cash payments are made or received. In particular:

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

1.3 Funding

The IJB is primarily funded through funding contributions from the statutory funding partners namely Inverclyde Council and NHS Greater Glasgow and Clyde. Expenditure is incurred as the IJB commissions specified health and social care services from the funding partners for the benefit of service recipients in Inverclyde.

1.4 Cash and Cash Equivalents

The IJB does not operate a bank account or hold cash. Transactions are settled on behalf of the IJB by the funding partners. Consequently the IJB does not present a 'Cash and Cash Equivalent' figure on the balance sheet. The funding balance due to or from each funding partner as at 31 March is represented as a debtor or creditor in the IJB Balance Sheet.

1.5 Employee Benefits

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

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

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

1.6 Provisions, Contingent Liabilities and Contingent Assets

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

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

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

1.7 Events After The Reporting Period

Events after the Balance Sheet date are those events, both favourable and unfavourable, that occur between the end of the reporting period and the date when the Annual Accounts are authorised for issue. Two types of events can be identified:

- Adjusting events: Those that provide evidence of conditions that existed at the end of the reporting period. The Annual Accounts are adjusted to reflect such events

- Non-adjusting events: Those that are indicative of conditions that arose after the reporting period and the Statements are not adjusted to reflect such events. Where a category of events would have a material effect, disclosure is made in the notes of the nature of the events and their estimated financial effect

Events taking place after the date of authorisation for issue are not reflected in the Annual Accounts.

1.8 Exceptional items

When items of income and expense are material, their nature and amount is disclosed separately, either on the face of the Income and Expenditure Statement or in the notes to the accounts, depending on how significant the items are to an understanding of the IJB's financial performance.

1.9 Related Party Transactions

As parties to the Inverclyde Integration Scheme both Inverclyde Council and NHS Greater Glasgow and Clyde are related parties and material transactions with those bodies are disclosed in Note 3 in line with the requirements of IAS 24.

1.10 Support services

Support services were not delegated to the IJB through the Integration Scheme and are instead provided by the Health Board and Council free of charge as a 'service in kind'. The support services provided are mainly comprised of: provision of financial management, human resources, legal, committee services, ICT, payroll, internal audit and the provision of the Chief Internal Auditor.

1.11 Indemnity Insurance

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

Unlike Health Boards, the IJB does not have any 'shared risk' exposure from participation in Clinical Negligence and Other Risks Indemnity Scheme (CNORIS). The IJB participation in the CNORIS scheme is therefore analogous to normal insurance arrangements.

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

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

1.12 Clinical and Medical Negligence

The IJB provides clinical services to patients under the statutory responsibility of NHS Greater Glasgow and Clyde. In connection with this it is responsible for any claims for medical negligence arising within the services it commissions, up to a certain threshold per claim. For claims in excess of this threshold the Health Board and IJB are members of CNORIS established by the Scottish Government which reimburses costs to members where negligence is established.

The IJB would make provision for claims notified by the NHS Central Legal Office according to the value of the claim and the probability of settlement. Where a claim was not provided for in full the balance would be included as a contingent liability. The corresponding recovery from CNORIS in respect of amounts provided for would be recorded as a debtor and that in respect of amounts disclosed as contingent liabilities are disclosed as contingent assets.

1.13 Reserves

Reserves are created by appropriating amounts out of revenue balances. When expenditure to be financed from a reserve is incurred, it is charged to the appropriate service in that year so as to be included within the Income and Expenditure Statement. Movements in reserves are reported in the Movement in Reserves Statement. Reserves ae classified as either usable or unusable reserves.

1.14 VAT

The VAT treatment of expenditure in the IJB's accounts depends on which of the partner agencies is providing the service as these agencies are treated differently for VAT purposes.

Where the Council is the provider, income and expenditure excludes any amounts related to VAT, as all VAT collected is payable to H.M. Revenue & Customs and all VAT paid is recoverable from it. The Council is not entitled to fully recover VAT paid on a very limited number of items of expenditure and for these items the cost of VAT paid is included within service expenditure to the extent that it is irrecoverable from H.M. Revenue and Customs.

Where the NHS is the provider, expenditure incurred will include irrecoverable VAT as generally the NHS cannot recover VAT paid as input tax and will seek to recover its full cost as Income from the Commissioning IJB.

2 Taxation and Non-Specific Grant Income

31 March 2019 Restated £000	Taxation and Non-Specific Grant Income	31 March 2020 £000
110,078	NHS Greater Glasgow and Clyde Health Board	116,353
47,321	Inverclyde Council	50,722
157,399	**TOTAL**	**167,075**

Health Board Contribution

The funding contribution from the Health Board above includes £23.635m in respect of 'Set Aside' resources relating to hospital services. These are provided by the NHS which retains responsibility for managing the costs of providing the services. The IJB however, has responsibility for the consumption of, and the level of demand placed on, these resources.

The funding contributions from the partners shown above exclude any funding which is ring-fenced for the provision of specific services. Such ring-fenced funding is presented as income in the Cost of Services in the Comprehensive Income and Expenditure Statement.

3 Related Party Transactions

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

31 March 2019 Restated £000		31 March 2020 £000
	Transactions with NHS Greater Glasgow & Clyde	
(110,078)	Funding Contributions received	(116,353)
(2,151)	Service Income received	(2,505)
95,463	Expenditure on Services Provided	102,200
(16,766)	**TOTAL**	**(16,658)**
	Transactions with Inverclyde Council	
(47,321)	Funding Contributions received	(50,722)
(6,829)	Service Income received	(9,877)
68,515	Expenditure on Services Provided	76,089
14,365	**TOTAL**	**15,490**

31 March 2019 Restated £000		31 March 2020 £000
	Balances with NHS Greater Glasgow & Clyde	
0	Debtor balances: Amounts due to the NHS	0
0	Creditor balances: Amounts due from the NHS	0
0	**Net Balance with the NHS Board**	**0**
	Balances with Inverclyde Council	
0	Debtor balances: Amounts due to the Council	0
5,820	Creditor balances: Amounts due from the Council	8,467
(5,820)	**Net Balance with the Council**	**(8,467)**

Key Management Personnel: The non-voting Board members employed by the Health Board or Council and recharged to the IJB include the Chief Officer, Chief Financial Officer, representatives of primary care, nursing and non-primary services, and staff representatives. Details of remuneration for some specific post holders is provided in the Remuneration Report.

4 IJB Operational Costs

31 March 2019 Restated £000	Core and Democratic Core Services	31 March 2020 £000
194	Staff costs	203
42	Administrative costs	38
25	Audit fees	27
261	**TOTAL**	**267**

The cost associated with running the IJB has been met in full by NHS Greater Glasgow and Clyde and Inverclyde Council. For the 2019/20 Accounts this is combined within the gross expenditure for both partners.

5 Short Term Debtors

31 March 2019 Restated £000	Short Term Debtors	31 March 2020 £000
7,298	Other local authorities	8,467
7,298	**TOTAL**	**8,467**

Amounts owed by the funding partners are stated on a net basis. Creditor balances relating to expenditure obligations incurred by the funding partners but not yet settled in cash terms are offset against the funds they are holding on behalf of the IJB.

6 Short Term Creditors

31 March 2019 Restated £000	Short Term Creditors	31 March 2020 £000
(17)	Other local authorities	(17)
(17)	**TOTAL**	**(17)**

7 Movement in reserves

The table below shows the movements on the General Fund balance, analysed between those elements earmarked for specific planned future expenditure, and the amount held as a general contingency.

2018/19			2019/20		
Balance at 31 March 2019 £000		To be used by	Transfers Out 2019/20 £000	Transfers In 2019/20 £000	Balance at 31 March 2020 £000
	SCOTTISH GOVERNMENT FUNDING				
98	Mental Health Action 15	31/03/2021	98	132	132
235	Alcohol & Drug Partnerships	31/03/2021	236	94	93
0	Covid - 19	31/03/2021	23	423	400
0	Primary Care Improvement Programme	31/03/2021	0	124	124
	EXISTING PROJECTS/COMMITMENTS				
43	Self Directed Support/SWIFT Finance Module	31/03/2021	0	0	43
25	Growth Fund - Loan Default Write Off	ongoing	1	0	24
11	Integrated Care Fund	ongoing	974	1,044	81
428	Delayed Discharge	ongoing	533	300	195
112	CJA Preparatory Work	31/03/2021	65	65	112
240	Service Reviews	complete	240	0	0
241	Primary Care Support	31/03/2020	178	209	271
27	SWIFT Replacement Project	complete	27	0	0
30	Rapid Rehousing Transition Plan (RRTP)	31/03/2021	0	53	83
0	Franks Law	complete	34	34	0
0	Physical Disabilities - CFCR	complete	70	70	0
0	Older People Wifi	31/03/2021	0	20	20
0	LD Estates	tbc	46	398	352
0	Refugee Scheme	31/03/2025	0	432	432
0	Tier 2 Counselling	31/03/2024	0	258	258
0	Complex Care	31/03/2021	0	0	0
0	Pay & Grading	complete	200	200	0
0	CAMHS Post	31/03/2022	0	90	90
100	Dementia Friendly Inverclyde	tbc	0	0	100
145	Contribution to Partner Capital Projects	ongoing	93	580	633
675	Continuous Care	ongoing	110	0	565
	TRANSFORMATION PROJECTS				
2,505	IJB Transformation Fund	ongoing	506	46	2,045
0	Addictions Review	31/03/2021	0	198	198
310	Mental Health Transformation	ongoing	0	300	610
	BUDGET SMOOTHING				
732	Adoption/Fostering/Residential Childcare	ongoing	407	0	325
88	Advice Service Smoothing Reserve	ongoing	88	0	0
0	Prescribing	ongoing	0	300	300
226	Residential & Nursing Placements	ongoing	3	0	223
6,271	**Total Earmarked**		**3,932**	**5,369**	**7,709**
	UN-EARMARKED RESERVES				
1,010	General		269	0	741
1,010	**Un-Earmarked Reserves**		**269**	**0**	**741**
7,281	**TOTAL Reserves**		**4,201**	**5,369**	**8,450**

8 Expenditure and Funding Analysis

31 March 2019 Restated £000	Inverclyde Integration Joint Board	31 March 2020 £000
	HEALTH SERVICES	
22,030	Employee Costs	24,630
20	Property Costs	37
5,815	Supplies & Services	7,667
25,547	Family Health Service	27,058
18,394	Prescribing	18,172
22,632	Set Aside	23,635
(1,171)	Income	(1,551)
	SOCIAL CARE SERVICES	
28,372	Employee Costs	29,815
1,028	Property Costs	1,060
1,242	Supplies & Services	1,207
411	Transport	416
770	Administration	735
40,568	Payments to Other Bodies	42,890
(7,672)	Income	(10,132)
	CORPORATE & DEMOCRATIC CORE/IJB COSTS	
194	Employee Costs	203
42	Administration	38
25	Audit Fee	27
158,246	**TOTAL NET EXPENDITURE**	**165,907**
(159,731)	Grant Income	(167,075)
(1,485)	**(SURPLUS) ON PROVISION OF SERVICES**	**(1,168)**

9 External Audit Costs

Fees payable to Audit Scotland in respect of external audit services undertaken in accordance with Audit Scotland's Code of Audit Practice in 2019/20 are £26,500. There were no fees paid to Audit Scotland in respect of any other services.

10 Post balance sheet events

These are events, both favourable and unfavourable, that occur between the end of the reporting period and the date when the Statement of Accounts is authorised for issue. An adjustment is made to the financial statements where there is evidence that the event relates to the reporting period; otherwise the financial statements are not adjusted, and where the amount is material, a disclosure is made in the notes.

The Chief Financial Officer issued the Unaudited Statement of Accounts on 23 June 2020 There have been no material events after the balance sheet date which necessitate revision of figures in the financial statements or notes thereto including contingent assets or liabilities.

The Annual Accounts were authorised for issue by the Chief Financial Officer on tbc September 2020. Events after the balance sheet date are those events that occur between the end of the reporting period and the date when the Statements are authorised for issue.

11 Contingent assets and liabilities

There are equal pay claims pending against both the Council and Health Board. Since the IJB is not the employer for any of the staff in question it is not financially liable for any amounts due.

12 New standards issued but not yet adopted

The Code requires the disclosure of information relating to the impact of an accounting change that will be required by a new standard that has been issued but not yet adopted. The IJB considers that there are no such standards which would have significant impact on its annual accounts.

Independent Auditor's Report

Independent Auditor's Report to the members of Inverclyde IJB and the Accounts Commission for Scotland

Report on the audit of the financial statements

AGENDA ITEM NO: 8

Report To:	**Inverclyde Integration Joint Board**	**Date: 23 June 2020**
Report By:	**Louise Long** **Corporate Director (Chief Officer)** **Inverclyde Health & Social Care Partnership**	**Report No: IJB/49/2020/LA**
Contact Officer:	**Lesley Aird** **Chief Finance Officer**	**Contact No: 01475 715381**
Subject:	**COVID 19 INVERCLYDE HSCP TRANSITION TO RECOVERY PLANNING**	

1.0 PURPOSE

1.1 The purpose of this report is to update the IJB on the recovery planning work that officers within the Health & Social Care Partnership (HSCP) are undertaking and the governance structures that have been put in place around this.

2.0 SUMMARY

2.1 The enclosed paper sets out the draft Inverclyde HSCP recovery strategy to coordinate services moving forward through future phases of the current covid19 pandemic.

2.2 A Recovery Group is in place to oversee this work and all services are engaged in developing action plans.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to approve the direction of travel and the ongoing recovery work and approve the enclosed Transition Plan.

Louise Long
Chief Officer

4.0 BACKGROUND

4.1 Over the course of the coming months, the HSCP requires to develop a new way of working that includes an element of catching up with activity that may have been scaled down or ceased as part of the Covid-19 pandemic response. This requires to be planned in a way which allows for flexibility to enable sufficient preparation and response to resurgence of waves of Covid activity.

4.2 In March as the pandemic began, the HSCP business continuity plan was updated and initiated to ensure a rapid but considered and safe response to Covid-19. New Standard Operating Procedures were drafted to reflect new social distancing requirements and national lockdown. A Local Response Management Team (LRMT) was established. Membership was comprised of HSCP officers, providers staff side and third sector reps. The LRMT initial met via teleconference three times each week, as the weeks have gone on the HSCP has been able to scale this back to once a week. In addition there are weekly care home governance meetings and daily commissioning support call arrangements and governance visits in place.

4.3 As the virus moves on so do the rest of us and as part of this organisations are now moving into recovery mode. As part of this the HSCP has been developing a recovery strategy and plan to steer services safely through the next few uncertain months.

5.0 RECOVERY PLANNING

5.1 The attached document is the HSCP Covid-19 Transition Plan. In essence it is intended to be an initial recovery strategy and recovery roadmap for the HSCP.

5.2 A set of guiding principles and strategic priorities have been pulled together as part of this. These key principles include:

- maximising use of digital opportunities
- delivering the majority of care outside hospitals and acute settings
- supporting people to manage their own health
- working across our health and care system
- equality of access and promoting the involvement of communities
- contact with staff and the level of support and supervision should be increased
- ensuring that all service users continue to get appropriate support and service
- maximising use of available workforce and local volunteer groups
- flexibility and remodelling workforce
- minimum necessary service – how do we step up from that
- buildings will be made safe for staff using them and adhering to social distancing

5.3 The document highlights

- the planning approach overview in section 6.4
- Anticipated recovery phases:
  - Phase 1 current to end June
  - Phase 2 to end Aug
  - Phase 3 to end Feb 2021
  - Phase 4 to end July 2021
- The overall approach is
  - Phased approach to restarting services
  - Learning and understanding what impact the shift in ways of working will or should have longer term
  - Ensuring we focus on staff wellbeing, the positive response from the workforce throughout this has been incredible and it is vital that we support

our staff through these next phases. A staff wellbeing questionnaire has been developed and is being rolled out with the support of the Staff Partnership Forum

5.4 An HSCP Covid-19 Recovery Group has been set up with representatives from each service area and staff side. Separate sub groups will focus on providers, carers, service users and third and independent sectors. The overarching Recovery Group had its first meeting on 1st June where it agreed the enclosed plan. The group meets fortnightly.

5.5 The HSCP Extended Management Group had an initial reflection session on 20th May subsequent feedback from teams across HSCP. General feedback was very positive with particular highlights noted as:

- Staff support for fast pace of change in initial stages
- Many staff going above and beyond and coping well despite the additional stress and anxiety brought on by the pandemic
- PPE – despite issues in many other areas Inverclyde successfully ensured it had sufficient PPE throughout those crucial first few weeks
- Community engagement and social prescribing – led by CVS we have seen an increase in local volunteering and lots of amazing examples of community unity and spirit throughout the past couple of months
- Improved independence for service users – many service users have been supported by community members which has promoted a degree of independence, making new connections with other members of their local communities – delivering on our Big Action 6 social prescribing outcomes. This is something that services will continue to monitor on a client by client basis to ensure any longer term changes are safe and appropriate.
- Sickness in services where people live such as Mental Health Inpatient, Children Houses have improved across the pandemic

Negatives were:

- IT and connectivity issues which we are working with the Council and Health Board to address
- Concerns about unseen harms across a number of services through increased domestic abuse etc – this is a nationwide concern and services are doing what they can to mitigate against this and maintain contact with all at risk service users. There has been an increased risk to vulnerable groups, for example we have seen a rise in the number of Child Protection Orders. Concerns across staff groups on the long term impact of the pandemic on vulnerable people.
- Inequality access to IT, number without phones, laptops or access to computers impacts on impact to do people visits.

5.6 Services have developed initial, phased recovery action plans which detail step up and step down arrangements for each service and staff group over the coming months. These are being reviewed and will be brought together in an overarching HSCP action plan which will be monitored by the HSCP Covid-19 Recovery Group.

6.0 IMPLICATIONS

FINANCE

6.1 There are no specific financial implications in this report.

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments

			£000		
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	**Budget Heading**	**With Effect from**	**Annual Net Impact £000**	**Virement From**	**Other Comments**
N/A					

LEGAL

6.2 There no specific legal implications arising from this report.

HUMAN RESOURCES

6.3 There no specific human resources implications arising from this report.

EQUALITIES

6.4 Has an Equality Impact Assessment been carried out?

	YES
X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

6.5.1 How does this report address our Equality Outcomes?

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	None
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

6.6 There are no clinical or care governance implications arising from this report.

6.7 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	Our recovery plan will contribute to the delivery of this outcome
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	As above
People who use health and social care services have positive experiences of those services, and have their dignity respected.	As above
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	As above
Health and social care services contribute to reducing health inequalities.	As above
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	As above
People using health and social care services are safe from harm.	As above
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	As above
Resources are used effectively in the provision of health and social care services.	As above

7.0 DIRECTIONS

7.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	X
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

8.0 CONSULTATION

8.1 The report has been prepared based on discussions with officers from the Council, Health Board, other 5 GG&C IJBs, the HSCP Extended Management Team and the HSCP Covid-19 Recovery Group.

9.0 BACKGROUND PAPERS

9.1 None.

APPENDIX

COVID-19 Inverclyde HSCP
Business Continuity and Transition Planning

1 CONTEXT

1.1 Across Scotland we are currently in the first wave of the COVID-19 outbreak. Novel coronavirus (COVID-19) is a strain of coronavirus first identified in Wuhan, China in 2019. Clinical presentation may range from mild-to-moderate illness to pneumonia or severe acute respiratory infection. COVID-19 was declared a pandemic by the World Health Organisation on 12 March 2020. We now have spread of COVID-19 within communities in the UK.

1.2 COVID-19 is expected to be an ongoing threat requiring continued social distancing until we, as a country, have built up overall immunity (approximately 60-80% population immunity) through vaccination or natural infection. In the meantime, we will have to deal with waves of COVID activity (infected individuals and public health measures), and also deliver other health and care services. In this first wave, we stopped a wide range of activity to allow us to prepare for COVID activity, comply with social distancing requirements and address high levels of staff absence in the first few weeks within the HSCP and the wider provider network. We have also put in abeyance many of our existing planning and governance structures.

1.3 Extensive measures have been implemented across the UK. Current recommendations for Scotland are for people to stay at home as much as possible and severely restrict their interactions with others outside the household.
Current government advice is that people only leave the house for very limited purposes, for example:

- for basic necessities, such as food and medicine. Trips must be as infrequent as possible
- daily exercise, for example a run, walk, or cycle - alone or with members of your household
- to ensure basic animal welfare needs are met, including taking dogs out when necessary
- any medical need, including to donate blood, avoid or escape risk of injury or harm, or to provide care or to help a vulnerable person
- travelling for work purposes, but only where you cannot work from home

1.4 The above measures have obviously had an impact on staff, our service users, key workers in other areas and the whole community and have required all organisations to adapt their normal operating models. The HSCP did this by moving to a hub model and pulling back on non essential face to face contact.

1.5 <u>Moving Forward</u>

Over the course of the coming months, the HSCP will require to develop a new way of working including an element of catching up with activity that may have been scaled down or ceased as part of the pandemic response. This will require to be planned in a

way which allows for flexibility to enable sufficient preparation and response to resurgence of waves of COVID activity.

1.6 We will need to consider services that will see an increased demand as a result of COVID-19 mitigation measures. To do this effectively, we cannot simply return to previous ways of working. We need to understand the changes we have made to services, assess the risks and opportunities in continuing with these changes and apply learning from the COVID response to our recovery planning. We also need to plan our recovery with the other Health Boards in the West of Scotland.

1.7 Measures initially designed to prevent the spread of Covid 19 are dynamic and subject to change at short notice. The main business consequence and continuity risks for the HSCP are:

(i) Increased community-based demand due to:
- reduced acute hospital capacity, as a result of Covid 19 emergency admissions;
- reduced informal carer capacity, as a result of carers becoming ill with Covid and/or of being unable to provide support due to self-isolation or lock-down;
- reduced day and respite services due to service closures;
- reduced wellbeing of vulnerable people, post-infection;
- mental health impact of self-isolation and community lock-down;
- potential for increase in harm to children and vulnerable adults, and domestic violence due to self-isolation and lockdown;
- increased levels of end-of-life care at home;
- the deferred impact of reduced health and social care referral rates for non-Covid related concerns.
- increase in demand for CJSW Court Reports and Social Work Community Sentences due to most summary Court business as of 10th April 2020 being deferred for 12 weeks.

(ii) Reduced service capacity due to:
- HSCP staff illness due to Covid-19 infection;
- HSCP staff illness due to work-related stress as a result of the significant extra demands of Covid-related work;
- Equivalent staff pressures in the commissioned social care sector, with voluntary and independent sector provision under significant pressure;
- Primary care impact with GPs providing additional Health Board-wide support to assessment centres and NHS24;
- Diversion of community-based resources (especially nursing) to acute hospitals.

1.8 The anticipated infection trajectory across the country means that the impact of these business continuity risks is highly significant and potentially critical.

2 INVERCLYDE HSCP BUSINESS CONTINUITY PLANNING

2.1 The HSCP has updated all of its departmental and service Business Continuity Plans (BCPs) to reflect the particular challenges of Covid-19 emergency planning

requirements. The HSCP's overarching BCP has also been updated and new Standard Operating Procedures (SOPs) developed. These documents cover:

- The new HUB model, including team consolidation and merging
- Essential service continuity and prioritisation
- Public protection
- Commissioned services
- Staffing
- Staff and public communications

2.2 A Local Response Management Team (LRMT) has been established that meets twice each week. These meetings are supported by ongoing Senior Management Team (SMT) meetings. The Chief Officer updates the Chair and Vice Chair and two other voting members of the Integration Joint Board (IJB) weekly and a virtual IJB will be held monthly from mid May. On a wider level, THE HSCP is part of robust and routine Council, Health Board and national emergency planning activity.

3 PREPARING FOR TRANSITION

3.1 It is clear that the process of transition through emergency planning and business continuity for Covid-19 will be neither linear nor guaranteed.

3.2 Scotland in common with all parts of the UK entered lockdown on 23rd March 2020. These constraints were implemented then strengthened through legislation (the Coronavirus (Scotland) Act 2020) and through the Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020. Under law, the UK and Scottish Governments must review this lockdown at least every three weeks. This ensures the impact of restrictions remains proportionate to the threat posed to wider societal and economic aspects.

3.3 In common with nations across the world, Scotland is planning for a managed **transition** away from current restrictions in a way that enables the suppression of transmission to continue. This will include ongoing physical distancing, the continued need for good hand hygiene and public hygiene, and enhanced public health surveillance - while seeking to very carefully open up parts of our economy and society.

3.4 As and when restrictions are lifted, the Scottish Government has indicated in its report *COVID-19 – A Framework for Decision Making (April 2020)* that it will need to put in place public health measures to stop cases becoming clusters, clusters becoming outbreaks, and outbreaks becoming an uncontrolled peak that would require a return to lockdown to avoid enormous loss of life and the overwhelming of our health and care system. This is a clear indication that the lifting of restrictions will be carefully phased and measured. The lifting of restrictions may also be reversed if the

"reproduction number" or "R" rises above 1, i.e. the number of cases each infected person passes the virus on to.

3.5 A framework of assessments will be undertaken by the Scottish Government to inform its decision in how it manages its response to the epidemic:

Scottish Government Assessment Framework

1. Options for physical distancing measures – easing, maintaining, (re)introducing – are technically assessed using the best available evidence and analysis of their potential benefits and harms to health, the economy, and broader society so as to minimise overall harm and ensure that transmission of the virus is suppressed.
2. Potential options – individual and combinations of measures – are assessed for their viability, for example taking account of how easy they are to communicate and understand, likelihood of public compliance, the proportionality of any impact on human rights and other legal considerations.
3. Broader considerations also include equality impacts and consideration of tailoring measures, for example to specific geographies and sectors.
4. Assessments will inform the required reviews of the Coronavirus regulations and collective assessment and decision-making with the UK Government and other Devolved Administrations as appropriate.

3.6 The Scottish Government's policy approach to transition provides a clear context within which the HSCP should prepare for its own transition, through its business contingency and continuity planning processes. It is essential that a plan is in place that allows the HSCP to take account of the path of the epidemic and the national response, while constantly re-orientating its continuity planning in line with presenting demand, shifting trends and trajectories and the impact of organisational capacity issues. In this respect, having clarity and perspective on our emergency arrangements is essential in order that we can act both reactively and proactively in response to the challenges we face.

3.7 The key principle which must guide recovery planning is the need to provide safe and effective services for people which maximise the health benefit for our population, promotes independence and protects the most vulnerable. Principles also include the need to minimise risk to staff and patients, to maximise the use of remote consultations where appropriate, and to ensure equality of access based on need.

3.8 The long term impact of Covid-19 will be significant so it is crucial that we learn from the pandemic and our response locally and nationally, use this knowledge and insight to guide and improve how we work now and how we plan ahead.

3.9 It is proposed that the successful aspects of rapid implementation across the health and care system, which were driven by the strategic and tactical COVID response groups are replicated in the recovery phase. Potential detrimental impacts should also be identified and addressed. Implementation of COVID responses has been supported

by public buy in, political and media support, finance/budget and a high degree of staff goodwill.

4 HSCP PRINCIPLES AND STRATEGIC PRIORITIES

4.1 Key principles established:

- maximising use of digital opportunities
- delivering the majority of care outside hospitals and acute settings
- supporting people to manage their own health
- working across our health and care system
- equality of access and promoting the involvement of communities
- contact with staff and the level of support and supervision should be increased
- ensuring that all service users continue to get appropriate support and service
- maximising use of available workforce and local volunteer groups
- flexibility and remodelling workforce
- minimum necessary service – how do we step up from that
- buildings will be made safe for staff using them and adhering to social distancing

These principles are set alongside the continuing need for social distancing, and the likelihood that future waves of COVID will drive the need for us to be able to flex our system to respond to this. Red, Amber, Green status for each action – Red – want to do but can't do just now because of current guidance, Amber – ready to do imminently, Green – good to go – Blue – done

4.2 Where possible, it is proposed that existing structures are used to develop the recovery plan, and the Senior Management Team will support these structures and processes. By working within a hub and spoke model, aligned to each of the key areas of recovery.

4.3

4.4 In order to provide governance and leadership, a local HSCP Recovery Group will be set up and chaired by Chief Officer with membership from across HSCP, 3rd Sector, Human Resources and Staff side representatives. The Recovery Group will report through the Recovery Tactical Group in the Health Board and the Council Recovery Group respectively through their reporting structures. This will enable a system-wide overview of component plans to inform recommendations presented to the IJB. Terms of Reference for the Group are enclosed at Appendix 1.

4.5 It is important not to lose sight of the wider strategic priorities that guide the work of the HSCP and the principles and values that underpin what we collectively and individually do in support of these priorities. Covid-19 emergency planning and response arrangements do not operate in isolation, although right now it can feel that they dominate matters almost to the exclusion of all else. Inverclyde HSCP continues

to be guided by its principles and values and a commitment to delivery of our overarching vision and Strategic Plan and 6 big actions:

Big Action 1: Reducing Health Inequalities by Building Stronger Communities and Improving Physical and Mental Health	Big Action 2: A Nurturing Inverclyde will give our Children & Young People the Best Start in Life
Big Action 3: Together we will Protect Our Population	Big Action 4: We will Support more People to fulfil their right to live at home or within a homely setting and Promote Independent Living
Big Action 5: Together we will reduce the use of, and harm from alcohol, tobacco and drugs	Big Action 6: We will build on the strengths of our people and our community

5 CLINICAL AND CARE GOVERNANCE

5.1 Given the ongoing pressures presented in managing the challenge of Covid-19, it has not been possible to maintain the normal range of clinical and care governance and functions. The NHS Strategic Executive Group approved adaptations to the arrangements for governance of healthcare quality. This includes suspension of the strategically supported Quality Improvement programmes, revisions to processes for clinical guidelines, audit and clinical incident management. NHS Acute, Partnership and Board Clinical Governance Forums are currently suspended.

5.2 Within Inverclyde HSCP there has been a temporary suspension of our clinical and care governance meetings. However it is important to note that the legal duty of quality and the requirement to maintain health and care quality continue to be standing obligations, therefore where local arrangements cannot be sustained, operational oversight of healthcare quality and clinical governance has been maintained by embedding the following essential functions in the local management arrangements:

- Responding to any significant patient feedback
- Responding to any significant clinical incident
- The approval and monitoring of any clinical guidelines or decision aids that are required for the Covid-19 pandemic emergency
- Responding to any significant concerns about clinical quality

5.3 Examples of the mechanisms currently in place to support the operational oversight at service level include: Corporate Management Team meetings with Inverclyde Council; participation in NHS Board COVID-19 governance; three times weekly HSCP Senior Management Team (SMT) meetings; daily SMT communication re Covid – 19 risk issues; development of dynamic risk assessments for all services with an overarching HSCP Covid -19 risk register which is reviewed weekly and is submitted to the Local Resilience Management Team (LRMT) and SMT and maintenance of communication

with individual staff and teams. The latter has been an essential element in the provision of operational and professional supervision and caseload management to identify areas of exception with escalation as appropriate to the LRMT and the SMT.

5.4 Plans are now in place to re-establish our governance arrangements. Inverclyde HSCP Clinical and Care Governance Group is scheduled to take place on 26 May. The primary focus of discussion will be clinical and care governance arrangements to support our Recovery Plan. We continue to closely monitor deaths of vulnerable individuals currently or previously known to our ADRS and our homelessness services given the particular vulnerabilities for these individuals

6 PROCESS

6.1 Detailed plans will be developed for the following areas:

1 Reflection and review with staff groups (see Appendix 2) within each hub in HSCP services, mental health, drugs and addictions, Children and Families ,Criminal Justice, Homelessness key processes and key priorities, longer term look at links to strategic plan 6 big action
2 Reflection within primary care, mental health inpatients, children and adults residential services
3 Review with 3rd sector, CVS and communities about how we continue to engage and harness support while maintaining social distancing
4 Assessment and Testing Centre and plans developed for step up and step down for assessment and testing as required
5 Emotional and operational recovery in the longer term will require managers and leaders to ensure there are regular opportunities for feedback and support for their teams and staff members.
6

The plans will include how key issues will be addressed, timescales and the following areas:

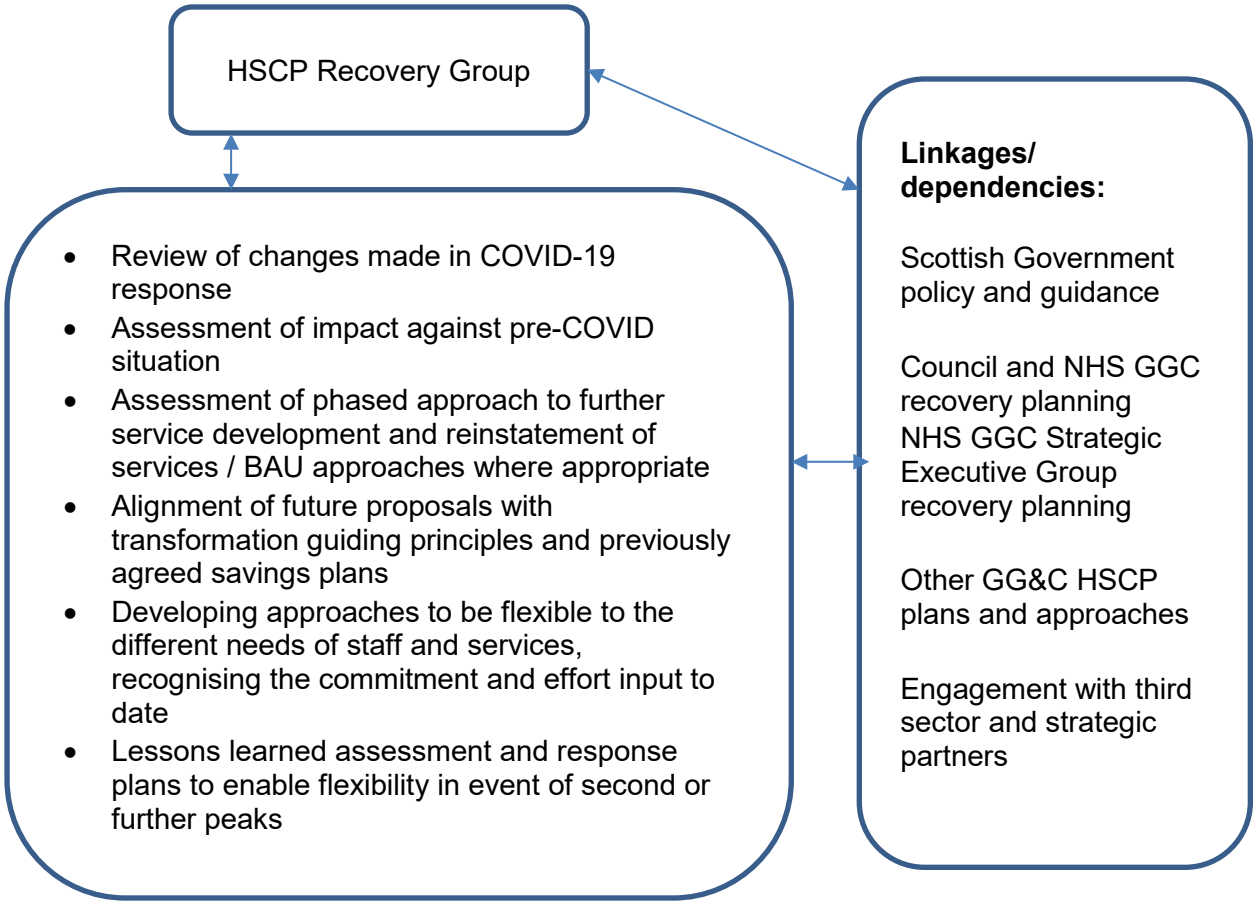
- governance, leadership and assurance
- sustainable improvement (aligning capacity and demand, standard operating procedures and training)
- managing clinical risk
- performance management
- communications
- risks and mitigations

6.2 These recovery plans will need to be drafted by mid-May. Staff sessions should take place across next 7 days in order to provide managers with initial feedback to support the production of clear reflections. It is proposed that the Extended SMT has an initial

morning session to review the initial feedback and thereafter a weekly Recovery Planning meeting.

6.3 A draft initial Recovery action plan was shared with the HSCP Covid-19 Recovery Group. This is a live document and is updated regularly and reported through the Recovery Group and Strategic Planning Group.

6.4 Planning Approach Overview



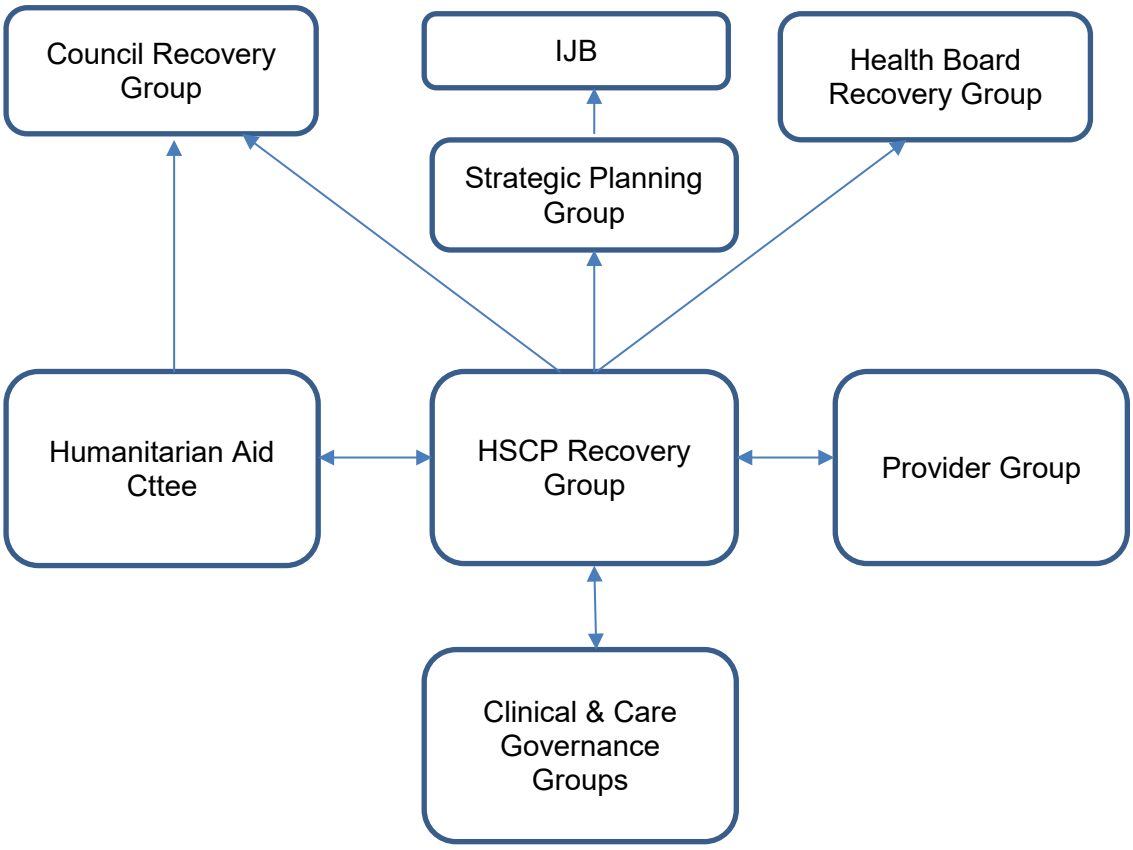
6.5 Anticipated Recovery Phases

It is anticipated that current conditions around lockdown, shielding etc will be lifted and adapted in phases. The table below reflects the anticipated phases and timescale of change linked to this.

Phase	Indicative Timescale	Scenario
One	Current (May-June 2020)	• Current position • Services remodelled to focus on critical and essential care • Lockdown in place with individuals shielding and social distancing • Support provided to shielding and Group 2 individuals • LRMT in place
Two	June-Aug 2020	• Gradual reduction in lockdown conditions • Social distancing maintained but potentially reduced to >1m • Individuals with underlying health conditions continue to shield • Support provided to shielding and Group 2 individuals • Increasing demand for HSCP services (as previously provided) • LRMT remains in place • Testing and tracing implemented –potential for impact of (multiple) staff self-isolations • Potential second peak of COVID-19 infections • Revisiting transformational and savings plans to review and update in light of new position
Three	Sept to Feb 2020 (3-6 mths)	• Lockdown removed but social distancing guidelines remain in place and shielding guidance reduced • Demand for HSCP services returns to pre-COVID levels with additional shifts towards particular services e.g. mental health • LRMT and national helpline support still in place with signs of demand reducing • Potential additional peak of COVID-19 infections remains • Testing and tracing in place -potential for impact of (multiple) staff self-isolations • Reform of services in line with transformation guiding principles and savings plans
Four	Feb-Jul 2021	• 'New normal' operating position • Potential additional peak of COVID-19 infections reducing • Testing and tracing in place -potential for impact of (multiple) staff self-isolations • Continued reform of services in line with transformation guiding principles and savings plans

6.6 The governance and reporting structures around this work are as follows:

Recovery Planning Governance and Reporting Overview



7 ALIGNMENT WITH COUNCIL AND HEALTH BOARD RECOVERY AND TRANSITION PROCESSES

7.1 It is important that the HSCP recovery and transition plan aligns strategically with Council and NHS processes. Inverclyde's Councils Strategic Recovery Plan and NHS Greater Glasgow and Clyde's NHSGGC COVID-19 Recovery Plan both set out common objectives and broadly similar approaches.

7.2 The unique governance and accountability frameworks that establish the HSCP Board and its strategic planning responsibilities place it central to the process of linking operational recovery and transition to longer-term strategic priorities, including integrated effectiveness, efficiency and economy. The HSCP Board's directions to the Council and Health Board to deliver operational services in line with these strategic priorities ensure that the Council and Health Board will wish to have confidence that operational recovery and transition processes are well planned and executed. Furthermore, for reasons of consistency, the Council and Health Board separately may wish to align their approaches across whole systems and cross-cutting corporate issues that may include or affect aspects of delegated services. This may create a potential overlap of recovery and transition planning activity. The HSCP will therefore work in partnership to harmonise recovery and transition planning in pursuit of outcomes that are mutually supportive and meet the needs of all parties.

8 CROSS-CUTTING AND COMMON THEMES

8.1 The Council has, in its recovery and transition planning arrangements, identified aspects and considerations which are common and are corporate in nature, including implications for shared space in buildings; health & safety and PPE; workforce; technology & digital; travel and transport; contracts & procurement, etc. As such, corporate considerations and implications will be collated and assessed by lead Corporate Director of the Council. To support this work and in anticipation of similar requirements by the Health Board, the Chief Officer will identify HSCP Heads of Service to act as HSCP points of contact for these issues.

8.2 In addition, the Chief Officer will identify cross cutting operational issues as they emerge from service-level recovery and transitional planning work and will identify an HSCP strategic lead for each of these, to minimise duplication of work at a service level and to consider strategic solutions in conjunction with Council and Health Board officers and colleagues in other HSCP areas. These cross-cutting issues may include but not be limited to: public protection, congregate models of care, HSCP governance, clinical and care governance, financial impact and planning.

9 CHANGE MANAGEMENT AND DUE DILIGENCE

9.1 With social distancing likely to be a feature of public health, social and economic life for the foreseeable future, concepts of "normality" and "recovery" become relative rather than absolute concepts. More accurately, the processes of recovery and transition are steps through continued business continuity and contingency planning. At each stage, changes to operating systems, processes and service models may be necessary to safeguard the health, safety and wellbeing of staff, our patients and service users, our communities, businesses, jobs and our partnerships. However tempting it may be to consider the value of permanent shifts to some of these

contingency arrangements (particularly as the people we support have experienced unexpected benefits in some of these), long term change should be by design and not by default.

9.2 The process of longer term service change requires careful consideration, consultation, evaluation and impact assessment. These elements of due diligence will be essential as we work through the transition process, so that the HSCP emerges stronger by design.

APPENDIX 1

HSCP Recovery Group Terms of Reference

Name of Group:	**Inverclyde HSCP Recovery Group**	Version 1.0
Constitution:	This Recovery Group has been established to coordinate and monitor the recovery planning of the Inverclyde HSCP and support the recovery planning work of NHSGG&C and Inverclyde Council. The role of the Group is to oversee the Inverclyde HSCP Covid 19 Recovery Planning process through initial development to implementation and close. Meetings will be held virtually through conference calls to allow for appropriate social distancing and other current safety measures to be accommodated. Initial focus will be on internal HSCP services, longer term this will be widened to include externally provided services and the group membership expanded accordingly.	
Composition/ Substantive Membership:	The Recovery Group membership will be constituted as follows: • Chief Officer (Chair) • Interim Head of Strategy & Support Services (Vice Chair) • Heads of Service • Chief Nurse • Clinical Director • 6 x Hub Managers • Service Manager Business Support • Service Manager Commissioning • Action Note taker • Staff side x 2 • HSCP Rep on Health Board Recovery Group	
Responsibilities:	The Group will plan, prepare, organise, monitor and communicate the transition from current model to normal activities to Council, NHS and community. This will include: • The development of overall principles in line with NHS Board and Council • A review of current arrangements • Preparation of a plan and phasing of implementation • Ensuring staff and members of the community are protected • Effective support for staff • Monitor the implementation including assessing risks • Communicate to staff, provider each step in the transition process through LMRT and NHS Tactical Group and Chief Officer brief • Report to Council, CMT, NHS and Strategic Planning Group ultimately to Health and Social Care Committee and IJB	

Frequency of Meetings:	Meetings shall be held weekly at the same set time or as directed by the Chair.
Quorum:	To be quorate at least 30% of the agreed membership including at least one member of the HSCP SMT must be at the meeting
Reporting Procedures:	One page hub summary report as per the enclosed template will be circulated to Group members at least 24 hours before the meeting. Following each meeting an updated action note will be distributed within two working days.
Action Note to be circulated to:	Action note from each meeting to be circulated to: • Recovery Group Members • HSCP SMT and Extended Management Team • Inverclyde Council Recovery Group • GG&C Recovery Group
Review Date:	These terms of reference will be reviewed every 3 months to ensure the Recovery Group is operating at maximum effectiveness.
Date Terms of Reference Approved:	31/08/2020 by the Recovery Group

APPENDIX 2

The approach can be described as consisting of three steps

1. Phased approach to restarting services

The Heads of Service and Service Managers would be required to use the Business Continuity plans in each of the Care areas as the framework for phasing a return to full provision of HSCP services, bearing in mind that the sequencing of this could be different to the retraction of the services. Areas to consider would be how in the immediate situation we utilise the experiences of staff (and ultimately service users/patients) to assist us to re-introduce services and identify.

- What has proven to be effective?
- What has been unhelpful and/or of little value?
- What processes/procedures/ways of working should be adopted and which should we consider discontinuing?
- What have we been doing that we need additional capacity and resource for?

2. Learning and understanding

The shift in ways of working will also have a long term impact and we need to review:

- Benefits of increased digital approaches to working from home, connecting with each other , running meetings formally and informally
- Early feedback suggests there are a number of skills to be developed to support this and this will need an ongoing programme
- The change in relationships with clients through the use of technology will also need to be considered for future ways of working
- Collecting this feedback and reviewing it should form a main strand of recovery and planning for the future

3. Staff wellbeing

The positive response from the workforce has been incredible and a number of supports have been put in place to sustain staff in the current time. Collect and report on the narrative around staff experience of support and resilience:

- Teams have continued to meet and support each other either in person, while adhering to social distancing protocols or through virtual meetings
- Managers have been connecting with individuals and teams
- Good questions for teams include:
    - What types of supports helped you through this?
    - What other things would have helped?
    - What did not help?

Inverclyde HSCP Covid-19 Recovery Action Plan

As At 16 June 2020

Phase 2 Plan

	HSCP PHASE 2 ACTION PLAN					
	Actions	**Responsible**	**Timescale**	**RAG Status**	**Comments**	**Date Complete**
Priorities and principles	• Identify which people are prioritised • Increase face to face contact • We deliver services to help people live healthier and fulfilling lives • We protect vulnerable people • We provide flexible response • Review hub operation with view moving back to service	Allen Stevenson	June	Green	Principle agreed IJB 23rd June	
Resources	• Ensure that all plans fully costed in mobilisation plan • ICT scope/cost	Lesley Aird	June/July	Green	Awaiting confirmation Living Wage costs provided.	
Human resources	• Ensure adequate staffing in place • Regular communication in place • Regular meeting with Trade Unions	Louise Long	July	Green	Impact childcare on keyworkers	
Ensuring Everyone is Safe	• Building assessed based on risk assessment • PPE • Wellbeing plan staff	Lesley Aird/ Sharon McAlees/ SPF	July	Green	Develop plan for building Develop plan for IT Plan for Wellbeing	

	HSCP PHASE 2 ACTION PLAN					
	Actions	**Responsible**	**Timescale**	**RAG Status**	**Comments**	**Date Complete**
Communications	• Provide platforms to listen to the needs of service users and the community • Clear communication plan	George Barbour	June	Green	Priority develop communication	

Phase 1 Plan

ISSUE	DESCRIPTION OF ACTIONS	LEAD	TARGET DATE
Governance Leadership Assurance	Actions Already Completed/Ongoing • Update the risk register to reflect the changing operational arrangements and protocols • HSCP Covid-19 Recovery Group established and meeting fortnightly	Louise Long / Lesley Aird / Deirdre McCormick	Complete
Sustainable Improvements	Actions Already Completed/Ongoing • Review 5 service hubs • Reflection sessions and feedback • Prioritise services process for reinstatement • Rolled out initiatives supported • Assessment / Testing centres remain in place with protocol • Support digital, home working • Review 3rd sector arrangements	Allen Stevenson / Sharon McAlees / Jeanette Hawthorn	Ongoing
Managing Risk	Actions Already Completed/Ongoing • Chief Officer Group (COG) meets regular • Clinical/Care Governance Committee Re-established • Develop step up protocol and stepdown • Develop professional frameworks for new operating model • New data dashboard – weekly reporting • Risk Register reviewed monthly by Local Resilience Management Team (LRMT)	Sharon McAlees / Deirdre McCormick /Hector MacDonald	Ongoing
Performance Management & Contract Governance	Actions Already Completed/Ongoing • Reporting contractual service – new template	Lesley Aird / Arlene Mailey	Ongoing

ISSUE	DESCRIPTION OF ACTIONS	LEAD	TARGET DATE
	• Contract management – (care homes – dashboard) • Public Protection dashboard • COVID19 measurements developed (STIREP report) • Finance reporting including the Mobilisation Plan • Following national guidance in relation to provider sustainability		
Communication	<u>Actions Already Completed/Ongoing</u> • Regular communication briefing to all staff • Public messaging • Regular briefings and reports to IJB • Objective Connect used as information store for staff • Regular updates on HSCP website	Louise Long / George Barbour	Complete
Staff Engagement	• Understanding the learning • Promoting well being	Staff Partnership Forum / Debbie Maloney	June/July
Staff Wellbeing	• Checks in place to ensure every member of staff is receiving appropriate supervision and support as required • Commission support and trauma training <u>Actions Already Completed/Ongoing</u> • All teams arrange regular team meetings - ongoing • Staff supervision is ongoing • Wellbeing service advertised widely • Online support / coaching available	Sharon McAlees	June/July

ISSUE	DESCRIPTION OF ACTIONS	LEAD	TARGET DATE
	• Clinical Psychology service has been set up to support staff • Risk Assessments • Staff wellbeing questionnaire • Support from Staff Partnership Forum		

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 9

Report To:	**Inverclyde Integration Joint Board**	**Date: 23 June 2020**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/46/2020/AS**
Contact Officer:	**Allen Stevenson**	**Contact No: 715212**
Subject:	**Support to Care Homes COVID19**	

1.0 PURPOSE

1.1 This report is to advise the Integration Joint Board of the actions taken by IHSCP to support Care Homes in Inverclyde during the COVID19 pandemic.

This report is an update to the previous report presented on 12th May 2020 to the Integration Joint Board.

2.0 SUMMARY

2.1 On 11th March 2020 the HSCP, along with the other HSCP's in GG&C, submitted a Hospital Discharge Mobilisation plan.

The focus of the plan was to:

- Facilitate quick and safe discharge from the Acute Sector
- Protect the Care at Home Service and to continue to provide a safe, albeit reduced service
- Sustain Care Homes for the projected loss in income

The plan included securing additional bed capacity in the care home sector through the block purchase of 50 care home beds. The additional cost of these beds will be coded against the COVID19 budget which has been set up within Health and the Council for all COVID related costs.

There has been a drop in care home placements reflecting the overall number of people who have died.

COSLA and the Scottish Government are currently consulting with all partners to determine a way forward to support care homes in the post COVID19 recovery phase. In the interim, joint guidance has been issued by COSLA and Health & Care Scotland regarding sustainability payments which are to apply until the end of June. The payment is to be based on usual care home occupancy levels. Officers are currently calculating the financial implications of this and an update will be provided to the next meeting.

On 17th May 2020 the Government issued new guidance around support and governance of care homes. The letter emphasised the need to monitor and support care homes around 3 key areas:

- Ensure support around workforce to maintain safe staffing levels.
- Infection control.
- Supply of Personal Protective Equipment. (PPE).

The Cabinet Secretary has also directed NHS Boards and Councils to ensure direct oversight of care home standards of care with scheduled meetings to be led by the Nursing Director, Chief Social Work Officer and Chief Officer.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked :

a) To note correspondence from the Cabinet Secretary regarding the arrangements to ensure appropriate clinical support and oversight to care homes and agree process of assurance;
b) To note the continued implementation of the Delayed Discharge Mobilisation Plan to address the pressures presented by the COVID19 pandemic;
c) To note the current arrangement to purchase 50 care home beds for 12 weeks until 15 June 2020 under the National Care Home Contract;
d) To note the current discussions between COSLA and the Scottish Government to determine how to support care home providers in the post COVID19 recovery phase;
e) To note that a future report on care homes, including analysis of the impact of COVID19, will be presented to a future IJB; and
f) To agree provider payment in line with Scottish Government guidance subject to funding being agreed.

Louise Long
Chief Officer

4.0 BACKGROUND

4.1 On 11th March the Scottish Government wrote to all NHS and local authority Chief Executives and IJB Chief Officers requesting submission of mobilisation plans.

4.2 A key element of these plans was to be how partnerships were scaling up general care home bed capacity and what they were doing to reduce delayed discharges to support acute services in tackling COVID19.

4.3 Plans were submitted through the Health Boards to the Scottish Government in late March and weekly updates have been submitted since then. For Inverclyde this included the bulk purchase of 50 additional care home beds from 23rd March for 12 weeks. This plan was subsequently approved by the Scottish Government.

4.4 The decision to purchase the additional 50 care home beds was to:

- Facilitate quick and safe discharge from the Acute Sector;
- Protect the Care at Home Service and to continue to provide a safe albeit reduced service, and sustain Care Homes for the projected loss in income.

4.5 COSLA and the Scottish Government have recognised the issues Care Home Providers will face in the post COVID19 recovery phase in particular in light of the reduced number of care home placements not only in Inverclyde but across Scotland. The principles have been agreed to govern this process and will look at vacancies and additional costs taken on by care home providers during the pandemic. There is a need for greater analysis of the impact on care homes and future sustainability. There will be no change to current arrangements until the Scottish Government agree the mechanism for future payments.

4.6 **Other non-financial support to Care Homes**

In Inverclyde there is an existing partnership approach between providers and the HSCP. The good relationship has allowed a continued high level performance around discharges from hospital.

4.7 Inverclyde HSCP are continuing to support Supporting Care Homes as previously reported/presented to the IJB.

We continue to have daily contact with all care homes as well as a weekly partnership meeting chaired by the Head of Health and Community Care. This allows oversight and quick escalation of any issues or concerns raised by care home providers.

4.8 **Offer of Support to Care Homes**

The HSCP wants to support independent and Third Sector care home providers to protect their staff and residents, ensuring that each person is getting the right care in the appropriate setting for their needs. Officers are working very closely with local care homes to offer any support they require including (but not limited to) the following:

- Appropriate information, guidance and support to safely admit, accept discharges from hospital, and care for patients during the pandemic with direct access to the Public Health Protection team.
- The right information and the right support to care for people within their care home.
- Ensure fair and prompt payment for existing care commitments by working with Commissioners.
- Ensure they have the right equipment and supplies, this includes appropriate Personal Protective Equipment (PPE) for care homes.
- training staff to correctly apply, remove and dispose of equipment safely and

appropriately ensuring that care is provided safely.

- staff receive the right training in donning the equipment, its safe removal (doffing) and disposal so that staff can provide care safely and that they are appropriately trained.
- Psychological support to staff working in care homes.
- Training opportunities and support to all care homes in GGC through Webinars.

4.9 **Testing of Residents in Care Homes**

Scottish Government Guidance has prescribed testing for COVID19 for all residents in care homes as well as key staff. This process will become an ongoing cyclical programme on a yet to be determined timescale. We have currently tested all residents and staff in 14 older people care homes. This led to only 2 care homes being identified as having COVID19 and both were visited by IHSCP officers to have oversight and reassurance that there were no concerns over the homes' performance in terms of infection control, workforce and supply of PPE. Both visits reported very positively on these visits and the findings of HSCP staff.

This testing of potential service users who will be placed into care homes has also extended to admissions from the community where all service users will be tested on admission and isolated for 14 days in line with Scottish Government guidance. This will allow for more confidence on the part of care homes to take admissions in the coming weeks.

Across Scotland all HSCP and Acute Sectors have been asked to look at practical support if staffing numbers in care homes fall below safe levels. This may require deployment of staff to these settings. All care homes in Inverclyde have contingency plans in place to address staff shortage and this option will only be employed if necessary.

Oversight and Support

On 17th May 2020, the Cabinet Secretary issued new guidance around support and clinical governance of care homes. The letter emphasised the need to monitor and support care homes around 3 key areas:

- Ensure support around workforce to maintain safe staffing levels.
- Infection control.
- Supply of Personal Protective Equipment. (PPE).

The Cabinet Secretary has also directed NHS Boards and Councils to ensure direct oversight of care home performance with daily meetings led by the Chief Social Worker Officer, Nursing Director and Chief Officers.

This will include a daily safety huddle to determine levels of risks within care homes around the 3 key areas and determination of the need to escalate these concerns and put in place extra support and if required management and staffing. The Scottish Government has put into place under the COVID Act 2020 powers for Local Authority to take over responsibility of management of any care home as well as the Local Health Nurse Director taking on governance and responsibility for this care in each care home.

Inverclyde HSCP have established a daily Safety Huddle and will submit a daily Sit Rep report which will inform the weekly meeting chaired by the Chief Officer and attended by the Chief Social Work Officer, Lead Nurse, Head Health and Community Care, Clinical Director and Public Health who will determine levels of risk and requirement to escalate support required to any care home in Inverclyde. (See appendix)

4.10 **Current Situation**

The purchase of extra beds began on Monday 23rd March 2020. The best/worst case scenario has not as yet materialised and contingency preparations put in place have been successful in managing the demand and pressures on a reduced service.

4.11 Though it was never envisaged that we would use 100% of the beds this is lower than expectations. Officers are reviewing the arrangements for additional bed provision in conjunction with care home providers and will amend bed commitments and forecasts accordingly as the pandemic continues.

4.12 The recent information released by National Records of Scotland has sadly confirmed that Inverclyde has been disproportionately affected by the disease. Whilst the most recent signs are that the spread of the disease and the number of deaths arising from COVID19 is slowing down the number of deaths being registered within Inverclyde remains higher than normal.

4.13 Deaths in care homes have increased during the pandemic. In April 2019 we experienced 22 deaths compared to 74 in April this year. Over a wider period between 18th March 2020 and 21st May 2020 (inclusive), Scottish Government Data shows there have been a total of 120 deaths in Inverclyde Care Homes. Of these deaths, 29% (35) were COVID19 related.

5.0 PROPOSALS

5.1 Though data suggests we may have passed the peak of cases there is limited understanding about current pressures, how long these will last and the medium term impact on Health and Social Care resources. It is likely that the recovery process will take many months or years.

5.2 The impact of this increase in vacancies will have a drastic effect on the sustainability of the care home sector and the potential reduction of income to a number of care homes may result in their becoming financially unsustainable and therefore result in care homes closing. This in turn leads to a risk of not having the necessary capacity in this sector for the needs of a growing elderly and frail population now and in future years.

A separate paper has been prepared looking at additional measures which can be put in place to provide additional financial assurance and support to the care home sector taking into account the Joint Guidance issued to Councils on 21 May.

The IHSCP are currently building on existing processes and structures to enact the Cabinet Secretary's guidance around oversight and support to care homes issued on 17th May 2020. Robust systems are in place to support Care Homes.

6.0 IMPLICATIONS

Finance

6.1 The cost of these beds for only the contracted 12 weeks would be £454k. COSLA is working with HSCPs to agree a Scotland-wide position on how we support the care home sector.

Financial Implications:

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report	Virement From	Other Comments
IJB COVID	Care Home	19/20 20/21	£454K		It is planned that any costs incurred will be

	Beds				fully funded by the Scottish Government via LMP returns.

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact	Virement From (If Applicable)	Other Comments
N/A					

LEGAL

6.2 There no specific legal implications arising from this report.

HUMAN RESOURCES

6.3 There are no specific human resources implications arising from this report.

EQUALITIES

6.4 Has an Equality Impact Assessment been carried out?

	YES
X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

6.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	Report relates to older people
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	This report is specific to older people
People with protected characteristics feel safe within their communities.	n/a
People with protected characteristics feel included in the planning and developing of services.	n/a
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	Staff are knowledgeable of needs for care homes
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

6.5 The changes under the COVID Act 2020 has placed responsibility for the governance of care provider by Care Home providers under the Health Board's Lead Nurse for a temporary period.

7.0 NATIONAL WELLBEING OUTCOMES

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	Maintain the viability and quality of care in Care Homes to support this indicator
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	Maintain the viability and quality of care in Care Homes to support this indicator
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Maintain the viability and quality of care in Care Homes to support this indicator
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Maintain the viability and quality of care in Care Homes to support this indicator
Health and social care services contribute to reducing health inequalities.	Maintain the viability and quality of care in Care Homes in Inverclyde to support this indicator
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	Maintain the viability and quality of care in Care Homes to support this indicator
People using health and social care services are safe from harm.	Maintain the viability and quality of care in Care Homes to support this indicator
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Maintain the viability and quality of care in Care Homes to support this indicator
Resources are used effectively in the provision of health and social care services.	Maintain the viability and quality of care in Care Homes to support this indicator

8.0 DIRECTIONS

8.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	X

9.0 CONSULTATION

9.1 The report has been prepared by the Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP. It is based on contact with Local Care Providers Scottish Care and other HSCP

in the GGC Area through the Care Home Tactical Group.

10.0 BACKGROUND PAPERS

10.1 Appendix 1

DRAFT CARE HOMES

Appendix 1

Local Daily Safety Huddle

Each partnership will group care homes into geographical are to have a manageable number of care homes for a daily huddle and make daily calls with every care home to collect information and offer support – they collect data and update the template format .This template will be analysed at a daily safety huddle by Nursing, Public Health, Social Work and Commissioning and Clinical Director and each care home is at that stage categorised red, amber or green. The categorisation scheme is based on risk linked to staffing, quality of care, testing, infection control measures, COVID19 cases and deaths.

Each safety huddle analyses information and use this to offer feedback, professional leadership, support and guidance to each care home where required, with follow up by lead HSCP Manager or appropriate professional lead. The categorisation of red or amber could lead to a multi-disciplinary visit from Nursing, Social Work and Public Health staff and if appropriate the Care inspectorate could also be involved. The information from the visit or feedback from the huddle should be used to provide feedback/advice to care home. This should be logged and actions followed up by monitoring via Care Inspectorate.

Escalation of issues from visits or any other triggers is fed into the daily Chief Officer Tactical Group meeting and from there appropriate action is taken and Chief Executives of the Council and NHS are informed.

Local Weekly Meeting

Public Health lead a weekly meeting attended by the HSCP commissioning manager, Chief Nurses, Clinical Directors, CSWO and the Care Inspectorate to analyse activity from across the week, including all aspects of COVID19, infection control, training and support.

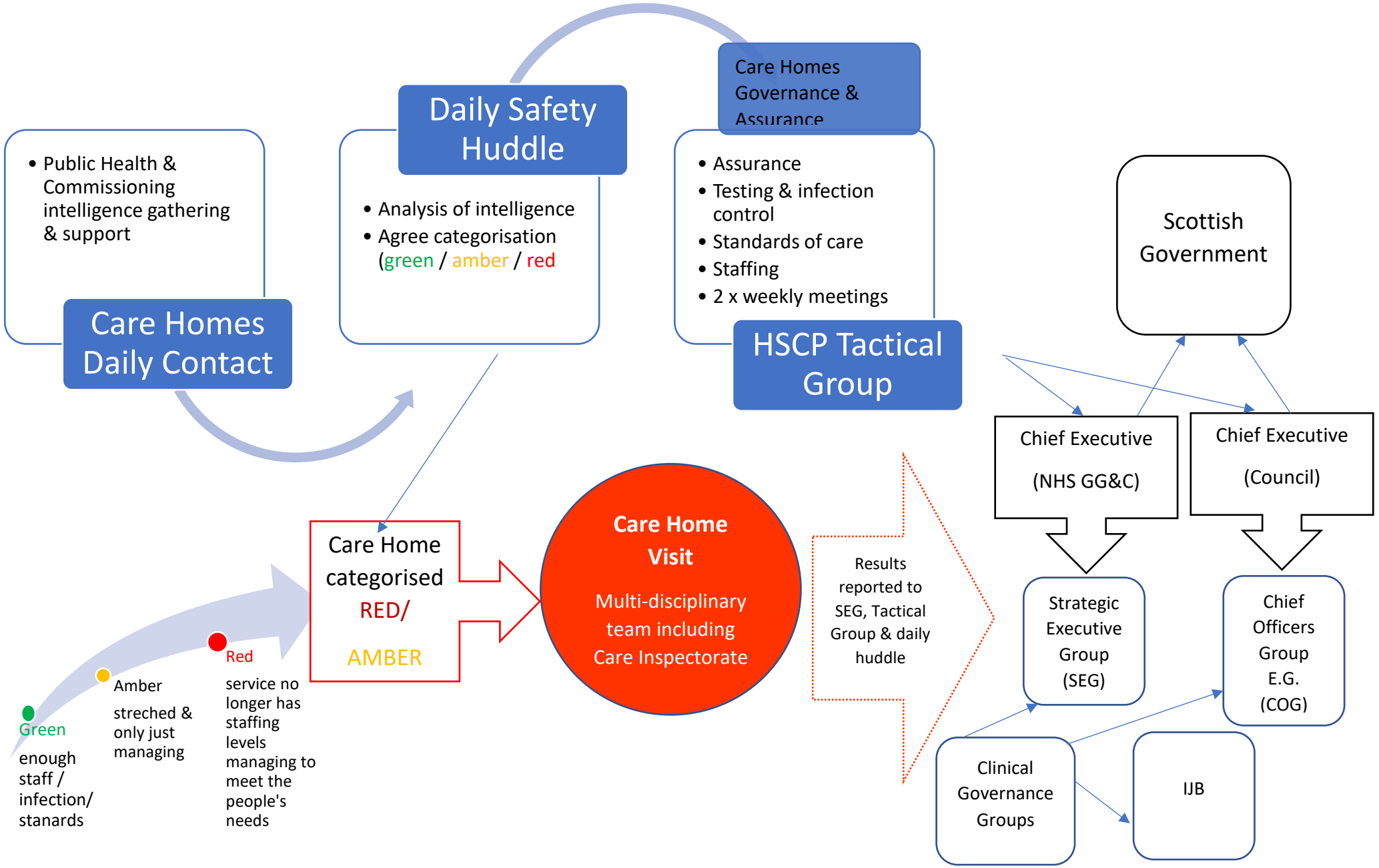
- Each care home is classified.
- The return to Scottish Government agreed.
- The Strategic Executive Group/HSCP Tactical Group and Care Home Governance Assurance Group receive a composite report of all classifications of care homes across all of GGC.

GGC Care Home Governance and Assurance Group

The GGC Care Home Group maintains oversight of support, testing, infection control, staffing and care standards for care homes within GGC. This group reports in to the Chief Officer Tactical Group which in turn feeds into SEG the LA Chief Exec and respective IJBs. Membership is as follows:

- Led by Director of Nursing and Public Health Director
- Chaired by a Chief Officer on behalf of Chief Officer
- CSWO representative
- 6 HSCP representatives
- Local authority service manager
- Scottish Care
- Clinical Directors x 2
- Care Inspectorate representative
- Chief Nurse x2

It will develop updated guidance on care homes for dissemination across GGC to support consist high quality care


Care Homes Daily Contact
• Public Health & Commissioning intelligence gathering & support
Daily Safety Huddle
• Analysis of intelligence
• Agree categorisation (green / amber / red
Care Homes Governance & Assurance
HSCP Tactical Group
• Assurance
• Testing & infection control
• Standards of care
• Staffing
• 2 x weekly meetings
Scottish Government
Chief Executive (NHS GG&C)
Chief Executive (Council)
Care Home categorised RED/ AMBER
Green
enough staff / infection/ stanards
Amber
streched & only just managing
Red
service no longer has staffing levels managing to meet the people's needs
Care Home Visit
Multi-disciplinary team including Care Inspectorate
Results reported to SEG, Tactical Group & daily huddle
Strategic Executive Group (SEG)
Chief Officers Group E.G. (COG)
Clinical Governance Groups
IJB

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date: 23 June 2020**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/44/2020/LL**
Contact Officer:	**Chief Financial Officer Inverclyde Health & Social Care Partnership**	**Contact No: 01475 715212**
Subject:	**UNSCHEDULED CARE COMMISSIONING PLAN**	

1.0 PURPOSE

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

2.0 SUMMARY

2.1 Progress has been made by all six HSCPs, the Acute Services Division and the NHS Board to develop a GG&C-wide strategic commissioning plan as part of the Moving Forward Together programme. This report updates the IJB on the development of the draft plan.

2.2 The draft Unscheduled Commissioning Plan will be presented to all six IJBs for consideration, recognising that further work is required on key aspects as outlined below.

2.3 The Unscheduled Care programme contributes to all nine National Health and Wellbeing Outcomes and in particular is fundamental to the delivery of Outcome 9: that resources are used effectively and efficiently in the provision of health and social care services.

2.4 One key aspect of the Unscheduled Care work is learning from the pandemic, during which we have seen a fall in unscheduled care activity. While the bulk of the draft Plan is still relevant, the learning from what has worked well during the pandemic will be incorporated in the key actions in the final version. This learning is outlined in Section 6.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to:

a) accept the attached draft Unscheduled Care Commissioning Plan for NHS Greater Glasgow & Clyde;
b) note the further work underway to finalise the plan including the planned engagement process, and

c) note that a further update and a finalised plan will be brought to the IJB later in the year.

Louise Long
Chief Officer

4.0 BACKGROUND

4.1 Further work has been undertaken by all six HSCPs in GG&C to develop a system-wide strategic commissioning plan in partnership with the NHS Board and Acute Services Division and in line with the IJB's Strategic Plan. The draft plan attached builds on the GG&C Board-wide Unscheduled Care Improvement Programme (http://www.nhsggc.org.uk/media/245268/10- unscheduled-care-update.pdf.) and is integral to the Board-wide Moving Forward Together programme (https://www.nhsggc.org.uk/media/251904/item-10a-paper- 18_60-mft-update.pdf).

4.2 A draft plan is presented to the IJB for consideration recognising that further work is required on key aspects as outlined below.

5.0 DRAFT UNSCHEDULED CARE COMMISSIONING PLAN

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

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

5.3 The draft outlines how we plan to support people better in the community and develop alternatives to hospital care so that we can safely reduce the over-reliance on unscheduled care services. The draft describes the delivery of an integrated system of health and social care services that we believe will better meet patients' needs. While this is a strategic plan outlining improvements for patients to be implemented over the next five years, the plan also includes some immediate actions that can be delivered in the short term in response to current imperatives.

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

Early intervention and prevention of admission to hospital to better support people in the community and includes actions on:

- implementing anticipatory care plans within specific patient groups; e.g. COPD, residential care home clients etc.;
- working with GPs through the national frailty collaborative to better manage frailty within the community;
- working with care homes to reduce hospital admissions;
- working with the Scottish Ambulance Service (SAS) to reduce the number of falls conveyed to hospital as part of a wider falls prevention strategy;
- continuing to develop the palliative care fast track service; and,
- extending the community respiratory service to provide a service over weekends.

Improving the interface between primary and secondary services to ensure our health and social care systems work smoothly and efficiently in the patients

interests:

- improved information sharing
- reducing emergency department attendances
- understanding public attitudes to A&E
- focus on right service right place through improved patient advice
- further development of minor injuries units
- focus on frequent attenders
- standardised approach to mental health A&E presentations
- GP assessment units at each main hospital site located close to emergency departments

Improving hospital discharge and better supporting people to transfer from acute care to community supports and includes actions on:

- expansion of the hospital discharge team;
- intermediate care improvement programme designed to reduce length of stay and improve the number of people returning home;
- additional intermediate care capacity introduced as part of the winter planning arrangements;
- additional Red Cross transport capacity purchased to assist with hospital discharge; and,
- continued robust performance management of delays.

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

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

5.7 Progress on these actions is reported regularly to the HSCP Unscheduled Care Planning Group and performance is reported in the quarterly performance reports to the IJB and the IJB Finance, Audit and Scrutiny Committee.

6.0 LEARNING FROM THE PANDEMIC

6.1 Unscheduled care services have seen dramatic changes as a result of the COVID-19 pandemic. As well as an unprecedented drop in A&E attendances, emergency admissions and delays, there have also been significant changes in primary and secondary care services. These changes include the opening of COVID-19 Assessment Centres, GPs operating by telephone triage, and new COVID-19 pathways introduced in secondary care. These changes, together with lockdown measures and a strong public messaging and information campaign, have impacted on unscheduled care activity. It is important, therefore, going forward that we learn lessons from what has worked well during the pandemic and might be followed through as part of our system-wide approach to improving patient services and managing demand effectively.

6.2 Examples of what has worked well and, subject to further testing, could be included in our Unscheduled Care Commissioning Plan include:

- the introduction of the Greater Glasgow and Clyde-wide community respiratory service to improve the management of COPD in the community and reduce hospital admissions.
- building on our approach to Shielding to improve community support to vulnerable patients with specific conditions, including working with the third

sector, and integrating this with our approach to Anticipatory Care Plans
- embedding actions to improve delays so this becomes standard practice across Greater Glasgow and Clyde.
- learning from the operation of the Community Assessment Centres to introduce an appointment-based model in GP assessment units with same day and next day appointments.
- aligned to this, accelerating the introduction of appointment based 'hot clinics' for specific conditions as part of an integrated primary/ secondary care pathway.
- refreshing and updating our re-direction protocol to coincide with the re-opening of Minor Injury Units and a wider public awareness-raising campaign on Unscheduled Care services.

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

7.0 NEXT STEPS

7.1 Key next steps include:

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

7.2 The plan will be subject to a period of **engagement** with key stakeholders and clinicians in primary and secondary care over the coming months. Key stakeholders include SAS, NHS24, the third and independent sectors, GPs and other primary care contractors, acute clinicians and staff and neighbouring HSCPs/NHS Boards. The draft will be discussed at various events and fora across GG&C. The engagement process will take place while the draft is being considered by the six IJBs in GG&C and by the Moving Forward Together programme. A period of public / patient engagement is planned in late summer and will be co-ordinated with other public engagement exercises to ensure a joined up and consistent message is given publicly.

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

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

- emergency admissions;
- acute unscheduled hospital bed days;
- A&E attendances; and,
- bed days lost due to delayed discharges.

8.0 IMPLICATIONS

8.1 **FINANCE**

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

8.2 The IJB's budget for 2020/21 includes a "set aside" amount for the commissioning of acute hospital services within scope (e.g. accident & emergency services). This is currently budgeted to be £23.956m for Inverclyde.

8.3 The draft plan includes a financial framework (section 8) to support delivery of the proposals in the plan. Work to identify the annual investment over the life of the plan is in hand. A finalised financial plan will be incorporated in the final plan to be reported to the IJB in September 2020.

8.4 Until this is complete only aspects of the plan which can be funded within existing budgets will be progressed.

LEGAL

8.5 The integration scheme for the IJB includes specific responsibilities for the strategic planning of certain acute hospital services.

HUMAN RESOURCES

8.6 There no specific human resources implications arising from this report.

EQUALITIES

8.7 Has an Equality Impact Assessment been carried out?

	YES
X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

8.7.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	None

Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

8.8 There no clinical or care governance implications arising from this report.

8.9 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	None
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	None
Health and social care services contribute to reducing health inequalities.	None
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None
People using health and social care services are safe from harm.	None
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	None
Resources are used effectively in the provision of health and social care services.	None

9.0 DIRECTIONS

9.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	X

10.0 CONSULTATION

10.1 The report has been prepared following consultation across the 6 GG&C IJBs and NHS GG&C and after due consideration with relevant senior officers in the HSCP.

11.0 BACKGROUND PAPERS

11.1 None.

NHS GREATER GLASGOW AND CLYDE
HEALTH AND SOCIAL CARE PARTNERSHIPS

D R A F T

Moving Forward Together

The challenge is change

D R A F T

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

March 2020

SUMMARY

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

KEY ACTIONS

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

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

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

CONTENTS

List of tables and figures

1. INTRODUCTION

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

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

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

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

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

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

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

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

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

What is unscheduled care?

1.10 Unscheduled care has been defined as:

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

Integration Joint Boards' responsibilities

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

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

- accident and emergency services provided in a hospital.

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

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

National picture

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

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

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

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

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

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

This draft plan

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

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

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

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

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

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

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

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

[8] https://www.nhsggc.org.uk/about-us/digital-as-usual/digital-strategy-outlook-2018-2022/

[9] https://www.nhsggc.org.uk/media/250803/item-12-primary-care-improvement-plans-18-49.pdf

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

[11] https://glasgowcity.hscp.scot/strategic-and-locality-plans

2. WHY WE NEED CHANGE

Introduction

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

Changes in Demand

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

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

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

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

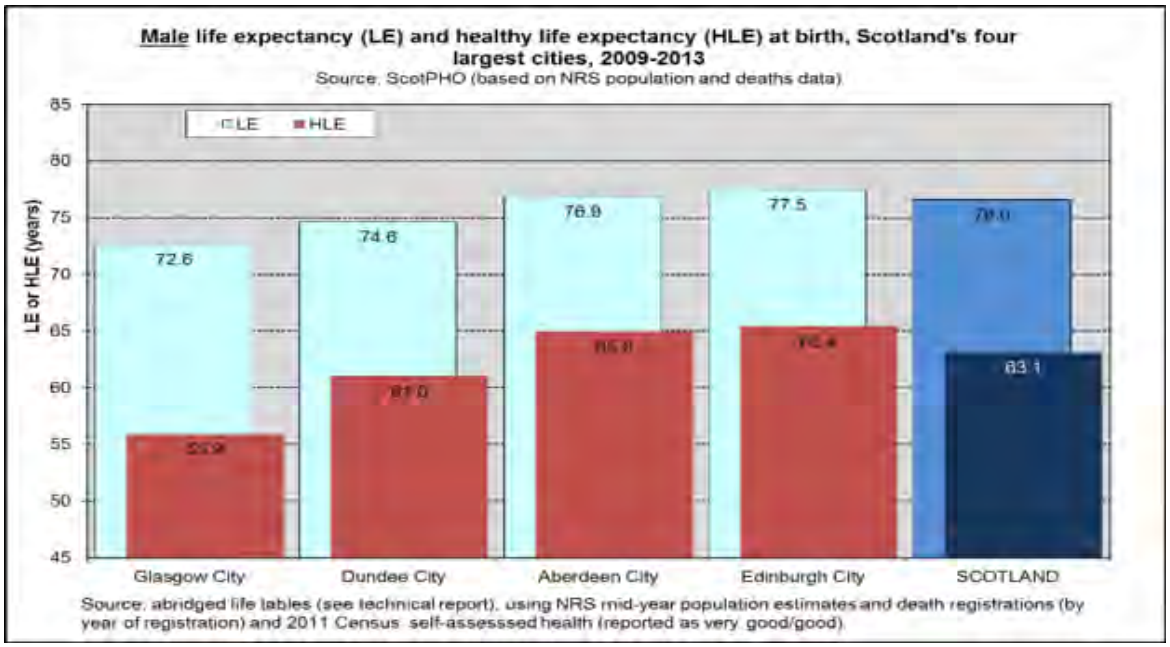
[13] https://www.gov.scot/publications/scottish-index-multiple-deprivation-2020/

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

Changes in our population

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

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

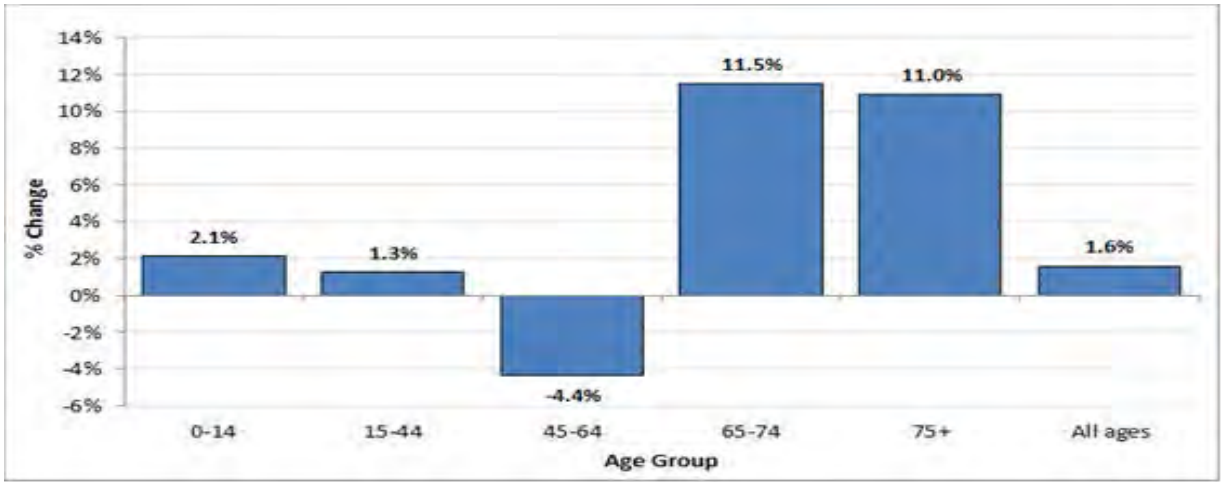


2.5 In addition it is projected that over the next ten years to 2030 in Greater Glasgow & Clyde we will see a 24% increase in the number of people aged over 65 and a 32% increase in the number of people aged over 90. There are also more immediate increases over the next five year with a projected 11%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

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

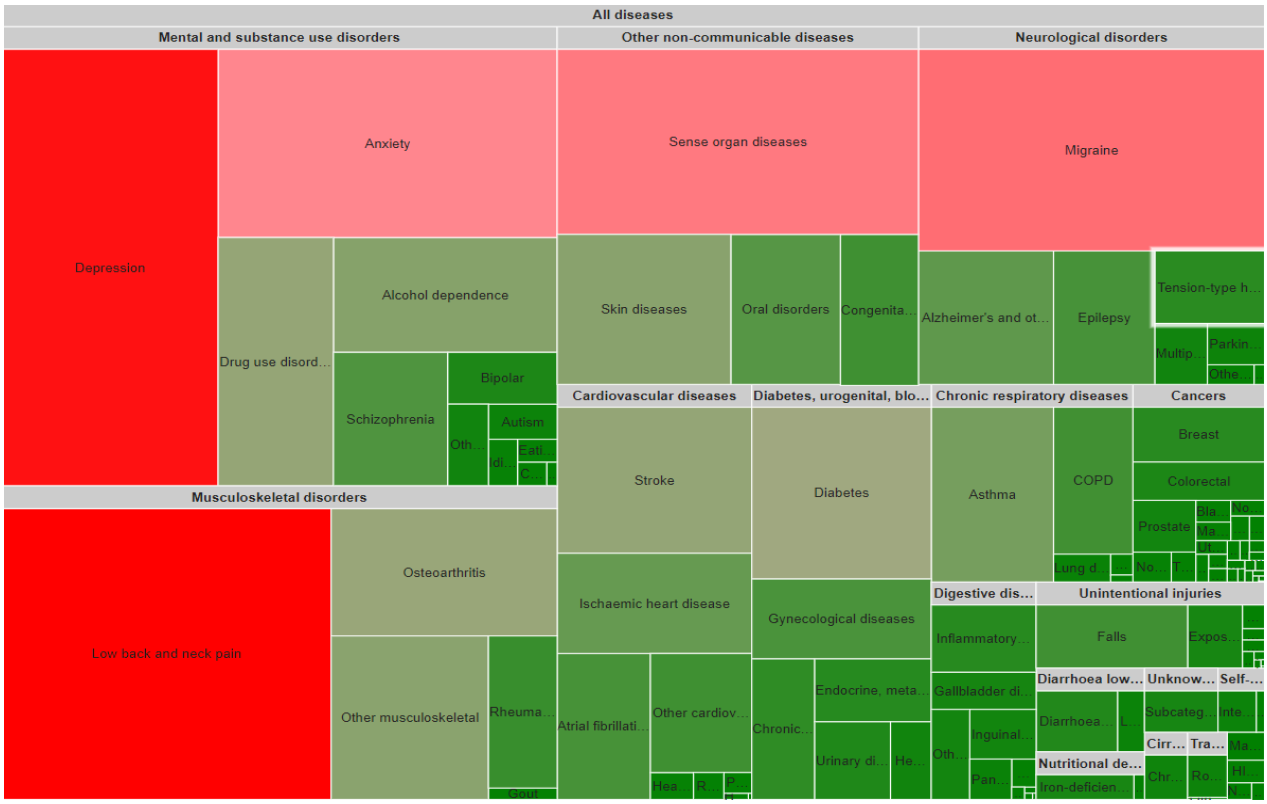
[16] http://www.understandingglasgow.com/indicators/health/trends/male_healthy_life_expectancy/scottish_cities/males

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



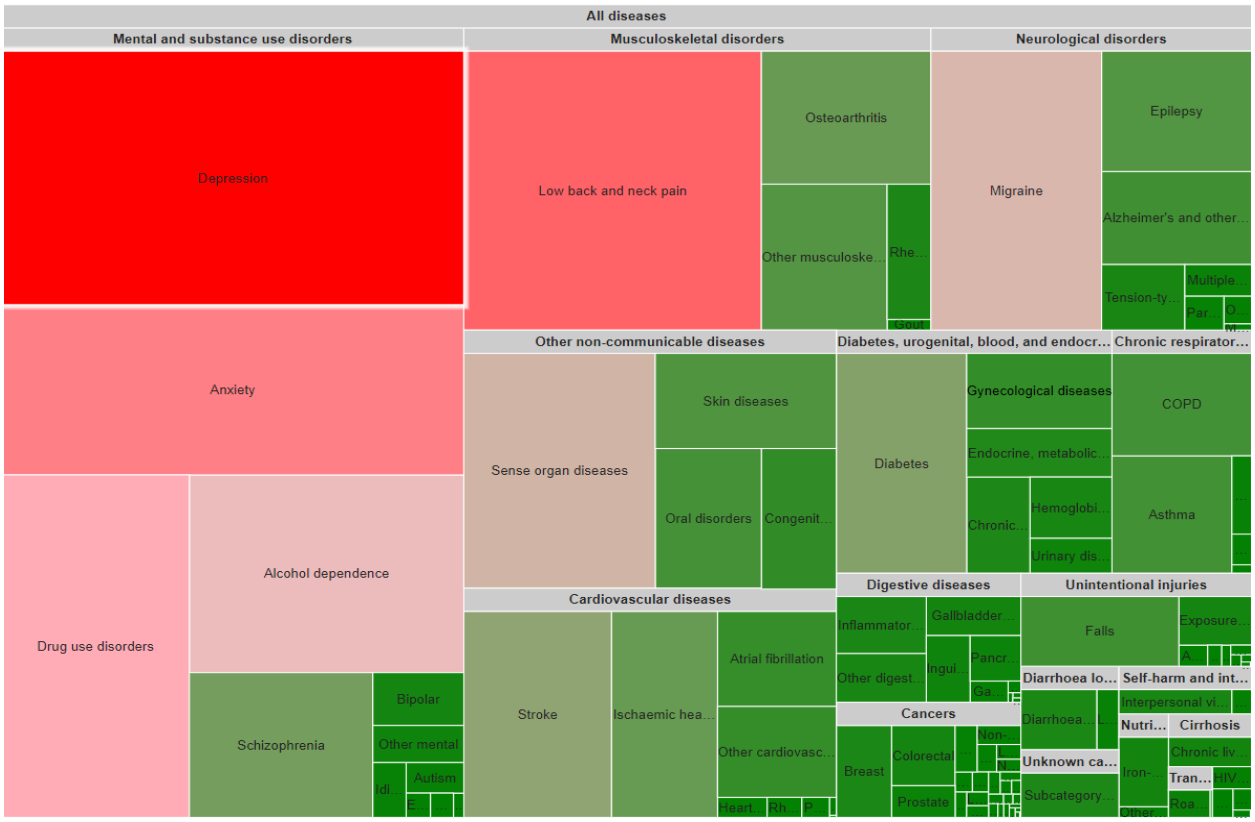
2.6 We can also look at the profile of disease in our population and while this shows considerable changes in the causes of ill health from ten years ago, it also shows differences within our population. The figure 3 below shows the burden of chronic illness and disability in the population as a whole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

Figure 3 – Chronic illness and disability all Scotland



Source: ISD

Figure 4 – Chronic disease and disability Scotland poorest 10%



Source: ISD

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

Understanding Current Trends[17]

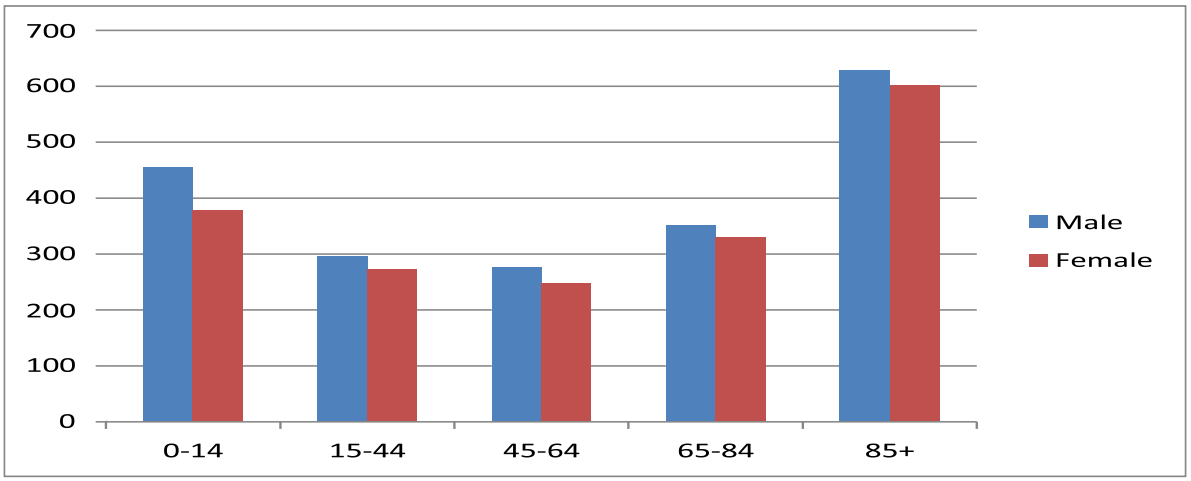
2.8 The current levels of unscheduled care activity in GG&C are unprecedented, and have been driven by demographic changes and the health of our population.

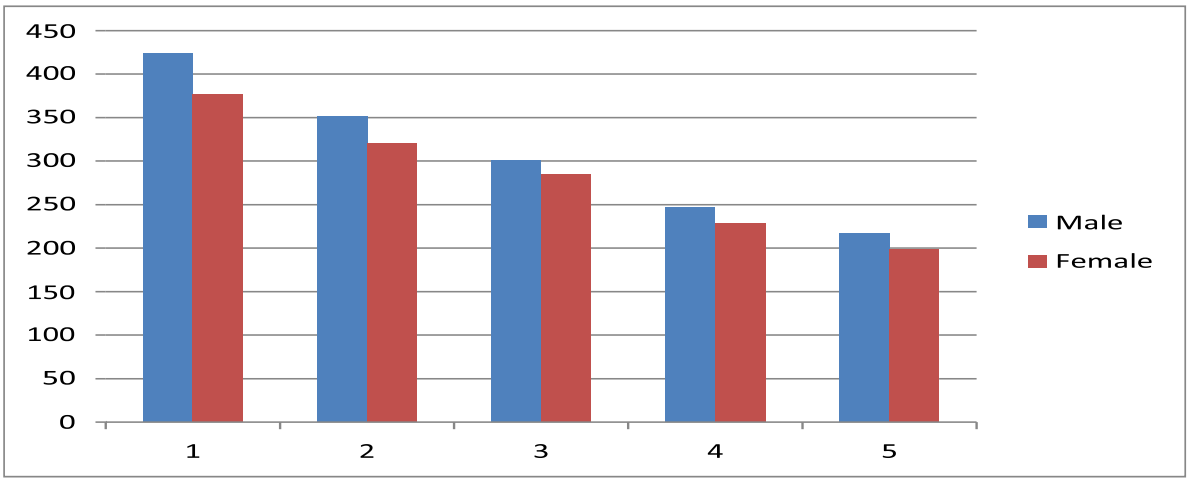
2.9 In 2018/19 there were a total of 517,730 unscheduled care attendances in secondary care. This includes attendances at emergency departments (EDs), GP assessment units (AUs) and minor injury units (MIU). This is a 4.3% increase on total attendances in 2017/18. Of these attendances 448,803 were GG&C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

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

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

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





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

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

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

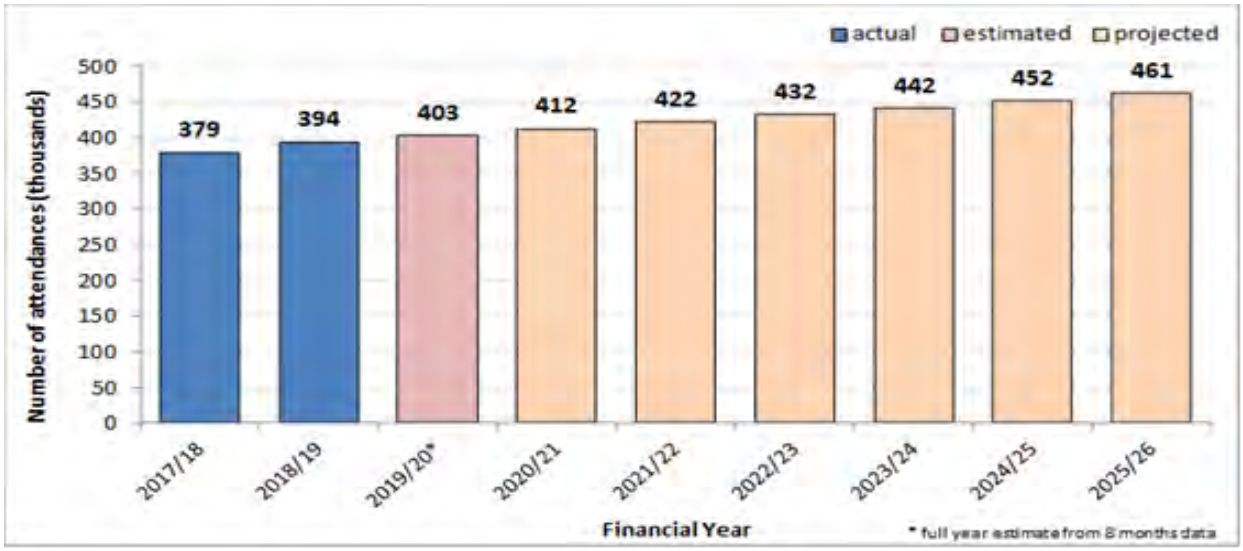
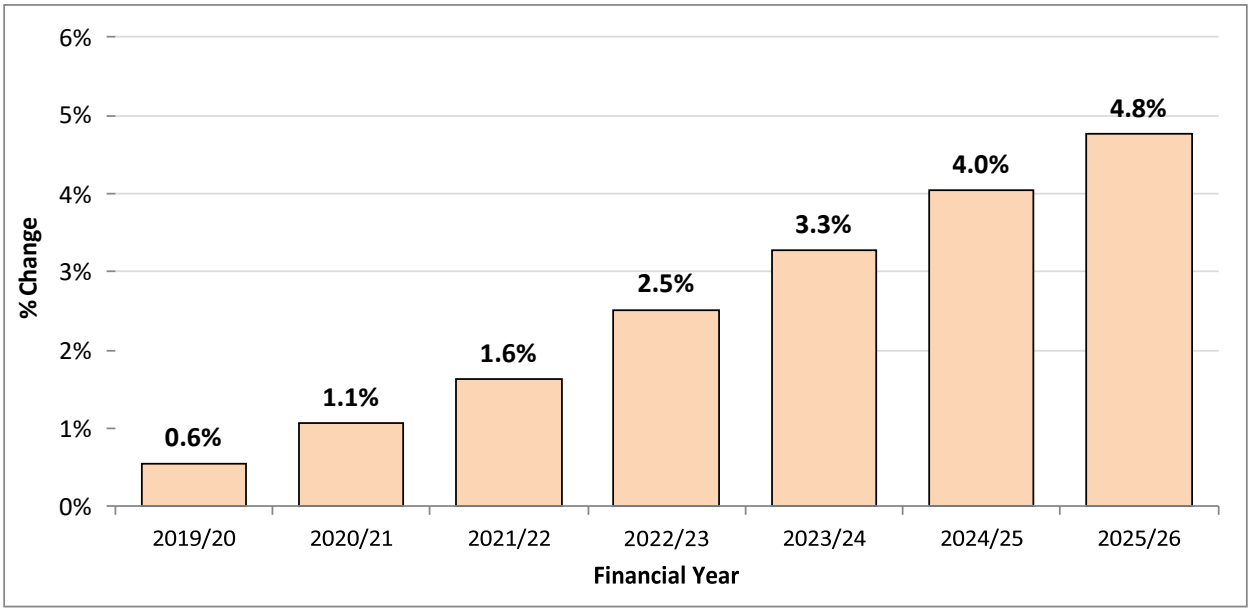


Figure 7: Projected percentage increase in emergency admissions from latest year 2018/19



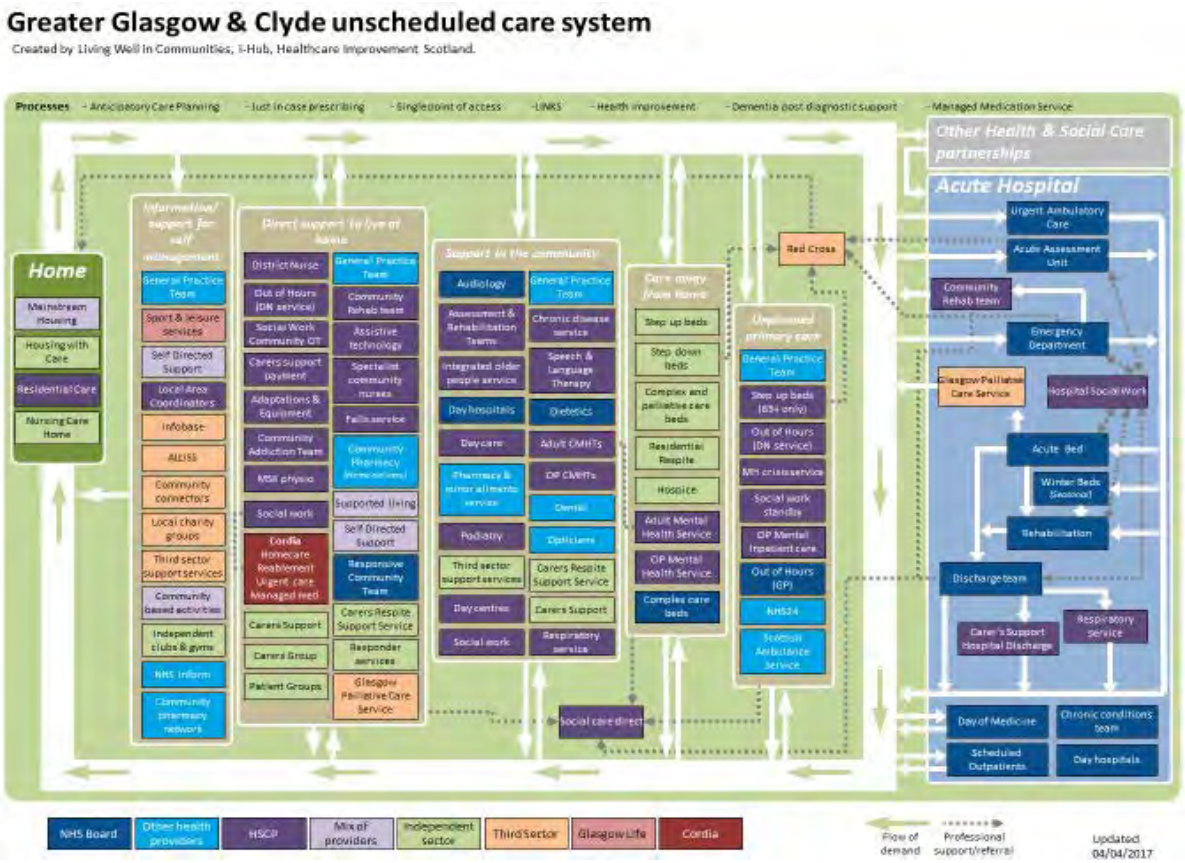
2.12 Unscheduled care is not just a secondary or acute care issue. Unscheduled care attendances also occur within primary care although data on this is not as readily available. We do however have data on GP out of hours activity (OOH). In 2018/19 there were 219,985 OOH consultations, at a rate of 187.2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

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

Unscheduled care system

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

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



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

[19] Chart produced by iHub and reproduced with thanks

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

Primary Care

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

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

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

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

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

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

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

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

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

Out of Hours Redesign

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

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

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

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

GP Out of Hours (OOHs)

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

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

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

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

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

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

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

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

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

Public Health Strategy

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

2.29 The strategic objectives of the strategy are to:

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

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

Summary

2.30 The key points from this section are:

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

3. OUR VISION

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

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

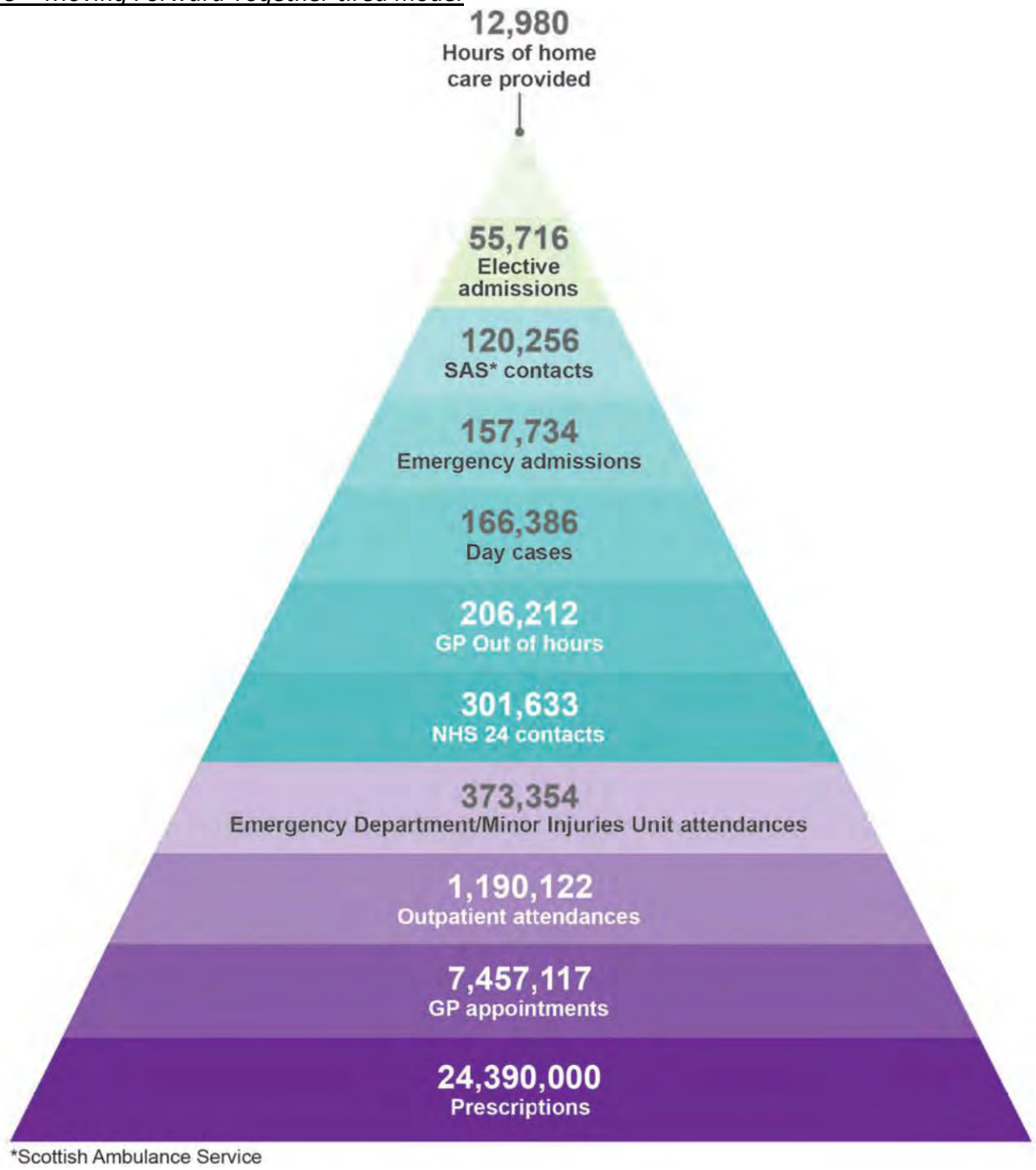
> ***"Our approach … should ensure people are admitted to hospital only when it is not possible or appropriate to treat them in the community. Admissions should be reduced whenever alternatives could provide better outcomes and experiences.***
>
> ***We should develop our system wide approach to unscheduled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

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

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

3.3 This can be illustrated in the model shown below.

Figure 9 – Moving Forward Together tired model



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

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

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

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

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

4. CHANGING THE BALANCE OF CARE

Introduction

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

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

Long term direction

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

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

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

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

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

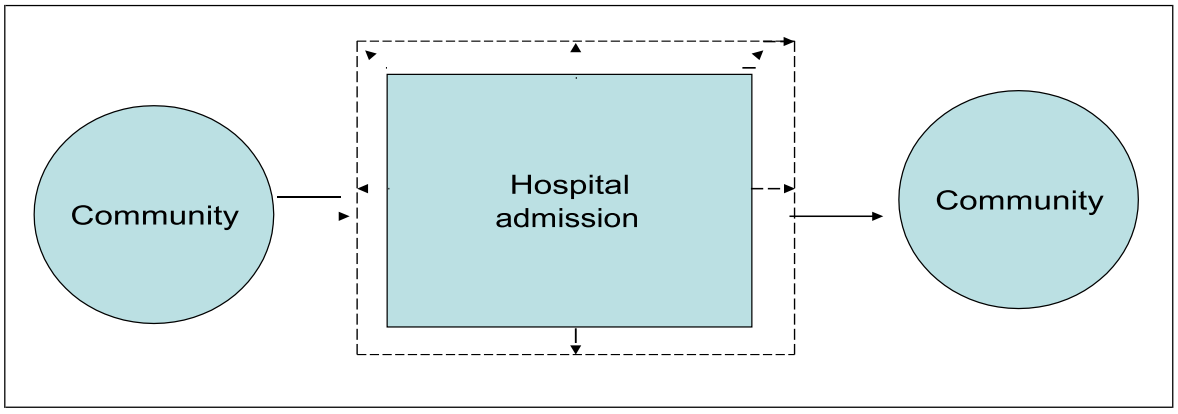
Our priorities

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

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

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

Figure 10 – current system of care



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

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

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

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

5. PREVENTION AND EARLY INTERVENTION

Introduction

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

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

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

Anticipatory care planning

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

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

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

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

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

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

Falls prevention

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

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

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

Frailty

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

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

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

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

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

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

<u>Carer support</u>

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

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

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

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

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

Primary care based community links workers

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

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

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

Avoidable admissions[35]

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

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

- COPD & pneumonia
- sepsis
- cerebral infarction

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

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

Table 1 – main reasons for hospital admission 2018/19

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

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

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

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

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

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

up and support.

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

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

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

Hospital at Home

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

Alternatives to admission

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

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

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

2020/21.

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

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

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

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

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

Reducing admissions from care homes

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

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

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

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

Summary

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

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

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

6. PRIMARY AND SECONDARY CARE INTERFACE

Introduction

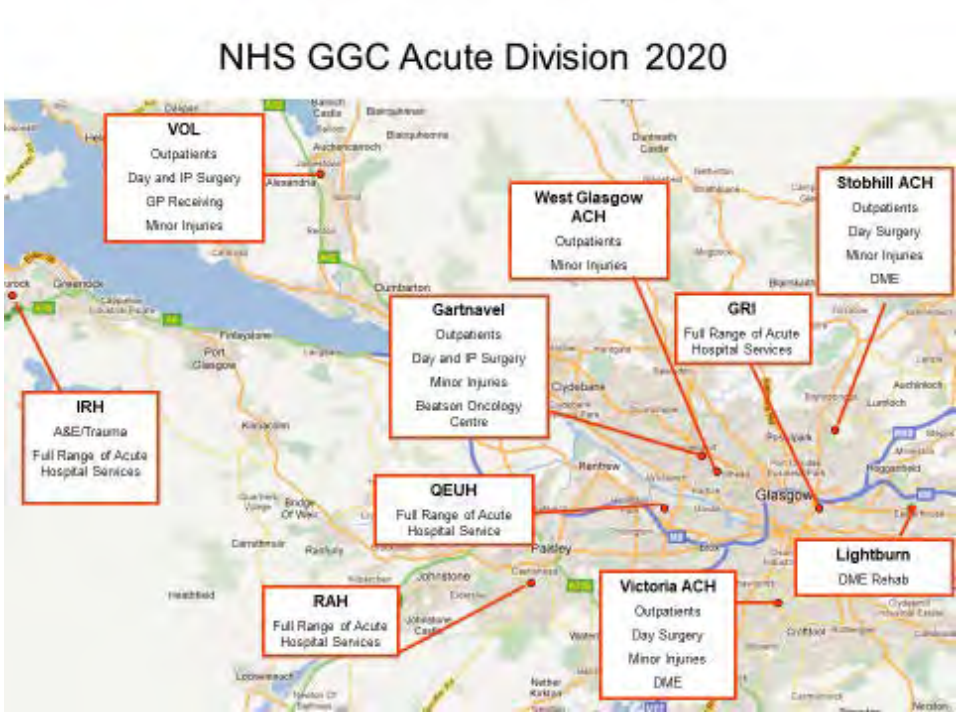
6.1 The interface between primary care, where most patients are seen, and secondary or acute hospital care, where patients attend for specialist treatment and investigations, is important in delivering a quality service to patients. It is in everyone's interest that the communications and links between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

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

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

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

Figure 11 – main acute hospital sites in GG&C



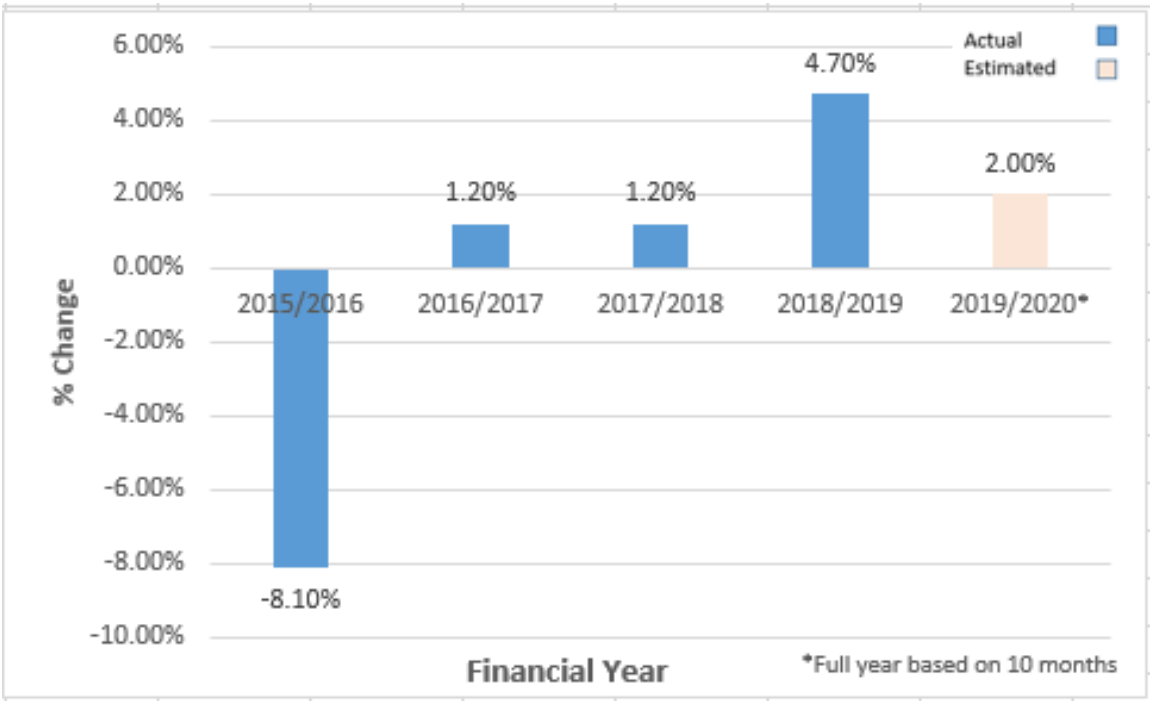
Information sharing

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

Emergency department attendances

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

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



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

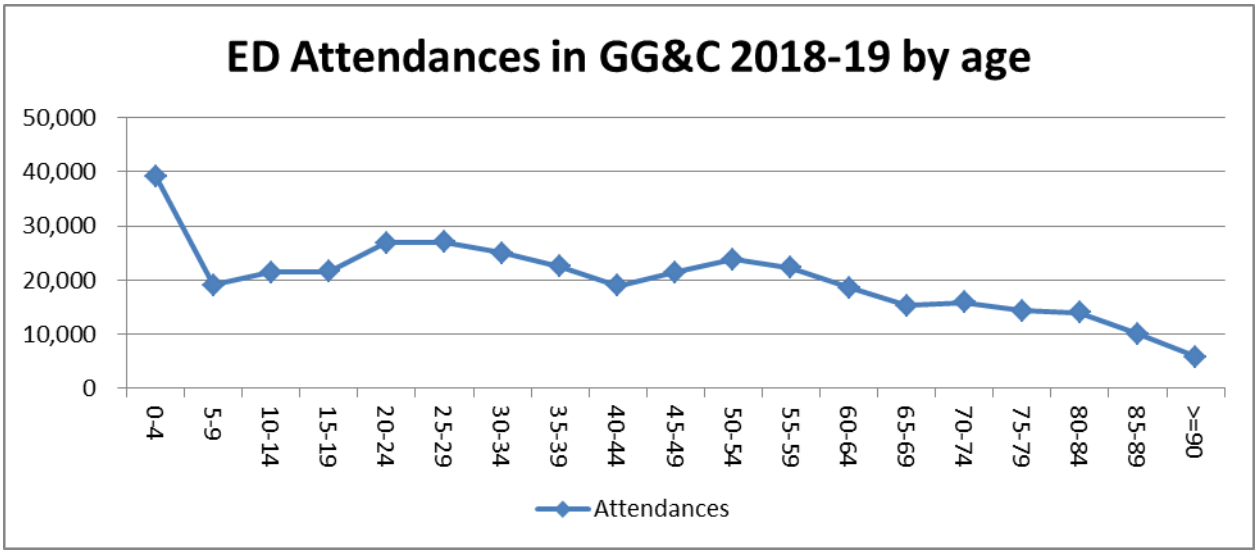
Table 2 – Emergency attendances and 4 hour target – GG&C

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

6.7 Analysis also shows that:

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

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



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

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

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

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

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

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

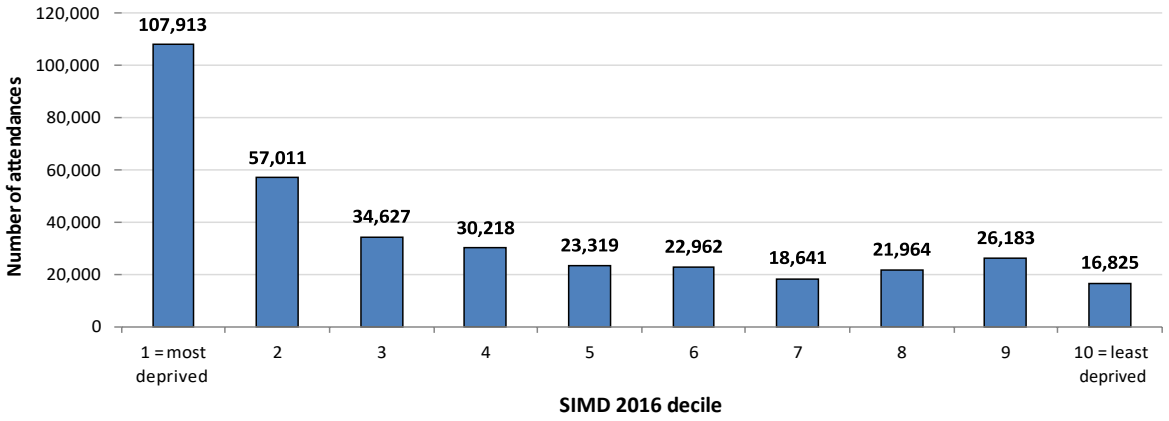
- in 2018/19, on average 58% of attendees referred themselves to ED while 8% were referred by a GP;

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

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

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

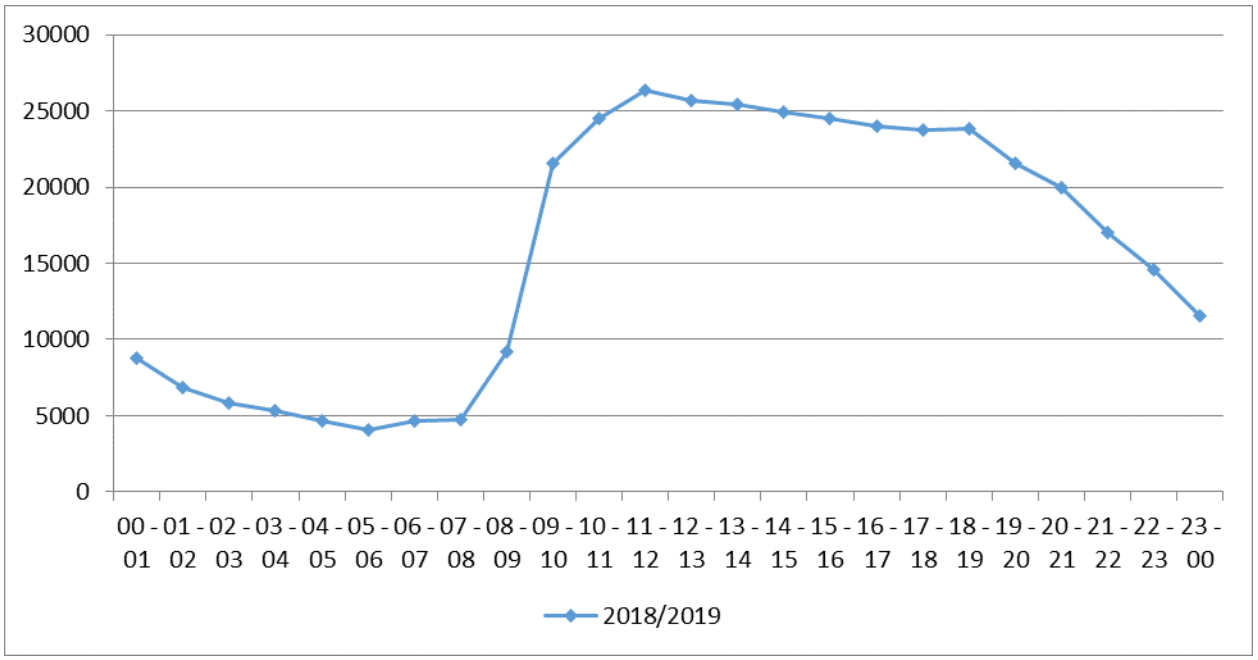
Figure 14 - attendances at all emergency departments in NHS GG&C (2018/19) by SIMD



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

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

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



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

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

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

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

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

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

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

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

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

Public attitudes to A&E

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The challenge is change

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

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

Patient advice - right service right place

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

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

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

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

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

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

Table 9 – potential impact of re-direction

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

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

Minor injuries

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

Table 10 – MIU attendances

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

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

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

Frequent attenders at Emergency Departments

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

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

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

Mental Health

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

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

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

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

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

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

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

GP assessment units

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

Table 11 – GP referrals to assessment Units

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

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

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

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

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

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

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

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

Advice to secondary care clinicians

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

Day of care survey

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

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

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

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

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

Length of stay

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

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

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

* - denotes small number of spells

Source: NSS Discovery dashboard

Notes:

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

Numerator: Total LOS (days)

Denominator: Number of spells

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

Consultant geriatricians and GPs

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

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

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

Summary

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

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

7. IMPROVING HOSPITAL DISCHARGE

Introduction

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

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

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

Improving discharge

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

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

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

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

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

Discharge process

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

7.8 Key to a successful discharge is:

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

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

Discharges before 12.00 noon

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

Intermediate care

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

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

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

Adults with Incapacity (AWI)

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

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

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

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

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

Improving Delayed Discharges

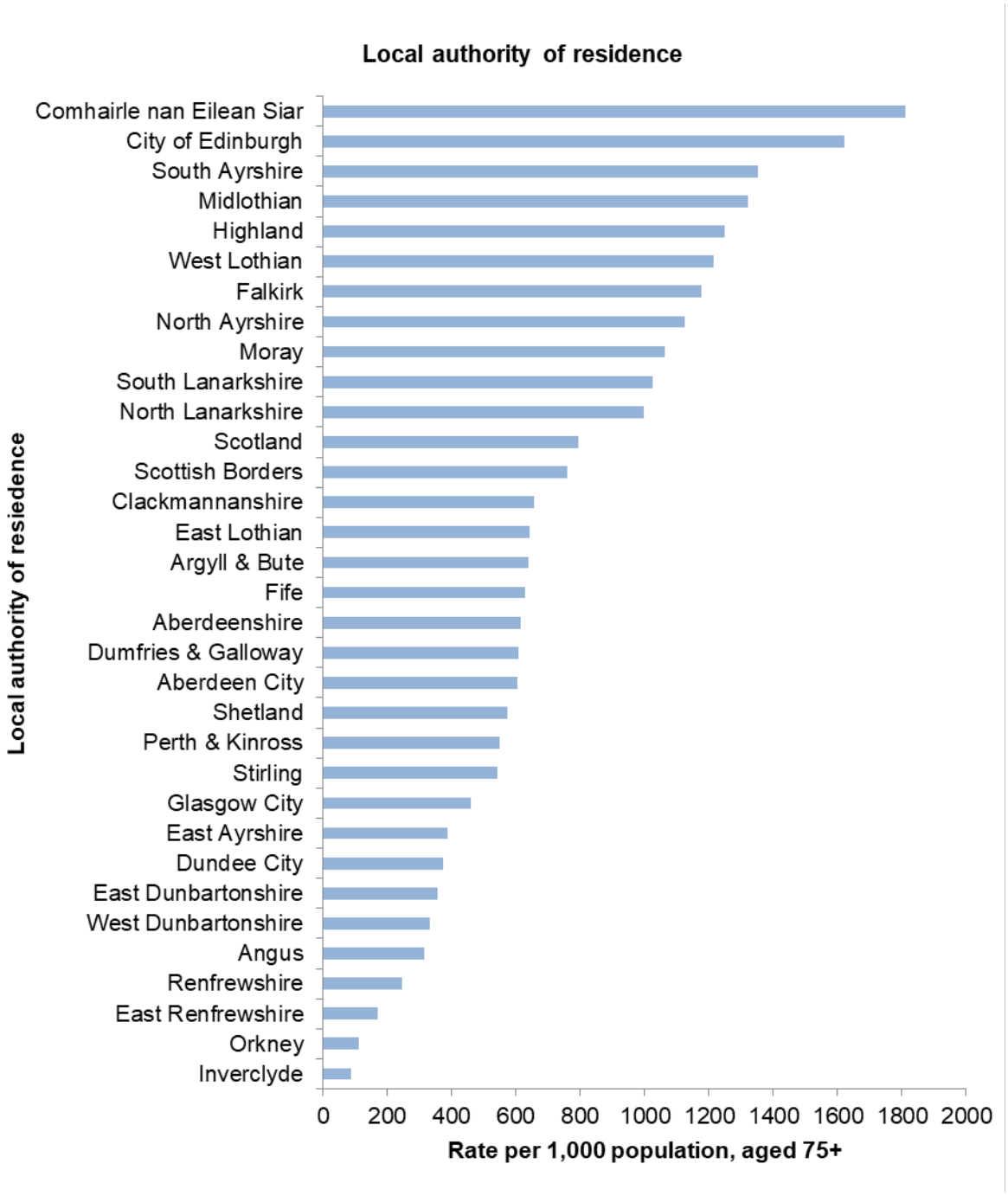
7.15 HSCPs have performed well in recent years in managing delayed discharges which have been on a downward trajectory since 2016. However, reflecting pressures in the wider health and social care system our performance has declined over the past 12 months. While this mirrors a trend nationally, GG&C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

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

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

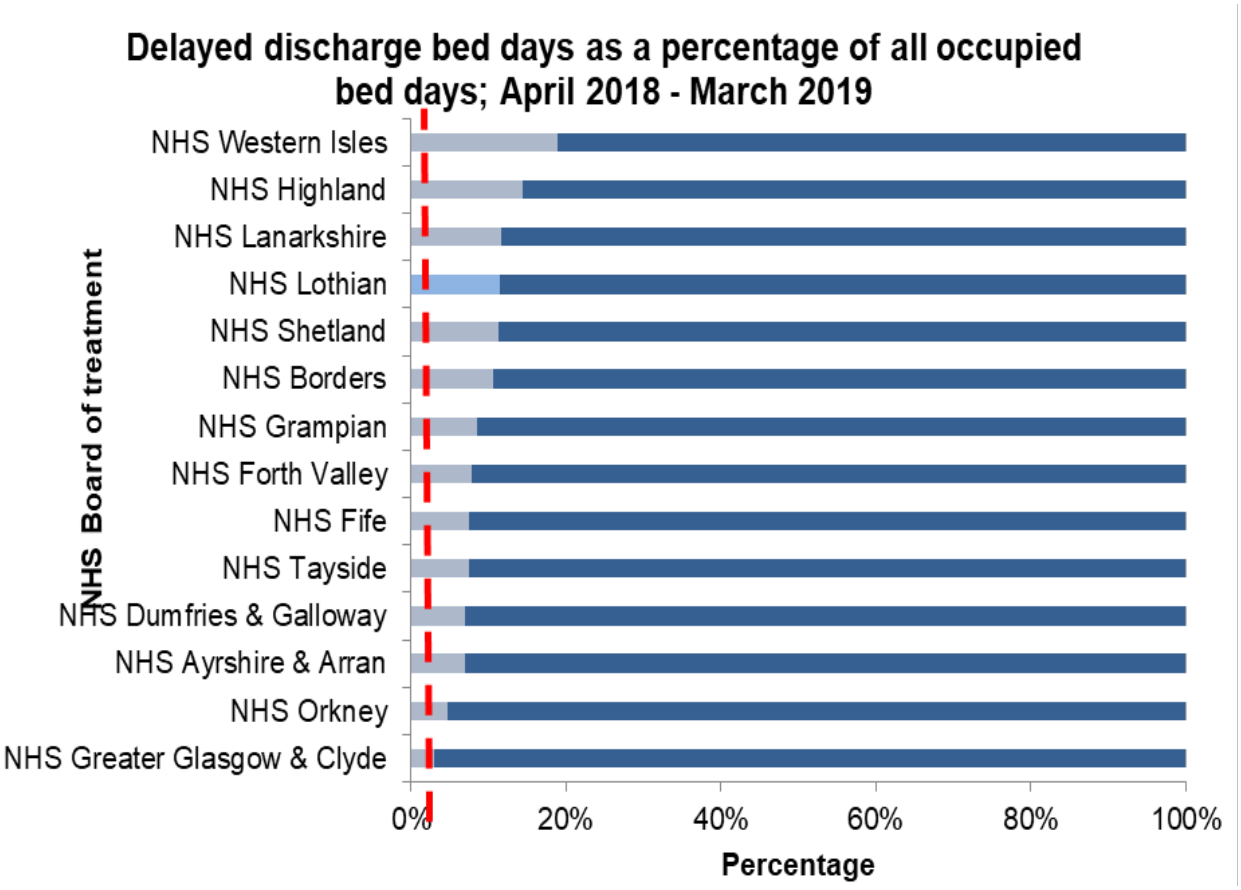
7.18 The current rate of delays (i.e. all delays) for all patients aged 75 plus per head of population by HSCP for 2018/19 is shown in figure 24 below and illustrates that the performance of GG&C HSCPs compares favourably with other HSCPs nationally.

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



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

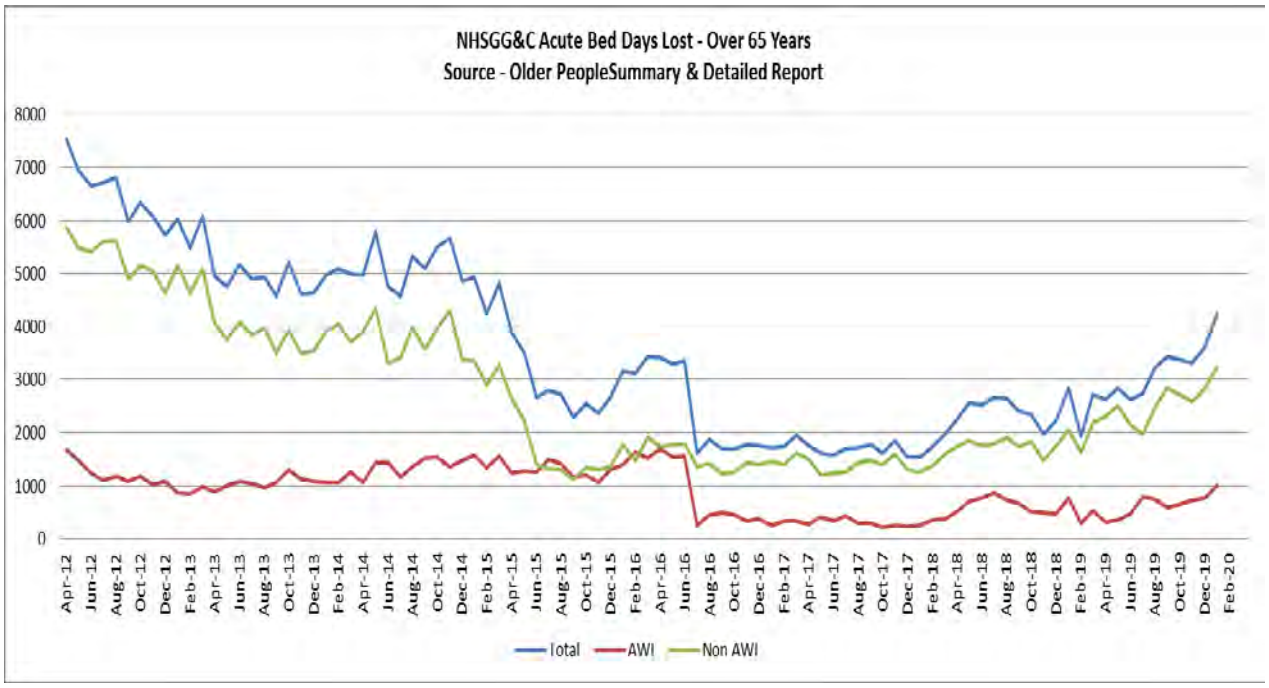
Figure 17 – delays as a percentage of acute beds – 2018/19



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

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

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



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

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

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

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

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

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

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

Managing capacity at peak times – seasonal planning

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

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

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

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

Summary

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

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

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

8. RESOURCING THE CHANGES

Introduction

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

Financial Framework

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

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

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

Acute Inpatient Beds Plan

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

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

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

Table 14 – acute inpatient beds benchmarks 2019

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

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

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

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

9. MEASURING IMPACT AND PROGRESS

Introduction

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

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

Key Measures

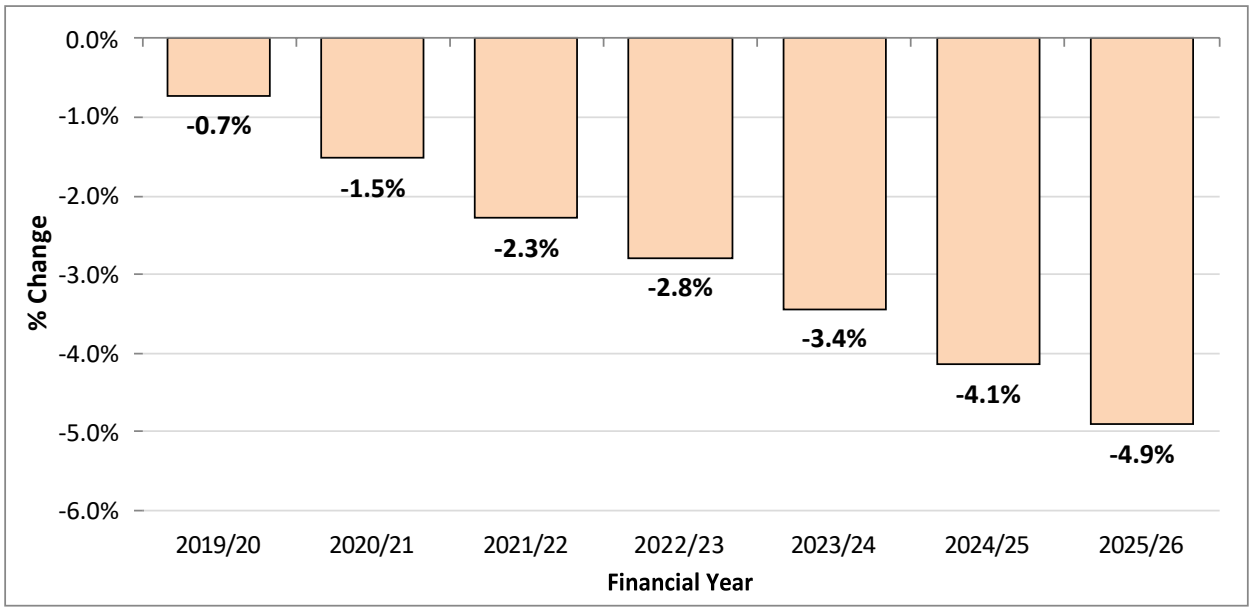
9.3 The key indicators we propose to use to measure the impact of our programme are:

- emergency departments attendances:
  - delivery of the four hour target
  - total attendances by age, sex and deprivation
  - total attendances per head of population
  - rates of admissions and discharges
  - frequent attenders
- minor injury units attendances:
  - delivery of the four hour target
  - total attendances by age, sex and deprivation
  - total attendances per head of population
  - rates of admissions and discharges
- GP assessment units attendances:
  - total attendances by age, sex and deprivation
  - total attendances per head of population e.g. 65-74, 75+
  - rates of admissions and discharges
  - GP referral rates
- emergency hospital admissions:
  - admissions by age, sex and deprivation
  - rates per head of population e.g. 65-74, 75+
  - length of stay
  - rates per GP practice
- acute unscheduled care bed days
  - rates per head of population e.g. 65-74, 75+
- acute bed days lost due to delayed discharges

- rates by age e.g. e.g. 65-74, 75+
- AWI and non AWI rates
- bed days lost as % of total acute beds

9.4 In assessing the impact of the programme outlined in section 5 to prevent admissions, and based on current rates of admission per head of population and for different age groups (e.g. 65-74, 75 plus) we estimate that the full implementation of this programme will likely result in a reduction in the rate of emergency admissions for over 65s by 4.9% by 20205 (see figure 19 below). This estimate takes into account the demographic changes forecast over this period.

Figure 19 – projected percentage change in emergency admissions (based on 2018/19 data)



9.5 An important caveat to these projections is that other changes in the population e.g. changes in life expectancy, wider society and the economy highlighted in section 1, will affect these numbers in ways that are difficult to predict at the present time.

9.6 Work is underway to identify the potential impact of all the actions outlined in this draft plan. Through this further work we aim to demonstrate that if plans are delivered in full by 2021/22 as envisaged this will not only enable increases in demand anticipated from changes in our population to be met, it will also result in a reduction in current costs.

10. CONCLUSION

10.1 The purpose of this plan is to outline how the six NHSGG&C HSCPs in partnership with Acute Division and other partners aim to respond to the continuing pressures on health and social care services in Scotland's largest Health Board. For a number of reasons health and social care services are stretched and we are struggling to meet key targets. In a large system such as GG&C a large number of patients are seen by health and social care professionals in a variety of different settings on a daily basis. When looking to the future we can see that demand will increase as the number of people aged over 75 is forecast to rise over the next five years. We need to change therefore if we are to both meet current and future demand.

10.2 The challenge is change. We need to do somethings differently (e.g. out of hours services) and we need to change some services (e.g. mental health services) to respond better to patients. We need to scale up some of what we are already doing (e.g. anticipatory care planning) and we need to try new things (e.g. "hot clinics" for GPs). We also need to look at putting new additional services in place (e.g. minor injury units) and changing how emergency departments operate more effectively.

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

10.4 The programme outlined in this plan is based on evidence from elsewhere of what works and our estimate of patient needs in GG&C. We believe it is the right way forward. The changes proposed will not take effect immediately or all at the same time. Some need testing and others need time to bed in. Change will be gradual but should be fully implemented by 2022/23. While the challenge is change to respond to current and future demand, the challenge is also maintaining the direction outlined in this plan over the longer term so that we can better meet the needs of the people we serve.

Annex A

SUMMARY OF THE EVIDENCE[47]

Redesigning elective care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Improved GP access to specialist expertise
Mixed evidence, particularly on overall cost reduction	• Peer review and audit of GP referrals • Shared decision-making to support treatment choices • Shared care models for the management of chronic disease • Direct access to diagnostics for GPs
Evidence of potential to increase overall costs	• Consultant clinics in the community • Specialist support from a GP with a special interest • Referral management centres

Redesigning urgent and emergency care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Ambulance/paramedic triage to the community
Emerging positive evidence	• Patients experiencing GP continuity of care
Evidence of potential to increase overall costs	• Extending GP opening hours • NHS 111 (NHS24 in Scotland) • Urgent care centres including minor injury units (not co-located with A&E)

Avoiding hospital admission and accelerating discharge

Relative strength of evidence of reduction in activity and whole-system costs	Initiative

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

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence Emerging positive evidence	Condition-specific rehabilitation Senior assessment in A&E Rapid access clinics for urgent specialist assessment
Mixed evidence, particularly on overall cost reduction	• Intermediate care: rapid response services • Intermediate care: bed-based services • Hospital at Home

Managing 'at risk' populations

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Additional clinical support to people in nursing and care homes • Improved end-of-life care in the community • Remote monitoring of people with certain long-term conditions
Emerging positive evidence	• Extensive model of care for high risk patients
Mixed evidence, particularly on overall cost reduction	Case management and care coordination Virtual ward

Support for patients to care for themselves and access community resources

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Support for self-care
Emerging positive evidence	• Social prescribing

Annex B

HSCP DELAYED DISCHARGE ACTION PLANS
SUMMARY

Each HSCP, working closely with the acute services division, has a number of actions in train to improve outcomes for patients and current performance. Progress on actions plans and performance is routinely reported to IJBs. Key actions being taken by HSCPs are summarised below.

East Dunbartonshire:

- Linked Mental Health Officer to Hospital Assessment Team to lead improvement in relation to AWI focusing on timeous completion of reports, local authority guardianship applications etc.;
- Dedicated Intermediate Care Unit;
- Palliative and Complex Care beds;
- Hospital attached Social Workers linked to wards who proactively engage with discharge co-ordinators and MDT discussions;
- Proactive use of unplanned inpatient activity dashboard to identify those who have been inpatient for 10 days+ and those with an EDD of 1 month+ to facilitate early referral and allocation of case;
- Same day response to care packages

East Renfrewshire:

- continued use of the inpatient dashboard to identify at earliest point East Renfrewshire residents in acute wards to support early referral;
- continue to strengthen relationships between our Hospital to Home Social Work Assistants aligned to acute sites, staff in acute wards and discharge co-ordinators;
- Proactive planning by Hospital to Home multidisciplinary team to support safe, early discharge collaborating with Care @ Home services and wider RES team;
- Further development of Intermediate bed capacity model as a result of Local Authority Care Home refurbishment over the winter period;
- Unscheduled Care daily huddles to identify those at risk of admission and planned discharges; and,
- Implementation of pan Greater Glasgow & Clyde AWI approach.

Glasgow City:

- a continuing programme of improvement in relation to intermediate care with a focus on reducing average length of stay;
- additional capacity recruited to the HSCP hospital social work team;
- for under 65s, a named Adult Service Manager in each locality to hold accountability and ensure progress with complex adult delays daily;

- improved links with complex wards to improve early referral and effective communication;
- the sharing of estimated day of discharge information to a give early indication of potential future discharges; and,
- a management focus on everyday activities, including:
    - a reduction in same day (as fit for discharge) referrals from Acute – which automatically generate delays;
    - more assiduous prioritisation of delays by HSCP community staff – these are marginal, as most cases are held by the hospital-facing Home Is Best team; and,
    - improved communication arrangements between ward staff and the hospital discharge team around individual patients i.e. single points of contact, more effective networks.

Inverclyde:

- 7 Day Service - we will continue to work in partnership with local Care Homes to accept safe weekend and evening discharges for new admissions;
- Following last Winter's successful Pilot we wish to again increase capacity in our Home care Service to cover 175 hours per week to focus upon evening and weekend discharges for new service users as well as restarting existing packages;
- Test of Change Care Coordination - Coordination of Emergency Department Frequent Re-Attenders will utilise existing Locality Meetings to identify people at risk of hospital re-attendance and implement review and development of appropriate support to address unnecessary presentation. This will be across Health and community Care (including OPMHT) and have similar process in place to address frequent attendances of people known to Alcohol and Drugs Service and Community Mental Health Team;
- Day Care Services - a further Test of Change is to utilise Day Care Services to prevent Unscheduled Attendance's at Hospital This will identify 10 Frailty Day Places which will help to address Isolation and Anxiety amongst Older People which we have identified as a factor for some attendance's and admissions. These will be short term placements with clear link to reablement and accessing community supports;
- Assessment and Care Coordination at Emergency Department - we also intend to support the strengthening decision making at Emergency Department with greater knowledge of community resources and services to allow safe return home rather than admit. To support this we are requesting funding for 6 months to cover a Care Management post who would link directly to IRH Emergency Department complete assessments and return people home with necessary support thus avoiding unnecessary admissions;
- Choose the right Service - we have also extended our local Choose the Right Service campaign to cover attendance at emergency department and families with children.
- Purchase of step up beds on call off basis to prevent inappropriate admissions and also short term placements to facilitate discharge as required.

Renfrewshire:

- Discharge Coordinator post created from November 2019. This dedicated role solely focuses on working with Families, Acute and HSCP Services to manage the discharge process;
- when available, beds at Hunterhill Care Home are used for the reablement of delayed discharged patients;
- Hospital discharge protocol to be finalised and implemented;
- Acute and HSCP meet 3 times a day to discuss discharge planning and review active cases/delayed discharges and agree appropriate actions;
- Hospital Social Work Team attending daily huddle including bank holidays; and
- Weekly meetings with the Care at Home Service Delivery Team Manager; Acute; and the Royal Alexandra Hospital Social Work Team to discuss delayed discharges

West Dunbartonshire:

- Full use of inpatient dashboard to identify patients with admissions of 10 days+
- Dedicated early assessment cohort (Social Care, Nursing, OT) undertaking assertive in reach in wards
- Continuing programme of robust review in relation to use of s13za for AW patients.
- Refresh of hospital discharge homeless policy in conjunction with WDC Housing to ensure streamlined approach
- Refinement of engagement by colleagues in mental health and learning disability services to support safe and timely discharge

Annex C

Acute Inpatient Beds Totals by Hospital site 2010-2025

2010	Beds	2015	Beds	2020	Beds	Projected 2025	Beds
Southern General	900	QEUH campus	1450	QEUH campus	1400	QEUH campus	1400
Victoria Infirmary	370	New Victoria	60	New Victoria	60	New Victoria	60
Western Infirmary	500						
Stobhill Hospital	440	Stobhill ACH	60	Stobhill ACH	60	Stobhill ACH	60
Glasgow Royal	930	Glasgow Royal	910	Glasgow Royal	870	Glasgow Royal	870
Gartnavel General	450	Gartnavel G	360	Gartnavel G	360	Gartnavel G	360
RHSC Yorkhill	230	RHC	215	RHC	215	RHC	215
RAH	650	RAH	550	RAH	550	RAH	550
IRH	320	IRH	300	IRH	300	IRH	300
VOL	90	VOL	80	VOL	80	VOL	80
Total	**4880**		**3985**		**3895**		**3895**

2008 – publication of QEUH business case
2015 – opening of QEUH/ closure of Victoria Infirmary, Southern General Hospital, Western Infirmary, conversion of Stobhill Hospital to ACH
2020 – year 1 of Joint Unscheduled Care Commissioning Strategy – figures include additional winter beds
2025 – year 5 of Joint Unscheduled Care Commissioning Strategy (will be the same as 2020 minus the winter beds)

Notes:

All numbers are rough estimates. Bed numbers fluctuate seasonally and for other operational pressures
2010 figures include total bed numbers in the catchments of each hospital, including continuing care beds, e.g. Drumchapel, Blawarthill, etc.
QEUH campus includes QEUH, Institute of Neurological Sciences, Maternity & Gynaecology, and the Langlands building. RHC shown separately
GRI numbers exclude Lightburn
Gartnavel campus is GGH and BWOSCC only

Annex D

Proposed Reduction of Use of Additional Winter Beds

	2019/20	2020/21	2021/22	2022/23	2024/25	2025/26
South	**88**					
North	**51**					
Clyde	**89**					
Total GG&C	**228**	**200**	**175**	**100**	**75**	**0**

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date: 23 June 2020**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/45/2020/SMcA**
Contact Officer	**Sharon McAlees Head of Children's Service and Criminal Justice**	**Contact No: 715282**
Subject:	**CHAMPIONS BOARD/PROUD2CARE**	

1.0 PURPOSE

1.1 The purpose of this report is to inform the Integration Joint Board of Proud2Care's activities, and partnership in establishing Inverclyde's Champions Board over the last 3 years.

1.2 The report will further outline a proposal for Proud2Care's partnership with the Champions Board over the next two years.

2.0 SUMMARY

2.1 The vision of the Council and the Health and Social Care Partnership (HSCP) is for nurturing and compassionate communities to work together to assist everyone to live active, healthy and fulfilling lives. Proud2Care and Inverclyde's Champions Board is an example of co-production in the aim to deliver this vision.

2.2. Over the last 3 years Proud2Care has established itself as a widening network of care experienced young people who share their experiences to inform the way they are supported and share with others within their communities.

2.3 The impact of care experienced young people has been tangible. They have been involved in activities at both a national and local level; informing the national consultation around the Independent Care Review and hosting a Better Children's Hearing event in Inverclyde to design a local action plan. In total in 2019/20 this has meant:

- 83 care experienced young people have engaged in Champions Board related activities
- 224 sessions to support Champions Board involvement have taken place
- 47 representatives from service providers and corporate parents have attended Champions Board activities, and

2.4 The establishment of Inverclyde's Champions Board and Proud 2 Care was supported by Life Changes Trust funding for three years 2017- 2020. Proud 2 Care activity has been facilitated by HSCP staff alongside Your Voice who in turn have provided employment opportunities for two care-experienced young people.

2.5 The Life Changes Trust has agreed additional 2 year funding aimed at widening

opportunities for care experienced young people and their families, however since the original funding applications were made and agreed, emerging themes have been identified and will require to be taken forward including the impact of Covid-19 on our community, the delivery of Inverclyde's response and pledges to the National Care Review and delivery of the HSCP Strategic Plan Big Actions.

2.6 Extending the involvement and funding to Your Voice for a further period of 18 months would allow Proud2Care's activities to continue on the same scale and progress the activities outlined above.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integrated Joint Board :

a. Notes the content of the report.

b. Agrees the proposal to continued funding and resourcing of Proud 2 Care including partnership with Your Voice.

Louise Long
Chief Officer

4.0 BACKGROUND

4.1 Inverclyde's partnership with the Life Changes Trust and development of the Proud 2 Care began in April 2017. Its objective was to invest and support the inclusion and empowerment of our care-experienced young people. The focus was to build over time, a confident and resilient group to establish and participate effectively in the Champions Board network.

4.2 This has been achieved in the three years of the match funding with LCT. It has been supported by corporate parents across the community planning partnership; to build networks of support and to grow the confidence of Proud 2 Care. This has been through inclusion to develop their interests, empowerment to participate in consultations, and by providing intergenerational opportunities to have an understanding of citizenship to achieve their goals. The consequence of these positive experiences has been to promote feelings of self-efficacy; that their contribution matters.

4.3 Life Changes Trust approved further funding for 20/21 and 21/22. This equates to £50,000 per year. The aim of this is to develop a trauma informed approach to engagement with a wider group of care experienced children, young people and their families supporting personal growth and resilience through the concept of ""Windows of Happiness". It is based on caring relationships that endure over time and helps build a legacy for other care-experienced children and young people to follow and emulate. One of the first projects will be with kinships carers and their family members, in partnership with RigArts and Clyde Muirshiel, focusing on local heritage sharing of stories and through a shared art project building on a sense of citizenship and sense of belonging.

4.4 Since the establishment of Proud 2 Care and the Champions Board a number of events have occurred that need a coordinated response – the impact of Covid -19 across our community, the progression of HSCP Big Actions and the delivery of The Promise outlined in the National Care Review will all benefit from care-experienced young people and their carers' insight and ideas

4.5 The partnership with Your Voice is integral to supporting Proud 2 Care and Champions Board activity currently and in the future in addition to which it has provided employment opportunity for two care-experienced young people. It is therefore proposed that £90,000 from the Transformation Fund be provided to enable the continued partnership with Your Voice over 18 months in conjunction with a budget of £20,000 to support continued Proud 2 Care activity.

5.0 IMPLICATIONS

FINANCE

5.1 One Off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
Children and Families	Trans Fund	20/21	£70,000		
Children and Families	Trans Fund	21/20	£40,000		

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

LEGAL

5.2 There are no legal issues within this Report

HUMAN RESOURCES

5.3 There are no specific human resources implications arising from this report.

EQUALITIES

5.4 Has an Equality Impact Assessment been carried out?

X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

5.4.1 How does this report address our Equality Outcomes?

There are no equality issues within this Report.

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	Proud2Care provides opportunity for care-experienced young people to access and influence service delivery
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	The work of the Champions Board and Proud 2 Care seeks to reduce stigma and discrimination experienced by care experienced young people including those in protected groups
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	The Champions Board and Proud 2 Care provide opportunity for care experienced young people to influence the development and delivery of services
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	Partnership between Champions Board and Proud2 Care
Opportunities to support Learning Disability service users experiencing gender based violence are	None

maximised.	
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

5.5 There are no clinical or care governance implications arising from this report.

5.6 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	**Implications**
People are able to look after and improve their own health and wellbeing and live in good health for longer.	Proud to Care provides opportunity for care-experienced young people to participate in a range of activities and shape the delivery of services aimed at improving health and wellbeing
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Proud 2 Care influence delivery of services for others and in process of participation have positive experience of working with Champions
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Focus of partnership between Champions Board and Proud2 Care is about promoting wellbeing for care experienced young people
Health and social care services contribute to reducing health inequalities.	Opportunity for care experienced young people to contribute to progression of Big Actions – reduction of health inequality
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None
People using health and social care services are safe from harm.	None
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	None
Resources are used effectively in the provision of health and social care services.	Investing and supporting care-experienced young people's participation in

	service development provides long term benefit for young people reducing future service demands

6.0 DIRECTIONS

6.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Inverclyde Council	X
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

7.0 CONSULTATION

7.1 The report has been prepared by the Chief Officer of Inverclyde Health and Social Care Partnership (HSCP) after due consideration with relevant senior officers in the HSCP.

8.0 BACKGROUND PAPERS

8.1 Proud 2 Care Report

APPENDIX

PROUD 2 CARE ANNUAL REPORT

YEARS 1, 2 & 3

NOTHING ABOUT US WITHOUT US

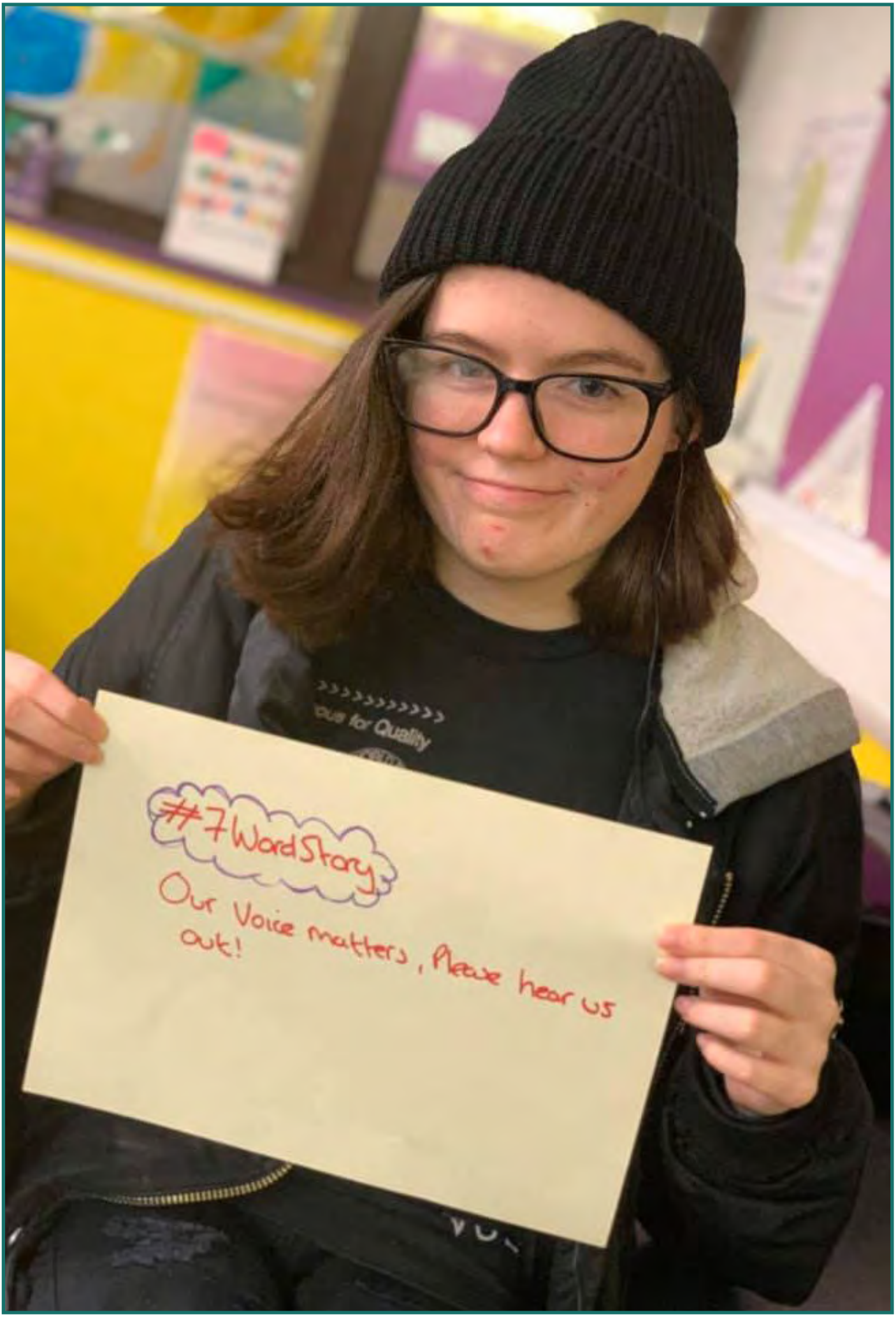
your voice Your Community Your Ideas

proud 2 care

Inverclyde council

life changes trust Creating better lives

INVERCLYDE HSCP Health and Social Care Partnership


#7WordStory
Our Voice matters, Please hear us out!

CONTENTS

INTRODUCTION

Welcome to Proud2Care's (Inverclyde Champions Board) combined Annual Report covering the period of 2017 – 2020.

We are delighted to share with you our journey so far and would like to thank everyone who has supported us over the last 3 years.

It has been 3 years of exciting developments, partnerships and bonding as a group. Our groups encourage trust, inclusion, understanding and empathy for care experienced young people within a safe, comfortable space on a weekly basis.

The profile of Proud2Care has been raised significantl , we have been approached by various organisations, services and teams to consult with our young people, resulting in our young people recognising their valuable voice and ability to influence service design redesign.

Hearteningly, Inverclyde HSCP recognise, value and aim to build on the success of Proud2Care and develop principles of coproduction to be included in all service redesigns and the development of services throughout Inverclydes 5 year strategic plan.

Whilst we look back over the last 3 years with pride - Abraham Lincoln famously stated that ***the best way to predict the future is to create it*** - we are excited to see what we can achieve together in the years ahead.

Some of our highlights include;

- Developing Champs & Mini Champs groups
- Forming Inverclyde Champions Board
- Hosting a MasCAREaid Ball
- Group members achievements being recognised at the Inverclyde Year of Young People Awards

At the groups I feel included, like my thoughts and feelings matter.
- Inverclyde young person

Our Champions Board empowers young people to use our life experiences in a positive way, giving us the platform, voice and confidence to make a di ference. Young People are fully involved in how our group is run, we are leading it and it is not something done to or for us. It puts us face to face with our corporate parents and gives opportunity for us to make a difference for young people in Inverclyde.
- D.F. Inverclyde young person

BACKGROUND

Hi I'm Roberta and I would like to give you a brief background to Proud2Care and what we have achieved in Inverclyde over the last few years.

We first all met in October 2016. Young people were invited by Golden Ticket to come along and find out about the group over pizza and some chat, now known as the legendary Pizza and Patter night!

In January 2017 we came up with the name Proud2Care and decided that we wanted to keep meeting as a group weekly to work on the topics that we were interested in and were supported by HSCP, Who Cares Scotland and Your Voice to do this. We now have a focused, active and dedicated Champs Group who are confident and engaged in influencing change

At the 2017 Child Protection Conference I and some of the other young people presented about Stigma, it went down very well. I was quiet nervous about doing it to begin with.

Also Dillon and I became Care Champion reps for Inverclyde and met together with other care experienced young people from all over Scotland with the support of Who Cares? Scotland.

Our group was visited by the Inspectors who wanted to find out about what we have been doing and they were impressed by the work our group had done. Some of our younger group members also presented at the LAAC Education conference where they spoke to over 100 professionals about their experiences and received a standing ovation. Following this we were asked to deliver our workshop in two secondary schools with plans for more.

We took part in the Independent Care Review (1000 voices) and some of the group shared our thoughts with the First Minister Nicola Sturgeon.

After celebrating our first birthday we started planning towards what we wanted to bring to a meeting with our corporate parents who were developing the Champions Board with us. We held our first Champions Board meeting, followed by a community day which was attended by over 100 people who all came to find out more about our group and what we hoped to achieve.

We also had a Christmas party where group members brought their friends. We felt this was important as it gave us the chance to share with people not involved with the group and this influenced our recent Connected2Care initiative where we include young people Connected2Care to get involved and support us to champion care experienced young people.

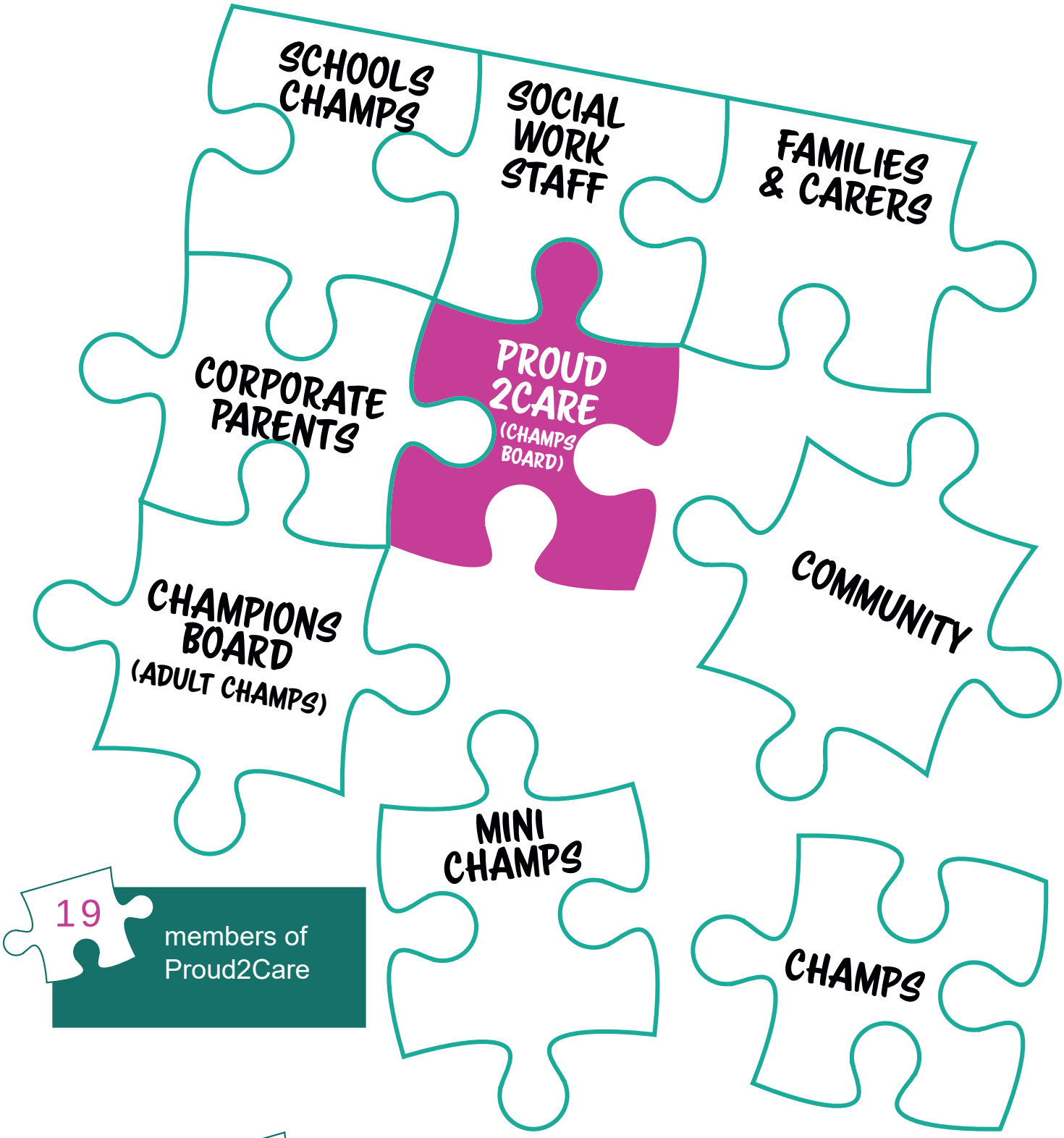
In the New Year of 2018 we set up Mini Champs which is for primary aged children and moved into the Greenock izone.

Over the years we've been visited by a number of different agencies such as the police, education and reviews officers who we've worked with to make some changes to how the review process happens in Inverclyde as well as several students and other interested people.

We also designed our Champs, Mini Champs and Proud2Care leaflets and created a short film 'Alice in Careland to promote our groups to young people, staff and carers, helping us to widen our membership and network.

By April 2019 we felt secure and established with strong supportive and nurturing local partnerships with Inverclyde HSCP, Inverclyde Council and 3rd sector organisation Your Voice. Over the last year we have continued to grow together, as young people, family and carers, staff, organisations and community. Together we are certain that we can #KeepThePromise for Inverclydes care experienced children and young people.

OUR NETWORK



19 members of Proud2Care

8 members of Champs

14 members of Mini Champs

Note: membership numbers above reflect average weekly attendance at groups

We participated in Cook School and hosted ‘Come Dine With Us’ with our families and corporate parents.

PROJECT AIMS

The aims for Inverclyde Champions Board are:

- Give a voice to Care Experienced young people.
- Influence change and development of the Care System
- Help care-experienced young people access the support systems available.
- Be treated with respect and get positive help from professionals.
- Change the experiences of young people in care.

OBJECTIVES

- Develop inverclydes champions board.
- Implement recommendations of the Independant Care Review.
- Work with staff and services to build relationships and influence culture change.

OUTCOMES

- Care experienced young people benefit from involvement in Champions Board
- Organisations strengthen their commitment, knowledge, skills and capacity.
- Policy and practice become more responsive to care experienced young people.
- Public awareness and attitudes become increasingly positive towards care experienced young people.
- Care experienced young people benefit from improvement outcomes.

68 individual young people have participated in our consultations

CHAMPS + MINI CHAMPS = PROUD2CARE

Having a fun, patient and supportive team with empathy for our young people and the enthusiasm and innovation to help them develop, is central to the success of the Proud2Care Network.

Funding allows the team time and space to build strong, trusting relationships, in turn making a difference in terms of encouraging participation and in effecting change.

Young people have told us that appreciating the importance of inclusion and feeling accepted, particularly on the first night, is central to them returning. Together we create a safe space where food is a common interest and helps to bring our group together, whether choosing what we would like to eat or planning and preparing our own food together.

Participation and engagement from corporate parents and heads of services gives our young people confidence that their voices are important, will be heard and acted on, keeping them engaged in local and national priorities.

> *"Being part of the Champs Board gives me the opportunity to have some what responsibility in making sure that the care system is good for all young people. Coming together with others who, in ways, share this responsibility is a great way for us all to bond. It's as if we are all pieces to a jigsaw coming together, each of us bringing great traits which contribute to our aims."*
>
> Kaine, 15

> *I have been coming to Proud2care right from the start. When I first came I was a bit nervous about joining in with discussions and would just keep myself to myself. Over time staff would encourage me to join in and share my thoughts and slowly but surely I felt more confident to do this and tell people what I think. Over the three years I have now been involved in lots of things including hosting a stall a 1000 voices event, been part of interview panels for lots of different types of job roles in social work. I have talked in front of people at large events and had everyone laughing, I always put myself forward to speak at things now coz I'm good at it! I helped out at so many things, one of the staff took me to get a proper ukulele at a music shop in Glasgow to say thank you for all the things I had been part of. I love my ukulele and play it all the time and used it for my music exam at school.*
> *I also help out at mini champs every two weeks. I help get some of the food and make toasties, my little sister is in the group and we don't live together so it's a good chance to spend some more time with her too!*
> *Proud2care is really important to me. I've made lots of new friends, developed new skills and confidence and I have been able to make a difference for other people like me. I've even met the First Minister.*
>
> 
>
> Ellie, 15

> *"Our young Champs inspire us every day. Being part of their journey, watching them grow and supporting them to build confidence and belief that they are valued, respected and have the power to make a difference is a privilage. We are proud of all their amazing achievements and we will continue to encourage them to use their care experience as their super power. "*
>
> Proud2Care Staff

CHAMPIONS BOARD

Over 40 young people have been actively involved in Inverclyde Champs Board so far, with many more involved in our wider consultations. Its outcomes include:

- Care-experienced young people have benefited from involvement in th Champions boards.
- Local care experienced young people have developed relationships with their corporate parents.
- Organisations strengthened their commitment, knowledge, skills and capacity.
- Policy and practice has become more responsive to care-experienced young people.
- Public awareness and attitudes have become increasingly positive towards care experienced young people.
- Care-experienced young people have benefited from service improvements
- Care experienced young people reporting they feel empowered and can see their voice matters.
- More care experienced young people know they have a platform to support them to have their voice heard.

Care experienced young people are more engaged with services and more actively engaged within their communities. Our Champs group composed a list of six areas they want to focus and where they feel there is a need for better support, action or improved policies for care-experienced young people. These include:

  - Stigma
  - Education
  - Relationships with corporate parents
  - Aftercare
  - Family – protect the relationships that are important to us
  - Health
  - Language and communication
  - Network: Making sure those who do not wish to attend groups are included in the Champs Board.

CHANGES TO POLICY & PRACTICE

Over the 3 years, our Champions Board have worked together with our local authority, HSCP and 3rd sector to influence positive changes for Care Experienced young people. Whilst some of these changes have been driven by us the young people, others have been driven by services themselves inviting us to contribute to improving their service, this value placed on 'lived experience' has increased our confidence as Champs and our belief that we can be and are, active change makers.

Education

We have produced two short films 'Alice in Care Land' and 'Stigma' to use as educational resources across Inverclyde. Our films have been shown at Inverclyde LAAC education Conference and head teacher quarterly meetings. Attainment money has been identified by Education and HSC for care experienced young people to progress attainment and wellbeing, allowing young people to apply for individual grants.

Children's Hearings

Our Champs have worked hard alongside our Children's Reporter to improve Children's Hearings services and we have visited the centre to be consulted in the re design of the centre. We have co designed resources to support YP that are visible in waiting areas such as a jargon buster wall, did you know wall and currently we are creating an interactive, child friendly version of the better hearings action plan, designed from the findings of the Proud2Hear consultation event. We are also working on panel member profiles in partnership with panel members. Nationally we are working with SCRA to design a local information leaflet.

Training

We delivered sessions to over 200 professionals across Inverclyde. Challenging attitudes and perceptions of care experienced young people, by sharing our experiences with professionals we cultivate a sense of reflection in their practice, encouraging them to explore their practice, and the relationships that they nurture with care experienced young people. In the year ahead we will be developing a new training pack that care experienced young people will deliver annually to Children's Hearings panel members alongside a wide range of professionals.

Participation & Support

Whilst our Champs meet every 2nd week, we have our Proud2Care group every week, this weekly space offers us time, connection and support from staff and peers. Spending time with other young people who are care experienced is important, we can use our care experience positively to support each other. Spending time with Staff not directly involved in our care planning can be liberating. We are supported at Proud2Care to manage positive friendships and relationships, be more independent, confident and use our care experienced positively to support other care experienced young people - this is our super power!

HSCP

Within Health and Social Care we have been involved in a wide range of service improvements, including the development of new review paperwork sent to children and young people before and after reviews, as well as a checklist of things for the review officers to work through during each revie . We have been involved in shaping the new tender document being created for advocacy services to ensure the service meets the needs/wants of young people directly, and we have been involved in a range of consultations such as Housing and Health & Well Being. We have also created a consultation in partnership with HSCP to look at improving the experiences of LAAC Medicals. From January 2019 almost every single post within children and families included a panel of care experienced young people for both 1 to 1 and group interviews. More recently young people have been involved in shaping WiFi Safety, the new continuing care accommodation, and currently a consultation is underway for older young people to shape the future of continuing care reviews. We will also be helping to lead the way by assisting HSCP to identify the local priorities from the Independant care review.

> *"Proud2Care have been instrumental in driving forward the Better Hearings agenda in Inverclyde – such a fantastically inspirational and ambitious group of young people that are passionate about making things better for all young people. Their Proud2Hear event really transformed the Better Hearings planning – it took the national perspective and through getting an understanding from all of the people involved locally, turned it into local priorities – they took ownership, and it is these priorities that are now driving the professional's plans for taking forward Better Hearings – as it should be!*
>
> *I have been so pleased to spend some time with the group as they have been working through this and have been blown away by their creativity and their commitment – looking forward to seeing what comes next!"*
>
> Lisa Bennett, Head of Strategy/OD and Corporate Parenting Lead, SCRA

We made puppets of ourselves. If we can't or don't feel like having our photograph taken, we can use our puppets!

To celebrate Care Experience Week 2019 we hosted a 'Kick about with your corporate kid'

OUTCOMES: ACTIVITY ANALYSIS

We hosted a stall at an LCT event in Perth.

We hosted a community day promoting Champions Board. approx 100 people attended.

We hosted a MasCAREaid Ball. Over 100 people attended with young people attending from across 7 Champ Boards.

We introduced the 'Top corporate parent award' in 2018.

We participated in a focus group developing a comic book and assessment resource for Adoption Services.

We presented at our local LAAC education conference.

We have hosted 3 Champions Board Meetings where we have explored the care review, Stop Go Pledge, getting to know you activities, and our community day.

We participated in a 'Corporate Kick about' for national care week with our corporate parents.

We hosted a Speed Networking employability event for 15 -26 year olds.

We had National Care Champ Reps and group members have attended national summer camp.

OUTCOMES: ACTIVITY ANALYSIS

We presented at the child protection conference.

We helped design and participated in a survey consulting on LAAC yearly medicals.

We interviewed candidates for HSCP social workers, unit manager and child protection officer posts

We participated in a visit from the care inspectorate.

We delivered a presentation to groups of teachers in various Secondary Schools across Inverclyde.

We participated in the C&YP services plan review.

We influenced and designed the introduction of a panel members profile for the children's hearings waiting room.

We participated in all stages of the national 1000 voices campaign and spoke directly to the first ministe .

We actioned the very 1st champs board meeting for Inverclyde and organised the champs board launch day.

We influenced and participated in a WHYfi? Consultation. Exploring needs and support required for wifi in children s residential.

To celebrate our 3rd Birthday we hosted a Better Hearings PARTYcipation engagement event. Over 80 people attended.

OUTCOMES: ACTIVITY ANALYSIS

We have volunteered looking after Birds of Prey for a day.

We took part in Inverclyde's Strategic plan consultation The 6 Big Actions

We took part in focused discussions with children's panels, LAAC/LAAH review officers

We participated in Fire Skills training – thanks to our corporate parent!

We have volunteered with compassionate Inverclyde at their Hub and put together some back home boxes.

We designed and produced leaflets promoting our groups.

We won awards! Shannon won Young Person of the year 2018. Dylan won Young Youth Worker of the Year 2019. As a group we were finalists at 3 Award Ceremonies.

We attended film school and produced two films we now use as educational resources to tackle stigma and promote our groups.

We participated in the 'meeting the standards' Engagement., looking at the new national care standards.

We influenced an co-created a new social work leaflet.

We are involved in the Better Hearings development & we delivered training to Panel Members.

OUTCOMES: ACTIVITY ANALYSIS

ADOPTION

Together
We Make A Family

Expanding our network, the Champions Board recognise the 'Care Experience' of adopted young people. We have supported Inverclyde HSCP Adoption Team to utilise our principles of co- production, developing Focus Groups with adopted young people and their families to co design a comic book that supports and explores adopted young people's right to information. The Champions Board continue to work with the adoption team and adopted young people, at present we are co-producing an adoption workbook that will be used with prospective adopters during the assessment period.

Our Champs group is proud to include Adopted young people, our adopted members enhance our understanding of adoption experiences and similarities, and raises awareness of the challenges and support needed for adopted children and their families.

6 adopted young people are members of our network

"I have had the pleasure of supporting the partnership and expansion of the champions board recently in to the area of adoption. This has involved a focus group of adopters, adoptees, the staff from champions board and the adoption team in collaboration with Magic Torch Greenock, to produce a fantastic comic book signposting resource for adopted children and their families, explaining how they can exercise their right to birth family information and care files. It has been a very positive experience whereby we have all got around the table and shared ideas and experiences, whilst being motivated by the enthusiasm and passion of the champions board work. I am delighted to continue this work with our local champions board and a group of young adoptees on a further resource which will gather questions for potential adopters, which adopted children feel should be asked during the assessment process. This partnership has been very worthwhile and I hope to continue to work with our champions board on other identified projects for the good of the Inverclyde HSCP community of adopters."

S McT
Social Worker

OUTCOMES: ACTIVITY ANALYSIS

AILEYMINIS

9 members of AileyMinis

I am the Nurture Teacher in Aileymill Primary and I have been piloting the group 'Aileymini's' for our p5-7 children who are care experienced in our school. The partnership between our school, Your Voice and Proud 2 Care has allowed our pupils to not only explore their care experiences in a safe, inclusive, fun environment but also provides an opportunity for them to spend time with other children who have similar experiences, something which otherwise would not have been possible within the school setting. One child commented that he now has a support group in school that actually helps him!

All of the children within the group are in a Nurture group within their year group and have built up positive relationships with myself over the years but this project has given me an insight that I didn't have previously into some of the issues faced by our children on a daily basis that we weren't as aware of as we should have been.

An example of this was highlighted during a session when one of our young people raised an issue he was struggling with in being made to feel 'different' with the amount of adults who were either working with him or removing him from his class to support him. He talked about all the different ID badges they wear and how this made him feel singled out. As a result of this, I was able to feed this back to my head teacher and we are in the process of writing a policy that will incorporate the child's wishes when working with different agencies.

Having a care experienced leader is invaluable as well and Dylan is always able to speak to them through his personal experiences, which adds value and meaning. He is a wonderful role model!

Our group also builds our knowledge of the support available to them e.g. Minichamps and the variety of activities that they can participate in fortnightly or during holidays. The fact that this is funded makes all the difference as 75% of our school come under the SIMD 1 and 2 categories and money is a huge barrier to our families. The sessions are all planned in advance by the children, giving them full automony and building their confidence and capacit . Their rights are promoted throughout every session and positive relationships are promoted throughout. For me, the benefits of this group are huge. Our children know that they are a priority and that they matter, despite their background or experience.

L. Q
Nurture Teacher

THE YEAR 2019/2020 IN NUMBERS

50 CARE EXPERIENCED YOUNG PEOPLE HAVE ENGAGED IN CHAMPIONS BOARD-RELATED ACTIVITIES MORE THAN TWICE

83 CARE EXPERIENCED YOUNG PEOPLE
HAVE ENGAGED IN CHAMPIONS BOARD-RELATED ACTIVITIES

14 CHANGES IN POLICY OR PRACTICE
HAVE BEEN MADE AS A RESULT OF CHAMPIONS BOARDS

WE HAVE PARTICIPATED IN 13 OPPORTUNITIES AND EVENTS
TO RAISE PUBLIC AWARENESS OF CARE EXPERIENCED YOUNG PEOPLE

224 SESSIONS TO SUPPORT
CHAMPIONS BOARD INVOLVEMENT WERE HELD IN THIS YEAR

69 PRACTITIONERS AND CARERS HAVE ATTENDED TRAINING
TO STRENGTHEN RELATIONSHIP-BASED PRACTICE WITH CARE EXPERIENCED YOUNG PEOPLE

47 REPRESENTATIVES FROM SERVICE PROVIDERS AND
CORPORATE PARENTS HAVE CHAMPIONS BOARDS-RELATED ACTIVITIES

WE HAVE PARTICIPATED IN 7 ENGAGEMENTS WITH OTHER CHAMPIONS BOARDS
6 PROUD2CARE YOUNG PEOPLE & VOLUNTEERS HAVE GAINED EMPLOYMENT

WE HAVE 6 SIBLINGS WHO ATTEND
PROUD2CARE, SPENDING TIME TOGETHER

CARE STATUS OF CHILDREN & YOUNG PEOPLE ENGAGED IN CHAMPIONS BOARD ACTIVITIES 2019/20

20 CHILDREN & YOUNG PEOPLE FROM RESIDENTIAL CARE

14 CHILDREN & YOUNG PEOPLE IN KINSHIP CARE

11 CHILDREN & YOUNG PEOPLE IN FOSTER CARE

14 CHILDREN & YOUNG PEOPLE LOOKED AFTER AT HOME

1 YOUNG CARE LEAVER

13 ADOPTED CHILDREN & YOUNG PEOPLE

We attended Film School!
We produced and starred in our films that we now use as educational resources.

Our Minis baked cookies for their corporate parents!

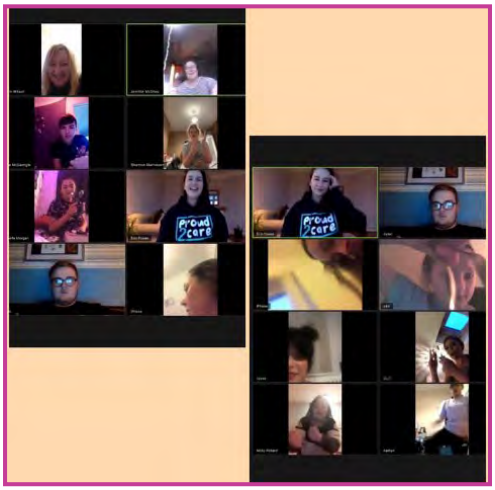
We hosted a Mas-CARE-ade Ball and invited other Champ Boards from across Scotland. Over 100 people attended including young people from 7 other local authorities! We chose everything from the activities on offer to the décor. Staff from the Independent Care Review attended and set up a space for everyone's voices to be heard.

We also surprised everyone with George Bowie who did a GBX set for us! It was an amazing night where we got to make lots of new friends.

COVID-19: RESPONSE

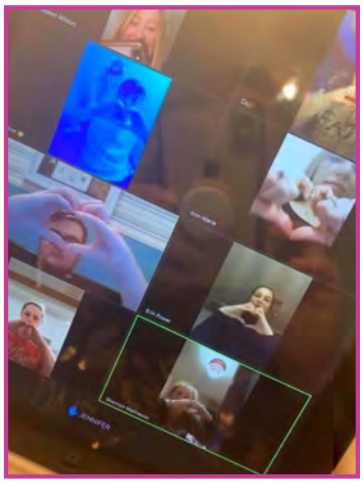
Physically distanced BUT Socially connected!

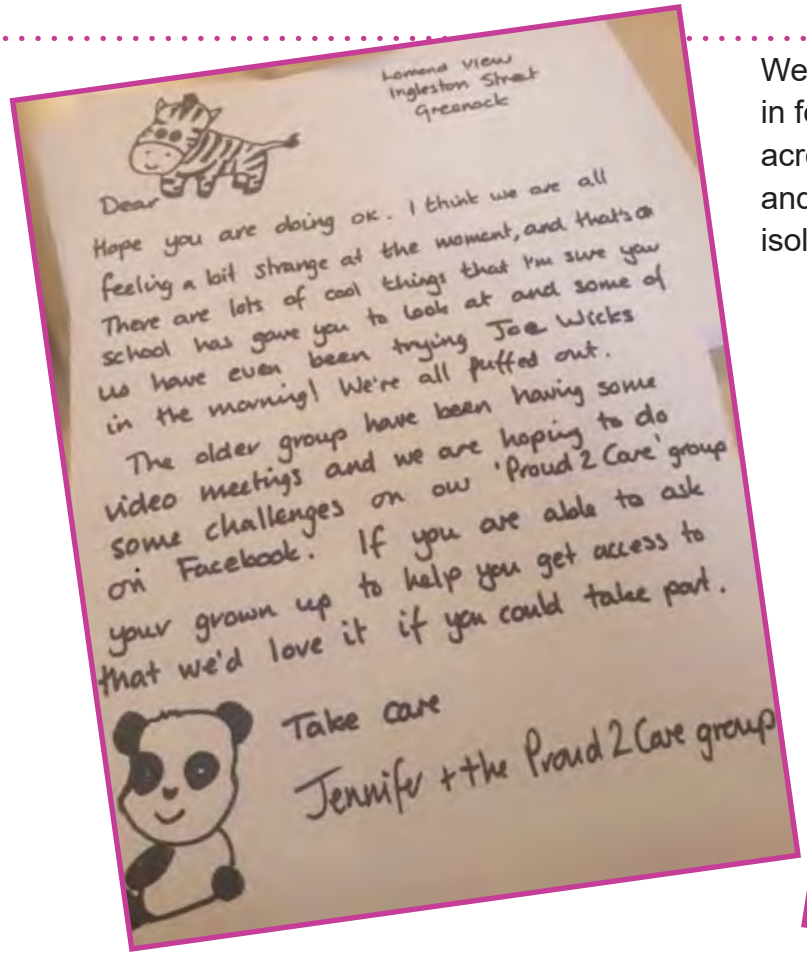
Being technically savvy young people we are now hosting Virtual Group Meetings on our usual Wednesday nights!



Magic Torch will be working with us virtually to develop our comic book. And we have plans in place to interview some of our corporate parents.

Proud2Care had so many things planned for over the coming months, including our Easter Camp activities. However, whilst we are feeling a little anxious and uncertain, we are as connected and creative as ever, we chat together on our Messenger group, play virtual scavenger hunts, quiz nights, sing alongs and support each other using online platforms. We have even tried PE with Joe Wicks and sharing our Tik Tok creations with each other. Creating a Proud2Care Tik Tok resource will be something we aim for over the coming weeks!





We have written a letter that is included in food isolation boxes being distributed across Inverclyde, offering some friendly and positive chat to those who are isolating in our community.

COVID-19: RESPONSE

The situation has given us opportunity to do some things we have been thinking about for a while, we have in the past discussed connecting with older people in residential homes as they too are care experienced, we have now become Pen Pals with a residential nursing home, we write weekly letters from Proud2Care to the residents and they write back each week. We have been sharing with the residents who we are, our work on the Champions Board, and the similarities in us all being Care Experienced!

We have agreed that when it is safe to do so we will visit and properly introduce ourselves!

A little poem we found, we hope you like it.

There was a cough and then another
The little cat ran to her mother.
"What can we do?" "We'll, wash your paws."
Her mother said, "And all your claws.
"We'll stay inside and shut the door.
You'll laugh and hide and read and draw
"And think of all the games you'll play!
You'll sleep and eat and then one day…
"You'll see the door is open wide -
The sun will shine, you'll run outside -
"Just look at how I've grown!" you'll say,
"Since all the time I've been away!"
So wash your paws and don't feel blue
The little cat knows what to do
And wait until the morning when
Our big old world is right again.

- Ursula Dubosarsky

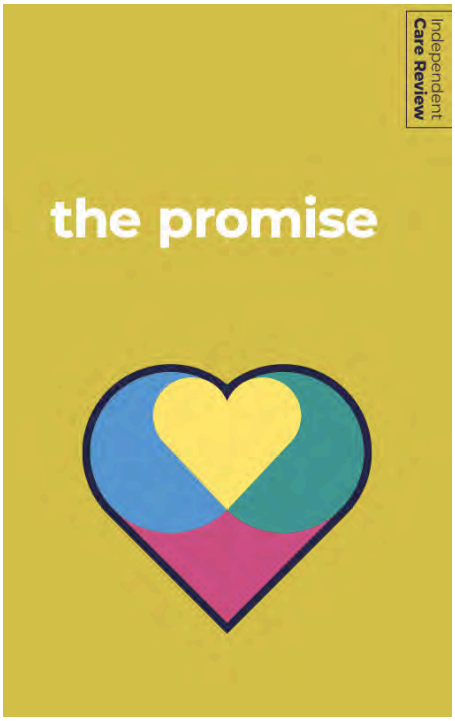
The Champs have also been getting down to business and informing the creation of a Jargon Buster Wall to help children and young people better understand some of the language used by professionals.

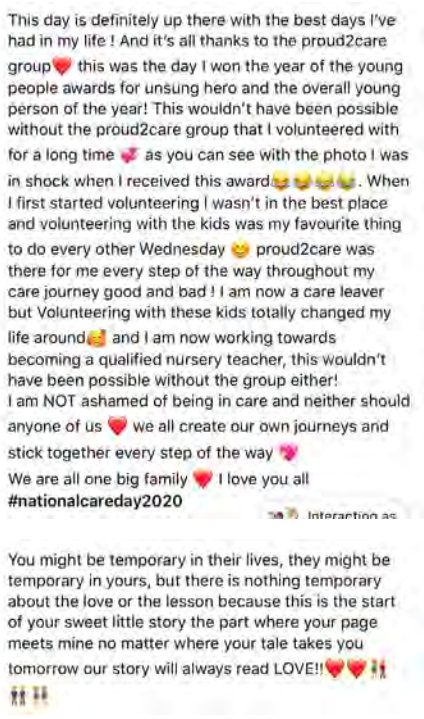
#KEEPINGTHEPROMISE

Pictured with the Care Review Team and our corporate parents.

Inverclyde Champs were involved in every stage of the Independent Care Review. The Independent Care Review Team came back to Inverclyde to visit once again and thanked us for our contribution.

Our champions board will now be helping to lead the way by assisting HSCP to identify our local priorities from the Independent care review. This will make sure we have a voice right through to the implementation of the priorities where we live.




This day is definitely up there with the best days I've had in my life ! And it's all thanks to the proud2care group❤ this was the day I won the year of the young people awards for unsung hero and the overall young person of the year! This wouldn't have been possible without the proud2care group that I volunteered with for a long time 💞 as you can see with the photo I was in shock when I received this award😭😭😭😭. When I first started volunteering I wasn't in the best place and volunteering with the kids was my favourite thing to do every other Wednesday 😊 proud2care was there for me every step of the way throughout my care journey good and bad ! I am now a care leaver but Volunteering with these kids totally changed my life around🥰 and I am now working towards becoming a qualified nursery teacher, this wouldn't have been possible without the group either!
I am NOT ashamed of being in care and neither should anyone of us ❤ we all create our own journeys and stick together every step of the way 💗
We are all one big family ❤ I love you all
#nationalcareday2020

You might be temporary in their lives, they might be temporary in yours, but there is nothing temporary about the love or the lesson because this is the start of your sweet little story the part where your page meets mine no matter where your tale takes you tomorrow our story will always read LOVE!!❤❤👫👫

WHAT NEXT FOR 2020 - 2021?

We are very proud of our achievements so far and move forward with enthusiasm to develop and action our aspirations for 2020.

Some of our planned actions for 2020 include;

- Producing Hugs Kits for young people moving into care inspired by Shannons Boxes.
- Creating a comfort comic as a way of letting young people know they are not alone on their journey
- Setting up positive links with secondary schools across Inverclyde to engage with unidentifie care experienced young people and promote the opportunities available to them - widening the Proud2Care Network.
- Developing a model of support within Inverclyde primary schools to connect children, families and teachers to the Proud2Care Network.
- Delivering volunteer training, child protection training, education and employment opportunities for our senior young people.
- Driving forward our 'Connected2Care' initiative.
- Consulting and informing LAAC Medical review.
- Launch our new group leaflets.
- 'Bring your corporate kid' to work day.
- Educating the educators – continue consulting with professionals and support the development of a 'professionals tool box'.
- Build on our Better Hearings partnership and continue influencing the next steps toward Better Hearings.
- Consulting care experienced young people regarding Continuing Care and Housing.
- Developing our 'permanence' information leaflet.
- Continuing to work with the Adoption Team in shaping their service.
- Help give care experienced young people a voice in shaping Throughcare and Continuing Care Reviews.

14 Number of consultations we have participated in

AREAS RECOGNISED FOR CONTINUED DEVELOPMENT

Going forward we would like to see more Inverclyde care experienced young people engaging with the network. Our challenge, therefore, is to inform staff, organisations, families, communities and care-experienced young people about Champs Board, to ensure care experienced young people know their rights, find their voices and have their voices heard

We want to see a culture change – we will continue challenging language used, keeping it simple, consistent, non-stigmatising and understandable, for example 'permanence' 'LAAC' 'unit'.

Continue building strong trusting relationships with our corporate parents, celebrating what we achieve together, encouraging more corporate parent involvement, developing the membership of representatives, for example the NHS and further education.

Encouraging and nurturing our young people to take more leadership opportunities within in the group, building skills, experience and ownership.

We want to further connect with our community as a group, educating, tackling stigma, building on partnerships, and nurturing our sense of belonging and attachment to where we live or where we have been placed to live.

We will develop our planning outcomes to reflect the recommendations of the National Care Review.

"I have the great privledge of being a corporate parent and a member of the Inverclyde Champions Board. When I was first elected in 2017 I barely knew what my responsibilities as a CP involved. With the thanks of the Proud2care group I now know what these are.

I love being part of the Champions Board, the kids have been so generous with sharing their experiences, opinions and their time. This has helped increase my knowledge of what it's like to be 'care experienced', ensuring my decision making at committee is informed and more effective.

The Proud2care group is such a asset to our young folk, you can clearly see the support and encouragement they receive. The safe space they provide has created an environment where the kids feel empowered to make their feelings known and also that they are able to suggest changes to the services that are provided to them.

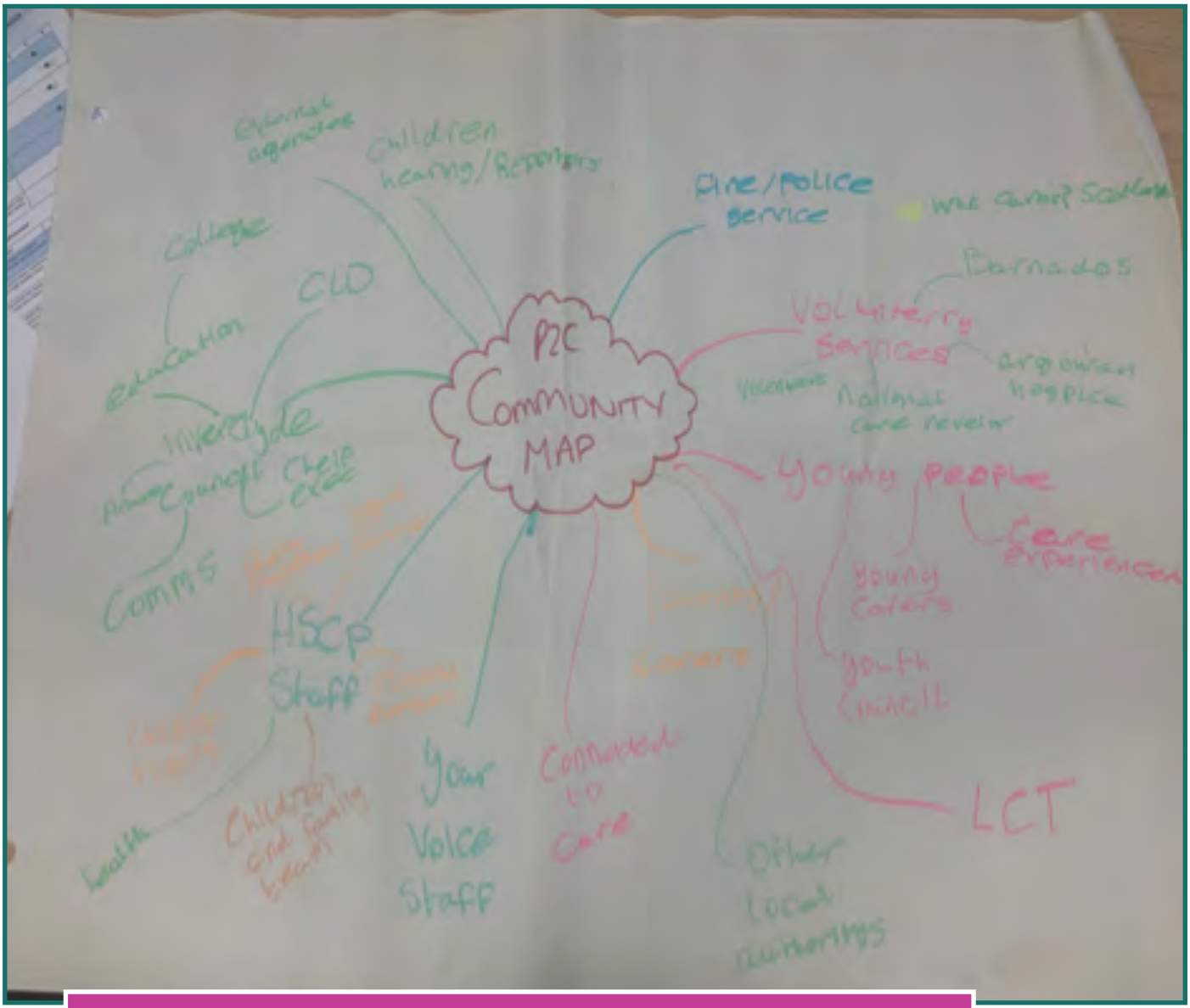
I have been so fortunate to have attended some of the events organised by the Proud2care Group, it is abundantly clear that the kids love being a part of it. It provides support, friendship and continuity in their lives. It is also a chance for the kids to get together and have some fun. I am so fortunate to get to have fun with them too. I'm a proud Corporate Mammy! "

Cllr Lynne Quinn

PARTNERSHIPS AND STAKEHOLDERS

Partnership working and resource sharing is central to the success of Proud2Care. On a weekly basis we have support from HCSP, Inverclyde Council and Your Voice to support us in the facilitation of our weekly groups alongside supporting engagements, consultations, administrative tasks, networking and planning.

Over the last 3 years we have worked with a diverse range of partners who have all contributed to the success of proud2care.



Community mapping diagram

#CONNECTED2CARE #PROUD2HEAR
#PROUD2CARE

"I would like to tell you all a little bit about what proud2care means to me. I heard about Proud2care at college when two individuals came in with volunteering opportunities. They explained that the group is for care experienced young people to come together to make positive changes within care. As a care experienced adult who grew up in Inverclyde and had both good and bad experiences, I was instantly intrigued. I thought wow, this is something I would definitely like to get involved with so, I signed up. During my time volunteering I experienced first-hand the positive impact the group has for the young people. It provides them with a secure and comfortable environment where they can come together and share their experiences of care both good and bad. Where they can leave stigma at the door and feel free to talk fluently and openly without the fear of discrimination or offending anyone. Where their voices are heard, valued, encouraged and supported.

I feel a real sense of belonging within proud2care that I struggled to find as a care experienced young person. A sense of belonging I then sought in dangerous environments. I keep thinking of my own experience of care wishing that proud2care had been around. The positive impact it could have brought to my life is undeniable. To experience that sense of belonging in a secure safe environment, to feel valued and supported and to be educated about my rights could have been just enough to reduce the feelings of low self-worth, lack of confidence, vulnerability and anxiety I went on to experience in early adulthood.

The bravery and drive I see in the young people that attend proud2care is inspiring. I am proud of them and everything they have achieved and so pleased to be able to support them in making care a better experience in Inverclyde."

Care Experienced Adult Volunteer

"I think the Proud2Care is a brilliant support for looked after young people and their carers.

It helps the young person meet other looked after young people, share how they feel, understand that there are many people like them.

It also encourages them to discuss and enables them to be involved in improving the services that support them.

They also arrange lots of fun activities with them, take them on outings during holiday periods.

All the above is a great support for me as a carer.

Also, I know that as the workers all build good relationships with our young people if I had concerns I could speak to the workers who would try to talk with my young person to address any issues. Thank you Proud2Care. "

Foster parent

Proud2Care has given both our niece and nephew a sense of responsibility and feelings of achievement. It is a great place for the kids to feel a sense of belonging and bonded with other young people in the community, which inevitably boosts their self-esteem and wellbeing.

A & MM
Kinship Carers

"Proud 2 Care group has been an outstanding influence on my daughter. A safe and open environment to openly discuss issues facing young people today, from her unique perspective as she trawls her way through the teenage years. She is inspired by her mentors at P2C, as well as her peers and has been able to increase her social skills as well transferring them to other aspects of her life at home, school and her life in general. Her coping strategies have been enhanced as well since she joined the group and she speaks highly and fondly of those that she now considers as role models.

As a parent, it is highly encouraging to see her develop her social skills, considering the pressures of the adolescent world today that kids are under, particularly with modern technologies and social networking, how the group have embraced this to further encourage my daughter to safely manage this, has been absolutely terrific. The work the group do should be championed, as given the complex needs of children with experience in care, P2C have no doubt produced a first class group for them all to share their varying experiences."

I.D, Adoptive Parent

"Having first taken up post for the Scottish Fire and Rescue Service (SFRS) as Station Commander for the Inverclyde locality 2018. I was heartened to see the approach being taken by council partners in Inverclyde to support young people with experiences in care. As a member of the Champions Board I will continue to deliver on the SFRS commitment to ensuring that the needs of looked after children and care experienced people are considered in its policy, planning and performance.

SFRS proactively support young people in Inverclyde by regularly hosting our Fire Skills programme at both Greenock and Port Glasgow with teamwork, communications skills, first aid, fire safety and personal resilience a few of the life skills that are developed during our 4 day course. Crews from the local fire stations regularly attend events the Proud2Care team deliver with the Corporate Kick About in October 2019 in support of National Care Week being a particular joy for the Amber Watch from Greenock fire station (they would have played all night).

The Proud2Care events I have attended have been excellent with the planning, delivery and passion displayed by our young people a joy to see. I look forward to supporting the Proud2Care team and the young people of Inverclyde in the coming years and guarantee the continued support from the SFRS team in Inverclyde"

M.M Station Commander

"The group has been a breath of fresh air for our young people. They look forward to meeting friends there without the pressures and stigma attached to going to other clubs in the community. They clearly feel this is a safe space for them and they trust the staff there. I feel it's crucial for their development to be able to see other people with similar stories, surviving and enjoying life.

We have even had a young person attend who has refused to engage in any other community based activities but yet has gone along to the group and really enjoyed it, looking forward to the next meeting.

Amidst this lockdown, the online alternative offered has been something our YP have looked forward to despite our technological difficulties at first

G.R.
Residential Manage

PHOTO GALLERY


INVERCLYDE
HSCP
Health and Social
Care Partnership
Proud 2 care

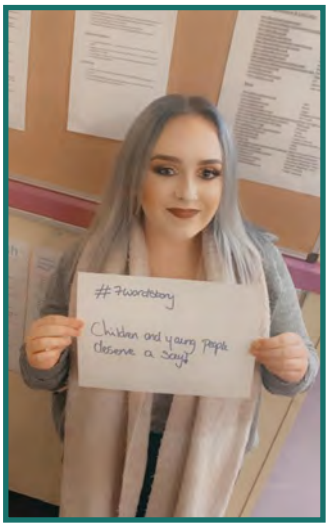

your voice


Proud 2care
Proud 2care


#7wordstory
We're not a number
We are People


i-zone


#7wordstory


#7wordstory
Children and young people
deserve a say!

THANK YOU!

Inverclyde HSCP are grateful to have received a grant for this project from the Life Changes Trust.

life changes trust
Creating better lives.

compassionate

your voice
Inverclyde Community Care Forum

our Library
Inverclyde Libraries
Inform ◦ Include ◦ Inspire

POLICE SCOTLAND
Keeping people safe

SCOTTISH FIRE AND RESCUE SERVICE

Proud 2 care

stepWell

INVERCLYDE HSCP
Health and Social Care Partnership

Inverclyde council

children's hearings scotland

MAGIC TORCH COMICS

who cares? scotland

Independent Care Review

SCOTTISH CHILDREN'S REPORTER ADMINISTRATION

This report was co produced by Proud2Care and staff
Should you require any further information on this report, please contact ERIN at Your Voice, Inverclyde Community Care Forum
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@YourVoiceICCF **@YourVoiceInver**

your voice

INVERCLYDE HSCP
Health and Social Care Partnership

AGENDA ITEM NO: 12

Report To:	**Inverclyde Integration Joint Board**	**Date: 23 June 2020**
Report By:	**Louise Long** **Corporate Director (Chief Officer)** **Inverclyde Health & Social Care Partnership**	**Report No: IJB/50/2020/DMcC**
Contact Officer:	**Dr Deirdre McCormick**	**Contact No: 07891 855805**
Subject:	**DISTRICT NURSING WORKFORCE**	

1.0 PURPOSE

1.1 The purpose of this report is to seek approval for proposed investment in our District Nursing workforce and the creation of five training places on the Specialist Practitioner Qualification in District Nursing at Glasgow Caledonian University commencing September 2020.

2.0 SUMMARY

2.1 This report seeks approval of investment to ensure local Band 6 District Nursing capacity is sustained in keeping with the NHS GGC District Nursing workforce model, to enable the delivery of safe, effective and person centred care.

2.2 The investment would enable up to five of our current community staff nurses within the District Nursing team to undertake the Specialist Practitioner Qualification in District Nursing at Glasgow Caledonian University commencing September 2020 at a cost of up to £207.3k. The full cost of this would be funded from in-year turnover savings resulting from delays in filling Health vacancies in this and other services.

2.3 This will become a rolling programme every second or third year to ensure the service workforce is maintained. A paper will come to the IJB to seek appropriate approval in future years as required.

3.0 RECOMMENDATIONS

3.1 It is recommended that the IJB approves the proposed investment of up to £207.3k to create the 5 training places.

Louise Long, Chief Officer

4.0 BACKGROUND

4.1 Role of District Nurses – Transformation

District Nurses have a central role in delivering transformational change defined around seven key elements where District Nurses have a key leadership role, public health, anticipatory care, assessment, care and case management, complexity/ frailty, intermediate care, palliative and end of life care.

4.2 District nurses provide a critical contribution to support the ambition of shifting the balance of care from hospital to community settings, avoiding unnecessary hospital admissions and enabling people to live longer and healthier lives at home by ensuring high quality person centred care. Their role in care co-ordination and joint working across health and care agencies is a crucial element of their work.

4.3 There is a board-wide and national shortage of District Nurses. All partnerships within NHS GG&C have experienced and continue to experience challenges in recruiting to Band 6 posts in order to sustain the current workforce model. Whilst staff retention in Inverclyde has been positive we are now also experiencing difficulties in recruiting to vacancies which is further compounded by our geography. It is therefore imperative that we ensure that we have a sustainable workforce model in place which will include "growing our own" staff. The National Health and Social Care Workforce Plan - Part 3 Primary Care[1], highlights the importance of the district nursing workforce in shifting the balance of care and the need to expand the current workforce. Of particular note the Scottish Government have published the Health and Care (Staffing) Scotland Bill[2], which will place a legal requirement on NHS boards and care services to ensure that appropriate numbers of suitably trained staff are in place at all times. Whilst national work has been undertaken in relation to refreshing the district nursing role as part of the Chief Nursing Officer Scottish Government transforming roles work stream, additional funding from the Scottish Government has only been made available to support training costs.

4.4 District Nurses Workforce Model

In 2012 NHS GGC commenced a review of the District Nursing Service. The aim of the review was to enable the delivery of increased time spent supporting patients and improved quality of care. The review proposed significant changes to the workforce, set out a governance framework and quality framework, maximised the efficiency benefits of agile working and defined an equitable and uniform service model which would support the move to Health and Social Care Partnerships in 2015. The proposals set out an initial phase of change for District Nursing over 3 years i.e. (2014/2017).

4.5 One of the outcomes of the review was the development of a workforce model for the service with a recommendation to move to a service model of: 1x Band 6 per 9000 registered GP patients supported by Band 5 x 2.2 WTE and Band 3 x 0.5 WTE. This gross population measure does not replace the requirement to review individual caseload size and complexity but is a safe mean target for District Nursing team configuration within partnerships. It also provided a staffing structure which aligns to the Resource Allocation Model in which age, deprivation and population are used to fairly distribute budgets across partnerships.

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[1] The National Health and Social Care Workforce Plan - Part 3 Primary Care (2018) Scottish Government

[2] Health and Care (Staffing) (Scotland) Bill (2018) Scottish Government

Table 1: Inverclyde HSCP District Nursing Team Staff Profile Base on the 2012 Model and at April 2020

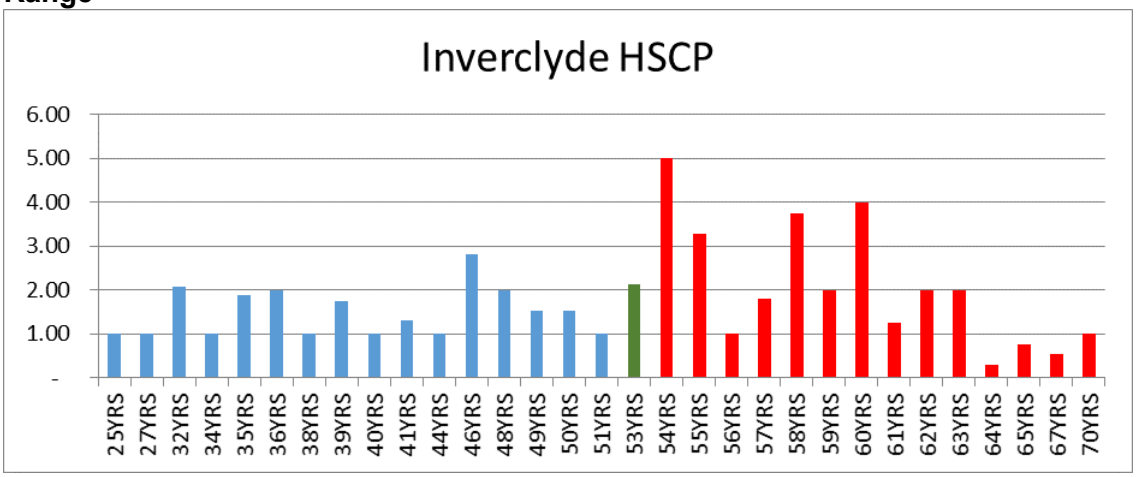
WTE	2012 Model	April 2020 Est
Band 7	1 wte	2 wte
Band 6	10 wte	6 wte
Band 5*	22 wte	22.60wte
Band 3	5 wte	4.99 wte

*Band 5: The data outlined above reflects the day care staff cohort

4.6 A second band 7 Team Leader post was agreed locally to address additional responsibilities and initiatives including treatment rooms, prevention and support service and practice development. For band 6 Inverclyde establishment is 10 WTE.

4.7 The following table illustrates the age breakdown of the Inverclyde District Nursing Team

Table 2: Inverclyde HSCP District Nursing Team Demographic Profile – Age Range



4.8 <u>Population Increase</u>

Since the District Nursing Review in 2012 the overall population within the NHSGG&C boundaries has increased from 1,289,256 to 1,313,332 – circa 14,000 (source ISD). As the original workforce model was based on one band 6 per 9,000 with pro rata additional staffing, the increase means that additional staffing is required to meet the population increase and associated increased demands for the service. From an Inverclyde perspective whilst there is depopulation in the younger age groups, older people groups are predicted to increase by 13.5% - 65 -74yrs / 8.43% - 75-84 yrs / 85+ 19.83% . Increasing morbidity and frailty are associated with increasing age. This, in turn potentially increases District Nursing caseload activity and workload.

4.9 Ageing Workforce

The average age within District Nurses day services is 45 years across NHS GGC with the out of hours element at 52 years. The service is not in isolation in relation to this average. However a key challenge of the age profile lies in the Band 6 cohort where the average age is creeps up to 51 years for day services and 56 years for Out of Hours. The average age for Band 5 staff is 41 years. It is of particular note that the average for DN services in 2013 was 42 years. As the workforce gets older, the incidence of increased absence due to sickness becomes more prevalent. The 4% National Absence target has been challenging to meet within the service.

Table 3: Staff Sickness Rates over Past 10 months

Month Year	2019 M9	2019 M10	2019 M11	2019 M12	2020 M1	2020 M2	2020 M3	2020 M4	2020 M5
Sickness Rate	6.51%	3.35%	4.03%	6.16%	8.49%	4.56%	5.09%	3.83%	4.66%

It is important to note that 12 months ago the service was under some significant pressure due to staff sickness, vacancies and other leave. This required the development of a dynamic risk assessment which was reviewed on a daily basis. The service was placed in a precarious situation which was further compounded by the lack of available staff from the Nurse Bank. This subsequently resulted in a meeting with the Professional Nurse Lead for NHS GG&C Nurse Bank to explore the possibility of identifying a staff cohort within the bank who could support the district nursing team in Inverclyde in order to develop a more local approach. Unfortunately this was not possible however it was agreed that the Professional Nurse Lead would promote working in Inverclyde and offer shadowing opportunities for bank staff and a passport outlining key skills and competencies would be developed to ensure requisite requirements to cover shifts within the community.

4.10 Additional Resource Required to Augment Current Services

It has become a trend that many District Nursing services both Day and Out of Hours have become reliant upon the Nurse Bank to plug rota gaps. Four years ago this need was little over a few hours per month. Today on average the hours used per month across NHS GGC exceeds 3,500 hours per month. To put this into context one person working fulltime for a month equates to circa 150 hours therefore this translates into 23 wte per week additional staffing. Whilst this constitutes 5% against day services in post the hours used have come from fewer than 100 per week. Bank use within Inverclyde for example in March 2020, prior to COVID-19 crisis, equated to 2.71 wte / £9,119.63.

Table 4: Bank Use in Hours by Reason – 12 Months January – December 2019

Reason Used for Bank - Hours	Grand Total	% use
Additional Sessions	324.75	0.9%
Excessive Activity	20.00	0.1%
Immunisation Programme	1,478.75	3.9%
Maternity/Paternity Leave	351.00	0.9%
Observational Studies	8.00	0.0%
Phased Retrial	106.00	0.3%
Sickness	23,879.20	62.5%
Special Leave	185.00	0.5%
Union Facility Time	21.00	0.1%
Vacancy	11,772.7	30.8%

	4	
Waiting List Initiative	15.00	0.0%
Winter Pressures	41.00	0.1%
Total hours Jan – Dec 2019	38,202.44	

4.11 The two main reasons cited for Bank usage are to cover vacancies and staff sickness. On average 2 out of 3 shifts cover sickness absence and 1 in 3 for vacancies. This trend is universal across all six HSCP's. The Bank activity data is shared across each HSCP on a monthly basis with Chief Officers and Senior Nursing staff.

4.12 Although Agency staff have not been accessed to support the service this could potentially become a reality in the future unless plans are put in place to sustain the current workforce through succession plans. The requirement for agency support during the most recent pressure on the service was avoided due to staff working additional hours and contribution from team leaders and senior nurse who supported front line care delivery. This was for a finite time period.

4.13 Staff Turnover

Overall the leaver's rate within DN services is constant. The main reason staff opt to retire is age related at around 60% for across NHS GGC.

Table 5: Inverclyde HSCP – District Nurse (DN) Leavers (wte's) – All Bands

Year	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20*	Grand Total
No of DN Leavers	2.06	1.84	2.88	4.21	4.47	3.81	19.27

*April – December (9months)

4.14 Band 6 Availability Changes Over the Next 12 Months

Retirals: Out of 10 Band 6 staff required for district nursing, 4 have confirmed retirement over the next 3 months with a further 2 planning to retire by 2021. Of the remaining 6, 3 have only qualified this year, and the remaining 3 are over 55 years. It is considered highly likely that the impact of the COVID-19 pandemic has contributed to staff bringing forward their retirement plans.

4.15 Band 5 Availability Changes Over the Next 12 Months

Over the past 2 years the Band 5 cohort have changed significantly due to leavers, retirements and subsequent recruitment. This has improved the staff demographic and the new staff are gaining invaluable experience with the support of the more experienced Band 5 community staff nurses and the District Nurses Band 6. It is recognised that there is great potential for future learning and development in this staff group and opportunity to access the District Nursing specialist programme.

4.16 District Nursing has been using the National Community Nursing Assessment Workload tool for several years. The findings on the actual breakdown of services and activity are shared and accessed locally. In summary, the trends of activity remain constant. On average three and a half days per week are aligned to patient care. The remainder is aligned to non-clinical administration. The clinical activity element indicates that most of the contacts require complex interactions and accounts for the majority of patient contact. Inverclyde District Nursing teams have performed consistently well in terms of both patient-facing time and non-face to face patient related activity with data for both above the NHS GG&C average. For example, data from the workload tool run in June 2019 highlighted the following: Band 3 - 72%

patient related activity (51% patient facing time), Band 5 – 69% patient related activity (47% patient facing time) and Band 6 – 38% patient related activity (23% patient facing time).

4.17 The other two elements of the tool – the Quality element and the Professional Judgement element to date have been difficult to determine mainly due to the construct of the recording mechanism. Managers are encouraged to record data in these two areas honestly in the window when the data is recorded with services described as they are with the appropriate rationale provided for actions taken. A numeric score is available through an algorithmic calculator that determines percentage performance of service and potential required in post. This can corroborate the "in post" available but not always. Efforts are ongoing to refine and develop a systematic and standardised approach to workforce and workload planning to ensure valid and reliable outcomes. Further work is required to refine the current tool.

4.18 District nursing activity is projected to see very significant increases by 2025 driven by an ageing population, increasing numbers of older people with complexities, frailty and co-morbidity issues. The impact of the demographic shift will be particularly pronounced within Inverclyde HSCP with very high projected increases in care associated with an increase in population in the older age group coupled with the level of deprivation.

4.19 Of particular note, the impact of the COVID-19 crisis has necessitated a review of district nursing workload with a focus on the delivery of more complex care and a greater emphasis on patient self-care and / or training relatives and carers to support delivery of specific interventions. This should be considered as part of discussions on our future service as we move into COVID- 19 recovery phase and beyond which is a key leadership task for Band 6 District Nurses.

4.20 Implementation of the General Practitioner contract and Primary Care Improvement Plans will require a significant shift of work from General Practitioners to the wider health care team and has implications for District Nursing workload. For example, the recent introduction and current implementation of the Confirmation of Death by registered healthcare professionals in Scotland has implications for District Nursing workload.

4.21 There are opportunities as part of our COVID- 19 recovery plans and in line with our transforming agenda to consider how to further develop and optimise the contribution of District Nurses and our Advanced Nurse Practitioners to adopt more integrated ways of working to meet future needs.

4.22 <u>Recruitment to the Specialist District Nursing Programme</u>

Traditionally, staff from Inverclyde have accessed the District Nursing programme at the University of the West of Scotland (UWS). However, as a result of the COVID-19 crisis and temporary pause of the current programme, UWS will not be offering the programme in September 2020 to a new student cohort. The programme will be run at Glasgow Caledonian University (GCU) on a full-time basis and interviews were held to recruit to the programme late May. Discussions have taken place with the programme lead at GCU to advice of a potential for 5 students from Inverclyde HSCP subject to required funding to support backfill and successful candidate interviews. As previously outlined, we will have 6 band 6 vacancies by 2021.

4.23 To date, no backfill has been provided for staff released to undertake the Specialist Practitioner Qualification. This has impacted on the workload of teams and has resulted in caseloads for Band 6 staff being higher than the model agreed during the NHS GGC District Nursing Review in 2012. As the five requested places are a full-time basis of one year, this will add an additional pressure within the service as there will

be no capacity for staff who would previously have been part time to continue to contribute part-time to service delivery.

4.24 In preparation of and in anticipation of funding, we have invited community staff nurses within the district nursing service to express interest in undertaking the programme starting in September 2020. We have had five expressions of interest. All staff are ready in terms of their experience and academic requirements, willing and able to commit to the demands of the programme.

5.0 PROPOSAL

5.1 Whilst it is recognised that all services will experience risks pre COVID -19 as we now move to recovery and forward into a new order, District Nursing services are arguably more vulnerable than most. Trend data suggests that absence rates are problematic and not likely to change and the evidence available indicates the use of the Nurse Bank to augment the service. These issues coupled with an ageing workforce, workload activity, rising demands of the service and the need for wider transformational change in line with our strategic plan have associated workload and workforce implications. As highlighted earlier, this position is not unique to Inverclyde and is reflected not only across NHS GGC but across Scotland.

5.2 The age profile within the existing workforce is placing growing demands on the district nursing service. The risks are principally with respect to the band 6 District Nursing workforce hence the requirement for robust succession plans to support a sustainable workforce. Evidence indicates that since the District Nurse review in 2012, demographic changes have and will continue to significantly increase demand pressures on the District Nursing service.

5.3 There is evidence of a growing gap between capacity and demand in district nursing services creating pressures which may impact on the quality of care, result in increasing task focused approaches and missed opportunities for prevention activity and anticipatory care. In order to meet the growing demand, it is therefore essential that the district nursing workforce is adequately resourced to meet the challenge of not only sustaining current workforce model but to meet the projected future workforce requirements for the service.

5.4 Understanding the cumulative impact of the identified factors on the District Nurse workforce has informed the projection of the workforce required to meet future demands. It is therefore proposed that for the academic year 2020-2021, Inverclyde HSCP requires to support 5 nurses to undertake the Specialist Practitioner Qualification in District Nursing, and agrees to provide financial support for the necessary backfill for the band 5 community staff nurses for the duration of their studies i.e. one year.

5.5 Five Community Staff Nurses within the District Nursing team have expressed interest in undertaking the programme. It is therefore proposed that these staff are presented to attend for interviews which will be held in collaboration with colleagues from GCU later this month/ early July. Backfill for the community nursing posts will be undertaken to ensure that those appointed are keen to pursue the programme at a future date to support workforce planning.

6.0 FUNDING

6.1 The cost of the training course for 5 places is £23,700 and this is fully funded by NHS NES. The associated costs of backfill on a fixed-term basis via additional staffing are outlined in Table 6, these are based on estimates at the top of the grade, actual costs might be lower depending where on Band 5 the backfill staff are placed.

Table 6: Associated Costs of 5 Band 5 Community Staff Nurses Undertaking the District Nursing Specialist Practitioner Programme Full Time at GCU

Backfill Staffing	Total Cost (incl ERS)
5 Band 5s for 40 weeks converting to Band 6s for last 12 weeks*	£207.3k

*In line with the workforce agreement across NHS GGC students will be uplifted to Band 6 for the final three months of their programme.

6.2 It is proposed that these costs are funded through in-year turnover savings from across the Health and Social Care Partnership. This year and in previous years the IJB agreed to use an element of its turnover savings to fund pressures in Mental Health Inpatients budgets. It is proposed that in 2020/21 £207.3k of turnover savings are allocated against this programme to support the District Nursing service. Overall turnover savings in relation to HSCP Health last year were £1.022k, excluding underspends relating to ringfenced Scottish Government funded projects such as Action 15, ADP and PCIP.

6.3 This will become a rolling programme every second or third year to ensure the service workforce is maintained. A paper will come to the IJB to seek appropriate approval in future years as required.

7.0 DIRECTIONS

7.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	X
	4. Inverclyde Council and NHS GG&C	

8.0 IMPLICATIONS

8.1 FINANCE

The financial implications are as outlined in this report.

One-off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
District Nursing	Emp Costs	2020/21	207.3	Emp Costs – in year turnover savings	

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

LEGAL

8.2 There are no specific legal implications arising from this report.

HUMAN RESOURCES

8.3 There are no specific human resources implications arising from this report.

EQUALITIES

8.4 There are no equality issues within this report.

8.4.1 Has an Equality Impact Assessment been carried out?

	YES
√	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

8.4.2 How does this report address our Equality Outcomes

There are no Equalities Outcomes implications within this report.

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	None
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

8.5 **CLINICAL OR CARE GOVERNANCE IMPLICATIONS**

The requested funding will ensure that the district nursing service will adhere to the NHS GGC District Nursing Model and enable the continued delivery of a safe, effective and person centred district nursing service for the people of Inverclyde.

8.6 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes

There are no National Wellbeing Outcomes implications within this report.

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	None
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	None
Health and social care services contribute to reducing health inequalities.	None
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None
People using health and social care services are safe from harm.	None
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Investment in our workforce and training is a key element of this outcome
Resources are used effectively in the provision of health and social care services.	This ensures we have an appropriately trained workforce in place to deliver key services

9.0 CONSULTATION

9.1 This report has been prepared by the Chief Nurse in consultation with other members of the Senior Management Team.

AGENDA ITEM NO: 13

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**23 June 2020**
Report By:	**Louise Long Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/48/2020/LL**
Contact Officer:	**Louise Long**	**Contact No:**	
Subject:	**COVID MORTALITY REPORT JUNE 2020**		

1.0 PURPOSE

1.1 The purpose of this report is to update the IJB on the epidemiological review by Public Health into the excess deaths in Inverclyde associated with COVID19.

2.0 SUMMARY

2.1 The enclosed paper sets out an analysis of excess deaths in Inverclyde associated with the current COVID19 pandemic.

2.2 Excess deaths associated with the COVID19 pandemic had been raised as an issue affecting the population of Inverclyde. The report considers a number of potential explanations for this, including age profile, socioeconomic deprivation and an earlier date of sustained transmission.

2.3 The report concludes that "*the most likely scenario ….is that the pandemic took hold earlier in Inverclyde in comparison with other areas of Scotland and NHSGGC. This fits with the higher positive rates of COVID19 testing in Inverclyde, and with the higher admission rates of patients with COVID19 in Inverclyde"*.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the report.

Louise Long
Chief Officer

4.0 BACKGROUND

4.1 COVID19 related deaths in Inverclyde were first reported in the week commencing 23 March 2020 when there were 3 reported deaths. The peak death rate with COVID19 was the week commencing 6 April 2020 when there were 32 deaths. From the report attached at Appendix 1, we can see that Inverclyde experienced an earlier rise in COVID19 deaths in comparison with NHSGGC and local partnerships, which were in turn higher than Scotland.

4.2 HSCP and Council officers engaged with Public Health to gain a better understanding of the disparity between the Inverclyde statistics on COVID19 and other excess deaths compared with the rest of GG&C and the rest of Scotland. This review and report were requested as part of those discussions.

5.0 CONCLUSIONS

5.1 It seems unlikely that age, sex and deprivation explain the pattern of COVID19 deaths in Inverclyde in comparison with NHSGGC.

5.2 There is some evidence that the COVID19 positive testing rate was higher in Inverclyde than in other areas.

5.3 The most likely scenario which explains the excess deaths in Inverclyde is that the pandemic took hold earlier in Inverclyde in comparison with other areas of Scotland and NHSGGC. This fits with the higher positive rates of COVID19 testing in Inverclyde, and with the higher admission rates of patients with COVID19 in Inverclyde. This most likely reflects the early nature of the pandemic experience in Inverclyde, and a greater propensity to admit cases where there was no experience of their clinical needs at an early stage of the pandemic.

5.4 There is no evidence that the quality of care or access to care was worse in Inverclyde, as the admission rates were higher than across the rest of NHSGGC, and there was no difference in the death rates from those in Inverclyde admitted with COVID19 in comparison with NHSGGC as a whole. This would not support the access and quality of care hypothesis.

6.0 IMPLICATIONS

FINANCE

6.1 There are no specific financial implications in this report.

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

LEGAL

6.2 There no specific legal implications arising from this report.

HUMAN RESOURCES

6.3 There no specific human resources implications arising from this report.

EQUALITIES

6.4 Has an Equality Impact Assessment been carried out?

	YES
X	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

6.5.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	None
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

6.6 There no clinical or care governance implications arising from this report.

NATIONAL WELLBEING OUTCOMES

6.7 How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	None
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	None
Health and social care services contribute to reducing health inequalities.	This report seeks to understand the increased COVID 19 mortality in Inverclyde and ensure it is not linked to Health Inequalities
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None
People using health and social care services are safe from harm.	None
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	None
Resources are used effectively in the provision of health and social care services.	As above

7.0 DIRECTIONS

7.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	X
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	
	4. Inverclyde Council and NHS GG&C	

8.0 CONSULTATION

8.1 The report has been prepared based on discussions between HSCP, Council and Public Health officers and the attached report from Public Health.

9.0 BACKGROUND PAPERS

9.1 None.

AN ANALYSIS OF EXCESS DEATHS ASSOCIATED WITH COVID19 IN INVERCLYDE

June 2020

John O'Dowd & Paul Burton

SITUATION

1. This paper sets out an analysis of excess deaths in Inverclyde associated with the current covid19 pandemic. It analyses the impact of deprivation and age and considers possible explanations.

BACKGROUND

2. Following the identification of a novel coronavirus in Wuhan, China in January of this year, deaths where the clinical disease associated with this virus, called COVID19, were recorded in Scotland starting in the week commencing 16 March 2020.

3. Deaths can be classified as relating to COVID19 in which the diagnosis COVID19 is mentioned somewhere on the death certificate, or non-COVID19 related. The main factors associated with raised death rates from COVID19 are: age, poverty (socio-economic deprivation); and having chronic diseases, so called 'co-morbidity'.

4. Excess deaths associated with the covid19 pandemic has been raised as an issue affecting the population of Inverclyde. A number of potential explanations for this finding need to be considered. Possible epidemiological reasons could include:

    a. The age profile of the population

    b. The socioeconomic deprivation profile of the population

    c. An earlier date of sustained transmission for coronavirus in Inverclyde in comparison with other areas.

5. An alternative possible explanation for excess deaths relate to access and quality of services. Data on numbers of cases of covid19 and deaths from covid19 in hospitals as well as the distribution of deaths across other settings have been examined in this report in order to explore this possible hypothesis.

METHODS

6. We explored the trajectory of deaths in Inverclyde, NHSGGC and other selected local authorities to identify if there was evidence that some of the excess deaths might be explained by an earlier impact of covid19 in Inverclyde. We used virus testing data to track the incidence of the disease. There is a significant caveat to the use of the testing data, as testing was not widespread or during the time in question, being limited initially to those meeting very tight case definition which involved travel or contact with a known case.

7. In order to explore the epidemiological hypotheses, we used the method of indirect standardisation in which the age, gender and area-based socioeconomic data across the wider NHSGGC population is applied to the local Inverclyde population in order to explore if the local rates are higher or lower than expected. In this method the rates from the NHSGGC population are applied to the Inverclyde population. The NHSGGC ratio is set at 100.A lower observed rate in Inverclyde is therefore lower than 100 and a higher rate is greater than 100. This standardised finding was then subjected to a statistical check to explore if the differences observed were robust, or if they may have arisen by chance. This method was designed to address hypotheses a and b: that the age and deprivation of the local population could explain all of the variation in Inverclyde. Hypothesis c was explored using the testing and disease data. Finally, the care access and quality hypothesis was explored by examining admission access to secondary care for covid19, and hospital-based death rates for those in hospital with covid19.

ANALYSIS

8. COVID19 related deaths in Inverclyde were first reported in the week commencing 23 March 20 when there were 3 reported deaths. The peak death rate with COVID19 was week 15, commencing 6 April 2020 when there were 32 deaths. From week 10 to week 23 there were 112 deaths with covid19. The cumulative mortality rate across local geographies is shown in Figure 1. This shows the higher crude rate per 100,000 residents across NHSGGC, local partnerships and Scotland, with a higher rate in Inverclyde in comparison with NHSGGC and local partnerships, which were in turn, higher than Scotland. The chart also shows an earlier rise in Inverclyde in comparison with the other geographies.

9. We know that socio-economic deprivation has a profound impact on covid19 related illness and death and on the requirements for recovery. Figure 2 shows an analysis of covid19 by deprivation quintiles across NHSGGC, with quintile 1 being people living in the most deprived areas, and quintile 5 being those in the most affluent areas. It can be seen that both hospitalisations and deaths from covid19 are significantly higher in those living in the poorest circumstances in comparison with those in the most affluent areas. This analysis is challenging to perform at a partnership level due to the smaller numbers involved.

Figure 1 Crude cumulative covid19 mortality rate for Inverclyde and local partnership and board areas.

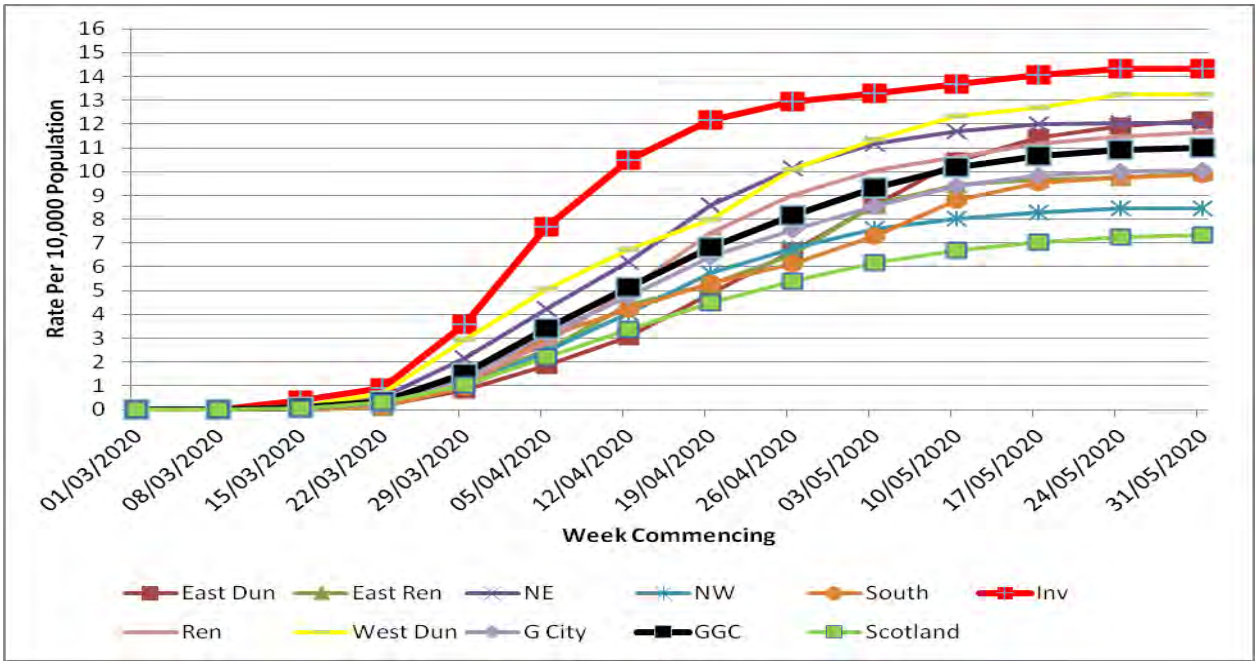
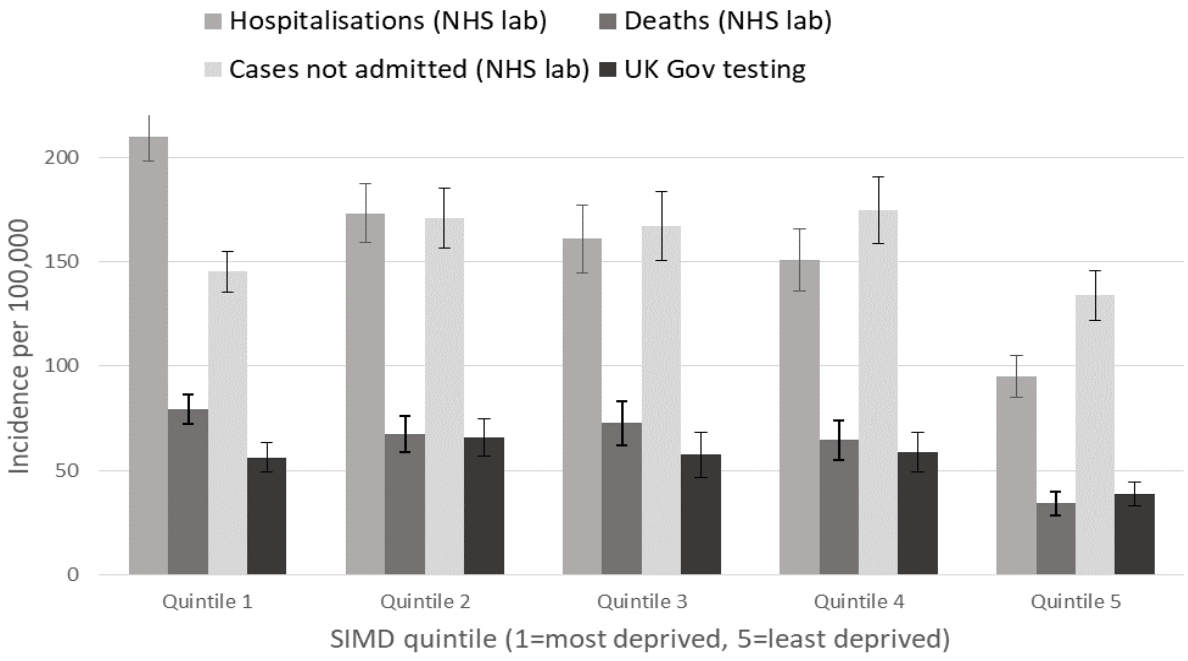


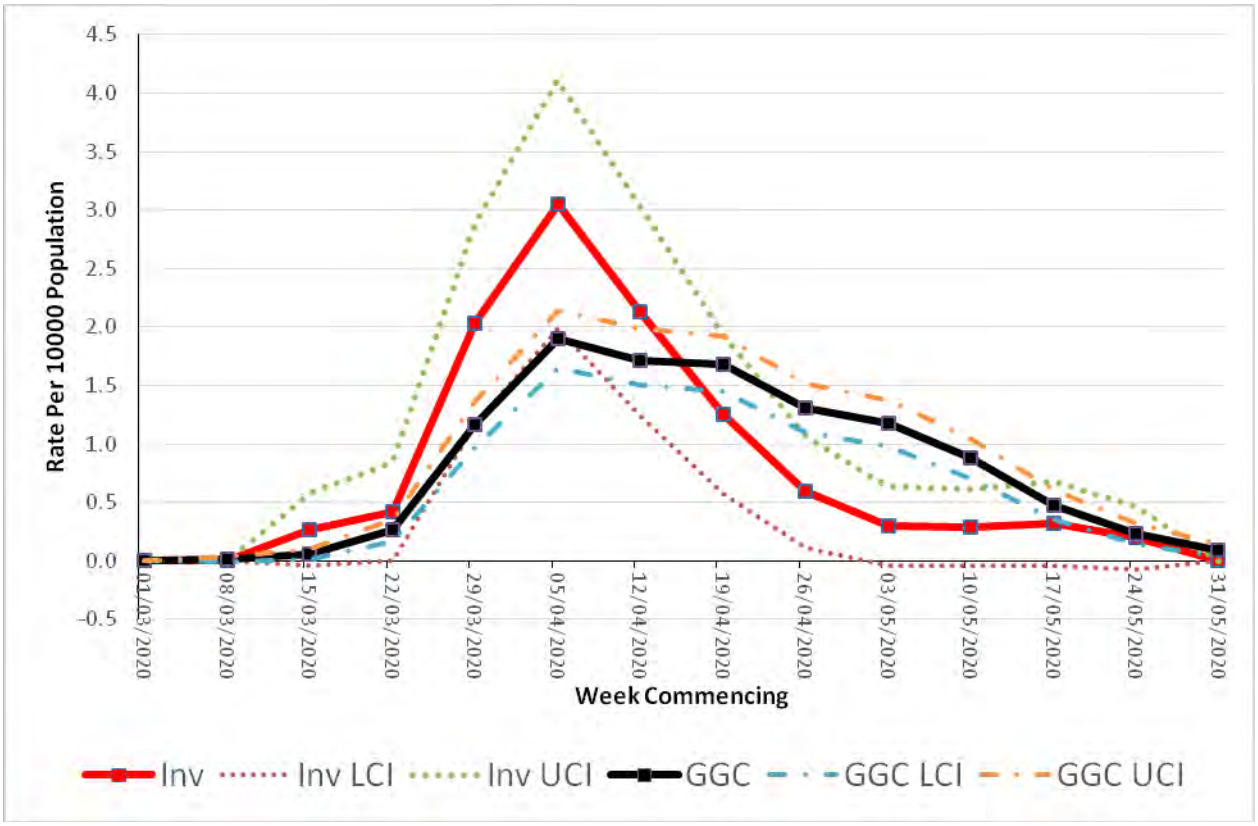
Figure 2 Incidence of confirmed Covid-19 hospitalisations, deaths, and cases not admitted to hospital, by SIMD quintile, NHSGGC, 01 March - 10 June 2020. Reproduced courtesy of Dr Iain Kennedy.



10. To test if the impact of an older population, or a more disadvantaged population might explain the higher numbers of deaths in Inverclyde, we used a method called indirect standardisation. This approach can be performed at local level and it involves taking the age, sex and deprivation specific death rates across NHSGGC and applying these to the Inverclyde population. In this method, the observed Inverclyde mortality is compared with the expected mortality which we would have seen had the NHSGGC rates applied in Inverclyde. In order to allow for the effect of chance in the figures we have calculated confidence intervals for this method.

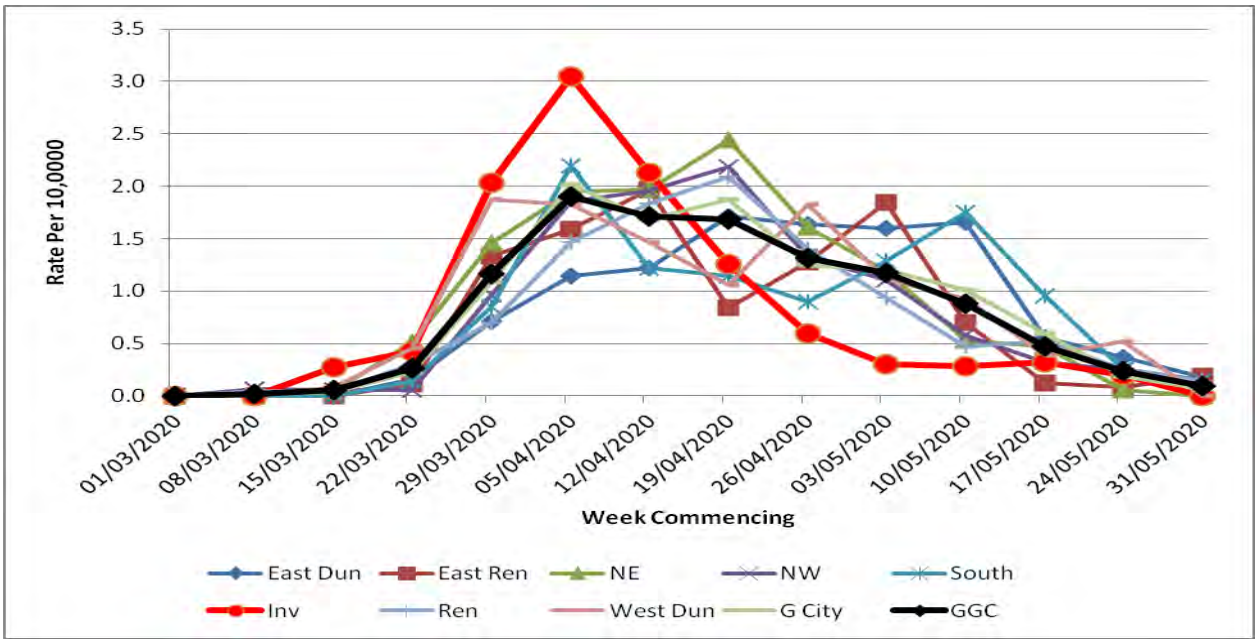
11. Figure 3 shows the weekly standardised mortality rates from covid19 for Inverclyde and NHSGGC. The solid lines represent the weekly rates. The dotted lines and the confidence limits for Inverclyde rates, and the dashed lines are the confidence limits for the NHSGGC rates. The Inverclyde limits are very wide as the population is small, increasing the uncertainty. The NHSGGC limits are narrower as the population is larger, which reduces uncertainty. The only point where the limits do not overlap is in late April and early May where NHSGGC is significantly **higher** than Inverclyde. In the early part of the pandemic, the SMR for Inverclyde is far higher than that of NHSGGC (3.0 versus 1.9 per 10,000) but the difference at this point was not statistically significant in comparison with NHSGGC rates. We can therefore see that with standardisation for age, sex and deprivation, whilst a higher mortality rate remains, **the difference may have arisen by chance.**

Figure 3 Weekly indirectly standardised mortality rates for covid19 for Inverclyde and NHSGGC. In addition to the rates, the 95% confidence intervals are plotted using dotted and broken lines.



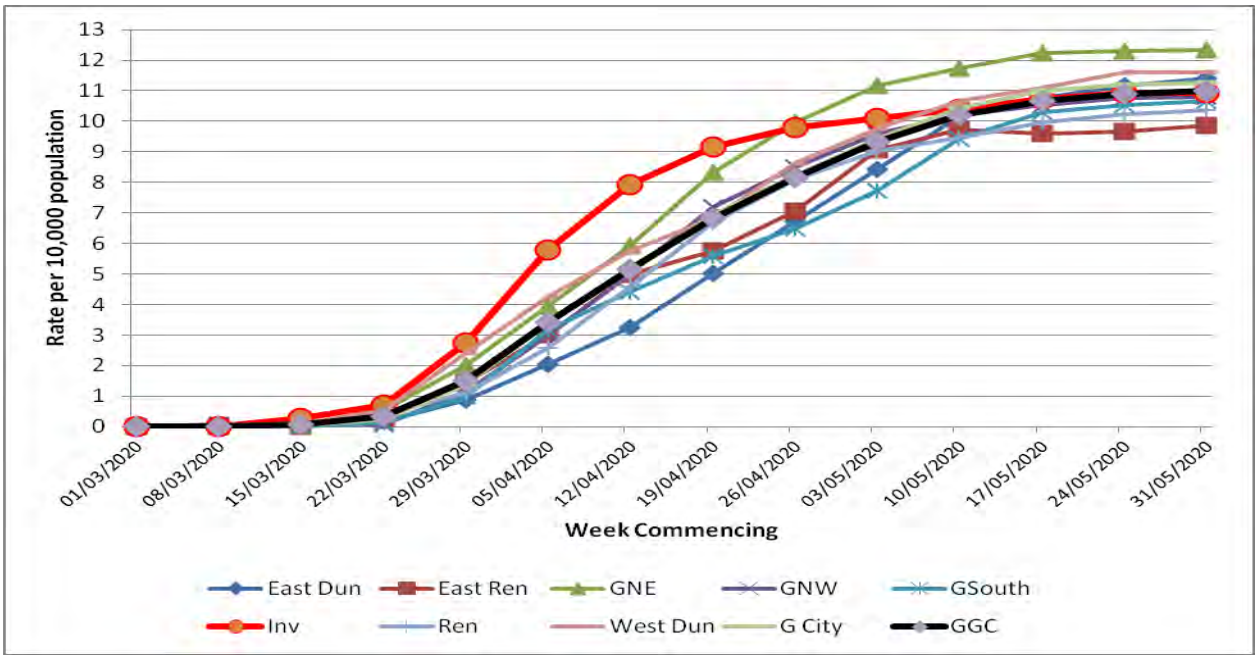
12. From Figure 4 we can see that Inverclyde experienced an earlier rise in COVID19 deaths than was the case in other similar-sized NHSGGC local authority areas.

Figure 4 Indirectly standardised covid19 death rate for NHSGGC areas by week.



13. Figure 5 displays the trajectory of standardised, cumulative covid19 death rates for Inverclyde versus NHSGGC, and this also clearly shows the faster initial rise in Inverclyde, with the rates catching up later across the rest of NHSGGC.

Figure 5 Standardised covid19 cumulative death rates per 10,000 residents for Inverclyde, NHSGGC and other local partnership areas. Source of data NRS.

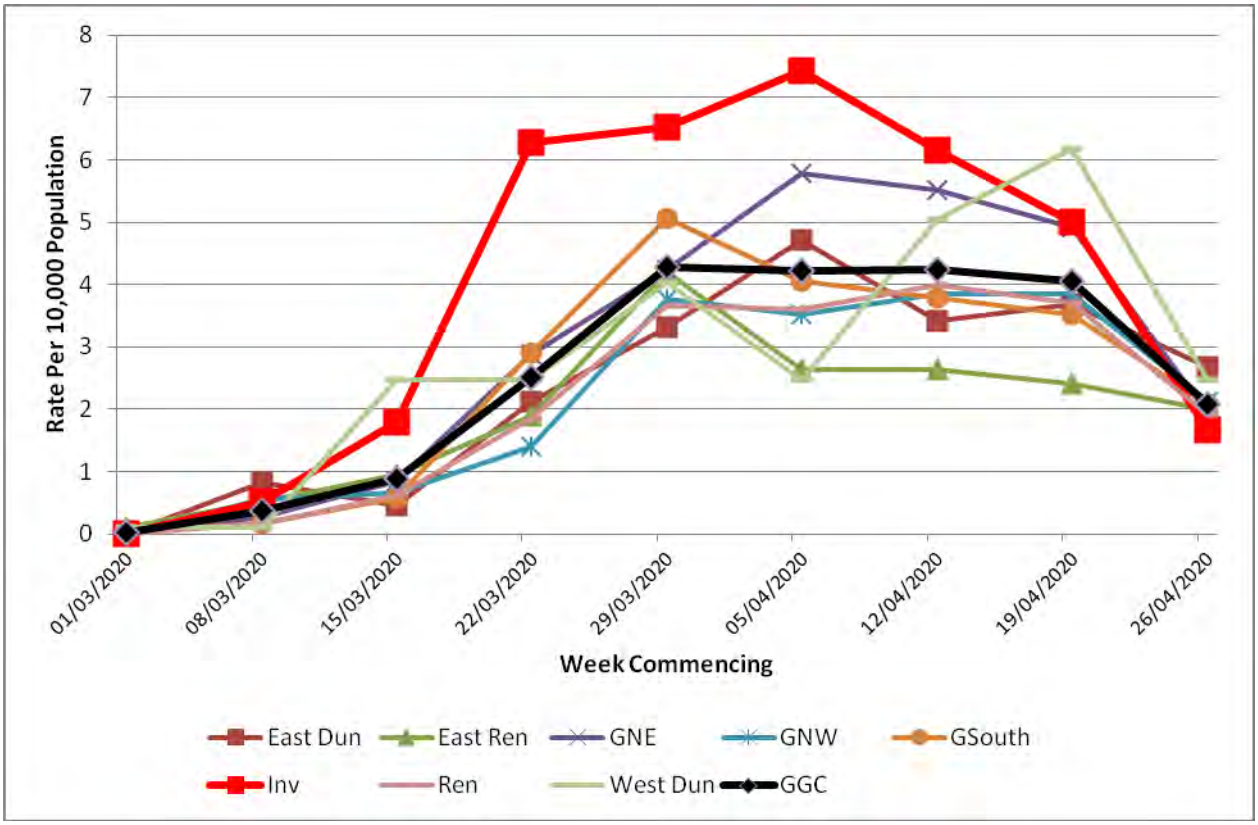


14. We examined the location of covid19 deaths: in hospital; in a care home; or other place. The crude proportion of covid19 deaths in Inverclyde initially appeared to be higher in hospital and lower in care homes in comparison with NHSGGC. However, when the deaths from covid19 were indirectly standardised, there was **no significant difference between Inverclyde and NHSGGC**.

15. We examined the admission rates with covid19 for Inverclyde versus NHSGGC, and over the period of the pandemic, the indirectly standardised **covid19 admissions rate in Inverclyde was significantly higher than that across NHSGGC as a whole** (SAR- Standardised Admission Rate – for Inverclyde was 121.8 in comparison with NHSGGC set at 100). We also compared the death rate from covid19 in Inverclyde with that across NHSGGC for the period, and in this case the SMR was 96.0 in comparison with 100 for NHSGGC: there was **no significant difference statistically**.

16. We examined the available covid19 testing data which was available from week 11 (w/c 8 March 2020) and this shows evidence of **higher rates of positive covid19 results per 10,000 population in Inverclyde in comparison with NHSGGC and other geographies**. It should be borne in mind that testing criteria and capacity were severely limited during the early part of the pandemic, however this evidence would suggest that there was a higher level of circulating covid19 in Inverclyde in comparison to the rest of NHSGGC (see Figure 6).

Figure 6 Positive covid19 tests per 10,000 people per week for NHSGGC geographies. Week 10 starts week commencing 8 March 2020.



FINDINGS

17. Inverclyde experienced earlier rises in death rates in the pandemic. Age, sex and deprivation alone are unlikely to explain all of this difference. It should be noted that after standardisation, the difference in death rates may have occurred by chance.

18. Inverclyde appears to have experienced higher positive covid19 rates throughout the pandemic, and it is considered likely that the rates were much higher than recorded due to testing criteria and availability early in the pandemic.

19. Inverclyde experienced significantly higher rates of admission of persons with covid19 in comparison with NHSGGC.

20. There was no significant difference in place of death between Inverclyde and NHSGGC.

21. There was no significant difference in the hospital death rates for persons admitted with covid19 in Inverclyde in comparison with NHSGGC.

CONCLUSIONS

22. It seems unlikely that age, sex and deprivation explain the pattern of covid19 deaths in Inverclyde in comparison with NHSGGC. This finding tends not to support hypotheses a and b.

23. There is some evidence that the covid19 positive testing rate was higher in Inverclyde than in other areas. This would tend to support hypothesis c.

24. The most likely scenario which explains the excess deaths in Inverclyde is that the pandemic took hold earlier in Inverclyde in comparison with other areas of Scotland and NHSGGC. This fits with the higher positive rates of covid19 testing in Inverclyde, and with the higher admission rates of patients with covid19 in Inverclyde. This most likely reflects the early nature of the pandemic experience in Inverclyde, and a greater propensity to admit cases where there was no experience of their clinical needs at an early stage of the pandemic.

25. There is no evidence that the quality of care or access to care was worse in Inverclyde, as the admission rates were higher than across the rest of NHSGGC, and there was no difference in the death rates from those in Inverclyde admitted with covid19 in comparison with NHSGGC as a whole. This would not support the access and quality of care hypothesis.