Municipal Buildings, Greenock PA15 1LY

Ref: DS

Date: 11 March 2022

A meeting of the Inverclyde Integration Joint Board will be held on Monday 21 March 2022 at 2pm.

This meeting is by remote online access only through the videoconferencing facilities which are available to members of the Integration Joint Board and relevant officers. The joining details will be sent to participants prior to the meeting.

In the event of connectivity issues, participants are asked to use the *join by phone* number in the Webex invitation.

Information relating to the recording of meetings can be found at the end of this notice.

IAIN STRACHAN
Head of Legal & Democratic Services

BUSINESS		
1.	**Apologies, Substitutions and Declarations of Interest**	**Page**
ITEMS FOR ACTION:		
2.	**Minute of Meeting of Inverclyde Integration Joint Board of 24 January 2022**	**p**
3.	**Voting Membership of the Inverclyde Integration Joint Board and Membership of the Inverclyde Integration Joint Board Audit Committee** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	
4.	**Rolling Action List**	
5.	**Financial Monitoring Report 2021/22 – Period to 31 December 2021, Period 9** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
6. **	**IIJB Budget** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
7.	**Unscheduled Care Commissioning Plan (Design & Delivery Plan 2022/23 – 2024/25)** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
8.	**Update on Implementation of Primary Care Improvement Plan** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**

ITEMS FOR NOTING:		
9.	**CPC Annual Report 2020-21** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
10.	**Age of Criminal Responsibility (Scotland) Act 2019** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
11.	**Dementia Care Co-ordination Programme Update** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
12.	**Care Home Assurance Themes and Trends Report** Report by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
13.	**Chief Officer's Report (Verbal Update)** Verbal update by Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	
14.	**Minute of Meeting of IIJB Audit Committee of 24 January 2022** NB There will also be a verbal update by the Chair of the IIJB Audit Committee providing feedback on their meeting earlier in the day	**p**
	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 paragraphs 6 & 9 of Part I of Schedule 7(A) of the Act.	
ITEMS FOR ACTION:		
15.	**Reporting by Exception – Governance of HSCP Commissioned External Organisations** Report by Interim 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.	**p**

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

Please note that the meeting will be recorded for publishing on the Inverclyde Council's website. Inverclyde Council is a Data Controller under UK GDPR and the Data Protection Act 2018 and data collected during any recording will be retained in accordance with Inverclyde Council's Data Protection policy, including, but not limited to, for the purpose of keeping historical records and making those records available.

By entering the online recording please acknowledge that you may be filmed and that any information pertaining to you contained in the video and oral recording of the meeting will be used for the purpose of making the recording available to the public.

Enquiries to – **Diane Sweeney** - Tel 01475 712147

Inverclyde Integration Joint Board
Monday 24 January 2022 at 2pm

PRESENT:

Voting Members:

Alan Cowan (Chair)	Greater Glasgow and Clyde NHS Board
Councillor Jim Clocherty (Vice Chair)	Inverclyde Council
Councillor Lynne Quinn	Inverclyde Council
Councillor Luciano Rebecchi	Inverclyde Council
Councillor Elizabeth Robertson	Inverclyde Council
Simon Carr	Greater Glasgow and Clyde NHS Board
Ann Cameron-Burns	Greater Glasgow and Clyde NHS Board
Ian Ritchie	Greater Glasgow and Clyde NHS Board

Non-Voting Professional Advisory Members:

Allen Stevenson	Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership
Anne Glendinning	On behalf of Sharon McAlees, Chief Social Work Officer
Craig Given	Chief Finance Officer, Inverclyde Health & Social Care Partnership
Dr Chris Jones	Registered Medical Practitioner

Non-Voting Stakeholder Representative Members:

Gemma Eardley	Staff Representative, Health & Social Care Partnership
Diana McCrone	Staff Representative, NHS Board
Charlene Elliot	Third Sector Representative, CVS Inverclyde
Christina Boyd	Carer's Representative
Hamish MacLeod	Service User Representative, Inverclyde Health & Social Care Partnership Advisory Group

Additional Non-Voting Member

Stevie McLachlan	Inverclyde Housing Association Representative, River Clyde Homes

Also present:

Vicky Pollock	Legal Services Manager, Inverclyde Council
Alan Best	Interim Head of Health & Community Care, Inverclyde Health & Social Care Partnership
Anne Malarkey	Head of Homelessness, Mental Health & Drug & Alcohol Recovery Services, Inverclyde Health & Social Care Partnership
Arlene Mailey	Service Manager, Quality & Development, Inverclyde Health & Social Care Partnership
Diane Sweeney	Senior Committee Officer, Inverclyde Council
Lindsay Carrick	Senior Committee Officer, Inverclyde Council
Karen Haldane	Executive Officer, Your Voice Inverclyde Community Care Forum

INVERCLYDE INTEGRATION JOINT BOARD – 24 JANUARY 2022

Chair: Alan Cowan presided

The meeting took place via video-conference.

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

Apologies for absence were intimated on behalf of:

Sharon McAlees	Chief Social Work Officer, Inverclyde Health & Social Care Partnership (with Anne Glendinning substituting)
Laura Moore	Chief Nurse, NHS GG&C
Dr Hector MacDonald	Clinical Director, Inverclyde Health & Social Care Partnership

Ms C Boyd declared an interest in agenda item 9 (Reporting by Exception – Governance of HSCP Commissioned External Organisations).

Prior to commencement of business the Chair advised that Ms Paula Speirs had resigned from the IIJB and that Mr Ian Ritchie was acting as proxy until the vacancy was filled. The Chair acknowledged the valuable contribution Ms Speirs had made to the IIJB and that she would be missed. The Chair further advised that Ms Ann Cameron-Burns was attending her first meeting following the resignation of Ms Dorothy McErlean, and welcomed Mr Ritchie and Ms Cameron-Burns to the meeting.
The Chair congratulated Ms Anne Malarkey on being formally appointed as Head of Homelessness, Mental Health & Drug & Alcohol Recovery Services, Inverclyde Health & Social Care Partnership.

2 Minute of Meeting of Inverclyde Integration Joint Board of 1 November 2021 **2**

There was submitted the Minute of the Inverclyde Integration Joint Board of 1 November 2021.
The Minute was presented by the Chair and checked for fact, omission, accuracy and clarity.
Decided: that the Minute be agreed.

3 Minute of Meeting of Inverclyde Integration Joint Board of 29 November 2021 **3**

There was submitted the Minute of the Inverclyde Integration Joint Board of 29 November 2021.
The Minute was presented by the Chair and checked for fact, omission, accuracy and clarity.
Decided: that the Minute be agreed.

4 Voting Membership of the Inverclyde Integration Joint Board **4**

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership advising the Board of a change in its voting membership arrangements.
The report was presented by Ms Pollock and advised that Ms Dorothy McErlean had recently stepped down as a Non-Executive Director of Greater Glasgow and Clyde NHS Board and that this membership role would now be filled by Ms Ann Cameron-Burns,

who had been appointed by Greater Glasgow and Clyde NHS (NHS GG&C) Board in terms of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

Decided: that the appointment by NHS GG&C Board of Ann Cameron-Burns as a voting member of the Inverclyde integration Joint Board be noted.

5 Financial Monitoring Report 2021/22 – Period to 31 October 2021, Period 7 **5**

There was submitted a report by the Interim 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 with a detailed report as at Period 7 to 31 October 2021.

The report was presented by Mr Given and noted that the Covid-19 pandemic had created significant additional cost pressures across the HSCP and that the figures presented included projected Covid costs offset against confirmed Covid funding. The report advised that at Period 7 there was projected overspend of £0.066m in core Social Care budgets and that this, with the IIJB financial commitments, meant that the IIJB reserves are forecast to decrease in a year by a net £7.185m.

The Board commented on the £0.481m Period 7 underspend for Health, detailed at paragraph 6.1 of the report, and Mr Given reiterated that this was mainly due to staff vacancies within the various services in this budget stream and advised the Board of the measures implemented to address this.

The Board requested further detail on the projected underspend of £0.276 in Older People Services, as detailed at paragraph 5.3 of the report, and sought reassurance that this would not impact on services. Mr Stevenson provided an overview of the commissioning of external organisations to provide homecare services and assured that there were systems in place to provide a consistent level of care. The Board enquired as to whether demand for services had fallen, and Mr Stevenson advised that there had historically been a number of staff vacancies within the homecare service and that as the service recovered from Covid the situation would become clearer.

The Board sought assurance that the risk associated with reducation in budget smoothing reserves was recognised and Mr Given advised that this would be monitored going forward.

Decided:

(1) that the current Period 7 forecast position for 2021/22 as detailed in the report at appendices 1-3 be noted and that it be noted that the projection assumes that all Covid costs in 2021/22 will be fully funded by the Scottish Government;

(2) that it be noted that in the event that there are any gaps in funding for Covid costs then the IIJB will review the reserves to meet this shortfall;

(3) that the proposed budget realignments and virements as detailed in appendix 4 to the report be approved and that officers be authorised to issue revised directions to Inverclyde Council and/or the Health Board as required on the basis of the revised figures as detailed at appendix 5 to the report;

(4) that the planned use of the Transformation Fund as detailed in appendix 6 to the report be approved;

(5) that the current capital position as detailed in appendix 7 to the report be noted; and

(6) that the key assumptions within the forecasts as detailed in paragraph 11 of the report be noted.

6 Model Code of Conduct **6**

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership seeking approval to adopt a revised code of conduct.

The report was presented by Ms Pollock and advised that the Ethical Standards in Public Life etc. (Scotland) Act 2000 required Scottish Ministers to issue a Model Code of Conduct for Members of Devolved Public Bodies (the Model Code), and that the current Model Code was issued in 2010 and reviewed in 2014. The Model code sets out clearly and openly the standards that IJB Members must comply with when carrying out their duties. Ms Pollock advised that the Model Code would be amended at paragraphs 1.9 and 3.7 to change references from Chief Executive to Chief Officer, to match changes made elsewhere in the document.

The Board requested guidance on the definition of 'operational management' as written at paragraph 3.7 of the Model Code, and Mr Stevenson provided an overview of the governance processes within the HSCP, and reassurance that there would be dialogue within the service and with IIJB Members to address any concerns. Ms Pollock added that she would determine if the Standards Commission had issued advice notes which could be issued to the Board.

The Board sought clarification on paragraph 3.11 'I will respect the principle of collective decision-making and corporate responsibility. This means that once the Board has made a decision, I will support that decision, even if I did not agree with it or vote for it.'. The Chair acknowledged that there was a variation in understanding between voting and non-voting Members and noted the opportunity to clarify the issue of collective responsibility for decisions at the forthcoming development session.

The Board noted that within the Gifts and Hospitality section at 3.13, there was no value applied to 'a minor item or token of modest intrinsic value offered on an infrequent basis', and asked if this could be clarified. The Chair advised that legal advice could be obtained should members have any concerns over this matter and that this could also be addressed at the forthcoming development session.

Decided:

(1) that the IIJB adopts the Model Code of Conduct for Members of the Devolved Public Bodies as detailed in appendix 1 of the report;

(2) agrees that the adopted Model Code of Conduct be submitted to Scottish Ministers for approval; and

(3) that it be noted that training will be provided to IIJB Members on the revised Model Code of Conduct.

7 Chief Social Work Officer Annual Report 2020/21 **7**

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership advising of the content of the Inverclyde Chief Social Work Officer Report for 2020/21.

The report was presented by Ms Glendinning, who drew the Board's attention to the dedication of the report to Ms Kate Christmas, Service Manager for Children's Services who passed away last year after a short illness. Ms Glendinning also acknowledged the loss of life across all services due to the pandemic.

The Chair requested that his thanks and appreciation be conveyed to Ms Sharon McAlees, Chief Social Worker, who was not in attendance at the meeting, and Mr Stevenson thanked all third sector contributors to HSCP services.

The Board queried what happened to the Report after its submission to the Scottish Government, and Ms Glendinning advised that all local authorities submit similar reports which are used to highlights challenges, identify issues and promote dialogue.

The Board requested greater detail on the options for Self-Directed Support available,

as detailed on page 76 of the Annual Report, and Mr Best provided an overview of various options available.
The Board sought further information on the impact of the changes to Universal Credit, and Mr Stevenson advised that a report could be brought to the Board on this matter.
There was discussion on the changes the pandemic brought to service provision, the lessons learned and changes made to operating procedures.
Decided:
(1) that the content of the report be noted;
(2) that it be remitted to officers to bring a report to a future meeting on grant dispersal and the impact of changes to universal credit; and
(3) that thanks and appreciation be conveyed to all connected with this report and the services provided which make up HSCP.

8 Update on Support to Care Homes During the Covid-19 Pandemic **8**

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on the ongoing actions taken by the HSCP to support Care Homes in Inverclyde during the Covid-19 pandemic.
The report was presented by Mr Best and advised that since March 2020 the HSCP in partnership with NHS GG&C and Care Home Providers had worked in partnership to support and secure the safety of Care Home residents in Inverclyde. The report detailed the measures taken to achieve this.
The Board noted the vaccination figures detailed at paragraph 4.9 of the report, and Mr Best provided an overview of the vaccination programme for residents and staff.
In response to a question and recognising the impact on individuals, the Board sought reassurance that Care Homes maintained a provision of hearing aid batteries, as failing to maintain hearing aids can lead to isolation, and not all residents have family members who can attend to this. Mr Best assured that he would raise this matter at the next meeting with Care Home Providers, and noted that batteries were available from HSCP.
Decided:
(1) that the ongoing and continued support to Older People and Adult Care Homes in Inverclyde by the HSCP and NHS GG&C be noted;
(2) that the continued implementation of the Delayed Discharge mobilisation plan to address the pressures presented by the Covid-19 pandemic be noted; and
(3) that the work of staff, managers and Care Home Providers in partnership with the HSCP to protect, safeguard and care for the wellbeing of the most vulnerable of service users be acknowledged.

9 Chief Officer's Report **9**

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on a number of areas of work underway across the Health & Social Care Partnership.
The report was presented by Mr Stevenson and provided updates on (a) Early Action System Change – Women Involved in the Criminal Justice System, (b) Inverclyde ADRS – Benefits of Service Redesign, (c) Inverclyde Alcohol and Drug Partnership Update, (d) Additional Winter 2021-22 Funding, and (e) Learning Disability Redesign – LD Community Hub Update.
The Board requested an update on the Naloxone programme, and Ms Malarkey advised that training had now taken place and Naloxone kits could now be provided. In recognition that the targets for Naloxone programme had not been achieved, the Chair

requested that a further update be included in the Chief Officer's report by the September Board meeting.
The Board emphasised the importance of public confidence in the environmental safety of the LD Community Hub site and Mr Stevenson assured that there were no environmental safety concerns, and that he hoped to soon be in the position to provide details of when building works would be commencing.
Decided: that the service updates be noted and that future papers will be brought to the IIJB as substantive agenda items.

10 Minute of Meeting of IJB Audit Committee of 20 September 2021 **10**

There was submitted the Minute of the Inverclyde Integration Joint Board of 20 September 2021.
The Minute was presented by the Chair and checked for fact, omission, accuracy and clarity.
The Chair requested that it be noted that he would not be joining the short-life working group as noted at minute reference paragraph 27.
Decided: that the Minute be agreed.

11 Minute of Meeting of IJB Audit Committee of 29 November 2021 **11**

There was submitted the Minute of the Inverclyde Integration Joint Board of 29 November 2021.
The Minute was presented by the Chair and checked for fact, omission, accuracy and clarity.
Councillor Robertson, Chair of the IJB Audit Committee, provided a brief feedback on the main issues discussed at their Committee meeting held at 1pm, noting that streamlining performance reporting, risk appetite and Locality Planning had been discussed. Councillor Robertson also acknowledged Ms Speirs resignation from the IJB Audit Committee, and conveyed her appreciation and thanks for her contribution.
Decided: that the Minute be agreed.

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)
Reporting by Exception – Governance of HSCP Commissioned External Organisations	**6 & 9**
Appendix to Minute of Meeting of Inverclyde Integration Joint Board of 20 September 2021	**1 & 6**
Tender for new Social Care Case Management Solution	**6 & 9**

12 Reporting by Exception – Governance of HSCP Commissioned External Organisations **12**

There was submitted a report by the Interim Corporate Director (Chief Officer),

Inverclyde Health & Social Care Partnership on matters relating to the HSCP Governance process for externally commissioned Social Care Services for the reporting period 24 September to 19 November 2021.
The report was presented by Mr Stevenson and appended the mandatory Reporting by Exception document which highlighted changes and updates in relation to quality gradings, financial monitoring or specific service changes or concerns identified through submitted audited accounts, regulatory inspection and contract monitoring.
Updates were provided on establishments and services within Older People, Adult and Children's Services.
Ms Boyd declared a non-financial interest in this item as a Director of Inverclyde Carer's 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.
The Board enquired as to the difference between 'registered' and 'non-registered' services and if the level of governance was different. Ms Malarkey explained the differences and the governance process which are in place.
Decided:
(1) that the Governance report for the period 24 September to 19 November 2021 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.

13 Appendix to Minute of Meeting of Inverclyde Integration Joint Board of 20 September 2021 **13**

There was submitted an Appendix to the Inverclyde Integration Joint Board Minute of 20 September 2021.
The Appendix was presented by the Chair and checked for fact, omission, accuracy and clarity.
Decided: that the Appendix be agreed.

14 Tender for New Social Care Case Management Solution **14**

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership advising the IIJB of the agreed recommendation from Inverclyde Health & Social Care Committee on 6 January 2022 that delegated authority be granted to the Head of Legal and Democratic Services to award a contract to the successful bidder in relation to the forthcoming mini competition for a new Social Care Case Management Solution to replace SWIFT in terms of 17.3(ii) of the Council's Standing Orders in relation to contracts.
Decided: that it be noted that a report requesting the Head of Legal and Democratic Services be granted delegated authority to accept the successful tender for a new Social Care Case Management Solution, provided the cost is within the budget allocation for the project, was approved by Inverclyde Council's Health and Social Care Committee.

AGENDA ITEM NO: 3

Report To:	**Inverclyde Integration Joint Board**	**Report To:**	**21 March 2022**
Report By:	**Allen Stevenson, Interim Chief Officer, Inverclyde Health & Social Care Partnership**	**Report No:**	**VP/LS/026/22**
Contact Officer:	**Vicky Pollock**	**Contact No:**	**01475 712180**
Subject:	**Voting Membership of the Inverclyde Integration Joint Board and Membership of the Inverclyde Integration Joint Board Audit Committee**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Inverclyde Integration Joint Board ("IJB") of a change in its voting membership arrangements and to agree the appointments of one voting and one non-voting member of the IJB to the Inverclyde Integration Joint Board Audit Committee ("IJB Audit Committee").

2.0 SUMMARY

2.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 sets out the arrangements for the membership of all Integration Joint Boards.

2.2 Ms Paula Speirs recently stepped down as a Non-Executive Director of Greater Glasgow and Clyde NHS Board ("the NHS Board"). The NHS Board has taken steps to fill this vacancy by appointing a new voting member.

2.3 Mr Stevie McLachlan recently intimated his resignation from the IJB Audit Committee and it is therefore necessary for the IJB to appoint a new non-voting member to the IJB Audit Committee to fill this vacancy.

2.4 This report sets out the revised membership arrangements for the IJB and the IJB Audit Committee.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Inverclyde Integration Joint Board:

a) notes the appointment by Greater Glasgow and Clyde NHS Board of Mr David Gould as a voting member of the Inverclyde Integration Joint Board;
b) appoints Mr David Gould to serve on the Inverclyde Integration Joint Board Audit Committee;
c) appoints Mr Simon Carr as Vice-Chair of the Inverclyde Integration Joint Board Audit Committee; and

d) appoints one Integration Joint Board non-voting member to serve on the Inverclyde Integration Joint Board Audit Committee with the nomination and appointment being made at the meeting.

Allen Stevenson
Interim Chief Officer
Inverclyde HSCP

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 ("the Order") sets out the arrangements for the membership of all Integration Joint Boards. As a minimum this must comprise:

- voting members appointed by the NHS Board and Inverclyde Council;
- non-voting members who are holders of key posts within either the NHS Board or Inverclyde Council; and
- representatives of groups who have an interest in the IJB.

5.0 IJB - VOTING MEMBERSHIP

5.1 IJB members will be aware that Ms Paula Speirs recently intimated her resignation from the IJB. The NHS Board agreed to nominate Mr David Gould as a voting member of the IJB with effect from 1 February 2022, to replace Ms Speirs. The current membership of the IJB is set out at Appendix 1.

6.0 AUDIT COMMITTEE – VOTING AND NON VOTING MEMBERSHIP

6.1 The current membership of the IJB Audit Committee is set out at Appendix 2.

6.2 Membership of the IJB Audit Committee comprises 4 IJB voting members (2 from the NHS Board and 2 from Inverclyde Council), with an additional 2 members drawn from the wider non-voting membership of the IJB.

6.3 As a result of Paula Speirs stepping down from the IJB and the NHS Board voting membership change highlighted in paragraph 5 above, it is necessary to change the voting membership of the IJB Audit Committee.

6.4 It has been agreed to recommend the appointment of David Gould as a NHS Board voting member of the IJB Audit Committee. It has also been agreed to recommend the appointment of Simon Carr as Vice-Chair of the IJB Audit Committee.

6.5 In relation to the non-voting membership of the IJB Audit Committee, Stevie McLachlan has intimated his resignation therefrom. As membership of the IJB Audit Committee is a matter for decision by the IJB, it requires to agree the appointment of a non-voting member to the IJB Audit Committee to fill the vacancy.

7.0 PROPOSALS

7.1 It is proposed that the IJB agree (a) the revised IJB voting membership arrangements as set out in Appendix 1 Section A, (b) the appointment of an NHS Board voting member to the IJB Audit Committee, (c) the appointment of the Vice-Chair of the IJB Audit Committee and (d) the appointment of a non-voting IJB member to the IJB Audit Committee.

8.0 IMPLICATIONS

Finance

8.1 None.

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

8.2 The membership of the IJB is set out in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014. Standing Order 13 of the IJB's Standing Orders for Meetings regulates the establishment by the IJB of the IJB Audit Committee.

Human Resources

8.3 None.

Equalities

8.4 There are no equality issues within this report.

8.4.1 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.

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

Clinical or Care Governance

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

National Wellbeing Outcomes

8.6 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

9.0 DIRECTIONS

9.1

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	

10.0 CONSULTATIONS

10.1 The Interim Chief Officer of the Inverclyde Health & Social Care Partnership has been consulted in the preparation of this report.

11.0 BACKGROUND PAPERS

11.1 N/A

Inverclyde Integration Joint Board Membership as at 21 March 2022

SECTION A. VOTING MEMBERS		
		Proxies (Voting Members)
Inverclyde Council	Councillor Jim Clocherty (Vice Chair) Councillor Luciano Rebecchi Councillor Lynne Quinn Councillor Elizabeth Robertson	Councillor Robert Moran Councillor Gerry Dorrian Councillor Ronnie Ahlfeld Councillor Jim MacLeod
Greater Glasgow and Clyde NHS Board	Mr Alan Cowan (Chair) Mr Simon Carr Ms Ann Cameron-Burns Mr David Gould	
SECTION B. NON-VOTING PROFESSIONAL ADVISORY MEMBERS		
Interim Chief Officer of the IJB	Allen Stevenson	
Chief Social Worker of Inverclyde Council	Sharon McAlees	
Chief Finance Officer	Craig Given	
Registered Medical Practitioner who is a registered GP	Inverclyde Health & Social Care Partnership Clinical Director Dr Hector MacDonald	
Registered Nurse	Chief Nurse Laura Moore	
Registered Medical Practitioner who is not a registered GP	Dr Chris Jones	
SECTION C. NON-VOTING STAKEHOLDER REPRESENTATIVE MEMBERS		
A staff representative (Council)	Ms Gemma Eardley	
A staff representative (NHS Board)	Ms Diana McCrone	
A third sector representative	Ms Charlene Elliott Chief Executive CVS Inverclyde	Proxy - Ms Vicki Cloney Partnership Facilitator CVS Inverclyde

A service user	Mr Hamish MacLeod Inverclyde Health and Social Care Partnership Advisory Group	Proxy - Ms Margaret Moyse
A carer representative	Ms Christina Boyd	Proxy – Ms Heather Davis
SECTION D. ADDITIONAL NON-VOTING MEMBERS		
Representative of Inverclyde Housing Association Forum	Mr Stevie McLachlan, Head of Customer Services, River Clyde Homes	

Inverclyde Integration Joint Board
Audit Committee Membership – as at 21 March 2022

SECTION A. VOTING MEMBERS		
		Proxies (Voting Members)
Inverclyde Council	Councillor Elizabeth Robertson (Chair) Councillor Luciano Rebecchi	Councillor Jim MacLeod Councillor Gerry Dorrian
Greater Glasgow and Clyde NHS Board	Mr Simon Carr (Vice Chair)** Mr David Gould**	
SECTION B. NON-VOTING MEMBERS		
A staff representative (NHS Board)	Ms Diana McCrone	
Vacant***	Vacant***	

**Appointments to be confirmed at IJB on 21 March 2022

***Nomination and appointment to be made at IJB on 21 March 2022

INVERCLYDE INTEGRATION JOINT BOARD
ROLLING ACTION LIST
21 MARCH 2022

	In progress, will be done but maybe within another paper		Remove from rolling action list
	Possibly remove or include in CO brief instead		

Meeting Date and Minute Reference	Action	Responsible Officer	Timescale	Progress/Update/ Outcome	Status	Open/Closed
23 June 2020 (Para 62(5))	Report on Care Homes including analysis of implications of COVID-19	Head of Health & Community Care	December	Report completed	Paper to IJB March	Open
23 June 2020 (Para 63(3))	Finalised Unscheduled Care Commissioning Plan	Head of Strategy & Support Services	March 2021	Glasgow HSCP led this work on behalf of GGC partnership.	Paper to March IJB 2022	Open
2 November 2020 (Para 106(2))	Development Session on Child Poverty (early 2021)	Sharon McAlees	February 2021	To be added to agenda of February Development Session	**Rearrange**	Open
25 January 2021 (Para 3(4))	Review of Decision-Making Arrangements	Chief Officer	March 2021 (and each meeting thereafter)	Review paper to March IJB	In decision making report	Open
29 March 2021 (Para 18(2))	Report on review of SMT structure at HSCP	Chief Officer	July 2022	Paper to IJB Summer		Open

Agenda Item No: 4

17 May 2021 (Para 35(3))	Update report Primary Care Improvement Plan – consultation with GPs and Local Medical Committee	Chief Officer	After consultations have concluded and an updated Primary Care Improvement Plan and Spending Plan been presented to IIJB	Paper to IJB March 22		open
17 May 2021 (Para 35(4))	Update report - Primary Care Improvement Plan – Physiotherapy waiting times	Chief Officer	No timescale – a future meeting	Paper to IJB September 2022		open
17 May 2021 (Para 38(3))	Further report detailing progress - Inverclyde Adult Support & Protection Partnership	Chief Officer	May 2022	Paper to IJB Summer 2022		open
21 June 2021 (Para 44(2))	Review meeting arrangements with regard to public health situation	Chief Officer	No timescale – a future date	TBC		Open
21 June 2021 (Para 46(4))	Development Session – Strategic Plan Refresh	Chief Officer	By September 2021 – before next meeting	Paper to IJB Summer 2022		Open
20 September 2021 (Para 61(8))	Guidance note on financial terms	Craig Given	No timescale	TBC		Open

1 November 2021 (Para 82(4))	Report – Advanced Clinical Practice Proposal – with timelines and anticipated outcomes	Chief Officer	By Sep 2022	Paper to IJB By September 2022		Open
24 January 2022 (Para 7(3))	Report on grant dispersal and impact of changes to Universal Credit	Chief Officer	No timescale – a future meeting	Paper to IJB September 2022		Open

Annual Report Schedule

March • Annual Budget	June • Draft Annual Accounts • Annual Performance Report • Clinical & Care Governance • Workforce Update
September • Audited Annual Accounts • Digital strategy	December • PCIP Update • Update Criminal Justice

Directions Register

- Hard Edges
- Care Homes

AGENDA ITEM NO: 5

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**21 March 2022**
Report By:	**Allen Stevenson Interim Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/20/2022/CG**
Contact Office	**Craig Given Chief Financial Officer**	**Contact No:**	**01475 715381**
Subject:	**FINANCIAL MONITORING REPORT 2021/22 – PERIOD TO 31 DECEMBER 2021, PERIOD 9**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Inverclyde Integration Joint Board (IJB) of the Revenue and Capital Budgets, other Income Streams and Earmarked Reserves position for the current year with a detailed report as at Period 9 to 31 December 2021.

2.0 SUMMARY

2.1 The detailed report outlines the financial position at Period 9 to the end of December 2021. The Covid-19 pandemic has created significant additional cost pressures across the Health & Social Care Partnership (HSCP). The figures presented include projected Covid costs and offset against that is confirmed Covid funding. It is anticipated that the balance of actual additional Covid costs will be received from the Scottish Government and funding has been projected on this basis.

2.2 The current year-end operating projection for the Partnership includes £6.657m of net Covid-19 costs for which full funding is anticipated from Scottish Government through local mobilisation plans and current Covid Earmarked reserves. At Period 9 there is a projected underspend of £0.044m in Social Care core budgets. This amount will be transferred to our free reserves.

2.3 As in previous years, the IJB has financial commitments in place in relation to spend against its Earmarked Reserves in-year for previously agreed multi-year projects and spend, including the impact of any transfers to/from reserves as a result of anticipated over and underspends. This together with the in year overspend means that the IJB reserves are forecast to decrease in year by a net £6.630m.

2.4 The Chief Officer and Heads of Service will continue to work to mitigate any projected budget pressures and keep the overall IJB budget in balance for the remainder of the year. It is proposed that as in previous years, any over or underspend is taken from or added to IJB reserves.

2.5 The report outlines the current projected spend for the Transformation Fund.

2.6 The assets used by the IJB and related capital budgets are held by the Council and Health Board. Planned capital spend in relation to Partnership activity is budgeted as £0.922m for 2021/22 with £0.381m actual spend to date.

2.7 The IJB holds a number of Earmarked and General Reserves; these are managed in line with the IJB Reserves Policy. The total Earmarked Reserves available at the start of this financial year were £14.191m, with £0.741m in Unearmarked Reserves, giving a total Reserve of £14.932m. The projected year-end position is a carry forward of £8.302m. This is a decrease in year due to anticipated spend of funding on agreed projects.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board:

1. Notes the current Period 9 forecast position for 2021/22 as detailed in the report Appendices 1-3 and notes that the projection assumes that all Covid costs in 2021/22 will be fully funded by the Scottish Government,
2. Notes that in the event that there are any gaps in funding for Covid costs, then the IJB will review the reserves to meet this shortfall,
3. Approves the proposed budget realignments and virement (Appendix 4) and authorises officers to issue revised directions to the Council and/or Health Board as required on the basis of the revised figures enclosed (Appendix 5);
4. Approves the planned use of the Transformation Fund (Appendix 6);
5. Notes the current capital position (Appendix 7);
6. Notes the key assumptions within the forecasts detailed at section 11.

Allen Stevenson
Interim Corporate Director (Chief Officer)

Craig Given
Chief Financial Officer

4.0 BACKGROUND

4.1 From 1 April 2016 the Health Board and Council delegated functions and are making payments to the IJB in respect of those functions as set out in the integration scheme. The Health Board have also "set aside" an amount in respect of large hospital functions covered by the integration scheme.

4.2 The IJB Budget for 2021/22 was set on 29 March 2021 based on confirmed Inverclyde Council Funding and indicative NHS GG&C funding. The table below summarises the agreed budget and funding together with the projected operating outturn for the year as at 31 December:

	Revised Budget 2021/22 £000	Projected Outturn £000	Projected Over/(Under) Spend £000
Social Work Services	75,847	75,803	(44)
Health Services	84,461	83,650	(811)
Set Aside	28,177	28,177	0
HSCP NET EXPENDITURE	**188,485**	**187,630**	**(855)**
FUNDED BY			
Transfer from / (to) Reserves	0	(855)	(855)
NHS Contribution to the IJB	130,932	130,932	0
Council Contribution to the IJB	57,553	57,553	0
HSCP FUNDING	**188,485**	**187,630**	**(855)**
Planned Use of Reserves	(6,630)	(6,630)	
Annual Accounts CIES Position (assuming Covid costs are covered in full)	**(6,630)**	**(6,630)**	

4.3 Updated Finance Position and Forecasting to Year-end

Timelines for Committee paper submission mean that, by necessity, finance reports are often a couple of months old by the time they come to the IJB. To address this, an updated finance summary detailing any significant changes to financial forecasts from the report date to the current period will be provided as part of the monitoring report presentation from the October report onwards each year.

This ensures that the Board continues to receive the full detailed finance pack but is also updated on any substantive changes to the forecast position between the pack date and the meeting date.

4.4 Covid-19 Mobilisation Plans

Local Mobilisation Plan (LMP) submissions are made regularly through the Health Board to the Scottish Government detailing projected and actual Covid costs on a month to month basis. This report reflects the current projected costs and confirmed income in relation to this.

4.5 Appendix 1B details the current projected Covid costs and confirmed income, this ties back with the latest LMP.

- Projected costs for the year based on the July submission are £6.957m (£5.915m Social Care and £1.042m Health).
- The table at the top of Appendix 1B details the projected spend across Social

Care and Health on Employee costs, Supplies and Services etc.

- The second table on Appendix 1a shows a summary of the specific areas this spend is projected across.

4.6 The IJB has provided the Scottish Government with regular updates in relation to forecasted spend for all services and the cost of responding to the pandemic and this will be used by the Scottish Government in assessing future funding needs. The IJB expects these costs to be fully funded from a combination of Scottish Government funding and the existing £2.89m Covid 19 Earmarked Reserve carried forward from last year.

5.0 SOCIAL WORK SERVICES

5.1 The projected net Social Care Covid spend is £5.915m for this year with the biggest elements of that being provider sustainability. It is expected that all Covid costs will be funded by the Scottish Government through the remobilisation plan. Assuming all Covid costs are covered by the Scottish Government there is a £0.044m projected underspend for core Social Work services. In line with previous practice it is expected that any year-end underspend would be added by the IJB free reserve.

5.2 The Mobilisation Plan which captures all Covid related spend and underspends. The Mobilisation Plan is updated and submitted to the Scottish Government monthly.

5.3 Appendix 2 contains details of the Social Work outturn position. Key projected social work budget variances which make up the projected core budget overspend, excluding covid costs, include the following:

Main areas of overspend are:

- A projected overspend of £962,000 in Children's Residential Placements, Foster, Adoption and Kinship, an increase of £373,000 of which £350,000 is because utilisation of the smoothing EMR is no longer planned in this financial year.

- Within Criminal Justice a £0.151m projected overspend as a result of client package costs.

- A projected overspend of £331,000 across Learning and Physical Disabilities client commitments, an increase of £268,000 of which £350,000 is because utilisation of the smoothing EMR is no longer planned in this financial year. This is offset by the allocation of £261,000 additional Living Wage funding for which no additional spend is anticipated in 2021-22. The balance of the movement is due to additional service users from those reported at period 7 together with other minor package changes.

- A projected overspend of £116,000 on Agency staffing costs within Children and Family Social Work teams.

- A projected overspend of £189,000 within Physical Disabilities client commitments with the increase of £74,000 since period 7 reflecting the increases in 2 care packages

Main areas of underspend are:

- A projected underspend of £0.752m in Older People. This is mainly due to a projected underspend of £0.499m within External Homecare. A projected

overspend of £0.160m in Homecare employee costs, Community Alarms, Day Care & Respite. A projected underspend of £597,000, from which Officers are showing a transfer of £186,000 to the earmarked reserve at the end of the year, leaving a £411,000 underspend against Core budgets. Overall this is a projected reduction in costs of £838,000 since period 7. £470,000 of the movement is due to the planned budget allocation from the new Social Care monies for Interim Beds, which reflects the placements being made during the year. A further £261,000 of the movement is due to the allocation of additional Living Wage funding for which no additional spend is anticipated in 2021-22. The balance of the movement is due to lower bed numbers than anticipated at period 7. A reduction of £124,000 in the projected overspend within Residential and Nursing Care other client commitments, which reflects a reduction in anticipated respite spend together with the ending of 1 care package ending and reductions in 2 care packages. A projected £74,000 under recovery of charging order income.

- The projected £0.283m underspend in Alcohol & Drugs underspend is against employee costs and due to a combination of delays in reviewing roles following the restructure together with slippage filling posts. Also reduction in package costs.

- A projected underspend in Mental Health services of £0.108m due to vacancies and slippage in filling posts.

- Projected £0.130m underspend in Assessment and Care primarily relates to client commitments and the reduction in the number of short breaks anticipated

- The projected underspend in Business Support of £0.126m due to vacancies and slippage in filling posts.

A detailed analysis of the social care variances has been prepared by the Council for Period 9. This is seen in Appendix 2.

6.0 HEALTH SERVICES

6.1 For Health, Covid spend is projected to be £1.042m for the year with the biggest elements of that being additional staffing costs.
The projected outturn for health services at 31 December is in line with the revised budget. At Period 9 an underspend of £0.811m is being reported. The current underspend is detailed as follows:

- Alcohol & Drug Recovery – £0.187m underspend mainly due to vacancies.
- Adult Community Services - £0.066m underspend mainly due to vacancies in Management posts and nursing. These are currently being recruited to.
- Adult Inpatients - £0.715m overspend mainly due to the use of premium agency in the service.
- Children's Community Services - £0.219m underspend mainly due to Health visiting vacancies.
- Children's Specialist Services - £0.267m underspend again mainly due to vacancies.
- Planning & Health Improvement - £0.229m underspend mainly due to Vacancies.
- Financial Planning - £0.231m underspend. This is mainly contingency funding which hasn't been used to date.
- Management & Admin - £0.327m underspend due to vacancies mainly in Finance Services and Business Support.

In line with previous years any underspend at year-end with will transferred to

reserves.
It is the IJB's proposal that the proposed underspend is used to create the following Earmarked Reserves:

- Recurring IT / Digitalisation Strategy £0.200m
- Additional Transformation Funding (Specifically for Health Projects) £0.611m

In addition to the above the Health side of the IJB is expecting to carry forward additional Earmarked Reserves for specific ring fenced funds for 2021/22. These are:

- Unspent Prescribing Budget to add to existing Smoothing Reserve £0.200m
- Homelessness EMR unspent funding £0.215m
- Dementia unspent funding £0.057m
- Primary Care Unspent funding £0.057m
- Mental Health Recovery & renewal unspent funding £0.491m
- Winter Planning MDT unspent funding £0.358m
- ADP unspent funding £0.291m

6.2 Prescribing

Currently projecting a breakeven position. This is on the basis of a proposed transfer of £0.200m to the prescribing Smoothing Earmarked reserve at Year-end. The prescribing position will continue to be closely monitored throughout the year, at present no significant pressures have been identified which will have an impact or require the use of the Prescribing smoothing reserve.

6.3 To mitigate the risk associated with prescribing cost volatility, the IJB agreed as part of this and prior year budgets to invest additional monies into prescribing. However, due to the uncertain, externally influenced nature of prescribing costs, this remains an area of potential financial risk going forward. This year Covid-19 and Brexit have both added to the complexity around forecasting full year prescribing costs.

6.4 GP Prescribing remains a volatile budget; a drug going on short supply and the impacts of Covid and Brexit can have significant financial consequences.

6.5 Set Aside

- The Set Aside budget in essence is the amount "set aside" for each IJB's consumption of large hospital services.
- Initial Set Aside base budgets for each IJB were based on their historic use of certain Acute Services including: A&E Inpatient and Outpatient, general medicine, Rehab medicine, Respiratory medicine and geriatric medicine.
- Legislation sets out that Integration Authorities are responsible for the strategic planning of hospital services most commonly associated with the emergency care pathway along with primary and community health care and social care.
- The Set Aside functions and how they are used and managed going forward are heavily tied in to the commissioning/market facilitation work that is ongoing
- The current budget is based upon cost book information to calculate the set – aside calculation. This is consistent with the requirements of Scottish Government for preparing accounting estimates for inclusion in Health Board and IJB accounts. At present within the all the Greater Glasgow IJB's actual costs of unscheduled care vastly overspend on their budget and are balanced overall at Board level. Work has been ongoing for a number of years now to try and find a methodology which could see these costs better split into IJB areas. To date there is no clear view and no national guidance which has led to this remaining as a notional budget in the IJB's accounts with budget equally

expenditure based on figures from Greater Glasgow.

- At present the set-aside calculation is very complex and requires significant manual intervention. This needs to be streamlined at Health Board level.
- Current set aside position is not a balanced budget therefor the IJB would not accept charges as per actual usage as this would put most IJB's into a deficit position.
- Work is currently ongoing at Board level to continue to review this with the onus being on the Health Board to produce a set aside mechanism which is fair, transparent and of no financial detriment to the Inverclyde IJB before it is accepted.

7.0 VIREMENT AND OTHER BUDGET MOVEMENTS AND DIRECTIONS

7.1 Appendix 4 details the virements and other budget movements that the IJB is requested to note and approve. These changes have been reflected in this report. The Directions which are issued to the Health Board and Council require to be updated in line with these proposed budget changes. The updated Directions linked to these budget changes are shown in Appendix 5. These require both the Council and Health Board to ensure that all services are procured and delivered in line with Best Value principles.

8.0 TRANSFORMATION FUND

8.1 Transformation Fund

The Transformation Fund was set up at the end of 2018/19. At the beginning of this financial year, the Fund balance was £1.085m. Spend against the plan is done on a bids basis through the Transformation Board. Appendix 6 details the current agreed commitments against the fund. At present there is £0.318m still uncommitted. Proposals with a total value in excess of £0.100m will require the prior approval of the IJB.

9.0 CURRENT CAPITAL POSITION

9.1 The Social Work capital budget is £10.829m over the life of the projects with £0.922m budgeted to be spent in 2021/22

9.2 Crosshill Children's Home:

- The former Neil Street Children's Home is in use as temporary decant accommodation for the Crosshill residents.
- The demolition of the original Crosshill building was completed in autumn 2018. Main contract works commenced on site in October 2018 and had been behind programme when the Main Contractor (J.B. Bennett) ceased work on site on 25th February 2020 and subsequently entered administration.
- The COVID-19 situation impacted the progression of the completion works tender which was progressed in 1st Quarter 2021 as previously reported. The completion work recommenced on 4 May 2021 with a contractual completion date in early November 2021.
- The works are progressing on site as summarised below:
    - Internal wall linings/finishes complete except for link corridors which are in progress.
    - Electrical final fix on-going (switches & sockets) with plumbing works 90% complete.
    - External drainage (foul & rainwater) complete, with Scottish Water connection complete.
    - Plumbing works to underfloor heating ongoing.

The Contractor has intimated delays due to supply chain issues and revised the anticipated completion date to 30th March 2022.

9.3 New Learning Disability Facility

The project involves the development of a new Inverclyde Community Learning Disability Hub. The new hub will support and consolidate development of the new service model and integration of learning disability services with the wider Inverclyde Community in line with national and local policy. The February 2020 Heath & Social Care Committee approved the business case, preferred site (former Hector McNeil Baths) and funding support for the project with allocation of resources approved by the Inverclyde Council on 12th March 2020.The COVID-19 situation has impacted the progression of the project. The progress to date is summarised below:

- Site information and detailed survey work has been completed including engagement of specialist consultants.
- Space planning and accommodation schedule interrogation work has been progressed through Technical Services and the Client Service to inform the development of the design.
- Property Services has procured the services of a Quantity Surveyor to progress the assessment of the estimated project cost at Architectural Stage 2 and comparison against the original project budget. As part of the preparation of the Architectural Stage 2 report, an energy model of the proposed building has been developed including a design based on current building standards and options for consideration (subject to funding / budget constraints) that align with the development of net zero carbon building standards. The assessment of costs is on-going which will include the assessment of the lower carbon option and an updated position in respect of the developing design solutions for the site specific abnormals identified through the completed detailed site surveys.
- The Council is investigating the possibility of funding support for the project and the Committee is requested to note that a stage 1 application to the Vacant and Derelict Land Investment Programme (VDLIP) has been successful with the Council invited to submit a stage 2 application by 18th February. Whilst the type of information required at stage 2 is similar to stage 1, significantly more detail is required including estimated project costs and delivery timetable. The stage 2 submission will be informed by the Architectural Stage 2 cost report currently in progress.

Consultation with service users, families, carers and learning disability staff continues supported by the Advisory Group.

9.4 Swift Upgrade

The project involves the replacement of the current Swift system. There has been a delay going back out to tender because of Covid and this is now happening in early 2022. Consequently slippage of £600,000 is now being reported for 2021/22.

10.0 EARMARKED RESERVES

10.1 The IJB holds a number of Earmarked and Unearmarked Reserves; these are managed in line with the IJB Reserves Policy.

- Total Earmarked Reserves available at the start of this financial year were £14.191m, with £0.741m in Unearmarked Reserves, giving a total Reserve of £14.932m.
- To date at Period 9, £4.757m of new reserves are expected in year (mainly due to addition monies from Scottish Government for ringfenced projects). This also includes the addition of the new Earmarked Reserve of £0.164m for Autism Friendly transferring from the Council and £0.215m for Covid related projects

transferring from the Council.

- £6.985m of the reserves funding has been spent in the year to date with an expected £11.431m to be spent by year-end.
- Projected carry forward at the yearend is £8.302m.
- Appendix 8 shows all reserves under the following categories:

Ear-Marked Reserves	Opening Balance	New Funds in Year	Total Funding	Spend to Date	Projected Spend	Projected C/fwd
Scottish Government Funding - funding ringfenced for specific initiatives	4,798	4,242	9,040	5,755	8,644	396
Existing Projects/Commitments - many of these are for projects that span more than 1 year	4,807	472	5,279	680	1,222	4,057
Transformation Projects - non recurring money to deliver transformational change	2,888	43	2,931	550	1,306	1,625
Budget Smoothing - monies held as a contingency for specific volatile budgets such as Residential Services and Prescribing to smooth out in year one off pressures	1,698	0	1,698	0	259	1,439
TOTAL Ear-Marked Reserves	**14,191**	**4,757**	**18,948**	**6,985**	**11,431**	**7,517**

General Reserves	**741**	**0**	**741**	**0**	**0**	**741**
In Year Surplus/(Deficit) going to/(from) reserves						44

TOTAL Reserves	**14,932**	**4,757**		**6,985**		**8,302**
Projected Movement (use of)/transfer in to Reserves						**(6,630)**

11.0 STATUTORY ACCOUNTS COMPREHENSIVE INCOME & EXPENDITURE STATEMENT (CIES) AND KEY ASSUMPTIONS WITHIN THE P9 FORECAST

11.1 The creation and use of reserves during the year, while not impacting on the operating position, will impact the year-end CIES outturn. For 2021/22, it is anticipated that as a portion of the brought forward £14.932m and any new Reserves are used the CIES will reflect a surplus. At Period 9, that CIES surplus is projected to be the same as the projected movement in reserves detailed in Paragraph 10.1 above and Appendix 8.

11.2 Key Assumptions within the P9 Forecast

- These forecasts are based on information provided from the Council and Health Board ledgers
- The social care forecasts for core budgets and covid spend are based on information provided by Council finance staff which have been reported to the Council's Health & Social Care Committee and provided for the covid LMP

returns.

- Prescribing forecasts are based on advice from the Health Board prescribing team using the latest available actuals and horizon scanning techniques.

12.0 DIRECTIONS

12.1

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

13.0 IMPLICATIONS

13.1 **FINANCE**

All financial implications are discussed in detail within the report above.

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

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

HUMAN RESOURCES

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

EQUALITIES

13.4 There are no equality issues within this report.

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.

13.5 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

13.6 **CLINICAL OR CARE GOVERNANCE IMPLICATIONS**

There are no governance issues within this report.

13.7 **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.	Effective financial monitoring processes ensure resources are used in line with the Strategic Plan to deliver services efficiently

14.0 CONSULTATION

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

15.0 BACKGROUND PAPERS

15.1 None.

APPENDIX 1

INVERCLYDE HSCP

REVENUE BUDGET 2021/22 PROJECTED POSITION

PERIOD 9: 1 April 2021 - 31 December 2021

SUBJECTIVE ANALYSIS	Budget 2021/22 £000	Revised Budget 2021/22 £000	Projected Out-turn 2021/22 £000	Projected Over/(Under) Spend £000	Percentage Variance
Employee Costs	52,863	61,519	59,713	(1,806)	-2.9%
Property Costs	1,002	1,039	1,078	39	3.8%
Supplies & Services	49,292	57,088	57,977	889	1.6%
Family Health Services	28,629	29,992	29,992	0	0.0%
Prescribing	18,508	19,346	19,346	0	0.0%
Transfer from / (to) Reserves	0	0	0	0	0.0%
Income	(2,440)	(8,676)	(8,653)	23	-0.3%
Funding/Savings still to be allocated	0	0	0	0	0.0%
HSCP NET DIRECT EXPENDITURE	**147,854**	**160,308**	**159,453**	**(855)**	**-0.5%**
Set Aside	28,177	28,177	28,177	0	0.0%
HSCP NET TOTAL EXPENDITURE	**176,031**	**188,485**	**187,630**	**(855)**	**-0.5%**

OBJECTIVE ANALYSIS	Budget 2021/22 £000	Revised Budget 2021/22 £000	Projected Out-turn 2021/22 £000	Projected Over/(Under) Spend £000	Percentage Variance
Strategy & Support Services	2,166	2,302	2,009	(293)	-12.7%
Older Persons	22,548	24,298	23,546	(752)	-3.1%
Learning Disabilities	8,974	9,412	9,485	73	0.8%
Mental Health - Communities	4,098	4,513	4,347	(166)	-3.7%
Mental Health - Inpatient Services	9,310	9,893	10,713	820	8.3%
Children & Families	13,905	15,170	15,736	566	3.7%
Physical & Sensory	2,461	2,487	2,649	162	6.5%
Alcohol & Drug Recovery Service	2,717	3,290	2,822	(468)	-14.2%
Assessment & Care Management / Health & Community Care / Business Support	14,072	19,086	18,437	(649)	-3.4%
Criminal Justice / Prison Service	75	118	191	73	0.0%
Homelessness	1,218	1,220	1,229	9	0.7%
Family Health Services	28,649	29,952	29,952	0	0.0%
Prescribing	18,695	19,533	19,534	0	0.0%
Resource Transfer *	18,393	18,294	18,294	0	0.0%
Contribution to Reserves	0	0	0	0	0.0%
Funding/Savings still to be allocated	0	0	0	0	0.0%
Unallocated Funds	573	740	509	(231)	0.0%
HSCP NET DIRECT EXPENDITURE	**147,854**	**160,308**	**159,453**	**(856)**	**-0.5%**
Set Aside	28,177	28,177	28,177	0	0.0%
HSCP NET TOTAL EXPENDITURE	**176,031**	**188,485**	**187,630**	**(856)**	**-0.5%**
FUNDED BY					
NHS Contribution to the IJB	93,202	102,755	102,755	0	0.0%
NHS Contribution for Set Aside	28,177	28,177	28,177	0	0.0%
Council Contribution to the IJB	54,652	57,553	57,553	0	0.0%
Transfer from / (to) Reserves	0	0	(855)	(855)	0.0%
HSCP NET INCOME	**176,031**	**188,485**	**187,630**	**(855)**	**-0.5%**
HSCP OPERATING SURPLUS/(DEFICIT)	**0**	**0**	**0**	**0**	**0.0%**
Anticipated movement in reserves *	0	(6,630)	(6,630)		
HSCP ANNUAL ACCOUNTS REPORTING SURPLUS/(DEFICIT)	**0**	**(6,630)**	**(6,630)**		

* See Reserves Analysis for full breakdown

APPENDIX 1b

INVERCLYDE HSCP - COVID 19

REVENUE BUDGET 2020/21 PROJECTED POSITION

PERIOD 9: 1 April 2021 - 31 December 2021

SUBJECTIVE ANALYSIS - COVID 19 based on Q1 Mobilisation Plan submission	Social Care Projected Out-turn 2021/22 £000	Health Projected Out-turn 2021/22 £000	TOTAL Projected Out-turn 2021/22 £000
Employee Costs	1,494	0	1,494
Property Costs	0	0	0
Supplies & Services	4,204	1,042	5,246
Family Health Services			0
Prescribing		0	0
Loss of Income	218		218
PROJECTED COVID RELATED NET SPEND	**5,915**	**1,042**	**6,957**

SUMMARISED MOBILISATION PLAN	Social Care 2021/22 £'000	Health 2021/22 £'000	Revenue 2021/22 £'000
COVID-19 COSTS HSCP			
Additional PPE	200	3	203
Contact Tracing			
Testing			
Covid-19 Vaccination	2		
Flu Vaccination			
Scale up of Public Health Measures		86	86
Additional Community Hospital Bed Capacity			
Community Hubs		236	236
Additional Care Home Placements	119		119
Additional Capacity in Community			
Additional Infection Prevention and Control Costs	70		
Additional Equipment and Maintenance	36	6	42
Additional Staff Costs	550		550
Staff Wellbeing	41		41
Additional FHS Prescribing		105	
Additional FHS Contractor Costs		36	36
Social Care Provider Sustainability Payments	2,697		2,697
Social Care Support Fund Claims			
Payments to Third Parties			
Homelessness and Criminal Justice Services	174		174
Children and Family Services	1,711		1,711
Loss of Income	218		218
Other		10	10
Covid-19 Costs	**5,818**	**482**	**6,300**
Unachievable Savings		0	0
Offsetting Cost Reductions		-105	
Total Covid-19 Costs - HSCP	**5,818**	**377**	**6,195**
REMOBILISATION COSTS - HSCP			
Adult Social Care			
Reducing Delayed Discharge	88		88
Digital & IT costs	9	15	24
Primary Care			
Other		650	650
Total Remobilisation Costs	**97**	**665**	**762**
Total HSCP Costs	**5,915**	**1,042**	**6,957**

APPENDIX 2

SOCIAL CARE

REVENUE BUDGET 2021/22 PROJECTED POSITION

PERIOD 9: 1 April 2021 - 31 December 2021

SUBJECTIVE ANALYSIS	Budget 2021/22 £000	Revised Budget 2021/22 £000	Projected Out-turn 2021/22 £000	Projected Over/(Under) Spend £000	Percentage Variance
SOCIAL CARE					
Employee Costs	29,677	32,028	31,033	(995)	-3.1%
Property costs	997	996	1,035	39	3.9%
Supplies and Services	805	905	953	48	5.3%
Transport and Plant	378	348	289	(59)	-17.0%
Administration Costs	723	734	880	146	19.9%
Payments to Other Bodies	42,904	45,799	46,553	754	1.6%
Resource Transfer	(16,816)	(18,294)	(18,294)	0	0.0%
Income	(4,016)	(4,963)	(4,940)	23	-0.5%
Funding/Savings still to be allocated	0	0	0	0	0.0%
SOCIAL CARE NET EXPENDITURE	**54,652**	**57,553**	**57,509**	**(44)**	**-0.1%**

OBJECTIVE ANALYSIS	Budget 2021/22 £000	Revised Budget 2021/22 £000	Projected Out-turn 2021/22 £000	Projected Over/(Under) Spend £000	Percentage Variance
SOCIAL CARE					
Strategy & Support Services	1,649	1,671	1,606	(65)	-3.9%
Older Persons	22,548	24,298	23,546	(752)	-3.1%
Learning Disabilities	8,435	8,842	8,965	123	1.4%
Mental Health	939	1,002	894	(108)	-10.8%
Children & Families	10,494	10,530	11,582	1,052	10.0%
Physical & Sensory	2,461	2,487	2,649	162	6.5%
Alcohol & Drug Recovery Service	960	876	594	(282)	-32.2%
Business Support	3,157	4,189	4,063	(126)	-3.0%
Assessment & Care Management	2,716	2,320	2,190	(130)	-5.6%
Criminal Justice / Scottish Prison Service	75	118	191	73	0.0%
Resource Transfer		0		0	0.0%
Unallocated Funds		0		0	0.0%
Homelessness	1,218	1,220	1,229	9	0.7%
SOCIAL CARE NET EXPENDITURE	**54,652**	**57,553**	**57,509**	**(44)**	**-0.1%**

COUNCIL CONTRIBUTION TO THE IJB	Budget 2021/22 £000	Revised Budget 2021/22 £000	Projected Out-turn 2021/22 £000	Projected Over/(Under) Spend £000	Percentage Variance
Council Contribution to the IJB	**54,652**	**57,553**	**57,553**	**0**	
Transfer from / (to) Reserves			**(44)**		

APPENDIX 3

HEALTH

REVENUE BUDGET 2021/22 PROJECTED POSITION

PERIOD 9: 1 April 2021 - 31 December 2021

SUBJECTIVE ANALYSIS	Budget 2021/22 £000	Revised Budget 2021/22 £000	Projected Out-turn 2021/22 £000	Projected Over/(Under) Spend £000	Percentage Variance
HEALTH					
Employee Costs	23,186	29,491	28,680	(811)	-2.7%
Property	5	43	43	0	0.0%
Supplies & Services	4,482	9,302	9,302	0	0.0%
Family Health Services (net)	28,629	29,992	29,992	0	0.0%
Prescribing (net)	18,508	19,346	19,346	0	0.0%
Resource Transfer	18,393	18,294	18,294	0	0.0%
Income	(1)	(3,713)	(3,713)	0	0.0%
Transfer to Earmarked Reserves	0	0	0	0	0.0%
HEALTH NET DIRECT EXPENDITURE	**93,202**	**102,755**	**101,944**	**(811)**	**-0.8%**
Set Aside	28,177	28,177	28,177	0	0.0%
HEALTH NET DIRECT EXPENDITURE	**121,379**	**130,932**	**130,121**	**(811)**	**-0.6%**

OBJECTIVE ANALYSIS	Budget 2021/22 £000	Revised Budget 2021/22 £000	Projected Out-turn 2021/22 £000	Projected Over/(Under) Spend £000	Percentage Variance
HEALTH					
Children & Families	3,411	4,640	4,154	(486)	-10.5%
Health & Community Care	6,420	10,674	10,607	(67)	-0.6%
Management & Admin	1,779	1,903	1,577	(326)	-17.1%
Learning Disabilities	539	570	520	(50)	-8.8%
Alcohol & Drug Recovery Service	1,757	2,414	2,228	(186)	-7.7%
Mental Health - Communities	3,159	3,511	3,453	(58)	-1.7%
Mental Health - Inpatient Services	9,310	9,893	10,713	820	8.3%
Strategy & Support Services	517	631	403	(228)	-36.1%
Family Health Services	28,649	29,952	29,952	0	0.0%
Prescribing	18,695	19,533	19,534	1	0.0%
Unallocated Funds/(Savings)	573	740	509	(231)	0.0%
Transfer from / (to) Reserves	0	0	0	0	0.0%
Resource Transfer	18,393	18,294	18,294	0	0.0%
HEALTH NET DIRECT EXPENDITURE	**93,202**	**102,755**	**101,944**	**(811)**	**-0.8%**
Set Aside	28,177	28,177	28,177	0	0.0%
HEALTH NET DIRECT EXPENDITURE	**121,379**	**130,932**	**130,121**	**(811)**	**-0.6%**

HEALTH CONTRIBUTION TO THE IJB	Budget 2021/22 £000	Revised Budget 2021/22 £000	Projected Out-turn 2021/22 £000	Projected Over/(Under) Spend £000	Percentage Variance
NHS Contribution to the IJB	**121,379**	**130,932**	**130,932**	**0**	
Transfer from / (to) Reserves	**0**	**0**	**(811)**		

Budget Movements 2021/22

Appendix 4

Inverclyde HSCP	Approved Budget	Movements				Revised Budget
Service	2021/22 £000	Inflation £000	Virement £000	Supplementary Budgets £000	Transfers (to)/ from Earmarked Reserves £000	2021/22 £000
Children & Families	13,905	3	354	908	0	15,170
Criminal Justice	75	43	0	0	0	118
Older Persons	22,548	414	357	979	0	24,298
Learning Disabilities	8,974	3	17	418	0	9,412
Physical & Sensory	2,461	0	0	26	0	2,487
Assessment & Care Management/ Health & Community Care	9,136	(452)	315	3,995	0	12,994
Mental Health - Communities	4,098	5	22	388	0	4,513
Mental Health - In Patient Services	9,310	33	545	5	0	9,893
Alcohol & Drug Recovery Service	2,717	0	(115)	688	0	3,290
Homelessness	1,218	0	0	2	0	1,220
Strategy & Support Services	2,166	29	16	91	0	2,302
Management, Admin & Business Support	4,936	374	(629)	1,411	0	6,092
Family Health Services	28,649	0	0	1,303	0	29,953
Prescribing	18,695	0	316	522	0	19,533
Resource Transfer	18,393	0	(99)	0	0	18,294
Unallocated Funds *	573	1,587	(1,446)	26	0	740
Transfer from Reserves						
Totals	147,854	2,039	(346)	10,762	0	160,309

* Unallocated Funds are budget pressure monies agreed as part of the budget which at the time of setting had not been applied across services eg pay award etc

Social Care Budgets	Approved Budget	Movements				Revised Budget
Service	2021/22 £000	Inflation £000	Virement £000	Supplementary Budgets £000	Transfers to/ (from) Earmarked Reserves £000	2021/22 £000
Children & Families	10,494		25	11		10,530
Criminal Justice	75	43				118
Older Persons	22,548	414	357	979		24,298
Learning Disabilities	8,435			407		8,842
Physical & Sensory	2,461			26		2,487
Assessment & Care Management	2,716	(454)	58			2,320
Mental Health - Community	939			63		1,002
Alcohol & Drug Recovery Service	960		(89)	5		876
Homelessness	1,218			2		1,220
Strategy & Support Services	1,649	26	(4)			1,671
Business Support	3,157	372	(694)	1,354		4,189
Resource Transfer	0					0
Unallocated Funds	0					0
Totals	54,652	401	(347)	2,847	0	57,553

57,553

Health Budgets	Approved Budget	Movements				Revised Budget
HEALTH Service	2021/22 £000	Inflation £000	Virement £000	Supplementary Budgets £000	Transfers to/ (from) Earmarked Reserves £000	2021/22 £000
Children & Families	3,411	3	329	897		4,640
Learning Disabilities	539	3	17	11		570
Health & Community Care	6,420	2	257	3,995		10,674
Mental Health - Communities	3,159	5	22	325		3,511
Mental Health - Inpatient Services	9,310	33	545	5		9,893
Alcohol & Drug Recovery Service	1,757		(26)	683		2,414
Strategy & Support Services	517	3	20	91		631
Management, Admin & Business Support	1,779	2	65	57		1,903
Family Health Services	28,649			1,303		29,952
Prescribing	18,695		316	522		19,533
Resource Transfer	18,393		(99)			18,294
Unallocated Funds/(Savings)	573					573
Transfer from Reserves	0	1,587	(1,446)	26		167
Totals	93,202	1,638	0	7,915	0	102,755

APPENDIX 5

INVERCLYDE INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

THE INVERCLYDE COUNCIL is hereby directed to deliver for the Inverclyde Integration Joint Board (the IJB), the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the IJB's Strategic Plan and existing operational arrangements pending future directions from the IJB. All services must be procured and delivered in line with Best Value principles.

Services: All services listed in Annex 2, Part 2 of the Inverclyde Health and Social Care Partnership Integration Scheme.

Functions: All functions listed in Annex 2, Part 1 of the Inverclyde Health and Social Care Partnership Integration Scheme.

Associated Budget:

SUBJECTIVE ANALYSIS	Budget 2021/22 £000
SOCIAL CARE	
Employee Costs	32,028
Property costs	996
Supplies and Services	905
Transport and Plant	348
Administration Costs	734
Payments to Other Bodies	45,799
Income (incl Resource Transfer)	(23,257)
Unallocated Funds	0
SOCIAL CARE NET EXPENDITURE	**57,553**

Health Transfer to EMR	0

OBJECTIVE ANALYSIS	Budget 2021/22 £000
SOCIAL CARE	
Strategy & Support Services	1,671
Older Persons	24,298
Learning Disabilities	8,842
Mental Health	1,002
Children & Families	10,530
Physical & Sensory	2,487
Alcohol & Drug Recovery Service	876
Business Support	4,189
Assessment & Care Management	2,320
Criminal Justice / Scottish Prison	118
Unallocated Funds	0
Homelessness	1,220
Social Care Transfer to EMR	
Resource Transfer	0
SOCIAL CARE NET EXPENDITURE	**57,553**

This direction is effective from 22 March 2022.

INVERCLYDE INTEGRATION JOINT BOARD

DIRECTION

ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

GREATER GLASGOW & CLYDE NHS HEALTH BOARD is hereby directed to deliver for the Inverclyde Integration Joint Board (the IJB), the services noted below in pursuance of the functions noted below and within the associated budget noted below.

Services will be provided in line with the IJB's Strategic Plan and existing operational arrangements pending future directions from the IJB. All services must be procured and delivered in line with Best Value principles.

Services: All services listed in Annex 1, Part 2 of the Inverclyde Health and Social Care Partnership Integration Scheme.

Functions: All functions listed in Annex 1, Part 1 of the Inverclyde Health and Social Care Partnership Integration Scheme.

Associated Budget:

SUBJECTIVE ANALYSIS	Budget 2021/22 £000
HEALTH	
Employee Costs	29,491
Property costs	43
Supplies and Services	9,302
Family Health Services (net)	29,992
Prescribing (net)	19,346
Resources Transfer	18,294
Unidentified Savings	0
Income	(3,713)
Transfer to EMR	0
HEALTH NET DIRECT EXPENDITURE	**102,755**
Set Aside	28,177
NET EXPENDITURE INCLUDING SCF	**130,932**

OBJECTIVE ANALYSIS	Budget 2021/22 £000
HEALTH	
Children & Families	4,640
Health & Community Care	10,674
Management & Admin	1,903
Learning Disabilities	570
Alcohol & Drug Recovery Service	2,414
Mental Health - Communities	3,511
Mental Health - Inpatient Services	9,893
Strategy & Support Services	631
Family Health Services	29,952
Prescribing	19,533
Unallocated Funds/(Savings)	740
Transfer to EMR	0
Resource Transfer	18,294
HEALTH NET DIRECT EXPENDITURE	**102,755**
Set Aside	28,177
NET EXPENDITURE INCLUDING SCF	**130,932**

This direction is effective from 22 March 2022.

APPENDIX 6

INVERCLYDE HSCP
TRANSFORMATION FUND
PERIOD 9: 1 April 2021 - 31 December 2021

Total Fund Balance as at 1 April 2021	1,085,000

Total Fund Balance as at 1 April 2021	1,085,000
Balance committed to date	767,027
Balance still to be committed	317,973

Project Title	Service Area	Approved IJB/TB	Social Care/ Health Spend	Agreed Funding	2019/20 Spend	2020/21 Spend	2021/22 Spend	Balance to spend
Sheltered Housing Support Services Review	Health & Community Care	TB	Social Care	99,970	13,847	37,867	21,191	27,065
Equipment Store Stock system - £50k capital plus 1.5 yrs revenue costs up to £20k in total	ICIL	TB	Social Care	70,000	0	42,405		27,595
Match Funding for CORRA bid to pilot 7 day Addictions Services	Addictions	IJB	Both	150,000			26,200	123,800
Long Term Conditions Nurses - 2 x 1wte Band 5 nurses to cover Diabetes, COPD and Hyper-tension for a fixed term of one year.	Community Nursing	IJB	Health	126,692	60,300	55,200	11,192	0
Autism Clinical/Project Therapist. 18 month post.	Specialist Children's Services	TB	Health	153,600	0	60,200	61,957	31,443
Strategic Commissioning Team - progressing the priorities on the Commissioning List.	Strategy & Support Services	IJB	Social Care	110,537	5,597	38,374	18,182	48,384
Care Navigator Posts - Pilot to develop a care co-ordinated response to clients with multiple complex issues.	Homelessness	IJB	Social Care	100,000		15,487	31,129	53,414
Temp HR advisor for 18 months to support absence management process and occupational health provision within HSCP.	Strategy & Support Services	TB	Social Care	66,000	3,118	49,587	13,295	0
Proud2Care to enable the continued partnership with Your Voice over 18 months to support continued Proud2Care activity.	C&F	IJB	Social Care	110,000		60,000	15,000	35,000
Inverclyde Cares - One off contribution to allow CVS to second a full time member of staff from Ardgowan Hospice to oversee both the Compassionate Inverclyde and Inverclyde Cares initiatives jointly.	Strategy & Support Services	SMT	Both	28,000				28,000
Review of Care and Support at Home. 12 month fixed term posts 0.5wte Grade 10 Project Lead and 2wte Grade 5s	Health & Community Care	TB	Social Care	98,600				98,600

CLDT Review Team and TEC response. 1wte Social worker post and 1wte Social Work assistant, both f/t 12 months.	CLDT	TB	Social Care	95,580				95,580

APPENDIX 7

INVERCLYDE HSCP - CAPITAL BUDGET 2020/21

PERIOD 9: 1 April 2021 - 31 December 2021

Project Name	Est Total Cost £000	Actual to 31/3/21 £000	Revised Budget 2021/22 £000	Actual YTD £000	Est 2022/23 £000	Est 2023/24 £000	Future Years £000
SOCIAL CARE							
Crosshill Children's Home Replacement	2,315	1,489	720	334	56	50	0
New Learning Disability Facility	7,400	67	200	47	750	5,248	1,135
SWIFT Upgrade	1,101	0	0	0	901	200	0
Completed on site	13	0	2	0	11	0	0
Social Care Total	**10,829**	**1,556**	**922**	**381**	**1,718**	**5,498**	**1,135**
HEALTH							
Health Total	0	0	0	0	0	0	0
Grand Total HSCP	**10,829**	**1,556**	**922**	**381**	**1,718**	**5,498**	**1,135**

EARMARKED RESERVES POSITION STATEMENT

APPENDIX 8

INVERCLYDE HSCP

Period 9: 1 April - 31 December 2021

Project	Lead Officer/ Responsible Manager	Planned Use By Date	b/f Funding 2020/21 £000	New Funding 2021/22 £000	Total Funding 2021/22 £000	YTD Actual 2021/22 £000	Projected Net Spend 2021/22 £000	Amount to be Earmarked for Future Years £000	Lead Officer Update
Scottish Government Funding			**4,798**	**4,242**	**9,040**	**5,755**	**8,644**	**396**	
Mental Health Action 15	Anne Malarkey	31/03/2022	343		343	343	343	0	Ongoing expenditure. Unspent budget will be carried into 22/23.
ADP	Anne Malarkey	31/03/2022	423		423	423	423	0	Any remaining balance will be carried forward into 22/23.
Covid-19	Allen Stevenson	31/03/2022	2896	4,027	6,923	4,322	6,923	0	Balance of Covid -19 funding received in 2020-21. Will be spent in 2021-22
IJB Covid Sheilding SC Fund	Allen Stevenson	31/03/2022	34	0	34	0	34	0	Balance of Covid -19 funding received in 2020-21. Will be spent in 2021-22
Rapid Rehousing Transition Plan (RRTP)	Anne Malarkey	31/03/2022	136		136	16	60	76	RRTP funding- progression of Housing First approach and the RRTP partnership officer to be employed. Full spend is reflected in 5 year RRTP plan The Rapid Rehousing provision paper shows a spend of £42k from this EMR this year - is that included in the projected spend?
IJB DN Redesign	Louise Long	ongoing	86		86	86	86	0	£35K to fund DN. £51k reallocated to Supplimentary Fixed Term Staffing
PCIP	Allen Stevenson	31/03/2022	560		560	560	560	0	Any remaining balance will be carried forward into 22/23.
Covid Recovery - Establish Inverclydes Board and Memorial	Allen Stevenson	31/03/2022		40	40	5	40	0	Approved P&R 25/05/21 - Covid Recovery Plans
Covid Recovery - Provide Passes for leisure access for physical activity	Allen Stevenson	31/03/2022		50	50	0	50	0	Approved P&R 25/05/21 - Covid Recovery Plans
Covid Recovery - Support participation in groups and to re engage with Communities	Allen Stevenson	31/03/2022		60	60	0	60	0	Approved P&R 25/05/21 - Covid Recovery Plans
Covid Recovery - Develop Food to Fork project to promote growing strategy	Allen Stevenson	31/03/2022		30	30	0	30	0	Approved P&R 25/05/21 - Covid Recovery Plans

Project	Lead Officer/ Responsible Manager	Planned Use By Date	b/f Funding 2020/21 £000	New Funding 2021/22 £000	Total Funding 2021/22 £000	YTD Actual 2021/22 £000	Projected Net Spend 2021/22 £000	Amount to be Earmarked for Future Years £000	Lead Officer Update
Covid Recovery - Develop Wellbeing Campaign	Allen Stevenson	31/03/2022		35	35	0	35	0	Approved P&R 25/05/21 - Covid Recovery Plans
Community Living Charge	Allen Stevenson	31/03/2022	320		320		0	320	LD money for 3 years only for Placements.
Existing Projects/Commitments			**4,807**	**472**	**5,279**	**680**	**1,222**	**4,057**	
Self Directed Support	Alan Brown	31/03/2022	43	-43	0		0	0	Now reallocated to SWIFT Project.
Growth Fund - Loan Default Write Off	Craig Given	ongoing	24		24		1	23	Loans administered on behalf of DWP by the credit union and the Council has responsibility for paying any unpaid debt. This requires to be kept until all loans are repaid and no debts exist. Minimal use anticipated in 2021/22. Possibly added to Capital or LD Hub
Integrated Care Fund	Allen Stevenson	ongoing	109		109		0	109	The Integrated Care Fund funding has been allocated to a number of projects, including reablement, housing and third sector & community capacity projects.
Delayed Discharge	Allen Stevenson	ongoing	88	334	422	311	422	0	Delayed Discharge funding has been allocated to specific projects, including overnight home support and out of hours support. Spend of £422k is expected for 2021-22.
Autism Friendly	Allen Stevenson	ongoing	0	164	164		0	164	Plans currently being developed.
CJA Preparatory Work	Sharon McAlees	31/03/2022	88		88	0	0	88	Funding community justice Third sector work, £13k along with funding shortfall in prison income and shortfall of turnover savings against core grant in 21/22
Continuing Care	Sharon McAlees	ongoing	425		425	79	131	294	To address continuing care legislation. Based on Period 9 projections it is assumed £131k of the EMR will be utilised in 2021/22.
Children & Young Person Mental Health & Welbeing	Sharon McAlees	ongoing	329		329	7	202	127	Plan and implement a programme aimed at supporting children and young people whose life chances are negatively impact through community mental health based issues. Expenditure will be on staffing: two FTE staff from Action for Children, two FTE staff from Barnardo's, one FTE research assistant based in Educational Psychology and 0.2 Educational Psychologist to act as development Officer with backfill. CAHMS Tier 2 now added to this.

Project	Lead Officer/ Responsible Manager	Planned Use By Date	b/f Funding 2020/21 £000	New Funding 2021/22 £000	Total Funding 2021/22 £000	YTD Actual 2021/22 £000	Projected Net Spend 2021/22 £000	Amount to be Earmarked for Future Years £000	Lead Officer Update
Dementia Friendly Inverclyde	Anne Malarkey	ongoing	100		100	10	30	70	Now linked to the test of change activity associated with the new care co-ordination work. Proposals for spend of circa £90k over 18 months, to fund a Development Worker post and a Training Co-Ordinator post. This will continue to be reviewed at the Steering Group. I've drawn down £10k of this funding in M9 to cover Dementia Digital Health and Care Innovation - development of APP, cost of £15k, requested by Anne Malarkey. It was agreed £10k would come from here and the £5k bal from Financial Planning.
Primary Care Support	Allen Stevenson	31/03/2022	274		274	105	105	169	Requires a spend plan to be created. Year to date actual is £78.4k, leaving a balance of £195.6k. Of this balance, £65k relates to Renfrewshire hosted services, which we have held for a number of years with no plans for spend that I'm aware of. £56k relates to GP Premises, funding. We've actually received a further allocation this year, so expect this reserve to increase. £15k relates to HENRY obesity plans which is part of PHI funding, I've asked Emma for plans but there are none. £57k relates to premises/backscanning, however I understand all of our practices have had this work completed. None of the GP funding can be spent without prior authorisation of Local Medical Committe.
Contribution to Partner Capital Projects	Craig Given	ongoing	610		610		50	560	This is a shared reserve & is coded to 94017. £130k was set up by L Aird at 17/18 & 18/19 year ends from health CFCR and Primary Care Reserve; £15k from the Council re Wellpark Centre. Full spend expected for Wellpark Centre. £310k complex care monies added to EMR at 2019-20 year end.
Welfare	Craig Given	ongoing	297		297		0	297	For IDEAS Plan
Anti Poverty - Community Support Fund	Craig Given	31/03/2022	0	17	17		17	0	£7k NDR relief Tail O The Bank, £10k HSCP Digital Devices
LD Redesign	Allen Stevenson	31/03/2022	383		383	5	22	361	To be developed further
Older People WiFi	Allen Stevenson	31/03/2022	7		7	0	7	0	Work has been carried out with balance looking to be fully spent this year.

Project	Lead Officer/ Responsible Manager	Planned Use By Date	b/f Funding 2020/21 £000	New Funding 2021/22 £000	Total Funding 2021/22 £000	YTD Actual 2021/22 £000	Projected Net Spend 2021/22 £000	Amount to be Earmarked for Future Years £000	Lead Officer Update
Refugee Scheme	Sharon McAlees	31/03/2025	737		737	163	194	543	Funding to support Refugees placed in Inverclyde. Funding extends over a 5 year support programme.
CAMHS Post	Sharon McAlees	31/03/2022	68		68		0	68	IJB reserve to be allocated. Originally had plans to use this for fixed term posts, however, we've had so many vacancies that I'm forecasting an underspend of around £260k for Children's services specialist as a whole, so don't need this now. We've also received loads of CAMHS funding as part of the MHR&R which will all need to go to EMR at the end of the year.
Tier 2 School Counselling	Sharon McAlees	31/07/2024	375		375	0	41	334	EMR covers the contract term - potentially to 31 July 2024. Contract commenced 1 August 2020.
Children & Families Residential Services	Sharon McAlees	31/03/2022	250		250		0	250	Potentially to be moved to smoothing reserve.
IJB Homelessness	Allen Stevenson	ongoing	200		200		0	200	IJB reserve to be allocated. I don't understand why ADP have been asked to fund this new Rapid Rehousing plan, £250k this year and £100k next year - which we're struggling to find from ADP, when there's a £200k balance within Homelessness EMR?
Supplementary Fixed Term Staffing Fund	Allen Stevenson	31/03/2022	400		400		0	400	IJB reserve to be allocated. Cost of Health covid fixed term posts which extend beyond March 22 is £100k, this potentially will need to be funded from here.
Transformation Projects			**2,888**	**43**	**2,931**	**550**	**1,306**	**1,625**	
Transformation Fund	Allen Stevenson	ongoing	1,085		1,085	254	767	318	Based on latest Transformational Board.
Social Care Records Replacement System Project	Sharon McAlees	30/06/2023	374	43	417	109	130	287	Project ongoing. £43k reallocated from Self Directed Support.
Mental Health Transformation	Allen Stevenson	ongoing	788		788		142	646	his funding is fully committed to fund PAC posts, 2wte Junior Docs for 6 months and Anne's Advanced Clinical Practice proposal.
Addictions Review	Anne Malarkey	31/03/2022	250		250		0	250	This funding is fully committed to pay for one year commissioned service with third sector suppliers re ADP next year.

Project	Lead Officer/ Responsible Manager	Planned Use By Date	b/f Funding 2020/21 £000	New Funding 2021/22 £000	Total Funding 2021/22 £000	YTD Actual 2021/22 £000	Projected Net Spend 2021/22 £000	Amount to be Earmarked for Future Years £000	Lead Officer Update
Children's Winter Plan	Sharon McAlees	31/03/2022	187		187	187	187	0	The winter pressure Fund funding has been allocated to a number of projects, direct awards to families and enhanced family support, additional staff to meet demands of additional workload associated with outstanding referrals, deferred children's hearing orders etc. This will be spent in full in 21/22
Staff Learning & Development Fund	Sharon McAlees	ongoing	204		204		80	124	So far £76k practice teachers to be funded from this EMR. I'm projecting there will be enough overall underspend within Adult Community Services to cover the additional expense of the SPQ nursing students backfill, so don't think we'll need to use this.
Budget Smoothing			**1,698**	**0**	**1,698**	**0**	**259**	**1,439**	
C&F Adoption, Fostering Residential Budget Smoothing	Sharon McAlees	ongoing	350		350		0	350	This reserve is used to smooth the spend on children's residential accommodation, adoption, fostering & kinship costs over the years. The projection assumes that the EMR will be fully utilised in 2021/22.
LD Client Commitments	Allen Stevenson	ongoing	350		350		0	350	Smoothing Reserve to aid in overspend pressure within LD Client Commitments. The projection assumes that the EMR will be fully utilised in 2021/22.
Residential & Nursing Placements	Allen Stevenson	ongoing	617		617		241	376	Smoothing Reserve to aid in overspend pressure within Residential/Nursing Client Commitments
Advice Services	Craig Given	31/03/2022	18		18	0	18	0	Smoothing reservce to aid the £105k 19/20 savings within advice service to be fully achieved by 21/22
Prescribing	Allen Stevenson	ongoing	363		363		0	363	Unlikely to be needed in 21/22 based on current projections
TOTAL EARMARKED			**14,191**	**4,757**	**18,948**	**6,985**	**11,431**	**7,517**	
UN-EARMARKED RESERVES									
General			741		741		0	741	IJB reserve to be allocated
			741	**0**	**741**	**0**	**0**	**741**	
In Year Surplus/(Deficit) going to/(from) reserves								44	

Project	Lead Officer/ Responsible Manager	Planned Use By Date	b/f Funding 2020/21 £000	New Funding 2021/22 £000	Total Funding 2021/22 £000	YTD Actual 2021/22 £000	Projected Net Spend 2021/22 £000	Amount to be Earmarked for Future Years £000	Lead Officer Update
TOTAL IJB RESERVES			**14,932**	**4,757**	**19,689**	**6,985**	**11,431**	**8,302**	

b/f Funding	14,932
Earmark to be carried forward	8,302
Projected Movement in Reserves	**(6,630)**

Reserves Summary Sheet for Covering Report

Ear-Marked Reserves	Opening Balance	New Funds in Year	Total Funding	Spend to Date	Projected Spend	Projected C/fwd
Scottish Government Funding - funding ringfenced for specific initiatives	4,798	4,242	9,040	5,755	8,644	396
Existing Projects/Commitments - many of these are for projects that span more than 1 year	4,807	472	5,279	680	1,222	4,057
Transformation Projects - non recurring money to deliver transformational change	2,888	43	2,931	550	1,306	1,625
Budget Smoothing - monies held as a contingency for specific volatile budgets such as Residential Services and Prescribing to smooth out in year one off pressures	1,698	0	1,698	0	259	1,439
TOTAL Ear-Marked Reserves	**14,191**	**4,757**	**18,948**	**6,985**	**11,431**	**7,517**
General Reserves	**741**	**0**	**741**	**0**	**0**	**741**
In Year Surplus/(Deficit) going to/(from) reserves						44
TOTAL Reserves	**14,932**	**4,757**		**6,985**		**8,302**
Projected Movement (use of)/transfer in to Reserves						**(6,630)**

AGENDA ITEM NO: 7

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**21 March 2022**
Report By:	**Allen Stevenson Interim Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership**	**Report No:**	**IJB/15/2022/AB**
Contact Officer:	**Alan Best, Head of Health and Community Care**	**Contact No:**	**01475 715212**
Subject:	**UNSCHEDULED CARE COMMISSIONING PLAN (DESIGN & DELIVERY PLAN 2022/23 – 2024/25)**		

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board and ask for approval of the NHS Greater Glasgow & Clyde Unscheduled Care Commissioning Design and Delivery Plan.

2.0 SUMMARY

2.1 The Unscheduled Care Programme contributes to all nine national outcomes, and in particular is fundamental to the delivery of outcome nine: that resources are used effectively and efficiently in the provision of health & social care services.

2.2 The plan ensures that Inverclyde HSCP along with other GG&C HSCP's, NHS Boards, Local Authorities and other care providers make full use of their powers and responsibilities to shift investment into community provision by reducing inappropriate use of hospital care and redesigning service provision across acute and community services.

2.3 Section 7 of the plan outlines the financial framework to deliver against the phased approach and highlights a funding gap between the current available financial resources and the funding required to deliver the program in full.

3.0 RECOMMENDATIONS

3.1 The Integration Board is asked to approve the Design & Delivery Plan 2022/23 – 2024/25 attached in Appendix 1 as the initiative updated and re-freshed Board Wide Unscheduled Care Improvement Programme.

3.2 The Integration Board is asked to approve the financial framework outlined in section 7 of the updated plan and the IJB is asked to note the substantial financial shortfall where of £11.128m required, only £5.089m of funding has been able to be identified on a recurring basis across GG&C level a funding gap of 6.039 million of which Inverclyde HSCP's share is 163,078 (Annex C).

3.3 The Integration Board is asked to note the performance arrangements to report on and monitor progress towards delivery of the plan and receive a further update on the delivery of the programme towards the end of 2022/23. All six Integration Joint Boards are receiving similar updates.

Allen Stevenson
Interim Chief Officer
Inverclyde Health and Social Care Partnership

4.0 BACKGROUND

4.1 The previous Unscheduled Care Plan was previously approved by the all GG&C HSCPs in 2021. The plan was developed in partnership with the NHS Board and Acute Services Division and built on the board's Programme (http://www.nhsggc.org.uk/media/245268/10-unscheduled-care-update.pdf.) which was integral to the Board-wide Moving Forward Together Program: (https://www.nhsggc.org.uk/media/251904/item-10a-paper-18_60-mft-update.pdf).

4.2 Since the original plan was developed in early 2020 there has been considerable change in the health and social system overall as a result of the coronavirus pandemic. While many of the actions in the draft plan approved by IJBs remain relevant, some needed updating to reflect the changed circumstances arising from our response to the pandemic, and additional actions added on the new challenges being faced by the health and social care system. This is a reflection of the need for the constant review and updating of such a large scale strategic system wide change programme as unscheduled care in Scotland's biggest, most complex and diverse health and social care economy with many moving and inter related parts

4.3 The purpose of the plan is to show how we aim to respond to the pressures on health and social care services across GG&C and meet future demand. The plan explains that with an ageing population and changes in how and when people chose to access services, change was needed and patients' needs met in different ways, with services that were more clearly integrated and with better public understanding.

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

- **early intervention and prevention** of admission to hospital to better support people in the community;
- **improving hospital discharge** and better supporting people to transfer from acute care to community supports; and,
- **improving the primary / secondary care interface** jointly with acute to better manage patient care in the most appropriate setting.

4.5 The final Design & Delivery Plan attached updates the actions in the draft unscheduled care plan reported previously to the IJB. The re-freshed programme follows through on the three key themes from the 2020 plan, and shows the key priorities to be progressed this year (phase 1), actions for 2022/23 (phase 2) and future years (phase 3).

4.6 An updated action plan is included in annex B, and revised performance trajectories included. It is projected that the overall impact of the programme on emergency admissions (65+) taking account of future population increases and current trends, as currently funded, has the potential to reduce emergency admissions for over 65s by 5% during 2022/23.

4.7 A financial framework has been developed in partnership with all six IJBs across Greater Glasgow and Clyde NHS Board to support the implementation of the Design and Delivery Plan. It should be noted that this has been completed on a 2022/23 cost base. We will develop a performance dashboard for use within the delivery plan.

4.8 The investment required to deliver on Phase 1 priorities has been fully costed and is included in the Financial Framework Annex C. This highlights the need for £33.130m of investment across Greater Glasgow and Clyde, of which £11.128m is required on a recurring basis and £22.002m is required non-recurrently. Full funding for the non-recurring investment has been found with partner bodies utilising reserve balances or managing within existing budgets to deliver the funding required. Of the recurring funding of £11.128m required, only £5.089m of funding has been able to be identified on a recurring basis. £1.012m of the funding gap relates to MHAU's for which recurring funding is still to be put in place by Scottish Government. The remaining funding gap recognises the challenge which all IJBs and the Health Board have had in securing full funding for Phase 1. This has implications for the delivery of the plan, even for Phase 1, with actions not able to be fully implemented in all IJBs until funding is secured.

4.9 Of the GG& C 6,039m funding shortfall contained within Annex C Financial framework Inverclyde HSCP' s funding gap is 163,078 (Annex C).

5.0 IMPLICATIONS

Finance

5.1 .

Financial Implications:

One off Costs

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

Annually Recurring Costs/ (Savings)

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

Legal

5.2 None

Human Resources

5.3 None

Equalities

5.4 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.

(a) 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 substantive change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required

5.5 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	Protects characteristic groups
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	Reduces discrimination

People with protected characteristics feel safe within their communities.	Protects communities
People with protected characteristics feel included in the planning and developing of services.	Promotes inclusion
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	Promotes diversity
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	Protects communities
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	Protects communities

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

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

NATIONAL WELLBEING OUTCOMES

5.7 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.	N/A
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	N/A
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Promotes positive experiences
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Improves quality of lives
Health and social care services contribute to reducing health inequalities.	Contributes to reducing health inequalities
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative	Supports carers

impact of their caring role on their own health and wellbeing.	
People using health and social care services are safe from harm.	Protects communities
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.	Promotes inclusion
Resources are used effectively in the provision of health and social care services.	Promotes best use of resources.

(b) Fairer Scotland Duty

If this report affects or proposes any major strategic decision:-

Has there been active consideration of how this report's recommendations reduce inequalities of outcome?

	YES – A written statement showing how this report's recommendations reduce inequalities of outcome caused by socio-economic disadvantage has been completed.
X	NO – This report does not affect or propose any major strategic decision.

(c) Data Protection

Has a Data Protection Impact Assessment been carried out?

X	YES – This report involves data processing which may result in a high risk to the rights and freedoms of individuals. A DPIA has been carried out as part of the procurement process.
	NO

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 CONSULTATIONS

7.1 The Interim Head of Legal and Democratic Services and the Corporate Procurement Manager have been consulted on the terms of this report.

8.0 BACKGROUND PAPERS

8.1 Un-scheduled Care Commissioning Plan (Design & Delivery Plan 2022/23 -2024/25)

8.2 Appendix B Updated Action Plan.

8.3 Annex C Financial Framework.

NHS GREATER GLASGOW & CLYDE

UNSCHEDULED CARE
JOINT COMMISSIONING PLAN

DESIGN & DELIVERY PLAN
2022/23-2024/25

March 2022

EXECUTIVE SUMMARY

Integration Authorities have responsibility for strategic planning, in partnership with the hospital sector, of those hospital services most commonly associated with the emergency care pathway, alongside primary and community health care and social care. This is known as unscheduled hospital care and is reflected in the set aside budget. The objective is to create a coherent single cross-sector system for local joint strategic commissioning of health and social care services and a single process through which a shift in the balance of care can be achieved.

In recent years unscheduled care services in Greater Glasgow & Clyde have faced an unprecedented level of demand. The health and social care system, including primary and social care, has not seen such consistently high levels of demand before. While we perform well compared to other health and social care systems nationally, and overall the system is relatively efficient in managing high levels of demand, we struggle to meet key targets consistently and deliver the high standards of care we aspire to. Change is needed therefore if we are to meet the challenges ahead.

This unscheduled care commissioning plan represents the first step in moving towards delegated budgets and set aside arrangements for Greater Glasgow and Clyde. This plan updates the unscheduled care Joint Commissioning Plan agreed by IJBs in 2020, and refreshes this Board-wide programme in the light of national changes introduced in 2020 and takes account of the impact of COVID-19. Our objective in refreshing this plan is to ensure that the programme remains relevant and tackles the challenges that face us now.

The plan is focused on three main themes reflecting the patient pathway:

- **prevention and early intervention with the aim of better support people receive the care and treatment they need at or close to home and to avoid hospital admission where possible;**
- **improving the primary and secondary care interface by providing GPs with better access to clinical advice and designing integrated patient pathways for specific conditions; and,**
- **improving hospital discharge and better supporting people to transfer from acute care to appropriate support in the community.**

Essentially our aim is that each patient is seen by the right person at the right time and in the right place. For acute hospitals that means ensuring their resources are directed only towards people that require hospital-level care.

The emphasis 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 and ongoing public awareness campaign so that people know what services to access when, where and how. We will also work with patients to ensure they get the right care at the right time.

Analysis shows that a number of services could be better utilised by patients such as community pharmacists. But we also need to change and improve a range of services to better meet patients' needs e.g. falls prevention services.

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. Work to measure the overall impact of the programme is in hand and we will issue regular updates and reports on progress.

CONTENTS

1. PURPOSE

1.1 The purpose of this plan is to re-fresh and update the Joint Strategic Commissioning Plan approved by IJBs in early 2020, and to present a revised Design and Delivery Plan for the period 2022/23-2024/25.

2. INTRODUCTION

2.1 This plan updates the draft Joint Strategic Commissioning Plan approved by Integration Joint Boards (IJBs) last year and (https://glasgowcity.hscp.scot/sites/default/files/publications/ITEM%20No%2012%20-%20Draft%20Unscheduled%20Care%20commissioning%20Plan.pdf. takes into account the impact of the Coronavirus pandemic, including the delivery of improvements introduced in 2020.

2.2 This Board-wide programme was developed by all six Health and Social Care Partnerships (HSCPs) jointly with the Acute Services Division and the NHS Board in response to an unprecedented level of demand on unscheduled care services, and as a first step towards delegated budgets and to developing set aside arrangements for Greater Glasgow and Clyde. While NHSGGC performs well compared to other health and social care systems nationally, and the system is relatively efficient in managing significantly higher levels of demand than in other Boards, we struggled to meet key performance targets. In particular we have struggled to deliver the four hour standard of 95% on a consistent basis and in 2019/20[1] we reported performance at 85.7%.

2.3 The COVID-19 pandemic has brought a series of new challenges, some of which will be explored further in this plan. The combination of reduced demand as a result of COVID-19 and new or redesigned services introduced has resulted in an improvement in performance against the four hour standard reporting 92.0% for 2020/21. Section 4 and annex A shows performance pre, during and post pandemic and illustrates that although demand reduced during the pandemic there is evidence that demand is on a rapid trajectory towards pre pandemic levels.

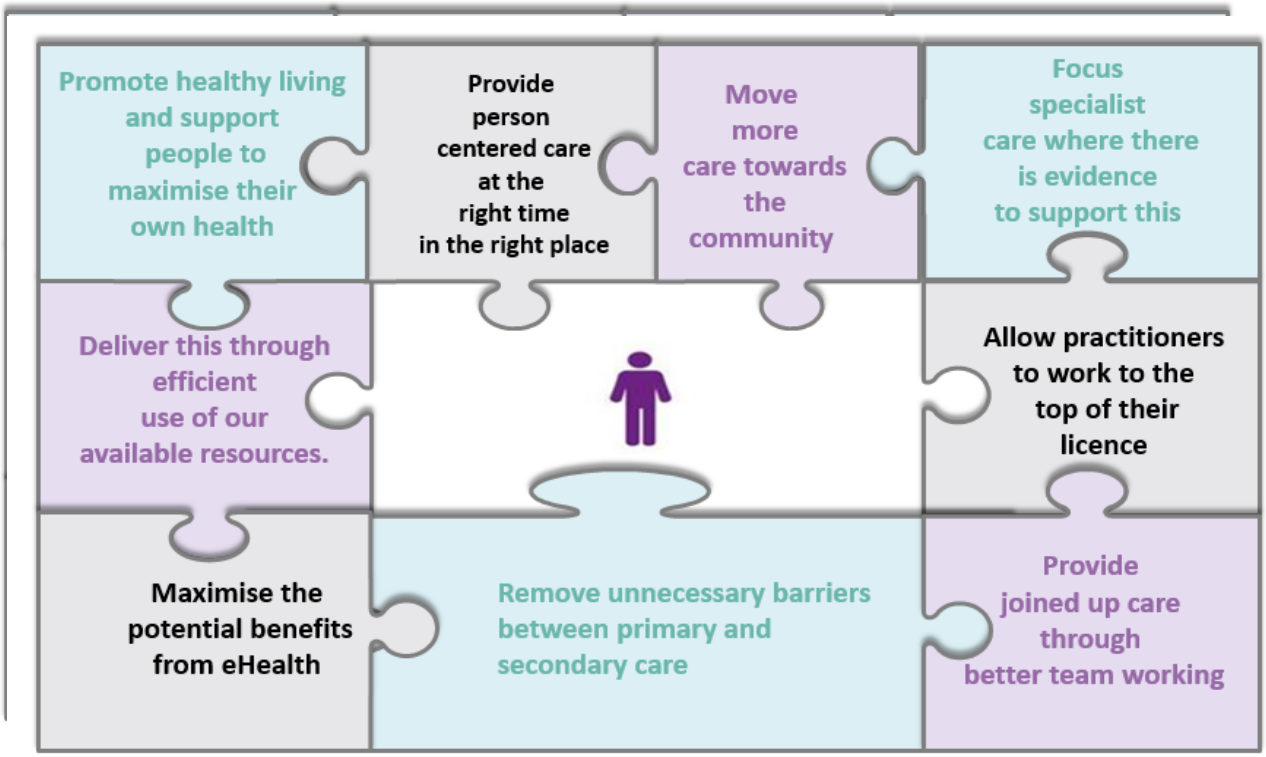
2.4 The 2020 draft plan outlined a major change programme to meet the challenge of what was then considered to be a continual year on year increase in urgent care demand. The aim of the programme was and remains to change the system so that patients are seen by the right person at the right time and in the right place, and in this way be more responsive to patients' needs. The emphasis continues to be on seeing more people at home or in other community settings when it is

[1] 2019/20 has been used as the baseline year for this plan as it was the last full year before activity levels were affected by the pandemic

safe and appropriate to do so and this has been further substantiated through a national programme of service redesign.

2.5 This direction of travel outlined in the Board-wide *Moving Forward Together* strategy continues to be the overarching ambition of our collective improvement efforts (https://www.nhsggc.org.uk/media/251904/item-10a-paper-18_60-mft-update.pdf) and as illustrated in figure 1 below.

Figure 1 – Moving Forward Together



2.6 The 2020 global pandemic changed everything. Levels of unscheduled care attendances were significantly reduced and admissions also reduced albeit not to the same extent. Emergency activity reduced overall as a direct consequence of the 'lockdown' measures and the significant restrictions on delivering elective procedures in a safe way for both patients and staff, as we focused on reducing the spread of the virus. New pathways and responses were introduced for COVID-19 patients and suspected COVID-19 patients. GPs, community health services, acute hospital services and other services changed how they delivered services to the public. Patient behaviour also changed. And new services such as the Mental Health Assessment Units, Community Assessment Centres and Specialist Assessment and Treatment Areas were established.

2.7

2.8 While some aspects of the original programme were progressed, albeit not as quickly as previously planned, other aspects were paused, modified or accelerated. It is right then at this juncture to re-fresh and update the programme to reflect the changed circumstances we are now operating in.

2.9 The remainder of this Design and Delivery plan :

- updates on progress against the actions in the draft programme agreed by IJBs;
- reflects on the impact of the pandemic on unscheduled care activity;
- updates on what was delivered in 2020 including the national redesign of urgent care;
- describes the re-freshed programme to be continued, and the content of the design and delivery phases;
- explains our proposals for ongoing engagement with clinicians, staff, patients and carers;
- outlines the performance and financial framework to support the delivery; and,
- describes the organisational governance arrangements that have been developed to ensure appropriate oversight of implementation of the plan.

3. UNSCHEDULED CARE JOINT COMMISSIONING PLAN 2020

3.1 The original unscheduled care improvement programme approved by IJBs in 2020 was prepared in and informed by the pre-pandemic days during 2019 and 2018. At that time unscheduled care services in NHSGGC were experiencing year on year increases in demand (e.g. A&E attendances, emergency admissions etc.) and there was evidence that some patients who attended A&E could be seen appropriately and safely by other services. In analysing demand at that time it was also acknowledged that the health and social care system was confusing for both patients and clinicians, with routes to access services not always clear or consistent. In addition we were also missing some key national and local targets (e.g. A&E four hour standard and delayed discharges). The conclusion was that to meet this challenge we needed to improve priority areas across the unscheduled care delivery system so that we could better meet current and future demand, and provide improved outcomes for patients.

3.2 The 2020 programme was based on the best available evidence of what works[2]. As a result the plan had 25 actions that were constructed around the patient pathway. The programme focused on three key themes:

- **prevention and early intervention** with the aim of better support people receive the care and treatment they need at or close to home and to avoid hospital admission where possible;
- **improving the primary and secondary care interface** by providing GPs with better access to clinical advice and designing integrated patient pathways for specific conditions; and,
- **improving hospital discharge** and better supporting people to transfer from acute care to appropriate support in the community.

3.3 The pandemic had a huge impact on the programme. Some of the original actions were paused during the pandemic (e.g. anticipatory care plans) some were overtaken by events (e.g. shorter waiting times in MIUs) and others were progressed but to a revised timeline (e.g. frailty pathway). The programme was described as a five year change programme with some actions being implemented sooner than others (e.g. improving delays), and some that required testing and evaluation before wider implementation (e.g. hospital at home).

3.4 Key achievements over the past 12 months have been:

- the introduction of a policy of signposting and re-direction in Emergency Departments for patients who could safely and appropriately be seen by other services;
- improvements in urgent access to mental health services through the introduction of mental health assessment units;
- improvements to discharge planning by the implementation of our discharge to assess policy;
- increased access to professional to professional advice across multiple specialties allowing GPs to make direct contact with clinical decision makers to obtain advice on further treatment for patients avoiding unnecessary hospital attendances; and,
- the Board has introduced and maintained new services and access routes to deliver a dedicated COVID-19 pathway as part of the pandemic response and national remobilisation plans.

[2] *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. IMPACT OF THE PANDEMIC

4.1 As explained above the global pandemic has had a massive impact on services, patients and the unscheduled care demand. The situation we face now in 2022 is significantly different from that in 2019 or early 2020. The data presented in annex A shows that during 2020 compared to the years before the pandemic our traditional access routes experienced a significant reduction as a consequence of the public lockdown as demonstrated in the 2020/21 activity data below:

- A&E reduced by 32.6% and MIU attendances reduced by 45.3%;
- GP referrals to the acute hospital assessment units (AUs) reduced by 55.7% however this is largely due to a change in access routes associated with COVID-19 and is further explained in 4.3 below; and,
- overall emergency admissions reduced by 17.7% compared to 2019/20.

4.2 As part of the COVID-19 response we did however see increases in hospital and primary care activity due to COVID-19. The introduction of a designated access route for patients with COVID-19 symptoms was established in April 2020 in the form of:

- **Community Assessment Centres** (CACs) - dealing with COVID-19 and suspected COVID-19 patients taking referrals directly from GPs and the national NHS24 public access route. During the 2020/2021 year there were 21,673 attendances to the eight Covid-19 centres in GG&C allowing GPs to maintain a service avoiding symptomatic patients; and,
- **Specialist Assessment and Treatment Areas** (SATAs) – providing a designated acute hospital pathway receiving patients from all urgent care services including GPs, A&Es and NHS24. During the 2020/21 year there were 40,802 attendances to acute hospital assessment units. In total the AUs and SATAs reported 71,553 attendances an overall increase of 3%.

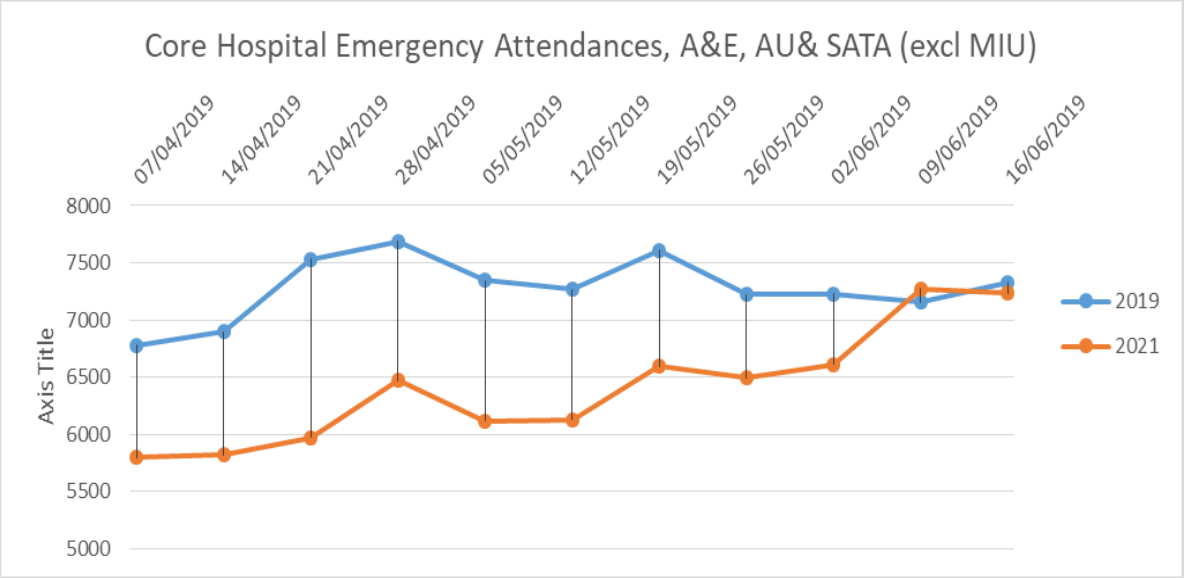
4.3 To ensure direct access for patients who required access to mental health service the Board established two new Mental Health Assessment Units (MHAUs). This provides direct access to specialty avoiding more traditional referral routes from A&E, Scottish Ambulance Service and the Police. During the period April 2020 to February 2021 there were 7,474 direct attendances to MHAUs.

4.4 The demand profile for unscheduled care has however changed, and the Board is experiencing a step change in demand in line with the success of the vaccination programme and easing of restrictions.

4.5 Figure 2 below shows activity over the first 11 weeks of 2021/22 for emergency hospital attendances including A&E, Assessment Units, and SATA (for COVID-19) and excluding the minor injury units (MIU).

4.6 This profile confirms that the cumulative emergency attendance reached the equivalent rate for the same period in 2019/20. This demonstrates the increased importance on the need to deliver on the improvement actions to ensure patients are seen in the right place by the right service at the right time.

Figure 2 - Core Hospital Emergence Attendances Chart



4.7 Innovation in how we deliver services to our patients has been accelerated through the use of digital technology and there have been significant step changes in service:

- GPs introduced telephone triage and Near Me consultations;
- mental health and other services introduced virtual patient management arrangements; and,
- specific pathways were introduced for COVID-19 patients in both acute and primary care settings across a range of service and specialties to allow patient consultations to continue.

4.8 The Scottish Government has prioritised four virtual pathways as part of an on-going national response to the pandemic – work on two of these is included in this plan – further work on the others is in hand. The four priority pathways are:

- the national roll out of Covid remote health monitoring;
- optimising hospital at home services (see section x below);

- community respiratory rapid response pathway (see section x below); and,
- Out-patient parental antibiotic therapy (OPAT) including anti-viral treatment.

4.9 These changes will continue to evolve as we deliver further opportunities for service design as the programme progresses. The changing profile of demand, and evidence from the pandemic recovery phase, means we will need to continually assess the impact of the pandemic on services as we go forward.

4.10 As a consequence of the significant impact of the pandemic and the associated changes in unscheduled care demand and activity during 2020 we have re-visited the original timescales as described in the Joint Commissioning Plan (JCP) and refreshed the actions to reflect the current position. We outline these in the next section.

5 DESIGN AND DELIVERY PLAN

5.1 In this section we describe the revised and updated programme to take into account of the changed circumstances we now face. The revised programme now has three phases of delivery:

- **Phase 1 – 2022/23** – implementation of the national redesign of urgent care and associated actions from the 2020 programme;
- **Phase 2 – 2023/24** – consolidation of the national programme and implementation of the remaining actions from the 2020 programme; and,
- **Phase 3 – 2024** onwards – further development of the programme including evaluation and roll out of pilots and tests of change.

Phase 1 – 2022/23

5.2 In phase one of this programme the focus and delivery of change and improvement was on responding to the pandemic and implementation of the emerging National Redesign of Urgent Care Programme. A number of step change projects that were grounded in the ambitions of the JCP have been implemented, these include:

5.3 **Flow Navigation Centre (FNC) implementation** - Our Flow Navigation Centre went live on 1st December 2020 supported by a soft launch. The admin hub operates 24/7 receiving all Urgent Care Referrals from NHS24. The clinical triage team currently operate from 10am – 10pm, with this deemed optimal based on a review of attendance profiles.

5.4 During this phase we have delivered a **Minor Injury Pathway** which incorporated a direct referral for remote triage and review. This provides the opportunity to deliver a scheduled care approach for individuals who do not require an urgent response/intervention. A temporary winter pathway to GGH (GGH MIU went live on 18th January 2021) to provide an alternative service within Glasgow however this has been largely underutilised as patients have now become more accustomed to the designate centres in Stobhill and the Victoria.

5.5 In the first six months of operation the FNC has completed virtual consultations for 7,000 patients with 32% of those being seen, treated and discharged without the need for further assessment.

5.6 **Signposting and Redirection Policy** - our signposting and redirection policy for Emergency Departments within NHS Greater Glasgow & Clyde was approved October 2020. National guidance was issued in November 2021. Implementation of this policy and supporting standard operating procedures aim to ensure Emergency Department attendees are appropriately reviewed in line with their presentation. The purpose of the policy is not to turn attendees away from the ED, but to direct patients to another appropriate service where their healthcare need can be met, and minimising the risk to themselves and others in overcrowded EDs. These processes also reduce the potential for crowding in the ED by maximising use of safe alternatives for attendees to access care.

5.7 It is recognised that ED signposting and redirection form part of a broader aim across the health and social care environment to ensure patients receive the right care, at the right time and in the right place.

5.8 **Primary Care Interface: alternatives to admission** has been extended to multiple specialties across NHSGGC**.** Professional to Professional Advice services through telephone and app technology are in place and working well. Surgical hot clinics and rapid access to frail elderly clinics are in place as well as the ability for GPs to request advice about patients rather than a direct referral. A pathway to provide access to the Assessment Unit (AU) for patients with DVT and cellulitis has also been implemented.

5.9 Across NHSGGC 212 GP practices have accessed advice via a telecoms application and the number of professional to professional calls made continues to increase month on month. The successful launch of Medical Paediatric Triage Referral Service in March 2020 has contributed to an overall rise since July 2020 and this service continues to receive the highest number of calls relative to other specialties. In addition from June 2021 the Mental Health Assessment Units have implemented the professional to professional advice service complimented by a new SCI Gateway referral process and uptake has been strong.

5.10 **Mental Health Assessment Units (MHAUs)** our two MHAUs were established in 2020 in response to the COVID-19 pandemic and consolidated through the winter period with a full redesign of the urgent care pathways and access routes. These units have continued to reduce demand on secondary care services by reducing footfall through Emergency Departments. The referral pathway provides an immediate route out of ED for those who present directly, with vulnerable patients largely being managed away from the stressful ED environment. The MHAUs also provide an alternative to patients who would otherwise have been conveyed to ED by SAS or Police Scotland. Between December 2020 and March 2021 there were a total of 4,400 patients seen through our MHAUs.

5.11 **COVID-19 Community Assessment Centres (CACs) –** these centres were also developed in response to the COVID-19 pandemic, and directed symptomatic patients who are potentially COVID-19 positive to separate facilities for assessment away from primary care and acute hospital services. Access to CACs is via NHS24. At the peak week in January 2021 there were a total of 566 attendances with 74% of these being maintained within the community with no hospital follow up required.

5.12 **Restructuring of GP Out of Hours (GPOOH)** - a new operating model introduced an appointments based service with access via NHS24 offering telephone triage. Those requiring a 4 hour response receive an initial telephone consultation by Advances Nurse Practitioners or GPs working in the service, including the use of 'Near me' consultation. This reduced the need for in person attendances by 60% freeing capacity to deal flexibly with other competing demands.

5.13 **Urgent Care Resource Hub Model -** HSCPs launched their Urgent Care Resource Hub models in January 2021. This model was established to bring together OOHs services in the community, enhancing integration and the co-ordination of care. The hub provides direct professional to professional access across the health and social care OOHs system and delivers a whole system approach to unscheduled and/ or emergency care via NHS 24.

5.14 **Delayed Discharge** we developed a response to delays that has seen a reduction in our non AWI delays in hospital across all of our sites. HSCPs adopted daily huddle approaches to problem solve and remove roadblocks to delays. Additionally we adopted process changes to the discharge process leading to the development and implementation of a new Discharge to Assess Policy as part of the overall discharge process. Joint working led to agreement with all six HSCPs and Acute on a standard operating procedure to improve effectiveness and reduce the risk of potential delays. This response builds on our 'Home First', if not home, why not ethos. A suite of patient communication

materials have been developed and distributed to key areas within the acute setting launching the Home First branding and outlining the benefits of being cared for at home or in a homely setting, once medical care is no longer required.

5.15 **AWI delays** have been a particular challenge during 2020/21 and 2021/22 as shown in figure 3. Since the Equality and Human Rights Commission ruling we have not been able to discharge patients to off-site beds with the consequence that the proportion of AWI delays is disproportionate to the overall number of delayed discharge patients. A peer review process is planned with a view to identify if there is learning and best practice clinical to ensure our process is as effective and efficient as possible. As there is constant pressure on the system to effectively manage the inpatient capacity across NHSGGC the aim is to ensure that the practice and process adopted is optimised for both patients and the overall health care service.

Figure 3 – AWI delays 2020/21 Glasgow City HSCP

Graph to be inserted

5.16

Phase 2 - 2023 -2024

5.27 During 2022 we will design a programme to deliver on a number of the actions continuing to align and be guided by the National Redesign of Urgent Care five national strategic priorities. The visual in figure 4 below encompasses the key actions to be delivered in the next phase.

Figure 4 - Phase 2 Unscheduled Care Improvement Programme Core Projects

Patient Flow & Flow Navigation Centre Processes	Optimising Discharge and Reducing Delays	Prof to Prof	MSK	Falls & Frailty
• ED Processes • 4 hour standard • Demand Prediction & Capacity Mgmt • FNC Process Optimisation (workflow)	• 'Home First' application of Discharge to Assess • Development of 'Hospital in Reach' processes • AWI Peer Review	• Scheduling urgent care to Medical and Surgical AU's • Community Pharmacy integration with GP in/out of hours and the FNC • SAS – access to FNC and Community Services prof to prof (falls, care homes, COPD) • Whole System Redirection (mutual aid FNC/GPOOHs/ OOHUCRH etc.)	• Develop MSK local FNH/onward community referral pathways and outflow services to reduce hospital and primary care based services • Development of NHS24 Physio resource to deliver National 111 MSK service	• Frailty Screening Tools • Anticipatory Care Planning • Falls Prevention & Management • Frailty at the Front door • Coordination & Integration of Community Models • Hospital at Home - Glasgow City Test of Change

5.28 NHSGGC's response to Phase 2 of the National Redesign of Urgent Care will be to further develop the Flow Navigation Centre and work will continue to develop and redesign urgent care pathways across the whole system over the next 18 months to include:

- **Primary Care/Acute Interface** – we will continue to develop pathways to convert unplanned to planned care with particular focus on scheduling urgent care within Assessment Units. Pathways under review/Development include: Care Homes (Falls), Head Injury, Acute and Surgical (Nat No 2)

- **MSK** – development of NHS24 Physio resource and local Flow Navigation Centre (FNC)/onward community referral pathways to reduce hospital and primary care based services (Nat No.5)
- **Community Pharmacy** – integration with GP in/out of hours and the FNC and to include signposting and direction from MIU/ED for minor illness (Nat No.1)
- **SAS** – development of Community Services and FNC prof to prof to access out of hospital/GP referral pathways e.g. COPD, Falls, Care Homes (Nat No.4)
- **Mental Health** - pathway development to include referrals from GP in/out of hours and the Flow Navigation Centre through prof to prof and scheduled virtual assessments (Nat No.3). This will build on the MHAU pathway fully embedded during 2020.
- **Waiting times** - additional non-recurring support to improve access and waiting times for scheduled care at QEUH and GRI to reduce times patients waiting for procedures delayed due to Covid and avoid the likelihood of them attending A&E.

5.29 Our Falls & Frailty Delivery Programme has six key priority areas of focus within Phase 2. The figure below illustrates the work streams and the key enablers to support the design and delivery of the programme.

Figure 5 - Falls & Frailty Programme Phase 2 Delivery Work streams

5.30 The approach agreed to drive and manage delivery has a strong focus on joint planning and active collaboration. Work streams have been implemented for each of the priority actions with HSCP and Acute leads appointed to each:

- Identification and screening of frailty within the population – to identify those over 65 living in the community with frailty using a frailty assessment tool, measuring deterioration over time and considering pathways to support triggered by frailty score;
- Anticipatory Care Planning – to increase anticipatory care planning conversations and ACPs available via Clinical Portal and the Key Information System (KIS) to support people living with frailty to plan for their future care needs, and when appropriate death. A baseline of 512 ACPs available on Clinical Portal was recorded in March 2021 by May this had increased to over 800;
- Falls Prevention & Management – to develop and implement a falls prevention and management strategy and policy with a view to preventing falls in the community and reducing unscheduled admissions for falls related injury, including care homes;
- Frailty @ the Front Door - enhanced presence by Frailty Team at the acute front door with direct access to a range of community services supporting joint patient centred planning to ensure the right care is given in the right setting, whether that is hospital, at home or in a homely setting;
- Co-ordination and integration of community models - review of current models/pathways and developing refreshed pathways to plan, support and coordinate the patients' journey from pre-frail through to end of life, supporting them to remain at home or a homely environment, ensuring when an intervention is required it is delivered in the right place, delivered by the right person and at the right time; and,
- Hospital @ Home - testing the concept of the Hospital @ Home model and principles. Initial Test of Change in South Glasgow over 12 months with a view to a system wide redesign, subject to evaluation and learning.

5.31 In addition phase 2 of the programme will take forward in GG&C the national work on developing virtual capacity for resilience and recovery. The four key areas of attention for new care pathways are:

- The roll out of Covid remote health monitoring;
- Hospital @ home (already in the programme):
- Community respiratory rapid response (also in the programme); and,
- Out-patient parental ant-biotic therapy (OPAT).

5.32 Key enablers have been identified to support delivery including Communication, IT and infrastructure and workforce:

- **Communication & Engagement Plan -** we fully intend to build on the positive GGC OOH Communication and Engagement programme. An overarching Communication Plan will be developed for 2022/23 for all stakeholders. The plan should seek to develop key principles, common language and key messages and where appropriate join up the learning, and recommendations from activity across GGC from programmes including East Renfrewshire Talking Points, Compassionate Inverclyde and the Glasgow City Maximising Independence programme. Learning from service users and their family/carers input and involvement will be key to helping us develop the plan. A Corporate Communications plan will be considered with quarterly updates generated and shared.

- **IT & Infrastructure eHealth Digital Solutions** – on-going challenges exist regarding interfaces between core systems and shared access to electronic patient information to deliver care closer to home. In the absence of shared systems across community teams, acute, primary care etc. we continue to develop processes with numerous work arounds that are not 'lean' and create barriers to sharing key patient information.

- **Workforce** – we face a significant challenge around workforce, in particular access to clinicians with advanced clinical assessment and management skills, whether this is ANPs or Advanced Allied Health Professionals. This has been evident across the Primary Care Improvement Plan and the Memorandum of Understanding resulting in 'in=post' training and mentoring taking place to develop the skills required.

5.33 Annex B shows the Design & Delivery plan priorities phased and where actions sit within the three priority areas of early intervention and prevention, primary & secondary care interface, and hospital discharge.

Phase 3 - 2024 and onwards

5.34 While a number of actions within the original Joint Commissioning Plan remain outstanding this does not mean they will not be designed for delivery within this timeline. As dependences become apparent and opportunities develop, and as appropriate resource and funding support are available, proposals will be developed and approval sought.

6 ENGAGEMENT

Patient Engagement

6.1 We are conscious we need to do more to engage with patients, carers and the general public and their representatives about what we are trying to achieve through this programme. It is our aim that all aspects of the programme (e.g. falls and frailty) will involve patients directly. Further information on how this will be achieved will be communicated through our HSCP engagement channels and networks.

6.2 We are also conscious that we need to communicate better with the general public about what services to access when and for what. That's why the first key action in our programme is on communications, and developing a public awareness campaign. This will be an ongoing action over the course of the programme.

Staff Engagement

6.3 This programme has significant changes for staff too in the way we delivery services, and develop new pathways. We will consult with and engage with staff in taking these changes forward, and regularly report to Staff Partnership Forums as we go forward.

Clinical Engagement

6.4 During 2021 we have continued to review our stakeholders, as part of this process we have reviewed representation across all three acute sectors. This has resulted in increased engagement with Clinical Service Managers, Consultant Physicians in Medicine for the Elderly, Chief Nurses, ED consultants and AHPs.

Primary Care

6.5 In 2020 we held a number of engagement sessions with GPs across NHSGGC. The engagement and involvement of GPs in shaping and developing this programme is crucial. We need to recognise that unscheduled care is a key issue within primary care too as most patient contact is by its nature unscheduled. .

6.6 We will continue to engage with GPs across NHSGGC both in the development of this programme and its implementation as GP feedback on progress is also important. We will do this at various levels by:

- engaging with GPs and their representatives on specific aspects of the programme e.g. ACPs, falls & frailty etc.;
- engaging with GPs through established structures such as GP committees, primary care strategy groups, QCLs etc.; and,
- engaging at HSCP and NHSGGC levels including arranging specific set piece events / sessions at appropriate times.

6.7 A key take away message from the engagement with GPs was that the unscheduled care programme needed to specifically recognise and include the contribution of PCIP to this agenda. The PCIP and unscheduled care programme direction of travel are closely aligned and are essentially about patients being seen by the right person at the right time. To recognise and acknowledge the contribution of PCIP more clearly within the re-freshed unscheduled care programme we have broadened this aspect of the plan include an action to support GPs to operate as expert medical generalists by expanding primary care teams so GPs can focus on managing complex care for vulnerable patients within community settings, and as part of our prevention and early intervention strategies.

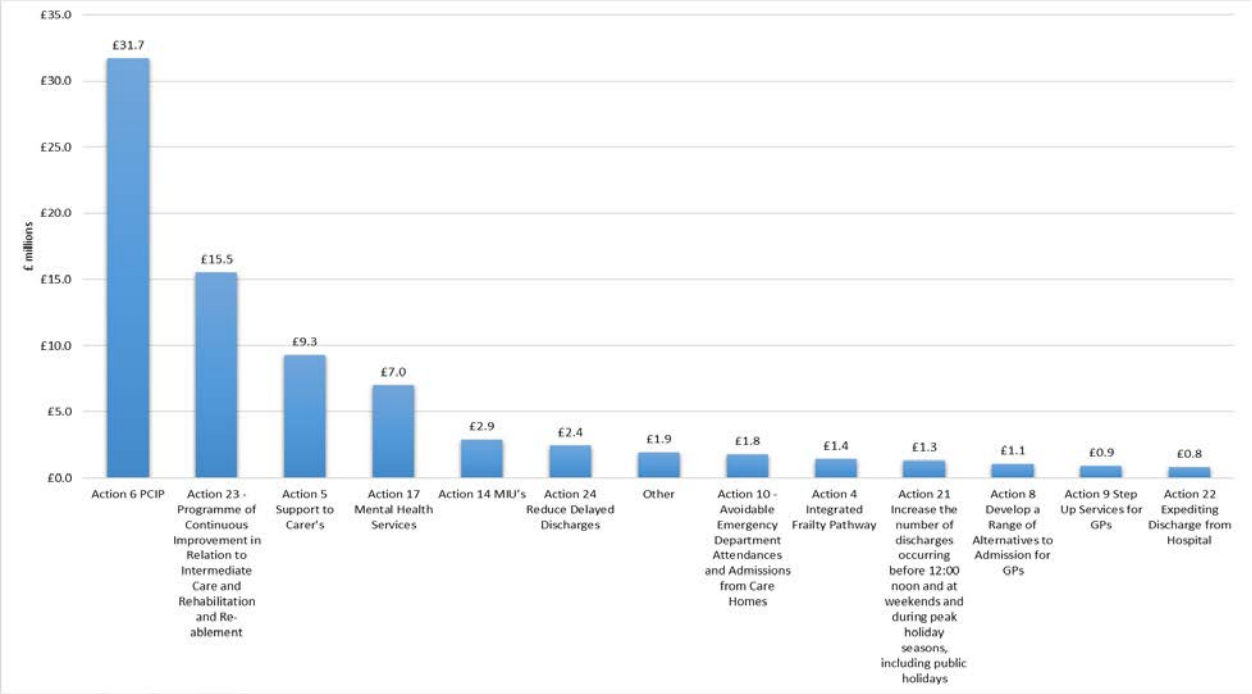
7. FINANCIALFRAMEWORK

7.1 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.

7.2 This Joint Commissioning Plan represents the first step in moving towards delegated hospital budgets and set aside arrangements within GG&C. In 2019/20 unscheduled care was estimated to cost GG&C £444.3m. With a budget of £415.1m identified by GG&C Health Board. This is a shortfall in funding of £29.2m and represents a significant financial risk to GG&C Health Board and the six IJBs with strategic responsibility for this area.

7.3 This budget shortfall impacts on the IJBs' ability to strategically plan for unscheduled care. Nationally there is an expectation that IJBs, 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 which assumes that 50% of savings released from the hospital sector will be redirected to investment in primary, community and social care service provision.

7.4 The ability to achieve this in GG&C is hindered by the existing financial position outlined at 7.2. above, and effectively means that there are no funds which can be released to support the investment required, which mean that each partner will be responsible for funding their own investment. There is already significant investment in community care settings to support unscheduled care, with existing investment totalling £78m.



7.5 The Joint Commissioning Plan identifies a number of key actions which require financial investment to deliver on the priorities within the Plan. The financial framework developed has highlighted a significant gap between current available financial resources and the funding required to deliver the programme in full. This will require the adoption of a phased implementation programme, where delivery is contingent on funding becoming available.

7.6 The investment required to deliver on Phase 1 priorities has been fully costed and the investment required is attached in annex F. It should be noted that this has been completed on a 2022/23 cost base. This highlights the need for £33.130m of investment, of which £11.128m is required on a recurring basis and £22.002m is required non-recurrently. Full funding for the non-recurring investment has been found with partner bodies utilising reserve balances or managing within existing budgets to deliver the funding required. This includes a one-off investment of £20m which has been identified by the Health Board to support this programme. This will be used to kick-start this programme by delivering waiting times activity which was delayed due to COVID. A significant proportion of this activity will be delivered from hospitals and clinics within the boundary of Glasgow City, particularly the GRI and QUEH. This will also have a positive impact on unscheduled care levels and support delivery of the Unscheduled Care Design and Delivery Plan reducing the time patients are waiting for procedures and thereby the likelihood of them attending A&E.

7.7 Of the recurring funding of £11.128m required, only £5.089m of funding has been able to be identified on a recurring basis. £1.012m of the funding gap relates to MHAU's for which recurring funding is still to be put in place by

Scottish Government. The remaining funding gap recognises the challenge which all IJBs and the Health Board have had in securing full funding for Phase 1. This has implications for the delivery of the plan, even for Phase 1, with actions not able to be fully implemented in all geographic areas until funding is secured. The table below highlights the Actions where partial implementation is proposed at this stage due to the funding gap which exists.

Table 1 - actions partially deferred for implementation or at risk – no funding in place (for detail on actions see annex D)

Action	Glasgow City	Inverclyde	East Ren	West Dun	East Dun	Renfrew	Health Board
Action 1 Comms	√	√	X	√	√	√	n/a
Action 2 ACP	√	X	X	√	√	√	n/a
Action 4 Frailty	√	√	√	√	√	√	n/a
Action 9 Step Up	√	√	X	√	√	X	n/a
Action 10 Care Homes	√	√	X	√	√	√	n/a
Action 13 Service in ED	n/a	n/a	n/a	n/a	n/a	n/a	X
Action 14 MIUs	n/a	n/a	n/a	n/a	n/a	n/a	X
Action 23 Improvement	√	√	√	√	√	√	n/a

7.9 Phase 2 and 3 will be costed fully as tests of change and work streams further develop their proposals. Some actions in Phase 2 and 3 have funding which has already been secured in some geographic areas. As a result, this investment is planned to proceed now as part of an early adoption of Phase 2 and 3. These have been highlighted in annex G.

8 PERFORMANCE FRAMEWORK

8.1 In this section we look at the performance framework to support delivery of the programme and the key measures we will use to monitor and assess progress. We also include an estimate of the potential impact on emergency admissions.

8.2 It is essential that we develop a performance framework to support all levels of data and information required including high level management reporting at both GGC and HSCP levels; operational management data to support local planning

and monitoring and wider data to support targeted review and improvement activity at HSCP and locality/community levels.

8.3 A Data, Information & Knowledge work stream has been developed with key stakeholders to develop the framework and build the requirements for the single repository to be used across HSCPs. The work stream has developed the key indicators we propose to use to measure the impact of our programme as outlined in annex F. Figure 6 provides a pictorial example of the levels of data within the performance framework, with the high level data required to evidence impact example presented

Figure 6 – Performance Management Framework

8.5 In a large and complex system such as NHSGGC with many moving parts estimating and forecasting the impact of specific interventions is never an exact science. As we have seen in 2020 and in 2021 there are many factors that can influence the impact of any given intervention – many of which are not in our direct control e.g. changes in the economy. Forecasting or estimating the potential impact of such a wide ranging programme as described in this plan on Scotland's largest health and social care system is even more difficult when looking into future years, and beyond Covid.

8.6 The numbers presented below should therefore be viewed with extreme caution and should not be considered as a firm guarantee of the impact of this

programme; the projections are a guide and our best estimate based on what we know of the health and social care system in NHSGGC. These numbers will need regular review and updating as we go forward to take account of progress in implementing the programme.

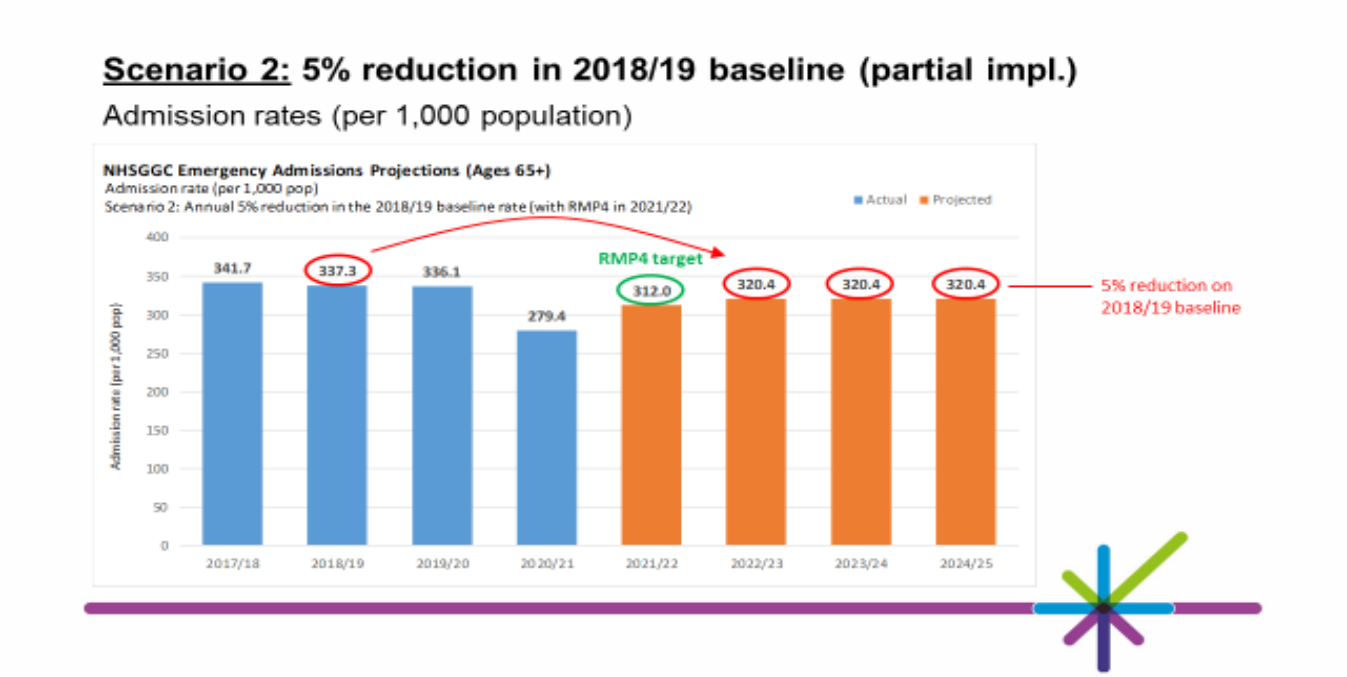
8.7 In providing an indication of the potential impact of the programme we have looked at emergency admissions as this is a key indicator of unscheduled care demand, and can also lead to delayed discharges (another key indicator). Reducing emergency admissions can alleviate pressure in other parts of the system such as A&E, GP assessment units and in primary care. We specifically look at emergency admissions for the 65+ population as they account for approximately 40% of all emergency admissions in GG&C.

8.8 To reach our estimate we have looked at current rates of admission by head of population for different age groups and taken into account the population projections for future years (see annex E). We present three scenarios in annex E recognising that the programme as a whole is not currently fully funded (see section 7 above):

- a do nothing scenario with no implementation of the programme showing the impact demographic changes might have on current rates;
- a partial implementation of the programme taking into account that significant parts of the programme are funded non-recurrently; and,
- full implementation showing what might be the case should the programme in its entirety be fully funded on a recurrent basis.

8.9 Below we show the partial implementation scenario (see annex E for the detail) that illustrates the impact of the programme could (with all the caveats outlined above) result in a reduction in the rate of emergency admissions for over 65s from 337.3 in 2018/19 (the last pre-Covid year) to 320.4 in 2022/23 – a reduction of 5%. This estimate takes into account the demographic changes forecast in NHSGGC over this period and also current projections for 2021/22 included in RMP4.

Figure 7 – projected change in rate of emergency admissions for over 65s in NHSGGC (based on 2018/19 baseline)



8.10 The development of our work streams to deliver step change will require key outcome and process measures to be developed to measure impact with a view to informing decisions regarding scale up or change of approach. These will be reported at HSCP and GGC level using locality team data in most cases.

Benefits Realisation

8.11 It is extremely challenging to draw a direct line in relation to the impact of activities currently underway and planned as part of Phase 2 delivery of this improvement programme. In many cases it is a sum of parts that result in a cumulative and measurable improvement. At the time of writing, work is progressing to develop outcome and process measures for each work stream. Below is a summary of the expected benefits of some of the actions that have been outlined:

Flow Navigation Centre (FNC)

8.12 The implementation of our Flow Navigation Centre during phase 1 realised significant benefits. The initial aim was to redirect up to 15% of the 2019 levels of self-referrals the equivalent of 96 consultations over 24 hours and 74 over 12 hours. The FNC has carried out 7,000 virtual assessments in the first six months with 36.7% of patients seen treated and discharged without the need for an ED or MIU attendance. Phase 1 has resulted in 2,569 patients avoiding attendance at ED/MIU, Phase 2 will work to increase this by 2,405 to 4974 patients in 6 months and therefore an estimated attendance avoidance of 9,948 per annum.

Increasing ACP & KIS availability

8.13 There is strong evidence from studies demonstrating that an ACP and a coordinated team-based approach with a clearly identified population that is at high risk of hospitalisation can reduce ED attendance, admission rates and occupied bed days. This approach to care also leads to an increased likelihood of being allowed to die at home. Our GGC activity is targeting those at high risk of hospitalisation including our care home residents and those with long term conditions.

8.14 Palliative Care - a recent retrospective Scottish study reviewing 1304 medical records of peoples who died in 2017 from 18 practices across 4 Scottish health boards, concluded that people with KIS were more likely to die in the community (home, care home or hospice) compared to those without one (61% versus 30%). NHSGGC reported n12, 612 deaths in 2019/20, 53.6% of these were within a community setting and the remaining 46.4% of deaths occurred in Acute Care. During 2019/20 there were 6045 admissions to hospitals across GGC resulting in death with an average LOS of 19 days. Our aim is to target ACP's for long term conditions and palliative care to achieve a 1% increase in the number who are supported with palliative care to die comfortably at home this could result in a saving over 1100 bed days and would reduce admissions by 60.

8.15 Pilot work by the Edinburgh city HSCP supporting the adoption of ACP in care homes and their aligned GP practices, saw a 56% reduction in avoidable hospital admissions and 20% reduction in A&E admission from care homes. A similar pilot in Lanarkshire in 2009 reported a reduction in the number of Accident and Emergency attendances, number of patients with an emergency inpatient admission, and a reduced total length of hospital stay following the introduction of anticipatory care planning in 8 care homes

8.16 In 2019/20 ED/AU attendances for over 65 years were n113, 283 with n65, 857 converting to an emergency admission. The majority of these admissions were to orthopedics, medical, surgical and care of the elderly. Non elective bed days in this period was n191, 212 therefore we can estimate 2.9 days average length of stay with 46% of these within care of the elderly wards. ACP conversations and sharing of the key information could reduce the number of ED attendances and admissions for a number of these patients as evidence above.

8.17 ACPs available on Clinical Portal across GG&C i.e. those added by Community teams has seen a marked increase from January to June 2021 with 386 ACPs created in this period compared with 192 in January to June 2020. This improvement can be accredited to the activity being undertaken as part of the ACP Work Stream newly invigorating the activity and also as a consequence of

Covid19. In total 851 ACPs are available on Clinical Portal as of June 2021, compared with only 9 available in 2019. Through the activity of the ACP improvement project we aim to significantly increase the number of ACPs available, the number has increased by over 100% in the first 6 months of 2021. We will aim to achieve a further 100% increase in the following 6 months till end of March 2022 and an estimated 20% reduction in admissions for those who have an ACP resulting in 340 avoided admissions and an estimated bed reduction of 986 (at 2.9 days LoS).

Falls Prevention & Management

8.18 About a third of people over 65 years old living in the community fall each year and the rate of falls related injuries increases with age. The Care Inspectorate recently reported that Falls are recorded as a contributing factor in 40% of care home admissions.

8.19 Falls incidence in care homes is reported to be about three times that in the community. This equates to rates of 1.5 falls per care home bed per year. Falls can have serious consequences, e.g. fractures and head injuries. Around 10% of falls result in a fracture. Most fall-related injuries are minor: bruising, abrasions, lacerations, strains, and sprains. However falls can also have a psychological impact, even in the absence of injury. Fear of falling is extremely common, can curtail physical activity and activities of daily living and lead to social isolation – even within the care home environment.

8.20 During 2019/20 across GGC there were n6,618 ED attendances for falls related incidents in our over 65 years population with n2,478 (37%) resulting in a hospital admission. Out of the 2,478 admission, 575 (23%) had a stay of 3 days or less utilising around 900 bed days. Through a number of actions within the falls work stream we will aim to reduce the number of individuals with short stays of 3 days or less by 10% saving at least 90 bed days per year.

8.21 January – June 2021 Scottish Ambulance Service (SAS) attended to n6051 fallers over 65 years in the community, including Care Homes. Conveyance to ED followed for n4652, 77% of calls. Work with SAS to reduce conveyance by a further 10% (465). A number of actions within the Falls Prevention & Management plan will contribute to a reduction in ED attendance and unplanned admissions such as:

1) using the Care Home Falls Pathway incorporating the Flow Navigation Centre for clinical triage assessing the need for urgent response and opportunities to plan any required diagnostics and or referral to community teams for support; and,

2) working more closely with SAS to reduce conveyance to hospital using FNC and the general falls prevention training and local HSCP action plans.

Frailty@ the Front Door

8.22 During the test of change week there were on average of 25 patients with frailty attending per day. On average eight were discharged each day following a length of stay of two days. The average LoS for patients over 75 years is ten days therefore we can estimate that we saved eight bed days per patient through new processes and ways of working. Over seven days this equates to 3228 bed days; the equivalent of nine hospital beds.

8.23 Bearing in mind this is on one hospital site. If scaled up across three sites given QEUH accounts for 30% of activity, this could result in saving of up to 27 beds every day over a 12 month period.

Discharge to Assess Policy impact on 11B & 27A

8.24 During financial year 2019/20 there were 10,654 bed days lost to 11B (awaiting community assessment) this has improved by 45% in 2020/21 with 5,826 bed days lost recorded. Bed days lost to 27A (wait for intermediate care) reduced by 29% n4652 in 2021 compared with n6579 in 2019/20. We will continue to embed the D2A Policy and Home First ethos encouraging strong communication and MDT working to discharge individual's home at the earliest opportunity to reduce the risk of deconditioning within the hospital setting.

8.25 In doing so we will aim to reduce the bed days lost to 11B codes by a further 10% aiming to save a further 580 bed days by end of March 2022. Bed days lost to 27A hasn't evidenced as big an improvement; this could be attributed to the challenges of COVID reducing the ability to discharge patients to another setting. We will seek to improve the bed days lost while waiting on an intermediate care placement by a further 2% aiming to save 93 bed days.

Mental Health Assessment Units

8.26 Total referrals to MHAUs in May 2020 totalled 442 compared to 1443 referrals in May 2020. This illustrates the significant growth in direct referrals to the MHAU's facilitating access for ED's SAS and the Police service and we anticipate this is having a positive overall effect on both ED attendances and admission rates. The average number of MHAU attendances referred by EDs was on average 314 per month over the three months to May 2021. We can therefore estimate that there will be 3,768 ED attendances avoided through this service over a 12 months period.

8.27 The development of our work streams to deliver step change will require key outcome and process measures to be developed to measure impact with a view to informing decisions regarding scale up or change of approach. These will be reported at HSCP and GGC level using locality team data in most cases.

8.28 It is the intention to develop mid-year and end year performance reports to allow the full impact to monitored going forward.

8.29 Projection modelling and what if scenario planning tools are being explored in collaboration with Public Health Scotland Local Intelligence Support Team (LIST). A work plan is being developed at the time of writing this paper.

9 GOVERNANCE ARRANGEMENTS

9.1 Governance arrangements have been updated to reflect the complexity of the Unscheduled Care programme. The approved structure is shown in figure 7 below. This structure will:

- facilitate strategic direction and operational leadership of UC;
- provide accountability for developing strategy and design via the Steering Group;
- demonstrate responsibility for implementation via Delivery Groups;
- embed the Programme Management approach to provide assurance that the programme is appropriately managed; and,
- to ensure alignment to system wide UC service profile.

9.2 At a strategic level the overall programme will report to the Strategic Executive Group (SEG) to provide oversight and overall governance assurance. As deemed appropriate there will be escalation to Corporate Management Team (CMT).

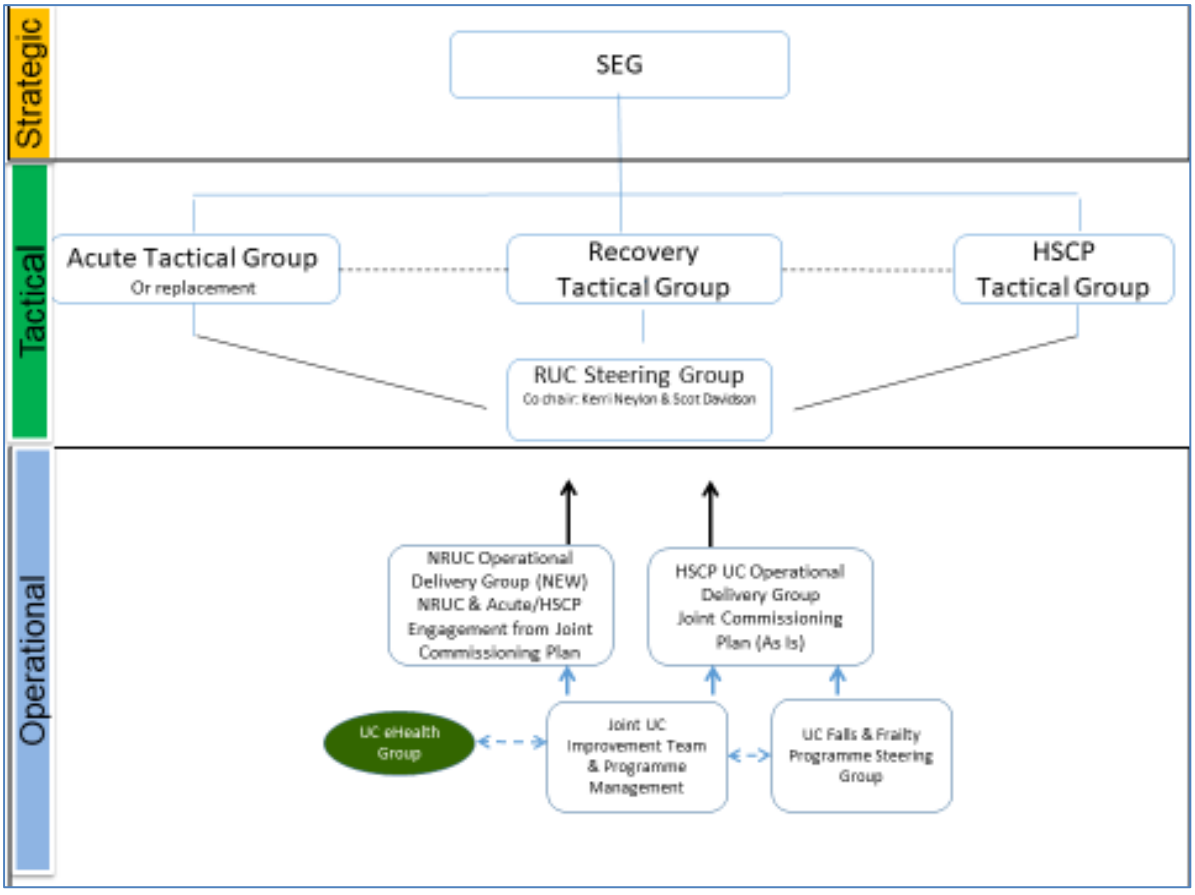
9.3 At tactical level reporting will continue to HSCP Tactical and Acute Tactical Group to steer, approve and sponsor the on-going unscheduled care programme activity including JCP and National Redesign of Urgent Care. The Recovery Tactical Group will approve and jointly agree project plans, assess proposals for cross system redesign and prepare update papers for SEG in conjunction with RUC Steering Group.

- **Redesign of Urgent Care (RUC) Group** - the role of this group is to develop a cross system approach to redesign, delivery of project plans for Redesign of Urgent Care including CACs, FNC, MHAUs. This will be a key group to link

and engage with both Acute & HSCP Tactical groups. This group will also ensure links with Acute Clinical Governance, Acute Partnership Forum, GP Sub and Area Partnership Forum;

- **NRUC Operational Delivery Group** – this is new group within the governance structure. This group will bring together the operation delivery of the NRUC and both Acute and HSCP engagement from the Joint Commissioning Plan;
- **HSCP Unscheduled Care Delivery Group** – this group is responsible for designing and delivering a programme to achieve the ambition set out in the Joint Commissioning Plan;
- **Joint UC Improvement Team & Programme Management** - this team support the development, design and delivery of the JCP & NRUC using a project management approach to provide assurance.

Figure 8 – Unscheduled Care Governance Arrangements



10 PROGRESS REPORTING

10.1 Progress on implementation of each action in the phases outlined above will be reported routinely firstly to the HSCP Delivery Group and then quarterly to the RUC Steering Group, Tactical Groups and onto SEG. Annual updates will also be provided to IJBs and the Health Board.

10.2 Where appropriate escalation of issues or areas of concern will be reported timeously.

10.3 Performance reports on the KPIs in annex F will be submitted monthly in line with existing performance reporting for delays, the four hour target, A&E attendances and other key measures.

10.4 The Data, Information & Knowledge work stream will develop a Standard Operating Procedure providing guidance to support reporting across all levels via appropriate governance routes.

11 NEXT STEPS

11.1 This Design and Delivery Plan provides an update on the 2020 Joint Commissioning Plan for unscheduled care services agreed by IJBs and refreshes our approach in line with the new baseline adjusted for the impact of COVID-19.

11.2 This revised plan has:

- reported on progress against the actions in the original 2020 programme agreed by IJBs;
- reflected on the impact of the pandemic on unscheduled care activity;
- reported on what was delivered in 2020 including the national redesign of urgent care;
- outlined a re-freshed and updated programme, and the content of the different delivery phases;
- explained our proposals for ongoing engagement with clinicians, staff, patients and carers;
- outlined the supporting performance and financial framework; and,
- the organisational governance arrangements to ensure appropriate oversight of implementation of the plan.

11.3 The plan will be presented to IJBs, the Health Board and be the subject of ongoing engagement as outlined in section 4 above, and progress reports issued at regular intervals.

Annex B

	Unscheduled Care Joint Commissioning Design & Delivery Plan Key Actions	Phase (2 or 3) (2021/23)	Progress update
Communications			
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 as anticipatory care plans, and key health promotion initiatives. The aim will be to have a more informed public consumer of health and care services	**2 & 3**	SG Comms campaign on-going re Right Person, Right Place. Opportunities to develop GGC wide comms and engagement strategy in development liasing with the Corporate Comms Team and Public Engagement Team. A number of awareness campaigns have taken place inlcuding Falls Week, ACP, POA etc HSCP local signposting materials are being reviewed in a number of HSCPs to ensure they are fully reflective of changes
Prevention & Early Intervention			
2	We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions	**2 & 3**	Via Falls & Frailty Programme Workstream 2: GGC ACP Design & Implementation Group well established with GGC Action Plan developed HSCP ACP Implementation Groups established with implementation plans developed. ACP Standard Operating Procedure developed due to be implemented Jan 2022. Approval routes via Clinical Advisory Group and Quality Outcomes Group. Number of ACPs on Clinical Portal has increased (working with ehealth to develop montly reporting Staff trained increased significantly in the last 12 months: since Aug 2020 till Dec 2021 818 completed emodule and 475 completied virtual training ACP Champions across GGC has improved over the last 12 months with 35 across GG&C Quality Assurance approach to be developed to ensure the information within the ACP is of a standard to support decision making
3	We will work 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	**2 & 3**	Work on-going with SAS to ensure all pathways are considered for patients who have had a fall but may not need converyed to A&E. This is being progressed via the Falls & Frailty Workstream and RUC FNC.
4	We will 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	**2 & 3**	Approved MDT Interface model development with enhanced roles including Advanced Practice Frailty Practitioner and other roles operating within a hub and spoke model to support prevention of conveynace to front door, supporting individuals at home or their homely setting and early turnaround of those individuals to the community for those who do not require clinical care within the hospital setting. Frailty Pathway and Operating Model being developed to support the implementation of the enhanced MDT teams for RAH and QEUH. This will include the identification of frailyt within the population and pathways to community supports (volunteers and managed services)
5	We will increase support to carers as part of implementation of the Carer's Act	**2 & 3**	Being monitored locally by each HSCP via their Carer's Plan. Connections and opportunities are considered across all the Falls & Frailty Work streams.
6	We will increase the number of community link workers working with Primary Care to 50 by the end of 20/21 Proposal to reframe this action to: We will increase community capacity to support individuals within their community engaging with 3rd sector, Culture & Leisure Trusts, Primary Care Link Workers etc	**2 & 3**	This is tracked via PCIP Trackers per HSCP and reported via RMP route. 66WTE recorded at end of March 2021 with a planned estimate of 92WTE by end of March 2022. Reframed action re commumity capacity building will be tracked within this programme via Work Stream 5 Sub Group 1A.
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	2 & 3	Community Respiratory Pathway ToC with SAS - North Glasgow Pilot for COPD patients already known to the CRT.
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	2 & 3	Activity on-going to extend the range of alternatives. Peformance updates provided via RMP process. OOHs pathways for Palliative and Care Homes in development
9	We will further develop access to "step up" services for GPs as an alternative to hospital admission	2 & 3	HSCP models being monitored. Work Stream 5 Sub Groups considering alernatives pathways to support individuals within the community to minimise the risk of an admission to hospital
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	2 & 3	Nursing/Care Home Falls Pathway via Flow Navigation Centre test phase OOHs pathway being developed
11	We will explore extending the care home local enhanced service to provide more GP support to care homes	2 & 3	Led by Primary Care
Primary Care & Secondary Care Interface			
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	**2 & 3**	NHSGGC representatives have collaboarted with Scottish Government colleagues to produce a National Redirection Policy guidance document that was launched on 02/12/2021 This updated guidance supports a 'Once for Scotland' approach. NHS Boards, Health and Social Care Partnerships, (H&SCPs), Primary Care (PC) and the Royal College of Emergency Medicine (RCEM) have worked collaboratively with the Scottish Government to review and amalgamate best practice examples from across the country and translate them into implementable guidance. GGC have developed local proceedures in line with the policy and a standard technical solution to recording activity and providing automated feedback to GP's is now being explored.
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	**2 & 3**	As part of the Redesign of Urgent Care programme aligned to the Right Care in the Right Place at the Right Time, NHSGGC designed and implemented a Flow Navigation Centre (FNC) to provide a new planned urgent care service in partnership with NHS24. The FNC directly receives clinical referrals through the NHS111 service providing rapid access to an appropriate clinical decision maker within the multidisciplinary team, optimising digital health through a telephone or video consultation where possible, minimising the need to attend A&E. The service has developed multiple speacilaty outflow pathways designed to provide an urgent but planned appointment that enables patients to be seen by the most appropriate clinician acoiding attendance at the ED, MIU and/or Assessment Units. This work continues with focus on further pathway development and interconections between other health and socail care service providers.
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	√	NHSGGC has three designated MIU's at Stobhill, Victoria and Vale of Leven. During the pandemic both GRI and QEUH estbalished designated MIU areas adjacent to the ED. Within RAH and IRH site configuration and resources have facilitated designated areas for minor injury patients to enable patients to be streamed accordingly , these are not adjacent units but areas within the existing units.
15	We will incentivise patients to attend MIUs rather than A&E with non-emergencies through the testing of a tow hour treatment target.	3	The Redesign of Urgent Care has included the introduction of planned urgent care services through the FNC and appointment based attendance at MIU's. This action has been aligned to phase 3 of the programme as it is anticipated that the changes made in the service provision to accommodate appointments within the MIU's may superscede the previous thinking aroudn this specific action.
16	We will explore extending MIU hours of operation to better match demand	3	The Redesign of Urgent Care work continues to review and align hours of operation to meet service demands. This action has been aligned to phase 3 of the programme as it is anticipated that the FNC pathway developemtn and the virtual appointment based system now in place may provide alternative options to extending MIU opening times that might achieve extended access for non urgent minor injuries.
17	We will improve urgent access to mental health services	**2 & 3**	Mental Health Assessment Units (MHAU) were established as part of the immediate response to Covid-19. NHSGGC's MHAU provides access for patients through the NHS111 service where further specialist assessment is required and in addition now provides direct access routes for ED's, SAS, the Police and in addition we have estabslised in hours and out of hours GP access. The service is now also enhanced through a professional to professional advice service where clinicans can discuss and refer patients of concern and rapid action taken to provide specialist input.

18	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.	**2 & 3**	During the pandemic ED's have introduced the signposting and redirection policy and in addition at a local level a number of bespoke approaches developed to ensure appropriate treatment plans are in place for individuals with high attendances. We have not progressed any whole systems change and therefore this action will be reviewed at a later date to agree how to progress.
19	We will reduce the number of people discharged on 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	3	This is a phase 3 action, work has however commenced on specialty pathways aligned to the FNC with a test of change compelted at the QEUH relative to developing a planned response for GP referrals. This work will continue through the Redeign of Urgent Care and future updates provided accordingly.
20	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 at risk of admission to hospital. Specific populations will be prioritised, including care home residents and people with frailty. (PILOT ONLY)	**2 & 3**	H@H pilot to launch February 2022. A significan programme of woirk has been undertaken to design the concept of a 'virtual ward' with technical and clinical processes developed to support the delivery of NHSGGC's H@H model. We will eb in a position to report progress following the Feb 2022 launch.
21	Improving access and waiting times for scheduled care at QEUH and GRI to reduce the time patients are waiting for procedures and thereby the likelihood of them attending A&E	2 & 3	
Improving Discharge			
21	We will work with acute services to increase by 10% the number of discharges occurring before 12:00 noon and at weekends and during peak holiday seasons, including public holidays	**2 & 3**	A number of actions underway: Discharge to Assess Policy implementation (review of implementation required) Hospital @ Home Pilot MDT Interface Model
22	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 it medically fit.	**2 & 3**	Discharge to Assess Policy Implementation Implementation of the MDT Interface Hub and Spoke Model
23	We will undertake a programme of continuous improvement in relation to HSCP intermediate care and rehabilitation and re-ablement in an effort to optimise efficient and effective use of these resources which are critical to the overall acute system performance	**2 & 3**	Being developed within Work Stream 5 of the Falls & Frailty Programme
24	We will reduce delayed discharges so that the level of delays accounts for approximately 2.5-3.0% of total acute beds, and bed days lost to delays is maintained within the range of 37,00-40,000 per year	3	All of the above actions will support this ambition
	Scottish Government Priority Actions Jan 2022		
1	Remote Monitoring of COVID	2	
2	OPAT Services	2	
3	Community Management of Respiratory	2	
4	H@H/Virtual Wards	2	

ANNEX C

Unscheduled Care : Financial Framework		Glasgow City IA					Inverclyde IA				
		Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Phase 1											
Communications											
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 as anticipatory care plans, and key health promotion initiatives. The aim will be to have a more informed public consumer of health and care services.	N/R	£74,000	£0	£0	£74,000	R	£10,000	£10,000	£0	£20,000
Prevention & Early Intervention											
2	We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions.	R	£52,460	£10,287	£0	£62,747	R	£66,200	£22,067	£0	£88,267
3	We will work 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.	R	£52,060	£17,353	£0	£69,414		£0	£0	£0	£0
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.	R	£791,231	£71,744	£0	£862,974	R	£11,000	£0	£0	£11,000
5	We will increase support to carers as part of implementation of the Carer's Act.		£0	£0	£0	£0		£0	£0	£0	£0
6	We will increase community capacity to support individuals within their community engaging with 3rd sector, Culture & Leisure Trusts, Primary Care Link Workers etc		£0	£0	£0	£0	£0	£0	£0	£0	£0
9	We will further develop access to "step up" services for GPs as an alternative to hospital admission.		£0	£0	£0	£0		£0	£0	£0	£0
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.		£0	£0	£0	£0		£0	£0	£0	£0
Primary Care & Secondary Care Interface											
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.		£0	£0	£0	£0		£0	£0	£0	£0
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.		£0	£0	£0	£0		£0	£0	£0	£0
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.		£0	£0	£0	£0	N/R	£5,000	£0	£0	£5,000

Unscheduled Care : Financial Framework		Glasgow City IA					Inverclyde IA				
		Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Primary Care & Secondary Care Interface											
17	We will improve urgent access to mental health services.	R	£547,673	£0	£0	£547,673	R	£74,811	£0	£0	£74,811
20	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 at risk of admission to hospital. Specific populations will be prioritised, including care home residents and people with frailty. (PILOT ONLY - SOUTH).	N/R	£1,353,000	£0	£0	£1,353,000		£0	£0	£0	£0
21	Improving access and waiting times for scheduled care at QEUH and GRI to reduce the time patients are waiting for procedures and thereby the likelihood of them attending A&E		£0	£0	£0	£0		£0	£0	£0	£0
Improving Discharge											
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 it medically fit.	N/R	£210,000	£200,000	£0	£410,000		£0	£0	£0	£0
24	We will undertake a programme of continuous improvement in relation to HSCP intermediate care and rehabilitation and re-ablement in an effort to optimise efficient and effective use of these resources which are critical to the overall acute system performance.	N/R and R	£210,000	£0	£0	£210,000	N/R	£10,000	£0	£0	£10,000
Total			**£3,290,424**	**£299,384**	**£0**	**£3,589,808**		**£177,011**	**£32,067**	**£0**	**£209,078**

	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Recurring	£1,543,424	£99,384	£0	£1,642,808	£162,011	£32,067	£0	£194,078
Non Recurring	£1,747,000	£200,000	£0	£1,947,000	£15,000	£0	£0	£15,000
Total	**£3,290,424**	**£299,384**	**£0**	**£3,589,808**	**£177,011**	**£32,067**	**£0**	**£209,078**

Funding : Recurring Expenditure	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Scottish Government Funding	£676,000	£0	£0	£676,000	£11,000	£0	£0	£11,000
Scottish Government Funding : COVID	£0	£0	£0	£0	£0	£0	£0	£0
IJB Budget	£319,751	£99,384	£0	£419,135	£10,000	£10,000	£0	£20,000
Total Funding Recurring	**£995,751**	**£99,384**	**£0**	**£1,095,135**	**£21,000**	**£10,000**	**£0**	**£31,000**
Funding Gap	**£547,673**	**£0**	**£0**	**£547,673**	**£141,011**	**£22,067**	**£0**	**£163,078**

Funding : Non Recurring Expenditure	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Earmarked Reserves	£0	£0	£0	£0	£15,000	£0	£0	£15,000
Manage within HSCP Budget	£284,000	£200,000	£0	£484,000	£0	£0	£0	£0
Scottish Government Funding	£1,463,000	£0	£0	£1,463,000	£0	£0	£0	£0
Total Funding Non Recurring	**£1,747,000**	**£200,000**	**£0**	**£1,947,000**	**£15,000**	**£0**	**£0**	**£15,000**
Funding Gap	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**

Unscheduled Care : Financial Framework		East Renfrewshire IA						West Dunbartonshire IA					
		Recurring (R)/ Non Recurring (N/R)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Phase 1												
Communications												
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 as anticipatory care plans, and key health promotion initiatives. The aim will be to have a more informed public consumer of health and care services.	R	£0	£22,000	£0	£0	£22,000	R	£10,000	£0	£0	£10,000
Prevention & Early Intervention												
2	We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions.	R	£0	£21,652	£7,217	£0	£28,869	R	£8,482	£0	£0	£8,482
3	We will work 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.		£0	£0	£0	£0	£0		£0	£0	£0	£0
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.		£0	£0	£0	£0	£0	R	£126,268	£0	£0	£126,268
5	We will increase support to carers as part of implementation of the Carer's Act.		£0	£0	£0	£0	£0		£0	£0	£0	£0
6	We will increase community capacity to support individuals within their community engaging with 3rd sector, Culture & Leisure Trusts, Primary Care Link Workers etc		£0	£0	£0	£0	£0		£0	£0	£0	£0
9	We will further develop access to "step up" services for GPs as an alternative to hospital admission.	R	£0	£85,696	£28,565	£0	£114,262		£0	£0	£0	£0
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.	R	£0	£93,194	£31,065	£0	£124,259	R	£61,876	£0	£0	£61,876
Primary Care & Secondary Care Interface												
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.		£0	£0	£0	£0	£0		£0	£0	£0	£0
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.		£0	£0	£0	£0	£0		£0	£0	£0	£0
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.		£0	£0	£0	£0	£0		£0	£0	£0	£0

Unscheduled Care : Financial Framework		East Renfrewshire IA						West Dunbartonshire IA				
		Recurring (R)/ Non Recurring (N/R)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Phase 1												
Primary Care & Secondary Care Interface												
17	We will improve urgent access to mental health services.	R	£0	£70,762	£0	£0	£70,762	R	£82,910	£0	£0	£82,910
20	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 at risk of admission to hospital. Specific populations will be prioritised, including care home residents and people with frailty. (PILOT ONLY - SOUTH).		£0	£0	£0	£0	£0		£0	£0	£0	£0
21	Improving access and waiting times for scheduled care at QEUH and GRI to reduce the time patients are waiting for procedures and thereby the likelihood of them attending A&E		£0	£0	£0	£0	£0		£0	£0	£0	£0
Improving Discharge												
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 it medically fit.		£0	£0	£0	£0	£0	R	£617,925	£0	£0	£617,925
24	We will undertake a programme of continuous improvement in relation to HSCP intermediate care and rehabilitation and re-ablement in an effort to optimise efficient and effective use of these resources which are critical to the overall acute system performance.		£0	£0	£0	£0	£0	R	£599,109	£0	£0	£599,109
Total			**£0**	**£293,304**	**£66,847**	**£0**	**£360,152**		**£1,506,570**	**£0**	**£0**	**£1,506,570**

	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Recurring	£0	£293,304	£66,847	£0	£360,152	£1,506,570	£0	£0	£1,506,570
Non Recurring	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total	**£0**	**£293,304**	**£66,847**	**£0**	**£360,152**	**£1,506,570**	**£0**	**£0**	**£1,506,570**

Funding : Recurring Expenditure	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Scottish Government Funding	£0	£0	£0	£0	£0	£1,405,178	£0	£0	£1,405,178
Scottish Government Funding : COVID	£0	£0	£0	£0	£0	£0	£0	£0	£0
IJB Budget	£0	£0	£0	£0	£0	£18,482	£0	£0	£18,482
Total Funding Recurring	**£0**	**£0**	**£0**	**£0**	**£0**	**£1,423,660**	**£0**	**£0**	**£1,423,660**
Funding Gap	**£0**	**£293,304**	**£66,847**	**£0**	**£360,152**	**£82,910**	**£0**	**£0**	**£82,910**

Funding : Non Recurring Expenditure	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Earmarked Reserves	£0	£0	£0	£0	£0	£0	£0	£0	£0
Manage within HSCP Budget	£0	£0	£0	£0	£0	£0	£0	£0	£0
Scottish Government Funding	£0	£0	£0	£0	£0	£0	£0	£0	£0
Total Funding Non Recurring	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**
Funding Gap	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**

Unscheduled Care : Financial Framework		East Dunbartonshire IA					Renfrewshire IA				
		Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Phase 1											
Communications											
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 as anticipatory care plans, and key health promotion initiatives. The aim will be to have a more informed public consumer of health and care services.	R	£10,000	£0	£0	£10,000		£0	£0	£0	£0
Prevention & Early Intervention											
2	We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions.		£0	£0	£0	£0	N/R	£20,000	£0	£0	£20,000
3	We will work 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.		£0	£0	£0	£0	R	£0	£0	£0	£0
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.	R	£393,679	£139,634	£0	£533,313	R	£0	£0	£0	£0
5	We will increase support to carers as part of implementation of the Carer's Act.		£0	£0	£0	£0		£0	£0	£0	£0
6	We will increase community capacity to support individuals within their community engaging with 3rd sector, Culture & Leisure Trusts, Primary Care Link Workers etc		£0	£0	£0	£0		£0	£0	£0	£0
9	We will further develop access to "step up" services for GPs as an alternative to hospital admission.	R	£400,648	£13,125	£0	£413,773	R	£131,598	£43,866	£0	£175,464
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.	R	£326,991	£0	£0	£326,991	R and N/R	£0	£0	£0	£0
Primary Care & Secondary Care Interface											
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.		£0	£0	£0	£0	N/R	£0	£0	£0	£0
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.		£0	£0	£0	£0		£0	£0	£0	£0
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.		£0	£0	£0	£0		£0	£0	£0	£0

Unscheduled Care : Financial Framework		East Dunbartonshire IA					Renfrewshire IA				
		Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Primary Care & Secondary Care Interface											
17	We will improve urgent access to mental health services.	R	£82,303	£0	£0	£82,303	R	£153,875	£0	£0	£153,875
20	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 at risk of admission to hospital. Specific populations will be prioritised, including care home residents and people with frailty. (PILOT ONLY - SOUTH).		£0	£0	£0	£0		£0	£0	£0	£0
21	Improving access and waiting times for scheduled care at QEUH and GRI to reduce the time patients are waiting for procedures and thereby the likelihood of them attending A&E		£0	£0	£0	£0		£0	£0	£0	£0
Improving Discharge											
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 it medically fit.		£182,007	£0	£0	£182,007		£0	£0	£0	£0
24	We will undertake a programme of continuous improvement in relation to HSCP intermediate care and rehabilitation and re-ablement in an effort to optimise efficient and effective use of these resources which are critical to the overall acute system performance.	R	£1,072,745	£0	£0	£1,072,745	N/R	£20,000	£0	£0	£20,000
Total			**£2,468,373**	**£152,759**	**£0**	**£2,621,132**		**£325,473**	**£43,866**	**£0**	**£369,338**

	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Recurring	£2,468,373	£152,759	£0	£2,621,132	£285,473	£43,866	£0	£329,338
Non Recurring	£0	£0	£0	£0	£40,000	£0	£0	£40,000
Total	**£2,468,373**	**£152,759**	**£0**	**£2,621,132**	**£325,473**	**£43,866**	**£0**	**£369,338**

Funding : Recurring Expenditure	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Scottish Government Funding	£2,059,079	£152,759	£0	£2,211,838	£0	£0	£0	£0
Scottish Government Funding : COVID	£0	£0	£0	£0	£0	£0	£0	£0
IJB Budget	£326,991	£0	£0	£326,991	£0	£0	£0	£0
Total Funding Recurring	**£2,386,070**	**£152,759**	**£0**	**£2,538,829**	**£0**	**£0**	**£0**	**£0**
Funding Gap	**£82,303**	**£0**	**£0**	**£82,303**	**£285,473**	**£43,866**	**£0**	**£329,338**

Funding : Non Recurring Expenditure	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Earmarked Reserves	£0	£0	£0	£0	£40,000	£0	£0	£40,000
Manage within HSCP Budget	£0	£0	£0	£0	£0	£0	£0	£0
Scottish Government Funding	£0	£0	£0	£0	£0	£0	£0	£0
Total Funding Non Recurring	**£0**	**£0**	**£0**	**£0**	**£40,000**	**£0**	**£0**	**£40,000**
Funding Gap	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**

Unscheduled Care : Financial Framework		Greater Glasgow and Clyde Health Board					Total				
		Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Phase 1											
Communications											
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 as anticipatory care plans, and key health promotion initiatives. The aim will be to have a more informed public consumer of health and care services.		£0	£0	£0	£0	£0	£126,000	£10,000	£0	£136,000
Prevention & Early Intervention											
2	We will implement a systematic programme of anticipatory care plans across GG&C with aim of supporting a reduction in emergency admissions.		£0	£0	£0	£0	£0	£168,794	£39,571	£0	£208,365
3	We will work 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.		£0	£0	£0	£0	£0	£52,060	£17,353	£0	£69,414
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.		£0	£0	£0	£0	£0	£1,322,178	£211,378	£0	£1,533,555
5	We will increase support to carers as part of implementation of the Carer's Act.		£0	£0	£0	£0	£0	£0	£0	£0	£0
6	We will increase community capacity to support individuals within their community engaging with 3rd sector, Culture & Leisure Trusts, Primary Care Link Workers etc		£0	£0	£0	£0	£0	£0	£0	£0	£0
9	We will further develop access to "step up" services for GPs as an alternative to hospital admission.		£0	£0	£0	£0	£0	£617,942	£85,556	£0	£703,498
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.		£0	£0	£0	£0	£0	£482,061	£31,065	£0	£513,126
Primary Care & Secondary Care Interface											
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.	R	£1,200,000	£0	£0	£1,200,000	£0	£1,200,000	£0	£0	£1,200,000
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.	R	£2,546,221	£0	£0	£2,546,221	£0	£2,546,221	£0	£0	£2,546,221
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.	R	£728,000	£0	£0	£728,000	£0	£733,000	£0	£0	£733,000

Unscheduled Care : Financial Framework		Greater Glasgow and Clyde Health Board					Total				
		Recurring (R)/ Non Recurring (N/R)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Primary Care & Secondary Care Interface											
17	We will improve urgent access to mental health services.		£0	£0	£0	£0	£0	£1,012,333	£0	£0	£1,012,333
20	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 at risk of admission to hospital. Specific populations will be prioritised, including care home residents and people with frailty. (PILOT ONLY - SOUTH).		£0	£0	£0	£0	£0	£1,353,000	£0	£0	£1,353,000
21	Improving access and waiting times for scheduled care at QEUH and GRI to reduce the time patients are waiting for procedures and thereby the likelihood of them attending A&E	N/R	£20,000,000	£0	£0	£20,000,000	£0	£20,000,000	£0	£0	£20,000,000
Improving Discharge											
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 it medically fit.		£0	£0	£0	£0	£0	£1,009,932	£200,000	£0	£1,209,932
24	We will undertake a programme of continuous improvement in relation to HSCP intermediate care and rehabilitation and re-ablement in an effort to optimise efficient and effective use of these resources which are critical to the overall acute system performance.		£0	£0	£0	£0	£0	£1,911,854	£0	£0	£1,911,854
Total			**£24,474,221**	**£0**	**£0**	**£24,474,221**	**£0**	**£12,535,376**	**£594,923**	**£0**	**£33,130,298**

	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Recurring	£4,474,221	£0	£0	£4,474,221	£0	£10,733,376	£394,923	£0	£11,128,298
Non Recurring	£20,000,000	£0	£0	£20,000,000	£0	£21,802,000	£200,000	£0	£22,002,000
Total	**£24,474,221**	**£0**	**£0**	**£24,474,221**	**£0**	**£32,535,376**	**£594,923**	**£0**	**£33,130,298**

Funding : Recurring Expenditure	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Scottish Government Funding	£2,840,252	-£2,840,252	£0	£0	£0	£6,991,509	-£2,687,493	£0	£4,304,016
Scottish Government Funding : COVID	£581,000	-£581,000	£0	£0	£0	£581,000	-£581,000	£0	£0
IJB Budget	£0	£0	£0	£0	£0	£675,224	£109,384	£0	£784,608
Total Funding Recurring	**£3,421,252**	**-£3,421,252**	**£0**	**£0**	**£0**	**£8,247,733**	**-£3,159,109**	**£0**	**£5,088,624**
Funding Gap	**£1,052,969**	**£3,421,252**	**£0**	**£4,474,221**	**£0**	**£2,485,642**	**£3,554,032**	**£0**	**£6,039,674**

Funding : Non Recurring Expenditure	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)	2021/22 (£)	2022/23 (£)	2023/24 (£)	2024/25 (£)	Total (£)
Earmarked Reserves	£20,000,000	£0	£0	£20,000,000	£0	£20,055,000	£0	£0	£20,055,000
Manage within HSCP Budget	£0	£0	£0	£0	£0	£284,000	£200,000	£0	£484,000
Scottish Government Funding	£0	£0	£0	£0	£0	£1,463,000	£0	£0	£1,463,000
Total Funding Non Recurring	**£20,000,000**	**£0**	**£0**	**£20,000,000**	**£0**	**£21,802,000**	**£200,000**	**£0**	**£22,002,000**
Funding Gap	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**

AGENDA ITEM NO: 8

Report To:	**Inverclyde Integration Joint Board**	**Date: 21 March 2022**
Report By:	**Allen Stevenson** **Interim Chief Officer** **Inverclyde Health & Social Care Partnership**	**Report No: IJB/14/2022/AB**
Contact Officer	**Alan Best** **Interim Head of Service: Health and Community Care, Inverclyde Health and Social Care Partnership (HSCP)**	**Contact No: 01475 715212**
Subject:	**UPDATE ON IMPLEMENTATION OF PRIMARY CARE IMPROVEMENT PLAN**	

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board on progress and the financial plans associated with implementation of the Primary Care Improvement Plan (PCIP).

1.2 To inform IJB of the publication (on the 18th January 2021) of Primary Care Improvement Plans (PCIPs). PCIP publication;

Primary care improvement plans - implementation: progress summary - March 2021 - gov.scot (www.gov.scot)

2.0 SUMMARY

2.1 A report was presented previously to the Integration Joint Board outlining challenges faced with regard to implementing the Memorandum of Understanding (MOU).

2.2 Subsequently, an updated Memorandum of Understanding (MoU 2) was published in August 2021. This confirms the priorities between The Scottish Government, the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards.

2.3 Since the last update the HSCP has updated the local PCIP and has progressed plans around Vaccinations, Urgent Care (ANPs), Pharmacotherapy Hub and Community Treatment and Care Services (CTAC).

2.4 Primary Care leads agreed to publish the PCIP tracker data, both in spirit of openness and also in recognition that it would be helpful for benchmarking performance and comparing progress across all MOU services for HSCPs.

The PCIP data was previously treated as management information and used as the basis for discussing progress with those organisations party to the MoU. However, there is also a clear and increasing public interest in this data.

3.0 RECOMMENDATIONS

3.1 The Integration Board is asked to note the progress made in delivery of 2020/21 Primary Care Improvement Plan (PCIP).

3.2 The Integration Joint Board is asked to agree the current plans for implementation of the Primary Care Improvement Plan.

3.3 The Integration Board is asked to note the overall indicative Primary Care Improvement Fund financial commitments for 2021/2022.

3.4 Due to the imperative associated with deploying resources it is recommended that, with engagement with local GP Sub representatives an update regarding the reserves and the formulation of a spend plan is presented at a future meeting.

Allen Stevenson
Interim Chief Officer

4.0 BACKGROUND

4.1 In September 2021 the Integration Joint Board was updated on the implementation of the Primary Care Improvement Plan including challenging factors associated with the Covid pandemic, recruitment, retention and finance.

4.2 The 2018 GP Contract Offer and its associated Memorandum of Understanding (MoU) between the Scottish Government (SG), the Scottish General Practitioners Committee of the British Medical Association (SGPC), Integration Authorities (IAs) and NHS Boards was a landmark in the reform of primary care in Scotland. The Contract Offer refocused the General Practitioner (GP) role as expert medical generalists to enable GPs to do the job they trained to do and deliver better care for patients. It committed to a vision of general practice being at the heart of the healthcare system where multidisciplinary teams come together to inform, empower and deliver services in communities for those people in need of care.

4.3 In 2021 the MoU was refreshed to cover the period 2021-2023 between the same Parties. The key aim remains expanding and enhancing multidisciplinary teams working to help support the role of GPs as expert medical generalists, to improve patient outcomes. The MoU Parties recognised a great deal has been achieved however there is still a way to go to fully deliver the GP Contract Offer commitments originally intended to be delivered by April 2021.

4.4 The original MoU sets out the six priority service areas where it has been agreed that IAs, in partnership with Health Boards and GPs, will focus:

- Vaccination Transformation Programme (VTP);
- Pharmacotherapy;
- Community Treatment and Care Services (CTAC);
- Urgent Care (ANPs);
- Additional Professional Roles;
- Community Links Workers (CLW).

4.5 **Updates to delivery of priority areas – current position**

The Vaccination Transformation Programme (VTP)

GP practices will not provide any vaccinations under their core contract from 1st April 2022. All vaccines provided under Additional Services have been removed from the GMS Contract. General Practice should not be the default provider of vaccinations. The VTP programme supports the redesign and implementation of vaccination delivery, including travel advice and travel vaccinations. The Travel Health Subgroup will determine a once for Scotland solution to be determined and put in place by April 2022 (currently out to tender). GPs will retain responsibility for providing travel advice to patients where their clinical condition requires individual consideration.

There are ongoing discussions around the future of COVID vaccinations/boosters and how the model will look for HSCP and Primary Care Services. Further clarification on the booster programme is expected imminently from the Joint Committee on Vaccination and Immunisation (JCVI). A local Vaccination Group is being established to progress with this work.

The housebound vaccination team continue to do mop up vaccinations to care homes and housebound clients. A request for funding to extend these contracts for six months has been made to the Primary Care Implementation Group.

Community Pharmacies will carry out mop up Flu clinics for the over 65s initially.

4.6 **Pharmacotherapy Services**

In line with the NHS GGC papers *Pharmacotherapy Phases of Delivery and Key Objectives* and *General Practice Aligned Pharmacy Service Delivery by 1st April 2022* main elements of the Pharmacy Service Delivery Model in Inverclyde are:

- By 1 April 2022, all Immediate Discharge Letter (IDLs) in all practices will be serviced by a Pharmacy Hub working to a standardised model, with Monday to Friday service, 48 hour turnaround and providing annual leave cover.
- Skill mix review will continue to agreed proportions of pharmacists, pharmacy technicians and pharmacy support workers. The initial aim is for pharmacists to be no greater than 50% of the staffing (PCI plus non-PCI funded).
- The proportion of GP practice aligned team time (PCI and non PCI) on level 1 will be no greater than 60%.
- The proportion of GP practice aligned team time (PCI and non PCI) allocated to level 2/3 will be no less than 40%. *Note that in Inverclyde HSCP around 40% of current service wte is non PCI.*
- Funding approved for 3.8 wte prescribing support workers, when recruited to a rate of max 1 per cluster to frontload quality improvement around acutes and serial prescribing.
- As the hub rolls out, pharmacist time on more complex care within practices will change in line with the HSCP service delivery model.
- We continue to explore all opportunities for additional skill-mix, in particular with a focus on mentoring, development and training (education facilitation).

4.7 **Community Treatment & Care Services (CTAC)**

Recruitment has been completed for Nurse lead and they are now in post. We are recruiting 4 health care support workers to support further rollout of the testing model of delivering phlebotomy in practices. Planned building works within Gourock Health Centre are complete, which has allowed us to increase phlebotomy appointments for all Inverclyde residents and works will commence in Port Glasgow to upgrade the Lithgow Wing to provide additional treatment room capacity in April 2022. Port Glasgow will then become our largest treatment room centre. Data collection is ongoing to quantify the amount of workload and appointments required to shift from practices, as demand across practices fluctuates, however we will keep our planned model under constant review via our local CTAC working group. Currently uploading patient's records to EMIS web for transition to Electronic Patient Records (EPR). Staff have completed online training and Q&A sessions arranged for Feb/Mar 2022.

4.8 **Urgent Care (Advanced Nurse Practitioners ANPs)**

The lead ANP is now in post and recruitment completed for three additional ANPs, who have now all started in post January 2022. How these will be deployed and the speed at which we can progress our plans will largely depend on the induction and development these clinicians will require. They are all at varying stages of their qualification and will require individual mentorship from allocated GP practices.

We will expand our community model by embedding other advanced roles, to include; Learning Disability ANP, Frailty ANP and Care Home Liaison Nurses (CHLN). Consideration will be given to how the skills / mix of other team members in community nursing can also support the model.

4.9 **Updates to delivery of non-priority areas for 21/22 and future years**

Additional Professionals - Advanced Physiotherapy Practitioners (APP)

Eight of our thirteen practices currently have access to this service and we will not prioritise further roll out at this time as per the MOU2. As with other HSCPs, we are engaging with the board Physiotherapy leads to explore future options for this service.

Physiotherapy recently completed a patient survey with very positive outcomes and feedback. The majority of the comments indicated a preference for face to face, but some were happy with a call followed by a face to face appointment. There were some concerns over telephone assessment not being accurate, and the Physiotherapist not knowing if the patient is doing the exercises correctly. Other comments preferred telephone to save travelling and felt same outcome was achieved.

4.10 **Additional Professionals – Mental Health**

The Distress Brief Interventions (DBI) service is currently being delivered by SAMH. The DBI programme provides a framework for creating a consistent, collaborative, connected, compassionate and effective response to people experiencing distress in Scotland - the programme has been extended until 2023. SCI Gateway referral pathway is being pursued, it is hoped to have this rolled out by end February. Referrals recorded as lower for January – and in the mainly from our community link workers.

4.11 **Community Link Workers (CLW)**

Community Link Workers remain in place via the commissioned CVS Inverclyde service within all 13 practices. From April – December 2021 CLWs have received 1000 new referrals. Many of these have been patients with complex needs and, while many services and resources weren't open or active in the same way through the restrictions. The majority of referrals have been around social prescribing for mental health, finance/benefits, housing and fuel poverty.

The CLW team have worked closely with Inverclyde HSCP Advice Services in the planning for Welfare Advice Workers to go in to practice (not PCIP).

CLW are at the final stages of implementing a new system (MILO). The system will provide a more secure system for CLWs to access/update information when not in practice, will ensure less space is being utilised on EMIS and will provide qualitative patient feedback and also provide more in-depth reporting systems.

5.0 IMPLICATIONS

FINANCE

5.1 In Septembers report we advised of the expected full year costs as £4,325,883 against funding of £2,527,000 (NRAC reduction). Earmarked reserve and part year costs meant we would achieve a balance despite the NRAC reduction. However, the accelerated PCIF MDT funding of £244,500 addressed the NRAC reduction.

FUNDING	
21/22 Allocation	£2,527,637
Additional recurring funding (Winter Planning)	£244,500
Total funding;	**£2,772,137**
Estimated costs as per original plan	£2,527,454
additional costs funded from Winter Planning;	
Band 4 Business Support	
Band 3 Pharmacy Support	
Band 7 ANP	
CTAC Band 3 HCSW	
	£243,757
Total estimated costs	**£2,771,211**
Estimated Under spend	**£926**

ESTIMATED COSTS OF FULL DELIVERY OF ALL MOU COMMITMENTS

COST CENTRE	Estimated Full Year Cost
Vaccination Transformation Programme G61582	350,597
Pharmacy G61583	603,207
PCIP MSK Physio G61584	175,218
PCIP Phlebotomy G61585 (CTAC)	522,881
PCIP Adv. Nurse Practitioner (ANP) G61586	513,808
PCIP GP Cluster Sessions G61587	0
PCIP Community Links Workers (CLW) G61590	267,475
PCIP Supervision and management G61591	94,267
Mental Health G61588	0
Data G61589	0
ESTIMATED SPEND 2021/22	**2,527,454**

In order to maintain financial balance we propose to:

- Hold any further development of Advanced Physiotherapists.
- Prioritise the development of the Pharmacotherapy hub, releasing efficiencies to increase delivery of Level 2 & 3 service and acknowledge that we will be unable to invest any further recurring costs in Pharmacotherapy.
- Keep ANP compliment at 7.6wte (inc lead ANP), there will be no increase to wte.
- Continuous improvement and monitoring of all PCIP service models via working group(s) to ensure we are utilising resource effectively and efficiently.

5.2 **LEGAL**

There are no legal issues raised in this report.

5.3 **HUMAN RESOURCES**

Workforce remains a significant challenge which PCIP leads have raised consistently with Scottish Government over the past three years. MOU2 states a Task and Finish group will be convened to oversee planning and pipeline projections.

5.4 **EQUALITIES**

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.

5.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	Through better availability and signposting of the range of primary care support/ professionals, availability of appointments with the right profession at the right time should improve.
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.	Specific education and sessions around the range of primary care services is underway.

5.5 **CLINICAL OR CARE GOVERNANCE IMPLICATIONS**

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.	Through better availability and signposting of the range of primary care support/ professionals, **availability of appointments with the right profession at the right time**
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	A wider MDT approach with additional/ extended skills to positively supporting individuals.
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Improved access to a wider range of professionals and education on services available within the wider primary care/ community setting.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Improved access to a wider range of professionals and

	education on services available within the wider primary care/ community setting.
Health and social care services contribute to reducing health inequalities.	Improved access and support within the communities with greatest need.
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.	Development of the MDT and additional investment will support practices and GPs to continue deliver primary care consistently and effectively.

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 CONSULTATION

7.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with

- Local General Practitioners and their teams
- Primary Care Implementation Group

8.0 BACKGROUND PAPERS

8.1 Memorandum of Understanding 2

Appendix 1

Memorandum of Understanding (MoU) 2

GMS Contract Implementation for Primary Care Improvement – Agreement between Scottish Government, British Medical Association (BMA), Integration Authorities (IAs) and NHS Boards

Introduction

The 2018 GP Contract Offer ("the Contract Offer") and its associated Memorandum of Understanding ("MoU") was a landmark in the reform of primary care in Scotland. The principles and values expressed in it remain undiminished, and three years on we now have considerable learning and experience to draw on to inform this next iteration of the MoU. Our key aim remains expanding and enhancing multidisciplinary team working to help support the role of GPs as Expert Medical Generalists, to improve patient outcomes. We remain committed to a vision of general practice and primary care being at the heart of the healthcare system where multidisciplinary teams come together to inform, empower, and deliver services in communities for those people in need of care.

This revised MoU for the period 2021-2023 between the Scottish Government, the Scottish General Practitioners Committee of the British Medical Association (SGPC), Integration Authorities and NHS Boards refreshes the previous MoU between these parties signed on 10 December 2017. The MoU Parties recognise we have achieved a great deal and it is important we do not lose sight of that. But we must recognise we still have a considerable way to go to fully deliver the GP Contract Offer commitments originally intended to be delivered by April 2021. It also reflects the early lessons as we continue to respond collectively to the Covid-19 pandemic, recognising the full extent of its impact is still to be understood. While this MoU runs until 31 March 2023, the National GMS Oversight Group will review progress in March 2022 to ensure it remains responsive to the latest situation.

The focus of this renewed Memorandum of Understanding remains the delivery of the General Practice Contract Offer, specifically the transfer of the provision of services from general practice to HSCP/Health Boards. Delivery of the GP Contract Offer should be considered in the wider context of the Scottish Government's remobilisation and change programme across the Scottish national health and social care landscape, including the four overarching Care and Wellbeing Programmes and the National Care Service (NCS). These programmes encompass Place, Preventative and Proactive Care, Unscheduled and Integrated Planned Care and together with the NCS seek to improve national system wide outcomes for population health, connect better with citizens and remove silos between health and other public sector bodies, and reduce health inequalities. The National GMS Oversight Group will consider at a national level the synergies between these Programmes of work and delivery of the GP Contract Offer. The National GMS Oversight Group will proactively develop policy and funding proposals to improve healthcare system co-ordination, collaboration, and patient outcomes.

Priorities

Multidisciplinary Team – Prioritised Services for 2021/22

Implementation of multidisciplinary team working should remain underpinned by the seven key principles outlined in the previous MoU: safe, person-centred, equitable, outcome focussed, effective, sustainable, affordable and value for money.

All six MoU areas remain areas of focus for the MoU signatories. However, following the joint SG/SGPC letter of December 2020, the parties acknowledge that the focus for 2021-22 should be on the following three services.

Vaccination Transformation Programme

GP practices will not provide any vaccinations under their core contract from 1 April 2022. All vaccines provided under Additional Services will be removed from the Additional Services Schedules of the GMS Contract and PMS Agreement regulations in October 2021. All historic income from vaccinations will transfer to the Global Sum in April 2022 including that from the five historic vaccination Directed Enhanced Services. The Vaccine and Immunisations Additional Service is broader than the Travel Vaccinations that are part of the Vaccination Transformation Programme. The Travel Health sub-group will consider how these remaining vaccinations[1] will be transferred from GP delivery.

Boards have assumed overall logistical responsibility for implementing vaccination programmes, facilitated through national digital solutions such as the vaccination management tool and NVSS appointment system. Learning from the delivery of last year's adult seasonal flu and pneumococcal programme, as well as the ongoing Covid-19 vaccination programme, should be capitalised on to ensure the implementation of the programme in full by April 2022.

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[1] Note that additional service vaccines relate only and specifically to:

Anthrax – to be offered to those identified as coming into contact with an identifiable risk of Anthrax, mainly those coming into contact with imported animal products

Hepatitis A – for those in residential care or an educational establishment who risk exposure if immunisation is recommended by the local director of public health

Measles, Mumps and Rubella (MMR) – For women who may become but are not pregnant and are sero-negative and for male staff working in ante-natal clinics who are sero-negative

Paratyphoid – Note no vaccine currently exists

Rabies (pre-exposure) – For lab workers handling rabies virus; bat handlers; and persons who regularly handle imported animals

Smallpox – Note the vaccine exists but is not available to contractors

Typhoid – For hospital doctors, nurses and other staff likely to come into contact with cases of typhoid and lab staff likely to handle material contaminated with typhoid organisms

Although general practice should not be the default provider of vaccinations, we understand that a very small number of practices may still be involved in the delivery of some vaccinations in 2022-23 and thereafter. There will be transitionary service arrangements in the regulations for practices in areas where the programme is not fully complete as well as permanent arrangements for those remote practices, identified by the options appraisal, where there are no sustainable alternatives to practice delivery.

The Travel Health sub-group will be reconvened to develop a Once for Scotland solution with substantial input from local areas, particularly on delivery of travel vaccinations. This solution will be determined by October 2021 and put in place by April 2022. This will also be covered by transitional arrangements in the regulations.

GPs will retain responsibility for providing travel advice to patients where their clinical condition requires individual consideration.

Pharmacotherapy

All parties acknowledge the progress that has been made with the majority of practices receiving some pharmacotherapy support.

Managing acute and repeat prescriptions, medicines reconciliation, and the use of serial prescribing (which form a substantive part of the level one service described in the GP Contract Offer) should be delivered principally by pharmacy technicians, pharmacy support workers, managerial, and administrative staff. Progress with all parts of the level one service should be prioritised to deliver a more manageable GP workload.

In tandem, focus on high-risk medicines and high risk patients, working with patients and using regular medication and polypharmacy reviews to ensure effective person-centred care are being delivered principally by pharmacists (the levels two and three described in the Contract Offer). This is helping manage this demand within GP practices and developing a sustainable service which will attract and retain pharmacists and further develop MDT working in Primary Care.

Whilst the Contract Offer and Joint Letter emphasise implementing the level one pharmacotherapy service, there are interdependencies between all three levels that require focus on the delivery of the pharmacotherapy service as a whole.

Regulations will be amended by Scottish Government in early 2022 so that NHS Boards are responsible for providing a pharmacotherapy service to patients and practices by April 2022. The use of medicines to treat and care for patients will remain an important part of GP work. The delivery of electronic prescribing is an essential requirement for all involved in prescribing, which will be prioritised by the ePharmacy Programme Board, supported by National Services Scotland and the NES Digital Service. Greater local standardisation and streamlining of prescribing processes in collaboration with GP subcommittees / Local Medical Committees will help enable delivery of a consistent service across practices. The national Pharmacotherapy Strategic Implementation Group will design and support the ongoing development of the pharmacotherapy service in line with existing contract

agreements, enabling a national direction of travel with local flexibility supported by agreed outcome measures. The group will develop guidance to clearly define GP, pharmacist, pharmacy technician, managerial and administrative staff roles in the overall prescribing process and will report to the National GMS Oversight Group. The guidance will be agreed with SGPC to ensure it is consistent with the requirements of the GMS contract agreements and will ultimately be ratified by the National GMS Oversight Group.

NHS Directors of Pharmacy, supported by National Education Service for Scotland, will support the delivery of national workforce plans that will reflect the staffing requirements of the pharmacotherapy service, in particular what is required for delivery of a level one service for each practice and the appropriate use and mix of skills by pharmacy professionals. This will be overseen by the Chief Pharmaceutical Officer and link into the wider Scottish Government workforce directorate plans

CTAC

Regulations will be amended by Scottish Government in early 2022 so that Boards are responsible for providing a Community Treatment and Care service from April 2022.

These services will be designed locally, taking into account local population health needs, existing community services as well as what brings the most benefit to practices and patients.

The previous MoU outlined that Community Treatment and Care Services include, but are not limited to, phlebotomy, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, suture removal, ear syringing and some types of minor surgery as locally determined as being appropriate. Given this service draws primarily on a nursing workforce, local areas should also consider how CTAC services and the Vaccination Transformation Programme could be aligned to increase the pace of implementation and efficiency.

Healthcare Improvement Scotland will establish a CTAC implementation group to help build mutual understanding as well as share best practice in the delivery of CTAC services. This Group will report to the National GMS Oversight Group.

Other Multi-Disciplinary Team Services

Plans for Urgent Care, Community Link Workers and Additional Professional roles should continue and services already in place should be maintained, but the expectation for 2021-22 is that their further development, where required, may progress at a slower pace to allow the commitments around VTP, CTAC and pharmacotherapy to be accelerated. Their development should also take into account wider system redesign, and opportunities to make connections and add value by exploring the joining up of pathways.

Urgent Care – The Scottish Government will bring forward secondary legislation so that Boards are responsible for providing an Urgent Care service from 2023-24.

Evidence from the Primary Care Improvement Plans suggests there is variation in how this service is being delivered.

Further guidance will be provided by the National GMS Oversight Group on delivery of this commitment in advance of April 2022. Consideration in particular will need to be given about how this commitment fits into the wider system Redesign of Urgent Care work currently in progress.

Community Link Workers – Link workers have proved valuable in helping deliver better patient outcomes, addressing financial exclusion and helping patients access support, particularly in areas of multiple deprivation, as well as improving linkages with the third sector. Consideration will need to be given by April 2022 as to how the Link Worker workforce interfaces with the Scottish Government's commitment to delivering 1,000 Mental Health Link Workers by the end of this Parliament.

Additional Professional Roles – MoU Parties will consider how best to develop the additional professional roles element of the MoU by the end of 2021. In particular with Mental Health, there is a need to consider how PCIF funded posts interface with Action 15 funded posts as well as new policy commitments for mental health. The Primary Care Mental Health Development group in Scottish Government is taking this consideration forward. Separate to this MoU and the arrangements in place to fund it, the commitment of additional Mental Health Link Workers is currently being considered in the context of the locally led model proposed by the Mental Health in Primary Care Short Life Working Group.

Expert Medical Generalist Role

The Contract Offer set out a re-focussed role for the GP, working as part of an extended multidisciplinary team as an expert medical generalist (EMG):

"This role builds on the core strengths and values of general practice-expertise in holistic, person-centred care-and involves a focus on undifferentiated presentation, complex care including mental health presentations and whole system quality improvement and leadership. All aspects are equally important. The aim is to enable GPs to do the job they train to do and enable patients to have better care."

The EMG role is not a new role, but the time GPs can commit to being EMGs is to an extent contingent on the delivery of MDT services and the identified need for 800 additional GPs by 2027 to meet Scotland's current health needs.

Feedback to date suggests there is variation in the understanding on how the EMG role works in practice and what else can be done to support GPs in this role. A group consisting of the MoU parties and a wider range of stakeholders, including NES and RCGP, will examine how GPs can be supported in this role and will publish a report of its findings by the end of 2021.

Transitionary Arrangements

Following Regulation change, HSCPs and Health Boards will be responsible for providing vaccination, pharmacotherapy and CTAC services to patients and GP practices.

GP practices will support HSCPs and Health Boards to provide MoU services in two ways to help ensure patient safety:

- The treatment of patients requiring medical care that is immediately necessary such as an immediate need for wound care, phlebotomy or repeat prescriptions. HSCP/Health Board MoU service provision must minimise the need for immediately necessary support from GP practices.
- Temporary support of routine MoU services, where necessary, under transitionary service arrangements from 1 April 2022.

Consistent with the commitments of the joint letter, SG and SGPC will negotiate transitionary service and payment arrangements where practices and patients still do not benefit from nationally agreed levels of HSCP/HB vaccination, pharmacotherapy, and CTAC services after 1 April 2022.

Transitionary service arrangements are not the preferred outcome of MoU parties, or something we see as a long-term alternative. All parties locally should remain focused on the redesign of services and delivery of the MoU commitments and transitionary arrangements should not be seen as a desired alternative.

Scottish Government and SGPC will develop a set of principles for how transitionary services and payment arrangements will work in practice by the end of Summer 2021. Acknowledging the invaluable expertise of Health Boards and Health and Social Care Partnership they will be fully consulted in the development of this work via the Oversight Group.

Funding

Integration Authorities should endeavour to ensure that ring-fenced Primary Care Improvement Fund ("PCIF") funding supports the delivery of the three priority areas for 2021-22 before further investment of PCIF monies in the other MoU commitments. Other services delivered to date, or planned and signed off by the IJB, should continue to be maintained and only developed where there is available funding to do this.

The MoU parties are committed to determining the full cost of delivering MoU services and refining the evidence base for this purpose. The Primary Care Improvement Plan Trackers have been amended to reflect this. All MoU parties are committed to developing an integrated PCIF proposition for financial years 2022-25 by Autumn 2021 for evaluation and approval by Scottish Ministers utilising Value for Money principles and a methodology that assumes at least £155m of funding per annum uprated in line with inflation, which will include increases in staff pay as set by the Scottish Government.

NHS Boards and Integration Authorities should also assume that the PCIF and any associated reserves would meet any funding required for transitionary service arrangements negotiated between Scottish Government and SGPC. Boards and Integration Authorities should also consider where wider resources may support the delivery of MoU services as well as other earmarked funds such as Action 15 monies.

Any change to the scope of the Primary Care Improvement Fund will be agreed jointly by MoU Parties. The present scope of the call on the PCIF remains unchanged, except for the inclusion of costs of transitionary services, by this MoU and it is expected that any further increase in scope will be supported by additional resources.

GP Subcommittee participation in the development of PCIPs has been enabled to date by dedicated annual funding to support their work. For planning purposes, partners should assume that this funding will continue for the duration of this MoU period.

Governance

Primary Care Improvement Plans

Primary Care Improvement Plans ("PCIPs") will continue to be developed locally in collaboration between Integration Authorities, Health Boards and GP Sub-Committees and will be agreed with Local Medical Committees. Six monthly trackers will be provided to the Scottish Government to allow for national analysis to be produced.

In remote and rural areas, the rural options appraisal process has also been developed to determine whether it is necessary for the anticipated small number of local GP practices to continue delivering MoU services due to their specific remote/rural circumstances. Options appraisals should be developed as part of the PCIP process and submitted to the National GMS Oversight Group for review.

Written plans only go so far in providing intelligence nationally on service redesign. A Primary Care Improvement Leads group has been convened to share best practice on implementation of MoU services as well as feed into Oversight Group discussions. The Scottish Government is also committed to holding informal meetings with 31 HSCPs and Health Boards where appropriate by the end of 2021 to gain understanding of on the ground issues and listen to what further support can be provided to accelerate implementation locally.

Oversight Group

The National GMS Oversight Group will continue to oversee implementation of this MoU and the commitments in the national Contract and will be reinvigorated to allow it to fulfil its originally envisaged role of providing proactive intervention and support where necessary to implement the contractual arrangements outlined in this MoU within the agreed timescales. A key function will be to assess the extent to which additional resources and workforce are required to deliver the MoU services. As we

enter a new administration, the Oversight Group's Terms of Reference will need to be refreshed to ensure it complements and links with future primary care reform programmes and governance structures.

The individual responsibilities of the parties to the MoU established in the previous MoU continue to form the basis by which each party will contribute to the ongoing work of contract implementation.

Enablers

The MoU parties recognise that progressing work on key enablers is fundamental to delivering this MoU – workforce, data requirements, digital and premises.

Workforce

MoU implementation relies on having access to an available workforce. Partners recognise the current constraints that a finite workforce has on planning for service transfer and that the pandemic will likely have a significant impact on the development of workforce.

Workforce planning and pipeline projections, building on the primary care improvement plan trackers, are required to support the delivery of the MoU. A 'task and finish' group will be established involving all 4 partners (Integration Authorities represented by Chief Officers, Scottish Government, BMA and NHS Boards) to direct and oversee this work. The Group will be a sub-group of the National GMS Oversight Group and its recommendations will be used to inform the next iteration of the National Health and Social Care Integrated Workforce Plan.

Data-Driven Delivery

The pandemic has further highlighted the need for consistent, good quality data on which can be made available to the practice, the cluster, the Integration Authority and collated nationally to support sustainability, planning and the evolution of the extended multidisciplinary team. It is also important as a means to developing more robust interface working. The MoU parties place particular focus on the following areas:

Workforce – the GP Practice Workforce Survey will be run on an annual basis by NSS. Alongside the primary care improvement trackers, this will give us a comprehensive overview of GP workforce capacity. All parties to the MoU support this activity.

Activity – PHS has been carrying out a temporary weekly survey of activity of GP practices. The MoU parties are committed to developing long-term solutions for the extraction of activity data from general practice.

Quality – It was agreed as part of the Contract Offer that GP practices would engage in quality improvement planning through clusters. This should be supported by a national quality dataset. An initial version of this dataset will be agreed in Summer 2021. This will aid local service planning, and future MDT development.

Premises

It is acknowledged that with an increase in MDT working that premises will need to be able to support new ways of working that support more care/services being provided closer to home. Consideration should be given to remote, blended as well as co-location in considering implementation of MDT Services.

We remain committed to supporting the agreed National Code of Practice for GP premises and a shift to a new model in which GPs no longer will be expected to provide their own premises. Assistance to GPs who own their premises is being provided through the GP Premises Sustainability Fund.

Digital

Developing systems that facilitate the seamless working of extended Board-employed multidisciplinary teams linked to GP Practices is fundamental to the delivery of this MoU.

As part of this, NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems for GPs in Scotland. This commitment is ongoing with the first product becoming available in Autumn 2021. All signatories recognise the need to progress the rollout of these clinical systems at pace.

Signatories

Signed on behalf of the Scottish General Practitioners Committee, BMA

Name: Andrew Buist, Chair, Scottish General Practitioners Committee, BMA
Date: 30 July 2021

Signed on behalf of Health and Social Care Partnerships

Name: Judith Proctor, Chair, Health and Social Care Scotland
Date: 30 July 2021

Signed on behalf of NHS Boards

Name: Ralph Roberts, Chair, Chief Executives, NHS Scotland
Date: 30 July 2021

Signed on behalf of Scottish Government

Name: Tim McDonnell, Director of Primary Care, Scottish Government
Date: 30 July 2021

AGENDA ITEM NO: 9

Report To:	**Inverclyde Integration Joint Board**	**Date: 21 March 2022**
Report By:	**Allen Stevenson Interim Chief Officer Inverclyde Health & Social Care Partnership**	**Report No: IJB/16/2022/AG**
Contact Officer:	**Anne Glendinning Acting Head of Service Children & Families and Criminal Justice Inverclyde Health & Social Care Partnership**	**Contact No: 715368**
Subject:	**CPC ANNUAL REPORT 2020-21**	

1.0 PURPOSE

1.1 The purpose of this report is to advise the Inverclyde Integration Joint Board of the publication of Inverclyde Child Protection Committee's Annual Report 2020-21.

1.2 Consider the report's findings in relation to Inverclyde Child Protection Committee's duty to provide an annual update of child protection business.

2.0 SUMMARY

2.1 Child Protection Committees (CPC's) are the key local bodies for developing, implementing and improving child protection work across and between agencies, bodies and the local community. A CPC is expected to perform a number of crucial functions in order to jointly identify and manage risk to children and young people, monitor and improve performance and promote the ethos that ***"It's everyone's job to make sure I'm alright".*** CPCs must ensure all of these functions are carried out to a high standard and are aligned to the local Getting It Right For Every Child arrangements.

2.2 One of the key functions of a CPC is to provide a report of CPC business on an annual basis. The author is generally the Lead Officer for Child Protection. The last report published covered work across 2017. The committee will note that the report under consideration spans from March 2018 to March 2020. The two year span is due to a vacancy in the Child Protection Lead Officer role during 2019. A report covering March 2020 to March 2021 is currently under construction and will be presented to committee later in the year.

2.3 The attached report was presented to and accepted by Inverclyde Child Protection Committee on 18 October 2021. It was presented to and accepted by Inverclyde Chief Officer's Group on 16 November 2021. It was presented to and accepted by Inverclyde Health and Social Care Partnership on 16 December 2021.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the content of this report

Allen Stevenson
Interim Chief Officer

4.0 BACKGROUND

4.1 CPC's have 4 functions: Continuous improvement; Public information engagement and participation; Strategic planning and connections; Annual reporting on the work of the CPC.

4.2 Continuous improvement: This involves the collation of data which records outcomes for children and audit activity which identifies gaps in provision and determines improvement activity. CPC's are also responsible for delivering training and other learning activity to ensure that practitioners across all services are aware of the best and most up to date practice initiatives. CPC also has a duty to ensure that policies, procedures and guidance are kept up to date and that practitioners are aware of their content and availability. Finally CPC's take the lead in terms of any learning when a child is significantly harmed or dies.

4.3 Public information, engagement and participation: CPC's have a role in raising awareness so that members of the public, including children and young people, know what child protection means and what to do if they have a concern for a child or young person. They must engage with local communities to raise awareness of indicators of concern and increase understanding of the role that communities and all adults have in protecting children and young people. Finally they must involve children, young people and families in the design and delivery of child protection systems.

4.4 Strategic planning and connections: CPCs must ensure strong and robust strategic planning links to wider integrated children's services planning arrangements in their local area in order to ensure that the need for support and protection of children and young people can be comprehensively met in well designed, effective and sustainable local services, programmes and initiatives. CPCs must also link effectively with other multi-agency partnerships and structures locally, regionally and nationally, including Chair and Lead officer participation in Child Protection Committees Scotland.

4.5 Annual reporting on the work of the CPC: CPCs must produce and publish an annual report, endorsed by the Chief Officers, which sets out the work undertaken by the Committee, delivery against key performance measures in that year as well as identified priorities for the year ahead.

4.6 The Inverclyde Child Protection Committee Annual Report begins with an account of the role and remit of the child protection committee within Inverclyde, set within the context of wider strategic planning groups. In the main body of the report it records the multiagency response to the COVID-19 pandemic and examines areas of best practice. The report then goes on to review the priority areas described in 4.2 to 4.4, detailing the work achieved in these areas via CPC's Performance Management, Training, Child Sexual Exploitation and Whole Family (previously CAPSM) sub groups. This section also reflects on work being undertaken by the Violence Against Women forum of which the CPC Lead Officer is a member, and notes work being done in the areas of parent and children's mental health. The report concludes by charting areas of future work.

4.7 In terms of public information and advice, Inverclyde CPC participated in the national **Eyes and Ears** campaign over the summer of 2020. This was intended to encourage family members and communities to keep an eye out for children who might be struggling or experiencing harm and a listening ear to their needs. This campaign was reissued over Christmas. The campaign was succeeded in March 2021 by **KeepingKidsSafeOnline**, a virtual poster campaign with information links for parents and carers encouraging them to check in on what their children are up to online. This was on the back of Police Scotland noting that there had been a 13.4% increase in reports of online abuse and exploitation since lockdown commenced.

Autumn 2020 was to see the launch of `Helping Hands' an Inverclyde specific campaign to promote access to early support for children and families in need. It was decided to delay this, however, in order to focus on the national rollout of the **Children (Equal Protection from Assault) (Scotland) Act 2019**. This act, known colloquially as the `smacking ban' removes the defence of 'reasonable chastisement', which a parent or carer could previously use to justify the use of physical force to discipline a child. The change in law necessitated a robust publicity campaign to ensure parents and carers were aware and our local early years services were particularly adept at communicating the change via parent packs despite the limitations imposed by ongoing social distancing. New guidance was developed for practitioners and a series of online information events were offered to multiagency staff teams. Inverclyde's Lead Officer for Child Protection joined the communications sub group of CPC Scotland in May 2021 and was party to the development of a more asset focused campaign over the summer of 2021 called **For Kid's Sake…**which encouraged extended family and local communities to keep a benign eye on children over the summer holidays and offer a helping hand to parents. A new and exciting development within CPC Scotland's sub group will encourage children and young people to become directly involved in the theming and co-production of future campaigns. Inverclyde's Lead Officer for Child Protection is encouraging Inverclyde's extremely active Champs and Little Champs, members of the Proud2Care network, to get involved and help shape the future of child protection communication.

4.8 With regard to learning and Development, COVID-19 has had a significant impact on delivery of training. However, during February and early March 2020 the 5 day Child Protection Course for enhanced practitioners and children affected by parental substance misuse training to multiagency teams was delivered. Within months, the training sub group was up and face to face training was provided virtually. In early 2021 The Assessment of Care: formerly known as the Neglect Toolkit was rolled and 5 sessions to 41 members of staff from social work, health and community learning and development. A twilight session has taken place for education staff. A recent evaluation session noted that the training has increased awareness of the impact of neglect though practitioners have struggled to use the toolkit with families given lockdown restrictions. Neglect training for the general workforce: A virtual programme is complete and ready to deliver to relevant agencies. Child Protection Awareness for the general workforce: This has been adapted to a virtual format and is now being delivered to a range of services. Scottish Drugs Forum: Everyone has a story, an account of the impact of problematic substance use on children and young people was delivered virtually to a multiagency staff team. All training is conducted with reference to the **assess-plan-do-review** cycle which means we revisit it with participants at regular intervals in order to assess how well learning is embedded in practice.

4.9 The draft Annual Report concludes with a plan of business. This includes plans to progress work already begun via CPC sub groups and deliver multiagency training in relation to neglect, child protection awareness and Whole Family Support for addiction. All of the objectives noted are underway and an update report will be offered within the next annual report. The Annual Report for 2020-2021 is attached below.

5.0 IMPLICATIONS

Finance

5.1 Financial Implications:

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 (If Applicable)	Other Comments
N/A					

LEGAL

5.2 There are no specific legal implications in respect of 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?

	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.

5.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	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

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.	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

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 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 CPC Annual Report attached as appendix 1

ICPCC
Report

March 2020
to
March 2021

Appendix 1

Forward

Louise Long, Chief Executive, Chair, Chief Officers Group

Welcome to the Annual Report for Inverclyde Child Protection Committee 2020-21. The report sets out the developments and improvements between March 2020 and March 2021. The outcomes framework at the end of the report contains the business plan 2021-22 and sets out key priorities for the coming year.

This has been a year like no other and much of the report's focus is necessarily on the impact of the COVID-19 pandemic as it affected Inverclyde and shaped committee business. The Inverclyde community was quick to respond to the crisis with an impressive humanitarian effort to deliver care, food and other resources to people in need. All services which have child protection within their remit were intent on identifying children and young people they deemed most vulnerable and worked well together to ensure that nobody was left out. My impression has been of a multi-agency community working well together to deliver frontline services in a manner that brought people together in an expression of community solidarity and pride.

The commitment of all agencies in ensuring that all children in Inverclyde are safeguarded and protected from harm and abuse is apparent in the day to day delivery of child protection services. It can also be seen in agencies' extensive contribution to the strategic improvements and developments carried out, even within the context of a global pandemic, in 2020.

The Child Protection Committee works with colleagues locally and nationally and across Integrated Children's Services. It aims to support the multi-agency workforce and members of the public to ensure Inverclyde is a safe place to grow up. It aims to promote the care and welfare of all our children and to protect them from abuse and harm.

We are committed to partnership working to ensure the protection and safety of the Council's children and young people. We are committed to understanding the child protection concerns which arise in our Council Authority and to making improvements together to address these.

The Child Protection Committee has representatives from social work, police, health, education, housing, the Children's Reporter and the third sector. The work of the Child Protection Committee could not have been delivered without the commitment and support of these agencies and the many front line practitioners. I would like to thank the Child Protection Committee members and the constituent subgroups of the Child Protection Committee for their continued commitment to ensuring that our vision and aims for children across Inverclyde are realised.

As the Chair of the Chief Officers Group I endorse this report and the outcomes framework which we hope you will find informative in detailing the work of the committee and its future planning.

Chief Executive

Countersigned Stephen McCabe
Leader of Council

Preface

Sharon McAlees, Chair, Child Protection Committee

I am very pleased to present the March 2020 to March 2021 Annual Report and Business Plan 2021-2022 for The Inverclyde Child Protection Committee.

All Child Protection Committees across Scotland produce an Annual Report and set out their priorities for the coming year. The following report describes how our Committee fulfilled its functions and tasks during 2020 to early spring 2021. The production of this report allows the Child Protection Committee an opportunity for reflection on the successes and challenges along the way and assists in planning our priorities for the year ahead.

As we undertake this opportunity for reflection we are compelled to consider the significant impact of the recent pandemic situation on children's services. The past year has tested our capacity beyond . In my role as chair of the Child Protection Committee but also as Head of Service for Children's Services within the HSPC and the Chief Social Work Officer, I can wholeheartedly reflect that the joint working and prioritisation of Inverclyde's most vulnerable children, from the very initial stages of service response to the pandemic within lockdown to the deliberate planning around recovery, has been thorough, innovative and nothing short of outstanding. As our initial focus in March 2020 was on identifying the most vulnerable children within Inverclyde for target monitoring and support, this meant that more strategically focused child protection business inevitably needed to be stepped back somewhat . The committee itself continued to meet through April to June with its focus being on maintaining communication sharing best practice. From July 2020 committee business returned to its more regular focus (whilst continuing to reflect on the ongoing impact of the pandemic) with sub groups also recommencing from around that time.

I am pleased to report an agile shift from in person training to virtual delivery with trainers showing creativity and innovation in their delivery of key strategic training aims. The roll out of multi-agency training in the Assessment of Care has been a particular priority and it has been good to see this delivered across the Health and Social Care Partnership. Delivery of child protection training is ensuring that our message around child safety and wellbeing is being received by a wide audience. Other training, offered via our Whole Family and Violence Against Women streams, ensures that practitioners are kept up to date with the most recent research and practice and also helps to build professional networks across agencies. I welcome the increased emphasis on a rights respecting approach to alcohol and drug service delivery in a change of name for our Whole Family Sub Group and look forward to similar discussions in relation to Child Sexual Exploitation Sub Group whose remit we wish to expand in the coming year. Our Performance Management Sub Group has completed valuable audit work even in the midst of a pandemic and has much planned to ensure that we continue to improve practice and learning from it. Most importantly our committee has embarked on the work of becoming a rights respecting forum and are underway in our journey to be assessed by our young people for the Inverclyde Respecting Rights of the Child Award.

This coming period will see updated National Guidance for Child Protection being published, alongside new guidance for Learning Reviews, the Age of Criminal Responsibility and incorporation of the United Nations Convention for the Rights of the Child into Scots law amongst many other new initiatives. As a Child Protection Committee then, we are outward facing, working closely with our regional and national colleagues to incorporate guidance and make sure that we are delivering services to national standards which ensure that the children of Inverclyde receive the best in protective services that we can deliver.

I am very proud of the way Inverclyde has come together as a community to offer a targeted humanitarian response to the pandemic. I believe this has greatly enhanced the ability of child protective services to focus at those children most acutely affected by high levels of need and risk. I would like to extend my sincere thanks to our partners and the frontline practitioners who deliver the protection services for vulnerable children in Inverclyde and who have continued to do so in the most testing of circumstances. I should also like to thank the members of the general public for their continuing support of the Child Protection Committee and of child protection within Inverclyde.

Section 1:

Introduction and overview

1.1 Our Vision and aims

The ICPC is an inter-agency strategic partnership responsible for the design, development, publication, dissemination, implementation and evaluation of child protection policy and practice across the public, private and wider 3rd sectors in Inverclyde.

Aims

We aim to:

- Improve the way we work to provide access to early help and support in order to improve the wellbeing of children, young people; targeting the most vulnerable;
- create systems and processes with a clear understanding of local needs, planning, governance, data support and service development;

- create a culture for all that provide protective services that is defined by high levels of support, alongside challenge and expectations to deliver our priorities; and
- Use GIRFEC principles when we work with children and young people in accordance with Children's rights under the UNCRC.

Priorities

We want to ensure that our Child Protection Committee:

- Knows who our most vulnerable children and young people are, and focus the work of the Child's Plan to improve outcomes for these children and young people;
- Hears the voice of children and young people; influencing their experience of our support, improving their outcomes and informing service planning;
- Understands that exposure to high levels of stress, neglect and abuse impacts on children's psychological wellbeing and self-esteem and seeks to promote and support resilience
- Supports families to give their children the best childhood they are able
- Gives practitioners the tools and support to make a difference

Our values

Embedding the Nurturing Inverclyde approach across children's services

Driving continuous improvement through a culture of collaboration, high aspiration, reflective practice and learning for success

Mitigating the adverse consequences of child poverty through an extensive cross-cutting range of strategies

Involving children and young people in every aspect of policy, planning and service development and promoting their rights

Investing significantly in prevention and early intervention, especially from pre -birth to commencement at school.

Our UNCRC charter

Article 2: The Convention applies to every child without discrimination

We will work together to make sure you enjoy these rights no matter who you are, how you look or where you come from ,

Article 3: your best interests shall be a primary consideration

By making sure that we ask everyone who knows you what you need to thrive· By making sure that our own practices and procedures are fit for purpose

Article 12: we promote your right to express your views freely

By listening to you carefully and recording your views in reports and for meetings· By offering you the support of an advocate if you would like one

Article 19: we aim to protect you from all forms of physical or mental violence, injury or abuse, neglect, maltreatment or exploitation

By supporting those who care for you to offer you the best care they can· By ensuring that we keep up to date with the best research on how to do this

Article 27: we recognise your right to a standard of living adequate for your physical, mental, spiritual, moral and social development

By working with Scottish Government & other agencies to end child poverty· By publishing data that tells us how we are doing in this area

Article 33: drug abuse, Article 3: sexual exploitation, Article 35: abduction, sale and trafficking

We will work together to help keep you free from harm and do our best to ensure that an environment exists where you are safe and protected· We will focus on areas where most harm is caused and look at ways to prevent this from occurring· We will support you and care for you if you become victim to any of these criminal behaviours and share information appropriately to safeguard you·

Article 39: we will take all appropriate measures to promote your physical and psychological recovery and social reintegration if you are harmed

By making sure we have the most up to date knowledge to help make things better· By making sure we learn from when things go wrong

1.2 What is the role and remit of Inverclyde Child Protection Committee?

Inverclyde Child Protection Committee (CPC) is a locally based, multi-agency strategic partnership responsible for the design, development, publication, distribution, dissemination, implementation and evaluation of child protection policy and practice across Inverclyde. The CPC are also responsible for the quality assurance of multi-agency practice and ensuring that the performance measures put in place ultimately lead to improving outcomes for children and young people. Child protection means preventing a child suffering significant harm from abuse or neglect. The CPC is committed to its responsibility to keep all children in Inverclyde safe from harm whether abuse or neglect has already taken place or looks likely to take place. In working to achieve that, the functions of the CPC are continuous improvement, strategic planning, public information and communication.

Who are the members of the Child Protection Committee?

The CPC has senior membership across the full range of agencies and services with child protection responsibility including Inverclyde Council (Social Work, Education and Housing), Police Scotland, NHS Greater Glasgow and Clyde, the Reporter to the Children's Hearing, Inverclyde Violence against Women Partnership and the third sector. The CPC has a chair, a vice chair and a lead officer to ensure tasks are taken forward. All members aim to consistently improve upon the delivery of robust child protection practices across the public, private and wider third sectors.

Who is responsible for the CPC?

The National Guidance for Child Protection in Scotland 2014, requires that each CPC be established and governed by a Chief Officer Group. The Local Police Commander and the Chief Executives of NHS Glasgow and Greater Clyde and Inverclyde Council are the Chief Officers responsible for the leadership, direction and scrutiny of the local child protection services and they have strategic responsibility for the CPC. Inverclyde CPC works collaboratively with other strategic partners; in particular, the Integrated Children's Services Board, Violence against Women Partnership, Adult Protection Committee and the Alcohol & Drugs Partnership. This means that child protection is seen alongside the wider context of supporting families and meeting children's needs. It ensures that partners are aligned in their aims, priorities and delivery of improvements as set out in the Child Protection Programme and the Local Outcome Improvement Plan (LOIP). We are committed to Getting It Right For Every Child. GIRFEC is the national practice model which aims to ensure children and young people are safe, healthy, achieving, nurtured, active, respected responsible and included.

Some areas of child protection activity are shared across local authority areas. In Inverclyde we work closely with partner agencies in Renfrewshire, West Dunbartonshire and Argyll and Bute regarding the delivery of child protection learning and development opportunities to the multi-agency workforce, including Joint Investigative Interview training. ICPC is also a member of the West of Scotland consortium which meets bi monthly and shares best practice initiatives across the 13 Local Authorities in the West of Scotland. The CPC also works in partnership with the Scottish Government and other CPC's nationally to take forward child protection policy and practice under the banner of Child Protection Committees Scotland.

How does the CPC work?

Inverclyde CPC normally meets six times each year. All the members have child protection skills and knowledge. They consider information from a variety of sources such as the local Child Protection Register, Children's Reporter, significant case reviews, formal inspections of Children's Services, case file audits and national developments. Identified areas for improvement and emerging trends in relation to child protection are then incorporated into the Child Protection Business Plan, which is detailed in this report.

The CPC has four permanent Sub groups, each reporting directly to the CPC. The Performance and Management Sub Group focuses on the monitoring and measuring of improvements in child protection practice. The Training Sub Group identifies and has oversight of the delivery of multiagency child protection learning. The Whole Family Sub Group (previously CAPSM, Children Affected by Parental Substance Misuse) has a focus on improving outcomes for children and delivering training in this area and links into the Council authority wide Alcohol and Drugs Partnership. The Child Protection & Domestic Abuse group has worked collaboratively with the Inverclyde Violence Against Women Partnership in the development of multi-agency guidance and the delivery of new approaches to assessing the risk from domestic abuse and identifying new interventions to reduce incidents of domestic abuse.

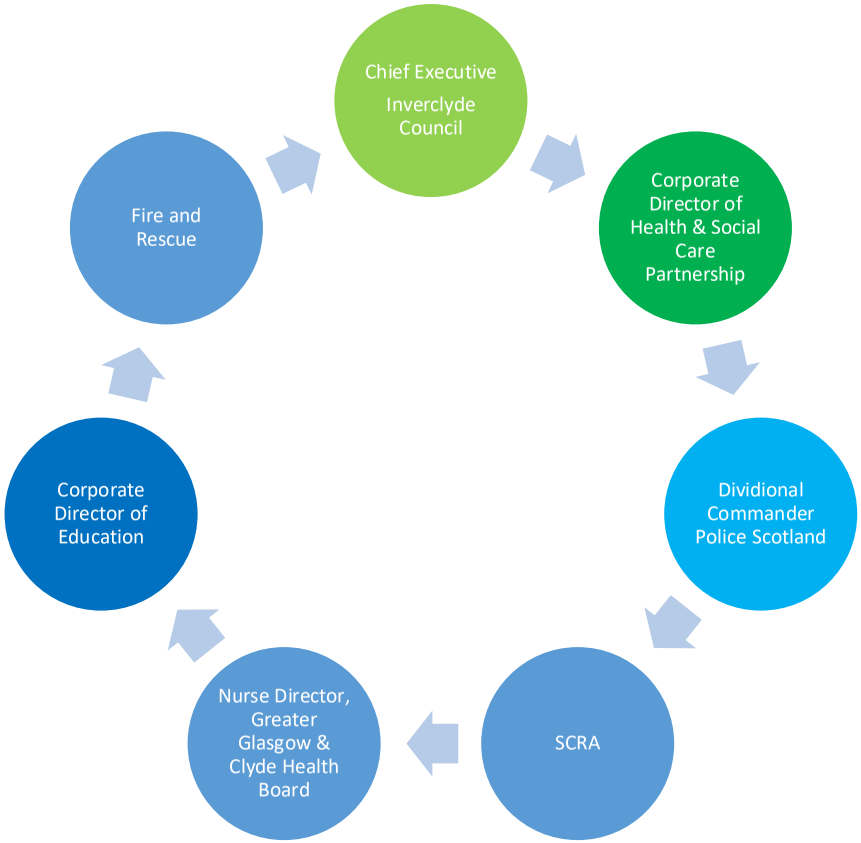
The CPC also implements short working groups once key areas of practice improvement are identified. The Child Sexual Exploitation working group was established in 2017 to undertake work in this area. The Addressing Neglect, Enhancing Wellbeing project, while also under the aegis of GIRFEC/Early intervention addresses its work towards the ICPC as getting it right at the earlier stages will have a positive impact on CPC work.

Links to other committees

We work consistently to ensure that the CPC links with wider strategic plans and committees structures to ensure robust governance and reporting arrangements and that our activity links to wider local authority , HSPC and national strategy. This includes the Public Protection Network, the Children's Service Planning Partnership, the GIRFEC Strategic Group, the Child Poverty Action Group, the HSPC Big Action planning and working groups, the Community Safety Partnership and the Inequalities Committee.

1.3 Chief Officers Group

Chief Officers across Scotland (Local Police Commanders and Chief Executives of Health Boards and Local Authorities) are individually and collectively responsible for the leadership, direction and scrutiny of their respective child protection services and their Child Protection Committees. This responsibility applies equally to the public, private and third sectors. They also have responsibility for maximising the involvement of those agencies not under their direct control, including the Scottish Children's Reporter Administration, the Crown Office and Procurator Fiscal Service and the third sector.



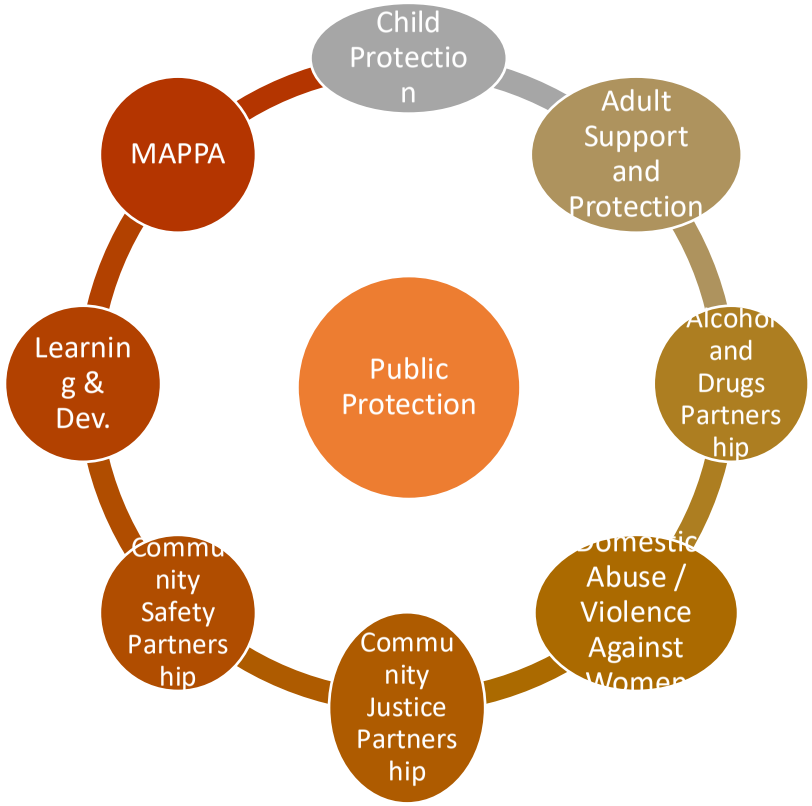
Chief Officers Group (COG)

The Chief Officers Group in Inverclyde meets quarterly with the Heads of Service and Lead Officers from the Public Protection Network. The Chief Officers are updated on the progress of the core functions of the Child Protection Committee and priority areas as outlined in the business plan along with updates on reactive matters. The Chief Officers provide leadership, direction and scrutiny and ensure that links are made with the wider governance structure.

1.4 The Inverclyde Public Protection Network

The Inverclyde Public Protection Network is the forum with responsibility for shaping public protection arrangements across Inverclyde. It aims to strengthen the links between the Child Protection Committee and other statutory and regulatory functions.

The image below illustrates the relationship between the various bodies and groups responsible for protecting the public in Inverclyde



The network aims to protect vulnerable people and keep people safe by promoting wellbeing, equality and diversity, collaborative joint partnership working, information sharing and communication, community engagement and capacity building, peer support and challenge, shared learning and understanding and partnership wide policy and practice developments. In early 2020 we have increased efforts to coordinate Public Protection Networking across the CPC, APC and MAPPA. This has included the creation of a common digital framework and an annual communication and engagement plan.

1.5 The Wider Agenda

The Child Protection Committee does not function in isolation. The collaboration and links with wider planning, strategic and operational groups facilitate effective partnership working and make the best use of resources and skills.

Getting It Right for Every Child in Inverclyde

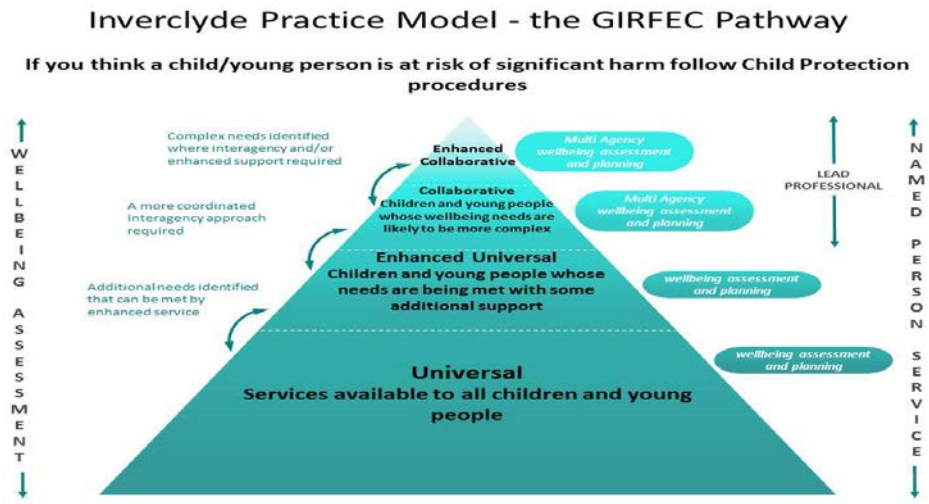
At the heart of the GIRFEC approach is an emphasis on early, proactive intervention in order to create a supportive environment and identify any additional support that may be required as early as possible. Early intervention and support can prevent a problem from escalating into a crisis and ultimately, ensure positive outcomes for children.

While all Child Protection interventions operate at the 'enhanced collaborative' level of service delivery, Inverclyde Child Protection Committee are committed in the promotion of achieving early help for children, young people and their families. The CPC has close links with the GIRFEC strategy group and the children's planning partnership. This ensures that planning for children is joined up and shares the same values across the council. This approach is encompassed within the 'Nurturing Inverclyde' approach which received a COSLA Gold excellence award in 2013 and is an area that we have continued to build on and develop.

Improvement actions identified in the Children and Young People's services plan

- Improving shared systems, paperwork and processes in order to enable more effective collaboration
- Improving consistency in the understanding and implementation of thresholds, roles and responsibilities within, across and between agencies
- Smooth transitions between Named Persons in different agencies ie., Health and Education at the commencement of Primacy School education
- Named Persons feel more supported in aspects of their Named Person role from training to implementation.
- Increase information, access and availability of the support for parents, providing the right help at the right time.

are linked into improvement actions within the CPC action plan. For example, information relayed into our National Minimum Dataset has identified a need for audit of step down supports from statutory to universal services which links to the work being undertaken around thresholds. A presentation by Child Protection Committees Scotland on the identification of risk at the universal level was shared with Health Visiting and Social Work teams to boost understanding the role of the named person. The GIRFEC Quality Assurance Group, which is coordinated by the CP Lead Officer, prompted the development of a more user friendly risk assessment document for health and inter-agency training around neglect has helped boost collaborative working between health, education and social work. Therefore, while Child Protection remains very much at the enhanced collaborative level of statutory intervention, we understand that to get things right for children and young people, CPC needs to be engaging in supportive action and developmental work at the universal level too.



1.6 The Environmental Context

In order to understand the context in providing Child Protection Services in Inverclyde it is essential to understand the area and the challenges faced by the citizens living here. The Inverclyde area stretches along the south bank of the river Clyde estuary and covers 61 square miles. It is one of the smaller local authority areas in Scotland with a population of approximately 80,000. At the most recent estimate, 20.3% of the population is 0 – 19 years of age. Over the period 2001- 2011, Inverclyde had the second highest drop in population of all council areas in Scotland. This decline has had a greater impact on young people, young families and working age people. The population is projected to be 70,271 by 2039 representing a decrease of 12 per cent. The under 16 population is projected to decline by 16% over the next 25 years.

The area's main towns are Greenock, which has the largest population, Port Glasgow and Gourock. The Scottish Index of Multiple Deprivation (SIMD) divides Scotland into small areas, called data zones, each containing around 350 households. The Inverclyde area has significant challenges in relation to deprivation and poverty. 51 (44.7%) of Inverclyde's data zones are in the 20% most deprived in Scotland, this is the highest local share in Scotland. Inverclyde has the second highest local share of data zones in the 15% most deprived in Scotland. The council with the highest local share is Glasgow. 22 (19.3%) of Inverclyde's data zones are in the 5% most deprived in Scotland, this is the highest local share in Scotland.

There has been an upward trend in the number of data zones moving into the 5% and 10% most deprived in Scotland category that were previously in the 10-20% most deprived category. Most of the deprived data zones are within Greenock and Port Glasgow.

Across Inverclyde 13,945 people are income deprived. This is 17.7% of the population and higher than the Scottish average of 12%. Of this number, 10,143 live in the 20% most deprived data zones, which means that 3,802 income deprived people do not reside in the 20% most deprived data zones. There are 7,126 people in Inverclyde that are employment deprived. This is 14.3% of the population and is higher than the Scottish average of 9%. There has been a small reduction in employment deprivation (1%) between 2016 and 2020. Of this number, 4,994 live in the 20% most deprived data zones, which means that 2,132 employment deprived people do not reside in the 20% most deprived data zones.

The area has further challenges in relation to child poverty. According to poverty figures published by End Child Poverty (2019), Inverclyde has the ninth highest level of child poverty in Scotland, after housing costs. It is estimated that just over 1 in 4 (35%) children and young people in Inverclyde are living in poverty. Poverty levels vary significantly across the authority with Inverclyde East Central and Inverclyde East having the highest levels of child poverty with over 30% with Inverclyde West decreasing the level of child poverty to 9%. In the school year 2015/16, there were 4,296 pupils enrolled in Inverclyde schools with 21% of these registered for free school meals compared to the national average of 14%.

Research into the relationship between poverty and neglect notes that children living in poverty are over represented on child protection registers and recognises the strong link between poverty and its impact on multiple life opportunities. All services in Inverclyde are committed to addressing the causes of poverty and improving the life circumstances of their children. This issue became even more prominent during 2020 as Inverclyde weathered the impact of the COVID-19 pandemic.

Section 2:

Inverclyde Child Protection Commitee in Action

2.1 Response to the COVID-19 pandemic

Community response to the crisis

Inverclyde has a long and proud history of community support and this was in evidence from day 1 as local volunteers and businesses worked with the Council to make and distribute meals to those in need and build up support systems for those experiencing social isolation.

Plan for minimum necessary intervention

In order to optimise the safe and effective delivery of services at the beginning of lockdown in March 2020, the HSCP moved to a Hub model of service delivery. A discrete Covid Response Team was established and led by the Corporate Director of the HSCP and supported by the Head of Health and Community Care and the Inverclyde Alcohol and Drug Partnership. The Chief Social Work Officer supported operations and the Chief Finance Officer/ Interim Head of Strategy supported coordination across the HSCP. At this time the HSCP focused service delivery efforts at the Critical Risk Level and where capacity allowed also provided services for service users in the substantial risk category. This was kept under review on a daily basis in terms of assessment of capacity and risk. The key principle underpinning service delivery during this period was safe delivery of services based on dynamic assessment of risk and vulnerability in a way that supported staff health and wellbeing and enabled optimum ongoing service delivery throughout the period.

Inter-agency communication and cooperation

This coordinated effort was mirrored by our partners in Police Scotland, education services and the Third sector with all agencies coming together to collate an at risk register for both children and adults, the aim being that no one should be left without help if they required it. Heads of Services consulted weekly and, in the initial weeks of the pandemic, twice or three times weekly via virtual platforms. It has since been acknowledged by all agencies that the improvements to communication channels enabled by Webex and Microsoft Teams, considerably enhanced partner relationships,

responsiveness to need and the speed of decision making. Indeed, 18 months on, virtual platforms continue to be used to expedite large group meetings with attendance at these enabled by not having to travel out with operational locations.

Move to hub working for children and families social work

The 7 children and family support teams were paired up to create 3 core teams across three locations that rotated to allow staff to work one week in the office and then one from a virtual hub.

Children and families support hubs

Staff triaged referrals for all cases in order to assess and manage risk, carry out Interagency Referral Discussions and put emergency safety plans is place. Support hubs ensured continued support to the most vulnerable children and families. Immediate tasks and practical or short term tasks were followed up either by office based staff or those in the virtual hubs.

Virtual support team – home based

The virtual support team carried out home based tasks for families on their caseload, contacting families through phone contact, report writing, chronologies, assessment completion as well as supporting the active teams with tasks and providing support advice and guidance to families during the pandemic by telephone. Home based staff could also be called in to cover shortage in active teams. A rota was established to rotate those staff working at home and those working from an office base.

The development of the Virtual Hub, as well as a pragmatic response to national guidance, was seen as vital in enabling the HSCP to respond at an optimal level throughout a prolonged period. This supported staff to practice social distancing in the working environment and enabled staff who were able to do so to work from home. Guidance for work allocation together with staff support and supervision was developed.

For those working from the office, guidance in relation to undertaking home visits, personal safety and protective equipment and contingencies for infection was issued. Regular keeping in touch contact by phone or email, supervision and support was built into the home working structure.

A list of our most vulnerable children was drawn up and categorised using a red, amber, green system. Bespoke support packages were agreed and contingency plans drawn up for those whose extended families would be unable to step in in a crisis. Partnership working continued to ensure food parcels, medicine and other essential items could be delivered to those in need.

Education hubs

Education hubs for the children of key workers were set up across Inverclyde. These hubs were also intended to support children identified as vulnerable. Every school and Early Learning Centre in Inverclyde in partnership with social worker services, identified children and young people whom they deemed vulnerable. Children's Services across the partnership worked to try to ensure that professionals had some contact with these children and their families each week. Advice was issued for all children on the vulnerable list who did not attend a hub. This included the allocation

of each child who was vulnerable to a member of the Senior Leadership / pastoral / guidance team/teacher/key person as appropriate. Team members also made phone contact with each allocated pupil /child 2/3 times per week to check safety and wellbeing and were directed to speak to the child (if age appropriate). A brief summary of conversation was recorded on SEEMIS. Guidance was issued on the reporting of concerns and escalation of these if necessary.

Weekly data collated on home visiting in Inverclyde evidenced a high level of vigilance in maintaining face to face contact with children on the Child Protection Register with almost 100% being seen weekly (exceptions were in relation to a new born baby who was in a hospital setting and a child who had moved to foster care). Vigilance in terms of contact with children subject to multi-agency plans was also maintained by social work professionals with over 70% being contacted every week. In addition many of these children were offered places at the Education hub and received support from partner agencies. Significant efforts were made to maintain contact with those young people in aftercare.

Support from our third sector colleagues

Our third sector colleagues via Community Volunteer Service and Barnardos were a fundamental part of our child welfare and protection system, providing not only weekly door step visits to vulnerable families but food parcels and much needed crafting materials, paper, glue and glitter pens along with ideas for parents to spend time with their children during lockdown. With the first lockdown encompassing a large part of the school summer holidays, anecdotal feedback suggests that families really welcomed the practical support offered by services and that this had a positive impact on families who, living in poverty, would normally view the summer holidays as a time of additional stress.

Like other CPC's Inverclyde CPC was aided by central support and communication via the publication of Interim Child Protection Guidance and the sharing of best practice by national partners. Information on available support, along with in the moment research on the impact of the pandemic, was coordinated by Child Protection Committees Scotland via a weekly publication Keeping Connected.

Immediate and longer term impact of the pandemic within Inverclyde

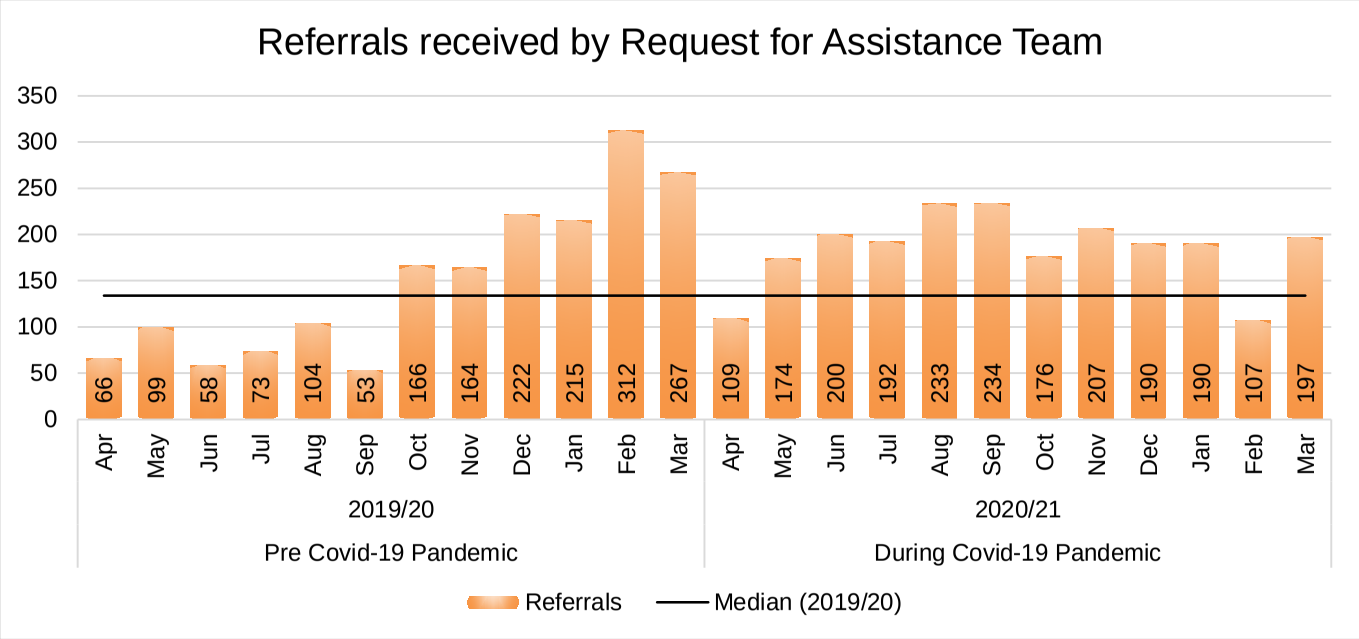
While Inverclyde's response to the pandemic was both robust and immediate, it needs to be acknowledged that COVID-19 has had a particularly devastating impact on communities that were already compromised by poverty and social inequality. With some of the poorest wards in Scotland, Inverclyde initially saw deaths soar, recorded in the first few months of the pandemic at over 13 times the Scottish average. While this did decline and Inverclyde found itself in a relatively positive position throughout the later part of 2020 and early 2021 compared to other areas of Glasgow and Greater Clyde, there is no doubt that the virus has had a significant impact in terms of increased personal and community experience of bereavement and loss. The social impact of the pandemic in relation to, not only lost educational opportunities, but suspected increases in rates of domestic abuse, sexual abuse (in both familial and online settings), decline in both children and parent's mental health and incidences of neglect, remains an ongoing enquiry albeit current data suggests a more positive picture than initially feared.

2.2 The Inverclyde Profile

The use and analysis of data and evidence is essential in order to measure the impact that Child Protection Services are having in Inverclyde. Over summer 2021 we collected data in order to compare pre-pandemic data from 2019 with data from 2020-21. This encompassed the first year of response to the COVID-19 pandemic and 2 national lockdowns. Of course data collation over such a short period needs to be viewed with caution especially within a Local Authority as small as Inverclyde. There will inevitably be some natural statistical variability across all years.

Child Protection Activity during the pandemic

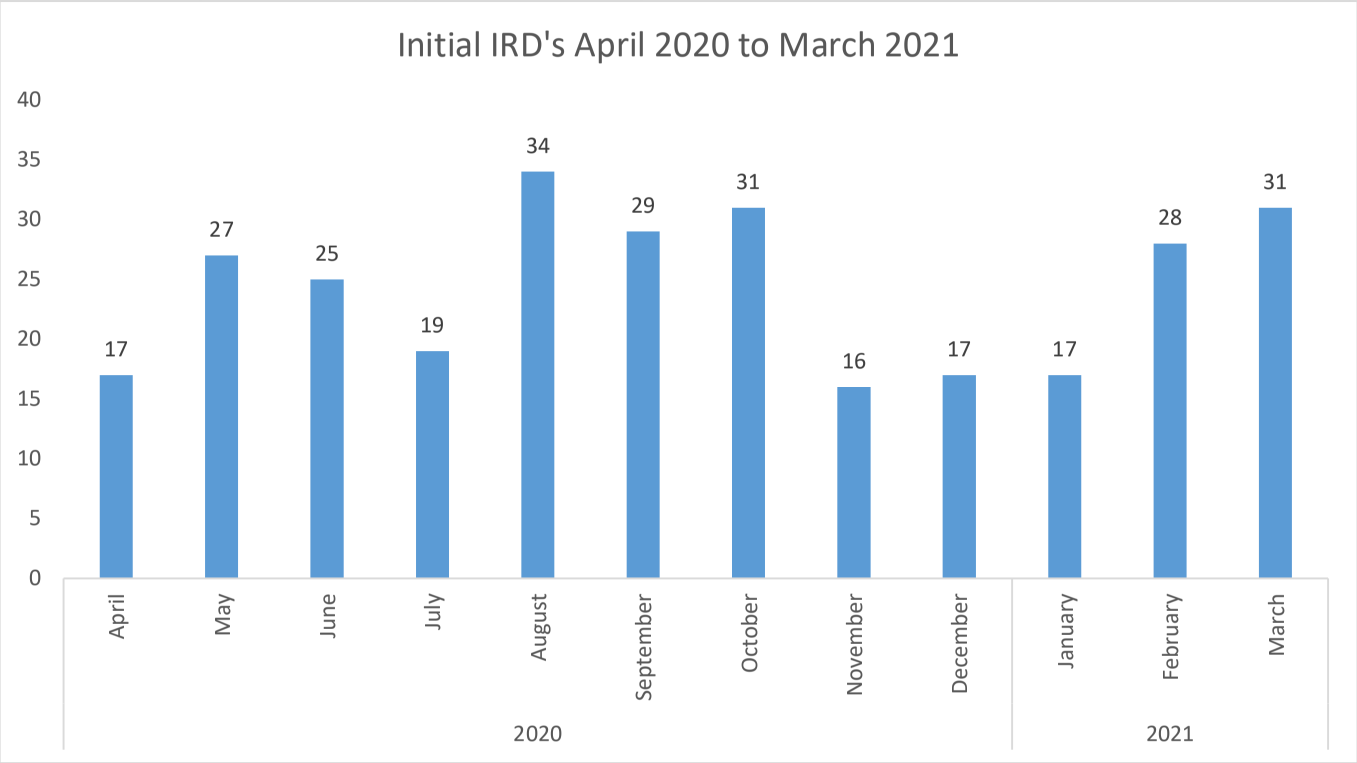
Initial referrals around Child Protection are made to the Request for Assistance Team (RFA). The chart below shows the referrals received by the RFA team for the last 2 years. Not all of these referrals will be assessed as child protection, nevertheless an increase in demand is apparent from October 2019 (pre-pandemic) and levels have, mostly, remained above the median (mid-point) value of 134 throughout the Covid-19 pandemic



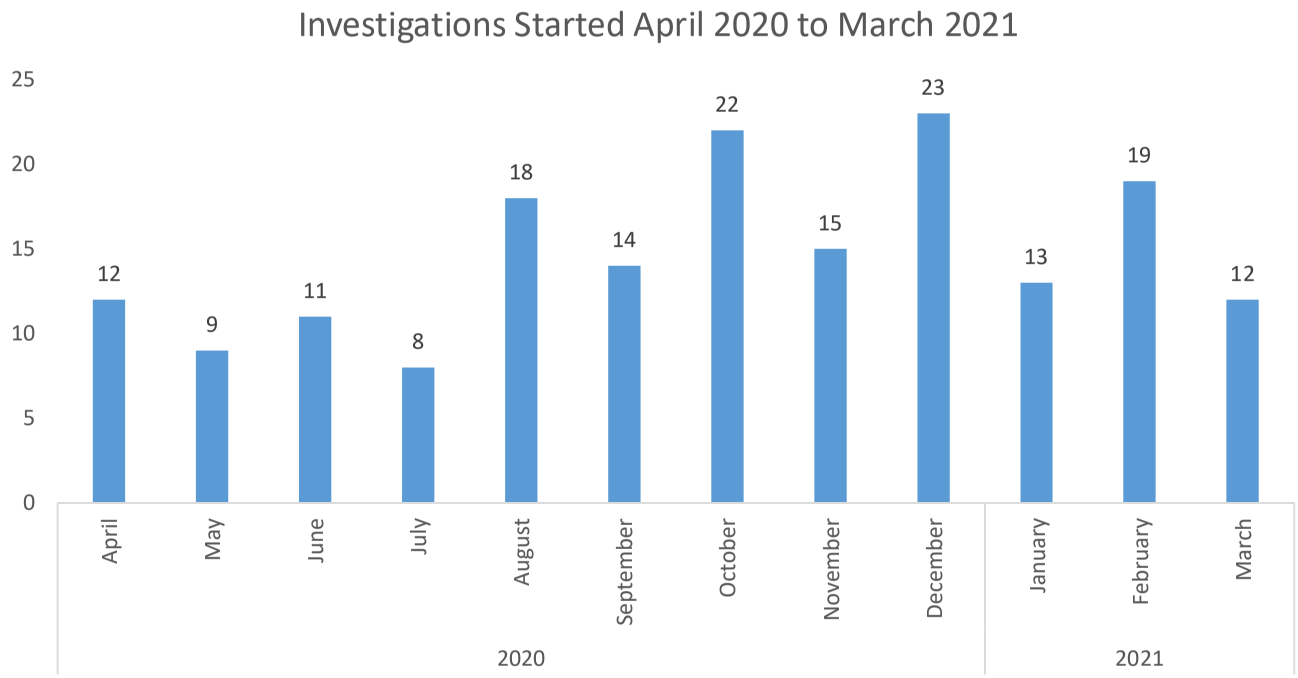
Interagency Referral Discussions

Interagency referral discussions are the meetings that take place between police, health and social work (with education and our third sector partners such as Barnardos, contributing to the discussion if they know the child(ren) in order to share information they hold. This helps assess the level of risk for the child and determines immediate actions, for example for police and social work to interview the child, or for social work to follow up on concerns as a single agency. From the chart below we can see a rise in IRD's post the two national lockdowns. This makes sense as lockdown often

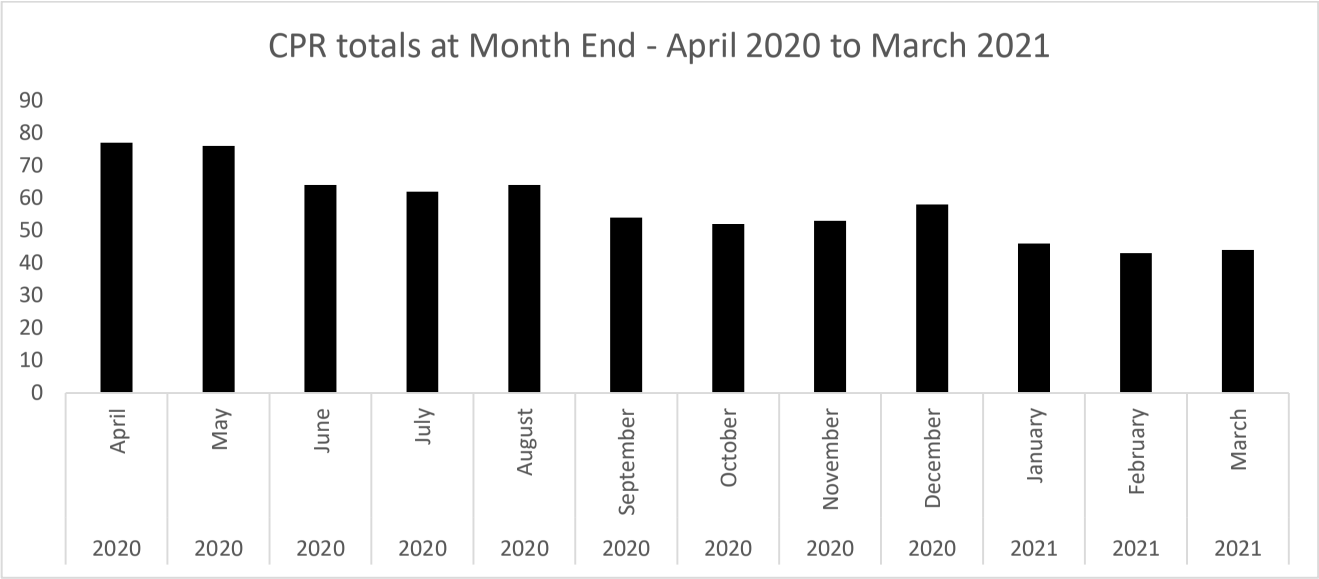
increased stress for families that would previously have been described as vulnerable. Children not previously deemed to be vulnerable would also not have been seen to the extent they normally would by education and our third sector colleagues during lockdown. As schools and nurseries returned to in person teaching so referrals to police and social services increased with a consequent increase in IRD's

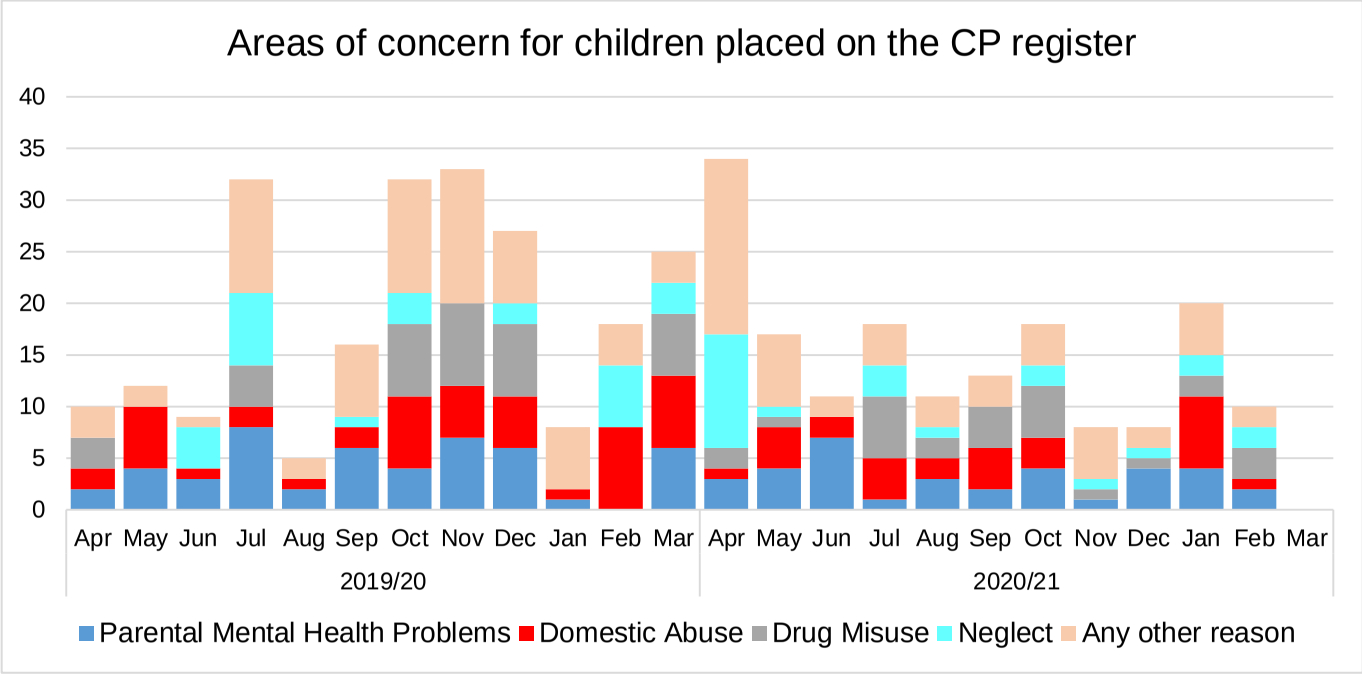


The increase in IRD's during the pandemic may also be a reflection of services taking a cautious approach to risk assessment where the usual lines of communication and information sharing might not have been so readily available (for example a social worker who knows the child and their family well might have been off with COVID-19, a school that would normally see a child daily and therefore be able to keep an eye on their wellbeing was closed). Where agreed as an outcome of an IRD, a child protection investigation is undertaken. This data is shown in the chart below



After an investigation a child may be placed on the child protection register; there are various reasons for this and sometimes multiple reasons are identified. The chart below highlights the main reasons for a child being added to the register. The child protection data provided should be considered in the context of COVID. In April 2020 during the first national lockdown a much higher than average number of children and young people were on the child protection register. This number remained high throughout most of 2020. The higher than average numbers, and the persistent nature of this can be in part explained by caution being applied by conference chairs in respect of stepping plans back from a child protection level whilst other multi-agency services were less available or less able to provide the usual level of support. One clear example would be children not attending school due to the national lockdown and therefore the ongoing assessment and support from the multi-agency team not being the same as pre-pandemic. The numbers do start to decrease as other services (some of which would have been impacted upon by redeployment of staff to the COVID effort) progressed through their recovery plans and were able to play a fuller role in child's plans. As can be seen from the data the numbers of children on the child protection register stabilised in the last quarter of the year.





'Any other reason' includes emotional abuse, physical abuse, sexual abuse, the child placing themselves at risk, alcohol abuse and non-engaging family.

Section 3:

What we've achieved in 2020-21

The planned activities and priorities for the Child Protection Committee were set out in its Business plan in April 2017 and built upon in the business plan of 2018-20. These plans were based on the functions and duties of a Child Protection Committee as set out in National Child Protection Guidance 2014. These have not changed since the publication of the National Guidance for Child Protection 2021 (published in June of this year) although the new guidance encourages a shift in the value base of child protection with more focus on the impact of poverty on familial vulnerability, and a more trauma informed approach to working with families who find it difficult to accept services within their lives. Inevitably, some of the work projected required to be redesigned due to the impact of the pandemic. However, Inverclyde CPC has continued to show creativity and innovation in the way it has responded to the constraints of two lockdowns and a shift to virtual working arrangements.

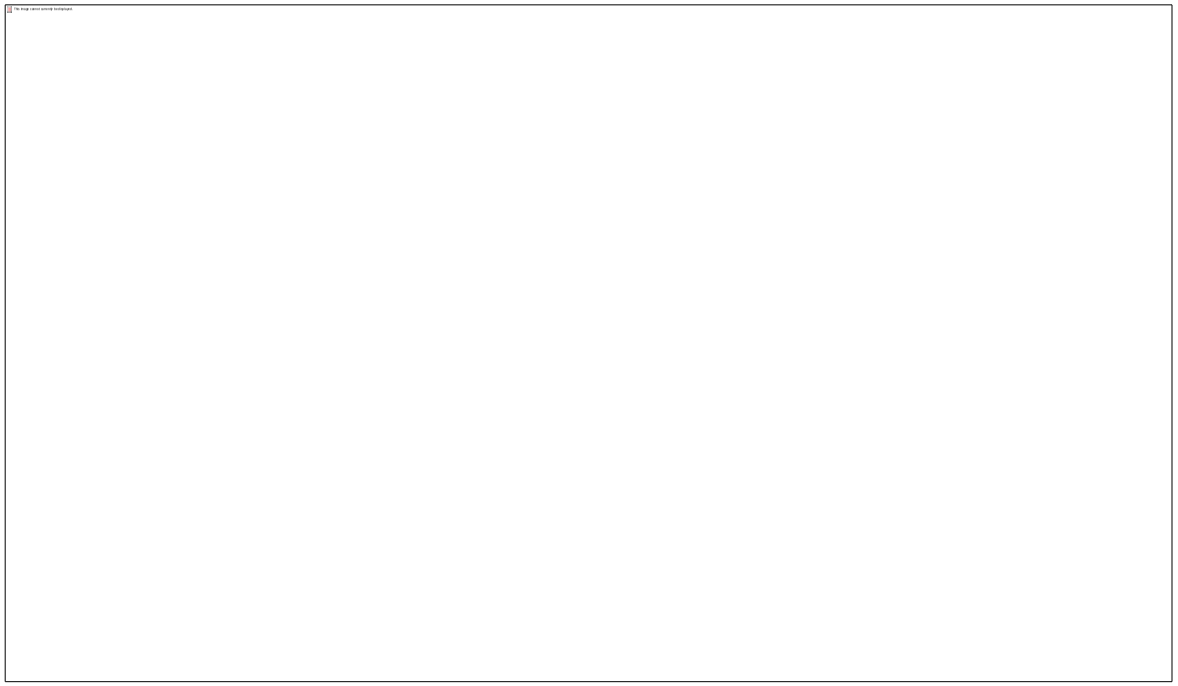
3.1 Public Information and Communication

Inverclyde CPC participated in the national **Eyes and Ears** campaign over the summer of 2020. This was intended to encourage family members and communities to keep an eye out for children who might be struggling or experiencing harm and a listening ear to their needs. This campaign was reissued over Christmas.

The campaign was succeeded in March 2021 by **keepingKidsSafeOnline**, a virtual poster campaign with information links for parents and carers encouraging them to check in on what their children are up to online. This was on the back of Police Scotland noting that there had been a 13.4% increase in reports of online abuse and exploitation since lockdown commenced.

Autumn 2020 was to see the launch of `Helping Hands' an Inverclyde specific campaign to promote access to early support for children and families in need. It was decided to delay this, however, in order to focus on the national rollout of the **Children (Equal Protection from Assault) (Scotland) Act 2019**. This act, known colloquially as the `smacking ban' removes the defence of 'reasonable chastisement', which a parent or carer could previously use to justify the use of physical force to discipline a child. The change in law necessitated a robust publicity campaign to ensure parents and carers were aware and our local early years services were particularly adept at communicating the change via parent packs despite the

limitations imposed by ongoing social distancing. New guidance was developed for practitioners and a series of online information events were offered to multiagency staff teams.



Inverclyde's Lead Officer for Child Protection joined the communications sub group of CPC Scotland in May 2021 and was party to the development of a more asset focused campaign over the summer of 2021 called **For kid's Sake…**which encouraged extended family and local communities to keep a benign eye on children over the summer holidays and offer a helping hand to parents.

A new and exciting development within CPC Scotland's sub group will encourage children and young people to become directly involved in the theming and co-production of future campaigns. Inverclyde's Lead Officer for Child Protection is encouraging Inverclyde's extremely active Champs and Little Champs, members of the Proud2Care network, to get involved and help shape the future of child protection communication.

CPC website

Improvements have been made to the website with existing information updated and a rolling news page regularly added to. New sections on `Interesting research' have been inserted and links to training have been made as user friendly as possible. It must be acknowledged that the website, now 13 years old, would benefit from an upgrade, however, and we look forward to a hoped for roll out of a more interactive virtual interface with our communities in time.

3.2 Continuous Improvement and self evaluation

Continuous improvement and self evaluation is undertaken on CPC's behalf by the Performance Management Sub Group. While undoubtedly the progression of work identified in 2019 was impacted by the pandemic, the PMG were meeting virtually by early June and have managed to complete a great detail of work over the past year as described below:-

Inverclyde National Minimum Dataset: The National Minimum Dataset encourages all CPC's to collate a national minimum of information with regard to data on child protection input and outcomes. CPC's are free to add other areas of data collection as they see fit. Inverclyde CPC has continued to collate data in order to assess performance and identify necessary areas of further audit. We are also contributing to the national conversation regarding the second iteration of the dataset which will be based on CPC's experiences of using it in practice.

CP file audit: Over the summer of 2020 a team of senior managers were able to undertake a file audit of child protection cases. This encompassed some 40 children and young people. Such a wide audit range means that we have now been able to collate data on patterns, themes and trends within child protection intervention. This has been particularly successful in relation to neglect however we are also looking at tailoring specific assessments in relation to children affected by domestic abuse and parental substance use. As a consequence, we are now able to tailor training and coaching on tools to aid assessment and intervention in a much more focused and strategic manner. Staged evaluation is built into this approach

with opportunities for social workers to revisit approaches with seniors and share best practice initiatives with peers. These are anticipated to have a positive impact on assessment, intervention and decision making which will in turn improve outcomes for children, young people and their families.

Analysis of 52 week reviews: 52 week reviews take place where a child's name has been on the Child Protection Register for over a year. These are inevitably some of our most complex and entrenched cases and it is deemed useful for a non-operational review team to revisit the case, review risk assessment, children's planning and review and identify there is anything else that could be done to reduce the risk of significant harm to the child including the provision of any other supports or services; whether an alternative plan should be considered at the next review and whether anything can be learnt from the way the case has been managed and services delivered during the period of registration. Over 2020 we saw a significant increase in the number of 52 week reviews, which is repeating itself in the first half of 2021. We surmise that this is an outcome of the COVID-19 pandemic but continue to keep a close eye on this. Findings from 52 week reviews are shared with the team around each child in order to note the positives in child protection care planning and identify any deficits.

Audit of stepdown planning: The early 2021 iteration of the National Minimum Dataset identified a need to audit transition plans for children. An audit is underway regarding children who come to ICPCC but are not registered. The audit is looking at reasons around this as well as the robustness of step down plans. A multi-agency audit is in the planning regarding step down from child protection to child in need with a further audit planned regarding step down from child in need to universal services. The purpose of these audits is to ensure that step down plans help reduce risk to children and prevent a subsequent escalation in concern. Any areas of improvement identified will be shared with multiagency operational services.

Initial Referral Discussion Quality Assurance group: This multiagency group which includes operational and non operational staff meets every two months and reviews 3-4 IRD's via a pre-determined quality assurance framework. This helps to promote consistency across teams and can identify any themes or issues before they become entrenched.

Inverclyde inspection improvement activity: Inverclyde has not been notified of an inspection but works on the basis that continuous improvement and self evaluation needs to be built into the framework of all activity. A plan in relation to Inspection question 1, `How good is the partnership at recognising and responding when children and young people need protection?' was reviewed in the light of audit activity across 2020 and that is in place or planned for the first half of 2021. This plan will be revisited and, if necessary, revised at each PMG.

All audit activity and improvement work within Inverclyde is carried out with reference to the **assess-plan-do-review** cycle in order to assess how well learning is embedded in practice. Inverclyde Performance Management Group has also taken heed of feedback from the 2017 inspection to ensure that any recommended improvements from audit activity continue to be supported and monitored even where we move onto other work.

Participation

Inverclyde's already strong focus on children and young people's participation showed no decline over the course of the pandemic with:-

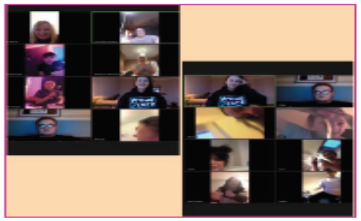
- Bespoke art boxes delivered to over 50 children

- Mental Health and Wellbeing boxes delivered to all members of the Champs group to encourage self-care – also sent to adult champs
- Took part in a virtual learning walk using FitBits we were able to provide to group members in partnership with corporate parents. The group walk a tour of Scotland and to Lorraine in France and back again – learning facts about each destination on route
- Took part in singing lessons and created a virtual Christmas concert, delivered cards/tea and biscuits to 27 residential care homes across Inverclyde for them to enjoy the concert
- Creation of Podcast – Care2Listen – young people are the podcasters interviewing people they have chosen
- Creation of a new Sports Club in partnership with CLD/Active Schools – Proud2BActive – members will receive free kit and resources to take home to continue to develop their new skills
- Creation of a new older group – Going4ward for young people involved in continuing care and through care service, helping to develop the service and create resources/ideas to support young people – this will include the creation of a cook book, a study group to support education/employment, a housewarming box and the group have already helped to develop new assessment paperwork
- Young people within residential have been supported to share their views on two areas concerning covid19 – this included their views on them and staff being tested for covid19 as well as their thoughts on family contact and ways to keep them and others safe

COVID-19: RESPONSE

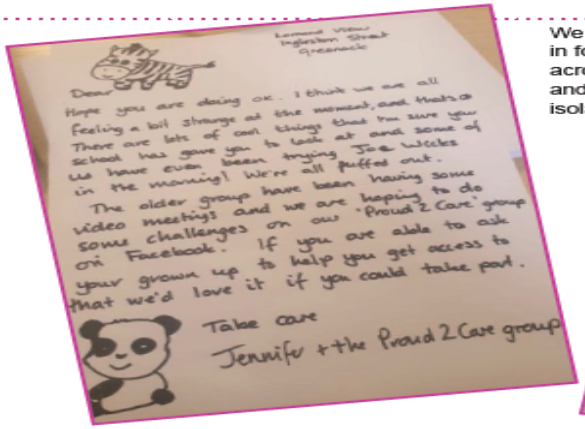
Physically distanced BUT Socially connected!

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.

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In terms of the child protection arena, anecdotal evidence was that many parents were preferring the move to virtual case conferences and core groups, since the former, in particular, were experienced by some parents (despite attempts by chairs to render them supportive) as still quite intimidating and alienating. The Child Protection Lead Officer tried to capture parental views initially via Survey Monkey and when this failed to elicit much response, via writing to parents on an individual basis inviting them to comment. This method also elicited only a minimal response and it was decided to ask case conference chairs to link in with parents post meeting regarding their views. With the country beginning to open up post the second lockdown, the Lead Officer is now hoping to be able to meet with parents either virtually or in person and gain their views on not only child protection case conferences, child protection procedures and protocols in general. This is with the hope of eventually moving to an environment where there is more co-production between services and families.

Policies, procedures, protocols and guidance

Inverclyde Child Protection Committee continues to guide and supportconstituent services and agencies to ensure that they have their own child protection policies, procedures and guidelines in place and promote their continued development around existing and emerging child protection issues.

Evidence based, up to date published procedures and guidance are available via the CPC website and these are reviewed on a regular cycle. As a result staff feel supported to deliver high quality services and children young people and their families receive a consistent service based on good practice. The suite of guidance documents is revised and updated in line with an approved schedule and emerging local and national themes. This year we have seen new guidance devised in relation to the Children (Equal Protection from Assault) (Scotland) Act 2019 (see p. 24) and we are currently working on updating guidance on Significant Case Reviews to coordinate with the shift to a Learning Review focus. We also need to update all existing policy and procedures to ensure they reflect the 2021 National Guidance for Child Protection.

Learning and Development

COVID-19 has had a significant impact on delivery of training to staff. Indeed, in the first few months of the pandemic CPC were unable to deliver any training. (fortunately, February and early March 2020 had seen delivery of both the 5 day Child Protection Course for enhanced practitioners and Children Affected by parental substance misuse training to multiagency teams). Within months, however, our training sub group was up and running virtually and we spent the following months converting in person training to a virtual format. In early 2021 we commenced training in:

The Assessment of Care: Formerly known as the Neglect Toolkit, we have so far delivered 5 sessions to 41 members of staff from social work, health and community learning and development. A twilight session has taken place for education staff. A recent evaluation session noted that the training has increased awareness of the impact of neglect though practitioners have struggled to use the toolkit with families given lockdown restrictions.

Neglect training for the general workforce: A virtual programme is complete and ready to deliver to relevant agencies.

Child Protection Awareness for the general workforce: This has been adapted to a virtual format and is now being delivered to a range of services

Children (Equal Protection from Assault) Act 2019: 2 briefing sessions were arranged in relation to the act, supported by representatives from Police, Scotland, Social Work, Health and Barnardos. This included a question and answer session which enabled staff to participate and ask questions about the act in relation to different scenarios that might come up.

Scottish Drugs Forum: Everyone has a story, an account of the impact of problematic substance use on children and young people was delivered virtually to a multiagency staff team.

Five to Thrive training: Barnardos translated this into a virtual format for delivery to the Newly Qualified Social Workers and other interested practitioners.

Child sexual exploitation: As well as delivering training concerned with the identification of CSE, we are currently in the process of developing training that looks at CSE within a wider context of exploitation and which offers practitioners ideas for intervening to reduce risk of harm

As the country reopens and we move towards COVID level 0, we are planning to return to face to face training with regard to Child Sexual Abuse and delivery of the 5 day Child Protection awareness course. These courses are delivered via an independent trainer whom we commission for the purpose. While we recognise the advantages of virtual training in terms of boosting attendance (in that practitioners find it easier to take an hour or two outside their working day to attend virtual training rather than having to add travel time) we recognise that some areas of child protection are not so suitable to a virtual format and that there is no substitute for in person contact in these moments.

All training is conducted with reference to the **assess-plan- do-review** cycle which means we revisit it with participants at regular intervals in order to assess how well learning is embedded in practice

The CPC Lead Officer also works with the West of Scotland Learning and Development group to develop and share training materials across the region. Currently we are working on an e-learning tool to support communication with children and young people.

3.3 Sub groups

3.3.1 Whole Family Sub group

A change of name has been agreed in 2021, moving away from Children Affected by Parental Substance Misuse. The name change is felt to be more in line with a Rights, Respect, Recovery focus. It also recognises that children and young people may also be impacted by their own alcohol and drug use, or those of their peers, as well as via family members.

A whole family approach to alcohol and drugs is promoted by Inverclyde HSCP and the group embraces this approach. In this we are supported by our colleagues at Barnardos and Scottish Families Affected by Alcohol and Drugs, both of whom undertake valuable partnership work with Inverclyde families.

Collation of accurate data across the different services represented in the group is an ongoing challenge but one which we need to tackle with regular updating of information. This is so we can be confident that we know how many families are affected by alcohol and drugs, and be sure that the services in place to support them are aware of them, and able to make a difference.

Training also remains a key function of the group which, like other areas, has had to adapt to delivering virtual training within the pandemic. Everyone has a Story, training delivered by Scottish Drugs Forum is about identifying the impact of problematic parental drug use from children's perspective. This training is followed up by The Story Continues. Training in the identification and support for children with a diagnosis of Foetal Alcohol Spectrum Disorder is also planned.

3.3.2. Children affected by domestic abuse

The Child Protection Lead Officer is a member of Inverclyde's Violence Against Women network and reports to CPC on initiatives in relation to gender based violence. The COVID-19 pandemic, in particular the first and second lockdowns were feared to be creating conditions that might have increased risk for those already experiencing domestic abuse. Isolation from family, friends, and employment; opportunities for constant surveillance of a victim; restrictions on access to the outside world; are all exacerbated by lockdown conditions and there is often no escape or respite for victims and their children outside of the home. The 'Stay home, stay safe' message does not work if a person has never been safe in their home. For people trapped at home with abusive partners, lockdown has been incredibly dangerous and has increased the risk of homicide, serious harm and coercive control. The changing situation as restrictions are eased also increased risk for victims as perpetrators are threatened by a loss of control resulting in an increase in abusive behaviour. While these are challenging times for services, help is available for people who are experiencing domestic abuse at the hands of a partner or ex-partner. Some of the national and local initiatives Inverclyde VAW network has been involved in are detailed below.

Domestic Abuse (Scotland) Act 2018. Since April 2019 perpetrators of domestic Abuse can be prosecuted for abusing their partners/ex-partners**.** Domestic Abuse is recognised as consisting of a range of behaviours that undermine the victim and restrict their freedoms that is more than physical or sexual harm. Coercive Controlling Behaviours have a long lasting effect on both the adult victim and children. Until now this has not been reflected in criminal law in Scotland. It now recognises that domestic abuse frequently involves patterns of repeated and often long term abuse including psychological abuse and coercive controlling behaviour and the cumulative impact of such behaviour on victims.

Disclosure Scheme for Domestic Abuse Scotland (DSDAS). If you have concerns about a person who you suspect may be at risk of domestic abuse at the hands of a current partner, you can raise your concerns through the 'Disclosure Scheme for Domestic Abuse Scotland' (DSDAS**).** This process can be utilised by anyone who has concerns about a person who they suspect may be at risk of domestic abuse at the hands of a current partner. Applications can be made by agencies, a concerned friend, neighbour, family member or indeed the person who is in the relationship. If applications are approved the person potentially at risk is visited by Police. At this point they are told that the individual they are in a relationship with has a history of domestic abuse with a previous partner/partners and the Police believe that if they continue in the relationship they will be at risk.

Ask for ANI ANI (**A**ction **N**eeded **I**mmediately) is a codeword scheme developed by the Home Office to provide a discreet way for victims of domestic abuse to signal that they need emergency help from the safety of their local pharmacy. Victims of domestic abuse are able to use the codeword in Boots Stores in Greenock and Port Glasgow to let staff know that they require an emergency Police response or help contacting a helpline or specialist support service. Participating pharmacies will display posters in their window and around the pharmacy to let customers know that they can approach their staff to seek help. Any information shared is treated confidentially.

Up2U Although work was temporarily delayed during the first lockdown with approaches needing to be developed within a virtual format, UP2U remains a key service for intervening in domestic abuse environments where harm can be reduced by focusing on healthy relationships and communication

Multiagency Risk Assessment Conferences (MARAC) MARAC's are held monthly and are chaired by Police Scotland with representatives from all social work, health, education and the third sector all of whom bring situations of concern to the table for assessment and mitigation of risk.

The Violence against women action plan is available for downloading here.

3.3.3. Children affected by neglect

Neglect is one of the most damaging childhood experiences and is associated with some of the poorest behavioural, emotional and cognitive outcomes. These affect life chances and contribute significantly to widening social, economic and health inequalities. The negative effects of child neglect ripple throughout society with high social and economic costs. The National Guidance for Child Protection 2021 describes neglect as: *'…the persistent failure to meet a child's basic physical and/or psychological needs, which is likely to result in the serious impairment of the child's health or development. There can also be single instances of neglectful behaviour that cause significant harm. Neglect can arise in the context of systemic stresses such as poverty and is an indicator of both support and protection needs.'* (1.43 National Guidance for Child Protection 2021)

The definition reflects wider research that a child may experience neglect through a failure to meet medical, nutritional, emotional, educational and physical needs and a lack of supervision and guidance. The impact of neglect is also felt across the age range from pre-birth if a mother's neglect of her own health during pregnancy can affect the development in the womb to infancy, pre-school, primary age to adolescence. The impact can manifest in different ways reflecting the different ages and stages of children through to young adults in terms of their relationships and their own health and wellbeing.

A further challenge is that different people - whether children, families or professionals may have different views on what it means to be neglected - and may have different views about which services need to be involved. The intergenerational nature of neglect in some families and the impact of living with poverty combined with the range of circumstances of children and young people who may be living with neglect can mean that sometimes practitioners feel stuck or become 'desensitised', normalising what they see or grappling with 'what's good enough'.

Research by Featherstone and Morris concluded that poverty is a contributory causal factor in child abuse and neglect and being poor significantly increases a child's chances of becoming looked after or subject to child protection registration. In Scotland, children living in more deprived neighbourhoods were nearly 20 times more likely to be looked after or on the Child Protection Register than those living in least deprived areas.

Not all parents who live in poverty neglect their children of course. However, living in poverty may undermine parents' ability to look after their children as it impacts on where they live, living conditions and availability of food. It can also impact on family relationships and parents' ability to function through increased levels of stress and anxiety. Parents often feel shame for not being able to provide for their families and live in deprived neighbourhoods with high unemployment and limited local resources. Services can reinforce the shame through their actions and inactions, e.g. not providing bus fares or making procedures for recovering bus fare money very bureaucratic. Poverty is a feature of everyday life and persistent poverty can contribute to an ongoing cycle of intergenerational trauma, which is hard to break.

Parents of neglected children can be some of the most economically and socially deprived adults, and neglected children are at risk of growing up to be amongst the poorest in society, with increased likelihood of poor health and wellbeing. Research has identified the range of factors present in the lives of children who may be experiencing neglect: parental risk factors of drug and alcohol use, domestic abuse, and mental ill-health; parental experiences of childhood abuse and neglect; and wider environmental issues such as poverty, homelessness and large family size. Living with any number of these factors does not mean a child is being neglected, however, the more factors present in a child's life increases the likelihood of neglect. Moreover, it is these families who may depend more on public services than other families, and their children are likely to be more affected by cuts to provision.

Children who live with neglect, and are exposed to parental substance misuse and/or witness or experience domestic violence suffer lifelong consequences. The longer such experiences persist may have a detrimental impact on a child's mental health. Studies have shown strong associations between all forms of maltreatment in childhood and a range of poorer child outcomes including depression, anxiety, post-traumatic stress, suicide, self-injury, severe and persistent behavioural problems, school failure, increased risk taking i.e. use of drugs and alcohol, sexual exploitation and crime. As the impact of neglect on children is often accumulative and gradual, it is important that all agencies identify emerging problems and potential unmet needs and seek to address these as early as possible. It is equally important that practitioners are alert to the danger of drift and 'start again' syndrome.

Neglect features as a category of concern on Inverclyde's Child Protection Register in its own right. However, it is also often a secondary feature in other categories of concern such as parental alcohol and drug dependence, domestic abuse or parental mental ill health. Its impact is corrosive, sapping resilience from children and their families. Early and effective intervention in cases of neglect has been the aim of Inverclyde for a number of years and was previously focused around the Addressing Neglect Enhancing Wellbeing programme (see annual report 2018-20). Research has shown that working alongside and in partnership with families to identify neglect and improve children's home situations, is an effective way of addressing neglect. In 1997 a group of community paediatricians led by Dr O P Srivastava, developed a practice tool for measuring the quality of a parent's commitment to meeting their child(ren)'s needs. The Graded Care Profile was subsequently developed by Barnardos and Glasgow Council in the Assessment of Care Toolkit and is now used in many Local Authorities to assess and mitigate the impact of neglect.

Assessment of Care.PDF

The Assessment of Care toolkit, which is attached above, divides care into three areas, physical, safety, love and esteem. These are then divided into additional sub areas of care. A traffic light system is used to grade care from 1 meaning a good standard of care is evident to 5, where care is so poor as to require intervention from child protection services. The toolkit is designed for partnership working with parents where a trusted professional, be this a social worker, health visitor, nursery lead or community support worker, works with the parent(s) to grade the care they currently offer their children and, where there is a deficit, to agree a plan of improvement. Having used the toolkit in my own professional practice, I can say that one of its advantages is that it can help to promote parents' self-esteem and confidence, for example where they are meeting their child(ren)'s needs and scoring 1s and 2s, whilst also offering them concrete examples of where they could improve their family's situations. For example, a parent might score highly on praise and reward in the love and esteem section but recognise that they need to improve on their capacity to keep their children safe from physical harm, for example by ensuring that a lock is secured on a back door to prevent their 4 year old running out into the street. Where neglect is intergenerational and a parent might be well intentioned but simply not understand what it is their children need in terms of physical or emotional security (because they never experienced this as children themselves) then the toolkit provides practical examples of what they can do to meet their children's needs.

Assessment Toolkit Action Points - Q's.do

Adapted toolkit developed by one of our social workers. This can be adapted to the needs of individual families and uses language that is family friendly.

During 2020-21 Inverclyde CPC has translated training around the identification and assessment of neglect into a virtual format and delivered this training to multiagency teams of health visitors, social workers, school nurses, teachers and our Barnardos colleagues. Built into this training are periodic catch up sessions to assess how well this training has embedded and whether it is helping lead to early identification of neglect and earlier mitigation of its harms. Increased understanding of neglect is also fundamental to our GIRFEC work streams (see p. 14) and the training sits

alongside training delivered to the general workforce (housing officers, tradespeople attending at people's homes, leisure staff) who may be the first to spot early evidence of child neglect within the community. As a persistent and corrosive harm, neglect will continue to be the focus of child protection committee business into 2022 and beyond.

3.3.4. Children affected by their own and parental/family mental ill health

Inverclyde is one of the most deprived areas in Scotland. Research shows that individuals in the most deprived areas are almost twice as likely as those in the least deprived areas to experience childhood adversity. Research informs us that multiple childhood adverse experiences can significantly increase an individual's likelihood of developing some chronic illnesses, enduring mental illness, experiencing incarceration and drug/ alcohol dependencies. It has been also been recognised that Covid 19 and the factors brought on by the pandemic such as unemployment, increased domestic abuse, social isolation, food and housing insecurity, bereavement and prolonged periods of lockdown may exacerbate current childhood adversity.

ACES research should be utilised alongside many other sources of evidence demonstrating how early adversity affects later outcomes. Intervention and trauma informed systems are part of a whole systems response however the focus should remain on the primary prevention of the causes of childhood adversity. This crucially necessitates supporting adults and communities and not seeing children in isolation from their environments.

Inverclyde CPC recognises the importance of continuing with a focus on developing a trauma informed workforce. There is growing evidence that 'trauma informed' systems and practice, where the impact of childhood adversity on those affected is understood by staff, can result in better outcomes for those affected. The application of trauma informed care reduces the distress caused by engagement with services, enhances good care and reduces the risk of re- traumatisation. This work is being led via the Inverclyde strategic children's partnership and the CPC are closely aligned with this work

We need to focus on promoting good mental health as well as responding to distress. By developing accessible mental health supports and a trauma informed children's services workforce we can ensure that everyone involved in the lives of children knows that their primary purpose is to develop patient, kind, trusting and respectful relationships with children and their families. We aim to address the specific barriers for those who have experienced adversity, meaning they can receive positive help and support when needed by experiencing nurturing care giving relationships, education, supportive social networks and communities.

3.3.5. Child sexual exploitation

The CSE sub group is considering a change of name in order to embrace a wider understanding of child exploitation, for example encompassing child criminal and commercial exploitation and child trafficking. In practice we often find that a number of different vulnerabilities may be present in children's lives and that it is not always possible to or useful to consider them separately. Online sexual exploitation of children and young people has increased exponentially over the pandemic and this is another area that the sub group intends to prioritise in upcoming work.

CSE training: It was agreed that while there is a need to continue to train in relation to help practitioners identify CSE, there is also a need to develop training in support and intervention. A small working group will be identified to develop the CSE support and intervention training.

Police information sharing protocol: The purpose of the Police information sharing protocol is to gather and share information within the community around CSE. This will help build intelligence around CSE.

Innovation during COVID

Changes to ways of working: Weeks into the pandemic Children's Planning Meetings moved to phone conferencing. Anecdotal feedback from some families is that they prefer this mode of interaction. However, not all are in favour with some families, and certainly many practitioners missing the opportunity to provide support face to face. In person support to our most vulnerable children and families actually increased during lockdown, with social workers and other support services visiting children at home (with the support of Personal Protective Equipment) or in their gardens. Texting, Whatsapp and phone calls were also employed to keep in touch. Some older children and young people have also indicated that they like the shift to a more virtual mode of communicating with their social worker and feel more comfortable communicating by text.. It is likely that a mix of communication platforms will be the legacy of the COVID-19 era, and that is the increased opportunities of communication within a blended approach that is giving added value.

A long pursued move to paperless meeting via Object Connect has been achieved by our Adoption and permanence panel. This not only minimises likelihood of data breaches but is a significant way of cutting down on environmental waste. Hopefully this will be extended to child protection paperwork at a later date.

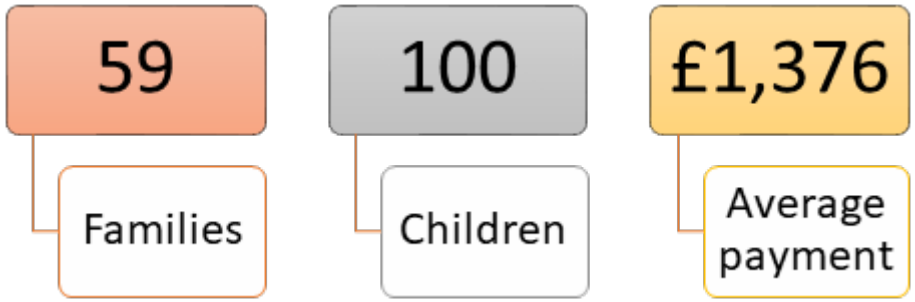
Barnahus/North Strathclyde Joint Interview and Investigation Cadre: This initiative, involving Inverclyde, East Renfrewshire, East Dunbartonshire, Renfrewshire, Police Division G and K and Children's 1st preceded COVID and was initially delayed by the onset of the pandemic, however is now up and running. It's aims are to ensure that interviews of children are conducted in an trauma informed manner; that children and their non-abusing care giver will have access to support and advice throughout the JII process with an opportunity to express their views, needs and concerns to inform a best evidence approach; that all interviews take place in a safe child friendly, age appropriate way that gives consideration to any developmental or additional needs; and that all children and their families will receive the practical and emotional support they require to recover. The project is in the process of purchasing a Barnahus, renamed in Scotland as a Bairns hoos, where children can be supported by a range of services in a single location. This will follow a Scandinavian model for supporting children and young people who are victims of abuse and aims to provide seamless support through investigation, interview and recovery.

Winter fund for Social Protection: In 2020, The Scottish Government allocated £22,000,000 in grant funding to local authorities as part of the winter plan for social protection and for the first time parts of this resource were earmarked to support Vulnerable Children & Young People. The grant was targeted to address the pressures around residential care for children and young people as a result of COVID-19, to address the extra social work demands posed by children's hearings recovery plans and to support services for vulnerable children and young people. The funds were distributed

per SIMD indicators and Inverclyde was allocated £387,686. £80,052 was allocated to residential care, £179,808 for the children's hearings recovery impact and £127,826 for vulnerable children and young people.

Following an exploration of needs the service has utilised the funds apportioned to residential care to ensure continuity of care within our residential services. As our children's houses are above capacity there are significant additional staffing and overtime costs and this grant will ease some of the budgets pressures upon this service. The service has utilised the further funds to directly benefit disadvantaged children, young people and their families, kinship carers and foster carers in the provision of direct aid and support. The funds have provided additional scaffolding for families to significantly improve their child's wellbeing outcomes and prevent a situation at home deteriorating. Some funds have also been used to stabilise kinship and foster placements, reducing placement breakdown which will reduce the likelihood of a child becoming accommodated and divert cases from the hearing system. As part of recovery funding made available during the Covid-19 pandemic, children' services were able to provide significant financial support to families most affected by poverty. It was observed that the Covid-19 pandemic was having a greater impact on vulnerable families and limiting the choices and options they had to adapt to national lockdown. Social work staff applied for payments for identified families that reflected their situation and the most impactful way to support them. Underpinning all of this was personal choice and using a model comparable to self-directed support to promote choice and to fully enshrine the families as the expert in their own needs.

A further area of work within this fund was to look at some aspects of poverty related neglect, in particular the physical environment in which many families live and often do not have their own financial means to make sustained changes. Whilst the average payment was around £1300 some families received significantly more allowing for large scale improvements to home environments for children and young people, promoting self-esteem, pride and overall safer living environments.



A shift to virtual training platforms: an immediate consequence of the pandemic, the shift has led to greater uptake of and attendance at training (see section on learning below). We do recognise that there are some challenges to delivering training via a virtual format, however, and look forward to a return to socially distanced training in some of our more challenging child protection subject areas in the hopefully not too distant future.

Inverclyde Newly Qualified Social Workers Academy: On the back of recruitment of a larger number of newly qualified social workers within children and families we have established the NQSW Academy which offers social workers access to regular coaching, subject specific workshops and up to date training. This will build knowledge and resilience in our workforce, forging the experienced practitioners of the future. Inverclyde HSCP has recently learned that we have been successful in receiving money from the Scottish Social Services Council to expand our academy to other social work sectors.

Pandemic recovery plan: The COVID-19 pandemic is of course far from over. However, with the initial crisis response of March-June 2020 being replaced by a move to the so called new normal of COVID-19 management throughout the rest of 2020, our thoughts in early 2021 began to turn to notions of COVID-19 recovery planning. These have included:-

A Council wide emphasis on health and wellbeing for staff. This incorporates the `three pillars' of health and wellbeing, covering mental, physical and financial wellbeing and includes a wide range of helping initiatives.

Children and Families Social Work Services have implemented a range of helping sessions for social work practitioners to promote health and wellbeing including mindfulness sessions and sessions on managing workplace stress and anxiety

Children and Families Social Work Services are also mindful of the impact of the pandemic on families who have experienced bereavement, as well as those families who have been placed at greater risk during lockdowns from domestic abuse and parental substance use, with support targeted at these areas where we have seen an increase in need. Children's services, alongside their partners, have also continued to support children living in neglect, and to work in partnership with families to address the conditions that lead to neglect.

Education Services have renewed their focus on supporting children and young people's health and wellbeing via their roll out of trauma informed practice to their staff meaning that children, young people and their families will consistently experience nurturing, compassionate and respectful relationships when engaging with services. Improving mental health and wellbeing is a priority area within the Children's Services plan with a commitment to offering community based support, education about healthy coping strategies, increased participation and co-production in the design, re-design and evaluation of health supports and services. As part of this plan Action for Children were commissioned to provide support to children and young people who have seen a deterioration in their mental health and wellbeing.

Midwives, Health visitors and Family Nurse Practitioners have maintained close contact with new parents throughout the pandemic and continue to reassure those with new borns and toddlers, who have spent much of their initial development within an environment where opportunities to experience life beyond their family bubble, that they will progress and develop. The National Health Service as a whole is of course continuing to manage high numbers of COVID-19 infections with a back log of other work and it is expected that recovery will be a matter of years not months.

The Courts are also grappling with a significant backlog of cases which is having a real impact on children who are witnesses in, for example, domestic abuse cases with victims services such as ASSIST taking on extra staff to support families to engage with justice services.

Inverclyde and the national picture

The National Child Protection Improvement Programme (CPIP)

The CPIP was set up in 2016 to make improvements in Scotland's Child Protections systems following the Brock report and the Care Inspectorate's Triennial review. The review identified 9 areas for improvement including neglect, child sexual exploitation, trafficking, data and evidence, systems, children's hearings, leadership and workforce development, inspections and internet safety.

Inverclyde CPC has embraced the opportunities offered by the CPIP. We are addressing the corrosive effects of neglect on children and young people via improved multiagency working and early and effective intervention. We have embedded learning via the National Minimum Data Set into our regular audit processes. The second iteration of the Barnahus/JIIT initiative (the project commenced in North and South Lanarkshire and has now moved onto Dumfries and Galloway) is well embedded as reported above. We are progressing with our understanding of CSE in terms of a wider concept of harm embracing a better understanding of community safety, and links between CSE, criminal exploitation of children and young people and trafficking. Finally we have adopted the National Learning Review as our guidance to approaching Significant Case Reviews (see below)

National Guidance for Child Protection 2021

The National Guidance for Child Protection was published in September 2021. This was almost a year on from the initial publication date which was delayed by the pandemic. The guidance sees a real change in values as far greater emphasis has been put on children's rights, a whole family and trauma informed approach from helping services, and turning the notion of parental resistance on its head to ask, what is it about our own systems that impede parents in being the best parents they can be. It is a much larger document than the 2014 guidance and is designed to be used on a virtual platform where practitioners are able to zoom into the area of guidance they wish to consult. Virtual links are also offered to up to date research and best practice. A delivery plan is underway to cascade training in the new guidance alongside a national update to local guidance, policies and procedures.

National Learning Review

As part of the National Child Protection Improvement Programme it was decided to embed a much more learning focused approach to investigations we undertake if things go wrong. The National Learning Review, published in September alongside the National Guidance for Child Protection illustrates this approach and is in the process of being adopted by CPC's within Scotland.

National Hub for Reviewing and Learning from the Deaths of Children and Young People

This is a Scottish Government initiative to help ensure that the death of every child and young person within Scotland is investigated and that, if there are lessons to be learned, these are shared locally and then nationally. Inverclyde are full participants in the Glasgow and Greater Clyde hub regarding this initiative.

Contextual safeguarding

Contextual safeguarding is an approach to understanding, and responding to, young people's experience of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse, for example, a park where young people gather that is targeted by adults for criminal exploitation. Therefore children's social care practitioners, child protection systems and wider safeguarding partners need to engage with this wider context in order to protect children. Inverclyde have begun to use the framework of contextual safeguarding in relation to episodes of community violence. We are keen to progress use of the approach in other areas of extra-familial harm.

Incorporation of the United Nations Convention on the Rights of the Child

Scotland is the first nation within the UK to incorporate the UNCRC and as such has brought children's rights into the centre of Government.

The Promise

The Independent Care Review published its findings in February 2020 and in Inverclyde we very much welcome its focus on community based intensive family support as this is a model we espouse and try to practice. Its policy of early and effective intervention also links in with our commitment to GIRFEC within Children's Services planning and CPC. Work is ongoing via our Children's Planning and Corporate Parenting structures to integrate the values of The Promise in every area of our work via the I Promise initiative.

Developing a trauma informed workforce

The Children's Service Partnership recognises the importance of continuing with a focus on developing a trauma informed workforce in the evaluation of the children service plan 2017-2020. There is growing evidence that 'trauma informed' systems and practice, where the impact of childhood adversity on those affected is understood by staff, can result in better outcomes for those affected. The application of trauma informed care reduces the distress caused by engagement with services, enhances good care and reduces the risk of re- traumatisation. We need to focus on promoting good mental health as well as responding to distress. By developing accessible mental health supports and a trauma informed children's services workforce we can ensure that everyone involved in the lives of children knows that their primary purpose is to develop patient, kind, trusting and respectful relationships with children and their families. We aim to address the specific barriers for those who have experienced adversity,

meaning they can receive positive help and support when needed by experiencing nurturing care giving relationships, education, supportive social networks and communities.

3.5. The next twelve months: in summary

Performance management group

The Performance Management Subgroup will continue the work described under continuous improvement and self-evaluation, seeking to better understand what the child protection performance data tells us and, via audit and training and coaching, support practitioners to continue to improve outcomes for children and their families.

Training group

The training sub group will continue to develop training on both a virtual and in person basis that is responsive to the needs of practitioners. Via the CPC Lead Officer there is also a direct link to West of Scotland and the National Training and Development Group to ensure we are always up to date with best practice. 2021-22 will see an enormous amount of work directed towards promoting the updated National Guidance for Child Protection and incorporation of the United Nations Convention on the Rights of the Child.

Children affected by domestic abuse

Work will continue via the Violence Against Women network to improve outcomes for children affected by domestic abuse. See the Violence against women action plan embedded here for further information

VAW Action Plan 2021-2022.docx

Whole Family Sub Group

Service mapping and the collation of more accurate data over the next year will ensure that we are targeting the right areas in terms of support, thus improving outcomes for children and young people. A robust training plan will ensure that our practitioners across all services are confident in applying the most up to date research and approaches to whole family support.

Children affected by neglect

2021-2 will see us building on the work we have already undertaken in relation to neglect and ensuring that this has been truly embedded in the Inverclyde workforce with a consequent reduction in cases.

Children affected by mental ill health

This is an area of development for 2021-23 with a whole family approach to mental health ensuring that we are targeting support where it is needed and supporting families to develop resilience and helpful strategies in their pursuit of positive mental wellbeing and health.

Children affected by CSE

The focus for the next year will be on expanding the understanding of exploitation to include criminal and trafficking, alongside developing training which supports interventionary strategies rather than simply focusing on identification. We also expect to incorporate a more sophisticated understanding of the importance of contextual safeguarding in our approaches.

Participation and communication

This is also an area for development with new approaches to encourage children and their families to help shape service provision and co-produce a child protection strategy which embodies and embeds the values of The Promise.

Playing our part in the COVID-19 recovery plan for children and young people

Inverclyde CPC will continue to link into, and produce our own, best practice to ensure that children and young people are supported during the post pandemic period with regard to mental health and well being, anti-poverty initiatives and ongoing support in relation to past trauma.

Section 4 – Forward Planning

Outcomes Framework 2021-2022

The main functions of the Child Protection Committee are ***Continuous Improvement (CI), Strategic Planning (SP) and Public Information and Communication (PI&C).***

ICPC Outcomes

1. **Children and young people are safe and protected from harm.**
2. **Children and young people affected by parental mental health, substance misuse, neglect and domestic abuse experience lower levels of risk.**
3. **The workforce that supports children and young people are well trained, motivated and feel valued.**
4. **Children and young people's lives are improved by effective multi-agency practice.**
5. **Children and young people are belter protected through ICPC's links to other multiagency planning partnerships and structures.**
6. **Children and young people's voices are evident in policy**
7. **Children, young people and families know where to go for help**

R.A.G. Status (copy and paste)

 **Red : Not commenced**  **Amber: Underway expected to meet timescale**  **Green : Completed**

Outcome Reference	ICPC Function	Development Area	Actions	Impact	Who is Responsible	Timescale
1	CI	Services take effective action to make children and young people safer. **Wellbeing Outcome : Safe**	Findings of multiagency QA activity in relation to early and effective intervention to be collated and presented to CPC, including early assessment of need and risk	Children are helped at an early stage, reducing risk of harm to them	Joint GIRFEC QA and Performance management sub group initiative	Ongoing
2 & 7	CI/PI&C		Undertake an audit of CP referrals pre, mid and post lockdown	Gives us information about how we responded under crisis and allows us to prepare in case of future lockdown	Performance management sub group	Data collated during the pandemic
2	CI	Robust and effective working groups target service delivery for children affected by **neglect, parental substance misuse**, **domestic abuse** and **mental health** and can evidence they are making children safer. **Wellbeing indicator**: **Safe**	**Whole Family Sub Group:** Undertake and report on a thematic case review on a sample of cases where a child is known to Children and Families Social Work Services. **CSE Sub Group:** Expand our understanding of exploitation, develop training which supports intervention, utilise contextual safeguarding in our approaches.	Children are better protected from harm that results from living with parental substance misuse	WF sub group	Ongoing In process

4		Develop a workforce that is competent and confident to promote the well-being of children and young people, protect them from harm and improve their outcomes. **Wellbeing indicator: Safe**	Establish a joint substance misuse, justice, mental health and homelessness sub group	Children and their families experience a more joined up service	Hard Edges sub group	This has been absorbed into our Whole Family Subgroup
3			Contribute to the implementation and evaluation of Up2U	Children are safer	Child Protection Lead Officer/area teams	Ongoing
			Continued involvement in the Strathclyde Joint Investigative Interview Pilot	Children experience the joint interview process as less frightening	CPC	Ongoing
			Continue to prioritise training and coaching in relation to Neglect and on the use of the Action for Children/GCC Assessment of Care Neglect toolkit. All training to be delivered with follow up coaching consistent with the values of implementation methodology	Children living in neglectful situations receive improved support from confident informed practitioners.	CPLO/Training Sub Group	Met and ongoing
		The Child Protection Committee shall develop	Contribute to the production of a Public Protection Network Strategy document.	Children are safer as a result of improved professional collaboration and co-operation.	Child Protection Committee / Public Protection Network	Ongoing

		more effective partnership working. **Wellbeing indicator**: **Safe**				
5	**SP**		Establish better links with Inverclyde Child Poverty Action Group and Children's Services Planning	Children are safer as a result of the CPC improving and developing its effectiveness based on shared learning	Child Protection Lead Officer / CPC	Met and ongoing
6	**PI&C**	To engage parents in child protection processes	Conduct an audit of the move to virtual Child Protection case Conferences and Core Groups with parents	Parents rights are respected and they are assisted to participate fully in decision making	Child Protection Lead Officer	31st March 2022
7	**PI&C**	To maintain a high level of awareness of Child Protection with children and young people, families and the wider community through the provision of information. **Wellbeing Indicator: Safe, Nurtured, Included and Respected**	Via publicity targeted around the Children (Equal Protection from Assault) Act Via the `Helping Hands' campaign	Children and adults within Inverclyde have information on how to keep children and young people safe and where they can get help.	CPLO Inverclyde Council Communications	Met Met, changed to For Kid's Sake

6		To offer children and young people a range of different ways to communicate their views and feelings. **Wellbeing indicator: Safe, Nurtured, Included and Respected**	Improve participation and communication for Inverclyde's children and young people via virtual platforms such as Mind of My Own.	Children have more ways of communicating their views	CPC/Area teams	31st March 2022
			Responding to requests in relation to the Historic Child Abuse Inquiry	People's rights are respected	CPC	Ongoing
	CI **PI&C**		Seek accreditation of Child Protection procedures as rights respecting	Children's rights are respected	CPLO/Children s rights officer	31st December 2021
7	**PI&C**	Ensure our work is communicated. **Wellbeing indicator: Safe**	Update and develop the Inverclyde CPC website.	Children, parents and professionals have access to up to date information relating to the protection of children.	Child Protection Lead Officer	Met and ongoing
4	**CI/SP/ PI&C**	Implement National Guidance for Child Protection 2021 and the Learning Review	Via practitioner training, public information and awareness, the updating of policy and procedures	Communities are aware of the changes within the new guidance and children are protected	Child Protection Lead Officer	2021-23 implement ation plan
		Play our part in Inverclyde's COVID-19 recovery plan for children and young people	Via involvement in best practice initiatives which support children and young people's mental well being	Children and young people in Inverclyde are supported	CPC	Ongoing

Appendix 1: Members of Inverclyde Child Protection Committee :

Membership	Agency
Sharon McAlees (Chair)	Inverclyde Health & Social Care Partnership
Anne Sinclair	Inverclyde Council: Legal & Administration
Clare Fallone	Inverclyde Child Protection Committee
Kenneth Ritchie	Scottish Children's Reporters Administration
Detective Superintendent Gerald McBride	Police Scotland
Alan Stevenson	Inverclyde Health & Social Care Partnership
Jane Simcox	Inverclyde Health & Social Care Partnership
David Robertson	Inverclyde Health & Social Care Partnership
Dr Catherine Addiscott	NHS Greater Glasgow & Clyde
Laurence Reilly	Inverclyde Council: Education Services
Michael Roach	Inverclyde Council: Education Services
Hazel Mitchell	Inverclyde Council: Education Services
Martin Mathieson	Barnardo's Nurture Service
Dr Kerry Milligan	NHS Greater Glasgow & Clyde
Lynda Mutter	NHS Greater Glasgow & Clyde
Lindy Scaife	Procurator Fiscal's Office
Hugh Scott	Inverclyde Health & Social Care Partnership
TBC	Local Housing Association
David McCarrey/Mark Meehan	Scottish Fire and Rescue Service

AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date: 21 March 2022**
Report By:	**Allen Stevenson Interim Chief Officer Inverclyde Health & Social Care Partnership**	**Report No: IJB/17/2022/AG**
Contact Officer:	**Anne Glendinning Acting Head of Service Children& Families and Criminal Justice Services Inverclyde Health & Social Care Partnership**	**Contact No: 715368**
Subject:	**AGE OF CRIMINAL RESPONSIBILITY (SCOTLAND) ACT 2019**	

1.0 PURPOSE

1.1 The purpose of this report is to inform the HSCC of the implementation of the Age of Criminal Responsibility (Scotland) Act 2019.

2.0 SUMMARY

2.1 The intention of the Act is to protect children from the harmful effects of early criminalisation while ensuring that incidents of harmful behaviour by children under 12 can be investigated effectively, and responded to appropriately.

2.2 The Act was fully implemented, on 17 December 2021. The Act raises the age of criminal responsibility in Scotland from 8 to 12 years of age. This means that children younger than 12 will no longer be treated as criminal suspects.

3.0 RECOMMENDATIONS

3.1 The Integration Joint Board is asked to note the content of this report

Allen Stevenson
Interim Chief Officer

4.0 BACKGROUND

4.1 The intention of the Act is to protect children from the harmful effects of early criminalisation, while ensuring that children and their families receive the right support. The child's wellbeing is a primary consideration. Interventions must aim to protect children, reduce stigma and ensure better future life chances. There is also a duty to protect the safety and meet the needs of those involved in an incident, including any victim(s) and the community.

4.2 The ethos of the Act is rights respecting and reflects Scotland's commitment to international human rights standards:

- children under 12 will no longer be stigmatised by being criminalised at a young age, due to being labelled as an 'offender';
- children under 12 are not disadvantaged by having convictions for the purposes of disclosure, which can adversely affect them later in life;
- the position for care experienced children improves (since adverse childhood experiences leading to care proceedings may increase the likelihood of a child finding themselves in situations of risk)
- the new age of criminal responsibility aligns with longstanding presumptions around maturity, rights, and participation;
- United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Bill is a proposed new law that will incorporate the UNCRC into the law in Scotland

The Act also brings a trauma informed approach to the centre of approaches to child justice.

4.3 The Act provides powers to Police to investigate incidents of serious harm. Children under investigation have access to independent advice, support and assistance. Things must be explained to them in an age appropriate way. Forensic samples and prints cannot be kept unnecessarily.

4.4 It is anticipated that numbers affected across Scotland will be very small, no more than 20 in an average year. Inverclyde has not experienced a child in this situation for well over a decade.

4.5 The Act limits the power of Police to question a child under 12 where a constable has reason to believe that the child: by behaving in a violent or dangerous way, has caused or risks causing serious physical harm to another person OR by behaving in a sexually violent or sexually coercive way has caused or risk causing harm (whether physical or not) to another person. The child can be interviewed (under strict conditions see below) but cannot be arrested, charged, or subject to processes via criminal justice.

4.6 Whilst the Act provides the police with the power to remove a child to a place of safety, the guidance is clear that police officers must consult with local authorities to identify an appropriate place of safety to best meet the needs of the child whilst taking the situation into account. Removal to a place of safety must only be used as a measure of last resort. The child can only be kept in a place of safety for as long as it is necessary to put in place arrangements for the care and protection of the child. The Act requires Scottish Ministers to compile, maintain and publish a list of places of safety across Scotland. The child's home may be designated the place of safety so long as this would not subject either the child or others to harm. A Police station should only be used as a last resort. A child cannot be held in a place of safety for more than 24 hours.

4.7 In the pursuit of information relevant to situation, a child can be subject to interview. However an interview can only take place with the agreement of the child, the parents, or where a Sheriff grants a Child Interview order, or where

there is risk of loss of life. The purpose of the interview is to help the police establish what has happened, and to help identify any additional support or protection needs that the child may have. Police must liaise with the Local Authority regarding the conduct of interview(s). An Interagency Referral Discussion will take place prior to interview to enable services to share information. A child who is under 16, or who is 16-17 and on a Compulsory Supervision Order (via the Children's Hearing system) may be interviewed as long as the behaviour investigated relates to when they were under 12 years of age and after the act commences.

4.8 The Act establishes the role of the Child Interview Rights Practitioner (ChIRP), who must be a solicitor registered with the Children's Legal Assistance Scheme. A child should not be interviewed without a ChIRP & they take part in the interview planning.

4.9 Responding proportionately to the needs of a child who has caused harm does not diminish the rights of victims. They will still be the victim of a crime and have the right to have that crime fully investigated by Police and offered the support that is available to all victims of crime.

5.0 IMPLICATIONS

Finance

5.1 Financial Implications:

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 (If Applicable)	Other Comments
N/A					

LEGAL

5.2 There are no specific legal implications in respect of 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	YES – EQIA completed by Scottish Government (attached as appendix 2)
	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?

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

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

NATIONAL WELLBEING OUTCOMES

5.6 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

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 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 7 Minute Guide attached as appendix 1.

Age of Criminal Responsibility (Scotland) Act 2019

1 Background

The intention of the Act is to protect children from the harmful effects of early criminalisation while ensuring that incidents of harmful behaviour by children under 12 can be investigated effectively, and responded to appropriately. Once fully implemented, on **17th December 2021**, the Act will raise the age of criminal responsibility in Scotland from 8 to 12 years of age, and children younger than 12 will no longer be treated as criminal suspects.

2 Powers and duties

The Act provides powers to Police to investigate incidents of Serious harm. Promotion and safeguarding of the child's Wellbeing is a primary consideration. Children under Investigation have access to independent advice, support And assistance. Things must be explained to them in an Age appropriate way. Forensic samples and prints Cannot be kept unnecessarily. Small numbers – estimate is around 20 cases a year across Scotland.

3 Scope

The Act limits the power of Police to question a child under 12 where a constable has reason to believe that the child: By behaving in a violent or dangerous way, has caused or risks causing serious physical harm to another person OR By behaving in a sexually violent or sexually coercive way has caused or risk causing harm (whether physical or not) to another person

4 Place of safety (1)

Whilst the Act provides the police with the power to remove a child to a place of safety, the guidance is clear that police officers must consult with local authorities to identify an appropriate place of safety to best meet the needs of the child whilst taking the situation into account. Removal to a place of safety must only be used as a measure of last resort. The child can only be kept in a place of safety for as long as it is necessary to put in place arrangements for the care and protection of the child.

5 Place of safety (2)

The Act requires Scottish Ministers to compile, maintain and publish a list of places of safety across Scotland. Inverclyde are working with WOS partners to identify a POS.

The child's home may be designated the place of safety so long as this would not subject either the child or others to harm. A Police station should only be used as a last resort. A child can not be held in a place of safety for more than 24 hours

6 Investigative interviews

An interview can only take place with the agreement of the child, the parents, or where a Sheriff grants a Child Interview order, or where there is risk of loss of life.

The purpose of the interview is to help the police establish what has happened, and to help identify any additional support or protection needs that the child may have. Police must liaise with the LA re the conduct of interview(s). An IRD will take place prior to interview and in Inverclyde the SCIM process will be utilised.

A child who is under 16, or who is 16-17 and on a CSO may be interviewed as long as the behaviour investigated relates

Appendix 1

7 Child interview rights practitioners

The Act establishes the role of the child interview rights practitioner (ChIRP), who must be a solicitor registered with the Children's Legal Assistance Scheme. A child should not be interviewed without a ChIRP.

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EQUALITY IMPACT ASSESSMENT - RESULTS

Title of Policy	The Age of Criminal Responsibility (Scotland) Bill
Summary of aims and desired outcomes of Policy	The main purpose of the Bill is to raise the age of criminal responsibility (ACR) in Scotland from 8 to 12, to align it with the current age of prosecution, and reflect Scotland's progressive commitment to international human rights standards so that: • Children under the ACR are not stigmatised by being criminalised at a young age due to being labelled an "offender"; • Children under the ACR are not disadvantaged by having convictions for the purposes of disclosure, which can adversely affect them later in life; • The new ACR aligns with longstanding presumptions around maturity, rights, and participation and improves the lives of children with care experience (especially children looked after away from home) whose behaviours are more likely to have been reported to police - and therefore to attract a criminalising state response - than Scotland's child population in general. In consequence of the change to the ACR, the Bill also provides for a number of measures to ensure that action can still be taken by the police and other authorities when children under the age of 12 are involved in serious incidents of harmful behaviour, to protect the child's rights and best interests, and the interests and rights of anyone harmed. While these measures include specific investigatory powers for the police, the Bill also makes provision for the sharing of information with victims in respect of actions taken by the children's hearings system and a right for a child under the ACR thought to be responsible for a

	serious incident to have access to a supporter and to an advocacy worker during a formal police interview. The Bill also makes changes to the disclosure system, removing the automatic disclosure of convictions for the behaviour of under 12s and putting in place independent review of information to be included in response to a disclosure check, when that check may disclose non-conviction, but potentially adverse, information dating back to when the applicant was under the ACR.
Directorate: Division: team	Directorate for Children and Families: Care, Protection and Justice Division: Youth Justice and Children's Hearings Unit

Executive summary

An equality impact assessment (EQIA) was undertaken in connection with the Age of Criminal Responsibility (Scotland) Bill to consider potential impacts across the protected characteristics for the provisions included in the Bill.

The Bill will make provision to raise the age of criminal responsibility from 8 to 12. This means:

- Children aged 8 to 11 involved in harmful behaviour will no longer be referred to a children's hearing on the ground that they have committed an offence. The behaviour can still be dealt with one of the sixteen existing non-offence referral grounds.

- No child will receive a criminal record for harmful behaviour committed when under 12.

In designing provisions consequential to raising the ACR, a special set of measures have been developed for young people under 12 who display serious harmful behaviour. These have a strong emphasis on both public protection and a child centred approach reflecting the Getting It Right for Every Child (GIRFEC) imperatives.

The Bill will provide for a number of measures to ensure that action can still be taken by the police and other authorities when children under 12 are involved in serious incidents. These measures will ensure that the harmful behaviour of children under 12 can continue to be investigated, and that authorities respect, and respond to, the needs of victims. These measures will include:

- changes to the disclosure system to ensure that non-conviction information relating to harmful behaviour that occurred when children were under the new ACR can still be disclosed as Other Relevant Information (ORI) on two types of disclosure, namely the enhanced disclosure under the Police Act 1997 and

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the scheme record under the Protection of Vulnerable Groups (Scotland) Act 2007, but only following independent review;

- the ability for a victim of a serious incident to receive information about the children's hearing disposal in respect of that incident;

- police powers to investigate suspected seriously harmful behaviour on the part of a child under 12, generally authorised by a sheriff or by a senior police officer unconnected with the investigation (although some immediate powers will be available in circumstances of urgency, emergency or risk to life);

- local authority social work services' involvement in planning and conducting investigative interviews with children under 12; and

- measures when a child is being formally interviewed, including a right to information, a right not to answer questions, assistance from an advocacy worker and a right to have a supporter present (usually an adult known to the child).

While the reform is aimed at providing children under 12 involved in harmful behaviour with an opportunity to change unencumbered by early criminal stigma, it is also designed to protect the rights of children and others who may be victims of harmful behaviour. Proposals in the Bill are, therefore, designed to ensure the change of age will augment public safety and retain public confidence.

The Scope of the EQIA

A variety of sources was used to help understand the likely impact of the proposed policies, and to refine those policies. In addition to ongoing engagement with a wide range of stakeholders, the sources of information that informed the EQIA included:

- The report of the Advisory Group on the Minimum Age of Criminal Responsibility, published in March 2016, which examined the implications for children and young people of raising the age of criminal responsibility.

- A public consultation based on the recommendations of the Advisory Group on the Minimum Age of Criminal Responsibility. This ran from 18 March until 17 June 2016, and was complemented by a programme of engagement with key interest groups such as young people and victims.

- Targeted engagement with children and young people aged from 8 to 22, focussing on those affected by current legislation and those that have experienced negative life experiences from being connected with the criminal justice system from an early age. This included meeting children and young people from the Scottish Youth Parliament, Children's Parliament, Who Cares? Scotland, Youth Advantage Outreach, Up-2-Us, YOI Polmont, Good Shepherd Secure Unit and Sacro. The methods used to elicit and record

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views ranged from scenario storytelling to quizzes, timelines, discussion groups, voting cards and artwork.

- The data collected by the Scottish Children's Reporter Administration (SCRA) on the age of children referred to the children's reporter and the ground(s) on which referral is made.

- The research published by SCRA in March 2016 which looked at the circumstances and outcomes of 100 children aged 8 to 11 referred for offending in 2013-14.

During the EQIA process, the potential impact on each of the protected characteristics was considered. However, our assessment identified that the policy was only likely to have a direct impact in relation to age and sex. This impact is discussed in more detail below.

The other protected characteristics - maternity and pregnancy; gender reassignment; sexual orientation; disability; race; religion or belief; and marriage and civil partnership – do not have a direct bearing on the conduct of children's hearings proceedings, police investigations or disclosure checks, and we did not encounter evidence that suggested people in these groups would be disproportionately affected by the changes in the Bill. Indeed, some of these characteristics are unlikely to be relevant for children under 12.

Key findings

Age

By raising the age of criminal responsibility and removing the automatic disclosure of a "conviction" that occurred before the age of 12, the Bill will impact on children under 12 and on persons over 12 if they have been involved in certain types of behaviour when they were under 12 years of age at the time.

The changes to the disclosure regime will mean that the disclosure of ORI about harmful behaviour that occurred while under 12 will be treated differently from harmful behaviour that occurred when aged 12 or over. Individuals of all ages will benefit from this change as their age at the time of their enhanced disclosure, or PVG scheme record application will not affect how any pre-12 behaviour that the chief constable proposes to disclose as ORI will be treated. In all cases, that proposed ORI will be subject to independent review. The distinction in treatment is derived for disclosure purposes from the principal change in the Bill, namely the increasing of the age of criminal responsibility for 8 to 12 years of age. The only way information about a person's conduct when aged under 12 will be disclosed will be through the 'Other Relevant Information' (ORI) process and only then on the enhanced disclosure, or the PVG scheme record. Such information will only be disclosable as ORI following an independent review of the chief constable's proposed ORI disclosure. The Independent Reviewer's decision will be final. An

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appeal to a sheriff, but only on a point of law, will be available by the person or the chief constable.

There is the possibility of an impact for those individuals who committed harmful behaviour while under eight. Under the proposed amended disclosure regime there is a possibility that information about harmful behaviour while under eight could now be disclosed as ORI by the police. However, this impact is expected to be minimal: Police Scotland has stated they have not disclosed any information about conduct committed when under eight since at least 2011. As such, we believe the overall impact for disclosure of behaviour under the age of eight will be neutral.

Under existing powers the Principal Reporter can tell victims of offences committed by children certain limited information about how a case has been disposed of via the children's hearings system. As a result of raising the age of criminal responsibility, victims of harmful behaviour by children aged 8 to 11 would no longer be able to receive information. To ensure victims' rights are not diminished, the Bill provides powers which allow the Principal Reporter to disclose information to victims of offences by children aged 12 and over, and to victims of harmful behaviour by children under 12. The persons who can access information and the information that can be disclosed are the same regardless of the age of the child but the description of the behaviour of children aged under 12 (harmful behaviour) is different to that of children aged 12 and over (offending behaviour). This distinction in the treatment of children on the basis of age is derived from the principal change in the Bill, namely the increasing of the age of criminal responsibility from 8 to 12 years of age and whether a child can commit an offence.

As a result of raising the age of criminal responsibility to 12, the police will treat children under 12 in a different way to children 12 and over. The behaviour of children under 12 will not be criminal, and therefore the police will not be able to use their criminal justice powers to investigate. That is why the Bill creates a bespoke package of powers that the police can use to investigate children under 12 whom they suspect have carried out seriously harmful behaviour. These new powers are designed to be appropriate for the child's age and stage of development, and the fact that their behaviour is not criminal.

The police will still be able to refer a child to the reporter but, as a result of the Bill, children under 12 will now only be referred on non-offence grounds (at present, children eight and older can be referred on offence grounds.) If a children's hearing is held, the hearing will have the same options available to it as it does for children aged 12 and over (for example, to put in place compulsory supervision orders). The hearing will also have the same obligation to treat the child's welfare as the paramount consideration, regardless of the child's age.

It should be noted that the police do not currently have powers to investigate the behaviour of children under eight, because that behaviour is not criminal. Under the Bill, the new police powers to investigate non-criminal behaviour in children will apply to all children under 12. In other words, investigatory powers will apply to children under eight for the first time. This is felt to be appropriate, as:

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- The provisions have been designed to take into account the fact that the police powers could theoretically be used with children under eight. Carefully tailored measures have been built in to protect children's interests and wellbeing, even if they are too young to effectively advocate for their own interests.

- A key focus of the investigative process is to identify and understand the child's needs, so that appropriate support or child protection measures can be identified. The aim is ultimately to promote the wellbeing of children rather than punish them – and that can benefit children under eight just as it can children aged 8 to 11.

- In some cases, the fact that current powers do not apply to children under eight arguably creates gaps that could jeopardise the safety of children or the wider public. For example, currently the police do not have the power to search a child under eight who they believe is in possession of a knife (even though an older person might choose to conceal a knife on a young child to evade search). The Bill will create a consistent position by applying powers equally to all children under 12.

- It was not felt justifiable to create a tiered system, in which children ages 8 to 11 were treated differently to children aged under eight, even though all were under the age of criminal responsibility.

Sex

The evidence suggests that boys are more likely than girls to be affected by the fact that it will no longer be possible for children under 12 to be referred to a children's hearing on offence grounds. In 2016-17, 177 boys and 28 girls aged between 8 and 11 were referred to the reporter on offence grounds. Under the Bill, these children would all be referred on non-offence grounds. 24 boys and 6 girls aged 8 to 11 were referred to the reporter for behaviour that would potentially be considered of sufficient seriousness to engage the police powers in the Bill. This suggests that boys are more likely than girls to be affected by the new police powers for this age group.

Under the Bill, children under 12 will no longer receive criminal convictions which would appear on a higher level disclosure should they apply for one later in life. In 2016-17, 224,483 applications for higher level disclosures came from females (this accounted for 68% of the applications received) and 104,159 applications came from males (this accounted for 32% of the applications received). Taking account of the incidence of convictions held by female and males in Scotland, we believe the benefit from the change in ACR will have a slightly bigger positive impact on males.

However, while it is important to understand how males and females may be affected by the legislation in different ways, a person's sex has no direct bearing on children's hearings proceedings, police investigations or disclosure.

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Recommendations and Conclusion

The policy focuses on the behaviour of 8 to 11 year olds, but has potential consequences for children and young people beyond the age of 18. By removing the disclosure of “criminal history” that occurred before the age of 12 the Bill will enable children and adults to put any harmful behaviour behind them, to get on with their lives and to contribute to society.

The current system of disclosure of information relating to harmful behaviour by children in the 8 to 11 age group is not considered justified since a young child could not have reasonably foreseen the impact the disclosure system could have on their lives at the time, and the child may no longer pose a risk by the time they reach adulthood.

It is acknowledged that police powers have the potential to interfere with civil liberties. However, the new powers in the Bill to enable the police to investigate concerns about harmful behaviour by children under 12 have been designed with many procedural safeguards to ensure that they will be used only in the most serious cases, in a way that is justifiable and proportionate to the circumstances, and is welfarist in focus. This is appropriate given that children under 12 will not be criminally responsible or subject to the criminal justice system.

The Bill only makes those powers available to the police where it is believed that a child’s behaviour has caused (or is reasonably likely to cause) death or serious injury, or that the child has been sexually violent or sexually coercive. The most recent statistics available show that, broadly speaking, 33 children per year in Scotland aged 8 to 11 are referred to the Children’s Reporter for an incident of that nature.

The EQIA process has not identified any issues which would have a detrimental impact on any of the protected groups. In the circumstances, the Scottish Government has concluded that no changes to the Bill are necessary.

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AGENDA ITEM NO: 11

Report To:	**Inverclyde Integrated Joint Board**	**Date:**	**21 March 2022**
Report By:	**Allen Stevenson Interim Chief Officer Inverclyde Health & Social Care Partnership**	**Report No:**	**IJB/19/2022/AM**
Contact Officer:	**Anne Malarkey Head of Mental Health, ADRS and Homelessness**	**Contact No:**	**715284**
Subject:	**DEMENTIA CARE CO-ORDINATION PROGRAMME UPDATE**		

1.0 PURPOSE

1.1 The purpose of this paper is to provide the Health and Social Care Committee with a progress report on the Inverclyde Dementia Care Co-ordination Programme.

2.0 SUMMARY

2.1 As part of Scotland's third national dementia strategy, Inverclyde HSCP was selected as the Dementia Care Co-ordination Programme implementation site. The Programme is supporting improvements and redesign of community based services to improve care co-ordination for people living with dementia and carers from diagnosis to end of life.

2.2 The Programme was due to end in March 2021, however during the first wave of the Covid-19 pandemic, the programme went into hibernation for 6 months. It was safely recommenced in September 2020 and, to mitigate impact from the pandemic, the Scottish Government agreed to fund the Programme for an additional year. Priorities and action plan were reviewed, taking account of what would be possible by March 2022. The Programme is now on its final 2 months and is due to end on the 31 March 2022.

2.3 Priority areas for improvement are: Ensuring a responsive and sustainable Post Diagnostic Support service; Integrated care co-ordination for people living in the moderate dementia that is aligned to Alzheimer Scotland 8 Pillar Model of Community Support and 12 Critical Success Factors for effective care co-ordination; and, Integrated care co-ordination for people living with advanced dementia at a palliative and/or end of life stage by testing Alzheimer Scotland Advanced Dementia Practice Model.

In addition the following actions are being implemented: Creating a sustainable approach to dementia workforce development; Development and testing of a self-management leaflet and app; Local implementation of the Dementia and Housing Framework; Enhancement of the Allied Health Professional contribution to an integrated and co-ordinated approach; Improvement in the completion and consistency of Anticipatory Care Planning for individuals with dementia; and, Re-establishment of Dementia Friendly and Enabled community work.

2.4 A Programme measurement plan which will measure impact of the Programme and will continue to monitor dementia related performance after the Programme finishes has been developed and agreed. The Scottish Government are in the process of commissioning an external evaluation. Plans are in place to share Programme learning across NHS GGC, Scotland and further afield, with an online webinar planned for March, 2022. End of Programme events are being organised with Inverclyde Dementia Reference Group and the Programme Steering Group. Discussions

and planning are underway to ensure the sustainability of improvements generated by the Programme beyond March 2022.

3.0 RECOMMENDATIONS

3.1 The IJB are asked to note the contents of this paper, Programme achievements, end of Programme planning in March 2022 and proposed sustainability plans beyond March 2022.

Allen Stevenson
Interim Chief Officer
Inverclyde HSCP

4.0 BACKGROUND

4.1 As part of Scotland's third National dementia strategy, Inverclyde HSCP was selected as the Dementia Care Co-ordination Programme implementation site. The Programme is supporting improvements and redesign of community based services to improve the experience, safety and co-ordination of care, services and support for people living with dementia from diagnosis to end of life. The emphasis is to support people to stay well at home or in a homely setting for as long as possible. Taking a whole systems and pathway approach from diagnosis to end of life, by March 2022, the programme aims to:

- Improve care co-ordination for people with dementia and their carers
- Develop and evaluate a model of effective care coordination for people with dementia and their carers
- Share learning across NHSGGC, Scotland and further afield.

4.2 Healthcare Improvement Scotland (HIS) are the National lead for the Programme on behalf of the Scottish Government. Funding associated with the Programme has allowed Inverclyde HSCP to recruit an Improvement Advisor to lead and co-ordinate the Programme and work with national and local stakeholders.

4.3 The Programme has actively involved stakeholders throughout. 92 stakeholders attended the launch event in September 2019, including people living with dementia, carers and representatives from local and national organisations. Priority areas were identified at the event and informed the overall Programme action plan. Shared learning, progress updates, improvement ideas and action planning have been generated through five Learning Sessions.

Arrangements were agreed to involve Inverclyde Dementia Reference Group (DRG). The DRG have been instrumental in informing and supporting key areas of work, e.g. participated in local stakeholder engagement work commissioned by HIS; development of a self-management leaflet; a single quality question for the Post Diagnostic Support service; shared their experiences during the first wave of the pandemic, which was used to inform National policy and; supporting the Programme evaluation with DRG membership included on the Programme Evaluation Project Team. Members of the DRG and others with lived experience of dementia or caring for someone with dementia have informed the development of the Living Well with Dementia app.

4.4 The Programme was due to end in March 2021, however during the first wave of the Covid-19 pandemic, the programme went into hibernation for 6 months to ensure no additional pressure on frontline services. The programme was safely recommenced in September 2020 and to mitigate impact from the pandemic, the Scottish Government agreed to fund the Programme for an additional year until March 2022. The Programme priorities and action plan were reviewed following recommencement, taking account of what was achievable until March 2022. Agreed priorities are listed in table 1:

Table 1: Dementia Care Co-ordination Programme Priorities February 21 to March 22

Actions: Dementia Pathway	**Actions: Cross Pathway**
Care co-ordination for people newly diagnosed with dementia, ensuring a responsive and sustainable Post Diagnostic Support service.	- Workforce Development - Clearer roles and responsibilities - Clearer service pathways including GP practices - Self- management leaflet and app - Dementia and Housing - Enhance the Allied Health Professional contribution to an integrated and co-ordinated approach - Anticipatory Care Planning and dementia - Dementia Friendly and Enabled community (aligned to Programme) - Measurement plan and evaluation
Care co-ordination for people living with moderate dementia. This will be aligned to the 8 Pillars Model of Community Support and 12 Critical Success Factors for effective care co-ordination.	
Care co-ordination for people living with advanced dementia at a palliative and or end of life stage by testing Alzheimer Scotland Advanced Dementia Practice Model.	

4.5 **Post diagnostic support (PDS) - a sustainable model**

Everyone newly diagnosed with dementia is entitled to receive a minimum of one year's post-diagnostic support, co-ordinated by a named Link Worker and have a person-centred support plan in place. This is centred on Alzheimer Scotland 5 Pillars Model of Post Diagnostic Support.

There is a PDS Local Delivery Plan (LDP) Standard which is reported in two parts:

1. The percentage of people estimated to be newly diagnosed with dementia who were referred for post diagnostic support – this is reported Scotland wide and by Health Board area.
2. The percentage of people referred who received a minimum of one year's support – this is reported Scotland wide, by Health Board and HSCP.

Data is exported to Public Health Scotland (PHS) from NHS GGC collectively. Management Information Reports detailing performance against the Dementia Post-Diagnostic Support LDP Standard are provided by PHS quarterly to each HSCP.

LDP Standard Performance: The percentage of people estimated to be newly diagnosed with dementia who were referred for post diagnostic support.

This part of the LDP standard requires the actual numbers diagnosed and referred for PDS as a percentage of the estimated incidence. Table 2 presents the proportion of people estimated to be newly diagnosed with dementia who were referred for PDS up to 31 March 2021. At the time of this report, 1 April 2016 to 31 March 2020, referral data is complete and 2020/21 is provisional. Less than half of the estimated projected numbers are diagnosed and referred to PDS across Scotland and NHS GGC. Data for 2020/21 has been impacted by the Covid-19 pandemic as there was a significant reduction in numbers diagnosed across Scotland.

Table 2: Proportion of people estimated to be newly diagnosed with dementia who were referred for PDS

Year	Scotland	NHS GGC
2016/17 (complete)	44.6%	42.7%
2017/18 (complete)	43.3%	43.1%
2018/19 (complete)	44.7%	47.6%
2019/20 (complete)	41.3%	43.1%
2020/21 (provisional)	32.2%	34.3%

LDP Standard Performance: The percentage of people referred who received a minimum of one year's PDS.

This section of the Standard is reported Scotland wide, by Health Board and by HSCP. There are two elements that are required to meet the Standard:

- PDS must commence, that is first direct intervention with a PDS Practitioner or team within one year from date of diagnosis and;
- A minimum of one year PDS is recorded from first direct intervention with a PDS Practitioner or team to PDS termination or transition date.

It can take up to two years from date of dementia diagnosis to complete PDS and LDP Standard requirements. Table 3 presents the proportion of people referred who received a minimum of one year's PDS up to 31 March 2021. Data for 2016/17, 2017/18 and 2018/19 are now complete, during this time Inverclyde HSCP compliance is 68.5%, 77.4% and 57% respectively. Remaining annual reports are provisional with PDS support ongoing. Work in underway within Inverclyde to improve LDP Standard compliance through increased investment in PDS Link Worker services.

Table 3: Proportion people referred who received a minimum of one year's PDS

Year	Scotland	NHS GGC	Inverclyde
2016/17 (complete)	75.5%	66.5%	68.5%
2017/18 (complete)	73%	63.8 %	77.4%
2018/19 (complete)	74.7%	64%	57%

2019/20 (provisional)	80%	61.4%	55.5%
2020/21 (provisional)	68.7%	43.2%	35.3%**

*** at the time of this report, PDS was ongoing for 52 referrals in 2020/21*

As a result of the investment in an additional two PDS Link Worker posts there has been a significant reduction in service waiting list and waiting times. The additional Link Workers commenced in April and May, 2021. Figure 1 below demonstrates a reduction in waiting list numbers from 85 in April to 31 with 105 new referrals during this time in October and Figure 2 illustrations a reduction in waiting times from 15 to 3 months. This has been sustained.

Figure 1: Improvements in Waiting List

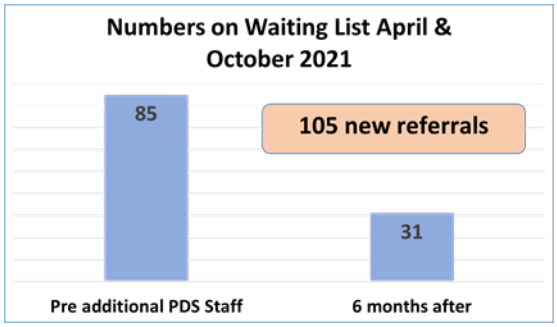
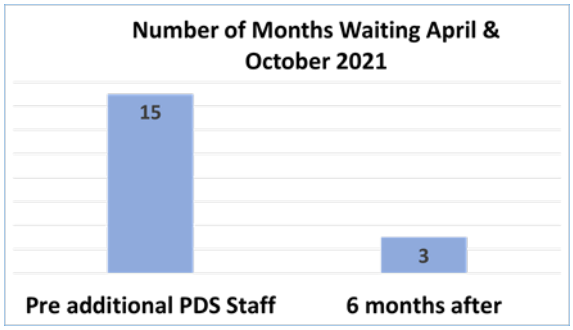


Figure 2: Improvements in Waiting Times



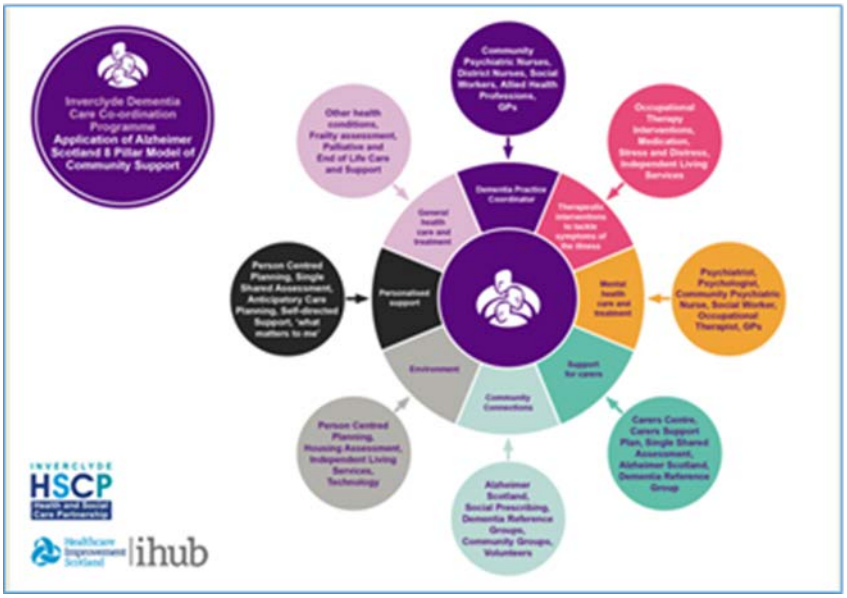
There are additional improvements ongoing including the development of a PDS service standard operating procedure; to incorporate a process of PDS service feedback and evaluation and to ensure equitable service provision that meets the requirements of the Equality Act, 2010.

4.6 **Care Co-ordination and 8 Pillar Model Community Support**

This applies to the stage of the dementia journey when people are living at home and are supported to live independently and remain connected to their community, for as long as possible, as dementia progresses. This is aligned to Alzheimer Scotland 8 Pillars Model of Community Support.

In October 2021 we hosted our 5th Programme learning session. The purpose of this was to increase awareness of services and supports for people living with dementia and carers. This was requested following feedback from participants who attended the 4th Learning Session. Plans are now underway to collate this information into a single services document that will be shared across Inverclyde. This will include a clear definition of the care co-ordination role in Inverclyde.

Figure 3: Application 8 Pillar in Inverclyde



We have also mapped existing services in Inverclyde to Alzheimer Scotland 8 Pillar Model of Community Support, (figure 3). The Model provides a coordinated and strategic framework for effective and integrated community support for people living with dementia and their carers. It addresses treatment of symptoms and aims to improve the resilience of people with dementia and their carers supporting them to live well and independently for as long as possible. It recognises that for people living with dementia to have optimal wellbeing both health and social needs required to be met.

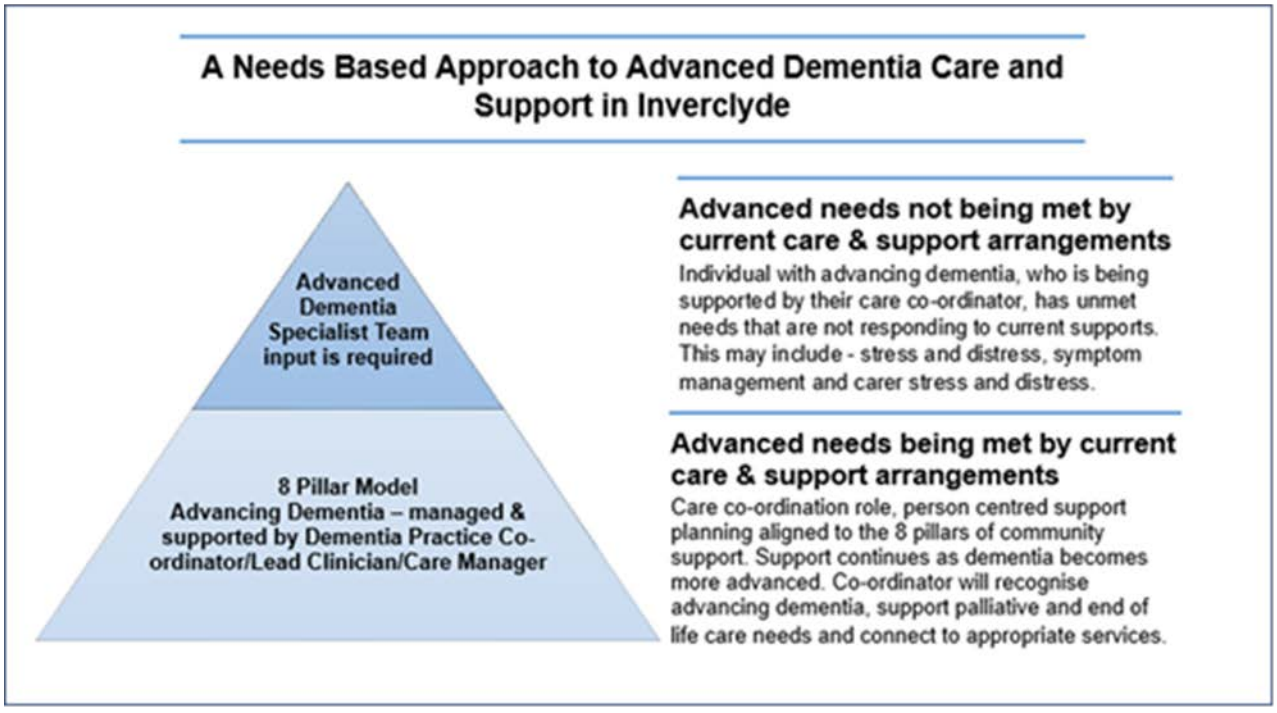
12 Critical Success Factors for Effective Care co-ordination

Work that was done elsewhere in Scotland identified 12 critical success factors that are required to ensure effective care co-ordination for people living with dementia and their carers. Inverclyde is currently collating results from the 12 critical success factors self-assessment. This will further inform local areas for improvement and action planning beyond the end of the Programme.

4.7 **Alzheimer Scotland Advanced Dementia Practice Model (ADPM)**

Testing Alzheimer Scotland ADPM is a requirement of the Programme. This Model sets out to ensure palliative and end of life (PEOL) care and support needs for people living with advanced dementia are met, including the needs of their family and or carers. A working group was established to agree how the ADPM should be implemented and tested in Inverclyde. A Needs Based Approach was agreed as a Framework to test and implement the ADPM in Inverclyde, see figure 4 below. It is recognised that the majority people living with advancing dementia will have their advancing dementia needs supported by their care co-ordinator. In order to successfully achieve this, staff need to be able to recognise if dementia is becoming more advanced. This can be difficult as the progression of dementia can be very gradual. PEOL identification tools assist in recognising changes in the stage of the illness. Where it is identified that health and social care needs are not being met, the care co-ordinator can consider if input from the Advanced Dementia Specialist Forum (ADSF) is required. In testing the ADPM we explored PEOL identification tool/s that could be used in Inverclyde and tested an Advanced Dementia Specialist Forum (ADSF) that brings together an Advanced Dementia Specialist Team.

Figure 4: Needs Based Approach to Advanced Dementia Care and Support in Inverclyde



Advanced Dementia Specialist Forum (ADSF)

The purpose of the ADSF is to ensure the best possible experience of care and support for people with advancing dementia, including their family and or carers. The Forum brings together multi-disciplinary and multi-agency expertise, including health, social care and third sector partners. The Forum aims is to facilitate discussion that leads to recommendations which support the effective and co-ordinated delivery of appropriate care and supports that takes account of the preferences of individual and their carers.

The Forum was tested over a period of 6 months from June to November 2021 and has now been evaluated. Initial reflections are that the Forum was valued and does make a difference to people with dementia and their carers. It also supports staff in managing complex situations. The multi-agency discussion and recommendations provided practical solutions to address unmet need and changed the trajectory of care and support. The Forum was particularly valued as a learning and development opportunity. There was an improved understanding of roles and

responsibilities of all health, social care and third sector services involved and the range of supports available for people living with dementia and their family or carers. Reflections from participants were that the Forum should continue, however a review of how this should be taken forward requires further consideration, in particular identifying cases for the Forum and ensuring this does not duplicate existing MDT arrangement. The final report and recommendations will be available by March 2022.

Palliative and End of Life Identification Tools

It is recognised that dementia gradually deteriorates over a longer period of time and often PEOL care and support needs are not recognised until end of life stage. It is therefore important that advancing dementia is recognised to ensure appropriate PEOL care and support is in place. A short life working group was established identify and agree an identification tool or a basket of tools that can be used in Inverclyde. Conclusions are, at the moment, that it has not been possible to determine if one tool is preferable to others. Choice of tool depends on the practitioner group, the setting and the purpose for using the tool. For example prognostication, identification of symptoms and concerns, early warning, rate of change, phase of illness and/or function is required. At this stage, Inverclyde is awaiting recommendations from the forthcoming SIGN guidelines. The identification of PEOL care and support needs will form part of local dementia workforce development plans.

Care Home Placement of Person with Learning Disability and Advanced Dementia

A need was identified by Inverclyde Community Learning Disability Team relating to the care home placement of an individual with a learning disability and advanced dementia. A short life working group was established involving local and national partners. The group has agreed to draft a guidance document for staff to support people with a learning disability and advancing dementia moving to move into a care home. It is anticipated the document will be completed by March 2022.

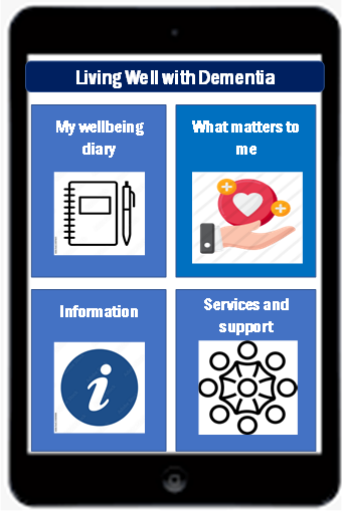
4.8 **Workforce Development**

The ambition for Inverclyde is to have a sustainable dementia workforce training and development plan in place. The Programme aims to ensure the workforce of Inverclyde, who support people living with dementia and their carers, have the appropriate knowledge and skills to support them to live well and live independently for as long as possible within their own community throughout their dementia journey. This plan will include health, social care, third sector, community groups, volunteers, housing and care home staff. A Dementia Training Co-ordinator has now been recruited and commences in January 2022. A dementia related workforce development plan will be agreed for Inverclyde.

4.9 **Dementia Friendly and Enabled Inverclyde**

Your Voice have been appointed to implement Dementia Friendly and Enabled Programme across Inverclyde. A dementia friendly community relates to relationships and inclusion within the community and a dementia enabled community is a physical environment that is adjusted to make life easier and places more accessible for people living with dementia. The Dementia Friendly and Enabled initiative commenced in October, 2021 for a period of 18 months. A progress report, will be presented to the Mental Health Programme Board in March 2022.

4.10 **Living Well With Dementia App**



A requirement of the Programme is to explore the use of digital solutions to transform services. This aims to support people living with dementia to live well and independently for as long as possible. A short life working group was established to develop the app and content. The app's development has been informed by people living with dementia and carers. Five sections have been agreed, they are:

- My wellbeing diary - to record how the user feels in a way that that can be measured over time, can be shared and links to support if required;
- What matters to me section, to record information about the user and their life story;
- A further information section;
- A services and support section;
- A section for carers will be included

We are now in the final stages of development and drafting content. It is anticipated the app will be ready for testing by the end of March 2022.

4.11 **Supports and Services Leaflet**

Plans are underway to evaluate the self-management leaflet with PDS Link Workers. The leaflet, provides information about services and supports for people living with dementia and carers and is now available. Paper copies can be obtained by calling Crown House on 01475 558000 or can be downloaded here Dementia Friendly Inverclyde - Inverclyde Council

4.12 **Dementia and Housing**

Discussions are underway to explore local implementation of the Housing and Dementia Framework. The Framework provides the tools for the housing sector to build on existing good practice and help people living with dementia, their families and carers to live in homes which have enabling environments and help them achieve the outcomes that matter most to them. Dementia awareness training, delivered by Alzheimer Scotland Dementia Advisor, is planned within local sheltered housing. Training is planned for PDS Link Workers to carry out early housing discussions.

4.13 **Allied Health Professional (AHP) contribution**

AHPs have a key role in supporting people living with dementia and their family and or carers.

Progress has been made in exploring and enhancing the AHP contribution to an integrated and co-ordinated approach as outlined in the Alzheimer Scotland AHP framework; Connecting People, Connecting Support. Occupational Therapy interventions such as Cognitive Stimulation Therapy, Journey Through Dementia and Home Based Memory Rehabilitation, are currently being delivered and evaluated in Inverclyde.

4.14 **Anticipatory Care Planning (ACP)**

There is currently improvement work in progress across Inverclyde relating to Anticipatory Care Planning. Part of this will ensure the completion and review of ACP for everyone with a dementia diagnosis. Planning is underway to train PDS Link Workers to complete and share elements of an ACP appropriate to their role.

4.15 **Measurement plan, Dementia Register and Evaluation**

A Programme measurement plan has been developed and agreed that will measure impact of the Programme, see section 8.1. This will become Inverclyde HSCP Dementia Measurement & Performance Framework after the Programme finishes. A recommendation of the Programme is to develop and test a Dementia Register for the population of Inverclyde. The aim of the register is understand Inverclyde's dementia population in terms of demographics and to inform planning that will meet local needs. Discussions are underway about how this will be collected and reported. The Scottish Government are in the process of commissioning an external evaluation of the whole Care Coordination Programme. An Evaluation Project Team has been established to oversee and steer the independent evaluation. It is anticipated that the evaluation will begin in March 2022 for a period of 6 months.

4.16 **Sharing Programme Learning**

A requirement of the Programme is to share learning across NHS Greater Glasgow and Clyde and more widely across Scotland. Programme updates have been provided at National events such as the National Post Diagnostic Support Leads meeting and shared through existing networks within NHS GGC. End of Programme events are being planned with Inverclyde Dementia Reference Group and the Programme Steering Group. An online webinar is being created to share learning from the Programme which will have a wider reach across Scotland and further afield.

4.17 **Sustainability**

The sustainability of improvements that have been generated by the Care Coordination Programme is a key focus of discussions within the closing months. As detailed in this report there are legacy pieces of work such as the training coordinator post and dementia friendly and enabled community initiative which will continue beyond the end of the Programme. Consideration is being given to reinstating the Inverclyde Dementia Strategy Group to continue work on the identified Programme priority areas and provide strategic direction and oversight to future developments.

5.0 IMPLICATIONS

Finance

5.1 Financial Implications:

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

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
TBC – Dementia earmarked reserve					Dementia training co-ordinator - approximately £26,245.50 for salary and other costs for 18 months. Dementia Friendly and Enabled Community project - approximately £62,000 for salary and other costs for 18 months.

Legal

5.2 No implications

Human Resources

5.3 Job description and person specification for the dementia training co-ordinator position was complete, Grade agreed and position recruited.

Equalities

5.4 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
X	NO -

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

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

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

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 CONSULTATIONS

7.1 Involving stakeholders has been central throughout the Programme. 92 stakeholders attended the Programme launch event in September 2019, including people living with dementia, carers and representatives from local and national organisations. Priority areas were identified and agreed and informed the overall Programme action plan. Shared learning, progress updates, improvement ideas and action planning were generated through 5 Learning Sessions.

Arrangements were agreed to involve Inverclyde Dementia Reference Group (DRG). The DRG have been instrumental in informing and supporting areas of work, e.g. participated in local stakeholder engagement work commissioned by HIS; development of a self-management leaflet; a single quality question for the Post Diagnostic Service; shared their experiences during the first wave of the pandemic, which was used to inform National policy and; supporting the Programme evaluation with DRG membership on the Programme Evaluation Project Team. Members of the DRG and others with lived experience of dementia or caring for someone with dementia have informed the development of the Living Well with Dementia app.

8.0 LIST OF BACKGROUND PAPERS

8.1 Inverclyde Dementia Care Coordination Programme Measurement Framework. (see appendix 1)

Inverclyde HSCP Dementia Measurement & Performance

Reporting Schedule	Frequency
Focus on co-ordination project evaluation/appraisal	End of project
Quality and Performance reporting	Monthly reports Quarterly meetings
Commissioning data sets	Monthly reports
Annual benchmarking of 12 CSF	Annually
Annual summary & assessment report	Annually

Monthly Reporting - PDS

Name of measure	Concept being measured and why it's important to look at this	Operational definition	Data collection
The impact of Post Diagnostic Support for people with a confirmed Dementia diagnosis.	The LDP Standard is that all people newly diagnosed with dementia receive a minimum of one year of post-diagnostic support (PDS) and have a person-centred plan in place at the end of that support period.	Monthly PDS LDP Standard report (Appendix)	Collected in the PHS LDP Standard report (Appendix)
Number/percentage of people with a Learning Disability with a dementia diagnosis	Knowledge of demographics of people with a Learning Disability with confirmed diagnosis of dementia	Numbers/percentages of people with confirmed Dementia diagnosis and known Learning Disability	Data collected by HSCP Data Analyst from Micro strategy
Number/percentages of people with a Learning Disability and confirmed dementia diagnosis receiving PDS provision	The LDP Standard is that all people newly diagnosed with dementia receive a minimum of one year of post-diagnostic support (PDS) and have a person-centred plan in place at the end of that support period.	Monthly PDS LDP Standard report	Collected in the PHS LDP Standard report (Appendix)

Appendix 1

Quarterly Reporting – OPMH Services

Name of measure	Concept being measured and why it's important to look at this	Operational definition	Data collection
The amount of time people with a confirmed Dementia diagnosis are placed on waiting lists for services (O)	It is anticipated that effective care co-ordination will reduce waiting list numbers and times	Numbers/percentages of people with a confirmed Dementia diagnosis and length of time placed on waiting lists for care co-ordination services including OPCMHT, Memory Clinic, AHP, Psychology, Psychiatry out-patients	Data collected by HSCP Data Analyst. Displayed monthly
Number/percentage of people receiving care co-ordination (O)	The numbers/percentages of people receiving care co-ordination will have increased	Numbers/percentages of people with a confirmed Dementia diagnosis in receipt of care co-ordination, 2019/2020, 2020/2021 & 2021/2022. This includes care co-ordination across all services e.g. OPCMHT, Access First, GP, District Nursing, Reablement, home care.	Needs data to be collected and linked from SWIFT, MH Dashboard and other systems. Diagnosis information recorded on EMIS. Use of outcome measures
Impact of care co-ordination for people with confirmed Dementia diagnosis (P)	Effective care co-ordination is based on the needs and values of service users, carers and communities	Collection of qualitative data and information of person experience of care co-ordination. This includes care co-ordination across all services e.g. OPCMHT, Memory Clinic, AHP, Psychology, Psychiatry out-patients, primary care, Access First, Reablement, home care, community supports.	Healthcare Experience Survey PDS Single Quality Question Case studies Learning events Other survey examples
Number/percentage of people with confirmed diagnosis of dementia receiving End of life care input (O)	The numbers/percentages of people with confirmed diagnosis of dementia receiving a form of EOLC will have increased.	Numbers/percentages of people with a confirmed Dementia diagnosis in receipt of EOLC input, 2019/2020, 2020/2021 & 2021/2022. This includes EOLC across all services e.g. OPCMHT, GP, AHP, District Nursing, home care, hospice, acute care.	Needs data to be collected and linked from SWIFT, MH Dashboard and other systems.
Impact of EOLC for people with confirmed Dementia diagnosis (P)	Compassionate EOLC is based on the needs and values of service users, carers and communities	Collection of qualitative data and information of person experience of care co-ordination. This includes EOLC across all services e.g. OPCMHT, GP, AHP, District Nursing, home care, hospice, acute care.	Advancing Dementia Practice Forum Case studies Learning events Other survey examples
The impact of the Allied Health Professionals contribution aligned with Connecting People Connecting Support in Action (O)	To measure/evidence developments in line with the CPCS 4 ambitions; enhance access, partnership and integration, skilled workforce and innovation and improvement	Collection of data and qualitative information associated with Occupational Therapy interventions. Including measures; Outcomes of QOL-AD tool Findings from Single Quality Question Findings from Occupation Based Question	Collected in Occupational Therapy performance reporting

Annual Reporting – Hospital Care

Name of measure	Concept being measured and why it's important to look at this	Operational definition	Data collection
Rate of unplanned acute inpatient admissions for patients with a dementia diagnosis. (O)	It is anticipated that effective care co-ordination would result in a reduction in unplanned admissions	The rate per 100,000 of unplanned acute inpatient admissions for patients with a dementia diagnosis, presented by month. Includes code 9 (AWI). Dementia diagnosis defined as documented in electronic patient records.	Data collected by HSCP Data Analyst and PHS LIST analyst. Displayed monthly
Rate of unplanned mental health inpatient admissions for patients with a dementia diagnosis. (O)	It is anticipated that effective care co-ordination would result in a reduction in unplanned admissions	The rate of unplanned mental health inpatient admissions, presented by month. Includes code 9 (AWI). Dementia diagnosis defined as documented in electronic patient records.	Data collected by HSCP Data Analyst and PHS LIST analyst. Displayed monthly
Rate of unplanned Geriatric Long Stay inpatient admissions for patients with a dementia diagnosis. (O)	It is anticipated that effective care co-ordination would result in a reduction in unplanned admissions	The rate of unplanned Geriatric Long Stay inpatient admissions, presented by month. Includes code 9 (AWI). Dementia diagnosis defined as documented in electronic patient records.	Data collected by HSCP Data Analyst and PHS LIST analyst. Displayed monthly
Rate of delayed discharges, and associate number of days (O)	It is anticipated that effective care co-ordination would lead to a reduction in the number of delayed discharges and the amount of time spent on delayed discharges	The rate of delayed discharges for patients with a dementia diagnosis per 100,000 population. Dementia diagnosis defined as documented in electronic patient records.	Data collected by HSCP Data Analyst and PHS LIST analyst. Displayed monthly
The numbers and length of time spent on delayed discharge for patients with a dementia diagnosis, as a % of all delayed discharges (O)	It is anticipated that effective care co-ordination would lead to a reduction in the number of delayed discharges and the amount of time spent on delayed discharges	Time spent as a delayed discharge for those with a dementia diagnosis as a percentage of total delayed discharge time (matches definition in Midlothian report)	Data collected by HSCP Data Analyst and PHS LIST analyst.
Unplanned admissions in last 3 months of life (O)	Effective care co-ordination should result in a reduction in unplanned admissions in the last 3 months of life	Numbers of people with a confirmed Dementia diagnosis admitted to in-patient facilities in last 3 months of life. Comparison with admissions without Dementia diagnosis.	PHS LIST analyst
Place of death (O)	Effective care co-ordination may result in an increase in the number of people die at home or in a homely setting	Numbers and percentages of the place of death of people with a confirmed Dementia diagnosis.	PHS LIST analyst

Dementia prevalence numbers and rates (B)	Knowledge of past trends can inform a trajectory of prevalence in the population for future service planning.	Source linkage files: persons aged 65+ with a dementia flag, derived from the diagnosis field in SMR hospital discharge data. Prescriptions: persons aged 65+ who received a drug associated with dementia (BNF 4.11) in the years 2012/13-2018/19. Source social care collection: persons aged 65+ flagged as having dementia in any of the quarterly submissions 2017/18 to 2018/19. Post diagnostic support (PDS): individuals aged 65+ diagnosed and referred for PDS in 2018/19. The dementia cohort was linked to death records to restrict membership to those who were alive at the end of 2018/19.	Data collected by HSCP Data Analyst and PHS LIST analyst.

Annual Reporting – Community Care & Care Homes

Name of measure	Concept being measured and why it's important to look at this	Operational definition	Data collection
Number of care home residents with a dementia diagnosis in calendar year	Percentage of care home residents with a confirmed diagnosis of dementia		
Number of people with dementia newly admitted to a care home within calendar year	Volume of admissions and prevalence of admissions with confirmed dementia diagnosis		
Reason for admission to care home	Common reasons/trends for need for admission to care home		
Age at care home admission with or without confirmed diagnosis of dementia	Average age of new admissions to care homes and comparison of confirmed dementia diagnosis and not		
Number of patients with a dementia diagnosis with a frailty score	Global analysis of population with confirmed dementia diagnosis and frailty scores. Links with service input.		

Number of patients with a dementia diagnosis with an Anticipatory Care Plan	Global analysis of population with confirmed dementia diagnosis and ACP. Links with service input.		
Number of patients with a dementia diagnosis with a Key Information Summary	Global analysis of population with confirmed dementia diagnosis and KIS. Links with service input.		
Number of patients with a dementia diagnosis in receipt of SDS	Global analysis of population with confirmed dementia diagnosis and SDS. Analysis of care provision and comparison with population without SDS.		
Number of patients prescribed drugs for dementia in the community, and total cost	Global analysis of population with confirmed dementia diagnosis and in receipt of pharmaceutical support. Analysis of cost and impact on service provision.		
Number of population with confirmed diagnosis of dementia in receipt of care from unpaid carer	Global analysis of population with confirmed dementia diagnosis and receiving unpaid care. Analysis of service input, impact on care co-ordination and supports.		

Appendix

Monthly Reporting - Post Diagnostic Support

Reference to Measurement plan	From PDS MicroStrategy Dashboard
Referrals to PDS	Number of referrals to PDS service
Discharges from PDS	Number of discharges from PDS service
PDS waiting list	Total numbers on PDS waiting list at end of each month
PDS waiting list	Waiting time: Median
PDS waiting list	Waiting time: 90th Percentile
PDS Caseload numbers and clients in receipt of 'model of care'	PDS Caseload total numbers
PDS Caseload numbers and clients in receipt of 'model of care'	PDS Caseload - Number receiving PDS 5 Pillars
PDS Caseload numbers and clients in receipt of 'model of care'	PDS Caseload - Number receiving PDS 8 Pillars
PDS Caseload numbers and clients in receipt of 'model of care'	PDS Caseload - Number receiving PDS ADPM
PDS Caseload numbers and clients in receipt of 'model of care'	PDS Caseload - Number PDS Not Appropriate
PDS Caseload numbers and clients in receipt of 'model of care'	PDS Caseload - Number receiving PDS - Model Yet to be determined

AGENDA ITEM NO: 12

Report To:	**Inverclyde Integration Joint Board**	**Date: 21 March 2022**
Report By:	**Allen Stevenson** **Interim Chief Officer** **Inverclyde Health & Social Care Partnership**	**Report No: IJB/13/2022/LM**
Contact Officer:	**Laura Moore** **Chief Nurse** **Inverclyde HSCP**	**Contact No: 715365**
Subject:	**CARE HOME ASSURANCE THEMES AND TRENDS REPORT**	

1.0 PURPOSE

1.1 The purpose of this report is to provide an overarching report on the themes and trends identified from the care assurance visits undertaken in the 13 older adult care homes across Inverclyde in late 2021. The report highlights the emergent themes and trends in addition to areas of good practice and areas for improvement. The report is being presented to the IJB for information and assurance.

2.0 SUMMARY

2.1 Care Home Assurance Tool (CHAT) visits commenced across all NHSGGC partnerships in May 2020 in response to the impact of COVID-19. The visits set out with the aim to provide additional clinical input, support and guidance to care homes which were under extraordinary pressure.

This report is based on a series of visits to the older adult care homes which took place in November and December 2021 using the GGC CHAT tool.

Outputs from the assurance visits have been analysed and this report provides a summary of emerging themes, including what care homes are doing well and where improvement work is required.

The report includes feedback and learning captured from the process itself as well as a series of recommendations and next steps.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Inverclyde Integration Joint Board notes the content of this report.

Allen Stevenson
Interim Chief Officer

4.0 BACKGROUND

4.1 Care Home Assurance Tool (CHAT) visits commenced across all NHSGGC partnerships in May 2020 in response to the impact of COVID-19. The visits set out with the aim to provide additional clinical input, support and guidance to care homes which were under extraordinary pressure. This work also aligned to the Executive Nurse Directors responsibilities set out by Scottish Government in which they were to provide nursing leadership, professional oversight, implementation of infection prevention and control measures, use of PPE and quality of care within care homes. Towards the end of December 2020 the roles and responsibilities of the Executive Nurse Directors were again extended to June 2022.

All care homes across Inverclyde received assurance visits in early 2021. Additional supportive visits particularly during COVID-19 outbreaks were also undertaken. Good practice and improvements were identified during the assurance process, with care homes taking ownership of the actions required and working in collaboration with HSCP colleagues to achieve improvements.

The assurance process has continued to be reviewed and updated using a Plan, Do, Study, Act (PDSA) approach. This report is based on a series of visits to the older adult care homes which took place in November and December 2021. The tool utilised for these visits was the current version at that time – version 7, which was updated and agreed in October 2021.

Outputs from the assurance visits have been analysed and this report provides a summary of emerging themes, including what care homes are doing well and where improvement work is required. It should be noted that care assurance visits are just one part of the supportive framework around care homes and sit alongside HSCP day to day relationships with individual care homes, HSCP oversight Huddles and the Care Home Assurance Group. However, the CHAT outcomes give the opportunity to discuss with care homes areas of strength as well as key priorities for the next 12 months. Going forward the Care Home Collaborative (CHC) model will support ongoing improvements.

The report includes feedback and learning captured from the process itself as well as a series of recommendations and next steps.

4.2 **Process**

Visits were planned in accordance with the NHSGGC Standard Operating Procedure (SOP), which was agreed in October 2021. The aim of the SOP is to ensure that the CHAT visits are approached in a consistent, collaborative way that promotes partnership with care homes to achieve high quality care that enables residents to live their best possible life aligned to what matters to them. CHAT visits should be person centred, supportive and collaborative in their approach and provide a link between HSCP to GGC Care Home Hubs to support improvement.

Care Home managers were informed of the planned visits and were sent the CHAT tool a couple of weeks prior to the visit and were asked to self-assess their current position against the criteria. Visiting teams utilised the previous visit report and the self-assessment to provide them with a background on the home pre the visit. Visiting teams were made up of a group of up to four staff representing nursing, commissioning, social work with a senior nurse leading the visit from the HSCP or Care Home Collaborative.

On the day of the visit, visiting teams spent a short amount of time outlining the purpose of the visit with the Care Home manager emphasising that this is a supportive process and asking the Manager about areas of good practice or concern that they would like to discuss. Members of the assurance team spent time walking around the units observing practices – e.g. handwashing, donning and doffing, social distancing and the interactions between staff and residents. Other members of the team looked at training records and care plans, discussing these with staff from the care home. At the end of the visit the

visiting team spent time with the manager giving preliminary feedback highlighting areas of good practice and any areas of improvement.

The visiting team worked collaboratively to complete the visit reports and these were sent back to the Care Home managers for factual accuracy checking and sign off. It is these reports from all 13 older adult care homes which have been analysed to produce this report.

It should be noted that only 12 of the 13 homes received actual visits from the visiting team. Due to upgrade works at Balclutha it was agreed to carry out their visit in late December, however due to the rise in the Omicron COVID 19 variant within the wider community, it was decided to carry out as much of the visit virtually as possible to minimise non-essential footfall to the home. The commissioning officer and Chief Nurse undertook virtual conversations and reviews of evidence and in January 2022 the Care Home Liaison Nurse did a walk round of the home when she was visiting the home to carry out a care visit.

4.3 **Thematic Analysis of Assurance Visits**

The GGC agreed assurance tool which is utilised for the visits focuses on three main areas:

1. Infection Prevention and Control
   - Environment inclusive of effective cleaning
   - PPE and handwashing
   - Laundry and waste management

2. Resident Health and Care Needs
   - Anticipatory Care Planning, caring for people who are unwell and at the end of life
   - Caring for people with cognitive impairment during lockdown
   - Resident safety

3. Workforce, Leadership and Culture
   - Staff resource
   - Staff wellbeing

This report will comment on the key areas of strength and any areas of improvement required in each of these areas, pulling out themes and trends from across all of the homes visited in relation to each of the three key areas.

There were many areas of exemplar practice identified throughout these visits. To illustrate these practices, examples of direct quotes from across the reports themselves have been included at the end of the health and care need section to share good practice. It is beyond the remit of this report to include every example of good practice that was evident, however the random selection included gives a good representation of the levels of care and practice that were observed.

4.4 **Infection Prevention and Control**

There are 69 questions within the Infection Prevention and control section of the CHAT tool, the section encompasses visualisation of the environment, observation of practice and discussion in relation to national Infection Prevention and control guidance. The aim of this section is to provide assurance that the home can keep their residents safe and prevent transmission of infection.

Areas of strength:

All of the homes visited showed a very high level of compliance against the IPC criteria in the report.

In particular –

- Homes had robust processes in place on entry to the home to undertake risk assessments and check LFT status of visitors
- The home environments were noted to be clean, tidy and odour free
- Physical distancing amongst staff and handwashing practice was good and consistently followed as per national guidance
- PPE was readily available and donning and doffing practices were good. Signage and guidance was clearly displayed around the homes
- In relation to admissions and visiting, all homes were implementing open with care, and had good processes in place to ensure regular contact could be maintained with the people who matter to the residents including virtually if required
- Good communication methods were being used to ensure staff were kept up to date of latest guidance
- Equipment and Sluice areas were clean and well maintained
- Housekeeping staff were knowledgeable about cleaning requirements as per guidance, cleaning schedules were in place and maintained
- Laundry areas demonstrated segregation of laundry and clear processes were in place
- The majority of homes are over 85% compliant for their IPC and COVID training
- All homes were aware of the processes to be followed in the event of an outbreak and knew who to contact
- Staff were aware of actions to be taken in the event of a suspected or confirmed case of COVID in the home, and were aware of isolation procedures
- Many homes had IPC champions in place
- Many homes had remained COVID free throughout the pandemic or for significant periods of time during the pandemic

There were a few areas in some of the homes visited where the review team noted that further work remains necessary to support all homes to achieve consistently high standards. These areas of improvement are listed below, and are all included in the actions plans for those individual homes.

Areas for improvement:

- Training was not at 100% for all homes in relation to IPC and COVID, this tended to be due to new staff, lack of time to release staff and difficulties accessing the training
- There were some areas of good practice that were not being captured, for example where homes were carrying out frequent handwashing audits but these were not being documented. Documentation is required to evidence this good practice
- Cleaning schedules didn't always cover all of the areas being cleaned or were not signed. Spot checks were reported but not documented. Documentation is required to evidence these practices
- There were some issues with lack of storage space, which led to inappropriate storage or decommissioning of bathrooms to accommodate storage of equipment
- Some of the homes had environmental improvements to be undertaken which were on work programmes

4.5 **Theme 2 - Resident Health And Care Needs**

There are 33 questions in this section of the tool which is focused on the care being planned and delivered across the home. A selection of resident care plans are discussed to assist understanding of the care planning process - including how staff are facilitating person centred care and personalisation, in addition to application of evidence to provide

safe and effective care.

Overall there was a lot of good practice evidenced in relation to resident health and care needs, which the assurance teams were impressed with. Particular areas of strength are noted below.

Areas of strength:

- There was evidence of homely atmospheres within the homes and that residents rooms were personalised with their own belongings and in some instances décor and furniture
- Positive and caring interactions were observed between staff and residents, and staff were observed to be kind and caring
- Activities were observed to be in progress in some of the homes which residents were clearly enjoying and care plans were observed which articulated 1-1 interests and music preferences
- There were only 6 Pressure Ulcers reported across the 13 homes during these visits and the majority of these had been acquired pre admission, good assessment processes were noted in relation to pressure area care and all homes reported timely access to pressure relieving equipment
- Care plans were person centred and up to date with evidence of regular reviews
- Anticipatory care plans were in place and homes were fully aware of specialist palliative care services if input was required
- DNACPR documentation was observed to be in place

Areas for improvement:

- MUST 5 is in use across all care homes, however in several homes training has not been completed
- Several managers reported issues with regard to contacting GP services due to long delays to get through on the phone. Some homes noted that they now had designated phone lines which had assisted with this, however there appeared to be a degree of inconsistency in provision of this service
- There were several homes who require Confirmation of Death training

Examples of Good Practice:

The below examples have been copied directly from the reports, and provide examples of good practice, high quality care and a person centred approach to care –

There were lots of different areas within the home, for staff to provide meaningful activities that supported individual resident's needs i.e. the quiet lounge with busy bench for a resident who now has dementia, but used to like to work with tools.

The home is involved in many community projects such as Together with Music project which connects them with a local school to carry out various activities.

The home is carrying out a North Coast 500 challenge at the moment and aim to "travel" a total of 500 miles collectively either walking or cycling. Residents are using pedalling machines and total distance being recorded. It has been noted that residents who had difficulties with mobility previously have improved due to participating in the challenge.

One member of staff talked openly about spending time with individuals who walk with purpose, and that with time he has learnt how to engage with them and make them smile.

There is a private Facebook page for the home and families can see resident activities and their family members' participation in these online.

One resident recently successfully visited family in England, this was done in conjunction with various other professionals and family.

There was a strong focus on person centred care, with residents being facilitated to enjoy activities and to eat together in small groups of 2 or 3 where this was their preference and facilitated nutrition and social contact.

We spoke to one family member who noted that in 3 years she had always been very happy with the care her Mother received. She discussed several scenarios where she had been able to have an open conversation with staff about her Mother's specific requirements, where she had been involved and felt supported by the team who clearly understood her Mother and her specific needs in relation to her cognitive impairment.

Evidence of 1:1 activities, include list of interests, music playlists recorded for each resident.

Care plans cover all physical and mental health needs as well as social and communication. They show resident choices for things like food and clothes. Also what toiletries they like, what bedding they prefer and how they like their room to be when they are asleep.

One of the files that was read had a stress distress care plan. It was up to date and detailed distraction techniques. Importantly it identified triggers and signs that the resident's mood was changing.

4.6 **Theme 3 - Workforce Leadership And Culture**

The final section looks at the workforce, culture and leadership within the home. There are 9 questions focused on current leadership, how supported staff feel and the overall culture of the home.

Many staff reflected on how difficult it had been throughout the pandemic, particularly when there were resident deaths in the homes and when the residents were not able to receive visitors. Staff reported that they felt supported by their management teams and were happy in their roles. There were a few homes who have experienced management changes but in the main management teams have remained relatively stable.

Areas of strength:

- Managers reported having structured 1-1 time with their senior management and that they felt supported
- Staff reported strong and visible leadership from their managers
- Managers are involved in walk rounds and audits to gain assurance that policies and procedures are consistently applied
- Good handover processes between shifts were reported with manager input
- Several homes have received awards recently – including Investors in People, RCN – Award for Meaningful Visits during Covid-19 Pandemic and awards from their companies

Areas for improvement:

- Recruitment of staff is an ongoing issue for many of the homes as per the national picture
- Mandatory training is an area which features on several of the homes action plans, as due to unprecedented pressures as a result of the COVID pandemic and in some cases accessibility of training staff are not all fully compliant

4.7 **Action Planning And Hscp Continuing Assurance**

All improvements that were suggested by the visiting team were discussed with the care home manager and captured within action plans by the assurance visitors. Actions are specific and measureable, and all have a named person in the care home as a lead and an agreed timescale for completion.

Many of the homes took immediate action to address areas of concern and fed back once they had reviewed the reports on actions already completed.

4.8 **Feedback And Learning From The Process**

The CHAT process is relatively new and therefore it is useful to gain feedback on the process which can be used as learning, and to develop the process for the next visits. In order to gain this feedback all of the visiting team staff members were asked to attend a virtual feedback session. The session was well attended and several areas for improvement were identified.

Overall the visiting team felt that the homes felt friendly and welcoming and it appeared that care home staff were more relaxed about the process, saw it as supportive and were keen to participate. It was agreed that asking the homes to undertake a self-assessment was really helpful and did meet the aim of the visits being more focused as a result of this.

Several areas for improvement were identified, most of which focused around evidence prior to the visit, clarity around the process and collation of the final report.

Key learning points are noted below –

- To continue with the self-assessment approach, but allow homes a longer time to complete this and request that they complete this electronically to assist with collation of the final report
- Clarity required around the process, particularly pre and post the visit, individual responsibilities and timescales to ensure all of those who are undertaking the visits are clear on what is required and that there is a consistent approach
- Participating in the visits and completing the reports is very labour intensive and is hard to accommodate in busy diaries – more notice and planning around the visits would assist this
- Contacting the home pre the visit to discuss what information is required on the day and confirm who will be attending is helpful preparation
- Until now only 1 nurse has attended the smaller homes as part of the process. Two nurses is beneficial if one of them (CHLN) knows the home and this assists with feedback and follow up of actions
- Collation of 4 separate reports per home is time consuming, having one master copy which everyone adds to, which once completed can be saved in the Master file would be much easier and reduce administrative burden. Process to include feedback to all contributors

- Action plans from visits require monitoring as part of commissioning team regular meetings with homes, to ensure all actions are completed as per timescales
- The feedback meeting was a useful exercise

Feedback was also obtained from the care homes themselves who were sent an email asking them for their experience of the visit and thoughts on what went well and what could be improved for next time. Only one home replied to the email however others provided informal feedback at the time.

Key points from the care home feedback were that overall the experience was positive and staff were happy to liaise with the visiting teams. Care homes found that completion of the self-assessment documentation prior to the visit was very helpful in helping them to analyse their current position.

4.9 **Recommendations For Future Visits**

All of the feedback gained has been pulled together to form the following recommendations, which are being taken forward in preparation for the next visits to refine the CHAT process -

- Self-assessment period to be extended to 1 month and homes to be asked to complete this electronically
- Flow chart to be developed to outline the overarching process, responsibilities and timescales. Flow chart to include preparation calls to the homes
- Flow chart to include process for collation of the reports, so that there is only one version
- Feedback sessions for all involved in the visits to be held routinely
- Programme of visits to be developed and shared for the year
- Two nurses to attend all visits, one from CHLN in addition to the lead nurse
- Action Plans to include names of responsible HSCP staff and to be monitored at regular meetings with the homes
- Action Plans to be collated in to one overarching document which includes every home, to provide assurance of monitoring and outcomes
- Overarching action plan to be discussed with the Care Home Collaborative team to identify areas where they can support homes to achieve compliance, particularly in relation to training requirements and access to this
- To work with the Medical Director, commissioning and primary care colleagues to address the issues of delays to being able to contact GP colleagues when required

Next Steps

CHAT visits will continue to be held on a six monthly basis, or more frequently if there is an identified need for a specific home. All of the agreed recommendations from this report will be implemented to assist both this process and the ongoing support to the care homes locally.

Each CHAT visit where improvements are identified, has led to a specific action plan for that home. These action plans will continue to be discussed and monitored regularly with the homes to ensure that any required support is identified and provided. In addition Managers of the care homes will be able to access the Care Home Collaborative to assist with the provision of advice and/or resource to support improvement, with the hub also offering support for the continuing development of the managers themselves.

CHAT reports for individual homes will all be submitted to NHSGGC for analysis as part of the Quarterly CHC CHAT reports, which are presented to the CHC Steering Group. Overarching themes and trends for GGC are pulled from this process which assists with the ongoing development of the CHC.

This report will be presented to the Senior Management Team (SMT) at the HSCP including the Chief Social Worker and Medical Director for information and assurance, in addition to the Clinical and care Governance Committee and the IJB.

The report will also be shared with the care homes themselves and teams who participated in the visits for information.

5.0 IMPLICATIONS

Finance

5.1

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

5.2 No implications.

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?

	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.

5.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	The CHAT process applies to all care homes and residents including individuals from protected characteristic groups
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	HSCP and the visiting teams would act appropriately to any identified issues regarding discrimination
People with protected characteristics feel safe within their communities.	The visiting team work to ensure that all people using the services feel safe.
People with protected characteristics feel included in the planning and developing of services.	Visiting teams speak to all residents and families willing and able to participate in the visits
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	As part of the process visiting teams examine care plans to provide assurance around holistic assessment - to ensure individual need is identified.
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	Any relevant opportunities would be highlighted in reports and actioned

Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	Positive attitudes are always encouraged in all aspects of these visits

5.5 **Clinical Or Care Governance Implications**

There are clinical or care governance implications arising from this report as this report is directly related to the care of residents within the care homes of Inverclyde. The report will be presented to the Clinical and Care Governance committee and all recommendations will be monitored through that governance route. The report is provided for quality assurance purposes.

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.	The visits are focused on the well-being of care home residents and person centred care to enhance this
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	The visiting team specifically look at the homeliness and patient centeredness of the care home environments
People who use health and social care services have positive experiences of those services, and have their dignity respected.	The visiting teams observe and discuss aspects of the care home residents experiences and dignity in all aspects of care provision
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	The visiting team are looking at all aspects of quality of life as parts of the process
Health and social care services contribute to reducing health inequalities.	The visiting team foster this approach at all times and take a consistent approach to visits
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.	Families and carers are included in the visit discussions if available to do so
People using health and social care services are safe from harm.	The CHAT tool and visiting teams specifically look at this across several domains
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.	Discussions take place with care home staff as part of the visits and training needs are identified and monitored as part of the action plans
Resources are used effectively in the provision of health and social care services.	Visiting teams look at the effective utilisation of resources in the provision of care

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 CONSULTATION

7.1 The report has been prepared by the Interim 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 None.

Inverclyde Integration Joint Board Audit Committee

Monday 24 January 2022 at 1.00pm

Present:

Voting Members:

Councillor Elizabeth Robertson (Chair)	Inverclyde Council
Councillor Luciano Rebecchi	Inverclyde Council
Simon Carr (Acting Vice Chair)	Greater Glasgow & Clyde NHS Board

Non-Voting Members:

Diana McCrone	Staff Representative, Greater Glasgow & Clyde NHS Board
Stevie McLachlan	Inverclyde Housing Association Forum Representative – River Clyde Homes

Also present:

Allen Stevenson	Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership
Anne Glendinning	On behalf of Sharon McAlees ,Chief Social Worker, Inverclyde Council
Alan Best	Interim Head of Health & Community Care, Inverclyde Health & Social Care Partnership
Craig Given	Chief Finance Officer, Inverclyde Health & Social Care Partnership
Andi Priestman	Chief Internal Auditor, Inverclyde Council
Vicky Pollock	Legal Services Manager, Inverclyde Council
Diane Sweeney	Senior Committee Officer, Inverclyde Council
Lindsay Carrick	Senior Committee Officer, Inverclyde Council
Andrina Hunter	Service Manager, Corporate Policy, Planning & Performance, Inverclyde Council

Chair: Councillor Robertson presided.

The meeting took place via video-conference.

Prior to the commencement of business the Chair advised that Ms Paula Speirs had resigned from the IIJB and IIJB Audit Committee and that Mr Simon Carr would act as Vice Chair at this meeting. The Chair acknowledged the valuable contribution Ms Speirs had made to the IIJB Audit Committee and that she would be missed.

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

No apologies for absence or declarations of interest were intimated.

2 Minute of Meeting of IJB Audit Committee of 20 September 2021 **2**

There was submitted the Minute of the Inverclyde Integration Joint Board Audit Committee of 20 September 2021.
The Minute was presented by the Chair and examined for fact, omission, accuracy and clarity.

Decided: that the Minute be agreed.

3 Minute of Meeting of IJB Audit Committee of 29 November 2021 **3**

There was submitted the Minute of the Inverclyde Integration Joint Board Audit Committee of 29 November 2021.
The Minute was presented by the Chair and examined for fact, omission, accuracy and clarity.
Decided: that the Minute be agreed.

4 IJB Audit Committee Rolling Annual Workplan **4**

There was submitted a list of rolling actions arising from previous meetings of the IJB Audit Committee.
Decided: that the Rolling Annual Workplan be noted.

5 Internal Audit Progress Report – 30 August to 17 December 2021 **5**

There was submitted a report by the Interim Chief Officer, Inverclyde Integration Joint Board on the progress made by Internal Audit during the period from 30 August to 17 December 2021.
The report was presented by Ms Priestman, being the regular progress report, and advised as follows:
1) there was one Internal Audit report finalised since the last Audit Committee meeting in September 2021;
2) that the Audit Plan for 2021/22 is now complete;
3) in relation to Internal Audit follow up, there were no actions due for completion by 30 November 2021. There are 8 actions being progressed by officers, all as detailed in appendix 1 to the report;
4) there have been no Internal Audit Reports relevant to the IJB reported to Inverclyde Council since the last Audit Committee meeting in September 2021;
5) there have been 3 Internal Audit Reports relevant to the IJB reported to NHS GGC since the Audit Committee meeting in September 2021;
6) Internal Audit within Inverclyde Council and NHS GGC have undertaken to follow up actions in accordance with agreed processes and will report on progress to the respective Audit Committees.
The Board sought reassurance that they would be provided with an update on the issues identified in the Internal Audit Report 'IJB Performance Management and Reporting Arrangements'(the Report), and referred to the 30 November 2022 deadline for this as noted at paragraph 5.6. Ms Priestman advised that an update would be provided. The Board enquired if the Report had been issued yet and Ms Priestman advised that it had been issued to officers and External Auditors with a summary being contained in this report. Ms Priestman advised that she would issue a copy of the Report to IIJB Audit Committee Members.
The Board welcomed the recommendations detailed at paragraph 5.5 to align performance reports, commenting that the volume and spread of data could be difficult to assimilate. There was discussion on the outcome of incorporating reports, with the general consensus being that reporting will be streamlined. Ms Hunter advised that a new performance management system, Pentana, had been purchased by Inverclyde Council and Inverclyde HSCP which will assist with this.
Decided: that the progress made by Internal Audit in the period 30 August to 17 December 2021 be noted.

6 Status of External Audit Action Plans at 30 November 2021 **6**

There was submitted a report by the Interim Chief Officer, Inverclyde Integration Joint Board on the status of current actions from External Audit Action Plans at 30 November 2021.

The report was presented by Ms Priestman and advised as follows:

In relation to External Audit follow up, there were no actions due for completion by 30 November 2021. There are 3 actions being progressed by officers, all as detailed in appendix 1 to the report.

Decided: that the Internal Audit Annual Report and Assurance Statement 2020/2021 be approved.

7 IJB Risk Appetite Development **7**

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on the status of the IJB Risk Appetite and its progress.

The report was presented by Mr Given and detailed the work undertaken to date by the short life working group which was set up following the recommendation of the IJB Audit Committee in June 2021 to review the IJB's approach to risk. The group agreed on three overarching risk categories: (1) Strategic, (2) Financial and (3) Reputational.

The Board enquired if there was a mechanism by which identified risks might be tested. Ms Priestman advised that a review of the new risk management arrangements could be included in the Audit Plan, and that feedback could be provided on this. The Chair requested that this be added into the process.

The Board enquired if there were plans to replace Ms Speirs on the short life working group, and Mr Stevenson advised that a replacement for Ms Speirs was actively being recruited.

Decided:

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

(2) that the testing of identified risks be included in the Audit Plan with appropriate feedback to IIJB Audit Committee on this matter.

8 IJB Risk Register

There was submitted a report by the Interim Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership (1) providing an update on the status of the IJB Strategic Risk Register, and (2) appending the most recent Risk Register reviewed by officers on 16 December 2021.

The report was presented by Mr Given and noted that the Register is reviewed twice a year and advised of changes to Risk 7 (Contingency Planning), 8 (Performance Management Information) and 9 (Locality Planning) since this matter was previously reported.

The Board queried how new risks are identified and Mr Given provided an overview of the process, with Mr Stevenson advising on the checks and balances procedures before a new risk is added to the Register.

The Board referred to the appended Register and noted that within the 'Additional Controls/Mitigating Actions & Time Frames With End Dates' column there were very few either 'end dates' or 'ongoing' timescales recorded and Mr Given agreed to review this. Ms Priestman added that the new Pentana system, which has a specific risk module, will provide a more robust reporting framework.

The Board referred to the section 'Locality Planning to Better Understand the Needs of the Community' and sought clarification on the number of Locality Planning Groups (LPGs). Mr Stevenson advised on the intention for there to be 6 LPGs, and that at present 2 had been formed and had met. The 2 LPGs were scheduled to meet again in March and afterwards there would be a review of progress with the remaining LPGs commencing on a stepped basis. He further advised that 6 Communication Groups had been established. The Board asked for the remaining LPGs established and the Chair requested that an update report be provided on this matter. Mr Stevenson agreed that a report will be submitted to the IIJB when appropriate.

The Board questioned if the 'Current Controls' and 'Additional Controls' noted for item 6 (Home Care) were robust enough. Mr Best advised that recruitment of staff and service development was continually monitored, with appropriate actions taken when required.

The Board asked if there was any intention to supply staff with body cameras, and Mr Stevenson advised there were no current plans to issue staff with cameras, but there were control mechanisms in place to address any concerns that staff may have.

Decided:

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

(2) that it be remitted to officers to submit a further report on the progress of the Locality Planning Groups.