Date: 17 June 2020
e-mail: eamonn.daly@eastrenfrewshire.gov.uk

TO: **MEMBERS OF THE EAST RENFREWSHIRE INTEGRATION JOINT BOARD**

Dear Colleague

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

A meeting of the East Renfrewshire Integration Joint Board will be held on **Wednesday 24 June 2020 at 10.00 am**.

Please note this is a virtual meeting

The agenda of business is attached.

Yours faithfully

Anne-Marie Monaghan

Chair

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EAST RENFREWSHIRE INTEGRATION JOINT BOARD
WEDNESDAY, 24 JUNE AT 10.00am

AGENDA

1. Apologies for absence.

2. Declarations of Interest.

3. Minutes of previous meetings

(i) 29 January 2020 (copy attached, pages 5 - 14).
(ii) 18 March 2020 (copy attached, pages 15 - 18).

4. East Renfrewshire HSCP Response to COVID-19 (copy attached, pages 19 – 28).

5. East Renfrewshire HSCP COVID-19 Recovery Plan (copy attached, pages 29 – 54).

6. Clinical and Care Governance Update (copy attached, pages 55 – 60).

7. Audit Scotland Annual Audit Plan 2019/20 (copy attached, pages 61 – 78).

8. Unaudited Annual Report and Accounts 2019/20 (copy attached, pages 79 – 144).

9. Revenue Monitoring Report 2020/21 (copy attached, pages 145 – 156).

10. Postponed Publication of 2019/20 Annual Performance Report (copy attached, pages 157 – 160).

11. Draft Unscheduled Care Strategic Commissioning Plan (copy attached, pages 161 – 246).

12. Calendar of Meetings 2021 (copy attached, pages 247 – 250).

13. Date of Next Meeting: Wednesday 12 August 2020 at 10.00am.

NOT YET ENDORSED AS A CORRECT RECORD

AGENDA ITEM No.3(i)

Minute of Meeting of the East Renfrewshire Integration Joint Board held at 10.30 am on 29 January 2020 in the Council Offices, Main Street, Barrhead

PRESENT

Anne-Marie Monaghan	NHS Greater Glasgow and Clyde Board (Chair)
Lesley Bairden	Head of Finance and Resources (Chief Financial Officer)
Councillor Caroline Bamforth	East Renfrewshire Council (Vice-Chair)
Susan Brimelow	NHS Greater Glasgow and Clyde Board
Dr Angela Campbell	Consultant Physician in Medicine for the Elderly
Anne Marie Kennedy	Third Sector representative
Dr Deirdre McCormick	Chief Nurse
Andrew McCready	Staff Side representative (NHS)
Geoff Mohamed	Carers' representative
Julie Murray	Chief Officer – HSCP
Kate Rocks	Head of Public Protection and Children's Services (Chief Social Work Officer)
Councillor Jim Swift	East Renfrewshire Council

IN ATTENDANCE

Kim Campbell	Localities Improvement Manager
Eamonn Daly	Democratic Services Manager, East Renfrewshire Council
Ruth Gallagher	Chief Officer, Voluntary Action
Candy Millard	Head of Adult Health and Social Care Localities

APOLOGIES FOR ABSENCE

Councillor Tony Buchanan	East Renfrewshire Council
John Matthews	NHS Greater Glasgow and Clyde Board
Councillor Paul O'Kane	East Renfrewshire Council
Flavia Tudoreanu	NHS Greater Glasgow and Clyde Board

DECLARATIONS OF INTEREST

1. Mrs Kennedy declared an interest in agenda item 9 – Talking Points – Update, by virtue of her role as Chair of Voluntary Action.

MINUTE OF PREVIOUS MEETING

2. The Board considered the Minute of the meeting held on 27 November 2019.

Commenting on the Minute and the discussions that had taken place in relation to levels of use of the CAMHS service, Councillor Swift enquired if it would be possible to obtain figures comparing levels of use of the service in East Renfrewshire against usage levels in other IJB areas.

The Chief Officer having confirmed that the information could be provided to a future meeting, the Board approved the Minute.

MATTERS ARISING

3. The Board considered and noted a report by the Chief Officer providing an update on matters arising from discussions that had taken place at the previous meeting.

ROLLING ACTION LOG

4. The Board considered and noted a report by the Chief Officer providing details of all open actions, and those that had been completed since the last meeting.

Responding to comments the Chief Officer confirmed that the form in relation to the reimbursement of carers' expenses would be finalised as soon as possible. She further confirmed that the status of the action in relation to the Care at Home Improvement and Redesign Programme would be changed from "Closed" to "Open". In relation to the progress report on Individual Budgets she also confirmed that this would take account of the technological solutions that were being introduced as this would have an impact on individual budgets.

The Board noted the report and the additional actions to be taken.

PERFORMANCE AND AUDIT COMMITTEE

5. The Board considered and noted the Minute of the meeting of the Performance and Audit Committee held on 27 November 2019.

ADDITIONAL INTEGRATION JOINT BOARD MEMBER

6. The Board considered a report by the Chief Officer seeking the appointment to the Board of a representative from Scottish Care.

The report explained that Scottish Care was a membership organisation and the largest representative body for independent care providers in Scotland, representing over 400 organisations.

Although locally there was a history of successful collaboration with the independent sector, the recent Joint Strategic Inspection suggested that in terms of strategic commissioning and planning, there was a need for greater involvement of the independent sector.

It was noted that Scottish Care were already represented on the Performance and Audit Committee and it was considered that having a Scottish Care representative on the Board would help to strengthen partnership working and be a valuable way of reflecting their contribution in East Renfrewshire. It was further noted that Scottish Care were represented on 8 IJBs, including on the Boards of some neighbouring IJBs.

Mrs Brimelow sought clarification of the representative nature of Scottish Care and whether or not in light of their role there was the potential for any conflict of interest were they to be offered membership of the Board.

In reply, the Chief Officer explained that the independent sector already participated in the Clinical and Care Governance Forum and the Scottish Care were already represented on the Performance and Audit Committee.

The Chair then invited Heather Molloy from Scottish Care, who was in the public gallery, to join the meeting to respond to Mrs Brimelow's questions. Thereafter Ms Molloy explained the role of Scottish Care, highlighting that it was a representative body with over 400 members providing both care home and care at home services. She explained that Scottish Care did not directly provide services and so the question of conflict of interest was one that should not arise. However she clarified that the organisation did have a framework in place to mitigate against any potential conflicts of interest.

Having heard Ms Molloy, and Mrs Brimelow welcome the assurances given, the Board agreed that the membership of the Board be extended to include a representative from Scottish Care, and that Scottish Care be invited to nominate a representative and substitute to serve on the Board

PARTICIPATION AND ENGAGEMENT STRATEGY - PRESENTATION

7. It was noted that the presentation had been made prior to the start of the meeting.

TALKING POINTS - UPDATE

8. Under reference to the Minute of the meeting of 1 May 2019 (Item 10 refers), when the Board noted a report by the Chief Officer providing an update on activity in the preceding 6 months and details of the new arrangements that would be in place from May 2019, the Board considered a report by the Chief Officer providing details of further progress in the implementation of Talking Points from May to October 2019.

The report explained that during that time, 69 Talking Points had taken place, leading to "good conversations", these being structured, asset-based discussions enabling people to identify what mattered to them and the development of a plan supporting people to achieve their outcomes. It was noted that the majority of conversations resulted from linking talking points to existing group activities, walk-ins, 3rd sector referrals and a social medial campaign, with less than 5% of attendances being as a result of a direct referral by HSCP staff.

The report provided details of the type of supports people were referred/signposted to, highlighting that the main changes from the initial 3-month pilot period were a reduction in requests for general community information and an increase in Council/Culture and Leisure Trust referrals.

The report also provided details of plans for the coming year. These would include a number of fixed Talking Points at the most popular/accessible venues including the 2 health and care centres, Barrhead and Newton Mearns Market Places and Giffnock Library, as well as monthly

themed Talking Points each led by a different partner. Details of the issues and the lead partners for each were listed.

The Head of Adult Health and Social Care Localities was heard further on the report in the course of which she introduced Ruth Gallagher, Chief Officer, Voluntary Action, which was heavily involved in the delivery of Talking Points.

In response to questions from Ms Monaghan on diversion routes and the relatively low number of referrals from HSCP staff, the Head of Adult Health and Social Care Localities explained whilst the report provided details of some of the organisations service users had been signposted to, as one of the key elements of the elements of the approach was to keep people out of the formal system, individual referral details were not recorded. Notwithstanding, the Chief Social Work Officer indicated that there was nothing to prevent users of these services being asked if they had been referred there through Talking Points. This could be considered further as the service developed.

Councillor Bamforth referred to the commercial status of some of the organisations listed in the report., and sought clarification of what arrangements were in place to ensure that the service did not simply become another income stream for these organisations. In reply, Ms Gallagher explained that before any organisation could become part of Talking Points they needed to participate in the Development Group. She clarified that it was only third sector organisations that were involved in Talking Points. However, the whole ethos of the project was about providing choice and giving people options, and that if any organisations who wanted to participate were already on the commissioning framework they would not be excluded.

The Board noted the report.

CONTINUING CARE – FINANCE AND POLICY IMPLICATIONS FOR KINSHIP AND FOSTER CARE

9. The Board considered a report by the Chief Officer on the impact of Part 11 of the Children and Young People (Scotland) Act 2014 (the Act) in relation to continuing care and outlining the financial implications of the policy implementation for looked after children and young people in East Renfrewshire in relation to kinship and foster care.

By way of background, the report referred to the new duties placed on local authorities by Part 11 of the Act to provide young people born after 1 April 1999 who ceased to be looked after on or after their 16th birthday, and whose final placement was “away from home”, with the continuation of the support they received prior to their 16th birthday. This support was to continue up to and including the age of 21.

It was highlighted that this was separate from the duties under Part 10 of the Act that extended the provisions relating to aftercare to young people as contained in Section 29 of the Children (Scotland) Act 1995. This enabled local authorities to provide advice, guidance and assistance to young people ceased to be looked after and eligible for aftercare, up to the age of 26.

The report noted that the average age for leaving care in Scotland was between 16 and 18 whilst the average age for leaving home was 25, and highlighted that moving on from care too early or abruptly and at times without the benefits of support and social networks could contribute to significantly poorer outcomes. To help address this in June 2016 East Renfrewshire Corporate Parents had signed up to the Scottish Care Leavers Covenant, which set out guiding principles for support to care leavers, with a particular keystone of the covenant being for corporate parents to encourage looked after children and care leavers to remain in positive care settings until they were ready to move on.

The report then outlined the existing local arrangements for kinship and foster care including providing details of existing financial arrangements, whereby from 2016 a financial parity model for formal kinship and foster care allowances had been adopted. However, there were still challenges to be addressed in relation to supported care where in certain circumstances financial support was either reduced or stopped altogether. This had in some cases contributed to young people moving on from care earlier than they were perhaps ready to do.

The report then outlined the proposed extended care and support mechanisms to be introduced as a result of the legislative changes. Details of the financial implications of increasing and extending allowances for continuing care were set out. It was noted that in terms of foster care to continuing care the proposed financial support for young people 18-21 would increase from £329.21 to £357.41 per week, whilst for kinship care where 18-21 year olds currently received no financial support, support of £182.70 per week would be introduced. The total estimated cumulative additional costs over the period 2019-2022 would be approximately £140,000 with current indications showing that additional funding would be required. However given the fluidity of numbers of looked after and accommodated young people the full implications for future years were difficult to predict.

Thereafter the report explained that existing planning arrangements for young people in continuing care were being revised, as well as revised guidance for children's social work being developed. This would better assist young people in their transition to adulthood.

The Chief Social Work Officer was heard further on the report referring to rising numbers of children in kinship care. She highlighted the differing ages for the cessation of financial support depending on the type of care provided and how particularly in respect of kinship care the cessation of funding could have an adverse impact on the young person being cared for often resulting in a knock on impact on other services. She commented further on the proposed financial changes outlined in the report and referred to the forthcoming report from the Care Inspectorate into the direct and indirect costs in relation to kinship care.

Referring to the financial implications of the new approach, Councillor Swift questioned whether or not East Renfrewshire Council would fund the additional costs.

Ms Monaghan having suggested that the determination of the overall funding provided to the IJB for those Council services delivered by the HSCP was a matter for the Council and not the Board, the Chief Financial Officer confirmed that the additional cost pressures had been included in the 2020-21 budget process.

Recognising the impact of legislative and policy changes for the HSCP and East Renfrewshire, the Board:-

(a) noted that local guidance would be strengthened to better support carers and young people to financially plan for young people leaving care; and

(b) approved the projected financial commitment in respect of Continuing Care.

EAST RENFREWSHIRE HSCP STRATEGIC IMPROVEMENT PLAN

10. The Board considered a report by the Chief Officer providing details of the proposed development actions in the Strategic Improvement Plan. An amended copy of the plan was tabled.

The actions had been drawn from the response to the areas for development identified in the Joint Strategic Inspection of Adult Services carried out by the Care Inspectorate and Health Improvement Scotland between April and June 2019; the improvement actions identified

following the self-evaluation conducted as part of the Ministerial Strategic Group for Health and Community Care Group review; and the findings from the Audit Scotland Report: *Health and Social Care Integration*.

The report explained that the Improvement Plan reflected the cross-cutting themes in the recommendations and proposals from the various bodies and that the plan was structured in relation to the 6 thematic headings used in the Audit Scotland report.

Commenting on the report the Chief Officer drew attention to the fact that the responses to the Care Inspectorate's recommendations contained in their report published in October had been incorporated into the Improvement Plan.

She reported that in relation to collaborative leadership, positive meetings between HSCP Chief Officers and council Chief Executives had already taken place and some public messaging on the appropriate use of services was being developed. A first meeting between Chief Finance Officers and NHSGGC Director of Finance had also taken place.

Further discussion followed in the course of which Mr Mohamed having emphasised the importance of key stakeholders being identified and involved in any engagement undertaken, Ms Monaghan welcomed that weaknesses in information gathering had been identified and that this was being addressed.

Mrs Brimelow welcomed the action plan highlighting the importance of adopting a strategic focus and the need for the pace of change to be maintained. Referring to the new head of service post that had been created she stated that it would be useful to see a copy of the management structure chart which would allow members of the Board to see where the position would sit within the HSCP management structure and the duties to be undertaken and responsibilities held by the postholder.

In reply the Chief Officer was heard on the role of the new post but also confirmed that a copy of the structure chart would be shared with members of the Board. Furthermore, in response to a question from Councillor Swift on benchmarking of IJB annual performance reports, the Chief Officer explained that the benchmarking criteria had still to be developed.

The Board noted the Strategic Improvement Plan.

CARE AT HOME IMPROVEMENT AND REDESIGN PROGRAMME

11. Under reference to the Minute of the previous meeting (Item 9 refers), when the Board had noted a report by the Chief Officer providing an update on the most recent report from the Care Inspectorate and setting out arrangements to develop a comprehensive programme to focus efforts on meeting the Care Inspectorate requirements, alongside a more fundamental service redesign, the Board considered a further update report giving progress against the programme, and outlining the timeline and key milestones to be reached to progress the service redesign.

Having outlined the membership of the Programme Oversight Board that had been established, the report explained that the key element in relation to meeting and sustaining the Care Inspectorate requirements was the review of frontline management roles and the development of new roles that were fit for the future. In this regard, it was explained that continuity of support for service users would require further recruitment and changes to work patterns to ensure staffing resource was aligned to service demand. Part of the recruitment strategy included advertising through television, radio and social media with the campaign timings being aligned to the national social care recruitment campaign being led by the Scottish Government.

The report then set out the key improvement activities within the programme for Quarter 1 (January to March) across all workstreams and whether they were on target to be delivered on time. It was clarified that in terms of the reporting mechanism used Green status did not indicate that an action had been completed but that it was on track to be delivered in accordance with the agreed delivery timescale.

The report also explained that Quarter 2 priorities were in the process of being set and would predominantly focus on service redesign.

Thereafter the report provided details of the current financial position in respect of the Care at Home Service, it being noted that there was a current projected overspend of £501K against a budget of £7.5M. Further information regarding the implications for current staff roles and working patters was also outlined.

The Chief Officer commented at length on the report, explaining that a more detailed report would be brought to the next meeting of the Board. She was heard on the challenges in relation to staff recruitment and explained that every effort was being made to improve the current financial position.

Responding to questions from Dr Campbell of the impact of staffing shortages on delayed discharges, the Chief Officer explained that despite staffing challenges delated discharges in East Renfrewshire had been well-managed with the numbers being relatively low. She also confirmed that only 1 person had been able to take up temporary residency in a care home to enable them to be discharged from hospital before to an appropriate homecare package had been put in place.

In support of the Chief Officer's comments, Mrs Brimelow explained that she had been monitoring levels of delayed discharge across the whole GGC area and East Renfrewshire performed well. Notwithstanding she suggested that it would be helpful for a paper regarding delayed discharges to be submitted to a future meeting of the Board. Any such paper should also include details of numbers, reasons for delay, numbers of patients who were kept out of hospital due to appropriate care packages, primary and secondary diagnoses.

The Chief Officer having confirmed that a paper would be brought to a future meeting, Mrs Brimelow sought further clarification of whether, in the Chief Officer's opinion, the Care Inspectorate requirements would be delivered by the end of March. In reply, the Chief Officer having explained the efforts that had been made and the ongoing collaborative work with the Care Inspectorate stated that in her opinion it was likely that the majority of the requirements would be delivered, however operational pressures in the winter period may present challenges to progress.

In support of the Chief Officer, the Chief Social Work Officer explained that as commented on earlier in the meeting, one of the challenges that was being addressed was the quality of management information and that the quality of existing information made it difficult to demonstrate to the Inspectorate the improvements that were being delivered. Improvements in data quality would make it easier to demonstrate to the Inspectorate the improvements that were being delivered.

Ms Monaghan having welcomed the assurances that everything possible was being undertaken to improve the service and Councillor Bamforth highlight that staff recruitment was a national issue the Board noted the report.

PRIMARY CARE IMPROVEMENT PLAN - PROGRESS

12. Under reference to the minute of the meeting of 1 May 2019 (Item 11 refers) when the Board had noted a report by the Chief Officer providing an overview of the activities during Year 1 of the East Renfrewshire Primary Care Improvement Plan (PCIP), in line with the Memorandum of Understanding (MOU), the Board took up consideration of a report by the Chief Officer providing a Year 2 mid-year update in relation to actions set out in the Plan.

Having set out the background to the creation of the Plan and associated purpose, the report provided information on the delivery of the commitments set out in the MOU, such as the Vaccine Transformation Programme, Pharmacotherapy, Community Treatment Room Services, Urgent Care (Advanced Nurse Practitioners), and Additional Professional Roles.

Information in relation to the key successes over the year was highlighted. This included excellent figures for the delivery of childhood vaccines, the broadest and most significant whole time equivalent (WTE) input of pharmacotherapy in the Greater Glasgow and Clyde area, and enhanced competency level for Community Health Care Assistants, amongst other things.

Some of the key challenges still to be addressed were outlined. These included uncertainty around the Vaccination Transformation Programme across the wider Greater Glasgow and Clyde area; staff cover during sickness absence, and limited funding from Scottish Government impacting on the ability to fully implement the Plan, amongst others.

The Localities Improvement Manager having been heard further on some of the issues raised in the report, Councillor Swift questioned whether the Advanced Nurse Practitioners and Advanced Practice Physiotherapists currently providing resource to a limited number of practices could be accessed by other practices. In reply the Localities Improvement Manager explained that access to these resources was restricted at the moment but that the possibility of introducing a cluster approach to widen service access in future had not been discounted. Furthermore, she explained that although the additional pharmacy resource was not introduced with the specific intention of achieving prescribing savings, this was a possibility.

The Chief Nurse was heard on the excellent levels of pre-5 flu vaccinations in East Renfrewshire which at 73.3% were significantly higher than in previous years and paid tribute to the efforts of all staff involved, reference being made in particular to the role of District Nurses in the immunisation regime. She did highlight the need to increase the cohort of suitable trained staff but this took time. In addition, in response to a question from Ms Monaghan on the possibility of restrictive contracts to ensure anyone trained by the partnership had to commit to staying there for a defined period, the Chief Nurse explained the challenges around such an approach and that a lot of work on this was taking place at an NHS Board-wide level.

The Localities Improvement Manager having been heard further on challenges associated with training and retention of staff not least of which was the lack of a national pay scale, the Board noted the delivery of achievements as set out as well as the challenges and considerations for forward planning.

RISK MANAGEMENT POLICY AND STRATEGY

13. The Board considered a report by the Chief Officer seeking approval of a revised Risk Management Policy and Strategy. A copy of the proposed Policy and Strategy accompanied the report.

Having set out the background to the establishment of the current Policy and Strategy, the report explained the steps that had been taken as part of the review. These had included seeking comment from a range of stakeholders and also peer review of the Policy and Strategy by other HSCPs.

Details of the feedback that had been received and the proposed recommendations/actions were outlined.

It was noted that the revised policy and Strategy had been considered by the Performance and Audit Committee at its meeting on 27 November 2019, when it had been agreed to remit the Policy and Strategy to this meeting for consideration.

The Board approved the revised Risk management Policy and Strategy.

REVENUE BUDGET MONITORING REPORT

14. The Board took up consideration of a report by the Chief Financial Officer providing details of the projected outturn position of the 2019/20 revenue budget, and seeking approval of a budget virement.

It was reported that against a full year budget of £120.066M there was a projected overspend of £0.231M (0.19%), with details of the projected overspend being provided.

It was noted that this was a reduction in spend of £0.032M from the position last reported. It was further noted that any overspend at the end of the year would be funded from reserves if required although every effort would be made to eliminate the operational overspend during the year.

Comment was made on the main projected variances, it being noted that at these would be subject to change as the year progressed.

It was also reported that the proposed budget virements as set out in Appendix 7 to the report reflected realignment of existing budgets

Commenting further, the Chief Financial Officer clarified that the figures presented did not take account of any further winter related costs and these would be included in the next report.

Mrs Kennedy having suggested that it may be useful for the budget monitoring report to be considered earlier on the agenda for future meetings, the Board:-

(a) noted the report; and

(b) approved the budget virements as set out in Appendix 7.

DATE OF NEXT MEETING

15. It was noted that the next meeting of the Integration Joint Board would be held on Wednesday 18 March 2020 at 10.30 am in the Eastwood Health and Care Centre, Drumby Crescent, Clarkston.

CHAIR

NOT YET ENDORSED AS A CORRECT RECORD

AGENDA ITEM No.3(ii)

Minute of Meeting of the East Renfrewshire Integration Joint Board held at 10.30 am on 18 March 2020 in the Eastwood Health and Care Centre, Drumby Crescent, Clarkston

PRESENT

Anne-Marie Monaghan	NHS Greater Glasgow and Clyde Board (Chair)(by teleconference)
Lesley Bairden	Head of Finance and Resources (Chief Financial Officer)(by teleconference)
Councillor Caroline Bamforth	East Renfrewshire Council (Vice-Chair)
Susan Brimelow	NHS Greater Glasgow and Clyde Board (by teleconference)
Councillor Tony Buchanan	East Renfrewshire Council
Julie Murray	Chief Officer – HSCP
Councillor Paul O'Kane	East Renfrewshire Council
Kate Rocks	Head of Public Protection and Children's Services (Chief Social Work Officer)
Flavia Tudoreanu	NHS Greater Glasgow and Clyde Board (by teleconference)

IN ATTENDANCE

Eamonn Daly	Democratic Services Manager, East Renfrewshire Council
Pamela Gomes	Governance and Compliance Officer

APOLOGIES FOR ABSENCE

Dr Angela Campbell	Consultant Physician in Medicine for the Elderly
Anne Marie Kennedy	Third Sector representative
Heather Malloy	Scottish Care representative
John Matthews	NHS Greater Glasgow and Clyde Board
Dr Deirdre McCormick	Chief Nurse
Andrew McCready	Staff Side representative (NHS)
Geoff Mohamed	Carers' representative
Ian Smith	Staff Side representative (ERC)
Councillor Jim Swift	East Renfrewshire Council

DECLARATIONS OF INTEREST

1. There were no declarations of interest intimated.

BUDGET 2020/21

2. The Board took up consideration of a report by the Chief Financial Officer proposing a budget for the 2020/21 financial year subject to agreement with and directions to East Renfrewshire Council and NHSGGC.

The report explained that the announcement of the Scottish Government draft budget had been made on 6 February 2020, and set out the main messages for the IJB from the announcement. These were that £100M nationally was being transferred from the health to the local government portfolio for in-year investment in health and social care and mental health services that were delegated to IJBs; the funding should be additional to and not substitutional to each council's 2019/20 recurring budget; and that in 2020/21 NHS payments to IJBs must deliver an uplift of at least 3% over 2019/20. Details of the services across which the £100M were to be apportioned and the corresponding local share of funding were outlined.

Further core revenue funding of £95M was provided to councils on 27 February 2020 and on 28 February the Scottish Government had issued a further letter in which it was clarified that as in the previous year local authorities were permitted to offset their adult social care allocations to Integration Authorities by up to 2% and a maximum of £50M based on local needs; that the Scottish Government and COSLA were working jointly to support plans to manage the deficit position in a small number of IJBs and their partner authorities and health boards; and that both the Scottish Government and COSLA had agreed joint political oversight to drive improved performance in health and social care delivery.

The report then explained that the Council had set its budget on 27 February, at that time recognising the additional £100M from the Scottish Government draft budget announcement. However it was noted that the Council budget may be subject to further variation as a result of the final confirmation of budgets of both the Scottish and UK Governments.

Thereafter, the report clarified that the proposed budget offer for the IJB was compliant with the Scottish Government conditions and that based on the information available the total revenue budget, excluding set aside and housing aids and adaptations was expected to be £124.054M, of which £0.6M would be funded by specific grant .

It was explained that within each partner contribution there were a number of cost pressures totalling £6.065M these being summarised. Also outlined was the funding of £3.633M available to meet the pressures and the proposals to close the £2.432M funding gap. Savings of £0.768M had been identified leaving a remaining funding gap of £1.664M to be met from care packages, and revised individual budgets to reflect prioritisation based on national criteria.

Further detailed information on pay and inflation cost pressures was provided, in addition to which the local demographic and demand pressures, as well as prescribing cost pressures and proposals to address these, were outlined.

The timing of the delivery of savings was explained, it being noted that whilst some savings could be delivered early in the year, others would take some time to achieve. This in turn may lead to the need for earmarked reserves to be released and the use of the general reserve if savings were not being delivered in time.

Thereafter, the report confirmed that in the view of the Chief Financial Officer, subject to caveats in relation to the UK Budget, Brexit, and the ongoing COVID 19 pandemic, the budget for 2020/21 was deliverable. However, it was explained that it would be extremely challenging and leave little in reserve for unforeseen circumstances or forward investment opportunity to develop the next Strategic Plan.

The Chief Financial Officer having been heard further on the proposed budget, full discussion took place in the course of which Ms Monaghan welcomed the proposals to pay in full the increase in the Living Wage, highlighting that the people most affected by this were female and part-time staff.

In response to Ms Tudoreanu, the Chief Financial Officer also clarified the uplift figures from the previous year.

Councillor O'Kane questioned whether there was any sense at this stage in relation to the financial impact of tackling the COVID 19 pandemic. In reply, the Chief Officer explained that the financial impact was unclear and this had been one of the main reasons why the Scottish Government had been keen for IJBs to set their budgets as this would enable IJBs to establish a financial baseline. In addition the Chief Financial Officer explained that mechanisms for capturing costs attributable to dealing with the pandemic had now been agreed between NHSGGC and the IJBs within the NHSGGC area. However at this stage, mechanisms in relation to reimbursement required to be developed.

Councillor Buchanan having been heard further on the budget in the course of which he referred to the lack of a multi-year settlement; the additional work that would be required to tackle the pandemic; the additional government funding that was being made available; and also having thanked the Chief Financial Officer for her efforts in preparing the budget in very challenging circumstances, the Board:-

(a) accepted the budget contribution of £51.313 million for 2019/20 from East Renfrewshire Council;

(b) accepted the £0.606 million for Community Justice expenditure funded by grant via East Renfrewshire Council;

(c) accepted the delegated budget for aids and adaptations of £0.550 million;

(d) accepted the indicative budget contribution of £72.135 million from NHS Greater Glasgow and Clyde;

(e) accepted the indicative set aside budget contribution of £31.674 million from NHS Greater Glasgow and Clyde; and

(f) agreed that directions are issued to East Renfrewshire Council and NHSGGC confirming the acceptance of the budget, caveated for amendment following the outcome of the UK budget announcement

DELEGATED AUTHORITY FOR THE CHIEF OFFICER

3. The Board took up consideration of a report by the Chief Officer seeking delegated authority for the Chief Officer for the foreseeable future to take operational decisions that would normally require Board approval.

The report referred to the ongoing COVID 19 pandemic and explained that investigations had been taking place into the Board's business continuity arrangements, including how decisions that required Board approval could be made if the Board was unable to meet.

To address this, the report proposed that delegated authority be granted to the Chief Officer to take any operational decisions that in normal circumstances would require Board approval. This would be subject to consultation taking place with the Chair and Vice-Chair. It was noted that whilst this arrangement would be for the foreseeable future it would be the subject of

ongoing review and normal board meeting arrangements would be reintroduced as soon as practicable.

The proposals having been supported, Ms Tudoreanu questioned whether there were any mechanisms in place to keep Board members up to date with developments. In reply the Chief Officer explained that regular situation reports were already being provided regularly to both internal and external groups and a similar arrangement could be introduced for the Board.

Board members having paid tribute to the efforts being made by all staff during the current situation, the Board agreed that:-

(a) delegated authority be granted to the Chief Officer to take operational decisions in respect of matters that would normally require Board approval, subject to consultation taking place with the Chair and Vice-Chair; and

(b) a weekly situation report be provided to members of the Board

DATE OF NEXT MEETING

4. It was noted that the next meeting of the Integration Joint Board was scheduled to be held on Wednesday 29 April 2020 at 10.00 am in the Council Offices, Main Street, Barrhead. However, in light of the decision in relation to delegated powers the meeting may not be necessary. Information regarding the need for the meeting to take place would be circulated to members as soon as possible.

CHAIR

AGENDA ITEM No.4

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 24 June 2020
Agenda Item	4
Title	East Renfrewshire HSCP Response to COVID-19

Summary

This report provides the Integration Joint Board with an overview of the work of East Renfrewshire HSCP and our partners to date in responding to the COVID-19 pandemic.

Presented by	Candy Millard, Head of Adult Health and Social Care Localities

Action Required

The Integration Joint Board is asked to note and comment on this report

Directions

- ☒ No Directions Required
- ☐ Directions to East Renfrewshire Council (ERC)
- ☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC)
- ☐ Directions to both ERC and NHSGGC

Implications

- ☒ Finance
- ☐ Policy
- ☒ Workforce
- ☐ Equalities
- ☒ Risk
- ☐ Legal
- ☐ Infrastructure
- ☐ Fairer Scotland Duty

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

24 JUNE 2020

Report by Chief Officer

EAST RENFREWSHIRE HSCP RESPONSE TO COVID-19

PURPOSE OF REPORT

1. This report provides the Integration Joint Board with an overview of the work of East Renfrewshire HSCP and our partners to date in responding to the COVID-19 pandemic.

RECOMMENDATION

2. The Integration Joint Board is asked to note and comment on this report.

BACKGROUND

3. The World Health Organisation (WHO) declared the Coronavirus disease (COVID-19) a global pandemic on 11 March 2020. The first cases in Scotland were notified on 1 March 2020. In light of the emerging COVID-19 situation delegated authority to the Chief Officer was agreed by the IJB at its meeting on 18 March 2020.

REPORT

Alleviating pressure on acute NHS services

4. Minimising unnecessary use of hospital services is a strategic priority of the HSCP and this became even more essential given the additional pressure it was feared coronavirus would put on acute NHS services.

5. During the period we increased the staff capacity of our hospital discharge team. The team has been working to continually improve referral processes, conducting continuous monitoring of hospital discharges and gathering accurate daily intelligence on care home vacancies and homecare capacity. Delayed discharges have remained low despite significant challenges as a result of the crisis.

GP Practice Response to COVID-19

6. At the start of the pandemic, GP Practices radically changed their appointment system overnight. They began using a GP / ANP (Advanced Nurse Practitioner) triage model, to provide telephone consultations. Near Me / Attend Anywhere technology was rapidly distributed to all Practices, and Practice staff trained how to use it.

7. Practices have developed new pathways to allow patients to send photographs by email securely. This has enabled patients to be treated or referred urgently to secondary care appropriately. Medical certificates have been emailed to patients, and closer working with Community Pharmacies has allowed prescriptions to be collected and dispensed, without the patient needing to collect from Practices. This has reduced footfall in Practices, and helped limit community activity in lockdown.

8. GPs and Practices have supported our Community Assessment Centre, by providing GPs as clinical decision makers to work in our assessment centre, despite workforce challenges and high workload in primary care. They produced thousands of Emergency Care Summaries and Advanced Care Plans for shielded patients.

9. Practices worked in collaboration with the HSCP to enhance their business continuity plans, and set up buddying arrangements. Fortunately despite several Practice staff being unwell, or self-isolating due to unwell family, all Practices in East Renfrewshire have remained open. Now we are moving into Recovery, Practices have begun working in partnership with the HSCP to build upon innovative models of care and to plan patient flow around Health Centres and Practice buildings.

Pharmacy Response

10. Community pharmacies have faced challenges in providing services during the COVID-19 outbreak. Pharmacies felt overwhelmed at the beginning of the outbreak. Initial shortages resulted in public panic buying and there were many challenges that had to be overcome. Assistance was given by NHS GGC with a suggestion to reduce opening hours and introduce social distancing and queuing systems. HSCP Pharmacy teams supported the humanitarian response in conjunction with East Renfrewshire Council and Voluntary Action and establishing new processes for volunteer drivers to deliver medications to vulnerable and self-isolating residents.

Support for vulnerable people in the community

11. In order to prioritise those in greatest need, all HSCP services established vulnerable people lists at the start of the crisis. We planned for a significant reduction in the existing care and support staff workforce (for all providers) and redeployed staff across services. Day care staff, Occupational Therapists, pharmacy technicians and other Council staff including non-frontline social care staff were redeployed to support the ongoing provision of care to vulnerable residents. Our Learning and Development Team put in place a condensed induction programme for new care staff.

12. Care and support services in the community have been reduced or suspended only where there has been agreement with people and/or families that it is safe to do so. Third/community sector or use of Technology Enabled Care (TEC) has been deployed as appropriate. To continue to support our residents we have maintained regular telephone contact with all clients and where appropriate their families, wherever services have been reduced or stepped down. Services are reinstated or increased should this be required. This involved putting in place additional call handling support and dedicated phone lines. We have been working closely with the third sector and community groups to coordinate the Council and community response to non-personal care requests and our wider support to isolated individuals. During the emergency phase, social work teams and staff from our Initial Contact Team have been visiting households to provide support as required.

13. Recovery services have continued to operate using a variety of mechanisms including Attend Anywhere and Near Me, telephone consultations and face to face consultations where required. Contacts have not dropped as a result of the COVID-19 pandemic. Depot and Lithium clinics have continued. Referrals to the services dropped initially but addictions are now increasing.

Support for vulnerable children and families

14. The HSCP has continued to support children and their families throughout the crisis. Children's services moved to a 1 in 3 week work pattern to support social distancing in offices and an emergency duty team system was put in place.

15. All children's services remain agile working for most part and have implemented priority working based on child protection, vulnerability and health needs. Home visiting is continuing to take place across services where this is essential.

16. The children's social work service was maintained throughout the COVID-19 lockdown period with an emergency vulnerability list which as of 4th May 2020 includes 94 children and young people comprising 79 families. These are the families for whom, in addition to those requiring children protection measures, there are additional vulnerability concerns as a result of current crisis which necessitates a heightened level of contact.

17. Social workers are maintaining keeping in touch contact will all of their other families, albeit engaging in different ways such as telephone, Zoom and now WhatsApp. Where there are high risk activities the emergency team responds to critical situations. Over the last four weeks there have been over 2000 contacts made with children and their families.

18. Following concerns about the low uptake of places in the Education Hubs, there was a renewed and concerted effort to encourage families to use the places. As a result, there has been a significant improvement of children and young people classed as vulnerable attending the Education Hubs. This has risen from an average of 31 children/young people week beginning 20 April 2020 to an average of 53 for the same days during the week beginning 27 April 2020. For the week 27 April to 1 May 2020 a total of 109 children who would be classed as vulnerable attended the Education Hubs.

19. The pressure on care placements for children and young people remains significant. Action has been taken to maximise what capacity there is remaining within our fostering service and to continue to find creative solutions in relationship to kinship placements. Virtual fostering and kinship panels are taking place on a regular basis to support arrangements. However, as additional demand has placed the service at capacity, the Chief Social Work Officer linked with the Care Inspectorate with regards to the need for emergency provision. An abridged process is being taken forward with a view to the recruitment of existing East Renfrewshire registered employees (e.g. children's social workers, teachers, nurses) to provide care if internal and external placements cease to be available.

Supporting families with children with complex needs

20. Within the community, families with children with complex needs / life limiting conditions have experienced an overall reduction in support as a result of services reducing or ceasing. Social work and education services continue to co-ordinate and deploy support, however families are reluctant to have children attend Education Hubs due to health fears.

21. Inclusive Support programmes have not been able to run as normal for children with additional needs. Instead, the team have been supporting the Education Hubs for children and young people with complex support needs. Sensory and activity bags have also been provided for young people and their families to support those isolating at home with children requiring high levels of structure and routine. In addition the team has supported adult supported living arrangements.

22. Children's community health services moved to priority provision in the face of agile working and reduced resource. Our school nursing resource and a significant proportion of our health visiting resource has been redeployed to support the East Renfrewshire COVID-19 Assessment Centre.

23. During the first three weeks of the COVID-19 lockdown, the CAMH service experienced an 80% increase in duty calls and higher levels of emergency face to face appointments due to high anxiety levels, in particular from families with young people with eating disorders. There has been an increase of tension within vulnerable family households with teenagers who find it difficult to be confined together with parents/family. As a result of changes in routines and structure, there have been heightened concerns in relation to children and young people diagnosed with Obsessional Compulsive Disorder and Autistic Spectrum Disorder.

Mental Health and Wellbeing Services for Children and Young People

24. The tier 2 Family Wellbeing Service is continuing to receive referrals during this period from GPs, although at a lower rate than previously. GPs are describing those families coming to them for help now as experiencing increased anxiety and exacerbated feelings of distress due to lockdown. The team have flagged recent themes of young people's distress being expressed as thoughts of self-harm. It is possible that children, young people and families are having to internalise their feelings of distress as they do not have the usual external outlets due to lockdown.

25. To date the impact of the COVID-19 outbreak on children's services staffing has been managed, although we are now seeing an exponential rise and risk for children as we move out of lock down.

Support for unpaid carers

26. We have been working in close collaboration with the voluntary sector to provide enhanced support to unpaid carers during the coronavirus crisis. This has seen the establishment of new tailored support and a communication/information strategy for unpaid carers. Carers have been accessing support through the Community Hub and as mentioned and we have established a pathway for carers to access PPE in collaboration with the Carers Centre.

Support to care homes

27. The care home sector has been particularly affected by the coronavirus outbreak with a high volume of cases across Scotland. In East Renfrewshire we put in place enhanced support to our care homes from the start of the pandemic. As with Care at Home we anticipated the significant impact the outbreak would have on staff absence and redeployed day service staff into Bonnyton Care Home to ensure continuing high quality provision. We have also collaborated with other partners within Greater Glasgow and Clyde to secure NHS Bank staff to support East Renfrewshire care homes if required.

28. Care homes have been given priority access to medication through our community pharmacies and we have established new procedures for the stocking of medication in care homes (e.g. specific palliative medication).

29. To ensure the adequate level of support we established frequent (daily) contact with care home management to discuss the issues they are facing, gather information on staffing, bed vacancies and COVID-19 cases, and to support collaborative working across the sector.

30. In line with HSCPs across Greater Glasgow and Clyde, we have introduced a daily safety huddle in which the Chief Officer, supported by senior nursing, commissioning, locality social work and testing administration review the daily information received about care homes. Each Wednesday the daily group is joined by Public Health and Care Inspectorate. The safety huddle analyses information and uses this to offer professional

support and guidance to each care home where required. Each care home is categorised red, amber or green based on risk linked to staffing, quality of care, testing, infection control measures, COVID-19 cases and deaths.

31. Care home liaison nursing and commissioning staff have undertaken enhanced assurance and support visits to any care establishments classified as amber (in need of support) and are offering visits to other homes classed as green (no issues identified). These visits follow a template developed across all partnerships in the Greater Glasgow and Clyde area, which offers guidance to support discussions between HSCPs and Care Homes in enabling delivery of person-led care during this challenging time. This is used to present an indication of how the care home is performing and forms the basis of any support plan required. The feedback from these visits has been positive with homes benefitting from independent assurance that they are implementing guidance correctly and some advice as to how to prepare for safe social distancing visits from relatives and friends. All East Renfrewshire homes are currently classed as green.

Testing and Assessment

32. The HSCP has recently established a testing team in response to the Scottish Government strategy to undertake enhanced outbreak investigation in all care homes where there are cases of COVID-19. Subject to individuals' consent, this will involve testing of all residents and staff, whether or not they have symptoms. This has been a significant operational task, with close working across NHSGGC to support the distribution and collection of test samples. HSCP staff visit homes and test where there are no nursing staff able to undertake this function.

33. As of week commencing 8 June 2020, our care home testing hub extended its work beyond outbreak testing to support weekly testing of all care home staff and sample surveillance testing in care homes that have not experienced an outbreak. The incidence of COVID-19 in local homes has fallen significantly in recent weeks and we are hopeful that we will shortly reach a COVID-19 free situation.

34. A Community Assessment Centre for people concerned about their COVID-19 symptoms was set up in Eastwood Health and Care Centre. This has involved some adaptations to premises, additional equipment and staffing resourced currently from existing HSCP staff. The service operated Monday to Friday from 10am - 2pm and at its peak was seeing on average 11 patients per day. The final session of our Assessment Centre was on Friday 5 June 2020. The number of people attending the centre had been reducing significantly over the past weeks, and in its final week we had only one attendance each day. Although we have closed our local centre, East Renfrewshire residents' continue to have access to COVID-19 assessment. The closest assessment centres are in Linwood and Barr Street in Glasgow and patient transport is available for all those that need it.

PPE for Health and Social Care

35. The HSCP implemented a centralised model of PPE stock control to ensure priority to front line services. The central PPE store is located at Eastwood Health and Care Centre. Standard PPE stock includes gloves, aprons, masks, eye protection and hand sanitiser. To date approximately 59,000 masks, 209,000 pairs of gloves, and 62,000 aprons have been distributed to frontline HSCP staff. The HSCP also contributes to the Council and NHSGGC PPE working groups.

36. As part of the national HUB model the HSCP is now responsible for distributing PPE to external providers, this includes personal assistants and unpaid carers. The HSCP is working in partnership with the Carers Centre to ensure those with caring responsibilities receive appropriate PPE. The Hub has provided PPE to approximately 95 providers and carers who have been unable to source required PPE through their normal routes.

CONSULTATION AND PARTNERSHIP WORKING

37. In partnership with Voluntary Action East Renfrewshire and the Council, the HSCP supports the Community Hub helpline which is a "one-stop shop" for residents needing help or those who cannot leave their house and with no means to organise their own essentials.

38. Staff partnership colleagues have been part of the twice weekly HSCP Local Resilience Management Team meetings. This group oversaw the HSCP response taking an overview of the developing situation and changes required.

39. The HSCP linked to the Council's Resilience Management Team (CRMT) and GGC tactical group in addition to regular GGC and National Chief Officer meetings and Chief Social Work Officer and Chief Financial Officer meetings have taken place.

IMPLICATIONS OF THE PROPOSALS

Finance

40. An HSCP COVID-19 mobilisation plan has been developed and submitted to the Scottish Government via NHSGGC Health Board. The mobilisation plan summarises that actions that the HSCP will take to ensure that a system-wide approach is taken to addressing the challenges to the NHS caused by coronavirus. The HSCP finance team are tracking all costs associated with the HSCP COVID-19 Response.

Workforce

41. Our staff have constantly risen to the challenge presented by COVID-19. There are many examples of individuals and teams being flexible, creative and innovative and finding new ways to support our residents and each other.

Risk

42. The HSCP has introduced a COVID-19 risk register, which is reviewed weekly by the management team.

DIRECTIONS

43. There are no directions arising from this report.

CONCLUSIONS

44. The HSCP has been at the front line in the response to the coronavirus outbreak, supporting our most vulnerable residents at home and in residential settings. As with other service areas, we have seen significant staffing constraints due the virus. Nonetheless, our staff teams have established and adapted to new ways of working and have continued to maintain and deliver safe and effective services to our residents. Across services we have taken innovative approaches and adapted provision to focus on our most vulnerable residents during the emergency phase of the crisis.

45. Over the last few weeks the HSCP has commenced work on Recovery Planning, whilst at the same time providing front line services in response to the changing requirements of the outbreak situation. All of our accommodation is currently being reviewed as this will form the backbone of much of our recovery planning, this work includes our local GP Practices.

RECOMMENDATIONS

46. The Integration Joint Board is asked to note and comment on this report.

REPORT AUTHOR AND PERSON TO CONTACT

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BACKGROUND PAPERS

None

AGENDA ITEM No.5

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 24 June 2020
Agenda Item	5
Title	HSCP COVID-19 Recovery Plan

Summary

This report sets out East Renfrewshire HSCP's approach to the transitional, post-emergency phase of the COVID-19 pandemic. The plan sets out key principles and priorities for the recovery period and outlines our wide-reaching planning approach and the arrangements being put in place to oversee our recovery.

Our recovery activity will follow a phased approach in line with the phased relaxation of lockdown outlined by the Scottish Government. This plan and our ongoing approaches are being developed in recognition of the recovery planning activity taking place at East Renfrewshire Council, NHS Greater Glasgow and Clyde and at the national level.

Presented by	Steven Reid, Senior Performance Management Officer

Action Required

The Integration Joint Board is asked to note and comment on the report.

Directions	**Implications**	
☒ No Directions Required	☒ Finance	☐ Risk
☐ Directions to East Renfrewshire Council (ERC)	☒ Policy	☐ Legal
☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC)	☒ Workforce	☒ Infrastructure
☐ Directions to both ERC and NHSGGC	☐ Equalities	☐ Fairer Scotland Duty

East Renfrewshire HSCP
COVID-19 Recovery Planning outline

1. Purpose of plan

This high-level planning documents sets out the approach East Renfrewshire HSCP will take to the transitional, post-emergency phase of the COVID-19 pandemic. During this recovery period we will be working across service areas in collaboration with partner organisations, service users and the wider community to gradually re-establish service provision to meet the needs of our residents.

This plan sets out key principles and priorities for the recovery period. It outlines our wide-reaching planning approach and the arrangements being put in place to oversee our recovery.

Our recovery activity will follow a phased approach in line with the phased relaxation of lockdown outlined by the Scottish Government. As is broadly recognised, the ongoing situation regarding the coronavirus pandemic is changing week-to-week and needs to be closely monitored particularly in relation to further waves of infection, potentially characterised by localised outbreaks. Given the developing situation it is essential that our approach to recovery recognises the need for flexibility and allows us to respond quickly to change.

This plan and our ongoing approaches are being developed in recognition of the recovery planning activity taking place at East Renfrewshire Council, NHS Greater Glasgow and Clyde and at the national level.

2. Context / background

The current phase of the COVID-19 emergency response has seen incredible resilience, commitment and creativity from staff in all services across East Renfrewshire HSCP. Within a very short space of time teams have established and adapted to new ways of working and have continued to maintain and deliver safe and effective services to our residents. There has been innovation and collaborative working across the health and care system including with external stakeholders and our communities.

Our response to the pandemic has necessarily been tailored within client groups to meet the specific needs of communities and respond to specific challenges posed within these services. The below list summarises the key actions taken across the HSCP:

- Redeployment of staff to work from home;
- Co-location and social distancing of staff to maximise use of buildings;
- Introduction of staff rotation and shift working for certain staff groups to ensure adequate support balanced with social distancing and staff protection;
- Roll out of technology such as Microsoft Teams to enable communication and meetings;
- Suspension of certain services (e.g. Day Care centres, group work);
- Redeployment of staff to cover essential services;

- Prioritisation of service provision based on the most urgent or complex needs (e.g. reduction of home visits to only critical need or the continuation of immunisations and first visits for children);
- Extensive use of technology to support advice and triage processes (e.g. telephone and video-based conferencing, Attend Anywhere);
- Introduction of new services and service models (e.g. telemedicine model, postal medicine/collection from clinic options and temporary Assessment Centre)
- Introduction of teleconsultation and video-consultation with service users.

It is clear that for many months to come, health and social care services will need to be responding and further adapting to the challenges from the COVID-19 pandemic. We now need to plan and deliver services beyond the current 'emergency phase' and through a transitional 'recovery phase' where we progressively return to more 'normal', planned provision of services.

For the HSCP this means thinking about how we have addressed the crisis, what we have learned about the way we deliver services, and what longer-term changes we may be seeing in terms of demand, needs and expectations. It means setting out practical approaches for an efficient return to more normal provision, and thinking creatively about how services can change for the better as a result of our experiences in 2020.

In developing our recovery planning activities we will need to think about the way we worked before COVID-19 and how we have adapted as a result of the crisis. We need to work through each element of how our services operate and, where appropriate, identify how we can re-establish areas of work that have been put on hold or significantly reduced. We also need to identify what new approaches have worked well for service users, staff and wider service delivery, and find ways to maintain those benefits and build on them where we can.

It is recognised that the recovery phase and the return to planned day-to-day arrangements is unlikely to be straightforward or predictable, given the ongoing requirement for social distancing and public health controls. Some aspects of recovery planning will be possible through planned steps, but often these will be dependent on policy decisions that are not yet known. In addition, there remains the potential for further waves of COVID-19 infection which may mean we are required to 'step back' to restrictions seen in previous phases.

The Scottish Government has set out its key principles and approach to decision-making for the transition out of lockdown in *Coronavirus (COVID-19): framework for decision making*, available here: https://www.gov.scot/publications/coronavirus-covid-19-framework-decision-making/pages/3/
Further information to support the framework, reflecting the latest position nationally, is available here: https://www.gov.scot/publications/coronavirus-covid-19-framework-decision-making-further-information/

3. Recovery principles

Since the COVID-19 outbreak our focus has been on implementing business continuity plans to ensure sustainable provision of health and social care services for East Renfrewshire residents. This has seen innovation and collaborative working across the health and care system including with external stakeholders and our communities. Reflecting on the approaches we have been taking will illustrate the benefits and challenges experienced during the period and highlight opportunities for better processes, models and collaborative relationships going forward. The long term impact of COVID-19 will be significant so it is crucial that we learn from the pandemic and our response locally and nationally, and use this knowledge and insight to guide and improve how we work going forward.

We would expect that most of the successful aspects of our COVID-19 response which saw rapid and effective change across the health and care system will be replicated in the recovery phase. Equally, less successful approaches with potentially detrimental impacts need to be identified and addressed.

The key principles underpinning our approach to recovery can be summarised as follows:

Phased approach - Restarting services should be managed via a phased approach using the Business Continuity plans and service-level Recovery Plans. Sequencing of restarting services may be different to the reduction/removal of services during the emergency and should focus on building the required infrastructure for consistent, high quality services to vulnerable citizens and be responsive to the easing of restrictions referred to in the Scottish Government's Route Map. Recovery activity should be considered early, and in tandem with incident response.

Safeguarding - The key principle which must guide recovery planning is the need to provide safe and effective services for people which maximise the health benefit for our residents, promotes independence and protects the most vulnerable. The safety of staff, service users, patients and carers will be paramount throughout recovery, including adherence to local and national testing and isolating guidelines and the continued provision of appropriate levels of PPE. The HSCP will ensure the safest environment and conditions possible for staff to best meet the needs of the population, recognising the safety and wellbeing of health and social care staff is on a par with the rest of our population.

Intelligence-led - Our recovery will be based on the lessons we have learned during the emergency phase; and also on lessons as they emerge during the transition for example around unequal impacts of the COVID-19 crisis on different groups and the changing nature of medium to longer term patterns of need and demand. We will collate learning from across service areas. We will keep any changes applied under review, collecting feedback from relevant stakeholders to inform ongoing recovery and planning for the future. Decisions made will be informed by evidence and learning about what has worked well during the response, what has not been successful and where might there be opportunities to make additional modifications to service provision to support long term, flexible recovery.

Flexibility - Restarting services must be done in a way that is considerate to the fact that COVID-19 still represents a very real public health challenge to the country and its population. The HSCP will be required to react quickly and decisively to additional outbreaks of the virus that may require further adaptations for services and staff, and to respond to external influences such as additional or changing guidance from the UK and Scottish Governments. Recovery of services will also have to be managed to cope with any predicted or unexpected increase in demand for services that may arise as lockdown restrictions are lifted.

Opportunities-focussed - The HSCP will seek to identify, and wherever possible, take advantage of any opportunities that have emerged during the response to the pandemic. A wide range of changes have been made to services. Some of those changes have been successful and consideration must be given to retaining and developing them in order to progress the strategic priorities of the IJB. Where opportunities emerge to stop working in ways that no longer meet requirements they should be explored and considered. Maximising opportunities will include building on the adoption of technological opportunities in response to the pandemic.

Collaboration - The restarting of services will be done on the basis of maintaining ongoing and meaningful collaboration and cross-system working with our key stakeholders. This includes staff, service users, partner providers and Trade Unions/Staff Side. The HSCP will seek to utilise the collective knowledge and experience across the sector to ensure services continue to meet the needs of residents in a sustainable and equitable manner. Decisions about changes to services will be informed by appropriate levels of consultation and engagement with those most affected, and with consideration and assessment of the impact in terms of equalities and human rights to ensure equity of access.

Compassionate leadership - The HSCP will take a long term approach to safeguarding the mental health and wellbeing and resilience of its staff by addressing any psychological impacts that result from our ongoing response to the pandemic. Embedding a culture of compassionate leadership will support individual and team resilience and well-being, learning from and harnessing the support mechanisms, techniques and behaviours which have evolved during the crisis.

Innovation and integration - A key element in the response to the pandemic has been the ability of the HSCP and its partners to demonstrate agility and innovation in making the changes required to meet the needs of our residents. Through recovery activity the HSCP seeks to harness, identify and support innovation and embrace new approaches and ways of working (e.g. digital).

Communication and transparency - The IJBs approach to recovery will include appropriate communication with all stakeholders. The success or failure of any re-starting of services or making/retaining changes to services will rely on ensuring those affected understand the decisions being taken and how that affects how they access the services. We are developing a dedicated communications strategy to ensure a high level of communication to staff and residents.

4. Learning from and building on our crisis response

In response to the emerging challenges resulting from COVID-19 the activity of the HSCP required to be significantly adapted, as discussed above. In many cases services were suspended and require in the recovery phase to be re-instated. In other cases more fundamental alterations were made to existing services and service models to enable services to continue within the constraints of the lockdown restrictions. The HSCP is currently reviewing changes made during the crisis to identify areas where change has been positive.

Examples of positive changes that have taken place during the crisis include:

- Use of digital technology to facilitate new and existing service user assessment, consultation and review (e.g. Attend Anywhere) where face to face methods are not essential

- Evidence of improved partnership/joint working and information sharing (e.g. daily liaison with partner providers)
- Expansion of Technology Enabled Care solutions
- Use of teleconferencing and videoconferencing amongst health and social care staff (where able to access the same platforms/software)
- Flexibility/permission for homeworking
- The growth of the wider network of community/voluntary supports and models of co-production
- An increased focus on mental well-being (including that of staff) and social connectedness.
- The opportunity for services to undertake a review of the priorities and optimal methods of meeting need
- Improved team working and strengthened team leadership

Over the emergency period there have been a range of specific issues that we have had to face. The issues listed below represent the potential barriers that we may face as we move forward through the recovery phases:

- Staffing levels (increased need for isolation anticipated once Test and Protect introduced);
- Confidence/willingness of service users to return to face to face service delivery;
- Ongoing lockdown and delay in returning staff to work in offices (ensuring social distancing guidance applied);
- Sufficient funding to support new ways of working and COVID-19 related costs;
- Capacity of staff able to work either from home/office;
- Reduction in current high levels of community support as people return to work;
- Potential gaps/delays in the recruitment process;
- Availability and capacity of IT to support staff to work from home where necessary;
- Access to the required resources and knowledge to maximise the effectiveness of new ways of working (e.g. digital inclusion);
- Closure / threat to sustainability of some partner organisations or specific services they provide
- Access to PPE
- Financial pressures as a result of increasing demand and decreasing capacity to respond
- Failure to engage and communicate with relevant stakeholders, leading to opposition to change or misconceptions.

Key enabling factors that will support our recovery include:

- Commitment and flexibility of staff
- Ability of staff to work in partnership to find innovative solutions
- Capturing the learning from staff across the system
- A readiness and enthusiasm to harness opportunities and consider new practices
- Capturing service user feedback as a regular part of service development and redesign
- Opportunities to deliver services using volunteers and/or different platforms.
- Opportunity to build on the sense of resilience, partnership and community spirit.

Consideration of the positive changes that have taken place during the COVID-19 crisis, the potential challenges and barriers that we will face as we transition to recovery, and the key enablers will inform our decisions on whether we reinstate 'business as usual' in specific service areas, amend service models or choose to stop delivering services.

5. HSCP-wide planning for recovery

Where possible, we will use existing structures for the ongoing development of the recovery plan, and the DMT will support these structures and processes. Our recovery planning will be developed and supported by a Recovery Planning Working Group made up of representatives from across services and involving staff representatives.

The Recovery Planning Working Group, chaired by the Head of Finance and Resources, will report to the DMT/LRMT and feed in to the Recovery Tactical Group in the Health Board and the Council Recovery and Renewal Sub Group respectively through their reporting structures. This will enable a system-wide overview of component plans to inform recommendations presented to the IJB.

Our recovery plan establishes how key issues will be addresses with estimated milestones. It sets out HSCP-wide approaches for issues such as premises, workforce and ICT and specific arrangements for service areas.

We are taking a programme management approach to the planning and ongoing delivery of activity during the transition / recovery phase. We have established eight thematic work-streams to address key HSCP-wide issues. The work-streams will be the arena for discussion and proposals relating to distinct areas of work, and will give clarity to services moving forward.

Each work-stream will be led by an appropriate key person with a strong understanding of the subject matter of the work-stream. Leads and deputies have been appointed. A summary of the work-streams including aims and objectives is given below.

Table 1 – Thematic work-streams for HSCP recovery planning

WORKSTREAM	DESCRIPTION	AIMS & OBJECTIVES
1. Governance	To manage the Governance framework for Programme Board and reporting to DMT, ERC, IJB, NHSGGC, Partner Organisations and Scottish Government. To ensure clear communication within the HSCP and to our population that we support.	• Implement learning from first IJB 'Teams' meeting on 24 June • Look at next scheduled PAC and consider approach • Look at next scheduled Clinical and Care Governance and consider approach • Restart governance groups such as the Joint Staff Form, Health and Safety Committee • Consider whether the HR Subgroup restarts as a stand-alone or as part of workstream 3. • Ensure cost implications are captured
2. Accommodation	The overall management of all HSCP buildings including HSCP staff areas, GP practices and patient/client interaction in a physical setting over the short, medium and longer term.	• Securing safe staff working environments within our buildings whilst social distancing measures remain in place; and creating user guidance on this. • Securing safe access and consultation arrangements for patients requiring physical, person-to-person interactions with GP and HSCP staff in our buildings • Drafting and agreeing a communications plan for staff, patients and service-users on expected compliance with any guidance created for the above • Assessing suitability of existing accommodation space to facilitate the above, including risk assessments. • Assessing need and viability of obtaining additional accommodation for use during current restrictions, including a realistic assessment of required 'decant' measures.

		• Agreeing a prioritisation matrix and schedule for the re-introduction of services and how these are delivered on a safe basis moving forward.
3. Workforce	All issues relating to staffing and working practices.	• Detailed aims and objectives currently being developed under the two main headings of HR Policy and Staffing Requirements
4. Partner Organisations	Continued partnership working with external support agencies and related commissioning activities.	• Planning – review strategic commissioning aims and objectives across the range of our partner providers. • Procurement – working with DMT to agree a procurement work plan. • Contract Management – review and recommend an approach to managing contracts that is proportionate in the recovery phase and move to a new framework • Data – data platform/s for commissioning and planning purposes be explored.
5. IT Requirements	Essential IT equipment, software and digital capacity required to support the recovery planning process and access to agile working.	• To confirm all status of agile equipment to ensure staff are appropriately equipped – including Window's 10 devices / O365 • Look at supplementary equipment required to enable agile working and quantify requirements • Utilise and consider maximising the use of MS Teams functionality • Utilise input from HSCP Digital Champions to support work-stream aims and objectives
6. PPE	Resourcing, storage and distribution of essential PPE.	• To review the existing management of PPE (ordering delivery, storage, distribution) and make recommendations for managing this service through recovery and eventually its return to business as usual across the HSCP. • To consider the location of the PPE Hub

7. Change Programme	Refresh and re-introduction of the projects that are on hold during the crisis.	• To formulate and agree a realistic timescale for the resumption of work on all projects forming part of the current HSCP Change Programme. • To acknowledge outcomes of work on other recovery work-streams that may require establishing new projects for consideration within the Change Programme and subsequently submit Project Mandates to DMT/Change Programme Board.
8. Ongoing COVID-19 Response	Continued focus on the ongoing crisis management work that is required at any point throughout the recovery period.	• Using the feedback from services on individual service recovery plans, creating the capacity and agility to assist in overcoming issues as they arise and providing HSCP input to ERC and NHSGGC recovery work.

In relation to the work-streams we recognise we need to be flexible and respond quickly to change. This means that work-streams may have to start, stop and adapt as appropriate to changing circumstances while the COVID-19 pandemic continues.

Immediate/short-term HSCP-wide priorities are being addressed and the accommodation work-stream is well under way. All of our accommodation is currently being reviewed with a prioritisation rationale being established. This will form the backbone of much of our recovery planning to ensure facilities are set up for social distancing measures, building access, changes to reception seating areas etc. This work includes GP and dental practices. In addition we are working with partner providers on changes to each building.

Currently working from home remains the default position. Where critical services are already being delivered from our buildings the current reduced footfall means there is sufficient space to continue to socially distance.

We will ensure a high level of communication to staff and residents on our approach to recovery. The HSCP has briefed their communication lead on recovery and an approach document has been drafted. This outlines the aims and objectives of the communications plan as well as considerations, audiences, timing and some initial ideas. The full communications plan has been drafted and will evolve alongside our recovery plan. Our communication approach will tie in with our partners to endure consistency and continuity.

6. Service-level recovery planning

HSCP-wide decision-making (e.g. on accommodation) as well as decisions taken at Board, Council and national level will gradually allow services to fulfil their own recovery plans and return to more normal models of service provision.

Detailed transition planning is underway across service areas. Service representatives, in collaboration with staff teams (and more widely if possible), were asked to undertake an initial planning exercise according to a consistent process and using a planning template. The intention is that our approach allows for flexibility while establishing clear activities and timescales that can be regularly reviewed as we move forward.

Teams were asked to set out what the impact of emergency lock-down has been for services (and for staff and resources), how these compare to normal (or desired) arrangements, and what process needs to be undertaken to return to ‘normal’ or establish new arrangements. Services have been encouraged to develop their plans following a process of open-minded creative discussion and robust risk assessment guided by up-to-date information and guidance.

The plans that have been produced clearly prioritise activities and set out timescales and responsibilities (subject to changing circumstances). The plans have allowed services to set out what needs to be undertaken immediately, and in the medium and long term.

We recognise that the delivery of service-level plans is highly dependent on HSCP-wide and national decisions on the pace of transition. As part of our planning approach we would expect services to review recovery plans regularly and make adjustments as required. Governance/reporting arrangements for the fulfilment of service-level plans will be established through the Governance work-stream. The service-level template has been included at Appendix One.

7. Recovery planning programme

Phased transition

The Recovery Planning Working Group have been considering the potential milestones and phases for the transition period, linking our planning to the 4 phases established by the Scottish Government on 21 May 2020 in *Scotland's route map through and out of the crisis,* available here: https://www.gov.scot/publications/coronavirus-covid-19-framework-decision-making-scotlands-route-map-through-out-crisis/pages/4/

We have produced a table drawing out the main elements in the Scottish Government routemap that are of particular relevance to the provision of health and care, and matched these to anticipated local scenarios. This considers the gradual easing of lockdown restrictions, the anticipated status of health and care services and the potential impact of initiatives such as Test and Protect. We have then set out the local planning response we would expect to be undertaking at each phase. The phases with potential timeframes are set out in Appendix Two.

Given the uncertainties of the pandemic, the potential that we may have to take backward steps, and the fact that some elements may move faster than others, it is unlikely that our recovery will move in perfect tandem with the national phases as currently set out. But this gives a good longer-term outline of the stages we can expect as we move out of lockdown and where would hope to be in our transition to recovery at each stage.

Our planned work programme

As stated, we are taking a programme management approach to the planning and ongoing delivery of activity during the recovery phase. We have established a work programme which allows us to assess options and identify priorities for the resumption of services suspended or reduced during the emergency period. The programme allows for a managed approach that balances the need to resume services alongside the on-going COVID-19 response including social distancing, support to shielding groups, PPE provision and other initiatives; as well as the potential impact of Test and Protect on staff capacity.

Accommodation issues are key to the recovery process. Early and ongoing decisions to ensure appropriate social distancing will enable services to gradually return to normal models of provision. The work programme will also explore opportunities for new and better ways of working for example through the use of digital technology and strengthened partnership working with our voluntary/community organisations and partner providers.

Initial Recovery Action Plan – Phase One

Tasks		Lead	Timescale
WS1 – Governance			
1.1	Ensure all interdependencies are captured and acted on	Lesley Bairden	June 20
1.2	Agree communication approach and plan		
1.3	Agree reporting protocol for this Recovery Programme of Work		
1.4	Complete mapping exercise on partner organisation liaison including timescales and forums to be considered		
1.5	Reinstate Joint Staff Forum and other groups		

1.6	Revise standing agendas to include Recovery		
WS2 – Accommodation			
2.1	Identify available office space for HSCP critical functions (for Health Centres initially)	Mairi-Clare Armstrong	19/06/20
2.2	HSCP critical functions template developed and updated by service representatives on Recovery Group		12/06/20
2.3	Meeting with ERC Corporate Landlord in relation to St Andrew's House requirements		09/06/20
2.4	DMT agreement on critical services working from Barrhead and Eastwood Health & Care Centres		10/06/20
2.5	Social Distancing plan developed for Barrhead & Eastwood Health & Care Centre		18/06/20
WS3 – Workforce			
3.1	HR Policy – to be developed	Lisa Gregson	*Tbc*
3.2	Staffing Requirements - to be developed		
WS4 - Partner Organisations			
4.1	Prepare and submit Strategic Planning Review (dependency on overall strategic review - so actual start date will require subsequent amendment).	Kevin Beveridge	04/12/20
4.2	Agree Procurement work plan with DMT including agreement and sign-off of resource requirements		14/09/20
4.3	Development of Engagement & Participation Strategy		28/08/20
WS5 - ICT Requirements			
5.1	Provide overview of 'as is' position of IT estate across HSCP	Claire Dillon	03/07/20
5.2	Agree prioritisation of roll out of Windows 10		31/07/20
5.3	All users live on Windows 10		29/06/20
5.4	Ensure all NHS equipment on order		22/06/20
5.5	List of all staff equipment		22/06/20
5.6	Record status of outstanding NHS kit		29/06/20
5.7	Issue formal data governance reminder for all staff		31/07/20
5.8	Issue Mobile Phones with email access to all staff who require this.		17/07/20
5.9	Review network connectivity for ERC staff in EHCC and BHCC		18/09/20
5.10	Implement changes identified in Task 31		18/09/20
WS6 – PPE			
6.1	Outline current practices and make recommendations for future progress, including location, to RPSG	Pamela Gomes	19/06/20
6.2	Implement changes and return all PPE ordering, storage and distribution to business as usual activity across the HSCP.		24/09/20
WS7 – Change Programme			
7.1	Review existing in-flight projects and provide recommendations on viable re-start dates for discussion at RPSG	Jim Anderson	12/06/20
7.2	Submit report to DMT on recommended resumption of Change Programme agenda		23/06/20
7.3	Resume discussions with IT and external suppliers on proposed Telephony Upgrade project		24/07/20
7.4	Convene Project Board meetings for in-flight projects to agree new timescales for project delivery in line with PIDs		07/07/20
7.5	Agree Project Brief for use of Payment Cards		07/07/20

7.6	Submit updated position to DMT for Homecare Mobile Phones and Application		14/07/20
7.7	Secure Project Resources		28/07/20
7.8	Agree Project Mandate for CM2000 System upgrade or replacement		07/07/20
WS8 – Ongoing COVID-19 response			
8.1	Collate all Service Recovery Plans as received	tbc	19/06/20
8.2	Approve overall view on service recovery plans to provide basis for HSCP reporting and input to ERC and NHSGGC Recovery Groups		19/06/20
8.3	Submit report to ERC Recovery Group		23/06/20
Cross-cutting			
	Development and review of service-level recovery plans	Steven Reid	June 20 and ongoing
	Participation in ERC and NHSGGC Recovery Planning Groups		Ongoing
	Collation of key learning outcomes from the emergency phase		June 20 and ongoing
	Agree approach for needs assessment and development of next HSCP Strategic Plan		tbc

A full (draft) Gantt chart setting out the work programme is included at Appendix Three. This includes anticipated timescales and highlights suggested critical milestones in red.

Addressing accommodation issues

It is recognised that acceleration of the accommodation workstream is crucial to the wider HSCP Recovery Plan. Ensuring that our buildings and those buildings from which HSCP staff work from are safe and meet the current health and safety requirements is paramount, as such a weekly update is provided to the DMT.

Due to social distancing measures the capacity of our buildings is vastly reduced. Work has already been undertaken to confirm safe numbers of staff and public within our buildings. For the HSCP this has meant that services working from our buildings have had to be prioritised based on service need and risk. This will continue to be reviewed in line with national guidance and service requirements.

The HSCP is working closely with our partners to ensure a consistent approach as our buildings are adapted to meet social distancing requirements and ensure a safe environment for staff and the wider public. We are working in partnership with GP and dental practices and other services who use our health and care centres to determine patient flow whilst ensuring the number of people in the building remains safe.

Progress to date incudes:

- Project team in place;
- Project plan and critical milestones identified;
- Building capacity calculated;
- Identification of critical services who require to work from the office;
- Social distancing plan for both health and care centres progressing collaborating with GPs, dentists and other services who use our buildings;
- Risk assessments being progressed.

Appendix One – Service-level Recovery Action Plan Template

Service / Resource Area (e.g. service, staff, resources)	**Current/Emergency Arrangements**	**Normal/Desired Arrangements**	**Process to achieve Normal / Desired Arrangements** (if to be delivered in stages, set these out)		**Decisions or Circumstances Needed for Change**	**Priority score and Risk Rating**	**Current position (RAG)**
			Activity	**Timescale**			

Appendix Two - COVID-19 Recovery Planning phases

Phase	Scenario / SG anticipated easing of restrictions	Planning response during phase
Lockdown (March to June 2020)	• Emergency position • Lockdown in place with individuals shielding and physical distancing • Full restrictions on movement with only essential travel allowed • Remote working is default position • All non-urgent care/heath care services stopped and capacity focused on COVID-19 response: hubs and assessment centres; urgent care; reducing delayed discharge and prioritising "home first"; prioritising safety and wellbeing of care home residents and staff. Urgent health care remains available. • HSCP services remodelled to focus on critical and essential care • Support provided to shielding and Group 2 individuals • East Renfrewshire CAC in place (15.04.20 – 05.06.20)	• Stocktake of current situation for staff and services – service delivery changes, redeployments, absences, wellbeing and transition requirements • Assess changed and potential future service demands • Consideration of HSCP-wide changes and recovery activities (in line with Board and national principles) • Recovery and transition planning underway by services and HSCP-wide • Establishment of governance structure for recovery and transition phase • Programme for recovery designed
Phase One *(Current: June to August 2020)*	• Gradual reduction in lockdown conditions begins • Physical distancing remains in place • Individuals with underlying health conditions continue to shield *(guidance on shielding being established)* • Remote working remains default position for those who can. Where workplaces are reopening, staggered starts / flexible working patterns encouraged. Testing and tracing implemented – potential for impact of (multiple) staff self-isolations • Gradual resumption of key services inc: - Greater direct contact for support services with at-risk groups and families - Access to respite/day care to support unpaid carers - (Potential) introduction of designated visitors to care homes - Restarting primary and community NHS services inc MH services - Roll out of NHS Pharmacy First Scotland service • Support provided to shielding and Group 2 individuals • Increasing demand for HSCP services • East Renfrewshire CAC remains in place with reduced capacity	• Establishment and implementation of clear HSCP-wide principles re shared issues e.g. building use, working practices and conditions etc • Establishment and coordination of thematic workstreams • Ongoing development and delivery of detailed HSCP-wide and service-level plans focusing on increased direct support to most vulnerable • Support the reassignment of staff and start phased reintroduction of suspended/reduced services • Revisit transformational and savings plans to review and update in light of new position

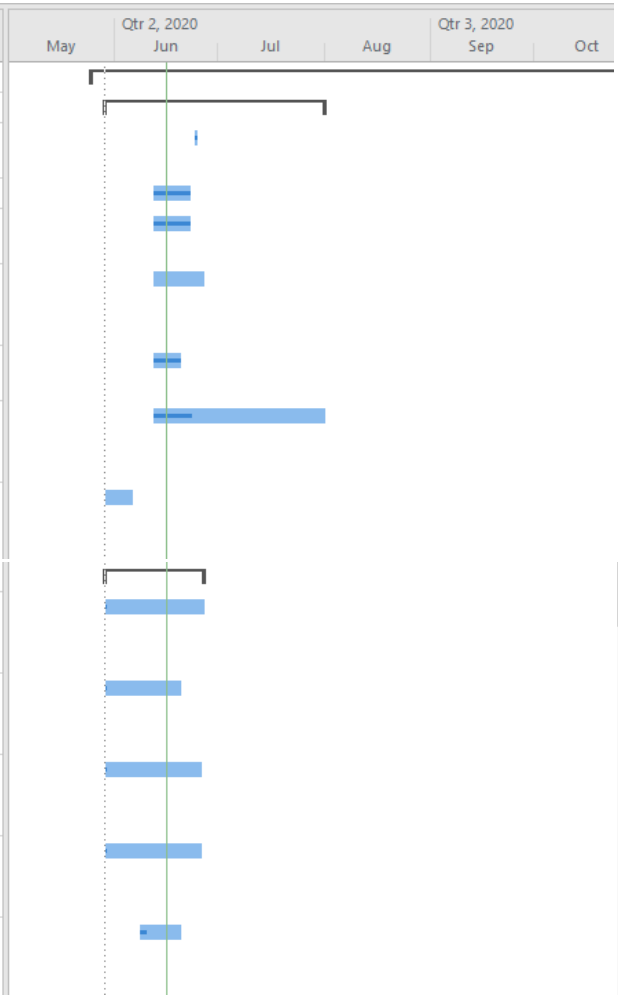
Phase Two *(July-Oct 2021)*	• Gradual reduction in lockdown conditions continues • Physical distancing remains in place • Individuals with underlying health conditions continue to shield *(guidance developing)* • Remote working remains default position for those who can. Where workplaces reopening staggered starts / flexible working patterns encouraged. • Testing and tracing continues – potential for impact of (multiple) staff self-isolations • Further scaling up of public services where safe to do so • Remobilisation plans implemented by Health Boards and Integrated Joint Boards to increase provision for pent up demand, urgent referrals and triage of routine services. • Increased number of home visits to shielded patients • Potential review of social care and care home services. • Expansion of GP services • Phased resumption of visiting to care homes by family members in managed way. • Demand for HSCP services continuing to increase with additional shifts towards particular services e.g. mental health • East Renfrewshire CAC closed	• Delivery of HSCP-wide and service-level recovery plans. • Support reestablishment of services/team structures where safe to do so in line with recovery plans • Continue the phased reintroduction of suspended/reduced services • Support the reestablishment of referral pathways as GP services are reintroduced • Support requirements from national review work re social care and care homes.
Phase Three *(Aug-Dec 2020)*	• Gradual reduction in lockdown conditions continues • Physical distancing remains in place • Individuals with underlying health conditions continue to shield – moving to more detailed clinical advice about personal risk *(guidance developing)* • Remote working remains default position for those who can. Non-essential indoor office workplaces can open. • Able to meet with people from more than one household indoors (making group work more viable). • Testing and tracing continues – potential for impact of (multiple) staff self-isolations • Continued scaling up of public services where safe to do so • Demand for HSCP services returning to pre-covid levels with shifts towards particular services e.g. mental health	• Continued reestablishment of services/team structures where safe to do so in line with recovery plans - with potential for increased group activity • Continue the phased reintroduction of suspended/reduced services • Re-establish full governance arrangements • Re-establish planning and performance reporting arrangements • Re-establish transformational planning arrangements

Phase Four *(Dec/Feb – July 2021)*	• Physical distancing requirements to be updated on scientific advice • Remote and flexible working remains encouraged – all workplaces open with improved hygiene • Full range of health and social care services provided and greater use of technology to provide improved services to citizens. • Potential for additional peak of COVID-19 infections reducing • Testing and tracing in place – lowered potential for impact of (multiple) staff self-isolations	• Fully re-establish 'normal' staff deployment and service delivery arrangements • Continued reform of services in line with strategic/transformation principles and savings plans • Stand-down planning and reporting to the IJB including costs, key lessons learned, successes, staff acknowledgements seeking authority to stand-down BCP • Stand down BCP

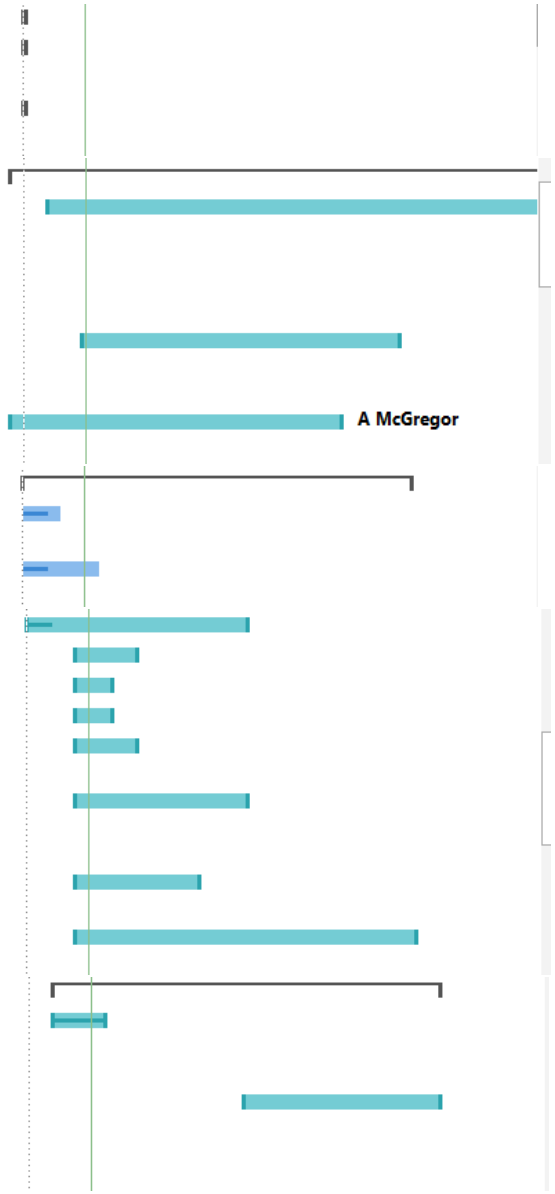
Appendix Three – Recovery Programme Gantt Chart (at 12 June 2020)

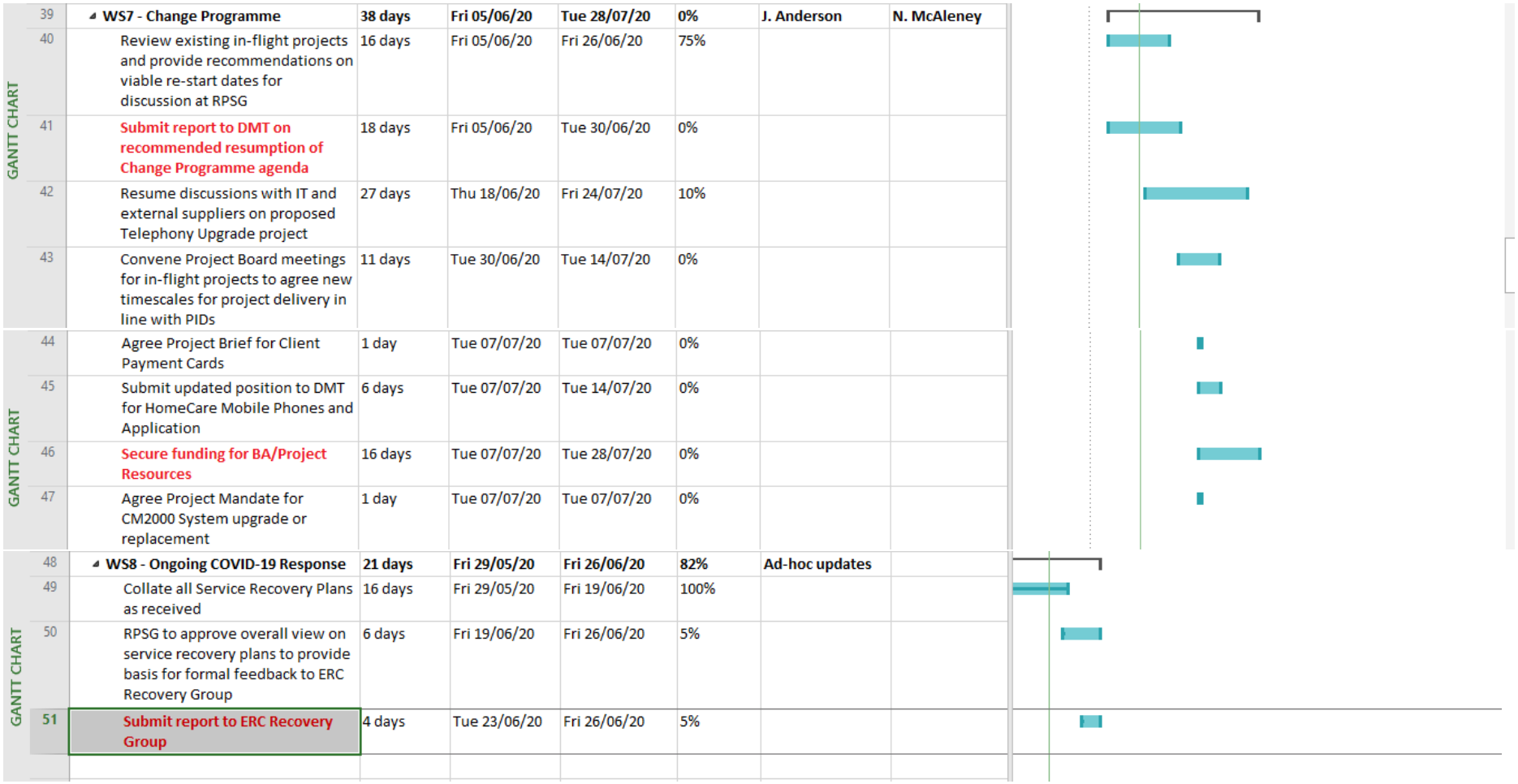
N.b. – Initial critical milestones in red

	Task Name	Duration	Start	Finish	% Work Complete	Resource Names	WSL Sub
1	**HSCP Recovery Planning Programme**	**140 days**	**Mon 25/05/20**	**Fri 04/12/20**	**14%**		
2	**WS1 - Governance**	**46 days**	**Fri 29/05/20**	**Fri 31/07/20**	**40%**	**L. Bairden**	**P. Gomes**
3	**Submit Recovery Planning report to IJB on 24 June**	1 day	Wed 24/06/20	Wed 24/06/20	100%		
4	Reinstate Joint Staff Forums	7 days	Fri 12/06/20	Mon 22/06/20	100%		
5	Put in place revised standing agenda for Joint Staff Forum	7 days	Fri 12/06/20	Mon 22/06/20	100%		
6	Complete mapping exercise on partner organisation liaison including timescales.	11 days	Fri 12/06/20	Fri 26/06/20	0%		
7	Agree reporting protocol for this Recovery Programme of Work	6 days	Fri 12/06/20	Fri 19/06/20	100%		
8	Ensure all interdependencies are captured, recorded and acted on accordingly	36 days	Fri 12/06/20	Fri 31/07/20	20%		
9	Agree communication approach and plan for Recovery Planning Programme	6 days	Fri 29/05/20	Fri 05/06/20	100%		
10	**WS2 - Accommodation**	**21 days**	**Fri 29/05/20**	**Fri 26/06/20**	**5%**	**MC Armstrong**	**J. Clark**
11	**Identify available office space for HSCP critical functions (for Health Centres initially)**	21 days	Fri 29/05/20	Fri 26/06/20	3%		
12	**HSCP critical functions template developed and updated by service representatives on**	16 days	Fri 29/05/20	Fri 19/06/20	4%		
13	Meeting with ERC Corporate Landlord in relation to St Andrew's House requirements	20 days	Fri 29/05/20	Thu 25/06/20	3%		
14	DMT agreement on critical services working from Barrhead and Eastwood Health & Care	20 days	Fri 29/05/20	Thu 25/06/20	3%		
15	Social Distancing plan developed for Barrhead & Eastwood Health & Care Centre	10 days	Mon 08/06/20	Fri 19/06/20	20%		



16	**WS3 - Workforce**	**1 day**	**Fri 29/05/20**	**Fri 29/05/20**	**0%**	**L. Gregson**	**L. Brown**
17	**HR Policy**	**1 day**	**Fri 29/05/20**	**Fri 29/05/20**	**0%**		
18	Tasks under development				0%		
19	**Staffing Requirements**	**1 day**	**Fri 29/05/20**	**Fri 29/05/20**	**0%**		
20	Tasks under development				0%		
21	**WS4 - Partner Organisatons**	**140 days**	**Mon 25/05/20**	**Fri 04/12/20**	**0%**	**K. Beveridge**	**L.Bairden**
22	Prepare and submit Strategic Planning Review (dependency on overall strategic review - so start date will require subsequent amendment.	131 days	Fri 05/06/20	Fri 04/12/20	0%		
23	Agree Procurement work plan with DMT including agreement and sign-off of resource	66 days	Mon 15/06/20	Mon 14/09/20	0%		
24	Developent of Engagement & Participation Strategy	70 days	Mon 25/05/20	Fri 28/08/20	0%	A McGregor	
25	**WS5 - IT Requirements**	**81 days**	**Fri 29/05/20**	**Fri 18/09/20**	**6%**	**MC Armstrong**	**N. McAleney**
26	Provide overview of 'as is' position of IT estate across HSCP	7 days	Fri 29/05/20	Mon 08/06/20	72%		
27	Agree prioritisation of roll out of Windows 10	16 days	Fri 29/05/20	Fri 19/06/20	32%		
28	**All users live on Windows 10**	46 days	Fri 29/05/20	Fri 31/07/20	11%		
29	Ensure all NHS equipment on orde	12 days	Fri 12/06/20	Mon 29/06/20	0%		
30	List of all staff equipment	7 days	Fri 12/06/20	Mon 22/06/20	0%		
31	Record status of outstanding NHS I	7 days	Fri 12/06/20	Mon 22/06/20	0%		
32	Issue formal data governance reminder for all staff	12 days	Fri 12/06/20	Mon 29/06/20	0%		
33	Issue Mobile Phones with email access to all staff who require this facility.	36 days	Fri 12/06/20	Fri 31/07/20	0%		
34	Review network connectivity for ERC staff in EHCC and BHCC	26 days	Fri 12/06/20	Fri 17/07/20	0%		
35	**Implement changes identified in Task 31**	71 days	Fri 12/06/20	Fri 18/09/20	0%		
36	**WS6 - PPE**	**80 days**	**Fri 05/06/20**	**Thu 24/09/20**	**24%**	**P. Gomes**	**L. Bairden**
37	Outline current practices and make recommendations for future progress to RPSG	11 days	Fri 05/06/20	Fri 19/06/20	100%		
38	Implement changes and return all PPE ordering, storage and distribution to BAU activity across the HSCP.	41 days	Thu 30/07/20	Thu 24/09/20	0%		





39	**WS7 - Change Programme**	**38 days**	**Fri 05/06/20**	**Tue 28/07/20**	**0%**	**J. Anderson**	**N. McAleney**
40	Review existing in-flight projects and provide recommendations on viable re-start dates for discussion at RPSG	16 days	Fri 05/06/20	Fri 26/06/20	75%		
41	**Submit report to DMT on recommended resumption of Change Programme agenda**	18 days	Fri 05/06/20	Tue 30/06/20	0%		
42	Resume discussions with IT and external suppliers on proposed Telephony Upgrade project	27 days	Thu 18/06/20	Fri 24/07/20	10%		
43	Convene Project Board meetings for in-flight projects to agree new timescales for project delivery in line with PIDs	11 days	Tue 30/06/20	Tue 14/07/20	0%		
44	Agree Project Brief for Client Payment Cards	1 day	Tue 07/07/20	Tue 07/07/20	0%		
45	Submit updated position to DMT for HomeCare Mobile Phones and Application	6 days	Tue 07/07/20	Tue 14/07/20	0%		
46	**Secure funding for BA/Project Resources**	16 days	Tue 07/07/20	Tue 28/07/20	0%		
47	Agree Project Mandate for CM2000 System upgrade or replacement	1 day	Tue 07/07/20	Tue 07/07/20	0%		
48	**WS8 - Ongoing COVID-19 Response**	**21 days**	**Fri 29/05/20**	**Fri 26/06/20**	**82%**	**Ad-hoc updates**	
49	Collate all Service Recovery Plans as received	16 days	Fri 29/05/20	Fri 19/06/20	100%		
50	RPSG to approve overall view on service recovery plans to provide basis for formal feedback to ERC Recovery Group	6 days	Fri 19/06/20	Fri 26/06/20	5%		
51	**Submit report to ERC Recovery Group**	4 days	Tue 23/06/20	Fri 26/06/20	5%		

AGENDA ITEM No.6

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 24 June 2020
Agenda Item	6
Title	Clinical and Care Governance Update

Summary

This report provides an overview of how the Health and Social Care Partnership is maintaining responsibility for monitoring and improving the quality of health and social care during its response to the COVID-19 emergency.

Presented by	Dr Deirdre McCormick, Chief Nurse

Action Required

The Integration Joint Board is asked to:-

a) note the contents of the report

b) identify any areas where further action may be required to ensure the Integration Joint Board is assured the duty of quality continues to be met

c) note that the Clinical and Care Governance Annual Report will be presented to the August IJB meeting.

Directions

- ☒ No Directions Required
- ☐ Directions to East Renfrewshire Council (ERC)
- ☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC)
- ☐ Directions to both ERC and NHSGGC

Implications

- ☐ Finance
- ☐ Policy
- ☐ Workforce
- ☐ Equalities
- ☐ Risk
- ☐ Legal
- ☐ Infrastructure
- ☐ Fairer Scotland Duty

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

24 JUNE 2020

Report by Chief Nurse

CLINICAL AND CARE GOVERNANCE UPDATE

PURPOSE OF REPORT

1. The purpose of this report is to provide East Renfrewshire Integration Joint Board with an overview of how the Health and Social Care Partnership is maintaining responsibility for monitoring and improving the quality of health and social care during its response to the COVID-19 emergency.

2. The report provides information that describes continued monitoring and the Integration Joint Board is asked to identify any areas where further action may be required to ensure the Integration Joint Board is assured the duty of quality continues to be met.

RECOMMENDATION

3. The Integration Joint Board is asked to:-

   (a) note the contents of the report;

   (b) identify any areas where further action may be required to ensure the Integration Joint Board is assured the duty of quality continues to be met; and

   (c) note that the Clinical and Care Governance Annual Report will be presented to the August IJB meeting.

BACKGROUND

4. The report sets out the impact of COVID-19 resulting in the temporary suspension of our clinical and care governance meetings and the mechanisms which have been put in place to ensure operational oversight of healthcare quality and clinical and care governance.

5. The HSCP is currently developing its COVID-19 Recovery Strategy and Action Plan and progress on this will be discussed at the IJB on 24 June 2020. Plans are now in place to re-establish our governance arrangements.

6. A draft of the East Renfrewshire HSCP Clinical and Care Governance Annual Report 2019-2020 has been prepared for circulation to relevant colleagues for comment and contribution.

REPORT

7. The World Health Organisation (WHO) was notified of the first case of a new disease; Coronavirus (COVID – 19) in December 2019 and declared it as global pandemic on 11th March 2020. The first cases in Scotland were notified on 1st March 2020.

8. The steps taken across Scotland to contain the virus are unprecedented. The manner in which everyone has responded by working together to ensure we protect ourselves, our families, our communities and our nation from the threat presented by COVID-19 has been remarkable.

9. The HSCP initiated its Business Continuity Plan to ensure core service delivery has continued as we navigate our way through the uncertainty with a number of extensive measures put in place as part of our specific response to COVID-19.

10. Given the ongoing pressures presented in managing the challenge of COVID-19, it has therefore not been possible to maintain the normal range of clinical and care governance functions. The NHS Strategic Executive Group approved adaptations to the arrangements for governance of healthcare quality. This includes suspension of the strategically supported Quality Improvement programmes, revisions to processes for clinical guidelines, audit and clinical incident management. NHS Acute, Partnership and Board Clinical Governance Forums which had been suspended are now being reconvened. The Acute Clinical Governance Forum met virtually on Monday 8th June and the Primary Care and Community Clinical Forum is due to meet virtually on 17th June. There are also plans for the Board Clinical Governance Forum to meet virtually. The Clinical Incident Quality Assurance process for both Mental Health and Primary Care are continuing to meet.

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

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

12. Mechanisms currently in place to support the operational oversight at service level include:

- Corporate Resilience Management Team meetings with East Renfrewshire Council;
- participation in NHS Board COVID-19 governance;
- weekly HSCP Management Team (DMT) meetings;
- daily SMT communication re COVID-19 risk issues;
- development of dynamic risk assessments for all services with an overarching HSCP COVID-19 risk register which is reviewed weekly and is submitted to the Local Resilience Management Team (LRMT) and DMT
- maintenance of communication with individual staff and teams. The latter has been an essential element in the provision of operational and professional supervision and caseload management to identify areas of exception with escalation as appropriate to the LRMT and the DMT
- Chief Officer's Public Protection Group every 3/4 weeks.

13. In addition to these groups there has been an increased attention in relation to our care homes resulting in further enhanced communication. Prior to COVID-19 the HSCP and local care homes had a joint Care Home Improvement network which met on a monthly basis. During COVID-19 this has moved to a weekly virtual meeting between care home managers, commissioning and HSCP Localities to offer mutual support and assistance. Commissioning staff have undertaken a daily situation update call to care homes to ascertain if support is required for staffing, PPE, or residents affected by COVID-19. This information has been fed into the HSCP daily COVID-19 monitoring and response. In line with national direction we have established a Care Home Clinical and Care Professional Oversight team which includes the Chief Officer, Chief Nurse, Clinical Director, colleagues from Public Health Directorate and the Care Inspectorate who join members of the safety huddle group on a weekly basis.

14. The Alcohol and Drug Partnership met on the 19th May 2020 with future meetings planned on 25th June and 13th August 2020.

15. The Chief Officers Public Protection meeting took place on 12th May 2020 with the next scheduled meeting on the 10th November 2020. There are extraordinary meetings planned in June and July 2020. The focus is for each service to highlight risks and advice on what has been put in place in relation to COVID-19. The Chief Officers Public Protection meeting will cover the current position with regards to Adult Support and Protection, Child Protection, MAPPA and Violence against Women and Girls.

16. The Child Protection Committee met on the 5th May 2020 and the next scheduled meeting is the 18th June 2020.

17. The Adult Protection Committee met on the 27th April 2020 and the next scheduled meeting is the 22nd June 2020.

18. Plans are now in place to re-establish all clinical and care governance groups. Due to the sequencing of our meeting schedule, the East Renfrewshire Clinical and Care Governance Group did not require to be suspended and met on 10th June as planned. Discussion majored on the following: COVID-19 current position; Care at Home; Support to Care Homes; Bonnyton House Inspection and COVID-19 update; Adult Support and Protection; Risk management with verbal reports from all professional leads and clinical incident reports.

19. Governance arrangements for Significant Case Reviews (SCRs) and MAPPA remain in place albeit via teleconference. This also applies to Significant Clinical Incident (SCIs) in accordance with issued guidance. At the time of completion of this report there has been one Initial Case Review (ICR) and no Significant Case Reviews (SCR).

20. Complaints continue to be responded to during the crisis. Since the pandemic was declared on 11th March until 11th June, a total of 16 complaints have been received. On average frontline complaints were responded to within 3 days, and investigation complaints within 14 days. 3 investigation complaints remain ongoing. A full report will be prepared for the Clinical and Care Governance Committee in September 2020.

21. Core data regarding child protection/adult protection/MAPPA and corresponding assurance statements are provided to Chief Officers group weekly. MAPPA continues to be governed by management oversight group and strategic oversight group. Both of these meetings continue to take place at the usual frequency via teleconference. In addition to 6 monthly reports, new quarterly reports are prepared for the Adult Protection Committee. In response to the pandemic there will also be weekly reporting to the Chief Officer for Public Protection and the Scottish Government.

22. As part of recovery arrangements the NHSGGC Strategic Executive Group, which acting as the de facto Acute, Partnership and Board Clinical Governance Forums during the COVID-19 outbreak introduced a template on 13th May to be completed by all areas including HSCPs on a monthly basis. The template is structured under four key headings; maintenance of key governance functions, risks to clinical quality, any other headlines, and key successes. To date two submission have been made with the next return due on 17th June.

23. The Annual Report for Clinical and Care Governance reflects the work of the Clinical and Care Governance Group and preparations to develop and submit the report to the NHSGGC Clinical and Care Governance Forum have been paused due to the current crisis. We anticipate that the annual report will continue to be required and a draft report has been prepared for circulation to relevant colleagues for their contribution. The annual report will be presented to the Integration Joint Board in August 2020.

CONSULTATION AND PARTNERSHIP WORKING

24. This report has been prepared by the Chief Nurse after due consideration with relevant senior officers in the HSCP.

IMPLICATIONS OF THE PROPOSALS

25. There are no implications arising from this report.

DIRECTIONS

26. There is no requirement for directions as a result of this report.

CONCLUSIONS

27. The Health and Social Care Partnership has maintained responsibility for monitoring and improving the quality of health and social care during its response to the COVID-19 emergency. Continued monitoring is ongoing to ensure the duty of quality continues to be met.

RECOMMENDATIONS

28. The Integration Joint Board is asked to:-

(a) note the contents of the report;

(b) identify any areas where further action may be required to ensure the Integration Joint Board is assured the duty of quality continues to be met; and

(c) note that the Clinical and Care Governance Annual Report will be presented to the August IJB meeting.

REPORT AUTHOR AND PERSON TO CONTACT

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Chief Officer, IJB: Julie Murray

BACKGROUND PAPERS

None

AGENDA ITEM No.7

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 24 June 2020
Agenda Item	7
Title	Audit Scotland Annual Audit Plan 2019/20

Summary

Audit Scotland's Integration Joint Board Annual Audit Plan 2019/20 was prepared for the March meeting of the Performance and Audit Committee. Meeting papers were published however as the meeting had to be cancelled due to the COVID-19 pandemic there was no opportunity for discussion and agreement. IJB members are therefore asked to formally agree the audit plan.

Presented by	Aimee MacDonald, Senior Auditor

Action Required

The Integration Joint Board is asked to agree the Integration Joint Board Annual Audit Plan 2019/20 as prepared by Audit Scotland.

AGENDA ITEM No.5

East Renfrewshire Integration Joint Board

Annual Audit Plan 2019/20 - DRAFT

AUDIT SCOTLAND

Prepared for East Renfrewshire Integration Joint Board
March 2020

Contents

Risks and planned work

1. This annual audit plan contains an overview of the planned scope and timing of our audit which is carried out in accordance with International Standards on Auditing (ISAs), the Code of Audit Practice, and guidance on planning the audit. This plan sets out the work necessary to allow us to provide an independent auditor's report on the annual accounts and meet the wider scope requirements of public sector audit.

2. The wider scope of public audit contributes to assessments and conclusions on financial management, financial sustainability, governance and transparency and value for money.

Adding value

3. We aim to add value to the East Renfrewshire Integration Joint Board (ERIJB) through our external audit work by being constructive and forward looking, by identifying areas for improvement and by recommending and encouraging good practice. In so doing, we intend to help the East Renfrewshire Integration Joint Board promote improved standards of governance, better management and decision making and more effective use of resources.

Audit risks

4. Based on our discussions with staff, attendance at committee meetings and a review of supporting information we have identified the following significant risks for East Renfrewshire Integration Joint Board. We have categorised these risks into financial statements risks and wider dimension risks. The key audit risks, which require specific audit testing, are detailed in Exhibit 1.

Exhibit 1
2019/20 Significant audit risks

	Audit Risk	Source of assurance	Planned audit work
Financial statements risks			
1	**Management override of controls** Auditing Standards require that audits are planned to consider the risk of material misstatement caused by fraud, which is presumed to be a significant risk in any audit. This includes the risk of management override of controls that results in fraudulent financial statements.	Owing to the nature of this risk, assurances from management are not applicable in this instance.	• Detailed testing of journal entries • Review of accounting estimates • Focused testing of accruals and prepayments. • Evaluation of significant transactions that are outside the normal course of business. • Cut-off testing
2	**New finance ledger** East Renfrewshire Council (ERC) introduced a new finance ledger, Integra, during the year. As ERIJB's	The IJB CFO is a member of the project board governing the implementation of the	• Take ISA 402 assurance over the work performed by ERC's external audit team regarding the

	Audit Risk	Source of assurance	Planned audit work
	financial statements are prepared using ERC's ledger and, as with any major change in financial systems, there is an increased risk of misstatement on the figures and balances.	new ledger and had input into all decisions. Assurances on testing and compliance were routinely provided by the dedicated project team. The Council's Chief Accountant and Chief Internal Auditor, along with HSCP Accountancy worked with the core team to ensure correct balances carried over. Data migration included input from Council internal and external audit. The HSCP was supported by the project team with preparation, implementation and training for the new system. Routine monitoring, reporting and reconciliations are in place and provide assurance.	completeness and accuracy of the new finance ledger.
3	**Staff Capacity** The Accountancy and Contracts Manager who took the lead in preparing the financial statements has retired and one of the financial accountants has left the post. This will have potential impact on capacity of the HSCP Accountancy Team and the timetable for the audit of the financial statements.	Whilst there are capacity issues as result of a reduced team – interim arrangementis are in place with an existing team member acting into the manager position. In addition the Head of Finance and Resources (Chief Financial Officer for the IJB) and the Client Finance Manager are qualified accountants with significant experience. The year end workload will be prioritised to ensure the annual report and accounts is produced to timetable and supported by the usual high standard working papers.	• We will liaise with both the Chief Financial Officer and the new Accountancy and Contracts Manager appointed throughout the audit.

⚠ Audit Risk	Source of assurance	Planned audit work
Wider dimension risks		
4 Financial sustainability **2019/20** The IJB is facing a funding gap of £3.6 million in 2019/20. A savings plan of £3.6 million has been identified to address this gap. As at the 29 February 2020, the IJB is facing a predicted year end overspend of £0.479m. The IJB intends to fund this overspend from reserves. **2020/21 Onwards** At the time of writing, the 2020/21 savings requirement is estimated between £3.1 million-£3.5 million and a savings plan has yet to be identified. There is a risk that ERIJB will be unable to achieve a sustainable outturn position going forwards, particularly given the uncertainty of future funding contributions.	The savings identified for 2019/20 are reported to every IJB and are detailed in a separate appendix within the revenue monitoring report. The budget that will be proposed to the the IJB in March identifies a funding gap of c£2.5 million along with savings proposals to close this gap. There will be a need to bridge some of the saving related to care packages which will lkely utilise in full the IJB budget saving and in year contingeny reserves.	• Review ERIJB's reported outturn financial position as part of the financial statements audit • Assess the delivery of in-year savings programs • Review the robustness of future savings plans identified
5 Financial management - Set Aside The 2018 Scottish Parliament report, "Looking ahead to the Scottish Government - Health Budget 2019-20: Is the budget delivering the desired outcomes for health and social care in Scotland?", concluded that the set aside budget is, generally, not operating as intended. Significantly, the report highlights that there is a disconnect between how the set aside budget should operate in principle compared with how it is operating in practice meaning that this mechanism for shifting the balance of care is not being utilised effectively. An effective set aside mechanism, which takes account of the shift in services from hospitals to community and social care, will provide the IJB more control in utilising the set aside budget to deliver its strategic objectives and help ensure financial sustainability.	An Unscheduled Care Commissioning Plan has been developed across NHSGGC HSCPs and will be brought to each IJB. This sets out the first steps in developing strategic plans for unscheduled care. The set aside budgets have been restated as the initial element of the work. The solution for East Renfrewshire HSCP will be part of this system wide work.	• Review the IJB's approach to using the set aside budget, specifically through its engagement with the Health Board to improve set-aside arrangements and report on progress made to date.

Source: Audit Scotland

5. As set out in ISA 240, there is a presumed risk of fraud in the recognition of income. There is a risk that income may be misstated resulting in a material misstatement in the financial statements. We have rebutted the risks of material misstatement caused by fraud in income recognition in 2019/20 because the ERIJB receives its income by way of budget allocations from East Renfrewshire Council (ERC) and NHS Greater Glasgow and Clyde (NHSGGC), limiting the opportunity for manipulation.

6. In line with Practise Note 10, as most public-sector bodies are net expenditure bodies, the risk of fraud is more likely to occur in expenditure. We have rebutted the risk of material misstatement caused by fraud in expenditure in 2019/20 because ERIJB expenditure is processed through the financial systems of ERC and NHSGGC. Consequently, the risk of expenditure manipulation lies with the partner bodies. Assurances over the accuracy and completeness of IJB transactions will be obtained from the auditors of ERC and NHSGGC.

Reporting arrangements

7. Audit reporting is the visible output for the annual audit. All annual audit plans and the outputs as detailed in Exhibit 2, and any other outputs on matters of public interest will be published on our website: www.audit-scotland.gov.uk.

8. Matters arising from our audit will be reported on a timely basis and will include agreed action plans. Our draft reports will be issued to the relevant officers to confirm factual accuracy.

9. We will provide an independent auditor's report to East Renfrewshire Integration Joint Board and Accounts Commission setting out our opinions on the annual report and accounts. We will provide the Accountable Officer and Accounts Commission with an annual report on the audit containing observations and recommendations on significant matters which have arisen during the audit.

Exhibit 2
2019/20 Audit outputs

Audit Output	Target date	Committee Date
Annual Audit Plan	10 March 2020	18 March 2020
Independent Auditor's Report	11 September 2020	23 September 2020
Annual Audit Report	11 September 2020	23 September 2020

Source: Audit Scotland

Audit fee

10. The proposed audit fee for the 2019/20 audit of the ERIJB is £26,560. [2018/19: £25,000]. In determining the audit fee we have taken account of the risk exposure of East Renfrewshire Integration Joint Board, the planned management assurances in place and the level of reliance we plan to take from the work of internal audit. Our audit approach assumes receipt of the unaudited annual report and accounts with a complete working papers package on 30 June 2020.

11. Where our audit cannot proceed as planned through, for example, late receipt of the unaudited annual report and accounts or being unable to take planned reliance from the work of internal audit, a supplementary fee may be levied. An

additional fee may also be required in relation to any work or other significant exercises out with our planned audit activity.

Responsibilities

Audit Committee and Chief Financial Officer

12. Audited bodies have the primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity that enable them to successfully deliver their objectives.

13. The audit of the annual report and accounts does not relieve management or the Performance and Audit Committee as those charged with governance, of their responsibilities.

Appointed auditor

14. Our responsibilities as independent auditors are established by the 1973 Act for local government, and the Code of Audit Practice (including supplementary guidance) and guided by the Financial Reporting Council's Ethical Standard.

15. Auditors in the public sector give an independent opinion on the financial statements and other information within the annual report and accounts. We also review and report on the arrangements within the audited body to manage its performance and use of resources. In doing this, we aim to support improvement and accountability.

Audit scope and timing

Annual report and accounts

16. The annual report and accounts, which include the financial statements, will be the foundation and source for most of the audit work necessary to support our judgements and conclusions. We also consider the wider environment and challenges facing the public sector. Our audit approach includes:

- understanding the business of the ERIJB and the associated risks which could impact on the financial statements
- assessing the key systems of internal control, and establishing how weaknesses in these systems could impact on the financial statements
- identifying major transaction streams, balances and areas of estimation and understanding how the ERIJB will include these in the financial statements
- assessing the risks of material misstatement in the financial statements
- determining the nature, timing and extent of audit procedures necessary to provide us with sufficient audit evidence as to whether the financial statements are free of material misstatement.

17. We will give an opinion on whether the financial statements:

- give a true and fair view in accordance with applicable law and the 2019/20 Code of the state of affairs of the body as at 31 March 2020 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2019/20 Code;
- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, the Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Statutory other information in the annual report and accounts

18. We also review and report on statutory other information published within the annual report and accounts including the management commentary, annual governance statement and the remuneration report. We give an opinion on whether these have been compiled in accordance with the appropriate regulations and frameworks in our independent auditor's report.

19. We also review the content of the annual report for consistency with the financial statements and with our knowledge. We report any uncorrected material misstatements in statutory other information.

Materiality

20. We apply the concept of materiality in planning and performing the audit. It is used in evaluating the effect of identified misstatements on the audit, and of any uncorrected misstatements, on the financial statements and in forming our opinions in the independent auditor's report.

21. Materiality values for East Renfrewshire Integration Joint Board are set out in Exhibit 3. The values will be revisited upon receipt of the 2019/20 annual report and accounts.

Exhibit 3
Materiality values

Materiality	Amount
Planning materiality – This is the figure we use to assess the overall impact of audit adjustments on the financial statements. It has been set at 1% of gross expenditure for the year ended 31 March 2020 based on the latest audited accounts for 2018/19.	£1.60 million
Performance materiality – This acts as a trigger point. If the aggregate of errors identified during the financial statements audit exceeds performance materiality this would indicate that further audit procedures should be considered. Using our professional judgement, we have set performance materiality at 70% of planning materiality.	£1.12million
Reporting threshold (i.e., clearly trivial) – We are required to report to those charged with governance on all unadjusted misstatements more than the 'reporting threshold' amount. This has been set at 3% of planning materiality.	£48,000

Source: Audit Scotland

Timetable

22. To support the efficient use of resources it is critical that the annual accounts timetable is agreed with us to produce the unaudited accounts. We have included an agreed timetable at Exhibit 4.

Exhibit 4
Annual report and accounts timetable

Key stage	Date
Consideration of unaudited annual report and accounts by those charged with governance	24 June 2020
Latest submission date of unaudited annual report and accounts with complete working papers package by ERIJB to Audit Scotland	30 June 2020
Latest date for final clearance meeting with Chief Financial Officer	09 September 2020
Issue of Letter of Representation and proposed independent auditor's report	11 September 2020
Agreement of audited unsigned annual report and accounts	11 September 2020
Issue of Annual Audit Report to those charged with governance	23 September 2020
Independent auditor's report signed by Audit Scotland	By 30 September 2020

Internal audit

23. Internal audit is provided by ERC and is overseen by the Chief Internal Auditor. As part of our planning process we carry out an annual assessment of the internal

audit function to ensure that it operates in accordance with the main requirements of the Public Sector Internal Audit Standards (PSIAS). ISA 610 requires an assessment on whether the work of the internal audit function can be used for the purposes of external audit. This includes:

- the extent to which the internal audit function's organisational status and relevant policies and procedures support the objectivity of the internal auditors
- the level of competence of the internal audit function
- whether the internal audit function applies a systematic and disciplined approach, including quality control.

24. We will report any significant findings to management on a timely basis.

Using the work of internal audit

25. Auditing standards require internal and external auditors to work closely together to make best use of available audit resources. We seek to use the work of internal audit wherever possible to avoid duplication. We have considered the findings of the work of internal audit as part of our planning process to minimise duplication of effort and to ensure the total resource is used efficiently or effectively.

26. From our initial review of internal audit plans we do not plan to use the work of internal audit as part of our audit of the 2019/20 accounts.

Audit dimensions

27. Our audit is based on four audit dimensions that frame the wider scope of public sector audit requirements as shown in Exhibit 5.

Exhibit 5
Audit dimensions

Source: Code of Audit Practice

28. In the local government sector, the appointed auditor's annual conclusions on these four dimensions will help contribute to an overall assessment and assurance on best value.

29. Our standard audits are based on four audit dimensions that frame the wider scope of public sector audit requirements. These are: financial sustainability, financial management, governance and accountability and value for money.

Financial sustainability

30. As auditors we consider the appropriateness of the use of the going concern basis of accounting as part of the annual audit. We will also comment on financial sustainability in the longer term. We define this as medium term (two to five years) and longer term (longer than five years) sustainability. We will carry out work and conclude on:

- the effectiveness of financial planning in identifying and addressing risks to financial sustainability in the short, medium and long term
- the appropriateness and effectiveness of arrangements in place to address any identified funding gaps
- whether there are arrangements in place to demonstrate the affordability and effectiveness of funding and investment decisions.

Financial management

31. Financial management is concerned with financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively. We will review, conclude and report on:

- whether arrangements are in place to ensure systems of internal control are operating effectively
- the effectiveness of budgetary control system in communicating accurate and timely financial performance can be demonstrated
- how the ERIJB has assured itself that its financial capacity and skills are appropriate
- whether there are appropriate and effective arrangements in place for the prevention and detection of fraud and corruption.

Governance and transparency

32. Governance and transparency is concerned with the effectiveness of scrutiny and governance arrangements, leadership and decision – making and transparent reporting of financial and performance information. We will review, conclude and report on:

- whether the ERIJB can demonstrate that the governance arrangements in place are appropriate and operating effectively
- whether there is effective scrutiny, challenge and transparency on the decision-making and finance and performance reports.
- the quality and timeliness of financial and performance reporting.

Value for money

33. Value for money refers to using resources effectively and continually improving services. We will review, conclude and report on whether the ERIJB can demonstrate:

- value for money in the use of resources
- there is a clear link between money spent, output and outcomes delivered.
- that outcomes are improving.
- there is sufficient focus on improvement and the pace of it.

Best Value

34. Integration Joint Boards have a statutory duty to make arrangements to secure best value. We will review and report on these arrangements.

Independence and objectivity

35. Auditors appointed by the Accounts Commission or Auditor General must comply with the Code of Audit Practice and relevant supporting guidance. When auditing the financial statements auditors must also comply with professional standards issued by the Financial Reporting Council and those of the professional accountancy bodies. These standards impose stringent rules to ensure the independence and objectivity of auditors. Audit Scotland has robust arrangements in place to ensure compliance with these standards including an annual "fit and proper" declaration for all members of staff. The arrangements are overseen by the Director of Audit Services, who serves as Audit Scotland's Ethics Partner.

36. The engagement lead (i.e. appointed auditor) for the ERIJB is John Cornett, Audit Director. Auditing and ethical standards require the appointed auditor, John Cornett, to communicate any relationships that may affect the independence and objectivity of audit staff. We are not aware of any such relationships pertaining to the audit of the ERIJB.

Quality control

37. International Standard on Quality Control (UK and Ireland) 1 (ISQC1) requires that a system of quality control is established, as part of financial audit procedures, to provide reasonable assurance that professional standards and regulatory and legal requirements are being complied with and that the independent auditor's report or opinion is appropriate in the circumstances.

38. The foundation of our quality framework is our Audit Guide, which incorporates the application of professional auditing, quality and ethical standards and the Code of Audit Practice (and supporting guidance) issued by Audit Scotland and approved by the Auditor General for Scotland. To ensure that we achieve the required quality standards Audit Scotland conducts peer reviews and internal quality reviews. Additionally, the Institute of Chartered Accountants of Scotland (ICAS) have been commissioned to carry out external quality reviews.

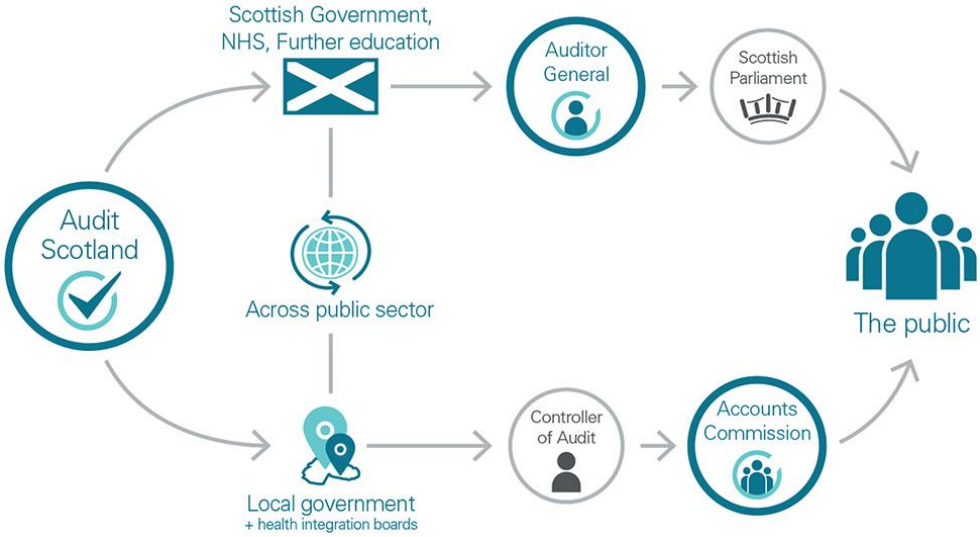
39. As part of our commitment to quality and continuous improvement, Audit Scotland will periodically seek your views on the quality of our service provision. We welcome feedback at any time and this may be directed to the engagement lead.

Appendix 1: Who we Are

Who we are

The Auditor General, the Accounts Commission and Audit Scotland work together to deliver public audit in Scotland:

- The Auditor General is an independent crown appointment, made on the recommendation of the Scottish Parliament, to audit the Scottish Government, NHS and other bodies and report to Parliament on their financial health and performance.
- The Accounts Commission is an independent public body appointed by Scottish ministers to hold local government to account. The Controller of Audit is an independent post established by statute, with powers to report directly to the Commission on the audit of local government.
- Audit Scotland is governed by a board, consisting of the Auditor General, the chair of the Accounts Commission, a non-executive board chair, and two non-executive members appointed by the Scottish Commission for Public Audit, a commission of the Scottish Parliament.



About us

Our vision is to be a world-class audit organisation that improves the use of public money.

Through our work for the Auditor General and the Accounts Commission, we provide independent assurance to the people of Scotland that public money is spent properly and provides value. We aim to achieve this by:

- carrying out relevant and timely audits of the way the public sector manages and spends money
- reporting our findings and conclusions in public

  identifying risks, making clear and relevant recommendations.

East Renfrewshire Health and Social Care Partnership Integration Joint Board

Annual Audit Plan 2019/20 - DRAFT

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AGENDA ITEM No.8

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 24 June 2020
Agenda Item	8
Title	Unaudited Annual Report and Accounts 2019/20

Summary

This report provides an overview of the unaudited annual report and accounts for the Integration Joint Board (IJB) covering the period 1 April 2019 to 31 March 2020

Presented by	Lesley Bairden, Head of Finance and Resources (Chief Financial Officer)

Action Required

The Integration Joint Board is requested to:

a) Agree the unaudited annual report and accounts
b) Agree the proposed reserves allocations
c) Note the annual report and accounts is subject to audit review
d) Agree to receive the audited annual report and accounts in September, subject to any recommendations made by our external auditors and/or the Performance and Audit Committee

Directions

- ☒ No Directions Required
- ☐ Directions to East Renfrewshire Council (ERC)
- ☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC)
- ☐ Directions to both ERC and NHSGGC

Implications

- ☒ Finance
- ☐ Policy
- ☐ Workforce
- ☐ Equalities
- ☐ Risk
- ☐ Legal
- ☐ Infrastructure
- ☐ Fairer Scotland Duty

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

24 JUNE 2020

Report by Chief Officer

UNAUDITED ANNUAL REPORT AND ACCOUNTS 2019/20

PURPOSE OF REPORT

1. The purpose of this report is to provide an overview of the unaudited annual report and accounts for the Integration Joint Board (IJB) covering the period 1 April 2019 to 31 March 2020 and outline the legislative requirements and key stages.

2. The report recognises that the normal process of remit of the of the annual report and accounts to the Integration Joint Board, following discussion and review by the Performance and Audit Committee is suspended under the current COVID-19 governance arrangements.

RECOMMENDATION

3. The Integration Joint Board is requested to:

(a) Agree the unaudited annual report and accounts;

(b) Agree the proposed reserves allocations;

(c) Note the annual report and accounts is subject to audit review; and

(d) Agree to receive the audited annual report and accounts in September, subject to any recommendations made by our external auditors and/or the Performance and Audit Committee

BACKGROUND

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

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

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

REPORT

7. The (unaudited) annual report and accounts for the IJB have been prepared in accordance with appropriate legislation and guidance. An overview of the process is set out below:

8. **Financial Governance & Internal Control:** the regulations require the Annual Governance Statement to be approved by the IJB or a committee of the IJB whose remit include audit and governance. This will assess the effectiveness of the internal audit function and the internal control procedures of the IJB. The Performance and Audit Committee normally meet this requirement, delegated by the IJB. The current governance arrangements during this COVID-19 pandemic mean the IJB will undertake this function, however should take assurance that all members of the Performance and Audit Committee have received this report and had the opportunity to comment.

9. **Unaudited Accounts:** the regulations state that the unaudited accounts are submitted to the External Auditor no later than 30th June immediately following the financial year to which they relate.

10. **Right to Inspect and Object to Accounts:** the public notice period of inspection should start no later than 1st July in the year the notice is published. This will be for a period of 3 weeks and will follow appropriate protocol for advertising and accessing the unaudited accounts. The required notice has been agreed with the external auditors and will be published on the HSCP website.

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

12. The Performance and Audit Committee will consider for approval the External Auditors report and proposed audit certificate (ISA 260 report) and the audited annual accounts at its meeting on 23 September 2020 and remit to the IJB for approval on that same day.

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

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

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

Management Commentary / Foreword	Chair of the IJB Chief Officer

Statement of Responsibilities	Chair of the IJB Chief Financial Officer
Annual Governance Statement	Chair of the IJB Chief Officer
Remuneration Report	Chair of the IJB Chief Officer
Balance Sheet	Chief Financial Officer

Note: for the unaudited annual report and accounts the only the Statement of Responsibilities and the Balance Sheet require to be signed by the Chief Financial Officer.

16. The main messages from the annual report and accounts are set out below:

17. We ended the year with an overspend of £0.185 million which was 0.15% of our budget for the year. This was in line with the position reported to the IJB through our regular revenue budget monitoring and is funded as planned from our reserves. We expected to draw from reserves as we recognised we would not achieve all savings required during the year as our individual budget approach would take many months to implement; we did not have capacity to work on our digital savings programme and we achieved part year savings from the second phase of our structure review.

18. The impact of COVID-19 in the closing weeks of 2019/20 will have resulted in some reduction in day to day costs.

19. The main variances to the budget were:

- Underspends in a number of services are from staff turnover and vacant posts during the year, reflecting the general trends of recruitment and retention issues within health and social care.
- Children's services purchased care costs, including residential care, foster and adoption were lower than budget during the year.
- Older Peoples and Intensive Services ended the year with a collective overspend of £0.835 million from care package costs for residential and care at home costs, reflecting the continued impacts of population growth in older people and the demand for services. We are addressing our care at home costs as an element within the action plan and redesign of this service.
- The overspend in prescribing is a result of both cost and volume across a number of drugs and also allowed for an expected spike in demand in February and March 2020 as the implications of the COVID-19 pandemic began to emerge.

20. During the year we used £1.763 million of reserves in year and we also invested £1.032 million into earmarked reserves. The categorisation and application of our reserves is shown in detail within the annual report and accounts.

21. I am proposing the following new reserves are approved:

- £0.311 million for school counselling which was transferred to the HSCP towards the end of 2019/20. This was part of the 2019/20 budget funding the Scottish Government announced and is supported within Children's Services by an implementation plan.
- £0.101 million for a new reserve for Augmentative and Alternative Communication, newly hosted by the HSCP during 2019/20. This reserve will allow the service to better deal with the flux in demand for assessment and equipment in this highly specialised area.
- £0.100 million for health visitors, within Children's Services to support training and capacity. It should be noted the existing reserve within District Nursing has been increased to £100k to similarly support training and capacity.

22. The focus on the draft unaudited accounts is to ensure full and accurate content which I am pleased we have achieved given current circumstances. We will use the time to September to produce the final document for publication and I intend to look further at how we:

a. Report our performance information, with more of an alignment to our in year reporting
b. Consider using infographics within the report
c. Considering any other presentational changes following IJB review

CONSULTATION AND PARTNERSHIP WORKING

23. The Chief Financial Officer would like to extend thanks to the HSCP Finance team and to colleagues in both partner organisations acknowledging the detailed work of all staff involved in the year end closure process for all operational spend within the partnership.

IMPLICATIONS OF THE PROPOSALS

24. All financial implications are included in the report above

25. There are no workforce, infrastructure, risk, equalities, policy or legal implications.

DIRECTIONS

26. There is no requirement to issue directions.

CONCLUSIONS

27. The preparation of the annual report and accounts for the IJB meets all legislative requirements. There has been no material movement to the projected outturn last reported to the IJB. There are no significant governance issues.

RECOMMENDATIONS/…

RECOMMENDATIONS/…

28. The Integration Joint Board is requested to:

(a) Agree the unaudited annual report and accounts;

(b) Agree the proposed reserves allocations;

(c) Note the annual report and accounts is subject to audit review; and

(d) Agree to receive the audited annual report and accounts in September, subject to any recommendations made by our external auditors and/or the Performance and Audit Committee

REPORT AUTHOR AND PERSON TO CONTACT

Lesley Bairden, Head of Finance and Resources (Chief Financial Officer)
Lesley.Bairden@eastrenfrewshire.gov.uk
0141 451 0746

12 June 2020

Chief Officer, IJB: Julie Murray

BACKGROUND PAPERS

PAC Paper: 18-03-2020 - Review of Integration Joint Board Financial Regulations and Reserves Policy - https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=26156&p=0

Annual Report and Accounts 2018/19
https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=25285&p=0

Annual Report and Accounts 2017/18
https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=23189&p=0

Annual Report and Accounts 2016/17
http://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=20434&p=0

Annual Report and Accounts 2015/16
http://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=17196&p=0

The relevant legislation is The Public Bodies (Joint Working)(Scotland) Act 2014, Local Government Scotland Act 1973

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

East Renfrewshire Health and Social Care Partnership Integration Joint Board

Annual Report and Accounts 2019/20

Covering the period 1st April 2019 to 31st March 2020

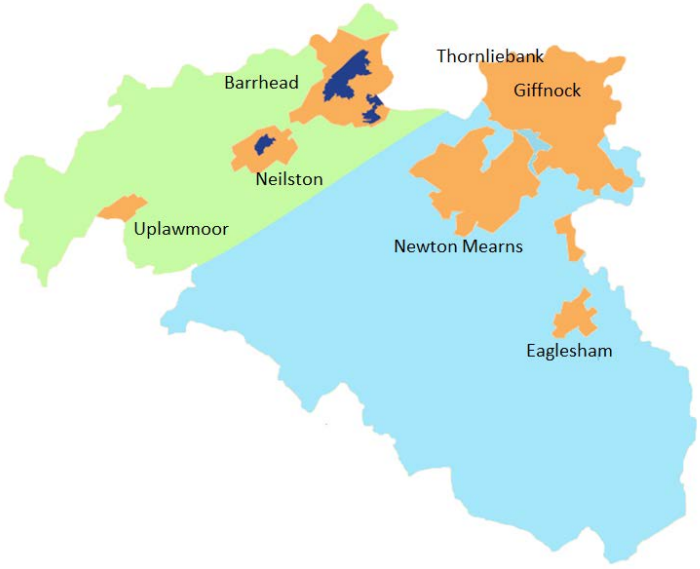
(UNAUDITED)

Contents

East Renfrewshire covers an area of 174 square kilometres and borders the City of Glasgow, East Ayrshire, North Ayrshire, Renfrewshire and South Lanarkshire.

Our population is growing and reached 95,530 in 2019. Geographically 75% of the population live in the Eastwood area (Busby, Clarkston and Williamwood, Eaglesham and Waterfoot, Giffnock, Netherlee and Stamperland, Newton Mearns and Thornliebank) and 25% live in the Barrhead area (Barrhead, Neilston and Uplawmoor).

East Renfrewshire has an increasing ageing population with a 42% increase in the number of residents aged 85 years and over during the last decade.



Management Commentary

Introduction

East Renfrewshire Integration Joint Board, hereafter known as the IJB, was legally established on 27th June 2015 and has the strategic responsibility for planning and delivery of health and social care services for the residents of East Renfrewshire. The vision, values, priorities and outcomes we aim to achieve through working together with the people of East Renfrewshire to improve lives are set out in our HSCP Strategic Plan 2018-21.

The IJB is a legal body in its own right, as set out in the legislation, the Public Bodies (Joint Working) (Scotland) Act 2014, which established the framework for the integration of health and social care in Scotland.

The Integration Scheme for the IJB sets out how we will meet the requirements of this legislation. We are responsible for planning, commissioning and delivery of services for children and adults from both of our partners, East Renfrewshire Council and NHS Greater Glasgow and Clyde, and also have the planning responsibility for our population's use of large hospital based services along with housing aids and adaptations. The Integration Scheme provides a detailed breakdown of all the services the IJB is responsible for.

Our current Strategic Plan covers the period 2018-21 and sets out how we will achieve the National Health and Wellbeing Outcomes prescribed by Scottish Ministers.

Our partnership vision statement is:

"Working together with the people of East Renfrewshire to improve lives"

Our touchstones are used to guide everything we do as a partnership:

- Valuing what matters to people.
- Building capacity with individuals and communities.
- Focusing on outcomes, not services.

This document and our Annual Performance Report demonstrate how we have supported delivery of our strategic priorities.

Strategic Plan 2018-21

With our Strategic Planning Group, we reviewed our first strategic plan, which covered 2015-18 and considered the progress we made and refreshed our strategic priorities for the three years 2018 to 2021. Our plan recognises that to meet future demand pressures from our continued growing and ageing population we needed to change the way we work together. We need to extend beyond traditional health and social care services to a wider partnership with our local people, carers, volunteers, community organisations, providers and community planners.

We need to look at the wider factors that impact on people's health and wellbeing, including activity, housing and employment; supporting people to be well, independent and connected to their communities.

Our emergency admissions, out of hours pressures and carers stress show us we still have work to do to get the right systems in place. We believe that by putting in the right amount of support at the right time we can improve lives, reduce demand and allow us to focus resource on those most in need.

We have identified seven strategic priorities where we need to make significant change or investment during the course of the plan:

- Working together with **children, young people and their families** to improve mental wellbeing
- Working together with our community planning partners on new **community justice** pathways that support people to stop offending and rebuild lives
- Working together with our communities that experience shorter life expectancy and **poorer health** to improve their wellbeing
- Working together with people to maintain their **independence at home** and in their local community
- Working together with people who experience **mental ill-health** to support them on their journey to recovery
- Working together with our colleagues in primary and acute care to care for people to reduce **unplanned admissions** to hospital
- Working together with **people who care for someone** ensuring they are able to exercise choice and control in relation to their caring activities

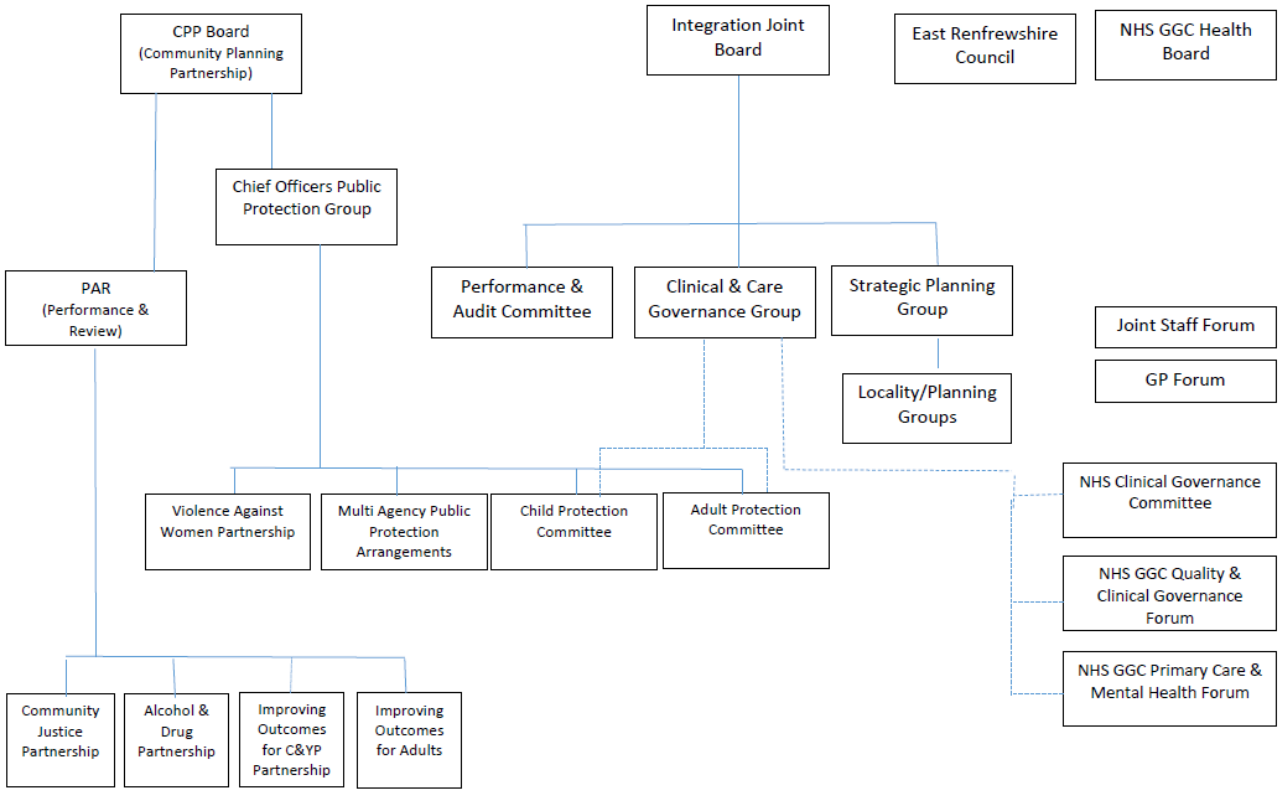
We have two localities: Eastwood and Barrhead. This best reflects hospital flows with the Eastwood Locality linking to the South Glasgow hospitals and the Barrhead Locality to the Royal Alexandra Hospital in Paisley. Our management and service structure is designed around our localities and we continue to develop planning and reporting at a locality level.

Our strategic plan is due to be updated for 2021-24. We will review our strategic needs assessment in light of the COVID-19 outbreak and develop our strategic priorities taking into

account the lessons learned and changing needs and expectations of local residents. The recovery work programme we have implemented will help inform our planning.

The IJB continues to build on the long standing delivery of integrated health and care services within East Renfrewshire and the continued and valued partnership working with our community, the third, voluntary and independent sectors, facilitating the successful operation of the Health and Social Care Partnership, hereafter known as the HSCP.

The chart below shows the governance, relationships and links with partners which form the IJB business environment.



Key Messages and Operational Highlights for 2019/20

This has been a year that falls into two clear parts; pre and post the COVID-19 pandemic. For the majority of the year we operated as normal however the final month of 2019/20 saw the unprecedented challenge of the COVID-19 pandemic. During the emergency, staff across the HSCP have responded with incredible resilience, commitment and creativity. Within a very short space of time teams have established and adapted to new ways of working and have continued to maintain and deliver safe and effective services to our residents. There has been innovation and collaborative working across the health and care system including with external stakeholders and our communities.

Children and families

Over the course of 2019/20 our Family Wellbeing Service has continued to deliver positive outcomes for children and young people with mental health and emotional wellbeing concerns. The service is delivered by Children 1st, providing holistic support through our GP surgeries.

Our commitment to supporting the mental wellbeing of our young people is reflected in our concerted work to reducing waiting times for specialist Child and Adolescent Mental Health Services. Steady improvement over 2019 saw us exceeding our waiting time target by the end of the year.

We have continued to deliver successful parenting programmes throughout the year with improved outcomes for the families taking part.

Our corporate parenting activity has resulted in strong performance in our support for looked after children, including: no delays in making permanence decisions; minimal placement moves; improving numeracy and literacy for our looked after children; levels of participation higher than national average.

Our Champions Board, a forum to support and improve the experience of young people in East Renfrewshire, provides opportunities for looked after young children giving them the chance to influence policy and practice in services affecting them.

During the COVID-19 outbreak we have adapted our services and have been able to continue supporting the most vulnerable families and individuals in East Renfrewshire, particularly those where there are public/child protection issues or an identified risk of harm. Throughout the emergency, staff have been maintaining contact with the families and individuals we support through telephone, online and visits as appropriate.

Criminal justice

We continue to support people completing Community Payback Orders, with a high volume of people reporting that they have been helped to address their offending behaviour. Throughout 2019/20 we have supported people subject to Orders through Work EastRen and the Strive preparation for work programme.

We have seen significant improvement and are ahead of our target for the personal outcomes of women who have been victims of domestic abuse.

During the COVID-19 emergency we targeted our services on our most vulnerable residents. Our recovery planning is prioritising the re-establishment and strengthening of our approaches to public protection.

Supporting health and wellbeing

We continue to support training and development initiatives to raise awareness and support health improvement. We maintained our Healthy Working Lives Gold award and ensured a focus on those with the greatest inequalities within HSCP and Council staff groups. Our partnership work with East Renfrewshire Culture and Leisure Trust was very successful in developing a range of health and wellbeing opportunities for older people. One of our Paths for All local projects, Rouken Glen Walkers were delighted to receive their award for Health Walk of the Year 2019.

Supporting independence at home

Our services continue to support older people and people with long-term conditions to live independently and well. We continue to meet our target for the proportion of adults who agreed that they are supported to live as independently as possible.

We continue to expand our telecare services to support people to live independently and we have 88% of people reporting that that their “living where / as you want to live” needs are being met.

Whilst 69% of those people receiving reablement have seen their care needs reduce and 58% of people aged over 65 with intensive needs are receiving care at home we know we need to do more work in our Care at Home service. During 2019/20 we have been implementing our improvement plan to support this.

Our Talking Points engagement events have been working well and demonstrating strong collaborative working with our third and community sector partners.

Care at Home

Following an inspection of our Care at Home services published in February 2019, an improvement delivery plan was put in place allowing the service to focus on activity to meet Care Inspectorate requirements. A follow-up inspection published in November 2019 and subsequent discussion with the Care Inspectorate highlighted that we would not meet their requirements in a sustainable way unless we embarked on a programme of service redesign for Care at Home.

The programme of improvement and redesign is being led by the Chief Officer and the Programme Oversight Board, chaired by the Council Chief Executive. Membership is drawn from staff side, HR and legal services as well as the Chief Officer, who is the Programme Sponsor, the Chief Social Work Officer, the Intensive Services Manager and a programme manager.

The key element in relation to meeting and sustaining the Care Inspectorate requirements is to review frontline management roles to ensure our home care support workers are properly

supported in the community. This will require the development of new roles that are fit for the future. Continuity of support for our service users will require further recruitment and a change to work patterns to ensure the staffing resource is better aligned to meet service demand.

Supporting people experiencing mental ill-health and supporting recovery from addiction

Our addiction services have seen an increase in the proportion of service users moving from drug treatment to recovery. The number of acute mental health bed days has reduced as a result of implementing the Bipolar Disorder Framework. We have commissioned Bipolar Scotland to deliver a self-management programme from East Renfrewshire.

In partnership with the third sector we have established peer support in mental health and addictions. In 2019/20 we recruited new posts funded by Action 15 and Alcohol and Drugs Partnership money and have undertaken a review of the support being delivered by our Mental Health Officers.

Reducing unplanned hospital care

Our new Hospital to Home team has been delivering targeted interventions to ensure local residents have the support they need in place to return home after a stay in hospital.

We continue to perform very well with delayed discharges, averaging around 3-4 per month. We perform well on emergency admissions to hospital which have remained stable during 2019/20. However, latest data shows our number of Accident & Emergency attendances showed a small increase to February 2020.

Our plans for Bonnyton House are to provide dedicated beds for intensive rehabilitation and end of life care, alongside our residential and respite provision. Our residents were temporarily decanted in January 2020 to a property we have rented in Crossmyloof to allow a significant refurbishment of Bonnyton House to take place. This refurbishment project was impacted by COVID-19 as work had to be suspended for a period of time.

Supporting unpaid carers

We have been providing support to unpaid carers in collaboration with our local Carers Centre and have seen significant improvement in the proportion of carers reporting that their needs are being met.

Working with our Partners

We continue to work with our partner service providers to ensure market choice and sustainability and fund the Living Wage and other Fair Work Practices. Following the COVID-19 pandemic, supporting the sustainability of our partner providers remains a key area of focus as we develop and implement new framework arrangements.

In 2019 we established our Initial Contact Team which is now established as our 'front door' to HSCP and partner supports. This is proving to be a positive approach with residents being directed to the most appropriate support whether through the third/community sector or through formal HSCP services.

During the year we established and embedded a new approach to calculating Individual Budgets for adult social care, and continued initiatives to implement the Carers Act.

We now host a new service supporting Augmentative and Alternative Communication (AAC) which uses a range of techniques to support communication when people do not have a voice, or when they find it difficult to be understood using their voice. AAC often involves the use of specialised computer-based equipment. The service also works with the Scottish Centre for the Communication Impaired (SCTCI) which is an expert AAC assessment service which provides assessment, training, and information and advice to 12 geographical NHS health boards in Scotland, including NHS Greater Glasgow and Clyde.

Management Information

This year we have continued to develop and improve our management information and use of data across services. This has seen service planning work for key adult services involving the development of new suites of local Performance Indicators and management information. New planning leads and business analysts have been appointed to support adult and children's services. The posts are working to support performance management and improve the quality and robustness of our data usage. This process is ongoing and we will continue to develop our management information and performance data to better inform our strategic and financial planning and decision making processes.

Strategic Inspection

In 2019, the Care Inspectorate and Health Improvement Scotland conducted a strategic inspection of East Renfrewshire HSCP looking at how well the partnership had: improved performance in both health and social care; developed and implemented operational and strategic planning and commissioning arrangements; established the vision, values, and aims across the partnership; and the leadership of strategy and direction. The inspection scored us positively for each element: performance; strategic planning and commissioning; leadership and direction. It found that the HSCP showed capacity for continuous improvement with its record of sound progress with the integration of health and social care services, supported by an integrated management structure and co-located teams of health and social care staff.

Of particular relevance to this annual report and accounts was the inspectors' comment on the Integration Joint Board's commendable record of sound financial performance. They reported that the Partnership managed its finances competently and well. It used its reserve funds creatively to develop new services to replace out-of-date services. The Medium-Term

Financial Plan was seen as a positive development in the face of the challenges the HSCP was facing.

The outcome of this inspection and the five areas of development identified were reported to the IJB on 27 November 2019.

COVID-19

The COVID-19 outbreak has impacted most seriously on older people and people with long-term conditions. We have focused our services on supporting those at greatest risk in both community and residential settings. This has seen additional staff support through redeployment and recruitment for care at home and our care home. There has been increased collaborative working with the third/community sector and additional support given to partner provider organisations, particularly our care home providers.

We needed to respond swiftly to the COVID-19 outbreak and to support this we created a mobilisation plan and associated financial implications. This plan was reported to the Scottish Government as part of the totality of the mobilisation by NHS Greater Glasgow and Clyde. The plan covers;

- Reducing the level of delayed discharges of patients in acute hospital provision through increased staffing of hospital discharge team and daily reporting on care home at care at home capacity
- Ensuring resilience and sustainability of care at home provision
- Purchasing additional care home bed capacity to prepare for expected increasing demand
- Recognising additional provider costs and potential sustainability concerns

Our financial implications across the period March 2020 to March 2021 are expected to be in the region of £9 million and these costs will continue to be monitored and revised as we work our way through this pandemic. The costs and provisions included in the 2019/20 accounts are just under £0.3 million. The working assumption for 2020/21 is that funding will be made available to meet the final costs. The main cost areas include: staffing additional hours and absence cover, both HSCP staff and our partner providers; the sustainability of our partner care providers; personal protective equipment (PPE); unachievable savings and prescribing.

A number of governance arrangements were put in place including drawing on business continuity plans to support critical functions, establishing our Local Resilience Management Team, participating in local and national working groups and establishing a COVID-19 Risk Register. We have also worked very closely with our partners' governance and response arrangements during the emergency, including East Renfrewshire Council, NHS Greater Glasgow and Clyde, National Chief Officer, Chief Social Work Officer and Chief Financial Officer meetings.

The IJB met in March as planned through a hybrid of physical and virtual attendance and this allowed the board to agree a budget for 2020/21 and delegate powers to the Chief Officer during the emergency. The Chairs of the IJB and its Performance and Audit Committee were regularly updated and consulted on developments and a weekly information bulletin ensured that all IJB members were updated weekly. Arrangements are in place for future meetings to take place using digital platforms.

Our staff teams have established and adapted to new ways of working and have continued to maintain and deliver safe and effective services to our residents. Across services we have taken innovative approaches and adapted provision to focus on our most vulnerable clients during the emergency phase of the crisis. We have also had to introduce new ways of working to respond to the crisis including the following areas:

Testing and Assessment: The HSCP established a testing team in response to Scottish Government strategy to undertake enhanced outbreak investigation in all care homes where there are cases of COVID-19. The HSCP as also responded to requests to establish weekly staff testing and surveillance testing in homes. A Community Assessment Centre for people concerned about their COVID-19 symptoms was set up in Eastwood Health and Care Centre. This involved some adaptations to premises as well as equipping and staffing the centre. The Centre closed in June as a result of falling referrals.

PPE for Health and Social Care: The HSCP implemented a centralised model of PPE stock control to ensure support and supply to those front-line services delivered by the HSCP and our partners providing a range of health and care services throughout East Renfrewshire.

Supporting vulnerable people in the community: In order to prioritise those in greatest need all HSCP services established vulnerable people lists at the start of the crisis. We planned for a significant reduction in the care at home workforce (for all providers) and redeployed staff from day services to support care at home and Bonnyton House. We tailored our training programme for redeployed, new and voluntary staff and this allowed us to prioritise our registered staff to support those most in need.

Care at home has continued to support the majority of people, only withdrawing services at the request of families. The number of visits for some people reduced where support could be provided by informal family care, third/community sector or use of Technology Enabled Care (TEC) where appropriate. To continue to support our residents we have maintained regular telephone contact supported by additional call handling and dedicated phone lines. We have been working closely with the third sector and community groups to coordinate the HSCP, the Council and the community response to non-personal care requests and for wider support to isolated individuals.

Community Pharmacy services has adapted to support people in the community giving priority access to medication for care staff and with HSCP and council support establishing new processes for volunteer drivers to deliver medications to vulnerable and self-isolating residents.

In partnership with Voluntary Action East Renfrewshire and the Council, the HSCP supports the Community Hub helpline which is a “one-stop shop” for residents needing help or those who cannot leave their house and have no means to organise their own essentials.

Supporting unpaid carers: We have been working in close collaboration with the voluntary sector to provide enhanced support to unpaid carers during the coronavirus crisis. This has seen the establishment of new tailored support and a communication/information strategy for unpaid carers. We established a pathway for carers to access PPE in collaboration with the Carers Centre.

Supporting people in care homes: The care home sector has been particularly affected by the coronavirus outbreak with a high volume of cases across Scotland. In East Renfrewshire we put in place enhanced support to our care homes from the start of the pandemic. We established frequent contact with care home management to discuss the issues they are facing, gather information on staffing, bed vacancies and COVID-19 cases, and to support collaborative working across the sector. Care homes have been given priority access to medication through our community pharmacies and we have established new procedures for the stocking of medication in care homes (e.g. specific palliative medication). Care home liaison nursing and commissioning staff are undertaking enhanced assurance and support visits to care. The feedback from these visits has been positive with homes benefitting from independent assurance that they are implementing guidance correctly.

Alleviating pressure on acute NHS services: Minimising unnecessary use of hospital services is a strategic priority of the HSCP, and this has become even more essential given the additional pressure coronavirus is putting on acute NHS services. During the period we increased the staff capacity of our hospital discharge team. The team has been working to continually improve referral processes, conducting continuous monitoring of hospital discharges and gathering accurate daily intelligence on care home vacancies and homecare capacity. Delayed discharges have remained low despite significant challenges as a result of the crisis.

The HSCP has also been supporting the primary care sector during the crisis, facilitating remote working arrangements for GPs and support staff through equipment and training. GP Practices worked in collaboration with the HSCP to enhance their business continuity plans, and set up buddying arrangements to mitigate staff absences and ensure the ongoing operation of GP practices.

Supporting vulnerable children and families: The HSCP continued to support children throughout the crisis. Social workers are maintaining keeping in touch contact will all of their other families, albeit engaging in different ways such as telephone, Zoom and now WhatsApp. Where there are high risk activity the emergency team responds to critical situations. Home visiting is continuing to take place across services where this is essential.

The pressure on care placements for children and young people during the COVID-19 lockdown remains significant. Action has been taken to maximise what capacity there is

remaining within our fostering service and to continue to find creative solutions in relationship to kinship placements. Virtual fostering and kinship panels are taking place on a regular basis to support arrangements. However, as additional demand has placed the service at capacity, the Chief Social Work Officer linked with the Care Inspectorate with regards to the need for emergency provision. An abridged process is being taken forward with a view to the recruitment of existing East Renfrewshire registered employees (e.g. children's social workers, teachers, nurses) to provide care if internal and external placements cease to be available.

There has been an increase of tension within vulnerable family households with teenagers who find it difficult to be confined together with parents/family. As a result of changes in routines and structure, there have been heightened concerns in relation to children and young people diagnosed with Obsessional Compulsive Disorder and Autistic Spectrum Disorder. CAMHS services have offered support through telephone, online and visits as appropriate.

Moving Towards Recovery

Whilst many of the services the HSCP provides are critical and continued to operate through the crisis period we still have a significant programme of work around Recovery and how we move to a "new normal". This will not simply be reinstating what was in place pre COVID-19, but will look at learning and opportunities from new ways of working. This work will range from small individual service areas to system wide changes in how we work within the HSCP and with our partners. We are using the Scottish Government Recovery Routemap phases to support and inform our recovery plan. A Recovery working group was established and the initial workstreams identified: governance; accommodation, workforce, partner organisations, information technology requirements, PPE, change programme and the ongoing response to COVID-19.

Our recovery planning and the impact on 2020/21 is still in the very early stages and subject to change in this unpredictable and fast-moving environment. Routine reporting and monitoring will take place however the dynamics mean we will have a period of uncertainty. The Medium-Term Financial Plan will be revised when the position stabilises, and the impacts become clearer.

2019-20 Performance Achievements

In addition to our quarterly reports, the Annual Performance Report will be submitted to the IJB later in 2020 and made publicly available on our website in line with statutory guidance. In this report, we review our performance for 2019/20 against local and national performance indicators and against the commitments within our Strategic Plan. Key areas where we have seen improvement or continued strong performance over the past 12 months are as follows:

Indicator	2019/20		2018/19
	Target	Actual	Actual
Children and families *(SP1: Working together with children, young people and their families to improve mental wellbeing)*			
% of positive response to Viewpoint question "Do you feel safe at home?" *(INCREASE)*	92%	**98%**	93%
Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral *(INCREASE)*	90%	**78%**	74%
100% of parents of children who have received an autism diagnosis have opportunity to access Cygnet post diagnostic programme within 12 months of receiving diagnosis. *(INCREASE)*	100%	**100%**	100%
Increase in improved outcomes for children after parent/carer completion of POPP *(INCREASE)*	84%	**96%**	89%
Balance of Care for looked after children: % of children being looked after in the Community (LGBF) *(INCREASE)*	Data only	**98%** (18/19)	93.6% (17/18)
Criminal justice *(SP2: Working together with our community planning partners on new community justice pathways that support people to prevent and reduce offending and rebuild lives)*			
Criminal Justice Feedback Survey - Did your Order help you look at how to stop offending? *(INCREASE)*	100%	**100%**	100%
% Change in women's domestic abuse outcomes (*INCREASE)*	70%	**79%**	64%
Living independently *(SP4: Working together with people to maintain their independence at home and in their local community)*			
People reporting 'living where you/as you want to live' needs met (%) *(INCREASE)*	90%	**88%**	92%
SDS (Options 1 and 2) spend as a % of total social work spend on adults 18+ (LGBF) *(INCREASE)*	Data only	**8.2%** (18/19)	7.5% (17/18)
Percentage of people aged 65+ who live in housing rather than a care home or hospital *(INCREASE)*	97%	**96%** (18/19)	96% (17/18)
Percentage of adults with intensive care needs receiving care at home *(INCREASE)*	62%	**64%** (18/19)	63% (17/18)

Supporting people experiencing mental ill-health *(SP5: Working together with people who experience mental ill-health to support them on their journey to recovery)*			
% of people waiting no longer than 18 weeks for access to psychological therapies *(INCREASE)*	90%	**65%**	55%
Reducing unplanned hospital care *(SP6: Working together with our colleagues in primary and acute care to care for people to reduce unplanned admissions to hospital)*			
People (18+) waiting more than 3 days to be discharged from hospital including AWI (NHSGGC data) *(DECREASE)*	0	**3**	4
Bed days lost to delayed discharge (Adults) (MSG data) *(DECREASE)*	1,734 (11 month target)	**1,629** (Apr 19 - Feb 20)	2,037 (Apr 18 – Feb 19)
Unscheduled hospital bed days (all acute) (MSG data) *(DECREASE)*	57,056	**61,191** (Oct 18 – Sept 19)	61,672 (Oct 17 – Sept 18)
% of last six months of life spent at home of in a community setting	86%	**89%** (at Q3 19/20)	86%
Supporting carers *(SP7: Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities)*			
People reporting 'quality of life for carers' needs fully met (%) *(INCREASE)*	72%	**92%**	78%

2019-20 Performance - Areas for Improvement

Ongoing improvement is sought across all services within the HSCP and the performance management arrangements in place are designed to facilitate this. There are specific areas we would like to improve going forward and these are set out in our current Strategic Plan.

Key indicators we would like to improve on include the following:

Indicator	2019/20		2018/19
	Target	Actual	Actual
Children and families *(SP1: Working together with children, young people and their families to improve mental wellbeing)*			
Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral *(INCREASE)**	90%	**78%**	74%
Criminal justice *(SP2: Working together with our community planning partners on new community justice pathways that support people to prevent and reduce offending and rebuild lives)*			
Community Payback Orders - % of unpaid work placement completions within Court timescale *(INCREASE)*	80%	**71%**	84%
Living independently *(SP4: Working together with people to maintain their independence at home and in their local community)*			
Number of people self-directing their care through receiving direct payments and other forms of self-directed support. *(INCREASE)*	600	**518**	514
% of people aged 65+ with intensive needs receiving care at home. *(INCREASE)*	62%	**57.5%** (18/19)	59.2% (17/18)
Supporting people experiencing mental ill-health *(SP5: Working together with people who experience mental ill-health to support them on their journey to recovery)*			
Percentage of people waiting no longer than 18 weeks for access to psychological therapies *(INCREASE)**	90%	**65%**	55%
Reducing unplanned hospital care *(SP6: Working together with our colleagues in primary and acute care to care for people to reduce unplanned admissions to hospital)*			
Number of A&E Attendances (Adults) (MSG data) *(DECREASE)*	16,804 (11 month target)	**18,961** (Apr 19 - Feb 20)	18,547 (Apr 18 - Feb 19)
Number of Emergency Admissions (Adults) (MSG data) *(DECREASE)*	7,124	**7,562** (Oct 18 – Sept 19)	7,258 (Oct 17 – Sept 18)

* *n.b. improving pre-COVID-19 outbreak and working to reach and maintain target performance*

Funding 2019/20

The net total health and social care funding from our partners for financial year 2019/20 was £153.559 million:

	£ Million
NHS Greater Glasgow and Clyde Primary Care	72.462
NHS Greater Glasgow and Clyde Large Hospital Services	31.223
East Renfrewshire Council Social Care	49.598
East Renfrewshire Council Housing Aids and Adaptations	0.276
Total Net Funding	153.559

The Comprehensive Income and Expenditure Statement (CIES) (page 49) shows the IJB gross income as £175.442 million, as that statement shows service income, grant funding, resource transfer and social care fund monies which are included within the net funding from our partners in the table above. The purpose of the CIES presentation is to show the gross cost of the services we provide.

Work continues to be progressed with the set aside funding for large hospital services, however arrangements under the control of the IJB (and those across Greater Glasgow) are not yet operating as required by the legislation and statutory guidance. Each Health Board, in partnership with the Local Authority and IJB, must fully implement the delegated hospital budget and set aside budget requirements of the legislation in line with the statutory guidance published in June 2015. A Greater Glasgow and Clyde wide Unscheduled Care Commissioning Plan has been developed and represents the first steps in developing strategic plans for the unscheduled care pathway (set aside) as set out in legislation. The IJB will consider this plan as part of its consultation, although this may be impacted by changes resulting from COVID 19 implications.

NHS Greater Glasgow and Clyde are now in a position to report the set aside figures based on actual expenditure of £31.223 million which has resulted in the restatement of 2018/19 figures. These were previously based on a notional budget figure of £16.624 million. The notional budgets for set aside were based on NRAC (resource allocation formula) activity and information from the cost book and were very high level. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

Resource Transfer shows NHS Greater Glasgow and Clyde specific funding for historic bed closures and is used to purchase care packages and community-based services. The Social Care Fund was allocated by the Scottish Government to IJBs, via the NHS funding stream, to meet specific costs such as living wage and other fair work practices and adult demographic pressures.

Financial Performance 2019/20

The annual report and accounts for the IJB covers the period 1st April 2019 to 31st March 2020, with comparable figures shown for 2018/19.

The budgets and outturns for the operational services (our management accounts) as reported regularly throughout the year to the IJB are summarised below:

Service	Budget	Spend	Variance (Over) / Under	Variance (Over) / Under
	£ Million	£ Million	£ Million	%
Children & Families	13.268	12.712	0.556	4.20%
Older Peoples Services	18.735	18.932	(0.197)	(1.06%)
Physical / Sensory Disability	5.498	5.478	0.020	0.37%
Learning Disability – Community	10.586	10.681	(0.095)	(0.90%)
Learning Disability – Inpatients	8.361	8.359	0.002	0.02%
Augmentative and Alternative Communication	0.220	0.220	-	-
Intensive Services	10.570	11.208	(0.638)	(6.03%)
Mental Health	4.130	3.941	0.189	4.58%
Addictions / Substance Misuse	1.111	1.098	0.013	1.14%
Family Health Services	23.805	23.805	-	-
Prescribing	15.779	16.090	(0.311)	(1.97%)
Criminal Justice (fully grant funded)	-	-	-	-
Planning & Health Improvement	0.230	0.132	0.098	42.81%
Finance and Resources	9.766	9.588	0.178	1.82%
Net Expenditure Health and Social Care	**122.059**	**122.244**	**(0.185)**	**(0.15%)**
Housing	0.276	0.276	-	-
Set Aside for Large Hospital Services	31.223	31.223	-	-
Total Integration Joint Board	**153.558**	**153.743**	**(0.185)**	**(0.15%)**

The £0.185 million overspend (0.15%) is broadly in line with the reporting taken to the IJB during the year and the overspend is funded, as planned, from our reserves. We expected to draw from reserves as we recognised we would not achieve all savings required during the year as our individual budget approach would take many months to implement; we did not have capacity to work on our digital savings programme and we achieved part year savings from the second phase of our structure review.

The impact of COVID-19 in the closing weeks of 2019/20 will have resulted in some reduction in day to day costs. The main variances to the budget were:

- Underspends in a number of services are from staff turnover and vacant posts during the year, reflecting the general trends of recruitment and retention issues within health and social care.
- Children's services purchased care costs, including residential care, foster and adoption were lower than budget during the year.
- Older Peoples and Intensive Services ended the year with a collective overspend of £0.835 million from care package costs for residential and care at home costs, reflecting the continued impacts of population growth in older people and the demand for services. We are addressing our care at home costs as an element within the action plan and redesign of this service.
- The overspend in prescribing is a result of both cost and volume across a number of drugs and also allowed for an expected spike in demand in February and March 2020 as the implications of the COVID-19 pandemic began to emerge.

The IJB receives regular and detailed revenue budget monitoring throughout the year.

The set aside budget is shown as nil variance as this currently is not a cash budget to the HSCP. To eliminate any "notional" variance to the IJB the budget is shown as the same value as the HSCP share of the collective costs. The budget equivalent share was identified as £25.516 million and the overspend of £5.707 million is contained within the Health Board. As outlined earlier work is ongoing to agree the mechanism for bringing the set aside budget into an operational stage and this includes ensuring a balanced budget will be achieved.

A number of services are hosted by the other IJBs who partner NHS Greater Glasgow and Clyde and our use of hosted services is detailed at Note 4 (Page 48). The hosted services are accounted for on a principal basis, as detailed at Note 11 (Page 53).

The information above reflects our management accounts reporting throughout 2019/20 whilst the CIES at Page 49 presents the financial information in the required statutory reporting format; the movement between these of £0.546m million is a result of the management accounting treatment of reserves.

Reserves

We used £1.763 million of reserves in year and we also invested £1.032 million into earmarked reserves. The year on year movement in reserves is set out at Note 8 (Page 52) and is summarised:

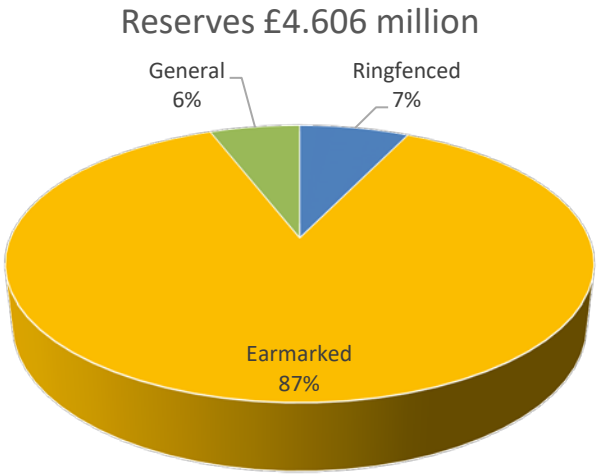
	£ Million	£ Million
Reserves at 31 March 2019		5.337
Planned use of existing reserves during the year	(1.763)	
Funds added to reserves during the year	1.032	
Net decrease in reserves during the year		(0.731)
Reserves at 31 March 2020		4.606

The purpose, use and categorisation of IJB reserves is supported by a Reserves Policy and Financial Regulations, both of which were reviewed in March 2020 in line with the statutory review of the Integration Scheme.

The reserves of the IJB fall into three types:

- Ringfenced: the funding is earmarked and can only be used for that specific purpose
- Earmarked: the funding has been allocated for a specific purpose
- General: this can be used for any purpose

The current balance of £4.606 million falls in these three reserves types:



Our ring-fenced reserves show the funding that comes from the Scottish Government to support national programmes including Primary Care Improvement, Mental Health Action 15 and Alcohol and Drugs. This funding is allocated from the Scottish Government based on the cost and activity returns we are required to submit throughout the year.

We started the year with £0.599 million ring-fenced reserves and during the year we spent £0.463 million. Of the £0.195 million we added in year, £0.078 million is new funding to support GP premises and the remaining £0.117 million is continued programme funding.

Our earmarked reserves are in place to support a number of projects, provide transitional funding for service redesign, provide bridging finance for in year pressures, add capacity to support service initiatives and to support longer term cost smoothing and timing.

We started the year with £4.466 million earmarked reserves and during the year we spent £1.300 million. The main areas of spend were:

- £0.639 million to support the timing and implementation of budget savings as agreed as part of our budget setting and financial planning.
- £0.229 million to support the revenue costs of the decant of Bonnyton House to allow the capital works, as part of East Renfrewshire Council capital programme, to be undertaken. This includes roofing work, internal and external refurbishment.
- £0.250 million to support the Care at Home action plan.

We also added £0.837 million during the year to earmarked reserves, including:

- £0.408 million added to our budget savings reserve which included release of £0.309 million funding previously held has deferred income and transfers from older reserves now closed.
- £0.311 million for school counselling which was transferred to the HSCP towards the end of 2019/20. This was part of the 2019/20 budget funding the Scottish Government announced and is supported, within Children's Services, by an implementation plan.
- £0.101 million for a new reserve for Augmentative and Alternative Communication, newly hosted by the HSCP during 2019/20. This reserve will allow the service to better deal with the flux in demand for assessment and equipment in this highly specialised area.

In addition to the above we have also closed two older reserves where the activity took place and was contained within the core budget (small projects and Learning Disability) and created two new reserves to support training capacity:

- £0.100 million for health visitors, new within Children's Services
- £0.100 million for district nursing (increased by £0.061 million)

We had also planned to meet some refurbishment costs for work within our Learning Disability in-patient units, however this work was delayed, and costs will be incurred in 2020/21. We have also committed funding from the transitional funding reserve for Learning Disabilities specialist services to meet the costs of a post; Challenging Behaviours Network Manager, for two years to support this work.

Our general reserve at £0.272 million is well below the optimum level at a value of 2% of budget we would ideally hold. The general reserve is currently 0.2% of the 2020/21 revenue budget.

Future Challenges

The IJB continues to face a number of challenges, risks and uncertainties in the coming years and this is set out in our current Medium-Term Financial Plan for 2019/20 to 2023/24 which supports our strategic planning process and provides a financial context to support medium-term planning and decision making.

This plan sets out the potential cost pressures of circa £5.1 to £5.7 million per year for the five years 2019/20 to 2023/24. The resulting funding gap will be dependent on the funding settlement for each year.

The 2020/21 budget settlement fell within the poor settlement range of scenario planning assumptions with cost pressures of just over £6 million and subsequent required savings of £2.4 million after all funding uplifts.

The budget agreed on 18th March 2020 set out how we will achieve the £2.4 million savings to balance our budget. We identified £0.8 million from specific budget areas and we will need to prioritise care package costs to meet the remaining balance of £1.6 million savings, as we had previously signalled, this will mean an impact on our frontline services and care packages.

This budget was agreed as the COVID-19 pandemic was emerging in Scotland and the rest of the UK, and regular monitoring of the operational budget and the COVID-19 Mobilisation Plan are in place and implications and risk will continue to be addressed as costs become clearer. There is a significant financial risk to the HSCP if additional costs are not fully funded.

The work undertaken to date on our recovery programme has focussed on the short to medium term to allow us to emerge from the crisis phase and work towards the “new normal”. There will be significant work coming from this programme that will inform our longer term strategic and financial planning.

Demographic pressures remain a very specific challenge for East Renfrewshire as we have an increasing elderly population with a higher life expectancy than the Scottish average and a rise in the number of children with complex needs resulting in an increase in demand for services.

In addition to COVID-19 the consequence of Brexit may also impact on the future of the services we provide and our ability to meet the needs of the communities we serve.

We have successfully operated integrated services for a number of years and we have already faced a number of challenges and opportunities open to newer partnerships. However our funding and savings challenge take no account of this history. Whilst we have agreed a population based approach for future (NHS) financial frameworks and models this does not address the base budget.

Prescribing Costs; The cost of drugs prescribed to the population of East Renfrewshire by GPs and other community prescribers is delegated to the IJB. This is a complex and volatile cost base of

around £16 million per year. The COVID-19 impact on prescribing in the medium to long term is unclear.

Delayed Discharge; In order to achieve the target time of 72 hours we continue to require more community based provision. The medium-term aspiration is that the costs of increased community services will be met by shifting the balance of care from hospital services. The work to agree a funding mechanism to achieve this remains ongoing with NHS Greater Glasgow and Clyde and its partner IJBs.

Care Providers: The impact on the sustainability of the care provider market following COVID-19 is unknown and we will continue to work closely with all our partners to work through issues, support where we can and look to develop the best way of working as we move forward. This will build on our work to date, including preparation to move to a new contractual framework.

We continue to develop our performance and financial reporting in more detail at a locality level to allow fuller reporting and understanding of future trends and service demands and include COVID-19 implications and scenarios.

We plan to deal with these challenges in the following ways:

- Our Recovery Plan will be implemented throughout 2020/21 and beyond and regular reports will be taken to the IJB.
- We will update our Medium-Term Financial Plan once COVID-19 impacts become clearer. This will allow us to continue to use scenario-based financial planning and modelling to assess and refine the impact of different levels of activity, funding, pressures, possible savings and associated impacts.
- We will continue to monitor in detail the impacts of COVID-19, Brexit and operational issues through our financial and performance monitoring to allow us to take swift action where needed, respond flexibly to immediate situations and to inform longer term planning.
- We will continue to work through our Care at Home action plan and service redesign, taking into account the changing COVID-19 landscape.
- We have identified savings proposals for 2020/21 and as we previously indicated will now need to move to a prioritisation and criteria-based model for care package support. Our individual budget calculator will be revised. We will continue to use our reserve through 2020/21 to phase in budget savings. It is possible we will deplete this reserve in 2020/21 so there is a significant risk associated with:
    - Ensuring savings are achieved on a recurring basis by the end of the financial year
    - Impact of a similar level of budget settlement in 2021/22
    - Unknown impact of COVID-19
- We will realign our adult services to reflect a change to our senior management structure which we have increased recognising, as supported in the Strategic Inspection, we had reduced capacity too far in previous savings delivery. We have recently recruited to our new post; Head of Recovery and Intensive Services.

- We routinely report our performance to the IJB with further scrutiny from our Performance and Audit Committee and our Clinical and Care Governance Group. The service user and carer representation on the IJB and its governance structures is drawn from Your Voice which includes representatives from community care groups, representatives from our localities and representatives from equality organisations including disability and faith groups.
- Governance Code; We have robust governance arrangements supported by a Governance Code.
- The IJB continues to operate in a challenging environment and our financial, risk and performance reporting continue to be a key focus of each IJB agenda.

We regularly review our strategic risk register for the IJB which identifies the key areas of risk that may impact the IJB and have implemented a range of mitigating actions to minimise any associated impact. A separate COVID-19 Risk Register is in place.

The challenges and our responses set out above include the main areas of risk that the IJB are facing, with the uncertainty of the impact of COVID-19, the capacity for the HSCP and its partners to deliver services and financial sustainability all very significant risks.

Conclusion

East Renfrewshire Integration Joint Board continued, pre COVID-19, to be well placed in the short term to meet the coming challenges, building on many years of delivering integrated health and social care services and continuing to lead on developing new and innovative models of service delivery, not only ensuring financial sustainability, but also meeting the needs of our population. There is a degree of uncertainty over the medium to longer term funding which could pose risk to meeting future demand, however we continue to plan ahead and prepare for a range of scenarios. The implications of the COVID-19 pandemic are largely unknown at this point and this conclusion must be caveated to that effect.

Anne-Marie Monaghan
Chair
Integration Joint Board **24th June 2020**

Julie Murray
Chief Officer
Integration Joint Board **24th June 2020**

Lesley Bairden ACMA CGMA **24th June 2020**
Chief Financial Officer
Integration Joint Board

Statement of Responsibilities

Responsibilities of the Integration Joint Board

The IJB is required to:

- Make arrangements for the proper administration of its financial affairs and to ensure that one of its officers has the responsibility for the administration of those affairs. In East Renfrewshire IJB, the proper officer is the Chief Financial Officer.

- Manage its affairs to secure economic, efficient and effective use of resources and safeguard its assets.

- Ensure the annual accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland Act 2003).

- Approve the Statement of Accounts.

I confirm that the audited Annual Accounts were approved for signature at a meeting of the Integration Joint Board on 23rd September 2020.

Anne-Marie Monaghan
Chair
Integration Joint Board **24th June 2020**

Responsibilities of the Chief Financial Officer

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

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

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

The Chief Financial Officer has also:

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

I certify that the financial statements give a true and fair view of the financial position of East Renfrewshire Integration Joint Board as at 31st March 2020 and the transactions for the IJB for the period covering 1st April 2019 to 31st March 2020.

Lesley Bairden ACMA CGMA
Chief Financial Officer
Integration Joint Board **24th June 2020**

Remuneration Report

Introduction

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

The IJB does not directly employ any staff in its own right. All staff are employed through either East Renfrewshire Council or NHS Greater Glasgow and Clyde. The report contains information on the IJB's Chief Officer's remuneration together with any taxable expenses relating to voting members claimed in the year. The remuneration of senior officers is determined by the contractual arrangements of East Renfrewshire Council and NHS Greater Glasgow and Clyde.

For 2019/20 no taxable expenses were claimed by members of the IJB.

The board members are entitled to payment for travel and subsistence expenses relating to approved duties. Payment of voting board members' allowances is the responsibility of the member's individual partnership body. Non-voting members of the IJB are entitled to the payment of travel expenses.

The IJB does not provide any additional remuneration to the Chair, Vice Chair or any other board members relating to their role on the IJB.

The information in the tables below is subject to external audit. The explanatory text in the Remuneration Report is reviewed by external auditors to ensure that it is consistent with the financial statements:

Integration Joint Board

The voting members of the IJB were appointed through nomination by East Renfrewshire Council and NHS Greater Glasgow and Clyde.

Senior Officers

The Chief Officer is appointed by the IJB in consultation with East Renfrewshire Council and NHS Greater Glasgow and Clyde. The Chief Officer is employed by East Renfrewshire Council and is funded equally between East Renfrewshire Council and NHS Greater Glasgow and Clyde.

The total remuneration received by the Chief Officer in 2019/20 amounted to £110,954 in respect of all duties undertaken during the financial year. In respect of the Chief Financial Officer, total remuneration for 2019/20 amounted to £84,772.

Name and Post	Salary, Fees and Allowances £	Taxable Expenses £	Total Remuneration £
Julie Murray, Chief Officer 2019/20	110,954	-	110,954
Julie Murray, Chief Officer 2018/19	107,767	-	107,767

Name and Post	Salary, Fees and Allowances £	Taxable Expenses £	Total Remuneration £
Lesley Bairden, Chief Financial Officer 2019/20	84,759	13	84,772
Lesley Bairden, Chief Financial Officer 2018/19	82,342	-	82,342

Voting Board Members 2019/20		Total Taxable IJB Related Expenses £
Councillor Caroline Bamforth (Vice Chair)	East Renfrewshire Council	Nil
Councillor Tony Buchanan	East Renfrewshire Council	Nil
Councillor Paul O' Kane	East Renfrewshire Council	Nil
Councillor Jim Swift	East Renfrewshire Council	Nil
Susan Brimelow	NHS Greater Glasgow & Clyde	Nil
John Matthews	NHS Greater Glasgow & Clyde	Nil
Anne-Marie Monaghan (Chair)	NHS Greater Glasgow & Clyde	Nil
Flavia Tudoreanu	NHS Greater Glasgow & Clyde	Nil

The equivalent cost in 2018/19 was nil for all IJB members.

The Pension entitlement for the Chief Officer for the year to 31st March 2020 is shown in the table below, together with the contribution made by the employing body to this pension during the year.

Name and Post	In Year Pension Contribution For year to 31st March £	Accrued Pension Benefit as at 31st March	
		Pension £	Lump Sum £
Julie Murray, Chief Officer 2019/20	21,414	42,146	58,504
Julie Murray, Chief Officer 2018/19	20,799	38,772	56,800

The Chief Financial Officer joined the pension scheme on appointment in August 2015 and under the terms of the scheme no lump sum benefit has been identified.

Name and Post	In Year Pension Contribution For year to 31st March £	Accrued Pension Benefit as at 31st March	
		Pension £	Lump Sum £
Lesley Bairden, Chief Financial Officer 2019/20	16,358	7,104	-
Lesley Bairden, Chief Financial Officer 2018/19	15,892	5,247	-

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

However, the IJB has responsibility for funding the employer's contributions for the current year in respect of the officer time spent on fulfilling the responsibilities of their role on the IJB. The table above shows the IJB's funding during 2019/20 to support officers' pension benefits. The table also shows the total value of accrued pension benefits which may include benefits earned from a previous employment and from each officers' own contributions.

General Disclosure by Pay Bands

The regulations require the Remuneration Report to provide information on the number of persons whose remuneration was £50,000 or above. This information is provided in bands of £5,000.

General Disclosure by Pay Bands

Number of Employees 31st March 2019	Remuneration Band	Number of Employees 31st March 2020
1	£80,000 - £85,999	1
1	£105,000 - £109,999	1

Anne-Marie Monaghan
Chair
Integration Joint Board **24th June 2020**

Julie Murray
Chief Officer
Integration Joint Board **24th June 2020**

Annual Governance Statement

Introduction

The Annual Governance Statement explains the IJB's governance arrangements and reports on the effectiveness of the IJB's system of internal control. This is in line with the Code of Corporate Governance and meets the requirements of the 'Code of Practice for Local Authority Accounting in the UK: A Statement of Recommended Practice', in relation to the Statement on the System of Internal Financial Control. This should ensure:

- A focus on the assessment of how well the governance framework is working and what actions are being taken.

- The importance of the role and responsibilities of partners in supporting IJB good governance is adequately reflected.

Scope of Responsibility

The IJB is responsible for ensuring that its business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for and used economically, efficiently and effectively. To ensure best value the IJB commits to continuous quality improvement in performance across all areas of activity.

To meet this responsibility the IJB continues to operate the governance arrangements first put in place during 2015/16, including the system of internal control. This is intended to manage risk to a reasonable level but cannot eliminate the risk of failure to achieve policies, aims and objectives and can therefore only provide reasonable, but not absolute assurance of effectiveness.

In discharging these responsibilities, the Chief Officer has a reliance on East Renfrewshire Council and NHS Greater Glasgow and Clyde systems of internal control that support compliance with both organisations' policies and promotes achievement of each organisations' aims and objectives, as well as those of the IJB.

The Purpose of the Governance Framework

The governance framework comprises the systems and processes and culture and values by which the IJB is directed and controlled and the activities through which it accounts to, engages with, and leads the community. It enables the IJB to monitor the achievement of its strategic objectives and to consider whether those objectives have led to the delivery of appropriate, cost-effective services.

The system of internal control is a significant part of that framework and is designed to manage risk to a reasonable level. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the IJB's policies, aims and

objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

We have robust governance arrangements and have consolidated these into a Governance Code.

The Governance Framework

The main features of the governance framework in place during 2019/20 are summarised below:

- The IJB, comprising all IJB Board members, is the key decision-making body.
- The scope, authority, governance and remit of the IJB is set out in constitutional documents including the Integration Scheme, Board terms of reference, scheme of administration and financial regulations and as reflected in our Code of Governance.
- The Performance and Audit Committee and Clinical and Care Governance Group provide further levels of scrutiny for the IJB.
- The IJB's purpose and vision is outlined in the IJB Strategic Plan which sets out how we will deliver the national health and wellbeing outcomes. This is underpinned by an annual implementation plan and performance indicators. Regular progress reports on the delivery of the Strategic Plan are provided to the Performance and Audit Committee and the IJB.
- The IJB has adopted a 'Code of Conduct' for all of its Board Members and employees. A register of interests is in place for all Board members and senior officers.
- The Performance and Audit Committee routinely review the Strategic Risk Register.
- The IJB has in place a continuous development programme with an ongoing series of seminars covering a wide range of topics and issues.
- The IJB has two localities Eastwood and Barrhead, aligned with hospital use and includes three clusters of GP practices. Each Locality has a dedicated Locality Manager.

The governance framework was put in place during 2015/16 when the IJB was established and the Governance Code was formalised and audited in 2017/18 and continues to operate effectively.

The System of Internal Financial Control

The system of internal financial control is based on a framework of regular management information, financial regulations, administrative procedures (including segregation of duties), management supervision, and a system of delegation and accountability. Development and maintenance of these systems is undertaken by East Renfrewshire Council and NHS Greater Glasgow and Clyde as part of the operational delivery of the HSCP. In particular, these systems include:

- Financial regulations and codes of financial practice.
- Comprehensive budgeting systems.
- Regular reviews of periodic and annual financial reports that indicate financial performance against the forecasts.
- Setting targets to measure financial and other performance.
- Clearly defined capital expenditure guidelines.
- Formal project management disciplines.
- The IJB's financial management arrangements complies with the governance requirements of the CIPFA statement: 'The Role of the Chief Financial Officer in Local Government (2010)'.

With regard to the entries taken from East Renfrewshire Council and NHS Greater Glasgow and Clyde accounts, the IJB is not aware of any weaknesses within their internal control systems and has placed reliance on the individual Statements of Internal Financial Control where appropriate.

Review of Adequacy and Effectiveness

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

The Chief Internal Auditor reports directly to the IJB Performance and Audit Committee on all audit matters, with the right of access to the Chief Officer, Chief Financial Officer and Chair of the Performance and Audit Committee on any matter. In accordance with the principles of the code of corporate governance, regular reports were made to the IJB's Performance and Audit Committee during 2019/20. A member of East Renfrewshire Council's Audit and Scrutiny Committee was co-opted to the IJB Performance and Audit Committee during 2016/17 to promote transparency.

The Internal Audit function has independent responsibility for examining, evaluating and reporting on the adequacy of internal control. The IJB's internal audit arrangements comply with the governance requirements of the CIPFA statement: 'The Role of the Head of Internal Audit in Public Organisations (2019).

The Chief Internal Auditor prepares an annual report to the audit committee of the IJB including an assurance statement containing a view on the adequacy and effectiveness of the systems of internal control.

The Chief Internal Auditors opinion will be included in the final Audited Accounts to be presented in September 2020, following the due audit process.

We have a formal Code of Governance and the sections in the code and our level of compliance can be summarised as detailed below:

Code Section	Level of Compliance
Integration Scheme	Full
Local Governance Arrangements & Delegation of Functions	Full
Local Operational Delivery Arrangements	Full
Performance and Audit	Full
Clinical and Care Governance	Full
Chief Officer	Full
Workforce	Part
Finance	Full
Participation and Engagement	Full
Information Sharing and Data Handling	Full
Complaints/ Dispute Resolution Mechanism	Full
Claims Handling, Liability & Indemnity	Full
Risk Management	Full

The area where we are partly compliant is:

- Workforce; we have a local workforce plan and learning & development plan. A three-year Workforce Plan covering 2021-24 needs to be approved and published by 31st March 2021.

Governance Issues during 2019/20

Whilst all operational and transactional governance issues are considered within our partner's governance frameworks the IJB Performance and Audit Committee take an overview on all actions resulting from both internal and external audit reports, covering all live actions whether pre or post 31st March 2020.

Regular reports on audit recommendations and associated actions are presented to and considered by the Performance and Audit Committee of the IJB. The IJB will also receive direct reports where appropriate.

The recommendations from the follow up audit on the implementation of the Care Finance system are taken to the Performance and Audit Committee with progress updates on a six-monthly timescale. Progress has been made on these recommendations however the planned audit follow up work in March 2020 was impacted by COVID-19 so this will be completed during 2020/21.

The IJB Risk Policy was audited during the year and was found to be compliant.

The redesign and improvement plan for the Care at Home service is ongoing and includes all Care Inspectorate requirements.

- The programme is led by the Chief Officer and the programme oversight board is chaired by the Council Chief Executive. Membership includes staff side, human resources, legal services, the Chief Social Work Officer and the Intensive Services Manager and Programme Manager.
- A Report on progress, timelines and key milestones is also taken to each meeting of the Integration Joint Board.

The implementation of a new finance system by East Renfrewshire Council was undertaken with the HSCP having full representation on the project board.

The COVID-19 pandemic has meant that how the IJB operates and therefore associated governance has been impacted. The IJB met on 18 March 2020 and agreed delegated powers to allow the Chief Officer and the HSCP the flexibility to adapt to the significant public health challenges resulting from this pandemic.

The Scottish Government introduced new legislation; The Health Protection (Coronavirus) (Restrictions) (Scotland) Regulations 2020. The HSCP has complied with this legislation as appropriate.

All decisions taken under delegated authority are logged and a full record of decisions taken supports the Local Resilience Management Team process put in place as well as our Mobilisation Plan.

The HSCP is working with all partners at a local and national level to play our part in the response to the pandemic and has had to respond swiftly to a number of challenges including establishing a community assessment centre and a PPE Hub; supporting care home testing, as well as implementing business continuity plans to ensure services can deliver as much support as possible and in particular to our most vulnerable and at risk residents.

The Recovery work which is underway builds on this initial emergency response phase and will help inform how we plan to reintroduce as much as we can as we move to the new normal. This will also help inform our next strategic plan for 2022 - 2025. Significant work is required to review the disruption to and impact on services and our aim is to build what we have learned during the initial response, not only by the HSCP, but also that of our partners and most importantly those who use our services.

There are significant implications from both the emergency response and from the ongoing recovery phase. Our Mobilisation Plan was agreed with the Scottish Government and the detailed cost tracker; the funding discussions are ongoing.

Action Plan

The IJB identified the following actions for implementation during 2019/20 and progress against each is shown:

Action	Progress
Ensure our Care at Home improvement plan is fully implemented, with progress against actions and target dates continuing to be reported to the Integration Joint Board throughout 2019/20.	Our Care at Home action plan is a standing agenda item for our IJB. This will continue to be reported until all actions are closed and the service redesign complete.
Continue to develop our management information to better inform our strategic and financial planning, commissioning strategy, change programme and decision-making processes.	We have developed our performance reporting including a new suite of local performance indicators. The changes we have made to our staff structure support and promote the benefits of robust data recording, development and analysis.
Maintain and report, at least annually an updated Medium-Term Financial Plan reflecting the latest intelligence and assumptions to support and inform future funding modelling and scenarios. This will be supplemented by seminars at specific stages in the budget setting process.	The budget report submitted to the IJB on 18 March stated that the MTFP would be revised for April following finalisation of any implications from the UK final budget. The subsequent COVID-19 pandemic has overtaken that date and the plan will be revised in due course. It is worth noting that the 2020/21 budget settlements fell within the scenarios of the existing MTFP.
Implement commissioning arrangements for the set aside budget and reduce our Accident and Emergency attendances.	A Greater Glasgow and Clyde wide Unscheduled Care Commissioning Plan has been developed and represents the first steps in developing strategic plans for the unscheduled care pathway (set aside) as set out in legislation. The IJB will consider this plan as part of its consultation.
Continue to work with NHS Greater Glasgow and Clyde regarding the timing of future years funding confirmation, the budget setting timescale for 2020/21 demonstrates progress despite timeframe constraints.	This is ongoing however the IJB did agree a budget on 18 March with offers from both partners, albeit with caveats around the timing of the UK budget and the emerging implications of the COVID-19 pandemic.
Regularly report on the local and national actions, along with our partners, resulting from the Audit Scotland Review of Integration and the Ministerial Strategic Group review of Health and Community Care.	The IJB now has one action plan which combines the actions from these two reports along with those resulting from the areas for development from our strategic inspection. This single action plan – our Strategic Improvement Plan was agreed by the IJB on 29 January 2020.
Develop and publish our three-year Workforce Plan for 2020-23.	The date for the three-year Workforce Plan has been revised, by the Scottish Government to 2021-24.

The actions to take in 2020/21 to improve strengthening our corporate governance arrangements are:

- Continue to report on our Care at Home action plan at each IJB until full implementation of redesign and closure of all actions.
- Revise our Medium-Term Financial Plan once the implications from the COVID-19 pandemic are clearer.
- Implement the commissioning arrangements for unscheduled care once the system wide commissioning plan is finalised.
- Continue to report on our Strategic Improvement Plan until fully complete.
- Review our Best Value reporting with our Annual Performance Report.
- Implement our Recovery work programme whilst recognising that this will need to flex and adapt to changing circumstances.

Conclusion and Opinion on Assurance

It is our opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the IJB system of governance.

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

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

Anne-Marie Monaghan
Chair
Integration Joint Board **24th June 2020**

Julie Murray
Chief Officer
Integration Joint Board **24th June 2020**

Independent auditor's report to the members of East Renfrewshire Health and Social Care Partnership Integration Joint Board and the Accounts Commission

Report on the audit of the financial statements

Opinion on financial statements

The report from Audit Scotland will be included in the final Audited Accounts to be presented in September 2020, following the due audit process.

The Financial Statements

The (Surplus) or Deficit on the Income and Expenditure Statement shows the income received from and expenditure directed back to East Renfrewshire Council and NHS Greater Glasgow and Clyde for the delivery of services.

COMPREHENSIVE INCOME AND EXPENDITURE STATEMENT

For the year ended 31st March 2020

2018/19					2019/20		
Gross Expenditure Re-stated	Gross Income Re-stated	Net Expenditure Re-stated	Objective Analysis	Note	Gross Expenditure £000	Gross Income £000	Net Expenditure £000
£000	£000	£000					
10,252	443	9,809	Children and Families		11,809	697	11,112
26,295	1,742	24,553	Older People's Services		24,927	2,246	22,681
5,312	264	5,048	Physical/Sensory Disability		5,775	58	5,717
17,939	1,631	16,308	Learning Disability – Community		18,966	709	18,257
9,422	1,460	7,962	Learning Disability – Inpatients		9,673	1,314	8,359
-	-	-	Augmentative and Alternative Communication		393	173	220
11,634	1,768	9,866	Intensive Services		13,173	1,848	11,325
4,904	176	4,728	Mental Health		5,289	178	5,111
2,099	65	2,034	Addictions / Substance Misuse		2,224	205	2,019
23,722	1,513	22,209	Family Health Services		25,276	1,471	23,805
16,194	-	16,194	Prescribing		16,090	-	16,090
563	563	-	Criminal Justice		609	609	-
225	-	225	Planning and Health Improvement		132	-	132
9,019	552	8,467	Management and Admin		10,115	1,366	8,749
215	-	215	Corporate Services	6	223	-	223
137,795	10,177	127,618	Cost of Services Managed by East Renfrewshire IJB		144,674	10,874	133,800
29,837	-	29,837	Set Aside for delegated services provided in large hospitals		31,223	-	31,223
290	-	290	Aids and Adaptations		276	-	276
167,922	10,177	157,745	Total Cost of Services to East Renfrewshire IJB		176,173	10,874	165,299
-	98,135	98,135	NHS Greater Glasgow and Clyde	3	-	103,447	103,447
-	48,557	48,557	East Renfrewshire Council	3	-	49,565	49,565
-	6,449	6,449	Resource Transfer	3	-	6,424	6,424
-	5,132	5,132	Social Care Fund	3	-	5,132	5,132
-	158,273	158,273	Taxation and Non Specific Grant Income		-	164,568	164,568
167,922	168,450	(528)	(Surplus) or Deficit on Provision of Services		176,173	175,442	731
167,922	168,450	(528)	Total Comprehensive (Income) and Expenditure		176,173	175,442	731

MOVEMENT IN RESERVES STATEMENT

This statement shows the movement in the financial year on the reserve held by the IJB, analysed into 'usable reserves' (i.e. those that can be applied to fund expenditure) and 'non usable reserves'. The (Surplus) or Deficit on the Provision of Services reflects the true cost of providing services, more details of which are shown in the Comprehensive Income and Expenditure Statement.

2018/19 £000	General Reserves	2019/20 £000
(4,809)	Balance as at 31st March 2019 brought forward	(5,337)
(528)	Total Comprehensive Income & Expenditure	731
(528)	**(Surplus) or Deficit on the Provision of Services**	731
(5,337)	**BALANCE AS AT 31st MARCH 2020 CARRIED FORWARD**	(4,606)

BALANCE SHEET

As at 31st March 2020

The Balance Sheet as at 31st March 2020 is a snapshot of the value at that reporting date of the assets and liabilities recognised by the IJB. The net assets of the IJB (assets less liabilities) are matched by the reserves held by the IJB.

31st March 2019 £000		Notes	31st March 2020 £000
5,469	**Current Assets**		**5,129**
5,469	Short Term Debtors	7	5,129
132	**Current Liabilities**		**523**
132	Short Term Creditors	7	523
5,337	**Net Assets**		**4,606**
(5,337)	Reserves	8	(4,606)
(5,337)	**Total Reserves**		**(4,606)**

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

The audited annual report and accounts were submitted for approval and issue by the IJB on 23rd September 2020

Lesley Bairden ACMA CGMA
Chief Financial Officer
Integration Joint Board 24th June 2020

Notes to the Financial Statements

1. Accounting Policies

1.1 General Principles

The Statement of Accounts summarises the IJB's transactions for the 2019/20 reporting period and its position as at 31st March 2020.

The East Renfrewshire IJB is formed under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 and is a joint venture between East Renfrewshire Council and NHS Greater Glasgow and Clyde.

IJBs are specified as Section 106 bodies under the Local Government (Scotland) Act 1973 and as such are required to prepare their financial statements in compliance with the Code of Practice on Local Authority Accounting in the United Kingdom 2019/20 supported by International Finance Reporting Standards (IFRS).

1.2 Accruals of Income and Expenditure

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

All known specific and material sums payable to the IJB have been brought into account.

Where revenue and expenditure have been recognised but cash has not been received or paid, a debtor or creditor for the relevant amount is recorded in the Balance Sheet.

1.3 Going Concern

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

1.4 Accounting Convention

The accounting convention adopted in the Statement of Accounts is a historic cost basis.

1.5 Funding

East Renfrewshire IJB receives contributions from its funding partners, namely East Renfrewshire Council and NHS Greater Glasgow and Clyde to fund its services. Expenditure is incurred in the form of charges for services provided to the IJB by its partners.

1.6 Reserves

Reserves are created by appropriate amounts from the Statement of Income and Expenditure in the Movement in Reserves Statement.

Reserves have been created in order to finance expenditure in relation to specific projects. When expenditure to be financed from a reserve is incurred it will be charged to the appropriate service

in that year and will be funded by an appropriation back to the Comprehensive Income and Expenditure Statement in the Movement in Reserves Statement.

A general reserve has also been established as part of the financial strategy of the East Renfrewshire IJB in order to better manage the risk of any future unanticipated events that may materially impact on the financial position of the IJB.

1.7 Events after the Balance Sheet Date

Events after the Balance Sheet date are those events, both favourable and unfavourable, that occur between the end of the reporting period and the date when the Annual Accounts are authorised.

Where events take place before the date of authorisation and provide information about conditions existing as at 31st March 2020 the figures in the financial statements and notes have been adjusted in all material aspects to reflect the impact of this information.

Events taking place after the date when the Accounts were authorised are not reflected in the financial statement or notes.

1.8 Related Party Transactions

As partners of East Renfrewshire IJB both East Renfrewshire Council and NHS Greater Glasgow and Clyde are related parties and material transactions with those bodies are disclosed in Note 5 (Page 49) in accordance with the requirements of International Accounting Standard 24.

1.9 Provisions, Contingent Assets and Liabilities

Provisions are made where an event has taken place that gives the IJB a legal or constructive obligation that probably requires settlement by a transfer of economic benefits or service potential and a reliable estimate can be made of the amount of the obligation.

Provisions are charged as an expense to the appropriate service line in the Statement of Income and Expenditure in the year that the IJB becomes aware of the obligation and measured at the best estimate at the Balance Sheet date of the expenditure required to settle the obligation, taking into account relevant risks and uncertainties.

When payments are eventually made they are charged to the provision held in the Balance Sheet. Estimated settlements are reviewed at the end of each financial year. Where it becomes less probable that a transfer of economic benefits will be required (or a lower settlement than anticipated is made) the provision is reversed and credited back to the relevant service.

A contingent asset or liability arises where an event has taken place that gives the IJB a possible obligation or benefit whose existence will only be confirmed by the occurrence or otherwise of uncertain future events not wholly within the control of the IJB. Contingent assets or liabilities also arise in circumstances where a provision would otherwise be made but, either it is not probable that an outflow of resources will be required or the amount of the obligation cannot be measured reliably.

Contingent assets and liabilities are not recognised in the Balance Sheet but are disclosed in a Note to the Accounts where they are deemed material.

1.10 Indemnity Insurance

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

Unlike NHS Boards the IJB does not have any 'shared risk' exposure from participation in CNORIS. The IJB participation in the CNORIS scheme is therefore similar to normal insurance arrangements.

In the event that known claims were identified they would be assessed as to the value and probability of settlement. Where material the overall expected value of any such known claims, taking probability of settlement into consideration, would be provided for in the IJB's Balance Sheet. No such claims were identified as at 31st March 2020

Similarly, the likelihood of receipt of an insurance settlement to cover any claims would be separately assessed, and where material, they would be presented as either a debtor or disclosed as a contingent asset. No such receipts were identified as at 31st March 2020.

The cost of participation in the CNORIS scheme was funded on our behalf by NHS Greater Glasgow and Clyde.

1.11 Corresponding Amounts

These Financial Statements cover the period 1st April 2019 to 31st March 2020, with corresponding full year amounts for 2018/19.

1.12 VAT

The IJB is not a taxable person and does not charge or recover VAT on its functions.

The VAT treatment of expenditure and income within the Accounts depends upon which of the partners is providing the service as these bodies are treated differently for VAT purposes.

The services provided by the Chief Officer to the IJB are outside the scope of VAT as they are undertaken under a specific legal regime.

1.13 Post - Employment Benefits – Pension Costs

The accounting requirements for pension costs in respect of Post - Employment Benefits under IAS9 and FRS17 are reflected in the accounts of East Renfrewshire Council and NHS Greater Glasgow and Clyde as the respective employers of current and former staff members. The IJB does not directly employ any members of staff in its own right and accordingly has accrued no liability in regards to post employment pension benefits.

2. Expenditure and Income Analysis by Nature

2018/19 Re-stated £000		2019/20 £000
(158,273)	Partners funding contribution and non-specific grant income	(164,568)
(10,177)	Fees and charges and other service income	(10,874)
(168,450)	**2019/20 TOTAL FUNDING**	**(175,442)**
36,602	Employee Costs	39,548
818	Premises Costs	1,069
375	Transport Costs	315
7,201	Supplies & Services	8,393
50,995	Third Party Payments	51,593
2,126	Support Costs	2,597
16,024	Prescribing	19,445
23,729	Family Health Service	21,767
29,837	Acute Hospital Services	31,223
190	Corporate Costs	196
25	External Audit Fee	27
167,922	**2019/20 COST OF SERVICES**	**176,173**

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

3. Taxation and Non Specific Grant Income

2018/19 Re-stated £000		2019/20 £000
48,557	East Renfrewshire Council	49,565
98,135	NHS Greater Glasgow and Clyde	103,447
6,449	Resource Transfer	6,424
5,132	Social Care Fund	5,132
158,273	**PARTNERS FUNDING CONTRIBUTION & NON SPECIFIC GRANT INCOME**	**164,568**

The funding contribution from NHS Greater Glasgow and Clyde includes £31.223 million in respect of East Renfrewshire's use of set aside for delegated services provided in large hospitals. These are provided by the NHS, which retains responsibility for managing the costs of providing the service. The IJB however, has responsibility for the consumption of and level of demand placed on these services.

4. Hosted Services - Learning Disability – Inpatients & Augmentative and Alternative Communication

As detailed at Note 11 the IJB has considered the basis of the preparation of the 2019/20 accounts in respect of Learning Disability In-Patient Services and Augmentative & Alternative Communication (AAC) services hosted by the East Renfrewshire IJB for other IJBs within the NHS Greater Glasgow & Clyde Area. Accordingly, the IJB is considered to be acting as a 'principal' and the 2019/20 financial statements have been prepared on this basis with the full costs of such services being reflected in the 2019/20 financial statements. The cost of the hosted service provided to other IJBs and consumed by East Renfrewshire in regards Learning Disability Inpatients and SCTCI is detailed below.

2018/19 £000	LEARNING DISABILITY IN PATIENTS SERVICES HOSTED BY EAST RENFREWSHIRE IJB	2019/20 £000
6,234	Glasgow	5,659
918	Renfrewshire	1,347
142	Inverclyde	199
570	West Dunbartonshire	846
-	East Dunbartonshire	196
7,864	Learning Disability In-Patients Services Provided to other IJB's	8,247
98	East Renfrewshire	112
7,962	**TOTAL LEARNING DISABILITY – INPATIENTS SERVICES**	**8,359**

2018/19 £000	AAC SERVICES HOSTED BY EAST RENFREWSHIRE IJB	2019/20 £000
-	Glasgow	72
-	Renfrewshire	7
-	Inverclyde	-
-	West Dunbartonshire	4
-	East Dunbartonshire	25
-	AAC Services Provided to other IJB's	108
-	East Renfrewshire	11
-	**TOTAL AAC SERVICES**	**119**

Likewise, other IJBs act as the principal for a number of other hosted services on behalf of the East Renfrewshire IJB, as detailed below; such costs are reflected in the financial statements of the host IJB.

2018/19 £000	SERVICES PROVIDED TO EAST RENFREWSHIRE IJB BY OTHER IJBs WITHIN NHS GREATER GLASGOW AND CLYDE	2019/20 £000
434	Physiotherapy	460
53	Retinal Screening	48
452	Podiatry	464
295	Primary Care Support	303
293	Continence	297
613	Sexual Health	618
876	Mental Health	906
858	Oral Health	868
335	Addictions	348
184	Prison Health Care	194
163	Health Care in Police Custody	162
3,811	Psychiatry	4,211
8,367	**NET EXPENDITURE ON SERVICES PROVIDED**	8,879

5. Related Party Transactions

The following financial transactions were made with East Renfrewshire Council and NHS Greater Glasgow and Clyde relating to integrated health and social care functions during 2019/20. The nature of the partnership means that the IJB may influence, and be influenced by its partners.

2018/19 Re-stated £000	Income – payments for integrated functions	2019/20 £000
102,698	NHS Greater Glasgow and Clyde	108,461
65,752	East Renfrewshire Council	66,981
168,450	**TOTAL**	**175,442**

2018/19 Re-stated £000	Expenditure – payments for delivery of integrated functions	2019/20 £000
102,698	NHS Greater Glasgow and Clyde	108,461
65,224	East Renfrewshire Council	67,712
167,922	**TOTAL**	176,173

6. Corporate Expenditure

2018/19 £000	Corporate Expenditure	2019/20 £000
190 - 25	Staff Costs Administration Costs Audit Fee	196 - 27
215	**TOTAL**	223

The cost associated with running the IJB has been met in full by East Renfrewshire Council and NHS Greater Glasgow and Clyde reflecting the continuation of the arrangement for the previous Community Health and Care Partnership.

The costs charged to the IJB in respect of non-voting members include the Chief Officer and Chief Financial Officer. Details of the remuneration for post holders are provided in the Remuneration Report.

The costs of other key management staff who advise the IJB, such as the Chief Social Work Officer and the Chief Nurse are reflected within operational budgets. Those costs above reflect only the IJB statutory posts.

NHS Greater Glasgow and Clyde did not charge for any support services provided in the year ended 31st March 2020.

The support services for East Renfrewshire Council are included within the funding provided to the IJB as set out in the Scheme of Integration and as such have been charged for in 2019/20.

Fees payable to Audit Scotland in respect of external audit services undertaken in accordance with Audit Scotland's Code of Audit Practice 2019/20 amounted to £26,560. There were no fees paid to Audit Scotland in respect of any other services.

VAT is not included in the costs identified.

7. Short Term Debtors and Creditors

2018/19 £000	Short Term Debtors	2019/20 £000
761	NHS Greater Glasgow and Clyde	550
4,708	East Renfrewshire Council	4,579
5,469	**TOTAL**	**5,129**

2018/19 £000	Short Term Creditors	2019/20 £000
71	NHS Greater Glasgow and Clyde	462
61	East Renfrewshire Council	61
132	**TOTAL**	**523**

8. Reserves

As at 31st March 2020 the IJB has created earmarked reserves in order to fund expenditure in respect of specific projects. In addition a general reserve has been created as part of the financial strategy of the IJB in order to better manage the risk of any future unanticipated events that may materially impact on the financial position of the IJB.

2018/19 £000	Reserves	Transfers Out £000	Transfers In £000	2019/20 £000
111	Mental Health Action 15	111	-	-
68	Alcohol & Drugs Partnership	-	15	83
420	Primary Care Improvement	352	102	170
-	GP Premises Fund	-	78	78
599	**Total Scottish Government Funding**	**463**	**195**	**331**
1,138	Budget Savings Phasing	639	408	907
500	In Year Pressures	229	-	271
222	Prescribing	-	-	222
1,860	**Total Bridging Finance**	**868**	**408**	**1,400**
664	**Children and Families**	**69**	**426**	**1,021**
1,039	**Transitional Funding Learning Disability Specialist Services**			**1,039**
39	District Nursing		61	100
55	Active Lives	55		-
109	Projects and Initiatives	109		-
49	Learning Disability	49		-
-	Augmentative & Alternative Communication		101	101
252	**Total Projects**	**213**	**162**	**201**
100	**Renewal and Repairs**			**100**
250	Care at Home	250		-
200	Partnership Strategic Framework	50		150
100	Organisational learning & Development	8		92
550	**Total Capacity**	**308**		**242**
5,065	**TOTAL EARMARKED RESERVES**	**1,763**	**1,032**	**4,334**
272	**TOTAL GENERAL RESERVES**			**272**
5,337	**TOTAL ALL RESERVES**	**2,001**	**1,270**	**4,606**

9. Contingent Assets and Liabilities

There are no contingent assets or liabilities as at 31st March 2020.

10. New standards issued but not yet adopted

The Code requires the disclosure of information relating to the impact of an accounting change that will be required by a new standard that has been issued but not yet adopted. The IJB considers that there are no such standards which would have a significant impact on the 2019/20 annual accounts.

11. Critical Judgements & Estimation Uncertainty

In applying the accounting policies set out above, the IJB has had to make a critical judgement relating to complex transactions in respect of Learning Disability Inpatients Services and AAC services hosted within the East Renfrewshire IJB for other IJB's within the NHS Greater Glasgow & Clyde area. Within NHS Greater Glasgow & Clyde each IJB has operational responsibility for services which it hosts on behalf of other IJB's. In delivering these services the IJB has primary responsibility for the provision of services and bears the risk and reward associated with this service delivery in terms of demand and the financial resources required. As such the IJB is considered to be acting as 'principal' and the full costs should be reflected within the financial statements for the services which it hosts. This is the basis on which the 2019/20 accounts have been prepared.

The figure included in the 2019/20 financial statements in respect of set aside for delegated services provided in large hospitals is provided by the NHS which retains responsibility for managing the costs of providing the services. The IJB, however, has responsibility for the consumption of, and level of demand placed on, these resources.

NHS Greater Glasgow & Clyde are now in a position to report the set aside figures based on actual expenditure which has resulted in the restatement of 2018/19 figures which were previously based on a notional budget figure. The notional budgets for set aside were based on NRAC activity and information from the cost book and were very high level. Actual figures are now based on a much more detailed approach including actual spend and activity for each year.

12. Post Balance Sheet Events

The 2019/20 Annual Report and Accounts were authorised for issue by the IJB on the 23rd September 2020. There have been no adjusting events (events which provide evidence of conditions that existed at the balance sheet date) and no such adjusting events have been reflected in the financial statements or notes. Likewise there have been no non – adjusting events, which are indicative of conditions after the balance sheet date, and accordingly the financial statements have not been adjusted for any such post balance sheet events.

Where to find more information

In This Document

The requirements governing the format and content of the IJB annual accounts follows guidance issued by the Integrated Resources Advisory Group and by The Local Authority (Scotland) Accounts Advisory Committee (LASAAC).

On Our Website

Further information on the Accounts can be obtained on East Renfrewshire Council's website **http://www.eastrenfrewshire.gov.uk/health-and-social-care-integration** or from East Renfrewshire HSCP, Eastwood Health and Care Centre, Drumby Crescent, Clarkston, G76 7HN.

Acknowledgement

I wish to record my thanks to staff within the HSCP for their co-operation in producing the Annual Report and Accounts in accordance with the prescribed timescale. In particular the support of the Accountancy and Policy & Performance staff within the partnership are gratefully acknowledged.

Anne-Marie Monaghan
Chair
Integration Joint Board **24th June 2020**

Julie Murray
Chief Officer
Integration Joint Board **24th June 2020**

Lesley Bairden ACMA CGMA **24th June 2020**
Chief Financial Officer
Integration Joint Board

AGENDA ITEM No.9

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 24 June 2020
Agenda Item	9
Title	Revenue Budget Monitoring Report 2020/21; position as at 31 May 2020

Summary

To provide the Integration Joint Board with financial monitoring information in relation to the revenue budget, as part of the agreed financial governance arrangements.

Presented by	Lesley Bairden, Head of Finance and Resources (Chief Financial Officer)

Action Required

The Integration Joint Board is asked to note the early indication of the projected outturn for the 2020/21 revenue budget.

Directions	**Implications**	
☐ No Directions Required	☒ Finance	☒ Risk
☐ Directions to East Renfrewshire Council (ERC)	☐ Policy	☐ Legal
☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC)	☐ Workforce	☐ Infrastructure
☒ Directions to both ERC and NHSGGC	☐ Equalities	☐ Fairer Scotland Duty

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

24 June 2020

Report by Chief Financial Officer

REVENUE BUDGET MONITORING REPORT

PURPOSE OF REPORT

1. To advise the Integration Joint Board of the projected outturn position of the 2020/21 revenue budget.

RECOMMENDATIONS

2. The Integration Joint Board is asked to note the early indication of the projected outturn for the 2020/21 revenue budget.

BACKGROUND

3. This report forms part of the regular reporting cycle for ensuring that the HSCP financial governance arrangements are maintained. This is the first report for the financial year 2020/21 and is earlier than revenue budget reporting would normally commence.

4. Given the current situation around COVID-19 and the associated financial uncertainty it is important the IJB have early sight of our current financial position and take some assurance on the amount of work that is taking place.

5. The HSCP costs related to COVID-19 activity are reported to the Scottish Government via NHS Greater Glasgow and Clyde as the health boards are the leads on this reporting. The HSCP provides detailed estimated and actual costs across a number of categories including; staffing additional hours and absence cover for both the HSCP and our partner providers, sustainability of our partner providers, PPE (personal protective equipment) and other equipment, unachievable savings and prescribing impacts.

6. The costs are c£9 million for the 13 months from March 2020 to March 2021 and include many assumptions and scenarios as we continue to work our way through the emergency response and as we move toward what the 'new normal' may look like.

7. There is no doubt that these costs will change as we move from high level assumptions, to more refined estimates as activity becomes clearer and through to actual costs incurred; the financial impacts and implications will be reported to the IJB throughout the year.

8. The current estimated costs are included in our overall financial position and the bottom line is a nil impact as the current planning assumption is that all costs will be fully funded. The sustainability costs supporting the social care market are supported nationally by an agreed set of principles. Clearly there is a risk should there be any change from all cots being funded in full.

9. The HSCP share of the £50 million allocated to date is £0.886 million.

REPORT

10. The consolidated budget for 2020/21, and projected outturn position is reported in detail at Appendix 1. This shows a potential projected overspend of £0.640 million against a full year budget of £125.6 million (0.5%).

11. The normal reporting timetable would not include projected cost variances at such an early stage in the financial year. The main elements of projected overspend are care packages and staffing.

12. The consolidated budget and associated financial direction to our partners is detailed at Appendix 4. This is reported to each Integration Joint Board and reflects in year revisions to our funding contributions and associated directions.

13. The main projected variances as set out below with projected costs based on known care commitments at April 2020 and estimated recruitment timescales for vacant posts.

14. **Children & Families Public Protection £179k underspend;** The projected underspend is due mainly to the current level of staff turnover; this will be subject to change as the year progresses.

15. **Adult Localities £264k overspend;** This reflects the current committed costs of care packages, offset in part by staff turnover.

16. **Intensive Services £523k overspend;** The main cost pressure is £667k in Care at Home (both purchased and the in-house service) and this is offset in part by staff turnover within day services. As with all care package costs this is an early indication and will continue to be closely monitored.

17. **Recovery Services Mental Health & Addictions £22k underspend;** This reflects the current expected cost of care packages and staff turnover.

18. **Prescribing Nil Variance;** The costs assumed to relate to COVID-19 are assumed fully funded. The costs associated with prescribing are being analysed in detail on a monthly basis and future reports will include more detail.

19. **Finance & Resources £74k overspend;** this budget meets the cost of a number HSCP wide costs, including recharges for prior year pension costs and a prudent projection is included.

20. **Primary Care Improvement Plan and Mental Health Action 15;** The usual financial monitoring appendices for these areas will be included in future reports. The IJB can take assurance that costs related to these functions are part of ring-fenced funding.

21. The current projected revenue budget overspend of £0.640 million will be funded from our budget savings reserve as required.

22. The reserves position is reported at Appendix 5 and is subject to audit, therefore provisional. The spending plans against reserves will be refined as we move through the year.

23. The provisional outturn for 2019/20 of £185k overspend is detailed in the annual report and accounts. This was an improvement on the projected overspend of £479k based on the expected costs as at January 2020.

IMPLICATIONS OF THE PROPOSALS

Finance

24. The savings agreed by the IJB as part of the budget set in March 2020 are set out at Appendix 6. Our capacity to deliver these savings in year is significantly impacted as we work through COVID-19. Progress on savings delivery along with any implications from our recovery programme will be reported to the IJB during the year.

25. Once the implications from COVID-19 are clearer our Medium-Term Financial plan will be reviewed.

26. The Scottish Government have recently confirmed additional funding to meet the costs of Fair Work Practices and our share of this funding (£157k) will offset some of the cost pressures of the 3.3% uplift agreed for 2020/21.

Risk

27. There are several risks which could impact on the current and future budget position; including:

- COVID-19 related additional costs not being fully funded
- Maintaining capacity to deliver our services
- Achieving all existing savings on a recurring basis
- The impact of COVID-19 on our partner providers and the care service market
- Prescribing costs exceeding budget and reserve
- Observation and Out of Area costs within Learning Disability Specialist Services
- Brexit implications

DIRECTIONS

28. The running budget reconciliation which forms part of financial directions to our partners is included at Appendix 4.

29. The report reflects a projected breakeven position after the potential contribution of £0.640 million from reserves for the year to 31 March 2020.

CONSULTATION AND PARTNERSHIP WORKING

30. The Chief Financial Officer has consulted with our partners.

31. This revenue budget reflects the consolidation of funding from both East Renfrewshire Council and NHS Greater Glasgow and Clyde. The HSCP operates under the Financial Regulations as approved by the Performance and Audit Committee on 18 December 2015 and reviewed March 2020.

CONCLUSIONS

32. Appendix 1 reports a potential projected overspend of £0.640 million for the year to 31 March 2021 being funded from reserves, as required.

RECOMMENDATIONS

33. The Integration Joint Board is asked to note the early indication of the projected outturn position of the 2020/21 revenue budget.

REPORT AUTHOR

Lesley Bairden, Head of Finance and Resources (Chief Financial Officer)
lesley.bairden@eastrenfrewshire.gov.uk
0141 451 0749

14 June 2020

Chief Officer, IJB: Julie Murray

BACKGROUND PAPERS

IJB 29.01.2020 – Revenue Budget Monitoring Report
https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=25576&p=0

IJB 27.11.2019 – Revenue Budget Monitoring Report
https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=25554&p=0

IJB 25.09.2019 – Revenue Budget Monitoring Report
https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=25150&p=0

IJB 14.08.2019 – Revenue Budget Monitoring Report
https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=24915&p=0

IJB 01.05. 2019 - Revenue Budget Monitoring Report
https://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=24320&p=0

East Renfrewshire HSCP - Revenue Budget Monitoring 2020/21 **Appendix 1**

Consolidated Monitoring Report

Projected Outturn Position to 31st March 2021

	Full Year			
Objective Analysis	**Budget £**	**Projected Outturn £**	**Variance (Over) / Under £**	**Variance (Over) / Under %**
Public Protection - Children & Families	12,495,000	12,316,000	179,000	1.43%
Public Protection - Criminal Justice	9,000	9,000	-	0.00%
Adult Localities Services				
Older People	19,073,000	19,038,000	35,000	0.18%
Physical & Sensory Disability	5,310,000	5,233,000	77,000	1.45%
Learning Disability - Community	13,407,000	13,783,000	(376,000)	(2.80%)
Learning Disability - Inpatients	8,432,000	8,412,000	20,000	0.24%
Augmentative and Alternative Communication	71,000	71,000	0	0.00%
Intensive Services	11,147,000	11,670,000	(523,000)	(4.69%)
Recovery Services - Mental Health	4,736,000	4,766,000	(30,000)	(0.63%)
Recovery Services - Addictions	1,501,000	1,449,000	52,000	3.46%
Family Health Services	24,110,000	24,110,000	0	0.00%
Prescribing	16,049,000	16,049,000	0	0.00%
Planning & Health Improvement	171,000	171,000	0	0.00%
Finance & Resources	9,099,000	9,173,000	(74,000)	(0.81%)
Net Expenditure	**125,610,000**	**126,250,000**	**(640,000)**	**(0.51%)**
Contribution to / (from) Reserve	**-**	**(640,000)**	**640,000**	**-**
Net Expenditure	**125,610,000**	**125,610,000**	**-**	**-**

Note; ERC & NHS figures for the month ended 31 May 2020

	£
Net Contribution To / (From) Reserves	**(640,000)**
Analysed by Partner;	
NHS	-
Council	(640,000)
Net Contribution To / (From) Reserves	**(640,000)**

Additional information - Adult Localities

	Full Year			
Objective Analysis	**Budget £**	**Projected Outturn £**	**Variance (Over) / Under £**	**Variance (Over) / Under %**
Localities Services - Barrhead	14,630,000	14,826,000	(196,000)	(1.34%)
Localities Services - Eastwood	23,160,000	23,228,000	(68,000)	(0.29%)
Net Expenditure	**37,790,000**	**38,054,000**	**(264,000)**	**(0.70%)**

East Renfrewshire HSCP - Revenue Budget Monitoring 2020/21 **Appendix 2**

Council Monitoring Report

Projected Outturn Position to 31st March 2021

	Full Year			
Subjective Analysis	**Budget £**	**Projected Outturn £**	**Variance (Over) / Under £**	**Variance (Over) / Under %**
Employee Costs	23,133,000	22,818,000	315,000	1.36%
Property Costs	947,000	1,042,000	(95,000)	(10.03%)
Supplies & Services	1,895,000	2,364,000	(469,000)	(24.75%)
Transport Costs	230,000	216,000	14,000	6.09%
Third Party Payments	38,807,000	46,716,000	(7,909,000)	(20.38%)
Support Services	2,354,000	2,354,000	-	0.00%
Income	(16,053,000)	(23,557,000)	7,504,000	(46.75%)
Net Expenditure	**51,313,000**	**51,953,000**	**(640,000)**	**(1.25%)**
Contribution to / (from) Reserve	**-**	**(640,000)**	**640,000**	**-**
Net Expenditure	**51,313,000**	**51,313,000**	**-**	**-**

	Full Year			
Objective Analysis	**Budget £**	**Projected Outturn £**	**Variance (Over) / Under £**	**Variance (Over) / Under %**
Public Protection - Children & Families	9,639,000	9,441,000	198,000	2.05%
Public Protection - Criminal Justice	9,000	9,000	-	0.00%
Adult Localities Services				
Older People	11,635,000	11,618,000	17,000	0.15%
Physical & Sensory Disability	4,722,000	4,645,000	77,000	1.63%
Learning Disability	7,692,000	8,123,000	(431,000)	(5.60%)
Intensive Services	10,173,000	10,696,000	(523,000)	(5.14%)
Recovery Services - Mental Health	1,557,000	1,587,000	(30,000)	(1.93%)
Recovery Services - Addictions	298,000	246,000	52,000	17.45%
Finance & Resources	5,588,000	5,588,000	-	0.00%
Net Expenditure	**51,313,000**	**51,953,000**	**(640,000)**	**(1.25%)**
Contribution to / (from) Reserve	**-**	**(640,000)**	**640,000**	
Net Expenditure	**51,313,000**	**51,313,000**	**-**	

Notes

1 Figures quoted as at 31 May 2020

2 The projected underspend / (overspend) will be taken to/(from) reserves at year end.

3 Contribution To Reserves is made up of the following transfer;

	£
Contribution from In Year Pressures Reserve	(640,000)

4 Additional information - Adult Localities

	Full Year			
Objective Analysis	**Budget £**	**Projected Outturn £**	**Variance (Over) / Under £**	**Variance (Over) / Under %**
Localities Services - Barrhead	8,070,000	8,330,000	(260,000)	(3.22%)
Localities Services - Eastwood	15,979,000	16,056,000	(77,000)	(0.48%)
Net Expenditure	**24,049,000**	**24,386,000**	**(337,000)**	**(1.40%)**

East Renfrewshire HSCP - Revenue Budget Monitoring 2020/21 **Appendix 3**

NHS Monitoring Report

Projected Outturn Position to 31st March 2021

	Full Year			
Subjective Analysis	**Full Year Budget £**	**Projected Outturn £**	**Variance (Over) / Under £**	**Variance (Over) / Under %**
Employee Costs	19,464,000	20,102,000	(638,000)	(3.28%)
Non-pay Expenditure	48,249,000	48,730,000	(481,000)	(1.00%)
Resource Transfer/Social Care Fund	10,896,000	10,896,000	-	0.00%
Income	(4,312,000)	(5,431,000)	1,119,000	(25.95%)
Net Expenditure	**74,297,000**	**74,297,000**	**-**	**0.00%**
Contribution to / (from) Reserve	**-**	**-**	**-**	**-**
Net Expenditure	**74,297,000**	**74,297,000**	**-**	**-**

	Full Year			
Objective Analysis	**Full Year Budget £**	**Projected Outturn £**	**Variance (Over) / Under £**	**Variance (Over) / Under %**
Childrens Services	2,760,000	2,779,000	(19,000)	(0.69%)
Adult Community Services	4,241,000	4,223,000	18,000	0.42%
Learning Disability - Community	1,070,000	1,015,000	55,000	5.14%
Learning Disability - Inpatient	8,432,000	8,412,000	20,000	0.24%
Augmentative and Alternative Communication	71,000	71,000	-	0.00%
Family Health Services	24,110,000	24,110,000	-	0.00%
Prescribing	16,049,000	16,049,000	-	0.00%
Recovery Services - Mental Health	2,441,000	2,441,000	-	0.00%
Recovery Services - Addictions	713,000	713,000	-	0.00%
Planning & Health Improvement	171,000	171,000	-	0.00%
Finance & Resources	3,137,000	3,211,000	(74,000)	(2.36%)
Resource Transfer	11,102,000	11,102,000	-	0.00%
Net Expenditure	**74,297,000**	**74,297,000**	**-**	**0.00%**
Contribution to / (from) Reserve	**-**	**-**	**-**	**0.00%**
Net Expenditure	**74,297,000**	**74,297,000**	**-**	**0.00%**

Notes

1 Figures quoted as at 31 May 2020

2 Resource Transfer and the Social Care Fund is re allocated across client groups at the consolidated level as detailed below;

	£
Public Protection - Children & Families	96,000
Adult Localities Services	
Older People	3,197,000
Physical & Sensory Disability	588,000
Learning Disability	4,645,000
Intensive Services	974,000
Recovery Services - Mental Health	738,000
Recovery Services - Addictions	490,000
Finance & Resources	374,000
	11,102,000
Localities Services - Barrhead	4,785,000
Localities Services - Eastwood	3,645,000

	£
3 Total Contribution to / (from) Reserves	-

4 Additional information - Adult Localities

	Full Year			
Objective Analysis	**Full Year Budget £**	**Projected Outturn £**	**Variance (Over) / Under £**	**Variance (Over) / Under %**
Localities Services - Barrhead	1,775,000	1,711,000	64,000	3.61%
Localities Services - Eastwood	3,536,000	3,527,000	9,000	0.25%
Net Expenditure	**5,311,000**	**5,238,000**	**73,000**	**1.37%**

East Renfrewshire HSCP - Revenue Budget Monitoring 2019/20 **Appendix 4**
Budget Reconciliation & Directions

	NHS £000	ERC £000	IJB £000	Total £000
Funding Sources to the IJB				
1 Original Revenue Budget Contributions	72,135	51,313		123,448
Criminal Justice Grant Funded Expenditure		606		606
Criminal Justice Grant		(606)		(606)
FHS / GMS budget adjustments	1,147			1,147
Adjustments to opening recurring budget	129			129
Covid-19 Funding	886			886
	74,297	51,313	-	125,610
Funding Outwith Revenue Contribution				
1 Housing Aids & Adaptations *		550		550
Set Aside Budget	31,674			31,674
Total IJB Resources	105,971	51,863	-	157,834
Directions to Partners				
Revenue Budget	72,135	51,313	-	123,448
Criminal Justice Grant Funded Expenditure		606		606
Criminal Justice Grant		(606)		(606)
Resource Transfer	(11,102)	11,102		0
Social Care Fund	(5,132)	5,132		0
Carers Information	58	(58)		0
	55,959	67,489	-	123,448
Housing Aids & Adaptations *		550		550
Set Aside Budget	31,674			31,674
	87,633	**68,039**	**-**	**155,672**

* includes capital spend

1 Subject to final budget confirmation following UK budget and associated partner approval

East Renfrewshire HSCP - Revenue Monitoring 2020/21 **Appendix 5**
Projected Reserves as at 31 March 2021

Earmarked Reserves	Reserve Carry Forward to 2020/21*	2020/21 Projected spend	Projected balance 31/03/21	comment
	£	£	£	
Scottish Government Funding				
Mental Health - Action 15	0		0	
Alcohol & Drugs Partnership	83,000	83,000	0	Assume applied in year
Speech & Language Therapy			0	Applied in year
Barrhead Health & Care Centre			0	Applied in year
Primary Care Improvement	102,000	102,000	0	Assume applied in year
Primary Care Transition Fund	68,000	68,000	0	Assume applied in year
GP Premises Fund	78,000	78,000	0	Assume applied in year
Scottish Government Funding	**331,000**	**331,000**	**0**	
Bridging Finance				
Budget Savings Reserve	907,000	640,000	267,000	Assume £640k needed to meet projected overspend
In Year Pressures Reserve	271,000		271,000	To support Bonnyton House decant as required
Prescribing	222,000		222,000	To smooth prescribing pressures
Bridging Finance	**1,400,000**	**640,000**	**760,000**	
Children & Families				
Residential Accommodation	460,000		460,000	To smooth the impact of high cost residential placements
Health Visitors	100,000	100,000	0	To support capacity and training
Home & Belonging	100,000		100,000	2019/20 part year funding requirement
School Counselling	311,000	311,000	0	Assume applied in year
Continuing Care / Child Healthy Weight	50,000	50,000	0	Assume applied in year
Children & Families	**1,021,000**	**461,000**	**560,000**	
Transitional Funding				
Learning Disability Specialist Services	1,039,000	50,000	989,000	Will fund Challenging Behaviour Manager post for 2 years
Total Transitional Funding	**1,039,000**	**50,000**	**989,000**	
Projects				
District Nursing	100,000	100,000	0	To support capacity and training
Augmentative & Alternative Communication	101,000		101,000	As required to meet specialist equipment needs
Projects	**201,000**	**100,000**	**101,000**	
Repairs & Renewals				
Repairs, Furniture and Specialist Equipment	100,000	30,000	70,000	Environmental works approved by IJB in 2019/20, delayed
Repairs & Renewals	**100,000**	**30,000**	**70,000**	
Capacity				
Partnership Strategic Framework	150,000	50,000	100,000	To fund post. Timing of other use being reviewed
Organisational Learning & Development	92,000		92,000	Timing of use being reviewed
Capacity	**242,000**	**50,000**	**192,000**	
Total All Earmarked Reserves	**4,334,000**	**1,662,000**	**2,672,000**	
General Reserves				
East Renfrewshire Council	109,200	0	109,200	
NHSGCC	163,000	0	163,000	
Total General Reserves	**272,200**	**0**	**272,200**	
Grand Total All Reserves	**4,606,200**	**1,662,000**	**2,944,200**	

* Provisional; subject to Audit

East Renfrewshire HSCP - Revenue Budget Monitoring 2020/21 **Appendix 6**

Analysis of Savings Delivery

Saving	Approved Saving 2020/21 Budget £	Projected Saving 2020/21 £	Comments
New savings to meet Social Care Pressures			
Adult Care packages	100	100	Reflected cost profile
Interim Income	100	100	Based on expected achievable income
Inflation revision	160	160	Saving expected from actual v's planned cost pressure
Discretionary spend moratorium	120	120	Saving assumed achieved. Review ongoing
Digital Efficiencies	250	250	Carried over from 2019/20, part of change programme
Individual Budget Calculator	1,664	1,664	Saving to be applied to all non residential care budgets
Sub Total	**2,394**	**2,394**	
New savings to meet NHS Pressures			
Non Pay Inflation	28	28	Saving assumed achieved. Review ongoing
LD Redesign - Non Recurring	100	100	Saving assumed achieved. Review ongoing
		-	
Sub Total	**128**	**128**	
Total HSCP Saving Challenge	**2,522**	**2,522**	

AGENDA ITEM No.10

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 24 June 2020
Agenda Item	10
Title	Postponed publication of 2019-20 Annual Performance Report

Summary

Following emergency legislation in response to the Covid-19 outbreak, public authorities have been granted the temporary power to delay publication of statutory reports where this would interfere with our coronavirus response. As a result, it has been decided that we will postpone publication of our Annual Performance Report to 30 September 2020, subject to IJB approval.

Presented by	Steven Reid: Policy, Planning and Performance Manager

Action Required

The Integration Joint Board is asked to note that the publication date for the HSCP Annual Performance Report 2019-20 has been postponed from 31 July 2020 to 30 September 2020 due to prioritisation of our Covid-19 pandemic response.

Directions	**Implications**	
☒ No Directions Required	☐ Finance	☐ Risk
☐ Directions to East Renfrewshire Council (ERC)	☐ Policy	☐ Legal
☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC)	☐ Workforce	☐ Infrastructure
☐ Directions to both ERC and NHSGGC	☐ Equalities	☐ Fairer Scotland Duty

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

24 JUNE 2020

Report by Chief Officer

POSTPONEMENT OF PUBLICATION OF 2019-20 ANNUAL PERFROMANCE REPORT

PURPOSE OF REPORT

1. The purpose of this report is to notify the Integration Joint Board of the decision to postpone publication of our Annual Performance Report for 2019-20.

RECOMMENDATION

2. The Integration Joint Board is asked to note that the publication date for the HSCP Annual Performance Report 2019-20 has been postponed from 31 July 2020 to 30 September 2020 due to prioritisation of our COVID-19 pandemic response.

BACKGROUND

3. The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report, setting out an assessment of performance in planning and carrying out those functions for which they are responsible. The 2014 Act requires publication of the report within 4 months of the end of the financial year being reported on, therefore by 31 July each year.

4. In recognition of the exceptional requirements being placed on public bodies as they responded to the COVID-19 outbreak, the Coronavirus (Scotland) Act 2020 made a number of temporary changes to statutory reporting and publication requirements (as well as Freedom of Information requests). This gave public authorities the temporary power to postpone publishing reports if they are of the view that continuing with report preparation would impede their ability to take effective action in response to the coronavirus pandemic.

REPORT

5. The Chief Officer has agreed to delay the publication date for the Annual Performance Report until 30 September in exercise of the power granted to public authorities under the Coronavirus (Scotland) Act 2020 to do so. The staff who would have been involved in the preparation of the report have been heavily engaged in supporting the COVID-19 pandemic response.

6. A draft of the report will be presented to the Integration Joint Board at its meeting on 23 September for approval. Subject to approval, the report will be published on our website by 30 September and promoted through media channels. We will post a public notification of the rescheduling of the report on our website before the original publication date of 31 July. This approach is in line with most other IJBs in Scotland.

RECOMMENDATION

7. The Integration Joint Board is asked to note that the publication date for the HSCP Annual Performance Report 2019-20 has been postponed from 31 July 2020 to 30 September 2020 due to prioritisation of our COVID-19 pandemic response.

REPORT AUTHOR AND PERSON TO CONTACT

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steven.reid@eastrenfrewshire.gov.uk

Chief Officer, IJB: Julie Murray

15 June 2020

AGENDA ITEM No.11

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 24 June 2020
Agenda Item	11
Title	Draft Unscheduled Care Strategic Commissioning Plan

Summary

This report provides the Integration Joint Board on progress in developing the strategic commissioning plan for unscheduled care. The system wide plan had been developed by all six HSCPs within Greater Glasgow and Clyde in partnership with the NHS Board and Acute Services Division and in line with the IJB's Strategic Plan.
The plan builds on the Board wide Unscheduled Care Improvement Programme and is integral to the Board-wide Moving Forward Together programme.

Presented by	Candy Millard Head of Adult Health and Social Care Localities

Action Required

The Integration Joint Board is asked to:

a) approve the draft commissioning plan for unscheduled care attached;
b) note the further work underway to finalise the plan, including the planned engagement process; and that it will receive a further update with a finalised plan

Directions	**Implications**	
☒ No Directions Required	☐ Finance	☐ Risk
☐ Directions to East Renfrewshire Council (ERC)	☐ Policy	☐ Legal
☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC)	☐ Workforce	☐ Infrastructure
☐ Directions to both ERC and NHSGGC	☐ Equalities	☐ Fairer Scotland Duty

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

24 JUNE 2020

Report by Chief Officer

DRAFT UNSCHEDULED CARE STRATEGIC COMMISSIONING PLAN

PURPOSE OF REPORT

1. The purpose of this report is to update the Integration Joint Board on progress in developing the strategic commissioning plan for unscheduled care.

RECOMMENDATION

2. The Integration Joint Board is asked to:-

(a) approve the draft commissioning plan for unscheduled care attached; and

(b) note the further work underway to finalise the plan, including the planned engagement process; and that it will receive a further update with a finalised plan.

BACKGROUND

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

4. The draft plan is being presented to all six IJBs for consideration recognising that further work is required. This includes learning from the Covid pandemic which has seen a dramatic fall in unscheduled care activity. Whilst the majority of the draft plan remains relevant, the learning from what has worked well during the pandemic will be incorporated in the final version.

REPORT

Draft Unscheduled Care Commissioning Plan

5. The purpose of the plan is to outline how we aim to respond to the continuing pressures on health and social care services in GG&C and meet future demand. The draft explains that with an ageing population, and changes in how, and when, people chose to access services, we need to change.

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

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

8. The programme outlined in the plan is based on evidence of what works and our estimate of patient needs in Greater Glasgow and Clyde. The programme is focused on three key themes:

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

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

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

9. The changes proposed will not take effect immediately or all at the same time. Some need testing first and others need time to bed in. Change will be gradual but should be fully implemented by 2022/23. While the challenge is to change to respond to current and future demand, it is also to maintain the direction outlined in the plan over the longer term so that we can better meet the needs of the people we serve. We also need to communicate more directly with patients and the general public to ensure people know how to access the right service at the right time and in the right place. Progress on these actions will be reported regularly to the Integration Joint Board.

Learning from the pandemic

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

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

- the introduction of the GG&C wide community respiratory service to better manage COPD in the community and reduce hospital admissions;
- building on our approach to shielding to improve community support to vulnerable patients with specific conditions including working with the third sector, and integrating this with our approach to Anticipatory Care Planning;
- embedding actions to improve delays so this becomes standard practice across GG&C e.g. discharge to assess;
- learning from the operation of the CACs to introduce an appointment based model in GP assessment units with same day and next day appointments;
- aligned to this, accelerating the introduction of appointment based "hot clinics" for specific conditions as part of an integrated primary / secondary care pathway; and,
- refreshing and updating our re-direction protocol to coincide with the re-opening of Minor Injury Units and a wider public awareness raising campaign on unscheduled care services.

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

Next Steps

13. Key next steps include:

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

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

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

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

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

RECOMMENDATIONS

17. The Integration Joint Board is asked to:

(a) approve the draft commissioning plan for unscheduled care attached; and

(b) note the further work underway to finalise the plan, including the planned engagement process; and that it will receive a further update with a finalised plan.

REPORT AUTHOR AND PERSON TO CONTACT

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Chief Officer, IJB: Julie Murray

BACKGROUND PAPERS

Greater Glasgow and Clyde Board wide Unscheduled Care Improvement Programme
http://www.nhsggc.org.uk/media/245268/10-unscheduled-care-update.pdf

Board-wide Moving Forward Together programme
https://www.nhsggc.org.uk/media/251904/item-10a-paper-18_60-mft-update.pdf

NHS GREATER GLASGOW AND CLYDE
HEALTH AND SOCIAL CARE PARTNERSHIPS

D R A F T

Moving Forward Together.

The challenge is change

D R A F T

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

March 2020

SUMMARY

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

KEY ACTIONS

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

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

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

CONTENTS

List of tables and figures

1. INTRODUCTION

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

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

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

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

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

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

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

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

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

What is unscheduled care?

1.10 Unscheduled care has been defined as:

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

Integration Joint Boards' responsibilities

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

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

- accident and emergency services provided in a hospital.

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

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

National picture

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

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

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

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

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

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

This draft plan

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

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

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

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

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

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

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

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

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

2. WHY WE NEED CHANGE

Introduction

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

Changes in Demand

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

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

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

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

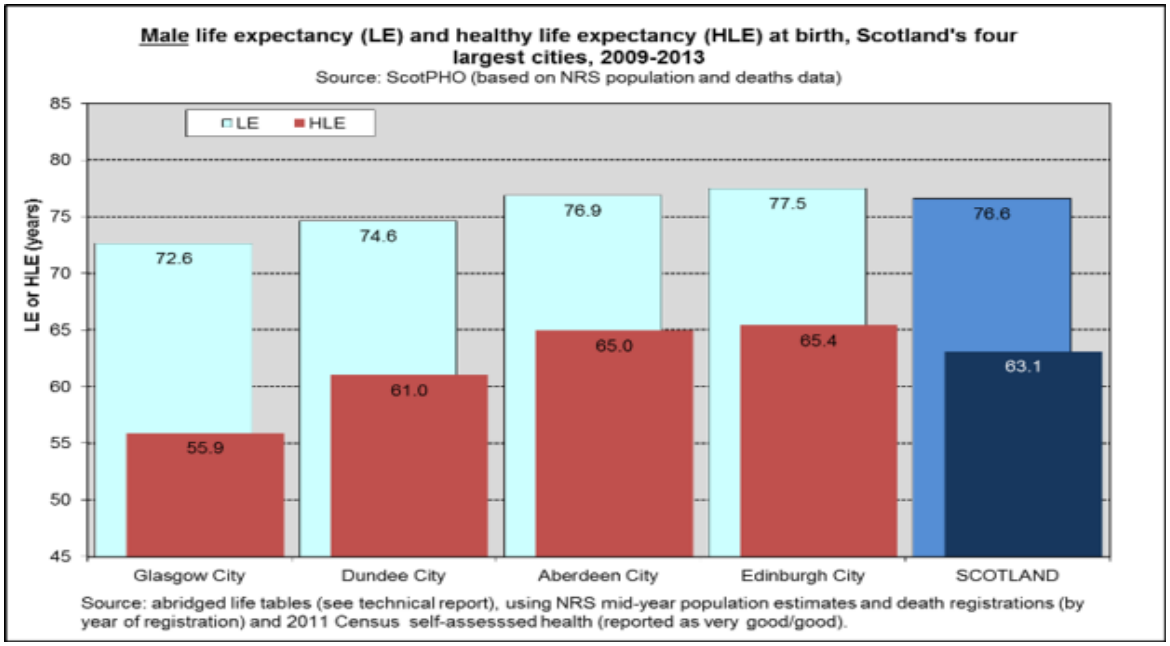
[13] https://www.gov.scot/publications/scottish-index-multiple-deprivation-2020/

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

Changes in our population

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

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

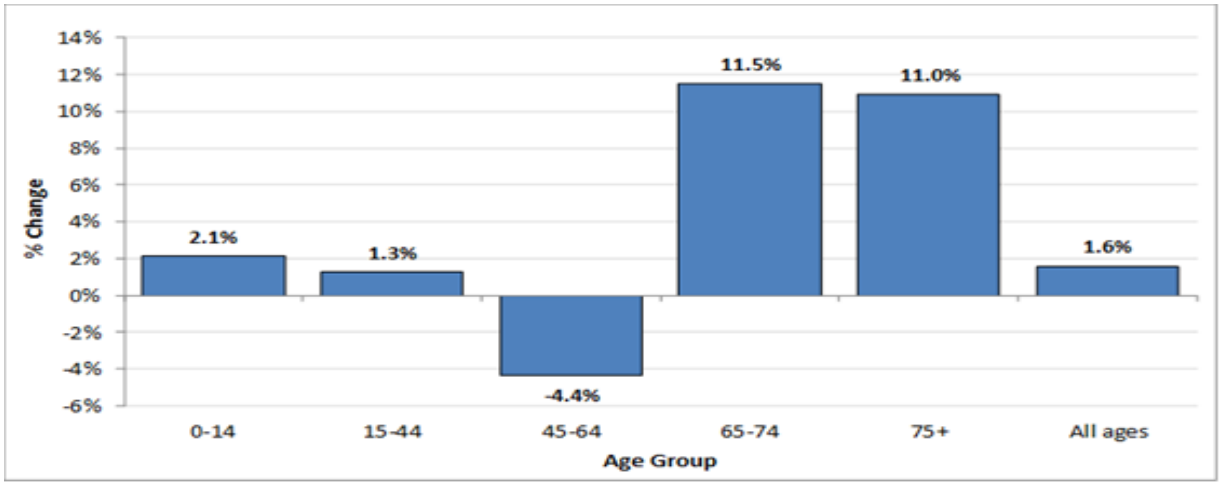


2.5 In addition it is projected that over the next ten years to 2030 in Greater Glasgow & Clyde we will see a 24% increase in the number of people aged over 65 and a 32% increase in the number of people aged over 90. There are also more immediate increases over the next five year with a projected 11%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

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

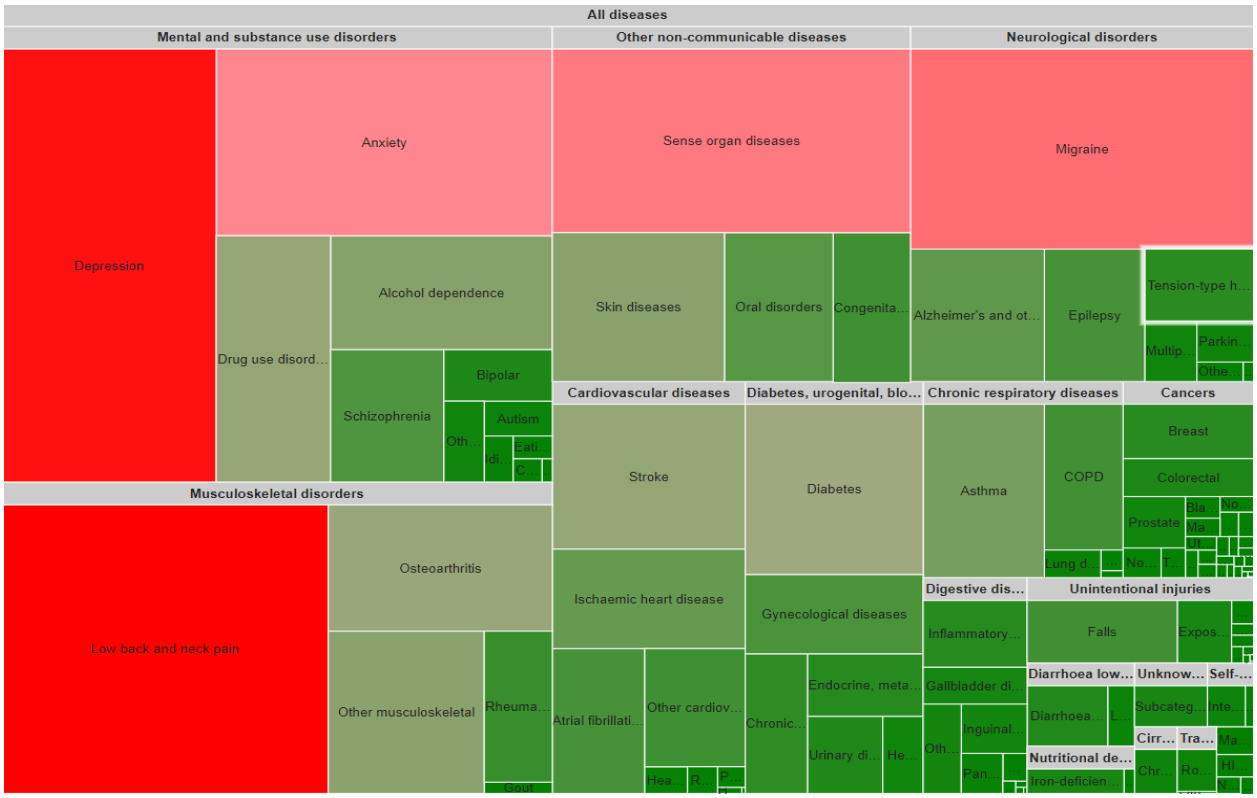
[16] http://www.understandingglasgow.com/indicators/health/trends/male_healthy_life_expectancy/scottish_cities/males

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



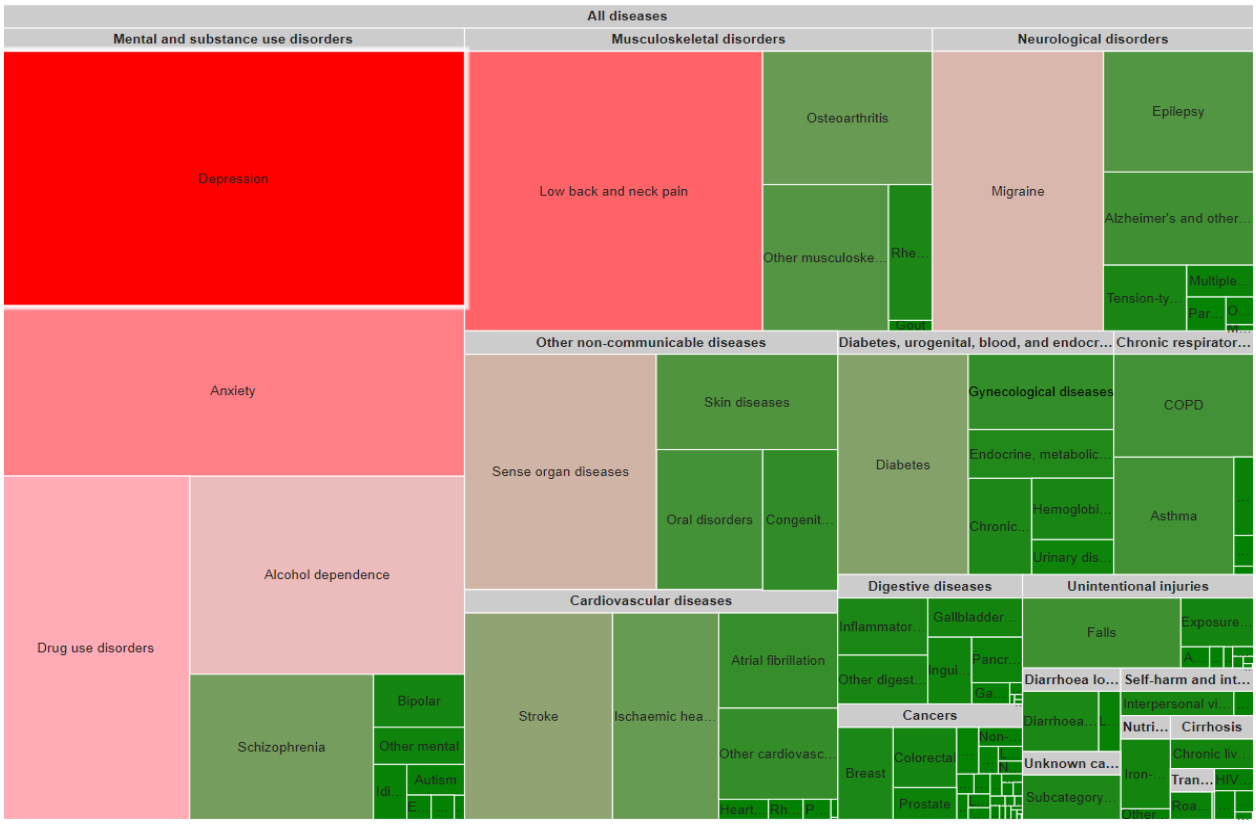
2.6 We can also look at the profile of disease in our population and while this shows considerable changes in the causes of ill health from ten years ago, it also shows differences within our population. The figure 3 below shows the burden of chronic illness and disability in the population as a whole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

Figure 3 – Chronic illness and disability all Scotland



Source: ISD

Figure 4 – Chronic disease and disability Scotland poorest 10%



Source: ISD

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

Understanding Current Trends[17]

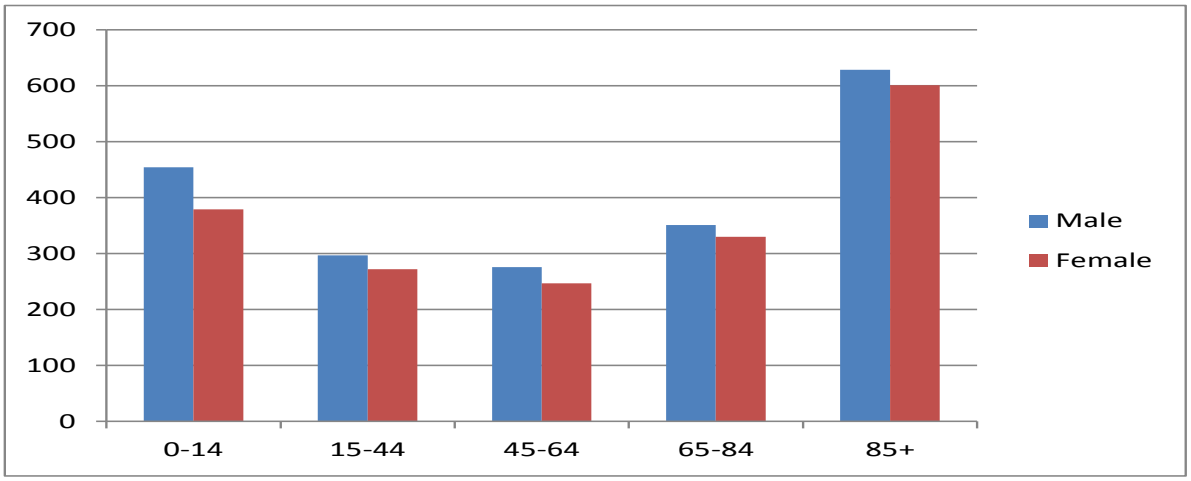
2.8 The current levels of unscheduled care activity in GG&C are unprecedented, and have been driven by demographic changes and the health of our population.

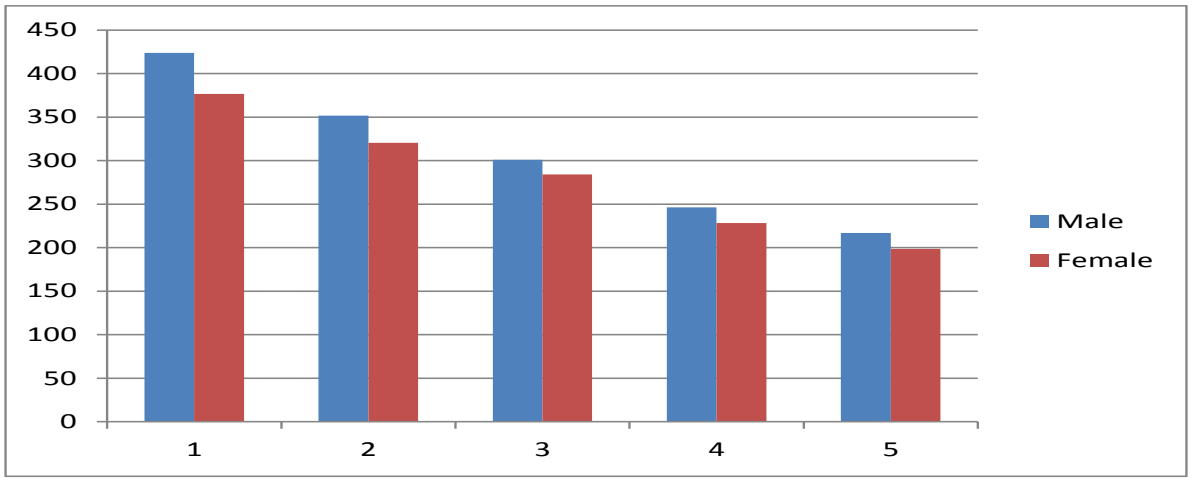
2.9 In 2018/19 there were a total of 517,730 unscheduled care attendances in secondary care. This includes attendances at emergency departments (EDs), GP assessment units (AUs) and minor injury units (MIU). This is a 4.3% increase on total attendances in 2017/18. Of these attendances 448,803 were GG&C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

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

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

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





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

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

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

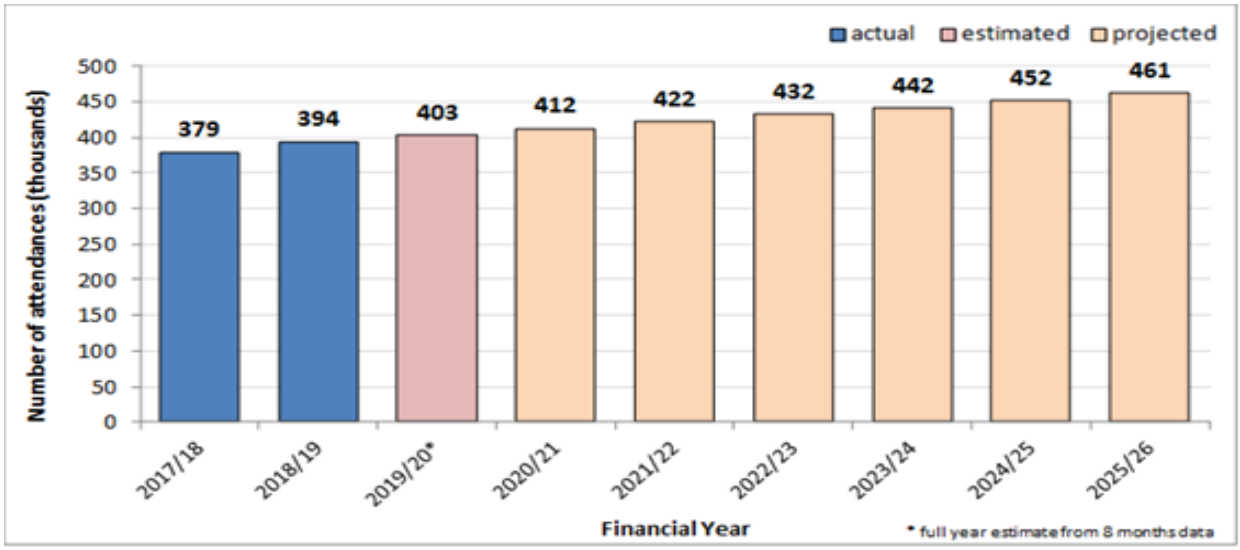
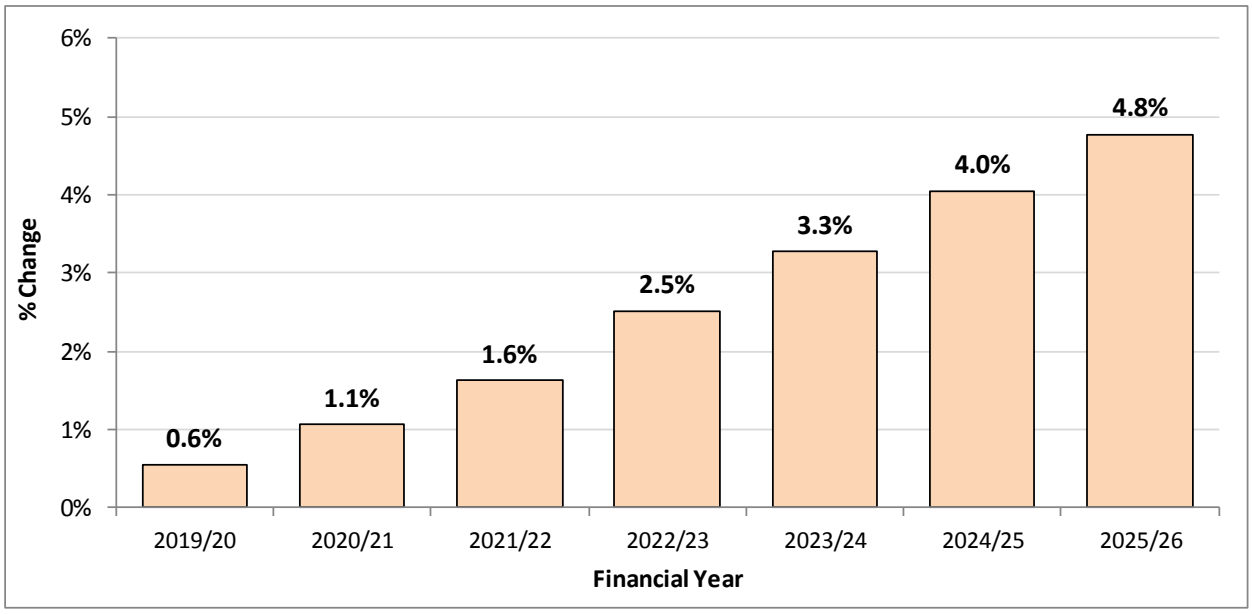


Figure 7: Projected percentage increase in emergency admissions from latest year 2018/19



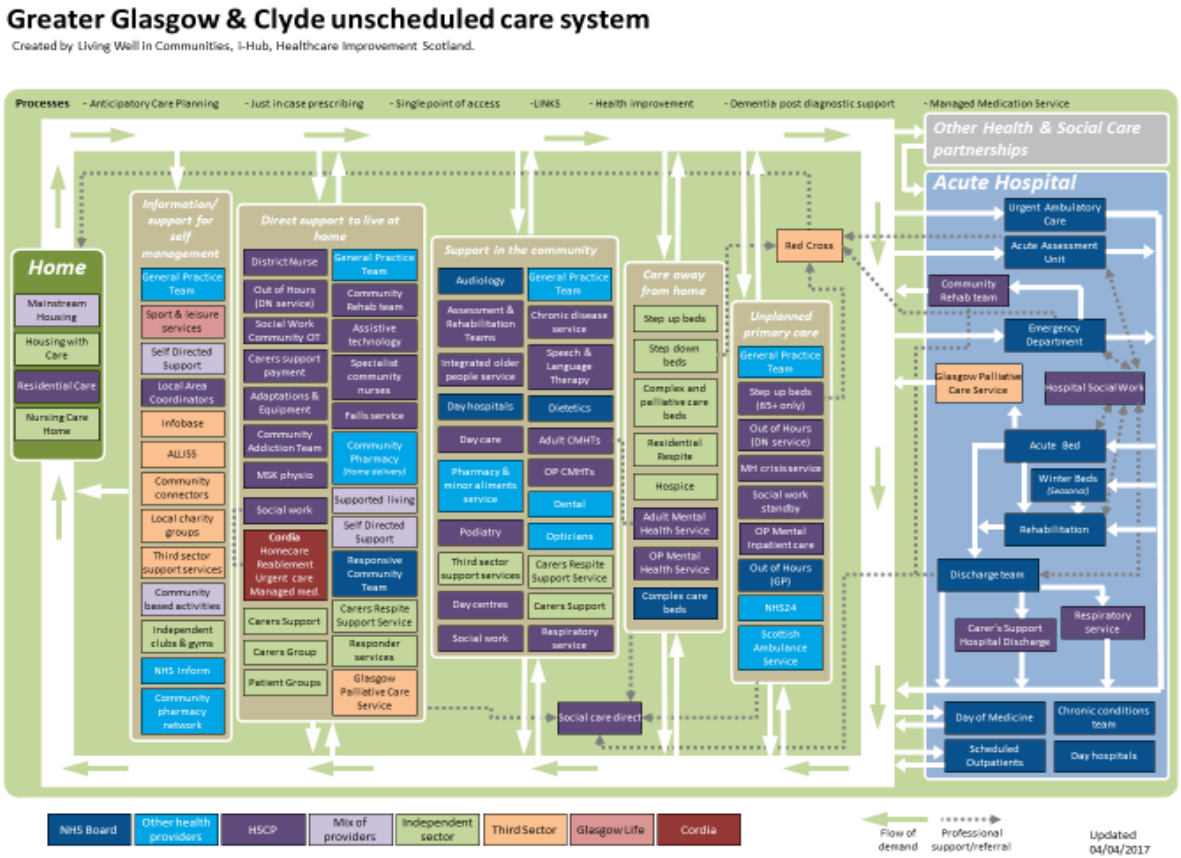
2.12 Unscheduled care is not just a secondary or acute care issue. Unscheduled care attendances also occur within primary care although data on this is not as readily available. We do however have data on GP out of hours activity (OOH). In 2018/19 there were 219,985 OOH consultations, at a rate of 187.2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

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

Unscheduled care system

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

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



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

[19] Chart produced by iHub and reproduced with thanks

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

Primary Care

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

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

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

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

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

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

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

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

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

Out of Hours Redesign

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

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

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

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

GP Out of Hours (OOHs)

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

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

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

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

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

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

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

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

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

Public Health Strategy

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

2.29 The strategic objectives of the strategy are to:

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

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

Summary

2.30 The key points from this section are:

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

3. OUR VISION

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

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

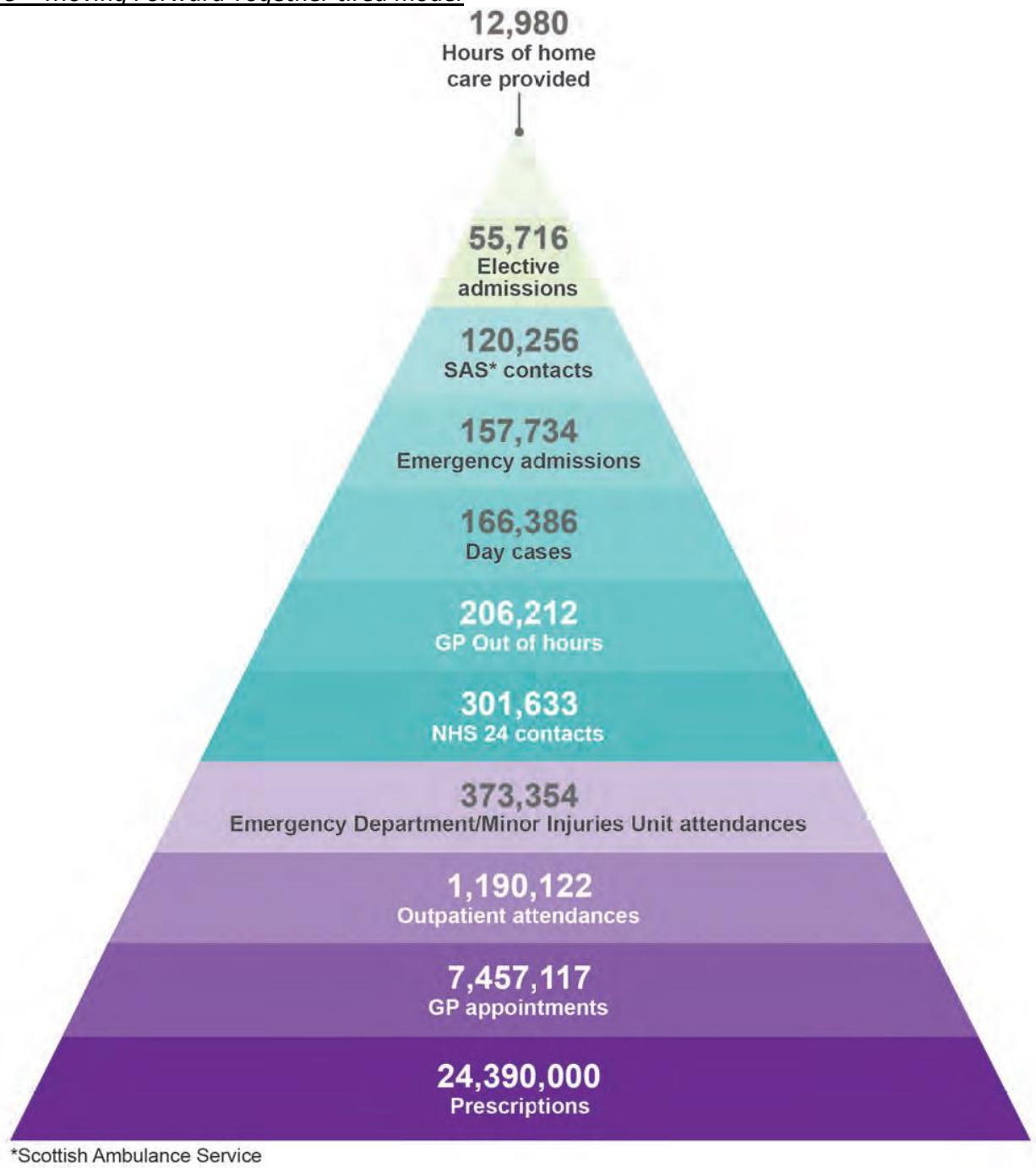
> ***"Our approach … should ensure people are admitted to hospital only when it is not possible or appropriate to treat them in the community. Admissions should be reduced whenever alternatives could provide better outcomes and experiences.***
>
> ***We should develop our system wide approach to unscheduled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

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

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

3.3 This can be illustrated in the model shown below.

Figure 9 – Moving Forward Together tired model



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

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

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

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

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

4. CHANGING THE BALANCE OF CARE

Introduction

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

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

Long term direction

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

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

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

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

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

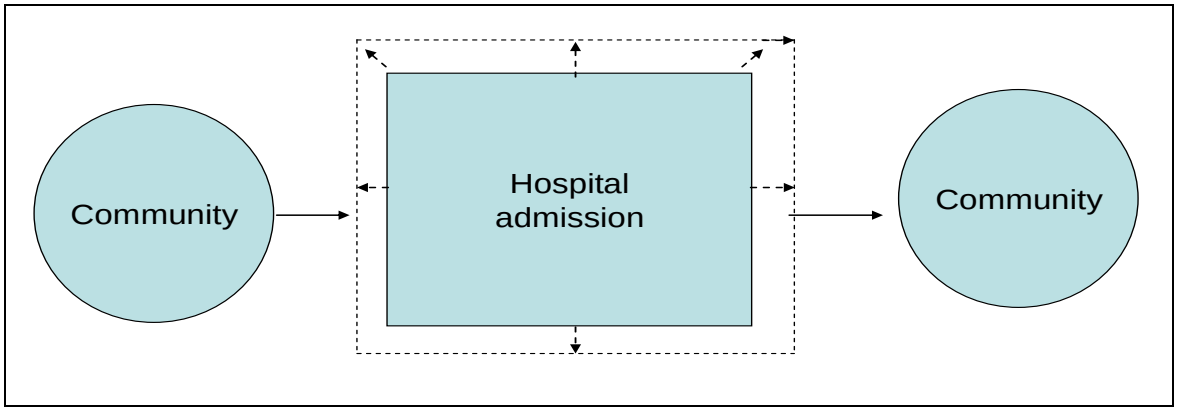
Our priorities

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

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

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

Figure 10 – current system of care



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

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

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

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

5. PREVENTION AND EARLY INTERVENTION

Introduction

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

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

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

Anticipatory care planning

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

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

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

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

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

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

Falls prevention

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

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

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

Frailty

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

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

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

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

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

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

Carer support

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

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

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

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

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

Primary care based community links workers

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

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

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

Avoidable admissions[35]

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

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

- COPD & pneumonia
- sepsis
- cerebral infarction

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

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

Table 1 – main reasons for hospital admission 2018/19

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

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

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

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

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

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

up and support.

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

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

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

Hospital at Home

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

Alternatives to admission

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

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

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

2020/21.

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

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

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

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

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

Reducing admissions from care homes

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

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

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

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

Summary

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

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

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

6. PRIMARY AND SECONDARY CARE INTERFACE

Introduction

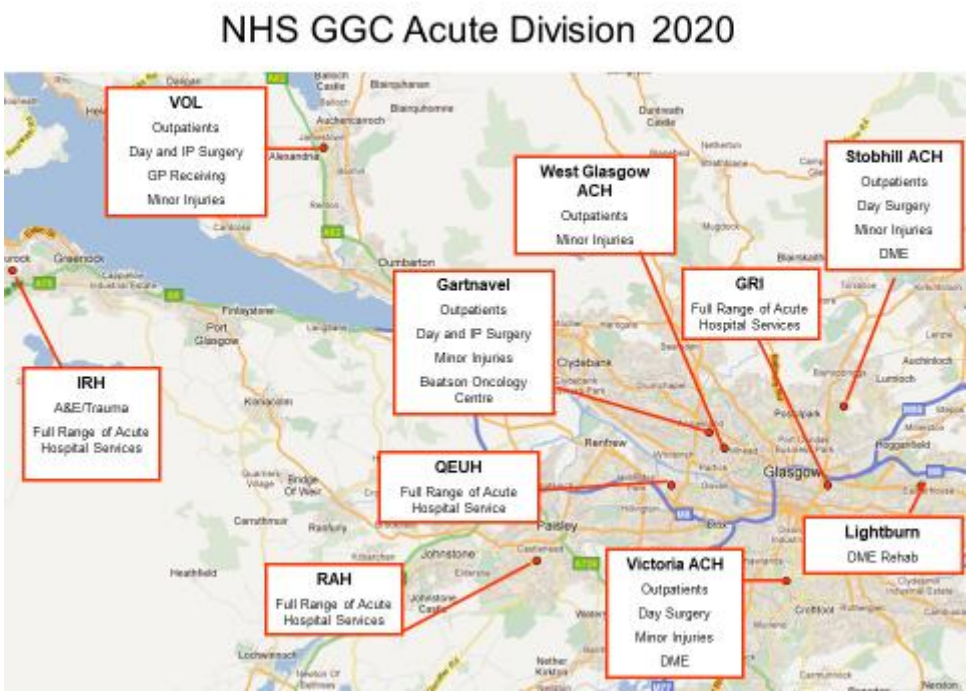
6.1 The interface between primary care, where most patients are seen, and secondary or acute hospital care, where patients attend for specialist treatment and investigations, is important in delivering a quality service to patients. It is in everyone's interest that the communications and links between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

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

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

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

Figure 11 – main acute hospital sites in GG&C



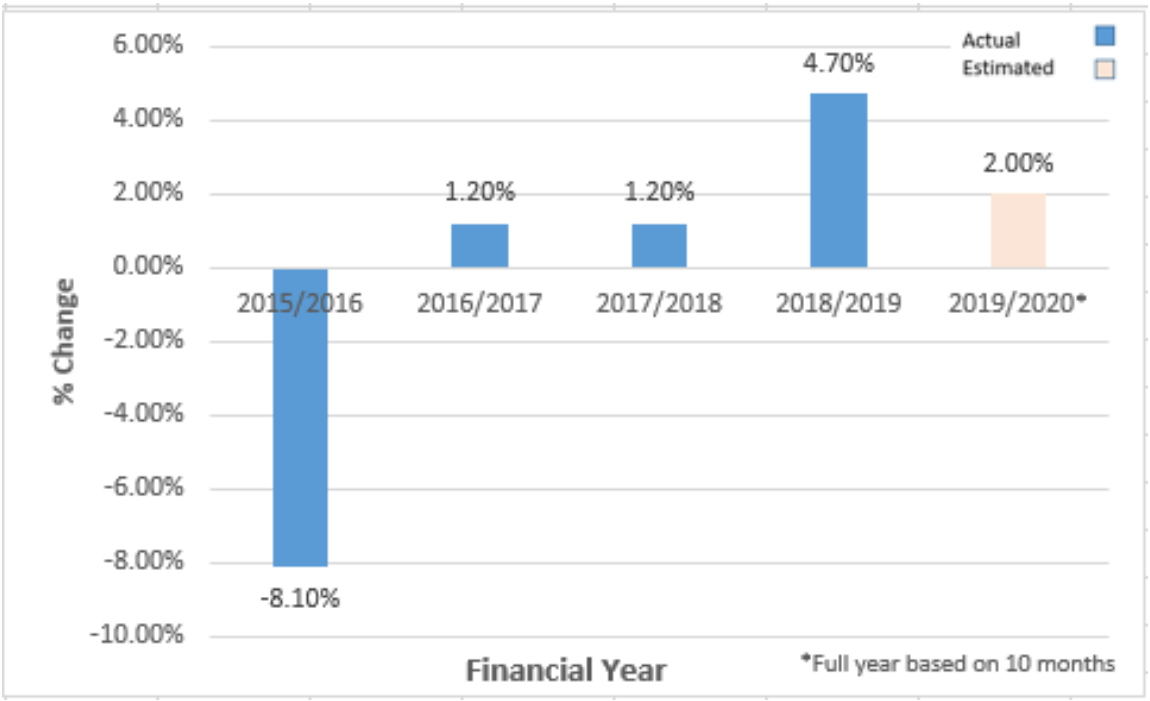
Information sharing

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

Emergency department attendances

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

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



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

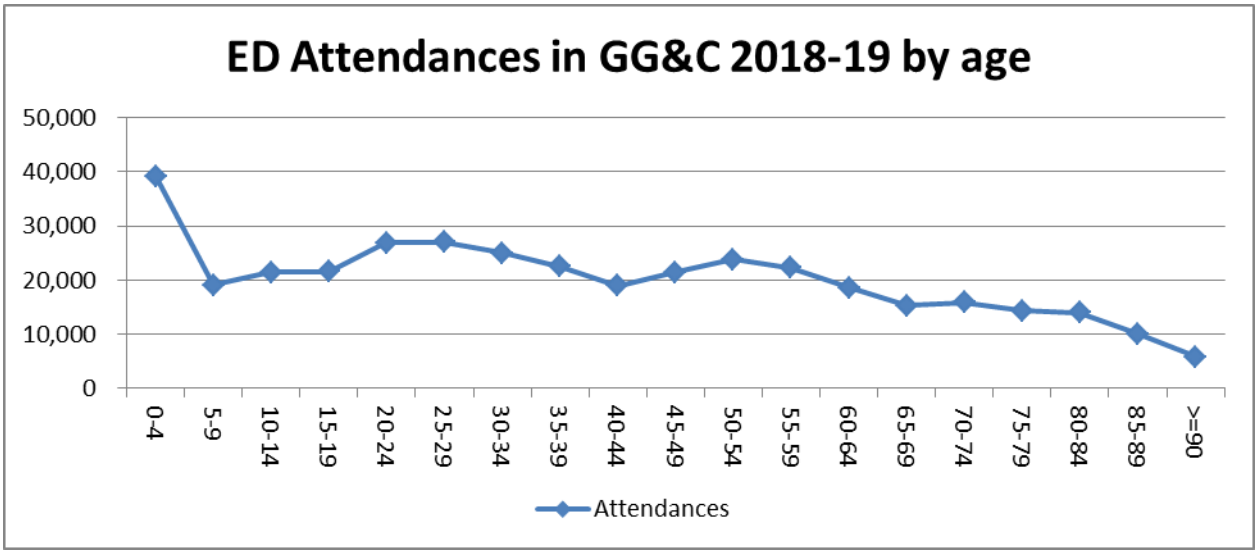
Table 2 – Emergency attendances and 4 hour target – GG&C

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

6.7 Analysis also shows that:

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

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



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

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

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

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

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

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

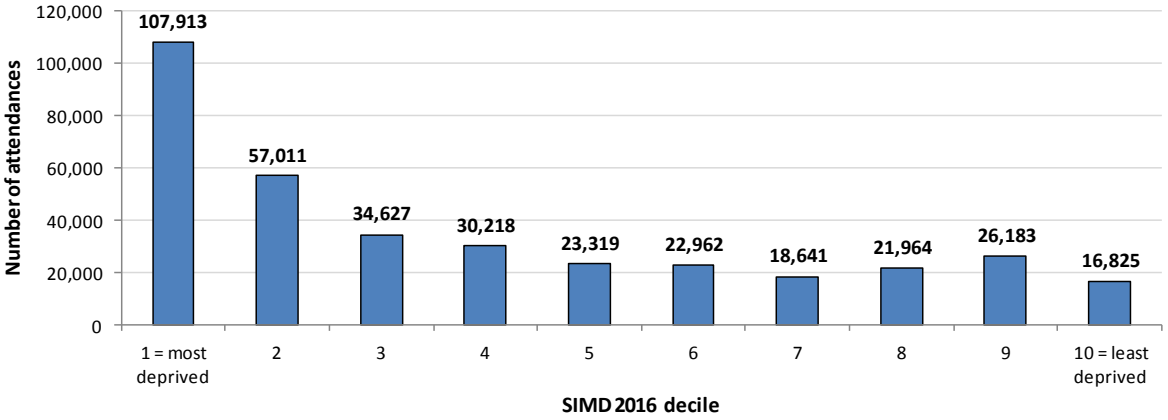
- in 2018/19, on average 58% of attendees referred themselves to ED while 8% were referred by a GP;

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

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

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

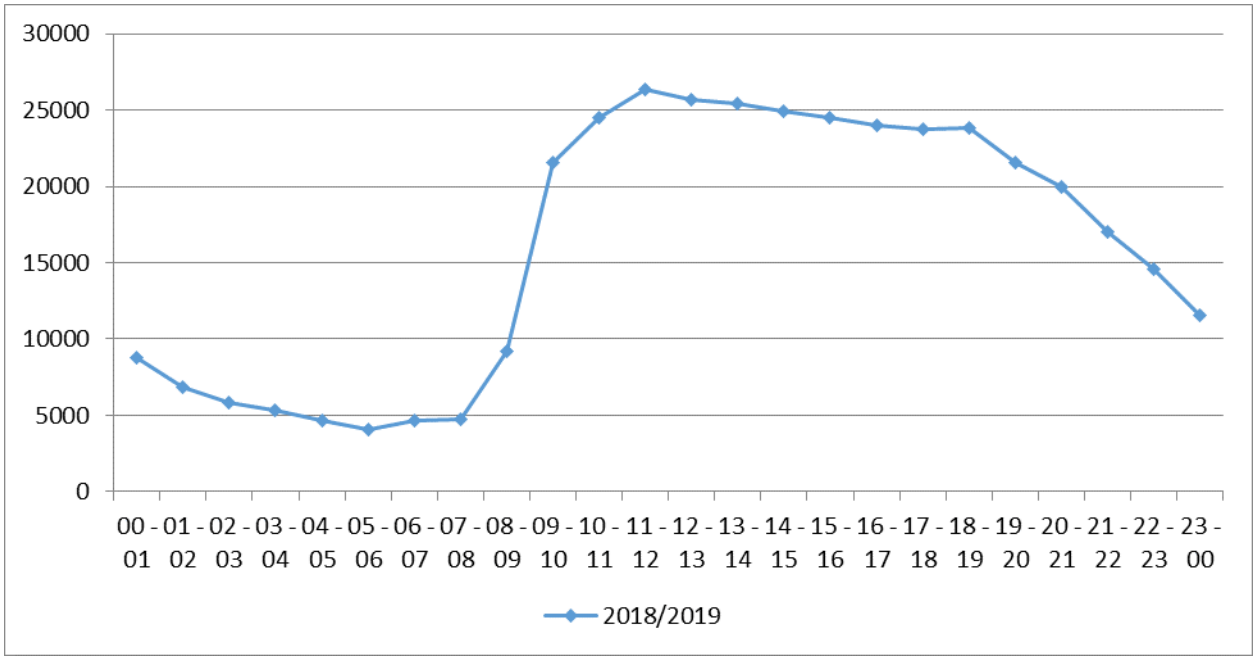
Figure 14 - attendances at all emergency departments in NHS GG&C (2018/19) by SIMD



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

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

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



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

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

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

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

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

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

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

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

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

Public attitudes to A&E

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The challenge is change

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

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

Patient advice - right service right place

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

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

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

[42] Demand and Capacity Model for NHS Greater Glasgow and Clyde, Final Report and Recommendations, NECS, 2019
[43] https://www.rcem.ac.uk/docs/SDDC%20Intial%20Assessment%20(Feb%202017).pdf

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

Table 9 – potential impact of re-direction

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

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

Minor injuries

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

Table 10 – MIU attendances

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

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

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

Frequent attenders at Emergency Departments

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

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

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

Mental Health

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

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

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

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

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

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

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

GP assessment units

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

Table 11 – GP referrals to assessment Units

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

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

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

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

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

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

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

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

Advice to secondary care clinicians

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

Day of care survey

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

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

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

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

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

Length of stay

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

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

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

* - denotes small number of spells

Source: NSS Discovery dashboard

Notes:

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

Numerator: Total LOS (days)

Denominator: Number of spells

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

Consultant geriatricians and GPs

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

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

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

Summary

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

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

7. IMPROVING HOSPITAL DISCHARGE

Introduction

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

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

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

Improving discharge

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

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

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

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

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

Discharge process

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

7.8 Key to a successful discharge is:

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

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

Discharges before 12.00 noon

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

Intermediate care

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

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

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

Adults with Incapacity (AWI)

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

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

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

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

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

Improving Delayed Discharges

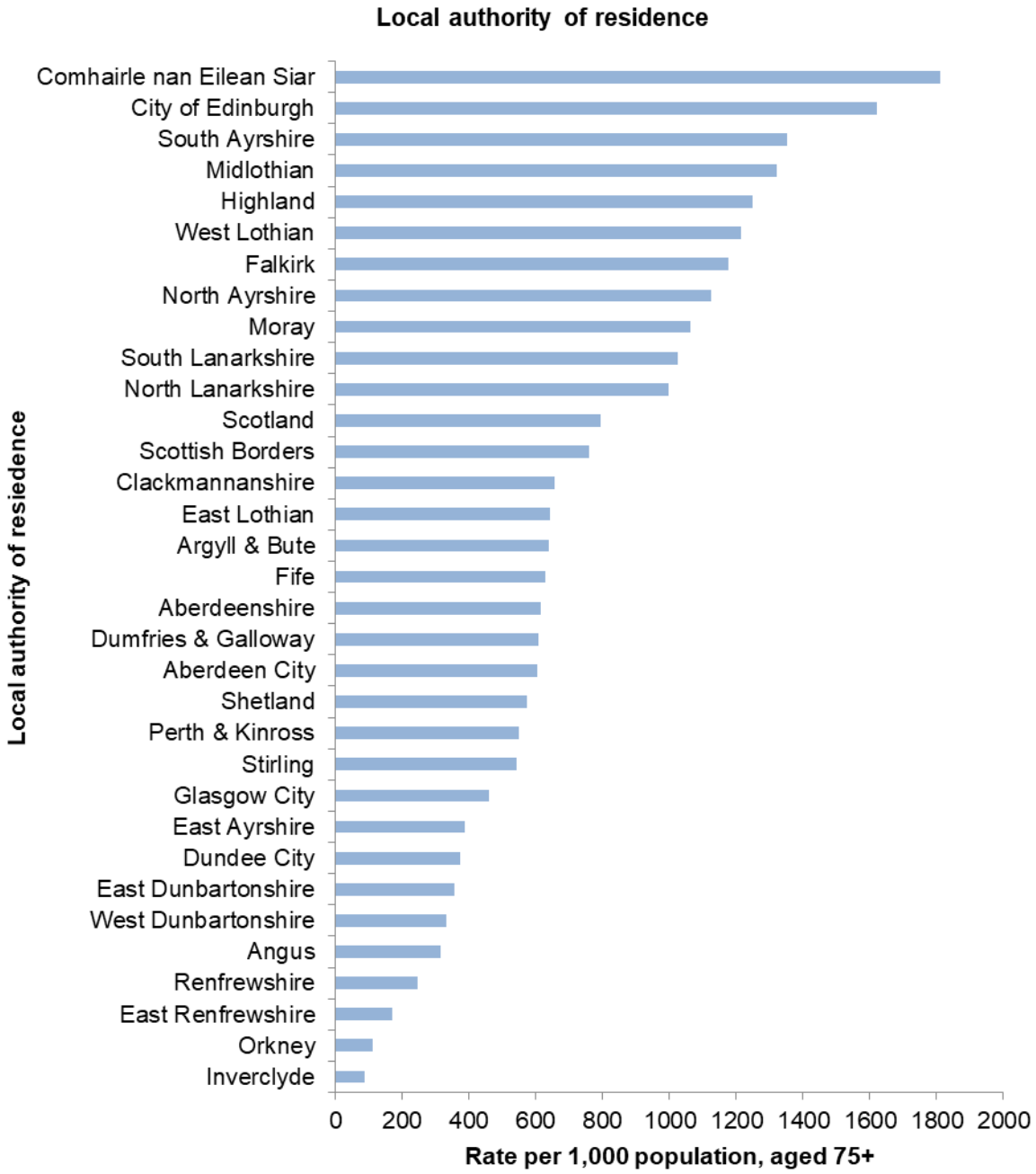
7.15 HSCPs have performed well in recent years in managing delayed discharges which have been on a downward trajectory since 2016. However, reflecting pressures in the wider health and social care system our performance has declined over the past 12 months. While this mirrors a trend nationally, GG&C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

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

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

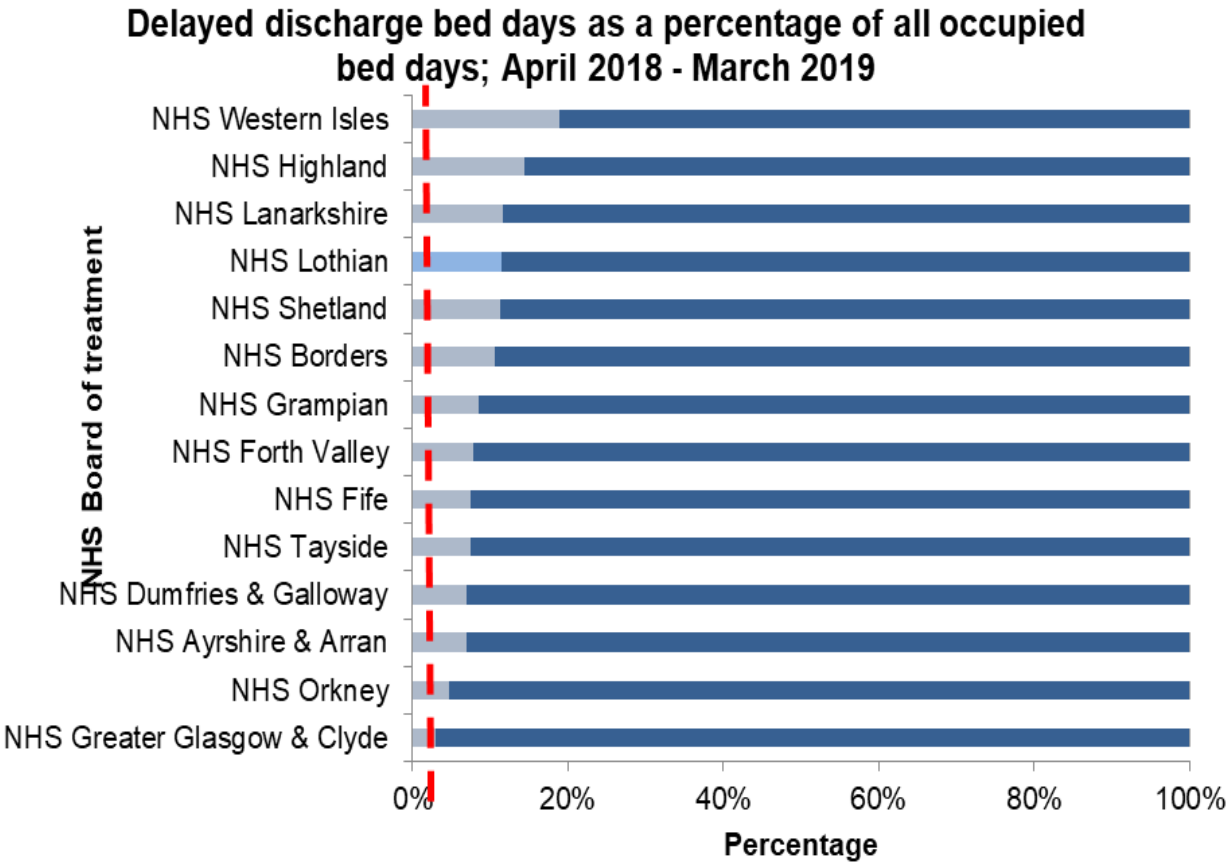
7.18 The current rate of delays (i.e. all delays) for all patients aged 75 plus per head of population by HSCP for 2018/19 is shown in figure 24 below and illustrates that the performance of GG&C HSCPs compares favourably with other HSCPs nationally.

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



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

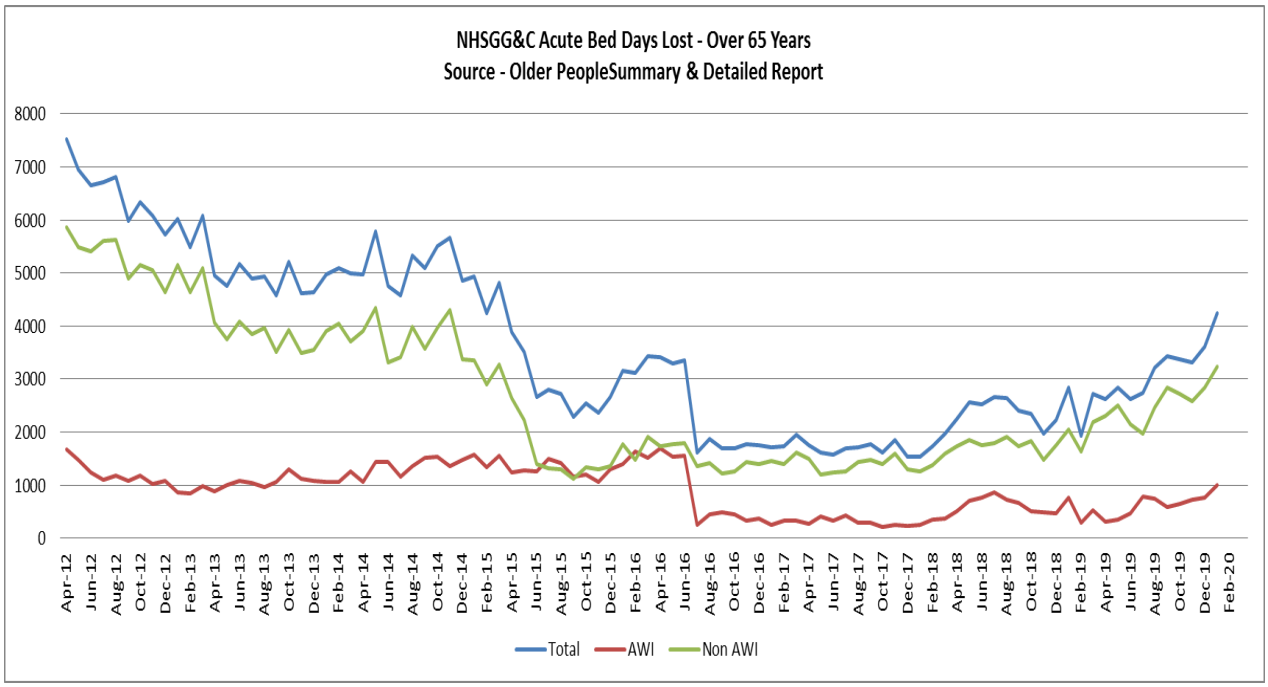
Figure 17 – delays as a percentage of acute beds – 2018/19



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

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

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



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

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

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

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

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

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

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

Managing capacity at peak times – seasonal planning

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

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

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

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

Summary

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

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

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

8. RESOURCING THE CHANGES

Introduction

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

Financial Framework

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

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

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

Acute Inpatient Beds Plan

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

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

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

Table 14 – acute inpatient beds benchmarks 2019

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

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

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

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

9. MEASURING IMPACT AND PROGRESS

Introduction

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

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

Key Measures

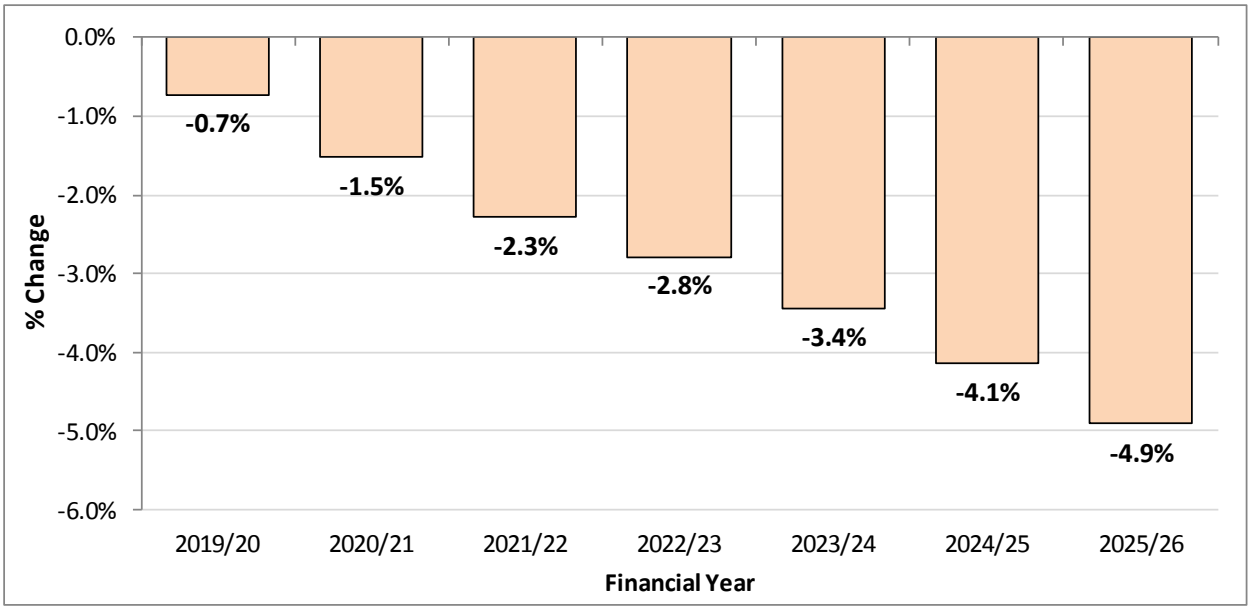
9.3 The key indicators we propose to use to measure the impact of our programme are:

- emergency departments attendances:
  - delivery of the four hour target
  - total attendances by age, sex and deprivation
  - total attendances per head of population
  - rates of admissions and discharges
  - frequent attenders
- minor injury units attendances:
  - delivery of the four hour target
  - total attendances by age, sex and deprivation
  - total attendances per head of population
  - rates of admissions and discharges
- GP assessment units attendances:
  - total attendances by age, sex and deprivation
  - total attendances per head of population e.g. 65-74, 75+
  - rates of admissions and discharges
  - GP referral rates
- emergency hospital admissions:
  - admissions by age, sex and deprivation
  - rates per head of population e.g. 65-74, 75+
  - length of stay
  - rates per GP practice
- acute unscheduled care bed days
  - rates per head of population e.g. 65-74, 75+
- acute bed days lost due to delayed discharges

- rates by age e.g. e.g. 65-74, 75+
- AWI and non AWI rates
- bed days lost as % of total acute beds

9.4 In assessing the impact of the programme outlined in section 5 to prevent admissions, and based on current rates of admission per head of population and for different age groups (e.g. 65-74, 75 plus) we estimate that the full implementation of this programme will likely result in a reduction in the rate of emergency admissions for over 65s by 4.9% by 20205 (see figure 19 below). This estimate takes into account the demographic changes forecast over this period.

Figure 19 – projected percentage change in emergency admissions (based on 2018/19 data)



9.5 An important caveat to these projections is that other changes in the population e.g. changes in life expectancy, wider society and the economy highlighted in section 1, will affect these numbers in ways that are difficult to predict at the present time.

9.6 Work is underway to identify the potential impact of all the actions outlined in this draft plan. Through this further work we aim to demonstrate that if plans are delivered in full by 2021/22 as envisaged this will not only enable increases in demand anticipated from changes in our population to be met, it will also result in a reduction in current costs.

10. CONCLUSION

10.1 The purpose of this plan is to outline how the six NHSGG&C HSCPs in partnership with Acute Division and other partners aim to respond to the continuing pressures on health and social care services in Scotland's largest Health Board. For a number of reasons health and social care services are stretched and we are struggling to meet key targets. In a large system such as GG&C a large number of patients are seen by health and social care professionals in a variety of different settings on a daily basis. When looking to the future we can see that demand will increase as the number of people aged over 75 is forecast to rise over the next five years. We need to change therefore if we are to both meet current and future demand.

10.2 The challenge is change. We need to do somethings differently (e.g. out of hours services) and we need to change some services (e.g. mental health services) to respond better to patients. We need to scale up some of what we are already doing (e.g. anticipatory care planning) and we need to try new things (e.g. "hot clinics" for GPs). We also need to look at putting new additional services in place (e.g. minor injury units) and changing how emergency departments operate more effectively.

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

10.4 The programme outlined in this plan is based on evidence from elsewhere of what works and our estimate of patient needs in GG&C. We believe it is the right way forward. The changes proposed will not take effect immediately or all at the same time. Some need testing and others need time to bed in. Change will be gradual but should be fully implemented by 2022/23. While the challenge is change to respond to current and future demand, the challenge is also maintaining the direction outlined in this plan over the longer term so that we can better meet the needs of the people we serve.

Annex A

SUMMARY OF THE EVIDENCE[47]

Redesigning elective care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Improved GP access to specialist expertise
Mixed evidence, particularly on overall cost reduction	• Peer review and audit of GP referrals • Shared decision-making to support treatment choices • Shared care models for the management of chronic disease • Direct access to diagnostics for GPs
Evidence of potential to increase overall costs	• Consultant clinics in the community • Specialist support from a GP with a special interest • Referral management centres

Redesigning urgent and emergency care pathways

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Ambulance/paramedic triage to the community
Emerging positive evidence	• Patients experiencing GP continuity of care
Evidence of potential to increase overall costs	• Extending GP opening hours • NHS 111 (NHS24 in Scotland) • Urgent care centres including minor injury units (not co-located with A&E)

Avoiding hospital admission and accelerating discharge

Relative strength of evidence of reduction in activity and whole-system costs	Initiative

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

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence Emerging positive evidence	• Condition-specific rehabilitation • Senior assessment in A&E • Rapid access clinics for urgent specialist assessment
Mixed evidence, particularly on overall cost reduction	• Intermediate care: rapid response services • Intermediate care: bed-based services • Hospital at Home

Managing 'at risk' populations

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Additional clinical support to people in nursing and care homes • Improved end-of-life care in the community • Remote monitoring of people with certain long-term conditions
Emerging positive evidence	• Extensive model of care for high risk patients
Mixed evidence, particularly on overall cost reduction	• Case management and care coordination • Virtual ward

Support for patients to care for themselves and access community resources

Relative strength of evidence of reduction in activity and whole-system costs	Initiative
Most positive evidence	• Support for self-care
Emerging positive evidence	• Social prescribing

Annex B

HSCP DELAYED DISCHARGE ACTION PLANS
SUMMARY

Each HSCP, working closely with the acute services division, has a number of actions in train to improve outcomes for patients and current performance. Progress on actions plans and performance is routinely reported to IJBs. Key actions being taken by HSCPs are summarised below.

East Dunbartonshire:

- Linked Mental Health Officer to Hospital Assessment Team to lead improvement in relation to AWI focusing on timeous completion of reports, local authority guardianship applications etc.;
- Dedicated Intermediate Care Unit;
- Palliative and Complex Care beds;
- Hospital attached Social Workers linked to wards who proactively engage with discharge co-ordinators and MDT discussions;
- Proactive use of unplanned inpatient activity dashboard to identify those who have been inpatient for 10 days+ and those with an EDD of 1 month+ to facilitate early referral and allocation of case;
- Same day response to care packages

East Renfrewshire:

- continued use of the inpatient dashboard to identify at earliest point East Renfrewshire residents in acute wards to support early referral;
- continue to strengthen relationships between our Hospital to Home Social Work Assistants aligned to acute sites, staff in acute wards and discharge co-ordinators;
- Proactive planning by Hospital to Home multidisciplinary team to support safe, early discharge collaborating with Care @ Home services and wider RES team;
- Further development of Intermediate bed capacity model as a result of Local Authority Care Home refurbishment over the winter period;
- Unscheduled Care daily huddles to identify those at risk of admission and planned discharges; and,
- Implementation of pan Greater Glasgow & Clyde AWI approach.

Glasgow City:

- a continuing programme of improvement in relation to intermediate care with a focus on reducing average length of stay;
- additional capacity recruited to the HSCP hospital social work team;
- for under 65s, a named Adult Service Manager in each locality to hold accountability and ensure progress with complex adult delays daily;

- improved links with complex wards to improve early referral and effective communication;
- the sharing of estimated day of discharge information to a give early indication of potential future discharges; and,
- a management focus on everyday activities, including:
    - a reduction in same day (as fit for discharge) referrals from Acute – which automatically generate delays;
    - more assiduous prioritisation of delays by HSCP community staff – these are marginal, as most cases are held by the hospital-facing Home Is Best team; and,
    - improved communication arrangements between ward staff and the hospital discharge team around individual patients i.e. single points of contact, more effective networks.

Inverclyde:

- 7 Day Service - we will continue to work in partnership with local Care Homes to accept safe weekend and evening discharges for new admissions;
- Following last Winter's successful Pilot we wish to again increase capacity in our Home care Service to cover 175 hours per week to focus upon evening and weekend discharges for new service users as well as restarting existing packages;
- Test of Change Care Coordination - Coordination of Emergency Department Frequent Re-Attenders will utilise existing Locality Meetings to identify people at risk of hospital re-attendance and implement review and development of appropriate support to address unnecessary presentation. This will be across Health and community Care (including OPMHT) and have similar process in place to address frequent attendances of people known to Alcohol and Drugs Service and Community Mental Health Team;
- Day Care Services - a further Test of Change is to utilise Day Care Services to prevent Unscheduled Attendance's at Hospital This will identify 10 Frailty Day Places which will help to address Isolation and Anxiety amongst Older People which we have identified as a factor for some attendance's and admissions. These will be short term placements with clear link to reablement and accessing community supports;
- Assessment and Care Coordination at Emergency Department - we also intend to support the strengthening decision making at Emergency Department with greater knowledge of community resources and services to allow safe return home rather than admit. To support this we are requesting funding for 6 months to cover a Care Management post who would link directly to IRH Emergency Department complete assessments and return people home with necessary support thus avoiding unnecessary admissions;
- Choose the right Service - we have also extended our local Choose the Right Service campaign to cover attendance at emergency department and families with children.
- Purchase of step up beds on call off basis to prevent inappropriate admissions and also short term placements to facilitate discharge as required.

Renfrewshire:

- Discharge Coordinator post created from November 2019. This dedicated role solely focuses on working with Families, Acute and HSCP Services to manage the discharge process;
- when available, beds at Hunterhill Care Home are used for the reablement of delayed discharged patients;
- Hospital discharge protocol to be finalised and implemented;
- Acute and HSCP meet 3 times a day to discuss discharge planning and review active cases/delayed discharges and agree appropriate actions;
- Hospital Social Work Team attending daily huddle including bank holidays; and
- Weekly meetings with the Care at Home Service Delivery Team Manager; Acute; and the Royal Alexandra Hospital Social Work Team to discuss delayed discharges

West Dunbartonshire:

- Full use of inpatient dashboard to identify patients with admissions of 10 days+
- Dedicated early assessment cohort (Social Care, Nursing, OT) undertaking assertive in reach in wards
- Continuing programme of robust review in relation to use of s13za for AW patients.
- Refresh of hospital discharge homeless policy in conjunction with WDC Housing to ensure streamlined approach
- Refinement of engagement by colleagues in mental health and learning disability services to support safe and timely discharge

Annex C

Acute Inpatient Beds Totals by Hospital site 2010-2025

2010	Beds	2015	Beds	2020	Beds	Projected 2025	Beds
Southern General	900	QEUH campus	1450	QEUH campus	1400	QEUH campus	1400
Victoria Infirmary	370	New Victoria	60	New Victoria	60	New Victoria	60
Western Infirmary	500						
Stobhill Hospital	440	Stobhill ACH	60	Stobhill ACH	60	Stobhill ACH	60
Glasgow Royal	930	Glasgow Royal	910	Glasgow Royal	870	Glasgow Royal	870
Gartnavel General	450	Gartnavel G	360	Gartnavel G	360	Gartnavel G	360
RHSC Yorkhill	230	RHC	215	RHC	215	RHC	215
RAH	650	RAH	550	RAH	550	RAH	550
IRH	320	IRH	300	IRH	300	IRH	300
VOL	90	VOL	80	VOL	80	VOL	80
Total	**4880**		**3985**		**3895**		**3895**

2008 – publication of QEUH business case
2015 – opening of QEUH/ closure of Victoria Infirmary, Southern General Hospital, Western Infirmary, conversion of Stobhill Hospital to ACH
2020 – year 1 of Joint Unscheduled Care Commissioning Strategy – figures include additional winter beds
2025 – year 5 of Joint Unscheduled Care Commissioning Strategy (will be the same as 2020 minus the winter beds)

Notes:

All numbers are rough estimates. Bed numbers fluctuate seasonally and for other operational pressures
2010 figures include total bed numbers in the catchments of each hospital, including continuing care beds, e.g. Drumchapel, Blawarthill, etc.
QEUH campus includes QEUH, Institute of Neurological Sciences, Maternity & Gynaecology, and the Langlands building. RHC shown separately
GRI numbers exclude Lightburn
Gartnavel campus is GGH and BWOSCC only

Annex D

Proposed Reduction of Use of Additional Winter Beds

	2019/20	2020/21	2021/22	2022/23	2024/25	2025/26
South	**88**					
North	**51**					
Clyde	**89**					
Total GG&C	**228**	**200**	**175**	**100**	**75**	**0**

AGENDA ITEM No.12

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	**Integration Joint Board** **24 June 2020**
Agenda Item	12
Title	**CALENDAR OF MEETINGS 2021**

Summary:

Proposed meetings dates for the Board for 2021.

Presented by	Eamonn Daly, Democratic Services Manager, East Renfrewshire Council

Action required:

That the Integration Joint Board approves the proposed meeting dates for 2021

Implications checklist – check box if applicable and include detail in report

Financial		HR		Legal		Equalities	Sustainability
Policy		ICT					

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

24 June 2020

Report by Chief Officer

CALENDAR OF MEETINGS 2021

PURPOSE OF REPORT

1. To seek approval of proposed meetings dates for the Board for 2021.

RECOMMENDATION

2. That the Integration Joint Board approves the proposed meeting dates.

REPORT

3. At the meeting of the IJB in June 2019 meeting dates for 2020 were approved. In order to assist Board members in programming their diaries the proposed meeting dates for 2021 are now submitted for consideration.

4. It is proposed that meetings of the IJB be held on the following dates.

Wednesday 27 January
Wednesday 17 March
Wednesday 12 May
Wednesday 23 June (draft accounts)
Wednesday 11 August
Wednesday 22 September (including annual accounts)
Wednesday 24 November

5. Following consultation with members of the Board, it is proposed that all meetings take place in the Eastwood Health and Care Centre, Clarkston. However, this will be qualified by circumstances at the time. It may be that the Board is still meeting remotely, or, depending on whatever social distancing guidelines are in effect at the time, it may be necessary to move to an alternative venue.

6. It should be noted that with regards to the meetings of 17 March, 23 June, 23 September and 24 November, subject to approval by the Performance and Audit Committee, arrangements will be made for the committee to meet prior to the meetings of the Board. In particular the meetings of the committee on 23 June and 22 September will meet to consider the draft and final annual accounts, prior to making a recommendation to the subsequent meetings of the Board.

7. To facilitate this, it is proposed to maintain the current arrangement that the meetings of the IJB being held on the above dates start at **10.30 am**. For the remaining dates on which there is no Performance and Audit Committee (27 January, 12 May, and 11 August), the start time will remain at 10.00 am.

FINANCE AND EFFICIENCY

8. There are no financial implications arising from this report.

CONSULTATION AND PARTNERSHIP WORKING

9. The dates suggested have been drawn up taking into account the meetings calendar for East Renfrewshire Council. A copy of the calendar once approved will also be sent to the Clerk to the Glasgow IJB to try and minimise meeting clashes.

IMPLICATIONS OF THE REPORT

10. There are no implications in respect of staffing, property, legal IT, equalities or sustainability arising from this report.

CONCLUSIONS

11. Confirmed meeting dates will help Board members to more efficiently manage their diaries and ensure that they are able to maximize attendance at Board meetings.

RECOMMENDATION

12. That the Integration Joint Board approves the proposed meeting dates.

REPORT AUTHOR AND PERSON TO CONTACT

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BACKGROUND PAPERS - NONE