Council Offices, Almada Street
Hamilton, ML3 0AA

Tuesday, 10 August 2021

Dear Member

South Lanarkshire Integration Joint Board

The Members listed below are requested to attend a meeting of the above Board to be held as follows:-

Date: **Tuesday, 17 August 2021**
Time: **14:00**
Venue: **By Microsoft Teams,**

The business to be considered at the meeting is listed overleaf.

Yours sincerely

Cleland Sneddon
Chief Executive
South Lanarkshire Council

Heather Knox
Chief Executive
NHS Lanarkshire

Members
South Lanarkshire Council
John Bradley, Allan Falconer, Richard Lockhart, Jim McGuigan

NHS Lanarkshire
Philip Campbell, Lilian Macer, Lesley McDonald, Lesley Thomson

Substitutes
South Lanarkshire Council
Maureen Chalmers, Hugh Macdonald, Richard Nelson, Margaret B Walker

BUSINESS

1 Declaration of Interests

2 Minutes of Previous Meeting 5 - 14
Minutes of the meeting of the South Lanarkshire Integration Joint Board held on 18 May 2021 submitted for approval as a correct record. (Copy attached)

3 Miuntes of the South Lanarkshire Integration Joint Board (Performance and Audit) Sub-Committee 15 - 24
Minutes of the South Lanarkshire Integration Joint Board (Performance and Audit) Sub-Committee held on 16 March 2021 submitted for noting. (Copy attached)

Item(s) for Monitoring

4 Financial Monitoring Report 2021/2022 25 - 44
Report dated 29 July 2021 by the Interim Chief Officer, Health and Social Care Partnership. (Copy attached)

5 Performance Monitoring Report 45 - 52
Report dated 29 July 2021 by the Interim Chief Officer, Health and Social Care Partnership. (Copy attached)

Item(s) for Consideration

6 Directions Progress Update 53 - 68
Report dated 29 June 2021 by the Interim Chief Officer, Health and Social Care Partnership. (Copy attached)

7 Draft Integration Joint Board Annual Performance Report 2020/2021 69 - 118
Report dated 25 June 2021 by the Interim Chief Officer, Health and Social Care Partnership. (Copy attached)

8 Development of Strategic Commissioning Plan 2022-2025 119 - 126
Report dated 28 July 2021 by the Interim Chief Officer, Health and Social Care Partnership. (Copy attached)

9 Integration of Mental Health Services and Development of a Community Mental Health and Addictions Partnership within South Lanarkshire Health and Social Care Partnership 127 - 136
Report dated 23 July 2021 by the Interim Chief Officer, Health and Social Care Partnership. (Copy attached)

10 Care at Home Update 137 - 144
Report dated 28 July 2021 by the Interim Chief Officer, Health and Social Care Partnership. (Copy attached)

11 New General Medical Services 2018 Primary Care Improvement Plan (PCIP) Update 145 - 174
Report dated 28 July 2021 by the Interim Chief Officer, Health and Social Care Partnership. (Copy attached)

12 Improving Hospital Delayed Discharge Across Lanarkshire 175 - 226
Report dated 26 July 2021 by the Interim Chief Officer, Health and Social Care Partnership. (Copy attached)

13 Autism Resources Co-ordination Hub (ARCH) Update 227 - 246
Report dated 18 June 2021 by the Interim Chief Officer, Health and Social Care Partnership. (Copy attached)

14 Appointment of Depute Standards Officer 247 - 250
Report dated 30 July 2021 by the Interim Chief Officer, Health and Social Care Partnership. (Copy attached)

15 Whole System Pressures
Presentation by the Chief Officer, Health and Social Care Partnership.

Any Other Competent Business

16 Any Other Competent Business
Any other items of business which the Chair decides is competent.

For further information, please contact:-

Clerk Name: Tracy Slater
Clerk Telephone: 01698 454719
Clerk Email: tracy.slater@southlanarkshire.gov.uk

SOUTH LANARKSHIRE INTEGRATION JOINT BOARD

Minutes of meeting held via Microsoft Teams on 18 May 2021

Chair:
Councillor John Bradley

Present:
Health and Social Care Partnership
V de Souza, Director, Health and Social Care and Chief Officer; M Moy, Chief Financial Officer
NHS Lanarkshire Board
Lilian Macer, Non Executive Director; Lesley McDonald, Non Executive Director; Lesley Thomson, Non Executive Director
South Lanarkshire Council
Councillors Allan Falconer, Richard Lockhart, Jim McGuigan

Attending:
NHS Lanarkshire
J Cringles, Business Support Manager; M Hayward, Head of Health and Social Care (Rutherglen/Cambuslang and East Kilbride); L Thomson, Nurse Director; P McCrossan, Director for Allied Health Professionals

Partners
L Craig, Carers' Representative; R Craig, South Lanarkshire Health and Social Care Forum; Dr K McIntyre, GP Representative; S Smellie, South Lanarkshire Council Trade Union Representative; S Sweeney, VASLan; T Wilson, Health Service Trade Union

South Lanarkshire Council
P Manning, Executive Director (Finance and Corporate Resources); I Beattie, Head of Health and Social Care (Hamilton and Clydesdale); C Brown, Planning and Performance Manager; E Devlin, Service Manager, Transitions; M Kane, Service Development Manager; G McCann, Head of Administration and Legal Services; J Mortimer, Project Governance Co-ordinator; L Purdie, Chief Social Work Officer; T Slater, Administration Adviser; M Tedford, Community Living Manager

Also Attending:
Audit Scotland
S Lawton, Senior Auditor
NHS Lanarkshire
G Lindsay, Senior Manager, Health Promotion
South Lanarkshire Council
J Fernie, Homelessness and Housing Support Manager
South Lanarkshire Leisure and Culture
P Murphy, Development Services Manager

Apologies:
NHS Lanarkshire
H Knox, Chief Executive; C Cunningham, Head of Commissioning and Performance
South Lanarkshire Council
C Sneddon, Chief Executive

Chair's Opening Remarks

The Chair advised the Board that this would be Val de Souza's last meeting before her retirement.

The Chair, on behalf of the Board, thanked Ms de Souza for the significant contribution she had made and indicated that there would be an opportunity at the end of the meeting for anyone who wished to speak.

1 Declaration of Interests

No interests were declared.

2 Minutes of Previous Meeting

The minutes of the meeting of the South Lanarkshire Integration Joint Board held on 2 March 2021 were submitted for approval as a correct record.

The Board decided: that the minutes be approved as a correct record.

3 Minutes of Special Meeting

The minutes of the special meeting of the South Lanarkshire Integration Joint Board held on 29 March 2021 were submitted for approval as a correct record.

The Board decided: that the minutes be approved as a correct record.

Councillor Falconer and T Wilson entered the meeting following consideration of this item of business

4 Financial Monitoring 2020/2021

A report dated 10 May 2021 by the Director, Health and Social Care was submitted providing a summary of the financial position of the Health and Social Care Partnership (HSCP) for the period 1 April 2020 to 31 March 2021 in relation to Health Care Services and Social Work and Housing Services.

A summary of the financial position as at 31 March 2021 was as follows:-

- an underspend of £5.116 million on core budgets within Health Care Services
- an underspend of £6.812 million in respect of the Primary Care Improvement Funding which would be transferred to a ring-fenced reserve
- an underspend of £2.230 million in respect of the Alcohol and Drug Partnership Funding which would be transferred to a ring-fenced reserve
- an underspend of £0.823 million on the core budgets within Social Care and Housing Services
- an underspend of £0.013 million on the core budgets within the Housing Revenue Account (HRA)
- Covid-19 funding totalling £31.329 million received from the Scottish Government in 2020/2021, of which £24.385 million had been incurred in 2020/2021 and £6.944 million would be transferred to a ring-fenced reserve to meet ongoing Covid-19 costs in 2021/2022
- additional funding of approximately £10.233 million had been received in 2020/2021, the planned commitments in respect of which would be incurred in 2021/2022

The reasons for major budget variances across the Health and Social Care Services budget, together with supporting information, was provided in Appendices 1 to 5 to the report.

The Integration Joint Board (IJB) Reserves Strategy for 2021/2022 was being developed in consultation with the Director of Finance, NHS Lanarkshire and the Executive Director (Finance and Corporate Resources), South Lanarkshire Council. The Strategy would be submitted to the IJB (Performance and Audit) Sub-Committee for approval at its meeting on 15 June 2021.

Following discussion on the authority delegated by the IJB to the Chief Officer to allow timely decisions to be taken during the response to the Covid-19 pandemic, Councillor Bradley, seconded by Councillor McGuigan, moved that the delegated authority remain in place. Lesley Thomson, seconded by Lesley McDonald, moved as an amendment that the delegated authority be removed.

On a vote being taken by roll call, members voted as follows:-

Motion
Councillor John Bradley, Councillor Richard Lockhart, Councillor Jim McGuigan

Amendment
Councillor Allan Falconer, Lilian Macer, Lesley McDonald, Lesley Thomson

3 members voted for the motion and 4 for the amendment which was declared carried.

The Board decided:

(1) that the indicative 2020/2021 year-end outturn for the South Lanarkshire HSCP, as detailed in Section 4 of the report, be noted;

(2) that, following consultation with the Director of Finance, NHS Lanarkshire and the Executive Director (Finance and Corporate Resources), South Lanarkshire Council, the IJB Reserves Strategy for 2021/2022 be submitted for approval to the IJB (Performance and Audit) Sub-Committee at its meeting on 15 June 2021; and

(3) that the authority delegated by the IJB to the Chief Officer, in consultation with the Chair and Depute Chair of the IJB, or their nominated deputes as necessary, NHS Lanarkshire's Chief Accountable Officer and Director of Finance, and South Lanarkshire Council's Chief Executive and Executive Director (Finance and Corporate Resources), to allow timely decision to be taken during the response to the Covid-19 pandemic, be removed.

[Reference: Minutes of special meeting of 30 March 2020 (Paragraph 2) and 2 March 2021 (Paragraph 4)]

5 Performance Monitoring Report

A report dated 26 April 2021 by the Director, Health and Social Care was submitted:-

- providing a summary of performance against the key performance measures assigned to the integration of Health and Social Care in South Lanarkshire
- highlighting the challenges faced by the Health and Social Care Partnership in the context of Covid safety restrictions and the resources which had been prioritised to address those challenges

An update against each of the 6 Ministerial Steering Group indicators was detailed in Appendix 1 to the report.

The data provided was for the period to January 2021, with 99% confidence in data completeness to December 2020, however, there was a lag period associated with 2 indicators,

unscheduled care admissions and unscheduled care bed days, and, therefore, admissions and beds days would increase.

In relation to unplanned admissions and Accident and Emergency attendances, information was provided on the significant work that had been undertaken over the last 14 months on managing Covid-19 patients outwith the hospital setting and establishing a Flow Navigation Centre. Appendix 2 to the report provided an overview of NHS Lanarkshire's Covid-19 Community Assessment Pathway.

Performance reporting continued across localities, with services and localities providing recovery trajectories, however, there were areas where clinical and non-clinical resources had been redeployed to support Covid-19 activity which might affect performance and the availability of some performance data.

There were still uncertainties concerning future demand and capacity. Complexities around reduced accommodation and restrictions on the numbers of people visiting facilities due to Covid-19 safety measures might also affect performance for services which required more face-to-face appointments. Work was underway to update trajectories for 2021/2022, which was challenging due to the ongoing uncertainty around demand for services.

The Board decided: that the report be noted.

[Reference: Minutes of 2 March 2021 (Paragraph 5)]

6 South Lanarkshire Strategic Commissioning Plan 2019 to 2022 – Homelessness Directions

A report dated 20 April 2021 by the Director, Health and Social Care was submitted providing an update on the progress made in implementing the Homelessness Directions which had been added to the strategic intentions of the South Lanarkshire Strategic Commissioning Plan 2019 to 2022.

The South Lanarkshire Strategic Commissioning Plan contained 13 strategic priorities, 2 of which directly related to housing and homelessness, namely:-

- Preventing and Reducing Homelessness
- Suitable and Sustainable Housing

The Strategic Commissioning Plan, Local Housing Strategy 2019 to 2022 and Rapid Rehousing Transition Plan 2019 to 2024 had all been developed and implemented to ensure a clear alignment between priorities and outcome frameworks.

On 16 February 2021, the Homelessness Prevention Review Group had submitted a report to the Scottish Government which contained a number of recommendations, including the implementation of a prevention duty on wider public bodies such as Health and Social Care Partnerships to identify the housing circumstances of patients and, where necessary, work with partners to ensure patients were assisted into suitable housing to help prevent the risk of homelessness. This proposal had been accepted and was now enshrined in the Scottish Government's revised Ending Homelessness Together Action Plan. The well-established links between the strategic planning frameworks for Health and Social Care and Homelessness in South Lanarkshire would provide a solid basis to deliver current and future national and local priorities in relation to the prevention of homelessness.

Information was provided on the progress of the Directions relating to homelessness and the proposals for the implementation of Directions during 2021/2022.

The Board decided:

(1) that the progress of the Directions relating to Homelessness be noted; and

(2) that the proposals relating to the further development of the Directions during 2021/2022 be approved.

7 Publication Scheme

A report dated 22 April 2021 by the Director, Health and Social Care was submitted providing an update on the refreshed South Lanarkshire Integration Joint Board Publication Scheme 2021.

The Freedom of Information (Scotland) Act 2002 required Scottish public authorities to produce and maintain a Publication Scheme which outlined classes of information they routinely made available and advised the public on how to access. The refreshed South Lanarkshire Integration Board Publication Scheme 2021, which was monitored regularly, was attached as an appendix to the report.

The Board decided: that the South Lanarkshire Integration Joint Board Publication Scheme 2021 be approved.

8 Integration Joint Board – Reappointment of Voting Members and Substitute Members

A report dated 27 April 2021 by the Director, Health and Social Care was submitted on the reappointment to the South Lanarkshire Integration Joint Board (IJB) of 2 of the voting members and 1 substitute voting member from South Lanarkshire Council.

The approved Standing Orders for the IJB allowed for the appointment of voting members for a period of 3 years. The appointment of Councillors John Bradley and Richard Lockhart, South Lanarkshire Council and Councillor Richard Nelson, also South Lanarkshire Council, as voting members and a substitute voting member, respectively, on the IJB had been due to expire. South Lanarkshire Council had confirmed the reappointment of Councillors Bradley and Lockhart as voting members and Councillor Nelson as a substitute voting member on the IJB for a period of 3 years, or until the next Local Government elections, with effect from 2 March 2021.

The Board decided:

(1) that confirmation of the reappointment of Councillors John Bradley and Richard Lockhart by South Lanarkshire Council as 2 of its voting members on the IJB be noted;

(2) that confirmation of the reappointment of Councillor Richard Nelson by South Lanarkshire Council as a substitute voting member on the IJB be noted; and

(3) that it be noted that the reappointments were for a period of 3 years or until the next Local Government elections, with effect from 2 March 2021.

9 Summary of Updates

A report dated 29 April 2021 by the Director, Health and Social Care was submitted on a number of recent national and local updates.

Summary of updates were provided on:-

- NHS in Scotland 2020 – Audit Scotland Report
- Citizens' Panel Mobilisation Recovery Report
- Chief Medical Officer Annual Report
- Near Me Evaluation
- Participation and Engagement Guidance
- Scottish Parliament Health and Sport Committee Legacy Report

The Board decided: that the report be noted.

10 Development of Strategic Commissioning Plan 2022 to 2025

A report dated 23 April 2021 by the Director, Health and Social Care was submitted providing an update on the development of the Strategic Commissioning Plan (SCP) 2022 to 2025.

The Public Bodies (Joint Working) (Scotland) Act 2014 placed a duty on Health and Social Care Partnerships to develop and have in place an approved 3-year SCP detailing the strategic objectives of the Partnership.

In preparing and publishing the SCP, full engagement of stakeholders was required and new guidance entitled 'Planning with People' had been issued by the Scottish Government and COSLA setting out how members of the public could expect to be engaged by NHS Boards, IJBs and local authorities.

Information was provided on the work that the Strategic Commissioning Group would lead and oversee in developing the draft SCP, which would be presented to the IJB for approval in March 2022.

Following concerns raised by a member in relation to the engagement process, officers provided further information on the challenges and future work to be undertaken.

The Board decided: that the communication and engagement approach, project plan and timeline of activities to support the development of the Strategic Commissioning Plan 2022 to 2025 be noted.

[Reference: Minutes of 25 March 2019 (Paragraph 2)]

11 Transformation and Service Improvement Programme

A report dated 22 April 2021 by the Director, Health and Social Care was submitted providing an update on the Transformation and Service Improvement Programme and the impact of Covid-19 in relation to the following services:-

- Care and Support Service Re-design
- South Lanarkshire's Care Facilities Modernisation Programme
- Mental Health Strategy
- Care at Home Service Improvement Programme
- Adult and Older People Day Services Review
- Equipment and Adaptations
- SWiSplus Replacement

The work supported the delivery of the Integration Joint Board's Strategic Commissioning Plan and continued to strengthen community-based supports.

The Programme endeavoured to put the people who used social care supports, their families and carers, and the people who worked in social care services at the centre of care. The recently published Independent Review of Adult Social Care was likely to influence the future work of this Programme.

Officers responded to a member's questions in relation to technology enabled homes and the Care at Home Service electronic scheduling system.

The Board decided: that the content of the report be noted.

12 Care and Support Service Review and Re-design

A report dated 23 April 2021 by the Director, Health and Social Care was submitted advising of the progress of the Care and Support Service Review and Re-design. The Service Manager, Transitions also gave a presentation on the Review.

South Lanarkshire Health and Social Care Partnership provided a Care and Support Service to adults with a learning disability to enable them to live safely in their own homes in the community. The 'Same as You' national learning disability strategy was implemented during the period 2000 to 2012. The Care and Support Service arrangements had changed little since its inception in 2004.

The Review commenced in 2019 and, as part of good governance and transparency, a Review Group was established. The Group was led by the Head of Health and Social Care and included multi-disciplinary professional stakeholders, both internal and external.

All areas of the Service were within the scope of the Review, including but not limited to:-

- service user profiling including robust review and re-assessment of complexity of care needs, dependency levels, choices, preferences and natural relationships
- current and future requirements of the Service, business continuity and workforce planning, including staffing structure and Working Time Directive
- legal powers (Guardianship)
- mapping the housing support model in tandem with service users' care and support needs and costs
- the costs of the Service and an opportunity to release financial efficiencies

Information was provided on the challenges facing the Service around changing demographics and service user profiles, together with opportunities to enhance and make the Service safe, effective and person centred.

It was proposed that the next stage of the re-design process would be based around the following recommendations:-

- care planning required to be led by Self-Directed Support (SDS) principles
- support plans should be configured within the person's SDS budget to meet outcomes and not be service led
- the Service Specification should be updated
- further review was required of existing physical assets to potentially maximise and use void tenancies which could offer individuals the opportunity to live with peer groups and friends whilst maximising their independence
- work with Housing colleagues to work towards a Core and Cluster housing model
- complete reviews of those service users with specialist and/or complex care needs to support informed choices about how to best deliver their care requirements
- conclude Adults with Incapacity processes for relevant service users
- consult on a review of shift patterns
- introduce assisted technology proportionately to support care requirements

It was anticipated that it would take 3 years to fully implement the recommendations and this would be completed in 2 phases. Further consultation and engagement with service users and stakeholders would be undertaken in relation to the recommendations.

Officers responded to members' questions.

The Board decided:

(1) that the findings of the Care and Support Service Review and Re-design be noted; and

(2) that the next phase of the development of the Care and Support Service Review and Re-design process be approved.

S Sweeney left the meeting following consideration of this item of business

13 Care Facilities

The Service Manager, Transitions gave a presentation on 'Investing to Modernise Care Facilities', providing information on the work that had been undertaken to develop the new state of the art Health and Social Care Hub in Blantyre. The Hub would have 20 transitional beds for adults and older people, a centre of excellence, a community-facing hub featuring a café and demonstration site and 20 technology enabled homes for adults and older people.

More detailed information was provided on:-

- the consultation, engagement and approval process
- the impact of the Covid-19 pandemic on the development
- the services that would be available in the technology enabled homes within the Hub
- specific areas of the care facility, including a rehab gym, café, student accommodation, lecture theatre and meeting rooms and visiting services and interview rooms
- anticipated dates for completion of the development
- the number of people supported since April 2020 through the intermediate care model within McWhirter House
- work that had been undertaken with carers and the third sector
- social prescribing activity
- work undertaken with the Science Centre in relation to the design of the Technology Zone
- community regeneration work

The Board decided: that the presentation be noted.

14 Carer's Fund – Increase to Establishment

A report dated 27 April 2021 by the Director, Health and Social Care was submitted on a proposal to increase assessment and care management capacity using Carer's Fund monies and thereby supporting the implementation of the Carers (Scotland) Act 2016.

The Health and Social Care Partnership's transformation workstreams had identified the need to focus and develop the assessment and care management capacity to ensure that statutory and regulatory duties were being met and that effective and personalised models of care were in place. These transformation workstreams such as Day Care and Care at Home provided interventions that supported carers as well as the supported person.

The Assessment and Care Management teams required an appropriate skill mix to meet those statutory responsibilities and deal with the volume of activity. From engagement with carers, it was evident that significant frustration related to timescales for accessing supports and the systems supporting this. Therefore, additional capacity was proposed to address this issue. It

was proposed that 16 full-time equivalent posts of Social Work Assistant (Assessment and Review) on Grade 2, Level 4, SCP 55-57 (£29,253 to £30,147) be added to the establishment.

The costs of the proposals would be met from 2021/2022 funding, totalling £1.595 million, from the Scottish Government to support the implementation of the Carers (Scotland) Act 2016.

The Board decided: that the changes to the establishment, as detailed in Section 4 of the report, be approved.

T Wilson left the meeting during consideration of this item of business
Councillor McGuigan left the meeting following consideration of this item of business

15 Update on a Range of Early Intervention and Prevention Physical Activity Programmes Delivered in Partnership with South Lanarkshire Leisure and Culture

A report dated 22 April 2021 by the Health Improvement Lead, South Lanarkshire Health and Social Care Partnership and Development Services Manager, South Lanarkshire Leisure and Culture was submitted on the current programmes that supported health and wellbeing, delivered in partnership with South Lanarkshire Leisure and Culture (SLLC).

The Health and Social Care Partnership (HSCP) had worked in partnership with SLLC over many years to develop, deliver and evaluate health improvement and physical activity interventions across the whole lifespan for people in our communities. Those programmes had been held in high regard nationally and had helped to inform the development of draft Physical Activity Referral Standards this year as a guide for those involved in physical activity referral.

The HSCP had continued to demonstrate the impact of those programmes and worked with others to expand and add value by responding to locally identified need or local priorities.

Information was provided on:-

- the programmes and their uptake
- the funding required to sustain future delivery and the shortfall in funding

Although it was recognised that a request for recurring funding could not be made to the Integration Joint Board (IJB) at this time, the Board was requested to note the following:-

- the IJB Medium to Long-term Financial Plan was being updated in consultation with the HSCP Senior Management Team and would be reported to a future meeting of the IJB (Performance and Audit) Sub-Committee
- the Scottish Government financial settlement for 2022/2023 was not likely to be announced until the end of January 2022
- this request was being considered alongside other requests and Strategic Commissioning Plan priorities to inform the proposed IJB Financial Plan 2022/2023, pending confirmation of the total financial envelope available, both recurring and non-recurring

The Board decided:

(1) that the existing range of evaluated programmes and their contribution to the health and wellbeing of the South Lanarkshire populated be noted; and

(2) that the budget outlined to ensure sustainability of the existing programmes and the developments planned to meet an increasing need following the Covid-19 pandemic be noted.

P McCrossan and L Findlay left the meeting during consideration of this item of business
G Lindsay and P Murphy left the meeting following consideration of this item of business

16 Staff Wellbeing

A report dated 27 April 2021 by the Director, Health and Social Care was submitted providing an update on developments to support staff wellbeing.

The impetus to support and care for staff wellbeing had been triggered by the Covid-19 pandemic, with national networks established to support the wellbeing agenda. The National Workforce Wellbeing Champions Network was established in 2020 with a representative Champion from South Lanarkshire Health and Social Care Partnership. The focus of the Network was to:-

- support and focus on connectivity across the full Health and Social Care workforce, including private and third sector workers
- share intelligence, experience of staff, activity and measurement, and lessons learned
- afford the opportunity to inform and influence national policy in this area

Information was provided on the progress of work undertaken to date and examples of wellbeing in action.

The Board decided: that the content of the report be noted.

17 Whistleblowing Standards Update

Lesley McDonald, Non Executive Director, NHS Lanarkshire Board and Whistleblowing Champion provided a verbal update to the Board on Whistleblowing Standards within NHS Lanarkshire.

This was about providing a route where employees felt safe about speaking up about an act or omission which could cause harm, with the focus on delivering a safe and effective NHS Service. The importance of the Health and Social Care Partnership and the Integration Joint Board promoting a culture where employees felt comfortable raising concerns about NHS Services was highlighted. It was further highlighted that this included South Lanarkshire Council employees who were part of the Health and Social Care Partnership.

The Board decided: to note the update.

18 Any Other Competent Business

Councillor Falconer proposed that meetings of the South Lanarkshire Integration Joint Board be recorded, similar to South Lanarkshire Council meetings in the spirit of openness and transparency.

The Director, Health and Social Care advised that a report would be submitted to a future meeting of the Integration Joint Board to consider this.

Closing Remarks

The Chair and members of the Board wished Val de Souza, Director, Health and Social Care well in her retirement and thanked her for her services to the South Lanarkshire Integration Joint Board.

Ms de Souza responded in suitable terms.

3

SOUTH LANARKSHIRE INTEGRATION JOINT BOARD (PERFORMANCE AND AUDIT) SUB-COMMITTEE

Minutes of the meeting held by Microsoft Teams on 16 March 2021

Chair:
Philip Campbell, Non Executive Director, NHS Lanarkshire Board

Present:
South Lanarkshire Council
Councillors John Bradley and Jim McGuigan
NHS Lanarkshire Board
Lesley Thomson, Non Executive Director

Attending:
Health and Social Care Partnership
V de Souza, Director, Health and Social Care and Chief Officer; M Moy, Chief Financial Officer

NHS Lanarkshire
C Cunningham, Head of Commissioning and Performance; T Gaskin, Chief Internal Auditor; C McGhee, Corporate Risk Manager

South Lanarkshire Council
I Beattie, Head of Health and Social Care (Hamilton and Clydesdale); C Brown, Planning and Performance Manager; Y Douglas, Audit and Compliance Manager; M Kane, Service Development Manager; L Purdie, Chief Social Work Officer; T Slater, Administration Adviser

Also Attending:
Audit Scotland
S Lawton, Senior Auditor; P Lindsay, Senior Audit Manager; D Richardson, Senior Audit Manager

Apologies:
NHS Lanarkshire
L Findlay, Medical Director; L Thomson, Nurse Director

Chair's Opening Remarks

The Chair advised the Sub-Committee that Dave Richardson, Senior Audit Manager, Audit Scotland was retiring and that this would be his last meeting of the South Lanarkshire Integration Joint Board (Performance and Audit) Sub-Committee.

The Chair, on behalf of the Sub-Committee, thanked Mr Richardson for the significant contribution he had made to establishing an effective governance framework for the South Lanarkshire Integration Joint Board and wished him a long and happy retirement.

1 Declaration of Interests

No interests were declared.

2 Minutes of Previous Meeting

The minutes of the meeting of the South Lanarkshire Integration Joint Board (Performance and Audit) Sub-Committee held on 15 December 2021 were submitted for approval as a correct record.

The Sub-Committee decided: that the minutes be approved as a correct record.

3 Financial Monitoring Report 2020/2021

A report dated 7 March 2021 by the Director, Health and Social Care was submitted providing a summary of the financial position of the Health and Social Care Partnership (HSCP) for the period 1 April 2020 to 31 January 2021 in relation to Health Care Services and for the period 1 April 2020 to 29 January 2021 in relation to Social Work and Housing Services.

A summary of the financial position as at January 2021 was as follows:-

- an underspend of £1.484 million on core budgets within Health Care Services
- a funding allocation of £13.710 million was currently being aligned to planned cost commitments in 2020/2021 and 2021/2022 in respect of the Covid-19 pandemic, Primary Care Improvement Plan and the Alcohol and Drug Partnership (ADP) programme in consultation with both partners
- an overspend of £0.039 million on Social Care and Housing Services
- an underspend of £0.009 million on the Housing Revenue Account (HRA)

The reasons for major budget variances across the Health and Social Care Services' budget, together with supporting information, was provided in Appendices 1 to 5 to the report.

A summary of the budget adjustments for the period 1 April 2020 to 31 January 2021 in relation to Health Care Services and for the period 1 April 2020 to 29 January 2021 in relation to Social Work and Housing Services was provided in Appendix 6 to the report.

With effect from 30 March 2020, authority had been delegated by the Integration Joint Board (IJB) to the Chief Officer, in consultation with the IJB Chair, IJB Depute Chair, or their nominated deputes as necessary, NHS Lanarkshire Chief Accountable Officer and Director of Finance and the South Lanarkshire Council Chief Executive and Executive Director (Finance and Corporate Resources), to allow timely decisions to be taken to maintain service continuity as far as practicable during this critical period, subject to all decisions taken being reported to the next meeting of the IJB for homologation. The continuation of the delegated authority was to be subject to further review at future meetings of the IJB. At its meeting on 2 March 2021, the South Lanarkshire Integration Joint Board (IJB) had approved that authority be delegated to the Chief Officer, in consultation with both Partners, to agree the expenditure plans in respect of the additional funding confirmed by the Scottish Government. Those plans would be included in future reports to the IJB and this Sub-Committee. The funding received from the Scottish Government would also be aligned to those expenditure plans between the financial years 2020/2021 and 2021/2022, as appropriate, and following consultation with both partners.

Specific additional funding had now been made available by the Scottish Government to meet the costs of the original planned efficiency savings for 2020/2021 which could not be implemented due to the pandemic. However, this funding was non-recurring. Confirmation has been received by each partner that, although there was an underachievement of the planned 2020/2021 savings, those savings would be achieved in full in 2021/2022.

Additional Scottish Government Funding had also been received to address the projected overspend on prescribing in 2020/2021 as a result of the price increase in 2 drugs and a breakeven position was now reported. This funding was non-recurring, however, and prescribing cost volatility continued to represent the most significant risk within the NHS element of the Partnership's budget. The re-establishment of the prescribing reserve was, therefore, being considered as part of the IJB Financial Plan 2021/2022.

The indicative funding allocation for 2021/2022 had been announced by the Scottish Government on 28 January 2021. Work was ongoing to establish the anticipated increase in costs in 2021/2022 for both partners, including the ongoing impact of the Covid-19 pandemic. The Lanarkshire Remobilisation Plan 2021/2022 had also been prepared and submitted to the Scottish Government on 26 February 2021.

In 2021/2022, financial pressures would include demographic growth, the withdrawal from the European Union, the Covid-19 pandemic and inflationary cost pressures. A funding gap was expected for both partners, which would need to be met by efficiency savings. The budgets released as a result of savings implemented would be retained by the IJB and redistributed to meet the inflationary cost increases and demand pressures. The IJB was required to approve its Financial Plan 2021/2022 before 31 March 2021. Efficiency savings options were, therefore, currently being developed and both partners would be kept fully informed of the progress and options.

The Sub-Committee decided:

(1) that the current financial position for the South Lanarkshire HSCP be noted;

(2) that the Scottish Government's confirmation of additional funding to meet the costs of the Covid-19 pandemic be noted;

(3) that the further work to reconcile the additional Scottish Government funding received in respect of Covid-19 costs, including the harmonisation of the financial planning assumptions between the partners, be noted;

(4) that the authority delegated to the Chief Officer, in consultation with both partners, to agree the expenditure plans in respect of the additional funding confirmed by the Scottish Government be noted;

(5) that the break-even position projected in respect of prescribing as a result of indicative non-recurring additional Scottish Government funding be noted;

(6) that the commitment to re-establish the prescribing reserve as part of the IJB Financial Plan 2021/2022 be noted;

(7) that the guidance from Audit Scotland in respect of the classification of the additional funding, as highlighted in Appendix 1, be noted;

(8) that the reserves position as at 31 January 2021 be noted; and

(9) that the additional partner contribution in 2020/2021 from NHS Lanarkshire totalling £2.764 million to contribute to the joint strategic commissioning priorities be noted; and

(10) that the work, which was progressing to develop the IJB Financial Plan for 2021/2022 and the requirement to identify efficiency savings, as highlighted at Section 5 of the report, be noted.

[Reference: Minutes of the Integration Joint Board of 2 March 2021 (Paragraph 4)]

4 Performance Monitoring Report

A report dated 23 February 2021 by the Director, Health and Social Care was submitted:-

- providing a summary of performance against the key performance measures assigned to the integration of Health and Social Care in South Lanarkshire
- outlining future performance reporting opportunities
- highlighting the challenges faced by the Health and Social Care Partnership in the context of Covid-19 safety restrictions and the resources which had been prioritised to address those challenges

An update against each of the 6 Ministerial Steering Group indicators was detailed in Appendix 1 to the report.

The data provided was for the period to November 2020, with 99% confidence in data completeness to September 2020, however, there was a lag period associated with 2 indicators, unscheduled care admissions and unscheduled care bed days and, therefore, admissions and beds days would increase.

Performance reporting continued across localities, with services and localities providing recovery trajectories, however, there were areas where clinical and non-clinical resources had been redeployed to support Covid activity which might affect performance and the availability of some performance data.

There were still uncertainties concerning future demand and capacity. Complexities around reduced accommodation and restrictions on the numbers of people visiting facilities due to Covid safety measures might also affect performance for services which required more face-to-face appointments. Trajectories might need to be revised as demand and service activity changed and the full impact of delays associated with Covid were understood.

In response to members' questions, officers agreed to look into the concerns raised in relation to the Care and Repair Service and it was a proposed that an update report be provided to the next meeting of the Sub-Committee.

The Sub-Committee decided:

(1) that the report be noted;

(2) that the proposed development work regarding performance management arrangements be noted; and

(3) that an update report on the Care and Repair Service be provided to the next meeting of the Sub-Committee.

[Reference: Minutes of the Integration Joint Board of 2 March 2021 (Paragraph 5)]

V de Souza and M Kane joined the meeting during this item of business

5 Annual External Audit Plan and Audit Fee 2020/2021

A report dated 28 February 2021 by the Director, Health and Social Care was submitted providing details of the External Auditor's Annual Audit Plan for 2020/2021, and to advise of the External Audit Fee for the South Lanarkshire Integration Joint Board (IJB).

The Public Bodies (Joint Working) (Scotland) Act 2014 placed a duty on IJBs to prepare annual accounts and for those accounts to be audited in accordance with Part VII of the Local Government (Scotland) Act 1973.

Audit Scotland had been appointed by the Accounts Commission and the Auditor General for Scotland as the external auditors of the South Lanarkshire IJB for the period 2016/2017 to 2020/2021. This term of appointment had been extended for a further year to include 2021/2022.

Details of the External Auditor's planned scope and timing of audit work was provided in the appendix to the report.

Based on an assessment of the following local circumstances, the 2020/2021 audit fee had been set at Audit Scotland's Audit Services Group standard fee applicable to IJBs of £27,330:-

- local risk areas for the IJB
- governance and accountability arrangements, control environment and risk assessment and management procedures
- an initial review of internal audit and the reliance that could be placed on its work
- review of the outcomes from previous audits
- systems and procedures in place for the production of timeous IJB financial statements
- progress with the implementation of the integration scheme and strategic plan
- any issues that might impact on the audit opinion

The Sub-Committee decided:

(1) that the content of the report be noted; and

(2) that the proposed fee of £27,330 be noted.

6 External Audit Review of Internal Audit

A report dated 28 February 2021 by the Director, Health and Social Care was submitted on the outcome of Audit Scotland's review of internal audit.

Audit Scotland's Code of Audit Practice required external auditors to undertake an annual assessment of the internal audit function to establish the effectiveness of internal audit arrangements.

The outcome from Audit Scotland's assessment of the South Lanarkshire Integration Joint Board's (IJB) internal audit service for 2020/2021 had concluded that the service operated in accordance with the Public Sector Internal Audit Standards. A letter of confirmation was attached as an appendix to the report.

As detailed in the letter of confirmation, the 2019/2020 Annual Audit Report highlighted the following 2 matters to be brought to the IJB's attention:-

- the requirement to approve the Internal Audit Plan earlier in the financial year
- the arrangements that were in place in respect of the provision of the Internal Audit Opinion for 2020/2021

The Internal Audit Plan had, therefore, been submitted to the March 2021 meeting of the Sub-Committee when previously it had been submitted to the September meeting.

The arrangements in place in respect of the provision of the Internal Audit Opinion for 2020/2021 had been reviewed and it was recommended that the joint Internal Audit approach, as detailed in the report, for 2020/2021 to 2022/2023 be endorsed.

The Sub-Committee decided:

(1) that the content of the report be noted; and

(2) that the joint Internal Audit approach for 2020/2021 to 2022/2023 be endorsed.

7 Progress Report on Agreed Actions

A report dated 28 February 2021 by the Director, Health and Social Care was submitted providing a summary of performance against the agreed actions to further develop the South Lanarkshire Integration Joint Board's (IJB) governance framework.

The External Auditor and Internal Auditors had made recommendations to further strengthen the IJB's governance framework. As a result, an action plan had been developed to monitor progress against those areas identified for improvement and details of the progress made were provided in the appendices to the report.

New actions recorded in the External Audit Annual Report 2019/2020, including revised deadlines for ongoing actions, were previously included in Appendix 1 to the report and reported to the IJB at its meeting on 29 September 2020.

The Sub-Committee decided: that the content of the report and progress to date be noted.

[Reference: South Lanarkshire Integration Joint Board of 29 September 2020 (Paragraph 9)]

8 Internal Audit Plan 2020/2021 Progress Report

A report dated 28 February 2021 by the Director, Health and Social Care was submitted providing an update on progress of the Internal Audit Plan 2020/2021.

Integration Joint Boards (IJBs) were required to establish an adequate and proportionate internal audit of the arrangements for risk management, governance and control of delegated resources. Internal Audit arrangements for the South Lanarkshire IJB were provided jointly by NHS Lanarkshire and South Lanarkshire Council.

The Internal Audit Plan 2020/2021 had been approved by the IJB at its meeting on 29 September 2020 and a summary of progress of audit activity was provided in the appendix to the report.

As reported previously to the Sub-Committee, at its meeting on 8 December 2020, the IJB approved an extension of the Terms of Reference of this Sub-Committee and, therefore, the 2020/2021 Unaudited IJB Annual Accounts would be presented to the Sub-Committee at its meeting on 15 June 2021.

The Sub-Committee decided: that the report be noted.

[Reference: Minutes of the meeting of 15 December 2020 (Paragraph 7)]

9 Integration Joint Board Medium to Long Term Financial Plan

A report dated 28 February 2021 by the Director, Health and Social Care was submitted on the preparation of the South Lanarkshire Integration Joint Board (IJB) Financial Plan 2021/2022.

The development of the IJB Financial Plan 2021/2022 would allow the IJB to take informed decisions about the priorities to be set out in the Strategic Commissioning Plan and the directions to each partner while ensuring financial sustainability across the partnership. The development of a 3 to 10-year Financial Plan was also recognised as good practice.

Information was provided on:-

- additional Scottish Government funding for 2020/2021 and 2021/2022 to address key strategic priorities, allocated through the Lanarkshire Mobilisation Plan and a range of specific policy initiatives
- financial planning assumptions for the year 2021/2022
- the progress of the development of the IJB Financial Plan 2021/2022, which would continue to be developed in consultation with both partners and taking into account the impact of the Covid-19 pandemic

The Sub-Committee decided:

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

(2) that the update in respect of the additional Scottish Government funding for 2020/2021 be noted;

(3) that the progress being made in respect of the development of the IJB Financial Plan 2021/2022, in consultation with both South Lanarkshire Council and NHS Lanarkshire, be noted; and

(4) that the requirement to include the revised financial planning assumptions in the IJB Medium to Long Term Financial Plan be noted.

10 Integration Joint Board Governance Update

A report dated 28 February 2021 by the Director, Health and Social Care was submitted providing an overview of the ongoing governance issues being addressed by the South Lanarkshire Integration Joint Board (IJB) and both partners, South Lanarkshire Council and NSH Lanarkshire.

Information was provided:-

- highlighting the unprecedented challenges faced this year due to the Covid-19 pandemic and the emergency response adopted by both partners and the IJB
- giving an update in respect of the principles for sustainability payments to social care providers during the Covid-19 pandemic
- giving an update on the additional funding received from the Scottish Government in respect of the Covid-19 pandemic
- highlighting the next steps in relation to the mobilisation and remobilisation plan for 2021/2022
- giving an update on the disaggregation of the mental health and learning disability services' budget and the progress made to date
- outlining the investment opportunity being discussed with Macmillan Cancer Support to develop services to improve the cancer journey and support individuals with long-term conditions
- giving an overview of the progress made in the preparation of the IJB Financial Plan 2021/2022 which was being developed in consultation with both partners

The Sub-Committee decided:

(1) that the unprecedented challenges as a result of the ongoing Covid-19 pandemic be noted;

(2) that, on the understanding that the Scottish Government would meet all reasonable additional provider costs in line with the agreed Mobilisation Plan, the ongoing compliance with the principles for sustainability payments to social care providers during the Covid-19 pandemic be noted;

(3) that the projected additional Covid-19 costs in 2020/2021 and the additional Scottish Government funding to support the emergency response to the Covid-19 pandemic, as highlighted at section 6 of the report, be noted;

(4) that the preparation of the Lanarkshire Remobilisation Plan for the IJB and both partners be noted;

(5) that the progress to date in respect of the disaggregation of the mental health and learning disability services budget be noted;

(6) that the investment opportunity in respect of the non-recurring Macmillan funding and the associated financial risks be noted;

(7) that the priority to further progress the development of the IJB Financial Plan 2021/2022 be endorsed; and

(8) that the authority previously delegated to the Chief Officer, in consultation with both partners, to agree the expenditure plans in respect of the additional funding confirmed by the Scottish Government be noted.

11 Internal Audit Plan 2021/2022

A report dated 28 February 2021 by the Director, Health and Social Care was submitted on the Internal Audit Plan 2021/2022.

The Public Bodies (Joint Working) (Scotland) Act 2014, required the South Lanarkshire Integration Joint Board (IJB) to comply with the accounts and audit regulations and legislation under section 106 of the Local Government (Scotland) Act 1973. A professional and objective Internal Audit Service arrangement had been established in accordance with recognised Internal Audit standards and practices as laid out in the Public Sector Internal Audit Standards, in order to comply with article 7 of the Local Authority Accounts (Scotland) Regulations 2014.

The proposed Internal Audit Plan for 2021/2022, attached as an appendix to the report, had been designed to target priority issues. All sources of assurance across the Health and Social Care Partnership's activities were mapped to assess the content and coverage of the Plan. The Plan, therefore, reflected the outcome of this review, together with the assessment of the IJB's top risks undertaken by the Council's Audit and Compliance Manager and NHS Lanarkshire's Chief Internal Auditor.

It might be necessary to adjust the Plan depending on the ongoing response to the Covid-19 pandemic and it was, therefore, proposed that the Chief Financial Officer be authorised to finalise the Internal Audit Plan for 2020/2021, including the agreement of the detailed scope of each audit assignment, the allocation of responsibilities for the completion of the assignments and the allocation of internal audit days for each assignment.

The Sub-Committee decided:

(1) that the Internal Audit Plan 2021/2022, attached as an appendix to the report, be endorsed and referred to the South Lanarkshire Integration Joint Board for approval; and

(2) that the Chief Financial Officer be authorised to discuss further with the Audit and Compliance Manager, South Lanarkshire Council and the Chief Internal Auditor, NHS Lanarkshire, the final Internal Audit Plan for 2021/20221, including the allocation of responsibilities for completion of assignments and the allocation of internal audit days for each assignment.

12 Risk Management Update

A report dated 24 February 2021 by the Director, Health and Social Care was submitted on the current risk management arrangements and the updated Risk Register for the South Lanarkshire Integration Joint Board (IJB) which had been developed in light of the Covid-19 pandemic.

In terms of governance and oversight, quarterly updates were taken on the Risk Register to reflect a number of areas, including:-

- any new risks which the IJB required to be advised of, together with the risk assessment and mitigating actions
- any risks within South Lanarkshire Council and NHS Lanarkshire risk registers which related to the delegated functions and impinged on the ability of the IJB to deliver its Strategic Commissioning Plan (SCP) where the risk had changed in status

The IJB currently had 14 identified risks, as detailed in Appendix 1 to the report. All of those risks were strategic in nature to reflect the role of the IJB as the body that commissioned services in line with the SCP.

From a Council and NHS Lanarkshire perspective, there were a number of operational risks as outlined in the report. The main change to those risks was the additional risk included to take account of the impact of Covid-19. A separate Risk Register, attached as Appendix 2 to the report, had been established to consider any potential risks related to Covid-19.

A workshop for members to review the risk strategy and the Risk Register would be held following this meeting.

The Sub-Committee decided:

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

(2) that the specific and detailed Risk Register in relation to the Covid-19 pandemic be noted; and

(3) that the outcome of the Risk Management Strategy workshop be reported to a future meeting of the Sub-Committee.

[Reference: Minutes of 15 December 2020 (Paragraph 8)]

13 Any Other Competent Business

There were no other items of competent business.

Closing Remarks

D Richardson thank the Chair for his earlier comments and intimated that it had been a pleasure to work with so many committed officers and members within an effective and challenging audit committee.

Agenda Item

4

Report

Report to:	**South Lanarkshire Integration Joint Board**
Date of Meeting:	**17 August 2021**
Report by:	**Interim Chief Officer, Health and Social Care Partnership**

Subject:	**Financial Monitoring 2021 - 2022**

1. Purpose of Report

1.1. The purpose of the report is to:-

- advise the Integration Joint Board of the financial position of the South Lanarkshire Health and Social Care Partnership (HSCP) for the period from 1 April to 30 June 2021 (Health Care Services) and 1 April to 18 June 2021 (Social Work and Housing Services)

2. Recommendation(s)

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that the contents of the report be noted;
(2) that the operational decision by the SLC partner to respond to the pressures across the whole system by recruiting additional Care at Home staff be noted;
(3) that the financial planning assumptions to address in-year costs through IJB ring-fenced reserves and anticipated additional non-recurring funding from the Scottish Government be noted;
(4) that the consultation with both partners on the partner contributions for 2022/2023 and beyond be progressed including dialogue with the Scottish Government to secure recurring additional funding for health and social care costs pressures; and
(5) that the continuance of the current hosted services principle in respect of the management of overspends and the retention of underspends by the lead partner for the financial year 2021/2022 is approved.

3. Background

3.1. This report is based on the financial monitoring reports received from the Director of Finance of NHS Lanarkshire (NHSL) and the Executive Director of Finance and Corporate Resources of South Lanarkshire Council (SLC).

3.2. The position detailed in these reports is therefore based on the information contained in each partner's respective financial systems and includes accruals and adjustments in-line with their financial policies.

3.3. This is the first financial monitoring report presented for the financial year 2021/2022.

4. Summary of Financial Position

4.1. The financial position as at June 2021 is summarised as follows:

- there is a net underspend of £0.265m on the core budgets within Health Care Services
- there is a break-even position reported in respect of the Primary Care Improvement Funding
- there is a net overspend of £0.006m on the core budgets within Social Care and Housing Services
- there is a break-even position reported in respect of the Housing Revenue Account (HRA)
- Covid-19 costs totalling £2.752m have been incurred to date and have been met from IJB ring-fenced reserves
- Additional Scottish Government funding is being requested to meet further projected costs in 2021/2022 in response to the Covid-19 pandemic
- The recurring impact for the SLC partner of the operational decision to recruit additional Care at Home staff in response to pressures across the whole system is highlighted at section 7.3
- The development of the IJB Financial Plan 2022/2023 and the agreement of strategic priorities and partner funding contributions is being progressed with support from both partners as highlighted at section 7.3
- The Scottish Government will continue to be alerted to the requirement for additional recurring funding for health and social care services from April 2022 onwards.

4.2. The reasons for major budget variances across Health and Social Care Services are outlined in Appendix 1, with further supporting information outlined at Appendices 2 to 6.

5. Covid-19 Pandemic Funding

5.1. Additional costs continue to be incurred across health and social care services in response to the Covid-19 pandemic as follows:

- Supporting hospital discharge and creating capacity in hospitals.
- The provision of Personal Protection Equipment.
- The establishment of the Community Assessment Centre.
- Additional payments to Primary Care Contractors.
- Additional psychological, physiotherapy and occupational therapy support.
- Mental Health Assessment Centres to divert mental health attendances from A&E.
- Staff absence rates as a result of the requirement to shield or self-isolate.
- Sustainability payments are also being made to external social care providers. The total value of these payments in 2021/2022 is not yet known.
- Providing additional support to Carers during the pandemic including support from Voluntary Action South Lanarkshire.

5.2. The additional health and social care costs which have been incurred in response to the Covid-19 pandemic will be reported to the Scottish Government through the Lanarkshire Remobilisation Plan for 2021/2022 on 30 July 2021 in order to secure additional funding for both partners to continue to respond to the Covid-19 pandemic.

5.3. The IJB ring-fenced reserves are to be drawn down in the first instance before any further funding will be allocated by the Scottish Government. The funding made available to date however is non-recurring. The cost of responding to the Covid-19 pandemic across health and social care services in 2021/2022 and beyond continues to be uncertain.

5.4. The financial planning assumption for 2021/2022 is that the Scottish Government will make additional funding available to offset the balance of the Covid-19 costs incurred including the underachievement of the 2021/2022 savings. Pending confirmation from the Scottish Government about further additional funding being made available in 2021/2022, this financial planning assumption is assessed as a high risk, particularly in relation to the receipt of additional funding to offset the underachievement of the 2021/2022 savings.

6. Employee Implications

6.1. The employee implications associated with the report are detailed in Appendix 1. These include vacancies and recruitment challenges.

7. Financial Implications

7.1. The financial implications are outlined in Appendices 1 to 6.

7.2. The IJB Reserves Strategy for 2021/2022 was agreed with the Director of Finance of NHSL and the Executive Director of Finance and Corporate Resources of SLC. This strategy was endorsed by the IJB (Performance and Audit) Sub-Committee on 15 June 2021.

7.3 Further information is provided at section 4.3 of appendix 1 in respect of the significant increase in the demand for Care at Home Services in July 2021 due to significant pressures across the whole system and the prompt action by the SLC partner to respond to the needs of the service.

7.3.1 As detailed at paragraph 4.3.1, the SLC partner is progressing the recruitment of additional Care at Home staff on a permanent basis to meet the increasing demand. The part-year cost of the additional recruitment in 2021/2022, if successful, will be approximately £1.9m for the period from now until March 2022. The financial planning assumption is that the cost of £1.9m in 2021/2022 will be offset by non-recurring Covid-19 funding in 2021/2022.

7.3.2 As detailed at paragraph 4.3.2, if the target increase of an additional 4,000 hours per week was achieved and maintained, the full year recurring cost of this recruitment from April 2022 would be approximately £3.8m. The impact of normal turnover and existing vacancies requires to be confirmed to establish how much of the increase in cost would be absorbed within the already agreed core budget and how much would be an additional cost pressure for which a funding solution would need to be identified. The 2022/2023 IJB Financial Plan is being developed in consultation with both partners. This additional cost will be included.

7.3.3 The additional recurring costs across social care services as a result of the Covid-19 pandemic and the demographic growth are being highlighted to the Scottish Government however additional recurring funding has not been confirmed for Local Authorities at this stage.

7.3.4 The IJB Chief Financial Officer will therefore consult with both partners about the options available to contribute to all 2022/2023 cost pressures including the additional recurring Care at Home cost pressure. These options will need to include a review of the partner contributions for 2022/2023 along with options to reduce expenditure across other services. These cost reduction options will be explored however the IJB Chief Financial Officer believes this will not release sufficient recurring funding to meet the total increase in all health and social care cost pressures.

7.4 The discussions with the Scottish Government and both partners are therefore vital if sufficient funding is to be secured to maintain key essential services. The IJB Medium to Long Term Financial Plan is being updated to reflect the operational and financial challenges and will be reported to the IJB when revised.

8. Climate Change, Sustainability and Environmental Implications

8.1. There are no implications for climate change, sustainability or the environment in terms of the information contained in this report.

9. Other Implications

9.1. The main risk associated with the IJB revenue budget is that either or both partners may overspend.

9.2. As highlighted at section 7.2 above and section 4.3 in appendix 1, demand for Care at Home Services continues to represent a significant risk within the Council's element of the partnership's budget.

9.3. The overall funding available for the Primary Care Improvement Plan and prescribing volatility continue to represent the most significant risks within the Health element of the partnership's budget.

9.4. The IJB and both partners require to manage the risks associated with the uncertainty of the withdrawal from the EU.

9.5. These financial risks are managed by the IJB, NHSL and SLC through their detailed budget management and probable outturn arrangements.

9.6. There are no other issues associated with this report.

10. Equality Impact Assessment and Consultation Arrangements

10.1. This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy and therefore no impact assessment is required.

10.2. Consultation was undertaken with both the Director of Finance for NHSL and the Executive Director of Finance and Corporate Resources of SLC in terms of the information contained in this report.

Marianne Hayward
Interim Chief Officer, Health and Social Care Partnership

29 July 2021

Previous References

- IJB (Performance and Audit) Sub-Committee 15 June 2021

List of Background Papers

- None

Contact for Further Information
If you would like to inspect the background papers or want further information, please contact:-
Marie Moy, Chief Financial Officer
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Email: marie.moy@southlanarkshire.gov.uk

Budget Adjustments and Significant Variances **Appendix 1**

1. Budget Adjustments

1.1. The adjustments to the 2020/2021 budget between January 2021 and March 2021 are detailed at Appendix 6. The adjustments to the opening budget and the additional funding received between April 2021 and June 2021 is also detailed at Appendix 6.

2. Health Services Variance Explanations

2.1. Locality and Other Services

2.1.1 There is a net overspend of £0.071m across the localities and other services. Other services include boundary service level agreements, Social Care Funding, management team costs, school nursing and the apprenticeship levy.

2.1.2 The net overspend on employee costs totals £0.115m and is mainly due to additional staff across localities, with the exception of East Kilbride. This is necessary to meet demand and pressures across the whole system as a result of the Covid-19 pandemic. There are incremental pay increases across many services however these cost pressures are being offset in-year by the vacancies.

2.1.3 There is a net underspend of £0.044m on non-pay costs. The main areas contributing to the underspend are the Localities (£0.078m).

2.1.4 There continue to be unidentified savings targets from previous years. Work is ongoing to confirm a recurring funding solution to address unidentified savings.

2.2. Cares Services (Addiction Services) and ADP Funding

2.2.1 There is an underspend of £0.005m.

2.2.2 The planned commitments in respect of ADP in 2021/2022 are currently being finalised.

2.3. Medical and Nursing Directorate

2.3.1 There is an overspend of £0.002m.

2.3.2 There is a net underspend of £0.011m within the medical directorate costs.

2.3.3 There is a net overspend of £0.013m within the nursing directorate costs.

2.4. Prescribing

2.4.1 A break-even position is reported at this stage.

2.4.2 The prescribing budget has also been adjusted for savings and uplifts in-year including Scottish Government changes to tariff prices. The prescribing budget has reduced by £0.798m since 31 March 2021. The majority of the budget reduction relates to the savings target of £0.682m which has been removed from the budget. Prescribing activity figures for April 2021 have been received. At this early stage of the financial year, a breakeven position is reported. Prescribing costs will continue to be closely monitored.

2. Health Services Variance Explanations (Cont.)

2.5. Out of Area Services

2.5.1 There is an overspend of £0.009m. Additional costs continue to be incurred in respect of the cost of services to support individuals with complex care needs.

2.6. Area Wide Services

2.6.1 There is an underspend of £0.001m.

2.7. Hosted Services Led by South Lanarkshire

2.7.1 The Hosted Services which are led by the South Lanarkshire HSCP are outlined at appendix 3.

2.7.2 There is a net underspend of £0.341m as at June 2021. The significant variances are in respect of the following services:

- Out of Hours Services £0.118m under
- Community Dental Services £0.099m under
- Physiotherapy Services £0.079m under

2.7.3 The underspend across Out of Hours Services (£0.118m) is as a result of an underspend across pay costs (£0.101m) and also an underspend across non-pay costs (£0.017m).

2.7.4 The underspend across Community Dental Services (£0.099m) is as a result of an underspend across pay costs due to vacancies (18.70 WTE - £0.077m) and non-pay costs (£0.022m).

2.7.5 The underspend across Physiotherapy Services (£0.079m) is as a result of an underspend across pay costs due to vacancies (6.42 WTE - £0.070m) and non-pay costs (£0.009m).

2.7.6 Primary Care Improvement Funding and Transformation Funding totalling £5.785m has been drawn down from IJB ring-fenced reserves. The IJB is also asked to note that there continues to be a shortfall in the overall funding for the PCIP. This continues to be discussed with the Scottish Government. Further updates will be provided to the IJB.

2.7.7 In line with the Integrated Resources Advisory Group Finance Guidance, the lead partner for a Hosted Service is responsible for managing any overspends incurred. With the exception of ring-fenced funding, the lead partner can also retain any underspends which may be used to offset the overspends. This arrangement has been in place since 01 April 2016.

2.7.8 The IJB were previously advised that the hosted services principals were being reviewed however due to the Covid-19 pandemic, progress to date has been limited. In the interim, the IJB is asked to approve the continuance of the current arrangement in respect of the management of overspends and the retention of underspends by the lead partner for the financial year 2021/2022.

2.8. Hosted Services Led by North Lanarkshire

2.8.1 The Hosted Services which are led by the North Lanarkshire HSCP are outlined at appendix 4. In-line with the Hosted Services agreement, a break-even position is reported.

2. Health Services Variance Explanations (Cont.)

2.9. Notional Set-Aside Budget

2.9.1 The set-aside budget is a notional budget which represents the consumption of hospital resources by South Lanarkshire residents. Based on the 2018/2019 activity data from the Information Services Division (ISD) at the 2020/2021 prices, the budget was restated to £59.501m.

2.9.2 The calculation of the notional set-aside allocation and the confirmation of actual activity levels is a complex accounting process. The NHSL Director of Finance, in consultation with the IJB Chief Financial Officer, continues to develop the monitoring arrangements for the Hospital Acute Services.

2.9.3 In line with the accounting policy previously agreed, this notional set-aside budget will be included in the IJB Annual Accounts 2021/2022 as an estimate of expenditure. It is recognised that this will not necessarily reflect the actual usage of these hospital services by the IJB however it has been endorsed as an acceptable approach pending further updates from ISD. It is also recognised that, in the future, the 2020/2021 activity levels will not be representative of previous normal activity levels due to the impact of the Covid-19 pandemic. This will require to be taken into consideration.

2.10. Covid-19 Costs

2.10.1 The financial position for 2021/2022 in respect of the Covid-19 pandemic is being updated in consultation with both partners.

2.10.2 During the period between April 2021 and June 2021, the additional actual costs incurred to date across Health Care Services as a result of the Covid-19 pandemic are estimated to be £0.388m. This additional cost will be met from ring-fenced reserves.

2.10.3 Further additional Scottish Government funding for 2021/2022 is being requested in respect of the total projected Covid-19 costs through the Lanarkshire Remobilisation Plan submission to the Scottish Government on 30 July 2021.

3. Average Vacancy Factor (NHSL)

3.1 The year to date WTE position against the funded establishment across Health Care Services is summarised as follows:

Establishment	Actual	Variance
1,402 WTE	1,356 WTE	46 WTE under
100%	97%	3% under

3.2. The actual workforce is 3% under establishment. Action is being taken to recruit to vacant posts particularly in key service areas. Additional hours are also worked through bankaide, overtime and excess part-time hours, the cost of which is included within the financial position reported.

4. Social Care Services

4.1. The position at 18 June 2021 is updated to report an overspend of £0.006m across Social Care and Housing Services. The costs to date of responding to the Covid-19 pandemic total £2.364m. In line with the Scottish Government guidance, it is assumed the additional costs will be offset by existing reserves and additional Scottish Government funding. This is detailed further at paragraphs 4.9 and 4.10.

4.2. There is a marginal overspend of £0.022m across Adult and Older People Services at this stage of the financial year. The overspend however is expected to increase significantly as the year progresses. The main factors contributing to the overspend are as follows:

- The ongoing response to the Covid-19 pandemic and the remobilisation of services.
- Care at Home recruitment to meet increasing demand, complexity of care and future vacancies to maintain staffing levels.
- Overtime costs to meet current service delivery demand.
- The cost of not achieving planned savings.

In respect of the projected overspend, it is expected the majority of the costs in the current financial year 2021/2022 will be in respect of responding to the Covid-19 pandemic and will therefore be eligible to be offset by existing reserves and additional Scottish Government funding as detailed at paragraphs 4.9 and 4.10. The additional Scottish Government funding is still to be confirmed.

4.3 The demand for Care at Home Services has increased significantly in July 2021 due to significant pressures across the whole system. Taking into consideration the significant increase in demand, the SLC partner acted quickly to respond to the needs of the service. This increase in demand was also being experienced by neighbouring Local Authorities. Based on the current demand, the future demand was recalculated.

4.3.1 In order to prepare for winter, the SLC partner is taking the operational decision to recruit an additional 4,000 hours per week (108 FTE) on a permanent basis. 5 FTE Community Support Co-ordinators and 7 FTE Social Work Assistants are also being recruited on a permanent basis to meet the increasing demand. The part-year cost of the additional recruitment in 2021/2022, if successful, will be approximately £1.9m for the period from now until March 2022. It is recognised that due to recruitment and retention challenges across Care at Home Services, the target increase may not be achieved in full. The success of the recruitment campaign will be monitored. The financial planning assumption is that the cost of £1.9m in 2021/2022 will be offset by non-recurring Covid-19 funding in 2021/2022.

4.3.2 If the target increase of an additional 4,000 hours per week was achieved and maintained, the full year recurring cost of this recruitment from April 2022 would be approximately £3.8m. The impact of normal turnover and existing vacancies requires to be confirmed to establish how much of the increase in cost would be absorbed within the already agreed core budget and how much would be an additional cost pressure for which a funding solution would need to be identified. The 2022/2023 IJB Financial Plan is being developed in consultation with both partners. This additional cost will be included.

4. Social Care Services (Cont.)

4.3.3 The additional recurring costs across social care services as a result of the Covid-19 pandemic and the demographic growth are being highlighted to the Scottish Government however additional recurring funding has not been confirmed for Local Authorities at this stage.

4.3.4 The IJB Chief Financial Officer will therefore consult with both partners about the options available to contribute to all 2022/2023 cost pressures including the additional recurring Care at Home cost pressure. These options will need to include a review of the partner contributions for 2022/2023 along with options to reduce expenditure across other services. These cost reduction options will be explored however the IJB Chief Financial Officer believes this will not release sufficient recurring funding to meet the total increase in all health and social care cost pressures. The discussions with the Scottish Government and both partners are therefore vital if sufficient funding is to be secured to maintain key services. The IJB Medium to Long Term Financial Plan is being updated to reflect the operational and financial challenges and will be reported to the IJB when revised.

4.4. A breakeven position is reported in respect of Substance Misuse Services.

4.5. An overspend is reported in respect of Performance and Support Services of £0.008m.

4.6. A breakeven position is reported in respect of the Housing General Account although the demand for adaptations in 2021/2022 is expected to increase due to the backlog in service provision. An earmarked reserve was established on 31 March 2021 to provide additional funding to meet the backlog in 2021/2022.

4.7. A breakeven position is reported in respect of the Housing Revenue Account.

4.8. An over-recovery of income is reported of £0.024m which is a favourable variance.

4.9. As highlighted at paragraph 2.10, the financial position for 2021/2022 in respect of the Covid-19 pandemic is being updated in consultation with both partners. During the period between April 2021 and June 2021, the additional actual costs incurred to date across Social Care Services as a result of the Covid-19 pandemic are estimated to be £2.364m. As highlighted above, the financial planning assumption is that the Covid-19 pandemic costs in 2021/2022 will be offset by non-recurring Covid-19 funding in 2021/2022. Further additional Scottish Government funding for 2021/2022 is being requested in respect of the total projected Covid-19 costs through the Lanarkshire Financial Performance Report submission to the Scottish Government on 30 July 2021.

4.10. A conservative approach continues to be adopted in respect of estimating accrued expenditure between April 2021 and March 2022 which has not yet been paid in response to the pandemic. These costs will also be included in the submission to the Scottish Government on 30 July 2021. The total amount of Scottish Government funding which will be made available to meet the additional costs of the Covid-19 pandemic is still to be confirmed. The underspend against the Covid-19 funding allocation for 2020/2021 which was transferred to the IJB reserves in order to meet ongoing Covid-19 pandemic costs in 2021/2022 is to be drawn down first before any further funding is received from the Scottish Government.

4. Social Care Services (Cont.)

4.11. The Social Care providers across Scotland raised concerns regarding their financial sustainability as a result of the Covid-19 pandemic. In order to support providers to remain sustainable through this period, a commitment has been given by the Scottish Government to meet reasonable additional costs arising from areas such as staff sickness absence, the requirement to purchase increased levels of Personal Protective Equipment (PPE) and the impact of reduced occupancy in for example Care Homes where it is clinically unsafe to admit more people. Principles were developed nationally to support the capture of reasonable costs for inclusion within Remobilisation Plans for HSCPs. These principles were initially adopted until the end of July 2020 however have since been extended beyond this initial period. Scottish Government guidance has been received which extends the supplier relief until September 2021.

5. Reserves

5.1. The position in respect of the South Lanarkshire IJB reserves is attached at appendix 5 for information.

5.2. A total of £7.006m has been drawn down from reserves to date (NHSL - £7.006m; SLC – Nil).

5.3. The reserves balances as at June 2021 are therefore as follows:

Ring-fenced reserves	£20.441m	68%
Ear-marked reserves	£7.637m	25%
Contingency reserves	£1.935m	7%
Total	£30.013m	100%

The IJB Reserves Strategy 2021/2022 was endorsed on 15 June 2021 by the IJB (Performance and Audit) Sub-Committee.

6. Risk

6.1 Risk management arrangements are in place for the IJB and each partner. The main risk associated with the in-scope budget is that either or both partners may overspend.

6.2 Across social care services, the service continues to face demand pressures for service provision within Care at Home and Care Homes. There was a high-risk the cost of social care services in 2020/2021 would exceed the budget available due to the demand for services, the additional costs related to the improvement activity in Care at Home services and the impact of the second wave of the Covid-19 pandemic. This risk however was mitigated following the confirmation by the Scottish Government of the additional funding. It is expected that the risks associated with demand pressures as a result of the Covid-19 pandemic in 2021/2022 will be mitigated partly by IJB reserves and also by further Scottish Government funding however this additional funding is still to be confirmed.

6. Risk (Cont.)

6.3 Prescribing volatility and uncertainty continues to represent a high-risk area within the NHSL element of the partnership's budget. Further prescribing efficiency savings will need to be achieved to reduce costs in 2021/2022. The prescribing reserve of £0.500m was re-established as part of the IJB Financial Plan 2021/2022.

6.4 The operational and financial risks associated with the emergency response to the Covid-19 pandemic continue to be closely monitored by the IJB and both partners in line with their agreed emergency response arrangements and also the recovery, redesign and remobilisation work to maintain services. These costs are now expected to be ongoing in 2022/2023 and beyond. There is a significant risk that the costs incurred in 2021/2022 in response to the Covid-19 pandemic which are being included in the Lanarkshire Remobilisation Plan 2021/2022 may not be funded in full in-year by the Scottish Government and may not be funded on a recurring basis from April 2022 onwards. Covid-19 funding not fully committed in 2020/2021 was transferred to IJB reserves in order to partly offset Covid-19 costs incurred in 2021/2022. This position will continue to be monitored and discussions will be progressed with both partners in respect of the partner contributions for 2022/2023. Current and anticipated cost pressures are being monitored closely.

6.5 The respective risks are managed by the IJB, NHSL and SLC through their detailed budget management processes.

Health and Social Care Services Analysis **Appendix 2**

South Lanarkshire Health and Social Care Partnership Budget	ANNUAL BUDGET 2020/2021 £m	YEAR TO DATE BUDGET Jun-21 £m	YEAR TO DATE ACTUAL Jun-21 £m	YEAR TO DATE VARIANCE GENERAL Jun-21 £m	YEAR TO DATE VARIANCE RING-FENCED Jun-21 £m	YEAR TO DATE VARIANCE TOTAL Jun-21 £m
Health Care Services						
Locality and Other Services	30.893	19.735	19.806	(0.071)		(0.071)
Addiction Services	4.038	0.971	0.966	0.005		0.005
Medical and Nursing Directorate	3.615	0.670	0.672	(0.002)		(0.002)
Prescribing	66.326	16.582	16.582	0.000		0.000
Out of Area Services	3.841	0.960	0.969	(0.009)		(0.009)
Area Wide Services	8.845	1.967	1.966	0.001		0.001
Hosted Services	115.501	27.014	26.673	0.341		0.341
Family Health Services	98.874	25.998	25.998	0.000		0.000
Set-Aside Budget	59.501	14.875	14.875	0.000		0.000
Covid-19	0.388	0.388	0.388	0.000		0.000
Expenditure - Sub Total	**391.823**	**109.160**	**108.895**	**0.265**	**0.000**	**0.265**
Social Care Services						
Adult and Older People Services	185.428	28.087	28.109	(0.022)		(0.022)
Substance Misuse Services	1.702	0.302	0.302	0.000		0.000
Grounds Maintence Services	0.084	0.084	0.084	0.000		0.000
Performance & Support Services	0.404	0.080	0.088	(0.008)		(0.008)
Housing Services - General Fund	2.133	0.355	0.355	0.000		0.000
Covid-19 Costs	2.364	2.364	2.364	0.000		0.000
Total Expenditure	**192.115**	**31.272**	**31.302**	**(0.030)**		**(0.030)**
Gross Income	(6.898)	(1.835)	(1.859)	0.024		0.024
Net Expenditure	**185.217**	**29.437**	**29.443**	**(0.006)**		**(0.006)**
Housing Services - HRA	2.882	0.479	0.479		0.000	0.000
Social Care and Housing Services Sub-Total	**188.099**	**29.916**	**29.922**	**(0.006)**	**0.000**	**(0.006)**
TOTAL EXPENDITURE	**579.922**	**139.076**	**138.817**	**0.259**	**0.000**	**0.259**
FUNDED BY:						
SLC Funding	138.271					
Total - SLC	**138.271**					
NHS Lanarkshire Funding	394.185					
Resource Transfer	23.588					
Social Care Funding	18.595					
Commissioned Services Funding	5.283					
Covid-19 Funding	0.000					
Total - NHSL	**441.651**					
TOTAL	**579.922**					

Hosted Services **Appendix 3**

Led by the South Partnership	TOTAL				South Lanarkshire IJB - 49% Share				North Lanarkshire IJB - 51% Share			
	Annual Budget 2021/2022 £m	YTD Budget 2021/2022 £m	YTD Actual 2021/2022 £m	YTD Variance 2021/2022 £m	Annual Budget 2021/2022 £m	YTD Budget 2021/2022 £m	YTD Actual 2021/2022 £m	YTD Variance 2021/2022 £m	Annual Budget 2021/2022 £m	YTD Budget 2021/2022 £m	YTD Actual 2021/2022 £m	YTD Variance 2021/2022 £m
Community Dental Services	6.527	1.667	1.568	0.099	3.198	0.817	0.718	0.099	3.329	0.850	0.850	0.000
Out of Hours Services	8.403	1.947	1.829	0.118	4.117	0.954	0.836	0.118	4.286	0.993	0.993	0.000
Palliative Care Services	7.210	1.784	1.814	(0.030)	3.533	0.874	0.904	(0.030)	3.677	0.910	0.910	0.000
Physiotherapy Services	10.002	2.489	2.410	0.079	4.901	1.220	1.141	0.079	5.101	1.269	1.269	0.000
Primary Care Services	0.741	0.189	0.161	0.028	0.363	0.093	0.065	0.028	0.378	0.096	0.096	0.000
Occupational Therapy Services	8.852	2.194	2.158	0.036	4.337	1.075	1.039	0.036	4.515	1.119	1.119	0.000
Diabetic Services	3.707	0.925	0.914	0.011	1.816	0.453	0.442	0.011	1.891	0.472	0.472	0.000
Sub Total	**45.442**	**11.195**	**10.854**	**0.341**	**22.267**	**5.486**	**5.145**	**0.341**	**23.175**	**5.709**	**5.709**	**0.000**
Ring Fenced Funding												
Primary Care Improvement Fund	10.256	1.513	1.513	0.000	5.025	0.741	0.741	0.000	5.231	0.772	0.772	0.000
Primary Care Transformation Fund	0.143	0.143	0.143	0.000	0.070	0.070	0.070	0.000	0.073	0.073	0.073	0.000
Sub Total	**10.399**	**1.656**	**1.656**	**0.000**	**5.096**	**0.811**	**0.811**	**0.000**	**5.303**	**0.845**	**0.845**	**0.000**
TOTAL	**55.841**	**12.851**	**12.510**	**0.341**	**27.362**	**6.297**	**5.956**	**0.341**	**28.479**	**6.554**	**6.554**	**0.000**

Hosted Services **Appendix 4**

Led by the North Partnership	TOTAL				South Lanarkshire IJB - 49% Share				North Lanarkshire IJB - 51% Share			
	Annual Budget 2021/2022 £m	YTD Budget 2021/2022 £m	YTD Actual 2021/2022 £m	YTD Variance 2021/2022 £m	Annual Budget 2021/2022 £m	YTD Budget 2021/2022 £m	YTD Actual 2021/2022 £m	YTD Variance 2021/2022 £m	Annual Budget 2021/2022 £m	YTD Budget 2021/2022 £m	YTD Actual 2021/2022 £m	YTD Variance 2021/2022 £m
Sexual Health Services	2.686	0.672	0.666	0.006	1.316	0.329	0.329	0.000	1.370	0.343	0.337	0.006
Continence Services	2.173	0.543	0.548	(0.005)	1.065	0.266	0.266	0.000	1.108	0.277	0.282	(0.005)
Immunisation Services	1.948	0.487	0.633	(0.146)	0.955	0.239	0.239	0.000	0.993	0.248	0.394	(0.146)
Speech and Language Therapy Services	6.027	1.507	1.509	(0.002)	2.953	0.738	0.738	0.000	3.074	0.769	0.771	(0.002)
Children and Adolescents Mental Health Services	10.629	1.821	1.708	0.113	5.208	0.892	0.892	0.000	5.421	0.929	0.816	0.113
Childrens Services	11.218	2.805	2.746	0.059	5.497	1.374	1.374	0.000	5.721	1.431	1.372	0.059
Integrated Equipment and Adaptations Store	0.567	0.142	0.142	0.000	0.278	0.070	0.070	0.000	0.289	0.072	0.072	0.000
Dietetics Services	3.697	0.926	0.878	0.048	1.812	0.454	0.454	0.000	1.885	0.472	0.424	0.048
Podiatry Services	4.299	1.080	0.989	0.091	2.107	0.529	0.529	0.000	2.192	0.551	0.460	0.091
Prisoner Healthcare Services	1.764	0.441	0.426	0.015	0.864	0.216	0.216	0.000	0.900	0.225	0.210	0.015
Blood Borne Viruses Services	1.503	0.376	0.323	0.053	0.736	0.184	0.184	0.000	0.767	0.192	0.139	0.053
Hospital at Home	2.206	0.552	0.594	(0.042)	1.081	0.270	0.270	0.000	1.125	0.282	0.324	(0.042)
Mental Health and Learning Disability Services	73.039	17.553	17.336	0.217	35.789	8.601	8.601	0.000	37.250	8.952	8.735	0.217
TOTAL	**121.756**	**28.905**	**28.498**	**0.407**	**59.660**	**14.163**	**14.163**	**0.000**	**62.096**	**14.742**	**14.335**	**0.407**

South Lanarkshire IJB
Position As At June 2021

Appendix 5

Useable Reserve	2020/2021 Balance as at March 2021	2021/2022 Transfers Out	Transfers To Contingency	Transfers From Contingency	Transfers In	Balance as at June 2021
Ring-Fenced Reserves	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Alcohol and Drug Partnership Fund	1.875	(0.080)				1.795
Primary Care Improvement Fund	5.792	(5.785)				0.007
GP Information Technology Fund	0.750					0.750
Community WIFI Fund	0.536					0.536
Remobilisation Fund	6.945	(0.388)				6.557
Integration Authority Support Fund	5.924					5.924
Primary Care Improvement Fund - Health Improvement Services	0.024					0.024
Adult Social Care Winter Preparedness Fund	2.573					2.573
Community Addiction Recovery Services (CAReS)	0.267					0.267
ADP - Drug Death Task Force	0.356	(0.066)				0.290
Community Living Change Fund	1.162					1.162
West Of Scotland Trauma Fund	0.655	(0.320)				0.335
District Nurse Fund	0.142					0.142
School Nurse Fund	0.059	(0.059)				0.000
Insulin Pump Fund	0.079					0.079
Total Ring-Fenced	**27.139**	**(6.698)**	**0.000**	**0.000**	**0.000**	**20.441**
Earmarked Reserves						
Palliative Care Services	0.394	(0.169)				0.225
Prescribing Fund	0.500					0.500
Social Care Contingency Fund	0.677					0.677
Transitional Fund	0.504					0.504
Training Fund - Health Visitors	0.220					0.220
Telehealth Fund	0.463					0.463
Health Promotion Activity Programme	0.119					0.119
iHub Project	0.032					0.032
Housing Services - General Fund	0.585					0.585
Physiotherapy Services	0.952					0.952
Technology Funds	0.400					0.400
GP IT Systems Replacement Fund	0.997					0.997
Community IT Fund	0.200					0.200
Director of Nursing Fund	0.065					0.065

South Lanarkshire IJB
Position As At June 2021

Appendix 5 (Cont.)

Useable Reserve	2020/2021	2021/2022				
	Balance as at March 2021	Transfers Out	Transfers To Contingency	Transfers From Contingency	Transfers In	Balance as at June 2021
Earmarked Reserves	**£m**	**£m**	**£m**	**£m**	**£m**	**£m**
Registered Nurse Recruitment Fund	0.191					0.191
CLAN Fund	0.045					0.045
Brain Injury Rehabilitation Fund	0.200					0.200
Area Wide Services - NES Training - Pharmacy	0.139	(0.139)				0.000
Area Wide Services - Health Inequalities Health Promotion Posts	0.082					0.082
Area Wide Services - Mental Health Initiatives - Health Improvement	0.201					0.201
Area Wide Services - Vulnerable Population Post - Health Improvement Services	0.065					0.065
Area Wide Services - Development of Health Promoting Culture	0.136					0.136
Area Wide Services - Third Sector Initiatives To Improve Health	0.294					0.294
Area Wide Services - Public Health Intelligence Data Analysts	0.059					0.059
Area Wide Services - Inequalities Funding	0.023					0.023
Health and Social Care Fund	0.402					0.402
Total Earmarked	**7.945**	**(0.308)**	**0.000**	**0.000**	**0.000**	**7.637**
Contingency Reserve	1.935					1.935
General Fund	**37.019**	**(7.006)**	**0.000**	**0.000**	**0.000**	**30.013**

South Lanarkshire IJB
Budget Reconciliation As At June 2021

Appendix 6

South Lanarkshire Health and Social Care Partnership Budget	Locality and Other Services £m	Addiction Services £m	Medical and Nursing Directorate £m	Prescribing £m	Out-of-Area Services £m	Area Wide Services £m	Hosted Services-South £m	Hosted Services-North £m	Family Health Services £m	Set-Aside £m	Covid-19 - Funding - NHSL £m	Social Work and Housing £m	Covid-19 - Funding - SLC £m	IJB Operating Costs £m	Total £m
Revised Budget As Per January 2021 Finance Report	**30.040**	**6.034**	**3.302**	**65.589**	**3.747**	**8.762**	**57.587**	**56.236**	**100.499**	**59.501**	**8.124**	**180.826**	**12.606**	**0.000**	**592.852**
Additional Pay Award 2020/2021	0.434		0.020				0.491								**0.945**
GP IT Funding							0.750								**0.750**
Diabetes Insulin Pumps Funding 2020/2021 Non-recurring							0.618								**0.618**
CARES Funding		0.267													**0.267**
Digital Improvement Funding							0.246								**0.246**
Technology Funding	0.200														**0.200**
Scottish Trauma Tranche 1 Funding							0.200								**0.200**
GP Community IT Funding	0.200														**0.200**
Covid-19 Pandemic Budget Adjustments	10.194										2.865		7.734		**20.793**
Other Budget Adjustments - Various	0.394	0.040	(0.002)		0.094		0.224					0.078		0.170	**0.998**
Prescribing Adjustment				1.535											**1.535**
Area Wide Services Adjustment						0.939									**0.939**
North Hosted Services Budget Adjustments								1.731							**1.731**
Family Health Services - Demand led budget									1.126						**1.126**
Budget Adjustments Total	**11.422**	**0.307**	**0.018**	**1.535**	**0.094**	**0.939**	**2.530**	**1.731**	**1.126**	**0.000**	**2.865**	**0.078**	**7.734**	**0.170**	**30.549**
Budget As Per March 2021 Finance Report	**41.462**	**6.340**	**3.320**	**67.124**	**3.841**	**9.701**	**60.117**	**57.967**	**101.625**	**59.501**	**10.989**	**180.904**	**20.340**	**0.170**	**623.401**
Opening Budget Adjustments Reversal of Non-recurring Funding 2020/2021 and Year-end Transfers to IJB Reserves	**(11.757)**	**(2.469)**	**(1.051)**	**0.000**	**0.000**	**0.000**	**(22.017)**	**0.000**	**0.000**	**0.000**	**(10.989)**	**(0.738)**	**(20.173)**	**0.000**	**(69.194)**
Opening Budget As At 1 April 2021	**29.705**	**3.871**	**2.269**	**67.124**	**3.841**	**9.701**	**38.100**	**57.967**	**101.625**	**59.501**	**(0.000)**	**180.166**	**0.167**	**0.170**	**554.207**

South Lanarkshire IJB
Budget Reconciliation As At June 2021

Appendix 6 (Cont.)

South Lanarkshire Health and Social Care Partnership Budget	Locality and Other Services £m	Addiction Services £m	Medical and Nursing Directorate £m	Prescribing £m	Out-of-Area Services £m	Area Wide Services £m	Hosted Services- South £m	Hosted Services- North £m	Family Health Services £m	Set-Aside £m	Covid-19 - Funding - NHSL £m	Social Work and Housing £m	Covid-19 - Funding - SLC £m	IJB Operating Costs £m	Total £m
Opening Budget As At 1 April 2021	**29.705**	**3.871**	**2.269**	**67.124**	**3.841**	**9.701**	**38.100**	**57.967**	**101.625**	**59.501**	**(0.000)**	**180.166**	**0.167**	**0.170**	**554.207**
Pay Award 2021/2022	0.749		0.010				0.651								**1.410**
Call Down of 2021/2022 Funding	0.799		0.288				0.043								**1.130**
Family Nurse Partnership 2021/2022			0.904												**0.904**
GP Out Of Hours Funding							0.616								**0.616**
Dental NES Income							0.602								**0.602**
West Of Scotland BI 2021/2022							0.320								**0.320**
Diabetes Insulin Pumps Funding 2021/2022 Outcomes Framework							0.256								**0.256**
Clan Monies 2021/2022							0.169								**0.169**
SP Travel Off Set NR Ret Apr 21	0.031						0.138								**0.169**
District Nurse Funding			0.142												**0.142**
School Nursing 2021/2022	0.059														**0.059**
Junior Doctors NES Funding							0.140								**0.140**
Telehealth Funding							0.081								**0.081**
Local Improvement Funding		0.080													**0.080**
Transfer From Acute Services (CoE)							0.121								**0.121**
Financial Settlement 2021/2022												4.120			**4.120**
Modern Apprenticeship Scheme Funding												1.000			**1.000**
Primary Care Improvement Fund & Transformation Funding							9.007						(0.167)		**8.840**
South Hosted Services Adjustments							5.210								**5.210**
Covid-19 Pandemic Budget Adjustments											0.388		2.364		**2.752**
Other Budget Adjustments - Various	(0.450)	0.087	0.002				0.387					0.449		(0.170)	**0.305**
Prescribing Adjustment				(0.798)											**(0.798)**
Area Wide Services Adjustment						(0.856)									**(0.856)**
North Hosted Services Budget Adjustments								1.693							**1.693**
Family Health Services - Demand led budget									(2.751)						**(2.751)**
Budget Adjustments Total	**1.188**	**0.167**	**1.346**	**(0.798)**	**0.000**	**(0.856)**	**17.741**	**1.693**	**(2.751)**	**0.000**	**0.388**	**5.569**	**2.197**	**(0.170)**	**25.715**
Budget As Per June 2021 Finance Report	**30.893**	**4.038**	**3.615**	**66.326**	**3.841**	**8.845**	**55.841**	**59.660**	**98.874**	**59.501**	**0.388**	**185.735**	**2.364**	**0.000**	**579.922**

Agenda Item

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Report

Report to:	**South Lanarkshire Integration Joint Board**
Date of Meeting:	**17 August 2021**
Report by:	**Interim Chief Officer, Health and Social Care Partnership**

Subject:	**Performance Monitoring Report**

1. Purpose of Report

1.1. The purpose of the report is to:-

- advise the Integration Joint Board on performance against the key performance measures assigned to the integration of Health and Social Care
- highlight the effect of Covid safety restrictions on performance

2. Recommendation(s)

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that the Integration Joint Board note and comment on the current performance trends.

3. Background

3.1. The Health and Social Care Delivery Plan and the work of the Ministerial Steering Group (MSG) in Health and Social Care have identified six key areas through which trends over time will be monitored, with a view to supporting improvement and learning within partnerships and across Scotland.

3.2. A key emphasis behind this work is realising the national ambition to shift the balance of care through strategic commissioning which shifts the focus from acute and residential settings to community based alternatives. This attached Appendix 1 gives a short overview of the South Lanarkshire position with regards to the following areas:

- unplanned admissions
- occupied bed days for unscheduled care
- A&E performance
- Delayed Discharges
- end of life care
- the balance of spend across institutional and community services

3.3. There is a lag period associated with two indicators, unscheduled care admissions and unscheduled care bed days. This is due to completion of episodes of care, coding and subsequent processing via Public Health Scotland (PHS). The data in this report is for the period to April 2021, with 99% confidence regarding NHSL data completeness up to March 2021, admissions and bed days will therefore increase.

3.4. The Health and Social Care Partnership (HSCP) is identifying the impact of the ongoing Covid emergency on Health and Wellbeing outcomes and associated performance indicators and targets. Performance reporting continues across localities, with services and localities providing recovery trajectories. However, there are a number of factors which are preventing full recovery and affecting performance and the availability of some performance data.

3.5. It should be noted that there is still uncertainty concerning future demand and capacity. Complexities around reduced accommodation and restrictions on the numbers of people visiting facilities, due to Covid safety measures, are affecting performance for services which require more face-to-face appointments.

3.6. In addition to routine performance reporting, the Head of Commissioning and Performance has been asked to set up a Recovery group to co-ordinate a consistent approach to recovery across both HSCPs.

4. Proposals

4.1. None

5. Employee Implications

5.1. There are no employee implications associated with this report.

6. Financial Implications

6.1. There are no financial implications associated with this report.

7. Climate Change, Sustainability and Environmental Implications

7.1. There are no Climate change, sustainability or environmental implications associated with this report.

8. Other Implications

8.1. There are no risk implications associated with this report.

8.2. There are no other issues associated with this report.

9. Equality Impact Assessment and Consultation Arrangements

9.1. There are no Environmental implications arising directly from this report. There was no requirement to undertake an equality impact assessment.

9.2. No specific consultation was required for this report. User and public involvement is key to the development of the partnership and all significant proposals will be subject to an appropriate level of consultation.

10. Directions

10.1.

Direction to:	
1. No Direction required	☒
2. South Lanarkshire Council	☐
3. NHS Lanarkshire	☐
4. South Lanarkshire Council and NHS Lanarkshire	☐

Marianne Hayward
Interim Chief Officer, Health and Social Care Partnership

Date created: 29 July 2021

Link(s) to National Health and Wellbeing Outcomes

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

Previous References

- none

List of Background Papers

- none

Contact for Further Information

If you would like to inspect the background papers or want further information, please contact:-

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Phone: 01698 453704
Email: craig.cunningham@lanarkshire.scot.nhs.uk

South Lanarkshire Health and Social Care Partnership
Health and Social Care Delivery Plan Measures

Summary of the MSG indicators in South Lanarkshire for currently available data

1. Year on Year comparison April – March 2019/20 against 2020/21

- A&E attendances **up** 89%
- Emergency admission **up** 57%*
- Unscheduled care bed days, Acute specialties **up** 4%*
- Unscheduled Care (UC) Bed days Acute/Geriatric Long Stay (GLS)/Mental Health (MH) **up** by **0.04% ***
- Delayed discharge non-code nine bed days **down** by **15%**

*(It should be noted that emergency admissions and unscheduled care bed days will increase as episodes of care are completed.)

2. Performance against targets

Figure 1 shows performance April 2021/22 for attendances, emergency admission and unscheduled care bed days. In addition delayed discharges performance is shown for most recently published data April – May 2021/22.

2021/22	Target	Performance	Variance	% variance
A&E Attendances	9,661	8,386	-1,275	86.8%
Emergency Admissions	3,864	2,968	896	76.8%
UC Bed days - Acute	18,617	12,739	5,878	68.4%
UC Bed days - Acute/GLS/MH	26,167	16,609	9,558	63.5%
Delayed Discharge bed days	4,575	2,445	2,130	53.4%

Figure 1 Performance against targets

Taking into account data completeness Figure 2 shows performance April – March 2020/21 for emergency admissions and unscheduled care bed days.

	Target	Performance	Variance	% variance
Emergency Admissions	30,948	32,536	**1,588**	**5.1%**
UC Bed days - Acute	200,752	197,829	-2,923	-1.5%
UC Bed days - Acute/GLS/MH	26,167	16,609	-9,558	-36.5%

Figure 2: Performance against targets April – March 2020/21 - accounting for data completeness

3. A&E Attendances

Figure 3 shows performance against trajectory April 2021/22, with 1275 fewer attendances than expected, 8,386 against 9,661.

It should be noted that NHS Lanarkshire **management information** shows there has been a significant increase in A&E attendances May through to July 2021.

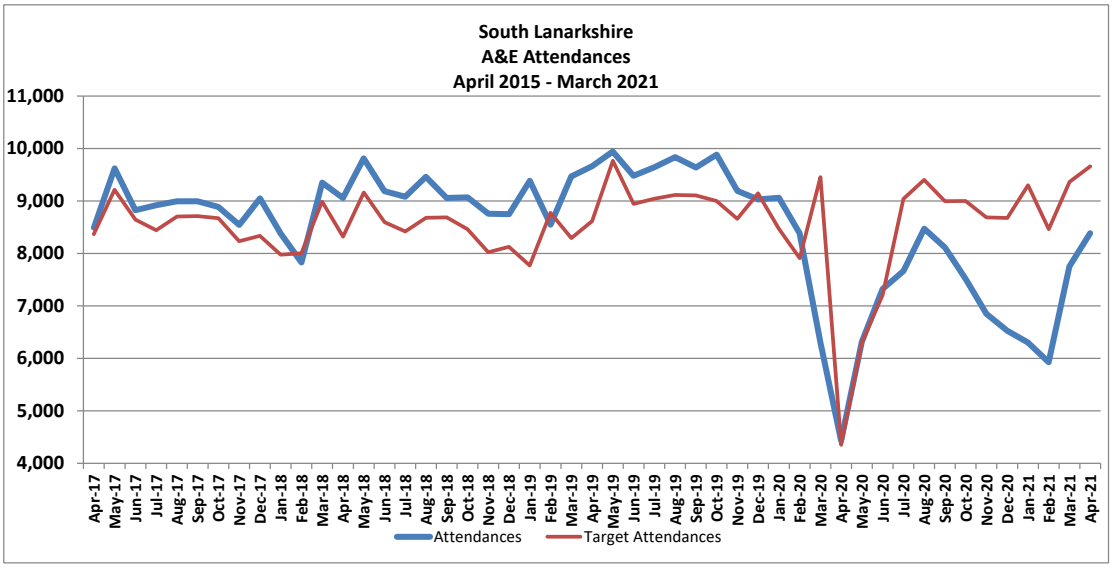

Figure 3 A&E Attendances

4. Emergency Admissions

Performance for emergency admissions (Figure 4) are below the expected level by 896 admissions, 2.986 against the target of 3,864.

Given the significant increase in A&E attendances the Partnership is expecting an increase in emergency admissions, trajectories for 2022 have taken this into account.

Admissions for this period **will** increase as episodes of care are completed.

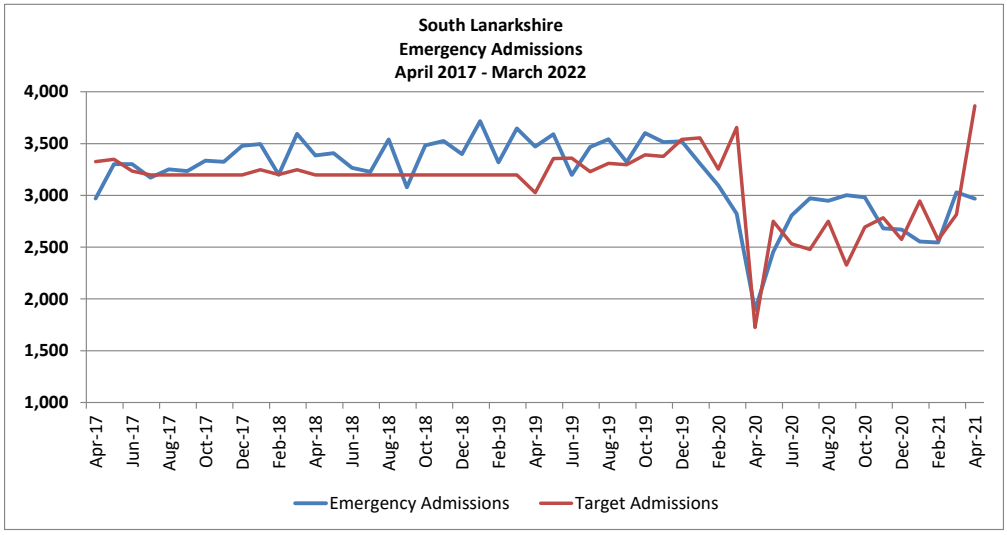

Figure 4 Emergency Admission against trajectories April 2021

5. Unscheduled Care Bed Days

Unscheduled Care Bed Day trajectories for 2021/22 include Acute, Geriatric Long Stay (GLS) and Mental Health (MH). For consistency the graph below (Figure 5) tracks the month-on-month performance longitudinally against the trajectory agreed for unscheduled bed days – Acute specialities. With the second graph (Figure 6) showing UC Bed days for Acute, GLS and MH. It should be noted that there is routinely a few months lag in terms of completed episodes of care and bed days for April 2021 **will** increase.

Unscheduled Bed Days – Acute.
April to January 2020/21 were 5,878 fewer bed days than anticipated, 12,739 against the target of 18,617 (Figure 5). This **will** increase over the next quarter.

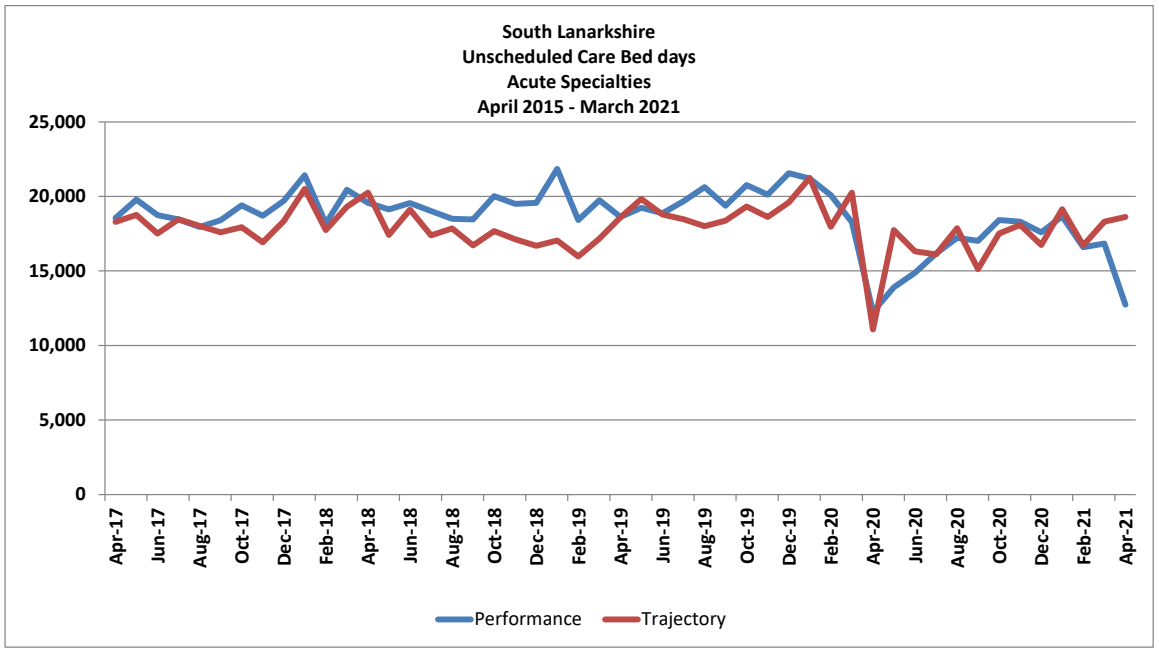

Figure 5 Unscheduled Bed Days - Acute Specialties

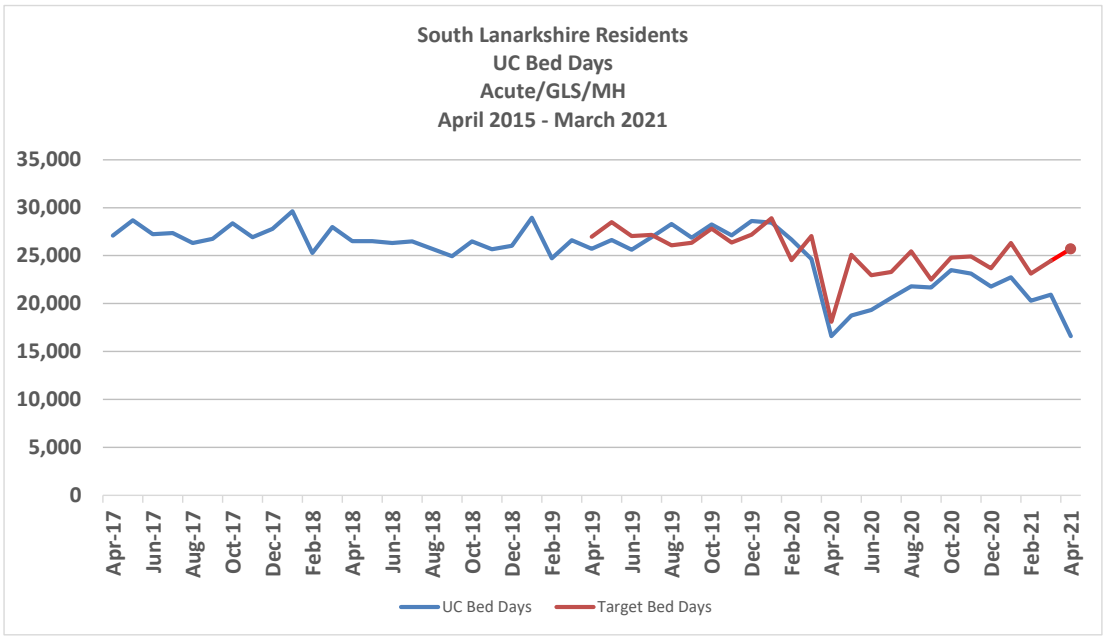

Figure 6 Unscheduled Care Bed Days - Acute/GLS/MH

UC Bed Days – Acute, GLS, MH.

April 2021 there were 9,558 **fewer** bed days than anticipated, 16,609 against the target of 26,167 (Figure 6). This **will** increase over the next quarter.

6. Delayed Discharge Bed Days

April – May 2021/22

As expected there has been a significant reduction in delayed discharge non-code 9 bed days from April (Figure 7), with the improved performance continuing through to February 2021 with 16,195 bed days against the target of 19,484.

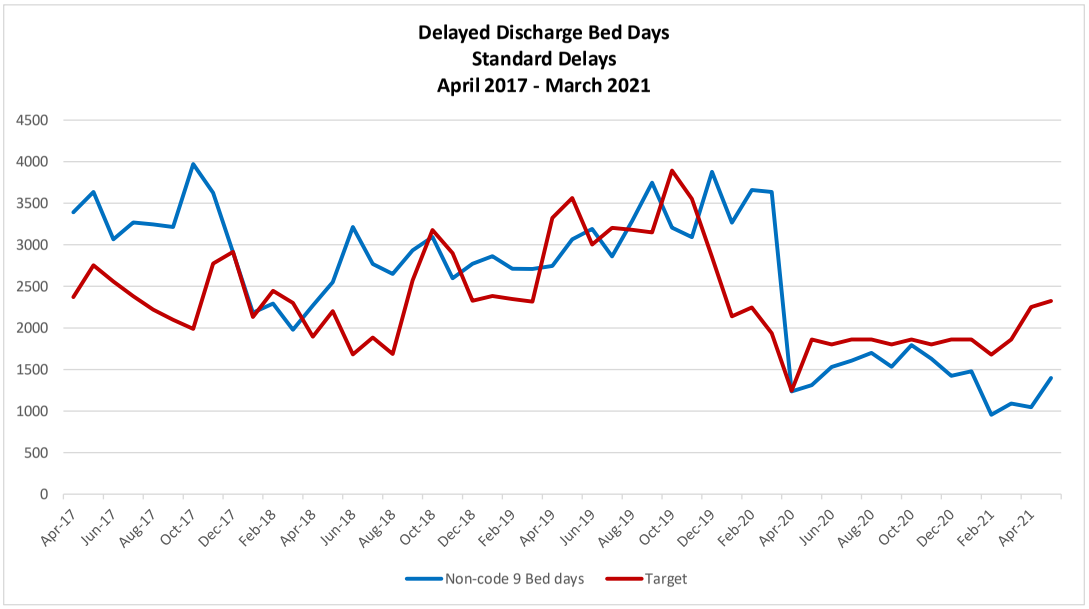

Figure 7 Delayed Discharge Bed Days - non-code 9

Figures 8 and 9 show **management information** for bed days and delays respectively on Mondays to 19th July 2021. This indicates that performance has deteriorate during June and July.

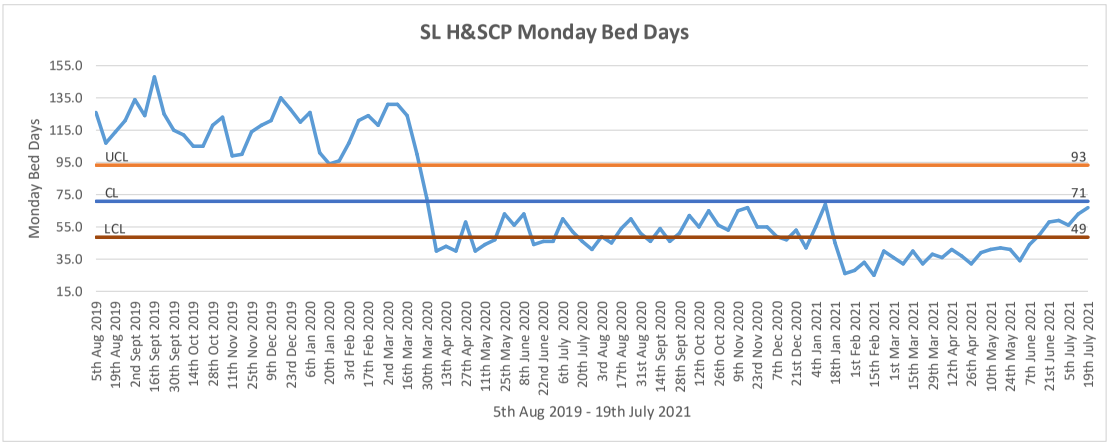

Figure 8 Monday Delay Bed Days

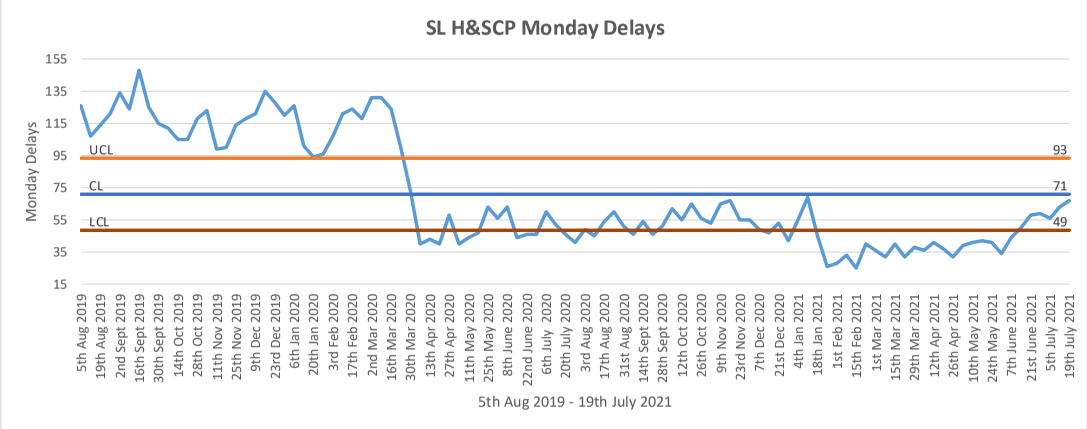

Figure 9 Monday delayed discharges

7. Last Six Months of Life by Setting

Percentage of people who spend their last six months in a community setting has steadily increased over the previous three years. As the range of services in the community setting increases, it is expected that the numbers of people who spend the last six months in the community will similarly increase.

The table below (Fig 11) confirms the Partnership is increasing the proportion of South Lanarkshire residents who spend the last six months of life in the community. The percentage of people who spend the last six months of life in a large hospital has fallen since 2013/14 to 10.1% during 2019/20, slightly above the target of 10.0%. Fewer people spend their last six months in either hospitals or hospice/palliative care units. It should be noted that the data provided is management information. Data for 2019/20 is provisional.

	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	2019/20P
Community	84.8%	85.2%	85.3%	87.2%	87.6%	88.5%	88.3%
Community Target	84.2%	84.4%	84.9%	87.0%	86.6%	88.4%	87.1%
Large Hospital	11.8%	12.1%	12.1%	10.7%	10.2%	9.9%	10.2%
Large Hospital Target	12.4%	12.9%	12.4%	11.1%	10.7%	10.0%	10.0%

Figure 10 Percentage of last six months of life by setting

8. Balance of Care

Figure 12 shows the percentage of people over 75 who are not thought to be in any other setting, or receiving any Home Care, has increased since 2015/16, although reducing slightly 2019/20, this may change as data is provisional. Given the increase in the 75+ age group, the 2015/16 percentage remains the target through to 2019/20.

	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020P
Home (unsupported)	81.6%	82.1%	82.2%	82.5%	83.5%	82.9%	83.3%
Home (unsupport) Target	81.0%	81.8%	81.7%	82.0%	82.0%	82.0%	82.0%
Home Supported	9.6%	9.0%	9.0%	9.0%	9.0%	9.3%	9.1%
Home Support Target	9.6%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%

Figure 11 Balance of Care – 2019/20 data provisional

Balance of care improvement figures, shown above, were based on the over 75 population, generally those with the more complex needs. Currently the percentage of people over 75 who remain at home without support is above target by slightly below 1%.

It should be noted that this data is management information. This indicator is still under development nationally and may change in future reports. Data for 2019/20 is provisional.

Agenda Item

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Report

Report to:	**South Lanarkshire Integration Joint Board**
Date of Meeting:	**17 August 2021**
Report by:	**Interim Chief Officer, Health and Social Care Partnership**

Subject:	**Directions Progress Update**

1. Purpose of Report

1.1. The purpose of the report is to:-

- provide an Update on the Progress of the Integration Joint Board's Directions

2. Recommendation(s)

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that progress in respect of the Integration Joint Board's Directions for the current financial year 2021/2022 be noted.

3. Background

3.1. In-line with the Public Bodies (Joint Working) (Scotland) Act 2014, on 30 March 2020 the Integration Joint Board (IJB) approved the Strategic Commissioning Plan (SCP) and the issue of Directions to the Health Board and the local authority for the financial year 2021/2022.

3.2. The Integration Joint Board (IJB), however, acknowledged the potential impact of the COVID-19 Pandemic on each partner's ability to implement the strategic commissioning intentions and the Directions as originally planned. It was, therefore, agreed that a report on the progress of achieving the IJB Directions should be a standing agenda item on future IJB meetings.

4. Progress Update

4.1. The progress to date in respect of the implementation of the 2021/2022 'Directions' is attached as an appendix recognising this progress has been impacted for the reasons outlined in Section 3.2. However, as the balance shifts from response to recovery and back to the transformation programme, more significant movement should be seen within future Directions reports, with some additional information being provided.

4.2. As reminder, the SCP is set against a commitment to:

- work towards the achievement of the nine National Health and Wellbeing Outcomes
- progress the 13 strategic priorities of the 2019-22 SCP
- 43 commissioning intentions are assigned against the 13 strategic priorities detailed in the SCP

- the mechanism to ensure that commissioning intentions are realised is through 'Direction' agreed by the IJB and implemented by either the Council, NHS Board or both. To date, the IJB has issued 37 Directions.

4.3. A summary status of all 37 Directions is given in the table below, with further detail in Appendix 1.

	On hold. Not possible to progress during this period	3	8%
	Progressing but a change in outcomes and/or delay expected	24	65%
	Progressing as originally planned	2	5%
	Direction completed	8	22%
	Total	**37**	**100%**

4.4. Although many of the 'Directions' are longer term pieces of work, progress has been impacted by having to re-prioritise over the last 15 months towards the Pandemic response. That said, many of the 'Directions' are longer term pieces of transformational activity and as such many of them continue to be reported as a work in progress or as amber.

4.5. Permeated throughout IJB agendas are reports which give more detailed and granular updates against specific 'Directions'. For example, at the previous IJB a detailed update on Homelessness 'Directions' was given and within the Transformation Report, which is an IJB standing item, updates are given against a number of 'Directions'

4.6. As part of developing the new Strategic Commissioning Plan (SCP) 2022-25, the current 'Directions' and potential future 'Directions' will be considered to ensure they still have the necessary strategic fit with the direction of travel that will be set out in the new plan.

5. Employee Implications

5.1. There are no employee implications associated with this report.

6. Financial Implications

6.1. There are no financial implications associated with this report.

7. Climate Change, Sustainability and Environmental Implications

7.1. There are no implications for Climate Change, sustainability or the environment in terms of the information contained in this report.

8. Other Implications

8.1. The IJB Risk Register is being updated to reflect the ongoing challenges associated with the current pandemic. As part of this review, the IJB Risk Register will be matched against the SCP to ensure that all relevant risks are taken account of and mitigation agreed.

8.2. There are no other issues associated with this report.

9. Equality Impact Assessment and Consultation Arrangements

9.1. This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy and therefore no impact assessment is required.

10. Directions

10.1.

Direction to:	
1. No Direction required	☒
2. South Lanarkshire Council	☐
3. NHS Lanarkshire	☐
4. South Lanarkshire Council and NHS Lanarkshire	☐

Marianne Hayward,
Interim Chief Officer, Health and Social Care Partnership

Date created: 29 June 2021

Link(s) to National Health and Wellbeing Outcomes

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

Previous References

- Integration Joint Board Directions 30 March 2021

List of Background Papers

- none

Contact for Further Information

If you would like to inspect the background papers or want further information, please contact:-

Martin Kane, Service Development Manager
Ext: 3743 (Phone: 01698 453743)
Email: martin.kane@southlanarkshire.gov.uk

Ref	Strategic Commissioning Intention	Is there an existing Direction (Y/N)	Direction Complete Yes / No / Ongoing	Direction Detail	Milestones/ Link PI	Outcomes	RAG Status	Further Information
1.	**Strategic Priority - Early intervention, prevention and health improvement**							
1.1	Work with partners to deliver an increased range of activities to mitigate the negative health consequences of poverty and welfare reform	Y	Ongoing	Directs NHS Lanarkshire and South Lanarkshire Council to participate in the development of the Local Outcome Improvement Plans (LOIPS) with a particular focus on early years, tackling social isolation, health inequalities, early intervention/prevention and community capacity building	NI 2 NI 3	Outcome 1 Outcome 5		Through Community Planning arrangements, both NHS Lanarkshire and South Lanarkshire Council play a key role in working towards the common overarching priority of tackling inequalities.
1.2	Work with key partners to implement the Strategic ambitions of Rights, Respect and Recovery – Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths	Y	Ongoing	Utilise additional investment from Programme for Government 2018/19 Scottish Government to reduce the impact of problem alcohol and drug use	NI 1 NI 2	Outcome 4 Outcome 9		There is an approved South Lanarkshire Alcohol and Drugs Partnership Strategy 2020-23 which outlines a number of actions in relation to early intervention/prevention, recovery, supporting children and families, public health and alcohol
1.3	Contribute to the South Lanarkshire Child Poverty Action Plan and deliver the relevant actions to address child poverty	Y	Ongoing	Directs NHS Lanarkshire and South Lanarkshire Council to participate in the development of the Local Outcome Improvement Plans (LOIPS) with a particular focus on early years, tackling social isolation, health inequalities, early intervention/prevention and community capacity building	NI 1 NI 2	Outcome 5		Through Community Planning arrangements, both NHS Lanarkshire and South Lanarkshire Council play a key role in working towards the common overarching priority of tackling inequalities
1.4	Support improvement programmes identified and in practice, as part of the Children and Young People Improvement Collaborative	Y	Ongoing	Directs NHS Lanarkshire and South Lanarkshire Council to participate in the development of the Local Outcome Improvement Plans (LOIPS) with a particular focus on early years, tackling social isolation, health inequalities, early intervention/prevention and community capacity building	NI 1 NI 2	Outcome 5		Through Community Planning arrangements, both NHS Lanarkshire and South Lanarkshire Council play a key role in working towards the common overarching priority of tackling inequalities
1.5	Working with VASLan and South Lanarkshire Leisure and Culture Trust, develop a local framework and pathway that offers a range of social and community based alternatives and supports from the third	Y	Ongoing	Directs NHS Lanarkshire and South Lanarkshire Council to participate in the development of the Local Outcome Improvement Plans (LOIPS) with a particular focus on early years, tackling social isolation, health inequalities, early intervention/prevention and community capacity building	NI 1 NI 2	Outcome 5		Through Community Planning arrangements, both NHS Lanarkshire and South Lanarkshire Council play a key role in working towards the common overarching priority of tackling

	sector organisations that provide a flexible and innovative approach to health and care that reach the most in need of support. These supports will reduce reliance on Health and Social Care and provide early intervention and prevention approaches that improve health and wellbeing and provide a cohesive social prescribing approach.							inequalities
				Through Integrated Care Fund Investment, increase capacity within the Third Sector and Leisure to promote alternatives to formal services	NI 1 NI 2	Outcome 5		Ring fenced funding has been made available to grow third sector capacity. All proposals and projects are required to demonstrate progress against the 9 Health and Wellbeing Outcomes and 13 strategic priorities outlined in the Strategic Commissioning Plan.
1.6	Provide a range of programmes in conjunction with SLL&C and other partners that support people to keep physically and mentally active, live life well, maintain community connections and so reduce isolation and the subsequent health consequence.	Y	Ongoing	Directs NHS Lanarkshire and South Lanarkshire Council to participate in the development of the Local Outcome Improvement Plans (LOIPS) with a particular focus on early years, tackling social isolation, health inequalities, early intervention/prevention and community capacity building	NI 1	Outcome 5		Through Community Planning arrangements, both NHS Lanarkshire and South Lanarkshire Council play a key role in working towards the common overarching priority of tackling inequalities
1.7	Deliver on the ambitions in the Green Health Partnership action plan and Our Natural Health Service ambitions given the noted benefits to Mental Health and wellbeing	Y	Ongoing	Directs NHS Lanarkshire and South Lanarkshire Council to participate in the development of the Local Outcome Improvement Plans (LOIPS) with a particular focus on early years, tackling social isolation, health inequalities, early intervention/prevention and community capacity building	NI 1	Outcome 4 Outcome 5		Through Community Planning arrangements, both NHS Lanarkshire and South Lanarkshire Council play a key role in working towards the common overarching priority of tackling inequalities
1.8	Align our key health improvement programmes and strategies to the National Public Health Priorities	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention
1.9	Deliver the actions in the Lanarkshire Healthy Weight Strategy and the Diabetes Prevention Framework to support people to be of a healthy weight and reduce the incidence of Diabetes	Y	Ongoing	Directs NHS Lanarkshire and South Lanarkshire Council to participate in the development of the Local Outcome Improvement Plans (LOIPS) with a particular focus on early years, tackling social isolation, health inequalities, early intervention/prevention and community capacity building	NI 1 NI 2 NI 11	Outcome 4 Outcome 5		Through Community Planning arrangements, both NHS Lanarkshire and South Lanarkshire Council play a key role in working towards the common overarching priority of tackling inequalities
2	**Strategic Priority - Delivering Statutory / Core Duties**							
2.1	Enhance the Self-directed Support (SDS) journey for service users and carers as part of increasing the choice and options available to people in accessing supports	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention

2.2	Target social care resources to the most vulnerable through the implementation of a prioritisation/eligibility framework	Y	Ongoing	Implement Prioritisation Framework in line with the four national categories of Low, Moderate, Substantial and Critical	NI 9	Outcome 9		Fieldwork social care services now operate a consistent model of prioritisation similar to other HSCP areas across Scotland
2.3	Continue to design/develop the Primary Care Transformation plan and ensure readiness to align to the new GMS contract effectively	Y	Ongoing	Directs NHS Lanarkshire to develop alternative and sustainable models within Primary Care to address existing challenges, for example, General Practitioner capacity	NI 1 NI 2 MSG 6	Outcome 8 Outcome 9		Much of this work has been impacted by the pandemic, with resources having to be diverted to this. GP sustainability and capacity remains a challenge across Lanarkshire and nationally
		Y	Ongoing	Reduce prescribing activity for South Lanarkshire to achieve a level which is more comparable with the national averages through: 1) Increased social prescribing 2) Alternative medicines and drugs 3) Changes to practice and culture	NI 1 NI 2	Outcome 9		Although the prescribing position shows a breakeven position early in the new financial year, this will be monitored closely and still remains a high-risk area to the Partnership.
		Y	Ongoing	Implement Primary Care Transformation programme in relation to general practice and community redesign, urgent care, the house of care model, pharmacy support in practice and GP sustainability	NI 1 NI 2 MSG 6	Outcome 1 Outcome 3 Outcome 8 Outcome 9		Whilst the principle and direction of travel remain correct from a strategic perspective, progress has been impacted by other challenges brought about by COVID. Currently, much of the focus and effort has been directed towards the Vaccine Transformation, the COVID Community Pathway and GP sustainability
		Y	Ongoing	Implement the new requirements with regards to General Medical Services 2018 Contract. Specifically the development of a Primary Care Improvement Plan (PCIP) by June 2018 to outline how existing and new services which affirm the role of GPs as expert medical generalists	NI 1 NI 2 MSG X 6	Outcome 8 Outcome 9		Whilst the principle and direction of travel remain correct from a strategic perspective, progress has been impacted by other challenges brought about by COVID. Currently, much of the focus and effort has been directed towards the Vaccine Transformation, the COVID Community Pathway and GP sustainability
		Y	Yes	Develop Memorandum of Understanding to support the production and implementation of the Primary Care Improvement Plan (PCIP)	NI 11	Outcome 8 Outcome 9		Approved by IJB in 2018
2.4	Deliver all services in line with statutory requirements as set	Y	Ongoing	Global Direction issued in relation to the delivery of all delegated functions	ALL NI MSG X 6	Outcomes 1 - 9		This Direction covers the delivery of all services

	out in the legislation covering Health and Social Care Services, for example, legislation pertaining to Public Protection; Mental Health, Learning Disability and Carers							delegated by the Parties (NHS Board and Council) to the IJB for strategic oversight.
		Y	Ongoing	Maintain existing commitments to ensure that all statutory and legal duties are delivered, for example adult support and protection, child health surveillance, immunisation, Self-directed Support (SDS), Community Empowerment and Mental Health requirements, safeguarding the interests of the most vulnerable within our society	ALL NI MSG X 6	Outcomes 1 - 9		All statutory duties continue to be operationally delivered by both Parties as outlined in the Strategic Commissioning Plan.
		Y	Ongoing	Directs that South Lanarkshire Council will develop an Advocacy Service specification	NI 1 NI 2 NI 3	Outcome 2 Outcome 3		Work is now underway to develop a service specification which will form the basis of a future tender process for advocacy services
2.5	Deliver locality based home care services which support the delivery of personal care and maximise the opportunity for people to be maintained at home	Y	Ongoing	Directs that South Lanarkshire Council will deliver Home Care Services in terms of the new contractual framework agreement; that mobile working and efficiencies in scheduling will be introduced	NI 2 NI 18 MSG 4	Outcome 2 Outcome 4		South Lanarkshire Council, in conjunction with its external partners continue to work to jointly deliver the required number of hours to meet demand for home care. Innovative work such as a new scheduling system through the Total Mobile solution are currently undergoing a phased roll out across localities
		Y	Ongoing	Implement the recommendations of the Home Care Service review to maximise capacity to support people at home	NI 2 NI 18 MSG 4	Outcome 2 Outcome 4		Work continues with regards to the full implementation of the actions associated with the care at home review and service modernisation programme
2.6	Support the personal outcomes and preferences of people in 'end of life' through the delivery of Palliative Care Services which focus on being: Safe; Person centred; Accessible; Efficient; Affordable; Deliverable	Y	Yes	Commission inpatient Palliative Care Services (12 beds) within the South Lanarkshire geographical area	NI 15	Outcome 2 Outcome 3 Outcome 4		The Palliative Care Strategy seeks to support people to be cared for in their place of choice, for example, home, care home or within a more specialist setting such as a hospice. In line with the strategy, there are palliative care beds within the South Lanarkshire area as a result of provision within Kilbryde Hospice in East Kilbride
3	**Strategic Priority - Mental Health and Wellbeing**							

3.1	Develop a single service approach for community based Mental Health Services across the four localities of South Lanarkshire	Y	Ongoing	Integration and co-location of Mental Health Services for Health and Social Care across the four localities within South Lanarkshire				A whole systems approach is being taken to community mental health services. Staff, Clinical and Care Governance structures have been agreed and implemented and details around the financial governance and budget transfer from North HSCP for the Community Mental Health Services are progressing. The detail of the 3 phases of implementation were updated to the IJB on 17/08/21
3.2	Implement the Good Mental Health for All local action plan to support Mental Health and wellbeing in the population	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention
3.3	Review the range of 'Link' workers already working across primary care and Mental Health Service and agree model to maximise posts – and to link people to alternative supports in the community	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention
3.4	Review the provision of Mental Health beds for adults and older people in South Lanarkshire.	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention
4	**Strategic Priority - Seven Day Services**							
4.1	Implement a programme of work to maximise efficiency within the care at home service	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention
4.2	Develop the number and range of services provided over seven days.	Y	Ongoing	Develop proposals for IJB approval which consolidate and co-locate out of hours services across Health and Social Care	MSG 1 - 4	Outcome 9		From an out of hours perspective, there has also been increased pressures emanating from the pandemic. New services such as the Acute Respiratory Illness Centre (ARIC) have been setup to respond directly to this, whilst at the same time, continuing to provide out of hours support to an

								increased number of patients.
4.3	Work with acute hospital colleagues to maximise seven day working and support flow across all areas	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention
4.4	Implement a model of day opportunities which support people's personal outcomes and preferences	Y	Ongoing	Develop and commission a day opportunities model for Adult and Older People which promotes enablement, independence, self-care and self-management	NI 2	Outcome 1 Outcome 2 Outcome 9		A full review of day services is nearing completion and will be presented to a future IJB for consideration. Regular updates have been given across the last 12 months with regards to progress with the review and also to seek the views of IJB members as part of a wider consultation and engagement programme
5	**Strategic Priority – Carers**							
5.1	Increase support to carers in maintaining their caring role through the implementation of the duties outlined in the Carers Act 2016 pertaining to: ♦ information and advice ♦ adult carer support plans ♦ young carer statements ♦ short breaks	Y	Ongoing	Implement the requirement of the Carers (Scotland) Act 2016 pertaining to: ♦ a new adult carer support plan with personal outcomes focus ♦ a new young carer support plan with a personal outcomes focus ♦ a duty to support carers including by means of a local eligibility criteria ♦ a duty to prepare a local Carers Strategy ♦ a duty to provide an information and advice and publish a short breaks services statement ♦ a duty to involve carers in the discharge from hospital of the people they care for	NI 8 NI 27	Outcome 6		The implementation of the Carers (Scotland) Act 2016 is a key action for the IJB and its partners. Good progress has been made against the 6 actions outlined with the Carers Strategy Group taking a lead in monitoring and reporting progress. Within the IJB forward plan, the Carers Strategy Group provides an update on progress and any issues to the IJB
5.2	Strengthen the 3rd Sector support model for carers through reviewing how existing services are commissioned in relation to carers support services, information and advice, consultation and engagement, training, practical support and consultation and engagement	Y	Ongoing	To procure services which provide equitable access to carer support services, information and advice, short breaks, consultation and engagement, training, practical support and assistance for adult and young carers	NI 8 NI 27	Outcome 6		A new arrangement for the delivery of carers support has been successfully procured with Lanarkshire Carers being the preferred partner. This arrangement is progressing well from a carers support, engagement, information, training and short breaks perspective. Further work is underway to consolidate the approach to Carer Support Plans
6	**Strategic Priority - Suitable and Sustainable Housing**							
6.1	Increase housing supply and improve access to and choice of	N	N/A	Actions being picked up through Local Housing Strategy 2017-22 and Rapid Rehousing				There is currently no Direction aligned to this

	housing options that suit people's needs and which they are able to afford and sustain			Transition Plan (RRTP)				Strategic Commissioning Intention
6.2	Ensure people with particular needs and their carers are better supported to live independently within the community in a suitable and sustainable home, reducing requirement for institutional care and risks of homelessness	N	N/A	Actions being picked up through Local Housing Strategy 2017-22 and RRTP				There is currently no Direction aligned to this Strategic Commissioning Intention
7	**Strategic Priority - Preventing and Reducing Homelessness**							
7.1	Improve and increase provision of housing support for households to live independently within communities	N	N/A	Actions being picked up through Local Housing Strategy 2017-22 and RRTP				There is currently no Direction aligned to this Strategic Commissioning Intention
7.2	Expand the scope and capacity of Housing First approach to be the first response for households with multiple complex needs.	Y	Ongoing	Directs NHS Lanarkshire and South Lanarkshire Council to prioritise access to general medical and universal health screening services for homeless people, including those currently engaged with the Housing First model.	NI 2 MSG 6	Outcome 1 Outcome 2		An update was given to the IJB meeting in May 2021 on both homeless Directions. Both Directions have been impacted by the pandemic but work is now underway to look at testing implementation within one locality of South Lanarkshire with a view to scaling this up across the remaining 3 localities
7.3	Increase awareness and reach of Health and Social Care services to help early identification of need and subsequent prevention of homelessness	Y	Ongoing	Directs NHS Lanarkshire to deliver routine enquiry across all services, including visiting outreach, GP services and A&E to identify housing issues and requirements	NI 2 MSG 6	Outcome 1 Outcome 2		An update was given to the IJB meeting in May 2021 on both homeless directions. Both Directions have been impacted by the pandemic but work is now underway to look at testing implementation within one locality of South Lanarkshire with a view to scaling this up across the remaining 3 localities
8	**Strategic Priority - Single Points of Contact**							
8.1	Reducing the impact of people being delayed in hospital through the implementation of ♦ rapid response short-term care at home teams ♦ integrated care and support teams	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention

	♦ remodelled assessment and care management systems ♦ Technology Enabled Services							
8.2	Across the four locality planning areas maximise opportunities to streamline how we support people who require Health and Social Care support. This will include: ♦ closer alignment of community based health and social care staff, including further co-location ♦ integrated support planning and review ♦ Sharing information across I.T systems ♦ workforce planning to identify areas of need and development	Y	Ongoing	Directs both South Lanarkshire Council and NHS Lanarkshire to implement an integrated locality planning and management model for the Partnership which has broad consistency across each of the four localities	MSG x 6	Outcomes 1 - 9		The development of a consistent locality operational model which also allows the flexibility to take account of unique local circumstances continues to be progressed. Locality Planning Groups, Core Management Groups and multi – agency decision making on complex cases all form part of this model
		Y	Ongoing	Develop whole system working approach to locality planning	MSG x 6	Outcomes 1 - 9		The development of a consistent locality operational model which also allows the flexibility to take account of unique local circumstances continues to be progressed. Locality Planning Groups, Core Management Groups and multi – agency decision making on complex cases all form part of this model
		Y	Ongoing	Implement a locality operational model across the four geographical localities of South Lanarkshire	MSG x 6	Outcomes 1 - 9		The development of a consistent locality operational model which also allows the flexibility to take account of unique local circumstances continues to be progressed. Locality Planning Groups, Core Management Groups and multi – agency decision making on complex cases all form part of this model
9	**Strategic Priority - Intermediate Care**							
9.1	Implement the new care facilities model across the four localities to provide people with more choice and options to be maintained at home and in the community	Y	Yes	Directs both South Lanarkshire Council and NHS Lanarkshire to complete a feasibility study which review care pathways and maximises use of existing community based resources – including all beds, regardless of setting	MSG x 6	Outcome 1 Outcome 2 Outcome 3 Outcome 9		Action was completed as part of locality planning and modelling work
		Y	Ongoing	Reduce reliance on Nursing and Residential Care through the development of proposals to	MSG x 6	Outcome 1 Outcome 2		Although initially impacted by the Pandemic, progress with

				remodel a proportion of residential care beds to focus on transitional support and the 'home for life' principle		Outcome 3 Outcome 9		the Blantyre development is now on schedule from a build and service planning perspective. Intermediate provision is currently available within Canderavon House and this will eventually transition to the new facility in Blantyre. An update on the next steps with this model will be presented to a future IJB
9.2	Enhance community based rehabilitation and re-ablement interventions as part of shifting delivery of services away from the hospital	Y	Yes	Strengthen community based services resulting from the re-allocation of resources from acute to community as a result of the agreed IJB Direction to close the Douglas Ward in Udston Hospital (30 beds)	MSG x 6	Outcome 1 Outcome 2		This was approved by the IJB and implemented in 2018
		Y	Ongoing	Support people to maximise their independence through the delivery of reablement (SYI)	MSG x 6	Outcome 1 Outcome 2		There is a recognised reablement approach within the home care service but this has been partly impacted by other services pressures and demands linked to the Pandemic
		Y	Ongoing	Redesignate off-site acute hospital beds within Udston and Stonehouse hospitals to support step down intermediate care patients undergoing a guardianship (AWI) process	MSG x 6 NI 9	Outcome 1 Outcome 2 Outcome 9		This has been impacted by the pandemic whereby additional capacity had to be utilised as part of the response due to pressure within the main 3 District General Hospital sites. Their remains significant pressure on acute hospital beds, not only from a demand perspective but also in terms of the levels of acuity/complexity
		Y	Ongoing	Integrate the Hospital at Home Service with other community based intermediate care services such as Integrated Community Support Teams (ICST)	MSG x 6	Outcome 1 Outcome 2 Outcome 9		Due to current demands with the vaccine programme and managing increasing demand, many of the staff associated with for example ICST, have had to be utilised in different ways. This has impacted the progress with this Direction
		Y	Yes	Re-designation of Lockhart inpatient beds to a community based facility	MSG x 6	Outcome 1 Outcome 2 Outcome 9		Completed and approved by IJB with Lockhart hospital currently bring utilised as a

								base for community resources including formal and 3rd Sector services
10.	**Strategic Priority - Unscheduled Care**							
10.1	Agree target for average length of stay across South Lanarkshire HSCP with regards to Older Peoples unscheduled care to reduce overall demand on the use of hospital beds	Y	Ongoing	Establish and implement an agreed average length of stay for emergency admissions related to Care of Elderly	MSG x 6	Outcome 1 Outcome 2 Outcome 9		The current average length of stay continues to be monitored and reported as part of the current performance reporting arrangements. However, figures related to this have been significantly impacted upon by the Pandemic
10.2	Agree and introduce Unscheduled Care Plan to include: ♦ Frailty ♦ Front Door Senior Decision Making ♦ Frequent Attendees	Y	Yes	Directs NHS Lanarkshire Acute Services to work jointly with the Health and Social Care Partnership to develop proposals which more effectively supports a reduced number of A&E attendances, associated admissions and generally shifts the balance of care and reduces unplanned care requirements in a hospital setting	MSG 1 - 4	Outcome 1 Outcome 2 Outcome 9		A number of proactive initiatives have been undertaken to reduce footfall at the hospital front door. Figures over the last year for attendances and admissions do not reflect previous trends due to the Pandemic effect. However, more recent data shows that there remains significant pressures, as it is not only increased footfall but also higher levels of acuity related people presenting at the front door. A number of public communications have been undertaken highlighting alternative supports that the public can access such that care can be prioritised to those in most need
10.3	Implement re-ablement approach to care across acute hospital ward settings.	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention
11	**Strategic Priority - Models of self-care and self-management**							
11.1	Further extend the use of Technology Enabled Care to support people to be active participants in managing their own health and wellbeing	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention
11.2	Through improved awareness and visibility of the 'Locator' tool link local Health and Social Care professionals to a wider network	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention

	of alternative interventions and support options. Note: this would equally link to intermediate care (step down), single point of contact, Mental Health and wellbeing and transitions							
11.3	Support the introduction of new unscheduled care pathways which maximise the use of Technology Enabled Care	N						There is currently no Direction aligned to this Strategic Commissioning Intention
12	**Strategic Priority - Transitional Arrangements**							
12.1	Review current transitional arrangements from Children's Service to Adult Services with a view to achieving better outcomes for vulnerable young people	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention
12.2	Work with carers as key partners in the review of 'Transitional arrangements'	N	N/A					There is currently no Direction aligned to this Strategic Commissioning Intention
13	**Strategic Priority – Enablers**							
13.1	Ensure that integration arrangements have the necessary support services capacity to underpin the delivery of better integrated strategic and operational delivery of Health and Social Care Services	Y	Yes	Develop and implement a performance management approach for the Partnership	All PIs	Outcome 9		Completed in 2017 and now a standing item on the IJB agenda
		Y	Ongoing	Further integration of IT and information sharing to allow access to partner IT systems	All PIs	Outcome 9		Continues to progress. In addition to eCare, further examples of integration includes the pilot work being undertaken within the Community Addictions and Recovery Service (CAReS) and also the forthcoming procurement of a new social care information system
		Y	Ongoing	Directs South Lanarkshire Council to create a Commissioning and Quality Assurance resource	All PIs	Outcome 9		The recruitment process for this new team is underway.

Agenda Item

7

Report

Report to:	**South Lanarkshire Integration Joint Board**
Date of Meeting:	**17 August 2021**
Report by:	**Interim Chief Officer, Health and Social Care Partnership**

Subject:	**Draft Integration Joint Board Annual Performance Report 2020/2021**

1. Purpose of Report

1.1. The purpose of the report is to:-

- present a draft copy of the Integration Joint Board's Annual Performance Report for 2020/2021 and to highlight performance

2. Recommendation(s)

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that the progress with the Annual Performance Report be noted; and

(2) that any final amendments to the Annual Performance Report are delegated to the Chief Officer and Head of Commissioning and Performance to approve.

3. Background

3.1. Section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014 requires that Annual Performance Reports (APRs) are prepared by an Integration Authority or Integration Joint Board (IJB) in a South Lanarkshire context. The 2014 Act obliges that the APR should cover the preceding year's activity and be published four months after the end of that reporting year.

3.2. The purpose of the APR is to ensure that performance is open and accountable, whilst at the same time providing an overall assessment of performance in relation to planning and carrying out integration functions.

3.3. Whilst there is no formal requirement to submit the APR to the Scottish Government, the content and assessment of performance within the Report is expected to be used and acted upon locally. The Report should also be of interest to the Health Boards and South Lanarkshire Council in monitoring the success of the integration arrangements they have put in place, as specified within their Integration Scheme.

3.4. To assist Health and Social Care Partnerships (HSCPs), the Scottish Government issued Guidance for HSCP Performance Reports in March 2016. Although it is at the discretion of local Partnerships to decide areas to include in their APR, this guidance provided a helpful framework and recommended the following areas for inclusion:

- a summary of progress against the nine National Health outcomes using as a minimum, the 23 core national performance indicators
- financial performance and best value
- reporting progress with localities
- inspection of services, summarising any activity undertaken by Healthcare Improvement Scotland, the Care Inspectorate, Audit Scotland, Accounts Commission and Scottish Housing Regulator in the year of review

3.5. As with previous years, the APR is aligned to reporting progress against the intentions outlined in the Strategic Commissioning Plan. For this particular APR, it will cover the second year of the 2019-2022 Strategic Commissioning Plan.

3.6. The Scottish Government have advised that the Coronavirus Scotland Act (2020) has been extended to 30 September 2021. Similar to last year, Integration Authorities can delay the release of their APR until November 2021 if they wish using the same mechanisms as last year and as laid out in Coronavirus Scotland Act (2020), Schedule 6, Part 3. To help accommodate this, Public Health Scotland will release two Core Suite Integration Indicator publications, the first in July and the second in September containing refreshed data. A standard set of wording has been provided within appendix 2 of the Draft Annual Performance Report to this effect. The timing of the APR publication will determine which release of the Core Suite Integration Indicators should be referred to, more detail is provided below.

4. Context to South Lanarkshire Draft Report and Format

4.1. A copy of the draft APR for the South Lanarkshire HSCP is attached at appendix 1. The draft APR for South Lanarkshire IJB covers each of the above areas and is structured as follows:

Section	Heading	Summary of Content
1	Introduction	Provides the context within which the Annual Performance Report has been produced.
2	Executive summary	Statement from Chief Officer and Chair of the IJB
3	South Lanarkshire: at a glance	South Lanarkshire demography
4	Local context	Locality snapshots
5	Strategic Overview	Summarises what the HSCP is working to achieve in South Lanarkshire.
6	Governance and accountability	Governance structure
7	Key partnership decisions	Outline of key decisions made by the IJB in 2020/2021
8	A quick look at our Partnership performance	Progress against our Strategic Priorities
9	Financial Performance and Best Value Summary	Provides an overview of the financial performance of the HSCP for 2020/21
10	Inspection of services	Provides an overview of our regulatory registered services.
11	National health and wellbeing outcomes	Overview

5. Summary of our headline achievements for 2020/21

5.1. Throughout 2020/21 South Lanarkshire Health and Social Care Partnership has made significant achievements through the incredible effort and commitment from staff across the partnership - working with individuals, their carers and families, with colleagues in other agencies and the voluntary and independent sector. These include:

- Establishment of a pan-Lanarkshire COVID-19 Assessment Hub as required by the Scottish Government. A telephone triage Hub and an assessment centre are operational within the Airdrie Out of Hours (OOH) base and there is an assessment centre within the Douglas Street Clinic in Hamilton. Over 43,000 patients have been through the Hub with over 15,000 being assessed and treated in the COVID-19 Assessment Centres.
- Staff and patient COVID-19 testing improving rapidly. Testing of residents in care homes quickly developed a higher profile and the HSCP worked with NHSL colleagues and providers to implement current guidance in this respect.
- Unused wards in Udston Hospital were brought back into use for rehabilitation patients who could be transferred out of Acute beds thereby freeing up ward space for COVID-19 patients.
- Community hospital beds re-configured to facilitate isolation and Community Nursing Teams continued to visit those patients requiring ongoing clinical care.
- The Integrated Community Support Teams (ICST) continue to provide care supporting patients in their homes to avoid hospital admission and timely discharge.
- High uptake of winter flu vaccination programme. This was quickly followed by the continuing COVID-19 vaccination programme and uptake is high.
- Use of Near Me technology has been used extensively allowing patients, families and carers to be supported during this period.
- Treatment room services were initially suspended with those patients who required ongoing support having this provided in their homes.
- Improvement on accident and emergency attendances (2019/2020 108,834 and 83,193 for 2020/21)
- maximised early hospital discharge and continued to reduce the number of Delayed Discharges from hospital (17,285 bed days against the target of 21,344).
- One of the key strategies for the HSCP is shifting the balance of care from hospital to community settings. The partnership continues to make steady progress towards this aim, from 88.3% during 2019/20 to 90.2% 2020.
- Work continues to progress well on phase 1 of the Blantyre development of the modernising care facilities programme.
- The adult and older people day care review is now complete with the agreement that the next stage of the review is to engage in consultation with key stakeholders on the options arising from the review.
- The review of the care and support service includes recommendations for improvement activity to sustain and modernise the service with a revised service specification to take account of self-directed support principles and operate within a cost effective and safe staffing model.
- Care at home transformation board continues to oversee several workstreams taking forward service redesign with significant improvement in Hamilton and Rutherglen Care at home services.
- Partners continue to contribute to preventing homelessness and progress with the implementation of the routine enquiry direction is proving successful with NHSL continuing to provide a Health and Homelessness nurse led service.

- Progress on the Lanarkshire Mental Health and Wellbeing Strategy 2019-2024 continues with work to transfer the operational management of SL Community Mental Health Teams to SL HSCP.

6. Next Steps

6.1. Following approval by the IJB, the draft APR will be subject to further changes and updating as appropriate in relation to data release as outlined at 3.6 above prior to publication. The Report will then be made available on the HSCP website.

6.2. The Strategic Commissioning Plan for the period 2019-2022 was approved by the IJB at its meeting of 25 March 2019. Engagement on preparation for the next Strategic Commissioning Plan 2022 – 2025 is being undertaken from August – October 2021.

7. Employee Implications

7.1. There are no employee implications associated with this report.

8. Financial Implications

8.1. There are no financial implications associated with this report.

9. Climate Change, Sustainability and Environmental Implications

9.1. There are no implications for climate change, sustainability or the environment in terms of the information contained in this report.

10. Other Implications

10.1. There are no additional risks associated with this report.

10.2. There are no other issues associated with this report.

11. Equality Impact Assessment and Consultation Arrangements

11.1. This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy and therefore, no impact assessment is required.

11.2. This report is an APR and relates to the Strategic Commissioning Plan 2019-2022, which was extensively consulted on.

12. Directions

Direction to:	
1. No Direction required	☒
2. South Lanarkshire Council	☐
3. NHS Lanarkshire	☐
4. South Lanarkshire Council and NHS Lanarkshire	☐

Marianne Hayward
Interim Chief Officer, Health and Social Care Partnership

Date created: 25 June 2021

Link(s) to National Health and Wellbeing Outcomes

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

Previous References

- Strategic Commissioning Plan 2019 - 2022
- Annual Performance Report 2019/2020

List of Background Papers

- Appendix 1 - Annual Performance Report 2020/2021

Contact for Further Information

If you would like to inspect the background papers or want further information, please contact:-

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South Lanarkshire Integration Joint Board 7

Annual Performance Report 2019/2020

1. Introduction

This is the fifth Annual Performance Report for South Lanarkshire Integrated Joint Board (IJB). It focuses on our performance between April 2020 and March 2021, outlines our priorities for 2021/22 and looks back at our performance since our inception in 2016.

In this report we would like to highlight the continued achievements and works of the staff of the Health and Social Care Partnership (H&SCP) throughout 2020/21. Particularly, in the face of increasing adversity of COVID 19; the work undertaken in managing the impact of the pandemic has been down to the incredible effort and commitment of staff from across the partnership and the selfless dedication from individuals, carers, family members, voluntary and independent partners and the third sector.

Following consultation with local people and staff, the first Strategic Commissioning Plan of the IJB was published in 2016. That plan set out the Partnership's objectives for attaining the Vision of the Integrated Joint Board (IJB) which is:

> Working together to improve health and wellbeing
> **in** the community - **with** the community

Our Strategic Commissioning Plan was reviewed to cover the period 2019-2022. This refreshed version focuses on the delivery of our strategic priorities aligned to the national health and wellbeing outcomes.

Our Annual Performance Report (APR) sets out the Partnership's performance between April 2020 and March 2021, outlining our priorities for 2021/22 and reflecting on performance since inception in 2016. Delivery on progress is structured under the nine health and wellbeing outcomes and our thirteen strategic priorities which are:

Our Strategic Priorities

National Health and Wellbeing Outcomes

Outcome 1

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

Outcome 2

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

Outcome 3

People who use health and social care services have positive experiences of those services and have their dignity respected.

Outcome 4

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Outcome 5

Health and social care services contribute to reducing health inequalities.

Outcome 6

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

Outcome 7

People using health and social care services are safe from harm.

Outcome 8

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Outcome 9

Resources are used effectively and efficiently in the provision of health and social care services.

2. Executive Summary

This has been a year like no other and our vision '*working together to improve health and wellbeing in the community **with** the community'* has been our strength as we have continued to respond to the demands of the COVID-19 global pandemic, ensuring that statutory essential services could be delivered safely. We commend the incredible effort and commitment from staff across the 'Partnership working with individuals, their carers and families, with colleagues in other agencies and the voluntary and independent sector.

The Partnership refocused its resources on key activities, supporting the community in responding to the prevailing COVID-19 situation. We have been working with acute hospital colleagues to support Covid inpatients and overall flow through the hospitals. In doing so, we have optimised access to critical and core functions and to ensure that services for the most vulnerable, such as Care at Home, Community Nursing, Primary Care and care homes, were and continue to be maintained.

The Partnership has been able to maximise early hospital discharge and reduce the number of Delayed Discharges from hospital. McWhirters House in Larkhall was temporarily re-commissioned and staffed to support a small number of service users with lower-level needs. We have had support from several other Council employees and staff from South Lanarkshire Leisure and Culture Services, with NHS Lanarkshire (NHSL) and Health and Social Care Partnership (HSCP) Managers delivering training to support these employees into Social Care and other roles to support the wider response to the pandemic. The Care at Home Team worked closely with Community Resources and Education to set up a Community Meals Service for a period of time which created resilience and enabled Care at Home resources to be directed to those greatest in need while ensuring those with lower-level needs continued to receive support with meals.

A pan-Lanarkshire COVID-19 Assessment Hub was established as required by the Scottish Government. A telephone triage Hub and an Acute Respiratory Assessment Centre (ARIC) are operational within the Airdrie Out of Hours (OOH) base and a further there is an assessment centre within the Douglas Street Clinic in Hamilton. Over 43,000 patients have been through the Hub with over 15,000 being assessed and often provided with treatment in the COVID-19 Assessment Centres. Approximately 3,000 of these patients were referred to hospital for further assessment/admission.

Unused wards in Udston Hospital were brought back into use for rehabilitation patients who could be transferred out of Acute beds thereby freeing up ward space for COVID-19 patients. Community hospital beds were re-configured to facilitate isolation and Community Nursing Teams continued to visit those patients requiring ongoing clinical care. The Integrated Community Support Teams (ICST) continue to provide care supporting patients in their homes to avoid hospital admission and timely discharge. The COVID vaccination programme has continued at pace with uptake being exceptionally high.

Allied Health Professional staff took part in training so they could carry out clinical tasks out-with their usual remit to support their colleagues. 'Near Me' software allowed patients, families and carers to be supported during this period. Treatment room services were initially suspended with those patients who required ongoing support having this provided in their homes.

Health Visiting Team and Family Nurse Partnership Teams continued to support pre-school children in line with Scottish Government guidance prioritising child protection and primary assessments. The extended assessment of children and support to families was supported using the Near Me software, with Universal Pathway assessments being undertaken in line with guidance and professional judgement.

Over the duration of the Pandemic, staff and patient testing has improved rapidly. Testing of residents in care homes quickly developed a higher profile and the Partnership worked with NHSL colleagues and providers to implement current guidance in this respect.

The initial challenges with the supply of Personal Protective Equipment (PPE) and the interpretations of the guidance around its use by stakeholders have now been overcome with a reliable supply and distribution of PPE now established.

The contribution of carers in South Lanarkshire is crucial and cannot be underestimated. In recognition of the need to improve support to carers to access supports, additional Social Work assistants were recruited to carry out care assessments and reviews.

Delivery of building based day services for adult and older people had to be paused with the service being mobilised to offer an outreach option within people's homes and communities for those with the most significant vulnerabilities. This service was delivered adhering to social distancing, public health and infection control guidelines. This outreach option, while developed in response to the COVID-19 situation will also help shape future service direction.

While the programme of transformation and service improvement by the Partnership slowed at the beginning of the pandemic due to the redeployment of resources, work on the transformation agenda has continued taking account of the risks of COVID-19. Work continues to progress well on phase 1 of the Blantyre development of the modernising care facilities programme. The adult and older people day care review is now complete with the agreement that the next stage of the review is to engage in consultation with key stakeholders on the options arising from the review. The review of the care and support service includes recommendations for improvement activity to sustain and modernise the service with a revised service specification to take account of self-directed support principles and operate within a cost effective and safe staffing model. Care at home transformation board continues to oversee several work streams taking forward service redesign. Implementation of the Primary Care Improvement Plan (PCIP) has been impacted both nationally and locally and the final delivery of outcome will be delayed. All work streams of the PCIP are remobilising and work is moving forward.

There have and will continue to be areas where we are challenged and where we will continue to strive to achieve excellence for the people of South Lanarkshire. In our last annual report, we highlighted the improvement journey for our registered care at home services in Hamilton and Rutherglen and we are happy to report significant improvement. The scale and pace of work undertaken by staff within both the Hamilton and the Rutherglen/Cambuslang Care at Home Services cannot be underestimated and the outcome is testament to their hard work and dedication. Improvements will continue to be progressed as lockdown restrictions are eased.

Councillor John Bradley, Chair

South Lanarkshire Integration Joint Board

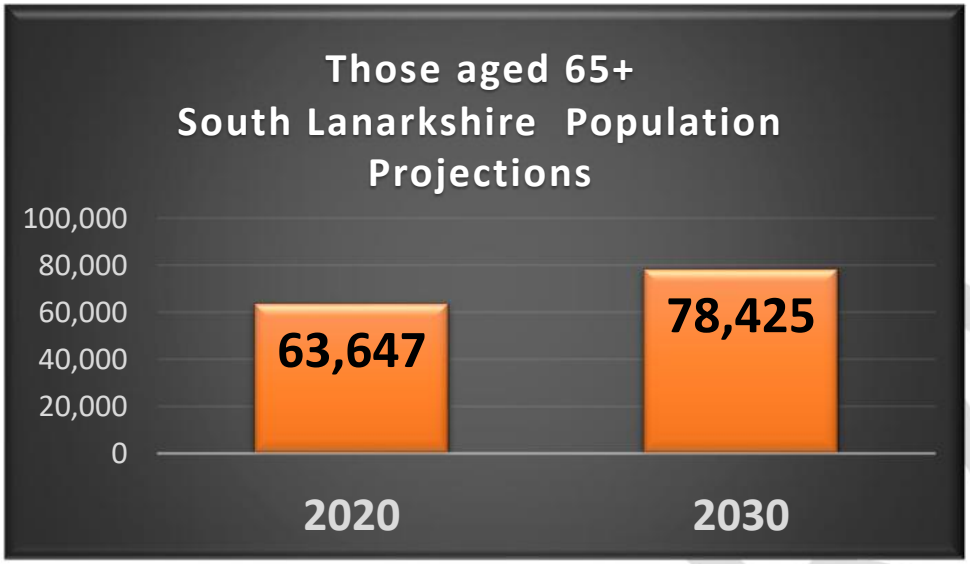
Director of Health and Social Care

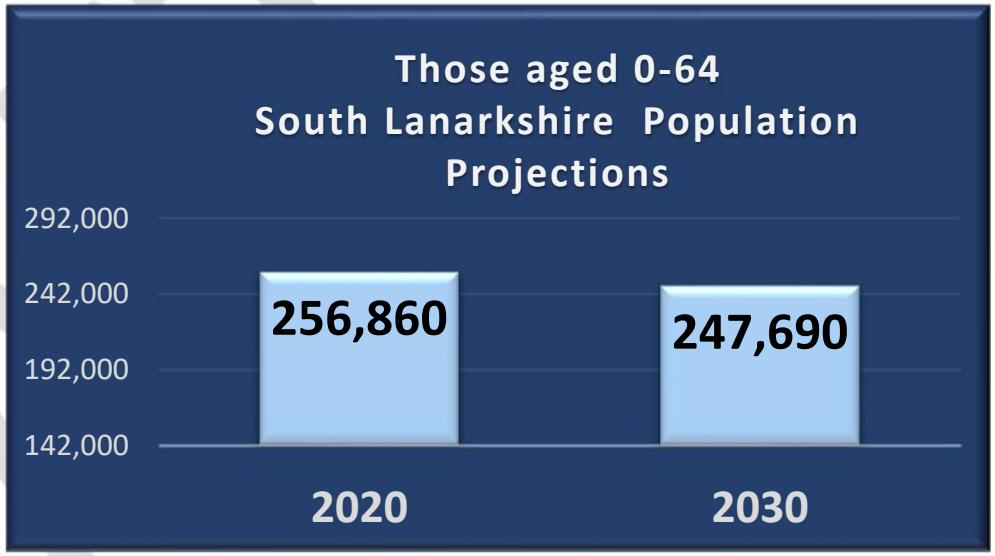
South Lanarkshire Health and Social Care Partnership

3. South Lanarkshire at a Glance

South Lanarkshire is home to approximately 319,020 people and covers an area of 700 square miles. The area stretches from the outskirts of East of Glasgow City, East Renfrewshire, West Lothian to the Scottish Borders. The area is divided into four localities, Hamilton. East Kilbride, Clydesdale and Rutherglen/Cambuslang. Population projections for the next ten years is noted below.

In 2020 the overall population was 319,020. By 2030 the population is expected to rise by 2% to 326,115





Reducing population of those aged between 0 > 64

Increasing population of those aged 65+

49% **Male Life expectancy for South Lanarkshire is currently 24th out of 32 Local Authority areas (76.8 years)**

51% **Female Life expectancy for South Lanarkshire is currently 23rd out of 32 Local Authority areas (80.6 years)**

Falls rate per 1,000 population aged 65+ for South Lanarkshire is below the Scottish average of 22.7, sitting at 21.5, placing us 16th out of 32 Local Authority areas and shows a positive trend.

Clydesdale Locality Profile

The overall **population** for the year was

61,613

49% were Male

51% were Female

4.6% were under the age of 5 (*below the Scottish average of 5%)*

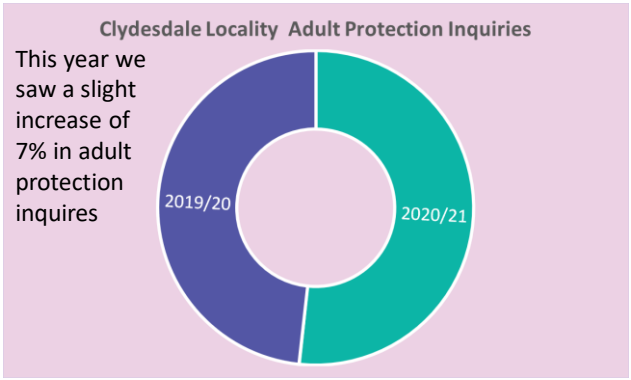
98% of 6-in-1 vaccinations completed by 12 months old (above the Scottish Average of 95.8%)

97% of MMR Vaccinations completed by 5 years old (above the Scottish Average of 96.8%)

Relatively **the same** housing tenure is being rented from the Council as other housing types

Relatively **fewer** economically active residents are unemployed

18 Adults with Incapacity Applications (AWI New / Renewal) made in the year (a reduction on previous year (44) by 59%)



Hamilton Locality Profile

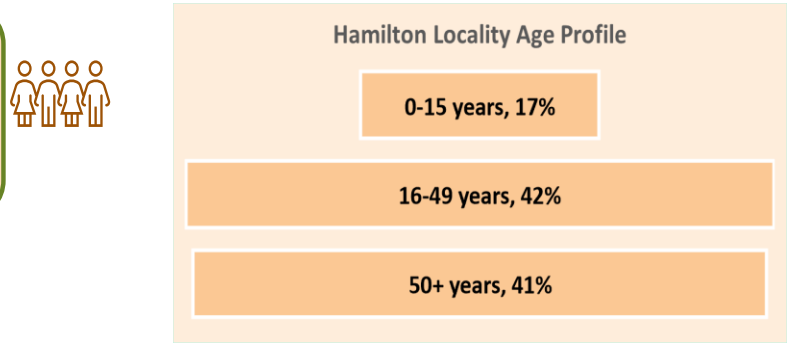
The overall **population** for the year was

108,979

48% were Male

52% were Female

5% were under the age of 5 (on par with the Scottish average)



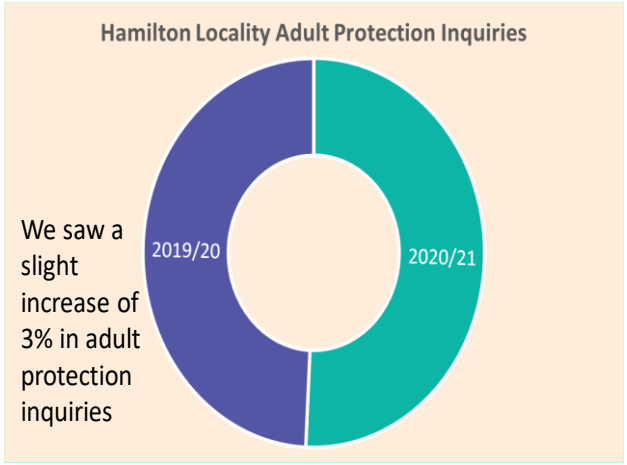
97% of 6-in-1 vaccinations completed by 12 months old (above the Scottish Average of 95.8%)

97% of MMR Vaccinations completed by 5 years old (above the Scottish Average of 96.8%)

Relatively **more** housing is being rented from the Council

Relatively , **more** economically active residents are unemployed

66 Adults with Incapacity Applications (AWI New / Renewal) were made in the year (a reduction on previous year (131) by 49%)



Rutherglen/Cambuslang Locality Profile

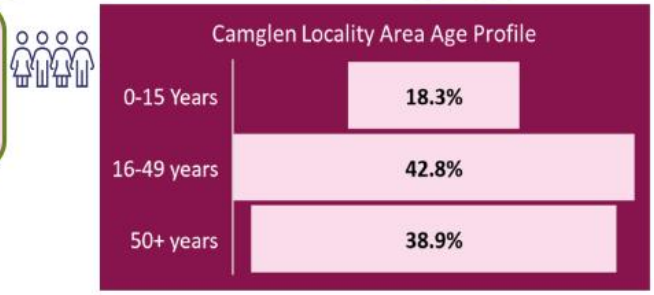
The overall **population** for the year was

60,956

48% were Male

52% were Female

6% were under the age of 5 (*above the Scottish average of 5%)*



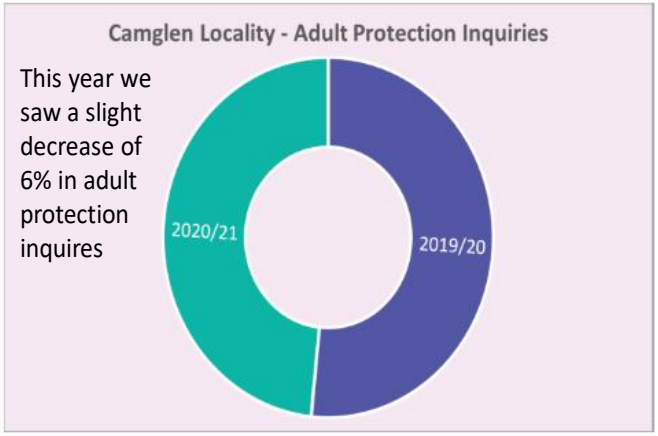
96% of 6-in-1 vaccinations completed by 12 months old (above the Scottish Average of 95.8%)

97% of MMR Vaccinations completed by 5 years old (above the Scottish Average of 96.8%)

Relatively **the same** housing tenure is being rented from the Council as other housing

Relatively **more** economically active residents are unemployed

38 Adults with Incapacity Applications (AWI New / Renewal) made in the year (a reduction on previous year (73) by 48%)



East Kilbride Locality Profile

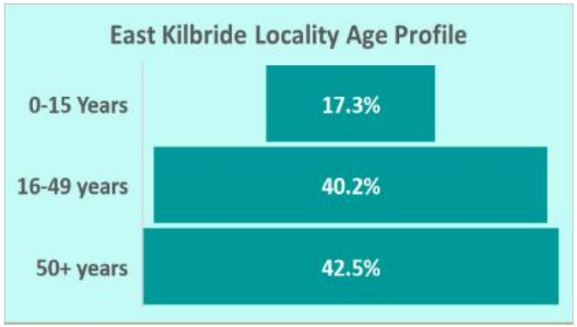
The overall **population** for the year was

88,982

49% were Male

51% were Female

5% were under the age of 5 (*on par with Scottish average of 5%***)**



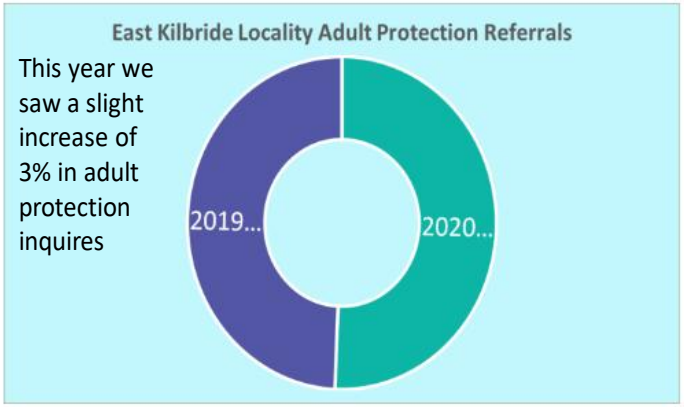
97% of 6-in-1 vaccinations completed by 12 months old (above the Scottish Average of 95.8%)

97% of MMR Vaccinations completed by 5 years old (above the Scottish Average of 96.8%)

Significantly **fewer** housing is being rented from the Council

Relatively **fewer** economically active residents are unemployed

25 Adults with Incapacity Applications (AWI New / Renewal) made in the year (a reduction on previous year (41) by 41%)



5. Strategic Overview

As a partnership our improvement objectives are wide ranging and must take account of complex national legislation and strategic policies. The Public Bodies (Joint Working) (Scotland) Act 2014 sets out the framework for integrating adult health and social care to ensure a consistent provision of quality and sustainable care services for the population we serve. This is our fifth year as an Integrated Joint Board; a formally constituted public body required to publish an annual performance report. Below is an insight into the many political, legislative, and strategic areas we focus on.

The Public Bodies (Joint Working) (Scotland) Act 2014

Eligibility Criteria

Self Directed Support

The Carers (Scotland) Act 2016

Community Empowerment (Scotland) Act 2015

Community Planning

South Lanarkshire Partnership
Stronger together

The Independent Review of Adult Social Care In Scotland; led by Derek Feeley concluded at the end of January 2021. the Report which contained recommendations from the Review was published on 3rd Feb 2021. Some of the recommendations made were:

- Establishment of a National Care Service
- National Improvement Programme
- Models of Care
- Commissioning for Public Good
- Fair Work
- Finance

In her priorities for Government statement the First Minister announced on 26 May 2021 that consultation on legislation to establish a National Care Service will begin and legislation to be introduced during the first year of parliament with the expectation the service will be operational by the end of the parliament.

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the promise

On 5 February 2020, the Care Review published seven reports, with 'the promise' narrating a vision for Scotland, built on five foundations. With cross-party support and broad commitment to #KeepThePromise, Scotland, its statutory agencies, local authorities, third sector and thousands of children and families knew that much needed to change to make sure that all Scotland's children grow up 'loved, safe and respected.'

The Promise team began work in July 2020 and is responsible for translating the findings of the Care Review into The Plan for change and driving the change needed to implement The Plan at pace.

The Plan will be phased across ten years from 2020-2030, with the initial phase focused on the urgent and immediate changes during years 2-4. These are the things that will have the greatest impact on the lives of children and young people and their families.

Locality Plans are an important aspect of work of the Locality Planning Groups (LPG). These plans take account of the overall strategic directions outlined in the IJB's Strategic Commissioning Plan (SCP) 2019-2022. Plans include local priorities, unique to each respective geographical location. Locality Objectives fit around our Strategic Commissioning Intentions and those of the local areas.

Continue to strengthen collaboration, support, engagement, and communication with and across our communities and agencies working directly with people who require support

Implement the Locality Plan in alignment with the Strategic Commissioning Plan 2019-2022

Identify areas for improvement and develop pathways to an achievable outcome

Demonstrate the impact against 9 National Health and Wellbeing Outcomes and associated performance measures

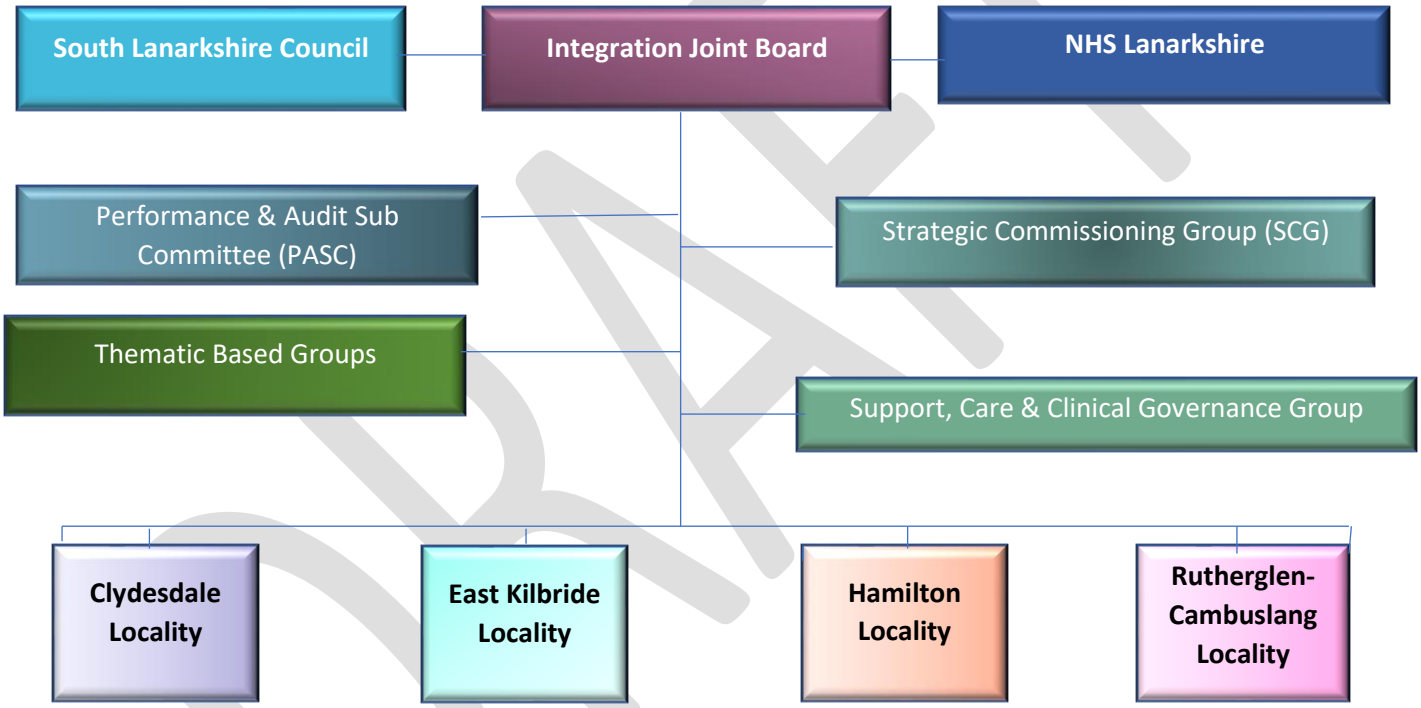
Provide strategic leadership for Health and Social Care Services

Develop systems and processes that secure wider communication, participation, and engagement

6. Governance and Accountability

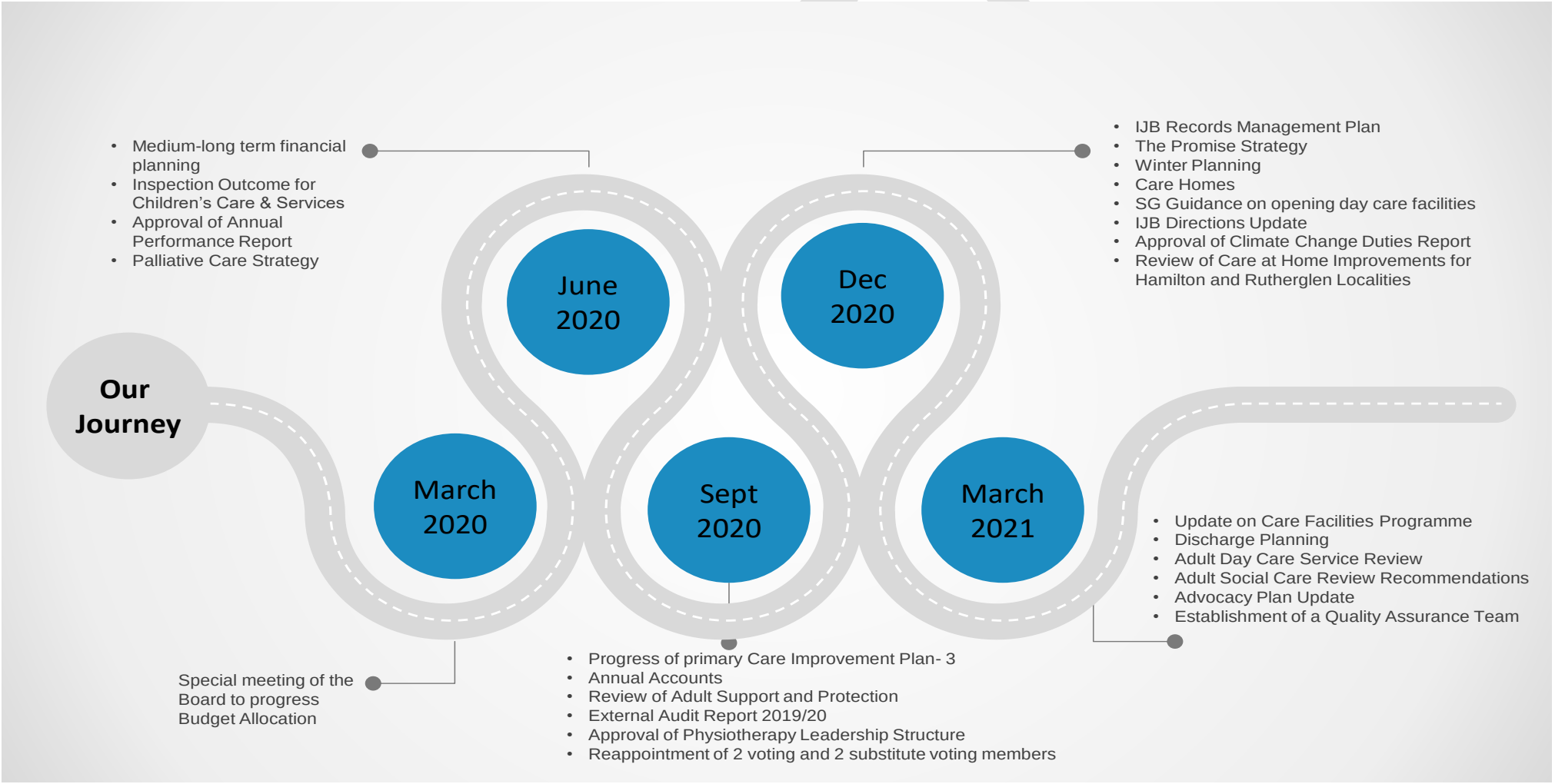
The governance structure for South Lanarkshire Health and Social Care Partnership provides a robust and streamlined process for efficient and effective Partnership decision making. Whilst the Integrated Joint Board (IJB) has the ultimate decision making and commissioning authority for the Partnership, The Performance and Audit Sub Committee provides a useful assurance function.

The Strategic Commissioning Group (SCG) is a multi-disciplinary team comprised of professional key leaders across the H&SCP, South Lanarkshire Council, NHS Lanarkshire and Third, Independent, Voluntary and Carers sectors. The group provides support and delivery of the thirteen priorities and national health and wellbeing outcomes of our SLHSCP Strategic Commissioning Plan. It also ensures the delivery of NHS Lanarkshire objectives in relation to service transformation and financial prudence as well as relevant elements of South Lanarkshire Council's Connect Plan 2017-2022. One function of the SCG is to ensure effective links to each of our four localities.



7. Key Partnership Decisions 2020/2021

For the period 2020/21; the Integration Joint Board (IJB) met regularly to transact business and participate in development sessions to ensure understanding and awareness of the more complex issues it will deal with throughout the year(s) ahead. Below is an example of some of the work considered and progressed by the Board during the year:



8. A quick look at our Partnership performance for 2020/21

The Partnership seeks to promote a culture of continuous improvement to deliver better outcomes for individuals and communities. Our Performance Management Framework provides the structure by which the Partnership can make informed decisions on future priorities, using performance information to identify and drive improvement work.

Core suite of national indicators

A core suite of national indicators has been agreed nationally to ensure consistency across all IJB areas. Nine of these indicators are survey based or qualitative measures which are gathered every two years from the national Health and Social Care experience survey, with the remaining indicators being regular health and social care performance measures.

	National Indicator	2015/16	2017/18	2019/20	SL HSCP trend from previous survey	Scotland trend from previous survey
NI 1	Percentage of adults able to look after their health very well or quite well	94.0%	91.6%	92.1%		
NI 2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	81.0%	81.0%	84.2%		
NI 3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	76.0%	69.4%	75.3%		
NI 4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	73.0%	74.4%	70.5%		
NI 5	Total % of adults receiving any care or support who rated it as excellent or good	77.0%	78.4%	80.5%		
NI 6	Percentage of people with positive experience of the care provided by their GP practice	83.0%	81.3%	73.2%		
NI 7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	81.0%	81.5%	78.1%		
NI 8	Total combined % carers who feel supported to continue in their caring role	39.0%	32.0%	31.1%		
NI 9	Percentage of adults supported at home who agreed they felt safe	82.0%	82.4%	82.0%		

	National Indicator	2015/16	2016/17	2017/18	2018/19	2019/20	2020*	SL HSCP Trend from Previous Year	Scotland Performance	Notes
NI 11	Premature mortality rate per 100,000 persons	431	438	460	431	421	Published figures on 13 July	↓	426	We have made progress in reducing premature mortality across South Lanarkshire. Premature mortality rates are below Scotland levels.
NI 12	Emergency admission rate (per 100,000 population)	13,403	13,886	14,088	14,627	14,220	12,151	↓	11,100	Emergency admission rates reduced during Jan - Dec 2020, this can be attributed to the Covid emergency. It is anticipated that the development of the Urgent Care Pathway will impact positively on unscheduled care performance.
NI 13	Emergency bed day rate (per 100,000 population)	141,616	129,413	125,216	120,694	123,022	101,111	↓	101,852	Emergency Bed day rates have decreased for SL residents and is below Scotland level. This indicator has been affected by the Covid emergency.
NI 14	Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	94	97	97	98	97	104	↓	114	The rate of emergency readmissions is below Scotland level however the rate for SL residents has increased.
NI 15	Proportion of last 6 months of life spent at home or in a community setting	85.3%	87.2%	87.6%	88.5%	88.3%	90.2%	↑	90.1%	One of the key strategies for the HSCP is shifting the balance of care from hospital to community settings. The Partnership is making steady progress towards this aim, from 88.3% during 2019/20 to 90.2% 2020.
NI 16	Falls rate per 1,000 population aged 65+	19.6	21.9	22.9	21.9	21.5	19.2	↑	21.7	Falls can have a significant impact on quality of life. We have developed a falls action plan and organised services to support the prevention of falls. Performance has improved against this

										indicator and is performing well against the Scotland rate.
NI 17	**Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections ***	**73.0%**	**84.3%**	**81.3%**	**82.6%**	**79.9%**	**n/a**		**81.8%**	**Performance has improved during 2019/20 and is above the Scotland level.**
NI 18	**Percentage of adults with intensive care needs receiving care at home**	**62.4%***	**61.1%***	**62.4%***	**61.3%***	**63.7%***	**Expected to be updated to 2020**		**63.1%***	**People want to stay at home for as long as possible rather than care home or hospital. We are slightly above Scotland for this indicator. We intend to improve through actions outlined in our Strategic Commissioning Plan.**
NI 19	**Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)**	**1,448**	**1,322**	**1,411**	**1,261**	**941**	**545****		**488**	**This has been an indicator which has been a major focus for the HSCP Working in partnership with NHS acute colleagues to introduce Planned Date of Discharge has assisted in this area.**
NI 20	**Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency**	**23.5%**	**22.8%**	**23.1%**	**22.8%**	**23.4%**	**19.4%**		**21.0%**	**SL H&SCP strategic commissioning plan outlines how we intend developing strong community services to ensure efficient use of resources**

*Calendar year 2020 is used here as a proxy for 2020/21 due to the national data for 2020/21 being incomplete.
We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships. Please note that figures presented will not take into account the full impact of COVID-19 during 2020/21.
**Financial year 2021/21
Covid, and the subsequent changes to utilisation of previous resources, will also impact on a number of the measures above.

National Indictors under development

NI 10	**Percentage of staff who say they would recommend their workplace as a good place to work**
NI 21	**Percentage of people admitted to hospital from home during the year, who are discharged to a care home**
NI 22	**Percentage of people who are discharged from hospital within 72 hours of being ready**
NI 23	**Expenditure on end of life care, cost in last 6 months per death**

Ministerial Strategic Group (MSG) Indicators

In addition to the operational core indicators the MSG for Health and Social Care have agreed a further six indicators.

	MSG Indicator	2016/17	2017/18	2018/19	2019/20	2020/21	Trend from previous period	SL HSCP Previous period target
MSG 1	**Number of emergency admissions**	**37,141**	**38,630**	**39,560**	**40,741**	**33,629***	↑	**33,081** 🛑
MSG 2	**Number of unscheduled hospital bed days (acute specialties)**	**243,632**	**228,935**	**229,671**	**232,237**	**204,217***	↓	**206,054** ✓
MSG 3	**Number of A&E attendances**	**98,167**	**101,790**	**105,604**	**108,834**	**83,193**	↓	**98,793** ✓
MSG 4	**Acute bed days lost to delayed discharges**	**N/A**	**36,780**	**33,128**	**39,632**	**17,285**	↓	**21,344** ✓
MSG 5	**% of last six months of life spent in Community setting***	**85.3%**	**87.2%**	**87.6%**	**88.5%**	**90.2%***	↓	**87.1%** ✓
MSG 6	**Balance of care: Percentage of population at home***	**82.2%**	**82.5%**	**83.5%**	**82.9%**	**83.3%**	↓	**82%** ✓

*Calendar year 2020 is used here as a proxy for 2020/21 due to the national data for 2020/21 being incomplete. We have done this following guidance from Public Health Scotland and to improve consistency between our report and those for other Health and Social Care Partnerships. Please note that figures presented will not take into account the full impact of COVID-19 during 2020/21.

9. Financial Performance and Best Value Summary 2020/21

Financial Year 2020/2021

Financial information is part of our performance management framework with regular reporting of financial performance to the IJB. National Health and Wellbeing Outcome 9 also requires resources to be used effectively and efficiently in the provision of health and social care services. The resources available to the IJB to deliver the delegated functions set out in the Integration Scheme and the Strategic Commissioning Plan (SCP) are comprised of the financial contributions from South Lanarkshire Council (SLC) and NHS Lanarkshire (NHSL). The financial position for public services continues to be challenging. Notwithstanding these pressures, within the financial envelope available to each partner and following a process of consultation, in March 2020 the IJB agreed a financial plan for 2020/2021 to ensure a balanced budget was achieved by 31 March 2021. The detail of this plan is available at IJB Financial Plan 2020/2021 (Agenda Item 2 Pages 3 to 26)[1].

Partner Contributions 2020/2021

The total funding for the IJB in 2020/2021 was £629.228m (NHSL- £489.627m; SLC - £139.601m). Both partners maintained the 2019/2020 baseline funding for the IJB in 2020/2021. The total funding available in 2020/2021 included additional funding to address the emergency response to the Covid-19 pandemic of £31.329m and also the draw down from reserves of £1.313m.

The Scottish Government established a process whereby the necessary activity and the additional costs incurred across health and social care services as a result of Covid-19 are reported through Mobilisation Plans. The expenditure incurred by both partners in response to the Covid-19 pandemic was fully funded by the Scottish Government in 2020/2021. A balance of funding received for 2020/2021 is being retained by the IJB in reserves to meet additional Covid-19 expenditure in 2021/2022.

A number of payment mechanisms were also altered to provide financial sustainability during the service disruption. Service level agreements between NHS Boards continued to be paid at the same level as in the previous year with an uplift equal to the general allocation uplift. Payments to Family Health Service Contractors were altered in line with Scottish Government guidance to cover additional costs incurred or loss of income due to Covid-19. Sustainability payments were introduced for Social Care Providers.

- Demographic growth, inflationary cost pressures and national priorities were originally projected to increase costs by £20.5m in 2020/2021.

- In addition to this, additional funding totalling £16m has been passed to the IJB by NHSL and SLC. This included £5.7m for the inflation uplift of 3% on the health care services delegated to the IJB and the additional funding of £10.3m to implement the agreed national priorities.

- The funding gap at the start of the financial year 2020/2021 was therefore £4.5m. It was originally intended that the funding gap of £4.5m would be addressed through planned savings (£2.2m), potential savings to be further developed (£1.1m), use of non-recurring reserves (£0.3m) and management actions (£0.9m). In respect of the savings proposals recommended to the IJB, these were the best fit with the strategic commissioning intentions and the best value requirement to use resources more effectively.

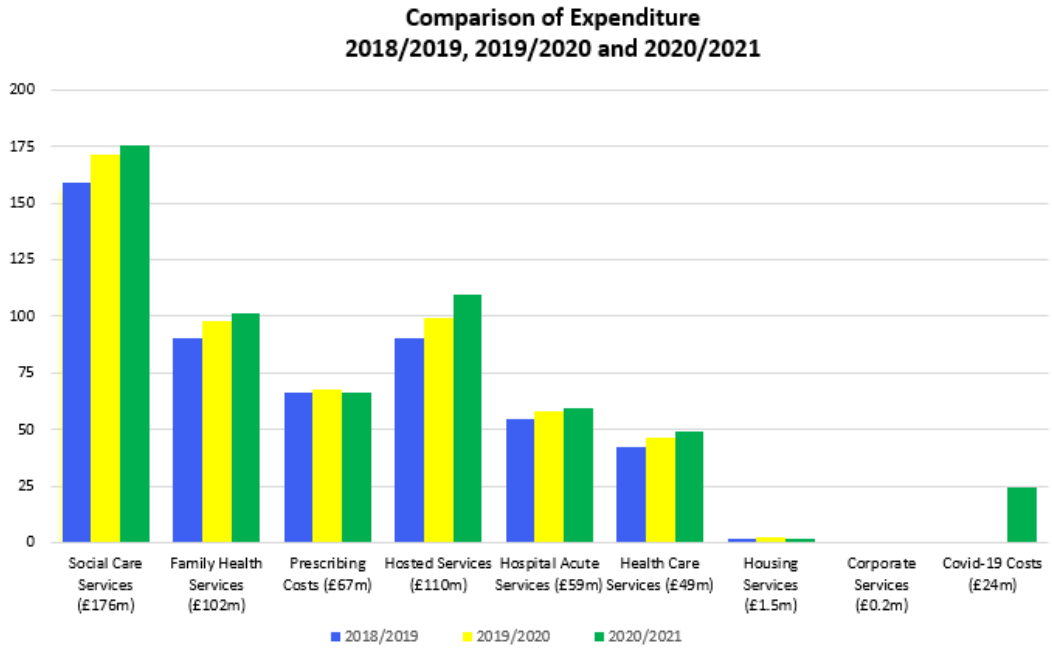
- The budgets released from savings have been retained by the IJB and re-allocated to address inflationary cost increases, demographic growth and the funding gap.

- Additional funding for NHSL was also issued during the year, the detail of which is included in the financial monitoring reports presented to the IJB and the PASC.

[1] https://www.southlanarkshire.gov.uk/slhscp/downloads/file/221/sl_ijb_special_meeting_papers_30_march_2020

The actual net expenditure incurred between 2018/2019 and 2020/2021 is summarised in the following table and is also represented in the graph below.

Expenditure	2018/2019 £m	2019/2020 £m	2020/2021 £m
Social Care Services	159.247	171.143	175.735
Family Health Services	90.661	97.615	101.625
Prescribing Costs	66.308	67.742	66.624
Hosted Services	90.041	99.138	109.828
Hospital Acute Services	54.919	57.768	59.501
Health Care Services	42.317	46.234	49.029
Housing Services	1.960	2.613	1.464
Corporate Services	0.163	0.165	0.170
Covid-19 Costs	0.000	0.000	24.384
Total	**505.616**	**542.418**	**588.360**



Taking into account income across social care services of £8.7m, the financial monitoring report for the year ended 31 March 2021 confirms an underspend of £32.2m (NHSL - £31.3m; SLC – £0.9m).

Between January 2021 and March 2021, additional funding was received from the Scottish Government to support the progress of key national policy priorities in 2021/2022 and beyond.

- Community Living Change Fund to deliver the redesign of services for people with complex needs or who have enduring mental health problems (£1.2m).
- Funding to support financial sustainability across the social care sector, new ways of working and additional capacity in response to the Covid-19 pandemic (£5.9m).
- Adult Social Care Winter Preparedness Plan Funding to support social care users in residential, community and home settings over the winter period (£2.6m).
- Alcohol and Drug Partnership (ADP) Funding (£1.7m).

There is a significant element of financial risk associated with the ongoing response and consequences of the Covid-19 Pandemic. The Chief Finance Officer and both partners identified costs to be set against the Mobilisation Plan for the Scottish Government. Significant additional funding totalling £32.3m was received from the Scottish Government to address the additional Covid-19 expenditure of £24.4m incurred in 2020/2021. The balance of the funding of £6.9m was transferred to a ring-fenced reserve to meet the ongoing costs associated with the Covid-19 pandemic.

Funding previously retained by the Scottish Government from previous years totalling £5.8m was released in respect of the Primary Care Improvement Fund. This is a hosted service led by South Lanarkshire IJB and funding will be transferred to the South Lanarkshire IJB reserve.

Funding previously retained by the Scottish Government from previous years totalling £2.1m was released in respect of Mental Health Action 15. This is a hosted service led by North Lanarkshire IJB and the funding will be transferred to the North Lanarkshire IJB reserve.

Non-recurring funding was also received from the NHSL partner to progress a range of joint strategic priorities in 2021/2022 (£2.8m).

In response to the Covid-19 pandemic, a range of core services had to be stood down in order to support the emergency response. As existing staff and resources were redeployed and funded from the additional funding to meet these additional Covid-19 costs incurred, the original core budget across Health and Social Care Services was therefore released. The net underspend across Health and Social Care Services totalled £5.3m.

£1.3m was drawn down from IJB reserves to fund planned expenditure in line with the IJB Financial Plan 2020/2021.

The net underspend of £0.013m was retained by the SLC partner in line with the accounting requirements for the Housing Revenue Account.

The underspend totalling £32.2m was transferred to the South Lanarkshire IJB reserve in order to meet planned commitments in future years. The total underspend represents approximately 5% of the total financial envelope available.

The balance on the IJB reserves at 1 April 2020 was £6.173m. The net movement on reserves in 2020/2021 is summarised in the table below.

Movement on Reserves	**NHSL £m**	**SLC £m**	**Total £m**
Balance as at 1 April 2020	5.561	0.612	6.173
Year-end Surplus	31.336	0.823	32.159
Transfers From Reserves	(1.140)	(0.173)	(1.313)
Balance as at 31 March 2021	**35.757**	**1.262**	**37.019**

The net movement on reserves was therefore £30.846m. The establishment of a minimum level of contingency reserves is recommended good practice to provide a contingency against demographic demand and service volatility. The contingency reserve was increased marginally from £1.920mm in 2019/2020 to £1.935m in 2020/2021.

Further details of the ring-fenced, ear-marked and general fund reserves totalling £37.019m is available at Note 10 of the Unaudited IJB Annual Accounts 2020/2021 (Agenda Item No X Pages X to X)[2].

[2] To Be Inserted

Employee Costs

- Employee costs total £153.103m (NHSL - £83.991m; SLC - £69.112m).

- The Health and Social Care Partnership (HSCP) workforce has been under considerable pressure during the pandemic, with high levels of work-related stress reported. Assessing risk and maintaining the safety of the workforce has been paramount. The availability of personal protective equipment is a priority to maintain this safety. National guidance, shared with staff, has been complied with to minimise the spread of the virus, maintain personal safety and that of the patients or service users.

- Similar to 2019/2020, the Urgent Care Out of Hours Service experienced insufficient staffing during 2020/2021 to support a two-site model at weekends. The Urgent Care Out of Hours Workforce Planning Group have been working on a plan to achieve a fully staffed two centre service. The plan includes active recruitment across a range of multi-disciplinary health care professionals.

Care At Home Services

- Care at Home Services continue to deliver essential services to some of the most vulnerable service users in our communities. At the outset of the pandemic, staff absence increased as a result of the Covid-19 pandemic which limited capacity across the service. The demand on the Care at Home Service is expected to increase.

- The Care at Home Improvement Board continues to oversee a number of work streams taking forward the service redesign. The Covid-19 response, improvement activity in the Hamilton and Rutherglen/Cambuslang localities and the work to implement the scheduling tool have been prioritised. Additional recurring investment in the Care at Home Service is required to maintain safe services, support the complexity of care and provide sufficient capacity to address the increase in demand as a result of demographic growth.

Physiotherapy Services

- Physiotherapy staff within the integrated teams are operationally managed and funded by the respective HSCPs. The Lanarkshire-wide Physiotherapy Service is hosted by the SLHSCP. The recently published "Framework for Supporting People Through Recovery and Rehabilitation During and After the Covid-19 Pandemic" provides a strategic framework with overarching principles and high-level recommendations, which inform and shape the provision of rehabilitation and recovery services across Scotland for the Coronavirus (Covid-19) period and post Coronavirus (Covid-19). To achieve this Scottish Government are seeking reassurance from all NHS Boards and IJBs that rehabilitation is essential.

- The professional leadership structure for Physiotherapy Services for both the SLHSCP and the North Lanarkshire HSCP has been strengthened with the appointment of an additional Professional Physiotherapy post. This additional leadership will also support the rehabilitation agenda which is now one of the highest government priorities and requires a strategic professional focus.

Carers Strategy 2019 to 2022

- There are 38,000 carers within South Lanarkshire and their contribution is crucial. The Carers Strategy 2019 to 2022 was developed in partnership with community organisations, local carers and partners including the Carers Partnership Group.

- It was evident from consultation and engagement with Carers that significant frustrations were experienced in relation to timescales for accessing supports. In response to this, 16 additional Social Work Assistants are being recruited to undertake care assessments and reviews and to ensure needs and outcomes are met and resources are targeted effectively through a regular and effective review processes. The cost of the additional staff is

£0.629m per annum and will be met from 2021/2022 funding for the Carers Act which totals £1.595m. The allocation of the balance of the Carers Act funding is currently being considered.

Primary Care Improvement Plan

- The General Medical Services (GMS) 2018 contract came into force on the 1 April 2018. The implementation of the Primary Care Improvement Plan (PCIP) is complex, both operationally and financially. The transformational change linked to the contract is supported by the Memorandum of Understanding (MOU) linked to the PCIP.

- The main challenges with the delivery of the MOU which are being worked through include financial settlement, workforce availability, IT availability, the use of physical space to accommodate and manage the extended workforce and the capacity for change within the system.

- The Covid-19 pandemic has allowed different ways of working but has also increased many of the challenges noted above. The Covid-19 pandemic has impacted on the delivery of the PCIP, both locally and nationally, and final delivery of outcomes will be delayed. All work streams are beginning to remobilise and work is now moving forward again. The PCIP Recovery Plan is a live working document that captures each area of the PCIP and details progress. It gives detail of considerations around the step up to a 'new normal' of covid secure provision and also the step down to realign staff to future covid responses should this be required.

- The work of the staff delivering the PCIP during the Covid-19 pandemic especially in the delivery of the Covid Assessment pathway is acknowledged. Measures for improvement and evaluation are in a late stage of development. There are national measures associated with the programme, not least the Primary Care national monitoring and evaluation strategy which will monitor the improvement in primary care reform up until 2028. Locally we are developing our own data and measurement plans for the PCIP and an interim evaluation has been undertaken.

Alcohol and Drug Partnership

- The South Lanarkshire Alcohol and Drug Partnership (SLADP) is a multi-agency strategic partnership focused on alcohol and drugs use issues in their local areas which was established in September 2017 following the disaggregation of the Pan-Lanarkshire ADP. SLADP has a responsibility for planning and commissioning services to deliver improved care and to achieve local outcomes. SLADP has in place financial planning and monitoring processes to support transparency and accountability in commissioning.

Mental Health and Learning Disability Services

- Mental Health and Learning Disability Services are a hosted service which is managed and strategically led within North Lanarkshire on behalf of both HSCPs. Mental Health and Learning Disability Services are a particularly complex grouping, with a range of Specialist and Inpatient Services, with significant cross-border payments to NHS Greater Glasgow and Clyde also part of the equation through the Health Board Boundary Changes. During 2020/2021, the Community Mental Health Services were localised. The North IJB will continue to hold the strategic responsibility for Mental Health and Learning Disability Services as per the Hosted Services agreement, co-ordinating and delivering the mental health and wellbeing strategy, in conjunction with all local partners. This is the first Hosted Service where part of the budget is being realigned to the directly managed locality budgets in both Partnerships, with officers aiming to maintain existing services and ensure an equitable model across both Partnership areas. At time of transfer, the CMHT budgets remain allocated on a historical basis and these allocations have been built into the 2021/2022 financial plans for both IJBs. Further discussions will take place post-pandemic to review the allocated budgets, acknowledging the complexity of such an exercise which could also explore inpatient and cross-border demand and wider Hosted Services.

- Changes are being implemented across Lanarkshire to make sure people get to the most appropriate service as quickly as possible. Similar to Accident and Emergency services, the way that people with mental health needs

engage with services when they do not have an appointment with a health care professional is therefore being improved. This work began in December 2020 and the outcomes are being monitored.

- In February 2021, the Scottish Government announced the provision of additional non-recurring funding of £20 million for Mental Health Recovery and Renewal allocated because of Barnett Covid-19 consequential funding. The key priorities for the allocation of this funding include promoting and supporting the conditions for good mental health and wellbeing at population level, providing accessible signposting to help, advice and support, providing a rapid and easily accessible response to those in distress and ensuring safe, effective treatment and care of people living with mental illness. SLHSCP is actively contributing to the service improvement and developments that will be required to achieve these key priorities within this additional funding.

- A Mental Health Primary Care (MHPC) Development Group was established by the Scottish Government to identify options to increase mental health capacity in Primary Care. Part of the additional Mental Health funding announced in the Finance Secretary's budget update in February 2021 will therefore focus on supporting improvements in Primary Care. From a Lanarkshire perspective, an options appraisal process and the additional funding will enable the development of robust enhanced pathways to and from Mental Health Services. By developing a MHPC Team primary care mental health, community mental health and community based psychological therapy services within Lanarkshire will be brought together.

- As part of the Action 15 Programme, the Primary Care Mental Health Liaison Nurse Service within GP practices is supporting people who are experiencing mild to moderate mental health problems of a short-term nature. Work is ongoing to expand this service into more GP practices across Lanarkshire and to develop the non-clinical aspect of the Primary Care Mental Health and Wellbeing service model. The "Well-Connected" app, which is free to download, was launched to make it easier to take part in and benefit from activities and services to improve our wellbeing.

Set-Aside Services

- Included within the funding available is a "set aside budget" totalling £59.501 million. This is a notional allocation in respect of "those functions delegated by the Health Board which are carried out in a hospital within the Health Board area and provided for two or more local authority areas''.

- The IJB is responsible for the strategic planning of these services but not their operational delivery. The methodology to cost these set-aside services is complex. The NHSL Director of Finance, in consultation with the Chief Financial Officer, continues to develop the monitoring arrangements for the Hospital Acute Services.

- In line with the accounting policy previously agreed, this updated budget is included in the IJB Annual Accounts 2020/2021 as an estimate of expenditure however it is recognised that this does not necessarily reflect the actual usage of hospital services by the IJB. This approach however has been endorsed as an acceptable approach pending further updates from Information Services Division.

Day Services

- During the Covid-19 period, delivery of the building-based Day Services was paused and the service mobilised to offer an Outreach option within peoples' own homes and communities for those who exhibited the most significant vulnerabilities. This service was delivered safely whilst adhering to the requirements of social distancing, public health and infection prevention and control guidelines.

- In line with the Scottish Government's route map out of Covid, the re-opening of day service buildings for adult and older people as part of the Covid-19 recovery planning commenced in May 2021 on a phased basis. The Outreach Service, which was developed in response to the Covid-19 situation, will continue.

- The Adult and Older People Day Service Review is now complete and the initial findings and recommendations were presented to the SLC Social Work Resources Committee and the IJB in March 2021. It was agreed that the next stage of review activity would be to engage in consultation with key stakeholders on the options arising from the review.

Care and Support Service

- The Review of the Care and Support Service has identified several key themes for ongoing improvement activity and includes recommendations for sustaining and modernising the service. A revised service specification will be a critical driver in the re-design of the Care and Support Services which will take account of self-directed support principles and operate within a cost effective and safe staffing model.

- The Care and Support Service is facing challenges linked to changing demographics and service users' profiles which include the increasing age and complexity of service users' care needs and its impact on current service delivery model, the increase in single tenancy arrangements leading to less shared tenancies and the loss of economies of scale, the geographic spread of service users across locality areas and the need to provide a sustainable, safe, person-centred and effective modern service. The service specification for the Care and Support Service has not been updated since inception of the service 17 years ago in 2004. Updating the staffing model, implementing telecare and assistive technologies, reviewing the care and assessment needs of service users, meeting overnight care needs, implementing self-directed support principles and working in partnership with Housing colleagues to identify potential void tenancies will be critical drivers in the re-design of the Care and Support Service.

Care Homes

- There are 93 Care Homes registered with the Care Inspectorate to provide adult care in Lanarkshire. During the first wave of the pandemic there were significant outbreaks and deaths across Care Homes in Lanarkshire. In response to the Covid-19 pandemic, the roles and responsibilities of staff within the SLHSCP changed under the emergency arrangements for Care Homes.

- In April 2020, the Coronavirus (Scotland) Act 2020 came into force, and over the course of the pandemic, a wide range of national guidance has been issued and adopted as appropriate. A service model was implemented by the NHSL partner in June 2020 to respond to these additional professional and clinical oversight responsibilities. The NHS Nurse Directors responsibility for providing enhanced clinical and care professional oversight to care homes during Covid-19 was extended. An integrated team was developed to provide additional nursing leadership support and specialist infection prevention and control advice. These roles and responsibilities were extended to 2021/2022 and funding was made available to support this work. The NHSL assurance mechanisms will therefore remain in place.

- Social Care providers across Scotland have also raised concerns regarding their financial sustainability as a result of the Covid-19 pandemic. In order to support providers to remain sustainable through this period, a commitment was given by the Scottish Government to meet reasonable additional costs arising from areas such as staff sickness absence, the requirement to purchase increased levels of personal protective equipment and the impact of reduced occupancy in for example Care Homes where it is clinically unsafe to admit more people. Principles have been developed nationally to support the capture of reasonable costs for inclusion within the Lanarkshire Remobilisation Plans.

Prescribing Quality and Efficiency Programme

- An enquiry was undertaken by the Health and Sports Committee to examine the management of the medicines budget, including the cost and clinical effectiveness of prescribing. Lanarkshire has a Medicines Quality Strategy, the focus of which is to develop and implement the strategic ambitions and vision as laid out in the Scottish Government's strategy 'Achieving Excellence in Pharmaceutical Care – A Strategy for Scotland'.

- By optimising the use of medicines and ensuring best value through reducing waste and unwarranted variation, prescribing quality and efficiencies are being achieved. An underspend of £0.5m was reported in respect of the prescribing budget at 31 March 2021.

Health Visiting Services

- In 2014 the Cabinet Secretary announced an additional 500 WTE Health Visitors (HV) across Scotland to support implementation of the Children and Young People (Scotland) Act (2014) and the Universal Health Visiting Pathway. NHSL was allocated an additional 37.4 WTE. The expansion to the workforce has been achieved. At point of recruitment, all trainees were guaranteed a permanent post on qualification.

- There was no financial pressure in 2020/2021 as the nursing education budget continued to fund over-established positions for the HV trainees until they were in receipt of their NMC registration in March 2021. A financial overspend position from April 2021 onwards has been highlighted estimated to be £0.121m. This will reduce throughout the following six to nine months as current cohort of trainees match to establishment vacancies. In 2021/2022, financial pressures are also likely to be mitigated to some extent by maternity leave and a reduction in bank costs.

Equipment and Adaptations Services

- There has been an ongoing review of equipment and adaptations provision since 2018. The SLHSCP currently have a contract for equipment provision with both Equipu (Glasgow) through SLC and North Lanarkshire Joint Equipment store for NHSL. The Project Board are working with stakeholders to develop options to achieve best value from a person-centred perspective and also a financial perspective.

IT Priorities

- The SLHSCP is in the final stages of securing approval and the budget to replace the current Social Care Information System (SWiSplus). This proposal represents an excellent opportunity to transform practice and re-direct more frontline staff time to working with service users and carers.

- The current IT system, whilst serving the SLHSCP well for 27 years does not now meet the business requirements of today and tomorrow. Agile working and the ability to undertake efficient case recording require the SLHSCP to have an IT system which will service this delivery model for the next 10 years and beyond. Once final sign off is secured, the project will start in earnest in June 2021 with an expected full implementation realised over the next 24 to 36 months.

- The focus of this project will not be restricted to replacing an IT system. It will and perhaps more importantly, seek to bring about a cultural shift in Social Care practice about how individual service user information is used and aggregated to drive future commissioning priorities.

- A successful initial roll out of the Total Mobile electronic scheduling system was recently completed within the Bothwell and Uddingston areas. Work is underway to fully implement the system throughout the Hamilton locality by the end of May 2021, with implementation then taking place within Rutherglen, Clydesdale then East Kilbride localities by the end of the year. This will bring significant improvements to the service in relation to communication with staff, more effective and efficient scheduling and improved recording of information.

Commissioning and Quality Assurance Resource

- In March 2021, the IJB approved the establishment of a Commissioning and Quality Assurance Resource led by a Service Manager and supported by a Team Leader and four Resource Officers. This will strengthen the

leadership, governance and management arrangements to support the delivery of statutory social care services and provide robust oversight of contracted services.

- Approximately £90m of services delegated to the IJB are commissioned by the SLC partner from external social care providers. The new team will initially be funded for a three year period from the Community Living Change Fund totalling £1.2m. It is expected that recurring efficiencies will be secured and an initial target of 1% per annum has been applied.

Key Financial Risks

Throughout the year, the financial monitoring reports provided updates on the management of the key financial risks. The main risk is that either or both partners may overspend. The additional costs associated with the Covid-19 pandemic, the uncertainty with the EU withdrawal, prescribing cost volatility and demand for care at home services continue to represent the most significant risks within the partnership's budget. These key financial risks are managed by both NHSL and SLC through their detailed budget management and probable outturn arrangements. Overall, the financial contributions of both partners and the additional funding provided by the Scottish Government helped to address a number of significant cost pressures across health and social care services in 2020/2021.

Internal Audit Opinion 2020/2021

The Internal Audit opinion was provided jointly by the Audit and Compliance Manager of SLC and the Chief Auditor of NHS Lanarkshire. The conclusion is that, overall, reasonable assurance can be placed on the adequacy and effectiveness of the partnership's framework of governance, risk management and control arrangements for the year ending 31 March 2021.

Looking forward to 2021/2022

The IJB and both partners continue to operate in an increasingly challenging environment.

The current SCP for the period 2019 to 2022 sets out the commissioning intentions for the sixth year of the HSCP. These intentions are supported by the IJB Directions to SLC and NHSL which are in alignment with the 9 National Health and Wellbeing Outcomes and the 6 Health and Social Care Delivery Plan Priorities. Four locality plans have also been developed which localise the ambitions detailed in the SCP.

The level of funding available to the IJB is significantly influenced by the grant settlements from the Scottish Government for NHSL and SLC. The financial settlement for 2021/2022 continues to be for one year only. The IJB Financial Plan 2021/2022[3], which was approved on 29 March 2021, sets out the parameters to achieve a balanced budget by 31 March 2022. The IJB requires to be financially sustainable and to manage the key risks and uncertainties linked to health and social care services however funding is not keeping pace with increasing demand and increasing costs. Although the 2021/2022 IJB Financial Plan has been agreed, there are concerns about the sufficiency of funding for the current and future years.

The Covid-19 pandemic continues to present a significant public health challenge and health and social care services have had to be adapted. This includes the establishment of Community Assessment Centres to support the testing of potential Covid-19 patients and also the creation of a hub to support the distribution of personal protective equipment. Working with acute colleagues to support patient flow and optimise access to critical functions, the measures that have been put in place are designed to support core functions and to ensure that services for the most vulnerable, such as Care at Home, Community Nursing, Primary Care and Care Homes, are maintained. The total financial cost of the Covid-19 pandemic is still unknown. The financial impact of managing emerging demand, supporting social distancing requirements and providing appropriate protective equipment is significant. It is assumed that additional funding will be provided by the Scottish Government in 2021/2022 to meet the additional costs incurred across the HSCP in response to the Covid-19 pandemic which are being reported to the Scottish Government through the Lanarkshire Remobilisation Plan. There is a risk that full funding may not be received and a balance of costs may require to be borne by the HSCP.

[3] https://www.southlanarkshire.gov.uk/slhscp/downloads/file/254/sl_ijb_special_meeting_papers_29_march_2021 (Agenda Item 4)

Social care services continue to face demand pressures for service provision within Care at Home and Care Homes. Subject to confirmation of additional non-recurring Scottish Government funding, there is a high risk the cost of social care services in 2021/2022 will exceed the core recurring budget available due to the demand for services, the additional costs related to the improvement activity in Care at Home services and the impact of the Covid-19 pandemic. Projected growth in elderly demographics and the increasing complexity of need, together with inflationary rises, continue to increase the demand for services and drive cost pressures. The demographic profile up to 2039 indicates a significant increase in the age group 65 years of age and over.

The modernisation of Primary Care Services and the General Medical Services Contract are two of the most significant planning and policy developments aimed at changing how services are developed and transformed to meet different demands in the future. The development of the primary care service therefore continues to be a priority for Lanarkshire.

Mental health and wellbeing is prioritised in the SCP. The partnership currently has an integrated model of mental health care which offers appropriate supports to individuals at the right time. A Lanarkshire Mental Health and Wellbeing Strategy has been jointly developed for Lanarkshire. Transformation of mental health in primary care is also a priority in the Primary Care Improvement Plan.

The Monklands Replacement / Refurbishment Project is an exciting and positive vision for the University Hospital Monklands and the local and wider community it serves. This is a major investment in the Lanarkshire hospital estate.

A Programme of Transformation and Service Improvement is being undertaken by the SLHSCP. This work supports the delivery of the SCP and continues to strengthen many of our community-based supports. The response to the Coronavirus (Covid-19) Pandemic however did slow progress as resources have had to be redeployed. However, the work on the Transformation agenda has continued and is taking account of the risks that Covid-19 has posed and the learning that is accruing.

The IJB financial strategy must ensure sustainability for the current and future years whilst recognising the current significant challenges for both partners. Efficient, effective and affordable services fit for the future will need to be developed as part of the integration and transformational change activities. Improving population health and reducing health inequality are key priorities within the SCP.

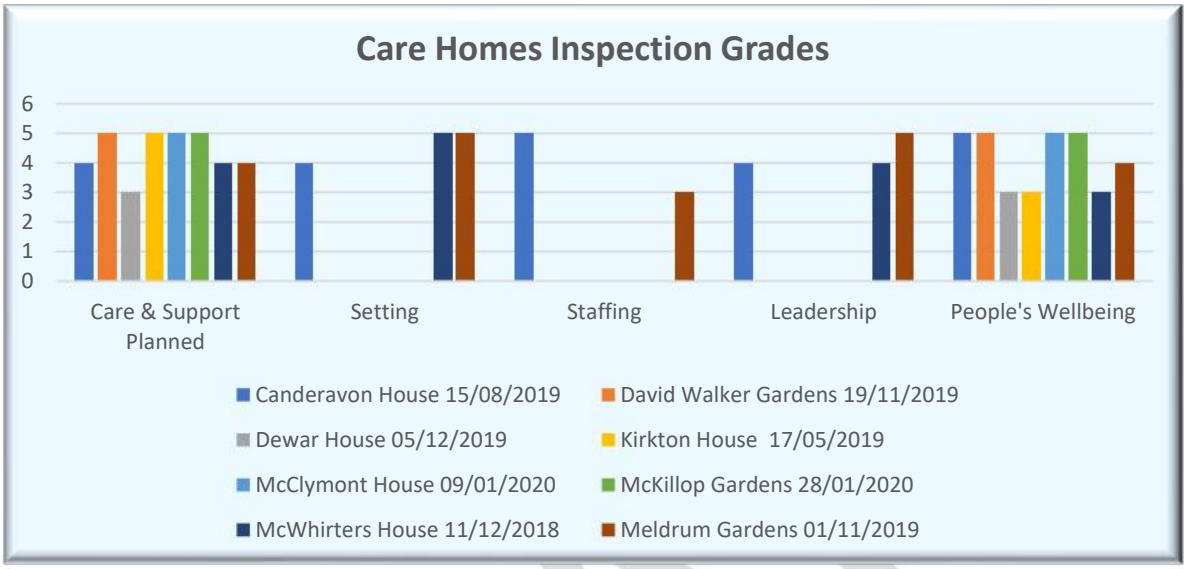
The Medium to Long Term Financial Plan is being updated in consultation with both partners. The pandemic is impacting on the IJB's ability to support full delivery of the SCP. It is also providing opportunities to consider new ways of working which could influence delivery of the SCP over the longer term for example the expansion of the Telehealth and Telecare Services.

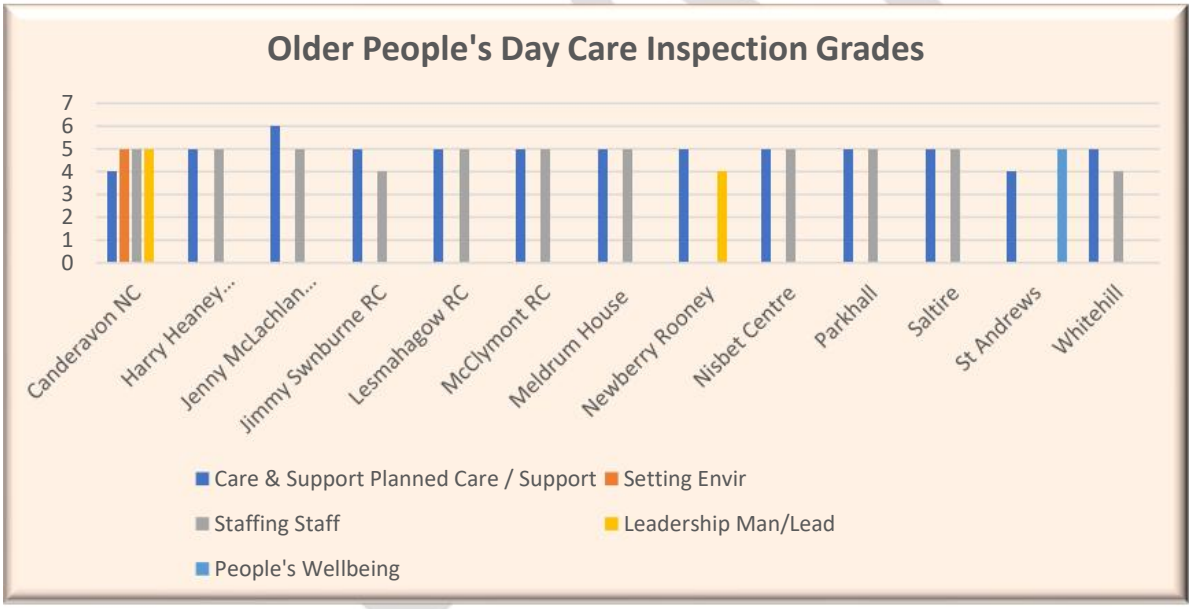
Our joint focus with all our partners and stakeholders will continue to be ensuring that all resources in scope are maximised and the health and social care system across South Lanarkshire is sustainable and operates efficiently and effectively.

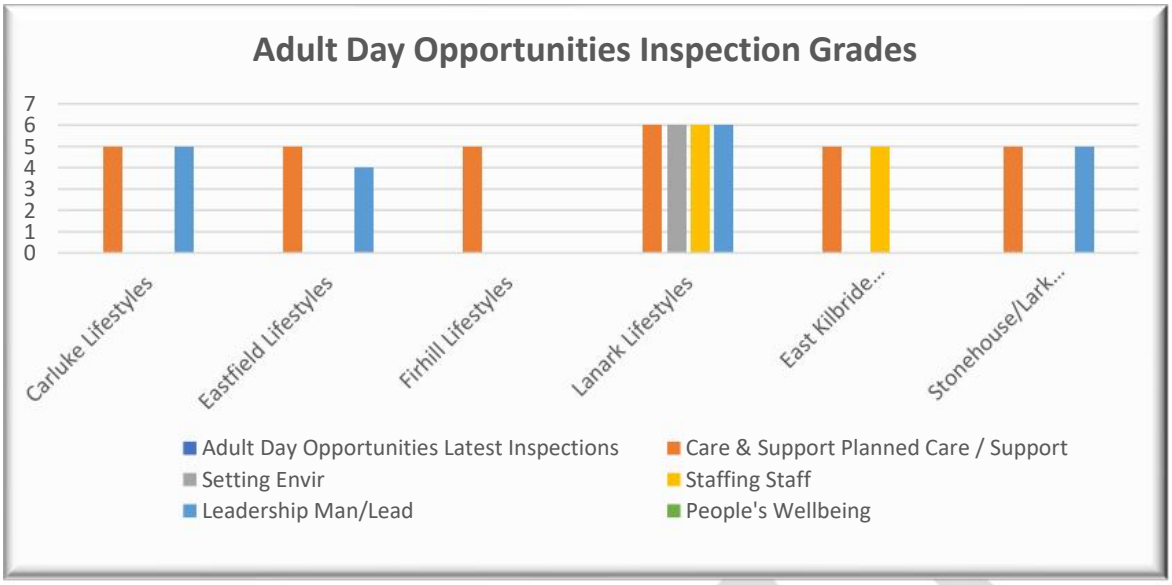
10. Inspection of Services

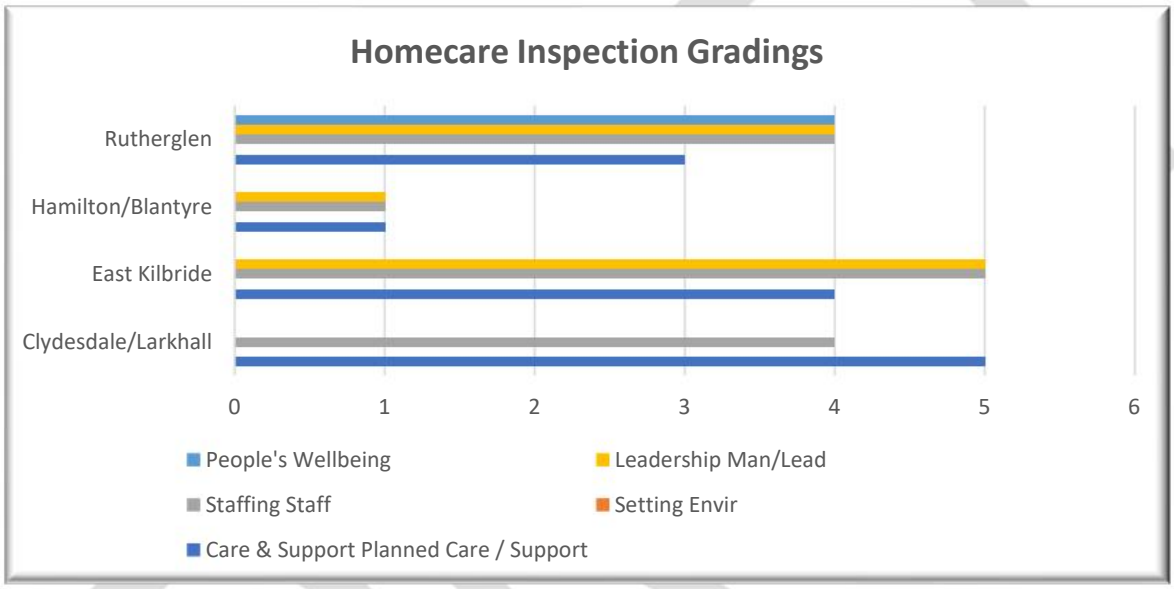
The Care Inspectorate continue to regulate and inspect our registered services for the Partnership. However, with the advent of the COVID 19 Pandemic, inspection activity and scrutiny were significantly reduced with the Care Inspectorate adapting how inspections are carried out. Data below shows the most recent inspection activity within the public domain.

Grade guide: 1 Unsatisfactory; 2 Weak; 3 Adequate; 4 Good; 5 Very Good; 6 Excellent






Adult Day Opportunities Inspection Grades
7
6
5
4
3
2
1
0
Carluke Lifestyles
Eastfield Lifestyles
Firhill Lifestyles
Lanark Lifestyles
East Kilbride...
Stonehouse/Lark...
Adult Day Opportunities Latest Inspections
Care & Support Planned Care / Support
Setting Envir
Staffing Staff
Leadership Man/Lead
People's Wellbeing


Homecare Inspection Gradings
Rutherglen
Hamilton/Blantyre
East Kilbride
Clydesdale/Larkhall
0
1
2
3
4
5
6
People's Wellbeing
Leadership Man/Lead
Staffing Staff
Setting Envir
Care & Support Planned Care / Support

Care at Home Improvement Work

Repeated published Care Inspectorate inspection reports for Registered Care at Home Services have included unsatisfactory or weak inspection grades resulting in several requirements for improvement for two service areas Hamilton and Rutherglen; however, some areas and actions identified for improvement were not progressed sufficiently, and there was a lack of evidence of corrective action being taken by the Council. To address this the Head of Service now chairs a 4-weekly Care at Home Transformation Board tasked with remodeling service to achieve positive outcomes and take forward improvement across the services.

Work streams established to support the Care at Home Transformation Board are:
Hamilton Improvement Plan; Rutherglen Improvement Plan; Scheduling; Community Meals; Learning and Development; Finance and workforce; Reablement and Rapid Response; Care at Home Infrastructure; Transport; Out of hours; Standards and Quality Assurance

An inspection in October 2020 for Hamilton Care at Home Service showed an improvement in grades.

- Care & Support from **1** (unsatisfactory) to **3** (adequate)
- Leadership & Management from **1** (unsatisfactory) to **3** (adequate)
- Staffing from 1 (unsatisfactory) to **2 (**weak)

(An inspection in June 2021 has seen further improvement with how well do we support people's well being graded 4, people get the most out of life graded 4, Infection prevention and control graded 3, Leadership and staffing arrangements are responsive to the changing needs of people experiencing care graded 4)

Most recent inspection (November 2020) Rutherglen/Cambuslang Service showed improvement in grades:

- How well to we support people's wellbeing – **4** (good)
- How good is our Leadership – from **1** (unsatisfactory) to **4** (good)
- How good is our Staff Team – from **2** (weak) to **4** (good)
- How good is our care planned – from **1** (unsatisfactory) to **3** (adequate)
- *Infection / Prevention control measures / COVID - good 4*

11. National Health and Wellbeing Outcomes

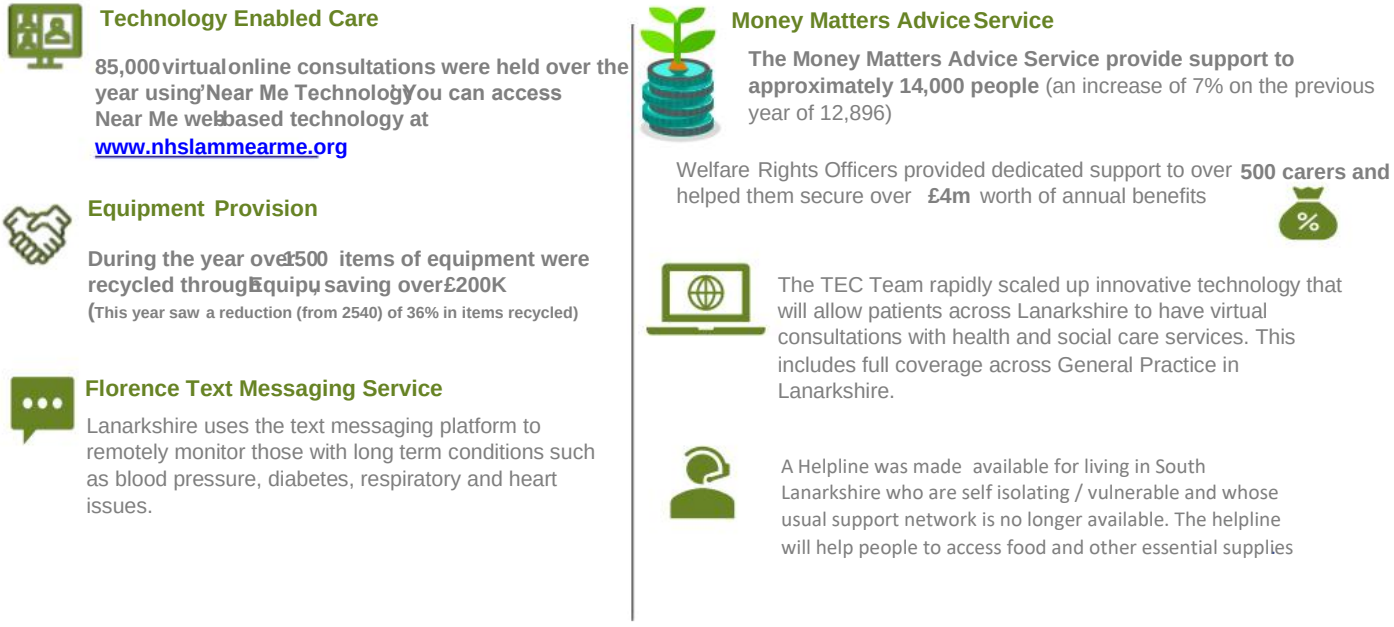
Outcome 1: People are able to look after their own health and wellbeing and live in good health for longer
Strategic Priorities: Early intervention, prevention and health improvement
Self-Care/Management

Last year's Performance Report contained a few Partnership Priorities that were to be delivered under our Strategic Priorities of early intervention, prevention, health improvement and self-care/management.

We know that the population of South Lanarkshire is ageing and that we need to change the way in which we can provide support. Part of this is about assisting people to care for themselves and for them to identify the health and care outcomes they desire. As part of this transformational approach, we need to promote the use of telehealth, telecare and other forms of technology enabled support to work smarter and provide information and knowledge to enable people to make informed choices in managing their own health and wellbeing.

Performance shows an improving picture on the percentage of adults who are able to look after their health very well (see National Indicator 1, page 19). Progress has also been made in reducing premature mortality across South Lanarkshire (National indicator 11, page 20)

Alongside this there is an increasing need to address child poverty and improvements for children and young people in South Lanarkshire through our Child Poverty Action Plan and The Children and Young People Improvement Collaborative (CYPIC). s



Progress on Child Poverty Action Plan

The impact of COVID-19 has and will continue to have a major economic and social impact on child poverty. The work of the Partnership is therefore important to assist in helping to address this. Evidence shows COVID-19 disproportionately affects those who are more socio- economically deprived and vulnerable. Increased poverty through loss of earnings and unemployment and resultant impact on wider determinants including food and housing security also add to health inequalities. Changes to how health

services are delivered, disruption to other essential services and education all impact. Maximising income into households with children is key to tackling child poverty – more and more families are dependent on welfare benefits. The Money Matters Advice Service provided support and will continue to increase the uptake of benefits. NHS Lanarkshire midwives and health visitors support pregnant women and new mothers to get benefits advice. Citizen's Advice in Hamilton and Rutherglen work with NHS Lanarkshire to offer outreach welfare advice at local hospital and community health facilities.

Outcome 2: People, including those with disabilities or long-term conditions, or are frail, are able to live, as far as practicable independently and at home or in a homely setting in the community.
Strategic priorities: Suitable and sustainable housing
Intermediate Care

Delayed Discharge

Development and implementation of a Planned Date of Discharge Policy and Procedure and production of an animation promoting our work in this area

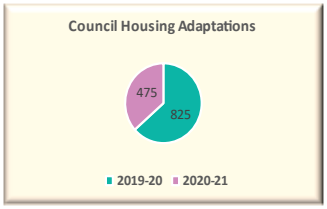
Rapid Rehousing Transition Plan

Launched in 2019, South Lanarkshire Rapid Rehousing Transition Plan 2019/2024 sets out how a range of partners aim to prevent and tackle homelessness over the next five years. Housing and Technical Resources continue to work closely with partners in Health and Social Care to understand trends, patterns and opportunities to prevent homelessness and respond at the earliest opportunity. This includes the introduction of specific 'Directions' within the Strategic Commissioning Plan 2019/2022.

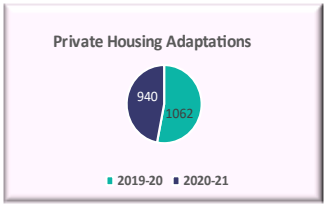
Homelessness

As a result of the inclusion of the Directions relating to homelessness in the SCP 2019 22, work has been progressed on the service arrangements to support the roll out of Routine Enquiry. This work aims to introduce test pilot projects in both primary and acute care settings and support appropriate recording and sharing of relevant information to identify those at risk of homelessness during key health and care consultations

Adaptations to people's homes



During 2020/21 **475** adaptations were completed in council homes. This was a 42% reduction on the previous year's activity.



During 2020/21 **940** adaptations were completed in private homes. This was an 11% reduction on the previous year's activity.

Modernising Care Facilities

Phase1 – Blantyre Development
Full mobilisation began onsite in January2021 with earthworks and drainage installation being a priority

Intermediate Care includes a range of community-based services and approaches that maximise a person's recovery including an appropriate alternative to unnecessary hospital admission, enabling timely discharge from hospital, and reducing premature admission to long term care.

There has been an increase in the percentage of adults who agree that the they have a say in how they are supported at home with their health and care needs (National Indicator 4, page 19) and we have increased the number of adults with intensive care needs receiving care at home (National Indicator 18, page 21)

Outcome 3: People who use health and social care services have positive experiences of those services and their dignity respected.
Strategic priority: Single points of contact

Over the last year the Partnership has worked together providing a co-ordinated support for those most vulnerable in our communities. Single points of contacts for health and social care services help us to reduce duplication of effort and potential bureaucracy. For example, a pan-Lanarkshire COVID-19 Assessment Hub was established as required by the Scottish Government. A telephone triage Hub and an assessment centre are operational within the Airdrie Out of Hours (OOH) base and there is an assessment centre within the Douglas Street Clinic in Hamilton. Over 43,000 patients have been through the Hub with over 15,000 being assessed and often provided with treatment in the COVID-19 Assessment Centres. Approximately 3,000 of these patients were referred to hospital for further assessment/admission.
The procurement, supply and delivery of suitable Personal Protective Equipment (PPE) to help protect frontline workers, carers, personal assistants and care homes was initially very challenging. A PPE hub was established at the Newberry Rooney Centre distributing much needed supplies. This operation has been very successful and involved health and social care staff, Council employees and assistance from the third and voluntary sectors.

The vaccination campaigns for both winter flu and COVID-19 have been extremely successful with the COVID-19 programme continuing through the tremendous effort of staff. Integrated Community Support Team staff have contributed by supporting vaccinations for housebound patients as well as continuing to work together to make discharge from hospital as smooth as possible and are constantly looking for ways to improve processes.

The percentage of adults able to look after their heath very well has improved since last year and the percentage of adults receiving care or support who rate it as excellent or good has increased to over 80%. (National Indicators 1and 5, page 19). There has been a slight decrease in the percentage of adults who agreed that their health and social care services are well co-ordinated (National Indicator 4, page 19)

<u>Outcome 4:</u> Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Strategic priority: Seven day services

It has long been recognised that health and social care services need to be flexible and responsive to the needs of the population it serves on seven days a week, 24 hours per day basis. During COVID this was even more challenging than normal, but through dedicated, focused, and efforts of our staff and the communities we serve, we were and continue to support those most in need in our communities:

Insight into some of our work during the COVID Pandemic

We established a Community Meals Service as part of the emergency response. The objective was to ensure those who needed support continued to receive well balanced and nutritional meals each day

Over **100** staff volunteers from South Lanarkshire Leisure and Culture, Education Resources and Housing and Technical Resources have helped coordinate and deliver over **14,000** meals over the last year, prepared by colleagues in Community Resources. An army of drivers have been on hand to check on the wellbeing of people each day and relay any concerns to the Care at Home service to follow up.

"Everything we're doing throughout the system is underpinned by a single, clear objective - protecting lives and keeping people safe." *Ms de Souza, Director Health and Social Care*

Care at Home

Our performance continues to show we are shifting the balance of care b providing care at home for 10+ hours

79% of hours delivered in the year to service users were for 10+ hours

We have over **1000** home carers working **365** days per with over **100** office based staff providing support

We have delivered approximately **25000** visits each week to over **14000** service users throughout the Pandemic

T-Mobile Scheduling Care at Home System implemented, providing support and real time information to our service users and home carers

Our integrated approach to work during the COVID Pandemic and, beyond

NHS Lanarkshire joined forces with Kilbryde Hospice to support care of COVID 19 patients at University Hospital Hairmyres

NHS Lanarkshire's work with local hospices to expand acute hospital capacity ahead of COVID 19 cases increasing

Setting up of self assessment hubs for those seeking medical attention for COVID 19 Dovetailing with Out of Hours Services

Helping Support Discharge

We set up three interim care facilities to support hospital discharge for those people who were being delayed at hospital. This enabled patients and service users to recuperate in a homely setting and free up acute beds

Personal Protective Equipment

The set up of distribution hubs throughout South Lanarkshire for the storage, provision and management of PPE across our Harry Heaney, Newberry Rooney, Harry Smith and Murray Owen centres

Vaccinations

Three of our centres above, hosted vaccinations for health and social care staff across the Partnership area

Activity in Out of Hours and Assessment Hubs

Around 30,000 patients dealt with
Over 10,000 assessed and treated
Approximately 3,000 of these patients referred to hospital

[4] COVID 19 Update Paper – South Lanarkshire Integration Joint Board – 2nd March 2021

4

Outcome 5: Health and social care services contribute to reducing health inequalities

Strategic priority: Mental health and wellbeing

We already know there is a need to be responsive and flexible to the needs of the population we serve. Mental health and wellbeing one of the key areas in addressing health inequalities for the Partnership. We make this possible through our Lanarkshire Mental Health and Wellbeing Strategy and the Pan Lanarkshire, Getting it Right for Every Person (GIRFEP) Plan. These strategies seek to improve access to mental health support in primary care and raise the profile of mental health and the challenges many face around culture, stigma and discrimination; whilst raising awareness about relationships to poverty, deprivation, addiction, homelessness and isolation.

Insight into some of our work during the COVID Pandemic

Remobilising Services

Remobilisationand Recovery of mental health services began in September 2020 following the restructure of some service activity at the beginning of the Pandemic. This involved new ways of working such as phone or video consultation. This blended approach to service provision created capacity within the Community Mental Health Teams and enabled us to support and provide a timely response to individuals experiencing the onset or recurrence of mental ill health

Improving access to Mental Health Services & Supports

The PrimaryCare Mental HealthLiaison Nurse Service provides support to people experiencing mild to moderate mental health problems of a short-term nature within GP practices. The service continued to provide triage services to patients across 40 GP practices throughout lockdown

Integration of Community Mental Health Teams

Work continues to transfer operational management of South Lanarkshire Community Mental Health Services to South Lanarkshire Health and Social Care Partnership (SLHSCP). An interim operational management structure for the Community Mental health and Addiction's Services (CAReS) has been put in place and will progress the implementation plan to facilitate the transfer of Adult and Older Adults CMHTs, alongside Psychological Therapies teams within our Partnership area.

Key Findings from COVID 19 Response

One of the key findings throughout the Pandemic was the need to have an experienced decision maker involved early in the patient's journey. Further work is in the early stages of development to improve and make positive change to our mental health unscheduled care response and is aligned with the Scottish Government intention that Mental Health Services broaden their approach to unscheduled care access and responding to distress

Further work across **our Improving Access to Mental Health Services and Support-Action 15- Programme** includes the following aspirations:

All GP Practices across Lanarkshire will have access to Primary Care Mental Health and Wellbeing Services by the end of 2022

Development of the following workstreams

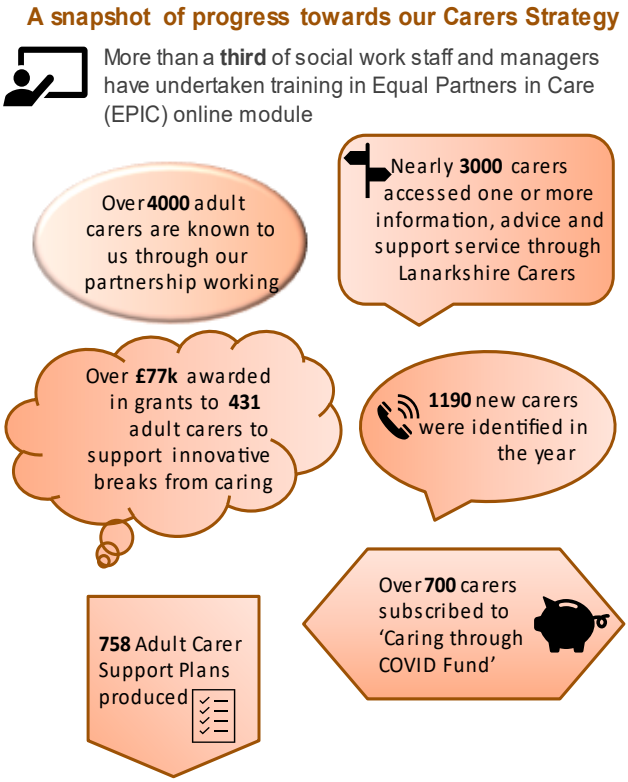
- Prisoner Healthcare
- Police Custody
- Emergency Department

<u>Outcome 6</u>: People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing

Strategic priority: Carers support

The role of unpaid carers is highly valued and recognised as crucial within the Partnership. Our commitment outlined in our Carers Strategy is one which we strongly believe in and hold in high esteem. While there has been a slight decrease in the number of carers who feel supported to continue in their caring role (National Indicator 8, page 19) our ethos continues to be to identify and offer support and responsive services that respond to personal circumstances.

‘



A Carer’s Case Study

Carer cares for her 23 -year-old son who has cerebral palsy. Her son cannot weight bear, is wheelchair bound and relies on full support to move. He has no communication skills. Caring role involves personal care, support to get her son around and assistance to communicate .

Outcomes; I would like to have more time to myself and improve my health and fitness levels.

After updating Adult Carer Support Plan (ACSP), it was identified that the carer felt that her fitness levels had decreased. During lockdown, her sons respite had stopped and she was indoors with him more. She was no longer able to attend the gym as they were closed. She was interested in taking up cycling again as this would increase her fitness levels and give her some time to herself. Her sister offered to sit with her son a couple of times per week to allow her time on her bike.

A creative break application was submitted and carer was awarded £250 towards the cost of a bike. Carer has since joined a cycling group on her new bike and absolutely loves the freedom she feels when cycling. Her fitness levels have improved and she has formed many friendships at the group.

‘I love my bike, I feel free and fitter on it. I have even named her ‘Bunty ‘!’

I would like to feel safe and less anxious when supporting my son with personal care. Due to the pandemic, carer was worried that she may pass the virus onto her son at any point. She did not feel safe or comfortable providing personal care to him in these difficult times. Discussion around using PPE and how we could support her with this. Carer makes referrals when needed and PPE is delivered regularly to carer.

‘This has made me feel so much less anxious when providing personal care to my son ’

5

Action for Children is the chosen provider for the delivery of the Young Carer Support Service in South Lanarkshire and works with key partners to support young carers to achieve and maintain their wellbeing and be fully informed and supported in relation to their caring role. Below is a sample of young carers’ comments; [6]

‘I didn’t think that I was a young carer at first. I just did what I could for my mum. Sometimes I missed playing out with friends. That was hard. But that’s what being a young carer can be like’
David, 11

‘I worry about whether my dad is all right while I am at school. I thought I was the only one but there are lots of others like me’
Jenny, 14

[5] Quarterly Performance Report – Lanarkshire Carers
[6] Action for Children – South Lanarkshire Young Carers Leaflet

<u>Outcome 7</u>: People using health and social care services are safe from harm
Strategic priority: Delivering statutory/core duties

It is our duty of care to ensure that people using our health and social care services are free and safe from harm. We do this in a variety of ways through:

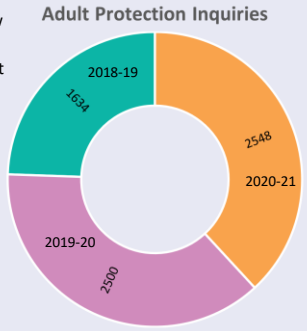
Supporting adults and families

Health Visiting Teams and Family Nurse Partnerships Teams continued to support pre -school children and prioritise child protection and primary assessments.

The School Nursing Service prioritised Child Protection and Looked after Children in recognition that young people require support more than ever

This year we saw a slight increase of 1.92% in Adult Protection Inquiries

2019/20 saw an increase of 35% in activity from previous year



The extended assessment of children and support to families was supported using the Near Me software, with Universal Pathway assessments undertaken in line with guidance and professional judgement

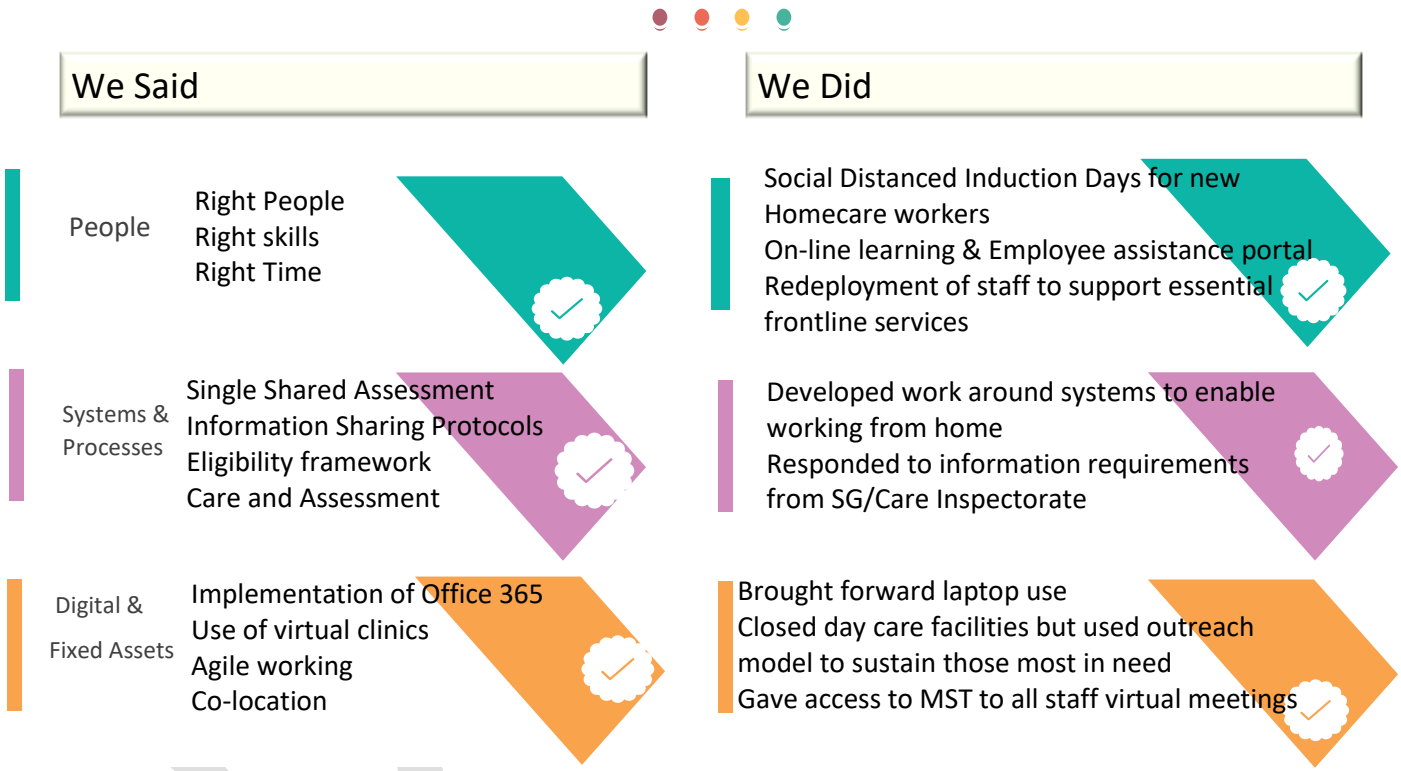
Lanarkshire Advocacy Plan 2020-2025

Lanarkshire Advocacy Plan has been developed in partnership with North Lanarkshire Health and Social Care Partnership (NLHSCP), South Lanarkshire Health and Social Care Partnership (SLHSCP), Lanarkshire Advocacy Planning Group, Lanarkshire Advocacy Network, and the service users and carers who have engaged with Advocacy Services. A a new direction has been issued to South Lanarkshire Council to develop an advocacy service specification with a view to commissioning a service which aligns to the priorities in the Strategic Commissioning Plan.

Outcomes 8 and 9: People who work in health and social care services feel engaged with the work they do and supported to continually improve information, support care and treatment they provide. Resources are used effectively and efficiently in the provision of health and social care services.

Strategic priority: Enablers

In the advent of COVID 19 Pandemic, we had to look at how we worked smarter, how we engaged with our people, how we supported them and ensured they had the skills to do their job, our buildings, our information infrastructure, and digital capabilities. How could we continue to provide much needed services and do this effectively and efficiently but most of all safely? Though our Partnership entered the unknown having never experienced a situation like COVID before, we were delighted with the innovative and exciting new ways of working that evolved from challenges presented to us. Below is a snapshot of our enablers:



Agenda Item

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Report

Report to:	**South Lanarkshire Integration Joint Board**
Date of Meeting:	**17 August 2022**
Report by:	**Interim Chief Officer, Health and Social Care Partnership**

Subject:	**Development of Strategic Commissioning Plan 2022-2025**

1. Purpose of Report

1.1. The purpose of the report is to:-

- update the Integration Joint Board on the proposed work to develop the next three-year Strategic Commissioning Plan 2022 - 2025

2. Recommendation(s)

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that the content of the report be noted; and
(2) that the programme of dates as currently available be noted.

3. Background

3.1. In-line with statutory requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, South Lanarkshire Council (SLC) and NHS Lanarkshire (NHSL) established formal integration arrangements to oversee the strategic development of Health and Social Care Services. On 01 April 2016, South Lanarkshire Integrated Joint Board (IJB) assumed responsibility of the strategic direction of Health and Social Care Services in South Lanarkshire. IJBs are required to prepare and agree three-year SCP setting out how resources will be directed to secure better health and well-being outcomes.

3.2. The main purpose of the Strategic commissioning Plan (SCP) is to set out how the IJBs will plan and deliver services in the area over the medium term, using the integrated budgets under their control. The SCP also provides clarity to the Parties (Council and NHS Board) regarding what they are required to operationally deliver and this sits alongside annual Directions issued by the IJB.

3.3. In preparing and publishing the SCP, IJB must ensure stakeholders are fully engaged in the preparation, publication and review of the SCP, in order to establish a meaningful co-productive approach, to enable Integration Authorities to deliver the nine National Outcomes for Health and Wellbeing and achieve the core aims of integration.

4. Current Position – South Lanarkshire IJB

4.1. In March 2016, South Lanarkshire IJB approved its first SCP covering the planning period 2016-2019. This Plan was very much seen as a first iteration of the future development of Health and Social Care Services in South Lanarkshire. The current SCP (2019 – 2022) built on the progress made by the first plan and was developed through an extensive participation and engagement process across the Partnership and within the four locality planning areas with 13 key priorities being identified with an agreed suite of commissioning intentions. These were matched against the National Health and Wellbeing Outcomes.

4.2. The current Plan runs to 31 March 2021 therefore preparation for the next SCP 2022 – 2025 requires to proceed imminently.

4.3. New guidance entitled Planning with People has been issued from the Scottish Government and COSLA on 11 March 2021 and sets out how members of the public can expect to be engaged by NHS Boards, IJBs and Local Authorities. The guidance complements existing engagement and participation strategies and features the national standards of community engagement which is central to the South Lanarkshire Health and Social Care Partnership (SLHSCP) existing engagement plan. There are seven standards: inclusion; support; planning; working together; methods; communications; and impact. The new guidance has been developed during the COVID-19 Pandemic recognising that forms of engagement have transformed and where appropriate digital approaches have been adopted. The guidance applies to all care services and should be followed by all health and care providers. Community engagement is key in the process of developing our SCP building on our good practice to date. Much of this is already reflected in the current IJB participation and engagement strategy.

4.4. In preparation of the SCP 2022 – 2025 planning process, the IJB agreed at its meeting on 18 May 2021, the proposed communication and engagement strategy.

4.5. The attached Appendix 1 provides members with details of the consultation sessions and dates set out thus far. It will be noted from this that already, there is an extensive programme which has been established covering a very wide range of stakeholders and opportunities for the people of South Lanarkshire and beyond to comment on the proposed Strategic Commissioning Plan for 2022 – 25.

5. Next Steps

5.1. In developing the new SCP, the Strategic Commissioning Group (SCG), will lead and oversee the development of a draft plan which will be presented for final approval to the IJB in March 2022.

5.2. Further updates will be brought back to the IJB re any emerging themes from the consultation process as well as a Draft Plan in due course.

5.3. Whilst our existing participation and engagement strategy is compliant with the key tenets of new guidance, work is ongoing to prepare a refresh of this document, to reflect the spirit and language of Planning with People.

6. Relationship to Other Planning Processes

6.1. In recognition of the planning/consultation processes being undertaken in a similar timeframe, for example, Community Panning Partnership ‘Can Do’ community survey and the refresh of ‘Achieving Excellence’ by NHSL, the Head of

Commissioning and Performance has met with respective lead officers for both SLC and NHSL. This is with a view to ensuring synergy and the opportunity to garner views pertinent to all as part of the IJB SCP engagement process (which is required by stature). In this regard any Health and Social Care themes identified by the 'Can Do' survey will be fed into the SCP locality engagement events. It also recognises the need to ensure there was clarity for the public regarding who was engaging and on which topics, recognising the potential for a cluttered landscape over the coming year.

6.2. This programme of dates has also been shared with partners such that they can join any of the sessions where there is potential to influence the respective strategies.

7. Employee Implications

7.1. There are no employee implications associated with this report.

8. Financial Implications

8.1. There are no financial implications associated with this report.

9. Climate Change, Sustainability and Environmental Implications

9.1. There are no implications for climate change, sustainability or the environment in terms of the information contained in this report.

10. Other Implications

10.1. There are no additional risk implications associated with this report.

10.2. There are no other issues associated with this report.

11. Equality Impact Assessment and Consultation Arrangements

11.1. This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy and therefore, no impact assessment is required.

12. Directions

12.1.

Direction to:	
1. No Direction required	☐
2. South Lanarkshire Council	☒
3. NHS Lanarkshire	☐
4. South Lanarkshire Council and NHS Lanarkshire	☐

Marianne Hayward
Interim Chief Officer, Health and Social Care Partnership

Date created: 28 July 2021

Link(s) to National Health and Wellbeing Outcomes

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

Previous References

- none

List of Background Papers

- **Strategic Commissioning Plan 2019 - 2022**

Contact for Further Information

If you would like to inspect the background papers or want further information, please contact:-

Name: Craig Cunningham, Head of Commissioning and Performance
Phone: 01698453704
Email: craig.cunningham@lanarkshire.scot.nhs.uk

Name: Colette Brown, Planning and Performance Manager
Mobile: 07385032009
Email: Colette.brown@southlanarkshire.gov.uk

Strategic Commissioning Plan 2022-25 Proposed Engagement Activity			
Date	**Forum**	**Lead**	**Notes**
11 August 2021 1:30pm – 3pm	Strategic Commissioning Group	C Cunningham	MST
17 August 2021 2pm – 5pm	IJB Paper SCP	C Cunningham	MST IJB development session in January 2022 with draft
24 August 2021 9:30am – 12:30pm	Extended SMT (Locality Managers in attendance)	C Cunningham	MST
24 August 2021 9.30 – 12.30pm	Clydesdale Locality Planning Group	C Cunningham, Karen Thompson	MST, Chair Councillor Lockhart
24 August 2021 2pm (invite still to be issued)	Homelessness Strategy Group	Craig Cunningham, Martin Kane	MST Contact is Lesley Cockburn. Agreed that we can have 1 hour of their agenda to do presentation and discussion and Lesley will circulate questions/survey for us thereafter
31 August 2021 10am – 11.30am	Carers Connected	C Cunningham/ B McAuley	MST Barbara confirmed Carers Connected can accommodate on their agenda on this date. Timeslot confirmed
2 September 2021 10 – 12pm (invite still to be issued)	Hamilton Locality Planning Group	C Cunningham, Kathy Blessing	MST, Chair Councillor Falconer

6 September 2021 9 – 10.30am	Elected members briefing Hamilton	SMT	MST
6 September 2021 2 – 3.30pm	Elected members briefing Cambuslang/Rutherglen	SMT	MST
7 September 2021 1 – 2.30pm	Elected members briefing East Kilbride	SMT	MST
7 September 2021 3 – 4.30pm	Elected members briefing Clydesdale	SMT	MST
9 September 2021 10.30am – 12pm (invite still to be issued)	VASLan	C Cunningham/Steven Sweeney	MST
14 September 2021 10am – 12pm	Local Housing Steering Group	C Cunningham/Annette Finnan/Cameron Mitchell	MST
15 September 2021 1pm (invite still to be issued)	Community Planning Partnership	C Cunningham	MST Rhonda Leith
16 September 2021 2 – 4pm (invite still to be issued)	East Kilbride Locality Planning Group	C Cunningham/ Nadia Ait-Hocine	MST, Chair
20 September 2021 (invite still to be issued)	Lanarkshire Carers Forum	B McAuley/C Cunningham	MST
28 September 2021 (invite still to be issued)	Carers Connected	B McAuley/ Cunningham	MST If further session required and depending on Carers Connected agenda

?? September 2021	Rutherglen/Cambuslang Locality Planning Group	C Cunningham, Andrea Tannahill/Alison McKerracher	MST, Chair Councillor McGuigan Emailed Sandra MacLeod awaiting response for date

?? September 2021	Independent Sector	C Cunningham/ R Ormshaw	MST – emailed Rhonda Ormshaw, awaiting response
HOLD Monday 13 September, 2021 – 2pm – 4pm AND Friday 17 September, 2021 – 2pm – 4pm	South Lanarkshire Health and Social Care Forum	C Cunningham	MST Robert Craig to confirm date
4 October 2021 at 2pm (invite still to be issued)	Registered Social Landlord Forum	C Cunningham/Annette Finnan	MST Karen Gillespie co-ordinates agenda karen.gillespie@southlanarkshire.gov.uk
31 October 2021*checking date WT*	Carers Connected	B McAuley/ Cunningham	MST If further session required and depending on Carers Connected agenda
October	Ad hoc sessions depending on requests		
October	Locality Managers to lead a wider locality sessions	Locality Managers	MST
October	Health and Social Care Local Forums	Locality Managers	MST
Sept/October	General offer to Community Councils	Tbc	MST
Sept/October	Health Board Session	C Cunningham	MST
July	Council CMT	M Hayward	MST
January 2022	IJB Development Session	C Cunningham	MST

Agenda Item

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Report

Report to:	**South Lanarkshire Integration Joint Board**
Date of Meeting:	**17 August 2021**
Report by:	**Interim Chief Officer, Health and Social Care Partnership**

Subject:	**Integration of Mental Health Services and Development of a Community Mental Health and Addictions Partnership within South Lanarkshire Health and Social Care Partnership**

1. Purpose of Report

1.1. The purpose of the report is to:-

- provide an update on the progress of developing an Integrated Community Mental Health Service within South Lanarkshire Health and Social Care Partnership
- provide an update in relation to Mental Health Services and the impact Coronavirus (COVID-19) has had on services

2. Recommendation(s)

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that the content of the report is noted.

3. Background

3.1. Within the changing landscape of Health and Social Care provision, key drivers which influence mental health practice directly or indirectly include 20/20 Vision, the Primary Care Improvement Plan and the Mental Welfare Commission patients' rights pathway. In addition, changes to legislation have influenced the 10 year national strategy for Mental Health Services leading to a focus on increasing access to seamless care pathways. Therefore efficient, effective utilisation of resources and evolving models of care will be required.

3.1.1. Mental health and wellbeing is prioritised in the Partnership's Strategic Commissioning Plan, as is Achieving Excellence, prevention and early intervention across the spectrum of children and young people, Adult and Older Adult Mental Health Services. These strategic drivers provide a strong foundation to support the achievement of key commitments and implementation of the National Mental Health Strategy (2012-2027). This framework has been applied to the development of service model for the integration of community based Mental Health Services within South Lanarkshire.

3.2. Lanarkshire Community Mental Health Services sit within the Mental Health and Learning Disability Service Hub and are hosted by North Lanarkshire Health and Social Care Partnership (HSCP). Within South Lanarkshire an Integrated Community Addiction Service (CAReS) was established in 2018. In October 2018 a Mental Health Integration Manager and Addictions Lead for South Lanarkshire HSCP, was appointed. Subsequently a model for establishing a South Lanarkshire Community Mental Health and Addiction Partnership was developed. This proposed partnership model was presented to and agreed by South Lanarkshire Integrated Joint Board (IJB) in February 2019.

3.3. In early 2020, the Lanarkshire Hosted Services group agreed to begin work towards achieving phase one of this process, which included the transfer of the management responsibility and accountability for the Community Mental Health Service in South Lanarkshire from the current hosting arrangements in North Lanarkshire HSCP.

4. Current Position

4.1. A transitional central operational management team comprising 1wte Mental Health Integration Manager and Addictions Lead, 1wte Community Mental Health Service Manager, 1 wte CAReS Service Manager and 1wte CAReS Operational Manager was established in July 2020 with the aim of devolving the operational management infrastructure and responsibility for Community Mental Health and Addiction Services into two host localities by 2022. The process of consultation and liaison with locality managers and Heads of Health and Social Care has commenced. Appendix 1 gives the current operational structure chart for information

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4.2. Staff, Clinical and Care Governance structures have been agreed and implemented and details around the financial governance and budget transfer from North HSCP for the Community Mental Health Services are progressing. See Appendix 2 for detail.

5. Outcome

5.1. A whole systems approach is being taken to develop a blended model of locality Community Mental Health and Addictions care inclusive of:

- NHS Adult and Older Adult CMHT's
- Social Work CMHT
- CAReS (Integrated Community Addiction and Recovery Service)
- Primary Care Mental Health and Wellbeing Service (in development as a workstream of Action 15 of the Mental Health Strategy 2017-2027)
- good Mental Health for All in South Lanarkshire Action Plan
- implementation of a pan Lanarkshire Mental Health Strategy (2017-2020)
- implementation of Rights, Respect and Recovery (2018) Alcohol and Drug Treatment Strategy

5.2. In order to manage this transition, it is proposed to take a phased approach to achieve whole system model for mental health that is embedded within the developing locality model for South Lanarkshire as per below:

Phasing the Model	Detail
Phase 1 (by April 2021)	The CMHT Integration Strategic Implementation group will take forward the development of an operational management structure for community based Mental Health Services with South Lanarkshire and an implementation plan that will enable the smooth transfer of Adult and Older Adults CMHT's to South HSCP. Performance, staff clinical and financial governance arrangements for the CMHT's will be agreed and implemented at the point of transfer to South HSCP
	During phase 1/2 a review of potential service models for the development of integrated Health and Social Work CMHT's will also be completed.
Phase 2 (by end of 2021)	Full implementation of a central Mental Health and Addictions operational management structure within South HSCP. Concurrently an integrated service model for NHS and Social Work CMHT's will be developed and submitted for consideration to appropriate health and social work governance structures and authorisation to test proposed integrated CMHT Service Model in one locality. Process of engagement with locality management teams in relation to the CMHT and CAReS Service Managers taking over operational management responsibility CMHT's and CAReS teams across two host localities will be commenced.
Phase 3 (by end of 2022)	Outcomes from testing an integrated service model for CMHTs will be reviewed. The transfer to South HSCP of the operational management responsibility and accountability will be completed. A review of performance monitoring, governance and reporting arrangements will be carried out. Operational Management responsibility and accountability for Community Mental Health and Addictions Services will be devolved to a designated locality manager in South-East and a designated Locality Manager in South-West Lanarkshire. The Mental Health and Addictions Service Managers will then be managed by the locality manager of these host localities. Professional and clinical governance responsibility for NHS Lanarkshire staff within CMHTs and CAReS teams will remain with the Associate Director of Nursing for Mental Health and Learning Disabilities (MHLD) and Professional and Care Governance for SLC staff with Head of Health and Social Care (Hamilton & Clydesdale) and Social Work Committee.
	It is anticipated that by April 2022, governance structures and processes in place will provide the necessary assurance to the partnership, Scottish Government, scrutiny and review bodies such as the Mental Welfare Commission, Health Improvement Scotland and the Care Inspectorate that ongoing commitment is in place to meet the Mental Health and Wellbeing intentions of the Strategic Commissioning Plan, Lanarkshire's Mental Health Strategy, Achieving Excellence and the dementia strategies and that these priorities for improving the Mental Health and Wellbeing for South Lanarkshire residents are included in locality planning and performance.

6. Governance Frameworks

6.1. The Mental Health Integration development group has reviewed existing governance frameworks in relation to care groups and services to ensure that these are appropriately aligned to the established governance structures within South HSCP and NHS Lanarkshire. This will provide the requisite levels of assurance in relation to service priorities and national targets. These groups include: MH, LD and Addiction Quality Governance Group, Lanarkshire Addictions Quality Governance Group and Social Work Governance Meeting. See Appendix 2 for detail.

6.2. A Lanarkshire wide Mental Health and Wellbeing Strategy was launched in 2019 and the devolvement of Community Mental Health Services to South Lanarkshire HSCP sits within the Specialist Services workstream of the strategy. The MHLD Hub continues to be responsible for the management, delivery, accountability and governance of mental health in-patient wards and pan Lanarkshire specialist Mental Health Services.

6.3. To achieve parity of service, alignment with care groups and seamless transition for patients accessing and leaving Mental Health Services, it is crucial that service provision and governance arrangements take cognisance of the work of the MHLD Hub and the Mental Health Strategy Action Plan.

7. Employee Implications

7.1. Consultation and engagement sessions with staff in South Lanarkshire Community Mental Health Teams (NHS) have taken place and it is not anticipated that there will be any adverse implications for employees. The Integrated CMHT Executive Group (Appendix 3) is exploring potential integrated Health and Social Work Community Mental Health Service models. The aim of which is to identify benefits that could be accrued from better alignment, communication and a potential reduction in duplication of effort within CMHTs.

8. Financial Implications

8.1. In respect of Health Care Services, in line with the IJB Integration Scheme, Mental Health and Learning Disability Services are a hosted service which is led by the North Lanarkshire IJB. The financial and operational management of this service is therefore the responsibility of the North Lanarkshire IJB. Mental Health Services are also provided by South Lanarkshire Council. This is a delegated function to the South Lanarkshire IJB who are responsible for the financial and operational management of this aspect of the Social Care Service.

8.2. The future resource requirements for South Lanarkshire should be reflected in the Health and Social Care Partnership Resource Prioritisation plan

8.3. The financial implications of the proposed blended model of locality care are not yet known. Non-recurring funding has been secured to support the Mental Health Integration Manager and Community Mental Health Service Manager posts until 31 March 2022. The Chief Financial Officer North and South Lanarkshire IJB is working with North and South Lanarkshire HSCP Chief Officers to identify substantive funding for these posts.

8.3.1. As the options for the potential integration of health and social work CMHTs are developed in phase 2, the costs of the preferred model will require to be contained within the total financial envelope available for 2022/2023. This will therefore require consultation and agreement with the North Lanarkshire IJB who are responsible for the delivery of the NHS Services on a pan-Lanarkshire basis and South Lanarkshire Council who are responsible for the delivery of the Social Care Services for South Lanarkshire residents.

8.4. The Hosted Services Group, which is jointly chaired by the Chief Officers of each IJB, will consider and review proposed service changes, including the financial and operational implications.

9. Climate Change, Sustainability and Environmental Implications

9.1. There are no implications for climate change in terms of the information contained in this report.

9.2. There are no implications for sustainability in terms of the information contained in this report.

9.3. There are no implications for the environment in terms of the information contained in this report.

10. Other Implications

10.1. There are no additional risk implications associated with this report.

10.2. There are no other issues associated with this report.

11. Equality Impact Assessment and Consultation Arrangements

11.1. This work will be undertaken in full consultation with all key stakeholders. From a delivery perspective, it does not introduce a new policy or change to an existing policy, rather it is about working more collaboratively. Therefore, no impact assessment is required. Service user involvement in process will be coordinated with third sector colleagues in LAMH and The Beacons. A communication strategy will be developed with support from the HSCP Comms Team to ensure all stakeholders are aware and have opportunity to contribute and be involved in changes being made.

11.2. There is also no requirement to undertake any consultation in terms of the information contained in this report.

12. Directions

12.1. The extent to which the existing directions to each partner require to be varied in is details in the table below:

Direction to:	
1. No Direction required	☐
2. South Lanarkshire Council	☐
3. NHS Lanarkshire	☐
4. South Lanarkshire Council and NHS Lanarkshire	☒

Marianne Hayward
Interim Chief Officer, Health and Social Care Partnership

Date created: 23 July 2021

Link(s) to National Health and Wellbeing Outcomes

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

Previous References

- South Lanarkshire Integration Joint Board on 13 February 2018 (Paragraph 8)

List of Background Papers

- None

Contact for Further Information

If you would like to inspect the background papers or want further information, please contact:-

Jennifer Russell, Mental Health Integration Manager and Addictions Lead
Ext: 4249 (Phone: 10698 454249)
Email: jennifer.russell@southlanarkshire.gov.uk

Appendix1

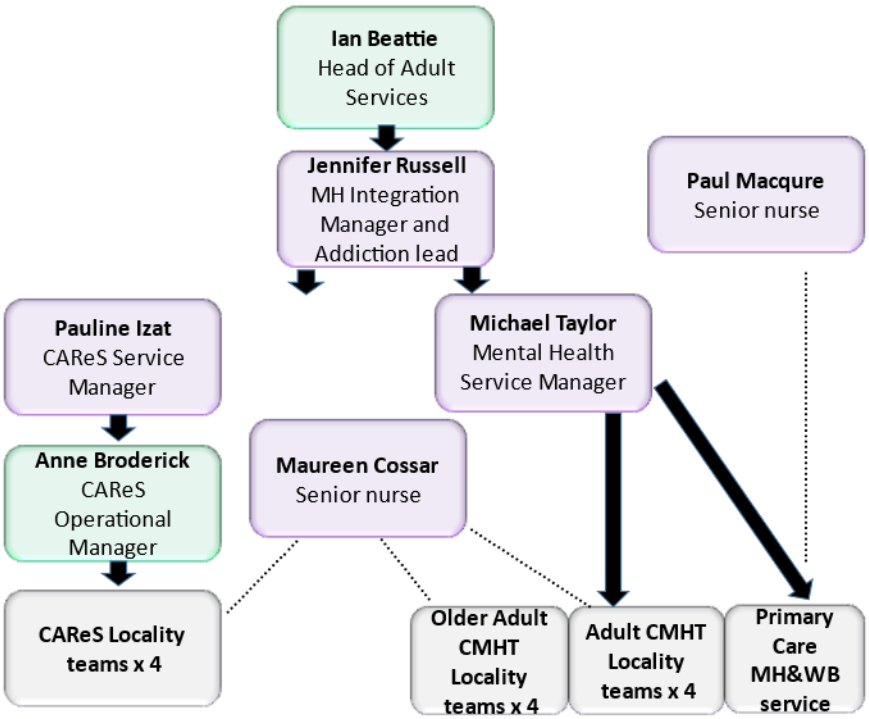
Community Mental Health and Addictions Partnership

Current organisational structure: July 2021

NHS=

Social Work=

Professional leadership= .....



Appendix 2

Mental Health and Addictions Governance Structure

- South Lanarkshire Support Care & Clinical Governance Group – South HSCP
- MH&LD and Addictions Clinical Governance Group –Chair Dr Adam Daly (Associate Medical Director)
- General Adult MH Clinical Governance Group –Chair Dr Anshu Bhatia (Clinical Director) and Dr M Carlin
- Old Age Psychiatry Clinical Governance Group – Chair Dr Raj Routh (Clinical Director)
- Addictions Psychiatry Clinical Governance Group – Chair Dr Adam Brodie (Clinical Director)
- Mental Health Professional Governance (Nursing Director/Associate Nurse Director Trudi Marshall/Karen McCaffrey)
- Social Work Governance Group – Liam Purdie
- South HSCP MH Strategy Group – Michelle McConnachie
- Adverse Incidents governance SAER/ Complaints Governance - (Paula Macleod General Manager MH&LD)/LIRG (Marianne Hayward/Liam Purdie)
- Psychology Therapy Teams - (Gary Tanner - Director of Psychological Services). Operational, professional and clinical governance structures for localities yet to be confirmed.

Integrated CMHT Executive Group Terms of Reference

Background:

The vision for Mental Health Services in Lanarkshire is to develop an integrated model that will put the person at the centre of decisions about their treatment and care, with greater understanding and confidence to manage their own condition, taking control of their life and having their voice heard. This is part of both North and South Lanarkshire's Strategic Commissioning Plans and the approach is at the foundation of rationale for health and social care integration.

In response to this a proposal to integrate South Lanarkshire Community Mental Health Services including the eventual transition of the locality psychological therapy teams was approved at South Lanarkshire Integrated Joint Board in February 2019. In order to manage this transition, a phased approach has been implemented to achieve a whole system model for mental health that is embedded within the developing locality model for South Lanarkshire by 2022.

The outline of what is included in this phased approach to achieve an integrated model of community mental health services in South Lanarkshire, is indicated in the body of the Integration Joint Board report. During phases 1/2 a scoping exercise will be carried out to review of options for the integration of NHSL and Social Work CMHT's and integrated service model developed for testing within a locality.

Remit of Executive Group:

This multi-disciplinary, joint agency group will be responsible for the scoping out and development of an Integrated Community Mental Health service (CMHS) model. In addition to overseeing the testing of the proposed Integrated CMHS model and agreed outcome measures in a defined locality.

Integrated CMHT Executive Group Aim:

Development, testing and evaluation of an Integrated CMHS model that meets the needs of the service user group in providing scheduled and unscheduled community mental health care and treatment.

The actions that will support development of an Integrated CMHS model are:

1. Collation of demand and activity data in relation to scheduled and unscheduled care for Clinicians, MHO's and SW Practitioners.
2. Does the data gathered highlight ways in which we can improve or work smarter together?
3. Describe the current position and working arrangements in CMHT's to identify:

a) what works well and we would wish to retain,

b) what would be do differently if developing the service from scratch,

c) what could we improve on to deliver better outcomes for service users.

4. Scoping out what a locality MHO rota would look like.

5. Access to both SWIS & MORSE for NHS and SLC staff to engender collective awareness and understanding of caseload profiles and promote collective ownership of Integrated CMHS caseload.

6. Identify optimum skill mix for Integrated CMHS in relation to MHO and SW Case Management roles and responisbilities.

Membership

Ian Beattie	Head of Health & Social Care South Lanarkshire H&SCP (Hamilton & Clydesdale)
Jennifer Russell	Mental Health Integration Manager & Addictions Lead: South Lanarkshire HSCP
Steven McKendrick	Clydesdale CMHT SLC Team Leader
Paul Thomson	Clydesdale CMHT NHSL Team Leader
Dr Anshu Bhatia	Clinical Director Adult Psychiatry South Lanarkshire
Michael Taylor	Service Manager South Lanarkshire CMHTs NHSL
Noreen McCarthy	Field Work Manager SLC East Kilbride Locality
Nadia Ait Hoicine	Locality Manager East Kilbride
Paul Donnelly	East Kilbride CMHT SLC Team Leader
Amanda Pollock	Admin Support to Marie Moy/Jennifer Russell South Lanarkshire HSCP

Agenda Item

10

Report

Report to:	**South Lanarkshire Integration Joint Board**
Date of Meeting:	**17 August 2021**
Report by:	**Interim Chief Officer, Health and Social Care Partnership**

Subject:	**Care at Home Update**

1. Purpose of Report

1.1. The purpose of the report is to:-

- update the Board on the outcome of the recent Care Inspectorate activity within the Care at Home Service
- update the Board in relation to current operational and financial pressures across the whole Health and Social Care system, in particular the Care at Home Service

2. Recommendation(s)

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that the contents of this report be noted in relation to the Care Inspectorate review for both Hamilton and Rutherglen Care at Home Services;

(2) that the current and future demand pressures and the operational and financial risks across the whole Health and Social Care system, in particular the Care at Home Service, are noted;

(3) that the actions being taken to mitigate the operational risks are noted; and

(4) that the work which is progressing to secure a funding solution to the current and recurring financial risks associated with the increase in demand for Health and Social Care Services is noted.

3. Background

3.1. Members will recall that South Lanarkshire Council (SLC) imposed a voluntary moratorium on the Care at Home Services in both Hamilton and Rutherglen in January 2020. This moratorium was introduced following concerns that had been highlighted in inspections carried out by the regulatory body, the Care Inspectorate and placed a suspension on new referrals to the Service.

3.2. The Care Inspectorate had been concerned about Hamilton Care at Home Service for some time resulting in Improvement Requirements in their Inspection Reports. In December 2019, the Hamilton Service was issued with a formal Improvement Notice that required improvements to be undertaken. The original notice, for a period of eight weeks, was extended to the end of May and then subsequently extended until 30 September 2020 because of the outbreak of the Pandemic.

3.3. Similar concerns were highlighted within the Rutherglen Service following an inspection in October 2019. This did not result in an improvement notice however, a decision was taken to initiate a moratorium on new referrals to enable the Service to focus on the improvement required.

3.4. The Services embarked on a significant programme of improvement to address the requirements arising from the inspection activity. This has been wide ranging and has involved the recruitment of new management teams that have developed and led improvement action plans aimed at bringing about positive change within the Service.

3.5. The Care Inspectorate had largely suspended its programme of Care at Home inspections during the Pandemic to enable it to focus on supporting services and the continued inspection of care homes in-line with temporary legislation. Services maintained weekly contact with the Care Inspectorate throughout the pandemic and the Care Inspectorate acknowledged that significant progress was being made within services. As a result of this progress, agreement was reached to lift the moratorium on new referrals in the Rutherglen service from the 31 August 2020.

3.6. The Hamilton Service was subject to a positive inspection in October 2020. This resulted in lifting of the Improvement Notice and agreement was reached to lift the moratorium on new services from 11 November 2020. This outcome reflects the exceptional work undertaken by staff within both services at a time when services were also working hard to respond to the challenges experienced because of the pandemic.

4. Current Position

4.1. As restrictions have eased, the Care Inspectorate have recommenced inspection activity within Care at Home services. Inspections have now taken place in Rutherglen and Hamilton Services, resulting in very positive outcomes with both services.

4.2. The Rutherglen Service was inspected in November 2020. Feedback from the inspection was exceptionally positive regarding the progress that had been made within the service and awarded the Service the following grades:

- how well to we support people's wellbeing 4
- how good is our Leadership 4
- how good is our Staff Team 4
- how good is our care planned 3

4.3. Not only was this confirmation of the excellent progress that had been made but also an acknowledgement of the exceptional work that has been undertaken by staff within the service. The Care Inspectors were so impressed with the progress that they recategorised the Service from high risk to medium risk.

4.4. The Hamilton Service was subject to a further inspection in June 2021. Again, feedback from the inspection was exceptionally positive, highlighting the very positive steps that had been taken to improve the service and the improvements in the management of the service. The Service was awarded the following grades:

- how well do we support people's wellbeing 3
- how good is our care and support 3

4.5. It should be noted that Inspectors highlighted that the service largely awarded grades of 4 for the sub-categories inspected and noted that continued progress in two areas would result in grades of 4 being awarded. These are areas are currently being progressed.

4.6. Inspectors highlighted several areas of good practice during the inspection and were complimentary regarding the scale of improvement that had been achieved in such a short period of time, amid a pandemic. The Hamilton Service has also been re-categorised from high risk to medium risk. This again reflects the excellent work undertaken by staff within the Service.

4.7. The Services continue to be on an improvement journey. However, the outcomes highlighted above underlines the positive progress that has been made to stabilise the Services and ensure that service users receive services of the highest quality.

4.8. The Rutherglen and Hamilton Services will now return to an annual regime of inspections, similar to those experienced within the Clydesdale and East Kilbride Services.

5. Current Demand Pressures and Risks:

5.1. A range of pressures are being experienced across health, social care, and social work services. NHSL have used social media to highlight the unprecedented levels of demand resulting from: increased COVID-19, maintaining and recovering services, and a shortage of staff due to annual leave or having to self-isolate as result of contacts outside work, or childcare arrangements where children require to self-isolate.

5.2. The pressures experienced in the three Lanarkshire hospital sites is at a level higher than would normally be experienced during the winter months and has a significant consequential impact on a range of community services, particularly the Care at Home service.

5.3. The same pressures are being experienced across the social work resource particularly Care at Home services. The issues are the same with a combination of COVID absences ranging from positive cases amongst staff to self-isolation due to close contacts. Over the past weeks we have in excess of 110 staff not available for duty. This is above normal absence levels as well as at a time when annual leave is higher due to it being a peak holiday period.

6. Current Position

6.1. **Delayed Discharge:** With the success of introducing Planned Date of Discharge (PDD) the delays in hospital had moved from 120 plus March 2020 with a gradual decrease and running for a significant period 30-40 delays through winter and first 3 months of 2021. Delays are now increasing and over past 2 months have steadily been increasing rising to high 70’s and are continuing to increase. This reflects whole system challenges and demand far outstripping capacity. The complexity of cases in the community continues to be a challenge with staff capacity.

6.2. **Equipment and Adaptation Service:** As a result of the complex interplay between C19, Brexit and the blockage in the Suez Canal, interruption in the supply of some metals and materials, particularly flame-retardant foam, has affected the availability of key equipment including commodes and hoists. Advice has been circulated widely within the H&SCP and in the three hospital sites about the importance of prioritising essential equipment.

6.3. **Move to Care Home**: negotiations are taking place with families for clinically fit for discharge patients to move to a residential home until their choice's options are available. This can only take place within an informed statutory framework and patients cannot be forced to move.

6.4. Negotiations and discussions with families and establishments is progressing on the basis that the increased activity and pressure on acute hospital sites, resulting in no available beds for acutely unwell patients, means that people who are clinically stable and no longer need care of an acute general hospital, will be moved to more appropriate care facility temporarily until the placement of their choice becomes available.

6.5. **Interim moves for people awaiting care at home**: The increased demand and pressure across the whole system has led to a difficult decision to consider interim residential care home placements on a respite basis for some adults who require care at home services to facilitate discharge. This requires careful discussion and negotiation with acute colleagues, the individual and family members / carers. Chief Officer has commissioned 12 emergency beds to facilitate some of these discharges.

6.6. To support the pressures and manage the impact of demand on the Care at Home, service managers have been holding daily huddles to share and manage priority cases. This is an ongoing prioritisation and reprioritisation of services to the community and in facilitating hospital discharge.

6.7. **Risks**: **Care at Home**: To manage demand and capacity pressures for new and existing work the following risks have been identified that are current, cumulative and intensifying:

- Missed visits, reduced, or suspended service
- Delays in discharge from hospital
- Delays in sourcing packages to meet need in communities
- Service capacity dealing with critical and substantial only
- Essential equipment not available
- Redeployment from other essential services reducing capacities elsewhere
- Health and wellbeing of staff compromised
- Resilience amongst the management team
- Increased concerns and complaints from public
- Care Inspectorate concerns
- Reputational damage for the council and H&SC Partnership
- Increase expenditure on direct service

6.8. **Total Mobile:** System now fully implemented in Hamilton and Rutherglen localities. Clydesdale and East Kilbride will follow thereafter. Agreement reached to extend Microsoft 365 accounts to all Home Carers. Pilot to take place in Bothwell and Uddingston and new shift patterns being introduced for staff as Total Mobile is implemented.

6.9. **External Providers:** In terms of External Providers, capacity across the sector is exceptionally challenging with providers experiencing the same issues as highlighted for NHSL and council Care at Home staff. Provider meetings take place fortnightly, and a group has now been established to develop procurement and consultation strategies going forward so in house and external providers are complementing each other's work.

6.10. A temporary variation to the Care at Home provider's contracts has been extended until 30 September 2021. This revised arrangement, will facilitate the retention of care packages for 3 days following admission to hospital. Voluntary moratorium in place for Care 1 following CI inspection grades of 2. Sustainability arrangements extended until 30 September 2021.

6.11. All alternative options to stand down other service are being considered however these pose alternative risks to services users. For example, the standing down of Day Centre support is not in the same position as pervious lock down with carers families and supports furloughed or isolating. The capacity to offer this support is no longer viable.

6.12. **Oversight and Management:** Arrangements continue for Care at Home and wider system issues.

- Daily 8.30 Extended Managment team calls re risks and pressures.
- Daily Care at Home operational management team calls re hospital discharge.
- Daily morning call re Care at Home community resources and prioritisation.
- Continued participation in the daily PDD calls
- Health and Social Care Partnership (HSCP) Emergency command structure stood back up chaired by Interim Chief Officer. Director of Social Work
- Weekly meeting with Trade Unions

7. Mitigation Actions

7.1. A scoping has been undertaken in relation to the unmet need in terms of hours and projected need to support current and future self-isolation. Also, with sustainability payments ceasing from September 2021, the service needs to prepare now for what will be increased demand due to providers not being able to sustain services as well as for winter planning. Recruitment and profiling in October 2021 will not give enough time for recruitment for carers or supervisor posts.

7.2. Financial projections and profiling of demand is currently being undertaken to address current demand and future demand. The current pressures are being described as winter pressures during the summer months, which is unprecedented.

7.3. In order to mitigate the operational risk as a result of the increase in demand, the HSCP has confirmed that increased costs will be incurred between September 2021 to March 2022 in respect of additional staff costs for the Care at Home Service, subject to workforce being available to recruit. This cost will also include the costs of uniforms, mobile phones, transport costs etc. There are also other costs being incurred in respect of the Covid-19 pandemic across both Health and Social Care Services.

7.4. The additional costs incurred in respect of the recruitment of the Care at Home Service and other Social Care staff to address the emergency response to the Covid-19 pandemic in 2021/2022 has been included in the Remobilisation Plan which has been submitted to the Scottish Government on 30 July 2021.

7.5. The Scottish Government have advised that current IJB Reserves are to be drawn down first before any further funding is made available. In respect of existing IJB reserves, there is a ring-fenced Remobilisation Fund reserve of £6.944m (SLC - £5.575m; NHSL - £1.369m). This was funding received in 2020/2021 to address the cost of the Covid-19 pandemic which was not spent in 2020/2021 but was carried forward to 2021/2022 through IJB reserves. All of this funding is held by Health. SLC will invoice Health to access this funding as appropriate, similar to last year.

7.6. There is an expectation that further funding will require to be sought from the Scottish Government to meet the total cost of the health and social care response to the Covid-19 pandemic in 2021/2022.

7.7. The IJB ring-fenced reserves funding and further Scottish Government funding made available, if any, is non-recurring. On the basis that it would be challenging to recruit to Social Care posts on a temporary basis, in order to mitigate the current and ongoing operational risks, approval has been given by the Chief Executive of South Lanarkshire Council to recruit staff on a permanent basis to mitigate the operational risks. The appointment of staff on a permanent basis will require an additional recurring funding contribution from the SLC partner from 1 April 2022.

7.8 The South Lanarkshire Chief Executive has linked with COSLA and the Scottish Government in relation to the current operational pressures and the recurring financial implications of these. There is currently an ongoing exercise being undertaken to scope the national pressures across all local authorities in relation to Care at Home. The Scottish Government have been advised of the financial risks associated with the service at this time and are being asked to make available a sufficient recurring financial settlement to meet the current and projected pressures.

7.9 The success of the recruitment drive will be dependent on the workforce availability. The risk of failing to deliver safe services to service users and carers is significant. There will also be a significant detrimental impact on the health and well-being of staff if sufficient additional staff capacity to meet the increase in critical and substantial complex care needs is not secured.

7.10 As highlighted above, the requirement to recruit staff on a permanent basis will require an additional recurring funding contribution from the SLC partner from 1 April 2022. At this point, there is no recurring budget available when the non-recurring ring-fenced reserve is exhausted.

8. General/Other Implications for Council/IJB

8.1. Reputational risk and service user risk are identified as a consequence for the council and registered services where no action is taken to mitigate the risks.

8.2. The South Lanarkshire Council Chief Executive and the Chair of the IJB have been apprised of the current risks though a Briefing Report and the Chief Executive has engaged in discussions with COSLA and Scottish Government in relation to current pressures. The IJB Chief Officer and the IJB Chief Financial Officer are also engaging with national forums to contribute to the request for sufficient recurring funding from the Scottish Government to maintain safe services when the non-recurring Covid-19 funding is exhausted.

9. Employee Implications

9.1. Staff wellbeing both physically and psychological is a key concern.

9.2. Management resilience across the Care at Home Service is a concern. Some of these posts are person dependent and the requirement to increase management capacity needs to be addressed as a priority.

9.3. Registration requirements could be compromised due to the safe staffing structures to meet current demand.

10. Financial Implications

10.1. The use of the ring-fenced reserve is a temporary funding solution to meet the additional demands and further work to mitigate the financial risks is ongoing between the Chief Officer, Chief Financial Officer of the IJB and Chief Executive and Chief Financial Officer of South Lanarkshire Council.

10.2. The SLC partner will require to confirm a recurring funding solution effective from 1 April 2022.

10.3. At this stage, further Scottish Government funding for 2021/2022 has not been confirmed. Any further funding will be non-recurring. No additional recurring funding has been confirmed for social care services by the Scottish Government. The Scottish Government financial settlement for 2022/2023 is not yet known.

11. Climate Change, Sustainability and Environmental Implications

11.1. There are no implications for climate change in terms of the information contained in this report.

11.2. There are no implications for sustainability in terms of the information contained in this report.

11.3. There are no implications for the environment in terms of the information contained in this report.

12. Other Implications

12.1. There are no additional risk implications associated with this report.

12.2. There are no other issues associated with this report.

13. Equality Impact Assessment and Consultation Agreements

13.1. Changes to policy and practice procedures to be mindful of the EIA's for protected groups.

13.2. There is a fortnightly Trade Union liaison meeting in relation to these demands and Trade Unions are aware of the challenges and supportive of a solution to ensure safe staffing levels and service delivery.

14. Directions

14.1. The implications of the content of this report in respect of IJB Directions is summarised as follows:

Direction to:	
1. No Direction required	☒
2. South Lanarkshire Council	☐
3. NHS Lanarkshire	☐
4. South Lanarkshire Council and NHS Lanarkshire	☐

Marianne Hayward
Interim Chief Officer, Health and Social Care Partnership

Date created: 28 July 2021

Link(s) to National Health and Wellbeing Outcomes

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

Previous References

- none

List of Background Papers

- none

Contact for Further Information

If you would like to inspect the background papers or want further information, please contact:-

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Agenda Item

11

Report

Report to:	**South Lanarkshire Integration Joint Board**
Date of Meeting:	**17 August 2021**
Report by:	**Interim Chief Officer, Health and Social Care Partnership**

Subject:	**New General Medical Services 2018/ Primary Care Improvement Plan (PCIP) Update**

1. Purpose of Report

1.1. The purpose of the report is to:-

- update members on the changes to dates on the implementation of new General Medical Services and the Primary Care Improvement Plan
- highlight that a new Memorandum of Understanding is imminent but at the point of writing not yet available
- highlight the update return to Scottish Government.
- update members on the implementation of the new General Medical Services 2018 contract and the Primary Care Improvement Plan.
- request support to uncouple the Community Treatment and Care Workstreams due to the revised time scale for delivery

2. Recommendation(s)

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that the PCIP4 tracker is approved;
(2) that the changed time frames for implementation are noted;
(3) that the addition of transitionary payments is noted;
(4) that a move back to separate workstreams to progress Community Treatment and Care and Urgent Care is supported;
(5) that the progress of the Primary Care Improvement Plan is noted; and
(6) that the areas of risk identified at section 6 and escalation via NHS Lanarkshire's Board risk register systems are noted.

3. Background

3.1. The General Medical Services (GMS) 2018 contract came into force on the 01 April 2018. The transformational change linked to the contract is supported by the Memorandum of Understanding (MOU) and linked to the Primary Care Improvement Plan (PCIP). The initial PCIP was agreed by the Integrated Joint Board's (IJB), Health Board and GP sub-committee in July 2018. At that time, it was agreed that six-monthly updates would be provided to chart progress and challenges against the MOU. The Pandemic has disrupted delivery of the PCIP and also the reporting schedules both locally and nationally.

3.2. A halfway assessment was undertaken by the Scottish Government, with returns on progress, barriers and mitigation as well as asks from Boards being required. These were considered Scotland wide by the National Oversight Group. However, the process was stood down as the nation responded to Covid-19. Between the first and second waves of the pandemic the PCIP 3 tracker was requested by the Scottish Government to allow a "stocktake" position by the National Oversight Group. Work was again paused as the second wave of the pandemic took hold and staff were again orientated towards the Covid response. A PCIP 4 tracker (Appendix 1) has now been submitted to Scottish Government.

3.3. The contract offers details for the PCIPs:

- how the services will be introduced before the end of the transition period in 2021
- that they will be overseen by a Scottish GMS oversight group
- clear milestones for the redistribution of GP workload
- development of effective primary care multidisciplinary team working
- Boards and Health and Social Care Partnerships (HSCP) will deliver clear arrangements to deliver on the commitments of the new Scottish GMS contract
- must be agreed by the GP sub-committee

4. Next Steps

4.1. The end date for delivery of the first phase of the contract was initially March 2021. However, it has been accepted that the pandemic has delayed the delivery.

4.2. That said, there is a desire that the PCIPs are moved forward and an agreement nationally that the principles of the PCIP are the correct ones, essentially collaborative multidisciplinary teams working alongside GPs in their role as Expert Medical Generalists to manage patients in their own community should continue to be the direction of travel.

4.3. The Scottish Government and British Medical Association (BMA) released a joint statement in December 2020 detailing the new agreements surrounding delivery of the contract. The detail of this will be crucial and is being worked through at a national level. The statement is attached at Appendix 2 and summarised in the table below:

Contract Area	Expectations	Timeframe	Additional information
Vaccine Services	Vaccinations that are still in the core GMS contract under the Additional Services Schedule	01 October 2021	New Transitionary Service basis to be negotiated by Scottish GP Committee (SGPC) and the Scottish Government in 2021 and payments will be made to practices providing these services from 2022-23
Pharmacotherapy	Regulations will be amended so that NHS Boards are responsible for providing a Level One Pharmacotherapy service to every general practice for 2022-23*	2022-23	Payments for those practices that still do not benefit from a Level One Pharmacotherapy service by 2022-23 will be made via a Transitionary Service until such time as the service is provided

Contract Area	Expectations	Timeframe	Additional information
Community Treatment and Care Services	Regulations will be amended so that Boards are responsible for providing a community treatment and care service for 2022-23	2022-23	Where practices do not benefit from this service, payment will be made via a Transitionary Service basis until such time the service is provided
Urgent Care Service	Legislation will be amended so that Boards are responsible for providing an Urgent Care service to practices for 2023-24	2023-24	Consideration will need to be given about how this commitment fits into the wider Redesigning of Urgent Care work currently in progress
Additional Professional Roles	The pandemic has highlighted the need for early local intervention to tackle the rising levels of mental health problems across all practices as well as the challenges in areas of high health inequalities		Working with Health & Social Care Partnerships and NHS Boards, we will consider how best to develop these services at practice level, and establish more clearly the 'endpoint' for the additional professional roles commitment in the Contract Offer by the end of 2021.
Premises	No update in the joint statement but work ongoing		

*Pharmacotherapy delivery and the different levels is particularly contentious and more detail is expected in the revised MOU.

4.4. The Contract is underpinned by a MOU; this is currently being reviewed nationally. A letter from Scottish Government in respect of this is attached at Appendix 3. The original MOU (Appendix 4) remains in effect until the details of the update are agreed.

4.5. We were directed to complete and submit the PCIP 4 tracker to Scottish Government by 30 May 2021, this is out of step with our IJB meetings and was submitted in draft until such times as it is approved at the IJB.

5. Summary

5.1. It is agreed that the principles of the PCIP are still the correct ones and needed to support the transformation of General Practice envisaged in the nGMS. Delivery timeframes have changed with prioritisation being given to Vaccine Transformation (VTP), Pharmacotherapy and Community Treatment and Care (CTAC) as detailed in the Cabinet Secretary/BMA letter of December 2020. A revised MOU is awaited. A PCIP Recovery Plan is in place and is being progressed.

6. General/Other Implications

6.1. The details of the Joint Statement from Scottish Government/BMA are being finalised nationally. There are emerging risks associated with the overall plan as well as individual workstreams. Risks identified are:

- PCIP will not be delivered within the timeframes due to recovery from the pandemic
- possibility of further Covid waves
- financial risk in that non delivery may lead to additional payments to General Practice to deliver the services
- reputational risk locally and nationally and workforce confidence.

- a number of the PCIP workforce remain deployed to the Covid effort, particularly in the Covid Community Pathway and Vaccination, which will delay delivery of the PCIP
- GP sustainability
- Financial risk to deliver the PCIP within existing budget allocation

6.2. Each PCIP work stream has an individual risk register which feed to an overarching risk register for the programme, the highest rated risks remain around workforce, funding and infrastructure. There is a requirement for the risk registers to be updated for each workstream and escalated to NHS Lanarkshire to reflect the emerging risks and options to mitigate the emerging risks.

6.3. GP sustainability remains a risk. The PCIP is a plan for medium to long-term development and sustainability of primary care in general and General Practice specifically. Without an effective primary care sector, no Health and Social Care system can function effectively.

7. Employee Implications

7.1. The PCIP as it stands has some detail on specific individual employee roles. This update specifies the number of new roles agreed to date. It is clear that the intention of the GP contract, the PCIP and the MOU taken together is to allow clinicians to work at a high level in expanded and integrated teams. This will have implications for many employees over the coming years and should be broadly welcomed by all involved. There are implications for those in changing roles, the development of new roles and the need to explore Transfer of Undertakings (Protection of Employment) (TUPE) for a number of but not all staff currently employed by GPs. For example, the contract is explicit about the development of practice nursing and practice manager roles, both of which will remain practice employees.

8. Financial Implications

8.1. Financially, implementation of the PCIP is complex. It requires a balance in expenditure between different workstreams, recycling of existing expenditure and efficiency of “back office” functions. Despite review and skill mixing the PCIP is not fully deliverable within the financial envelope indicated and this has been highlighted previously and again in the PCIP 4 tracker. The Integration Authorities and Board will continue to be appraised of the developing financial implications.

9. Climate Change, Sustainability and Environmental Implications

9.1. There are no implications for climate change in terms of the information contained in this report

9.2. There are no implications for sustainability in terms of the information contained in this report.

9.3. There are no implications for the environment in terms of the information contained in this report.

10. Equality Impact Assessment and Consultation Arrangements

10.1. There is no requirement to carry out an impact assessment in terms of the proposals contained within this report. However, consultation will continue to be extensive. The Equality Impact Assessment for the programme is being refreshed.

10.2. Consultation and engagement across a wide range of stakeholders is pivotal to the successful implementation of the PCIP. The programme has a dedicated communications and engagement officer, who is currently redeployed to support the Covid pandemic response.

11. Directions

11.1.

Direction to:	
1. No Direction required	☒
2. South Lanarkshire Council	☐
3. NHS Lanarkshire	☐
4. South Lanarkshire Council and NHS Lanarkshire	☐

Marianne Hayward
interim Chief Officer, Health and Social Care Partnership

Date created: 28 July 2021

Link(s) to National Health and Wellbeing Outcomes

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

Previous References

- none

List of Background Papers

- PCIP4 Tracker

- Joint Statement Scottish Government/BMA December 2020
- Letter regarding the MOU from Scottish Government April 2021
- Original Memorandum of Understanding

Contact for Further Information

If you would like to inspect the background papers or want further information, please contact:-

Dr Linda Findlay
Phone: 01698 453844
Email: linda.findlay@southlanarkshire.gov.uk

Local Implementation Tracker Guidance

The following tracker should be used by Integration Authorities in collaboration with Health Boards and GP sub-committees to monitor progress of primary care reform across their localities, and in line with service transfer as set out within the Memorandum of Understanding.

The **MoU Progress tab** should be used through local discussions between Integration Authorities and GP sub-committee to agree on progress against the six MoU priority services as well as that the barriers that areas are facing to full delivery. Integration Authorities should provide information on the number of practices in their area which have no/partial/full access to each service. The sum of these should equal the total number of practices in each area. Please only include numbers (or a zero) in these cells; comments boxes have been provided to supply further information.

If you are funding staff through different funding streams, for example, mental health workers through Action 15 funding, please include this information in the relevant section so we are aware that you are taking steps to recruit staff in this area.

The **Workforce and Funding Profile tab** should allow Integration Authorities to consider financial and workforce planning required to deliver primary care improvement, and reassure GP sub-committee of progress.

For the workforce numbers and projections, we are limiting our questions to WTE numbers, but are also asking you to provide headcounts for community links workers so that we can monitor progress towards the commitment to 250 additional CLWs.

If you are funding staff through different funding streams, for example, recruiting mental health workers in Action 15, do not record these in Table 1. However, they should be included in Tables 2 and 3 to inform workforce planning.

We have included new rows this time at the foot of Tables 1 and 3 (shaded in red). Please include here your estimate of total required spend (Table 1), and total required staff (Table 3) in order to reach full delivery across each of the services.

We would also ask that this local implementation tracker be updated and shared with Scottish Government by **31st May 2021.**

Covid PCIP 4

Health Board Area: NHS Lanarkshire
Health & Social Care Partnership: North Lanarkshire HSCP and South Lanarkshire HSCP
Total number of practices: 100

MOU PRIORITIES

2.1 Pharmacotherapy	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices with NO Pharmacotherapy service in place	0	0	0	0	0	0
Practices with Pharmacotherapy level 1 service in place	0	100	0	0	100	0
Practices with Pharmacotherapy level 2 service in place	0	100*	0	0	100*	0
Practices with Pharmacotherapy level 3 service in place	0	0	0	0	0	0

What assumptions are you using to determine full delivery, and what specific barriers are you facing in achieving this? Assumptions for full service delivery are based on delivering all tasks from the Level 1 pharmacotherapy table outlined in the GMS 2018 contract. Barriers to this include insufficient funding structure and workforce nationally (as pharmacists are now on national shortage profession list), Board specific barriers include identifying premises to accommodate staff and IT solutions to enable remote working (such solutions are required due to challenges in basing all staff required to deliver a full level 1 service physically in practices). The national delays in progressing digital prescribing directly impact on achievement of pharmacotherapy Level 1. We are using workforce to manage tasks that could be supported by better digital solutions, this is inappropriate and undermines the ability to eliver Level 1 and retain and recruit staff. These would need to be agreed nationally eg. electronic prescribing.
*Aspects of Level one and level two pharmacotherapy are interlinked. For example, whilst clinically assessing the appropriateness of high risk medications under level one, if any issues are identified, the pharmacist has a professional responsibility to resolve these issues (categorised under level 2 in the pharmacotherapy table) in the interest of patient safety. A national view on where this sits with the L1 delivery would be welcome.

2.2 Community Treatment and Care Services	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices with access to phlebotomy service	0	100	0	0	0	*100
Practices with access to management of minor injuries and dressings service	0	100	0	0	0	*100
Practices with access to ear syringing service	**100	0	0	0	0	*100
Practices with access to suture removal service	**100	0	0	0	0	*100
Practices with access to chronic disease monitoring and related data collection	**100	0	0	0	0	*100
Practices with access to other services	0	100	0	0	0	*100

What assumptions are you using to determine full delivery, and what specific barriers are you facing in achieving this?
Prior to Covid, Lanarkshire was delivering Treatment Room Services to some extent in all ten localities. For the majority of practices, this included all aspects on this return except chronic disease monitoring and related data collection. All GP practices had been surveyed to identify tests and task activities still being carried out by practices, rather than by CTAC, with a view of addressing historical arrangements through levelling up of provision. Early scoping around long term conditions, chronic disease monitoring and related data collection had begun.
Treatment and care services activity altered during the first wave of the pandemic and an urgent/ emergency service was put in place through domiciliary services. Currently, treatment and care services are being 'stood up' on a phased basis across Lanarkshire; phlebotomy, dressings and injections being the first provisions to recommence. Capacity has been greatly reduced by the need for physical distancing and the increased infection prevention and control measures required. Scoping of long term conditions and chronic disease monitoring and related data collection has recommenced and testing commenced during October 20 for 3 conditions with the aim to scale and spread across all of Lanarkshire. The CTAC Operational Group has reconvened regular meetings from end April 21 to begin progressing this workstream requirements.
* Access to treatment and care services by 31/03/22 is dependent on the ongoing pandemic and the responses required to manage it.
** This was a reduction compared to previous returns due to the impact of Covid.

2.3 Vaccine Transformation Program	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Pre School - Practices covered by service	0	0	100	0	0	100
School age - Practices covered by service	*catch-up - various 100	0	* Flu 100	0	0	100
Out of Schedule - Practices covered by service	100	0	0	0	0	100
Adult imms - Practices covered by service	100	0	0	0	0	100
Adult flu - Practices covered by service	0	0	100	0	0	100
Pregnancy - Practices covered by service	0	0	100	0	0	100
Travel - Practices covered by service	100	0	0	0	0	100

What assumptions are you using to determine full delivery, and what specific barriers are you facing in achieving this?
Full delivery will be on those cohorts that were identified in the original contract offer. For all vaccines other than travel health, full delivery will be dependent on pulling information from GP systems in the first instance to identify patients who are to receive vaccine. Travel health cannot deliver in this way as these vaccines are ad hoc in nature and as such will be patient identified. Our initial modelling was on cohort uptake until 19/20 and a provision for 75% uptake, but over the 20/21 flu season, we saw an increased uptake in all three GP / PCIP cohorts, which is to be welcomed, but modelling for future years will need to consider this. The flu programme was achieved through a mass vaccination model for flu season 2020-2021, as such the 20/21 staffing requirement and accommodation requirement was impacted by social distancing, and careful consideration will need to be given to the possible need for revision of funding allocations which were informed on pre-covid uptake levels.

A VTP SLWG has progressed project plans to map out the remainder of the vaccination services that require to be transferred to Board managed services. This exercise has identified a number of areas where we are awaiting national information on or where local solutions are required, these are detailed below.
Barriers:
Travel Health - require clarification the Fit for Travel has been updated to be the source of initial information and point for linking into Board vaccination service.
Travel Health– require clarification if provision of national initial call handling provision (NHS24) will be available, or indeed if not immediately, in future as this would inform the selection of local solutions.
Travel Health – require confirmation that national PGDs will be provided including when they will be provided, if not, will require to locally develop.
VTP / IT – access to patient records to ensure patient safety specifically for Shingles, Travel Vaccinations, and Pneumococcal.
VTP – National IT system provision, require confirmation of what will be made available and by when. Require confirmation that future proofing of IT solutions includes certification of vaccine module in national IT system provision.
VTP – increased pressure on available accommodation due to covid response limits options of where vaccination clinics can be delivered.
There is a need for clarification regarding timelines detailed in joint BMA/Cabinet Secretary Letter with full implementation to be October 21 or by March 22?
There is an assumption that recently announced additional cohorts are not to be funded by PCIP, nor indeed shall they default to GPs to deliver.

2.4 Urgent Care Services	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices supported with Urgent Care Service	89	11	0	*79	*21	0

What assumptions are you using to determine full delivery, and what specific barriers that you are facing to achieving this?
Currently there are ANPs in training across 11 practices in NHSL, and progress towards the planned urgent care model continues. The team of ANPs have been supporting the Covid community assessment centres since March 2020, the CACs remain reliant on this redeployment. NHS Lanarkshire continues to recruit training and qualified ANPs, in addition to Senior ANPs, who will support the delivery of urgent care going forward. Potential barriers: ANPs being available to support urgent care model will vary depending upon ongoing response required to the pandemic. Furthermore, there remains a concern that the redeployment to Covid Assessment Centres could detrimentally affect recruitment and retention of ANPs. The Covid pandemic and changing ways of working has given us an opportunity to revisit the urgent care model, and this will be further explored in the coming months. The numbers are indicative of the current funding for ANPs. Wider modelling is being undertaken to review how more practices can be supported with an urgent care service, however, even with this access, will remain partial without further funding for Advanced Practitioners in Urgent Care .

* Practices with access may differ as a result of ongoing urgent care model review/provision.

Additional professional services

2.5 Physiotherapy / MSK	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing APP	94	3	3	95	3	3

Comment / supporting information
Current practice allocation is on a ratio of 1 wte APP to 15,000 practice population. We have a desire to have a service across all practices but will be dependent on further additional funding from Scottish Government. Access to MSK provision across the community system has been significantly adversely affected with the standing down of the national number. This has impacted negatively on practice workload.

2.6 Mental health workers (ref to Action 15 where appropriate)	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing MH workers / support through PCIF/Action 15	61	0	39	20	0	80
Practices accessing MH workers / support through other funding streams	81	0	19	20	0	80

What are the specific barriers to your practices receiving a full MH service? Please attach a copy of your Mental Health action plan if you have one.
We have a total of 20wte staff for the PCMH&Wellbeing service which is mainly Mental Health Nurses. Our plan has always been to recruit to the full complement of additional mental health staff working in primary care (which is approximately 50) by end of Action 15 programme in 2022 & we have a recruitment plan in place to achieve that. We have MH Liaison Nurses in 39 GP practices which should increase to 45 by early summer. The 39 practices that have a mental health liaison nurse have allocated sessions per week. Some practices have 1 session, some have 2 sessions and a few have 4 sessions.
The 19 practices that have access to the mental health workers have full access to the resources being provided. We are hopeful that we will be in all GP practices (depending on recruitment) by the middle of 2022.

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2.7 Community Links Workers	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing Link workers	0	0	*10	0	0	100

Comment / supporting information
Model is:
2wte co-ordinators who are in post.
18wte GP Community Link Workers.
10wte Financial Welfare Advice workers (via a SLA with 3rd sector partners) - this provision was in place for 1 April 2021.

* as of 31/03/21, 10 practices had full access to a GP Community Link Worker. Phasing of availability of capacity across 100 practices is in line with recruitment detailed below.
As of 30/04/2021, 22 practices had full access. We continue to engage directly with all GP practices with a view to going live at a time that works best for them within the constraints of the phasing detailed below.

18wte GP Community Link Workers = 180 half day sessions across 100 practices.
As of 31/03/2021 10.6wte (106 sessions - 59%) was in place and available.
By July 21 a further 4wte (40 sessions - 22%) will be available.
A final 3.4wte (34 sessions - 19%) will be added by September 21.

2.8 Other locally agreed services	Practices with no access by 31/3/21	Practices with partial access by 31/3/21	Practices with full access by 31/3/21	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing service	0	0	0	0	0	

Comment / supporting information -
Phase 2 testing of the delivery of the **Occupational Therapy Service in Primary Care Test of Change** was initiated in January 2020, however, this service is not funded by PCIP but through transformation funding. There is no substantive funding stream at the current time. In this second phase of testing, it was proposed that occupational therapy services be aligned with GP services across the Hamilton and Bellshill localities, (25 GP Practices). The planned roll out of Primary Care Occupational Therapy Service across Hamilton and Bellshill localities was suspended W/B 16th March 2020 in response to the COVID pandemic. Primary Care Occupational Therapists (n = 7) were redeployed to community rehabilitation teams, in response to NHS Lanarkshire's COVID service re-design. Primary Care OT staff (n=4), continued to support 2 general practices (from phase 1), providing a remote early intervention and prevention service. They were able to offer support and therapeutic interventions to people with significant complex co-morbidities and long term health conditions and those who were shielding or experiencing negative effects of lockdown. A combination of telephone consultations, Near Me and other digital resources such as online materials and apps were utilised. Approval for the Occupational Therapy Primary Care recovery was granted by RRROG on 11th June, to enable the occupational therapy staff to return to GP practice. Currently Occupational Therapy provision is aligned to 18 practices, supporting GP colleagues, who are experiencing a period of high activity and increased workload demands. Occupational Therapy offers essential supports to patients, experiencing occupational performance difficulties due to mental or physical health or combination of both, whether COVID related or pre-existing or newly diagnosed long term condition.

Whilst good progress has been made since the service recovered, the stepped introduction of occupational therapy services into the 25 GP practices has been impacted upon. A small number of staff were again deployed to the Vaccine Programme in March 2021. A combination of accommodation pressures and IT difficulties, such as remote access to Vision and service re-design in response to COVID have impacted at times, on progress. Therefore the target of 25 practices has not been reached by March 2021, as initially planned. Phase 2 funding initially expired in July 2021 but this had been temporarily extended to December 2021. This should enable the remaining 7 GP Practices in the Hamilton and Bellshill Localities to be given access to the Primary Care Occupational Therapy service. Data collection from phase 2 is currently being evaluated and will be presented in June 2021. Opportunities will be sought to link with appropriate stakeholders, explore funding opportunities/work streams in effort to secure permanent funding to enable the PCOT service to continue.

2.9 Issues FAO National Oversight Group

Please detail the impact of Covid on the PCIP process and where you are in that process. How has Covid impacted previous projected delivery.

There is a need to ensure a more coordinated approach to workforce planning at a national level.

Clarification is needed as to whether funding for workforce and maintenance of GP premises which have been taken over by the board is to come from PCIP funding or another funding stream, noting that this will affect different boards differently. In Lanarkshire, 14 possible lease transfers have been identified, of which 10 have submitted applications registering leases they wish to transfer and 4 assignations have been completed.

Delays in progressing sustainability loans is causing concern. For example, sustainability loans processing was initiated by NHSL / practices nearly two and a half years ago - we are not aware of any practices being paid out for these - the delays in pay out has hindered planning at a practice / board level further reducing confidence in sustainability of General Practice as a partnership entity - given the new covid environment, we would expect that this process should be delivered on a timeous basis remotely or otherwise.

We are expecting at some time that boards will be expected to take practice premises wholly into public ownership as the loan schedule increments - given this, clarity around timescale would allow both boards and practices to plan for the future post covid world with confidence.

The pandemic is likely to continue to impact on the delivery of PCIP.

Review of funding offered against PCIP ask is required. It is evident from the detail in the return under workforce and funding profile (lines 13 -19), that the current funding envelope does not cover the ask.

The on-going pandemic beyond May 2021 will affect PCIP delivery. This will impact on timescale for delivery due to continued Covid response and time required to recover from providing Covid support.

There is a need for a clearer definition of 'in direct support of general practice', better acknowledgement and articulation of the transformational vs transactional aspects of

2.10 Health Inequalities

Covid has highlighted existing health inequalities and without mitigation the response to Covid is likely to increase health inequalities. Ministers are keen to see all sectors renewing their efforts on this and will be encouraging all sectors to work together. HSCPs and GPs are already taking significant actions to close the gap. HSCPs are using their position to bring sectors together to help take a whole-system approach to big issues. GPs are playing their part - whether through referrals to services for weight management or smoking cessation, or through outreach to the communities which are hardest to reach and where most inequality is experienced.

Please provide any comments on the impact of Covid on health inequalities and any measures taken to mitigate this impact. Please attach a copy of your EQIA/Fairer Scotland Duty Assessment /Health Inequalities Assessment if you have them.

See embedded Word document below for wider Health Promotion activities and programmes:

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Funding and Workforce profile

Health Board Area: NHS Lanarkshire
Health & Social Care Partnership: North Lanarkshire HSCP

Table 1: Spending profile 2018 - 2022 (£s)
Please include how much you spent in-year from both PCIF and any unutilised funding held in reserve

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)		Service 4: Urgent care (£s) * see comment box under Table 3		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend		274	1548969	86922	913705	286928	0	0	304930	160230	0	0
2019-20 actual spend	682231	31968	3234717	55506	2387398	248372	0	0	478792	258064	28202	8012
2020-21 actual spend	2175240	264862	5219653	5905	3877380	106256	0	0	445246	-46728	173536	19441
2021-22 planned spend	1576000	50000	7514000	150000	7282000	150000	0	0	662000	160000	1080000	20000
Total planned spend	4433471	347104	17517339	298333	14460483	791556	0	0	1890968	531566	1281738	47453
Total additional spend required for full delivery	112200	36000	9178000	106000	2644800	1499000	0	0	12002000	175000	135000	20000

Table 2: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 6: Community link workers
TOTAL headcount staff in post as at 31 March 2018	0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	0
INCREASE in staff headcount (1 April 2019 - 31 March 2020)	2
INCREASE in staff headcount (1 April 2020 - 31 March 2021)	11
PLANNED INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	7
TOTAL headcount staff in post by 31 March 2022	20

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 3: Workforce profile 2018 - 2022 (WTE)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a] - Senior ANPs	** Mental Health workers	MSK Physios	Occupational Therapists* Not funded from PCIP, Test of Change only	
TOTAL staff WTE in post as at 31 March 2018	20	6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.08	1.2	0.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	20.0	3.0	0.0	55.0	24.5	9.0	0.0	0.0	0.0	0.0	0.0	0.0
INCREASE in staff WTE (1 April 2019 - 31 March 2020)	40.0	2.4	38.7	0.0	0.0	7.0	0.0	2.0	0.0	0.0	8.6	2.0
INCREASE in staff WTE (1 April 2020 - 31 March 2021)	11.5	0.0	21.0	0.0	0.0	9.0	0.0	2.0	20.0	0.0	2.6	10.8
PLANNED INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	0.0	64.0	31.0	22.9	5.0	6.0	0.0	1.0	30.0	0.0	0.0	7.2
TOTAL staff WTE in post by 31 March 2022	91.5	75.4	90.7	77.9	29.5	31.0	0.0	5.0	50.0	2.08	12.4	20.0
Total staff (WTE) required for full delivery	170.5	85.0	100.7	89.9	29.5	68.5	0.0	10.0	142.0	56.0	61.2	20.0

[a] please specify workforce types in the comment field
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Comment:
Pharmacotherapy - The 66WTE planned increase in technicial workforce in 2021/22 is a broken down into 2 senior technicians, 15 trainee technicians and 49 pharmacy support workers. 2 WTE senior technician posts have been filled and recruitment will commence for student technicians and pharmacy support workers in 2021/22. The staff in post before 31st March 2018 were funded under GPCP which has now evolved into pharmacotherapy. *85 includes all technical staff (Band3 Pharmacy Support Workers, Band 4 Student Technicians, and Band 5 technicians).
ANPs - It takes two full academic years to train an ANP and support them to attain the Post Graduate Diploma in Advance Practice. If we are to deliver the urgent care model in time, we would need to pull forward the recruitment of trainee ANPs now and double run some of the modules to have a fully trained and equipped workforce to deliver by March 2023. If we do not recruit to the additional 37.5 posts just now, to begin academic programme in September 2021, there is a significant risk that we will not be able to deliver urgent care.
*** Urgent Care funding** is included in the Community Treatment and Care figures in Table 1.
Community Link Workers - commitment of 30 WTE has been spread across a combined delivery between health & social care partnership members. NHL Lanarkshire has recruited against 20 wtes and the funding for 10 wtes has been released via SLAs to third sector partners to provide specialist financial advice. As such, it is not possible to define a headcount for the SLA component but it relates to a provision of service rather than the employment of posts.
Premises - there will be additional costs in relation to securing sufficient premises across the Board estate to host PCIP workforce, and this is further increased by ensuring that this is Covid secure.
IT infrastructure/equipment - there will be additional costs in relation to providing an IT infrastructure for all services and equipment ie. laptops and phones for all PCIP staff.
** **Mental Health** - In Lanarkshire, the current Mental Health provision sits under Action 15, if we wished to fully develop this across all practices under PCIP the increased numbers and finance would be needed.

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BMA

Prior to the Scottish LMC Conference, we want to take this opportunity to emphasise our continuing commitment to the 2018 General Medical Services Contract in Scotland document ("the Contract Offer" or "Blue Book") and to reconfirm the investment commitment into general practice and primary care. Our experiences and those of the wider system during the pandemic have confirmed to us that the principles and aims contained within the Contract Offer remain the right ones - collaborative multi-disciplinary teams working alongside GPs in their role as Expert Medical Generalists to manage patients in their own community.

We have achieved a great deal and it is important we do not lose sight of that. But we must recognise we still have some way to go. Nowhere is this clearer than in our efforts over the last two and a half years to deliver enhanced multi-disciplinary teams; a key commitment in the Contract Offer. This is why we intend to make the reforms we have made a permanent part of the support that you receive from NHS Boards and Health & Social Care Partnerships – by putting them on a contractual footing.

This presents a number of challenges as we will need to do it in such a way that continues the development of NHS Board-employed multi-disciplinary teams and the transfer of responsibility for services from practices to Health & Social Care Partnerships, as was originally intended in the Contract Offer. Patient safety will be paramount in our efforts to transform primary care and there can be no gap in service provision as a result of our proposed changes. On this basis, we have jointly agreed to the following approach for each of the multi-disciplinary team services committed to in the Contract Offer.

Vaccination Services – Vaccinations that are still in the core GMS contract under the Additional Services Schedule, such as childhood vaccinations and immunisations and travel immunisations, will be removed from GMS Contract and PMS Agreement regulations by 1 October 2021. All historic income from vaccinations will transfer to the Global Sum 2022-23 including that from the five vaccination Directed Enhanced Services[1].

Whilst our joint policy position remains that general practice should not be the default provider of vaccinations, we understand that practices may still be involved in the delivery of some vaccinations in 2022-23 arrangements. Where this is necessary, it will be covered on a new Transitionary Service basis to be negotiated by SGPC and the Scottish Government in 2021 and payments will be made to practices providing these services from 2022-23.

[1] The Childhood Immunisation Scheme, the Influenza & Pneumococcal Scheme, the Meningitis B Immunisation Scheme, the Pertussis immunisation programme for pregnant and post-natal women, and the Shingles (Herpes Zoster) Immunisation Scheme.

Pharmacotherapy – Regulations will be amended so that NHS Boards are responsible for providing a Level One Pharmacotherapy service to every general practice for 2022-23. Payments for those practices that still do not benefit from a Level One Pharmacotherapy service by 2022-23 will be made via a Transitionary Service until such time as the service is provided.

Community Treatment and Care Services – Regulations will be amended so that Boards are responsible for providing a community treatment and care service for 2022-23. Where practices do not benefit from this service, payment will be made via a Transitionary Service basis until such time the service is provided.

Urgent care Service – Legislation will be amended so that Boards are responsible for providing an Urgent Care service to practices for 2023-24. Consideration will need to be given about how this commitment fits into the wider Redesigning of Urgent Care work currently in progress.

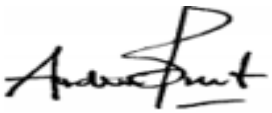
Additional Professional Roles (e.g. Mental Health Workers, Physiotherapists, Community Link Workers) – The pandemic has highlighted the need for early local intervention to tackle the rising levels of mental health problems across all practices as well as the challenges in areas of high health inequalities. Working with Health & Social Care Partnerships and NHS Boards, we will consider how best to develop these services at practice level, and establish more clearly the 'endpoint' for the additional professional roles commitment in the Contract Offer by the end of 2021.

Let us both be clear that we are not proposing to make any changes to practices' responsibilities to provide essential services. There may be times where it is appropriate for a practice to provide a service opportunistically such as wound care, phlebotomy or repeat prescriptions. GPs will also still retain responsibility for providing travel advice to patients where their clinical condition requires individual consideration. But you will all have a contractual right to extended multi-disciplinary support in your communities as set out above. We also recognise that there will be by exception some practices in **remote and rural communities** where there are no alternatives to ongoing practice delivery identified through a satisfactory options appraisal. The Scottish Government and SGPC will negotiate a separate arrangement including funding for these practices.

We also want to be clear that transitionary services are not our preferred outcome nor something we see as a long-term solution. We are keen for NHS Boards, Health & Social Care Partnerships and Board-funded GP sub-committees to do everything they can at local level to accelerate service redesign in the next 18 months. Regulation changes strongly signal our intent that GP practices will not be the default provider of these services in future and community multi-disciplinary teams will be a permanent part of the health and social care landscape. Throughout the process for making these changes, we will rely on your input, that of NHS Boards and Health & Social Care Partnerships as well as the public at large to ensure the changes proposed here are done in ways that remain true to the Contract Offer commitments. On this note, work will now begin between Scottish Government, the BMA, NHS Boards and Health & Social Care Partnerships on updating the Memorandum of Understanding under which these services will be delivered.

We are also aware that whilst the focus of this letter has been on recommitting to and charting a course for the delivery of multi-disciplinary teams, we will however not enhance the sustainability of general practice through these steps alone. The Scottish Government remains committed to investing an additional £500 million per year in Primary Care by the end of this Parliament, including £250 million in direct support of general practice. It is important that we continue to have an updated understanding of the general practice workforce in itself and to that end, we commit to jointly analysing the workforce data provided by practices as soon as practical in 2021 as well as issuing a voluntary workload survey shortly. This will be an important part of the groundwork for delivering the expansion of GP numbers by 2027 that Scottish Government is committed to. Finally, we remain committed to Phase Two of the GP Contract and will analyse the earnings and expenses data previously provided by practices in 2021.

Our shared aim is to create for Scotland a world class publicly funded health care system which starts with General Practice and all the support networks around it. We look forward to further sharing our vision with you on how we make that happen with you at the Scottish LMC Conference.



Jeane Freeman
Scottish Government

Andrew Buist
British Medical Association

02 December 2020

Primary Care Directorate
GP Contract Division

Scottish Government
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Addresses

Chief Executives NHS Boards
Chief Officers
Scottish GP Committee/BMA
Primary Care Leads

Enquiries to:
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13 April 2021

Dear Colleague

The 2018 GP Contract Offer ("the Contract") was underpinned by a Memorandum of Understanding ("MoU") which set out an agreement between Scottish Government, SGPC, Integration Authorities, and Health Boards on how to implement and deliver the Contract.

The MoU covered the period from 1 April 2018 until 31 March 2021 three years being the negotiated period for implementation of the Contract. Scottish Government and SGPC have since recognised that it has not been possible for full implementation to be achieved by the original deadlines, in part as a result of the Covid pandemic, and agreed that the timeframe for implementation needed to be revised and extended. Details are outlined in the joint letter issued in December 2020. We therefore intend to issue an updated MOU as soon as possible. Until that time, the original MoU remains in effect until an updated version is agreed.

While the updated MoU will not change the focus or the commitments of the original it will build upon what we have learnt since 2018 about developing and transferring services.

Yours sincerely

Naureen Ahmad

Deputy Director and Head of GP Contract Division

Memorandum of Understanding between Scottish Government, British Medical Association, Integration Authorities and NHS Boards

GMS Contract Implementation in the context of Primary Care Service Redesign

Introduction and Context

The principles underpinning the approach to general practice in Scotland were set out in a document *General Practice: Contract and Context – Principles of the Scottish Approach* published by the Scottish General Practitioners Committee ("SGPC") of the British Medical Association (BMA) and the Scottish Government in October 2016, noting that the Scottish Government and the SGPC are the two negotiating parties on commercial general practitioner (GP) contractual matters in Scotland. This Memorandum of Understanding ("MOU") between **The Scottish Government**, **the Scottish General Practitioners Committee of the British Medical Association, Integration Authorities and NHS Boards** builds on these arrangements and represents a landmark statement of intent, recognising the statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014) ("the Act") of Integration Authorities in commissioning primary care services and service redesign to support the role of the GP as an expert medical generalist. The MOU also recognises the role of NHS Boards in service delivery and as NHS staff employers and parties to General Medical Services ("GMS") contracts.

For the purposes of this MOU, we refer to Health and Social Care Partnerships (HSCPs) responsible for the planning and commissioning of primary care services.

As an Expert Medical Generalist (as defined in the Scottish GMS contract offer document for 2018 the "Scottish Blue Book"), the GP will focus on:

- undifferentiated presentations,
- complex care,
- local and whole system quality improvement, and
- local clinical leadership for the delivery of general medical services under GMS contracts.

Expert Medical Generalists will strive to ensure robust interface arrangements, connection to and coherence with other parts of the wider primary care team (e.g. nurses physiotherapists), health and social care community based services and with acute services where required. The EMG will be supported by a multi-disciplinary team (MDT); maximising the contribution of both clinical and non-clinical staff in medicine, nursing, allied health professions, links workers, practice management, administration and others.

Delivering improved levels of local care in the community will have a clear benefit for patients and must rely on effective collaboration between GPs, HSCPs, NHS Boards and other partners, both in and out of hours, valuing the respective contributions of those who deliver these services. This will require clear articulation of the respective roles and responsibilities of GPs and other members of

the primary care team both generally and in respect of each of the services set out in a HSCP Primary Care Improvement Plan (see Sections F and G of this MOU).

The development of primary care service redesign in the context of delivery of the new GMS contract should accord with seven key principles:

Safe –Patient safety is the highest priority for service delivery regardless of the service design or delivery model.

Person-Centred - Partnerships between patients, their families and those commissioning and delivering healthcare services work to provide care which is appropriate and based on an assessment of individual needs and values and is outcome focussed, demonstrates continuity of care (in the context of both professionals and services), clear communication and shared decision-making. Having regard to the five principles underpinning the Health and Social Care Standards: dignity and respect, compassion, to be included, responsive care and support and wellbeing.

Equitable – fair and accessible to all.

Outcome focused – making the best decisions for safe and high quality patient care and wellbeing.

Effective - The most appropriate treatments, interventions, support and services will continue to be accessible, provided in the most appropriate place by the right person at the right time to everyone. Changes to service delivery should not result in any diminution of care or outcomes for patients.

Sustainable – delivers a viable long term model for general practice that is resilient in the context of the wider community care setting on a continuous basis; and promotes and supports the development of the skill mix within the practice setting.

Affordability and value for money – Making the best use of public funds; delivering the general practice model within the available resources; with appropriate quality assurance processes.

An important determinant of success will be how the planned changes are implemented, seek to influence and depend on wider services.

This change has already started with the move away from the Quality and Outcomes Framework introduced in the 2004 GMS contract. The new approach introduced by the GMS Statement of Financial Entitlements for 2016-17, sees GP practices working together in local Clusters with their HSCP and NHS Boards to identify priorities and improve the quality of services and outcomes for people.

<u>Further key enablers for change include:</u>

(1) Premises: The National Code of Practice for GP Premises sets out how the Scottish Government will support a shift, over 25 years, to a new model for GP premises in which GPs will no longer be expected to provide their own premises. The measures outlined in the Code represent a significant

transfer in the risk of owning premises away from individual GPs to the Scottish Government. Premises and location of the workforce will be a key consideration in delivering the multi-disciplinary arrangements envisaged in the HSCP Primary Care Improvement Plan. Details on the criteria for lease transfer and for accessing interest free loans will be set out in the premises Code of Practice and summarised in the GMS contract offer document which sets out the terms of the proposed new Scottish GMS contract.

*(2) Information Sharing Arrangements***:** The Information Commissioner's Office (ICO) has issued a statement that whilst they had previously considered GPs to be sole data controllers of their patient records; they now accept that GPs and their contracting Health Boards have joint data controller processing responsibilities towards the GP patient record.

The new GMS contractual provisions in Scotland will reduce the risk to GPs of being data controllers by clarifying respective responsibilities within this joint controller arrangement. These contractual changes will support ICO's position that GPs are not the sole data controllers of the GP patient records but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GPs' responsibilities and GPs will not be exposed to liabilities relating to data outwith their meaningful control.

The new contractual provisions will lay the foundations for increased lawful, proactive and appropriate sharing of information amongst professionals working within the health and social care system for the purposes of patient care.

*(3) Workforce***:** The national health and social care workforce plan published on 28 June 2017 noted that Part 3 of the Plan, which would determine the Scottish Government's thinking on the primary care workforce, would be published in early 2018 following the conclusion of the Scottish GMS contract negotiations. The Plan will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team. This will include plans for recruitment, training and development of specific professional groups and roles.

A. Purpose and aim of the MOU

This MOU will cover an initial 3 year period 1 April 2018 to 31 March 2021 and is structured to set out the key aspects relevant to facilitating the statement of intent the document represents:

Section A – Purpose and aim
Section B - Parties and their responsibilities
Section C - Key stakeholders
Section D - Resources
Section E - Oversight
Section F – Primary Care Improvement Plans
Section G – Key Priorities

It provides the basis for the development by HSCPs, as part of their statutory Strategic Planning responsibilities, of clear HSCP Primary Care Improvement Plans, setting how additional funding will be used and the timescales for the reconfiguration of services currently delivered under GMS contracts. Plans will have a specific focus on the key priority areas listed at Section G of this MOU with the aim of transitioning their delivery by the wider MDT between 2018 and 2021.

Taken together with the Scottish GMS contract offer document, the National Code of Practice for GP premises, and the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018, this MOU underpins the new Scottish GMS contract; and enables the move towards a new model for primary care that is consistent with the principles, aims and direction set by the Scottish Government's National Clinical Strategy (NCS) and the Health and Social Care Delivery Plan.

In addition, The *National Health and Social Care Workforce Plan: Part 3 Primary Care,* to be published following agreement on the new Scottish GMS contract, will set out the context and arrangements for increasing the Scottish GP and related primary care workforce and both the capacity and capability of the multi-disciplinary team.

This MOU will be reviewed and updated by the parties before 31 March 2021 through arrangements that will be agreed by March 2018.

B. Responsibilities (of parties to the MOU)

The respective responsibilities of the parties to this MOU are:

Integration Authority responsibilities (typically delivered through the Health and Social Care Partnership delivery organisations):

- Planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the HSCP Strategic Plan.
- The development of a HSCP Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders including NHS Boards that is supported by an appropriate and effective MDT model at both practice and Cluster level, and that reflects local population health care needs.
- Collaboration with NHS Boards on the local arrangements for delivery of the new Scottish GMS contract.
- Section 2c of the National Health Service (Scotland) Act 1978 places a duty on NHS Boards to secure primary medical services to meet the reasonable needs of their NHS Board area. To achieve this, NHS Boards can enter into GMS contracts. HSCPs will give clear direction to NHS Boards under sections 26 and 28 of the 2014 Act in relation to the NHS Board's function to secure primary medical services for their area and directions will have specific reference to both the available workforce and financial resources.

- Where there is one or more HSCP covering one NHS Board area, the HSCPs will collaborate under section 22 of the 2014 Act in relation to the effective and efficient use of resources (e.g. buildings, staff and equipment) to achieve coherence and equity across service planning, design and commissioning.
- Ensuring that patient needs identified in care plans are met

Scottish General Practice Committee responsibilities:

- Negotiating, with the Scottish Government, the terms of the GMS contract in Scotland as the negotiating committee of the BMA in Scotland.
- Conducting the poll (and any future poll) of its members on the terms of the GMS contract in Scotland.
- Representing the national view of the GP profession.
- Explaining the new Scottish GMS contract to the profession (including communication with Local Medical Committees (LMC) and GP practices).
- Ensuring that GP practices are supported encouraged and enabled to deliver any obligations placed on them as part of the GMS contract; and, through LMCs and clusters, to contribute effectively to the development of the HSCP Primary Care Improvement Plan.

NHS Territorial Boards responsibilities:

- Contracting for the provision of primary medical services for their respective NHS Board areas
- Ensure that primary medical services meet the reasonable needs of their Board area as required under Section 2C of the NHS (Scotland) Act 1978.
- Delivering primary medical services as directed by HSCP as service commissioners.
- Arrangements for local delivery of the new Scottish GMS contract via HSCPs
- As employers, NHS Boards will be responsible for the pay, benefits, terms and conditions for those employees engaged in the delivery of the priority areas set out in Section G.

Scottish Government responsibilities:

- Setting the legislative framework underpinning the commissioning of primary medical services by HSCPs and delivery by NHS Boards.
- In collaboration with NHS Boards and with HSCPs, shaping the strategic direction and the development of commissioning guidance in respect of primary care that is in line with the aims and objectives set out in National Clinical Strategy and the Health and Social Care Delivery Plan.
- Providing financial resources in support of the new Scottish GMS contract and primary care transformation (including the transfer of services) in line with the Scottish Government spending review process.

- Making arrangements with stakeholders to meet the future GP workforce requirements both in terms of numbers and education and training.
- Agreeing the metrics and milestones against which progress will be measured; with regular progress reporting as part of the existing statutory arrangements for reporting performance against Strategic Plans.

C. Key Stakeholders

HSCPs must collaborate with NHS Boards as partners in the development and delivery of their Strategic Plan (and the associated Primary Care Improvement Plan). Local and Regional Planning arrangements will need to recognise the statutory role of the HSCP as service commissioners; and the partnership role of NHS Boards as NHS employers and parties to the GMS contracts for the delivery of primary medical services in their Board area.

In addition to this, HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users. In relation to the development of the Primary Care Improvement Plan that would include (but not be limited to):

- Patients, their families and carers
- Local communities
- SAS and NHS 24
- Primary care professionals (through, for example, GP subcommittees of the Area Medical Committee and Local Medical Committees)
- Primary care providers
- Primary care staff who are not healthcare professionals
- Third sector bodies carrying out activities related to the provision of primary care

In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of patient's needs, life circumstances and experiences it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that patient engagement is a key part of their Primary Care Improvement Plans.

Good communications and understanding across the wider health and social care interfaces with both services and professional groups (e.g. primary/secondary, community health and social care services, district nursing, out of hours services, mental health services) will also be required to address direct patient care issues, such as prescribing, referrals, discharges, follow up of results and signposting. An important principle here is that each part of the system respects the time and resources of the other parts. There should not be an assumption that patient needs or work identified in one part of the service must be met by another without due discussion and agreement. This should ensure that patients do not fall through gaps in the health and care system.

D. Resources

General Practice funding – through the GMS contract funding allocated to NHS Boards, general practice funding represents a significant element of the public investment in community and primary care. The published draft Primary Medical Services budget was £821 million in 2017-18 – funding the remuneration of 4,460 General Practitioners; the c.3000 practice staff they employ, both nursing and non-clinical, and the non-staff expenses of running practices. This investment enables over 23 million healthcare interactions every year. The Primary Medical Services investment funds the part of the system that is the first port of call for most people's healthcare needs most of the time. In addition to the direct care enabled by this investment, the clinical decisions GPs make – whether to treat; how to treat; whether to refer to further specialist treatment – have a much wider impact on the health and social care system. The "GP footprint" is estimated to be as much as four times the direct investment in Primary Medical Services. This investment through the contract is, therefore, critical to the sustainability of the whole health and care system.

In March 2017 the Cabinet Secretary for Health and Sport announced that in addition to the funding for the provision of general medical services, funding in direct support of general practice will increase annually by £250 million by the end 2021-22. In 2017-18 £71.6 million was invested through the Primary Care Fund in direct support of general practice. Further investment will see this increase over the 3 financial years from 1 April 2018 to £250 million 2021-22.

<u>Process</u>

Specific levels of resource will be agreed as part of the Scottish Government's Spending Review and budget processes and allocated in line with the arrangements set out in this MOU.

Where appropriate these resources will be allocated to HSCPs through their NHS Board partners in line with the Scottish Government's National Resource Allocation formula (based on population need and taking account of geography and of life circumstances, including deprivation). Resources will be spent for the purposes set out in this Memorandum and in line with each HSCP Primary Care Improvement Plan to enable the transition to be managed and implemented effectively. The HSCP Plans must demonstrate how the funding will flow/be used to enable the redistribution of work from GPs to others and to optimise the role and functionality of the wider MDT. HSCPs will agree these Plans locally. These plans will be developed in collaboration with local GPs and others and should be developed with GP Subcommittee (or representatives of by agreement locally) as the formally agreed advisors on general medical service matters. However, the arrangements for delivering the new GMS contract will be agreed with the Local Medical Committee. Integration Authorities will hold their officers to account for delivery of the milestones set out in the Plan, in line with their responsibility to ensure delivery of Strategic Plans, and through regular reporting to the Authority. Key partners and stakeholders should be fully engaged in the preparation, publication and review of the plans.

The resources and any associated outcomes and deliverables (aligned to the Scottish Government's National Performance Framework and the six Primary Care Outcomes) will be set out in an annual funding letter as part of the Scottish Government's budget setting process.

The extent and pace of change to deliver the changes to ways of working over the three years (2018-21) will be determined largely by workforce availability, training, competency and capability, the availability of resources through the Primary Care Fund, and will feature as a key element of the National Health and Social Care Workforce Plan: Part 3 Primary Care.

E. Oversight

New oversight arrangements for the implementation of the GMS contract in the context of wider primary care transformation in Scotland will be developed including:

A *National GMS Oversight Group* ("*the national oversight group*") with representatives from the Scottish Government, the SGPC, HSCPs and NHS Boards will be formed to oversee implementation by NHS Boards of the GMS contract in Scotland and the HSCP Primary Care Improvement Plans, including clear milestones for the redistribution of GP workload and the development of effective MDT working.

National issue specific groups – A range of national issue specific groups with members drawn from a range of stakeholders, including NHS Boards, HSCPs and SGPC where appropriate will support and provide policy and professional advice to the national oversight group on a range of national policy areas relevant to the delivery of primary care transformation. These may include: GP Contract Implementation Group; GP premises; GP IT, e-Health; Data and Information; Remote and Rural; Nursing; GPN Group; Vaccination Transformation Programme; Patient Groups.

As well as the requirements on the HSCP to develop a Primary Care Improvement Plan as set out in Section D, NHS Boards with HSCPs will develop clear arrangements to deliver the commitments in respect of the new Scottish GMS contract as set out in the Scottish GMS contract offer document. These arrangements will include the priority areas set out in Section G of this MOU and must be agreed with the LMCs.

HSCPs should establish local arrangements to provide them with advice and professional views on the development and delivery of the Primary Care Improvement Plan. Arrangements will be determined locally and will take account of the requirement to engage stakeholders as set out above. The HSCP Primary Care Improvement Plan should be agreed with the local GP subcommittee of the Area Medical Committee with the arrangements for delivering the new GMS contract being agreed with the Local Medical Committee as set out above. HSCPs and NHS Boards will discuss and agree locally the arrangements for providing appropriate levels of support to enable this advice to be provided.

Within HSCPs, GP clusters have a critical role in improving the quality of care in general practice and influencing HSCPs both regarding how services work and service quality. Improving Together: a new quality framework for GP Clusters in Scotland[i] provides a framework for how that learning, developing and improving may be achieved. As GP Clusters mature, they will be expected to have a key role in proactively engaging with HSCPs, advising on the development of HSCP Primary Care Improvement Plans and working with their MDT and wider professional networks to ensure highly

effective health and social care provision within and across the HSCP area and where relevant across HSCPs.

HSCPs will support and facilitate GP Clusters to ensure their involvement in quality improvement planning and quality improvement activity as part of whole system improvement. *Healthcare Improvement Scotland* will work in support of HSCPs where required to ensure that GP clusters have the support they need to engage effectively in quality improvement activity.

The *Local Intelligence Support Team* (LIST) already provides support to HSCPs and has been commissioned to provide support through HSCPs to GP clusters. This support involves on-site expert analytical advice to provide local decision-makers with meaningful and actionable intelligence, leading to improved outcomes for service users.

F. Primary Care Improvement Plan

The collaborative implementation of the new GMS contract in Scotland should be set in the context of the HSCP Primary Care Improvement Plan. Plans must determine the priorities based on population healthcare needs, taking account of existing service delivery, available workforce and available resources. To support that aim HSCPs will collaborate on the planning, recruitment and deployment of staff.

Some services which are currently provided under general medical services contracts will be reconfigured in the future. Services or functions which are key priorities for the first 3 years from 2018 - 2021 are listed in Section G below. The expectation should be that, where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices.

Additional investment is intended to provide additional MDT staff, which should, where appropriate, be aligned to GP practices to provide direct support to these practices under the oversight of GPs as senior clinicians. It will be important that GPs continue to work to their responsibility to ensure that their premises remain fit for purpose, services remain accessible to patients, that they are responsive to local needs and can maintain continuity of care; all of which will allow GPs to deliver an effective, integrated service as part of the MDT.

The HSCP Primary Care Improvement Plans will be considered alongside the NHS Board arrangements for the delivery of the GMS contract in Scotland in line with the requirements of the Scottish contract offer document.

The Plan should also consider how the new MDT model will align and work with community based and where relevant acute services, subject to wider stakeholder engagement to be determined by the HSCP in line with their statutory duty to consult.

<u>Key Requirements of the Primary Care Improvement Plan:</u>

- To be developed collaboratively with HSCPs, GPs, NHS Boards and the stakeholders detailed in Section C;

- To detail and plan the implementation of services and functions listed as key priorities under Section G, with reference to agreed milestones over a 3 year time period;

- To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas under Section G and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs.

- To provide detail on available resources and spending plans (including workforce and infrastructure);

- To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract.

- Initial agreement for the Primary Care Improvement Plan secured by 1 July 2018

G. Key Priorities

Existing work to develop and test new models of care has shown benefits from the effective deployment of other professional staff working within a wider MDT aligned to general practice. The priority between 2018 and 2021 will be on the wider development of the services detailed below. Changes to services will only take place when it is safe to do so. The service descriptions and delivery timescales given here are provided for the purposes of this MOU.

(1) The Vaccination Transformation Programme (VTP) was announced in March 2017 to review and transform vaccine delivery in light of the increasing complexity of vaccination programmes in recent years, and to reflect the changing roles of those, principally GPs, historically tasked with delivering vaccinations.

In the period to 2021, HSCPs will deliver phased service change based on a locally agreed plan as part of the HSCP Primary Care Improvement Plan to meet a number of nationally determined outcomes including shifting of work to other appropriate professionals and away from GPs. This has already happened in many parts of the NHS system across Scotland for Childhood Immunisations and Vaccinations. This change needs to be managed, ensuring a safe and sustainable model and delivering the highest levels of immunisation and vaccination take up. As indicated above, there may be geographical and other limitations to the extent of any service redesign.

(2) Pharmacotherapy services – These services are in three tiers divided into core and additional activities, to be implemented in a phased approach.

By 2021, phase one will include activities at a general level of pharmacy practice including acute and repeat prescribing and medication management activities and will be a priority for delivery in the first stages of the HSCP Primary Care Improvement Plan. This is to be followed by phases two (advanced) and three (specialist) which are additional services and describe a progressively advanced specialist clinical pharmacist role.

(3) Community Treatment and Care Services - These services include, but are not limited to, basic disease data collection and biometrics (such as blood pressure), chronic disease monitoring, the management of minor injuries and dressings, phlebotomy, ear syringing, suture removal, and some types of minor surgery as locally determined as being appropriate. Phlebotomy will be delivered as a priority in the first stage of the HSCP Primary Care Improvement Plan.

This change needs to be managed to ensure, by 2021 in collaboration with NHS Boards, a safe and sustainable service delivery model, based on appropriate local service design.

(4) Urgent care (advanced practitioners) - These services provide support for urgent unscheduled care within primary care, such as providing advance practitioner resource such as a nurse or paramedic for GP clusters and practices as first response for home visits, and responding to urgent call outs for patients, working with practices to provide appropriate care to patients, allowing GPs to better manage and free up their time.

By 2021, in collaboration with NHS Boards there will be a sustainable advance practitioner provision in all HSCP areas, based on appropriate local service design. These practitioners will be available to assess and treat urgent or unscheduled care presentations and home visits within an agreed local model or system of care.

(5) Additional Professional roles **-** Additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting (as part of the wider MDT); this would be determined by local needs as part of the HSCP Primary Care Improvement Plan. For example, but not limited to:

- *Musculoskeletal focused physiotherapy services*
- *Community clinical mental health professionals (e.g. nurses, occupational therapists) based in general practice .*

By 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. Service configuration may vary dependent upon local geography, demographics and demand.

(6) Community Links Worker (CLW) is a generalist practitioner based in or aligned to a GP practice or Cluster who works directly with patients to help them navigate and engage with wider services, often serving a socio-economically deprived community or assisting patients who need support because of (for example) the complexity of their conditions or rurality. As part of the Primary Care Improvement Plan HSCPs will develop CLW roles in line with the Scottish Government's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models/systems of care and support.

Workforce As part of their role as EMGs, GPs will act as senior clinical leaders within the extended MDT as described in this MOU. Many of the MDT staff deployed in the priority areas under (1) to (6) of Section G in the MOU will be employed by the NHS Board and work with local models and systems of care agreed between the HSCP, local GPs and others. Staff will work as an integral part of local MDTs. NHS Boards, as employers, will be responsible for the pay, benefits, terms and conditions for these staff. Some MDT members will be aligned exclusively to a single GP practice while others may be required to work across a group of practices (e.g. Clusters). Workforce arrangements will be determined locally and agreed as part of the HSCP Primary Care Improvement Plans.

Existing practice staff will continue to be employed directly by practices. Practice Managers, receptionists and other practice staff will continue to have important roles in supporting the development and delivery of local services. Practices Managers should be supported and enabled to contribute effectively to the development of practice teams and how they work across practices within Clusters and in enabling wider MDT working arrangements.

Signatories

Signed on behalf of the Scottish General Practice Committee

Name: Alan McDevitt, Chair, Scottish GP Committee of the British Medical Association
Date: 10 November 2017

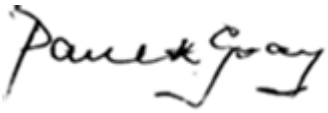
Signed on behalf of Health and Social Care Partnership Chief Officers

Name: David Williams, Chief Officer, Glasgow HSCP and Chair, Chief Officers, Health and Social Care Scotland
Date: 10 November 2017

Signed on behalf of NHS Boards

Name: Jeff Ace, Chief Executive, NHS Dumfries & Galloway and Chair, Chief Executives, NHS Scotland
Date: 10 November 2017

Signed on behalf of the Scottish Government



Name: Paul Gray, Chief Executive, NHS Scotland
Date: 10 November 2017

Agenda Item

12

Report

Report to:	**South Lanarkshire Integration Joint Board**
Date of Meeting:	**17 August 2021**
Report by:	**Interim Chief Officer, Health and Social Care Partnership**

Subject:	**Improving Hospital Delayed Discharge Across Lanarkshire**

1. Purpose of Report

1.1. The purpose of the report is to:-

- update the Integration Joint Board on the progress of the Improving Hospital Delayed Discharge Work stream
- introduce the Scottish Government Principles Paper on Improving Hospital Discharge

2. Recommendation(s)

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that the progress and impact of the work stream is noted; and

(2) that they note the content of the Scottish Government Principles Paper on Improving Hospital Discharge.

3. Background

3.1. Improving Delayed Discharge work stream is a work stream that was commissioned by the Whole System Unscheduled Care Board. Initially the work was directly related to reducing Delayed Discharges. This involved introducing Planned Date of Discharge (PDD). However, this has evolved and now includes, data/information, discharge information, digital discharge and patient/ service user experience work.

3.2. At the onset of Covid there was pressure to improve capacity on the acute hospital sites across Lanarkshire. To address this, stringent processes were put in place to plan discharges and monitor referrals for care. This meant that a plan was put in place for every South Lanarkshire Health and Social Care Partnership (HSCP) patient on all hospital sites. This was then discussed through a daily conference call, involving Care at Home, Social Work, AHPs, Discharge Facilitators and Social Work staff. At this point there were 140 South Lanarkshire patients delayed in acute beds.

3.3. Early 2020, Delayed Discharges across Lanarkshire were the highest in Scotland, combined with the highest demand for care in Scotland. With the improvements that have been put in place, there has been substantial improvement to reduce delays to 75% less in January 2021 than they were in January 2020, a reduction in the demand for care and improved experience on discharge for patients.

3.4. Other areas of improvement has been the patient information work, which includes the development of a discharge policy, discharge passport and animation. These have been successfully implemented across all three acute sites, mental health wards and community hospitals.

3.5. There has also been the launch of a communication pack, briefing and training for staff in relation to PDD across all acute wards and community settings.

4. Impact of the Discharge Work stream

4.1. Early 2020, Delayed Discharges across Lanarkshire were the highest in Scotland, combined with the highest demand for care in Scotland. With the improvements that have been put in place there has been substantial improvement to reduce delays to 75% less in May 2021 than they were in May 2020, a reduction in the demand for care and improved experience on discharge for patients. The impact can be seen in the IJB performance report.

4.2. Planned date of discharge has also improved the patient and staff experience in relation to discharge planning. This was evidenced through a patient and staff survey.

4.3. Unfortunately, progress in the discharge improvement has been stalled and delays have risen over the last three weeks (50 to 80). This has been due to rising demand for care due consequences on peoples acuity after a long lockdown. This rising demand has been met with staffing challenges due to sickness absence, self-isolation and annual leave. At any given time there has been 110 staff unavailable.

4.4. A number of mitigating actions have been put in place to address the delays, including addressing the short fall in care at home staffing, including short term investment for a further recruitment in Care at Home staff, interim beds in care homes and maximising intermediate care.

4.5. The principles of 'Planned Date of Discharge' and good discharge planning, has continued to be followed across the whole system during this time. It is clear without this approach and whole system working the number of delays would be higher.

4.6. South Lanarkshire HSCP will be working closely with acute colleagues, North Lanarkshire HSCP and Scottish Government to explore short term and long terms solutions to the current demands.

5. Optimising Whole System Discharge Planning

5.1. The Optimising Whole System Discharge Planning work stream was part of a suite of improvement work streams under the Scottish Government "Building on Firm Foundations Programme". The result has been the development of a range of recommendations for Health and Social Care Partnerships to consider implementing. These recommendations are based on gathered 'best' practice from across Scotland.

5.1.1. This work stream also included recommendations for community hospitals and intermediate care. This is has been highlighted in a separate document.

5.2. The principles within the recommendations include 'home first', single point of access, PDD, whole system approach, outcomes and data and enablers.

5.3. South Lanarkshire HSCP is in a positive place to implement these recommendations as many have already been actioned, such as PDD and whole system approach. Work is still ongoing on ensuing a 'home first' approach, single point of access and a uniform data set.

5.4. The next steps are to complete the readiness questionnaire along with acute and North Lanarkshire Health and Social Care Partnership colleagues and work with the Scottish Government to take forward any actions.

6. Employee Implications

6.1. There are no employee implications currently associated with this work.

7. Financial Implications

7.1. There are no funding implications associated with this report..

8. Climate Change, Sustainability and Environmental Implications

8.1. There are no Climate change, sustainability or environmental implications associated with this report.

9. Other Implications

9.1. There are no other risks associated with this report.

10. Equality Impact Assessment and Consultation Arrangements

10.1. This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy and therefore no impact assessment is required.

11. Directions

11.1.

Direction to:	
1. No Direction required	☒
2. South Lanarkshire Council	☐
3. NHS Lanarkshire	☐
4. South Lanarkshire Council and NHS Lanarkshire	☐

Marianne Hayward
Interim Chief Officer, Health and Social Care Partnership

Date created: 26 July 2021

Link(s) to National Health and Wellbeing Outcomes

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

People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonable practicable, independently and at home or in a homely setting in their community	☒
People who use Health and Social Care Services have positive experiences of those services, and have their dignity respected	☒
Health and Social Care Services are centred on helping to maintain or improve the quality of life of people who use those services	☒
Health and Social Care Services contribute to reducing health inequalities	☒
People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing	☐
People who use Health and Social Care Services are safe from harm	☒
People who work in Health and Social Care Services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	☒
Resources are used effectively and efficiently in the provision of Health and Social Care Services	☒

Previous References

- none

List of Background Papers

- none

Contact for Further Information

If you would like to inspect the background papers or want further information, please contact:-

Marianne Hayward, Interim Chief Officer, Health and Social Care Partnership
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Report of the Discharge Planning Sub-Group

The discharge planning work stream heard of many instances of accepted good practice and of initiatives that worked locally. However, it also identified areas for improvement. Discharge activity is not routinely spread across seven days and batching of decisions can occur on certain days, particularly following extended holiday weekends or at times of severe pressure on beds. The lack of weekend activity is across the whole system; decisions on readiness for discharge do not appear to be made and non-routine discharges are not being made over the weekend.

It has been said that a weighty document is not what is needed. It has further been suggested we avoid “buzz words” and just list the component parts that constitute good discharge arrangements. We have tried to take those suggestions on board. However, it has also been suggested that everyone involved knows what it is they are to do. Sadly, despite the remarkable performance in reducing delayed discharges last spring and, given the serious difficulties faced by the social care sector in the last year, the even more outstanding achievement in sustaining delays at lower levels, the evidence suggests that not everyone does know what to do. Or, if they do, they are not always doing it. The data, which shows lengthy hospital stays before and after readiness for discharge, a lack of activity at weekends, batching of referrals and referrals happening on or after the ready for discharge date, supports this. The conversations held with every health and social care partnerships also highlighted issues, noting there were also many examples of excellent joined up working.

The work stream agreed that a range of tools should be made available to support health and social care partnerships, also that whatever we propose needs to be measurable and accountable. Key actions could be developed in to a plan for local areas to decide how they will implement this locally. Agreed principles could be subject to scrutiny by Healthcare Improvement Scotland.

The resources to support good discharge planning should be set alongside work that is about to commence on delays associated with adults with incapacity, the work stream on community hospitals and intermediate care, and the Community Living Change Fund, aimed at tackling the entrenched complex delays involving people with severe learning disabilities and enduring mental health issues. It should also be placed in context of the wider work to redesign urgent care.

DOT JARDINE
Discharge Manager
NHS Greater Glasgow & Clyde

MARIANNE HAYWARD
Head of Health & Social care
South Lanarkshire HSCP

On behalf of the Discharge Planning Sub Group

REPORT FROM THE DISCHARGE PLANNING SUB-GROUP

Contents

Introduction

Good discharge planning is an essential element of acute hospital patient flow and community service capacity, with the mismatch of demand and capacity an almost constant pressure for the NHS. Access is dependent on effective discharge processes to create sufficient flow. The planning of discharges, along with the importance of keeping to the plan, is therefore vital for bed management and patient flow. However, it is also important to allow strategic commissioners to plan for the requisite care in the community. This document attempts to bring together the key parts of good discharge planning.

There is good reason that the words “planning” and “plan” are used repeatedly in the opening paragraph. The words that will feature repeatedly in the rest of the document are “planned” and “early”. Early referrals, early involvement of the multidisciplinary team, including social care expertise, planning from an early stage in the patient’s journey through hospital. This involvement can seldom be too early and needs to be invited by timely and appropriate communication.

Guidance has long advocated the early setting of an Estimated Date of Discharge (EDD), also sometimes referred to as an expected or anticipated date. This has not always been consistently used and is even less often followed. It is also rarely subject to multi-disciplinary agreement, often arbitrarily set by ward staff. In terms of ensuring discharge arrangements are in place, evidence suggests it is not done in a planned way.

That is why we now want to change from EDD to PDD – Planned Date of Discharge. This is not just a change of word, although that in itself is important to drive behaviour from an “estimation” to a “plan” for each patient, but rather a cultural shift towards everyone involved in hospital discharge, including the patient, family and carers, to all work towards a jointly agreed date rather than, at present, working individually from the ready for discharge date.

We mention patients, family and carers, not just because there is a duty to involve them, but simply because they too need to be able to make their own plans for discharge and it is in everyone’s interests to ensure these are aligned. Older people and their carers should be involved from the outset so that their strengths can be properly identified, their goals discussed and expectations properly managed.
This equally cannot just be about setting the PDD to be as early as possible. It has to be realistic and that realism should then extend to conversations with families and carers about what support is wanted, is needed and can be offered. Premature discharge can be as poor an outcome as a delayed discharge and often leads to readmission.

There is much talk of the “whole system”. Delayed discharge is a whole system problem that needs a whole system solution. Delays come about when that whole system

working becomes fractured. Quite simply, in a system such as health and social care, the whole has to be more than the sum of its parts. It cannot operate by dividing the system in to parts and optimising the different parts. That is only likely to spin the wheels of one part of the system faster than the others when they need to operate in clockwork fashion with each other. The "journey" for the individual patient needs to be a seamless transition and not a series of handoffs. We discuss the different roles and responsibilities later in the paper and how they interplay with each other.

Good discharge planning should result in fewer delayed discharges, shorter lengths of stay and reduced hospital readmissions. Early actions and the use of PDD should enable an assertive approach to managing risk. Equally, reducing lengths of stay will require being seen by the right person in the right ward, early involvement of the multi-disciplinary team, consistency in the use of PDD and clear clinical criteria for discharge. PDD will only work effectively if there is sufficient capacity to support people to return home or to another setting. Data will be important in monitoring the effectiveness of PDD but also to enable the strategic planning of services to support discharge, particularly in commissioning the support of the third sector.

Poor discharge planning for older people can lead to adverse outcomes, lengthy delay in discharge and readmission.

When talking about good discharge planning supporting the management of hospital pressures, it is ironic that many cultural and behavioural improvements were seen in the early stages of the pandemic, when attendances and admissions were vastly reduced and when, for a short period, there was little pressure on hospital beds.
This paper identifies the key themes of good discharge planning, taking account of the lessons learned exercise that was carried out in July 2020, which looked at the changes made in March-June 2020 that saw delayed discharges reduce by over 60%. We need to build on the collaborative working that was in evidence at that time, when there was a strong common sense of purpose, with shared goals and joint commitment.

Summary of Discussion

The group initially developed discussion along key themes – Home First, single point of access, rapid response, intermediate care/community hospitals, staff profile/staff mix, whole system approach, outcomes and data, communication, and enablers and agreed key actions against them. These actions are listed in the report and are separated in to actions that each partnership "must do", "should do" or "could do".

The "must do" actions are those that the group felt needed to be in place across Scotland for consistency. These include the adoption of Planned Date of Discharge and the need for early referrals. Bed based intermediate care works in most areas but it is accepted that there are good reasons why some partnerships decided against it, so actions such as that are listed as "should do". In addition, there are a few actions that partnerships "could do", where they might want to check further information of what works well elsewhere. For example, some partnerships operate successful discharge hubs which can be located in an acute hospital or the community. There are is also

contrasting evidence about whether it is better to have dedicated social work teams based in an acute hospital or have community teams in reaching.

Home First

The principles behind a successful Home First approach are now fairly well established. These are largely inter-changeable with “discharge to assess” or just good discharge planning, but also bring in admission avoidance, accessing the right acute specialty where admission is required and quick turnaround for those admitted. All essentially things that are aimed at keeping people at home, living as independently as possible, for as long as possible. Unnecessary or prolonged hospitalisation, can lead to deconditioning and long-term loss of independence, often resulting in premature and avoidable placement in residential care.

That is not to suggest hospitalisation should be avoided at all costs. There is strong evidence that a comprehensive, multi-disciplinary assessment for those frail, older people presenting at hospital reaps longer-term benefits and can avoid unnecessary entry to institutional care. However, it is vital that such patients are directed to the right specialty on admission and that the period in hospital be as short as possible so that the individual can return home, with the care and support they need to retain their independence. This is where good discharge planning comes in.

Data shows that people who go on to encounter a delay in their discharge have often endured far longer than average lengths of stay prior to being ready for discharge. The longer that length of stay the more likely the outcome will be a care home placement. This may be an indication of the complexity of needs for such patients that have necessitated a lengthy stay in hospital. However, it may also be that we have kept a patient in hospital for too long, trying to make them “a little bit better yet”. Certainly, we have heard stories of hospitals “hanging on to people”. Prolonged unnecessary stays in hospital will rarely improve physical or mental capabilities and recovery is better at home. Hospital should ensure that a patient is “medically optimised” so that they can go home at the right opportunity. Missing that moment can lead to a deterioration, a prolonged length of stay and a much poorer outcome.

A separate work stream looking at community hospitals has also received data that shows most patients in community hospitals entered via an acute hospital and that they go on to experience lengthy further periods of in-patient care. In many cases these people could have gone directly home and received further rehabilitation in their own home, re-engaged with family and their community.

We need to rebalance the approach to risk and consider ‘realistic care’. We know that in many cases, social care support is over-prescribed when assessed in an acute setting. Often the maximum package is sought, “to be on the safe side”. We are looking for the gold standard for people coming out of hospital, keeping them there if it is not available. Knowing the harms and knowing that people will want to be back home, we still choose to keep people in hospital. Because it is a choice. We could discharge them with “enough” support to get home rather than waiting for more than enough. People manage at home waiting on packages of care that are often greater than people stuck in hospital are waiting for. Local audits have shown that up to 40% of packages of care can be reduced through screening by social care staff.

The Home First approach invites all health and care professionals to ask the questions “why not home, why not now?” at every stage of the hospital pathway, from the front door, through admission, to discharge. It requires risk to be properly managed, putting the individual’s needs and wishes at the forefront and centre of any decision making. “Realistic Medicine” suggests that doctors often prescribe more for their patients that they would for themselves. The same could be said about assessments for community services. Unless absolutely necessary, ward staff should avoid any mention of care homes, so that the patient and family focus on returning home. The earlier the communication with the family on the discharge plan the better. Very few people want to go to a care home or would choose that option, and for those that do then these should be examined from the community rather than in hospital following a time of acute care. Everybody should be offered the opportunity to recover in their own home or in a more homely setting and transfers directly from acute hospital care to long-term residential care avoided wherever possible.

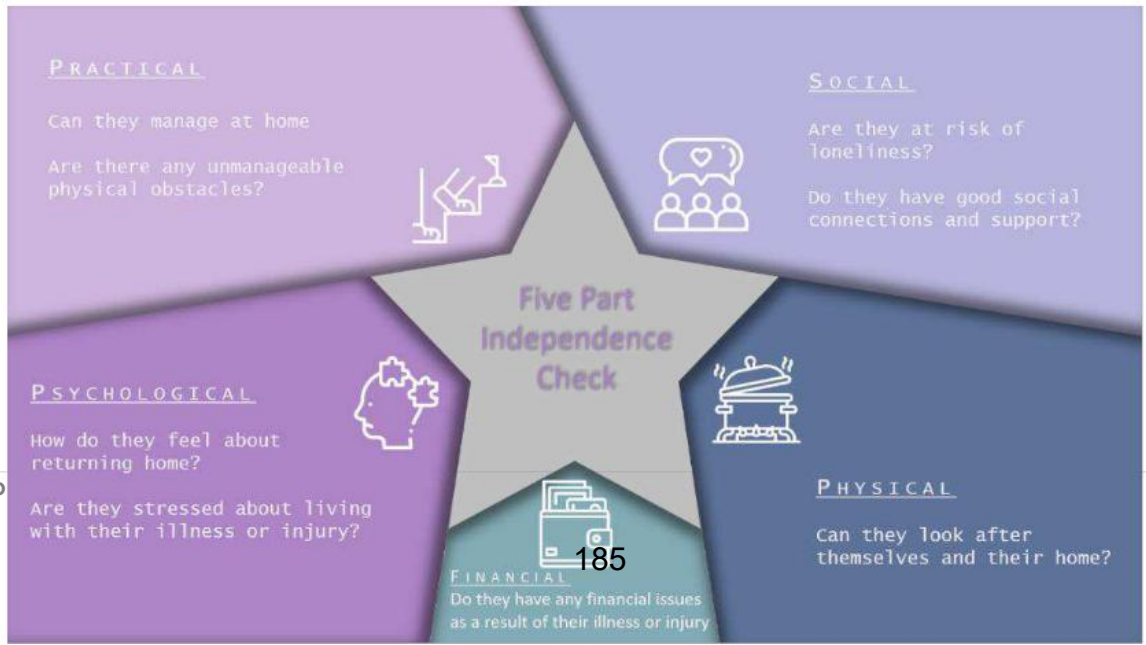
Mention of care homes can pre-judge the outcome of an assessment and when the suggestion has been made by medical staff, whose utterances will be trusted, it can be hard to change people’s mind-set that a care home placement is inevitable.
Ideally any assessment of long-term needs will be carried out in the individual’s own home where people are surrounded by their own belongings in a familiar environment. The work stream was unanimously agreed that an acute setting is the worst place to assess someone yet we frequently have a quarter of all delays in hospital waiting on the assessment happening. We need to move to a discharge to assess system where people are routinely discharged home, without delay, to be assessed in their normal environment, where they will be more confident and comfortable.

There will be cases where someone is unable to go straight home, when they will need a period of rehabilitation, with time to recover, and for a longer assessment to take place. Most partnerships have developed intermediate care beds where this recovery and recuperation can take place. It is important that these beds are dedicated for this purpose, that there is a clear criteria for using them and that each episode is time limited (while allowing some flexibility to realise every opportunity and potential for going home).

Not all partnerships use bed based intermediate care with some preferring this level of care to be home based. Such intensive support following hospitalisation should again be time limited to allow for handover to conventional care at home services. Professor John Bolton, of the Institute of Public Care, has worked with several partnerships in Scotland. He suggests a dedicated home from hospital service ("Transition Team"), arguing that a partnership should be able to predict how many older people will need intensive support to get them home from hospital and a multidisciplinary team be established solely for this purpose. Others with lesser needs would be cared for over the short-term by reablement teams and/or voluntary organisation. Although mentioning 'reablement teams' it is important to think of reablement as an ethos that should run through all care at home rather than a separate service.

Two of the biggest third sector organisations that support discharge have compiled reports based on their own experience and interviews with service users. The Royal Voluntary Service (RVS) campaign, '*Let's End Going Home Alone'*, called for a united effort to improve the support provided to older people leaving hospital. It showcased the central role volunteers and the public can play in supporting the NHS and revealed the positive impact that non-medical support can have on older people's recovery and well-being. The campaign had six essential principles (in the words of those who know):

A Red Cross report "*Home to the unknown: Getting hospital discharge right"*, sets out factors that illustrate the importance of considering how the wider context of a person's life, beyond their immediate, clinical needs, need to be accounted for in planning for



their discharge. It recommended a five-part independence check should be completed as part of an improved approach to patient discharge, either prior to discharge or within 72 hours of going home. This would help inform the setting of a realistic discharge date and would include assessing:

Partnerships say they are embedding a Home First ethos. But how many continue to admit when unnecessary and then pass people round the hospital system from specialty to specialty? How many continue to assess someone's long-term needs in an acute hospital? How many people transfer directly from an acute hospital to long term residential care? How many people continue to endure a delay in discharge? And in answering those, how many partnerships are really embracing Home First?

Key actions

- **Establish a multi-disciplinary agreed Planned Date of Discharge.**
- **Develop a "discharge to assess" model so that older people can be assessed for their long-term needs in their own home.**
- **Commission a dedicated "Hospital to Home" transition team to support older people home to be assessed and supported in the days after discharge.**
- **Utilise intermediate care "step-down" beds to provide a halfway house between hospital and home, for those who need additional recovery time before going home.**

Single Point Of Access

Acute staff should have a single point of contact/entry in order to readily access community support. This should apply at the front door, A&E or a component of the flow navigation centre, so that staff a can seek alternatives to hospital admission, and the back door, so that ward staff have a point of referral. This referral, for ongoing support in the community, should be as early as possible after admission, to alert social work and other community services to the probable need for support to discharge.

Referral should be early and appropriate, with the right level of detail that allows initial judgements to be made. Sometimes, if a patient is seriously ill with no likelihood of imminent discharge then there is little point in a referral. Otherwise though they cannot be too early, noting that in many cases currently they are far too late. Social Work cannot be expected to make immediate arrangements if the referral is on or after the ready for discharge date.

It is important to avoid referrals that are untimely (on or after the ready for discharge date), unnecessary (where the individual could go straight home for further assessment) or inappropriate (with suggested levels of care that raise expectations). We asked partnerships during the stocktake if referrals could be too early? The near unanimous response was that no, they couldn't and the earlier the better so that at least they had some warning of what might be needed down the line. What was helpful, in addition to the earliness of the referral, was ensuring the right level of detail was passed on. This should avoid any prejudgement of the referral itself ("patient needs a care home" was one often still reported), providing enough to justify the need for an assessment and start the process. Social work staff should if possible be part of the MDT making the decision concerning the referral.

Wherever possible, people should be supported to go home without delay so that a self-directed support assessment can take place when settled back home. This calls for an "interim assessment" at ward level to ensure it is safe for the patient to be discharged. Many partnerships allow ward staff to directly order home care for this purpose. This can speed up the discharge process but it needs to be carefully monitored, not just ordering the maximum allowed. Not only can this be expensive and difficult to match to service availability but it may lead to increased dependency. It also contradicts the choice and control of the patient.

There is no consistent method for making referrals. In some cases this is done verbally or by email, while many are made via the Patient Management System. The fact that patient management systems and social care databases are not linked remains an inhibitor. While consistency of approach would be beneficial there is not considered any advantage in dictating any one process over another and this should be left to local discretion. Referrals however should be of a good quality and standard to allow the right care to be sought. This is a requirement of the Care Inspectorate.

Likewise, many partnerships have social work teams based in acute hospitals, which could help foster closer relations with ward staff. Others remain convinced that in reach to hospitals from community based teams is better. There are advantages in both and it is for local partnerships to agree which works better for them. The key area is relationship building and shared understanding of roles. Having a common purpose in discharge planning speeds up the pathway and encourages ' realistic care.

The single point of contact should also be able to signpost the individual to other supports, such as those provide by third sector organisations, community supports, assistive technology, telehealth as well as statutory services

An alert on admission should be available to inform ward staff that the individual is known to social work. This could sit alongside an Anticipatory Care Plan (ACP) and Key Information Summary (KIS) and be available to those that need to access them.

Previous work identified the key factors in an effective integrated discharge hub:

The key factor is that it must be integrated and in some areas the discharge hub is solely an acute function managing beds and flow. It is difficult to know how a discharge hub can successfully operate without those who have major roles in discharging patients. So integrated is vital, as is the team being co-located with equal access to computer systems. They should be involved in tracking patients from the point of admission but only getting actively involved in non-routine discharges. Routine cases should be the responsibility of ward staff to discharge without delays.

Good examples describe a managed service network as an integrated team focussed on discharge planning.

That said, ward staff should have good knowledge of social work eligibility criteria which may only allocate support to those deemed critical or substantial. Some basic testing will be required on individual's competencies in mobility, feeding and toileting. This might also require the acceptance of shared assessment documentation.

The Delayed Discharge Expert Group had previously highlighted that partnerships making progress had identified a single, senior manager who works across integrated services and acute hospitals to tackle the delayed discharge problem, identifying solutions and driving sustainable change. The group chairs had written to all partnerships suggesting such an approach be adopted, and that taking a Home First approach, they should be empowered by Chief Officers and NHS and local authority Chief Executives, with sufficient authority, knowledge and experience to challenge poor discharge decision making and processes, including the management of risks. They should be able to cut through bureaucratic red tape and ensure there are no valid impediments to timely discharge home. In addition, they should ensure longer-term sustainability and that delayed discharge be seen as a collective responsibility rather than one person's.

What has previously shown as bad practice is where either the Hub or Discharge Manager becomes the solution to complex cases and everyone else abdicates their own responsibilities. Hospital staff must own and communicate that a patient if ready for discharge and therefore cannot remain indefinitely in hospital.

Key actions

- **Ensure community services have a single point of access.**
- **Where there is a clear need for on-going support on discharge early referral for community services must be made, well in advance of discharge.**
- **Referrals should contain sufficient but concise detail to allow timely and appropriate interventions.**
- **Ensure that people already receiving community support are discharged as soon as it is safe to do so, with re-starts of care and minimal cancellation of existing services.**
- **Sitting alongside an Anticipatory Care Plan and KIS, an alert could be available on admission to inform ward staff the patient is already known to social work.**

Rapid Response

There is a strong argument to be made for integrated “transition teams”. These would take the form of rapid response services and come under the banner of intermediate care and help the transition between hospital and home. These prevent admissions as well as facilitating discharge.

Many partnerships successfully operate dedicated teams which support hospital discharge, sometimes called hospital to home (H2H), not to be confused with clinical Hospital at Home. These teams, function to transfer someone home with enough immediate support to ensure their safety. These can often involve the third sector and can be anything from a safety check (is there food in the fridge, running water, heating, electricity?) to extensive care and support for the first 48 hours resettlement. Ideally a reablement approach should be taken. The third sector can also assist in schemes such as the “back home box” in Inverclyde.

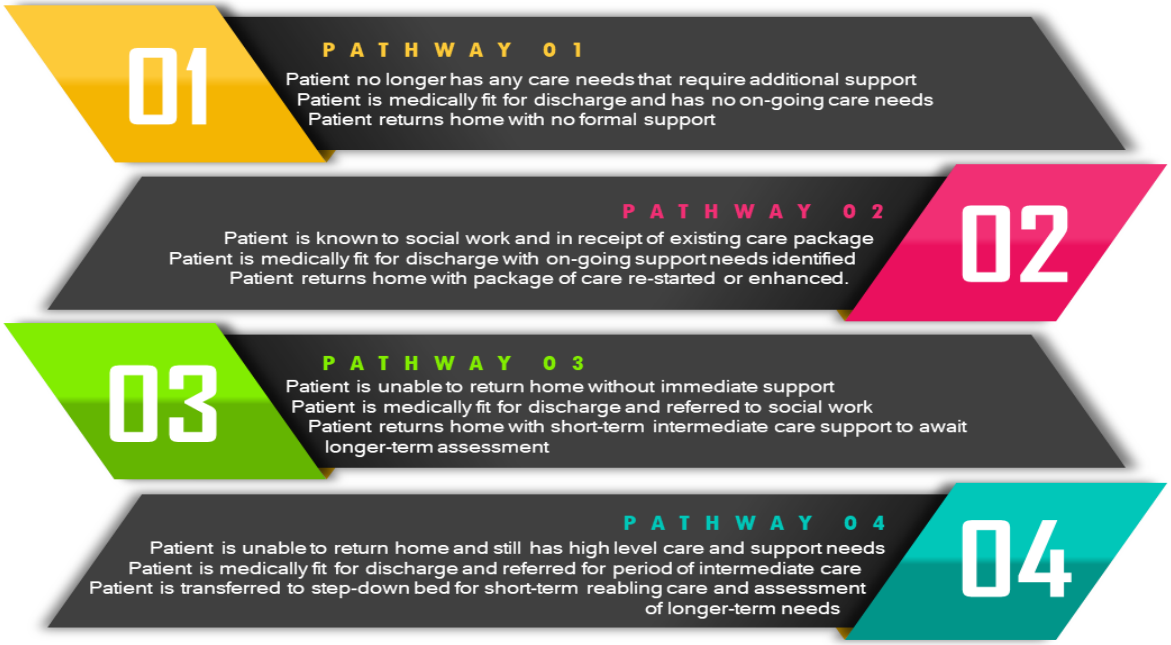
If the voluntary sector has been mobilised and more informal care and support has been provided, the requirement for statutory services may have reduced. There is a need to harness the general goodwill to fellow citizens, in terms of the informal care and support through wider networks of family, friends and neighbours and further develop support such as help with shopping, delivering food etc. There are excellent examples of this happening during covid, with community meals, community supports and befriending. A study by the Royal Voluntary Service demonstrated a halving of readmission rates, and enhanced confidence and satisfaction in recently discharged older people who had received support from volunteers. Other case studies have shown how local handyperson schemes have also reduced readmissions and improved support through simple housing adaptations.

The Red Cross research found that some people came home to houses that had not been prepared for their return – for example, with no hot water or heating on. Others returned to homes that were unsuitable or inappropriate for their recovery and their changed or changing needs. This ranged from struggling with a single step up to a front door, to feeling unable to get upstairs to the toilet.

Those who were sent home to conditions inappropriate for their recovery faced increased risk of falling, as well as other hazards, once discharged from hospital. This, of course, has a significant impact on a person’s recovery trajectory. For a person living with frailty, falls are not the only driver for hospital admission, but we know that delayed discharge has negative influences on longer-term recovery and increases the likelihood of re-admission.

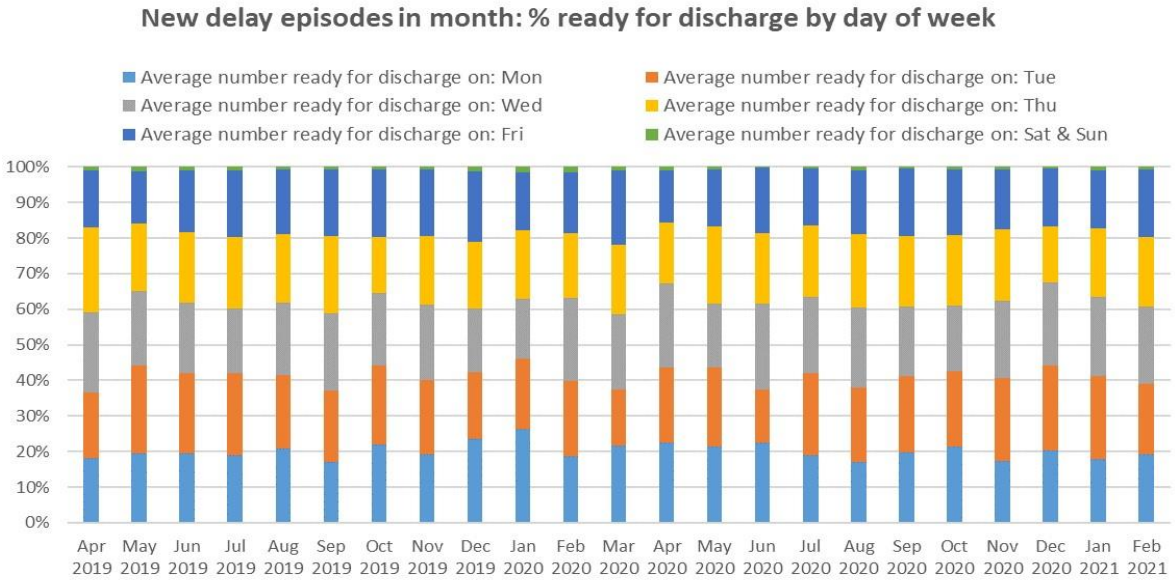
Discharge to assess (D2A) is varyingly described as an ethos, a team or service. It is about ensuring someone is safe to go home so a full assessment of their long-term needs can take place within their own environment, rather than in an acute hospital.

Several NHS Trust's in England use a diagrammatic "pathway" model, such as the one below.



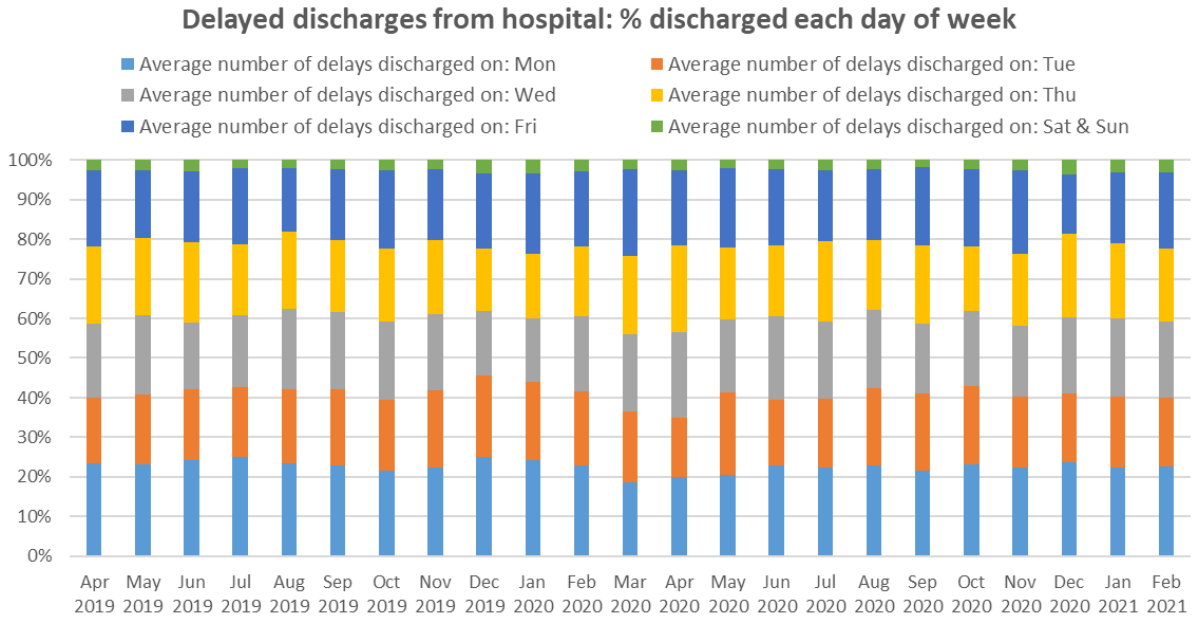
Patients on pathway 01 are routine discharges with no formal support needed and patients on pathway 02 discharged home with restarted support. Transitional intermediate care support comes in for pathways 03 while some sort of interim move might be needed for pathway 04.

Seven day working is also necessary for providing a rapid response in preventing needless delay in discharge. Previously thought of as social care being unable to match the NHS in 24/7 working, data has shown the reality of an absence of senior clinical decision making within hospitals being the major constraint.



Often social work teams have been stood up to take referrals over the weekend but none were received. That said, there is a reluctance of private sector providers to accept new clients over the weekend with a preference suiting care homes and care at

home rotas for people to be discharged on a Monday. While the previous chart showed the day of decision on readiness for discharge, the following chart shows the actual day of discharge. Both charts only include delayed discharge patients and show little activity over the weekend. It is acknowledged that routine discharges and decisions are more likely across seven days.



True seven day working to become a reality needs all parts of the system to be geared up to do their part each day.

Key actions

- **A dedicated team 'Hospital to Home' could be established in all areas, which includes third sector and or their local community support.**
- **Discharges and discharge decisions should be made across seven days.**
- **Use Criteria Led Discharge to allow decisions over the weekends or senior clinical decision makers should support discharge planning**
- **The anticipated default position for all older patients should be that they (ultimately) return to where they were admitted from.**
- **Private sector providers both care at home and care homes should be commissioned to accept referrals over 7 days.**

Intermediate Care/Community Hospitals

The Community Hospital Short Life Working Group (SLWG) was established to investigate the current provision and use of community hospitals and Intermediate Care across Scotland, and gather examples of best practice in their use from across the UK.

The group discussed the current operation of community hospitals from their perspective, and considered what good practice might look like for the differing models in operation.

It was recognised that the operation and use of community hospitals varied across the country, and that there was not a one size fits all example of good practice due to this variation. The group agreed to the development of a set of Key Principles that could inform service development and improvement.

Given the time available the group has not had an opportunity to look at the provision of Intermediate Care in care homes in any detail. However, the group felt that the key principles within the Intermediate Care Framework were still fit for purpose, although the overall Framework did possibly require a review.

Currently, there is no national data available for Intermediate Care, whether provided in a hospital, care home or a person's own home. Work needs to be carried out with PHS and local partnerships to develop a national dataset for Intermediate Care services to allow us to track developments.

The report includes a number of recommendations for the Scottish Government and Key Actions for HSCPs to help make optimum use of their community hospitals. Further toolkits and guidance will also be developed.

Recommendations and Key Actions can be found in the Community Hospital and Intermediate Care Report [add link].

Staff Profile and Staff Mix

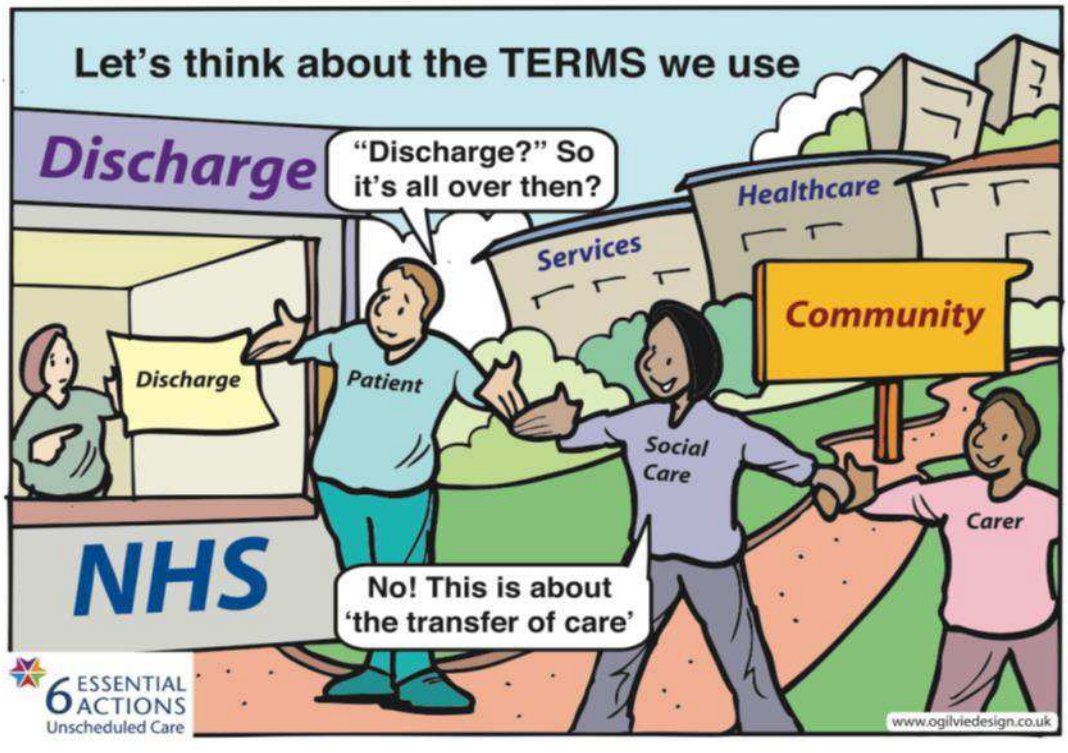
Most teams would be described as multi-disciplinary with a necessary mix of staff and disciplines. These will vary from team to team but will usually benefit from having easy access to specialist expertise such as consultant geriatricians.

The aim of good discharge planning is to ensure that patients are discharged from hospitals safely and in a timely way. This approach involves multiple people who have a vested interest in a person's care arrangements pre and post discharge from hospital.

Having an effective framework of patient-centred multidisciplinary and multi-agency teamwork manages all aspects of the discharge process and ensures the patient receives continuity of care as they are transferred from one setting to another.

We should not underestimate the importance of engaging and including the patient's family and carers from the offset as they know the patient best and can lend a helping hand with the patient's recovery. A family's ability, availability and willingness to provide a level of care is important for the wellbeing of the patient.

Red Cross research revealed that many of the challenges in co-ordination between teams stemmed from the clinical handoff, with the communication of patient needs breaking down between ward staff and those working on discharge. The person or people responsible for discharge differed from one hospital to another. Often discharge planning was tacked onto the patient journey at the end, rather than being integral to decision-making while a patient was on a ward. The lessons learned report highlighted this issue with an animation on its cover.



As with any collaborative working, staff involved in the discharge process need to know their own roles and responsibilities, while respecting those of others in the team. It is

important to work as “one team” and to work together towards agreed, shared goals with a common sense of purpose. To achieve this, we need to identify the key roles and responsibilities involved in discharge planning arrangements. The Delayed Discharge Expert Group agreed the following descriptors of individual roles:

Patient, family and carers
• Should be fully engaged in the discharge process from the earliest stage • Should be given information, advice and support about the discharge process, including access to independent advocacy services • Support the need for timely discharge and avoid unnecessary barriers and delays
All staff
• Should be consistent in the messaging that patients should go home and that remaining in hospital is not an option • Ensure the involvement of family and carers in discussions about care needs • Agree a Planned Date of Discharge • Work on discharge arrangements towards the planned discharge date and not from it
The clinician
• Assess when someone is clinically ready for discharge (as part of MDT process) • Support sensitive discussions around options to go home or to intermediate care if home is not an immediate option • Take a positive attitude to risk enablement and management • Ensure timely production of Immediate Discharge Letter • Ensure prompt arrangements of any discharge medicines • Ensure that all infection prevention and control measures are followed per HPS guidance
Nursing and ward staff [AHPs?]
• Ensure effective and inclusive engagement with the patient, family and carers throughout the discharge process • Senior Charge Nurse will use their expertise in discharge planning in line with Home First principles and practice • Ensure discharge planning starts as early in the process as possible • Liaise with social work staff to ensure early notification of people who might

need on-going support • Provide information and advice to ensure people have realistic expectations of care • Keep patients as active and stimulated as possible to avoid deconditioning
Social Work staff
• Ensure discharge planning starts as early in the process as possible • Support family and carers through the process • Commission provision of on-going community support where required • Ensure a re-ablement approach is taken and avoid unnecessary delivery of care • Lead the completion of assessment of ongoing need and supports, post-discharge from hospital

When talking about multi-disciplinary teams, or any team for that matter, team working is of the utmost importance. Much of that is down to leadership and relationships, but in any team it is vital that each individual knows what their role is. Equally important though is knowing others' roles, and their responsibilities. Team working can break down when people step outside of their own role to try and do those of others.

Some blurring of roles can be good. However, you would expect medical advice to be provided by a medical practitioner and the same principle applies to social care. Advice around social care needs to be provided by social care professionals. There are many examples of integration bringing teams together which have blurred the boundaries between roles. However, good practice in this theme is perhaps better described by a poor practice example, heard at a daily huddle. This involved discussion on patients awaiting "assessment for a care home placement". The assessment hadn't taken place, or been asked for, but the narrative had formed that a care home place was needed, prejudging, and also potentially prejudicing the outcome of the assessment.

The hospital is the operational ground for Home First and the main site where a cultural shift will be necessary. As such hospitals need to ensure all staff, including clinicians, nursing, AHPs and social care workers, fully embrace the philosophy and have robust communication and education plans in place. To effectively realise a cultural shift, those who will be most impacted by the shift need to be engaged throughout the implementation process.

Clinical Staff

Clinicians in the hospital and community should be targeted separately due to their direct involvement in patient care and planning. Although part of a multi-disciplinary process, the ultimate decision regarding a patient's discharge rests with the clinician. For Home First to be successful clinical support is critical and any change in process or culture must be owned by the clinician for it to be accepted by the patient, family and wider multi-disciplinary team.

Nurses
Nurses are often the health care providers that spend the most time with patients, therefore it is critical that the nursing team is fully aware and supportive of the Home First philosophy. Nurses are also a key point of contact for the patient and family. They can respond to their questions and reassure them of their ability to manage at home. In working with patients, nurses can also identify barriers and challenges and work with colleagues to identify potential solutions. Nurses often serve as a link between physicians, allied health professionals and the care providers. They are a conduit for knowledge transfer, and their ability to provide information as well as provide support should be capitalised.

Allied Health Professionals
While allied health professionals (AHPs) is a broad term that includes many health care professionals, for the purposes of this guide, allied health professionals refers primarily to physiotherapists and occupational therapists, as they are the AHPs most involved with Home First processes. Furthermore, the Home First philosophy can be applied to other types of care including rehab, mental health and convalescent care where allied health practitioners may act as primary care givers.

Social Work and Social Care
Multi-disciplinary working and close collaboration is to be encouraged at all times. While diagnosis, treatment and hospital care and recovery are the rightful domain of healthcare professionals, on-going social care needs should be led by social work and social care professionals who have in-depth knowledge and experience of what can be safely provided in the community.

Primary care
Primary care is often the first contact for patients with an undiagnosed health issue and also provide continuing care for various medical conditions. They can exert great influence on patient choices and experiences as patients tend to heavily rely on and trust in the advice and recommendations of their doctor. GPs should also actively monitor their patients while they are recovering and receiving care at home to ensure timely recovery and avoid unnecessary readmissions to hospital.

Clinical Leadership
Clinical leadership's support for the philosophy is required to effectively engage clinicians and allied health professionals hospital wide. Clinical leadership can provide advice on how to best reach clinical audiences and can also be at the forefront of physician and allied health communication and education.

Key actions

- **There should be a designated senior person(s) to manage delayed discharge performance, with oversight of the Discharge Hub (where applicable), delegated authority and funding to make instant decisions,**

respect and authority to be able to challenge poor decision making and control of the data.

- **Everyone should have a clear understanding of their own roles and responsibilities and those of others.**
- **Multi-disciplinary should have the necessary skill mix and ready access to expert professional advice.**
- **Teams should be well linked with co – location as an ideal. Where this is not possible, regular 'virtual' meetings across teams should be the ideal.**

Whole System Approach

All health policies aim to be person-centred, putting the patient at the heart of everything we do. Yet very often delayed discharges distil down to numbers and trying to reduce the number to ease pressure on other parts of the system. It is worth recalling a previous Health Minister saying “action should not be motivated merely by beds, budgets and statistics but by the need to provide person-centred solutions to the problem. This is not just an exercise in reducing numbers – it must be about improving lives”. Delayed discharge is a whole system problem that needs a whole system solution. Yet it is often the subject of blame, where it is seen as someone else’s fault, someone else’s problem that someone else needs to fix.

The early stages of the pandemic showed what can be done. Everyone in it together, with shared goals and a common sense of purpose. People working collaboratively between teams and professionals. This sort of partnership working across the whole system needs to become commonplace.

Discharge should not be seen in isolation, it is merely a part of the whole journey, a journey that starts before admission. The simplest way to stop a delayed discharge is to avoid the admission in the first place, acknowledging that for a frail, older person a short admission to a geriatric specialty might be want is needed to get someone back on their feet and regain their confidence. However, evidence shows that failing to access the right specialty can add days to the length of stay in hospital, a longer length of stay leads to someone becoming delayed in their discharge and the longer that length of stay becomes, the more likely a care home placement will be the end result. So we need to address the whole pathway.

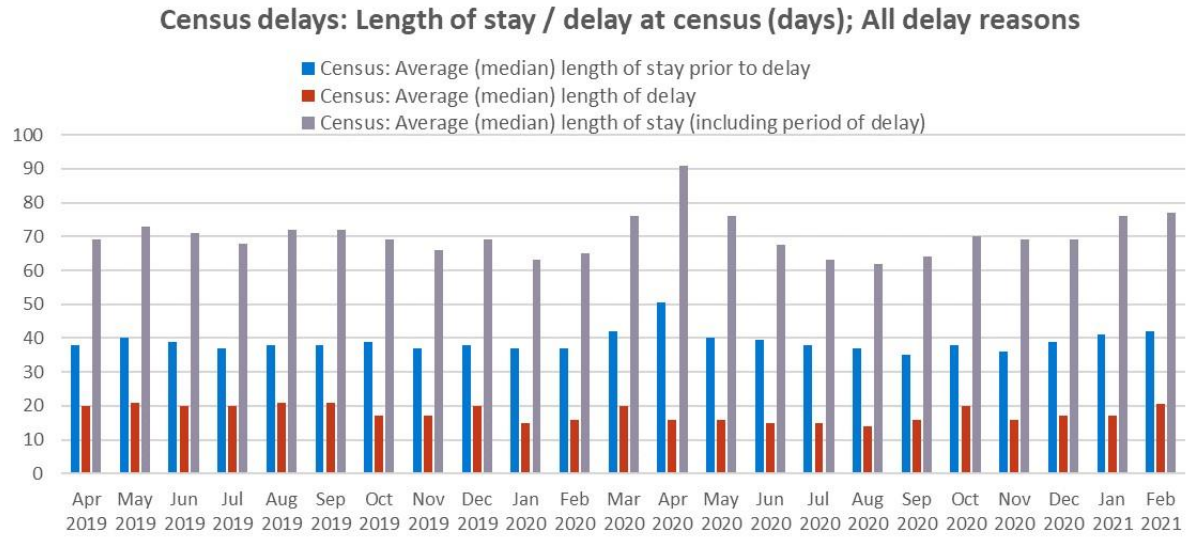
Most partnerships have unscheduled care boards or working groups, discharge planning should be a key action of these groups and this should be reflected in action plans.

The best partnerships track their patients through this journey, knowing when they have been admitted and proactively planning for their discharge. It is important that hospitals play their part. We know that people will lose muscle capacity and general life-skills the longer they are bedded.

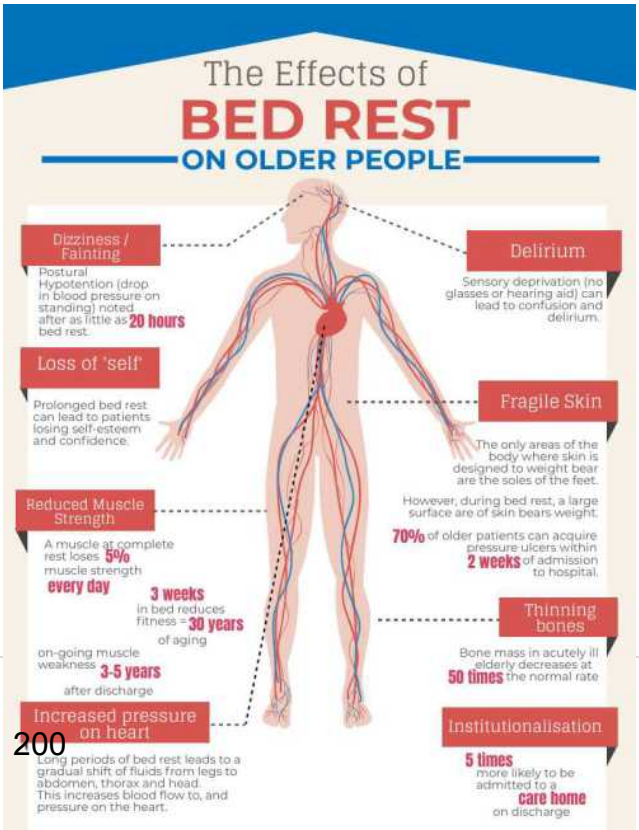
That is not to say people should avoid hospital. The use of acute hospital beds for older people can be reduced through avoiding emergency admission and/or reducing excessive lengths of stay. Key to this is ensuring frail, older people are seen in the right place by the right team. The SCoOP report on acute hospital outcomes stated “every one day spent waiting to get to a specialty bed adds three days to overall length of stay. Priority must be given therefore to creating easier access to specialty beds for older people with frailty”.

When older people are admitted to hospital they are often needlessly passed from doctor to doctor before they are seen by a geriatrician, to discover that what is wrong with them is that they are old and frail. Healthcare Improvement Scotland's 'Frailty at the Front Door' collaborative work has already shown results in reducing lengths of stay.

PHS provided data on average lengths of stay, including the periods before and after the ready for discharge date. Much is known through delayed discharge data about the length of delays but it was striking how long people had been in hospital prior to being ready for discharge.



Work in one partnership found the average length of stay in acute hospital was 5.1 days. For patients who became delayed discharges, the average went up to 47 days. The work uncovered the bulk of that length of stay (on average 30 days) was before they were deemed ready for discharge. In such circumstances the patient will have become deconditioned to the extent he or she may never return home. That deconditioning will rarely be down to the presenting illness but rather to the unnecessary time spent in hospital. One of the health and wellbeing outcomes states "people using health and social care services are safe from harm". The sad truth is that for older people, it may well be that the longer we keep them in hospital the more harm we are causing.



We have produced a poster that many clinicians have taken to display in the Emergency department and has been regularly tweeted.
It is an uncomfortable message but one that the Health & Sport Committee reproduced in it a report sub-headed

“when is hospital bad for your health?”. We have shown it to older people’s groups who have all suggested this be shared more widely and perhaps it could form the basis of a public information campaign. We have a number of similar graphics we use.
There are already a number of campaigns aimed at reducing the effects of bed rest. The best known is the end PJ paralysis campaign, with the slogan “get up, get dressed, get moving” in order to “get better and go home”. We need to change the culture of people in our hospital away from being passive recipients. We suggest people bring their night clothes and reading material if coming in to hospital. One of the first things ward staff will do is give the patient a menu and ask them to tick their meal selections for the next few days. Everything is geared up for a long stay rather than a quick turnaround and go home.

Key actions

- **To ensure older people do not become dependent or disabled in hospital a reabling approach throughout the patient’s journey through, and out of, hospital should be adopted.**
- **More co-ordinated approach to rehabilitation and reablement should be taken, encompassing hospital and community staff, aimed at providing this in the home wherever possible.**

Outcomes And Data

The working group considered a range of data, both existing and desired, which were subsequently discussed with Public Health Scotland.

Data and Outcomes	PHS Comments
Increase in number of discharges without delay	• Data to support this measure is included in current data output. Note that a delay is counted only if it was immediately prior to discharge. • Data caveat: Need to acknowledge differences in completeness of SMR hospital discharge data as this affects some HBs more than others.
Reductions in delays to discharge and length of delay.	• Data to support reduction in delays and length of stay and length of delay measures are included in the current data output provided.
Reduction in bed days occupied	• Data to support this is included in current data output.
Increase in discharges home	• Data to support this is included in current data output for delayed discharges. Further development would be required to analyse this for all hospital discharges • and dependent on data quality on discharge destination.
Increase in planned referrals / Reduction in unplanned referrals	• Data to support this is included in current data output, comparing date referred to social work before or after the ready for discharge date.
Social work assessments for long term support being carried out in hospital	• Not sure how reduction in social work assessments carried out in hospital is intended to be measured? • Future requirement.
Reduction in inappropriate admissions	• How would inappropriate admissions be measured? Data is not currently included in the current data output.
Reduction in AWI through 13za	• Nationally PHS don't have data to support this – how would this be measured?
Measurement of delays due to equipment	• Not specifically identified in current data output. What measures would be required here?

First and foremost, the data needs to be accurate and agreed ("single, shared version of the truth") and this is not always the case. This can often lead to disputes about who is truly a delayed discharges and debates about the correct reason code to use. The original delayed discharge expert group report in 2011 said that "the correct data is the intelligence that partners need to solve the problem". They emphasised the importance of that data being accurate. What gets measured, gets managed.

Several partnerships asked for training on delayed discharge data collection. PHS has recently concluded a consultation on the presentation of the data and will shortly announce any changes. This consultation included a proposal to incorporate s subset of codes for patients going through the adults with incapacity legal process, to provide a better understanding of where in the system delays are occurring.

Following the consultation, the Scottish Government and PHS should consider what training might be necessary to ensure a consistent understanding of the data definitions and coding. As examples, one lengthy delay was queried to be told "that patient died three months ago" but had remained on the data system as ready for discharge. In other cases, medical staff were not allowing the discharge of patients considered ready for discharge. There needs to be accurate recording of data, verified locally and signed off, as per the current PHS guidelines, by the HSCP Chief Officer or nominated representative. Some areas used the Discharge Hub or Daily Huddle to agree the data. Whatever method is used it is important to have a verification process built in to regular working practices. A simple test might be to ask "if everything was already in place, could the patient be discharged today". If the answer is yes, and they are not discharged, then they will likely be classed as a delayed discharge whereas that would be unlikely if the answer is no.

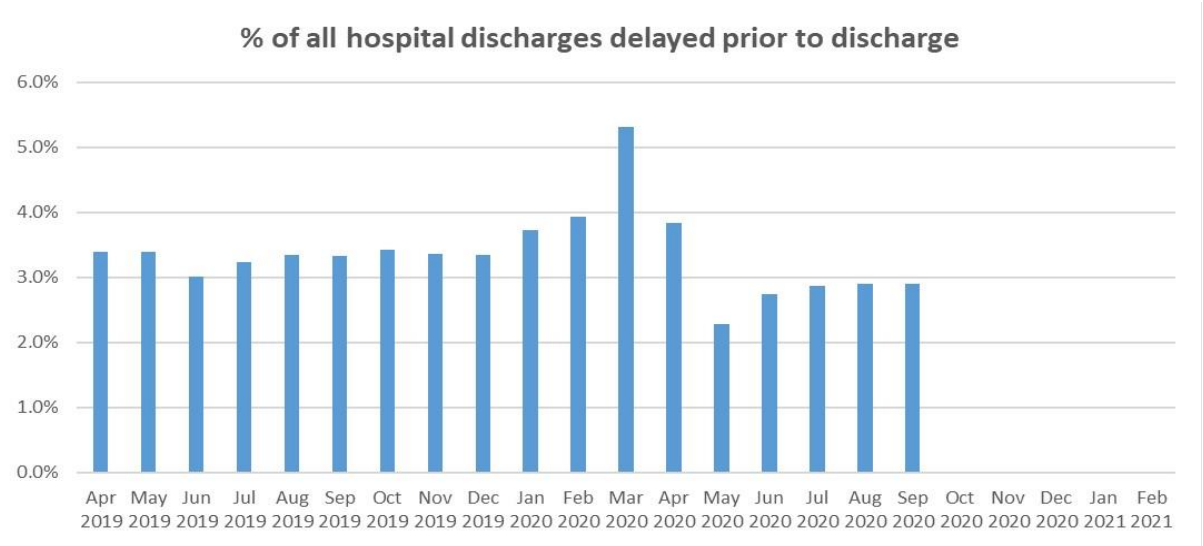
Where an out of area case is identified then the Health Board of treatment and HSCP of residence must be notified as early in the patient's journey and once likely on-going care and support needs have been identified.

It is also important that the code accurately reflects the reason for delay. For example, for planning purposes it will be important to know if someone is waiting for a specialist dementia bed rather than a nursing or other residential care place. Equally, it is important to separate delays awaiting equipment or adaptations from other care arrangement codes. It is particularly important to correctly code those delays for which the main delay is a patient/family/carer related issue. Some partnerships admitted that if there was any dispute or if the reason was unknown, code 11A was the default code, so presenting an inaccurate picture of the assessment delays.

The group considered data on referral dates and whether this was before, on or after the ready for discharge dates. In some cases, this field is not being completed and others defaulted to the ready for discharge date. This is important knowledge to have on how the system is working, so vital that this is filled in correctly. We will need to consider how to collect, manage and monitor the effective use of Planned Date of Discharge going forward.

Among other data considered, of particular note was the information on lengths of stay (prior to and after readiness for discharge) linked to the discharge destination (home or placement). This raised a lot of discussion within the group and would undoubtedly do so among partnerships, so this data should be shared more widely and a summary published within PHS's annual report on delayed discharges.

Also of interest was the data on the proportion of all discharges that encounter delay. Given the relentless focus on delayed discharges there was some surprise that the latest available month (and this data had a time lag of around 6 months) showed 97.2% were discharged without any delay in their discharge. In addition, there was some surprise that only 2.8% of all discharges were delayed, although this varied from 0.3% to 8.0% between partnerships. The group considered this a more meaningful statistic than just a census total of delays and that it allowed the delayed discharge issue to be seen in the wider activity context. If targets were to be considered then this might better reflect continuous improvement, increasing that proportion from 97.2% by incremental percentage points.



Key actions

- **A rigorous approach must be taken to the accurate recording and coding of patients encountering a delay in their discharge.**
- **Chief Officers, or their nominated representative, are ultimately responsible for validating local data submissions.**
- **Patient Management Systems should have a field for Planned Date of Discharge**
- **Partnerships should accurately record PDD to monitor implementation.**
- **The date of referral should be recorded and monitored to ensure this is as early possible and practicable.**
- **The additional data made available to the work stream should be made available as management information to partnerships, and a summary published within PHS's annual report.**

Communication

We talk about communication in several guises. Communication between professionals and the patient - involvement of family and carers in these discussions; ensuring necessary information is available in different formats; making sure conversations are realistic and manage expectations; managing choice and brokering constructive conversations. Communication between agencies - early referral, with the right amount of details; everyone knowing their roles and responsibilities.

We also need to embrace the changes during the pandemic, making best use of digital technology. Daily face to face, multi-disciplinary huddles are no longer needed with everyone in the same room when technological alternatives have been so successfully used.

Good communication and joint working are pre-requisites for a well-coordinated and timely patient journey from pre-admission through to their discharge home or to a permanent place of residence.

Section 28 of the Carer (Scotland) Act 2016 placed a duty on Health Boards to involve carers in the discharge planning of patients who may require on-going care after discharge from hospital. Carers play a significant role in helping people with health and social care needs return home after a hospital admission. They know the people that they care for better than anyone else and can provide information about the person's needs and circumstances beyond medical conditions or physical needs. This means discharge planning can be more comprehensive and may reduce the likelihood of the person being readmitted to hospital

From the outset of a patient being admitted to hospital, the multi-disciplinary team, along with the patient, family and carers need to have a clear expectation of what is going to happen during the stay in hospital. Discharge planning conversations are a critical component for patients when they are admitted to or leaving the hospital setting to ensure a smooth, safe and supported transition from hospital to home. Effective and timely involvement of patient, carer and family members from the outset is therefore required as they are central to the decision making process being productive. This will also include POA / Welfare Guardians for patients who lack capacity.

Communication and engagement between primary, secondary and social care is required to ensure that, prior to admission and on admission, each individual receives the appropriate care and treatment they need. This approach should ensure that patients are then discharged from acute and non-acute inpatient facilities in a safe and timely manner and to the appropriate setting.

Discharge planning conversations are a critical component for patients when they are admitted or are leaving the hospital setting. Comprehensive discharge instructions are necessary to ensure a smooth transition from hospital to home. Effective and timely involvement of patient, carer and family members from the outset in discharge planning

is required as they are central to the decision making process being productive. Patient, carer and family should be prepared (physically and psychologically) to transfer home or to another setting and this will be impacted by the level of timely communication of information regarding the patients discharge. Relevant parties involved in the decision making process should feel engaged, informed and communicated with from the first day of care/admission. Part of this process should involve the multidisciplinary team where appropriate or hospital staff setting and recording the Planned Date of Discharge on the day of admission or as soon as possible after admission and this should be communicated to the patient and all parties. Any change to this date should be recorded in the patients notes and relevant parties notified. 'Near me' can be used to have communication with family and carers, often there is anxiety from families when they haven't seen their loved one for some time due to covid restrictions.

Hospital and social work staff can also make clear and communicate that discharge will be organised as soon as the patient is clinically appropriate, with all parties clear that remaining inappropriately in hospital and people will not be able to stay in a bed after the point where this is clinically necessary. For people leaving hospital this should mean that (where it is needed), the holistic assessment and organisation of ongoing care will take place when they are in their own home. Where it is not possible for someone to be discharged directly home, a period of intermediate care should be considered and discussed with the patient.

While stressing the importance of good communication with patient, families and carers what is not said is equally important, so ward staff should carefully guard against saying anything about post-hospital support that might inappropriately raise expectations. The key messaging should be about the patient going home. Hospitalisation is a stressful time for older people and their confidence in their own ability to live independently must not be eroded.

Although the potential for recovery should always be examined and every opportunity to go home maximised, there will be occasions where someone will transfer directly to a care home. This is a life-changing situation for people, who may never see their own home again. People have a statutory right of choice of accommodation, as to where they will go on to live. This process should not unduly delay discharge and choices have to be realistic. Guidance is clear that choices of care home should be suitable; available; at the usual weekly rate; and the home has to be willing and able to provide accommodation.

On occasion, some patients can go home without understanding critical information about their hospital stay, leaving them at risk for hospital readmission. However, efforts have been made to improve discharge education with a focus placed on increasing communication between care provider and patient. Some HSCPs have introduced patient_centered educational materials in the form of discharge information leaflet/guide for patients, their families and carers. The leaflet, given to the patient on or prior to admission, outlines the process of discharge planning and how the patient's needs are assessed, moving on process etc. Some areas have seen a simple, professionally set,

self-managed programme of rehabilitation improve recovery and reduce readmission rates.

Consideration must be given to the requirement for each board/partnership to have a discharge planning communication plan embedded into their discharge policies. This plan will be based across all acute and community sites and should inform leadership teams and staff of what works well and what areas can be improved in relation to effective discharge planning for the patient.

One of the major factors influencing the quality of discharge is the preparation made in the hospital prior to the patient's discharge home. Effective communication with patients and between staff and community staff, to include a detailed discharge plan is critical to the achievement of this.

Information technology has remained a barrier for systems ability to talk to each other. Yet some partnerships have overcome accessibility problems, with NHS Greater Glasgow & Clyde now having an agreed electronic referral system. It is important to stress that technology should not replace personal contact. Nearly all partnerships expressed the importance of teamwork, with co-location of staff being seen as vital in helping to bond the team together.

While there is unlikely to be a one size fits all solution, we should add details of such solutions to a library of help, support and advice, readily accessible by all partnerships.

It is usually beneficial to share pertinent information with families and carers so that they are aware of how they might contribute to safe and timely discharge. However, it is also worth pointing out that while it may sometimes appear to be obvious that a patient is happy for information to be shared with family, this should be checked to avoid any misunderstanding.

Key actions

- **The key message is that no person should suffer unnecessary delay in their discharge from hospital.**
- **Communication should be clear that the expectation is the patient goes home – "the best bed is your own bed".**
- **Active participation of patients and their carers is central to the delivery of good discharge planning.**

Enablers

Technology Enabled Care (TEC)

Telecare (including community alarms) can be an important part of the care and support provided on hospital discharge.

Like any other care or support, the need for telecare should be considered as early as possible, with early referral to the telecare service. With more than 20% of people aged over 75 receiving telecare, many patients will already receive a service, and it may be that their telecare package will need to be restarted, reviewed or enhanced to support hospital discharge.

There should be staff within the multidisciplinary team or discharge hub, including social work or social care professionals and occupational therapists, who are able to assess for, and request community alarms and/or telecare. A specialist assessor from the HSCP TEC or telecare service may need to be involved in the assessment of patients with more complex needs. There should be an identified person who will facilitate communication between the hospital and the TEC service.

As part of discharge planning, the person undertaking the assessment for technology enabled care should:

- have a good understanding of telecare and what can be offered – to prevent over, under or inappropriate provision of telecare;
- be aware of ethics and issues of informed consent regarding telecare (for example for people with dementia);
- provide the level of information the telecare service requires to install equipment and initiate the service – this will often involve liaison with family and carers;
- provide the patient, and where appropriate, their family and carers, with information about the service so they fully understand they will have devices in their home that connect to an alarm receiving centre, and that they will need to nominate key holders or contacts;
- inform the patient and where appropriate, their family and carers that a charge for telecare applies. Almost all telecare services in Scotland charge, however some offer a free trial period.

Hospitals that discharge patients to more than one HSCP area should be aware that the telecare service offering may vary between HSCPs.

In some areas and/or in some situations, telecare devices can be installed prior to discharge, with the assistance of the patient's family or carers, who will be instructed on how the devices work, and the service operates. However, in some cases the installation will be within 24 hours of discharge. To enable this to work effectively, telecare services should be notified of any changes to the discharge date or time. Together with early referral, this is key to preventing telecare installation delaying

discharge. Many telecare services prioritise referrals to support hospital discharge, but sufficient notice is still required.
Examples of what's working well:

- Telecare awareness training for hospital staff, provided by the HSCP telecare service.
- A free initial trial of telecare – to remove a barrier to uptake.

Lifestyle Monitoring

Lifestyle Monitoring is a digital activity monitoring system that can help care professionals complete objective and evidence-based assessments, enabling people to receive the right level of care and support. It involves installing discreet door and movement sensors around a person's home for a limited assessment period, providing an overview of their daily activity, and helping professionals make proportionate care decisions.

Lifestyle Monitoring is available in most areas, and can be a useful tool to support Discharge to Assess. The HSCP TEC service should be contacted for more information, and for local referral, installation and monitoring arrangements.

Remote Health Monitoring

Remote Health Monitoring is the use of digital remote monitoring technology to enable patients outside of hospitals to receive, record and relay clinically relevant information about their current health and wellbeing. It is used to guide selfmanagement decisions by the user / patient and to support the health and care team in their treatment and care planning.

Restarting or introducing remote health monitoring of blood pressure, COPD and diabetes should be considered in appropriate situations.

Near Me

Near Me is a video consulting service. It is a web-based system the helps public sector providers offer the option of video calls. Near Me can be used to facilitate all people involved in a patient's discharge – professionals and families and carers – being active participants.

Apart from internet access, all people need to use Near Me is a suitable device and the Chrome, Edge or Safari web browser. Computer users will also need a web camera (usually built into laptops) and a headset or speakers.

Equipment

To ensure seamless arrangements for the discharge from hospital settings, it is important that a range of staff within the hospital (occupational therapists, physiotherapists, liaison nurses, and staff within multi-disciplinary discharge teams) can assess and order directly, equipment for 'safe discharge', for their patients. It important that these staff are supported to provide all aspects of the assessment role including

follow-up and conclusion of the assessment following provision. This may be supported by in-reach models.

Ongoing community needs, require to be referred to appropriate community services so these can be properly assessed in the context of the person's home environment and as part of their recovery plan. Therefore, although hospital based staff can access a wide range of equipment, they will only provide what is appropriate to support the service user to safely return to the community.

In addition, it is essential that clear pathways are in place to allow hospital staff, to refer to relevant community staff for the assessment and ordering of equipment for more complex, ongoing needs i.e. tissue viability, seating. Ideally, this should ensure that one assessor will take on the provision of all relevant equipment for discharge to avoid duplication and multiple deliveries.

In the case of tissue viability needs, it is important that hospital-based referrers avoid over-prescription for those patients with non-complex needs, and services agree provision of simple solutions, to ensure a safe discharge and allow for a review of needs and more specialist provision, if required, once the person is back in their home environment.

There will also be circumstances where joint working should prevail, and the expertise of the hospital based practitioner should be utilised alongside the skills of the community professional to meet the needs most effectively e.g. service users with Spinal injuries, Children, and/with complex needs, or requirement for equipment for use within planned adaptations related to discharge.

It is hoped that this approach will greatly support the more effective provision of equipment and also ensure the opportunity to clarify other wider needs related to the home environment e.g. need to discuss re-housing and/or the need for adaptations. An example Protocol has been developed to assist local services clarify roles and responsibilities for the provision of equipment, between the hospital and community settings, and support the implementation of clear and effective pathways.

Key actions

- **Where there is a clear need for the introduction, or enhancement of telecare, early referral should be made, well in advance of discharge.**
- **Referrers should have a knowledge of telecare and an awareness of referral processes, and liaise with TEC/telecare service as required.**
- **Referrals should contain the right level of detail to allow timely and appropriate installations; liaising with families and carers.**
- **The patient, and their family and carers, where appropriate, should be made fully aware of what telecare is, and that there is a charge.**
- **Telecare installers must be kept informed of discharge dates and notified of any changes, to prevent any installation delays.**

- **Lifestyle Monitoring can be considered to support assessment for care and support.**

Annex B: Driver Diagram


PRINCIPLE AIM: NO-ONE SHOULD STAY IN HOSPITAL LONGER THAN NECESSARY OR BE DELAYED IN THEIR DISCHARGE
AIMS
PRIMARY DRIVER
SECONDARY DRIVER
CHANGE IDEAS
Home is the default for all people leaving hospital.
Adopting a "Home First" approach, asking "why not home, why not now" at all points of a patient's journey.
Developing a range of intermediate care services
Assertive attitudes towards risk management
A quick turnaround from admission – avoid long lengths of stay.
Take a reabling approach. Help patients to stay active in hospital
Avoid unnecessary transfers in hospital/to community hospitals
✓ Discharge Lounges
✓ Back Home Boxes
✓ Prof to Prof Support
✓ End PJ Paralysis
All parties work to an agreed Planned Date of Discharge.
Patients, families and carers involvement in the discharge planning arrangements.
Discharge planning to be started early in the patient journey, preferably on admission.
Everyone working as one team, with one goal.
Early referral to social work
Dedicated social work staff dealing with hospital discharges.
Clear roles and responsibilities.
✓ Discharge Hubs
✓ Dedicated Discharge Managers
✓ Daily Huddles.
People are not assessed for their long-term support needs in an acute environment when at their most vulnerable.
Adopt "Discharge to Assess" ethos.
Commission a dedicated "Transition Team" (H2H) to support people for the first 72 hours.
Use of step-down beds in Intermediate Care, Community Hospitals and supported housing.
Involve the Third Sector
Signposting to alternative support
Strength based assessment and outcomes focused conversations
✓ Red Cross Hospital to Home
✓ "What Matters to You?"
Decisions are made and discharges occur across 7 days
Community services available to start/re-start across 7 days.
Availability of key decision makers.
Criterial led discharge
Timely access to equipment, Pharmacy & transport.
✓ Technology Enabled care
✓ Trusted assessors
There is good communication between professionals and with the patient, family and carer.
Patients, families and carers involvement in the discharge planning arrangements.
"Realistic conversations" – managing expectations & public perceptions.
Use agreed methods for transfer of referral detail.
Adopting robust choice protocols.
Single point of contact / access
Conversations about care homes are avoided
Put the person at the heart of decision making
✓ "What Matters to You?"
There is robust data and a series of indicators by which to measure performance and identify concerns.
Agreed single version of the truth
Importance of accurate coding
Indicators to measure progress
SMART Objectives
Training
Target: proportion of all discharges encountering a delay.
✓ "What Works Tool"
✓ Training videos

OPTIMISING WHOLE SYSTEM DISCHARGE PLANNING - SELF-ASSESSMENT TOOL

Background

As part of the unscheduled care “Building on Firm Foundations” programme, a work stream on “optimising discharge” made a number of recommendations for health and social care partnerships. These have been described in a one-page driver diagram (see annex A) with the following key aims.

Home should be the default position for all people leaving hospital	• This will mean partnerships must adopt a Home First approach, asking “why not home, why not now” at every stage of a person’s hospital journey. A range of intermediate care services will need to be developed and an assertive attitude taken to risk.
All parties work towards an agreed Planned Date of Discharge	• This will require everyone working as one team with a shared goal, working towards the PDD rather than from the ready for discharge date. Early referral will be needed for any on-going support needs.
People should not be assessed for their long-term support needs in an acute environment when at their most vulnerable.	• Partnerships should adopt “Discharge to Assess” as an ethos and commission dedicated “Transition Teams” to provide immediate support on discharge. As a rule, no-one should transfer directly from an acute setting to a long-term residential care setting without all options to go home being exercised.
Decisions are made and discharge occur across seven days.	• This will need decision makers and decision making processes in place across seven days and for providers to be available for new starts or re-starts of community based care. Transition Teams should be available to support weekend discharges. Pharmacy and transport must also be available, along with technology and other equipment to support safe discharge. Early discharge planning should support timely ordering and availability.
There is good communication between professionals and with the patient, family and carer.	• Community supports must have a single point of contact and access, and be readily accessible. Patients, family and carers should be involved in discharge planning with good, accessible information on what will be available to support discharge arrangements.
There is robust data and a series of indicators by which to measure performance and identify concerns.	• There must be a single, agreed, version of the truth, with accurate numbers and coding, to fully understand the key indicators of successful performance. SMART (Specific Measurable Achievable Realistic Timely) objectives should be set to measure the impact of these key aims.

The work stream also pledged to develop a self-assessment “what works” template so that partnerships could reflect progress against the various drivers.

Purpose

Self-assessment is widely used across public services and the private sector. It allows organisations to identify their strengths and weaknesses, highlighting areas where improvements could be made, resulting in actions being developed to make those improvements which are then monitored against a set of agreed indicators to measure progress.

The tool is intended to allow health and social care teams and managers to continually test their discharge planning arrangements and put remedial actions in place where it is demonstrated there are shortcomings. It is meant for internal use locally and should not be used as a critique of individual or team performance. Neither should the scoring be used in any way to belittle those involved in the operational frontline. Rather it is intended to assess the whole system and be used as an aide to improvement.

Who should use the tool

Delayed discharge is recognised as a whole system problem that requires a whole system solution. It is important therefore that responses to the tool are from a range of people involved in discharge planning. The template can be completed as an individual survey and the scores aggregated to obtain an average score for each intention. One particularly effective method for completing it is to hold facilitated staff focus groups to discuss and agree a score for each intention. This has the benefit of promoting open and honest discussion, although care needs to be taken to avoid blame being pointed at one part of the system.

How to use the tool

The tool is divided in to six broad themes, representing they key aims within the driver diagram. This is then broken down in to the primary and secondary drivers from the driver diagram and supplemented by other recommendations from the optimising discharge work stream report. The “status” column should be used to assess the partnership’s current status against each intention. A score from 0-5 should be set against each driver with “0” meaning the driver is not in place at all and “5” meaning it is wholly embedded in the system. The “impact” column should be used to consider the impact of each intention, either anticipated where it is not yet in place or anticipated where it is still to be established. Subsequent improvement actions should focus on those intentions that score low in status and high in impact.

Improvement actions should be well described and documented, have an agreed timeline for delivery and a nominated official to lead the work. Progress should be measured against national data where available or against agreed local indicators.

The scoring methodology is described in more detail below.

STATUS SCORING		IMPACT SCORING	
0	The current status is not defined locally or not known	0	There would be no impact at all adopting this intention
1	There is an informal understanding of the intention but no formal description in place	1	There would be minimal impact from this intention
2	This intention is well documented and understood	2	This intention would improve the current position but not be a priority
3	The intention is well defined locally and carried out routinely	3	The intention would show a significant impact
4	The intention is regularly measured and monitored, and actions in place where necessary	4	The intention is necessary and vital for improvement
5	The intention is embedded, consistently meeting needs	5	The intention is essential in order to provide better outcomes

Measure might include, but not exclusively:

- Delayed discharge number
- Delayed discharge bed days
- Overall occupied bed days
- Proportion of bed days that are delay
- Proportion of all discharges that encounter a delay
- Date of referral (c/w date of admission, ready for discharge date, actual discharge date)
- Planned Date of Discharge (c/w date of admission, ready for discharge date, actual discharge date)
- Proportion of PDD met (not met by how long?)
- Readmission rates

THE TOOL

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
Home is the default position for all people leaving hospital						
A "Home First" approach should be adopted, asking "why not home, why not now" at every point of a patient's journey						
A range of intermediate care services should be developed						
An assertive attitudes towards risk management should be taken						
Long lengths of stay should be avoided with a quick turnaround from admission						
A reabling approach should be taken, with patients helped to stay active in hospital						
Clear information and advice should be available on the effects of "bed rest" and the benefits of activity and rehab						
Unnecessary transfers in, or to other, hospitals should be avoided						

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
All parties work to an agreed Planned Date of Discharge (PDD)						
Involve patients, families and carers in discharge planning arrangements						
Discharge planning should be started early in the patient journey, preferably on admission						
Everyone involved in discharge planning should work as one team, with common goals, including the core message that “no delay is acceptable”.						
There should be early referral to, and involvement of, social work teams						
Referrals should contain sufficient but concise detail to allow timely and appropriate interventions						
Dedicated social work teams dealing with hospital discharge are known to work						
Everyone should have clear roles and responsibilities, and an understanding of others’ roles						
There should be a designated senior person to manage discharge performance, with oversight of the Hub (where applicable) and delegated authority to make and						

challenge decisions.						

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
People are not assessed for their long-term needs in an acute environment what at their most vulnerable						
A “Discharge to Assess” ethos should be adopted						
All staff adopt the key message that “the best bed is your own bed”						
Consider commissioning a dedicated “Transition Team” (Hospital to Home) to support people for the first 72 hours						
Consider the use of “step-down” beds in intermediate care facilities, community hospitals or supported housing						
Consider using the third sector within the wider Hospital to Home support						
Ensure easy signposting to alternative supports						
Carry out “strength based” assessments and outcomes focussed conversations						

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
Decisions are made and discharges occur across seven days						
Community services should be available to start or re-start across seven days						
Wherever possible existing packages of care should be kept open to avoid any delay						
Key decision makers should be available at weekends and public holidays						
Have guidelines in place for Criteria or Nurse Led Discharge						
Ensure timely access to equipment, pharmacy and transport						
Telecare providers must be kept informed of discharge dates and notified of any changes to prevent any installation delays						

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
There is good communication between professionals and with the patient, family and carer						
Ensure “realistic conversations” with patients, families and carers, that manage expectations and perceptions						
Use agreed methods for rapid transfer of referral details						
Ensure robust choice protocols are in place with an escalation policy						
Create a single point of contact/access that is well known to ward staff						
Avoid conversations about care homes prior to any assessment						
Put the person at the heart of decision making						

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
There is robust data and a series of indicators by which to measure performance and identify concerns						
Ensure there is an agreed, single version of the truth						
Accurate coding is key to having the correct knowledge of the problem						
Adopt a set of indicators to measure progress						
Ensure the PDD and referral date are accurately recorded and monitored						
Adopt SMART objectives for all actions and objectives						
Provide adequate training for all staff involved in discharge planning						
Adopt local improvement measures and targets. Where possible make these “positive” targets such as “increasing the proportion of all discharge that encounter no delay”						
Chief Officers have processes in place to allow them to “sign off” the validated data						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Agenda Item

13

Report

Report to:	**South Lanarkshire Integration Joint Board**
Date of Meeting:	**17 August 2021**
Report by:	**Interim Chief Officer, Health and Social Care Partnership**

Subject:	**Autism Resources Co-ordination Hub (ARCH) Update**

1. Purpose of Report

1.1. The purpose of the report is to:-

- advise Integration Joint Board of the background and current progress of the development of ARCH since the last update to Board
- advise re: development of the South Lanarkshire Local Autism Action Plan to sit within the Scottish Strategy for Autism
- outline ARCH's role in supporting the Autism community during the COVID-19 Pandemic: March 2020-March 2021

2. Recommendation(s)

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that the progress made as highlighted in the present report be noted;

(2) that the Resource Plan to develop the revised and updated Local Autism Action Plan outcomes during the post-COVID-19 recovery and transformation period post COVID-19 be noted; and

(3) that the aim, as highlighted at 3.3 and 6.2, that over the coming months the Resource will actively engage with our autism community and partners to determine how we can realise the vision of the ARCH becoming a truly community lead resource be noted.

3. Brief Background (Recap)

3.1. Following the closure of the pan-Lanarkshire One Stop Shop based in Motherwell, which was managed by Scottish Autism in May 2016, interim arrangements were put in place to deliver an alternative South Lanarkshire autism-specific support service.

3.2. Following the school summer holidays in 2016, the ARCH Service moved to its own premises in Burnbank, Hamilton where it remains.

3.3. The model of service delivery adopted in ARCH continues to promote and embody the Asset Based Community Development (ABCD) approach which seeks to engage and mobilise the capacities of all autism partners in the Private, Statutory, Voluntary and Parent Led sectors within South Lanarkshire.

3.3 When the ARCH was established it was the intention as noted in the Executive Committee Report dated March 2017 that 'the aim is to establish the ARCH as a South Lanarkshire resource that reaches out to all parts of the local authority through existing groups and to work towards supporting the Autism community to assume the running of the resource on behalf of the community.'

3.4. The ARCH remains the flagship of South Lanarkshire's commitment to promoting and implementing the four strategic outcomes outlined in the revised Scottish Strategy for Autism – Outcomes Approach (2015) and Revised Outcomes and Priorities 2018-2021 as well as the five overarching themes in the South Lanarkshire Local Autism Action Plan 2018-2023.

3.5. ARCH has remained pro-active in facilitating the development of services within the community; many of which are designed and delivered in partnership with the community itself alongside partners in the statutory, private and third sectors. Parent Carer support groups are arranged and delivered collaboratively between parent carer volunteers in two autism charities working from ARCH; COAST (Champions of Autism Spectrum Together) and SAIL (Supporting Autism In Lanarkshire) alongside ARCH staff who deliver guidance, signposting and support to autistic children, young people and adults as well as their parent carers. Pre-COVID lockdown restrictions, Lanarkshire Carers was commissioned to provide a staff member to co-work/facilitate one of the weekly parent carer support groups held in the centre.

3.6. A range of autism stakeholders remain actively involved in collaborating on designing and delivering supports based within ARCH.

4. Development of the ARCH Service – March 2020-March 2021

4.1. The implementation of the strategic themes outlined in the South Lanarkshire Local Autism Action Plan 2018-2023 have continued to be progressed throughout the Pandemic and subsequent lockdown restrictions via regular meetings between ARCH and autism stakeholders in the third, statutory and private sectors.

4.2. ARCH has also represented the South Lanarkshire Autism voice within an unprecedented number of vitally important national developments relating to The Post-Scottish Strategy for Autism (2011-2021) proposals published by the National Autism Implementation Team (NAIT) (Appendix 1 outlines the graphic produced following the ARCH consultation event), the Scottish Government post COVID-19 Transformation and Recovery plans, publication of the Cross Party Group on Autism report; 'The Accountability Gap' (link to report in background papers), publication of the review into Scotland's ASN Education provision chaired by Angela Morgan, including the Scottish Government's unanimous acceptance of the recommendations therein, and the proposed Disabled Children and Young People (Transition to Adulthood) (Scotland) Bill by Johann Lamont MSP.

4.3. At the same time, ARCH has continued to be guided by the South Lanarkshire Autism community's vision statement encapsulated by the phrase; "Think National - Act Local" by ensuring that the autism-informed supports and services offered within South Lanarkshire continue to meet the needs identified by our community throughout the Pandemic period.

4.4. ARCH has also been instrumental in furthering the primary strategic objective of raising autism awareness and informed practice throughout the South Lanarkshire workforce and community via public events including flag raising outside Headquarters for Autism Pride day in 2020 and Autism Awareness Week 29 March-04 April 2021 as well as online training and development sessions with, amongst others a wide range of stakeholders in; Health, Scottish Ambulance Service, Education, Further Education, Money Matters, Housing and Social Work Resources (Adult, Justice, Children's Houses and Children and Families).

4.5. ARCH continues to facilitate ongoing workforce development via nominations onto the SVQ Level 2 and 3 in Understanding Autism offered by the West of Scotland College. This has resulted in over 300 professionals in all services obtaining the award. ARCH has also contributed to revised Child Protection documents and is currently collaborating with Housing colleagues on a focus group to inform revised Housing policy.

5. Further Developments

5.1. ARCH has developed an innovative Autism profiling tool specifically designed for ease of use by the autism community itself, as well as informing professionals engaged in supporting autistic people in all sectors. This is called the 'My Autism Profile' tool and has been approved by the Senior Management Team within the Health and Social Care Partnership (HSCP), as well as being incorporated into the newly constructed South Lanarkshire Autism Internet page developed and produced by ARCH in partnership with Planning and Communications Team colleagues (link to report in background papers).

5.2. Throughout the Pandemic, from the initial announcement of lockdown in March 2020, ARCH immediately set about collaborating with centre user charities to obtain access to online platforms which allowed the support offered to our community to remain unbroken. This has allowed many online groups and workshops to being hosted via ZOOM and Microsoft (MS) Teams. This provision has been described by many as 'a real lifeline' throughout what has otherwise been a very isolating experience for the community as a whole and autistic people specifically.

5.3. ARCH also continues to undertake staff development session via these online platforms.

5.4. In a very real sense ARCH adapted in response to the COVID reactive needs of the South Lanarkshire autism community by also offering our phone and email advice and support lines, throughout. Alongside the ZOOM and MS Teams Social Media platforms, ARCH has received an unprecedented number of 'crisis calls' from autistic people and their parent carers struggling with the implications of lockdown restrictions. Whilst never intended to be or established as a crisis intervention service, ARCH has supported autism families through very difficult situations which would have otherwise been referred on to statutory, targeted services who by their own acknowledgement, would have undoubtedly struggled to provide autism-informed responses. The 2019-2020 statistics reflect this ongoing work and support. (Appendix 2).

5.5. The ARCH mailing list has continued to steadily increase during lockdown and now totals 1,549 recipients.

5.6. ARCH continues to collaborate with Education Inclusion Services in ensuring the ongoing provision of the National Autistic Society's 'Early Bird' programme throughout South Lanarkshire during lockdown.

5.7. ARCH is currently involved in participating as a Pathfinder authority in a pilot programme using the Development and Wellbeing Assessment tool (DAWBA). The implications of the pilot will potentially transform current professional assessment, identification and support of neurodivergent conditions including Autism, as well as other mental health issues in children and young people aged 11-23 years. The early identification of these issues will allow interventions to be much more specific and targeted in accordance with assessed support needs. The DAWBA was used by the NHS in their survey of mental health in school children in England and Wales in 2017, and is highly recommended by NIMH is the U.S. It is also the preferred diagnostic tool currently used in Denmark and has over 4500 academic citations having been successfully used for millions of children worldwide since its creation in 1995.

6. The Post COVID Recovery Plan

6.1. ARCH is already in detailed discussion with centre user charities about the resumption of face-to-face groups and services, once current lockdown restrictions are eased. These plans will be consistent with the CoSLA approved 'Towards Transformation' plan (link to report in background papers).

6.2. Further to 3.3 above and in recognition of a change in the delivery of supports provided by the ARCH and its Third Sector partner; the Resource over the coming months will actively engage with our autism community and partners to determine how we can realise the vision of the ARCH becoming a truly community lead resource.

7. Employee Implications

7.1. There are no employee implications associated with this report.

8. Financial Implications

8.1. There are no financial implications associated with this report

9. Climate Change, Sustainability and Environmental Implications

9.1. There are no implications for Climate Change associated with this report.

9.2. There are no sustainable development issues associated with this report.

9.3. There are no Environment Implications associated with this report.

10. Other Implications

10.1. There are no other implications associated with this report.

10.2. There no other issues associated with this report.

11. Equality Impact Assessment and Consultation Arrangements

11.1. This report does not introduce a new policy, function or strategy, or recommend a change to existing policy, function or strategy and, therefore, no impact assessment is required.

12. Directions

12.1.

Direction to:	
1. No Direction required	☐
2. South Lanarkshire Council	☐
3. NHS Lanarkshire	☐
4. South Lanarkshire Council and NHS Lanarkshire	☐

Marianne Hayward
Interim Chief Officer, Health and Social Care Partnership

Date created: 18 June 2021

Link(s) to National Health and Wellbeing Outcomes

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

Previous References

- Executive Committee Report 2017

List of Background Papers
https://www.gov.scot/publications/learning-intellectual-disability-autism-towards-transformation/#:~:text=The%20Scottish%20Government's%20'Towards%20Transformation,their%20lives%2C%20the%20same%20as

The Cross Party Group on Autism report; **'The Accountability Gap'**:
https://s3.chorus-mk.thirdlight.com/file/1573224908/63654983914/width=-1/height=-1/format=-1/fit=scale/t=445041/e=never/k=2910a506/CPG%20on%20Autism%20report%20-%20The%20Accountability%20Gap%2006.10.2020.pdf

My Autism Profile Tool:
https://www.southlanarkshire.gov.uk/downloads/file/13763/my_autism_profile

Appendix 1


South Lanarkshire - local views of autism

Appendix 2


Arch Statistics.xls

Contact for Further Information
If you would like to inspect the background papers or want further information, please contact:-
Arun Singh, Service Manager, Children and Justice Services
Ext: 3764 (Phone: 01698 453764)
Email: arun.singh@southlanarkshire.gov.uk

LOCAL VIEWS OF AUTISM SERVICES + STRATEGY
SOUTH LANARKSHIRE

PLEASE SHARE YOUR STORIES

HOW HAS THE NATIONAL STRATEGY INFLUENCED AUTISM SERVICES IN YOUR AREA?

Tick-Box TRAINING
ONLY ACCESSED BY THOSE WITH A VESTED INTEREST

- IT DOESN'T GET USED
  - AVAILABLE TRAINING ISN'T MANDATORY OR PRACTICALLY SUPPORTED
  - PRIMARY ASN TRAINING IS OPT-IN
  - YOU HAVE TO DO IT IN YOUR OWN TIME
- IT'S THE SAME
  - I'M A NURSE
  - I'M A SOCIAL WORKER
  - I WORK IN A HIGH SCHOOL

EVERYTHING HAS BEEN DEVELOPED BY 3RD SECTOR - LITTLE STATUTORY INVOLVEMENT
- VOLUNTARY GROUPS
- PARENTS

FOR TRAINING THE COUNCIL WAS GENEROUS

It led to SOME funding for services + posts

FOR DELIVERY THERE WAS NOTHING

MICROSEGMENTATION REPORT CRUCIAL IN HELPING WIN THE HEARTS AND MINDS OF SOME INFLUENTIAL PEOPLE

PARENTS AND CARERS ARE DOING THE DELIVERY

We make things happen (as parents) but we have to FIND it.

THE ONE STOP SHOP CLOSED

WE GET NO DIRECTION OR SUPPORT AS PARENTS

SHOUTING WITH A VOICE OF RIGHTEOUS INDIGNATION

AN OVERVIEW OF AUTISM ACTIVITY

SOUTH LANARKSHIRE COUNCIL

THINK NATIONAL ACT LOCAL
- HEALTHY LIFE
- CHOICE + CONTROL
- INDEPENDENCE
- ACTIVE CITIZENSHIP

MUST BE TANGIBLE LOCAL IMPROVEMENTS

AUTISM COORDINATION HUB
- STATUTORY
- 3RD SECTOR
- PEERS

WE HAVE INFLUENCED POLICY AT A LOCAL AND NATIONAL LEVEL.

THE SCOTTISH NATIONAL STRATEGY HAS HAD A NEGLIGABLE IMPACT

1/3 children have additional support needs

AND YET

EDUCATION WAS NOT INCLUDED IN STRATEGY

MICROSEGMENTATION REPORT
- MOST COSTS FROM AUTISM ARE ESCAPABLE ... WHY THEN, HAVE WE NOT ESCAPED THEM?
- AUTISTIC PEOPLE HAVE AN AVERAGE 20 YEARS SHORTER LIFE EXPECTANCY

HOW HAS THIS CHANGED IN RECENT YEARS?

NOTHING GETS FOLLOWED UP

THERE'S NO INFORMATION

To find direction through DIAGNOSIS.

THERE IS A HUGE DEFICIT IN PROVISION

WE DON'T HAVE ENOUGH POST-DIAGNOSTIC SUPPORT

WE NEED TO INVEST IN THE COMMUNITY BEING AUTISM INFORMED

THERE'S AN ASSET BASED COMMUNITY LED APPROACH HERE

WE HAVE ALOT OF TALENT TO OFFER

EDUCATION

IT SHOULDN'T BE BECAUSE YOU'VE GOT AN AUTISTIC CHILD THAT YOU HAVE ACTIVELY GONE TO GET PROFESSIONAL TRAINING

CHILDREN DON'T DEVELOP SKILLS TO LIVE INDEPENDENTLY

SCHOOLS AREN'T SET UP TO SUPPORT AUTISTIC CHILDREN THROUGH MAINSTREAM

THE STRATEGY DOESN'T HAVE TEETH

POCKETS OF GOOD PRACTICE ARE DEPENDENT ON PEOPLE WITH A VESTED INTEREST

A PARENT CARER GROUP CAN'T DO EVERYTHING

IT'S NOT SUSTAINABLE

ARCH IS GOOD BUT IT IS UNDER THREAT

There's no STABILITY

PEER SUPPORT

FOR THOSE ACCESSING AUTISM SERVICES

WHAT IS WORKING WELL?

BRINGING PARENTS TOGETHER TO SHARE INFORMATION

The Early Bird training was good.. But then there was no support to deliver training

GOOD PRACTICE HAS COME FROM BOTTOM UP

IF SOMEONE HAS HAD A GOOD EXPERIENCE WE WILL HEAR ABOUT IT.. WE DON'T HEAR MUCH

WHAT DIFFERENCE HAS THIS MADE TO PEOPLE ACCESSING AUTISM SERVICES?

NO JOINED UP APPROACH

No one is JOINING UP THE DOTS

It's NOT FEASIBLE FOR US TO RUN ARCH - OUR VOLUNTARY TIME IS VALUABLE

FINANCE

FINANCES Spending money wisely on Autism saves money

COUNCILLORS MAKING DECISIONS DON'T HAVE THE KNOWLEDGE

BUDGETS NEED TO BE FOCUSED ON SUPPORTING + TRAINING PEOPLE TO DELIVER SERVICES TO DO SO

SHOULD BE ABOUT VALUE.. NOT THE BOTTOM LINE

HOW COULD LOCAL SERVICES IMPROVE?

ENSURE AUTISTIC PEOPLE DON'T GET STUCK IN LONG-TERM ACCOMODATION

DIAGNOSTIC PATHWAY is too medicalised
- BE CLEAR
- BE CONSISTENT
- BE USEFUL
- BE KIND
- BE TRANSPARENT

There's NO FORMAL ADULT DIAGNOSTIC PATH

TOO MANY PEOPLE ARE MISSED + FALL OUT OF SYSTEM

DON'T PENALISE FOR NOT APPEARING AUTISTIC ENOUGH

GET BETTER AT OFFERING SERVICES TO MAINSTREAM PUPILS AS WELL AS ASN BASE

TRANSITION SERVICES OPEN TO ALL

Don't underestimate the anxiety underlying a calm exterior. MASKING A "FIRE"

PLAN AHEAD

MUST NOT HAVE TO REACH CRISIS POINT TO GET SUPPORT

TAKE A Personal Sensitive APPROACH

In EDUCATION Its good if the HEADTEACHER is leading way

EDUCATION MUST BE PART OF THE STRATEGY

Guidelines aren't Sufficient

NEEDS TO BE EXPLICIT

Tailored.

TEACHERS MUST BE RESOURCED + SUPPORTED TO DO THIS

In SCHOOL SMALL CHANGES MAKE A HUGE DIFFERENCE

(eg enable typing work instead of writing it)

Being autistic isn't odd, or taboo

INSPIRE YOUNG PEOPLE, INFORM EMPLOYERS

As a professional autistic adult there is a lack of understanding from colleagues + other professionals

Autistic people can bring huge assets to EMPLOYMENT

until TRAINING is MANDATORY it will always be PATCHY

Professional training must be practically supported

As in England - Oliver McGowan Process

WHAT IS REQUIRED AT A LOCAL OR NATIONAL LEVEL TO HELP MAKE THESE IMPROVEMENTS HAPPEN?

Autism friendly vs all friendly

LISTEN TO, AND LEARN FROM AUTISTIC PEOPLE, PARENTS + CARERS

THEN FOLLOW THROUGH

PASS ON INFORMATION

ACT ON IT

MUST BE PRACTICAL NOT JUST THEORETICAL

US AT THE COAL FACE NEED TO BE INVOLVED

NATIONAL GUIDANCE/MANDATE

CAPACITY BUILDING SUPPORT FOR PARENT LED GROUPS

SUSTAINABLE FUNDING FOR SERVICES

ACCOUNTABILITY

JOINED-UP WORKING

STRATEGY DEVELOPMENT NEEDS TO COME FROM THE BOTTOM UP

MANDATORY TRAINING
FOR ALL HEALTH, SOCIAL CARE + EDUCATION STAFF

drawn by Jenny
WWW.MORETHANMINUTES.COUK
FEB 2021

Telephone Enquiries to ARCH 2018

January	February	March	April	May	June	July	August	September	October	November	December	Total
64	50	87	58	55	65	66	61	55	95	94	90	**840**

13

Telephone Enquiries to ARCH 2019

January	February	March	April	May	June	July	August	September	October	November	December	Total
88	104	78	60	104	319	159	179	126	161	136	68	**1582**

Telephone Enquiries to ARCH 2020

January	February	March	April	May	June	July	August	September	October	November	December	Total
120	110	93	65	70	100	107	130	137	119	112	42	**1,324**

Telephone Enquiries to ARCH 2021

January	February	March	April	May	June	July	August	September	October	November	December	Total
80	165	168	90	84+								

ARCH Visitors 2018

January	February	March	April	May	June	July	August	Septembe	October	November	December	Total
										620	372	**992**

ARCH Visitors 2019

January	February	March	April	May	June	July	August	Septembe	October	November	December	Total
496	434	434	620	378	485	586	606	468	667	719	406	**6299**

ARCH Visitors 2020

January	February	March	April	May	June	July	August	Septembe	October	November	December	Total
446	438	296	L'Down	L'Down	138	175	111	122	69	84	233	**2,112**

December included the COVID Socially Distance Santa Event for 60+ families.

ARCH Visitors 2021

January	February	March	April	May	June	July	August	Septembe	October	November	December	Total
L'Down	L'Down	80	60	111+								

ARCH Staff Emails 2020

January	February	March	April	May	June	July	August	September	October	November	December	Total	Staff
10	43	90	30	30	14	33	52	61	71	59		434	Liz

Staff Emails 2021

January	February	March	April	May	June	July	August	September	October	November	December	Total	Staff
10	43	90	30	30	14	33	52	61	71	59		434	Liz

Worshops and Activities in ARCH 2021

			Partner	SLCouncils	Autism Info	Parent	Total	Running
Month	**P & C S. Group**	**Adult Group**	**Workshops**	**Staff D.Days**	**College/NHS**	**Consultations**	Month	**Total**
January (ZOOM)	45	5				14	64	64
February (ZOOM)	45	5	26			15	91	155
March	55	2			4		61	216
April	35	4	4				43	259
May	38	4		IFS			42	
June								
July								
August								
September								
October								
November								
December								
TOTALS								

Workshops
Blake Stev. Consul.
Blake Stev. Consul.
Lanarkshire Carers
CAMHS
O.T. Toileting

Worshops and Activities in ARCH 2020

			Partner	SLCouncils	Autism Info	Parent
Month	**P & C S. Group**	**Adult Group**	**Workshops**	**Staff D.Days**	**College/NHS**	**Consultations**
January	77	20		12		
February	75	32	24	25	3	6
March (ZOOM)	70	15				
April (ZOOM)	25					
May (ZOOM)	52	8				
June (ZOOM)	40	12				
July (ZOOM)	57	8	15		5	6
August (ZOOM)	44	8	8			
September (ZOOM)	56	8	18		12	
October (ZOOM)	37	12	3		4	
November (ZOOM)	44	8	15			
December (ZOOM	64	12	24	12		
TOTALS	641	143	107	49	24	12

WORKSHOPS

Lifeskills
Sensory
Internet Safety
F. Fund -Ipad
F.Fund - Andriod
Promoting P.Relationships
P.O.A/Guardianship x 2
Family Fund
Social Security Scotland
LBGTQI

ARCH Visitors 2019

January	February	March	April	May	June	July	August	September	October	November	December	Total
496	434	434	620	378	485	586	606	468	667	719	406	**6299**

ARCH Visitors 2020

January	February	March	April	May	June	July	August	September	October	November	December	Total
446	438	296	L'Down	L'Down	138	175	111	122	69	84	233	**2,112**

ARCH Visitors 2021

January	February	March	April	May	June	July	August	September	October	November	December	Total
L'Down	L'Down	80	60	111+								

Telephone Enquiries to ARCH 2019

January	February	March	April	May	June	July	August	September	October	November	December	Total
88	104	78	60	104	319	159	179	126	161	136	68	**1582**

Telephone Enquiries to ARCH 2020

January	February	March	April	May	June	July	August	September	October	November	December	Total
120	110	93	65	70	100	107	130	137	119	112	42	**1,324**

Telephone Enquiries to ARCH 2021

January	February	March	April	May	June	July	August	September	October	November	December	Total
80	165	168	90	84+								

ARCH Mailing List Emails 2020

January	February	March	April	May	June	July	August	September	October	November	December	Total
		14,910	32,802	11,928	20,874	11,928	17,892	5,964	8,958	13,572	13,572	**138,828**
		10	22	8	14	8	12	4	6	9	9	**102**

ARCH Mailing List Emails 2021

January	February	March	April	May	June	July	August	September	October	November	December	Total
6,080	4,767	7,885	7,885	3,154+								
4	**3 + 5 x 20**	5	5	2								

Workshops/Support Groups 2020

January	February	March	April	May	June	July	August	September	October	November	December	Total
97	107	85	25	60	52	65	52	64	49	52	76	**784**

Workshops/Support Groups 2021

January	February	March	April	May	June	July	August	September	October	November	December	Total
64	91	60	41	42+								

Annual Emails	
2019	**1,800**
2020	**2,000+**
2021	

ARCH Mailing List Emails 2020

January	February	March	April	May	June	July	August	September	October	November	December	Total
		14,910	32,802	11,928	20,874	11,928	17,892	5,964	8,958	13,572	13,572	138,828
		10	22	8	14	8	12	4	6	9	9	102

ARCH Mailing List Emails 2021

January	February	March	April	May	June	July	August	September	October	November	December	Total
6,080												
4												

SMART PLAY 2019

	No: of Families	Total
21 November 2019	5	17
22 November 2019	7	22
28 November 2019	5	17
29 November 2019	8	8
05 December 2019	4	12
06 December 2019	6	13
12 December 2019	2	6
13 December 2019	7	18
	44	**113**

SAIL Visitors Wednesday Group - 2019

Week	January	February	March	April	May	June	July	August	September	October	November	December	Total
1	14	10	4	0	0	10	3	13	9	6			
2	12	14	7	0	13	19	0	8	15	3			
3	4	8	17	8	16	5	0	26	8	10			
4	6	12	0	13	10	9	6	10	0				
5							0						
Total	**36**	**44**	**28**	**21**	**39**	**43**	**9**	**57**	**32**	**19**			**328**
	8%	11.00%	9.00%	5.00%	8.00%	10.00%	4.50%	12.00%	8.00%	5.00%			8.00%

ARCH Summer Programme 2019

Week	July	August	Total
1	80	53	
2	100	74	
3	40	25	
4	154	138	
5	84	50	
6	84	46	
7	68	28	
Total	**610**	**414**	**1,024**

Agenda Item

14

Report

Report to:	**South Lanarkshire Integration Joint Board**
Date of Meeting:	**17 August 2021**
Report by:	**Interim Chief Officer, Health and Social Care Partnership**

Subject:	**Appointment of Depute Standards Officer**

1. Purpose of Report

1.1. The purpose of the report is to: -

- advise the Integration Joint Board of the requirement to appoint a Depute Standards Officer.

2. Recommendation(s)

2.1. The Board is asked to approve the following recommendation(s): -

(1) that the Board formally nominate Margaret Mary Cairns, Legal Services Manager, South Lanarkshire Council as Depute Standards Officer of the Integration Joint Board.
(2) that the Board note the responsibilities for the role as outlined at Appendix 1 and
(3) that the Board agree to the submission of the nomination to the Standards Commission for approval.

3. Background

3.1. In March 2016 the IJB adopted the Model Code of Conduct for Members of Devolved Public Bodies (as amended), which was created by the Ethical Standards in Public Life (Scotland) Act 2000. At that time Members were advised that Scottish Ministers were working on a standardised Code of Conduct for IJB Members (the Code of Conduct) which would be based on the Model Code and that all IJBs would be expected to adopt it subject to any amendments or branding of their choice approved by the Scottish Government.

3.2 On 28 June 2016 the IJB considered and adopted the Code which sets out a framework for members in the carrying out of their duties in order to meet the principles and requirements of the Ethical Standards in Public Life (Scotland) Act 2000.

3.3. The Code of Conduct for members of the South Lanarkshire Integration Joint Board was subsequently issued to Scottish Government for approval at the end of June 2016.

4. Standards Officer

4.1 The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Amendment Regulations 2003 requires a Standards Officer to be appointed for the IJB and sets out the statutory responsibilities for that Officer. In addition, the Standards Commission for Scotland produced guidance which outlined the role of the officer and the duties they might be expected to discharge. The guidance is not prescriptive as the Commission recognises that the Board will wish to have input to their internal governance arrangements.

4.3 On 13 September 2016 the Board formally nominated Geraldine McCann, a qualified solicitor, employed by South Lanarkshire Council as the Council's Head of Administration and Legal Services and the Council's Monitoring Officer and Jan Todd, a qualified solicitor employed by South Lanarkshire Council as a Legal Services Adviser as Standards Officer and Depute Standards Officer respectively. Both appointments were subsequently approved by the Standards Commission.

4.4 The Board also approved the key responsibilities of the Standards Officer and Depute Standards Officers which are outlined in Appendix 1 attached.

4.5 Jan Todd, Depute Standards Officer has retired from her position within the Council and therefore it is necessary to nominate another Officer to undertake this role. It is proposed that Margaret Mary Cairns, a qualified solicitor, employed by South Lanarkshire Council as Legal Services Manager be nominated to undertake the role of Depute Standards Officer and that this nomination is forwarded to the Standards Commission for approval.

5 Employee Implications

5.1 None.

6 Financial Implications

6.1 None.

7 Other Implications

7.1 The creation of the Standards Officer role is a statutory requirement and as such a failure to appoint a Standards Officer would be a breach of statutory duty.

7.2 There are no risk or sustainability issues in terms of the information contained within this report.

8. Equality Impact Assessment and Consultation Arrangements

8.1 This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function, or strategy and therefore no impact assessment is required.

8.2. There was also no requirement to undertake any consultation in terms of the information contained in this report.

Marianne Hayward
Interim Chief Officer, Health and Social Care Partnership

30 July 2021

List of Background Papers

- None

Contact for Further Information

If you would like to inspect the background papers or want further information, please contact: -

Geraldine McCann, Standards Officer
Ext: 4658 (Phone: 01698 454658)
Email: geraldine. McCann @southlanarkshire. gov.uk

Appendix 1

The South Lanarkshire Integration Joint Board
Standards Officer
Key Responsibilities.

1. The Standards Officer is responsible for ensuring that appropriate training is given or made available to Board Members on the Ethical Standards Framework, the Model Code of Conduct and any associated guidance issued by the Standards Commission.

2. The Standards Officer shall provide advice and support to Members on the interpretation and application of the Code of Conduct.

3. The Standards Officer shall be responsible for ensuring that the Integration Joint Board keeps and maintains a Register of Members Interests. The Standards Officer shall arrange for a reminder to be sent to all Members to update their Registers of Interests at least once per year.

4. The Standards Officer shall be responsible for ensuring that a Register of Gifts and Hospitality is established and maintained. The Standards Officer shall arrange for a reminder to be issued to all Members at least once per year to update the Register of Gifts and Hospitality.

5. The Standards Officer shall ensure that the Board has a method for obtaining and recording declarations of interest at the start of its meetings.

6. The Standards Officer may have an investigatory role if local resolution is attempted in respect of complaints or concerns about a member's conduct.

7. The standards Officer shall ensure that the Board's senior officers are aware of the requirements of the Members Code of Conduct.

8. The Standards Officer may be required to report to the Board on any matters relating to the Ethical Standards Framework that may require a review. Any concerns about compliance with the Code shall be reported to the Chief Officer.

9. The Standards Officer shall be the main point of contact for the Standards Commission and shall liaise with the Standards Commission whenever necessary in all matters relating to the Ethical Standards Framework including complaints.

10. The Standards Officer shall keep up to date with all relevant developments of the Ethical Standards Framework including trying to attend any events arranged by the Commission and reviewing the Professional Briefings and Case Decisions in order to appropriately advise Members.

11. The Standards Officer shall coordinate on behalf of the Board responses to any consultations issued by the Standards Commission in respect of the Code of Conduct or Guidance.