Notice of Meeting and Agenda
Renfrewshire Health and Social Care Integration Joint Board

Date	Time	Venue
Friday, 16 September 2016	09:30	Abercorn Conference Centre, Renfrew Road, Paisley, PA3 4DR

KENNETH GRAHAM
Clerk

Membership

Councillor Iain McMillan: Councillor Derek Bibby: Councillor Jacqueline Henry: Councillor Michael Holmes: Dr Donny Lyons: Morag Brown: John Legg: Dorothy McErlean: Karen Jarvis: Alex Thom: Liz Snodgrass: David Wylie: Alan McNiven: Helen McAleer: Stephen Cruickshank: John Boylan: Graham Capstick: David Leese: Sarah Lavers: Peter Macleod.

Councillor Iain McMillan (Chair) and Donny Lyons (Vice Chair)

Membership

Further Information

This is a meeting which is open to members of the public.

A copy of the agenda and reports for this meeting will be available for inspection prior to the meeting at the Customer Service Centre, Renfrewshire House, Cotton Street, Paisley and online at www.renfrewshire.cmis.uk.com/renfrewshire/CouncilandBoards.aspx

For further information, please either email democratic-services@renfrewshire.gov.uk or telephone 0141 618 7112.

Members of the Press and Public

Members of the press and public wishing to attend the meeting should report to reception where they will be met and directed to the meeting.

Items of business

Apologies

Apologies from members.

Declarations of Interest

Members are asked to declare an interest in any item(s) on the agenda and to provide a brief explanation of the nature of the interest.

11 Date of Next Meeting

Note that the next meeting of the Integration Joint Board will be held at 9.30 am on 25 November 2016 in the Council Chamber, Renfrewshire House, Cotton Street, Paisley.

Minute of Meeting
Renfrewshire Health and Social Care Integration Joint Board

Date	Time	Venue
Friday, 24 June 2016	12:30	Abercorn Conference Centre, Renfrew Road, Paisley, PA3 4DR

PRESENT

Councillors Iain McMillan, Derek Bibby, Jacqueline Henry and Michael Holmes (all Renfrewshire Council); Donny Lyons, John Brown, Donald Sime and Morag Brown (all Greater Glasgow & Clyde Health Board); Karen Jarvis (Registered Nurse); Stephen McLaughlin (Registered Medical Practitioner (GP)), Alex Thom (Registered Medical Practitioner (non-GP)); Liz Snodgrass (Council staff member involved in service provision); Alan McNiven (third sector representative); Helen McAleer (unpaid carer residing in Renfrewshire); John Boylan (trade union representative for Council staff); Graham Capstick (trade union representative for Health Board staff); and David Leese, Chief Officer and Sarah Lavers, Chief Finance Officer (both Renfrewshire Health and Social Care Partnership).

CHAIR

Councillor Iain McMillan, Chair, presided.

IN ATTENDANCE

Ken Graham, Head of Corporate Governance (Clerk), Scott McNeill, Service Manager (Care at Home) and Elaine Currie, Senior Committee Services Officer (all Renfrewshire Council); Fiona Mackay, Head of Planning & Health Improvement, Katrina Philips, Head of Mental Health, Addictions and Learning Disability Services, J Still, Head of Administration and J Higgins, Health and Social Care Integration Project Officer (all Renfrewshire Health and Social Care Partnership).

APOLOGIES

David Wylie (Health Board staff member involved in service provision); Stephen Cruickshank (service user residing in Renfrewshire) and Peter Macleod, Chief Social Work Officer (Renfrewshire Council).

DECLARATIONS OF INTEREST

Helen McAleer declared an interest in relation to item 12 of the agenda as Greensyde Carers had submitted an application for funding. She did not consider it necessary to leave the meeting.

Alan McNiven declared an interest in relation to item 12 of the agenda as Engage had submitted an application for funding. He did not consider it necessary to leave the meeting.

CHAIRMAN'S UPDATE

Councillor McMillan advised that since the last meeting of the IJB he had visited Renfrew Health Centre, Aranthrue Health Centre, Foxbar Health Centre and the Carers' Centre. He had also attended a meeting of the GP Forum. He advised that he was impressed by the work being carried out in the community with staff assisting service users with various problems. Further that David Leese, Chief Officer, kept him up-to-date with the progress being made on matters concerning the IJB at weekly meetings.

Councillor McMillan further advised that he had written to the Cabinet Secretary for Health and Sport, Shona Robison MSP expressing concern about the Health Board's financial contributions to the IJB and a copy of her response dated 23 June 2016 was tabled.

1 MINUTE

The Minute of meeting of the Integration Joint Board (IJB) held on 18 March 2016 was submitted.

DECIDED: That the Minute be approved.

2 UNAUDITED ANNUAL ACCOUNTS 2015/16

The Chief Finance Officer submitted a report relative to the unaudited annual accounts for the IJB for 2015/16, a copy of which formed the appendix to the report.

The report intimated that the annual accounts fully complied with International Financial Reporting Standards and would be submitted for audit by the statutory deadline of 30 June 2016. The Auditor planned to complete the audit process by early September 2016 and the report on the accounts would be made available to members and submitted to a future meeting of the IJB Audit Committee for consideration.

A summary of the total costs attributable to the IJB in its shadow year 2015/16 was detailed on page 12 of the accounts. As no services were delegated to the IJB in 2015/16 these costs related to the Chief Officer, Chief Finance Officer and Strategic Plan.

DECIDED:

(a) That, subject to audit, the unaudited annual accounts 2015/16 be approved; and

(b) That it be noted that the Auditor planned to complete the audit of the accounts by early September 2016 and that the report would be made available to members and submitted to a future meeting of the IJB Audit Committee for detailed consideration.

3 FINANCIAL REPORT 1 APRIL 2015 TO 31 MARCH 2016

The Chief Finance Officer submitted a report relative to the revenue and capital budget year-end position for the Health and Social Care Partnership (HSCP) for the 2015/16 financial year.

It was proposed that a report be submitted to the next meeting of the IJB to be held on 16 September 2016 relative to the underspend within Children's Health Services addressing the general nursing underspends within the specialist Panda Service; ongoing recruitment issues for psychologists within the Children and Adolescent Mental Health Services (CAMHS); and what was being done at a national level and Greater Glasgow and Clyde level around the problems associated with recruitment in the Psychology service. This was agreed.

DECIDED:

(a) That the year-end position for the Health and Social Care Partnership be noted; and

(b) That a report be submitted to the next meeting of the IJB to be held on 16 September 2016 relative to the underspend within Children's Health Services addressing the general nursing underspends within the specialist Panda Service; ongoing recruitment issues for psychologists within the Children and Adolescent Mental Health Services (CAMHS); and what was being done at a national level and Greater Glasgow and Clyde level around the problems associated with recruitment in the Psychology service.

4 RENFREWSHIRE INTEGRATION JOINT BOARD RESERVES POLICY

Under reference to item 3 of the Minute of the meeting of this Joint Board held on 18 March 2016 the Chief Finance Officer submitted a report relative to the Renfrewshire IJB Reserves Policy, a copy of which formed the appendix to the report.

The report intimated that the policy explained the purpose of holding a reserve; identified the principles to be employed by the IJB in assessing the adequacy of the reserves; detailed the role of the Chief Finance Officer with regards to reserves; indicated how frequently the reserves would be reviewed and the optimum level of reserves the IJB would aim to hold and set out arrangements relating to the creation, amendment and use of the reserves and balances.

Section 106 of the Local Government (Scotland) Act 1973 as amended, empowered the IJB to hold reserves which must be accounted for in the financial accounts. The IJB was entitled to hold reserves in order to meet the needs of the HSCP. As the IJB did not have any capital assets of its own it could only currently hold two types of reserves, a General Reserves and a Renewal and Repair Reserves. This position would change if the IJB held capital assets in the future.

The Chief Finance Officer was responsible for advising on the targeted optimum levels of reserves the IJB would aim to hold. Based on this advice, the IJB would approve the appropriate reserve as part of the annual budget setting process, depending on the level of resources available. In determining the level of reserves to be held, the Chief Finance Officer must take into account the strategic, operational and financial risks facing the IJB over the medium term and the IJB's overall approach to risk management. In light of the size and scale of the IJB's responsibilities, over the medium term the level of general reserves proposed was a maximum of 2% of the net budget of the IJB, depending on the year-end position and ability at that time to transfer monies into a reserve for future use.

The report proposed that authority for the use of IJB reserve funds up to a maximum of £500,000 be delegated to the Chief Finance Officer, in consultation with the Chief Officer, Chair or Vice-chair of the IJB. The use of each reserve would be reported to the next meeting of the IJB together with a description of the analysis and determination of the use of funds and where possible plans for replenishment to restore the level of reserves.

DECIDED:

(a) That the Renfrewshire IJB Reserves Policy, which formed the appendix to the report, be approved;

(b) That in the medium term, IJB reserves be set at a maximum limit of 2% of the net budget of the IJB and that the value of reserves be reviewed annually as part of the IJB budget and strategic plan and depending on the financial environment at that time;

(c) That authority for the use of IJB reserve funds up to a maximum of £500,000 be delegated to the Chief Finance Officer, in consultation with the Chief Officer and Chair and Vice-chair of the IJB; and

(d) That it be noted that the Chief Finance Officer would report the use of each reserve to the following meeting of the IJB accompanied by a description of the analysis and determination of the use of funds and where possible plans for replenishment to restore the level of reserves.

5 RENFREWSHIRE HSCP PERFORMANCE MANAGEMENT REPORT 2015/16

Under reference to item 5 of the Minute of the meeting of this Joint Board held on 18 March 2016 the Chief Officer submitted a report relative to the Renfrewshire HSCP Performance Management Report 2015/16.

The report intimated that a performance framework was required to ensure that the HSCP operated with informed, effective and efficient management of services and to provide a coherent picture of the outcomes achieved by the HSCP.

The report provided a final update on performance agreed at the meeting of the Joint Board held on 18 September 2015. A summary of performance progress against the nine national outcomes formed Appendix 1 to the report; a quarter four update on the agreed performance scorecard for 2015/16 formed Appendix 2 to the report and performance exception reports for all indicators which showed a red status formed Appendix 3 to the report.

The report detailed a proposed Performance Management Framework for 2016/17 which had been informed by Scottish Government guidance published in March 2016 and the views of IJB members and HSCP managers from the development session held on 12 May 2016.

It was proposed that the next update report contain information in relation to the following actions: HSCP/AS/AS/19 - number of carers' assessments completed for adults (18+); HSCP/AS/AS/20 - number of carers' assessments received for adults (18+); HSCP/AS/OT01 - percentage of clients on the OT waiting list allocated a worker within four weeks (Social Work only); HSCP/AS/OT04 - the average number of clients on the Occupational Therapy waiting list; CHP/CF/DD/01 - number of acute bed days lost to delayed discharges (including AWI); CHP/CD/DD/02 - number of acute bed days lost to delayed discharges for Adults with Incapacity; and HSCP/CS/H&S/01 - percentage of staff with completed Knowledge Skills Framework/Personal Development Plan (eKSF/PDP). This was agreed.

DECIDED:

(a) That the quarter four update on the 2015/16 performance scorecard, which formed Appendix 2 to the report, be noted;

(b) That it be noted that the indicators in the scorecard were reported at a number of frequencies and that information might not always be available at the end of a reporting period;

(c) That the 2016/17 Performance Management Framework, as detailed in the report, be noted; and

(d) That the next update report contain information in relation to the following actions:

HSCP/AS/AS/19 - number of carers' assessments completed for adults (18+);

HSCP/AS/AS/20 - number of carers' assessments received for adults (18+);

HSCP/AS/OT01 - percentage of clients on the OT waiting list allocated a worker within four weeks (Social Work only);

HSCP/AS/OT04 - the average number of clients on the Occupational Therapy waiting list;

CHP/CF/DD/01 - number of acute bed days lost to delayed discharges (including AWI);

CHP/CD/DD/02 - number of acute bed days lost to delayed discharges for Adults with Incapacity; and

HSCP/CS/H&S/01 - percentage of staff with completed Knowledge Skills Framework/Personal Development Plan (eKSF/PDP).

6 2016/17 CHANGE AND IMPROVEMENT PROGRAMME

The Chief Officer submitted a report confirming that, in line with the Public Bodies (Joint Working) (Scotland) Act, all the necessary processes, policies and plans were now in place to allow the formal closure of the 2015/16 Change and Improvement Programme.

The report intimated that with the exception of approving the IJB's 2016/19 Strategic Plan and 2016/17 Financial Plan, the 2015/16 Change and Improvement Programme had now been successfully delivered. The report proposed that the IJB agree the formal closure of this programme and that approval of the final Strategic and Financial Plans be carried forward into the 2016/17 work programme.

The report provided an overview of the HSCP 2016/17 Change and Improvement Programme which would deliver the in-year financial savings and pressure mitigation measures through more sustainable service delivery models, ensuring resources were focused on areas of greatest need and deliver the best outcomes for service users and establish a health and social care service which was managed and delivered through a single organisational model in order to optimise the benefits which could be derived from integration. The 2016/17 Change and Improvement Programme formed Appendix 2 to the report.

As the health budget to be delegated to the IJB had still to be finalised, the current programme of work did not take into account any further NHSGG&C saving targets beyond those already agreed that would need to be delivered during 2016/17 or future year targets from both parent organisations. Once the IJB's budget was finalised the Chief Officer would advise the IJB of the operational implications of any viable, deliverable and agreed health savings and the impact to current service delivery and performance levels. An updated 2016/17 Change and Improvement Programme would then be submitted to the IJB in line with the final 2016/19 Strategic Plan and 2016/17 integrated budget.

The 2016/17 Change and Improvement Programme would address a number of prioritised areas which would enable the IJB to mitigate a number of the key demographic and financial pressures identified within social care and these were detailed in the report. These prioritised areas reflected the national policy direction to shift the balance of care, promote independent living and ensure person-centred care. The service reviews would critically appraise and challenge current models of service delivery to ensure resources were focused on greatest need delivering the best outcomes for service-users. The findings of these reviews and supporting recommendations would be submitted to the IJB for consideration and direction.

The report detailed the work to be undertaken in order to optimise integrated working and the programme governance and delivery model arrangements. The Chief Officer advised that he would submit a report to the next meeting of the IJB to be held on 16 September 2016 relative to what was being done to embed a new level of engagement and culture within the HSCP.

Following a discussion on issues arising from the health budget delegation for the IJB not being finalised, the report was approved.

DECIDED:

(a) That the formal closure of the 2015/16 Change and Improvement Programme, which formed Appendix 1 to the report, be approved;

(b) That it be agreed that approval of the final 2016/19 Strategic Plan and 2016/17 Financial Plan would be carried forward into the 2016/17 work programme;

(c) That the 2016/17 Change and Improvement Programme, which formed Appendix 2 to the report, be approved and that it be noted that this would be subject to further review once the IJB's final 2016/19 Strategic Plan and 2016/17 integrated budget were finalised;

(d) That it be noted that the Chief Officer would submit regular reports to the IJB on the progress of the 2016/17 work programme;

(e) That it be noted that the findings of service reviews and supporting recommendations would be submitted to the IJB for consideration and direction; and

(f)That the Chief Officer submit a report to the next meeting of the IJB to be held on 16 September 2016 relative to what was being done to embed a new level of engagement and culture with the HSCP.

7 APPROVAL OF CODE OF CONDUCT AND APPOINTMENT OF STANDARDS OFFICER

The Chief Officer and the Clerk submitted a joint report relative to the approval of a Code of Conduct and the appointment of a Standards Officer for the IJB.

The report intimated that as a devolved body, the IJB was required to produce a Code of Conduct setting out how members should conduct themselves in undertaking their duties. The Scottish Government had produced a model Code of Conduct for use by IJBs, a copy of which formed Appendix 1 to the report, and the report proposed that Renfrewshire IJB adopted the model code.

The IJB was also required to appoint a Standards Officer and at the meeting of this Joint Board held on 18 March 2016 the IJB agreed that Renfrewshire Council's Head of Corporate Governance would perform the role of Standards Officer, subject to approval by the Standards Commission for Scotland. The required approval had now been received and a copy of the letter from the Standards Commission for Scotland formed Appendix 2 to the report.

One of the duties of the Standards Officer was to maintain a register of interests of members of the IJB. This would be a separate register from the ones members would have with their constituent authorities and the report set out the arrangements for the register of interests.

It was proposed that the non-voting members should also complete the register of interests.

DECIDED:

(a) That the model Code of Conduct, which formed Appendix 1 to the report, be approved for adoption by the IJB;

(b) That it be noted that the Standards Commission for Scotland had approved the appointment of Renfrewshire Council's Head of Corporate Governance as the Standards Officer for the IJB;

(c) That the arrangements, as set out in section 6 of the report, for the establishment and maintenance of a register of interests for members of the IJB be noted; and

(d) That the non-voting members of the IJB should also complete the register of interests.

8 CARER CHAMPION

The Chief Officer submitted a report relative to the establishment of the role of Carer Champion for Renfrewshire.

The report intimated that Renfrewshire HSCP acknowledged the significant role carers played and recognised them as partners in the delivery of care. Supporting carers was a key priority at a local and national level. The recent Scotland's Carers publication noted that 17,760 people in Renfrewshire identified themselves as carers.

Renfrewshire's Carer Strategy 2013/16 recognised the good work and the support available locally to support carers in their caring role but acknowledged that more needed to be done. The establishment of the role of Carer Champion for Renfrewshire would provide a focus for promoting the carer agenda which would be set out in the new Renfrewshire Carer Strategy.

It was proposed that consideration of this report be continued to a future meeting of the IJB and this was agreed.

DECIDED: That consideration of the report be continued to a future meeting of the IJB.

9 CHILDREN AND YOUNG PEOPLE (SCOTLAND) ACT 2014 - GETTING IT RIGHT FOR EVERY CHILD

The Chief Officer submitted a report relative to Parts 4, 5 and 18 of the Children and Young People (Scotland) Act 2014 – Getting it Right for Every Child (GIRFEC).

The report detailed the progress made within Renfrewshire to comply with the legal duties under those Parts of the Act by 31 August 2016 and in particular in relation to a Named Person made available to every child 0 to 18 years (and beyond if still in school); the legal requirement to share information with the Named Person as appropriate; and a single system for assessment and planning through a Child's Plan.

The report intimated that the duties in the Act fell on organisations and not on individual members of staff, however, the duties would require to be carried out by practitioners delivering services on behalf of the relevant organisation.

It was proposed that a more detailed report covering all aspects of the Children and Young People (Scotland) Act 2014 be submitted to the next meeting of the IJB to be held on 16 September 2016. This was agreed.

DECIDED:

(a) That the progress made to implement Parts 4, 5 and 18 of the Children and Young People (Scotland) Act 2014 concerning Getting it Right for Every Child be noted; and

(b)That a further report covering all aspects of the Children and Young People (Scotland) Act 2014 be submitted to the next meeting of the IJB to be held on 16 September 2016.

10 CARE AT HOME SERVICES

The Chief Officer submitted a report providing members of the IJB with a position statement on the Care at Home Services, highlighting the key challenges being faced by the service and outlining work currently underway to mitigate them and develop the service for the future.

The report intimated that work was underway to bring forward developments within the service to modernise it for the future. The Chief Officer had agreed that the service would receive additional investment from the Integrated Care Fund and this would be used to pilot changes and shape developments in the service.

An Improvement Action Plan had been established and the report detailed the work being undertaken in relation to each of the key themes of workforce planning and development; developing the business case for a Care at Home management, rostering and monitoring system; review of business processes and service pathways; review of supervision and management capacity; and alignment with new geographic boundaries and considering opportunities for streamlining and integrating service delivery.

DECIDED: That the report be approved and that it be noted that the Chief Officer would submit further reports to the IJB to update members on progress within the Care at Home service.

11 HOSPICES IN RENFREWSHIRE

The Chief Officer submitted a report relative to Hospices in Renfrewshire. The report intimated that Renfrewshire HSCP's Integration Scheme noted that among the services currently provided by the Health Board which were to be integrated were 'palliative care services provided outwith a hospital'.

Hospices played an important role in the provision of local palliative care services and worked in partnership with primary care, district nurses and other third sector organisations. There were two hospices in Renfrewshire where services had previously been planned and commissioned through NHS Greater Glasgow and Clyde Health Board. From 1 April 2016 this responsibility lay with Renfrewshire HSCP and the HSCP would identify a palliative care lead.

Accord Hospice in Paisley has eight beds and provided 15 day places over four days and St. Vincent's Hospice in Howwood has eight beds and provided 10 day places over three days. Both hospices provided a range of other related services such as outpatients, community nurse specialists, AHP services, complementary therapies, bereavement services, training and education.

Funding was governed by CEL(12) 2012 which required health boards to meet 50% of the agreed hospice running costs. Service Level Agreements had been agreed and signed by both hospices covering the period to March 2018.

The report detailed the current arrangements and future arrangements in relation to the hospices and the next steps to be taken.

DECIDED:

(a) That the new arrangements for the planning and commissioning of hospice services be noted; and

(b) That the next steps, as detailed in section 5 of the report, be agreed.

DECLARATIONS OF INTEREST

Helen McAleer and Alan McNiven having declared interests in the following item of business remained in the meeting.

12 **SECTION 10 GRANTS TO VOLUNTARY ORGANISATIONS - APPLICATIONS 2016/17**

The Chief Officer submitted a report relative to applications received for funding for 2016/17 under Section 10 of the Social Work (Scotland) Act 1968. Following the integration of health and adult social care services, this report related to funding applications from organisations whose work was primarily with adults. A separate report relating to children and young people would be considered by Renfrewshire Council's Education and Children Policy Board.

A total of 18 organisations had submitted grant applications for Section 10 funding, 16 of these relating to work with adults. Details of the applications were provided in Appendix 1 to the report. It was proposed that funding amounting to £28,650 be awarded to the 13 organisations as detailed in Appendix 1. Appendix 2 to the report detailed the criteria and process for approval of Section 10 funding.

DECIDED: That the funding in respect of the organisations detailed in Appendix 1, totalling £28,650, be approved as follows:

Renfrewshire Sound – Awarded £1,700

Wednesday Social Club – Awarded £500

Renfrewshire Access Panel – Awarded £930

Barnardo's – Awarded £2,100

Cornerstone Drop In – Awarded £500

Cotton Club – Awarded £500

Engage – Awarded £9,900

Forever Young (Intergenerational Quiz) – Awarded £800

Greensyde Carers – Awarded £499

Music In Hospitals – Awarded £321
Renfrewshire Seniors Forum – Awarded £2,900

Renfrewshire Visually Impaired Forum – Awarded £1,000

Victim Support – Awarded £7,000

Cairn Heights – Declined

Deafblind Scotland – Declined

BEI Lunch Club - Declined

13 **RISK MANAGEMENT UPDATE**

Under reference to item 16 of the Minute of the meeting of the IJB held on 18 March 2016 the Chief Officer submitted a report relative to the risk management arrangements to reflect the strategic and operational responsibilities of the HSCP. The risk register formed Appendix 1 to the report and the risk matrix formed Appendix 2 to the report.

The report intimated that the risk register had been prepared in accordance with the Risk Management Policy and Strategy approved by the IJB at its meeting held on 18 September 2015. Both Renfrewshire Council and NHS Greater Glasgow and Clyde would continue to apply their existing policies and systems for risk management.

It was proposed that the final risk register be submitted to the IJB once the final budget was known.

DECIDED:

(a) That it be agreed that the Chief Officer and senior management team monitor and manage the risk register on a monthly basis and that summarised reports be submitted to the IJB twice-yearly;

(b) That the HSCP risk register, which reflected the HSCP's strategic and operational responsibilities in relation to the delivery of health and adult social care services from 1 April 2016, be approved; and

(c) That the final risk register be submitted to the IJB once the final budget was known.

14 AUDIT COMMITTEE - MEMBERSHIP AND DEPUTE CHAIR POSITION

Under reference to item 6 of the Minute of the meeting of the IJB held on 18 March 2016 the Chief Officer submitted a report relative to the appointment of a Depute Chair to the Audit Committee and seeking nomination of a sixth and final representative from the non-voting membership of the IJB so sit on the Audit Committee.

The report proposed that Councillor Derek Bibby be considered and nominated as the Depute Chair of the Audit Committee and this was agreed. The non-voting members were requested to consider nominating a second representative to the Audit Committee. It was proposed that the Chief Officer contact the non-voting members of the IJB to establish if any of them wish to sit on the Audit Committee and this was agreed.

DECIDED:

(a) That Councillor Derek Bibby be appointed as Depute Chair of the Audit Committee; and

(b)That the Chief Officer contact the non-voting members of the IJB to establish if any of them wish to sit on the Audit Committee.

15 FINANCIAL REPORT 1 APRIL TO 31 MAY 2016

The Chief Finance Officer submitted a report relative to the revenue and capital budget positions from 1 April to 27 May 2016 for Social Work and from 1 April to 31 May 2016 for the Health Board, as detailed in Appendix 1 to the report.

The key pressures were highlighted in sections 4 and 5 of the report. The report provided an update on implementation of the Living Wage; adult social care charging; Integrated Care Fund proposed governance arrangements; and the health board's contribution to the IJB.

Information relating to changes in buffers, tapers, savings, personal allowances, free personal care payments and any fixed chargeable services were detailed in Appendix 2 to the report; the care at home rates for 2015/16 and 2016/17 were detailed in Appendix 3 to the report; details of the uplifts for pays, non-pays and prescribing growth in 2016/17 were detailed in Appendix 4 to the report; and the Scottish Government guidance to support delivery of the Living Wage commitment which confirmed that the fund applied only to care workers providing direct care and support to adults in care homes, care at home and housing support services formed Appendix 5 to the report.

The overall revenue position for the HSCP at 31 May 2016 was a breakeven position but this position might change pending the outcome of the NHSGG&C financial planning process for 2016/17. The Chief Finance Officer had made a number of assumptions in the current projections being that for all delegated health services the same level of funding as 2015/16 would be transferred to the HSCP, less the current agreed savings of £496,000; a reduction in property costs reflecting the transfer of responsibilities for facilities management budgets to the NHSGG&C Board; and

increases reflecting the changes to uplifts for pays, non-pays and prescribing growth in 2016/17.

DECIDED:

(a)That the financial position to date be noted and that it be noted that the overall financial position might change depending on the outcome of the NHSGG&C financial planning process for 2016/17;

(b)That the progress made on the financial planning process for 2016/17 be noted;

(c)That the progress of the Living Wage Implementation Project be noted;

(d)That the changes to the HSCP's Adult Social Care financial assessment and charging framework for 2016/17 be noted;

(e)That the progress with the financial planning process for 2016/17 in respect of the NHSGG&C contribution to the IJB be noted; and

(f)That the Chief Officer submit a report to the next meeting of the IJB to be held on 16 September 2016 detailing all currently funded Integrated Care Fund (ICF) projects, planned spend for 2016/17, terms of reference and membership details of the HSCP ICF group.

16 **DATE OF NEXT MEETING**

DECIDED: That it be noted that the next meeting of the IJB would be held at 9.30 am on 16 September 2016 in the Abercorn Conferencing Centre, West College Scotland Paisley Campus, Renfrew Road, Paisley.

To: **Renfrewshire Integration Joint Board**

On: **16 September 2016**

Report by: **Chair**

Heading: **Chairman Update**

1. Summary

1.1 The first year (2015/16) of the IJB focussed primarily on working through the legal requirements and the development of a number of key strategies and policies which were vital in shaping and defining our new organisation.

1.2 As Chairman I considered it equally important that I undertake a programme of site and service visits to gain a better insight and understanding of the range of services and related issues facing the IJB. I wanted to hear directly from frontline staff about the work they do as well as some of the challenges they are facing.

2. Recommendation

It is recommended that the IJB:

- Note the content of the Chairman's report.

3. Background

3.1 As I have been part of Local Authority for a number of years and have a good knowledge of Social Work Adult Services, I particularly wanted to learn about the Health side of the business also. I wanted to initiate a programme of visits that would bring me into direct contact with frontline staff to introduce myself, to hear from them how the HSCP delivers its business in particular the challenges, the things we do well and where we can improve.

3.2 Visits to a range of services in the HSCP were planned, where possible, as part of pre-arranged team meetings. The schedule of visits undertaken to date are set out below:

Service	Date	Venue
Health Visiting	12 May 2016	Foxbar Clinic
Rehabilitation and Enablement Service (RES)	19 May 2016	Aranthrue Centre
Family Nurse Partnership (FNP)	2 June 2016	Renfrew Health & Social Work Centre
Community Mental Health Team (CMHT)	1 August 2016	Charleston Centre

District Nursing	23 August 2016	Linwood Health Centre
Community Mental Health Team Leaders	24 August 2016	Mile End Mill
Renfrewshire Learning Disability Service (RLDS)	30 August 2016	Spinners Gate Resource Centre
Inpatient Mental Health Services (RAH)	6th September 2016	RAH

3.3 During my visits I was struck by the enthusiasm and commitment of the staff. It was encouraging to hear about the many things we are doing well including:

- Family Nurse Partnership - staff described the strengths based approach and the positive outcomes achieved through delivery of the programme. They also described the benefits of good working relationships with some of the newer initiatives in the area such as Families First.
- Health Visiting - staff provided an overview of how the new technology and implementation of the new EMIS web system was of benefit, even with some of the frustration experienced around connectivity. They also acknowledged how well the interface between health and local authority Children's Services is working and the benefits of accessing Families First and other local initiatives to improve the outcomes for children.
- District Nursing - staff described the benefits of new technology and the application of a range of pathways of care. They also discussed opportunities for new ways of working with other adult services and with Acute Hospital Services.
- Rehabilitation and Enablement Services - staff provided an overview of how joint working/integration is developing and the opportunities for further development in particular the value in co-location of services.

3.4 Some of the challenges described by services include:

- the increasing demand across all services and the impact of this on services already operating at full capacity.
- the positive elements of new technology implemented but also challenges associated with the equipment and connectivity.
- staff concern around increasing time spent on administrative tasks.
- challenges around the accommodation used in relation to the layout, how others use the buildings and the capacity in some buildings.

3.5 In addition I attended a meeting of the HSCP GP Forum. This includes a representative GP from each of our 29 General Practices in Renfrewshire. At this meeting I heard of the operational issues faced by GPs and of how working within the emerging HSCP was progressing. Separately on today's IJB meeting you will hear from the Chief Officer regarding our development work with GP practices regarding 'cluster working' – a central change to the 2016/17 GP contract and a central change to how we are developing our ways of working to optimise the benefits of health and social care being managed and delivered through a single organisational model.

3.6 From each of these visits, I have worked closely with the relevant Head of Service to ensure that issues raised are followed up and that there is appropriate feedback to the staff regarding these issues including what actions are being taken to address or progress actions.

3.7 In terms of next steps, I have worked with the Chief Officer to agree an ongoing programme of site and service visits until the end of March 2017 and these will include the Vice-Chair wherever possible. I will ensure a further report comes back to the IJB early in 2017 updating on the detail of the programme and feeding back on issues raised. The next phase of the programme will include a visit to the Care at Home Service, a session with addiction service staff and with the health improvement team. I also hope to arrange to spend time within a General Practice.

3.8 I believe this programme has been vital to raising the profile and visibility of the Chairman's role within the IJB and has personally been central to helping me understand much more about our services. The new Chairman and Vice Chairman will, I believe, benefit from such a programme throughout 2017/18 and I know the Chief Officer is planning to put such a programme in place.

Implications of the Report

1. **Financial - none**
2. **HR & Organisational Development – none**
3. **Community Planning – none**
4. **Legal – none**
5. **Property/Assets – none**
6. **Information Technology – none**
7. **Equality & Human Rights - T**he recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.
8. **Health & Safety – none**
9. **Procurement –none**
10. **Risk – none**
11. **Privacy Impact** – None. The information to be made available via the Publication Scheme is information which would be disclosed in response to a request under the Freedom of Information (Scotland) Act 2002. This therefore would not include Personal Data as defined by the Data Protection Act 1998.

List of Background Papers – none.

Author: Councillor Iain McMillan

To:	**Renfrewshire Integration Joint Board**
On:	**16 September 2016**
Report by:	**Head of Administration**
Heading:	**Changes to Membership of the Integration Joint Board and Development Sessions for 2016/17**

1. Summary

1.1. The purpose of this report is to confirm changes of membership of the Integration Joint Board (IJB) and proposed arrangements for development sessions for members during 2016/17.

1.2. On 16 August 2016, the NHS Greater Glasgow & Clyde Health Board considered a report regarding amendments to Committee and IJB Memberships across the NHSGGC area.

1.3. Within this report it confirmed changes to the Voting Members for Renfrewshire IJB in that Mr John Brown and Mr Donald Sime will be replaced by Mr John Legg and Ms Dorothy McErlean respectively.

1.4. It is intended that these new arrangements will take effect from 16 August 2016.

1.5. In addition to the above, Dr Stephen McLaughlin has resigned from the post of Clinical Director in Renfrewshire HSCP and therefore from his non-voting position (representing a Medical Practitioner/GP) on the Renfrewshire IJB.

1.6. Arrangements are in place to recruit to the Clinical Director position. In the interim period Dr Christopher Johnstone and Dr Aileen van der Lee (Associate Clinical Directors) will cover the role. It is proposed that Dr Johnstone will attend Renfrewshire IJB meetings in the interim period.

Development Sessions 2016/17

1.7. A paper was submitted to the Shadow IJB on 20 March 2015 setting out a proposed development approach for members.

1.8. Throughout 2015/16, a number of development sessions took place with IJB members to begin taking forward the development programme.

1.9. Following discussion with IJB members, a further series of development sessions are set out in the table below. A programme for each session will be shared with members approximately two weeks in advance of each session.

Date	Time	Venue
28 October 2016	1pm to 3pm	Abercorn Conference Centre West College Scotland
13 January 2017	1pm to 3pm	
3 February 2017	9am to 11am	

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2. Recommendation

It is recommended that the IJB:

- Note the changes to the substantive membership.
- Approve the proposed arrangements for IJB Development Sessions for 2016/17.

Implications of the Report

1. **Financial –** None
2. **HR & Organisational Development** – None
3. **Community Planning** - None
4. **Legal –** None.
5. **Property/Assets –** None
6. **Information Technology –** None
7. **Equality & Human Rights –** The recommendations containted within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be publised on the Council's website.
8. **Health & Safety –** None
9. **Procurement** – None
10. **Risk** – None
11. **Privacy Impact** – None

List of Background Papers – NHSGGC Revised Committee and IJBs Membership (16 August 2016) http://www.nhsggc.org.uk/media/238759/nhsggc_board_paper_16-50.pdf

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Author: Jean Still, Head of Administration

To: **Renfrewshire Integration Joint Board**

On: **16 September 2016**

Report by: **Chief Officer**

Heading: **Carer Champion**

1. Summary

1.1 Renfrewshire HSCP acknowledges the significant role carers play and recognises them as partners in the delivery of care. Supporting carers is a key priority at a local and national level. According to the recent 'Scotland's Carers'[1] publication 17,760 people in Renfrewshire identify themselves as carers.

1.2 Renfrewshire's Carer Strategy 2013-16, recognised the good work and the support available locally to support carers in their caring role, but acknowledged that more needs to be done. The establishment of the role of Carer Champion for Renfrewshire will provide a focus for promoting the carer agenda, which will be set out in the new Renfrewshire Carer Strategy, across Renfrewshire.

2. Recommendations

It is recommended that the IJB approve:

- The establishment of the role of Carer Champion for Renfrewshire;
- The proposal that the role of Carer Champion should have autonomy from the Integrated Joint Board; and
- The proposal that the current Provost fulfil the role of Carer Champion until 31 March 2017.

3. Background

Local Context

3.1 The Renfrewshire Carer Strategy 2013-16 acknowledges the significant role carers play in supporting the people they care for and recognises carers as partners in the delivery of care. According to the recent 'Scotland's Carers'[2] publication 17,760 (10%) people in Renfrewshire identify themselves as carers, however the census also demonstrates a

[1] http://www.gov.scot/Publications/2015/03/1081
[2] http://www.gov.scot/Publications/2015/03/1081

considerable shift towards high intensity caring based on the number of hours each week that people provide unpaid care.

3.1.1 The Strategy recognises the significant amount of work being driven locally by a partnership which includes local carers, Renfrewshire Carers Centre, Renfrewshire HSCP, the Council, and other local voluntary organisations. Key developments and achievements include:

- Supporting the identification young carers in schools;
- Supporting young adult carers as they move into further education;
- Support for early identification and better information for carers;
- Support for specialised carer support groups;
- Increased respite provision.

National Policy Context

3.2 The Carers (Scotland) Act received Royal Assent on the 9th March 2016. The Act covers a range of areas relating to supporting carers including a number of new duties and requirements which impact on the HSCP. The Act:

- changes the definition of a carer to a carer is "an individual who provides or intends to provide care for another individual".
- gives local authorities a duty to prepare an adult care and support plan (ACSP) or young carer statement (YCS) for anyone they identify as a carer, or for any carer who requests one. The ACSP and YCS replace the existing Carer Assessment.
- gives local authorities a duty to provide support to carers that meet local eligibility criteria.
- requires local authorities and NHS boards to involve carers in carers' services.
- requires local authorities to establish and maintain advice and information services for carers.
- introduces the requirement for a timescale for preparing a support plan for the carer of a terminally ill person.
- provides a joint duty for both health boards and local authorities to create local carer strategies.
- introduces the requirement for carers to be involved in the hospital discharge procedures of the person they care for.
- provides a requirement for an adult carer support plan or young carer statement to include emergency plans.
- provides a requirement for Scottish Ministers to prepare a Carers Charter.

3.3 The Self-directed Support Act introduced a new power to provide support to the carer; support which helps to address the carer's needs to continue in their caring role. Where such support is provided, the same options should be offered to the carer for their support as are provided to service users.

Role of Carer Champion

3.4 There is a broad network of organisations supporting carers in Renfrewshire and the role of carer champion will not sit in isolation. It is proposed that the role of the Carer Champion will include:

- articulating the collective views of the wider carer population within Renfrewshire and speak on carer issues.
- being consulted and involved in the development of policies and practice that affect carers.
- raising the profile of unpaid carers with a view to influencing and developing strategies and policies which will make life better for carers and those they support, including across the HSCP, the Council, and Community Planning.
- raising the profile of unpaid carers at a national level with the Scottish Government and the range of National Carer Organisations.
- leading the Carer Strategy Group to develop and implement the new Renfrewshire Carer Strategy and report progress to relevant Boards.
- publicising initiatives which support carers to continue in their caring role, including the breaks for carers funded through the HSCP's Louden Trust Fund.

3.5 The Carer Champion should be someone who has a recognised profile within the Renfrewshire Community and will be seen to have some independence from the Integrated Joint Board. The current Renfrewshire Provost has been recognised as an advocate for carers and would be prepared to fulfil this role on an interim basis. These arrangements will be reviewed at the end of March 2017.

3.6 Following appointment, there will be the opportunity for the Carer Champion to meet with local carers to discuss any issues they are experiencing relating to their caring role as well as what works well and keeps them supported to continue to care.

Implications of the Report

1. **Financial –** None.
2. **HR & Organisational Development –** None.
3. **Community Planning –** None.
4. **Legal –** None.
5. **Property/Assets –** None.
6. **Information Technology –** Managing information and making information available may require ICT input.
7. **Equality & Human Rights -** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights.

No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.

8. **Health & Safety –** None.
9. **Procurement –** None.
10. **Risk –** None.
11. **Privacy Impact** – None. The information to be made available via the Publication Scheme is information which would be disclosed in response to a request under the Freedom of Information (Scotland) Act 2002. This therefore would not include Personal Data as defined by the Data Protection Act 1998.

List of Background Papers – None

Author: Ian Beattie, Head of Health and Social Care (Paisley)

To:	**Renfrewshire Integration Joint Board**
On:	**16 September 2016**
Report by:	**Chief Finance Officer**
Heading:	**Financial Report 1st April 2016 to 31st July 2016**

1. Purpose

1.1. The purpose of this report is to advise the Integration Joint Board (IJB) of the Revenue and Capital Budget current year position as at the 24th July 2016 (Social Work) and 31st July 2016 (Health), and to provide an update on:

1.2.

- Health Board Contribution to the IJB
- Implementation of the Living Wage
- Financial planning proposals for budget setting
- Integrated Care Fund (ICF) proposed governance arrangements

2. Recommendation

It is recommended that the IJB note:

- The financial position to date is an overspend of £457k with a potential full year adverse variance of £1.378m;
- The NHSGGC budget allocation for 2016/17 including the notional Set Aside budget for 2016/17;
- The due diligence work update on the Health Board Contribution to the IJB which has highlighted areas of financial risk to the Health Care budget allocation for 2016/17;
- At this point there are no approved plans are in place to deliver against the health services savings gap of £1.378m which accounts for the reported overspend position reported in the first quarter of this financial year and the potential full year adverse variance;
- The forecast position for the remainder of the financial year assumes the overspend position will continue unless service changes and cost reductions are achieved;
- That the NHS Board has identified that non-recurring funding is available to offset the in-year shortfall against savings targets and that discussions are underway to determine how non-recurring funding will be allocated to Partnerships within this financial year thereby reducing the potential in-year overspend;
- The progress of the Living Wage Implementation Project;
- The establishment of a HSCP strategic integrated service and financial planning model; and
- The proposed ICF governance arrangements.

It is recommended that the IJB:

- Approve that cost savings options to restore recurring financial budget balance to the Health budget in 2016/17 will be presented to the HSCP for review in November 2016.
- Request an additional one-off payment by NHSGGC to fund any identified shortfall due to the impact of unallocated savings.
- Request written assurance from the Director of Finance for NHSGGC that no future savings targets will be applied in respect of the 2015/16 unallocated savings of £7.8m.
- Delegate authority to the Chief Officer to issue updated Directions on their behalf, as required.

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3. Summary

3.1. The overall revenue position for the HSCP at 31st July 2016 is an overspend of £457k as detailed in the table below (and Appendix 1), with a projected year-end adverse variance of £1.378m.

Division	Current Reported Position	Previously Reported Position
Social Work – Adult Services	£2k underspend	Breakeven
Renfrewshire Health Services	£459k over spend	Breakeven
Total Renfrewshire HSCP	**£457k overspend**	**Breakeven**

3.2. The key pressures are highlighted in section 4 and 5.

3.3. Appendix 2 provides a reconciliation of the main budget adjustments applied this current financial year to bring us to the net budget as reported.

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4. <u>Social Work – Adult Services</u>

Current Position: **Net underspend £2k**
Previously Reported: **Breakeven**

4.1 **Older People**
Current Position: Net underspend of £79k
Previously Reported: Net overspend of £4k

Currently, the position within Older People is an underspend. This underspend has been achieved by the use of resources from the integration monies allocated by the Scottish Government for Adult Social Care for 2016/17. As previously reported, there are significant and increasing pressures within the care at home service despite additional funding being invested by the Council in the service as part of the 2016/17 budget process. In order to achieve a breakeven position within the homecare service in 2016/17, further investment of £1.1m in the current year is required.

A report was presented to the IJB on 24th June 2016 which included a position statement on the Care at Home service, and, proposals for the modernisation of the service. The report highlighted the need for an appropriate ICT system to support the service and outlined work that was in progress to finalise a business case for a Care at Home Management, Monitoring and Scheduling system. The business case has now been approved and work is underway to develop a tender for a suitable system with implementation scheduled to commence during 2017/18.

It is anticipated that the introduction of this technology will realise a number of benefits and will result in efficiencies that will assist with the current financial pressures experienced within the service. The costs of the proposed system

and its implementation will be met from the planned slippage of the 2015/16 Integrated Care Fund allocation.

4.2 **Physical Disabilities**

Current Position:	Net overspend of £121k
Previously Reported:	Net overspend of £5k

As previously reported, this overspend is due to increases in the purchase of equipment to support service users to stay in their own homes reflecting the shift in the balance of care to the community and their associated needs. This increase reflects the well documented impact of changing demographics where more people with complex needs require support. In addition, pressures are emerging within the Adult Placement budget due to the impact of Self Directed Support (SDS) as detailed in paragraph 4.5

4.3 **Learning Difficulties**

Current Position:	Net underspend of £82k
Previously Reported:	Breakeven

As part of the 2016/17 budget allocation for adult social care, Renfrewshire Council invested £170k in Learning Difficulties day services in order to meet growing demand for the future, specifically in relation to transitions. Due to the timescales required to undertake the feasibility process associated with changes to the physical environment and the recruitment of staff there has been limited call on the budget to date, however from September 2016 onwards staff will be in post and service changes undertaken as the redesign moves forward in preparation to enable services meet demand in 2017 onwards.

This underspend offsets pressures within their Adult placement budget due to the impact of SDS along with increased demand on the service as detailed in 4.5.

4.4 **Mental Health**

Current Position:	Net overspend of £36k
Previously Reported:	Breakeven

As detailed in 4.5, the overspend within Mental Health Services relates to pressures within the Adult Placement budget reflecting both the impact of increasing demand and SDS.

4.5 **Self Directed Support (SDS)**

In line with current legislation, all clients who have been assessed as requiring support from adult social care are given a number of options regarding how they wish their care to be provided:

- **Option 1:** The person chooses to take the budget as cash via a direct payment (Direct Payment)
- **Option 2:** The person chooses to select their support and have the local authority make arrangements to provide it on their behalf (Directing the Available Support)
- **Option 3:** The person chooses to have the local authority select their support and make arrangements to provide it on their behalf (Arranged Services)

- **Option 4:** The person chooses a mix of the above options for different types of support (Mixed Package).

To enable us to fund those packages where a client chooses either Option 1 or 2, the budget is removed from the council service that would normally have provided that element of the care package. This affects our day care services, external and internal home care, and adult placement and respite budgets. For day care, internal homecare and older people's respite, the budgets which fund options 1 and 2 are payroll budgets. Therefore, as the number of clients choosing options 1 and 2 increases these services will become less financially sustainable. Prior to the introduction of SDS, demand for services such as Day Care was limited by the availability of places whereas now their SDS budget is made available to them more immediately. Previously, SDS services users had fewer options to choose from and may have declined a service such as day care. SDS now enables people to tailor their interventions and in so doing receive social care funding they might not have accessed previously. Whilst this is a positive development it adds to the real and growing pressures on the budget.

As part of the 2016/17 budget allocation for adult social care Renfrewshire Council invested £220k in the adult placement budget, however, due to the rising pressures within this budget, as detailed above, the current projected overspend position is being managed through the use of non-recurring monies which will only be available in the current year. As part of our planning for next year, we will consider how these demand and cost led pressures can be mitigated and managed in 2017/18

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5. Renfrewshire Health Services

Current Position: **Net overspend (£459k)**
Previously Reported: **Breakeven**

5.1 Addiction Services

Current Position: Net underspend of £34k
Previously Reported: n/a

Currently, the net position within Addiction Services is an underspend due to vacancies within the medical cohort of staff. These are currently being recruited to.

5.2 Adult Community Services *(District and Out of Hours Nursing; Rehabilitation Services, Equipu and Podiatry)*

Current Position: Net underspend of £53k
Previously Reported: Net underspend of £62k

This net underspend is due to a number of contributory factors: within District nursing and the rehabilitation services there are a number of vacancies which are actively being recruited to. In addition, there is an underspend within the podiatry service due to the impact of maternity leave, vacancies and career breaks some of which are covered by bank staff. These underspends offset pressures in relation to the community equipment budget (EQUIPU), travel costs and enteral feeding related costs.

5.3 **Children's Services**

Current Position: Net underspend of £48k
Previously Reported: n/a

The underspend within Children's services is mainly due to lower than anticipated payroll costs reflecting the position staff are currently placed on the pay scale, along with savings associated with career breaks.

5.4 **Hosted Services** (***support to GP's for areas such as breast screening, bowel screening)***

Current Position: Net underspend of £76k
Previously Reported: Net underspend of £57k

This underspend reflects historical underspends within the service due to vacant administrative and special project posts.

5.5 **Mental Health**

Current Position: Net overspend of £165k
Previously Reported: Net overspend of £49k

Overall, Mental Health services are reporting an overspend of £165k. As previously reported, this overspend is due to a number of contributing factors within both adult and in-patient services which are offset by an underspend within the adult community budget due to vacancies within the service.

As highlighted throughout 2015/16 and in previous reports this financial year, the main overspends within in-patient services relate to significant costs associated with patients requiring enhanced levels of observation across all ward areas which is not a separately funded element of service. Reliance is on the nurse bank to provide safe staffing levels to meet this level of demand and activity. In addition, pressures continue in relation to maintaining the recommended safe staffing and skill mix for registered nurse to bed ratios.

5.6 **Other Services *(Business Support staff; Admin related costs, hotel services and property related costs including rates and rental costs)***

Current Position: Net overspend of £496k
Previously Reported: Net overspend of £53k

The overspend within other services is due to the additional allocation of savings by NHSGGC to Renfrewshire, for which no agreed savings plan is yet in place.

5.7 **Prescribing**

Current Position: Breakeven
Previously Reported: Breakeven

The reported GP Prescribing position is based on the actual position for the year to 31 May 2016. The overall position across all Partnerships to 31 May 2016 is an overspend of (£0.259m) with Renfrewshire HSCP reporting a £0.45m overspend. However, under the risk sharing arrangement across NHSGG&C the over spend has been adjusted to report a cost neutral position.

As GP Prescribing is extremely volatile, there continues to be an element of financial risk and this will continue to be carefully monitored throughout 2016/17. Variances specific to Renfrewshire HSCP are currently being investigated by Prescribing Advisors.

6. 2016/17 Capital Programme

Description	Original Budget	Revised Budget	Spend to Date	Still to Spend
Anchor Centre Roof Replacement	£400k	£400k	£0k	£400k
Total SW	**£400k**	**£400k**	**£0k**	**£400k**

Work on the roof replacement has now commenced and it is anticipated that the work will be completed and invoiced before Christmas.

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7. Garden Assistance Scheme and Housing Adaptations

Description	Full Year Budget	Year to date Budget	Spend to Date	Year-end Projection
Garden Assistance Scheme	£296k	£91k	£114k	£296k
Housing Adaptations	£932k	£166k	£108k	£932k
Total	**£1,228k**	**£257k**	**£222k**	**£1,228k**

7.1 As highlighted in the due diligence report presented to the IJB on March 18 2016, in addition to the adult social care budget, under the Public Bodies (Joint Working) (Scotland) Act 2014 Housing Adaptations and Gardening Assistance functions and associated budgets, which sit within the Council's Development and Housing Services Directorate, were delegated to the IJB on 1 April 2016.

7.2 The summary position for the period to the 24th July 2016 is reported in the table above and reports an overall spend of £222k to date with an anticipated year-end breakeven position. Members should note that the current years budget for Housing Adaptations includes one-off additional non-recurring monies (£174k) to assist with the current waiting list issues.

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8. Implementation of the Living Wage - update

8.1 Renfrewshire Council has recently received Full Living Wage Accreditation from the UK Living Wage Foundation and NHS GCC is working towards achieving Full Living Wage Accreditation by the end of this year.

8.2 Renfrewshire Health and Social Care Partnership remain wholly committed to delivery on this so that all care workers providing direct personal care and housing support services to adults in Renfrewshire should be paid the Living Wage of £8.25 per from 1st October this year.

8.3 Following initial contact with providers in scope (those who are currently paying the living wage), a financial model has been developed which calculates an increase in individual provider hourly rates based on a number of key factors. This hourly rate will cover the direct costs incurred by providers, less a provider contribution of 25%.

8.4 Providers have confirmed that they are also wholly committed to the process however they have expressed concern that the 25% contribution may not be sustainable. As well as direct costs associated with increasing salaries to £8.25, providers will incur significant indirect costs associated with the need to maintain grade differentials. Provider's current salary models reflect the level of workforce skill, experience and responsibility, removing lower grades and

introducing a flat pay rate of £8.25 for care assistants and care workers presents a significant risk for providers in respect of staff development, motivation and retention. The funding provided by the Scottish Government did not take account of the impact of this element.

8.5 Renfrewshire Health and Social Care Partnership will continue to work closely with providers to deliver the Living Wage commitment by 1st October 2016 however the Integrated Joint Board is asked to note the potential risk that providers may be unwilling to agree to proposed hourly rates which do not reflect the whole cost to provider organisations.

8.6 Future Funding: In addition to the HSCP's commitment to deliver the Living Wage by 1 October 2016, a further annual increase to the Living Wage is anticipated. In recent years, the Living Wage has increased annually in November. The increase in November 2015 was 40 pence from £7.85 per hour to £8.25 per hour. At this time Renfrewshire Health and Social Care Partnership are unable to make any commitment to further increase hourly rates to account for future increases in the Living Wage anticipated in November 2016.

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9. Due Diligence update: NHSGGC Contribution to Integration Joint Board 2016/17

NHSGGC's draft Financial Plan for 2016/17

9.1 NHSGGC's draft Financial Plan for 2016/17 was approved by the NHSGGC Board on 28 June 2016 (Appendix 3). This includes an overall increase in the resources allocated to NHSGGC for 2016/17. However, increased demand and rising costs associated with both staffing and prescribing mean that NHSGGC requires to deliver £69m of recurring savings in 2016/17 to break even. The draft financial plan for 2016/17 identifies a number of savings schemes which are rated according to their ability to be delivered and their impact on services.

9.2 A total £56.5m of savings have so far been identified, £44.8m have been rated as either green or amber, which means the likelihood of these being achieved is relatively high. A further £11.7m have been rated as red which means there is a substantial level of risk in these being delivered.

9.3 The draft financial plan for this year therefore remains out of balance with further savings to be identified from all parts of NHSGGC. The Director of Finance for NHSGGC has confirmed that the financial plan will be reliant on the use of reserves and non-recurrent funding in 2016/17 to achieve a break even position.

9.4 It should be noted that NHSGGC Board members approved this plan with its risks. They have asked all Directors and Chief Officers to identify additional savings plans in order to reduce the residual gap.

2016/17 Financial Allocation to Renfrewshire HSCP

9.5 The Chief Officer for Renfrewshire HSCP received formal notification on the 5 July 2016 of the Partnerships 2016/17 Health allocation (Appendix 4).

NHSGGC budget allocation for Renfrewshire for 2016/17 is a net £151.063m. However, this includes £8.774m of funding allocated to the HSCP is in respect of Renfrewshire's share of the £250m Integration Fund allocated by the Scottish Government for Adult Social Care Services which NHS GGC was

required to allocate directly to Renfrewshire Council. The opening budget for Renfrewshire Health services is therefore £142.289m. The main adjustments applied to confirm the 2016/17 HSCP opening budget are summarised in the table below.

2016/17 Health Financial Allocation to Renfrewshire HSCP	**£k**
2015/16 Renfrewshire HSCP Closing Budget:	149,525.5
less: non recurring budgets (allocated annually)	-4,644.9
= base budget rolled over	**144,880.6**
Additions:	
Pay increases	511.1
National Insurance rebate withdrawal cover	762.8
Superannuation auto enrolment	108.3
Resource Transfer uplift (1.7%)	282.0
Non-pay inflationary uplifts	51.3
Social Care Integration Fund to transfer to Council	8,774.0
	10,489.5
Reductions:	
Transfer of facilities budget to Corporate	-7.0
Transfer of depreciation budget to Corporate	-1,592.0
Realignment of GMS / FHS budgets	-833.8
	-2,432.8
Savings:	
Agreed 2016/17 savings	-496.0
Unallocated savings applied by NHS GGC	-1,378.2
	-1,874.2
Budget allocated as per 2016/17 Financial Allocation 5th July 2016	**151,063.1**

9.6 Appendix 2 provides a reconciliation of the main budget adjustments applied this current financial year to bring us to the net budget as reported in month 4.

Unallocated Savings Target

9.7 As detailed in NHSGGC's draft Financial Plan for 2016/17 the overall funding gap for NHSGGC was £69m, with savings targets of £49m allocated to the Acute/Corporate sector and £20m to Health and Social Care Partnerships. It should also be noted that the draft Financial Plan does not include unallocated savings carried forward from 2015/16 (at which point Renfrewshire health and adult social care services had not been delegated to the IJB) for Partnerships this equates to £7.8m on a recurring basis.

9.8 Although it is clear that NHSGGC has a significant budget challenge the 'proportionate' share approach to allocating savings targets does not reflect the Scottish Government's aim for shifting the balance of care to a greater emphasis on prevention, anticipatory care and improving care and support to enable people to live at home.

9.9 Members should note that in addition to the above savings target there is a possibility that NHSGGC may request further contributions from Partnerships to fund any shortfalls against the 2016/17 Financial Plan. Partnerships are currently seeking assurance that this will not be the case and to date the NHS Board Director of Finance is indicating that the available in-year non recurring funding should be sufficient to cover any shortfalls where it has not been possible to deliver viable savings options in year.

9.10 To date, £10.2m of savings against the Partnership target of £20m has been approved; this includes £496k from Renfrewshire HSCP. This leaves a recurring gap for the HSPC's to deliver of £9.8m, of which £1.378m is Renfrewshire HSCP's share.

9.11 At this stage there are currently no plans in place to deliver against the above savings gap of £1.378m. IJB members should be aware that this has resulted in a reported overspend for the Health component of the Partnerships budget of £459k, with a year-end projected recurring overspend of £1.378m.

9.12 NHSGGC has identified in its draft Financial Plan for 2016/17 that there is potentially £32m of non-recurring monies available to offset the current unallocated savings target across all services. Discussions are currently underway with the Director of Finance for NHSGGC to agree the amount of non-recurring monies which will be made available to Partnerships in the current year against the unallocated savings target.

9.13 Due to the level of unallocated savings applied to Renfrewshire HSCP's Health budget, there is a clear risk that the HSPC will not be able to achieve a recurring financial balance in 2016/17. Currently it is estimated that for 2016/17 the HSCP Health budget carries a financial risk of £1.378m, for which there are no reserves in place to provide cover.

Delivering Additional Savings

9.14 Given the constraints within which Partnerships currently operate it is not clear how the unallocated savings of £1.378m can be delivered. The table below shows the budgets against which savings can be applied (based on the Partnerships 2016/17 opening budget):

Health Revenue Budgets against which savings can be applied

	Annual Budget £000's
Total Net Opening Budget	**144,859**
less: budgets against which savings cannot be applied (by partnerships):	
Resource Transfer	(16,590)
Family Health Services	(77,078)
Share of Hosted services	(19,940)
	(113,608)
= relevant / directly managed budget against which savings can be applied	**31,252**
% of budget against which savings can be applied	**21.57%**

9.15 The savings gap of £1.378m represents a 4.4% reduction in the Partnership's directly managed Health budget, the majority of which is staff related costs. Given the NHS in Scotland has a no redundancy policy any approved service redesign must offer lifetime protection to existing staff. In addition, there remains a commitment to sustain existing staffing levels within a number of services. It is therefore difficult to easily define and describe how the savings gap can be delivered on a recurring basis within existing NHSGGC employee terms and conditions.

9.16 Members are therefore asked to note that the Health component of the HSCP budget is not in recurring balance and that the Chief Officer will bring an update on the in-year financial position and outline savings proposals to the November 2016 meeting of the IJB. Such savings will be required to achieve recurring financial balance against the 2016/17 budget allocation, at least from April 2017 onwards. These will be in addition to further such savings that are expected to be required for the financial year 2017/18 to address health service related funding challenges.

9.17 Members should also note that the level of savings required are expected to impact on the Partnership's ability to deliver the outcomes identified in the draft Strategic Plan. Details of the risks and impact of all savings options will be included in the proposals to the next IJB meeting in November 2016.

Other Budget Pressures within the Health Budget Allocation

9.18 The Due Diligence update presented to members on 18 March 2016, referred to a number of budget pressures within the Partnerships Health allocation, for which no additional resource has been allocated in the 2016/17 budget allocation from NHSGGC, namely:

9.19 *Special Observations within Mental Health Services*: significant costs associated with increasing numbers of patients requiring enhanced levels of observation across all ward areas which is not a separately funded element of service, and pressures in relation to maintaining the recommended safe staffing and skill mix for registered nurse to bed ratios.

9.20 C*hanges to GP contract*: which may require local recurring funding from the HSPC outwith the core General Medical Services (GMS) Contract.

9.21 *Prescribing budget:* the prescribing budget is currently showing a significant NHS Board wide overspend, and it is unlikely that a year-end break-even position will be achievable. NHSGGC maintains a risk sharing arrangement not to pass any over-spends to HSCPs however, this is dependent on the NHS Board's financial position.

Set Aside

9.22 As detailed in the Due Diligence update to the IJB on 18 March 201, the IJB has delegated responsibility for the strategic planning and commissioning of a range of in scope hospital based services for unscheduled care. The Director of Finance for NHSGGC notified the Chief Finance Officer of the Renfrewshire notional set aside allocation for Renfrewshire on 17th August 2016.

9.23 The services within the scope of the Set Aside budgets for the HSCP are:

- Accident and emergency provided in a hospital
- Inpatient hospital services relating to the following specialities
  - general medicine;
  - geriatric medicine;
  - rehabilitation medicine;
  - respiratory medicine;
  - psychiatry of learning disabilities;
  - psychiatry for older people;
  - accident and emergency services provided in a hospital;
  - inpatient hospital services relating to the following specialties:
- palliative care services provided in a hospital;

- inpatient hospital services provided by general medical practitioners (N/A in NHSGGC);
- services provided in a hospital in relation to an addiction or dependence on any substance; and
- mental health services and services provided by GPs provided in a hospital except secure forensic mental health services.

9.24 The Director of Finance for NHSGGC has worked with the six Partnerships within NHSGGC to develop a methodology to apportion these in scope hospital based services within the unscheduled care budget based on HSCP's anticipated consumption. The notional allocation for 2016/17 is £32.3m as detailed in Appendix 5.

9.25 Details of the methodology used to calculate the notional set aside is included in Appendix 6.

Assurance statement

9.26 The delegated Health budget for 2016/17 has been assessed against criteria based on the national guidance (Integrated Resources Advisory Guidance), (applicable to the Health component of the 2016/17 RHSCP budget), set out in the table below:

Due Diligence Assessment Criteria

1.	the identification of the former Community Health Partnership budget to be delegated is clear, including hosted services
2.	the identification of the NHSGGC's budget relating to the delegated set aside (Acute Services) budget is clear
3.	the identification of that part of the Council's former SW and Housing budgets relating to the delegated services is clear
4.	the treatment of corporate support services is clear
5.	the prior year figures can be reconciled back to Council and NHSGGC budget papers and final management accounts, or equivilent.
6.	the review of prior years and into 2015/16 show adequate budget provision for the delegated functions.
7.	the assumptions used in rolling forward the budget from 2014/15 to 2015/16 plans and the associated risks are fully transparent.
8.	material non-recurrent funding and expenditure budgets for the delegated services and related risks are transparent.
9.	the medium term financial forecast for the delegated services and associated assumptions and risks is reviewed
10.	savings and efficiency targets and any schemes identified are clearly identified and the assumptions and risks are understood by all partners
11.	corporate efficiency targets are clear from parent organisation Board papers
12.	demand management activity in relation to health and adult social care services is transparent
13.	the amount set aside for the IJB consumption of large hospital services is consistent with the methods recommended in the IRAG guidance on the set aside resource and that the assumptions and risks are assessed
14.	the budget has been set taking into account: • Cost inflation • Activity change such as demographic pressure • Cost impact of any legislative changes • Efficiencies

9.27 Members should note that in approving Integration Schemes, NHSGGC agreed to the IJB's being established on a financially viable basis. It is the opinion of the Chief Financial Officer that the 2016/17 Health care budget allocated to the HSCP is not sufficient to sustain the outcomes delivered in 2015/16 and to deliver on those highlighted within the draft Strategic Plan. Recurring savings will therefore be required in order to deliver a balanced budget in 2016/17.

9.28 In the case where NHSGGC is unable to provide non recurring relief to offset the in-year shortfall against the unallocated savings target, the Chief Financial Officer recommends that in line with the IJB's Financial Governance Manual, "Managing Overspends" (para 3.4.3 on page 15 approved by the IJB on 18 September 2015):

"If the recovery plan is unsuccessful and there are insufficient general fund reserves to fund a year-end overspend, then the partners have the option to:

- Make additional one-off payments to the IJB;
- Provide additional resources to the IJB which are then recovered in future years, subject to scrutiny of the reasons for the overspend and assurance that there is a plan in place to address this; or
- Reprioritise in-year expenditure subject to other governance arrangements."

9.29 The IJB should request an additional one-off payment by NHSGGC to fund the identified shortfall, given that the budget allocated for the first year of the Partnership having full responsibility for the delegated Health budget was not sufficient to meet the identified costs associated with their delivery. In addition, the IJB should request written assurance from the Director of Finance for NHSGGC that no future savings targets will be applied in respect of the 2015/16 unallocated savings of £7.8m given that these relate to a period prior to the delegation of services to the partnerships.

9.30 The risk register for the HSCP be updated to reflect the risks highlighted in this report.

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10. Financial Planning Proposals for HSCP Budget Setting

10.1 At its meeting on 24 June 2016, IJB members received an update on the HSCP's Change and Improvement Programme. This programme is intended to deliver adult social care in-year financial savings and demand pressure mitigation measures.

10.2 The report of 24 June 2016 committed to bring further advice and recommendations to members once the 2016/17 integrated budget was finalised; taking account of NHSGGC saving targets to be delivered in 2016/17 and future years for both parent organisations.

10.3 In light of the challenging financial position and the underlying recurring financial imbalance facing the IJB, a more strategic integrated service and financial planning model is required. Therefore, a dedicated HSCP Finance and Planning Group is being established, jointly led by the Chief Finance Officer and Head of Strategic Planning, to develop a three year financial planning cycle which will align with our Strategic Plan. Terms of Reference can be found in Appendix 7.

10.4 The HSCP will seek to proactively transform our health and social care services, exploiting the opportunities integrated working offers with service

redesign being informed by a strategic commissioning approach. The Finance and Planning Group will adopt a collaborative approach, working in consultation with our key stakeholders including staff, the HSCP Leadership Network, the Strategic Planning Group and parent organisations.

10.5 This in turn will support the long term financial sustainability of the Partnership and deliver the savings required to address the IJB's medium term budget deficit. This process will involve transformation projects, as part of the Partnership's wider Change and Improvement Programme, being developed on a continuous basis and presented for approval to the IJB throughout each year and across financial years.

10.6 To support this new strategic financial planning model, the Chief Officer and Chief Finance Officer will regularly brief the Chair and Vice Chair of the IJB on savings options in relation to the annual financial planning process for both health and social care and proposed integration transformation projects.

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11. Integrated Care Fund

11.1 As of 1 April 2016, the IJB assumed responsibility for Renfrewshire's Integrated Care Fund (ICF). The current funding allocation is £4.14m per year which includes a Renfrewshire Council contribution of £650k.

11.2 At the last meeting on 24 June 2016, IJB members agreed that new local governance arrangements should be put in place and that supporting Terms of Reference for a reformed ICF Group would be brought to the next meeting.

11.3 In light of the new strategic financial planning approach being introduced by the HSCP, as set out in section 10 of this report, it is now recommended that this fund is managed in line with all other IJB funding streams. This approach aligns with recent national guidance which recommends that "planning and reporting arrangements for the ICF should be congruent with the broader requirements on Health and Social Care Partnerships".

11.4 It is therefore recommended that the HSCP's new Finance and Planning Group plan for and manage Renfrewshire's ICF allocation as part of its wider, strategic approach to integrated service and financial planning which will work in collaboration with the IJB's Strategic Planning Group.

11.5 The HSCP will also work with the Third Sector, Providers and Community Groups to develop an appropriate interface forum, to provide strong engagement with the HSCP's strategic commissioning process; to influence the effective use of IJB resources and make recommendations on the allocation of resources available in line with local priorities.

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12. Directions

12.1 Directions are the mechanism by which the IJB instruct the constituent authority to carry out the delegated functions. These are documents which set out how the IJB expect the constituent bodies to deliver each function, and spend IJB resources, in line with the Strategic and Financial Plans.

12.2 As approved by the IJB on 18 March 2016, the Chief Officer issued Directions to the parent organisations on 1 April 2016. In line with national guidance,

there is a requirement for the IJB to update Directions to reflect any change in local circumstances (e.g. budget change, a change of payment) in relation to their respective delegated functions.

12.3 Members are asked to delegate authority to the Chief Officer to issue updated Directions on their behalf, as required. A copy of updated Directions will be shared with members.

Implications of the Report

1. **Financial –** Financial implicaitons are discussed in full in the report above.
2. **HR & Organisational Development** – none
3. **Community Planning** - none
4. **Legal –** none
5. **Property/Assets –** none.
6. **Information Technogloy –** none
7. **Equality & Human Rights –** The recommendations containted within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be publised on the Council's website.
8. **Health & Safety** – none
9. **Procurement** – Implementation of the living wage impact on existing contracts with providers and their aiblity to dleiver within the allocated funding package
10. **Risk –** There are a number of risks which should be considered on an ongoing basis: a) adequate funding to deliver core services, delivery of additional unallocated savings within the current finiancial year and the allocation of non-recurring funds by NHSGGC Board to meet this shortfall in 2016/17.
11. **Privacy Impact** – none.

List of Background Papers – none

Author: Sarah Lavers, Chief Finance Officer

Appendix 1

Social Work Revenue Budget Position
1st April 2016 to 24th July 2016

Subjective Heading	Annual Budget	Year to Date Budget	Actual to Date	Variance		
	£000's	£000's	£000's	£000's	%	
Employee Costs	25,720	7,922	7,730	192	2.4%	underspend
Property Costs	363	112	118	(6)	-5.4%	overspend
Supplies and Services	1,555	479	508	(29)	-6.1%	overspend
Contractors	44,756	13,785	13,876	(91)	-0.7%	overspend
Transport	722	222	203	19	8.6%	underspend
Administrative Costs	231	71	73	(2)	-2.8%	overspend
Payments to Other Bodies	9,343	2,878	2,852	26	0.9%	underspend
Capital Charges	-	-	-	-	0.0%	breakeven
Gross Expenditure	**82,690**	**25,469**	**25,360**	**109**	**0.4%**	**underspend**
Income	**(21,800)**	**(6,714)**	**(6,607)**	(107)	1.6%	overspend
NET EXPENDITURE	**60,890**	**18,755**	**18,753**	**2**	**0.01%**	**underspend**

Position to 24th July is an underspend of **£2k** **0.01%**
Anticipated Year End Budget Position is a breakeven of **£0** **0.00%**

Client Group	Annual Budget	Year to Date Budget	Actual to Date	Variance		
	£000's	£000's	£000's	£000's	%	
Older People	41,275	12,714	12,635	79	0.6%	underspend
Physical or Sensory Difficulties	5,209	1,604	1,725	(121)	-7.5%	overspend
Learning Difficulties	11,898	3,665	3,583	82	2.2%	underspend
Mental Health Needs	1,115	343	379	(36)	-10.5%	overspend
Addiction Services	743	229	235	(6)	-2.6%	overspend
Integrated Care Fund	650	200	200	-	0.0%	breakeven
NET EXPENDITURE	**60,890**	**18,755**	**18,757**	**(2)**	**-0.01%**	**overspend**

Position to 24th July is an underspend of **£2k** **0.01%**
Anticipated Year End Budget Position is a breakeven of **£0** **0.00%**

Health Revenue Budget Position
1st April 2016 to 31st July 2016

Subjective Heading	Annual Budget	Year to Date Budget	Actual to Date	Variance		
	£000's	£000's	£000's	£000's	%	
Employee Costs	43,892	14,597	14,428	169	1.2%	underspend
Property Costs	611	217	223	(6)	-2.8%	overspend
Supplies and Services	18,596	2,085	2,223	(138)	-6.6%	overspend
Purchase of Healthcare	44	15	17	(2)	-13.3%	overspend
Resource Transfer	16,872	5,624	5,624	-	0.0%	breakeven
Family Health Services	79,436	26,279	26,276	3	0.0%	underspend
Savings	(1,454)	(485)		(485)	100.0%	overspend
Capital Charges	-	-	-	-	0.0%	breakeven
Gross Expenditure	**157,997**	**48,332**	**48,791**	**(459)**	**-0.9%**	**overspend**
Income	**(5,093)**	**(2,287)**	**(2,287)**	-	0.0%	breakeven
NET EXPENDITURE	**152,904**	**46,045**	**46,504**	**(459)**	**-1.00%**	**overspend**

Position to 31st July is an overspend of **(£459k)** **-1.00%**
Anticipated Year End Budget Position is an overspend of **(£1,378k)** **0.00%**

Client Group	Annual Budget	Year to Date Budget	Actual to Date	Variance		
	£000's	£000's	£000's	£000's	%	
Addiction Services	2,391	560	526	34	6.1%	underspend
Adult Community Services	13,708	4,219	4,166	53	1.3%	underspend
Children's Services	5,236	1,746	1,698	48	2.7%	underspend
Learning Disabilities	977	326	330	(4)	-1.2%	overspend
Mental Health	19,051	6,366	6,531	(165)	-2.6%	overspend
Hosted Services	3,451	1,173	1,097	76	6.5%	underspend
Prescribing	35,260	11,651	11,651	-	0.0%	breakeven
GMS	21,416	7,074	7,073	1	0.0%	underspend
Other	20,471	6,806	6,806	-	0.0%	breakeven
Planning and Health Improvement	1,123	367	373	(6)	-1.6%	overspend
Other Services	9,817	(162)	334	(496)	306.2%	overspend
Resource Transfer	16,872	5,624	5,624	-	0.0%	breakeven
Integrated Care Fund	3,131	295	295	-	0.0%	breakeven
NET EXPENDITURE	**152,904**	**46,045**	**46,504**	**(459)**	**-1.00%**	**overspend**

Position to 31st July is an overspend of **(£459k)** **-1.00%**
Anticipated Year End Budget Position is an overspend of **(£1,378k)** **0.00%**

for information:

1. Adult Community Services includes: District and Out of Hours Nursing; Rehabilitation Services, Equipu and board wide responsibility for Podiatry
2. Children's Services includes: Community Services - School Nurses and Health Visitors; Specialist Services - Children's Mental Health Team, Speech Therapy
2. GMS = costs associated with GP services in Renfrewshire
3. Other = costs associated with Dentists, Pharmacists, Optometrists
4. Hosted Services = board wide responsibility for support to GP's for areas such as eg breast screening, bowel screening
5. Other Services = Business Support staff; Admin related costs, hotel services and property related costs including rates and rental costs.

2016/17 Health Financial Allocation to Renfrewshire HSCP

	£k
2015/16 Renfrewshire HSCP Closing Budget:	149,525.5
less: non recurring budgets (allocated annually)	-4,644.9
= base budget rolled over	**144,880.6**
Additions:	
Pay increases	511.1
National Insurance rebate withdrawal cover	762.8
Superannuation auto enrolment	108.3
Resource Transfer uplift (1.7%)	282.0
Non-pay inflationary uplifts	51.3
Social Care Integration Fund to transfer to Council	8,774.0
	10,489.5
Reductions:	
Transfer of facilities budget to Corporate	-7.0
Transfer of depreciation budget to Corporate	-1,592.0
Realignment of GMS / FHS budgets	-833.8
	-2,432.8
Savings:	
Agreed 2016/17 savings	-496.0
Unallocated savings applied by NHS GGC	-1,378.2
	-1,874.2
Budget allocated as per 2016/17 Financial Allocation 5th July 2016	**151,063.1**
Subsequent Budget Adjustments posted in month 4	
Keepwell funding 16/17	31.8
Auto enrolment	73.9
Staffing budget adjustments and general uplifts (staff transfe	123.4
Family Health Services Adjustment	-78.0
Prescribing budget increase	1,949.8
ICF payments to Acute (to be reversed)	-259.9
	1,841.0
Health Budget as reported @ 31 July 2016	**152,904.1**

2016/17 Adult Social Care Financial Allocation to Renfrewshire HSCP

	£k
2016/17 Renfrewshire HSCP Opening Budget:	60,875.2
	60,875.2
Additions:	
Net Payroll Ajustments relfecting transfers of staff to HSPC / Council	14.8
Adult Social Care Budget as reported @ 24 July 2016	**60,890.0**

NHS Greater Glasgow & Clyde

NHS BOARD MEETING

Director of Finance **June 2016** **Paper No: 16/32**

Financial Plan 2016/17

The Board is requested;

- **To consider the content of/and approve the 2016/17 Financial Plan; and**
- **To note the need for a change in financial planning for 2017/18 and beyond.**

Purpose of Paper:-

The purpose of this paper is to present the 2016/17 Financial Plan to the Board.

The Plan outlines the key elements of income and expenditure underpinning the financial challenge, together with explanation of financial pressures, potential investments and costs savings required. The Plan also outlines key risks to be managed and tangible actions to be implemented for the Board to have a chance of financial break-even.

The Plan also outlines the need for a change in financial planning for 2017/18 and beyond.

Key issues to be considered:-

The Board is facing the significant challenge of requiring £69m of recurrent in-year savings in order to break even. A comprehensive planning process involving all Directors and a wide range of managers, and in concert with the IJBs, set out to identify savings schemes to address the financial gap.

Within this Financial Plan, "green and amber" savings totalling £44.8m full year effect (£34.9m part year effect) have been identified. In addition, a range of "red rated" schemes have been identified, including some service redesign propositions totalling £11.7m full year effect (£8.6m part year effect). Consideration must also be given to both the underachievement of the Acute Cost Containment Programme and unachieved saving from 2015/16.

Taking into account all savings schemes identified, on a full-year effect for 2016/17, the Board still has a gap of £9.1m (rounded up to £10m). It is proposed at this stage that these savings maybe realised through the National Workstreams, or alternatively from additional savings schemes identified across the key parts of the business in-year.

Any Financial Implications from this Paper:-

Due to the timing of the implementation and impact of these schemes in-year, the Board has again recognised the need to cash manage the business towards the realisation of these savings. This will be achieved through the further utilisation of non-recurring provisions and reserves. For 2016/17, this will include a timing benefit repayable in future years through the reversal of historic provisions totalling £32.5m for NHSGGC.

This reliance on non-recurring sources of funding and reserves to achieve in-year balance is clearly not sustainable. The continued use of non-recurring funds and reserves in 2016/17 to fund day-to-day business will create a significant risk to the sustainability of the Board into 2017/18 and beyond. There is a real risk the Board enters 2017/18 with minimal reserves.

Although not a direct financial implication, this paper also highlights the need for a change in financial planning for 2017/18 and beyond. Due to the scale of the financial challenge and underlying recurring financial imbalance, a transformation programme will be required to deliver a step change in the size and scale of recurring savings and efficiencies needed in 2007/18 and beyond.

Any Staffing Implications from this Paper:-
A number of savings schemes involve elements of workforce rationalisation.

Any Equality Implications from this Paper:- None.

Any Health Inequalities Implications from this Paper:- None

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-

To have a chance of break-even, definitive management action and tangible results must be achieved around the following key risks;

- Achievement of the Acute cost containment programme, locum agency spend and sickness absence rates driving nurse bank and agency spend;
- Continued support from the Scottish Government around the achievement of key waiting times targets, particularly in the winter period;
- Managing any changes to the unscheduled care model within the current financial envelope;
- Achievement of all savings schemes outlined above, including service redesign propositions;
- Continued work to finalise, consult, approve and deliver the “red” rated schemes; and
- Achievement of £10m savings from the National Workstreams and/or identification, presentation and delivery to the October 2016 Board meeting of additional schemes equal to that sum from the three key areas of the business.

In terms of quantifying risk inherent in achieving break-even, and in addition to the unidentified £10m FYE gap, it is estimated the Financial Plan carries financial risk of between £20m to £25m. Should this risk crystallise, there are insufficient reserves to provide cover. It would require receipts from projected land sales to ensure financial balance. However, the complexity and uncertainty over the timing and level of receipt of land sales must also be highlighted.

Highlight the Corporate Plan priorities to which your paper relates:-

Improving Quality, Efficiency and Effectiveness

Author – Director of Finance
Tel No – 0141 201 4470
Date – 22nd June 2016

16/32

NHS Greater Glasgow and Clyde

2016/17 - Financial Plan

June 2016

1. INTRODUCTION

1.1 This document presents the Board's 2016/17 Financial Plan (the Plan).

1.2 The Plan outlines the key elements of income and expenditure underpinning the financial challenge, together with explanation of financial pressures, potential investments and costs savings required.

1.3 The Plan also outlines key risks to be managed and tangible actions to be implemented for the Board to have a change of financial break-even.

1.4 The Plan highlights the significant and unprecedented financial challenge facing NHSGGC in 2016/17. Directors and Management have worked extensively to identify and design savings schemes to address the financial gap identified. This continued effort and dedication will also be required to deliver such a challenging savings programme.

1.5 The purpose of this paper is to present the 2016/17 Financial Plan to the Board. The Board is asked to;

- Approve the overall Plan and its underlying assumptions;
- Approve the setting of budgets and savings, allocated proportionately to each part of the business;
- Approve the budget with a £10m gap, to be met from the outcomes from the National Workstreams, or from £10m of additional savings schemes on a proportionately basis from each budget holder and presented to the October 2016 Board meeting;
- Approve the on-going work and discussions to address recurrently the underachieved projected 2015/16 recurrent savings (Acute £3m and HSCPs £7m);
- Approve the continued use of non-recurrent funding and reserves to manage the business in-year, accepting the diminishing levels of reserves and significant risks this creates to the financial sustainability of the Board;
- Approve the level of risk inherent in the Plan and the potential to use remaining reserves to cover this risk if required; and

1.6 The Board is also asked to note the need for a change in financial planning for 2017/18 and beyond. This will require the development and embedding of a more collegiate, continuous improvement environment that delivers savings on a more consistent basis. In addition, due to the scale of the financial challenge and underlying recurring financial imbalance, a transformation programme will be required to deliver a step change in the size and scale of recurring savings and efficiencies needed in 2007/18 and beyond.

Mark White
Director of Finance

2. BACKGROUND AND CONTEXT

2.1 In line with every year, the Board has been working through the financial planning cycle for several months. The financial planning process for 2016/17 has been particularly challenging as we interpret the amended Acute structure, including the running of the new Queen Elizabeth University Hospitals, and the formation of Integration Joint Boards (IJBs).

2.2 As we survey both the political and financial landscape into 2016/17 and beyond, it is imperative the Board establishes a process which ensures financial decisions which relate to a coherent strategic direction. This involves moving forward in concert with the IJBs. The Board now shares responsibility for strategic planning with the IJBs but retains responsibility for the allocation of the NHS budget between the services for which we retain direct operational responsibility and those managed by IJBs. IJBs need to develop and approve integrated service and financial plans for the NHS and Council services which are legally delegated to them before the end of this financial year.

2.3 While the LDP process has enabled Boards to set budgets beyond the beginning of the financial year, that flexibility has been in a context of relative certainty when we can set, or come close to setting, a balanced financial plan. As we continue to work through the financial planning process, setting a balanced Financial Plan is becoming more difficult each year.

2.4 That challenge also needs to be considered against the current overspends within the Acute Division, largely to sustain services in terms of staffing to ensure we deliver the national targets and meet pressures.

2.5 Therefore, in the current year, and going forward, we are significantly challenged to meet the costs of our current configuration of services and to deliver the required national targets.

3. STRATEGIC POSITION

3.1 The Board has a strategic direction which sets our purpose as:

> "***Deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities."***

3.2 That purpose is amplified with five strategic priorities to move us towards achieving that purpose, these are:

- Early intervention and preventing ill-health;
- Shifting the balance of care;
- Reshaping care for older people;
- Improving quality, efficiency and effectiveness;
- Tackling inequalities.

3.3 The Board needs to set a fresh strategic direction for 2016/17 in Partnership with IJBs which are developing their own strategic plans. In many respects we have the material to set that clear strategic direction and to develop, alongside IJBs, the detailed service change plans which we need to put in place to deliver.

3.4 NHSGCC has:

- A mental health strategy progress through final capital development to deliver modern mental health services;
- A Clinical Strategy which maps out a clear direction for acute services, although not yet translated into detailed service plans and with a number of delivery challenges to be resolved;
- A pattern of change in community services which has improved the range and efficiency of those services but not yet the more radical developments to enable us to change the acute sector;
- Emerging local thinking about the development of primary care which we need to use to shape the national direction.

3.5 However, the financial and policy constraints within which we are working present real challenges to coherently move forward the five strategic priorities which will deliver our purpose. One of the key aims of the 2016/17 (and beyond) planning process is to make changes which align with our strategic direction, priorities and clinical strategies and enable us to deliver financial balance.

3.6 Further points of context are:

- The increasing demand (scheduled and unscheduled) and costs of acute services, means that we have made minimal progress in shifting resources to substantially develop primary care and community services;
- There are major workforce issues, filling staffing gaps is a major current cost problem, driven by:
    - medical workforce issues, which will only worsen;
    - staffing models which increase the unit costs of our current services; and
    - high levels of sickness absence;
- Immediate pressures on number of points on the system;
- Social care budget pressures including major issues in the care home sector;
- GP services struggling with demand pressures;
- real pressures on services which are impacted on by increasing numbers of vulnerable people;
- Drugs costs driven by the changed national regime.

4. PROPOSED PRINCIPLES FOR PLANNING

4.1 In order to ensure that we make financial decisions which align with our strategic direction we have established the proposed principles for planning. These have shaped the planning programme. The principles are:-

- Make financial decisions for 2016/17 which are in line with and enable us to move in coherence with our purpose, strategic direction and related strategies;
- Continue to give priority to patient facing services and ensuring these are always high quality and safe;
- Continuing to play our part in trying to reduce the inequalities which affect our population and have a strong focus on equality impacts in making our decisions;
- Ensure that our decisions do not have unintended consequences such as unplanned transfers of pressures, responsibilities or costs to other parts of the system;
- Our approach is whole system not localised savings targets, and is driven by:-
    - cost scrutiny in every part of the organisation, led by the local teams;
    - a whole system programme of change to deliver cost reduction;
- Our aim is to continue to deliver the key Scottish Government targets;
- We focus first on changes which make clinical and service sense and increase efficiency and productivity and reduce our unit costs;
- Where we propose to restrict access to services or stop planned developments we will have a clear framework for prioritisation of patient care linked to clinical benefit;
- We are committed to shifting the balance of care and resources but also recognise the pressures on acute services.
- All new national initiatives and proposals which have financial implications will be tested against our strategy and reported to Board for decision;
- Our decision making is under pinned by evidence about what delivers the safest, highest quality and most cost effective healthcare;
- We explicitly consider risks and benefits in making decisions;
- We remain committed to the importance of innovation and research to shape changes in the way we deliver care;
- We will work across boundaries with other Health Boards and public bodies to identify ways in which we can deliver services more efficiently.

We recognise that the scale of the challenge we face means that we are entering a period of significant change. Fundamental principles of our decision making are:-

- A commitment to engagement with patients and the wider public;
- A commitment to fully engage with our staff and their representatives in shaping, planning and delivering the changes to services which will be required.

5. DETAILED FINANCIAL POSITION

5.1 The Scottish Government set out its budget to the Scottish Parliament in December 2015. This set out an up lift of £511m or 5.3 % to the Health budget. The £511m is split £476m to territorial Boards and £35m to Special Boards. The table below highlights the key strands of funding available to NHS Scotland territorial Health Boards, and demonstrates how these translate for NHSGGC.

TABLE 1: The total uplift 2016/17

	All Boards £m	NHS GGC £m	Paragraph reference
Base Uplift @ 1.7%	147.0	33.7	5.2
Social Care Funding	250.0	59.4	5.3
SGHSCD Uplift	476.0	93.1	
Income from Other Boards		6.9	5.4
Reduction in Bundled Funding		(7.0)	5.5
Reduction in New Medicines Fund		(5.4)	5.6
Total Uplift		**87.6**	

5.2 A general uplift is provided by SGHSCD to support Boards in meeting expected additional costs related to pay, supplies (which includes prescribing growth and utilities charges) and capital charges.

5.3 SGHSCD has provided £250.0m, to be directed to Integrated Health and Social Care Partnerships, to ensure improved outcomes in social care.

5.4 By applying an agreed general inflationary uplift to the value of service level agreements with other NHS Boards related to patient services provided by NHSGGC, NHSGGC can reasonably expect to receive further income of around £6.9m in 2016/17. This includes a further £2.0m from NHS Highland as it stabilises its SLA value.

5.5 SGHSCD has confirmed that funding outwith Boards' recurring allocations will be reduced. The total reduction is likely to be £7.0m, comprising Alcohol (£2.1m), Drugs (£2.2m) & other bundled funding (£2.7m).

5.6 In 2015/16 the SGHSCD distributed £85m of receipts from the Pharmaceutical Price Regulation Scheme as income to Boards. For NHSGGC this represented £20.1m of income. In our initial 2016/17 financial planning, in the absence of any other information, we assumed a similar 2015/16 position. However, it was confirmed that in 2016/17 SGHSCD estimated the receipts to be approximately £60m (down from an initial estimate of £90m). As such, our share in 2016/17 is likely to be £14.7m. This represents a reduction of £5.4m of income.

5.7 A summary of the Financial Plan is shown below. Each of the items is explained in more detail in **Appendix 1**.

TABLE 2: The overall financial position 2016/17

		Jan 16 £m
2016/17 Funding Uplift		
Total uplift		87.6
Carry Forward from 2015/16		
Forecast recurring over/under commitment		(0.0)
Cost Drivers		
Pay Cost Growth		(50.5)
Prescribing Cost Growth		(25.6)
Energy Cost Growth		(0.0)
Capital Charges Growth		(4.0)
Other Cost Inflation		(10.1)
		(90.2)
Service Commitments		
Social Care		(59.4)
Pressures and Investments		(7.0)
		(66.4)
Cash Releasing Financial Challenge		**(69.0)**
Cash Releasing Financial Challenge		**3.3%**

5.8 Important points to note in relation to the pharmacy number in the above table are;

- prescribing savings of £3.0m (Acute) & £5.0m (Primary Care) which have been netted off the relevant prescribing uplifts;
- Reductions in prices of drugs for the treatment of Hepatitis C will release £9.1m.

5.9 In developing the Plan we have assessed relevant risks. It is proposed we retain the Board's £5.0m recurring contingency. It is not appropriate to decide at this stage how these funds will be used but it is clearly prudent to build some central flexibility into a Plan that has £3.0bn of expenditure, potential unexpected pressures and a larger number of areas of significant financial risk.

5.10 In addition, some of the key operational risks that the Board will face in-year 2016/17 include medicines and integration of health and social care. These risks are described below:

- Medicines risks include the cost of new medicines, including those for Hepatitis C, and orphan / ultra-orphan and end of life medicines. In line with SGHSCD guidance, the Plan includes assumptions about funding available from the new medicines fund.

- The Board is responsible for allocations to the new IJBs. In approving Integration Schemes the Board agreed in principle to allocations which reflected IJBs financial and savings plans for 2016/17 with the likelihood of enabling financial balance to be achieved in 2016/17 and the IJBs to be established on a financially viable basis. A number of the savings plans may be non recurrent, posing real challenges for the IJBs to deliver recurrent balance in 2016/17. It is also important to underline the substantial pressures on social care budgets which will flow through from Council allocations to IJBs from 2016/17 onwards.

- The Acute division continues to experience significant cost pressures in Medical pay where significant expenditure on agency and locum cover has been incurred to support activity levels. Actual non elective and elective inpatient activity continues to increase significantly, together with long-term vacancies, difficulties recruiting and the requirement for waiting list initiatives to achieve TTG targets. Nursing pay also continues to be a significant cost pressure, with excess bank and agency spend driven by activity levels and accentuated by higher than average sickness/absence rate.

5.11 Other key risks to the Plan are set out below.

- Savings Schemes: The delivery of savings schemes, including the bed model, at a time when capacity is already stretched is a major challenge.

- Prescribing: Prescribing costs are demand driven and vary throughout the year. Although we believe that our projections of costs and savings are realistic, we continue to monitor this area closely to ensure that we are aware of any changes in prescribing patterns.

- Referral to Treatment Standard: To help support delivery of referral to treatment performance, SGHSCD has made available additional non-recurring funding. If funding is no longer available, this may have an impact on our performance.

- Winter Pressures: We recognise the seasonal impact that winter has on demand for services. We need to consider whether we factor in funding non-recurringly to meet the additional costs incurred.

6. SAVINGS TO ACHIEVE FINANCIAL BALANCE

6.1 The assessment of the financial position in 2016/17 was first conducted in October 2015 and presented to the Board at an Away Day. Whilst the projections were evolving and subject to continual updating, in parallel, the Executive Management team commenced a process to identify a set of strategic savings initiatives that would deliver the required savings to achieve financial balance.

6.2 As outlined above, this process continued through the winter months, with a summary of progress delivered to the Board Seminars / Away Days in February and early April 2016.

6.3 A process of consultation was also conducted with staff side and with the Scottish Government Health and Social Care Directorates.

6.4 As savings schemes were identified within the Board, each was quantified in terms of its full year effect / current year effect and allocated a “risk rating” (green, amber or red) in terms of;

- its achievability/likelihood;
- accuracy of the projected saving;
- extent of impact and consequences;
- requirement for Board approval / public consultation.

6.5 The breakdown of these numbers, split into green/amber and red, is provided in greater detail below and in **Appendices 3-5**;

TABLE 3: Breakdown of savings position 2016/17 - Green and Amber Schemes

NHSGCC	CYE	FYE	
Green and Amber Schemes	**16/17 £m**	**16/17 £m**	
Corporate Budgets			
Department			
Facilities	7.00	9.06	**Refer appendix 3**
Finance	0.50	0.50	**Refer appendix 3**
HI&T	1.51	1.51	**Refer appendix 3**
HR	0.60	0.60	**Refer appendix 3**
Nursing	0.20	1.20	
Public Health	0.95	0.95	**Refer appendix 3**
Corp Planning and Policy	0.25	0.25	
Corp Affairs	0.25	0.25	
Medical Director - Corporate	0.70	0.70	**Refer appendix 3**
Procurement	2.15	3.40	**Refer appendix 3**
	14.11	**18.42**	
Balance sheet management			
Re-assessment of asset lives and non-cash DEL	**3.00**	**3.00**	
Partnerships			
Staff and service rationalisation	7.75	7.75	**Refer appendix 4**
Bundled funding (including A&D)	1.80	1.80	**Refer appendix 4**
	9.55	**9.55**	
Bundled funding - Board share			
E- health - held from Strategic Fund	**1.30**	**1.30**	
Acute			
Various Acute local schemes	5.52	10.72	**Refer appendix 5**
Review use of Douglas Inch Forensics Estate	0.00	0.04	
	5.52	**10.77**	
Other initiatives			
Additional Pharmacy Efficiencies - DOACs	1.00	1.00	
Cease supply of gluten free bread	0.50	0.80	
	1.50	**1.80**	
Total Green and Amber Schemes	**34.98**	**44.83**	

TABLE 4: Breakdown of savings position 2016/17 - Red Schemes

NHSGCC			
Red Schemes			
	£m	**£m**	
Corporate			
VAT Reclaim Schemes	1.50	1.50	
	1.50	**1.50**	
Balance sheet management			
Re-assessment of asset lives and non-cash DEL	**3.00**	**3.00**	
Partnerships			
Physio	0.14	0.14	
Health Improvement	0.40	0.70	
	0.54	**0.84**	
Acute			
Clinically led service redesign propositions 2016/17	**3.09**	**5.89**	
Miscellaneous			
Reduction in medicines waste	0.50	0.50	
	0.50	**0.50**	
Total Red Schemes	**8.63**	**11.73**	

6.6 It is also important to highlight a number of clinically led service redesign initiatives included within the above schedules. Work continues around these, including dialogue and consultation where required.

Assumptions and Investments

6.7 Within the Financial Plan there are a number and range of assumptions and proposed investments (Table 1 and Appendix 1 point 7). As these are constantly subject to analysis and revision, the following key amendments require to be highlighted and adjusted with this LDP:

- Auto-enrolment – within the pay cost growth figure of £50.5m in Table 2 and Appendix 1 (point 1) is a provision of £5m for auto-enrolment to superannuation. This figure represents a prudent estimate of the number of staff who would enrol. However, since the April pay-run, a significant number of staff have opted out of the pension scheme and we expect more staff to opt out through June 2016. This provision has therefore been reduced to £3m.
- Service Investments – we continue to provide a range of specialist national services. The initial provision of £1.3m for increasing costs for Deep Brain Stimulation will be contained within the current service provision and income recovery model.

Overall Position and Remaining Gap

6.8 Summarised below in Table 5 is a summary of the current overall position.

TABLE 5: The overall savings position 2016/17

NHSGCC	CYE	FYE
Savings Summary	**16/17**	**16/17**
	£m	**£m**
2016/17 Savings Target	**69.00**	**69.00**
Savings summary achievability		
Green	20.08	20.35
Green/Amber	9.40	12.85
Amber	5.50	11.63
Total Green and Amber	**34.98**	**44.83**
Red	8.63	11.73
Total savings identified to date	**43.61**	**56.56**
Remaining gap - further savings required	**25.39**	**12.44**
Revisions to initial assumptions/investments	-3.30	-3.30
	22.09	9.14
Acute Division - cost containment cover	7.50	0.00
Cash requirement in-year	**29.59**	**9.14**

6.9 Acute Management drafted a £10m cost containment strategy in December 2015 to take effect before the 31st March 2016 in order to start the new financial year at, or close to, balance. However, this has proved extremely challenging, with the pressures around increasing demand and vacancies driving locum agency spend and sickness absence rates driving nurse bank and agency spend, and the continual use of winter beds which have remained open at a cost of circa £1.2m per month.

6.10 The Board will require to provide cash coverage (£7.5m) whilst the cost containment programme delivers. In addition, the Acute Division underachieved projected 2015/16 recurrent savings by £3m and HSCPs underachieved by £7m. These were covered non-recurrently in-year by each Division. However, further work and discussions are currently on-going to establish if these can be covered internally again in 2016/17.

6.11 It is clear from the above table that in addition to £11.7m of complex and challenging "red risk" rated schemes, on a full-year effect for 2016/17, the Board still has a savings gap of £9.1m (rounded up to £10m). It is proposed at this stage that these savings maybe realised through the National Workstreams.

National Workstreams

6.12 Through the joint work of the Chief Executives, Directors of Finance and Scottish Government colleagues a number of workstreams have been developed both to support Boards in their local delivery of savings plans, and to examine whether a national approach to certain propositions can be agreed and delivered. Work is on-going to determine whether these national initiatives will have a further positive impact locally.

6.13 A number of these workstreams are already incorporated in our local schemes (and 2016/17 cost containment programme) but a small number could deliver savings to NHSGGC. This includes a review of effective prescribing medicines and Shared Services for both corporate and clinical support functions.

6.14 However, until the outcome of these national workstreams become clear and for the purposes of achieving financial balance, the £10m will be allocated proportionately, and the three parts of the business are therefore required to identify additional schemes to close the gap – and present these to the October 2016 Board meeting. Should the national workstreams subsequently deliver the projected savings in-year, these additional local savings schemes will be deferred into 2017/18.

Allocation of Budgets

6.15 In order to ensure that we make financial decisions which align with our strategic direction we established a set of the principles which have previously been reported to the Board. These principles, explained above, have underpinned a whole system approach to financial planning and addressing savings in 2016/17.

6.16 However, in order to set budgets across the organisation, and to enable IJB Chief Officers to start setting Commissioning Strategic Plans the Board's uplift (1.7% / £33.7m) and cost pressures (£102.7m) must be apportioned across the three key parts of the business (Table 6 below) proportionately. This was performed on an indicative basis and communicated in writing to Chief Officers (and Non-executives) in March 2016 to enable financial planning. The £59.4 million allocated wholly to IJBs to fund Social Care has been excluded. It is for each individual IJB to separately negotiate their share of these monies.

TABLE 6 – 2016/17 Allocation of Uplift and Cost Pressures Across the Board

	Corporate Functions and Acute £m	Partnership £m	Total £m
Allocation of Uplift	20.8	12.9	33.7
Cost Pressures	69.8	32.9	102.7
2016/17 Gap	**49.0**	**20.0**	**69.0**

6.17 Upon approval of this Financial Plan, all budget holders will be formally notified of their budgets and the need to find additional savings to achieve the £69m target.

Managing in-year

6.18 As outlined above, Directors and Managers continue to work to address the remaining savings gap and finalise a balanced Plan. Due to the timing of the implementation and impact of these schemes in-year, the Board has again recognised the need to cash manage the business towards the realisation of these savings.

6.19 This will be achieved through the further utilisation of non-recurring provisions and reserves. For 2016/17, this will include a timing benefit repayable in future years through the reversal of historic provisions totalling £32.5m for NHSGGC. This was identified as part of the national Balance Sheet Flexibility Group and involves reclassifying the funding source of pre-2010 provisions, particularly in relation to Pension and Injury Benefit provisions. This does not impact on the actual level of provision, just the funding source, and will involve a charge to the RRL as the liabilities crystallise over a number of future years.

7. SUMMARY AND CONCLUSION

7.1 This Financial Plan demonstrates how the Board has worked, and will continue to work, to achieve financial balance in 2016/17. A significant number of savings schemes have been identified to address the financial gap. However, many of these are "red" rated and as such, there are significant risks around their delivery.

7.2 The current Plan contains a £10m FYE gap. The Board has previously intimated it has a risk appetite for setting a budget with a gap. Whilst this gap is expected to be covered by the outcomes from the National Workstreams, to mitigate that risk, each key budget holder will be required to (proportionately) present schemes to this value at the October 2016 Board meeting.

7.3 In addition, discussions and wider consultations remain ongoing with Scottish Government colleagues around various elements of this Plan.

Managing the Risk

7.4 It is clear from the above detail there is a real risk the Board will not achieve financial break-even in 2016/17. There are numerous risks to achieving break-even, the more operational risks of which are summarised above at paragraph 5.12.

7.5 To have a chance of break-even, all these risks must be managed. In addition, definitive management action and tangible results must be achieved around the following key risks;

- Achievement of the Acute cost containment programme, locum agency spend and sickness absence rates driving nurse bank and agency spend;
- Continued support from the Scottish Government around the achievement of key waiting times targets, particularly in the winter period;
- Managing any changes to the unscheduled care model within the current financial envelope;
- Achievement of all savings schemes outlined above, including service redesign propositions;
- Continued work to finalise, consult, approve and deliver the "red" rated schemes; and
- Achievement of £10m savings from the National Workstreams and/or identification, presentation and delivery to the October 2016 Board meeting of additional schemes equal to that sum from the three key areas of the business.

7.6 In terms of quantifying risk inherent in achieving break-even, and in addition to the £10m FYE gap outlined above, it is estimated the Plan carries financial risk of between £20m to £25m. Should this risk crystallise, there are insufficient reserves to provide cover. It would require receipts from projected land sales to ensure financial balance. However, the complexity and uncertainty over the timing and level of receipt of land sales must also be highlighted.

7.7 Whilst the Board at this point continues to work toward a balanced budget for 2016/17, it is apparent that again in 2016/17 the Board will be reliant on non-recurring sources of funding and reserves to achieve in-year balance. This position is clearly not sustainable. The continued use of non-recurring funds and reserves in 2016/17 to fund day-to-day business will create a significant risk to the sustainability of the Board into 2017/18 and beyond. There is a real risk the Board enters 2017/18 with minimal reserves.

Financial Planning 2017/18 and Beyond

7.8 As part of the 2015/16 financial planning process, the Board's internal auditors (PwC) were invited to perform a review of the process. The report concluded that "*the financial planning process is operating as intended and has evolved to reflect the significance of the financial gap and establishment of Integration Joint Boards".*

7.9 However, the report also highlighted *"the need for the timing of the financial planning process should commence earlier in the financial year*" and *"transparency at Board level is required of the progress being made to deliver the plan and to support strategic decision making that may be required".*

7.10 There is a need for a change in financial planning for 2017/18 and beyond. This will require the development and embedding of a more collegiate, continuous improvement environment that delivers savings on a more consistent basis. The Board has an excellent track record of achieving savings and improving efficiency. However, due to the scale of the financial challenge and underlying recurring financial imbalance, a transformation programme will be required to deliver a step change in the size and scale of recurring savings and efficiencies needed in 2007/18 and beyond.

7.11 This will include the Board devising a 3-5 year Strategic Plan, drafted in conjunction with IJBs, to ensure a model of affordable service delivery and quality patient care up to, and beyond, 2020.

APPENDIX 1 – NOTES TO SECTION 5 (Table 2)

1. Pay cost growth:

Pay cost growth comprises:

	£m
Provision for 1% uplift	15.3
Provision for additional low pay costs	4.2
Provision for additional Employers' National Insurance	25.0
Provision for discretionary points	1.0
Provision for auto-enrolment to Superannuation	5.0
	50.5

Pay provision: Current indications are that a provision of 1.0% for pay uplift in 2016/17 is reasonable. On top of the 1.0%, provision has been made for a minimum payment of £400 for staff earning up to £22,000.

Superannuation: A provision of £25.0m has been made for the abolition of the employers' 3.4% "contracted out" rebate for staff members of the NHS Superannuation scheme.

Discretionary Points: A provision of £1.0m has been made for the on-going impact of funding additional discretionary points.

Auto-enrolment to Superannuation: A provision of £5.0m has been made for the estimated cost of employees remaining in the superannuation scheme after auto-enrolment.

Incremental pay progression – AfC: The experience of monitoring Agenda for Change (AfC) related pay trends has helped the Board develop a detailed understanding of the effect of incremental pay progression. This has enabled us to carry out a detailed forecast of pay growth for 2016/17, using current staff turnover ratios by staff category. The pay modelling has indicated incremental pay progression for AfC will not be a cost pressure in 2016/17, so no provision has been made for additional costs.

Incremental pay progression – Consultants: There was an increase in average seniority, and hence costs, of consultants in the past two years. This is because of a fall in turnover. However, the pay modelling has indicated incremental pay progression for Consultants will not be a cost pressure in 2016/17, so no provision has been made for additional costs.

2. **Prescribing:** The prescribing cost growth projection for 2016/17 is based on information from the Board's Prescribing Advisers. It includes provision for likely cost increases related to growth in new and existing drug treatments within Acute Sector, including new drugs approved by SMC, and makes a realistic level of provision for likely growth in volume / prices, based on current trends, related to drug treatments prescribed within Primary Care. The results of this work are summarised below.

	£m
Primary Care	20.7
Acute	22.0
Hepatitis C	(9.1)
Gross Uplift	33.6
Primary Care Savings	(5.0)
Acute Savings	(3.0)
Total	**25.6**

Current estimate of Hepatitis C costs for 2016/17 is £10.9m. The existing recurring budget is £20.0m, so a reduction of £9.1m is required

3. **Energy:** Current estimates are, given the recent oil price decline, that no additional provision is required for 2016/17.

4. **Capital charges:** Indexation of asset values is anticipated to add £4.0m to capital charges.

5. **Other costs inflation:** 1.0% general provision has been set aside for inflation on non-pay costs excluding prescribing costs, energy costs, and capital charges costs. 1.7% has been set aside for uplifts to Resource Transfer, inflation on legal / contractual cost commitments and inflation on amounts payable to other NHS Boards, Local Authorities and Voluntary Organisations, related to SLAs.

6. **Social care:** SGHSCD has provided £59.4m, to be directed to Integrated Health and Social Care Partnerships, to ensure improved outcomes in social care.

7. **Pressures and Investments:** £7m has been set aside to fund the following key pressures and potential investments:

	£m	
Nursing Skill Mix	4.0	Potential additional costs
National Services	1.3	Deep Brain Stimulation
Robotic Prostatectomy	0.7	Per business case
Satellite Radiotherapy	0.7	Per business case
Research & Development	0.3	Reduction in funding
	7.0	

APPENDIX 2 – SUPPORTING NOTES TO SECTION 5

1. Represents the excess of recurring expenditure commitments over recurring funding carried forward from 2016/17.

2. An uplift of 1.7% has been assumed.

3. Assumed uplift to existing funding allocations where notification remains outstanding. This includes uplifts to a number of SGHSCD funding allocations, uplifts to national services and service level agreements with other Boards.

4. 0.5% uplift assumed for Primary Care Medical Services (PMS) & non cash limited funding and associated expenditure. Cost neutral impact.

5. For 2017/18 & 2018/19 a provision of 1.0% for general pay uplifts with a minimum of £400 for lower paid staff has been made.

6. This covers anticipated price inflation related to existing PPP commitments plus 1% to cover general inflation and growth on non pay costs.

7. This is based on an assessment of prescribing advisers' outline cost projections for acute and primary care services. For 2017/18 & 2018/19, indicative values based on general uplifts in 2016/17 have been used. This is a volatile area where, depending on drug approvals, cost pressures could be significant.

8. Provision for ongoing real increase in energy costs. The provision is an estimate of the possible increase in tariff charges.

9. Provision for increase in capital charges as a result of indexation of asset values.

10. Provision for inflationary uplift of service level agreements with other NHS Boards related to NHSGGC patients and of resource transfer agreements with local authorities.

11. 0.5% provision for increased spend on PMS & non cash limited services is in line with assumption of 0.5% increase in funding allocation. The overall impact is cost neutral.

12. This grouping includes all other unavoidable service commitments including:

- Robotic prostatectomy full year effect;
- Possible loss of R&D income.

13. Provision for cost pressures to come. This amount required will be kept under review.

14. Cost savings values required to bring the Plan into balance.

APPENDIX 3 – DETAILS OF CORPORATE SAVINGS SCHEMES

Corporate Budgets	CYE	FYE
GREEN AND AMBER SCHEMES	**16/17 £m**	**16/17 £m**
Facilities		
Soft FM pay and staff savings	2.295	3.060
Efficiencies in non essential maintenance budgets	1.500	1.500
Further soft FM pay savings	0.917	1.223
Catering - staff and patients. final phase of patient catering strategy	0.500	0.500
Catering - improve commercial performance of outlets	0.300	0.300
Transport and travel - various rationalisation proposals	0.140	0.247
Biomass boiler and Board wide Energy Saving campaign	0.752	1.014
Replace rental of Clyde channels by outright purchase	0.250	0.507
Various initiatives ahead of National Shared Business Case	0.234	0.507
Other minor schemes	0.116	0.199
	7.004	**9.057**
Finance		
Rationalisation of team structure	0.350	0.350
Audit contracts renegotiations	0.025	0.025
Other minor schemes	0.125	0.125
	0.500	**0.500**
HI&T		
Review of eHealth Record Services	0.370	0.370
eHealth redesign of IT services	0.080	0.080
eHealth staff rationalisation	0.264	0.264
Others/Slippage 15/16	0.800	0.800
	1.514	**1.514**
Human Resources		
Dept Restructuring and rationalisation of posts	**0.600**	**0.600**
Public Health		
changes to national vaccine programme	0.250	0.250
reductions in discretionary spend on professional fees	0.045	0.045
research commissioning	0.051	0.051
HI programme delivery and staffing reduction	0.486	0.486
Other minor schemes	0.114	0.114
	0.946	**0.946**
Medical Director - Corporate		
Various schemes TBC	**0.700**	**0.700**
Procurement		
Commercial/gain share Review of top 50 suppliers	1.000	2.000
NSS/WoS contract/tendering efficiencies	0.750	1.000
Scottish Govt Framework Contracts Temp Workers	0.250	0.250
Various schemes	0.150	0.150
	2.150	**3.400**
Grand Total	**13.414**	**16.717**

APPENDIX 4 – DETAILS OF PARTNERSHIP SAVINGS SCHEMES

Partnerships	CYE	FYE
GREEN AND AMBER SCHEMES	**16/17 £m**	**16/17 £m**
Universal Childrens Services	0.900	0.900
Workforce Planning	3.200	3.200
MH Inpatient Services Redesign	0.600	0.600
Oral Health	0.500	0.500
Integration - realignment in ED	0.250	0.250
Mental Health Strategy	1.000	1.000
Adult Cont Care	1.300	1.300
- Bundled funding (including A&D)	1.800	1.800
Grand Total	**9.550**	**9.550**

APPENDIX 5 – DETAILS OF ACUTE SAVINGS SCHEMES

Acute Budgets	CYE	FYE
GREEN AND AMBER SCHEMES	**16/17 £m**	**16/17 £m**
Workforce		
Admin review and management costs	0.430	0.802
Nursing and AHP reviews	0.353	0.785
Junior Doctors review in W&C	0.100	0.325
Identification of long term vacancies	0.080	0.080
Radiotherapy staff review	0.080	0.080
	1.043	**2.072**
Prescribing Targets across all Directorates	**0.909**	**1.534**
Service Redesign		
Review GGH beds and 7 day wards	0.188	0.226
West MIU	0.310	0.414
Clyde Orthotics to in-house service	0.090	0.125
Diagnostics - Point of Care Testing, DCPB/Med		
Illustration Review, Test Type Changes	0.150	0.250
Regional - Haematology, Rotational Physios Skill Mix, CIC	0.116	0.193
South Day Hospital	0.046	0.092
North - review of Psychology Service	0.025	0.050
North Sector Weight Management & Pain Service Reviews	0.000	0.145
	0.925	**1.495**
Non-pay		
Standardise/Rationalise	0.177	0.350
Procurement - all sectors	0.255	0.690
Diagnostics	0.087	0.115
Regional Services	0.048	0.061
Women & Childrens	0.400	0.800
HoP - system wide procurement review	0.500	1.900
	1.467	**3.916**
Bed Model		
Bed Model - beds identified re activity/occupancy	0.100	0.100
Regional Services Bed Model review of low occupancy	0.135	0.162
	0.235	**0.262**
Productivity		
Speciality Reviews	**0.270**	**0.495**
Others		
Income opportunities		
- Womens and Childrens	0.150	0.300
- Regional Services	0.130	0.130
- Diagniostics	0.025	0.080
Westmarc Review	0.040	0.040
CRES gains 15/16	0.250	0.250
Protection Costs Recovery via Staff Turnover	0.075	0.150
	0.670	**0.950**
Grand Total	**5.519**	**10.724**

NHS Greater Glasgow & Clyde

NHS BOARD MEETING

Director of Finance and Director of Facilities and Capital Planning **June 2016**

Capital Plan 2016/17 to 2018/19

The Board is requested to consider the content of/and approve the Capital Plan 2016/17 to 2018/19

Purpose of Paper:-

The purpose of the paper is to present the Board's Capital Plan for financial years 2016/17 to 2018/19 for approval. Refer to Appendices 1 & 2.

Key Issues to be considered:-

The purpose of the paper is to set out how the Board plans to deploy the initial allocation of capital funds on individual schemes in 2016/17. In recognition that many of the 2016/17 schemes have spend profiles that continue into 2017/18, the Board is asked to approve the capital plan for 2016/17 and 2017/18 and to note the indicative 2018/19 plan at the present time.

Expenditure on all capital schemes will be monitored throughout the year and reported to the Capital Planning Group to ensure that a balanced capital position is maintained. The Capital Planning Group is scheduled to meet on a bi-monthly basis throughout the forthcoming year in order to oversee the process of managing expenditure levels within available funds and ensuring that any new capital funds are approved in line with delegated authority levels.

The Capital Plan 2016/17 to 2018/19 sets out the Board's capital investment intentions across the Acute, Mental health, E health, Formula Allocation and HUB Schemes.

The draft capital plan has been submitted to and approved by the Capital Planning Group (CPG). The plan submitted to the Board for approval has a few minor adjustments to the plan approved by the CPG.

Any Patient Safety /Patient Experience Issues:- The core capital programme is aimed to improve the quality of the built environment which will lead to improvements to tangible and intangible benefits to the patient experience.

The Formula Capital (minor works) will be invested in spend to save schemes (eg, installation of energy efficient LED lights), schemes that will also positively impact on the backlog maintenance position and condition improvement of the built environment.

Any Financial Implications from this Paper:-

Financing of the capital plan is predicated on the estimated capital receipts for land disposals being realised and Board members should be aware that any under achievement will require the cash flows note in the capital plan to be re forecast. The Director of Finance and the Director of Facilities and Capital Planning will monitor capital receipt forecasts and income generation with support from colleagues seconded from the Scottish Future's Trust (SFT).

Any Staffing Implications from this Paper:- None.

Any Equality Implications from this Paper:- None.

Any Health Inequalities Implications from this Paper:- None

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome:-

No. However, Board members should be note that risk assessments will be carried out for individual projects noted in the capital plan during the procurement process.

Highlight the Corporate Plan priorities to which your paper relates:-

Improving Quality, Efficiency and Effectiveness

Author – Director of Finance and Director of Facilities and Capital Planning
Tel No – 0141 211 0270
Date – 21st June 2016

APPENDIX 1

Capital Plan 2016/17 to 2018/19

	Allocation 2016/2017 £'000	Allocation 2017/2018 £'000	Indicative Allocation 2018/19 £'000
Forecast Capital Resources	**£85,652**	**£65,364**	**£46,744**
Expenditure			
Gartnavel Hospitals Campus			
OPD Transfer from WIG to GGH	£0	tbc	tbc
Refurbishment of Laboratory at GGH	£400	£0	£0
GGH Theatres	£0	£2,700	£1,300
Level 7 - GGH	£1,010	£0	£0
Gartnavel Tower - Further Works	£180	£0	£0
Relocation of Drumchapel Hospital to GGH (Level 8)	£4,647	£0	£0
Ambulance Bay Works at GGH	£693	£1,500	£0
Improvements to Regeneration Kitchen at GGH	£2,780	£0	£0
Demolition of Shelley Court at GGH	£400	£0	£0
Demolition of Modular Unit at GGH	£50	£0	£0
Demolition of Water Tower at GGH	£130	£0	£0
Development of Masterplan at GGH	£200	£0	£0
Car Parking Provision at Gartnavel Hospitals	£600	£0	£0
Total Gartnavel Hospitals Campus	**£11,090**	**£4,200**	**£1,300**
Glasgow Dental Hospital			
Dental Hospital Phased upgrade	£1,364	£1,000	£500
Total Glasgow Dental Hospital	**£1,364**	**£1,000**	**£500**
Glasgow Royal Infirmary			
Demolition of Lister Building at GRI	£480	£475	£0
GRI Upgrade Wards 12a and 12	£1,500	£0	£0
GRI Upgrade Wards 20 and 21	£0	£2,441	£0
Further Phase of GRI Ward Upgrade Programme	£0	£0	£2,300
Total Glasgow Royal Infirmary	**£1,980**	**£2,916**	**£2,300**
Inverclyde Royal Hospital			
Infrastructure - IRH	£400	£2,000	£1,500
Total Inverclyde Royal Hospital	**£400**	**£2,000**	**£1,500**

APPENDIX 1

Capital Plan 2016/17 to 2018/19

	Allocation 2016/2017 £'000	Allocation 2017/2018 £'000	Indicative Allocation 2018/19 £'000
QEUH and RHC Campus			
QEUH - Remaining Works, including S.75 Payments	£10,736	£0	£0
Remaining Car Parking Provision	£4,012	£0	£0
Demolition of SGH Buildings Post QEUH Migration & Landscaping	£2,192	£0	£0
QEUH Enabling Works - HV/LV Cable	£43	£0	£0
INS - Overcladding & Window Upgrade	£1,947	£0	£0
INS Theatres Suite Redevelopment	£300	£4,000	£2,600
INS Ward 62 Refurbishment	£100	£2,300	£0
INS Infrastructure	£2,520	£2,500	£3,000
INS/ Spinal Unit - Upgrade to Ground Floor Corridor	£200	£0	£0
Neurology Entrance	£100	£1,800	£0
Neurology Recladding	£750	£750	£250
Neurology Link Bridge	£150	£2,000	£0
AMB/ CMB - External Façade Upgrade	£1,000	£0	£0
AMB/ CMB - Internal Refurbishment	£0	£5,000	£2,000
NHSGGC Floor in ICE Building	£6,038	£0	£0
Increase Capacity at Langlands Unit	£1,600	£800	£0
Total QEUH and RHC Campus	**£31,688**	**£19,150**	**£7,850**
Royal Alexandra Hospital			
RAH - Refurbishments and Reconfiguration (Fees)	£350	£0	£0
RAH - ITU	£1,000	£3,200	£0
RAH Infrastructure	£600	£0	£0
Total Royal Alexandra Hospital	**£1,950**	**£3,200**	**£0**
Stobhill Hospital			
Enabling Works for Stobhill site Rationalisation	£264	£0	£0
Development of Rowanbank Clinic	£500	£5,000	£2,500
Total Stobhill Hospital	**£764**	**£5,000**	**£2,500**
Yorkhill Hospital			
Interim Office Accommodation at Yorkhill	£253	£0	£0
Relocation of CAMHS at Yorkhill	£650	£0	£0
Total Yorkhill Hospital	**£903**	**£0**	**£0**
Diagnostics			
Radiotherapy Equipment Replacement	£3,288	£5,681	£6,150
PET Scanner	£0	£0	£2,671
Total Diagnostics	**£3,288**	**£5,681**	**£8,821**

APPENDIX 1

Capital Plan 2016/17 to 2018/19

		Allocation 2016/2017 £'000	Allocation 2017/2018 £'000	Indicative Allocation 2018/19 £'000
Corporate				
Board Wide Formula Allocation for Works Schemes - covering	}	£12,312	£8,000	£10,000
- Backlog Maintenance	}			
- Health & Safety	}			
- Service Developments	}			
- HAI	}			
Laundry Equipment		£1,800	£0	£0
Medical Equipment		£5,084	£3,500	£5,000
Carbon Emissions (Purchase of Carbon Credits)		£100	£100	£100
Energy Invest to Save Schemes		£2,382	£0	£0
eHealth Relocation - Leasehold Improvements		£220	£0	£0
Land Acquisition at Johnstone Hospital		£55	£0	£0
Brand Street - Leasehold Improvements		£200	£0	£0
Works in connection with Sandyford Services		£0	£2,000	£0
Total Corporate		**£22,153**	**£13,600**	**£15,100**
eHeath Schemes				
eHealth Formula		£2,250	£4,650	£2,000
TOTAL HI&T		**£2,250**	**£4,650**	**£2,000**
Mental Health				
Adult Mental Health Programme				
Stobhill Ward 43		£1,662	£0	£0
Stobhill Ward 44		£1,659	£0	£0
Stobhill Broadford		£46	£772	£0
Gartnavel Tate		£1,848	£1,752	£0
Gartnavel Clyde (Design)		£185	£0	£0
Total Mental Health		**£5,400**	**£2,524**	**£0**
Investment in Hub Schemes				
Enabling Costs re Hub Schemes (Land Acquisitions)		£360	£0	£0
Invt of Subordinated Debt in respect of Potential Hub Schemes		£304	£484	£0
Equipping requirements of Hub Schemes		£1,392	£150	£1,549
Contribution to Hub Schemes		£0	£0	£2,400
Total Investment in Hub Schemes		**£2,056**	**£634**	**£3,949**
Total Spend		**£85,286**	**£64,555**	**£45,820**
Net Slipage/(Acceleration)//(Over-commitment) /Unallocated		**£366**	**£809**	**£924**

Appendix 2

Summary of Forecast Disposals

Net Book Value

Site	2016-17					2017-18				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Lennox Castle Hospital (Ph 2)					**£0**		£350,000			**£350,000**
Cowglen Land Excess		£1,500,000			**£1,500,000**					**£0**
Lenzie					**£0**			£2,000,000		**£2,000,000**
Broomhill Surplus Land					**£0**			£4,250,000		**£4,250,000**
Mansionhouse Geriatric Hospital			£525,000		**£525,000**					**£0**
Merchiston Hospital		£6,000,000			**£6,000,000**					**£0**
Stoneyetts Surplus Land					**£0**				£3,000,000	**£3,000,000**
Victoria Infirmary					**£0**				£2,250,000	**£2,250,000**
Johnstone Hospital				£150,000	**£150,000**					**£0**
Irh - Gateside Laundry					**£0**	£300,000				**£300,000**
Maryhill Health Centre				£300,000	**£300,000**					**£0**
Ruchill				£1,250,000	**£1,250,000**					**£0**
Blawarthill	£1,500,000				**£1,500,000**					**£0**
Clarkston		£20,000			**£20,000**					**£0**
Elizabeth Martin Clinic			£50,000		**£50,000**					**£0**
Crail Street	£80,000				**£80,000**					**£0**
Drumchapel				£150,000	**£150,000**					**£0**
Carsewell House					**£0**				£90,000	**£90,000**
Acorn Street					**£0**				£20,000	**£20,000**
Total	**£1,580,000**	**£7,520,000**	**£575,000**	**£1,850,000**	**£11,525,000**	**£300,000**	**£350,000**	**£6,250,000**	**£5,360,000**	**£12,260,000**

Greater Glasgow and Clyde NHS Board

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NHS
Greater Glasgow and Clyde

David Leese
Chief Officer
Renfrewshire Health and Social Care Partnership
Renfrewshire House
Cotton Street
Paisley
PA1 1AL

Date: 5th July 2016
Our Ref: RC/BOB

Enquiries to: Robert Calderwood
Direct Line: 0141-201-4614
E-mail: mailto:robert.calderwood@ggc.scot.nhs.uk

Dear David

2016/17 Financial Allocation to Renfrewshire Health & Social Care Partnership

The Board approved the 2016/17 Financial Plan for NHS Greater Glasgow and Clyde on 28 June 2016.

The attached paper outlines the main assumptions as they apply to HSCPs and Appendix I gives specific details for your partnership including some recently agreed adjustments to Facilities budgets. Some further adjustments are required for telecoms, property maintenance and rates budgets. The prescribing out-turn figures for 2015/16 which form the basis for setting the current year budget have only recently become available and therefore the net uplift to your current prescribing budget will be applied during July.

The adjustments in the attached schedule will be processed in the Health Board ledger in time for the closure of the June reporting period and should be reflected in the out-turn you report to your HSCP Board for the first quarter of 2016/17.

Yours sincerely

Robert

Robert Calderwood
Chief Executive

NHS
Greater Glasgow and Clyde

FINANCIAL PLAN 2016/2017
UPLIFTS TO PARTNERSHIPS

Summary

The Board's Financial Plan was approved by the Board on 28 June 2016.

This paper provides details of uplifts for pays, non-pays and prescribing growth in 2016/17. This will form the basis for updating budgets for 2016/17.

Salaries Inflation

(1) Agenda for Change

A provision has been made for an increase of 1.0%. In addition, a provision has been made for a flat rate increase of £400 for staff earning less than £22,000.

(2) Medical & Dental

A provision has been made for a general increase of 1.0%.

(3) Other Staff Groups

A provision has been made for a general increase of 1.0%.

(4) Employers' National Insurance

A provision has been made for the abolition of the contracted out rebate of 3.4% in employers' national insurance contributions in respect of staff who are members of the superannuation scheme.

For paragraphs (1) to (4), this gives a composite uplift of 2.98% with the following recurring uplift:

Salaries Inflation	£9,583,168

(5) Incremental Pay Progression – AfC

The experience of monitoring Agenda for Change (AfC) related pay trends has helped the Board develop a detailed understanding of the effect of incremental pay progression. This has enabled us to carry out a detailed forecast of pay growth for 2016/17, using current staff turnover ratios by staff category. The pay modelling has indicated incremental pay progression will not be a cost pressure in 2016/17, so no provision has been made for additional costs.

(6) Incremental Pay Progression – Consultants

The pay modelling has indicated incremental pay progression will not be a cost pressure in 2016/17, so no provision has been made for additional costs.

(7) Auto-enrolment to Superannuation

A provision has been made for the estimated cost of additional staff remaining within the Superannuation scheme following automatic re-enrolment on 1 April 2016. This will be applied to budgets as the actual costs are confirmed.

(8) Discretionary Points

A provision has been made for the on-going impact of funding additional discretionary points. This gives the following recurring uplift:

Discretionary Points	£100,000

Supplies Inflation

(1) PPP and similar costs

Provision has been made for the following recurring uplift:

PPP Inflation	£209,813

(2) General non pay uplifts – a provision of 1.0% has been made for other supplies, excluding drugs which will be separately funded. This gives the following recurring uplift:

Supplies Inflation	£603,142

Capital Charges

It is not possible to establish allocations for capital charges costs at this stage until the effects of the revaluation are assessed and capital charge forecasts are finalised. When this is complete the funding allocations for 2016/17 will be confirmed. It has been agreed that capital charges budgets will be removed from partnerships during 2016/17 and managed on a whole system basis.

Prescribing Growth – Primary Care

The prescribing cost growth projection for 2016/17 is based on information from the Board's Prescribing Advisers. It includes provision for likely growth in volume / prices, based on current trends, related to drug treatments prescribed within Primary Care.

The recurring uplift for 2016/17 is:

Partnerships	
Increase in Volume	£12,200,000
New Drugs	£8,500,000
Targeted Cost Savings	(£5,000,000)
Prescribing Growth	£15,700,000

NHS
Greater Glasgow and Clyde

FINANCIAL PLAN 2016/2017
UPLIFTS TO PARTNERSHIPS

Allocations to individual partnerships are currently being finalised and will be applied to budgets prior to closure of the June reporting period. The Board will continue to operate the risk sharing arrangement for prescribing costs during 2016/17.

Resource Transfer

A provision of 1.7% has been made for uplifts to resource transfers. This gives the following recurring uplift:

Resource Transfer	£2,207,688

Cost Savings

Local Cost Savings plans for 2016/17 have not yet been fully developed and quantified. An interim recurring amount of £10.4m has been identified for 2016/17 reflecting the collective cost savings programme to achieve £69.0m.

Chief Officers were advised by the Chief Executive on 14 March 2016 that further recurring local savings will be required during 2016/17 to meet the overall partnerships savings requirement of £20.0m. The allocation of the overall savings requirement is shown in appendix I.

Cost Savings	(£20,000,000)

It is recognised that Partnerships may not be able to release the full £20.0m in 2016/17. Non recurring relief is limited but availability of non-recurring relief to offset the full year effect will be subject to further discussion during the year, so no funding will be released at this stage.

The Board will endeavour to cover 2015/16 unachieved savings of £7.8m from non recurring sources, however further savings schemes may need to be identified as part of the contribution to the £10m of unidentified savings in the Board's financial plan should the national programme of work fail to identify sufficient savings to cover this gap.

Service Commitments

Provision has been made to fund service commitments arising from specific funding allocations. This gives the following recurring uplifts:

Integrated Care Fund	£59,354,000

Funding for other service commitments will be dealt with separately.

NHS
Greater Glasgow and Clyde

FINANCIAL PLAN 2016/2017
UPLIFTS TO PARTNERSHIPS

Appendix I

Details of the specific uplifts and other adjustments are detailed in the table below.

Partnership Budgets	Renfrew £k
Rollover Budgets	*144,880.6*
Uplifts Applied	
Pay incl low pay allowance	511.1
National Insurance rebate withdrawn	762.8
Auto Enrolment (NR - Amounts to M2 only)	108.3
RT Uplift incl addictions RT	282.0
Non Pay Uplift	51.3
PPP	
Net Prescribing adjustment tbc	
Social Care funding	8,774.0
Facilities Budget withdrawn	-7.0
Depreciation Budget Withdrawn	-1,592.0
Savings	
Savings Targets Applied (Month 2)	-496.0
Outstanding Savings Targets to be applied (Month 3)	-1,378.2
2016.17 Opening Budget	**151,896.8**
Anticipated Funding & Minor adjustments	-833.8
2016.17 budget as at 30.06.16	**151,063.0**

Comparison of 2016/17 Notional Set Aside Budgets with NRAC Share

	2013/14 Activity			2014/15 Activity				Average Activity			2014/15	2015/16	2016/17	NRAC		NRAC Variance
Inpatients	SMR Discharges	Activity OBD	A&E Attendances	SMR Discharges	Activity OBD	A&E Attendances	£000	SMR Discharges	Activity OBD	A&E Attendances	£000	£000	£000	%	£000	£000
Renfrewshire	19,295	100,344		20,539	106,456		24,290	19,918	103,400		24,490	24,735	24,982	14.96838	27,789	2,807
A&E Outpatients																
Renfrewshire			47,148			47,102	4,504			47,125	4,509	4,554	4,599	14.96838	4,517	(82)
Total																
Renfrewshire	19,295	100,344	47,148	20,539	106,456	47,102	28,794	19,918	103,400	47,125	28,999	29,289	29,582	14.96838	32,306	2,725

Notes

1 2014/15 Notional Budget is based on the average of 2013/14 and 2014/15 activity
4 Cost based on PLICS applied to activity by ISD reconciled to 2014/15 Cost Book
3 1% annual uplifts applied to 2014/15 budgets to derive 2016/17 budgets
4 NRAC shares for 2016/17 used as a comparison

2016/17 Notional Set Aside Budgets by Specialty

		2013/14			2014/15				Average activity			Cost Base 2014/15	2015/16	2016/17	NRAC		NRAC Variance
		Treated in GGC Hospitals			Total in scope IP treatment												
HSCP	Specialty	SMR Discharges	SMR OBD	A&E attendances	SMR Discharges	SMR OBD	A&E attendances	£	SMR Discharges	SMR OBD	A&E attendances	£000	£000	£000	%	£000	£000
Renfrewshire	Accident & Emergency	330	507		238	308		122	284	408		169	171	172			
	General Medicine	15,926	50,989		17,234	53,534		13,829	16,580	52,262		14,220	14,362	14,506			
	GP other than Obstetrics	9	25		8	16		6	9	20		16	16	16			
	Rehabilitation	12	136		15	617		150	14	376		124	126	127			
	Respiratory	77	350		57	370		137	67	360		165	167	168			
	Sub Total	16,354	52,007		17,552	54,846		14,244	16,954	53,426		14,694	14,841	14,990			
	Geriatric Assessment				2,870	42,545		8,367									
	Geriatric Long Stay				117	9,065		1,679									
	Geriatric Medicine	2,941	48,337		2,987	51,610		10,046	2,964	49,973		9,796	9,894	9,993			
	Inpatients Total	19,295	100,344		20,539	106,456		24,290	19,918	103,399		24,490	24,735	24,982			
	A&E Outpatients			47,148			47,102	4,504			47,125	4,509	4,554	4,599			
	Total Set aside budget	**19,295**	**100,344**	**47,148**	**20,539**	**106,456**	**47,102**	**28,794**	**19,918**	**103,399**	**47,125**	**28,999**	**29,289**	**29,582**	14.96838	32,306	2,725

Comparison of 2016/17 Notional Set Aside Budgets with NRAC Share

Inpatients	2013/14 Activity SMR Discharges	Activity OBD	A&E Attendances	2014/15 Activity SMR Discharges	Activity OBD	A&E Attendances	£000	Average Activity SMR Discharges	Activity OBD	A&E Attendances	2014/15 £000	2015/16 £000	2016/17 £000	NRAC %	NRAC £000	NRAC Variance £000
Renfrewshire	19,295	100,344		20,539	106,456		24,290	19,918	103,400		24,490	24,735	24,982	14.96838	27,789	2,807
A&E Outpatients																
Renfrewshire			47,148			47,102	4,504			47,125	4,509	4,554	4,599	14.96838	4,517	(82)
Total																
Renfrewshire	19,295	100,344	47,148	20,539	106,456	47,102	28,794	19,918	103,400	47,125	28,999	29,289	29,582	14.96838	32,306	2,725

Notes

1 2014/15 Notional Budget is based on the average of 2013/14 and 2014/15 activity
4 Cost based on PLICS applied to activity by ISD reconciled to 2014/15 Cost Book
3 1% annual uplifts applied to 2014/15 budgets to derive 2016/17 budgets
4 NRAC shares for 2016/17 used as a comparison

2016/17 Notional Set Aside Budgets by Specialty

		2013/14			2014/15				Average activity			Cost Base 2014/15	2015/16	2016/17	NRAC		NRAC Variance
		Treated in GGC Hospitals			Total in scope IP treatment												
HSCP	Specialty	SMR Discharges	SMR OBD	A&E attendances	SMR Discharges	SMR OBD	A&E attendances	£	SMR Discharges	SMR OBD	A&E attendances	£000	£000	£000	%	£000	£000
Renfrewshire	Accident & Emergency	330	507		238	308		122	284	408		169	171	172			
	General Medicine	15,926	50,989		17,234	53,534		13,829	16,580	52,262		14,220	14,362	14,506			
	GP other than Obstetrics	9	25		8	16		6	9	20		16	16	16			
	Rehabilitation	12	136		15	617		150	14	376		124	126	127			
	Respiratory	77	350		57	370		137	67	360		165	167	168			
	Sub Total	16,354	52,007		17,552	54,846		14,244	16,954	53,426		14,694	14,841	14,990			
	Geriatric Assessment				2,870	42,545		8,367									
	Geriatric Long Stay				117	9,065		1,679									
	Geriatric Medicine	2,941	48,337		2,987	51,610		10,046	2,964	49,973		9,796	9,894	9,993			
	Inpatients Total	19,295	100,344		20,539	106,456		24,290	19,918	103,399		24,490	24,735	24,982			
	A&E Outpatients			47,148			47,102	4,504			47,125	4,509	4,554	4,599			
	Total Set aside budget	**19,295**	**100,344**	**47,148**	**20,539**	**106,456**	**47,102**	**28,794**	**19,918**	**103,399**	**47,125**	**28,999**	**29,289**	**29,582**	14.96838	32,306	2,725

Renfrewshire Health and Social Care Partnership
Finance and Planning Group
***Draft* Terms of Reference**

1. Introduction

1.1. The Finance and Planning Group will be a sub group of the Health and Social Care Partnership (HSCP) Senior Management Team.

1.2. The overarching purpose of the Finance and Planning Group will be to establish a strategic integrated service and financial planning approach within the HSCP; to improve outcomes for our service users where possible, whilst ensuring the Integration Joint Board delivers financial balance.

2. Membership

Member	Designation
Sarah Lavers (Joint Chair)	Chief Finance Officer
Fiona MacKay(Joint Chair)	Head of Strategic Planning and Health Improvement
David Leese	Chief Officer
Jean Still	Head of Administration
Katrina Philips	Head of Mental Health, Addiction and Learning Disability Service
Ian Beattie	Heads of Health and Social Care (Paisley)
Mandy Ferguson	Heads of Health and Social Care (West Renfrewshire)
Frances Burns	Change and Improvement Manager

3. Chairmanship

3.1. The Group will be jointly chaired by the Chief Finance Officer and the Head of Strategic Planning and Health Improvement.

4. Quorum

4.1. The quorum of members at any meeting of the Finance and Planning Group will be at least three members of the Group, including one of the group Chairs and an Operational Head of Service.

5. Meeting Frequency

5.1. The Finance and Planning Group will meet monthly, following every 2nd Senior Management Team meeting.

6. Remit

6.1. Establish a strategic integrated service and financial planning approach within the HSCP;

6.2. Oversee the delivery of the HSCP's Strategic Plan and Financial Plan on behalf of the Integration Joint Board;

6.3. Establish a three year financial planning cycle which will align with our Strategic Plan;

6.4. Work with Renfrewshire Council and NHS GGC to ensure alignment with the IJB's parent organisations' budget planning process and change programmes;

6.5. Provide financial advice and recommendations to the IJB which are underpinned by strategic commissioning and evidence based models;

6.6. Adopt a collaborative approach to service and financial planning, consulting with our key stakeholders including the Strategic Planning Group, HSCP Leadership Network and parent organisations and wider HSCP partners within NHSGGC;

6.7. Enable strong Third Sector, Provider and Community Group engagement with the HSCP's strategic commissioning process; to influence the effective use of the IJB's resources, and make recommendations on the allocation of such resources in line with local priorities;

6.8. Identify and scope projects on a continuous basis and, as part of the Partnership's wider transformation programme, to be presented for consideration and approval to the IJB throughout each year and across financial years; and

6.9. Develop and deliver a supporting transformation Change and Improvement Programme, to where possible, improve outcomes for our service users whilst ensuring the IJB delivers financial balance.

7. Attendance

7.1. Other professional advisors and senior officers will be invited by the Chair(s) to attend as required.

8. Reporting

8.1. The Finance and Planning Group will provide relevant and timely advice to the Integration Joint Board regarding budget and financial planning arrangements and delivery of the Strategic Plan.

8.2. The Finance and Planning Group will present proposed transformation projects for consideration and approval to the IJB, as part of the HSCP's wider transformation Change and Improvement Programme.

9. Conduct of Meetings

9.1. A meeting agenda will be circulated to member in advance of each meeting.

9.2. A record of each meeting will be circulated to group members following each meeting.

To:	**Renfrewshire Integration Joint Board**
On:	**16 September 2016**
Report by:	**Chief Officer**
Subject:	**Renfrewshire HSCP Performance Management Exception Report**

1. Summary

1.1 It was agreed that an update on performance would be presented at all IJB meetings. The full scorecard updating all performance measures will be presented twice yearly, with the next one to be reported at the 25th November 2016 meeting.

1.2 This report provides an update on four indicators from the Performance Scorecard 2016/17 that were discussed at the IJB in June 2016:

- % of clients on the Social Work Occupational Therapy (OT) waiting list allocated a worker within 4 weeks;
- % of long term clients receiving intensive home care
- % of Primary Care Mental Health Team patients referred to first appointment offered within 4 weeks;
- The number of non-smokers at the 3 month follow up in the 40% most deprived areas.

2. Recommendation

It is recommended that the IJB:

2.1 Note the updates on performance in Occupational Therapy, Home Care, Community Mental Health and Smoking Cessation and supports the remedial actions proposed.

2.2 Note that the full scorecard updating all performance measures will be presented at the 25th November 2016 meeting.

3. Exception Reporting

3.1 Background

The Performance Report 2015/16 presented at the last IJB meeting on 24th June 2016 has a range of performance measures across health and adult social work. The full scorecard will be presented to the IJB showing performance at mid year. Exception reports will be taken to all IJB meetings.

3.2 An exception report on two health measures and two social work measures are included in this report. All these measures show an improvement in performance. The Occupational Therapy and the Primary Care Mental Health referral targets have not yet been achieved but good progress has been made in both areas.

3.3 A summary of performance on the four measures is included at Appendix one. Detailed exception reports are included in Appendix two.

3.4 **Red status indicator - Social Work Occupational Therapy (OT) waiting list allocated a worker within 4 weeks**

There are two performance measures for Social Work OT. The average number of clients on the OT waiting list and those on the waiting list allocated a worker within 4 weeks. The target for the average number of clients on the waiting list is a maximum of 350 and at March 2016 this was achieved, with 297 clients on the waiting list. The second measure of allocating a worker within 4 weeks for non critical cases is proving more challenging.

There has been an increase of around 50% in referrals to Adult Services over the past 3 years. Requests for OT assessments constitute a substantial element of these referrals. Over this period the OT service has been reorganised, resulting in improved working practice. Despite this, the upward trend in referral rates has continued and increased productivity by OTs has a consequential impact on both equipment and adaptation budgets.

Quarter one in 2016/17 shows 50% of clients on the OT waiting list were allocated a worker within 4 weeks; an increase from 20% at March 2016 but still less than the 70% target.

It remains a challenge to allocate non critical cases with the 4 week period due to the 50% increase in referrals over the past three years and the increasing complex needs that service users present with. Please see appendix 2 for more detail.

3.5 **Amber status indicator - Percentage of Primary Care Mental Health Team patients referred to first appointment offered within 4 weeks**

At July 2016, 94% of Primary Care Mental Health Team patients were referred to their first appointment within 4 weeks, 6% below the 100% target but an increase of 6% on the financial year end figure of 88% (red status). While there was a further dip in April 2016 to 60%, July's performance of 94% now shows the current status as amber.

Over this period GP venue refurbishment has caused difficulty in operating appointments for face to face assessment and treatment in

two locations. This issue has now been addressed by relocating staff and offering appointments in alternative venues.

Two new have now been filled and are expected to start in September 2016. This will improve the team's capacity and flexibility in assessing and will be crucial in expanding our ability to provide face to face appointments. This was an area where most of the previous 8 breaches were noted. Continued improvement is expected throughout 2016.

3.6 **Green status indicators – Home Care and Smoking Cessation**

Home Care - good progress has been made in the performance of care at home service during 2015/16. Performance at March 2016 was the first time the national target of 30% of long term care clients receiving intensive home care (10 hours plus) was achieved. This is reflective of the increasingly complex needs of individuals who are being supported at home; it is anticipated that the figure will continue to rise as the older population increases.

Smoking cessation - at March 2016, there were 254 non smokers at the 3 month follow up in the 40% most deprived areas, an encouraging 48.5% above the annual target of 171. Quarter 4, January-March 2016 saw the biggest increase with 83 quits against the quarter target of 43.

To maintain performance in 2016/17, all clinics are now open access to maximise accessibility with no booking or referral required. In addition, clinics will run in a rolling format, therefore clients can access the service at any point and stay for the duration they require to achieve 12 weeks' Smokefree. A shared-care pharmacy clinic has also been established in Ferguslie Park.

Implications of the Report

1. **Financial –** None
2. **HR & Organisational Development –** None
3. **Community Planning –** None
4. **Legal –** Meets the obligations under clause 4/4 of the Integration Scheme.
5. **Property/Assets –** None
6. **Information Technology –** None
7. **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. However a positive impact has been noted for smoking cessation in the 40% most deprived areas, where 2015/16 performance was 48.5% above target. This is an encouraging result, which should contribute to reducing the health gap across communities.

If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be publicised on the Council's website.

8. **Health & Safety –** None
9. **Procurement –** None
10. **Risk –** None
11. **Privacy Impact –** None

Author:

- Clare Walker, Planning and Performance Manager
- Gayle Fitzpatrick, Service Planning and Policy Development Manager

Renfrewshire Integration Joint Board Scorecard 2016/17

Appendix 1

PI Status	
	Alert
	Warning
	OK
	Unknown
	Data Only

Direction of Travel	
	Improvement
	Deterioration
	Same as previous reporting period

National Outcome 2. People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.						
PI code & name	2014/15 Value	2015/16 Value	Latest 2016/17 Value	Target	Direction of Travel	Status
Local Indicators						
HSCP/AS/HC/02 Percentage of long term care clients receiving intensive home care (National Target: 30%)	28%	31%	Annual %	30%		
HSCP/AS/OT/01 Percentage of clients on the OT waiting list allocated a worker within 4 weeks (Social Work only)	13%	20%	50%	70%		

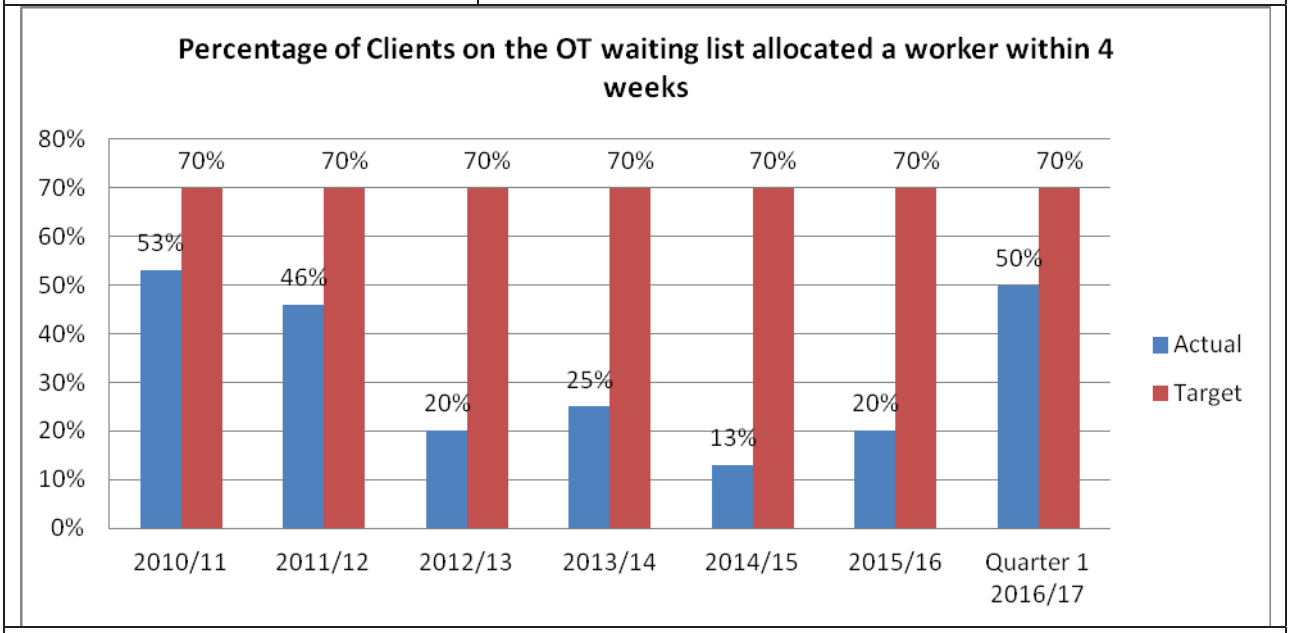
National Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.						
PI code & name	2014/15 Value	2015/16 Value	Latest 2016/17 Value	Target	Direction of Travel	Status
Local Indicators						
HSCP/MH/PCMHT/03 Percentage of Primary Care Mental Health Team patients referred to first appointment offered within 4 weeks	-	88%	94%	100%		

National Outcome 5. Health and social care services contribute to reducing health inequalities.						
PI code & name	2014/15 Value	2015/16 Value	Latest 2016/17 Value	Target	Direction of Travel	Status
HSCP/HI/AD/01 Smoking cessation - non smokers at the 3 month follow up in the 40% most deprived areas	-	254	Not yet available	171		

Appendix 2

Exception Report: Percentage of clients on the OT waiting list allocated a worker within 4 weeks – Outcome 2

Measure	Percentage of clients on the OT waiting list allocated a worker within 4 weeks. Social Work only target.
Current Performance	During the first quarter of 2016/17, 50% of clients on the waiting list were allocated a worker within 4 weeks. Current performance is lower than the target of 70%, but has significantly improved on the 2015/16 year end figure of 20%.
Lead	Ian Beattie, Head of Health & Social Care Services, Paisley and Mandy Ferguson, Head of Health & Social Care Services, West Renfrewshire.



Commentary

There has been a significant increase of around 50% in referrals to Adult Services over the past 3 years. Requests for OT assessments constitute a substantial element of these referrals, resulting in considerable additional demand on OT services. At Quarter 4 in 2014/15, adult services received 7,335 contacts compared with 5,531 in the first quarter of 2012/13.

Over this period the OT service has been reorganised, resulting in improved working practice. Despite this, the upward trend in referral rates has continued, while the resource to respond has remained static. The exception to this is the Reablement service. Increased productivity by OT's has a consequential impact on both equipment and adaptation budgets, and there has been particular pressure on waiting times for OT assessment.

Performance in relation to OT assessment, the provision of equipment and the installation of small adaptations has actually improved over the period and the waiting list numbers have reduced.

Actions to Address Performance

- Vacant posts in the locality teams have now been filled which has increased capacity and reduced waiting times. We continue working to improve performance and pathways in Occupational Therapy across the Partnership.

- To address high levels of demand in particular areas, managers are now allocating OT work across the whole Renfrewshire area to ensure a more even distribution.

- OT duty systems ensure non complex cases are dealt with quickly and not added to the waiting list.

- Urgent cases will be seen quicker and lower priority may wait longer.

- Work to increase collaboration and pathways between community based social care and health OTs. This may produce a benefit in the short term, although the impact of this change of practice on both services will require to be evaluated.

Timeline For Improvement

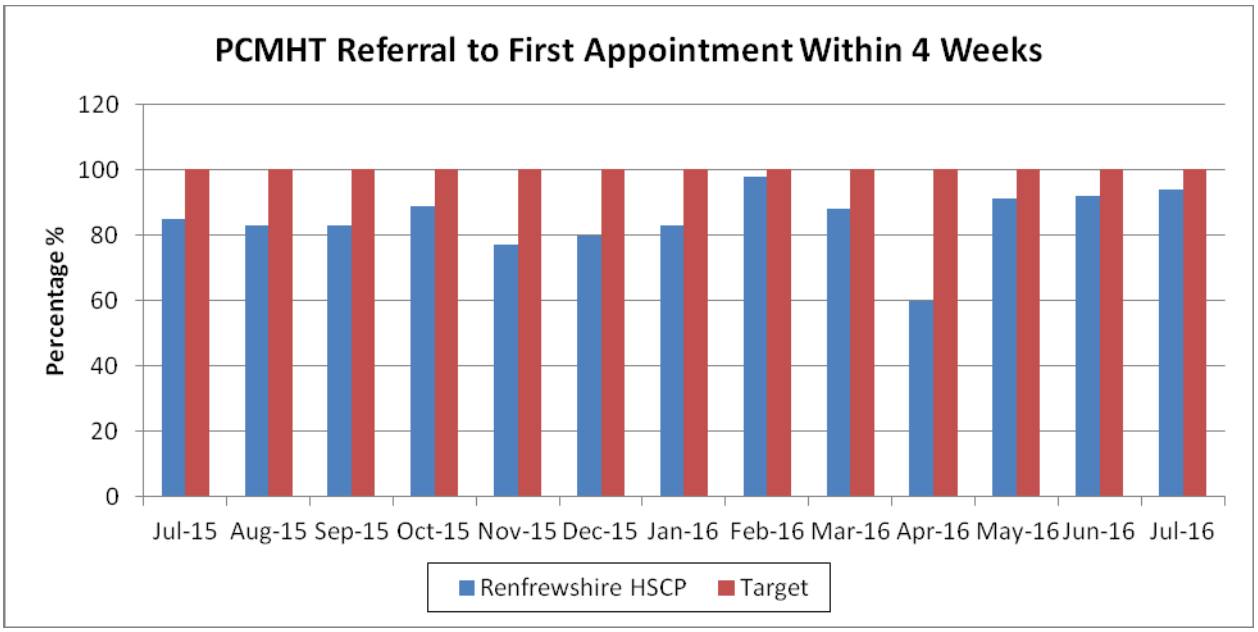
- Over the next 12 months overall performance and waiting times will be closely monitored.

- OTs are currently performing well and coping with additional demand and increases complexity of referrals. It will remain a challenge to allocate non critical cases within a 4-week period and consideration should be given to revising this target.

Appendix 2

Exception Report: Percentage of Primary Care Mental Health Team patients referred to first appointment offered within 4 weeks – Outcome 3

Measure	**Percentage of Primary Care Mental Health Team patients referred to first appointment offered within 4 weeks**
Current Performance	**At July 2016, 94% of patients were referred to first appointment within 4 weeks against a target of 100%**
Lead	**Katrina Phillips, Head of Mental Health, Addiction and Learning Disability Services**



Commentary

At July 2016, 94% of Primary Care Mental Health Team patients were referred to their first appointment within 4 weeks, 6% below the 100% target but an increase of 6% on the financial year end figure of 88% (red status). While there was a further dip in April 2016 to 60%, July's performance now means the status has returned to amber.

Currently (at August 16), the Doing Well service has capacity to ensure all telephone assessments are carried out within 28 days. The service has adjusted over the last few months to staff leaving posts and subsequently recruiting to these posts.

Over this period GP venue refurbishment has caused difficulty in addressing appointments for face to face assessment and treatment in two locations. This issue has now been addressed by relocating staff.

At times, patient expectations and demands do not meet the target demands of the service. For example, patients self-referring then advising they wish an assessment appointment outwith the 4-week target; or patients requesting a particular venue and matching the request to availability of clinical space.

Actions to Address Performance

Currently the Team Leader at Doing Well is in the process of re-allocating staff resources to meet the current demand across Renfrewshire GP practices regarding both assessment and treatment.

Doing Well staff are using admin time to open up extra clinics/appointments to meet the team's demand for assessment and treatment.
Staff are aware of caseload management and improvements in performance and the need for further continued effort are covered at team meetings. The Team Leader is monitoring team assessment activity through PIMS and BOXI systems for accuracy and demand.

The Team Leader supports staff in monitoring/ensuring prompt attention to demand for face to face assessments.
Two new staff have been recruited and will start with Doing Well in the next 8 weeks. This will enable the service to increase its ability and flexibility to meet patients' demands on the service in the forthcoming months.

The Team Leader attends monthly one-to-one management meetings with the Service Manager to review capacity and demand.

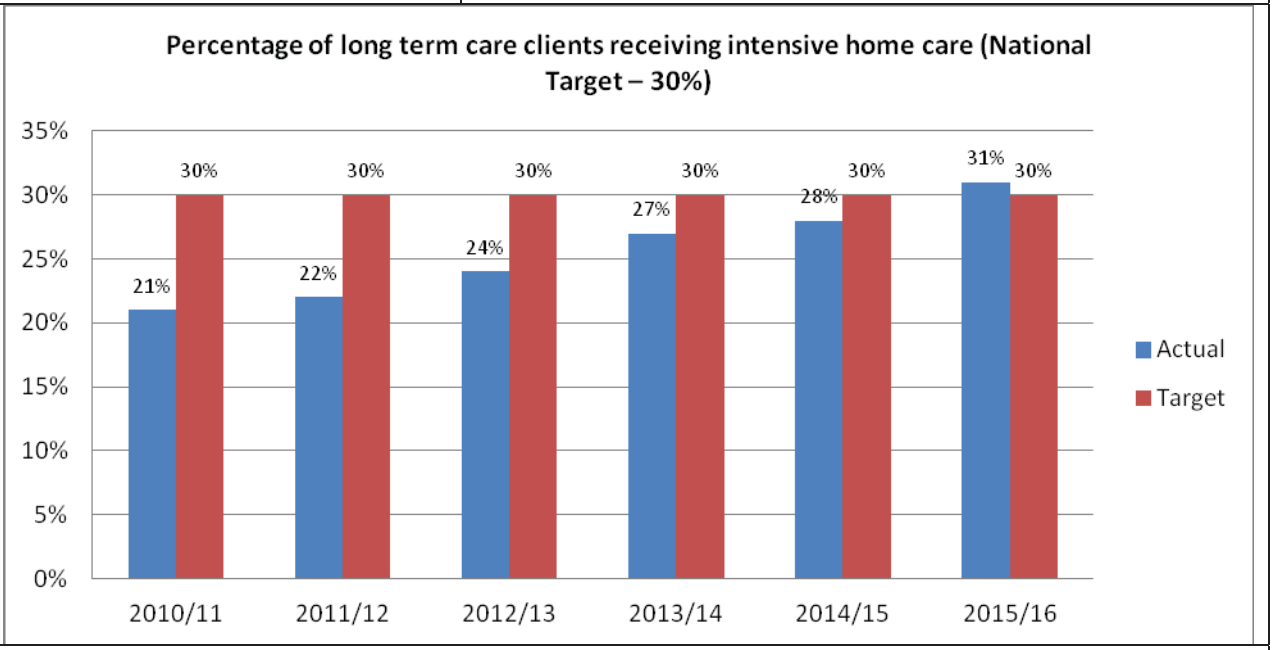
Timeline For Improvement

Performance figures for Renfrewshire have shown an improvement for assessment of 94% for July 2016. Assessments = 136< 28days, 8> 28 days.
Team Leader is monitoring assessment activity on a weekly basis by manual and electronic measures.
Two new members of staff have been recruited and are expected to start in September 2016. This will improve the team's capacity and flexibility in assessing and will be crucial in expanding our ability to provide face to face appointments. This was an area where most of the 8 breaches were noted.
The Service Manager and Team Leader expect continued improvement in August and September 2016.
With full staffing available in October, the 100% target is achievable.

Appendix 2

Exception Report: Percentage of long term care clients receiving intensive home care Outcome 2

Measure	Percentage of long term care clients receiving intensive home care (National Target: 30%) Social Work only target.
Current Performance	As at year end 2015/16, 31% of long term care clients received intensive home care services. Current performance exceeds the national target of 30%.
Lead	Ian Beattie, Head of Health & Social Care Services, Paisley and Mandy Ferguson, Head of Health & Social Care Services, West Renfrewshire.



Commentary

Good progress has been made in the care at home service during 2015/16.For the first time the national target of 30% of long term care clients receiving intensive home care (10 hours plus) has been met. This is reflective of the increasingly complex needs of individuals who are being supported at home and it is anticipated that the figure will continue to rise as the older population increases.

Actions to Maintain Performance

Care at home services continue to focus on reablement intervention and reviewing care packages to ensure that the most vulnerable clients receive the right level of support and that independence is maximised wherever possible.

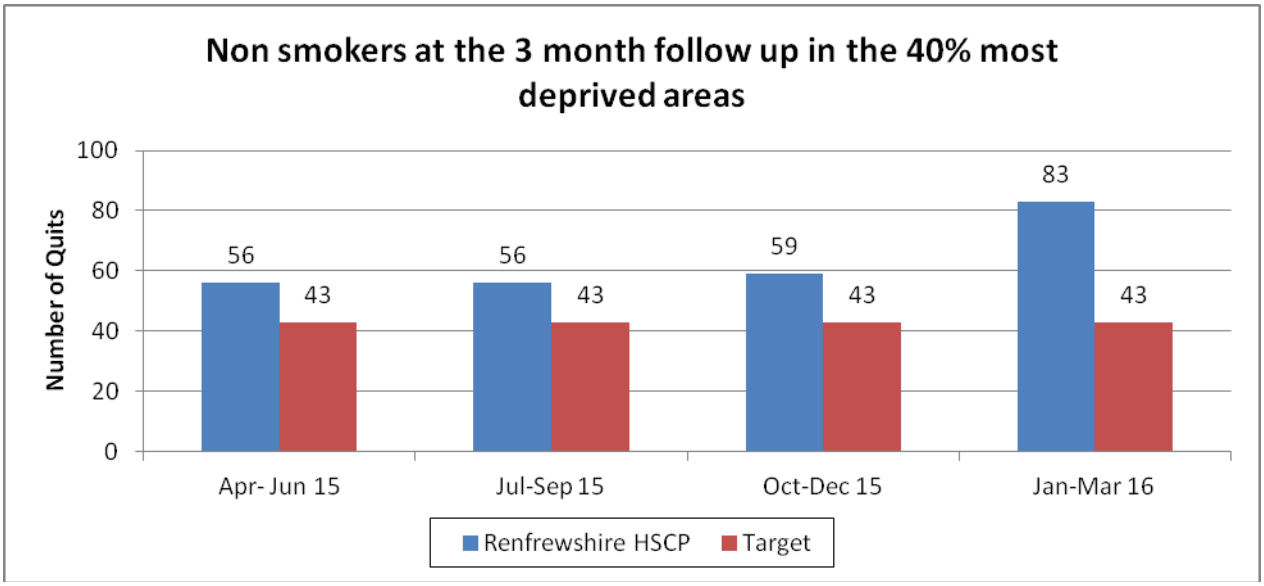
The procurement of the scheduling and monitoring system will enable improved management information that will better enable the service to monitor service delivery in real-time. This will be introduced over 2017/18.

We continue to monitor the levels of care to ensure that clients receive the appropriate levels of support to meet their care needs.

Appendix 2

Exception Report: Smoking cessation - non smokers at the 3 month follow up in the 40% most deprived areas – Outcome 5

Measure	**Smoking cessation - non smokers at the 3 month follow up in the 40% most deprived areas**
Current Performance	**At March 2016, there were 254 non smokers at th month follow up in the 40% most deprived areas**
Lead	**Fiona Mackay, Head of Strategic Planning and Health Improvement**



Commentary

At March 2016, there were 254 non smokers at the 3 month follow up in the 40% most deprived areas, an encouraging 48.5% above the annual target of 171. Quarter 4, January-March 2016 saw the biggest increase with 83 quits against the quarter target of 43.

Actions to Maintain Performance

- The number of clinics running each week will be maintained.
- A shared-care pharmacy clinic has been established in Ferguslie Park.
- All clinics are now open access to maximise accessibility; no booking or referral required.
- All clinics now run in a rolling format, therefore clients can access the service at any point and stay for the duration they require to achieve 12 weeks' Smokefree.
- Marketing materials have been improved and updated.
- Referral routes have been modernised to include digital referral via the NHS Board website. A Cognitive Behaviour Therapy programme is also being piloted which links to the 'Living Life to the Full' programme. This will help clients gain more self-help materials for coping with stress, anxiety and low mood with the potential to reduce relapse.

To:	**Renfrewshire Integration Joint Board**
On:	**16 September 2016**
Report by:	**Chief Officer**
Heading:	**GP Cluster Working and New GP Contract Arrangements**

1. Summary

1.1 As part of the Integration Work Programme, Renfrewshire HSCP has developed an effective and dynamic approach to 'locality' and 'cluster' based working to build collaboration and joint working between General Practitioners, HSCP services and staff to better support the needs of local patients, service users and communities.

1.2 The principle of practices working more closely together for the benefit of patients, and the wider health and social care system is reflected in the Scottish Government's Localities Guidance issued to support Health & Social Care integration and by the BMA Scottish GP Committee vision and UK RCGP 2022 vision.

1.3 The HSCP has made good progress in establishing GP practice based locality working to progress early gains from 'integration'. Over 2015/16 we have taken a structured approach through a series of individual GP practice meetingsand cluster based development sessions to involve and engage GPs, to ensure they are meaningfully part of the wider network and collaboration of team and service based working. These arrangements are continuing to mature and develop during 2016/17.

1.4 During 2015 Renfrewshire HSCP contributed to an extensive 'system wide' engagement and listening exercise undertaken together by NHS Greater Glasgow & Clyde with HSCP Chief Officers. The aim of this engagement process was to better understand the pressures facing GP services and to reach a shared view about what we should do to addresses these pressures. A detailed set of actions has now been developed which Renfrewshire HSCP will take forward in partnership with the Health Board, other HSCPs and the Local Medical Committee. Appendix 1 provides further detail.

1.5 In April 2016 changes were made to the National GP Contract. These changes move away from the Quality Outcomes Framework (QOF) approach therefore uncoupling the link between activity and payment for GP practices. The new arrangements have a sharper focus on multi-practice 'cluster' based working, the development of a Cluster Quality Improvement Programme, and the identification of a Practice Quality Lead (PQL) and Cluster Quality Leads (CQLs).

1.6 Renfrewshire HSCP established a short life working group to scope out the role and function of the PQL and CQLs and this work is now being used across all HSCPs in NHSGG&C to shape the emerging approaches to cluster working.

1.7 It is expected that there will be further changes to the GP contract in Scotland for 2017/20. The Chief Officer will provide the IJB with further information on these arrangements once information is available.

1.8 Renfrewshire HSCP has worked with local GP Practices to confirm a named GP within each practice (29) to fulfil the Practice Quality Lead role and work will commence in late September 2016 to identify and appoint the Cluster Quality Leads. They will provide a quality improvement leadership role in the cluster working to enable work between praactices and between practices and the the HSCP.

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2. Recommedation

It is recommended that the IJB:

- Note the progress made to establish GP Cluster Working;
- Note the new GP Contract Arrangements for 2016/17; and
- Note the work being undertaken by NHS Greater Glasgow & Clyde, HSCPs and the Local Medical Committee (LMC) to address pressures within GP services.

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3. Background

3.1 Clusters are small groups of geographically connected GP practices, who will work collaboratively, agreeing with relevant local partners a clear set of outcomes and a means to review these outcomes collaboratively, improving outcomes through further cycles with those same outcomes or moving onto other outcomes across the patient pathyway, in a repeating pattern, underpinned by an evidence based approach to improvement.

3.2 Renfrewshire has twenty-nine GP practices which were initally formed into 10 clusters, initially aligning with existing District Nursing Teams. As we worked with local practices we have now moved to a six cluster approach now established under our two localities - Paisley and West Renfrewshire. These are outlined in Appendix 2.

3.3 In Renfrewshire we held a series of half day Cluster Development Sessions earlier in 2016 which provided the opportunity for those responsible for the delivery of service to the cluster population to come together to consider how we unlock the benefits of integration and to begin to develop future ways of working. Through these sessions, each cluster has developed an initial Cluster Improvement Plan which is being progressed via 30, 60, 90 day improvement approach, with agreed timescales and named lead managers/GPs. Actions are themed to the type of change they are and are noted in improvement methodology terms as:

- Quick Wins (things that can be done now to improve how we work)
- Projects (work strands that take a bit more time, effort and may require input from others)
- Events (full scale rapid improvement work).

Sessions have identified a number of actions which are common to most Clusters in Renfrewshire and some issues specific to one cluster. A number of individual cluster 'tests of change' have also been identfied, which will be progressed over 2016/17. Further detail can be provided on request.

Some examples of the work being undertaken are:

- Scoping of the value of 'Treatment Rooms' type services
- Supporting GPs with financial/benefit support for patients
- Developing ways of working and relationships between a cluster of GP Practices and local pharmacists, to improve prescribing related work flows
- Releasing GP capacity by realignment of the HSCPs Prescribing Support Pharmacists
- Identifying shared caseloads (between a practice and HSCP services) to look at improving how we work to support the patient/service users e.g. improving prevention and anticipatory care planning
- Direct access to self-referral services.

3.4 Three supporting subgroups have also been established to review how HSCP services currently work and to present options on future ways of working to support cluster working. These have specifically emerged from our Cluster Development Sessions and include:

- **Mental Health/Addictions Sub Groups (x2)**

  1) The GP Cluster Subgroup will review how Renfrewshire HSCP Mental Health Services currently work with GP practices and recommend options on how Mental Health and Addiction Community Services will work within a future Cluster Framework.

  2) The Unscheduled Care Sub Group will review unscheduled care within Mental Health and Addiction Services and will make recommendations to maximise effectiveness, resources and improve patient journey.

- **Practice Nursing (PN) / District Nursing (DN)**

  3) The PN/DN Sub Group will examine ways of PN/DN working smarter together or where necessary and appropriate interchangeably, on agreed areas of work with clear aim to optimise available resource versus workload.

3.5 Significant progress has already been made to ensure our other HSCP services align with clusters to minimally ensure we operate single points of access and contact wherever we can and to ensure that our services are fully connecting into wider primary care extended team/profession meetings. This is targetting at information sharing and building robust joint working.

3.6 A Clinical Leadership induction and development programme will be developed to support PQLs/CQLs, which will focus on building knowledge, understanding and awareness about the HSCP, its structures, how it works and also of the wider relevant NHS and Council arrangements and begin to shape ways of working between CQLs; between CQLs and PQLs and between CQLs with HSCP Managers.

Implications of the Report

- **Financial –** Practice Quality Lead (PQLs) are funded directly by Scottish Government. Chief Officer and Chief Finance Officer are agreeing arrangements to fund local Cluster Quality Leads (CQLs).
- **HR & Organisational Development – Nil**
- **Community Planning – Nil**
- **Legal – Nil**
- **Property/Assets – Nil**
- **Information Technology –** managing information and making information available may require ICT input.
- **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.
- **Health & Safety – Nil**
- **Procurement – Nil**
- **Risk – Nil**
- **Privacy Impact – Nil**

List of Background Papers: None

Author: Angela McLelland, Change & Improvement Officer
(Change & Improvement Team)

Renfrewshire
Health & Social Care Partnership

Renfrewshire Council

NHS Greater Glasgow and Clyde

Appendix 1

Renfrewshire HSCP Clusters

Paisley = 13 Practices

Cluster	Practice Code	GP Practice	Most dep 15	List Size
5.	8752-1	Kelburn Medical Practice	18.56	4246
	8754-1	Greenlaw Medical Practice	15.99	6521
	8760-6	Barony Practice	25.12	6123
	8747-1	Anchormill Medical Practice	22.87	7877
	8762-5	Abbey Medical Practice	17.02	10541
	8751-7	Glenburn Medical	18.73	3249
	8746-6	The Charleston Surgery	16.17	5902
6.	8750-2	The Consulting Rooms	13.04	7193
	8748-5	The Tannahill Centre	66.67	3711
	8749-0	King Street Surgery	24.86	9390
	8757-4	St James Medical Centre	32.23	3133
	8755-5	Mirin Practice	25.04	8915
	8756-0	Love St Medical Centre	31.16	5820

West Renfrewshire = 16 Practices

Cluster	Practice Code	GP Practice	Most dep 15	List Size
1.	8711-2	Bishopton Medical Practice	0.00	7135
	8718-4	Mains Medical Centre	0.00	8622
	8723-5	Bridgewater Medical Centre	0.08	2172
	8724-0	Bargarran Medical Practice	0.35	4351
2.	8769-7	Braehead Medical Practice	13.69	6697
	8770-0	Clydeview Medical Practice	16.47	8126
	8771-4	Kingsinch Medical Practice	13.02	6538
3.	8729-2	Ludovic Medical Practice	18.93	6745
	8733-9	Riverview Medical Centre	22.44	5074
	8772-9	Westfield Medical Practice	35.05	4976
	8714-6	Ranfurly Surgery	0.12	10256
	8740-9	The Health Centre,Linwood	12.68	5672
4.	8732-4	Ravenswood Surgery	16.51	6375
	8743-2	Mistylaw Medical Practice	0.98	4582
	8730-5	Quarryside Medical Practice	23.68	4637
	8734-3	Linden Medical Practice	25.00	3981

NHS GREATER GLASGOW AND CLYDE

Developing GP Services: Engaging and listening

Summary and next steps

Message from Board Chief Executive and Partnership Chief Officers

The services delivered by GPs and practice staff are the bedrock of the NHS. We established the engagement process to understand the pressures facing GP services and to reach a shared view about what we could do to address those pressures. The engagement and listening exercise has enabled us to hear from GPs and other primary care and community staff through a range of individual and collective discussions across Greater Glasgow and Clyde.

The actions outlined in this paper have been developed collaboratively and are our response to begin to address the issues which have been identified. We recognise that to sustain GP services, we must continue to work together to progress these actions – this will be done in partnership between the Health Board, our six Health and Social Care Partnerships and the Local Medical Committee.

We know there are real challenges to overcome but we have also heard a positive, consistent message that the endeavour to deliver high quality primary care services remains a compelling one for our GPs who continue to focus on the needs of patients. Levels of demand and workload pressures are now creating unsustainable pressures.....this programme is a commitment from us to focus real effort, energy and commitment to reduce those pressures.

We know that this local programme of work will not in itself be enough to address the issues and we will continue to work at National level to ensure that the changes required in terms of investment and workload are reflected in the new national contract. We will also continue to focus on ensuring our new Health and Social Care partnerships establish strong relationships with primary care.

Robert Calderwood, Chief Executive, NHS Greater Glasgow & Clyde

David Williams, Chief Officer, Glasgow City HSCP

David Leese, Chief Officer, Renfrewshire HSCP

Julie Murray, Chief Officer, East Renfrewshire HSCP

Keith Redpath, Chief Officer, West Dunbartonshire HSCP

Karen Murray, Chief Officer, East Dunbartonshire HSCP

Brian Moore, Chief Office, Inverclyde HSCP

1. Proposed Next Steps

During 2015 we increasingly heard from GPs about the pressures they were facing and established an engagement and listening exercise to help us to understand those pressures and to shape how the Board and HSCPs could respond.

This paper brings together the feedback from that work and sets out our work programme to respond to the issues which have been raised. The intention is to use the proposals in this paper to start to address the problems identified.

We will also continue engagement so that we build programmes of change which visibly and effectively address the issues which GPs have raised. We want to ensure our GPs and the staff who are aligned to and work with practices can deliver the best care to our patients and that our GP services are secure for the future.

The programme will operate at a number of levels:-

- Within Partnerships, which are responsible for working with GPs and for the delivery of all local health and social care services;
- Within the new clusters which are being established as part of the 2016/17 contract;
- Between Partnerships and across the Heath Board are where issues relate to contracts and systems of working;
- Between primary care and the Acute Services Division.

1.2 Workload and demand: GP described major workload pressures and we propose action as follows:-

- Implement the QoF changes and make similar changes to our local enhanced services to reduce bureaucracy to a minimum;
- Across the Board, and in each HSCP, identify with GPs areas of inappropriate or unnecessary workload and the action required to enable that workload to be stopped or dealt with elsewhere in the system;
- Identify care pathways where the GP function is as a gatekeeper not providing an appropriate clinical intervention and deliver alternative routes of access to these pathways;
- Invest in additional pharmacists to pilot ways to reduce GP workload;
- Work at a national level to ensure that the further development of the new national contract reduces GP workload;
- As HSCPs develop and deliver their plans to transform services to older people consider how a team approach can better deliver care;
- Take stock of support to care homes and identify actions which would complement and support the GP role;
- Review the potential to develop a patient engagement programme to reinforce the role of GPs and alternative services;
- Through the PCTF test new ways of assessing those patients who on account of illness are unable to attend in person their local GP surgery;
- Review the potential to provide support to GPs in dealing with complaints through HSCP teams;
- Work with the LMC to identify any additional ways in which we could support practices.

1.3 **Relationship with Secondary Care:** there was a strong and consistent theme of real challenges in working effectively with secondary care:-

- Through the existing interface group we will identify more comprehensive priority programmes of work which will make a real difference to GPs;
- We will establish a review of how a number of agreed priority complex care pathways are coordinated and how this could be done more efficiently and appropriately;
- We will ensure that the acute service change proposals which will be developed by HSCPs deliver positive benefits for GP services.

1.4 **Information Technology:** a range of issues about HIT were identified:-

- The Director of Health Information & Technology and a nominated Chief Officer will lead a short comprehensive review of the HIT available to GPs and how that links to other parts of the system to support efficient and informed patient flows.

1.5 **Access:** there are major issues about how patients access GP services, with pathways often defaulting to GP consultations when these are not required:-

- Each HSCP will work with GP practices in their area to develop pathways to ensure ready access to the most suitable healthcare professional and that the GP is not the routine default;
- As part of our use of the PCTF we will establish work to test approaches to address this issue.

1.6 **Primary Care and Community Teams** the clear message is that the way our wider community teams relate to GPs is a major issue**:-**

- Each HSCP will review the organisation and relationships between their employed staff and practices to develop proposals for improvement;
- As HSCPs develop they will explore how to deliver more productive and structured relationships between social care staff and systems and GP practices;
- We will establish a single system review to look at how our mental health services interface with GP practices and develop proposals for improvement;

1.7 In addition to these actions the rest of this section outlines how we will use the primary care transformation fund to support this work and the wider priorities which HSCPs will take forward in their planning which will impact on GPs.

1.8 **Cluster and Practice Quality leads and the Primary Care Transformation Fund**

The development of C and PQL's is a major opportunity to develop productive quality focussed working within and between practices and we want to ensure that we have proposed to Scottish Government that we have allocations as follows, to support the:-

- Development of cluster working with an allocation to each Partnership;
- New Ways Programme in Inverclyde;
- After clusters are established to develop with them transformation proposals for three areas:-
  - Chronic disease;
  - Acute interface with a focus on older people;
  - Home visiting.

1.9 Interface Priorities for HSCP Planning

The themes set out below have been agreed with Chief Officers they cover areas where the effective planning and delivery of changes in services are critical to the delivery of our Clinical Services Strategy; to the intent that the establishment of HSCPs will transform care and to the requirement to reshape acute care into an affordable configuration which can meet demand:-

- **Better management of older people and chronic disease in the community:-**
  - Improving out of hospital care and patient pathways including innovative support to GPs;
  - Improving systems and services to deliver early discharge;
  - Improving care in nursing homes;
  - Extended and integrating arrangements for domiciliary support;
  - Identifying developments which delivery the CSS joined up care system;
  - Reshaping out of hours services.

- **Enabling acute care to be focused on patients with acute needs;**
  - Action to enable patients to die at home;
  - Identifying care pathways which can be modified to reduce reliance on hospital services;
  - Delivery of the Paisley development programme outputs in each HSCP area
  - Shifting care from an unplanned to planned basis;
  - Further reducing delayed discharges.

- **Changes to address service pressures and inefficiencies;**
  - Identifying and addressing variation in use of diagnostics;
  - Identifying and addressing variation in the use of outpatient and inpatient services;
  - Reviewing a number of care pathways where there is potential for efficiency;
  - Transport

Finally, this paper has focussed on the changes we can make through local action. The development of the **new National contract** is the major opportunity to address workload pressures, to recognise the impact of deprivation in the distribution of resources and to deliver real additional investment in primary care.

We have derived from this engagement exercise a clear shared statement of what we think the new contract needs to deliver.

2. <u>Introduction and Background</u>

General Practice, with registered patient lists, everyone having access to a family doctor, delivering continuity of care, is one of the great strengths of the NHS. Our model of GP services brings together the management of illness and disease, increasingly complex, with continuity, empathy and humanity. GP services are the bedrock of the NHS delivering over 90% of our patient contacts, skilfully assessing undifferentiated patient presentations and managing the care of the overwhelming majority of patients within their own practices. NHS Greater Glasgow and Clyde has over 240 practices with nearly 800 GPs and we spend £154 million on our GP services.

In September 2015 we launched a programme to engage a wide range of interests in developing a direction for GP services in NHS Greater Glasgow and Clyde. There were a number of different **reasons for the timing of the engagement:-**

- We heard from GPs about the pressures they are experiencing in the level of demand, the complexity of the care they need to deliver; the challenges of responding to the needs of deprived patients; the growing number of patients with chronic diseases and an increasing elderly population;
- As well as those general pressures, many of our practices are involved on the Deep End national group which brings together GPs from the most deprived practices in Scotland. This Group has worked to highlight the major issue of unmet needs for patients in deprived areas;
- GPs also describe extensive inappropriate use of their time and skills with demands from a range of routes including in relation to social security benefits, acute hospital services and NHS 24, these pressures are in addition to the increasing demands for care from patients;
- There are major challenges in recruiting and retaining GPs and attracting junior doctors into GP training;
- These pressures on GP services are compounded by pressures elsewhere in the system including on our acute hospitals, on mental health services, on NHS community and social care services and on voluntary and community service organisations;
- We have developed a clinical services strategy for the services which we deliver. The strategy relies on supporting and developing the services which GPs provide;
- There is a Scotland wide process under way to develop a new, Scottish, contract for GP services.....we are the largest Health Board in Scotland and we want to work closely with the Government and with GPs to shape that new contract;
- Our new health and social care partnerships need to establish close relationships with GP practices so that GPs have a central role in the Partnership's responsibilities to plan and commission hospital services for their populations;
- We need to look at the way our employed community staff work with GP practices;
- New information systems enable us to take a fresh look at how GPs and hospital services share information about patients;
- It is increasingly difficult to staff the current out of hours GP services;
- In the current contract it is difficult for GP practices to work together although that may help them address some of these issues and work better with other NHS services.

Part of the pressure of demand relates to the rising needs of our ageing population with increased chronic disease and the health issues created by deprivation. But it is also the case that patients often go to their GPs with issues which could be dealt with elsewhere and do not require skilled medical intervention. The open access nature of GP services, an important strength, means that GPs are a point of service for a wide range of demands.
In setting out the engagement programme we described **our thinking on the changes which need to happen in primary care:-**

- More services organised around groups of GP practices, more resources for primary care and new models of primary care delivery;
- More investment in social care services to support people living in the community and in care homes;
- Concentration of specialist inpatients services accessed for the shortest possible periods of intervention;
- More people supported to die in the setting of their preference;
- Services which enable people to manage their own conditions;
- Specialist NHS medical and nursing skills supporting local and community based services, including care homes rather than focussing on hospitals;
- Care homes used more flexibly, providing better care and meeting higher levels of physical and mental frailty and need, with more input from specialist clinical services to support this change;

- Creating a reshaped workforce to deliver this strategic direction with, more staff in community settings and more care delivered by multi disciplinary teams.

The engagement exercise included:-

- Discussions within each Partnership;
- A widely publicised website aimed at GPs and their staff, at patients, at hospital staff and other staff working in the community;
- Discussion in the Board's Advisory Committees.

The purpose of this paper is to summarise the responses we received and create a discussion about the way we will address the issues which have been identified.

Since we ran the engagement there have been three significant national changes:-

- The QoF has been dismantled, reducing the pressures of bureaucracy on GPs and creating the space to establish a new approach to quality in primary care;
- That new approach includes practice quality leads and new clusters of GPs working together with a cluster quality lead;
- A National Primary Care Transformation Fund has been established to develop and support new ways of working.

In addition, of significance to our local position are:-

- The Inverclyde test of change programme linked to the work to develop the new national contract;
- Initiatives to support GP services, including providing link workers in Drumchapel, the Govan project and additional pharmacists to try to reduce workload.

3. Issues from Responses

We had a wide range of responses for GPs, practice staff, and patients. This section draws out the key themes and issues from the response we received.

3.1 Workload and Demand: the most consistent and significant issue raised is the excessive burden of work carried by GPs, the impact of that on their working life's, morale, commitment to continue in the profession and on the ability to attract and retain new GPs.

- The pressures created by growing numbers of older people with complex chronic conditions, who need more time with GPs;
- Patient expectations and demands, often inappropriately including for minor self limiting illnesses and demands for urgent access when that is not required. A major theme was the need to re educate patients and to stop unreasonable demand;
- QoF and our local enhanced services creating unhelpful bureaucracy;
- GPs being used as a gatekeeper for a wide range of other services and functions including health care but also access to benefits, sick notes and other state processes;
- Acting as the only point of for coordination complex care;
- Increasing demand for house calls;
- Repeat prescriptions and medications management and underutilisation of the community pharmacy chronic medication service;
- Pressures generated by nursing homes;
- Services being deliver by GPs which could be delivered by others, examples included immunisation;
- Opening hours should not be extended;

- GPs should have maximum list sizes and a clearly defined role;
- Too much time on administrative work;
- Complaints were repeatedly raised as a further source of pressure;
- The need for longer appointments.

3.2 **Relationships with Secondary Care:** there was a strong and consistent theme of real challenges in working effectively with secondary care, issues included:-

- A feeling that workload is being transferred from secondary care without matching resources;
- Real challenges in working with secondary care, with positive examples of what works well, including direct access to consultants and wider forms of urgent care secondary care;
- IT and info flow not working well;
- Variation between specialties and consultants;
- Direct contact should be norm and is key;
- Workload shifting including phlebotomy, results coordination and dealing with DNAs;
- Continuity in complex cases relies on the GP.

Thoughts on how these points could be addressed included shared education, more outreach and better transfer of information.

3.3 **Working with Other Contractors:** the exercise identified:-

- The potential to extend and support the development of additional patient services and access to other contractors;
- This would require clear systems of care, lines of accountability and information sharing.

3.4 **Information Technology:** a range of issues about HIT were identified including:-

- Sharing information with community health staff;
- Links between other contractors and GPs;
- Continuing issues with systems across GPs and acute.

3.5 **Workforce:** a range of issues were raised:-

- The age profile of current GPs and primary care staff creates serious risk of exodus;
- Need more and different roles in practices, pharmacists most often mentioned;
- Recurrent theme of other staff not working to the full potential, extent to which this reduces work they can take from GPs;
- The projects in Glasgow with links workers and social care staff were highlighted as very positive for GPs;
- Lack of access to locums is a major issue.

3.6 **Access:** there are major issues about patients access GP services:-

- there is no limit to demands on GPs or their responsibilities;
- as the easiest place to get a service the model of access to GP attracts work which could be dealt with elsewhere as many other services have barriers to entry.

3.7 **Primary Care and Community Teams:** the clear message is that the way our wider community teams relate to GPs is an issue.

- Where effective relationships and ways of working are described they generate highly positive experience and comment; but the reality is that there is a common theme from GPs and those wider staff, across a range of our teams, that the relationships and ways of working are not as effective as they could be;
- There is a strong sense that as legitimate changes to the delivery of these wider services take place relationships with GPs have fractured;
- There were particularly strong views about the value of access to social worker and social care services but the difficulties in establishing effective ways of working;
- Mental health services were also repeatedly raised as highly positive when access and relationships worked but with real challenges in achieving that. Clear message that we need new models of team working.

4 Conclusion

This paper has focussed on the areas and issues highlighted as in need of change, but it is also important to acknowledged consistent positive feedback about GP services:-

- Continuity of care and lifelong relationships;
- Universal coverage;
- A focus in local communities;
- The effectiveness of the gatekeeper role to wider health services;
- A focus on wider health promotion and prevention;
- Access is free and unimpeded;
- Single point of contact for other services.

A consistent message is that GPs still enjoy seeing patients, the core role is great, the levels of demand and workload pressures are not.....The aim of the work programme outlined in this paper is to deliver change which will support GP practices by addressing pressures.

Final version June 2016

To:	**Renfrewshire Integration Joint Board**
On:	**16 September 2016**
Report by:	**Chief Officer**
Heading:	**Strategic Planning in Renfrewshire HSCP**

1. Summary

1.1. This paper describes the proposed strategic planning structure for Renfrewshire HSCP, including Community Planning and Joint Planning with NHS Greater Glasgow & Clyde for Acute services.

2. Recommendation

2.1 It is recommended that the IJB:

- Notes the updated arrangements for Renfrewshire's Strategic Planning Group;
- Notes the transition process for moving from current arrangements to the new planning arrangements;
- Notes the process agreed by NHS Greater Glasgow & Clyde on 28 June 2016 to develop a strategic plan for acute services;
- Notes the National Clinical Strategy.

3. Strategic Planning Group

3.1 The Strategic Planning Group was established in accordance with section 32 of the Public Bodies (Joint Working) (Scotland) Act 2014. The main role of the SPG is to report views gathered during the development, implementation and review of the strategic plans of the Renfrewshire Integration Joint Board (IJB) on behalf of the Renfrewshire HSCP. The SPG is the main forum within the strategic planning process that represents the interests of different local stakeholder groups in relation to health and social care services. It has a wide membership with representation from both statutory and non statutory organisations. The aim of the SPG is to develop and support engagement, communicate and share information locally to deliver the 9 national health and wellbeing outcomes in Renfrewshire.

3.2 The Health and Social Care Partnership requires that the SPG will continue to be a key partner in developing and supporting engagement, communicating and sharing information locally in order to deliver the national health and wellbeing outcomes in Renfrewshire. The SPG reports directly to the Integration Joint Board (IJB).

3.3 The Strategic Commissioning Plan guidance describes an ongoing role for SPGs beyond the development of the first Strategic Plan. If the IJB plans to make a decision that would have significant effect on the provision of an integrated services (outwith context of strategic planning cycle), the SPG must be consulted. In addition, the Strategic Plan must be reviewed at least every 3 years, considering views of the SPG.

3.4 The Renfrewshire Strategic Planning Group is currently chaired by the HSCP Chief Officer and consists of 24 members with representation from:

- Renfrewshire Council
- NHS Greater Glasgow and Clyde
- Health professions representing: doctors, allied health professionals, nurses, pharmacists and optometrists
- Social care professionals representing: mental health officers, social workers and occupational therapists
- A third sector body carrying out activities relating to health and social care
- A person who uses local social care services
- A person who uses local health care services
- A carer of a person who uses local social care services
- A carer of a person who uses local health services
- A non-commercial provider of health services
- A non-commercial provider of social care services
- A commercial provider of social care services
- A commercial provider of health services
- A on-commercial provider of social housing
- A Nominee representing strategic housing planning

3.5 Where required, the Strategic Planning Group will seek input from other relevant stakeholders that will add value to its work. This input may be as a one-off, for the duration of a defined piece of work/agenda item or on a recurring basis and will be arranged at the discretion of the Chair in agreement with the individual(s) invited. All care groups are directly represented in the SPG current membership. The SPG may also set up short life working groups to take forward specific pieces of work. Renfrewshire has invited experienced Public Partnership Forum (PPF) members from the former CHP to become part of the SPG.

3.6 In accordance with Strategic Planning Guidance the SPG will be required to develop a work programme moving to the second year which will include a review of chairperson, terms of reference, membership and function. The SPG will plan four meetings per year to deliver the priorities of the programme. An additional public meeting will be arranged each year to communicate the progress of SPG work to a wider audience.

3.7 The Terms of Reference were reviewed at the first meeting of the Strategic Planning Group 2016-2017. These are attached as Appendix 1.

4. Previous Arrangements and Transition to New Arrangements

4.1 This section summarises the main changes to the strategic planning arrangements. It proposes the formal ending of previous planning structures,

including the Public Partnership Forum (PPF) and social work/health joint planning arrangements. The role and functions of these previous arrangements are replaced by the Strategic Planning Group and a supporting structure which includes the Alcohol and Drugs Partnership (ADP). The HSCP continues to have a key role in Community Planning and in Adult and Child Protection arrangements.

Public Partnership Forum (PPF)

4.2 Within the former Renfrewshire Community Health Partnership (CHP), the PPF was the primary mechanism by which the CHP engaged, communicated and maintained contact with the community, stakeholders, service users and carers. The PPF network included in excess of 200 members living or working in Renfrewshire.

4.3 The PPF nominated two members to sit on the CHP Committee, ensuring a strong voice in the decision making process for community representatives. PPF members were involved in service redesign and planning across a range of care groups and were central to the public involvement process in building the new Renfrew Health and Social Work Centre.

4.4 PPF members have been invited to join the Strategic Planning Group. A Third Sector, Providers and Community Group will be established to ensure that these communities of interest continue to have a strong voice in influencing the work of the HSCP.

Joint Planning Arrangements

4.5 Within the CHP structure Joint Planning and Performance Groups (JPPIGs) were established in 2007 to provide a joint planning structure to enable agencies to work together to plan the delivery of services that are provided within people's own homes and local communities across health and social care. The JPPIGs reported and were accountable to the Joint Management Group (JMG) which brought together the former NHS CHP senior management team together with the former Council Directorate of Social Work senior team.

4.6 A recent review of joint planning arrangements concluded that the role of JPPIGs had now been superseded by the establishment of the Strategic Planning Group where there is representation from all key stakeholders and care groups.

4.7 For now, existing chairs of JPPIGs will review current work programmes to ensure that there is a smooth transition to new arrangements. It is considered important that some care groups will continue to require planning meetings. For example, the Carers' JPPIG will continue to meet as a working group to develop a Carers' Strategy. The Palliative Care JPPIG will meet quarterly with a new focus on the changed planning and commissioning arrangements for hospices. Terms of reference and membership for the planning groups will be developed and agreed as soon as possible. These Groups will report into

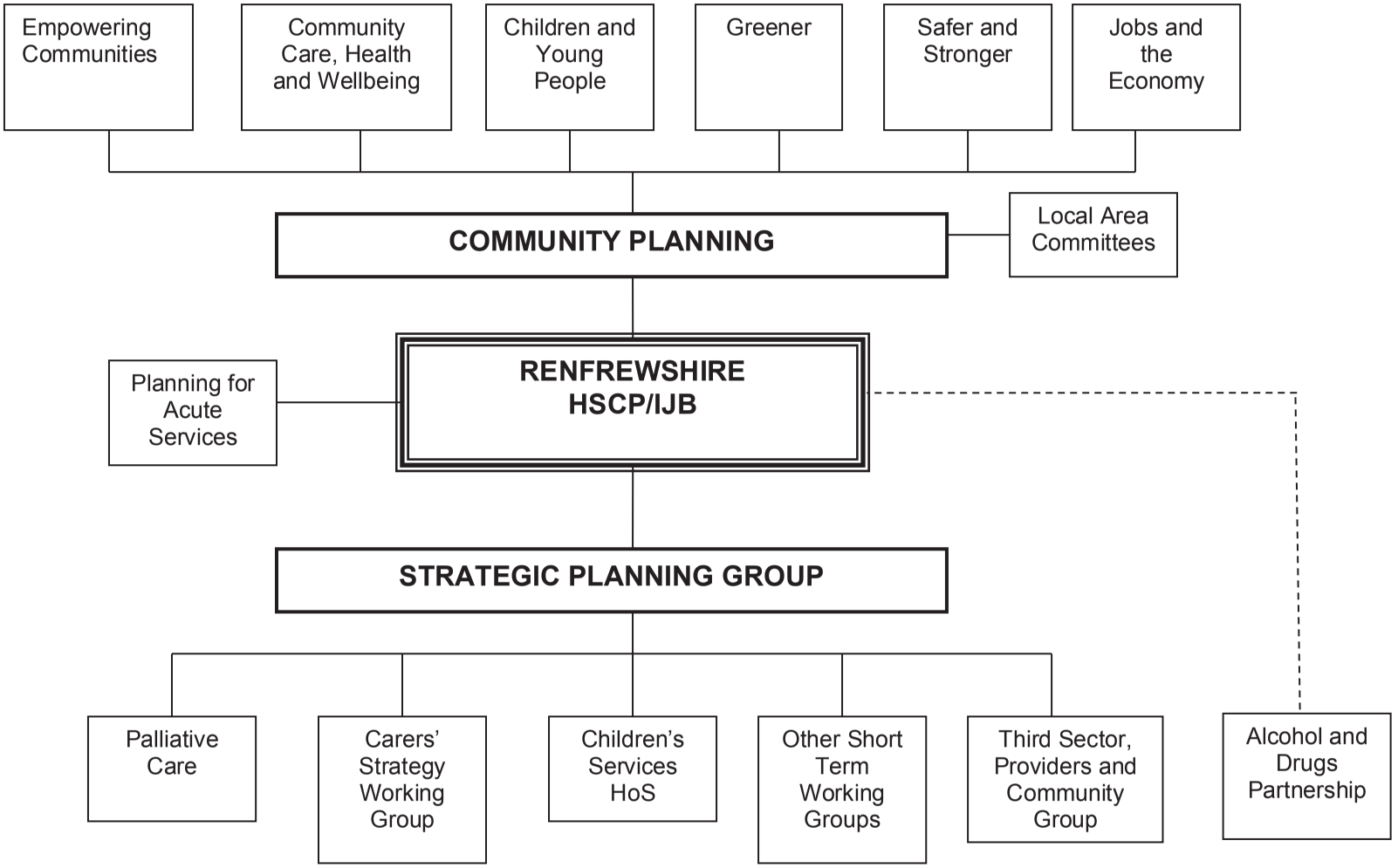
the SPG. As agreed by Chief Officers on 19 May 2016, the Alcohol and Drugs Partnership (ADP) will report directly to the Integration Joint Board.

4.8 Similarly the function of the Joint Management Group has been superseded by the new arrangements of the Health and Social Care Partnership and no longer meets. To maintain a strong interface with Children's Services, a Joint Heads of Service interface group has been established with senior managers from the Council's Childrens Services Directorate.

Community Planning

4.9 Renfrewshire HSCP continues as a key Community Planning partner and contributes to all the Thematic Boards. The Chief Officer is the lead officer for the Community Care, Health and Wellbeing Thematic Board. The governance arrangements and role of the Alcohol and Drugs Partnership (ADP) has been reviewed and were approved by our IJB in June 2016. This is now the key planning mechanism for all addictions within the HSCP. Its accountability is now through the IJB and its work will clearly link into the wider planning role of the SPG. The ADP also links closely with the Community Planning arrangements locally.

4.10 The diagram overleaf details the planning arrangements for 2016/17 and beyond.


Empowering Communities
Community Care, Health and Wellbeing
Children and Young People
Greener
Safer and Stronger
Jobs and the Economy
COMMUNITY PLANNING
Local Area Committees
Planning for Acute Services
RENFREWSHIRE HSCP/IJB
STRATEGIC PLANNING GROUP
Palliative Care
Carers' Strategy Working Group
Children's Services HoS
Other Short Term Working Groups
Third Sector, Providers and Community Group
Alcohol and Drugs Partnership

5. Acute Planning

Background and Purpose

5.1 The paper at Appendix 2 has been approved by the NHS Board as the basis to develop a strategic plan for acute services. Responsibility for strategic service planning is now shared between the NHS Board and Integration Joint Boards. Work to shape how this joint working will progress has now commenced through the NHS Board Whole System Planning Group.

5.2 The NHS Board is responsible for the overall planning for acute services, working with IJBs on planning the delivery of unscheduled care and on the shaping of the primary care and community services which are critical to the delivery of acute care. The IJBs are responsible for strategic planning for the health and social care services for which they are responsible and for the strategic commissioning of unscheduled care services. The set aside budget for unscheduled acute services is £32.3m.

5.3 The paper acknowledges the importance of the relationship to IJBs in this regard as:

- Integration of planning for acute services with the planning led by IJBs for community and primary care services;
- Shaping of acute services to respond to IJBs Strategic Commissioning Plans, including forward financial planning.
- Achieving early patient and public engagement;

Current Position

5.4 The paper outlines the local, regional and national position on planning for acute services.

5.5 At national level, there are a series of programmes of work which will inform strategic planning and the National Clinical Strategy (NCS) was published in February 2016 following an extensive programme of development and engagement. The Strategy sets out a framework for the development of health services across Scotland for the next 10-15 years. It gives an evidence-based high level perspective of why change is needed and what direction that change should take. The Strategy sets out the case for:

- Planning and delivery of primary care services around individuals and their communities;
- Planning hospital networks at a national, regional or local level based on a population paradigm;
- Providing high value, proportionate, effective and sustainable healthcare;
- Transformational change supported by investment in e-health and technological advances.

5.6 The full strategy can be found at http://www.gov.scot/Publications/2016/02/8699

5.7 A further critical part of the national scene, particularly critical to the IJB, is the work to develop a new GP contract which needs to provide the platform to enable the transformation of primary care.

5.8 There are well established regional planning arrangements which set the direction for a number of our services which are provided to populations beyond the Board area.

5.9 At NHS Board level there is a comprehensive Clinical Services Strategy approved by the NHS Board in January 2015 and endorsed by the IJBs.

5.10 The key aims of that strategy are to ensure:

- care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
- services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
- sustainable and affordable clinical services can be delivered across NHSGGC;
- The pressures on hospital, primary care and community services are addressed.

5.11 Renfrewshire's first Strategic Commissioning Plan has been developed and highlights the need to establish a real focus on changing the way our population uses hospital services.

Proposed Process

5.12 The NHS Board proposes a two stage process with the aim of developing and describing the changes we need to make in 2017/18 in the context of describing a longer term strategic change programme.

5.13 The first stage, to be completed by October 2016, is to update the key elements of the Clinical Services Review including:-

- Population health analysis;
- Drivers for change;
- Future clinical models;
- Progress on implementation;
- An informed forward look at population and other changes which will require service transformation;
- A joint appraisal with IJBs of the implications of their strategic commissioning plans for the delivery of acute services;
- Analysis of service changes emerging from regional and national planning to deliver the National clinical strategy;
- An outline of proposed service changes for 2017/18 from the Acute Division's clinical planning processes, which are focussed on delivering high quality, safe and sustainable care;
- A strategic service and estate appraisal of our hospital sites;
- an initial forward financial framework for acute services, developed with the Integration Joint Boards;

5.14 The NHS Board proposes extensive clinical engagement and engagement with wider stakeholders during this stage.

5.15 The output of this first stage would enable further discussion with IJBs with the aim that this work can be finalised to move to a second stage with the NHS Board approving for publication, and formal public engagement, proposed service changes for 2017/18 set in the context of a longer term strategic plan.

Conclusion

5.16 The shape and delivery of acute services are critical to the responsibilities of the IJB and will also be an important issue for local people. Therefore active engagement as this work develops is important.

5.17 The NHS Board has committed to work with IJB Chief Officers to establish the detail of the required processes to develop robust planning framework.

Implications of the Report

1. **Financial –** None
2. **HR & Organisational Development** – None
3. **Community Planning** - None
4. **Legal –** None.
5. **Property/Assets –** None
6. **Information Technology –** None
7. **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be publised on the Council's website.
8. **Health & Safety –** None
9. **Procurement** – None
10. **Risk** – None
11. **Privacy Impact** – None

List of Background Papers – None.

Author: Fiona MacKay, Head of Strategic Planning and Health Improvement

Renfrewshire
Health & Social Care Partnership

Renfrewshire Strategic Planning Group
Terms of Reference

The Renfrewshire "Strategic Planning Group" (SPG) is established in accordance with section 32 of the Public Bodies (Joint Working) (Scotland) Act 2014.

These Terms of Reference are the procedures of the Strategic Planning Group as determined by the Integration Joint Board in accordance with section 32(11).
Purpose of the Group

The main role of the Strategic Planning Group is to give its views during the development, implementation and review of the strategic plans of the Renfrewshire Integration Joint Board on behalf of the Renfrewshire Health and Social Care Partnership.

The Strategic Planning Group is the main group within the strategic planning process that represents the interests of different local stakeholder groups in relation to health and social care services.

1. **Objectives**

To fulfil its purpose, the Strategic Planning Group should aim to:

- Make representations to the Integration Joint Board in a timely manner at each stage of the strategic planning process.
- To consider the following questions to inform the Group's representations:
  - How many people will need services and what type will they need?
  - What is the current provision, is it the right level, quality and cost?
  - How can these services improve people's lives?
  - Which services will best achieve this?
  - How do we develop these services at an affordable cost?
  - How do we procure and deliver these services to best effect?
  - How do we monitor and review these services?
- To shape and develop the Integration Joint Board's strategic proposals, policy documents, plans and services by giving due consideration to the draft materials produced by the Integration Joint Board.
- To identify gaps in the evidence base or in the mechanisms identified to address the gaps and suggest ways to deal with these gaps.

The Health and Social Care Partnership envisages that the SPG will be a key partner in developing and supporting engagement, communicating and sharing information locally to deliver the national health and wellbeing outcomes in Renfrewshire.

2. Membership of the Group

The Renfrewshire Strategic Planning Group consists of the following full time members:

- Chief Officer of the Renfrewshire Health and Social Care Partnership
- 2 Nominees from Renfrewshire Council
- 3 Nominees from NHS Greater Glasgow and Clyde
- Health Professionals representing: doctors, allied health professionals, nurses, pharmacists, and optometrists
- Social Care Professionals representing: mental health officers, social workers and occupational therapists
- A third sector body carrying out activities related to health and social care
- A person who uses local social care services
- A person who uses local health care services
- A carer of a person who uses local social care services
- A carer of a person who uses local health services
- A non-commercial provider of health services
- A non-commercial provider of social care services
- A commercial provider of social care services
- A commercial provider of health services
- A non-commercial provider of social housing
- A nominee representing strategic housing planning

- During the period of a strategic plan, representatives of the relevant localities will also be members of the Strategic Planning Group

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

3. Operation of the Group

3.1 Work Programme and Meetings

The Strategic Planning Group will determine its programme of work in line with the national Strategic Commissioning Plans Guidance on an annual basis and agree a schedule of meetings sufficient to deliver the priorities of the programme. Work planning will be undertaken at the first meeting of a calendar year, except in the first year of operation, when it will be undertaken as reasonably practicable.

3.2 Chair

The Strategic Planning Group will elect a Chair and Vice Chair to hold office for a one year term. The Chair and Vice Chair will be elected at the first meeting of a calendar year, except in the first year of operation, when Health and Social Care Partnership Chief Officer will assume the Chair and nominate a Vice Chair. Holding the Chair or Vice Chair position in one year will not prevent these individuals from also being elected in the following year.

The Chair whom failing, the Vice Chair will coordinate the efficient operation of Strategic Planning Group meetings to ensure appropriate consideration of agenda items in the time available. The Chair whom failing, the Vice Chair will manage discussions during meetings to ensure these are balanced, productive and on point.

The Chair whom failing the Vice Chair will be responsible for facilitating consensus within the group and articulating the conclusions reached for the purpose of the Minutes.

3.3 Role of Members

Members are expected to attend Strategic Planning Group meetings and to have read reports and papers in advance of meetings so that the time available can be used for productive discussions. Members are expected to actively contribute to the Strategic Planning Group's discussions in a way that represents the interests of their stakeholder group.

The Health and Social Care Partnership will offer members reasonable support, including expenses, to enable them to attend meetings and fulfil their duties.

3.4 Removal or Replacement of Members

Members will be expected to: attend meetings regularly to progress the Strategic Planning Group's work programme timeously and effectively, actively contribute to the discussions of the Strategic Planning Group, fairly represent the interests of the relevant stakeholder group, act and behave in such a way that supports the Health and Social Care Partnership's public reputation and to support the Health and Social Care Partnership to deliver the national health and wellbeing outcomes via its strategic plans.

The Integration Joint Board may remove or replace members where these expectations are not met.

Where this is the case, the Integration Joint Board will notify the member in writing.

A member of the Strategic Planning Group may ask the Integration Joint Board to be removed or replaced at any time for any reason, should they wish to stand down. Where the member has identified a potential replacement for themselves, they should provide details of that person to the Chair whom failing the Vice Chair. Appointments are at the discretion of the Integration Joint Board, which may choose to appoint by other means.

3.5 Quorum

The Quorum for the Strategic Planning Group will be one third of the members, at least 3 of whom will be from the non-statutory partner organisations. If inquorate, agenda items may be discussed however no representations may be made to the Integration Joint Board on these matters until such times as a quorum of members have acceded to them.

If necessary to deliver the Strategic Planning Group's work programme, the Chair whom failing the Vice Chair will be responsible for obtaining the agreement of enough members to

achieve a quorum outwith scheduled meetings, in order to make representations to the Integration Joint Board.

3.6 Apologies and Substitutes

Strategic Planning Group members are expected to submit their apologies in advance of any meeting they are not able to attend.

It is permissible for members to nominate another individual who represents their stakeholder group as a substitute to attend meetings. Members will be asked to nominate their substitute at the first meeting they attend. It will be for the IJB to decide on the suitability of the substitutes nominate. Substitutes are expected to be representative of their stakeholder group and otherwise display the same behaviours expected of members, as detailed in paragraph 3.3.

4. Support

Support will be provided to the Strategic Planning Group by Health and Social Care Partnership staff.

This support will include; arranging meetings, producing meeting agendas, taking minutes and action notes and circulating papers to members to facilitate the Group.

5. Minutes

The minutes of the Strategic Planning Group will be submitted to the Integration Joint Board for information at its next meeting following their approval by the Group.

6. Terms of Reference

These Terms of Reference will be reviewed at least annually, at the first meeting of the Strategic Planning Group in each financial year, or at any time the IJB considers a review to be necessary in the light of experience or emerging issues. The findings of the review will be recorded in the minute and submitted to the Integration Joint Board as above. The final determination on the suitability for purpose of the Terms of Reference rests with the Integration Joint Board.

NHS Greater Glasgow & Clyde

NHS BOARD MEETING
28th June 2016

Paper No: 16

Catriona Renfrew
Director of Planning and Policy

Strategic Service Planning

Recommendation:

The Board consider the approach to Strategic planning for acute services.

1. Background and Purpose

1.1. This paper proposes a process for the strategic planning for acute services. The approach outlined will enable:-

- Coordination of our planning with the developing regional and national approaches.
- The wide engagement of our clinical staff in strategic planning;
- Integration of planning for acute services with the planning led by IJBs for community and primary care services;
- The shaping of acute services to respond to IJBs Strategic Commissioning Plans.
- The further development of our existing extensive planning;
- The delivery of early patient and pubic engagement;

1.2. This purpose of the paper is to enable the Board to contribute at this early stage to shaping the strategic planning process, informing the further development of the process.

2. Planning Roles and Responsibilities

2.1. Responsibility for strategic service planning is now shared between the Health Board and Integration Joint Boards.

2.2. The Health Board is responsible for the overall planning for acute services, working with IJBs on planning the delivery of unscheduled care and on the shaping of the primary care and community services which are critical to the delivery of acute care.

2.3. The IJB's are responsible for strategic planning for the health and social care services for which they are responsible and for the strategic commissioning of unscheduled care services.

3. Strategic direction and principles for planning

3.1. The Board already has a clear strategic direction which sets out our purpose as:

"***Deliver effective and high quality health services, to act to improve the health of our population and to do everything we can to address the wider social determinants of health which cause health inequalities."***

3.2. That purpose is amplified with five strategic priorities, these are:

- Early intervention and preventing ill-health.
- Shifting the balance of care.
- Reshaping care for older people.
- Improving quality, efficiency and effectiveness.
- Tackling inequalities.

3.3. In planning for 2016/17 the Board also developed a series of principles to establish a clear framework for planning. These principles, set out below continue shape our approach to planning, particularly our approach to the assessment of available resources and how they should be deployed.

- Make financial decisions which are in line with and enable us to move in coherence with our purpose, strategic direction and related strategies all of which are focussed on ensuring our services are focussed on the needs of patients.
- Continue to play our part in trying to reduce the inequalities which affect our population and have a strong focus on equality impacts in making our decisions.
- Ensure that our decisions do not have unintended consequences such as unplanned transfers of pressures, responsibilities or costs to other parts of the system.
- Aim to continue to deliver the key Scottish Government targets.
- Focus first on changes which make clinical and service sense and increase efficiency and productivity and reduce our unit costs.
- Ensure that where we propose to restrict access to services or stop planned developments we will have a clear framework for prioritisation of patient care linked to clinical benefit.
- Shift the balance of care and resources but also recognise the pressures on acute services.
- Test all new national initiatives and proposals which have financial implications against our strategy and report to Board for decision.
- Underpin our decision making with evidence about what delivers the safest, highest quality and most cost effective healthcare.
- Explicitly consider risks and benefits in making decisions.
- Remain committed to the importance of innovation and research to shape changes in the way we deliver care.
- Work across boundaries with other Health Boards and public bodies to identify ways in which we can deliver services more efficiently.
- Take a whole system approach not localised savings targets, that approach driven by:
  - cost scrutiny in every part of the organisation, led by the local teams; and
  - a whole system programme of change to deliver cost reduction.
- Commitment to engagement with patients and the wider public.

- Commitment to fully engage with our staff and their representatives in shaping, planning and delivering the changes to services which will be required

3.4. The Strategic Direction, strategic priorities and principles will underpin our approach to strategic planning for acute services.

4. Current position on strategic planning for acute services

4.1. This section describes the local, regional and national position on planning for acute services, which set the context within which this next phase of our planning will be developed.

4.2. At **national level,** there are a series of programmes of work which will inform our strategic planning. These include:-

- The work of the Transformation Board which is overseeing a range of reviews including for planning for seven day services, the review of out of hours services and the current maternity and neonatal services review.
- Service strategies including for cancer;
- Planning being established for future scheduled care capacity;

4.3. In addition to these elements of national direction, the National Clinical Strategy (NCS) was published in February 2016 following an extensive programme of development and engagement. The Strategy sets out a framework for the development of health services across Scotland for the next 10-15 years. It gives an evidence-based high level perspective of why change is needed and what direction that change should take. The Strategy sets out the case for:-

- Planning and delivery of primary care services around individuals and their communities;
- Planning hospital networks at a national, regional or local level based on a population paradigm;
- Providing high value, proportionate, effective and sustainable healthcare;
- Transformational change supported by investment in e-health and technological advances.

The full strategy can be found at http://www.gov.scot/Publications/2016/02/8699 The programe to establish the framework, which will enable implementation of the strategy, bringing together Scottish Government Directors with Board Chief Executives, is currently being established.

4.4. A final a critical part of the national scene is the work to develop a new GP contract which needs to provide the platform to enable the transformation of primary care.

4.5. At **Regional level,** there are well established planning arrangements which set the direction for a number of our services which are provided to populations beyond the Board area. The Regional Planning Group is discussing how to extend the range and depth of planning done at regional level to respond to the NCS and the growing reality that a wider range of services need to be planned for larger populations and that we need to create clinical networks for service delivery beyond Board boundaries.

4.6. At our **Board level** we have a comprehensive Clinical Services Strategy approved by the Board in January 2015 and since endorsed by the IJBs.

4.7. The key aims of the strategy are to ensure:

- care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
- services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
- sustainable and affordable clinical services can be delivered across NHSGGC;
- The pressures on hospital, primary care and community services are addressed.

4.8. This strategy provides a framework to ensure that best clinical outcomes are achieved for patients and that services are:-

- safe and sustainable;
- patient centred;
- integrated between primary and secondary care;
- efficient, making best use of resources;
- affordable, provided within the funding available;
- accessible, provided as locally as possible;

4.9. We have also developed a delivery plan for the Acute Division which focuses on resolving short term challenges but also describes a series of strategic service issues which we need to address.

4.10. IJBs have published their first Strategic Commissioning Plans, these highlight the need for Partnerships to establish a real focus on changing the way their populations use hospital services in their future planning.

5. Developing our Strategic Plan: proposed process

5.1. We know from our planning for 2016, and from the material outlined in the previous section, that it is imperative that we reshape acute services in the short, medium and longer term. Our proposed approach is to bring together those three horizons for planning into an integrated process so that we develop and describe the changes we need to make in 2017/18 in the context of describing a longer term strategic change programe.

5.2. To begin this process it is proposed that we complete a series of strands of work for consideration by a Board seminar in October 2016. The proposed strands are:-

An update of the key elements of the Clinical Services Review including:-

- Population health analysis;
  Drivers for change;
- Future clinical models;
- Progress on implementation;
- An informed forward look at population and other changes which will require service transformation;

- A joint appraisal with IJBs of the implications of their strategic commissioning plans for the delivery of acute services;
- Analysis of service changes emerging from regional and national planning to deliver the National clinical strategy;
- An outline of proposed service changes for 2017/18 from the Acute Division's clinical planning processes, which are focussed on delivering high quality, safe and sustainable care;
- A strategic service and estate appraisal of our hospital sites;

5.3. We also need to produce an initial forward financial framework for acute services, developed with the Integration Joint Boards;

5.4. The development of each of these strands will include extensive clinical engagement and engagement with wider stakeholders including other Boards and Scottish Government

5.5. The Acute services Committee will receive regular updates as this work develops to ensure continuing Non Executive input. Following the October Seminar, enabling the Board to consider and shape this material, there would be further discussion with IJBs with the aim that this work can be finalised to enable the Board to approve for publication, and public engagement, proposed service changes for 2017/18 set in the context of a longer term strategic plan.

6. Conclusion

6.1. Subject to the Board discussion the Board Executive team will work with IJB Chief Officers to establish the required processes to develop the material outlined in this paper.

To:	**Renfrewshire Integration Joint Board**
On:	**16 September 2016**
Report by:	**Chief Officer**
Heading:	**Quality, Care and Professional Governance Framework – Update Report**

1. Summary

1.1 At the Integration Joint Board (IJB) meeting on 18 March 2016, the IJB noted progress made to implement Renfrewshire HSCP Quality, Care & Professional Governance Framework and the supporting implementation plan.

1.2 Appendix 1 to this report provides an update on progress made to deliver the key actions set out within the implementation plan, with the following supporting governance structures now fully established within Renfrewshire:

- Renfrewshire HSCP Executive Governance Group (REGG)
- Renfrewshire HSCP Professional Executive Group (PEG)
- Renfrewshire HSCP Service Pod - Locality Services
- Renfrewshire HSCP Service Pod - Mental Health, Addictions and Learning Disability Services
- Renfrewshire Chief Social Work Officers Professional Group (CSWO)

1.3 Any outstanding actions from the implementation plan will be progressed via the two Service Pods workplans, which are currently under development. These workplans set out how we will build upon delivery of the framework and ensure that legislative and regulation requirements continue to be met within Renfrewshire HSCP, through a defined set of actions.

1.4 Appendix 2 to this report provides a copy of the Role of Chief Social Work Officer guidance issued in July 2016 to local authorities by Scottish Ministers under section 5 of the Social Work (Scotland) Act 1968. This Guidance replaces guidance previously issued in 2009 and is being shared with members for their information. Appendix 3 summarises the key changes to the role and how this applies to the Integration Joint Board.

2. Recommendation

It is recommended that the IJB:

- Note the progress made to implement Renfrewshire HSCP Quality, Care & Professional Governance Framework.
- Note the ongoing work to develop clinical and care governance work plans.
- Note the Role of Chief Social Work Officer revised guidance issued by Scottish Ministers in July 2016.
- Note that future update reports will be submitted to IJB members on progress.

Implications of the Report

1. **Financial – Nil**
2. **HR & Organisational Development – Nil**
3. **Community Planning – Nil**
4. **Legal – Nil**
5. **Property/Assets – Nil**
6. **Information Technology –** managing information and making information available may require ICT input.
7. **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report. If required following implementation, the actual impact of the recommendations and the mitigating actions will be reviewed and monitored, and the results of the assessment will be published on the Council's website.
8. **Health & Safety – Nil**
9. **Procurement – Nil**
10. **Risk – Nil**
11. **Privacy Impact** – None. The information to be made available via the Publication Scheme is information which would be disclosed in response to a request under the Freedom of Information (Scotland) Act 2002. This therefore would not include Personal Data as defined by the Data Protection Act 1998.

List of Background Papers

- Renfrewshire HSCP Quality, Care & Professional Governance Framework (approved by the IJB on 18 September 2015)

Author: Katrina Phillips,
Head of Mental Health, Addictions and Learning Disability Services

Renfrewshire
Health & Social Care Partnership

Appendix 1

August 2016

Renfrewshire HSCP
Quality, Care & Professional Governance Framework
Implementation Group - Implementation Plan

This plan should be read in conjunction with:

- Renfrewshire HSCP Quality, Care & Professional Governance Framework

Sponsors:
Renfrewshire Quality, Care & Professional Governance Framework Implementation Group

Key

G	On target
A	Some slippage/minor issues which may impact on delivery
R	Not running to target/ significant blockages or pressures
√	Process ongoing
C	Complete

Renfrewshire HSCP Quality, Care & Professional Governance Framework Implementation Group - Implementation Plan

Core Components of Renfrewshire Quality, Care & Governance Framework:
Person Centred, Timely, Outcome Focused, Equitable, Safe, Efficient & Effective

Ref	Agreed Actions	Timescale	Update	Progress
1.1	Develop paper describing the Health & Safety Arrangements across the partnership	June 2016	Terms of Reference developed and agreed.	C
1.2	Review the Health & Safety Committee	June 2016	Health & Safety Committee - Development Session has taken place - Group now established with Head of Admin as Chair and Social Work Service Manager as Co-chair - Membership agreed - Terms of Reference developed - Schedule of meeting developed.	C
1.3	Extend building management manual	2016	Will be part of ongoing work with health and safety systems. Once agreed, will be rolled out by March 2017.	√

2. Renfrewshire Locality Quality, Care & Professional Governance Pods **- Two pods will be established including Locality Services/ Mental Health, Addictions & Learning Disabilities**				
2.1	Develop Renfrewshire Health and Social care Locality Quality, Care & Professional Governance Pod: - Agree Chair / Co-chair - Agree Membership - Develop Terms of Reference (6 weekly meetings) - Agree core agenda - Develop workplan - Feed local issues into Professional Executive Governance Group - Develop 3 key messages from each meeting Note: Work has already been established to establish Renfrewshire Mental Health, Addictions & Learning Disabilities Pod.	Jan 2016	Locality Governance Group - Group now established with Heads of Health and Social Care Services rotating Chair and Clinical Director as Vice Chair - Membership agreed - Terms of Reference developed - Schedule of meetings- 6/8 weekly - Standing agenda items agreed and detailed within Terms of Reference Mental Health Governance Group - Group now established with Clinical Director/Clinical Lead rotating Chair and Vice Chair role - Membership agreed - Terms of Reference developed - Schedule of meeting -monthly - Standing agenda items agreed and detailed within Terms of Reference	C C
2.1.1	**Note**: Renfrewshire Locality Quality, Care & Professional Governance Pod responsibilities to include: - Incident Management, reporting and investigation (e.g. SCI. SCR) - Complaints - Patient/Service User/Client Feedback - Identify action plans for service improvement - Shared learning - Escalation - Implementation of guidance policies etc - Professional Registration - Public Protection - Quality Improvement, monitoring & development - Review external reports (e.g. MWC, Care Inspectorate			

2.2	Arrange and confirm admin support for Renfrewshire HSCP Locality Quality, Care & Professional Governance Pod	May 2016	Admin Support in place to support governance arrangements of Pods	C
2.3	Develop reporting templates for Renfrewshire Quality, Care & Professional Governance Service Pods - Status Report Interim/Yearly Report Templates	Dec 2015 Feb 2016	Status report templates have been developed. 6 monthly service pods reports have been developed and were presented at the first HSCP Exec Governance Group in August 2016.	C

3. Renfrewshire Professional Executive Group				
3.1	Arrange meeting to develop Renfrewshire Professional Governance Group - Agree Chair /Co-chair - Agree Membership – all professional leads - Develop Terms of Reference (Quarterly meetings) - Agree core agenda - Develop workplan - Develop 3 key messages from each meeting.	Jan 2016	Professional Governance Group: - Group now established with Clinical/Associate Director as Chair and Nurse Professional Adviser as vice chair - Membership agreed - Terms of Reference developed - Schedule of meetings - bi-monthly - Standing agenda items agreed and detailed within Terms of Reference	C
3.1.1	**Note**: Renfrewshire HSCP Professional Executive Governance Group responsibilities to include: - Cross-system leading for localities, care groups and professional groups within and beyond HSCP - Professional regulation, fitness to practice issues - Impact of assessment and guidance to localities about policies, guidance, inspections etc - Mental Health Officer (MHO) service.			
3.2	Arrange and confirm admin support for: - Renfrewshire Professional Leads Executive Governance Group	May 2016	Admin Support in place to support governance arrangements	C
3.3	Develop reporting templates for Renfrewshire HSCP Executive Governance Group: - Status Report - Interim/Yearly Report Templates	Dec 2015	Status report templates have been developed and are being implemented. 6 monthly reports were developed and presented at the first HSCP Exec Governance Group in July 2016.	C

4. Renfrewshire HSCP Executive Governance Group				
4.1	Arrange meeting to develop Renfrewshire HSCP Executive Governance Group - Agree Chair /Co-chair - Agree Membership – all professional leads - Develop Terms of Reference (Twice yearly meetings) - Agree core agenda - Develop workplan - Develop 3 key messages from each meeting.	March 2016 Jan 2016	Clinical Risk Support will attend Renfrewshire Executive Governance Group and provide support to Service Pods as required. Exec Governance Group: - Group now established - Initial membership agreed - Terms of Reference developed - Schedule of meetings 3/4 times yearly - Standing agenda items detailed within Terms of Reference	C C
4.1.1	**Note**: Renfrewshire HSCP Executive Governance Group responsibilities to include: - Impact of assessment and guidance to localities about policies, guidance, inspections etc - Analysis, leaning from incidents & complaints - Quality Assurance for locality level - Promoting Person Centred Care through ongoing service development and review.			
4.2	Arrange and confirm admin support for Renfrewshire HSCP Executive Governance Group	May 2016	Admin Support in place to support governance arrangements for Executive Governance Group.	C
5. Datix				
5.1	Explore whether Datix can be expanded for Social Work	Target date mid 2017	At present, we cannot use Datix for social work incidents or complaints. The Datix Team currently do not have capacity to include social work incidents or complaints on Datix. Further work planned to work through issues if possible.	√
5.2	Organise Training & Development Session on Datix (including running reports)	Target date mid 2017	JS has had initial discussion with Datix Manager. Datix team will do this once new system rolled out to key staff.	√
5.3	Review and improve on usage of actions module within Datix by NHS staff	Dec 2016	AMCL has requested Datix module for locality Services.	√

6. Complaints				
6.1	Review complaints process – central location for HSCP (Health/SW)	2017	Work in progress – awaiting guidance from SPSO (April 2017) regarding new streamlined process	√
6.2	Develop Flow chart for complaints	Dec 2016	In progress.	√
6.3	Review complaints process to ensure appropriate governance and ability to obtain meaningful information on outcomes	Dec 2016	New web based Datix system will assist with this. Training being arranged for key members of staff Staff currently progress actions and record these on paper copy – work underway to have action plan electronically	√
7. Incident Reporting				
7.1	Review usage of Accident Incident Report Database (AIRD) for staff for incident reporting.	2017	Needs wider discussion and comparison with Datix for incident reporting.	√
8. Communication & Engagement				
8.1	Agree escalation list and briefing system for Rapid Alert (email group)	Feb 2016	Process in place via Chief Officer.	C
8.2	Develop closer working relationships to support initial Service Pods reporting and working arrangements.	Dec 2016	AMCL and NH now meeting regularly and maintaining close working relationship to support HSCP Heads of Service with ongoing governance arrangements.	C
8.3	Ensure service areas have read and understood responsibilities to implement Renfrewshire HSCP Quality, Care & Professional Governance Framework	Jan 2016	HSCP Quality, Care & Professional Governance Framework has been promoted at Leadership Network Session(s) and Staff Events. E-Link to papers have been shared via Team Brief	C
9. Other				
9.1	Consider remit / TOR's for CSWO professional group and how it fits into structure	Jan 2016	CSWO Governance Group: - Group now established with CSWO as chair - Initial membership agreed - Draft Terms of Reference developed - Schedule of meetings developed – Quarterly - Standing agenda items detailed within Terms of Reference	C

9.2	Arrange and confirm admin support for CSWO Professional Governance Group	April 2016	Admin Support in place to support governance arrangements.	C
9.3	Provide diagram of structure and identify board wide and council groups relationship / engagement with HSCP structure	Jan 2016	Final structure has been developed for Renfrewshire HSCP.	C
9.4	Consider how dashboard might support the process and provide meaningful information to inform service development and improvement.	Dec 2016	Will be developed as part of Service Pod workplans which are currently under development.	√
9.5	Update progress schedule in preparation for IJB in March 2016	Feb 2016	Progress report went to IJB meeting in March 2016 and update report submitted to September 2016 meeting.	C
9.6	Develop work plans for governance groups.	Sept 2016	Each service pod is currently developing a clinical and care governance workplan.	√
9.7	Share learning across all HSCP governance groups.	On going	Process to share learning across all HSCP Governance will be via status report template which has now been developed and is being implemented.	C
9.8	Hold an annual care governance event for wider stakeholders.	Annual	Annual event will be organised for summer 2017.	√
9.9	Develop training programme to support governance arrangements i.e. Root Cause Analysis	March 2017	A training plan is currently under development.	√

The Role of Chief Social Work Officer

Guidance Issued by Scottish Ministers

pursuant to Section 5(1) of the Social Work (Scotland) Act 1968

Revision of Guidance First Issued In 2009

Revised Version – July 2016

This guidance has been developed in partnership with local government and supported by COSLA

July 2016

The Scottish Government
Riaghaltas na h-Alba

INTRODUCTION

1. The Social Work (Scotland) Act 1968 (the 1968 Act) requires local authorities to appoint a single Chief Social Work Officer (CSWO) for the purposes of listed social work functions.

2. This document contains statutory guidance. It is issued to local authorities by Scottish Ministers under section 5 of the 1968 Act. The local authority must have regard to this guidance. It must follow both the letter and the spirit of the guidance. It must not depart from the guidance without good reason. The Guidance replaces guidance previously issued in 2009.

PURPOSE

3. The guidance is for local authorities and will also be of use to bodies and partnerships to which local authorities have delegated social work functions. Local authorities must have regard to this guidance when carrying out their functions under the 1968 Act. Recognising the democratic accountability which local authorities have in this area, clarity and consistency about the role and contribution of the CSWO are particularly important given the diversity of organisational structures and the range of organisations and partnerships with an interest and role in delivery of social work services.

4. This guidance summarises the minimum scope of the role of the CSWO. It will assist elected members in ensuring that the role is delivered effectively and that the local authority derives maximum benefit from the effective functioning of the role. Effective delivery of and support for the role will assist local authorities to be assured that there is coherence and effective interfacing across all of their social work functions.

5. The guidance is intended to:

(a) support local authorities in effective discharge of responsibilities for which they are democratically accountable;

(b) help local authorities maximise the role of the CSWO and the value of their professional advice – both strategically and professionally;

(c) provide advice on how best to support the role so that the CSWO can be effective in their role both within the local authority and in regard to other entities, such as Community Planning Partnerships, whilst recognising that local authorities operate with different management and organisational structures and in different partnership landscapes;

(d) assist Integration Joint Boards (IJBs) to understand the CSWO role in the context of integration of health and social care brought in through the Public Bodies (Joint Working) (Scotland) Act 2014 (the 2014 Act).

(e) be read alongside the wide range of guidance relevant to social work functions of local authorities and relevant guidance issued relating to the 2014 Act.

(f) be sufficiently generic to remain relevant in the event of future management or organisational structural change.

REQUIREMENT

6. The requirement for every local authority to appoint a Chief Social Work Officer is set out in section 3 of the 1968 Act. This requirement is for the purposes of the local authority functions under the 1968 Act and the enactments listed in section 5(1B) of the Act. The role provides a strategic and professional leadership role in the delivery of social work services. In addition there are certain functions conferred by legislation directly on the CSWO by name.

7. The Scottish Office explicitly recognised that the need for the role was driven by "*the particular responsibilities which fall on social work services in that they affect personal lives, individual rights and liberties to an extent that other local authority services do not*." (Circular: SWSG2/1995 May 1995)

8. The Public Bodies (Joint Working) (Scotland) Act 2014 provides for the delegation of certain social work functions by a local authority to an integration authority. The CSWO's responsibilities in relation to local authority social work functions continue to apply to functions which are being delivered by other bodies under integration arrangements. However, the responsibility for appointing a CSWO cannot be delegated and must be exercised directly by the local authority itself.

THE CHIEF SOCIAL WORK OFFICER ROLE

Overview

9. The CSWO role was established to ensure the provision of appropriate professional advice in the discharge of a local authority's statutory functions as described in paragraph 6. The role also has a place set out in integrated arrangements brought in through the 2014 Act. As a matter of good practice it is expected that the CSWO will undertake the role across the full range of a local authority's social work functions to provide a focus for professional leadership and governance in regard to these functions.

10. The CSWO should assist local authorities and their partners in understanding the complexities and cross-cutting nature of social work service delivery – including in relation to particular issues such as corporate parenting, child protection, adult protection and the management of high risk offenders - and also the key role social work plays in contributing to the achievement of a wide range of national and local outcomes. The CSWO also has a contribution to make in supporting overall performance improvement and management of corporate risk.

11. It is for local authorities to determine the reporting and management structures that best meet their needs. Where the CSWO is not a full member of the senior management team or equivalent, elected members must satisfy themselves that the officer has appropriate access and influence at the most senior level and is supported to deliver the complex role described in this guidance.

Competencies

12. Scottish Ministers' requirement is that the CSWO role will be held by a person who is qualified as a social worker and registered as such with the Scottish Social Services Council. Local authorities will also want to require this as they will need to ensure that the CSWO:

- can demonstrate extensive experience at a senior level of both operational and strategic management of social work and social care services and;
- has the competence and confidence required to provide effective professional advice at all levels within the organisation and with the full range of partner organisations
- receives effective induction to support them in full delivery of their role

(NB At the time of writing, SI 1996/515, which sets out minimum qualifications for a CSWO is being reviewed with a view to amendment so that the social work degree is specifically included.)

13. Further information on the skills and competencies required of a CSWO is available in the Standard for Chief Social Work Officers (issued by the Scottish Social Services Council in July 2015) which underpins the Level 11 Award for CSWOs which was launched in August 2015 as a further professional accredited qualification aimed at enhancing CSWO competence.

Scope

14. The scope of the role relates to the functions outlined in paragraph 6 whether provided directly by the local authority; through delegation to another statutory body or in partnership with other agencies. Where social work services and support are commissioned on behalf of the authority, including from the independent and voluntary sector, the CSWO has a responsibility to advise on the specification, quality and standards of the commissioned services and support. The CSWO also has a role in providing professional advice and guidance to an Integration Joint Board or NHS Board to which social work functions have been formally delegated.

Responsibility for values and standards

15. The CSWO should:

(a) promote values and standards of professional practice, including all relevant national Standards and Guidance, and ensure adherence with the Codes of Practice issued by the Scottish Social Services Council for social service employers.

(b) work with Human Resources (or equivalent function) and responsible senior managers to ensure that all social service workers practice in line with the SSSC's Code of Practice and that all registered social service workers meet the requirements of the regulatory body;

(c) establish a Practice Governance Group or link with relevant Clinical and Care Governance arrangements designed to support and advise managers in maintaining and developing high standards of practice and supervision in line with relevant guidance, including, for example, - the *Practice Governance Framework: Responsibility and Accountability in Social Work Practice* (SG 2011);

(d) ensure that the values and standards of professional practice are communicated on a regular basis and adhered to and that local guidance is reviewed and updated periodically.

16. The CSWO must be empowered and enabled to provide professional advice and contribute to decision-making in the local authority and health and social care partnership arrangements, raising issues of concern with the local authority Elected Members or Chief Executive, or the Chief Officer of the Integration Joint Board as appropriate (or the Chief Executive of a Health Board if appropriate in the context of a lead agency model), in regard to:

(a) effective governance arrangements for the management of the complex balance of need, risk and civil liberties, in accordance with professional standards.

(b) appropriate systems required to 1) promote continuous improvement and 2) identify and address weak and poor practice.

(c) the development and monitoring of implementation of appropriate care governance arrangements;

(d) approaches in place for learning from critical incidents, which could include through facilitation of local authority involvement in the work of Child Protection Committees, Adult Support and Protection Committees and Offender Management Committees where that will result in the necessary learning within local authorities taking place;

(e) requirements that only registered social workers undertake those functions reserved in legislation or are accountable for those functions described in guidance;

(f) workforce planning and quality assurance, including safe recruitment practice, probation/mentoring arrangements, managing poor performance and promoting continuous learning and development for staff;

(g) continuous improvement, raising standards and evidence-informed good practice, including the development of person-centred services that are focussed on the needs of people who use services and support;

(h) the provision and quality of practice learning experiences for social work students and effective workplace assessment arrangements, in accordance with the SSSC Code of Practice for Employers of Social Service Workers;

Decision-Making

17. There are a small number of areas of decision-making where legislation confers functions directly on the CSWO by name. These areas relate primarily to the curtailment of individual freedom and the protection of both individuals and the public. Such decisions must be made either by the CSWO or by a professionally qualified social worker, at an appropriate level of seniority, to whom the responsibility has been formally delegated and set out within local authority arrangements. Even where responsibility has been delegated, the CSWO retains overall responsibility for ensuring quality and oversight of the decisions. These areas include:

- deciding whether to implement a secure accommodation authorisation in relation to a child (with the consent of a head of the secure accommodation), reviewing such placements and removing a child from secure accommodation if appropriate;
- the transfer of a child subject to a Supervision Order in cases of urgent necessity;
- acting as guardian to an adult with incapacity where the guardianship functions relate to the personal welfare of the adult and no other suitable individual has consented to be appointed;
- decisions associated with the management of drug treatment and testing orders
- carrying out functions as the appropriate authority in relation to a breach of a supervised release order, or to appoint someone to carry out these functions.

18. In addition to these specific areas where legislation confers functions on all CSWOs, there will be a much larger number of areas of decision-making which have been assigned by individual local authorities to Chief Social Work Officers reflecting "*the particular responsibilities which fall on social work services in that they affect personal lives, individual rights and liberties to an extent that other local authority services do not"* noted in paragraph 7. These areas may include responsibilities assigned through guidance or other routes. For example:

- the 2014 guidance on Multi Agency Public Protection Arrangements (MAPPA) makes explicit reference to the role of the CSWO in responsibility for joint arrangements, in co-operation with other authorities.
- although mental health services are delegated to Integration Joint Boards, some of these functions require to be carried out by local authority officers with a social work qualification (Mental Health Officers). Local authorities will want to be reassured via the CSWO that these functions are discharged in accordance with professional standards and statutory requirements

It is for each local authority to make transparent which additional specific areas of responsibility in regard to their social work functions they have assigned to their CSWO

Leadership

19. The CSWO is responsible for providing professional leadership for social workers and staff in social work services. The CSWO should:

(a) support and contribute to evidence-informed decision making and practice – at professional and corporate level – by providing appropriate professional advice;

(b) seek to enhance professional leadership and accountability throughout the organisation to support the quality of service and delivery;

(c) support the delivery of social work's contribution to achieving local and national outcomes;

(d) promote partnership working across professions and all agencies to support the delivery of integrated services;

(e) promote social work values across corporate agendas and partner agencies.

The CSWO role in the context of partnerships and integration

20. In the context of Health and Social Care Integration and the 2014 Act, the CSWO is required to be appointed as a non-voting member of the Integration Joint Board (IJB) (or, in lead agency models, the Integration Joint Monitoring Committee). Scottish Ministers are strongly of the view that the influence of high quality professional leaders in the integrated arrangements is central to the effectiveness of improving the quality of care locally and nationally.

21. The CSWO also has a defined role in professional and clinical and care leadership and has a key role to play in Clinical and Care Governance systems which support the work of the Integration Joint Board, as set out in the partnership Integration Schemes and relevant guidance.

22. The local authority should ensure that appropriate arrangements are in place to include the CSWO in relevant strategic and operational forums that provide direct access to the Chief Executive and elected members so that the CSWO is in an optimum position to support and advise them in regard to their social work function responsibilities in their partnership contexts.

Reporting

23. The CSWO has a role in reporting to the local authority Chief Executive, elected members and IJBs – providing comment on issues which may identify risk to safety of vulnerable people or impact on the social work service and also on the findings of relevant service quality and performance reports, setting out:

- implications for the local authority, for the IJB, for services, for people who use services and support and carers, for individual teams/members of staff/partners as appropriate;
- implications for delivery of national and local outcomes;
- proposals for remedial action;
- means for sharing good practice and learning;
- monitoring and reporting arrangements for identified improvement activity.

24. The CSWO should also produce and publish a summary annual report for local authorities and IJBs on the functions of the CSWO role and delivery of the local authority's social work services functions (however these are organised or delivered). A template for this report is available from by the Office of the Chief Social Work Adviser, Scottish Government.

ACCESS, ACCOUNTABILITY AND REPORTING ARRANGEMENTS

25. To discharge their role effectively, the CSWO will need:

(a) direct access to people and information across the local authority, including the Chief Executive, elected members, managers and frontline practitioners and also in partner services, including in Health and Social Care Partnerships. Specific arrangements will vary according to individual councils, but should be clearly articulated locally;

(b) to be able to bring matters to the attention of the Chief Executive to ensure that professional standards and values are maintained;

(c) to be visible and available to any social services worker and ensure the availability of robust professional advice and practice guidance;

(d) to provide professional advice as required to senior managers across the authority and its partners in support of strategic and corporate agendas.

26. Local authorities will need to agree:

(a) how the CSWO is enabled to inform and influence corporate issues, such as managing risk, setting budget priorities and public service reform;

(b) the specific access arrangements for the CSWO to the Chief Executive and elected members;

(c) the relationships, responsibilities and respective accountabilities of service managers and the CSWO;

(d) a mechanism to include an independent, professional perspective to the appointment of the CSWO;

(e) procedures for removal of a CSWO postholder, bearing in mind the need for continuity in the provision of the CSWO functions, the value of independent professional advice and the arrangements for the appointment and removal of the local authority's other proper officers;

(f) clear and formal deputising arrangements (with similar skills and experience available) to cover any period of absence by the CSWO and appropriate delegation arrangements where scale of business requires this.

27. This document complements the wide set of guidance underpinning the delivery of safe, accountable and effective social work practice and high quality social services in Scotland.

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Appendix 3

The Chief Social Work Officer Role within the Renfrewshire Integrated Joint Board

1. The requirement for every local authority to appoint a Chief Social Work Officer (CSWO) is set out in the Social Work Scotland Act 1968. The role of the Chief Social Work Officer (CSWO) role was established to ensure the provision of appropriate professional advice in the discharge of a local authority's statutory functions.
2. The Public Bodies (Joint Working) (Scotland) Act 2014 provides for the delegation of certain social work functions by a local authority to an integration authority. The CSWO's responsibilities in relation to local authority social work functions continue to apply to functions which are being delivered by other bodies under integration arrangements. However, the responsibility for appointing a CSWO cannot be delegated and must be exercised directly by the local authority itself.
3. As a matter of good practice within the integrated arrangements, it is expected that the CSWO will undertake the role across the full range of a local authority's social work functions to provide a focus for professional leadership and governance in regard to these functions.
4. The CSWO should assist the Integrated Joint Board in understanding the complexities and cross-cutting nature of social work service delivery - including in relation to particular issues such as corporate parenting, child protection, adult protection and the management of high risk offenders - and also the key role social work plays in contributing to the achievement of a wide range of national and local outcomes. The CSWO also has a contribution to make in supporting overall performance improvement and management of corporate risk.
5. The CSWO also has a role in providing professional advice and guidance to the Integration Joint Board. The CSWO should promote values and standards of professional practice, including all relevant national Standards and Guidance, and ensure adherence with the Codes of Practice issued by the Scottish Social Services Council for social service employers.
6. There are a small number of areas of decision-making where legislation confers functions directly on the CSWO by name. These areas relate primarily to the curtailment of individual freedom and the protection of both individuals and the public. Such decisions must be made either by the CSWO or by a professionally qualified social worker, at an appropriate level of seniority, to whom the responsibility has been formally delegated and set out within local authority arrangements.
7. The CSWO retains overall responsibility for ensuring quality and oversight of the decisions. These areas include:

    - acting as guardian to an adult with incapacity where the guardianship functions relate to the personal welfare of the adult and no other suitable individual has consented to be appointed
    - decisions associated with the management of drug treatment and testing orders;
    - the transfer of a child subject to a Supervision Order in cases of urgent necessity;
    - Multi Agency Public Protection Arrangements (MAPPA) makes explicit reference to the role of the CSWO in responsibility for joint arrangements, in co-operation with other authorities.
    - although mental health services are delegated to Integration Joint Boards, some of these functions require to be carried out by local authority officers with a social work qualification (Mental Health Officers). CSWO has a responsibility to ensure that these functions are discharged in accordance with professional standards and statutory requirements
    - providing professional leadership for social workers and staff in social work services

The CSWO role in the context of the Renfrewshire Partnership and Integration

8. Within Renfrewshire, the CSWO is Peter MacLeod, Director of Children's Services. He acts as CSWO for both Children's Services and for the Renfrewshire Health and Social Care Partnership (RHSCP). In the context of Health and Social Care Integration, the 2014 Act requires that he is a non-voting member of the Renfrewshire Integration Joint Board (IJB).

9. The CSWO has a defined role in professional and clinical and care leadership and has a key role to play in Clinical and Care Governance systems which support the work of the Integration Joint Board, as set out in the partnership Integration Schemes.

10. Appropriate arrangements are in place to include the Renfrewshire CSWO in relevant strategic and operational forums that provide direct access to the Chief Executive and elected members so that the CSWO is in an optimum position to support and advise them in regard to their social work function responsibilities in their partnership contexts.

11. The CSWO has a role in reporting to the local authority Chief Executive, elected members and IJBs - providing comment on issues which may identify risk to safety of vulnerable people or impact on the social work service and also on the findings of relevant service quality and performance reports.

12. The CSWO is also required to produce and publish a summary annual report for local authorities and IJBs on the functions of the CSWO role and delivery of the local authority's social work services functions (however these are organised or delivered).

13. In the Renfrewshire HSCP context, a CSWO Quality and Performance Sub-group has been established and meets on a 3 monthly basis. The purpose of this meeting is to support the CSWO to evaluate quality of practice across social work services and to analyse performance reports in relation to a range of service areas. In addition to the CSWO, RHSCP Heads of Service attend this meeting along with operational leads responsible for adult protection, mental health, learning disabilities, and locality team services. Areas covered include:

    - Significant events; incidents and alerts
    - Complaints Overview
    - Outcomes from recent Inspections of registered services
    - Professional registration issues
    - Contract monitoring and compliance
    - Mental health officer functions including Guardianship
    - Adult/public Protection
    - Risk – significant events and actions
    - Service Improvement / Redesign
    - Good practice examples

14. Revised guidance on the role of the Chief Social Work Officer was issued by the Scottish Government in July 2016. Analysis of the guidance indicates that Renfrewshire HSCP is compliant with the requirements in respect of the role of the CSWO.