DRAFT MINUTE OF
ARGYLL & BUTE HEALTH & SOCIAL CARE PARTNERSHIP
(HSCP)
INTEGRATION JOINT BOARD
Wednesday 27 September 2017 at 1.30pm in the Council Chamber, Kilmory, Lochgilphead

Present:

Robin Creelman	NHS Highland Non-Executive Board Member (Chair)
Councillor Kieron Green	Argyll & Bute Council (Vice Chair)
Christina West	Chief Officer, Argyll & Bute HSCP
David Alston	NHS Highland Chair
Liz Higgins	Lead Nurse, Argyll & Bute HSCP
Alex Taylor	Head of Children and Families & Criminal Justice
Elaine Garman	Public Health Specialist, Argyll & Bute HSCP
Caroline Whyte	Chief Financial Officer, Argyll & Bute HSCP
Denis McGlennon	Independent Sector Representative
Dr Kate Pickering	General Practitioner
Linda Currie	AHP Lead
Fiona Thomson	Lead Pharmacist
Maggie McCowan	Public Representative
Elizabeth Rhodick	Public Representative
Heather Grier	Unpaid Carer Representative
Catriona Spink	Unpaid Carer Representative
Dawn McDonald	Staff Representative (Health)
Alison McGrory	Health Improvement Principal
Gaener Rodger	NHS Highland Non-Executive Board Member
Lorraine Paterson	Head of Adult Services (West)
Jim Littlejohn	Acting Head of Adult Services (East)
Heidi May	Board Nurse Director, NHS Highland
Stephen Whiston	Head of Strategic Planning & Performance - Argyll & Bute HSCP
Councillor Jim Anderson	Argyll & Bute Council
Councillor Iain Paterson	Argyll & Bute Council

In Attendance:

David Ritchie	Communications Manager, Argyll & Bute HSCP
Laura Blackwood	Executive Support Officer, Argyll & Bute Council (Minutes)

Apologies:

Dr Michael Hall	Associate Medical Director, Argyll & Bute HSCP
Dr Peter Thorpe	Secondary Care Adviser, Argyll & Bute HSCP
Glenn Heritage	Argyll & Bute Third Sector Interface

ITEM	DETAIL	ACTION
1	**WELCOME**	
	The Chair welcomed everyone to the meeting and introductions were made around the table.	

	The Chair advised that this would be Elaine Garman's last meeting and expressed his thanks for her hard work and dedication over the years, and the notable difference she has made in undertaking her role. The Chair also welcomed Heidi May to her first meeting of the IJB.	
2	**APOLOGIES**	
	Apologies were noted.	
3	**DECLARATIONS OF INTEREST**	
	The following declarations of interest were recorded from Gaener Rodger:- • Item 5.1 – a family member works within the Care at Home sector • Item 5.4 – Gaener has recently taken up a post as a Sessional Worker in Sexual Health Education with Waverley Care.	
4	**APPROVAL OF MINUTE OF INTEGRATION JOINT BOARD 02-08-17 AND ACTION PLAN**	
	The minute was noted as an accurate record. Matters Arising:- (a) Trust Housing Association (p5) – an update was requested in respect of the action to flag any identified gaps in the service, which create risk, to the IJB. Christina West advised that she has ongoing dialogue with local managers on this matter and that operational managers continue to undertake risk assessments. Action Log Updates:- 1 – Christina West advised that the use of webcasting will be discussed at the Council in due course and that HSCP IT colleagues should continue to explore the possibility of using Webex, linking in with the Council where possible. 5 – Stephen Whiston noted that a further meeting has been arranged to discuss the review of GP OoH Services in the Vale of Leven. 6 – A visit is taking place by Dr Rod Harvey, NHS Highland Board Medical Director on 4th October to progress. 8 – Caroline Whyte advised that she has liaised with the Council's Section 95 Officer who is not aware of any further financial decisions by the Council which may impact on IJB financial plan. 9 – Caroline Whyte noted that the formal directions will be issued to NHS Highland and Argyll & Bute Council shortly.	

	10 – Stephen Whiston noted that this information gathering is in hand. 11 – Christina West advised that she has undertaken discussions with her SMT on this and Officers will be asked to have regard to staff governance when bringing reports to the IJB. 12 – Caroline Whyte advised that this detail will be issued by the end of the week.	
5	**BUSINESS**	
5.1	**Clinical and Care Governance**	
	Report from Liz Higgins, Lead Nurse outlining the current Clinical and Care Governance issues, and any actions required to address performance was circulated. The following points were noted/agreed in respect of the key issues:- i. Diabetic Retinopathy Screening – there is currently a waiting list for slit lamp and possible solutions to resolve are being actively pursued. The IJB will be kept appraised of progress on this matter. ii. Oban Laboratory – a meeting is scheduled for 4 October to finalise the clinical lead/management structure. iii. Complaints – Complaints Handling Process (CHP) for Argyll and Bute IJB has been submitted to the SPSO and awaiting feedback on compliance. It was noted that during quarter one there were 8 complaints at stage 1 and 19 at stage 2 for Health, and in respect of Social work there were 2 at stage 1 and 12 at stage 2. iv. Infection Control – Staphylococcus Aureus Bacteraemia (SAB) there have been no new cases reported since the beginning of April 2017, and no incidences of Clostridium difficile infection (CDI) since the last report. In respect of ICNet it was agreed that an update on this should be provided at the next IJB or Clinical and Care Governance Committee, whichever is sooner. v. Care at Home Service – Lorraine Paterson provided an overview of the issues in respect of Mears and the work that is being undertaken to arrange a TUPE transfer of their staff to other homecare providers, and to maintain service continuity to clients. In respect of the latter point, Councillor Green passed on his thanks to everyone involved in ensuring that service provision has continued. Arising from discussion the following was agreed:- • That a joint report from management and the	**LH**

	commissioning team would be prepared for the next IJB in respect of home care. • As part of the report being prepared re. Port Appin and Lismore, an explanation on why this didn't work/transfer should be included. • Unmet need – Christina West to arrange for a breakdown at an Argyll and Bute / locality level to be included within the report being prepared by the Commissioning Team for the IJB in November.	**LP** **LH** **LP**
5.2	**Criminal Justice Social Work Governance**	
	Report from Alex Taylor advising on the recent changes in legislation and the need to review and confirm the Criminal Justice Social Work Service (CJSWS) governance arrangements was circulated. The IJB agreed the reporting arrangements set out, that governance for the CJSWS sits with the IJB, and that an IJB Development Session on the CJSWS should be scheduled for later in the year.	**AT**
5.3	**Finance**	
	i. <u>Audited Annual Accounts 2016-17</u> A copy of the Audited Annual Accounts 2016-17, which require to be signed off by the IJB by 30 September 2017 was circulated and agreed. ii. <u>External Audit Annual Report 2016-17</u> A copy of the External Audit Annual Report 2016-17 was circulated and noted. The four key recommendations for improvement detailed on pages 100-101 will be monitored by the Audit Committee on an ongoing basis. iii. <u>Budget Monitoring – July 2017</u> Report from Caroline Whyte setting out the financial position for Integrated Services as at the end July 2017 was circulated. The terms of the report were noted, including:- • The year-end forecast outturn position for the July period is a projected overspend of £4.412M • In terms of deliverability of the Quality and Finance Plan for 2017-18 there are significant savings to be met within a short timescale. To the July period £1.880M of the approved £8.158M savings target has been met. • Endorsed and supported the IJB Chair's response to the Council in relation to the communication received in respect of the HSCP projected overspend position. Arising from discussion the following additional points	

	were noted/agreed:- • Adult Care budget pressures – Caroline Whyte to provide Heather Grier with a breakdown of the various pressures • Financial Recovery Plan – Councillor Green enquired about the measures that are in place to ensure consistency of approach across Heads of Service. Christina West advised that Heads of Service will be supporting Managers and that a meeting is being held next Monday with Officers with regard to ensuring that a consistent approach is adopted. The Adult Services Resource Group will also have an overview, ensuring consistency in approach and that issues are being escalated in an appropriate manner. iv. <u>Quality and Finance Plan Programme Board</u> Report from Caroline Whyte proposing the establishment of a Quality and Finance Plan Programme Board to provide additional oversight to the delivery and ongoing development of the Plan was circulated. The IJB agreed to establish the Board, approved the terms of reference and appointed the following 4 members:- • Robin Creelman • Councillor Kieron Green • Heather Grier • Councillor Jim Anderson In order to progress matters quickly it was noted that the first meeting will be convened next week. v. <u>Strategic Risk Register</u> Report from Caroline Whyte was circulated. The IJB noted:- • the current version of the Strategic Risk Register for the HSCP; • that it has been subject to a full review and updated following the IJB risk management development session held in August 2017;and • that a separate paper on risk appetite will be considered at item 5.3 (vi) below. vi. <u>Risk Appetite</u> Report from Caroline Whyte proposing a set of risk appetites for approval, following the IJB development session held in August 2017, was circulated. The IJB noted the requirement for them to formally articulate the risk appetite for the Board,	**CWh** **CWh**

	and approved the risk appetites as set out within the report. vii. <u>IJB Audit Committee Membership</u> Report from Caroline Whyte outlining the requirement for the IJB to make new appointments to the Audit Committee and to appoint a new Chair was circulated. The IJB approved the recommended changes to the terms of reference, and made the following appointments; • Heather Grier – Chair of the Audit Committee • Maggie McCowan – member of the Audit Committee	
5.4	**Public Health Report**	
	Report from Alison McGrory outlining some of the programmes in Argyll and Bute to improve sexual health across the population was circulated. Arising from discussion the following points were noted/agreed:- i. The embedded report with regard to service provision should be circulated alongside today's minute of the IJB. ii. Sexually transmitted diseases – data is currently not published at an Argyll and Bute level and a resolution to this is currently being pursued by Alison Hardman. iii. Accessibility to services - Alison McGrory to liaise with Alison Hardman in respect of establishing whether there has been any complaints regarding access to services. iv. C-Card Pilot – a review of the pilot will be undertaken and if deemed successful will be rolled out to other areas. v. Training – Kate Pickering advised that it would be beneficial to explore the possibility of some staff groups being trained at a local level, for example on Islay, rather than travel to the Sandyford Clinic in Glasgow, which is not always feasible. vi. The IJB noted the importance of sexual health programmes and sexual health services in Argyll and Bute HSCP.	**AM/LB** **AM** **AM**
5.5	**Performance Report**	
	Report from Stephen Whiston was circulated. The IJB noted the HSCP performance against the National Health and Well Being Outcomes 1, 2, 3, and 4 for FQ1 17/18, the actions identified to address deficiencies in performance and also noted the performance against the Ministerial Steering Group Performance Indicators at June 2017. Arising from discussion an issue was raised by Catriona Spink in relation to the transfer of patients to Greater Glasgow and Clyde and the waiting time/discharge concerns which can arise. It was noted that this is an issue which should be picked up further outwith this meeting, including the decisions taken at a local level which result in the transfer.	

5.6	**Staff Governance**	
	Report presented by Stephen Whiston setting out the quarter 1 performance data and current key issues for staff governance in the HSCP was circulated and the content noted by the IJB, including:- • Sandy Wilkie will take up post as Head of HR at end October 2017 • e-KSF / Personal Development Plans – noted that managers are being actively encouraged to use the e-KSF system to record engagements with staff. The iMatter survey results have confirmed that staff feel positively engaged and steps now need to be taken to ensure that these communications are recorded. • Sickness absence costs – agreed that Stephen would arrange for the cost of sick pay to be included within future reports.	**SW**
5.7	**Carers Eligibility Criteria**	
	Report from Linda Currie outlining the requirement for Argyll and Bute HSCP to establish an eligibility criteria for carer services for implementation of the Carers Act by 1st April 2018 was circulated. The IJB:- • Noted the timeline for agreement of the proposed criteria and the consultation which will take place from 1st October 2017; • Agreed the proposed Eligibility Criteria • Agreed that a further report would come back to the IJB in February 2018.	**LC**
5.8	**Children and Young Peoples Service Plan**	
	Report from Alex Taylor setting out the new Children and Young People's Services Plan was circulated and approved by the IJB, subject to the following:- • P227 – in respect of the 3 indicators regarding children reaching their developmental milestones it was agreed that Alex Taylor would check whether the baseline/target data for these relates to the % of children or the number of reviews completed and confirm the position to the IJB by email. It was noted that once ratified by the IJB and the Council, the Plan will be published and submitted to the Scottish Government. It was also noted that monitoring of the Plan will be overseen by the Argyll and Bute Children's Strategic Group, with annual performance and progress reports to the IJB and Community Services Committee.	**AT**
5.9	**West of Scotland Regional Planning Principles**	
	Report presented by Stephen Whiston setting out the requirement for the West of Scotland to produce a first Regional Delivery Plan for	

	March 2018 was circulated. The IJB noted the terms of the paper from John Burns, Chief Executive, West of Scotland Regional Planning for Health Board and Integrated Boards.	
5.10	**Chief Officer Report**	
	Report from Christina West was circulated and the following key points noted:- • TSI Volunteer of the Year – this year's health award was presented to Volunteers Aquacare who have volunteered thousands of hours and helped hundreds of people to live their lives in their own homes. Congratulations! • West Coast Review Community Magazine – the HSCP's communications department has been working closely with the magazine to proactively highlight the ongoing work that health and social care professionals are carrying out in the Oban, Lorn and Isles locality. • Cowal Community Hospital Facebook Page – the page is being well used by the local community and staff, with over 500 followers and 500 likes since being set up in August. The IJB members were encouraged to use the page and like/share posts.	
	Date of Next Meeting: Wednesday 29 November 2017 at 1.30pm in the Council Chambers, Kilmory, Lochgilphead	

ACTION LOG – INTEGRATION JOINT BOARD 27-09-17

	ACTION	LEAD	TIMESCALE	STATUS
1	Update on ICNet to be provided at next IJB or Clinical and Care Governance Committee	E Higgins		
2	(a) Joint report from Management and Commissioning Team to next IJB in respect of home care. (b) Breakdown of unmet need at Argyll and Bute/locality level to be included in report to IJB in November.	L Paterson L Paterson	Nov 2017 Nov 2017	
3	Port Appin/Lismore Homecare report – an explanation of why this didn't work/transfer to be included	L Paterson		
4	IJB Development Session in respect of Criminal Justice to be arranged	A Taylor	Nov 2017	
5	Adult Care budget pressures – breakdown to be provided	C Whyte	Oct 2017	
6	First meeting of Quality and Finance Plan Programme Board to be convened	C Whyte	Oct 2017	
7	Public Health Report – IJB to be advised if there has been any complaints regarding access to services	A McGrory	Oct 2017	
8	Public Health Report - Training at a local level to be explored further	A McGrory		
9	Sickness Absence costs to be included in future performance reports	S Whiston		
10	Carers Eligibility Criteria – further report to IJB in February 2018	L Currie	Feb 2018	
11	Children and Young People's Service Plan – baseline/target data regarding children meeting developmental milestones to be reviewed and position clarified to IJB by email.	A Taylor	Oct 2018	

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.1

Date of Meeting: **29 November 2017**

Title of Report: **Clinical and Care Governance**

Prepared by: **Elizabeth Higgins, Lead Nurse**

The Integration Joint Board is asked to :

Note complaints and Significant Adverse Events Reviews (SAER) activity.
Note feedback from Mental Welfare Commission visits.
Note update on Oban Laboratory.
Note Infection Control surveillance information and challenges and risks in the service.
Note information regarding Vaccination Transformation Programme.

1. EXECUTIVE SUMMARY

Report detailing:

1. Complaints and SAER
2. Significant Adverse Event Reviews
3. Mental Welfare Commission Visits
4. Vaccination Transformation Programme
5. Oban Laboratory
6. Infection Control

2. INTRODUCTION

Clinical and care governance is the system by which Health Boards and Local Authorities are accountable for ensuring the safety and quality of health and social care services, and for creating appropriate conditions within which the highest standards of service can be promoted and sustained.

Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured. It should create a culture where delivery of the highest quality of care and support is understood to be the responsibility of everyone working in the organisation – built upon partnership and collaboration within teams and between health and social care professionals and managers.

It is the way by which structures and processes assure Integration Joint Boards, Health Boards and Local Authorities that this is happening.

This report provides information about complaints performance, significant adverse event review activity, infection control, feedback on Mental Welfare Commission visits, Oban Laboratory status, and an update on the Vaccination Transformation Programme**.**

3. DETAIL OF REPORT

3.1 Complaints Performance Quarter 2 (01 July – 30 September 2017)

Table 1: Stage 1 Health Complaints by Month

	July	August	Sept	Total
No stage 1's received	1	8	11	20
Number Withdrawn	0	0	0	0
Number stage 1's investigated / closed	1	8	11	20
Medical General	1	2	1	4
Medical Administration			1	1
Other Administration		1		1
Mental health Services - Community		1	1	2
Mental health Service – Adult Psychiatry			1	1
Medical- Dermatology		1		1
Medical – Cardiology			1	1
Public Dental Health Services		1		1
Midwifery		1		1
Hotel Services – Catering		1		1
Hotel Services – Telecommunication			1	1
AHP - Radiography			1	1
AHP - Podiatry			2	2
Outpatients			1	1
Other			1	1
Overall achievement against 5 working days	1(100%)	7(88%)	8(73%)	
Fully upheld	1	1	2	4
Partially Upheld	0	5	8	13
Not Upheld	0	2	0	2
Number escalated to stage 2	**0**	**0**	1	1

Table 2: Stage 2 Health Complaints by Month

	July	August	Sept	Total
No stage 2's received	7	2	6	15
No stage 2's investigated	7	2	6	15
Medical Emergency Care	1		2	3
Surgical - General	1	0	0	1
AHP - Physiotherapy	1	0	0	1
General Practice Services - salaried	1	1	0	2
Mental Health Service – Adult Psychiatry	1	1	1	3
Mental Health Services – Substance Misuse	0	0	1	1
Mental Health Services – Clinical Psychology	0	0	1	1
Surgical - Urology	1	0	0	1
Radiology	1			1
Corporate Service - Finance			1	1
Overall achievement against 20 working days	29%	0%	0%	
Fully upheld	2	1	1	4
Partially Upheld	2	1	0	3
Not Upheld	2	0	1	3
Response outstanding	1	**0**	4	5

Table 3: Themes Stage 1 Health Complaints

Complaint Theme	**Count**
Administration e.g. appointments, letters, reports, telephones, travel	12
Staff Attitude	2
Waiting time in Clinic or Department	2
Food in Hospital	1
Service Provision (Dental)	1
Waiting Time (Surgical)	1
Clinical Care	1
Total	**20**

Table 4: Themes Stage 2 Health Complaints

Complaint Theme	**Count**
Administration e.g. appointments, letters, reports, telephones, travel	6
Clinical Care	5
Staff Attitude	3
Waiting Time for Assessment (Autism)	1
Service Provision (Urology)	1
Total	**16***

*15 Complaints

Table 5: Stage 1 Social Work Complaints

Service	No	Responded to within 5 days	Upheld	Partially Upheld	Not Upheld
Children and Families	1	0	0	0	1
Adult Care	2	2	0	0	2
Total	**3**	**2 (67%)**	**0**	**0**	**3**

Table 6: Stage 2 Social Work Complaints

Service	No	Responded to within 20 days	Upheld	Partially Upheld	Not Upheld
Children and Families	2	0 (0%)	0	1	1
Adult Care	5	0 (0%)	1	0	4
Outstanding responses	6				
Outcome (upheld / not upheld) still to be graded	2				
Total	**15**	**0 (0%)**	**1**	**1**	**5**

Table 7: Themes Social Work Stage 1 and Stage 2 Complaints

Service	Complaint Theme	Count
Children and Families	Procedure	2
	Communication	1
Adult Care	Care / Support	9
	Staff Conduct	3
	Charges – Care Home	1
	Withdrawal of Service	1
	Procedure	1
	Total	**18**

3.2 Significant Adverse Event Reviews (SAER)

The table below summarises HSCP SAER activity / status at 03 November 2017. SAERS are overseen by the HSCP SAER Scrutiny Group.

Table 8: SAER Status

Type of Event	Number: waiting further information to inform decision on level of review	Number: Investigation in progress	Number: Draft SAER Report being prepared	Number: SAER Reports Awaiting Ratification	Number: SAER Reports Ratified in Quarter 2
Complaint: Care and treatment	1	0	0	0	0
Care and treatment			2		1
Unexpected Death	1	1	0	0	2
Suicide / Probable suicide of person who had contact with mental health services within 12 months before their death	0	1	0	0	0
Failure to follow procedure	0	0	1	0	0
Totals	**2**	**2**	**3**	**0**	**3**

3.2.1 Learning summaries are generated for all SAERs and widely disseminated to support shared learning.

3.2.2 Continuous improvements are made in relation to SAER processes.

Current development /improvement work includes:

- A focus on suicide reviews, to make further improvements, particularly in relation to family engagement and support and staff support.
- Development of an audit programme based on SAERs in mental health to check that actions identified through SAERs have been embedded.
- Development of a flowchart to communicate decision making about review processes for Social Work adverse events.

3.3 Mental Welfare Commission;

Themed visit to people with dementia in community hospitals

In Summer 2017 the Mental Welfare Commission (MWC) carried out a series of visits to Community Hospitals across NHS Highland. In Argyll & Bute HSCP they visited Mid Argyll Community Hospital, Cowal Community Hospital, Rothesay Hospital and Campbeltown Hospital.

The aim of these visits is to enable the MWC to assess and compare the care and treatment of people with a diagnosis of dementia or other cognitive impairment including delirium, not managed by mental health services, receiving mostly GP input but also care under Physicians.

The focus was on the care of individuals and their carers throughout their hospital stay and on discharge/ transfer from Community Hospitals. Findings will be used to help services learn from good practices and respond to any issues addressed and to inform a national themed report due to be published in January 2018. The MWC are keen to find out about the care experience from the patient, relatives, carers and staff perspective.

The Mental Welfare Commission is an independent organisation who works to safeguard the rights and welfare of everyone with mental illness, learning disability or other mental disorder including dementia. Their duties are set out in mental health and capacity law and they hold powers in relation to visiting. The MWC announced their intention in advance, to make visits, to increase the chance of being able to engage with key members of staff and carers.

Each Senior Charge Nurse was given verbal feedback on the day of the visit and overall this was very positive. Some have since received written feedback and positives include, the role of the Dementia Champions, evidence of good multidisciplinary working and the use of a 'Home from Hospital' scheme.

Areas for improvement were in regards to provision of activities and the clinical, although person centred, care plans which focused almost exclusively on physical health.

Once all feedback has been received we will share learning and improvement across Argyll & Bute and NHS Highland wide via our Quality Care in Hospitals group and the Dementia Steering Group.

Unannounced local visit to Succoth Ward, Mid Argyll Community Hospital

On 14 September 2017 the Mental Welfare Commission (the Commission) attended Succoth ward at Mid Argyll Community Hospital on an unannounced local visit.

Succoth ward is an adult psychiatric admission ward providing inpatient care and treatment for men and women. The ward has 21 beds and is arranged so 4 beds can be used as an enhanced care unit if this is required. The ward has only recently transferred from the old Argyll and Bute Hospital building to a clinical area in the Mid Argyll Community Hospital. This provides 13 single en-suite rooms and two 4 bedded bays.

The Commission last visited this service on 12 August 2015 when they made two recommendations about care planning and recording information in files. They also visited the ward on 14 June 2016, as part of the national themed visit to all adult acute psychiatric wards across Scotland. On that visit it was noted that care plans for most patients were detailed and personalised but some care plans had limited information. The main issue identified then was that the physical environment was very poor in Succoth ward, but this issue has now been addressed with the move into Mid Argyll Community Hospital.

The draft report from the visit was received in mid November and overall is a very positive report, with evidence of improvements informed by previous visits. The report details positive patient experience regarding participation and inclusion in care planning and staff support. One patient reflected that all staff in the ward were very helpful and approachable, and that this did not only include nursing staff but also medical and domestic staff.

The report made two recommendations in regards to advocacy facilitated ward conversations and monitoring of the garden area which require a response within 3 months. The Local Area Manager for Mental Health will lead on the improvement work identified.

3.4 Vaccination Transformation Programme (VTP)

Scottish Government is undertaking a major review and change in the way vaccines are given in Scotland. A national Vaccination Transformation Programme (VTP) has been established to implement the new ways of working. This will be a 3 year transitional programme (2018-2021). Initially the programme was to commence in 2017/18 but this has now been designated as a planning year by the SG.

Locally there is a need to redesign the delivery of vaccinations across NHS Highland to respond to Scottish Government led changes to policy and practice. This may have significant implications and costs for services in both North Highland and Argyll and Bute. However, there are indications that the SG will make funding available to assist Boards with the programme.

Vaccination is the single most cost-effective medical intervention that exists. Its public health impact is second only to clean water. It continues to offer effective primary prevention to the entire population, for a progressively wider range of important and often life-threatening diseases. Vaccination uptake in Scotland is currently amongst the highest in the world.

The principal aims of vaccination are threefold:

1. To protect the individual from infectious diseases, with associated mortality, morbidity and long term sequelae.
2. To prevent outbreaks of disease.
3. Ultimately to eradicate infectious diseases world-wide, as in the case of smallpox.

Vaccination is a community based programme of interventions for whole populations, and large at-risk populations. Successful vaccination programmes such as that in Scotland require many things; sophisticated organisation, skilled and committed staff, information systems support, integration with other care interventions, adequate resourcing, professional and political commitment and resilience especially in the face of scepticism and controversy. All these qualities are relevant in making the transformation proposals work.

It is estimated there are 3.5million vaccines administered each year in Scotland. The vast majority of these, around 3 million, are administered in Primary Care through GP practices.

Estimated figures of NHS Highland population eligible for vaccinations across routine programmes can be seen in Appendix 1.

In recent years the Vaccination schedule has significantly increased and become more complex.

The schedule involves a number of different programmes:

- Infant and childhood vaccinations administered under the responsibility of GPs
- Adult vaccinations such as flu, pneumococcal and shingles, administered under the responsibility of GPs.
- Vaccinations delivered to individuals on the basis of specific clinical need or identified risk factors e.g. people who are immunocompromised, pertussis to pregnant women, hepatitis B, HPV to MSM.
- School age vaccinations delivered through school programmes (HPV, flu, Men ACWY, Teenage boosters). The responsibility for delivery of the school programmes currently sits with the commissioned service in Care and Learning Highland Council and the Argyll and Bute Health and Social Care Partnership.

Since 2008 we have seen the addition of vaccines into each of the programmes noted above. These have added to the complexity along with some of the vaccines having complex qualifying criteria that require careful clinical assessment by practitioners e.g. shingles.

Significantly the majority of these programmes are currently delivered through GPs. Scottish Government and GP leaders are in the process of reviewing the role, function and responsibilities of GPs – the new GP contract. The stated desire of GP leaders is that responsibility for vaccination is transferred to other parts of the NHS. The VTP has been established with the presumption that GPs/Primary Care will no longer be the default preferred providers. The current model of delivery is likely to no longer exist as an outcome of the Primary Care reform. NHS Highland alongside every health board is therefore required to consider different delivery models for the vaccination programmes.

In addition, to the Primary Care reform there is a national review being undertaken in relation to the role of School Nurses and Health Visitors. NHS Highland currently delivers the school programme through school nursing teams and in some areas Health Visitors are also heavily involved in delivery of infant and childhood immunisations.

Scottish Government has recognised that there will not be “one size which fits all.”

Nationally a VTP Project Board is being established comprising NHS Board Immunisation Coordinators, Health Protection Scotland and others. SG also wish to strengthen the role and remit of Board Immunisation Coordinators but recognize that operational delivery and governance will still sit firmly with frontline clinical staff and operational managers.
The landscape of vaccination delivery is changing significantly and we now need to plan and redesign local vaccination services accordingly.

Across Scotland there is a mix of delivery models. In recent years some NHS boards have been developing vaccination teams to deliver specific aspects of the national programme. At a recent national workshop it was clear that many other Board areas have already introduced vaccination teams of community/school nurses in particular, who now deliver the entire schools vaccination programme in their areas. One or two Boards are even beginning to deliver pre-school vaccines through their new teams.

As an essentially rural health board, with small pockets of population widely dispersed, we will have to look carefully at how best to maintain and sustain delivery at a local level. However, options for the development of vaccination teams for the larger more densely populated areas need to be urgently considered and progressed as new potential delivery models.

The different structural arrangements of the Integration Joint Board in Argyll and Bute and the lead agency model for children’s services in Highland offer additional complexity for future funding and governance.

Data systems will be an integral part of any new delivery model and this will pose a major challenge as vaccination call/recall is currently embedded in both the SIRS National Immunisation system but also within each GP practice data system.

Scottish Government has requested that “Business Change Managers” are appointed locally to develop the local model and manage it to new “business as usual”. This person needs to work closely with the Immunisation Coordinator who needs to be fully engaged in and lead the process as well.

Actions to date or wider recommendations to consider are as follows:

1. A multidisciplinary group to implement the VTP in NHS Highland has been established. This group includes representation from public health, nursing, children’s services, primary care, operational managers and finance. The first meeting was held on 13 July 2017.

2. Two pilots commenced in September with the aim to re-model the provision of the school vaccination programme in North Highland and both the pre-school and school

vaccination programme in Argyll and Bute. This will involve the initial development of an immunisation team in the Inner Moray Firth operational unit and a team in Helensburgh. These will act as pilots and be evaluated but some sort of "team" model is likely to need to continue as the main route of vaccine delivery in all the more populated areas of the Highlands. Sustainability will be a key feature of the pilots.

The pilots will run from September 2017 through to Spring 2018. A lessons learned exercise will be undertaken to inform future service models.

3. In the more remote and sparsely populated areas it is likely that some form of GP involvement and delivery will still be required. It is proposed to begin early discussion with the GP subcommittee/LMC and other primary care colleagues to explore whether some GP clusters or some practices are willing to continue to deliver all, or some immunisations.

4. Plans should begin to be made for Year 1 (2018-19) by the VTP Highland working group to further expand the role of the immunisation teams to other areas and to include other vaccinations, in more of the densely populated parts of Highland and Argyll. These require to be fully costed as SG will ask in due course for funding requirements for Year 1 and beyond. (timescales for these bids are not yet clear)

3.5 Oban Laboratory

In August 2016, the Lorn & Islands Hospital (LIH) laboratory underwent a UK accreditation Service (UKAS) ISO 15189 transition inspection and review of their current Clinical Pathology Accreditation (CPA). The CPA accreditation is no longer required by Laboratories and it is now recommended that all Laboratories obtain UKAS ISO15189 accreditation.

As a result of the UKAS inspection, the Laboratory CPA accreditation was suspended and the Oban Laboratory chose to voluntarily withdraw from the CPA accreditation. As a result, a detailed action plan and review of service has been undertaken by local managers and NHS Highland's Laboratories service manager.

Following a mock inspection by the Scottish Blood transfusion service, which was requested by Local management, some gaps were identified relating to the statutory completion of the annual blood compliance document. As a result, NHS Highland notified the MHRA (Medicines & Health Care Products agency) who undertook an inspection in October 2016. The action plan for MHRA is progressing well and on target. It is anticipated that a further inspection will take place in 2018.

The majority of the actions to address the issues identified are being progressed and improvements made. A key recommendation however, relating to the clinical governance arrangements of the service, remains outstanding, specifically the absence of a Clinical Director who assumes the lead governance role for LIH laboratory. This has proved extremely difficult to achieve and has been escalated to NHS Highland Medical Director, and to the NHS Highland Board for support and action.

In October 2017 the NHS Highland Board Medical Director visited Lorn & Islands Hospital to discuss this situation and it was identified that a crucial competent which would allow a Clinical Director to be put in place, is a supportive IT system which allows clinicians in Inverness access to results generated from Oban Lab as this is currently not possible due to Oban being linked to the Glasgow lab system. NHS Highland Medical Director has asked for the IT system issues to be prioritised and work is underway to achieve this. A new Lab IT system is being rolled out within Raigmore Hospital, which would allow access to results generated within the Oban Lab, it is hoped that this will be in place early 2018.

To ensure a quality and safe service, the Oban Lab is now linked to NHS Highland Quality Management system; we have line management responsibilities from Raigmore Quality manager to Oban Lab. Regular monthly meetings occur between Inverness & Glasgow and Management. The Clinical Director for Raigmore laboratories has been very supportive and visited Oban.

3.6 Care at Home Service

Mears homecare provider served formal notice of withdrawal of their service in the Oban area on Monday 18 September. The TUPE process for Mears staff to alternative local providers was completed on 6 November 2017. 552 hours have successfully been commissioned with alternative providers. The remaining hours are currently being provided by a contingency worker, with commissioning happening on a daily basis to reduce the outstanding hours.

3.7 Infection Control

Infection Outbreaks

There have been no reported outbreaks of infection in any care setting since the last report.

***Staphylococcus aureus* bacteraemia (SAB)**

SAB is the subject of a HEAT target due to the high mortality rate (up to 50%). Healthcare associated SAB (as opposed to community acquired) is considered preventable until found otherwise and all are subject to detailed surveillance to assess the root cause and learn lessons.

	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17
MRSA	0	0	0	1	0	0	0	0	0	0	0
MSSA	2	1	1	0	0	0	0	1	4	1	0
Total Sabs	2	1	1	1	0	0	0	1	4	1	0

There have been 5 new SABs reported in the HSCP since the beginning of August 17.

1 Healthcare Associated infection was reported in a 41 year old female from Dunoon who had respiratory infection following an episode in Intensive Care, where she required invasive ventilation. This patient has since recovered.

4 Community Acquired SABs are reported in patients from Dunoon, Rothesay, Campbeltown and Oban (tourist). 3 patients have recovered from infection and 1 died the day following admission.

All 5 patients have been reported to the Infection Control Doctor. No Root Cause Analysis has so far been requested.

***Clostridium difficile* infection (CDI)**

CDI is the subject of a HEAT target as the predisposing factors include antibiotic ingestion and prolonged use of protein pump inhibitor(PPI) agents. Elderly females are at greatest risk although the disease is seen in all ages, especially during concurrent abdominal illness or chemotherapy treatment. Infection can spread to other vulnerable individuals in health and social care settings.

Some classes of antibiotic are considered to be greater risk and guidelines are updated regularly to assist antimicrobial prescribing decisions and ensure that patients only receive the narrowest spectrum drug indicated for the shortest possible time.

CDI symptoms range from mild diarrhoeal illness to severe, life threatening disease. All cases are subject to enhanced surveillance to assist in control and minimise the risk of recurrence and person to person transmission.

	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17
Ages 15-64	1	0	1	0	1	1	0	0	0	0	0	0
Ages 65 plus	2	0	3	0	2	0	1	0	0	0	0	2
Total	3	0	4	0	3	1	1	0	0	0	0	2

There have been 2 patients reported as having CDI since the last report.

Patient 1: 76 year old female on 4th recurrence of infection (Oban Community). Currently being considered for faecal transplant therapy in Glasgow.

Patient 2: 92 year old male had recurrence of CDI infection first occurred in Glasgow (QEUH). Recovered from infection following admission to Campbeltown Hospital.

ONGOING CHALLENGES & RISKS

Challenges

ICnet (Infection Control Software programme) has been scheduled to be introduced into Argyll & Bute since June 2015. It is intended to support safe practice in the transfer of clinical data between in the Infection Control service in Argyll & Bute and the team in Inverness. The implementation has been extremely slow and fraught with delays and whist we have endeavoured to influence the process, we have been unsuccessful thus far in doing so effectively, and at the time of the report full implementation if ICnet is still outstanding.

Currently the Infection Prevention and Control nurses (IPCN) have access to ICnet data however it requires manually inputting data onto the system by the nurses. The system is also being used for all clinical record keeping by the Infection Control Team. This has greatly improved communication within the team, allowing each ICN to view the records of all current patients throughout the NHSH and facilitating cross cover at weekends and periods of leave.

Reasons given for the delays in implementing ICnet includes; IT interface between GG&C Health Board and Argyll & Bute, the cyber attack earlier this year and the company (ICnet) reprioritising work to the detriment of the Argyll & Bute project.

A formal complaint was raised by NHS Highland to ICnet in July 2017. This resulted in a project manager being appointed and weekly teleconference to allow for updates on progress and reasons for delays. Unfortunately timescales have once again slipped to January 2018 for going live and the NHSH Control of Infection Committee have taken the decision to formally write to the CEO of ICnet to voice their concern regarding the delays and ask for an earlier resolution to this issue.

Actions to address the ongoing risk in not having the live feed continue and include excellent and constant communication across the whole NHSH Infection Control Team

Risks

The microbiology laboratory situation is unchanged since the last report.

4 CONTRIBUTION TO STRATEGIC PRIORITIES

Robust governance arrangements are key in the delivery of strategic priorities

5 GOVERNANCE IMPLICATIONS

5.1 Financial Impact

Potential for financial impact if adequate funding for VTP is not forthcoming.

5.2 Staff Governance

Application of robust governance and risk management in all proposed changes ensures staff wellbeing and safety

5.3 Clinical Governance

Robust management of complex change process essential for good governance and safety

6 EQUALITY & DIVERSITY IMPLICATIONS

There are no equality and diversity implications

7 RISK ASSESSMENT

Risks articulated within the report.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

The membership of the Clinical and Care Governance Committee and the Health and Safety Group include public representation

9. CONCLUSIONS

The report provides updates and information about some key areas of work in relation to clinical and care governance.

Appendix 1 - NHS Highland Immunisations

The table below details the cohorts eligible for Childhood Primary Immunisations, school programmes and Routine Adult immunisations. It does not however contain figures for other aspects of the Scottish Vaccination programme as detailed below the table. The figures are based on CHI data from October 2016.

Age	No Jabs	No Appts	% Target	North Highland	Argyll & Bute	Total	Total appts 100%
Childhood Primary Care							
0-1	9	3	95%	4246	1393	5639	16,917
1-2	4	1	95%	4604	1508	6112	6112
Pre-school	2	1	95%	4905	1620	6525	6525
Flu - 2-5	1	1	70%	9685	3263	12,948	12,948
Total				23,440	7784	31.224	42,502
School Programme							
Flu 5-11	1	1	70%	17,742	6010	23,752	23,752
HPV 11-13	2	2	95%	3665	1239	4904	9808
Teen booster/Men ACWY 14-15	2	1	95%	4921	1744	6665	6665
Total				26,328	8993	35,326	40,235
Adult Primary care							
Flu/pneum - 65	2	1	70-95%	3218	1307	4525	4525
Flu - 66-100	1	1	70%	46,472	19,964	66,436	66,436
Shingles - 70	1	1	60%	2835	1239	4074	4074
Totals				52,525	22,510	75,035	75,035

Flu 'at risk' groups which incorporates child age 6 months – 2 years, < 65years with qualifying criteria conditions, pregnant women

Pertussis for pregnant women

Vaccination for immunocompromised individuals e.g. post stem cell treatment, splenectomy, chemotherapy

Hepatitis A/B for at risk groups e.g. babies born to HBV positive mothers, PWID, MSM,

BCG to 'at risk' babies

Multitude of travel vaccinations e.g. typhoid, rabies, hepatitis A&,

Lorraine McKee 11/03/17

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.2(i)

Date of Meeting : **29 November 2017**

Title of Report : **Budget Monitoring – October 2017**

Presented by : **Caroline Whyte, Chief Financial Officer**

The Integration Joint Board is asked to :

- **Note** the overall Integrated Budget Monitoring report for the October 2017 period, including:
  - Integrated Budget Monitoring Summary
  - Quality and Finance Plan Progress
  - Financial Risks
  - Reserves
  - Financial Recovery Plan
- **Note** that as at the October period there is a projected year-end overspend of £3.4m primarily in relation to the outstanding budget gap at the start of the year, the expected deliverability of the Quality and Finance Plan, the cost of medical locums and continuing overspends from demand for social care services.
- **Note** the financial progress with the delivery of the Quality and Finance Plan and the overall forecast shortfall in delivery of savings.
- **Note** the updated financial recovery plan and support the actions therein to ensure the delivery of a balanced integrated budget for the 2017-18 financial year.

1. EXECUTIVE SUMMARY

1.1 The main summary points from the report are noted below:

- The IJB started 2017-18 with an outstanding budget gap of £2m with the intention of managing this through a reduction in the SLA for acute health services negotiated with NHS Greater Glasgow and Clyde and with the remaining balance being delivered through in-year efficiency savings. This position has deteriorated. This is due to ongoing overspends for locums and agency staff, continuation of overspends in social care services and the expectation that not all of the service changes in the Quality and Finance Plan will be delivered.
- This report provides information on the financial position of the Integrated Budget as at the end of October 2017. The projected year-end outturn position is an overspend of £3.4m. A financial recovery plan was presented to the IJB in

September which outlined a number of actions to address the financial position, these were in the main management actions and controls. This financial recovery plan is not delivering the planned improvement to the financial position and has therefore been updated to include additional actions to ensure financial balance can be achieved by the year-end.

- There is a likelihood that not all savings in the Quality and Finance Plan will be achieved, the IJB are aware some areas are high risk and there may be a significant lead-in time to deliver some of the more complex service changes. There is an agreed project management process in place and the Quality and Finance Plan Programme Board has been established to focus efforts on ensuring the service changes are delivered as any delays or non-delivery of savings will result in short term actions to deliver financial balance.
- In addition to the projected overspend position there are significant financial risks in terms of service delivery for 2017-18 and there are mitigating actions in place to reduce or minimise these, these risks should continue to be closely monitored together with the delivery of the Quality and Finance Plan.

2. INTRODUCTION

2.1 This report sets out the financial position for Integrated Services as at the end of October 2017. Budget information from both Council and Health partners has been consolidated into an Integrated Budget report for the Integration Joint Board.

3. DETAIL OF REPORT

3.1 INTEGRATED BUDGET MONITORING SUMMARY

3.1.1 This main overall financial statement is included as Appendix 1. This contains an objective (service area) financial summary integrating both Health and Council services, with a reconciliation of the overall split of the budget allocation.

3.1.2 There is an overall increase in funding of £2.569m compared to the approved budget. There is an increase in available funding from £258.885m to £261.454m, the in-year changes in funding are noted in Appendix 1. This relates to an increase in Health Funding, mainly relating to additional non-recurring funding allocations from the Scottish Government and a small increase to Council funding which relates to the drawdown of budget from reserves.

Year to Date Position – YTD Overspend - £0.871m

3.1.3 The main areas to note from this are:

- The overall Year to Date variance is an overspend of £0.871m. This consists of an underspend of £0.872m in Council delivered services and an overspend of £1.743m in Health delivered services.
- Within Health provided services the overspend is mainly in relation to the budget profile of savings for 2017-18 which have not yet been implemented and additional costs in relation to locums, the year to date position is in line with the forecast outturn position.
- Within Council provided services the year to date overspend is mainly in relation to delays in receipt and processing of supplier payments. This year to date underspend position is not necessarily an indication of the

likely year-end outturn position, as the year to date position for the Council is reported on a cash not accruals basis.

3.1.4 Council and Health partners use different financial systems and treatments for the monthly profiling of budgets and recording of actual costs which results in financial information relating to the year to date position for the integrated budget not being a reliable indicator of the year-end position.

Forecast Outturn Position – Projected Overspend - £3.415m

3.1.5 The year-end forecast outturn position for the October period is a projected overspend of £3.415m. The main areas are noted below:

ADULT CARE – Projected Overspend £5.0m (July £4.5m)

- Anticipated shortfall of £3.2m in the delivery of Adult Care savings as part of the Quality and Finance Plan
- Budget overspends in relation to locum cover for vacancies and sickness absence, the overspend in medical locums to October is £1.1m.
- Projected overspends for demand for social work services including care home placements, supported living services and integrated equipment store. The projected overspend in adult social care services is £1m, these are generally areas which were overspent at the 2016-17 year-end and are areas of focus for the Quality and Finance Plan for 2017-18 onwards. Significant work is required to contain the expenditure within budget before any deliverable savings can be released.

CHIEF OFFICER – Projected Underspend £1.1m (July £1.2m)

- £1.7m of this overspend is reflective of the outstanding budget gap for social care services at the start of 2017-18, the balance will be held as a projected overspend until such a time as savings are identified to offset this.
- This has been partly offset by the expected over-recovery of vacancy savings and funding set aside to fund cost pressures for war pensions and continuing care which have not as yet been required.

CHILDREN AND FAMILIES – Projected Underspend £0.3m (July £0.2m)

- Projected underspends in relation to fostering, kinship and supporting young people leaving care reflecting the level of demand on these budgets.
- Underspend in criminal justice services due to staff vacancies and interim management arrangements.
- This overall position is reflective of the current level of demand for services, which can be volatile and a small change in demand can have a significant impact on costs. The projected underspend position also assumes that the majority of the savings agreed on the Quality and Finance Plan will be delivered in 2017-18.

GG&C COMMISSIONED SERVICES – Projected Underspend £0.3m

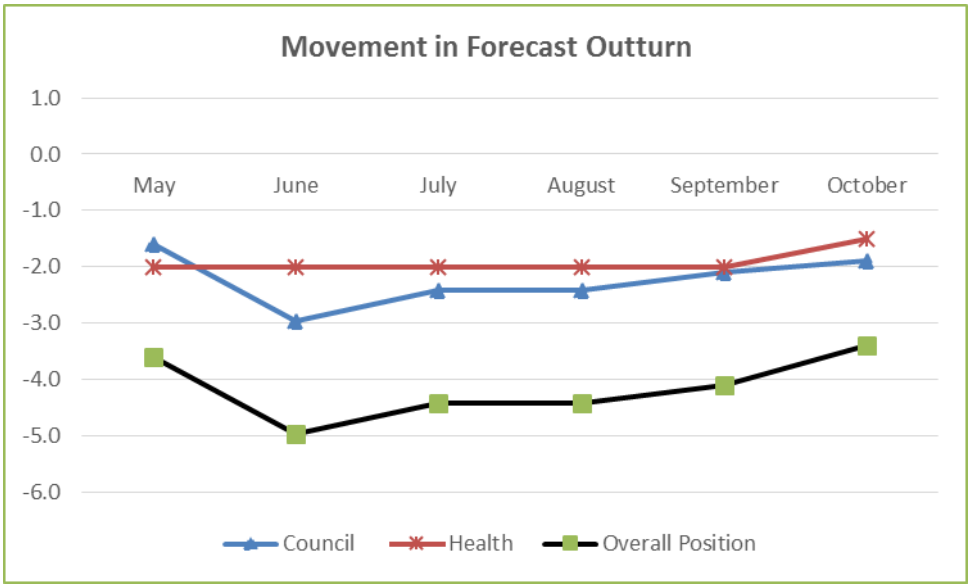
- The HSCP has been clear with NHS GG&C around our commissioning intentions and the plan to reduce delayed discharges and unscheduled care activity. Part of the financial plan at the start of the year was to reduce the SLA value with NHS GG&C, although at that time the potential savings were not able to be quantified. The SLA value for 2017-18 remains under negotiation but there is an intention to withhold the historic payment for delayed discharges and move to a current activity payment basis, this would see a potential reduction of £0.5m to the payment to NHS GG&C.
- There are a number of service areas which are charged on a variable activity basis where demand for services has increased, this growth in demand is partly offsetting any potential reduction in the SLA value.

BUDGET RESERVES – Projected Underspend £1.5m (July £1.0m)

- Represents the uncommitted element of budget reserves which can be utilised to offset the overall projected outturn position. The level of budget reserves has significantly reduced as many of the balances were removed as part of the Quality and Finance Plan for 2017-18, this estimate is based on an assessment of the likely outturn informed by financial performance in previous years. It is also possible that some of these allocations will require to be re-provided in 2018-19

3.1.6 The forecast outturn position is reliant on a number of assumptions around the current and expected level of service demand and costs, this is subject to change and is reported through routine monthly monitoring, clearly the closer to the financial year-end the more accurate the projected position becomes. The position at the end of the September period was a forecast overspend of £4.1m, this has reduced to £3.4m as at October.

3.1.7 The chart below shows the movement in the forecast outturn position during the 2017-18 financial year:



Financial Recovery Plan

3.1.8 The financial position is moving in the right direction in terms of financial recovery, based on the position at October there would require to be a monthly improvement of £0.7m to have confidence that the recovery plan will deliver the necessary reductions to deliver financial balance by the year-end. The position has improved from the previous forecast of £4.4m when the recovery plan was agreed in August. This would indicate that the scale of cost reduction and momentum to deliver financial balance is not in place. In 2016-17 when the IJB had a similar financial recovery plan and moratorium on spend in place there was a monthly improvement of £0.4m per month towards the end of the financial year, an improvement of this scale would not address the current year financial position in the required timescale.

3.1.9 The financial recovery plan has been updated to include further actions to deliver financial balance, the updated plan is included as Appendix 5. These are additional actions over and above the previously agreed control measures. These have been issued to local management teams and budget managers together with a strong communication of the overall financial position and the priority of addressing this position.

3.1.10 Whilst the new actions now included on the plan may appear to be high level management actions they will ultimately impact on front line service delivery across all services and may lead to delays in services being provided, increased waiting times and will generate some resistance from staff and communities. They include actions such as a recruitment freeze, a review of all temporary and fixed term posts, reviewing care packages with a view to reducing and halting all further community investment funding.

3.1.11 Any overspend in the 2017-18 financial year would require to be added to the budget gap for 2018-19 as the IJB would require to borrow funding from the Health Board and/or Council and repay this. Based on current projections this would require a further £3.4m of savings to be delivered in 2018-19 together with the in-year budget gap due to funding and pressures.

3.2 QUALITY AND FINANCE PLAN PROGRESS

3.2.1 Progress with the individual budget reductions outlined in the Quality and Finance Plan is detailed in Appendix 2. This notes the financial savings delivered to the October 2017 period and any estimated year-end shortfall.

3.2.2 To the October period £3.3m of the savings have been delivered on a recurring basis, a number of these are savings which had been carried forward from 2016-17 or are efficiency savings. This leaves total savings of £5.4m to be delivered in 2017-18, this is in addition to the £2m of unidentified savings.

3.2.3 The update on progress includes an estimate of the recurring shortfall in the delivery of savings for each individual service change, in terms of the overall position at this stage an estimate of £3.7m has been included in the forecast outturn position as the indicative level of savings forecast not to be delivered in 2017-18. The main areas where there are expected to be shortfalls or delays in savings delivered are:

- Rural Cowal Out of Hours Service (£0.3m)
- Re-design of community pathways and community hospital services to shift the balance of care as a result of reduced length of stay, reduced delayed discharges and reduced emergency admissions – Campbeltown, Mid Argyll, Cowal, Bute, Islay (£1.4m)
- Lorn and the Islands Hospital Future Planning (£0.3m)
- Struan Lodge Service Re-design (£0.2m)
- Corporate and Support Staff Efficiencies (£0.3m)
- Catering and Cleaning and other Ancillary Services (£0.3m)
- Prescribing (£0.2m)

3.2.4 For 2017-18 we have a consistent project management approach in place for the monitoring of the Quality and Finance Plan, to enable progress on the delivery of the plan to be monitored both in operational and financial terms. SMT will ensure there are clear lines of responsibility for projects, that there is clear oversight of the progress of all projects, risks and timelines are clearly identified and monitored and any deviations from plans or risks of non-delivery are identified at the earliest opportunity.

3.2.5 The Quality and Finance Plan Programme Board has now been established and includes representation from officers, IJB members and staff side. Part of their role is to monitor, challenge and support the delivery of the Quality and Finance Plan. The Board provide assurance to the IJB that appropriate challenge, support and rigour is applied to the implementation and development of the Quality and Finance Plan.

3.2.6 There is a reported forecast overspend of £3.4m as at the October 2017 period, this is partly in relation to the expected shortfall in the delivery of the Quality and Finance Plan. With the current estimate being that £3.7m of the agreed savings will not be deliverable in 2017-18 it is clear that there needs to be a focus on accelerating the pace of change to release the recurring savings, if these were on track to be delivered as planned there would be no reported overspend position.

3.3 FINANCIAL RISKS

3.3.1 An assessment of financial risks together with the likelihood and impact and the potential financial consequences for the Integrated Budget is included as Appendix 3. This only includes financial related risks and highlights areas where there are potential cost or demand pressures facing service delivery.

3.3.2 There are 7 financial risks with a potential financial impact of £2.6m noted at the October 2017 period. These are assessed in terms of likelihood and a summary of the risks is noted in the table below:

Likelihood	Number	Potential Financial Impact £000
Almost Certain	0	0
Likely	0	0
Possible	7	2,600
Unlikely	0	0
Remote	0	0
TOTAL	**7**	**2,600**

3.3.3 The potential financial impact represents the estimated full year impact on the budget, this value will reduce as we progress through the financial year. Where financial risks do not materialise or are mitigated entirely the risk will be removed, where risks materialise the impact will be reported through the forecast outturn position.

3.3.4 At October the number and likelihood of risks has reduced from earlier in the financial year and the risk exposure is less significant, however this may be partly due to some previous risks having materialised and now being reported through the forecast outturn position. There remains significant exposure to risks in relation to demand and in some service areas, for example children's services, a small increase in demand can result in a significant increase in cost.

3.4 RESERVES

3.4.1 The overall position for reserves is noted below:

	£'000
Opening Reserve Balance at 1 April 2017	479
Earmarked Balances	(451)
Unallocated Reserves at 1 April 2017	28

3.4.2 As the current forecast outturn position for 2017-18 is a projected overspend it is not anticipated that there will be additional reserves at the 2017-18 year-end. Likewise as there are only £0.028m of unallocated reserves there are minimal reserves available to offset any potential year-end overspend.

3.4.3 There are balances totalling £0.451m earmarked from IJB reserves, progress with utilising these reserves in line with their agreed purpose is included in Appendix 4.

3.4.4 In addition to the IJB reserve balance there are inherited reserve balances from Council delivered services. These balances for 2017-18 total £0.1m. These historic balances are mainly in relation to unspent grant monies carried forward or funds the Council earmarked specifically from the general fund for service development. The funds are committed for specific projects previously approved by the Council, this includes funding for:

- Sensory Impairment
- Autism Strategy
- Early Intervention (Early Years Change Fund)
- Criminal Justice Transformation
- Violence Against Women Training

4. CONTRIBUTION TO STRATEGIC PRIORITIES

4.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery, monitoring this budget through the financial year is key to ensuing a balanced budget position.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

5.1.1 As at the October 2017 monitoring period significant financial risks have been identified and services are forecasting a year-end overspend of £3.4m. The financial position has improved during the year, however indications are that the previously agreed recovery plan is not providing sufficient momentum or assurance that the financial position can be brought back into line. Therefore this has been updated to include further actions to address the position. The financial position and recovery plan will continue to be closely monitored

5.2 Staff Governance

The Quality and Finance Plan includes service changes which will impact on staff roles, the IJB will comply with the appropriate staff governance standards.

5.3 Clinical Governance

None

6. EQUALITY & DIVERSITY IMPLICATIONS

Actions in the financial recovery plan may result in delays or increased waiting times for services.

7. RISK ASSESSMENT

7.1 Financial risks are monitored as part of the budget monitoring process. Operational and clinical risks will be taken into account as part of the implementation of the financial recovery plan.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

8.1 Where required as part of the delivery of the Quality and Finance Plan local stakeholder and community engagement will be carried out as appropriate in line with the re-design of service provision. The financial recovery plan requires to be implemented very quickly to ensure the financial position can be addressed, as part of this there will be engagement with individual affected service users.

9. CONCLUSIONS

9.1 This report summarises the financial position of the Integrated Budget as at October 2017. The forecast year-end outturn position is a projected overspend of £3.4m. The starting point for the year was an outstanding budget gap of £2m, therefore there has been an overall deterioration to the position. However there has been some improvement to the in-year position following the implementation of the financial recovery plan.

9.2 The financial recovery plan has been updated to include further actions to accelerate the impact of the plan and there requires to be an ongoing focus on delivering the savings on the Quality and Finance Plan as this will have the biggest impact on the overall financial position. With only 5 months remaining in the financial year there requires to be a push by services to address this position with a monthly improvement of £0.7m required to the end of the financial year to ensure we can deliver services from within the delegated budget.

APPENDICES:

Appendix 1 – Integrated Budget Monitoring Summary – October 2017
Appendix 2 – Quality and Finance Plan Progress – October 2017
Appendix 3 – Financial Risks – October 2017
Appendix 4 – Earmarked Reserves – October 2017
Appendix 5 – Financial Recovery Plan

INTEGRATED BUDGET MONITORING SUMMARY - OCTOBER 2017

	Year to Date Position				Forecast Outturn			Previous Period (Sept)	
	YTD Actual £000	YTD Budget £000	YTD Variance £000	Variance %	Annual Budget £000	Forecast Outturn £000	Forecast Variance £000	Forecast Variance £000	Movement in month £000
Service Delegated Budgets:									
Adult Care	76,495	73,754	(2,741)	-3.7%	130,419	135,445	(5,026)	(4,921)	(105)
Alcohol and Drugs Partnership	546	598	52	8.7%	1,123	1,053	70	60	10
Chief Officer	(11,211)	(11,147)	64	-0.6%	(5,178)	(4,059)	(1,119)	(1,057)	(62)
Children and Families	10,483	11,116	633	5.7%	19,820	19,511	309	308	1
Community and Dental Services	2,096	2,365	269	11.4%	4,055	3,655	400	349	51
Estates	2,972	2,825	(147)	-5.2%	5,109	5,338	(229)	(248)	19
Lead Nurse	760	774	14	1.8%	1,319	1,305	14	28	(14)
Public Health	641	708	67	9.5%	1,322	1,196	126	113	13
Strategic Planning and Performance	1,932	1,897	(35)	-1.8%	3,653	3,677	(24)	(7)	(17)
	84,714	82,890	(1,824)	-2.2%	161,642	167,121	(5,479)	(5,375)	(104)
Centrally Held Budgets:									
Budget Reserves	0	788	788	100.0%	1,686	186	1,500	1,200	300
Depreciation	1,462	1,460	(2)	-0.1%	2,504	2,504	0	0	0
General Medical Services	9,115	9,088	(27)	-0.3%	15,868	15,925	(57)	0	(57)
Greater Glasgow & Clyde Commissioned Services	34,691	34,565	(126)	-0.4%	59,254	58,914	340	(155)	495
Income - Commissioning and Central	(798)	(721)	77	-10.7%	(1,237)	(1,267)	30	29	1
Management and Corporate Services	1,361	1,431	70	4.9%	4,734	4,683	51	21	31
NCL Primary Care Services	4,937	4,937	0	0.0%	8,508	8,508	0	0	0
Other Commissioned Services	1,874	2,047	173	8.5%	3,508	3,308	200	175	25
Resource Release	2,909	2,909	0	0.0%	4,987	4,987	0	0	0
	55,551	56,504	953	1.7%	99,812	97,748	2,064	1,270	795
Grand Total	**140,265**	**139,394**	**(871)**	**-0.6%**	**261,454**	**264,869**	**(3,415)**	**(4,105)**	**691**

Reconciliaton to Council and Health Partner Budget Allocations:

	Year to Date Position				Forecast Outturn			Previous Period	
	YTD Actual £000	YTD Budget £000	YTD Variance £000	Variance %	Annual Budget £000	Forecast Outturn £000	Forecast Variance £000	Forecast Variance £000	Movement in month £000
Argyll and Bute Council	24,959	25,831	872	3.4%	56,405	58,319	(1,914)	(2,105)	191
NHS Highland	115,306	113,563	(1,743)	-1.5%	205,049	206,550	(1,501)	(2,000)	500
Grand Total	**140,265**	**139,394**	**(871)**	**-0.6%**	**261,454**	**264,869**	**(3,415)**	**(4,105)**	**691**

INTEGRATION JOINT BOARD

APPENDIX 1

FUNDING RECONCILIATION - OCTOBER 2017

Partner	£000	£000	£000
Argyll and Bute Council:			
Opening Funding Approved		56,360	
Annual Budget at October 2017		56,405	
Movement		**45**	
Details:			
Non-recurring drawdown of budget from Reserves			45
			45
NHS Highland:			
Opening Funding Approved:			
Core NHS Funding	197,945		
Additional SG Funding	4,580		
Opening Funding Approved		202,525	
Annual Budget at October 2017		205,049	
Movement		**2,524**	
Details:			
Other SG funding increases/decreases			2,444
Transfer from SW to fund ICAT Team			80
			2,524

INTEGRATION JOINT BOARD **APPENDIX 2**

QUALITY AND FINANCE PLAN PROGRESS - OCTOBER 2017

Ref	Description	Detail	Key Date	Previously approved 2016-17 saving?	2017-18 Budget Reduction £000	Achieved to October 2017	Remaining	Estimated Shortfall	2018-19 Budget Reduction £000
CHILDREN'S SERVICES:									
CF01	Redesign of Internal and External Residential Care Service	Minimise the use of external placements, increase the capacity of our residential units by adding satellite flats and developing a core and cluster model. Develop social landlord scheme to support 16+ young people moving from foster care or residential care. Further review and where possible bring back all 16+ year olds to local area.	Apr-17	No	300	300	0	0	400
CF02	Redesign staffing structure across Children and Families service to cope with duty under CYP Act and government initiatives within NHS.	Scoping of children and Families staffing requirements as case load increases due to the requirements of the Children and Young People (Scotland) Act the service will be looking after children for longer. For the next 8 years there will be a steady increase only levelling out in 2026. Incrementally the service will require 5 additional social workers. Health visiting pathway requires additional Health Visitors, additional services for children in distress are required. Requirement to scope and cost a new staffing structure through consultation with staff and those who use the service, we will develop a programme board and look at front line staff and management structure to further develop integrated teams. Reviewing workloads and supporting third tier sector to undertake social care tasks.	Sep-17	No	100	26	74	59	200
CF03	School Hostels - Explore the opportunities to maximise hostel income.	May be opportunities to actively market accommodation over holiday periods and use annexe accommodation to attract locums at a reduced cost. Although we have an income budget that we currently do not achieve we would hope to over recover income.	Mar-18	No	0	0	0	0	10
LORN AND THE ISLANDS HOSPITAL:									
AC01	Lorn and the Islands Hospital Future Planning to improve the local services and engage specialist services appropriately to deliver best possible care.	LIH group established with representation from public, community, third and independent sector working jointly to design services that will minimise or avoid all delayed discharges, offer excellent quality local care complemented by specialist care out of area as required. Prevention of admissions to be achieved by shfiting the overall balance of care and staff to ensure anticipatory care planning in place. Working wth the LIH group to explore clinical options and offer continued, consistent appropriate hospital care. Data collection and scrutiny to inform the service design. Recruitment and retention strategies to support the service.	Dec-18	Yes, partly.	347	30	317	255	647
AC02	Further improvement and investment in the scope of OLI Community Wards to offer quality services and support on discharge and timely assessment and reablement.	Community staff further upskilled through training and understanding of scope of services. Resource to ensure that 'virtual wards' feel and give a service which is perceived as real and more effective than location based services.	Estimated April 18	No	included above	included above	included above	included above	included above
CARE HOMES:									
AC03	Putting environment, independent living and service user choice at the heart of care support by reviewing the current buildings and care service employed by Ardfenaig and Eader Glynn to deliver an improved environment, better choice and control.	Identify all options with partners to better provide support when care at home is no longer possible. Seek engagement to review all options with full regard for choices and control of people who use these services.	Anticipate Jan 19	No	0	0	0	0	53
AC04	Identified demand for greater choice of support care on Tiree, currently and for future planning. .	Island demand to be quantifiifed, and provision reviewed in line with current and emerging demands.	Jan-19	No	0	0	0	0	46

Ref	Description	Detail	Key Date	Previously approved 2016-17 saving?	2017-18 Budget Reduction £000	Achieved to October 2017	Remaining	Estimated Shortfall	2018-19 Budget Reduction £000
LEARNING DISABILITY:									
AC05	Redesign of Learning Disability services including day services and support at home for adults across Argyll and Bute, the priority needs to be given to service user need and demand in each local area.	Utilise learning from Helensburgh redesign, and engage with stakeholders. Full account of service user views and the current and emerging needs, encouraging independence and shifting the balance of care.	Phased from Aug17	Yes, partly.	175	67	108	25	525
COMMUNITY MODEL OF CARE:									
AC06	Repatriate top 15 high cost young adult care placements from outwith Argyll and Bute. This includes service users who are in residential care and some who are receving specialist supported living services outwith the area.	Identify then review top 15 adults outwith the area currently and undertake review with a view to bringing their care package back to Argyll and Bute. Need to link with housing providers and social care providers to identify capacity and cost to bring adults back to shared tenancy arrangements.	Quarterly rolling reviews from April 17	No.	73	0	73	0	194
AC07	Supported living is categorised into four categories. Critical (P1) and substantial (P2) needs will be met and others will be signposted to self-help and community resources.	Review existing supported living care packages to ensure that cases meet the priority of need framework. Promote use of SDS. Introduce Area Resource Groups to scrutinise adult care supported living and delayed discharge packages.	Quarterly rolling reviews from April 17	No.	0	0	0	0	460
AC08	Review the delivery of services for older people to consider alternative ways of delivering services for older people.	Ensure all new packages adhere to Value for Money principles. Consider alternative ways to deliver support/meet the assessed outcomes of service users.	Ongoing from 16-17	Yes, partly.	200	200	0	0	200
AC09	Redesign the provision of sleepovers provided by the HSCP.	Shift to new model of care using telecare/overnight response teams. Work with care providers to redesign unavoidable sleepover provision and look for opportunities to share provision across multiple service users.	Ongoing from 16-17	Yes	200	0	200	0	200
AC11	Investment in 'Neighbourhood Team' approach to delivery of care at home for the community across Mid Argyll, Kintyre and Islay. Putting service users at the heart of service design.	More responsive and person centred approach to delivery, better meeting needs. A best practice model, which is truly person centred, maintains independence and recognises dignity alongside independence, and improved outcomes.	Oct-17	No	0	0	0	0	0
AC12	Investment in 'Neighbourhood Team' approach to delivery of care at home for the community across Oban Lorn and the Islands. Putting service users at the heart of service design.	More responsive and person centred approach to delivery, better meeting needs. A best practice model, which is truly person centred, maintains independence and recognises dignity alongside independence, and improved outcomes.	Oct-17	No	0	0	0	0	0
AC14	Modernise community hospital care in Campbeltown establishing a cross agency 'Planning for the Future' group, to actively review range of bed space uses and options. Aim to achieve community based, and community focussed hospital model linking seamlessly with enhanced community services.	Review group to identify and engage with stakeholders on best use of bed spaces to maintain a quality and responsive service 24/7 which supports patients appropriately and timeously. Improving community focus and hospital criteria aims to reduce or negate delayed discharges, improve prevention and anticipatory care planning. Potential for greater joined up working with other hospitals, and effective use of data assumed.	Apr-18	Yes, partly.	232	0	232	232	232

Ref	Description	Detail	Key Date	Previously approved 2016-17 saving?	2017-18 Budget Reduction £000	Achieved to October 2017	Remaining	Estimated Shortfall	2018-19 Budget Reduction £000
AC15	Improvements to community focussed care in Mid Argyll, with focus on improving the model of delivery and service in MACHICC. Improved responsive community services able to repsond 24/7 supporting patients in their own homes. Shifting the balance of care and ensuring effective and efficient use of hospital services.	Improvements and expansion of community based services in Mid Argyll to achieve reduced or nill delayed discharges, greater prevention and anticpatory care planning to enable people to live in their own homes, or return to their own homes as quickly aspossible.	Apr-18	Yes, partly.	170	20	150	150	170
AC16	Continue with the review and redesign in-patient ward in Cowal Community Hospital currently reviewing the acute observation beds, short term assessment beds, delayed discharges, prevention of admissions and A&E breeches. The review will include considering enhanced community care to prevent admissions.	Continue the current review and consider how we deliver community services in Cowal to provide 24/7 response to support patients at home.	Sep-17	Yes, partly.	537	35	502	502	537
AC17	Continue with the review and redesign GP in-patient ward in Victoria Hospital currently reviewing the acute observation beds, short term assessment beds, delayed discharges, prevention of admissions and A&E breeches. The review will include considering enhanced community care to prevent admissions.	Redesign of community services in Bute to provide 24/7 response to support patients at home. Community and staff engagement.	Sep-17	Yes.	250	0	250	250	250
AC18	Improve and expand community based care on Islay through investment in preventative measures to address dealyed discharge and reduce admissions. Shifting the balance will include making better use of Islay Hospital and Gortanvogie Care home to meet community care demands.	Review use and need of community services on Islay to better support people to live at home with quality services. Enhancing community based care including using technology where appropriate, and consider use of alternative booking systems. Support from and engagment with both communities and staff to help shift balance.	Commencement Oct 17 - duration likely 9 - 12 months.	Yes, partly.	330	100	230	230	330
AC19	Review of AHP Out-patient service delivery	Consider increasing protocol driven review of follow-up and domicilarry visits. Use of technology like VC and Flo. Review whether AHPs could offer review instead of trips to GG&C to see consultants. Extension of roles like Orthopaedic triage and 'First Contact' input into GPs.		No	0	0	0	0	0
AC20	Seek to ensure care at home services offer flexibility and choice and are person centred and fit for purpose. Current in-house services are restricted and review would enable options to be explored with external providers to improve West Argyll service.	Neighbourhood teams with external providers give flexibility and should be considered within options following period of market testing. Would require input from procurement and commissioning staff to expand and improve the current care at home service.	Apr-18	Yes, partly.	0	0	0	0	160
AC25	In older people day resource centres improve and address issues of high levels of management structure to integrate and consolidate services within realistic opening hours based on client demand.	Review the management at HSCP operated day services. Consider a reduction in opening hours of adult day services. Evidence indicates shorter opening hours would be appropriate and acceptable in day services. Moreover, there is a high management resource which is capable of rationalisation. Engagement and consultation with service users and with staff to align needs and demands.	Oct-17	No	50	0	50	0	208

Ref	Description	Detail	Key Date	Previously approved 2016-17 saving?	2017-18 Budget Reduction £000	Achieved to October 2017	Remaining	Estimated Shortfall	2018-19 Budget Reduction £000
MENTAL HEALTH SERVICES:									
AC21	Improve community based support and services for dementia to achieve shift in balance of care and respond to need and demand in person centred service.	Implement full review and scoped options for community models which meet user demand, support carers and person centred otucomes. Appraise neighbourhood model and scope options which shift balance of care.	Dec-18	No	250	213	37	0	250
AC22	Deliver improved mental health consultant support and create dedicated consultants to each locality Community Mental Health Team, and a dedicated consultant for inpatients. Better sharing of on call services, additional locality clinics and support for crisis response and places of safety.	CMHT services and patients would benefit from the redesign to support an improved model. Locality consultation and with CMHT's to support change, and achieve better outcomes.	Oct-17	No	0	0	0	0	0
AC23	Steps to ensure and maintain patient and community safety will be taken by redesignating and maintaining a secure locked environment for those with the most fragile mental health requiring extra care. This is based on the needs of service users, and experience from current Intensive Patient Care Unit.	Actions required pertain to legislation relevant to service delviery, which will be strictly followed. Work with staff to make changes to overall establishment and working practices and to agreee robust admission criteria. Some work with GG&C should needs arise for additional services.	May-17	No	100	100	0	0	200
AC24	Further enhancement to community based care to ensure those with mental health issues have the same opportunities and choices. To include consideration of a step up / step down model for Lochgilphead and area service users.	Adopt community focussed approach, and use technology when possible, to review use of Ross Crescent to make this appropriate for a modernised mental health service. Ensuring patient choice and views are at the centre of service provision, with independence encouraged and supported.	Dec-17	No	45	0	45	0	45
CORPORATE SERVICES:									
CORP1	Front line health and social care staff working together in same locations, and move corporate and support staff.	Co-locate staff into unused space in our hospitals, close the corporate support HQ building in Lochgilphead, move to other sites in Lochgilphead including council offices. Savings expected to be achieved from a range of departmental budgets including; finance, planning, IT, HR, pharmacy management, medical management, lead nurse and estates.	Apr-17	No	335	76	259	185	335
CORP2	Integrate health and social work administration, implement digital technology and centralise appointment systems.	Follow on from co-location CORP 1, a targeted piece of work would commence in 2017-18 to extend the review of social work administration and medical record keeping. The implementation of electronic solutions to improve efficiency and a move to electronic medical records would be required.	Sep-17	No	120	23	97	69	325
CORP3	Management /Professional Leadership Review	Review the overall management structure.	Apr-18	No	tbc	tbc	tbc	tbc	tbc
CORP4	Rationalisation of Estates/Property-linked to CORP's 1 and 2.	Review of current property portfolio and opportunities to rationalise this. Review the current leases in place and find alternative accommodation to reduce costs.	Sep-17	No	75	0	75	75	75
CORP5	Implement Lync/Skype for Business	Implement Skype for Business (Microsoft Lync) communications platform, this will reduce telephone and travel costs and improve communication and collaboration. Business case is due to be finalised It is required to maximise benefits in Corp 1 and Corp 2.	Apr-18	Yes	0	0	0	0	0
CORP6	Catering and Cleaning and other Ancillary Services	Reduction in buildings occupied and opportunities to work with our partner organisations, take opportunities to reduce costs for catering and domestic services. Significant opportunities to share services and reduce costs.	Sep-17	No	505	78	427	293	505

Ref	Description	Detail	Key Date	Previously approved 2016-17 saving?	2017-18 Budget Reduction £000	Achieved to October 2017	Remaining	Estimated Shortfall	2018-19 Budget Reduction £000
CORP7	Vehicle Fleet Services	Explore opportunities for the centralisation of shared fleet service (as in part of NHS Grampian), look to share vehicles with partners, and a review of the provision of services.	Sep-17	No	0	0	0	0	0
CORP8	The agreement with NHS Greater Glasgow & Clyde (NHSGG&C) provides hospital services outside Argyll and Bute.	Invest in community services and IT to reduce delayed discharges and patients length of stay in NHS GG&C hospitals, and commission NHSGG&C to reduce return appointments and follow up rates. Activity targets to be agreed based on national target for Scotland to free up 400,000 occupied bed days.	Apr-17	No	tbc	tbc	tbc	0	tbc
CORP9	Capital projects - Dunoon GP practices new build, Bute Health and care campus, Care Home redesign, and new model of care relocation of Salen Surgery to Craignure & elements of CORP 4	Formal capital design projects at large and small scale, latter to be costed by March 2017 for inclusion in capital programmes for next 2 years. Large scale projects require formal processes and resource.	TBC	No	0	0	0	0	0
CORP10	Alcohol and Drugs Partnership	The ADP will look to review and reduce costs being incurred in delivering alcohol brief interventions, supporting the voluntary sector and the ABAT statutory service sector. The reduction in 17-18 equates to 8% of the total budget for ADP.	Apr-17	No	100	100	0	0	150
TOTAL					**4,494**	**1,368**	**3,126**	**2,325**	**6,707**

2016-17 QUALITY AND FINANCIAL PLAN

PREVIOUSLY APPROVED SAVINGS - STILL TO BE DELIVERED:

1	Prescribing		100	100	0	0	100
5	Redesign of the Out of Hours Service for Cowal		300	55	245	245	300
13	Closure West House	*updated to reflect actual shortfall in 2016-17 - increased by £170k	270	50	220	0	270
14	Closure AROS		150	42	108	108	150
15	Kintyre Medical Group	*updated to reflect actual shortfall in 2016-17 - increased by £50k	75	0	75	75	75
21	Review Day Hospital Services for Older People with Dementia	*updated to reflect actual shortfall in 2016-17 - increased by £25k	25	25	0	0	25
27	Kintyre Patient Transport		25	0	25	25	25
29	Mid Argyll Operational Teams Redesign	*updated to reflect actual shortfall in 2016-17 - increased by £20k	20	0	20	20	20
45	Ardlui		10	10	0	0	10
51	Supporting Young People Leaving Care		17	17	0	0	17
52	Consultation Support Forum		5	5	0	0	5
55	Struan Lodge	*updated to reflect actual shortfall in 2016-17 - increased by £175k (full year saving of £350k planned from 2018-19)	175	0	175	175	175
56	Thomson Court	*updated to reflect actual shortfall in 2016-17 - increased by £10k (full year saving of £20k planned from 2018-19)	10	0	10	0	10
59	Bowman Court Progressive Care Centre		80	80	0	0	80
61	Internal Mental Health Support Team		60	0	60	0	60
62	Assessment and Care Management		12	0	12	12	12
63	Assessment and Care Management		30	0	30	30	30
66	Supported Living Services	*updated to reflect actual shortfall in 2016-17 - increased by £100k	100	0	100	50	100
			1,464	**384**	**1,080**	**740**	**1,464**

2016-17 SAVINGS - FULL YEAR IMPACT:

55	Struan Lodge	0	0	0	175	175
56	Thomson Court	0	0	0	0	10
58	Tigh a Rhuda	22	22	0	0	22
		22	**22**	**0**	**175**	**207**

Ref	Description	Detail	Key Date	Previously approved 2016-17 saving?	2017-18 Budget Reduction £000	Achieved to October 2017	Remaining	Estimated Shortfall	2018-19 Budget Reduction £000
2016-17 APPROVED SAVINGS - ADDITIONAL SAVINGS DELIVERABLE:									
1	Prescribing				700	175	525	200	1,400
3	Further Savings from closure of Argyll and Bute Hospital				282	249	33	32	282
27	Kintyre Patient Transport.				25	0	25	25	75
5	Redesign of the Out of Hours Service for Cowal				29	0	29	29	29
10	NHS GG&C contract / services				100	0	100	100	100
					1,136	**424**	**712**	**386**	**1,886**
NEW:									
EFFICIENCY SAVINGS:									
1	Commissioned Services				500	400	100	0	500
3	Budget Reserves				350	320	30	0	200
4	Equipment Depreciation				50	46	4	0	50
5	Increased patients' services income				50	50	0	0	50
6	Community Dental Services				20	20	0	0	20
7	Review of Podiatry Services Budgets				20	0	20	0	20
8	Helensburgh & Lomond Locality - local initatives, recurring underspends				20	20	0	0	20
9	Medical Physics Department - review of supplies budget to make best use of resources based on in year underspend.				45	0	45	0	45
10	Energy Costs for Health Buildings (excluding A&B Hospital & Aros)				50	10	40	0	50
11	Oban, Lorn & Isles Locality - patients' travel				40	40	0	0	40
12	Review of Radiography Services Budgets				50	17	33	0	50
13	Mental Health Bridging Funding				0	0	0	0	400
14	HEI Budget - reduction on basis that requirement will reduce in line with beds				0	0	0	0	50
15	Mid Argyll Social Work Office				10	0	10	0	10
16	Admin - travel reduction				3	3	0	0	3
17	Planning				51	51	0	0	51
18	Review MAKI management structure to ensure best use of resources.				130	0	130	20	250
19	Children and Families - Respite				10	10	0	0	10
20	Children and Families - Carers Payments				10	10	0	0	10
21	Children and Families - Children Affected by a Disability				10	10	0	0	10
22	Adult Services Fees and Charges				50	50	0	0	50
23	Children and Families - Child Trust ISAs				10	10	0	0	10
24	Adult Services Charging Order Long Term Debt Adjustment				25	25	0	0	25
25	Social Work Utility Costs				33	33	0	0	33
26	Mull Medical Group - reduction in use of GP locums				50	0	50	50	50
					1,587	**1,125**	**462**	**70**	**2,007**
GRAND TOTAL					**8,703**	**3,323**	**5,380**	**3,696**	**12,271**

* highlighted figures have been updated for actual remaining balance following 2016-17 year-end

INTEGRATION JOINT BOARD **APPENDIX 3**

FINANCIAL RISKS - OCTOBER 2017

				LIKELIHOOD		
Ref	**TITLE OF RISK**	**DESCRIPTION OF RISK**	**MITIGATIONS/ACTIONS IN PLACE**	**SCORE**	**OVERALL LIKELIHOOD**	**POTENTIAL FINANCIAL IMPACT £000**
1	Prescribing	Costs increase through national pricing agreements, new drugs are introduced, volumes dispensed increase.	Closer working with prescribers to ensure formulary compliance and Best Value.	3	Possible	500
2	Commissioned Services	The volume of high cost care packages increases.	Closer scrutiny of applications for care packages.	3	Possible	250
3	Adult Care - Older People Service Demand	Demand for services for older people (ie over 65s) exceeds the demand pressure already factored into the budget.	Ongoing monitoring and reporting of service demand and provision costs to IJB management team.	3	Possible	600
4	Medical Locums	Need for use of locums increases in A&B Hospital, Lorn & Islands hospital and Mull GP services, and risk of new requirement in other areas.	Pursue new models of service provision with NHS Glasgow and Greater Clyde and the local teams.	3	Possible	200
5	Children and Families - Looked After Children Residential Placements	Increased demand for services, level of support or increased placement cost. High cost service where small movement in demand can significantly increase costs.	Regular client reviews to minimise duration of placements and maximise existing resources where possible.	3	Possible	250
6	Adult Care - Sustainabilty of Commissioned Service Providers	Risk of financial and operational sustainablity of care at home and care home commissioned providers, leading to additional financial support or costs of re-provision of services locally.	Commissioning team contract monitoring process and the ongoing dialogue with commissioned providers. Support with workforce and recruitment issues across Argyll and Bute, open to innovative ways to provide support and support tests of change as part of the National Care Home Contract work.	3	Possible	300
7	NHS Greater Glasgow & Clyde SLA	Charges from GG&C increase due to growth in activity levels, risk that with SLA negotiations GG&C pass on activity changes in-year, this would include charging for delayed discharges.	Management of contract and negotiations, monitoring of any cases passed onto the IJB on a cost basis, information flows in place with GG&C. Ensuring patient flow and capacity in the community supports shift in the balance of care and reduces activity in GG&C.	3	Possible	500

INTEGRATION JOINT BOARD **APPENDIX 4**

EARMARKED RESERVES MONITORING -OCTOBER 2017

Description	Opening Balance £	Forecast Spend 2017-18 £	Forecast Spend Future Years £	Lead Officer	Progress Update
Technology Enabled Care	208,000	208,000	0	Stephen Whiston	Project is progressing. 17/18 budget is £405k which includes £208k c/f.
Mull GP transformation	65,000	65,000	0	Annie MacLeod	Project is progressing for completion in 17/18.
Mastermind Project	25,000	25,000	0	Nicola Gillespie	Project is progressing, awaiting recruitment.
Everyone's Business	41,000	10,000	31,000	Gillian Davies	Project is progressing, awaiting recruitment. There could be delay in spend.
Primary Care Transformation Fund - Developing GP Clusters	18,000	18,000	0	Joyce Robinson	Project is progressing. Payments to support Cluster Groups
Primary Care Transformation Fund - Buurtzorg Model in Appin	50,000	10,000	40,000	Pamela McLeod	Delayed due to recruitment. Project Manager Post advertised.
Primary Care Transformation Fund - Urgent Care Resource Hub - Bute	44,000	44,000	0	Joyce Robinson/Liz Higgins	Project is progressing. Prescribing Link Worker advertised and associated costs. Plans being developed to spend any uncommitted balance.
TOTAL	**451,000**	**380,000**	**71,000**		

Argyll & Bute Health & Social Care Partnership

Financial Recovery Plan 2017-18 – Updated November 2017

The purpose of this document is to provide details of the immediate mitigating actions proposed to achieve financial balance in 2017-18.

The Integration Joint Board were presented with the first budget monitoring report for 2016-17 in August 2017 which estimated a projected year-end overspend position of £5m (as at the June 2017 period). The IJB started the year with an outstanding budget gap of £2m, which at that time was perceived to be manageable through negotiations of the SLA with NHS GG&C for acute health services and in-year efficiency savings. Following the first financial quarter there was a deterioration reported to the financial position, the main reasons being:

- High level estimate that not all planned savings in the Quality and Finance Plan will delivered in-year;
- Continuing demand for social care services, outstripping the available budget;
- Overspends in locums, agency and supplementary staffing.

It was noted by the IJB that this projection was relatively early in the financial year, was a projected position based on the levels of demand and activity at that time and from a total budget of £260m represented a 2% variance. It was agreed that a number of actions should be taken to ensure the position can be brought back into line, including:

- Develop a detailed recovery plan to be approved by the IJB in September (this was approved);
- Continue to deploy management actions to identify efficiencies in-year to generate opportunistic underspends;
- Continue to pursue negotiations with NHS Greater Glasgow and Clyde to get a final agreement for the SLA value for acute services;
- Push forward the momentum for delivery of the Quality and Finance Plan, and by following the agreed project management approach, ensure that any further appropriate action is taken to ensure the delivery of planned savings;
- Ensure the Integration Joint Board secures a fair share of any additional funding from Health and Council partners.

The Integration Scheme notes that where an overspend is forecast that a financial recovery plan will be prepared setting out how this position will be addressed to ensure the partnership can deliver financial balance. The original financial recovery plan to address the projected overspend focused on 6 main areas, these were:

1. Control Measures
2. Discretionary Spend
3. Staff Costs
4. Funding/Income
5. Projects

6. Quality and Finance Plan

The financial recovery plan approved in September, in the main, included management actions that could be taken forward to address the financial position. These were mainly non-recurring actions to achieve financial balance, however where recurring savings were identified as part of the implementation of the recovery plan the opportunity will be taken to recognise these on a recurring basis.

The overall financial position at October 2017 is a projected overspend of £3.4m, therefore while there has been some improvement it is clear that the previously agreed financial recovery plan is not delivering the planned improvement required to the financial position. The plan has been updated to include further additional actions to ensure financial balance can be delivered by the year-end. Where the further actions are similar themes to the previously agreed actions the further actions supersede the previously agreed actions.

These actions are now included in the plan, whilst these may appear to be high level management actions they will ultimately impact on front line service delivery across all services and may lead to delays in services being provided, increased waiting times and will generate some resistance from staff and communities.

It is clear the real focus and efforts should be directed in pushing forward the momentum of the delivery of the Quality and Finance Plan. It is estimated that £3.7m of the agreed savings will not be delivered this year. It is essential that efforts are focussed on pushing forward the service re-designs to ensure a financially sustainable position for the IJB not only for 2017-18 but in future years.

The projected outturn position will continue to be closely monitored, the projection is an estimate based on commitments at a point in time, this position has potential to change and there a number of financial risks with the potential to impact further, however as we move closer to the end of the financial year there is more certainty over the financial forecasts and also less time available to address the position.

The Integration Scheme notes that *"where recovery plans are unsuccessful and an overspend occurs at the financial year end…….then the Parties will be required to make additional payments to Argyll and Bute Integration Joint Board"….."Any additional payments by the Council and NHS Highland will then be deducted from future years funding/payments".*

There is a short term financial risk to the Council and Health Board of the IJB not delivering financial balance, however the financial risk to the IJB is far greater with any overspend having longer term financial implications for the financial sustainability of the partnership.

November 2017

FINANCIAL RECOVERY PLAN

Proposal	Action (s) Required	Service Implications	Responsible Officer	Recurring/Non Recurring	Estimated Benefit £m
1. CONTROL MEASURES:					**0.5**
Escalate authorisation processes	Review authorisation levels for vacancy approval, overtime, locum and agency staff and where appropriate escalating these to Head of Service level to ensure approriate scrutiny of spend and consistency.	Potential delays and reduction in agreed expenditure which could lead to service delays and managing expectations of service users.	Heads of Service	tbc	
Establish Argyll and Bute Wide Adult Services Resource Group	Establish ASRG to approve all adult social care packages over £20k. Governance group would ensure rigorous compliance with eligibilty criteria and a consistency of approach across localities. The decision making would be restricted to a key group of senior managers and no packages would be agreed without the ASRG group approval.	Will ensure a consistency of approach across localities. Will also improve the timeliness of financial and case data which will support the accuracy of financial projections. Finance will support services to ensure value for money principles are followed and the financial implications of decision making are fully understood.	Heads of Adult Care	Rec	
NHS Policy - Medical Staff Locum Recruitment	Compliance with NHS Highland approach to ensure medical locum staff can be obtained at a competitive hourly rate.	There could be short term disruption to services, services will be required to develop contingency plans.	Associate Medical Director	Rec	
2. DISCRETIONARY SPEND:					**0.5**
Improved Housekeeping	Communication issued to all budget managers to ensure efficient approach to daily working, including avoiding unnecessary journeys, switching off lights, efficient use of resources.	Cultural acceptance of using VC and other means to carry out meetings.	Chief Officer	tbc	
Budget Challenge with Finance Support	Finance contacts to liaise with budget managers to review budgets and current commitments with a view to identifying any uncommitted discretionary expenditure budgets, budget holders will be advised these amounts to remain uncommitted. The position will be monitored and any material deviation from agreed position will require to be reported.	Reduced flexibilty for services to re-divert discretionary budgets to fund service pressures, delays in taking forward any pro-active service developments or initatives.	Budget Managers/Finance	tbc	
Review of stocks and stores	Review of stock control processes and procedures for all equipment including a review of storage locations, eg OT equipment, telecare, stationery.	More efficient just in time use of resources.	Heads of Service	Non-R	
Prioritise Training Expenditure	Deliver mandatory training only, do not approve any staff training requests outwith the statutory or mandatory training requirements.	Reduced capacity for staff development, may result in an increased training need in 2018-19.	Budget Managers	Non-R	
3. STAFF COSTS:					**0.5**
Review Workforce Monitoring Process	Establish consistent approach to workforce monitoring, including a review of participants and staffside/partnership input, will assist with workforce planning.	Clearer overview of overall HSCP position in terms of recruitment, clearer formalised process.	SMT	tbc	
Vacancy Management	Review current staffing establishment and closely scrutinise vacancies. Classify posts in terms of risk to service provision and apply an appropriate delay to filling positions. Escalate the approval for vacancies to be filled to Head of Service level.	Delays in recruiting to positions may have impact on the timely provision of services and may also impact on other staff.	SMT	Non-R	
Managing Attendance	Support from HR to promote and manage attendance across the partnership to reduce both sick pay and cover costs. Potential investment in specific HR resource to support the information requirements of managers and with more complex long term cases.	Positive impact on services and staff.	SMT	Rec	

FINANCIAL RECOVERY PLAN

Proposal	Action (s) Required	Service Implications	Responsible Officer	Recurring/Non Recurring	Estimated Benefit £m
Reduce use of Overtime	Escalate approval of overtime to Head of Service level, where this should only be approved on an exceptional basis. Overall position in terms of expenditure closely monitored and reported to SMT to provide opportunity to challenge and ensure consistency of approach.	Short term impact to services and requirement for contingency plans. Potential to promote services to better plan services on the basis of operating without reliance on overtime working.	Heads of Service	Rec	
4. FUNDING/INCOME:					**0.5**
NHS Highland - Waiting Times Funding	Pursue NHS Highland for the Argyll and Bute NRAC share of national waiting times funding, circa £0.9m	This will strengthen the negotiating position with NHS GG&C over the SLA for acute health services.	Head of Strategic Planning and Performance	Non-R	
NHS Highland - New Medicines Funding	Ensure NRAC share of funding allocated by NHS Highland. Assumed there would be no funding allocated in 2017-18 by SG and £0.7m included as a cost pressure as a result.	None. Service would be funded via SG funding allocation.	Chief Financial Officer	tbc	
In-year allocations	Ongoing review of health in-year allocations. Where funding is not fully committed and there is a requirement to re-provide facilitate this via a cost pressure in 2018-19.	None. Any underspends in funding allocations where required to be re-provided will be, may adversely impact on overall 2018-19 budget outlook.	Chief Financial Officer	Non-R	
Social Work client charges	Review client charges and charging waivers, ensure plan is in place to work with clients to reduce and remove waivers over an agreed period of time, where appropriate. Work will be reviewed by ASRG.	Clients will be asked to reorganise their spending and accept their services in order to assume responsibility for payment.	Chief Financial Officer	Rec	
5. PROJECTS:					**0.5**
Delays in Community and Project Management Investment Plan	No specific action required, anticipated there will be delays with implementation of investment as a result of recruitment delays etc.	Investment plan is to lever Q&F Plan changes, whilst slippage in these costs results in a positive contribution to immediate financial position the financial benefits of delivering on the Q&F plan successfully would be far greater.	Project Leads	Non-R	
Integrated Care Fund Allocations	Expected delays in fully committing Locality Planning Group allocations of ICF funding, no specific instruction that funding is being restricted, however any unspent element will not be reprovided at the year-end.	Delays in taking forward work to support integration objectives.	Heads of Service	Non-R	
Moratorium on new service developments	Any proposed new service developments not already included as part of the budget or Quality and Finance Plan will not be approved during 2017-18.	May delay services in progressing positive service developments, service users may require to wait for new services.	Strategic Management Team	n/a	
6. QUALITY AND FINANCE PLAN:					**0.5**
Q&F Plan Project Management Approach	Regularly and appropriately report progress with Q&F plan projects, ensuring any risks of non-delivery and mitigating actions are clearly identified and actioned.	Positive impact, longer term sustainability of services through re-design of services. Additional pressure on services to push forward with implementation of service redesigns.	SMT	Rec	
Establishment of Quality and Finance Plan Programme Board	Terms of reference include monitoring progress with delivery of Q&F Plan and providing support and assistance to drive forward momentum of service changes which are off-track.	Longer term sustainability of services through re-design of services.	Chief Financial Officer	Rec	
Reduction in NHS GG&C SLA for acute health services	Ongoing negotiations with NHS GG&C over level of SLA payment, expectation that resource will be released through a reduction in overall activity levels, supported by investment in community services, focus on reducing occupied bed days and delayed discharges.	Supports strategic direction, no negative impact on services and is a measure of success if activity levels are reduced successfully.	Head of Strategic Planning and Performance	tbc	
Identification of further Q&F Plan savings	Services to work with finance to identify further potential savings to be added to the Q&F plan on a recurring basis, these may be picked up as part of the review of discretionary budgets or vacancy management process.	Positive impact of sustainabilty of overall services supported by the identification of further recurring savings.	Heads of Service	Rec	

FINANCIAL RECOVERY PLAN

Proposal	Action (s) Required	Service Implications	Responsible Officer	Recurring/Non Recurring	Estimated Benefit £m
7. FURTHER ACTIONS					**2.0**
Review Care at Home Packages	Review care at home packages in areas where the provision is disproportionatly higher than in other areas, particularly in the West of Argyll. Assessment and review with an expectation that packages can be reduced.	Additional assessment work required by local teams, may be some resistance from services users to a reduction in service provided. Would however ensure equality of provision across Argyll and Bute and provide a solution to capcity issues in some localites.	Heads of Adult Care	Rec	
Recruitment Freeze - all services	Hold current vacancies and delay recruitment of all posts until April 2018. The only exceptions being critical front line service delivery positions, to fulfil a statuory requirement or where financially it would be more cost effective to fill (eg elimination of agency costs).	Delays in recruiting to all positions will have a negative impact on the provision of services, there will be delays to service delivery and waiting times for services will increase. Negative impact on current staff group in terms of workload and morale.	SMT	Non-R	
Agency and Locum Staff	Services to review current use of agency and locum posts with a view to reducing, services have proposed potential areas where these arrangements could cease.	Removal of high cost agency and locum posts may leave gaps in services which cannot be covered through normal recruitment arrangements. May lead to delays to service delivery and a reduced level of service.	Heads of Service	tbc	
Remove Temporary and Fixed Term Posts	Services to review all temporary, fixed terms posts and secondment arrangements with a view to reducing. This assessment would be in line with the recruitment freeze criteria. Services have proposed potential areas where these arrangments could cease.	A number of temporary and fixed term staff may be given notice. Will lead to delays to service delivery and a reduced level of service. If secondment arrangements are ended there will be impact across different areas of service.	Heads of Service	tbc	
Increase momentum of review of Sleepovers and Supported Living Services	Progress with reviewing sleepovers and supported living services is not being made in line with expectations to reduce the historic overspend in service delivery. More proactive push with clients and families to change services to reduce high cost of services.	Resistance from services users, their families and staff to changing how services are delivered. This may generate some negative feedback for the HSCP.	Heads of Adult Care	Rec	
Community Investment and Project Management Funding	Hold all funding currently allocated for investment where this has not already been committed, with funding not to be committed until April 2018.	Delays in supporting the delivery of service changes, however if investment has not already progressed limited impact this financial year.	SMT	Non-R	
Reduce Residential Care Placements (in line with assessed need)	Assess clients current in care homes with a view to supporting in the community.	Assessment would be on a case by case basis in line with care needs and assessment of need for care in the community.	Heads of Adult Care	Rec	
Reduce High Cost Care Packages	Review of all high cost care packages with a view to reducing, support for front line practitioners to review on the basis of equality of service and value for money.	Resistance from services users and their families and also front line practitioners to reducing care packages already in place.	Heads of Adult Care	Rec	
Moratorium on Non Essential Travel	Ban on non-essential travel across services until the end of the financial year, this includes removing face to face meetings, utilising pool cars where essential and only attending statutory and mandatory training.	Reduced capcity to be involved in sharing knowledge across Agyll and Bute and with colleagues, reduced capcity for training and development. However together with financial gain should be productivity gains.	SMT	Non-R	
TOTAL					**5.0**

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.2 (ii)

Date of Meeting : **29 November 2017**

Title of Report : **Updated Budget Outlook 2018-19**

Presented by : **Caroline Whyte, Chief Financial Officer**

The Integration Joint Board is asked to :

- **Note** the indicative budget outlook and resulting estimated in-year budget gap for 2018-19 and the estimate that further service changes will require to be added to the Q&F Plan to deliver a further £11.4m of savings in 2018-19.
- **Note** the significant impact of the 2017-18 financial position and the delays in progressing service changes in the Quality and Finance Plan in the current year.
- **Note** the challenge for 2018-19 in delivering the estimated £18.7m of service redesigns which would require to be delivered through the Q&F Plan.
- **Note** the requirement for the IJB to approve a balanced Integrated Budget by March 2017 and the ongoing work in the localities and by the Quality and Finance Plan Programme Board to deliver on this requirement.

1. EXECUTIVE SUMMARY

1.1 Financial assumptions have been updated for 2018-19, the latest budget outlook presented to the IJB was in May 2017. Overall the in-year position has not changed materially but there is a significant impact from the progress with delivery of savings during 2017-18 and the projected financial year-end overspend, which if not addressed will require significant additional savings to be identified for 2018-19.

1.2 The estimated in-year budget gap for 2018-19 is £9.1m, taking into account previously agreed savings, and the projected outturn position for the current year there would be a requirement to add further service changes delivering savings of £11.4m to the Q&F Plan in 2018-19.

1.3 The Quality and Finance Plan for 2018-19 will require to include service changes to address any new in-year budget gap and also any savings previously included which have not yet been delivered, based on current estimates there would be £18.7m of service changes required to be delivered in 2018-19. It may be very ambitious to expect this scale of savings to be delivered in one financial year.

2. INTRODUCTION

2.1 The Integration Joint Board require to plan for a balanced budget position in 2018-19, this report updates the previous financial assumptions and the estimated requirement for further savings to be identified and added to the Quality and Finance Plan.

3. DETAIL OF REPORT

3.1 Financial assumptions for 2018-19 have been updated based on the current information available for the expected funding, cost and demand pressures, inflationary cost increases and the previously agreed savings. These have been incorporated into an updated budget outlook position.

3.2 There is an intention to further develop the current Quality and Finance Plan to add additional service changes required to deliver financial balance and therefore agree a one year budget by March 2018 which will take the HSCP to the end of the current Strategic Plan period. This would also be in line with the expectation that the Council and Health Board will both make one year offers of funding to the IJB for 2018-19.

Updated Budget Outlook

3.3 The current updated outlook position compared to the previous estimate is noted below:

	FOR INFO ONLY **2017-18 £m**	***PREVIOUS ESTIMATE*** **2018-19 £m**	***UPDATED POSITION*** **2018-19 £m**
Baseline Budget	256.1	258.9	259.5
Cost and Demand Pressures	7.8	4.2	4.2
Inflation	2.0	2.6	4.1
Total Expenditure	265.9	265.7	267.8
Total Funding	(258.9)	(257.3)	(258.7)
Budget Gap	**7.0**	**8.4**	**9.1**
Q&F Plan 2016-17	3.7	-	-
Updated Budget Gap	**10.7**	**8.4**	**9.1**
Cumulative Budget Gap	**10.7**	**19.1**	**19.8**
Approved Q&F Plan Savings	(8.7)	(12.3)	(12.3)
Remaining Budget Gap	**2.0**	**6.8**	**7.5**
Projected Outturn 2017-18			3.4
Reinstate Project Funds			0.5
Updated Remaining Budget Gap			**11.4**

3.4 The key points to note are:

- £9.1m represents the in-year budget gap for 2018-19, this is due to estimated year on year funding changes and cost changes due to cost and demand pressures and inflation.
- £7.5m represents the shortfall in savings currently identified on the Q&F plan compared with the budget gap, if all savings were on track in 2017-

18 and the year-end position was balanced this would be the additional savings requirement for 2018-19.

- £11.4m represents the remaining savings to be identified plus the impact of the current year projected overspend position, if this position is not addressed the IJB would require to repay any overspend to the Council and/or Health Board.

3.5 Overall the estimated remaining budget gap position for 2018-19 has not changed significantly from previous estimates, i.e. from a remaining budget gap of £6.8m to £7.5m. There have been many movements within that overall position, including updated assumptions around funding, cost and demand pressures and inflationary costs. These are still planning assumptions at this stage which will be updated and refined on an ongoing basis.

3.6 Full detail of the funding assumptions, cost and demand pressures and inflationary increases are not included within this report as these are required to be further scrutinised for endorsement by the Quality and Finance Plan Programme Board before being presented to the IJB for final approval. A report with the full detail of the financial assumptions will be presented to the IJB in January.

3.7 There is a significant challenge for 2018-19 in achieving financial balance, this challenge will be significantly more difficult if the 2017-18 projected overspend position is not addressed. Based on the projected overspend at October there will be an overspend of £3.4m at the year-end. There would also be an expectation that £0.5m may require to be re-provided for ring fenced funding, this would ordinarily be facilitated through the use of reserves. This would require us to "borrow" funding from Council and Health partners and the addition to our budget gap represents the requirement to repay these funds back to our partners.

3.8 The overall requirement to identify new service changes to add to the Quality and Finance Plan is therefore likely to range between £8m and £11m, this range is very much dependant on the progress with addressing the forecast overspend in 2017-18. Work is ongoing in localities to identify potential service changes to allow the IJB to be in a position by March 2018 to take decisions and set a balanced budget.

Quality and Finance Plan Delivery 2018-19

3.9 The successful delivery of the Quality and Finance Plan during 2018-19 will not only include any new service changes which are required to be added due to the in-year budget gap but also any undelivered savings which will require to remain on the plan to be delivered in 2018-19. This means that the requirement for savings delivery in 2018-19 may be far greater than any new savings that require to be added to the plan.

3.10 Based on current estimates the savings that would require to be delivered during 2018-19 are included in the table below:

	£m	£m
2018-19 Budget Gap:		
In-Year Budget Gap	7.5	
Increase in Approved Q&F Plan Savings	3.6	
		11.1
2017-18 Impact:		
Estimated Savings Delivery Shortfall	3.7	
Impact of Projected Overspend Position	3.9	
		7.6
TOTAL		**18.7**

3.12 There are further savings of £3.6m to be delivered from the agreed Q&F Plan in 2018-19, this relates to services changes impacting from 2018-19 or where part-year savings were expected in 2017-18. For 2017-18 there have also been delays in delivering the Q&F plan and there is estimated to be a shortfall of £3.7m at the year-end, this progress is contributing to the projected overspend position.

3.13 Progress with delivering on the Q&F Plan in 2017-18 has a significant impact on the financial position for 2018-19, with not only the service changes being required to be delivered in 2018-19 but also the impact this has on the 2017-18 financial outturn position.

3.14 The in-year savings delivery requirement is estimated to be £11.1m, this is before the impact of the progress and delivery of financial savings in 2018-19, this increases to an estimated £18.7m if the financial position and acceleration of delivery of the Q&F Plan are not addressed. It would be very ambitious to expect savings of £18.7m to be deliverable in one year, compared with the estimated delivery of £5m of recurring savings in 2017-18. Consideration would also require to be given as to whether this scale of savings could be delivered in the required timescale and still remain in line with the delivery of the Strategic Plan. Therefore it is absolutely critical that the financial position in 2017-18 is addressed to limit the impact on 2018-19 budget.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

4.1 The Integration Joint Board has a responsibility to set a budget which is aligned to the delivery of the Strategic Plan and to ensure the financial decisions are in line with priorities and promote quality service delivery.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

5.1.1 The Board is required to set a balanced budget for 2018-19, the Quality and Financial Plan is being developed to ensure this can be achieved within the required timescale.

5.2 Staff Governance

The Quality and Finance Plan includes service changes which will impact on staff roles, the IJB will comply with the appropriate staff governance standards.

5.3 Clinical Governance

None

6. EQUALITY & DIVERSITY IMPLICATIONS

None

7. RISK ASSESSMENT

None

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

8.1 Where required as part of the development and delivery of the quality and financial plan local stakeholder and community engagement will carried out as appropriate in line with the re-design of service provision.

9. CONCLUSIONS

9.1 The estimated budget gap and requirement to identify new service changes is estimated to range between £7.5m and £11.4m. There are a number of high level assumptions and estimates included within this position and these will be subject to change, however this is the best estimate we have based on the information available and these are the current planning assumptions that should be used for further developing the Q&F Plan for 2018-19.

9.2 There is no doubt that the 2018-19 financial year is going to be very challenging, there is a requirement for significant new savings to be identified together with the continued delivery of the service changes already included in the Q&F Plan and addressing the impact of delays with this and the impact this has on the financial position for the current year.

9.3 The Integration Joint Board has a responsibility to set a balanced budget, work has started in localities to review and update the Quality and Finance Plan to incorporate further proposed service changes. This work is progressing to ensure the IJB will be in a position to make decisions to allow a balanced budget to be agreed by March 2018.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.2 (iii)

Date of Meeting : **29 November 2017**

Title of Report : **Quality and Finance Plan – Closure of AROS Building**

Presented by : **Caroline Whyte, Chief Financial Officer**

The Integration Joint Board is asked to :

- **Note** the shortfall in planned savings from the closure of the AROS building in Lochgilphead.
- **Approve** proceeding with the planned closure. Recognising that this is required to co-locate support service staff and to disinvest from a building which is no longer fit for purpose.
- **Approve** the savings shortfall to be added to the existing corporate saving (CORP1) which will be met from the co-location of corporate staff.
- **Approve** the non-recurring costs to facilitate the staff moves to be funded from the Community Investment Plan.

1. EXECUTIVE SUMMARY

1.1 The closure of AROS was agreed as part of the Quality and Finance Plan for 2016-17 with savings of £150k expected to be delivered. The approved savings did not account for any replacement accommodation costs for staff or residual costs from retaining any elements of the building.

1.2 Plans have been developed to move the 83 staff based in AROS to alternative accommodation and the project has reached a juncture where the IJB require to make a decision on whether to proceed as planned with the closure of the building. The expected savings will not be delivered in full as currently there are 22 staff for whom alternative accommodation is yet to be identified, there would be replacement accommodation costs for the 46 staff proposed to move to Council buildings in Lochgilphead and there is some uncertainty around the deliverability of savings from Non Domestic Rates.

1.3 There would be property works required in the short term to keep the AROS building open, and a significant financial investment if there was no longer term plan to close the building completely. The closure of the building will allow for opportunities to co-locate corporate teams with Council colleagues and the efficiencies that could be gained as a result of this. Subject to formal approval and agreement, council officers have agreed to the principle of an annual rental based on a fair share of property costs, with the HSCP funding any one-off and incremental costs of co-location.

1.4 It is expected that corporate services co-location will facilitate the delivery of efficiencies which would partly offset the shortfall in savings, and therefore in the year following the staff relocation any element of unmet saving could be transferred to the corporate services savings target on the Quality and Finance Plan.

1.5 The report recommends proceeding with the closure of AROS, this would be in line with the strategic direction to integrate services, including corporate services, and would allow the HSCP to reduce the overall asset footprint and to disinvest from a building in poor condition which would require significant investment. Estates would continue to work on identifying suitable alternative accommodation for the remaining staff in the building.

2. INTRODUCTION

2.1 The closure of the AROS building, the Health corporate support headquarters in Lochilphead, was included as a saving on the Quality and Finance Plan for 2016-17. The building has not yet been closed and a decision requires to be taken as to whether this is to proceed on the basis that the full agreed saving will not be achieved.

3. DETAIL OF REPORT

Original Plan

3.1 The premise for the closure of the AROS building was two-fold, firstly this would enable the HSCP to reduce our overall asset base and disinvest from a building which is in poor condition and secondly would facilitate the co-location of corporate Health and Council staff.

3.2 The planned savings from the closure were £150k, this was based on £120k for fuel and £30k rates. No progress has been made in terms of staff being moved from the building, however a saving of £42k has been achieved from utilities due to the installation of a biomass boiler. The balance of savings to be found is therefore £108k.

Progress

3.3 There are currently 83 staff based in AROS, while alterative accommodation has been identified for 61 of these there remain 22 staff for which alternative accommodation requires to be identified. There is no plan in place at this stage which would see the full closure of AROS, although estates are confident that alternative accommodation can be identified for the remaining staff.

3.4 A summary of the staff groups to be relocated and the alternative accommodation identified is noted below:

Staff Group	Number of Staff	Proposed Relocation
Management inc PAs, HR, Planning and e-Health	34	Kilmory
Finance and Health & Safety	12	Whitegates
Community Mental Health Team	13	Old Succoth
Misc Staff	2	MACHICC
CAMHS, Dental, ADP and Nursing Admin	22	To be identified

3.5 The proposed relocation of the individual staff groups has been aligned to the areas where co-location may have the greatest benefit in terms of joint working, for example the Health Finance team would be located in the Whitegates office to be co-located with the Council's Social Work Finance team.

3.6 The relocation of 43 staff proposed to move to Council premises in the Whitegates and Kilmory offices in Lochgilphead will incur costs. There would be one-off costs in relation to enabling works, IT connection installations, removal costs and IT contractor costs which would be incurred. In addition the Council have indicated that they would intend charge an annual rental for occupancy of the offices. These costs are estimates at this stage, and are summarised below:

- One-Off Costs: £73k
- Recurring Costs: £30k

3.7 The rental arrangement with the Council has been negotiated on the basis that the HSCP will pay the fair share of the running costs of the buildings based on occupancy share in addition to any one-off relocation costs and any specific increases in occupancy costs, such as IT. This arrangement is a fair proposal for both parties, this is subject to formal agreement by the Council.

3.8 There are staff residences as part of AROS which provide short term accommodation for junior doctors and new staff moving into the area. There may also be residual costs associated with retaining the residences. There may also be replacement accommodation costs for the remaining 22 staff, efforts would also be made to minimise these costs.

Next Steps

3.9 The remaining saving to be delivered is £108k. From this £78k was planned from utility costs and £30k from rates. It is unclear if the rates saving is fully deliverable as the AROS site is part of a rateable value site which not only includes AROS but the residences and the MACHICC. Further clarity is required to establish if there would be potential rates relief from the partially unoccupied site. There would also be the requirement to provide for residual running costs for the residences and the part of the AROS office building which would require to remain occupied in the short term until suitable alternative accommodation can be identified for the remaining 22 staff.

3.10 The replacement accommodation costs were not taken into account when the saving for the closure of AROS was proposed, it was potentially unrealistic to assume there would be no replacement accommodation costs. The relocation of 43 staff into Argyll and Bute Council properties potentially could cost £30k which would reduce the potential financial saving from the closure.

3.11 It is proposed that if the staff moves are progressed that the replacement costs are funded via a cost pressure in 2018-19 for one year only. Following this however any recurring shortfall in savings being delivered would be added to the existing corporate saving (CORP1 from the Quality and Finance Plan), as the premise behind co-location of support services should be to provide efficiencies, but it should be recognised that these will not be delivered immediately. Reallocating the saving within corporate services would protect front line services from the shortfall in this saving.

3.12 There would be non-recurring costs estimated to be £73k, it is proposed that these would be met by the Community Investment Plan, this would be similar to the funding allocated for the co-location of front line services. The Council would need three months notice to carry out the enabling works, the transfer of staff could be progressed following this period.

3.13 If the closure does not proceed there would be a definite shortfall in savings of £108k. This would require to be removed from the Quality and Finance Plan as it would be unrealistic to allocate this to corporate services given the savings for support services were predicated on staff being co-located to share knowledge, integrate processes and ultimately take advantage of the economies of scale and resilience that a larger team provides.

3.14 There would also be the requirement to invest in the AROS building to address risks in relation to the property condition. The scope of this work would include roof repairs, electrical works, repairs to windows and facilities, the estimated cost of this work being in excess of £200k. If AROS was to be retained in the short-term a reduced cost option undertaking bare minimal work could be considered which may cost around £100k.

Recommendation

3.15 It is clear that the planned savings from the closure of AROS will not be achieved in full, this would be the case whether the closure proceeds or not. The advantages and disadvantages of both options are outlined below:

OPTION 1 – DO NOT CLOSE AROS:

ADVANTAGES	DISADVANTAGES
• No staff moves required, a number of staff are resistant to the move • Staff allowed to remain in familiar teams and environment • No plan currently to relocate all staff, therefore some staff will remain in the short term, alternative accommodation has not yet been identified	• No potential for savings and investment required in building to address condition and suitability • Short term approach, AROS would require significant financial investment to continue to be occupied in the medium to longer term • Alternative accommodation identified for co-location may not be available in the future
FINANCIAL IMPACT – non delivery of £108k of savings, investment required to address property works, unmet savings to be removed from Q&F Plan	

OPTION 2 – PROCEED WITH CLOSURE:

ADVANTAGES	DISADVANTAGES
• Co-location of support services provides opportunity for new ways of working, integrating of teams and efficiencies • Improved working environment, disinvestment from a building in poor condition • Reduce overall HSCP asset footprint and liability for future maintenance and works • Improved car parking availability for MACHICC	• Planned savings will not be delivered in full from closure • Additional non-recurring costs for enabling works • Some staff are resistant to move • Plan not currently in place to enable all staff to move and allow for full closure
FINANCIAL IMPACT – one-off non-recurring costs £73k, plus reduced deliverable saving due to residual NDR and utility costs and replacement accommodation costs, any shortfall (est max £80k) would be added to corporate efficiency savings target	

3.16 The overall recommendation is to proceed with the closure of the AROS building despite the shortfall in savings. This is to avoid any further investment in a building which is in poor condition and to facilitate the co-location of support service staff between Health and Council partners. A short term solution would be to pause the closure until accommodation is identified for all staff to completely close the building, but even in this scenario there would still be replacement accommodation costs and the full saving would not be delivered. Meanwhile there would be the requirement to invest in a building which is no longer fit for purpose. The relocation options currently available will incur

additional costs, both one-off and recurring but deliver the potential to lever additional savings through the productivity and efficiency of corporate services and processes and this would be the preferred longer term option for the HSCP.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

One of the overarching areas of focus for the HSCP is to "operate as a single services and single health and care team at locality level by integrating services and our workforce supported by integrated strategy, corporate service, systems and procedures". The co-location of support service staff between Health and Council partners will facilitate the integration of the corporate services, systems and procedures.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

The financial impact is noted below:

Option 1 – Do not Close AROS – agreed savings of £108k on the Q&F Plan will not be deliverable and will require to be removed from the plan, there would be investment required in AROS to improve the condition of the building (potentially £200k).
Option 2 – Proceed with Closure – agreed savings of £108k will not be delivered in full, there will be replacement accommodation costs and delays in releasing savings due the building not being fully closed immediately. One-off costs estimated at £73k will be met from the Community Investment Plan and any savings not delivered will be added to the savings target for corporate services on the Quality and Finance Plan.

5.2 Staff Governance

Staff consultation has taken place to keep staff informed of the plans to close the AROS building and re-locate to other accommodation in Lochgilphead. Council staff in Whitegates and Kilmory have also been informed of the planned move. Staffside representatives have previously indicated their support for moving staff out of the AROS building.

5.3 Clinical Governance

None

6. EQUALITY & DIVERSITY IMPLICATIONS

None

7. RISK ASSESSMENT

Risk assessments will have been carried out for any alternative accommodation prior to staff moves.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

None

9. CONCLUSIONS

9.1 The plans to close AROS and relocate the 83 staff have not proceeded as planned. The saving was approved as part of the 2016-17 budget and has not yet been delivered due to delays in identifying suitable alternative accommodation for all staff and the potential that savings may not be delivered in full. Work is still ongoing to identify suitable replacement accommodation for the remaining 22 staff.

9.2 The closure of the building is now at a juncture where the IJB require to make a decision on whether to proceed as planned. There are replacement accommodation costs associated with any relocation of staff and there is uncertainty around residual rates and utility costs and the move will not generate the planned financial savings. However proceeding with the move would allow the HSCP to disinvest from a building which is in poor condition and to progress with the co-location of Health and Council corporate services staff. There would be longer term potential to achieve efficiencies and productivity benefits from co-location with HSCP partners.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.3i

Date of Meeting : **29 November 2017**

Title of Report : **NHS Highland Director of Public Health Annual Report 2017: Realistic Medicine**

Presented by : **Hugo van Woerden**
Director of Public Health & Health Policy

The Integration Joint Board is asked to :

- **Receive the report.**
- **Recognise the work that has been undertaken to develop Realistic Medicine in NHS Highland.**
- **Support the dissemination of the report and its findings.**

1. EXECUTIVE SUMMARY

NHS Highland's Director of Public Health report for 2017 considers the ethos and role of Realistic Medicine in delivering higher quality health and social care.

Realistic Medicine as a concept was launched by the Chief Medical Officer in her annual report in 2015 and was further developed in her subsequent annual report entitled Realising Realistic Medicine.

The 6 core elements of Realistic Medicine are:
- Shared decision making
- Personalised approach to care
- Reducing unwarranted variation
- Reducing harm and waste
- Managing risk better
- Making innovative improvements

Many of the tenets of Realistic Medicine have long been recognised as indicators of quality and have been at the heart of much improvement work. But through uniting these concepts in one shared philosophy in a challenging financial climate Realistic Medicine has gained a momentum and following across Scotland.

This report includes examples of Realistic Medicine in action from across NHS Highland and reflects on frailty and end of life care in particular as areas from which further benefits could be reaped using a Realistic Medicine approach. Many of the case studies have been kindly provided by the Area Clinical Forum.

2. INTRODUCTION

This year's report begins by illustrating the current challenges facing the health and care of our population from both a Scottish and a NHS Highland perspective. Spending on health and social care delivery has been increasing as a percentage of gross domestic product (GDP) since 1900 and has resulted in an impressive rise in life expectancy. There are multiple drivers for the costs of health and social care delivery including: increased and earlier onset of chronic disease and multi-morbidity conditions, developments in medical and pharmaceutical technology, an ageing population and increases in the national minimum wage.

As a result of all of these factors both health and social care provision has also become more complex and potentially unsustainable so there is a need to adopt new approaches. One example is considering new models of housing provision such as extra care, modular housing as an alternative to current care home and home care arrangements.

In Scotland these challenges have resulted in a shift in thinking about how to maximize value in health and social care and have precipitated Realistic Medicine. Internationally other countries have developed their own approaches, many examples of which are shared in this report. For example the Buurtzorg district nurse model originated in the Netherlands and is being piloted in NHS Highland. A comparison of these international approaches demonstrates they have many similarities however it also highlights the importance of the local culture and context in determining each model's success. In light of this it is recommended that robust evaluation work accompanies any adoption of international models.

3. DETAIL OF REPORT

This report considers in depth two areas which could benefit from a Realistic Medicine approach: end of life care and frailty.

1) End of Life Care
   Across NHS Highland there is substantial variation in where people die. This variation is affected by geography, gender, condition type and age. Over the last 35 years there has been a reduction in the proportion of people dying at home and an increase in those dying in acute hospital and care homes. Men are more like to die in their own home than women, those dying from dementia and related conditions are most likely to die in community settings and those dying from renal, liver or respiratory related conditions are more likely to die in an acute setting.

   Providing good end of life care requires clinical, community and family support. One firmly established way in which clinicians can support end of life care by being proactive in discussing individual's wants and needs and recording this in the form of Anticipatory Care Plans (ACPs) and key information summaries. Prognostic uncertainty has been identified as a barrier to such discussions and the absence of an ACP may result in people receiving futile and invasive

treatment. It is estimated that between 30-38% of patients may have received non-beneficial treatment near the end of their lives.

The public health team have been working with Highland Hospice to develop the concept of a Compassionate Community and this is now embedded within the hospice's three year strategy. Helmsdale is also developing as a compassionate community in the form of a Dementia Friendly Community. The public health team have also piloted the use of Eco-mapping in a ward setting to support more personalised care. Eco-mapping is a practical tool which can be used prior to discharge to help both the patient and the healthcare team to map out the range of support a person may have on returning home including both formal and informal supports.

2) Frailty

Frailty is a common condition particularly, although not exclusively, among our older population. Within NHS Highland there are an estimated 13,000 frail older people living in the community and around 1,100 in residential care homes or nursing homes. Frail individuals have up to ten times the rate of adverse outcomes such as falls, and hospitalisation. They are less able to adapt to stressors such as illness and trauma and have higher mortality rates. There is significant variation in emergency hospital admission rates across Highland and Argyll and Bute, suggesting that there is variation in the way in which such frailly is dealt with.

To reduce frailty we need to promote interventions that improve physical functioning, particularly during hospital admissions, by increasing muscle mass and strength, particularly progressive resistance strength training, exercise involving gait, balance, co-ordination, and encourage walking on a daily basis. For hospitalised patients, better outcomes for patients are associated with care delivered by geriatric-specific and multi-disciplinary teams, particularly when these were delivered in designated units or wards. This approach has been successfully used for hip fracture management in Raigmore and resulted in national recognition. Other Interventions identified by the literature that reduce hospitalisation include certain types of nurse-led unit, tele-healthcare for long-term conditions, discharge planning from hospital to home, case management in heart failure and integration with generic case management. Whilst some of this work is already being undertaken there is scope to do more.

Recommendations to support Realistic Medicine

A wealth of work is ongoing in NHS Highland which is aligned to Realistic Medicine and this should be acknowledged and commended. This report has highlighted some areas in which current efforts could be expanded, as follows:

- Continue to pursue alternative models to providing health and care to our older people for example the use of modular housing and further piloting of the Buurtzorg district nurse model
- Evaluate Realistic Medicine aligned initiatives to inform an emerging and sparse evidence base
- Utilise the evidence base provided on end of life care needs and place of death to improve palliative care in NHS Highland, seeking to reduce variation in place of death and to better manage risk by recognising when a patient is nearing the end of their life and adjusting care appropriately

- Empower communities to become compassionate communities who can support people who are frail or dying in the contexts in which they are most at home
- Recognise the prevalence of frailty and support the implementation of evidence based interventions to prevent and slow the progression of frailty through improving physical functioning and increasing muscle mass
- Continue to provide integrated specialist geriatric care to across the hospital and community and explore alternative models of delivering that care.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

Applying Realistic Medicine could assist in delivering the vision laid out in Argyll and Bute Health and Social Care Partnership 3-year Strategic Plan: that people in Argyll and Bute will live longer, healthier, happier independent lives. In particular it could assist in:

- Efficiently and effectively managing all resources to deliver Best Value
- Support people to live fulfilling lives in their own homes for as long as possible
- Reduce avoidable emergency admission to hospital and minimise the time people are delayed
- Support staff to continuously improve the information, support and care they deliver

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

Implementing Realistic Medicine and care will provide better health and social care for patients. It is anticipated that through reducing excessive or non-beneficial investigation and treatment and reducing harm, waste and variation in health and social care delivery that efficiency savings would be made.

5.2 Staff Governance

There are no direct staff governance impacts.

5.3 Clinical Governance

There are no direct clinical governance impacts.

6. EQUALITY & DIVERSITY IMPLICATIONS

It is acknowledged that some elements of Realistic Medicine have the potential to be in conflict with each other. For example it may be challenging to provide more personalised care at an individual level whilst reducing unwarranted variation at a population level.

7. RISK ASSESSMENT

None carried out.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

This annual report will also be presented to the NHS Highland Board, Highland Council, and Argyll and Bute council. It will also be disseminated to a wide range of stakeholders, with support from the communications team.

There is ongoing discussion regarding an event to celebrate the local work which has been done to support Realistic Medicine and gather ideas for future work going forward.

Dr Catherine Flanigan
Specialty Registrar, Public Health
6th November 2017

The Annual Report of the **Director of Public Health**

NHS Highland

2017

Realistic Medicine

Acknowledgements and list of contributors

I would like to thank the following colleagues for their contributions:

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Contents

Introduction

Significant financial constraints, accelerating health and social care demand and the impact of wider political factors on the NHS have kept health care firmly in the public and media spotlight[1]. This year's annual report reflects on these challenges both practically and ethically, using the framework of Realistic Medicine.

Last year's annual report focused on loneliness, recognising that 67% of people aged 65 years and over in Highland feel lonely. The 'Reach Out' campaign linked to that report has made significant progress in mobilising a wider societal response to this issue. A grasp of the importance of Realistic Medicine will also lead to a recognition that we have to respond to health and social care needs as a society. The public sector cannot meet all of society's needs and part of a realistic approach will need to include empowering communities to increasingly develop approaches to meeting their own needs.

Since July the 2nd 1948, when the NHS was born, it has operated on the principle of being free at point of delivery to the whole population[2]. The NHS originated not from a legal duty to provide healthcare but from a combination of moral conviction and economic prudency[3]. However, prior to the commencement of the NHS, Aneurin Bevan predicted that, "Expectations will always exceed capacity"[4]. Almost 70 years later this analysis remains accurate. As a result, we must ensure that we maximise our available capacity to provide valued, high quality care and to minimise harm, waste and unwarranted variation through personalised and innovative patient centred care. This is the core message of Realistic Medicine[5].

The generosity of spirit underpinning the NHS has to be balanced against the need to allocate scarce resources as efficiently as possible. Public health is often viewed as a utilitarian discipline, seeking to maximise the greatest good for the greatest number. However, this is overly simplistic: public health also champions equity, recognising that unequal need requires unequal provision based on a moral duty to care for those in need.

Earlier this year the Scottish Public Health Network (ScotPHN) considered what contribution public health could make to realising Realistic Medicine and highlighted the roles of ensuring the wise use of available evidence, empowering communities and leading and supporting innovation and implementation. All of these elements have been considered in this report.

I want to end by thanking the team who have put together this year's report for their professionalism and commitment to the population we serve.

Professor Hugo van Woerden

Director of Public Health and Health Policy, NHS Highland
Stiùriche na Slàinte Phoblach, Bòrd Slàinte na Gàidhealtachd

Chapter One - Understanding the challenge

Why has the nomenclature of Realistic Medicine or Prudent Healthcare caught the imagination of many so effectively? This chapter explores some of the drivers that have been building up over many decades and that have led to the issue coming into focus.

The financial context

Total healthcare expenditure in the United Kingdom (UK) has increased inexorably as a percentage of GDP over the last 100 years. Healthcare spend is now over 8% of gross domestic product (GDP) as shown in Figure 1.1[1]. This could rise to as much as 19% of GDP by 2061[1]. One of the drivers for Realistic Medicine is a recognition that this trend has to be addressed if healthcare free at the point of delivery is to be societally affordable over the long term.

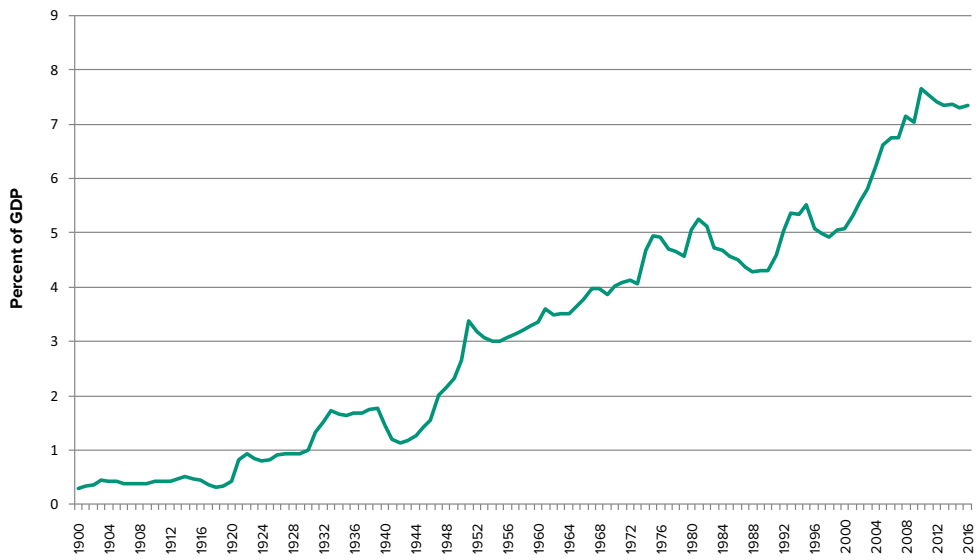


Figure 1.1 - Percent of General Domestic Product for the UK spent on Health
Source: ukpublicspending.co.uk[2]

There is no optimum amount of expenditure on health. However, there is some evidence that each extra increment of expenditure beyond a certain point leads to diminishing returns. Many high income economies are on the part of the curve where there are diminishing returns (Figure 1.2).

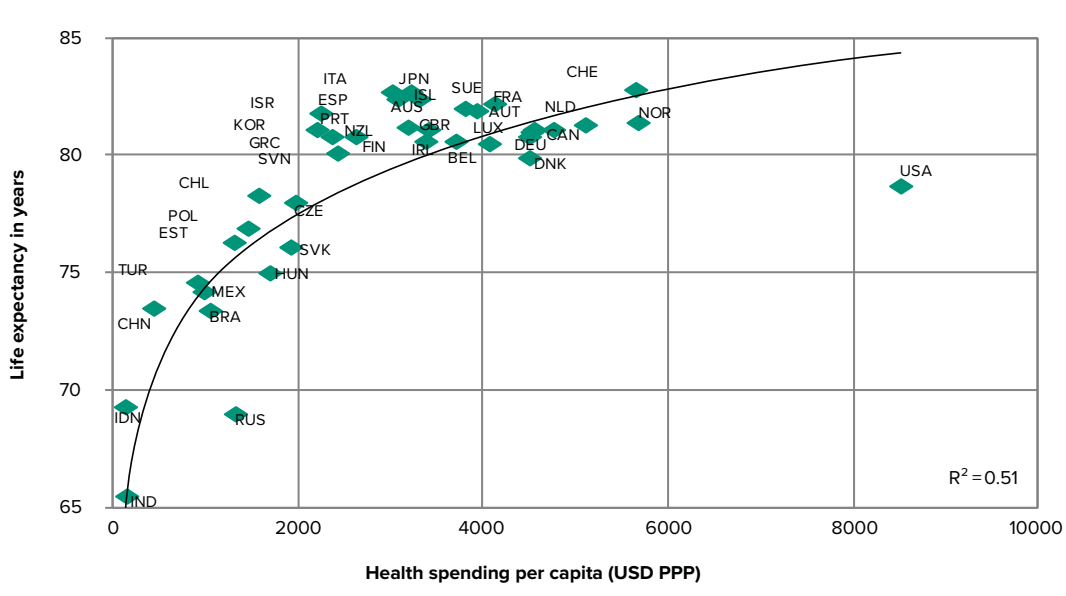


Figure 1.2 - Life expectancy at birth and health spending per capita, 2011
Source: OECD Health Statistics 2013[3]

Figure 1.2 indicates that there is a relationship between spending and health. A significant proportion of the relationship is simply a reflection of the relationship between Gross Domestic Product, or the wealth of a country and life expectancy, as income is one of the most important determinants of health. However, the graph clearly demonstrates that beyond a certain point, additional expenditure on health provides relatively little return, and that many wealthy countries are on the part of curve. This suggests that from a realistic or prudent healthcare perspective, major additional investment in healthcare may result in relatively modest benefit.

Scotland spends more per person on healthcare than the other nations of the United Kingdom (UK), although this gap is reducing over time, as healthcare spend per person in other UK jurisdictions is catching up[4]. In 2015/16, £11.2 billion was spent on Scottish health services. The bulk of healthcare spend occurs in secondary care with more than 50% of the budget spent on hospital care and less than 10% on General Practice as shown in Figure 1.3[5]. Part of the Scottish Government's commitment is to reverse this trend and to increase the proportion of spending in primary and community care; an initiative that is very much in line with Realistic Medicine. However, this is extremely challenging in practice as the 'drivers' in the system have been in the opposite direction for many decades. The ethos of Realistic Medicine is that providing more personalised and appropriate care will lead to better value care and as a result more efficient spending.

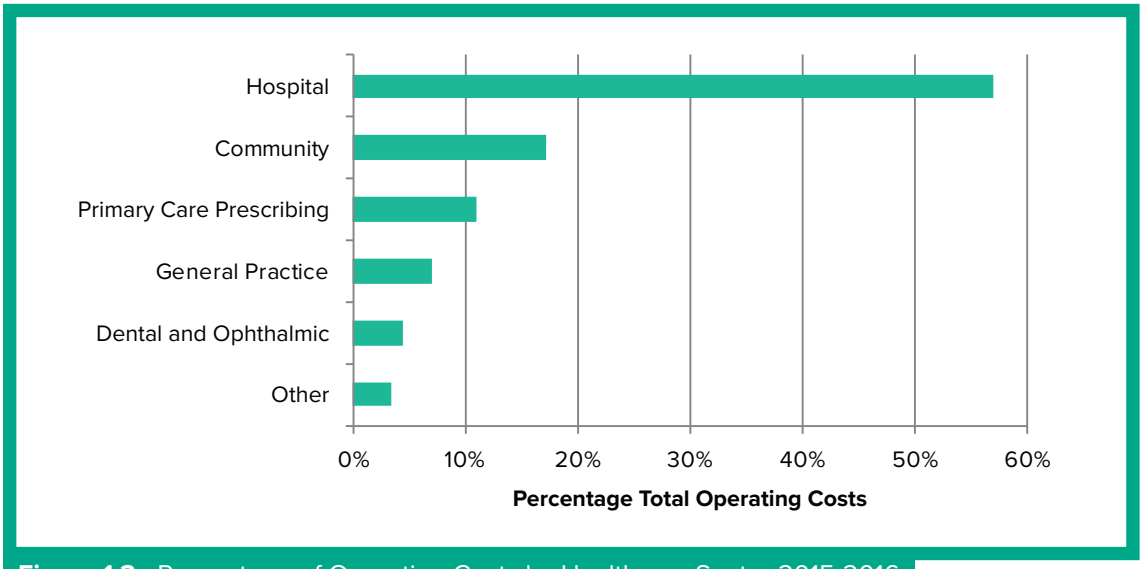


Figure 1.3 - Percentage of Operating Costs by Healthcare Sector 2015-2016
Source: Information Services Division (ISD), Scottish Health Service Costs[5]

The cost of social care

In Scotland between 2004 and 2014, social care spending has seen a 15% increase in real terms for older people aged 65 and over, with 44% of the £4 billion spent in 2013/14 being on this group[6]. Across England social care spending has also risen consistently as a percentage of national income from 1977 to 2016[4]. However, despite the growth in expenditure, due to the rapid growth in the population aged 65 and over, there has been a 1% decrease in real terms per capita spending on social care over the decade between 2004 and 2014. Although there are also changes in where this money is spent the majority is still spent on care homes, which may not be the approach that gives the best value for money. Across Scotland, 38% of the spend on adult social care was on care homes and 25% on home care (2013/14 figures)[6]. There is a case for spending a greater proportion on home care.

Drivers for health and social care costs

The ageing population has been described as a 'population time bomb' responsible for continuously escalating health and social care costs. The truth is more nuanced. There are many drivers for increased costs including:

- Increasing prevalence of patients with multiple co-morbidity (perhaps undiagnosed in past generations and over diagnosed in our own)
- increases in the national minimum wage and greater competition with alternative occupations
- spiralling medication costs, largely driven by industry
- developments in high cost medical technology
- increasing life expectancy, extending the duration of treatment for long term conditions[1,7]
- earlier onset of chronic conditions associated with obesity such as osteoarthritis and diabetes[7]
- rising identification of cognitive decline, impaired mental function, and dementia against a background of a world in which cognitive skills such as using the internet is increasingly essential
- changes in social cohesion and a common perspective around the social contract.

Some of these issues are explored further within this report. We must remain mindful of this complex array of factors which are driving changes in healthcare cost and demand. The growth of our older population is a success story of modern medicine and modern public health interventions which have resulted in people living longer, healthier lives and should be celebrated. Our older population are also a valued and vital part of our community and contribute a wealth of experience and skills. Many of the older population are active members of the community, contribute to third sector organisations and work as informal carers supporting the role of the NHS.

Ageing and co-morbidity

A number of interacting factors related to ageing, co-morbidity, identification of sub-clinical levels of disease and increased therapeutic options, which have driven costs upward, have perhaps resulted in a desire to see the pendulum swing in the opposite direction and driven realistic or prudent healthcare initiatives. Figure 1.4 presents some aspects of this complex relationship between different long term conditions in our ageing Scottish population.

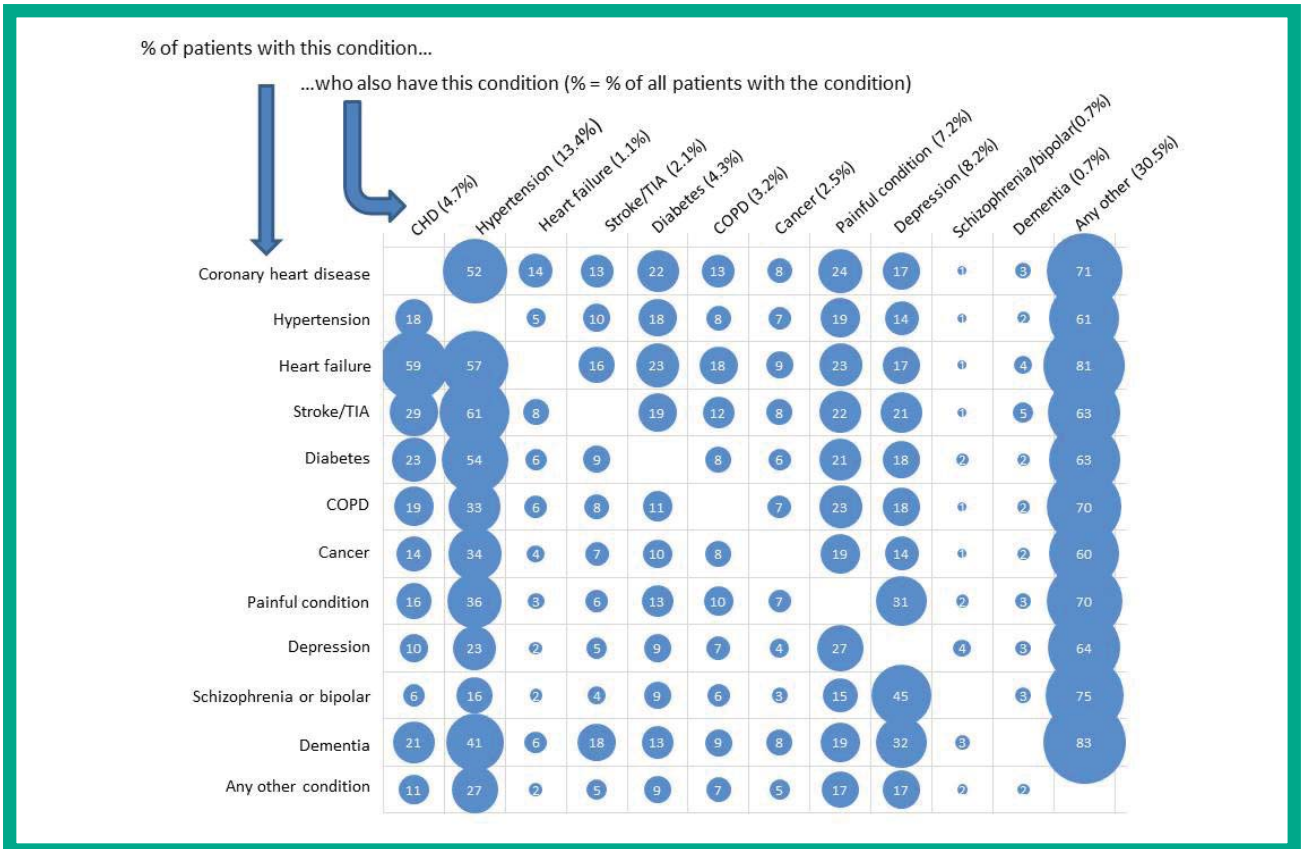


Figure 1.4 - Combinations of long term conditions that define multi-morbidity among GP patients in Scotland
Source: The Scottish School of Primary Care Research Multi-morbidity in Scotland, slide five[8]

Old age is increasingly 'medicalised', as it is in the interests of pharmaceutical companies to support the identification of multiple healthcare problems that would previously have been treated as simply an inevitable part of ageing[9]. Each 'diagnosis' can then be subjected to a panoply of therapeutic interventions that only make a minor improvement to survival or quality of life, but which are sufficiently common to sell in large volumes, generating significant profits[10]. This is a global issue related to the way in which we develop new medicines and the extent to which such development should be leveraged via a profit motive. Current mechanisms encourage the develop of a 'me too' drugs, as opposed to genuine innovation, for example in relation to diseases of the developing world, which will not yield big profits.

Caring for the elderly and vulnerable

Free healthcare has probably been provided for the 'destitute and dying' in the Highlands since the establishment of monasteries such as that in Iona in 563 AD, Applecross in 673 AD, and Rosemarkie around 716 AD. A subsequent post-reformation growth in homes and care to the elderly in almshouses occurred in the 16th century[11]. Table 1.5 charts the timeline of nursing homes and residential homes from then to the present day[12].

Table 1.5 - Historical Timeline of Care Provision in the UK from 16th Century To present Day[12,13,14]

16th Century	Almshouses provide charitable care to 'elderly, poor and insane'.
19th Century	Workhouses and then poorhouses became main residences for these patients.
1880s	• Nursing Homes emerge for paying customers including surgery and maternity, numbers double every 10 years. • The first district nurses are trained for the 18 districts of Liverpool.
1930s	• Public Assistance institutions replace workhouses. • District Nursing provided on provident basis through District Nursing Associations, poor and elderly usual for free.
1948	• Home nursing provided through newly formed NHS. • New duty on local authorities to provide residential accommodation. Formal separation of nursing and residential homes.
1950s	1950s growth of NHS and emergence of geriatrics as a medical speciality, new recognition of needs of older people.
1960s-1970s	• Residential homes move from small 30 bedded homes to around 60 beds. • National Assistance act requires local authorities to enable people to remain in own home as long as possible.
1968	Social Work (Scotland) Act 1968. Local councils have a duty to assess a person's community care needs and take account of their preferences to inform assistance.
1980s	New regulation allows public funding of private bed spaces for residential care. Private sector expands but growth declines.
1980s-1990s	• As inpatient geriatric beds close, nursing home beds continue to increase. • Number of people receiving nursing and care at home declines as level of assistance increases.
2000s	Intermediate Care Teams and rehab services open as short stay residences. Both residential and nursing homes are renamed as care homes.
2010s	Level of need and cost for those in care homes increasing.
2014	The Public Bodies (Joint Working) Act 2014. Requires NHS boards and local authorities to jointly submit an integration scheme for integrating health and social care.

In 1948, the government placed a duty on local authorities to provide residential care for their population. From then until the 1980s the numbers of residents in care homes continued to increase, followed by a similar growth in nursing home residents from the 1990s[12].

A considerable expansion of the private sector accompanied the increasing numbers, so that by 2014, 74% of residential care home capacity and 86% of nursing home capacity was provided by the private sector. However, a large proportion of private provision remains funded in part or in full by local authorities (LAs), or in the case of the Highland Council area, via a commissioning arrangement between Highland Council and NHS Highland[15].

A realistic approach to care has to take account of the changes in the demography of those using care homes. In Scotland, over the last decade, the number of long stay care home residents aged 85 years and over has increased by 12%, the number of residents with dementia has increased by 30% and the average level of assistance required by those in such facilities to support activities of daily living (ADLs) has also increased[15,16].

The population in care homes is changing. Those residing in care homes are older, frailer and require more assistance than was the case in the past. In England, the population aged 65 years and over increased by 11% over the last 10 years, but in contrast, the nursing home population increased by only 0.3%. This suggests that only those with the highest levels of need are being admitted to nursing homes. This shift has been paralleled by the emergence of 600,000 unpaid carers (English data), who may receive Carer's Allowance, but who are not formally employed in the care industry. This emerging workforce has been integral to enabling more people to remain in their own homes[17].

In Scotland, estimates of the number of carers are derived from a combination of census data and the Scottish Health Survey, with the most recent estimates from 2011 and 2012/13 publications respectively[18]. The surveys found that 759,000 (17%) of the adult population (aged 16+) were carers and 29,000 (4%) of these carers were aged less than 16 years[17]. Although the percentage of the population in Scotland who are carers has been constant between 2001 and 2011, a higher proportion of those caring are providing 20 or more hours of care and 13% fewer carers providing 19 or less hours of care[17]. In carers aged 65 and over 47% are providing care for 50 hours or more[17].

Across Scotland 40% of carers had been caring for more than a year and a further 40% for between 5 and 20 years. Although the proportion of the population who are carers is the same regardless of deprivation status, those in the most deprived areas were 23% more likely to be providing 35 or more hours of unpaid care, which is the threshold for receiving the maximum level of Carer's Allowance.

Caring has an impact on the carer's wellbeing. While those providing up to 19 hours of unpaid care have comparable self reported health to the rest of the general population, those providing care for 20 or more hours per week report increasing levels of poor health. This effect is compounded by age.

Only 56% of carers are employed and this reduces to 35% in those who are providing 35+ hours of care per week. Those receiving the maximum level of Carer's Allowance are only allowed to work 10 hours per week. Estimates suggest that fifty percent of carers are entitled to, but do not receive, carers allowance, a figure which rises to over 95% of carers aged 65 and over. Across NHS Highland females aged 50-64 years are most likely to be carers.

NHS Highland context

Across both Scotland and NHS Highland the population is ageing and over the next 20 years there is likely to be a significant rise in the number of those aged over 70 years who have multi-morbidity and high levels of frailty (see Figure 1.6).

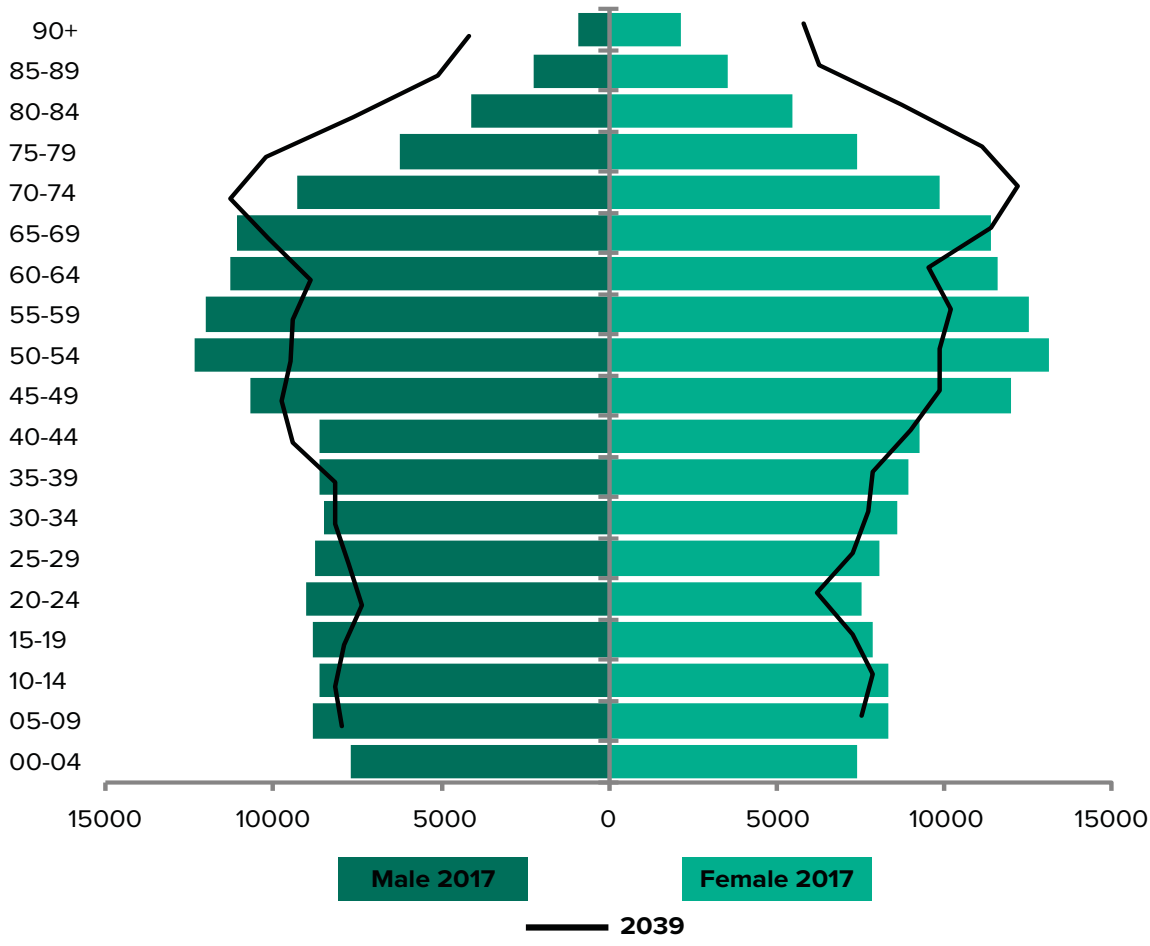


Figure 1.6 - Current and projected population, NHS Highland
Source: National Records of Scotland (NRS) Population Projections for Scottish Areas (2014-based)

As the population bulge shown in Figure 1.6 becomes older, new and imaginative solutions will need to be developed to respond to the needs of this population.

High resource individuals

Health and social care resources are not utilised evenly by all individuals in the population. The distribution of expenditure is very skewed. In north Highland, 2.2% of the population (3,903 individuals; 2015/16 data) utilised 50% of health and social care resources. Across NHS Highland there were 16.7 High Resource Individuals (HRIs) per 1,000 population[19]. Expenditure on the average person in HRI group across all age bands was £30,353 per person, whilst the average expenditure on the rest of the population was £644.61 per year.

Analysis of the pattern of expenditure is useful in effective planning and exploring realistic approaches to the management of service delivery. There is a strong correlation between having a long term condition (LTC) and an increased risk of admission to hospital, or of being classed as a High Resource Individual.

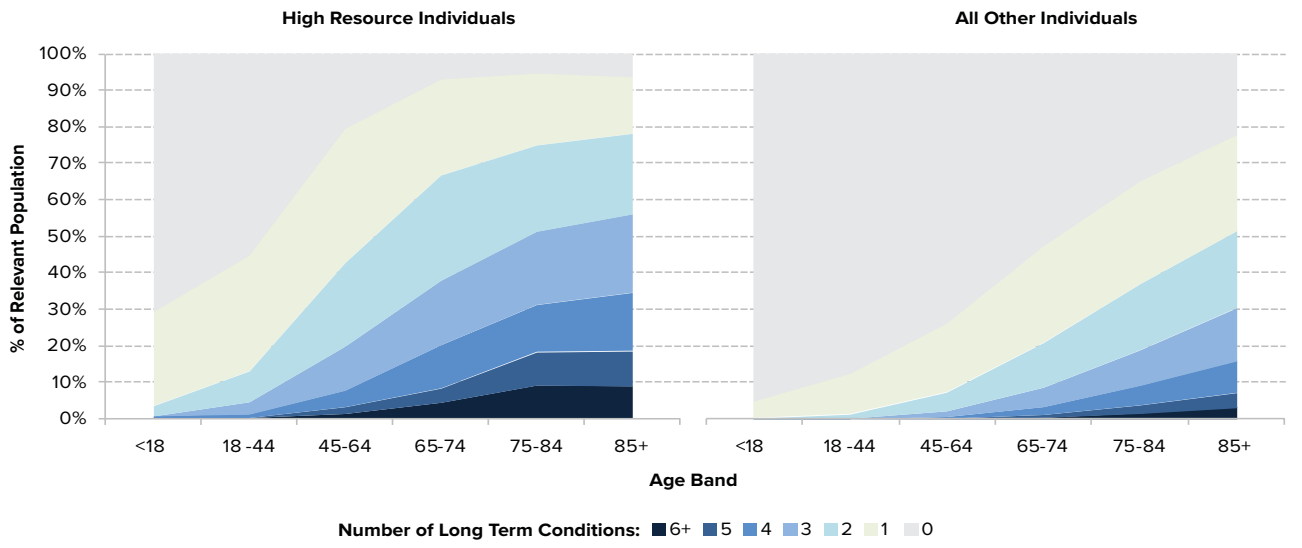


Figure 1.7 - Relationship between multiple long term conditions and age for High Resource Individuals

Figure 1.7 demonstrates that, apart from some expensive paediatric cases, High Resource Individuals generally have multiple long-term conditions. Table 1.1 provides a breakdown on the main diagnoses for HRIs.

Table 1.1 - High Resource Individuals by Long Term Condition

Diagnosis Group	Number of HRIs*	Percentage of HRI Cohort*	Percentage of Other Service Users*
Cardiovascular	2738	70%	13%
Cancer	1298	33%	6%
Arthritis	1091	28%	8%
Respiratory	1042	27%	8%
Liver Disease / Renal Failure	638	16%	2%
Diabetes	623	16%	4%
Neurodegenerative	472	12%	1%
Epilepsy	185	5%	1%

*Note that patients within multiple LTCs will be counted in several groups.

Table 1.1 indicates that diagnoses of cardiovascular disease, cancer, arthritis, respiratory disease, diabetes, neurodegenerative disease, liver disease and renal failure are particularly associated with high levels of expenditure.

Care at home

From 1962, the National Assistance Act required local authorities to make plans that would enable people to remain in their own homes for as long as possible[14].

The lack of housing that is suitable for the frail elderly is a major challenge across the UK including NHS Highland. Bungalows and extra care housing do not deliver as high profit margins as two story homes and this has led to a significant mismatch between what is needed by the population in the future and what is currently being built by the construction industry. This mismatch might be rebalanced if it was addressed by local government planning initiatives, working in conjunction with social housing providers, as there are funding sources for initiatives that would provide housing for those with high levels of dependence.

It would be possible to model the required number of extra-care houses required for each community across NHS Highland and take steps that facilitated the building of such accommodation. The main advantage for the NHS would be that it could increase flow though hospitals, allowing patients who are currently inappropriately stuck in hospital beds to move on to accommodation that is more suitable. Hospitals can be dangerous places to be for those who are frail, but not acutely ill, as such individuals are at particular risk of contracting 'hospital acquired infections' that can be fatal. Housing provision is one element of the wider challenge of providing appropriate care to individuals with high levels of dependence. The other challenge is providing staff to care for such individuals, which is addressed elsewhere in this report.

Integration of health and social care

National policy on integration of health and social care staff is aimed at improving seamless care that wraps around the individual and responds to their needs. Different parts of NHS Highland have approached integration in different ways. A lead agency model has been adopted in north Highland, with Highland Council as the lead agency for children's community health and social care services and NHS Highland as the lead agency for adult health and care services. A body corporate approach led by an Integrated Joint Board (IJB), has been taken in Argyll and Bute. The IJB and Health and Social Care Partnership in Argyll and Bute has delegated responsibility, from both NHS Highland and from Argyll and Bute Council, in relation to health and social care[20]. In the years since integration, many benefits have been realised across both models, including the forming of joint assessment teams and direct access for patients to a wide range of multidisciplinary teams.

Sustainable services

One of the aims of service integration is to reduce unnecessary admission to hospital and to reduce the number of delayed discharges, delivering a more efficient and effective use of available resources[20]. Progress has been made in this area, but more work remains to be done. Reducing the number of bed days occupied by people who are 'medically fit for discharge' has the potential to save money and deliver a more sustainable service. The costs associated with bed days occupied due to delayed discharges in NHS Highland is significant. Between £1.8 to 2.2 million could be saved if we were able to reach average practice in Scotland (based on 2015/16 figures).

Although this money might not be realised as 'cash releasing savings', it represents a significant opportunity to create greater system capacity. Sustaining flow though hospitals is a challenge across the world, but is particularly acute in a remote and rural area such as NHS Highland, as patients who need ongoing care at home cannot be discharged to remote areas until suitable care can be identified in that area. A realistic health and social care approach will require an ongoing focus on maximising flow through acute care beds and the development of new care at home models.

Residential or nursing home facilities are generally not financially viable unless they have at least 40 residents, but small rural communities do not justify facilities of this size. In addition, it is difficult to find staff in remote and rural areas who are willing to work in care homes or to provide care at home. These factors have resulted in some patients remaining inappropriately accommodated in hospital for long periods of time whilst staff and families try to find a suitable solution. Some areas have developed sustainable solutions, for example, the Howard Doris Centre in Lochcarron, which delivers support for individuals with a range of different levels of need. Interestingly, this initiative grew out of local initiative and vision rather than being driven by the public sector. It demonstrates the value of communities considering their own needs, finding out what options have been tried elsewhere in the world, and applying this to developing local solutions..

There are new sustainable models which provide care in remote and rural areas. One approach being piloted by NHS Highland in conjunction with Albyn Housing, local universities and a local housing manufacturer, is Fit Homes. These homes are an example of modular housing incorporating

high levels of technology which can be rapidly constructed and even transported to new locations to meet changing need. Modular housing is designed to monitor the activities of residents who have high levels of care needs intensively and trigger appropriate action when the technology identifies a problem. Although this is currently being undertaken as a research project, there is an urgent need to consider ways in which this strategy can be replicated across Highland.

The challenges of frailty

A major challenge in the context of Realistic Medicine or Prudent Healthcare is managing frailty. No single definition of frailty exists but it is generally accepted as 'a state of increased vulnerability in which individuals have diminished ability to respond to stressors and are at an increased risk of adverse outcomes'[21].

In theory, early detection of frailty should facilitate interventions that reduce the risk of admission to acute care, although there is a lack of robust research to that effect. There are a number of tools that attempt to facilitate such a process. The Scottish Patients at Risk of Re-admission or Admission (SPARRA) score calculates the probability that a patient will have an emergency admission within the next 12 months. A 40% chance of admission or readmission is considered a high risk state[22]. Figure 1.8 shows the SPARRA scores for NHS Highland showing how the risk of admission varies with age and is highest among women aged 80-89 years old.

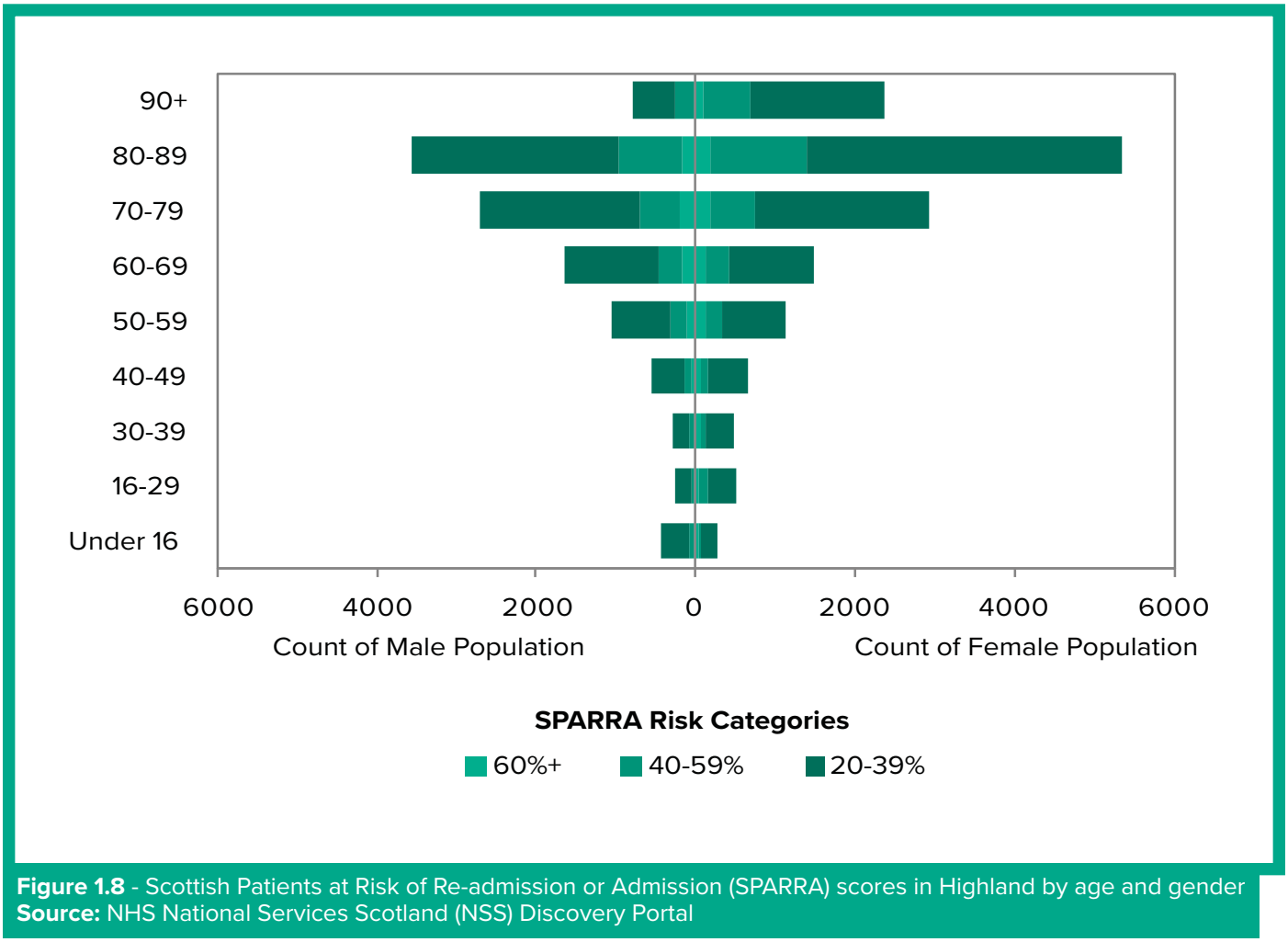


Figure 1.8 - Scottish Patients at Risk of Re-admission or Admission (SPARRA) scores in Highland by age and gender
Source: NHS National Services Scotland (NSS) Discovery Portal

However in comparison to other health board areas NHS Highland has the lowest rate of emergency admissions for those aged 75 and over, and has achieved a sustained reduction over the last five years. This important quality outcome indicator reflects the success of focussing on preventative and community based care for older adults.

Social care provision

Care homes and nursing homes are being utilised less than in the past and those in such facilities have, on average, greater levels of dependency. In some ways this trend is to be welcomed as these type of facilities do not meet the needs of a large proportion of the population. The availability of care home places, per 1,000 population, has reduced slightly across Scotland and Highland over the last ten years as shown in Figure 1.9[15]. The average weekly costs for Scotland have also increased, with those self funding with nursing care placements seeing the greatest increase in cost from £552 per week in 2007 to £814 per week in 2016[15].

Amongst longer stay adults in care homes in North NHS Highland the number requiring nursing care has reduced by 15% over the last 10 years whilst the number with dementia or another physical disability or chronic illness has increased as has the proportion aged 85 and older[15]. So whilst rates of care home use have reduced, the residents are older and have more long term conditions than was previously the case. It is not possible to determine whether this reflects changes in supply or demand. It may be that need for nursing care has reduced with a healthier older population or that the number of care home places and available nursing care has not kept pace with the increased number of older people, so that only those with the greatest need are accessing this type of care.

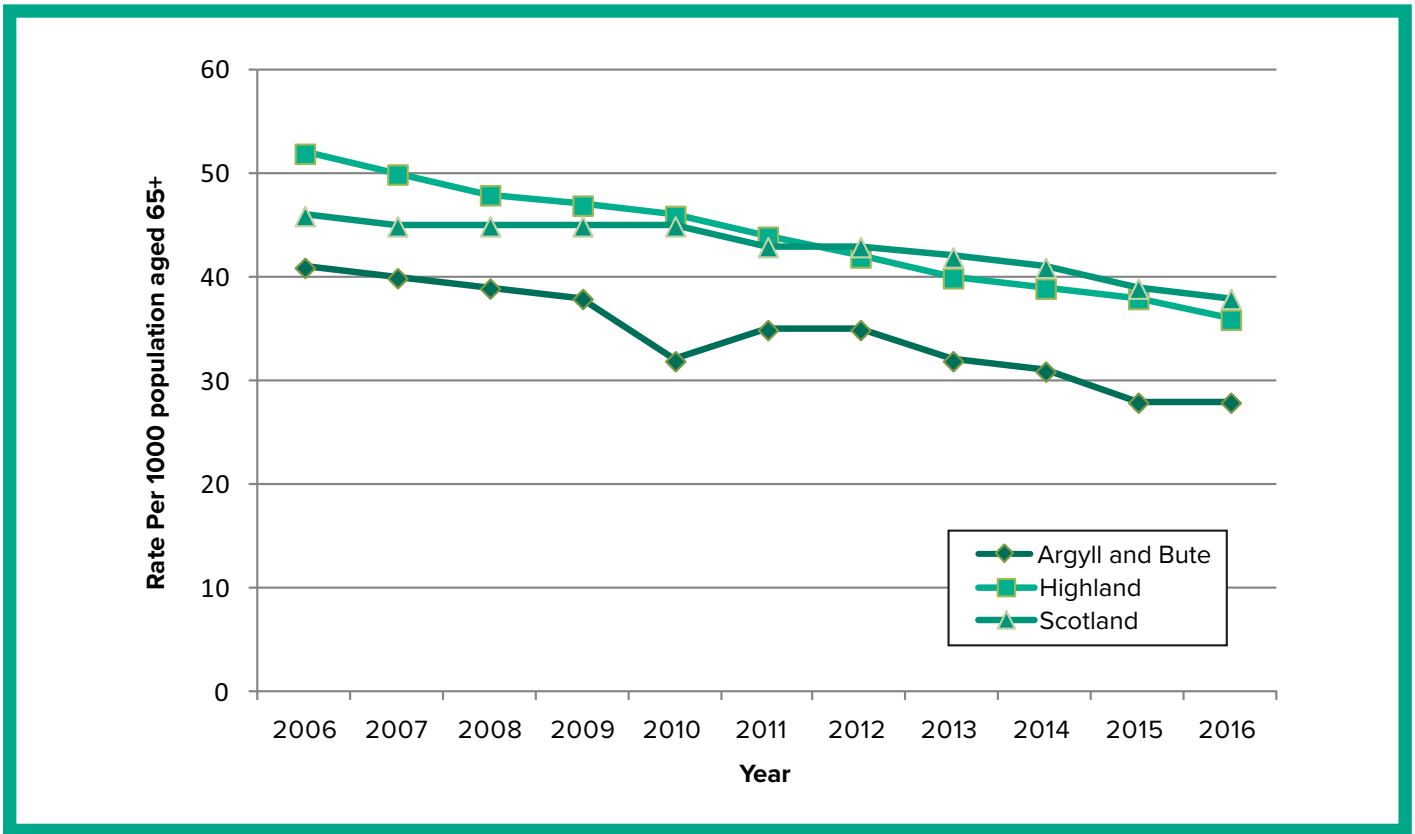


Figure 1.9 - Number of Registered Places in Care Homes for Older People per 1,000 Population Aged 65+, 2006-2016
Source: Information Services Division (ISD) Scottish Care Home Census 2006-2016[15]

The NHS Highland Public Health department has investigated what the situation could be in the next 20 years in terms of the requirement for Care Home places, if current use per population aged over 65 years remains the same in Highland. Unless we develop new ways of working, then twice the number of care home places will be required by the year 2035[23].

This prediction assumes that the current proportions by dependency state remain the same, and that two thirds of the population with high dependency are cared for in care homes (see Figure 1.10). A better way of thinking about this issue is to focus on levels of frailty or dependence that can be expected in the population and to plan to design support mechanism, in conjunction with communities, for the expected populations at each levels of frailty.

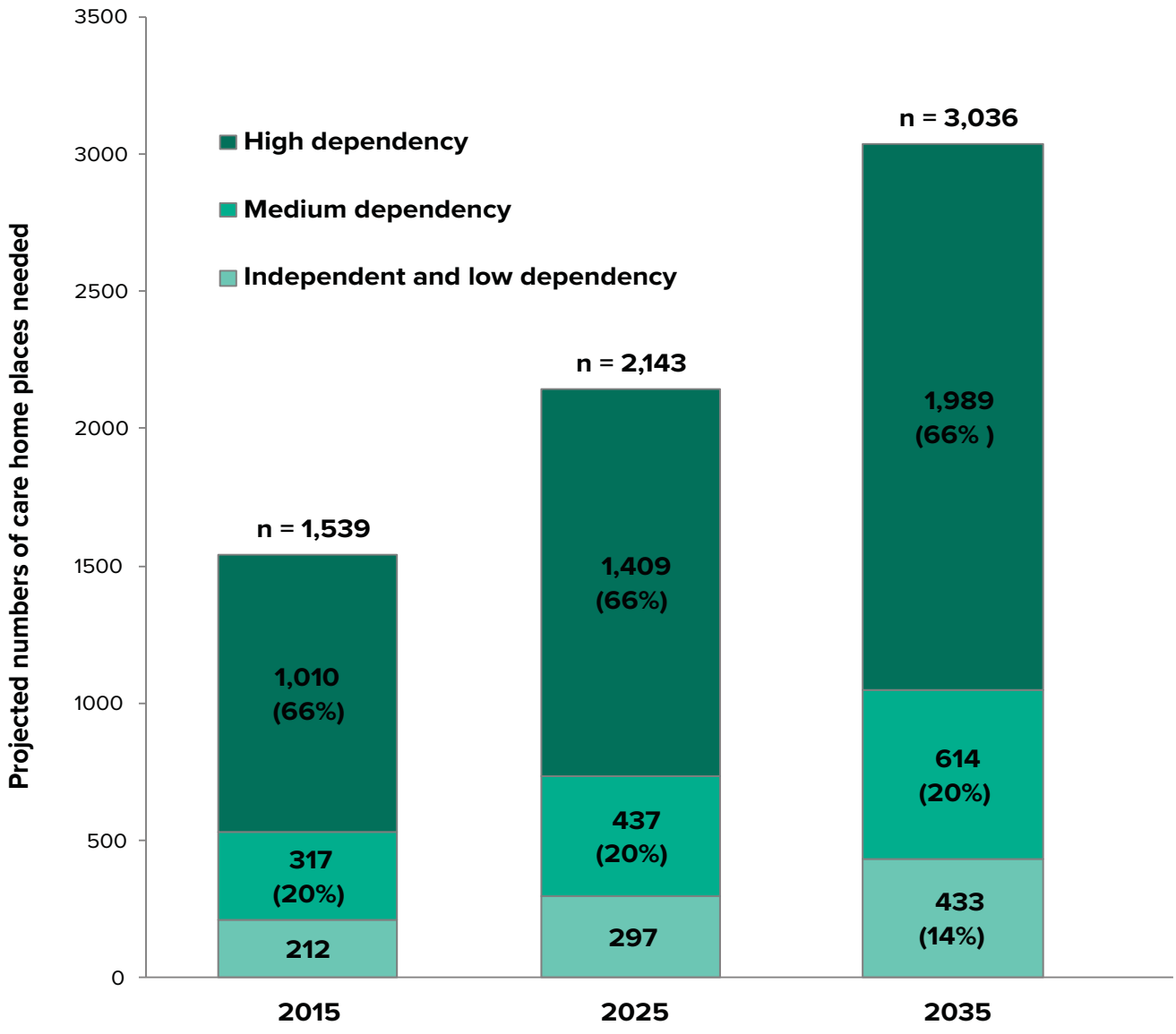


Figure 1.10 - Highland council area: projected numbers of care home places needed for older people (Scenario 1)
Source: MacPherson, F and Vaughan S 2017[23]

A separate piece of work using different methodology also reported an almost doubling (94% increase) in the number of care home places that would be needed by the year 2037 unless we move to new and more effective models of care delivery[24].

Community nursing

A key group in the provision of community care are community nurses who provide a diverse range of services from promoting health, enabling self management of long terms and end of life support. As of September 2016, there were 286.6 whole time equivalent (WTE) community nurses in NHS Highland, comprising 9.4% of all NHS Highland nursing and midwifery staff[25]. It can be argued that there should be an aspiration, over the next 15 years, for the proportion of nurses in the community to rise to around 40% of the total nursing workforce, although further modelling should be undertaken to substantiate that estimate and to consider an appropriate skill mix.

The majority of patients seen by community nurses within NHS Highland are aged 65 years and over and the section of the population is expected to increase substantially over the next 10 years[26]. The community nursing workforce is ageing with more than half of district nurses in NHS Highland

aged 50 years or older. The per capita cost of community nursing provision in those aged 75 and older is 12 times greater than that of those aged under 75 years.

NHS Highland is experimenting with new models of neighbourhood nursing, based on a Buurtzorg model in the Netherlands, that will be key to meeting the needs of an ageing population. A recent local review of district nursing services has reflected on the importance of skill mix within district nursing and the need to increase the proportion of staff time that is utilised for face to face to interventions, as opposed to other activities. There is a case for work to improve equity of access to nursing care across NHS Highland, particularly out of hours, which could have a significant impact on hospital admissions.

The cost of social care in Highland

In 2013-2014, Highland Council and Argyll and Bute Council spent £72.5 million and £34.4 million respectively on older people's social care[6]. There is some evidence that the figure for Highland Council is lower than in other parts of Scotland. The figure for north Highland is supplemented by additional funding by NHS Highland to the tune of £34m since integration.

There is significant variation across Scotland in spend per capita on services for older people, as shown in Figure 1.11. Some of the variation may be related to the fact that in Argyll and Bute and in north Highland the cost per hour of providing care at home is high[27]. This reflects some of the challenges in providing care in remote and rural settings. However Figure 1.11 shows that both Highland and Argyll and Bute actually have lower expenditure per capita on older people's social care than the Scottish average when the full range of social care services provided is considered.

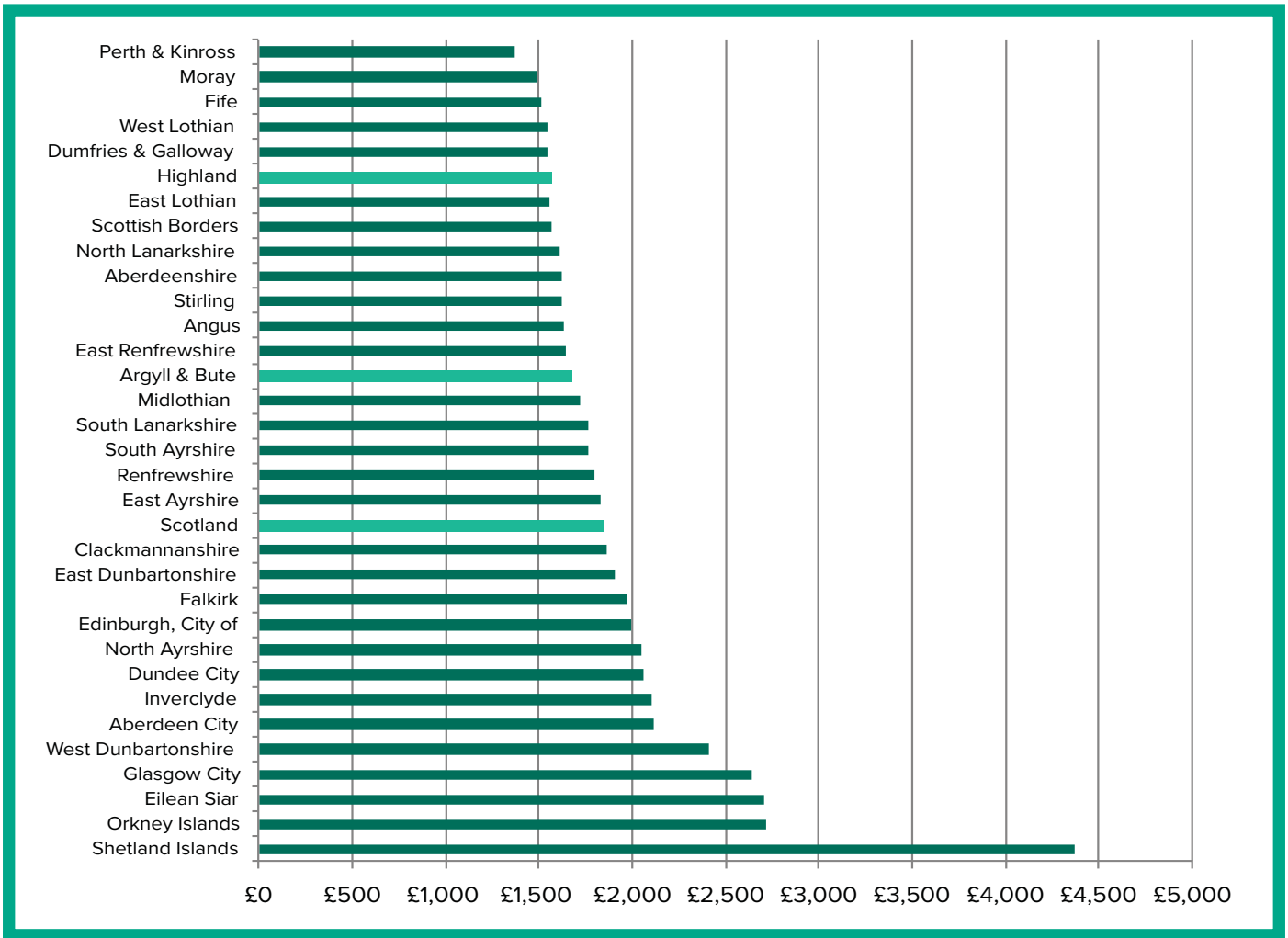


Figure 1.11 - Expenditure Per Capita on Social Services for Older People (aged 65+) 2013-14
Source: Information Services Division. Gross Expenditure in Older People in NHS Highland, Tab 7A[6]

What does it mean for our older population?

A 1962 report was the first on the conditions of residential homes. It stated that they "did not create a substitute community or a network of social relationships which could sustain a sense of individual purpose or pride"[12]. More than fifty years on this remains true and loneliness remains a significant problem for people living in nursing homes with one study finding more than half of nursing home residents reported feeling lonely, the effects of which were discussed in last year's report[28]. A Scandinavian study found loneliness to be 10% higher amongst older people living in an institution compared to those living in their own homes[29]. There is clearly a need to find alternative solutions.

NHS Highland is taking part in work on intergenerational communities and experiments to combine nursery education with care homes. Early evidence suggests that this is beneficial to both groups and this is an intervention that merits wider implementation.

There can also be physical effects from living in a care home or other low activity environment. Amongst healthy adults as little as one week of bed rest can cause muscle atrophy and this is accelerated amongst older people[30]. Muscle atrophy and weakness (sarcopenia) has been found to be present in 80% of nursing home residents. Muscle atrophy is associated with slower walking speed and greater risk of falls[31]. Imaginative programmes to increase physical activity are being pursued across NHS Highland to address this issue, but is remains a major challenge that needs to be addressed, and which is very much in line with the aims of Realistic Medicine or Prudent Healthcare.

In addition to the physical and mental effects, admission to a nursing home is in itself associated with increased mortality. A study in Nottingham found that survival at one year was 76% in residential homes compared to 66% in nursing homes. Other factors associated with decreased life expectancy were: male gender, admission to a dual registered home, placement from hospital and increased age[32]. Some of this effect may be due to selection bias, but it does suggest that there are problems with current models of residential and nursing home care.

What does it mean for our society?

Current models of care risk creating levels of dependency that are unsustainable in future generations as both costs and demand continue to rise. Family support and informal caring is still the single biggest contributor to caring for the older population but has decreased over the last few generations. In many non-western cultures there is a higher level of respect for the elderly, and a higher status for those who care for older family members.

Historic patterns of care in Scotland relied heavily on unpaid female members of the family to provide care[33]. Wider changes in society have reduced intergenerational living, altered rates of separation and divorce, increased the proportion of women in paid employment and led to family members living further apart. All of these have contributed to challenges in delivering care. There is a need for imaginative thinking to generate new ideas that can encourage support by families for older members of their extended family.

Realistic Medicine Case Study

Innovative use of Chaplain Services to prevent staff burnout

The Chaplaincy service is working with the Occupational Health service to prevent burnout in staff using an innovative group discussion tool called "values based reflective practice". There are 12 staff in NHS Highland who are trained or undergoing accredited training in the use of this approach. The model uses four key questions shown below:

Question	Quality Strategy	Values-based Practice
1. What does this encounter say about my practice?	Safe? Effective?	How was power used?
2. What does this encounter tell me about me as a person?	Person–centred? (enhance self awareness)	Do I inhabit the role with integrity?
3. How does this encounter sit with/raise questions about my beliefs, values, world view?	Person centred? (vocational motivation)	Dignity? Compassion? Whole person care?
4. Whose need was met in this encounter?	Person-centred?	What was valued, over valued, under valued?

Source: Paterson and Kelly (2013), Values-based Reflective Practice: A Method Developed in Scotland for Spiritual Care Practitioners in Practical Theology. Available at: http://bit.ly/2iV8Fak

Realistic Medicine Case Study

Integrated Services in Highland

NHS Highland has been on a journey of transformational change in health and social care for the past 5 years. An Integrated Lead agency model has provided a platform to deliver realistic care.

Redesign work in Highland has been positive, including work across hospitals and communities, delivering continuity of care and improvements in patient flow across health and social care. NHS Highland's Highland Quality Approach is working to apply a philosophy of service improvement, creating standard work to eliminate waste and minimise unnecessary variation in practice provided through integrated multidisciplinary teams delivering joined up services. This supports the philosophy of Realistic Medicine by delivering services which are person centred. Integration has included development of a single point of contact in each local area for initial management of referrals into integrated teams for triage and onward assessment and provision of care delivered by the appropriate professionals.

Work to support long term condition management has improved system flow with a more streamlined approach to care planning, supported self-management and carer support, keeping a person centred approach but with a strong focus on maximising independence. Finally, utilising available technology platforms has helped professionals work together more efficiently, helping to streamline services, improve access and reduce the waste of inefficient systems.

Key points

- Around 2.2% of the population utilise 50% of health and social care resources.
- Provision of both health and social care is expensive and costs are increasing.
- There are multiple drivers for escalating health and social care costs including an ageing population and increasing prevalence of long term conditions and multi-morbidity.
- Both care home residents and home care recipients have increasingly complex needs.
- The largest proportion of social care funds for older people are spent on care homes although most people would prefer to be cared for at home.
- The lack of appropriate housing for those with frailty, such as extra care housing, is adversely affecting discharge from hospital.
- New housing solutions for the frail elderly could reduce admission to hospital and help sustain flow though acute care facilities.

Chapter Two - Realistic care

So how can we respond to the challenges that we face? In 2014, the Scottish Chief Medical Officer (CMO), Dr Catherine Calderwood, published her first CMO report entitled Realistic Medicine, which focused on how we deliver value to patients by providing personalised, person centred healthcare and healthcare systems which reduce harm, waste and variation[1].

Figure 2.1 - CMO Report 2014-15

The Realistic Medicine report asked six questions of the healthcare community (Figure 2.1). The questions remind us of the need to collaborate with patients[2], to make informed and shared healthcare decisions[3], to recognize when additional investigation and treatment has the potential to harm, and to think innovatively about how best to provide health and social care.

The following year's CMO report 'Realising Realistic Medicine' continued this theme. It recognised that many of the elements of Realistic Medicine and care are already in place but have previously lacked a shared language. A consistent nomenclature has allowed for more effective communication and recognition of aligned work across Scotland.

One focus within this second report was on creating the right conditions based on effective communication, collaboration and culture that allow Realistic Medicine to thrive. There was also more explicit recognition of the role of public health, social work, dental services and the third sector in providing realistic healthcare.

Realistic Medicine is being taken forward across Scotland in many ways[4] including the formation of a Realistic Medicine team in Scottish Government, who are developing a range of initiatives at national level. Aligned work is also happening in health boards, research communities and voluntary organisations across Scotland - some examples are shown in Figure 2.2[5,6,7,8,9].

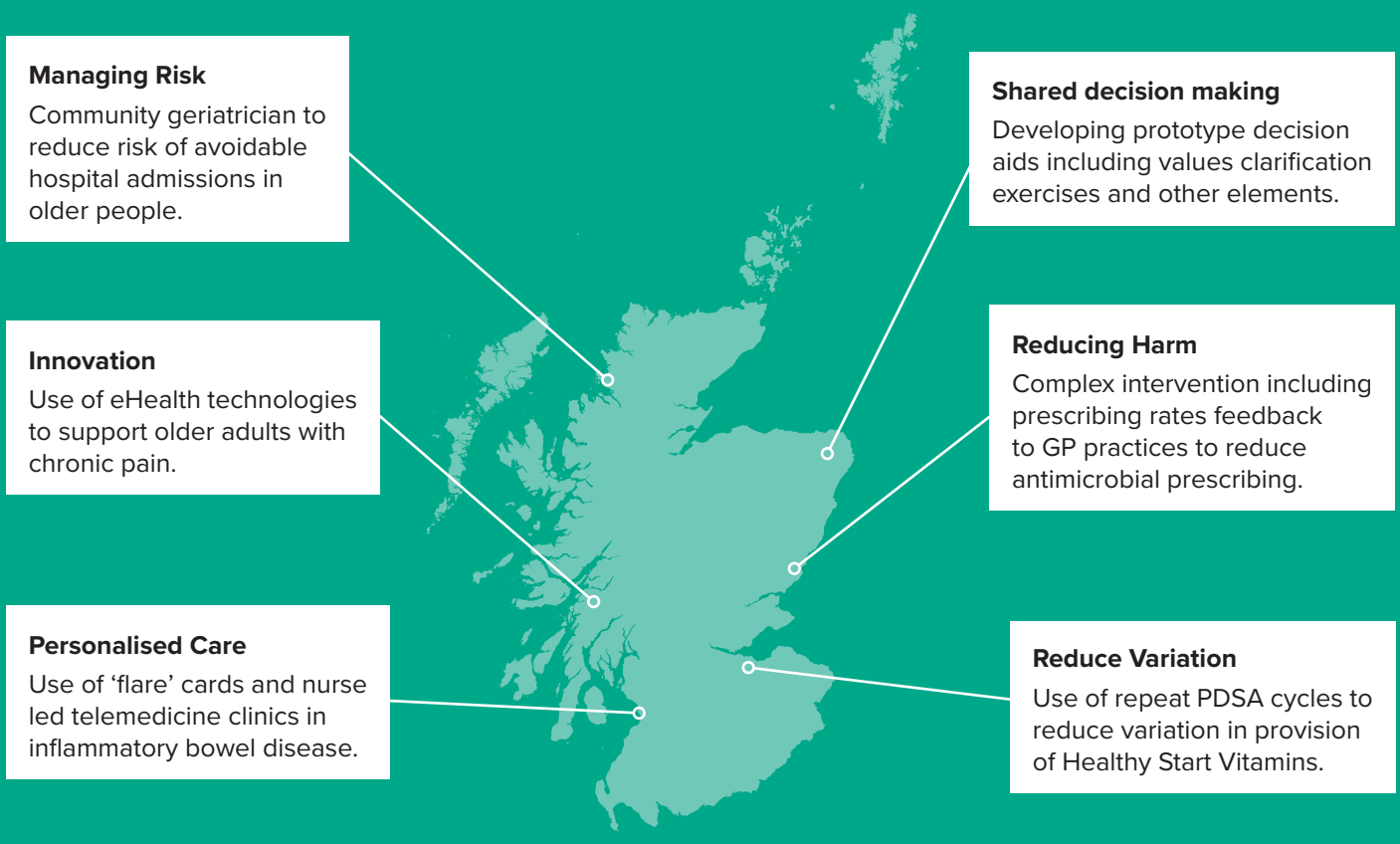


Figure 2.2 - Examples of Realistic Medicine across Scotland

When Realistic Medicine concepts are applied in combination, there is the potential to amplify their effectiveness. For example, the use of patient held 'flare' cards in Clyde Valley Hospital has helped patients with Inflammatory Bowel Disease and their GPs to respond effectively to flare ups of disease. This intervention has offered more personalised care, assisted in shared decision-making, improved risk management, and minimised harm associated with unnecessary hospital visits.

Leadership of Realistic Medicine in NHS Highland

In NHS Highland, Dr Rod Harvey, the Medical Director, has led the development of Realistic Medicine in conjunction with the Area Clinical Forum, chaired by Dr Andrew Evennett. The Area Clinical Forum is a formal sub-committee of the NHS Highland Board, bringing together a number of professional groups. Each of the professions represented at the Clinical Forum have collated examples of Realistic Medicine, which are presented as case studies throughout this report.

There is a very natural link between Realistic Medicine and the Highland Quality Approach. Figure 2.3 shows a driver diagram developed by the North and West Operational Unit, NHS Highland, which demonstrates these links.

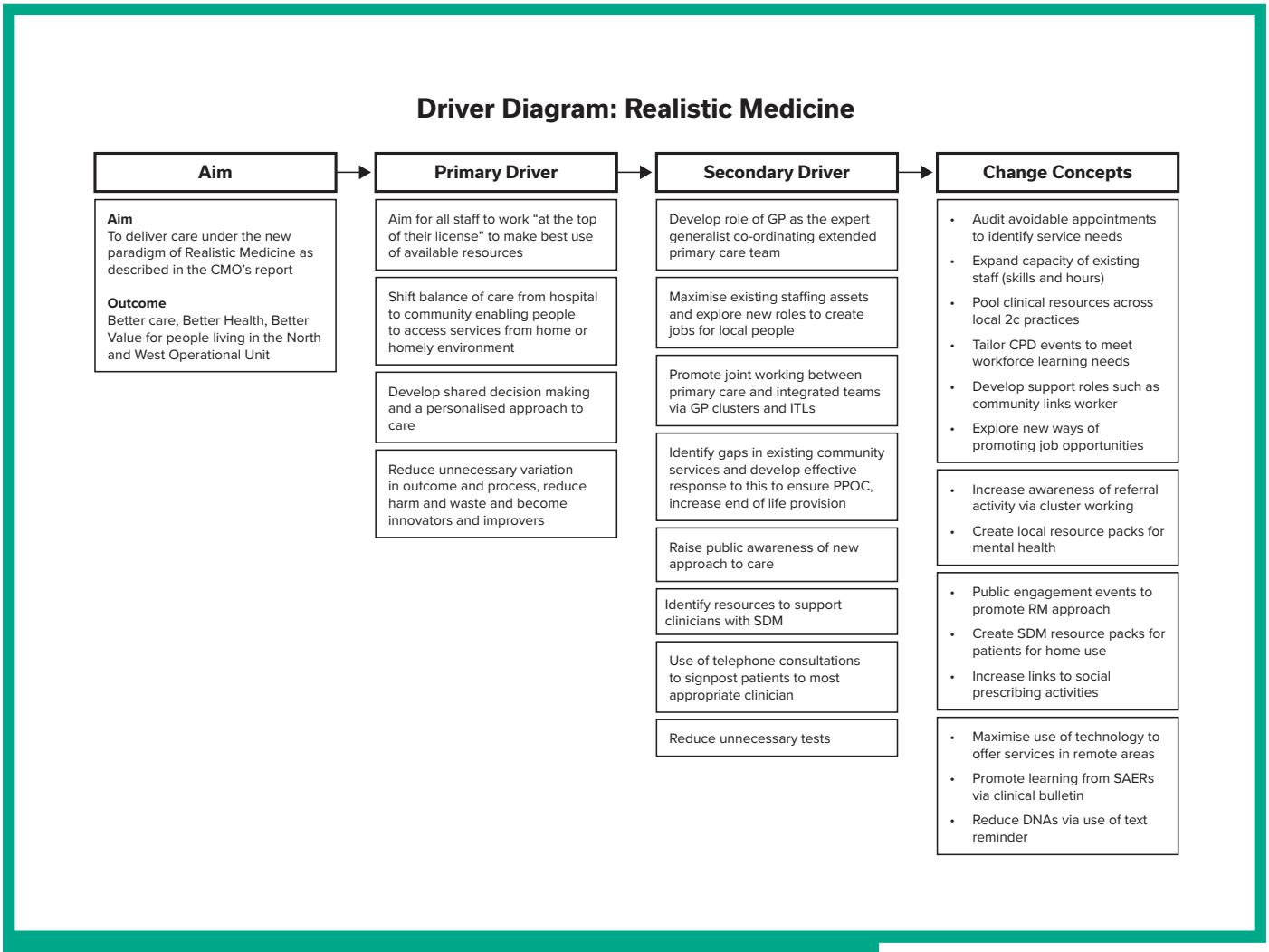


Figure 2.3 - North and West Operational Unit Drive Diagram: Realistic Medicine

The international context

The pursuit of Realistic Medicine in Scotland is part of a wider global movement recognising common problems with the delivery of healthcare in high income economies. **The International Consortium for Health Outcomes Measurement (ICHOM)**[10] is consolidating some of this thinking by developing standard measuring of the quality of care. ICHOM state that their mission is to "unlock the potential of value-based health care by defining global Standard Sets of outcome measures" and thereby reduce health care costs, support informed decision-making, and improve health care quality.

There are opportunities for us in NHS Highland to learn from best practice elsewhere. A number of international examples of national and regional initiatives that are similar to Realistic Medicine are therefore provided below.

Wales has developed a concept that is similar to Realistic Medicine called **Prudent Healthcare**[11]. The initiative was developed to respond to rapidly rising health and social care costs and increasing societal expectations, whilst maintaining high quality healthcare. The three primary objectives of Prudent Healthcare are to:

- Do no harm
- Carry out the minimum appropriate intervention
- Promote equity between professionals and patients

In New Zealand, the **Canterbury District Health Board**[12] has pursued a holistic approach (one system, one budget) to health and social care delivery. As can be seen from the pictogram below, the patient is very much at the centre of the model, with the hospital on the periphery of the health and social care system, and not, as traditionally viewed, at its heart[13].

Figure 2.4 - Pictogram of Canterbury's health care system[14]

NB: Visualisation originally created by the Redbridge Primary Care Trust and developed by the Canterbury Health System, New Zealand

The **Nuka System of Care of the Southcentral Foundation in Alaska, USA** [15,16] is a system-wide, community-led model with "customer-ownership" of care services, where the customer-owner takes ownership of his or her own care. As in the Canterbury model of service delivery in New Zealand, the emphasis is very much on a trust relationship between practitioners and patients, and on engagement with the community in service planning, design and delivery.

The **Buurtzorg, district nurse model in the Netherlands**[17] is another example of a community-focused model where the district nurse provides care in the community for a defined population and where the emphasis is on providing patient-centred care based on a high trust relationship between the practitioner and the service-user.

"The organisation has shown that a single, unhurried visit by a highly-trained district nurse is more effective than several visits by specialised care workers, each performing their allotted tasks."

Buurtzorg model[13]

The importance of patient-centred care is further illustrated in the **Esther Network**[18] which is part of the healthcare system in Jönköping, Sweden. This network approach evaluates services from the patient's perspective, to understand what matters most to them. The result appears to be increased patient and staff satisfaction, significantly reduced waiting times, more effective treatment, and reduced costs.

In Finland, as part of the **ICARE4EU project**[19] there has also been an emphasis on the development of person-specific care plans, jointly developed between the patient and the nurse, which is then agreed by the physician in charge. The **Danish Clinic Silkeborg programme** focuses on one-day/one-stop consultations undertaken by a multidisciplinary team within a clinic, which is reported to have resulted in time saved by the patient and improved collaboration between GPs and hospital specialists.

Through a public/private sector finance initiative, the **Alzira model of care in Spain**[20] has created incentives that are reported as having increased patient satisfaction, reduced readmission rates and saved the Valencia Health Agency 14 million Euros.

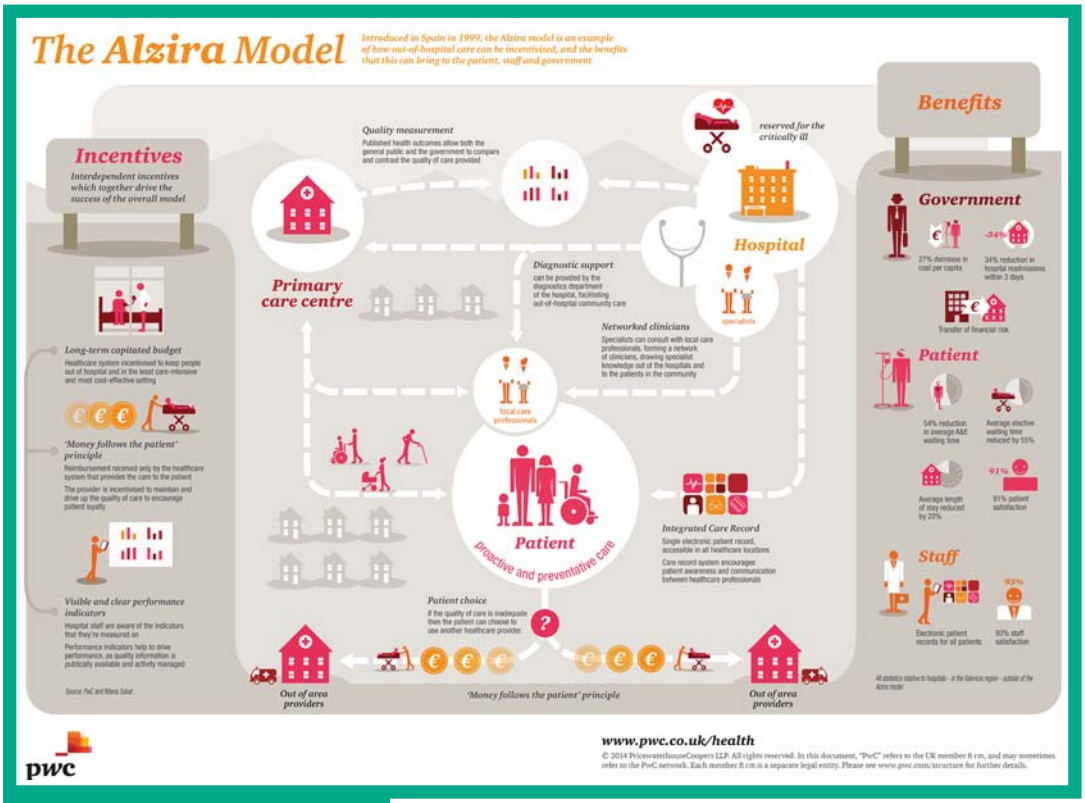


Figure 2.5 - The Alzira Model[21]

Choosing Wisely[22] is an initiative led by the American Bureau of Internal Medicine Foundation, which encourages clinicians and patients to take part in conversations about the overuse of unnecessary tests and procedures.

"It is estimated that as much as 30 per cent of US health care delivered was unnecessary duplication of earlier treatment or unnecessary itself"

Choosing Wisely Campaign[17]

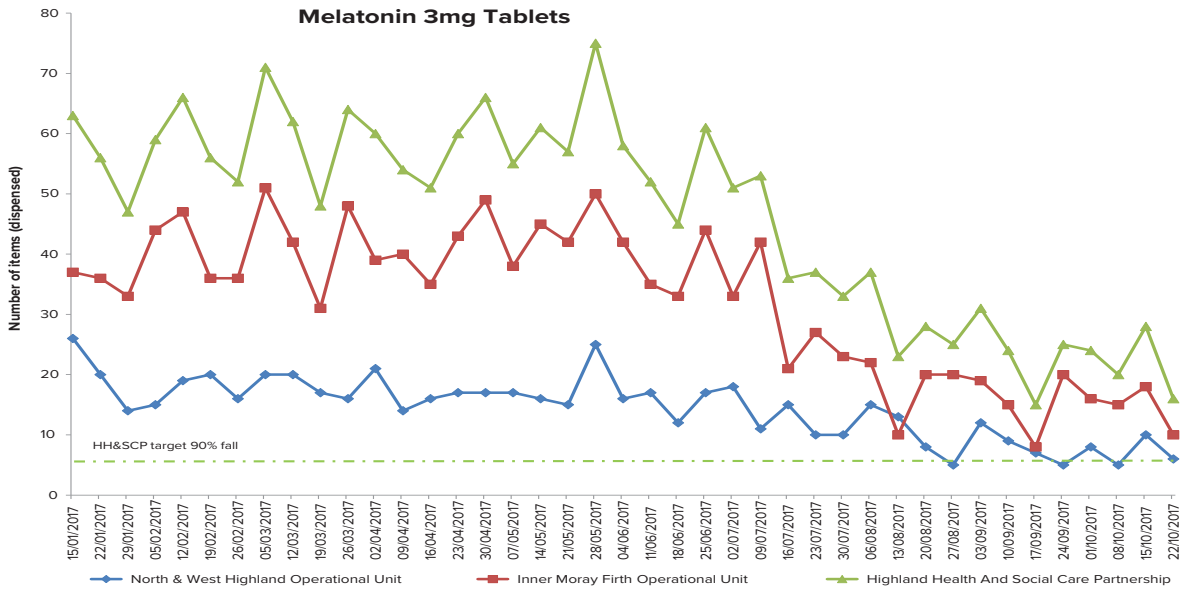
The Choosing Wisely Initiative has been influential in several countries including the United Kingdom. Related initiatives established in different part of Europe include Smarter Medicine in Switzerland and Slow Medicine in Italy[3].

Realistic Medicine Case Study

Reducing variation in melatonin prescription and harm through unnecessary medication provision

A recent review of prescribing in NHS Highland noted that the rate of melatonin prescribing to treat delayed sleep onset in children and adolescents was rising sharply. Further investigation showed that the same pattern was seen in other health boards and across the UK. NHS Highland approached the issue in two ways:

1. Improving efficiency by changing prescribing policy from tablets to capsules which releases resource for other care
2. Asking specialists recommending melatonin to review patients and consider using non-pharmacological methods to manage delayed sleep onset. For example eg minimising TV or computer use in the hours before bedtime.



Source: Ian Rudd, Director of Pharmacy, NHS Highland

Realistic Medicine Case Study

Reducing Polypharmacy and resultant harm and medication variation

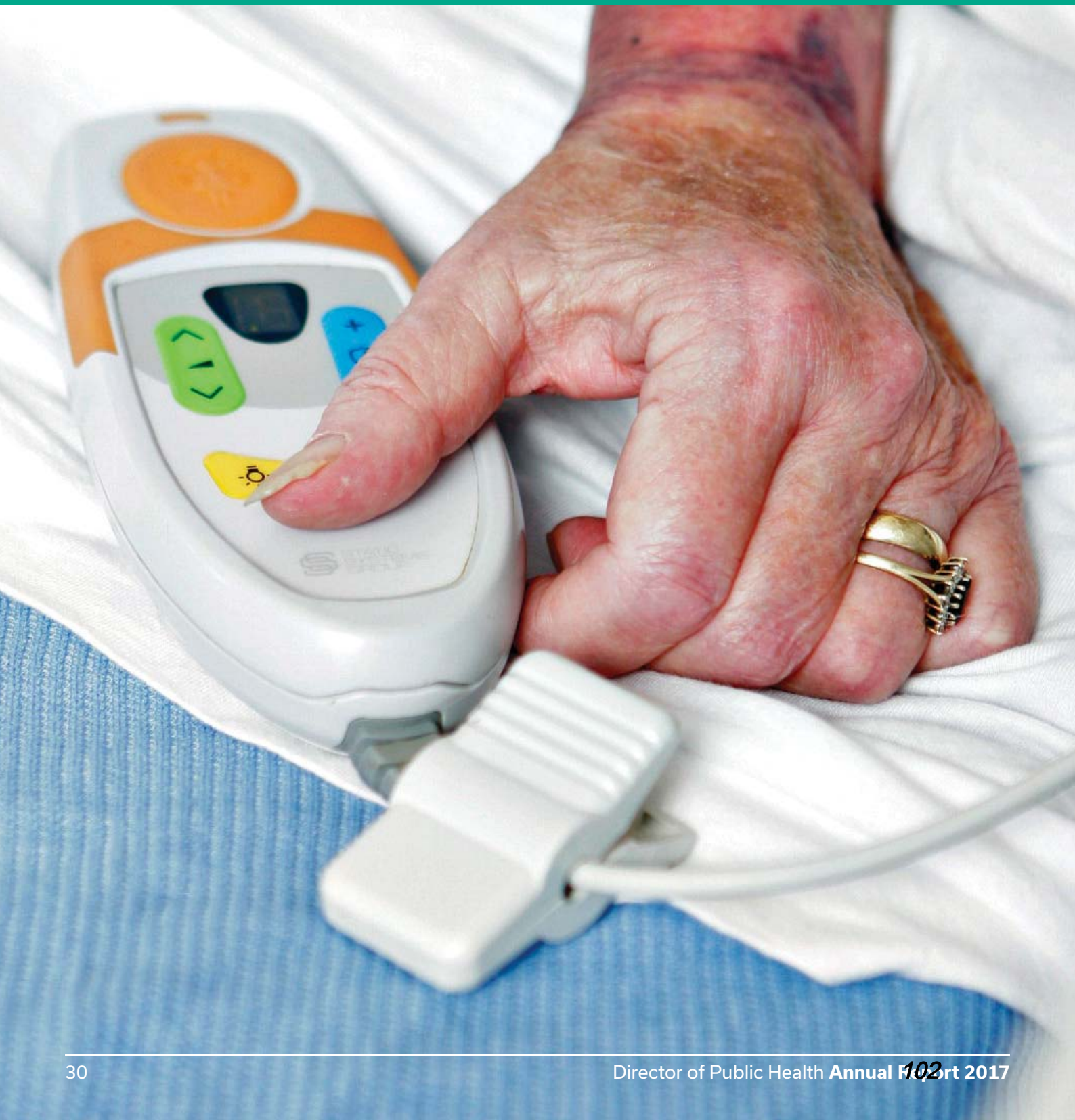
Polypharmacy relates to patients who are taking many medications. Addressing polypharmacy is a key role for Specialist Clinical Pharmacists linked to primary care and Care of the Elderly clinics.

A patient had a fall and a pharmacist was asked to visit him at home to provide a medication review. The pharmacist discovered that the patient had been started on heart failure medication pending further investigation. These investigations turned out to be negative but his medication had not been stopped 11 years later, increasing his risk of falls. The unnecessary heart failure medicines were reduced and then stopped. Pharmacists have a role is such contexts in reducing waste and variation in relation to medication.

Key points

- Realistic Medicine is about providing value to patients through personalised healthcare, reducing harm, waste, and variation and improving risk management.
- Significant progress has been made in implementing Realistic Medicine in NHS Highland, but there is more that we can do.
- Internationally, there are many examples of models, which are similar to Realistic Medicine, which could provide ideas that we can adopt or adapt.
- Common elements of international care models that have similarity to Realistic Medicine include:
  - An emphasis on one whole system (adopting a holistic approach)
  - High quality relationships between patient and professional (shared decision-making)
  - Putting patient experience at the centre of the health and social care system (patient-centred care)
  - A recognition of the importance of patient and community engagement in service planning, design and delivery
- However, there remains a lack of rigorous research and a lack of robust programme evaluations for overarching paradigms such as Realistic Medicine.
- A major challenge in undertaking research into paradigms such as Realistic Medicine is that the specific culture, context and the clinical circumstances within which a particular health care model is delivered, often determine its success or failure.
- Given the importance of contextual factors, transferring models of care from one country to another requires accompanying local evaluation using principles such as Plan, Do, Study, Act.

Chapter Three -
End of life care: what it means in NHS Highland



In this chapter we describe the population within NHS Highland that is likely to have palliative or end of life care needs and the epidemiology around place of death.

Healthy and disabled years of life

The majority of us will experience some degree of frailty in old age and will require some hands on care. Unless as a society we take action to live healthier lives, as life expectancy increases we can expect a greater proportion of our lives to be affected by some degree of disability. In a global health study, life expectancy rose by 6.2 years between 1990 and 2013, but only 5.4 of those extra years were in good health[1]. The concept of healthy and disabled life has been used extensively by the World Health Organisation in their epidemiological reports. Although the concept can be criticised as being overly simplistic, it is a useful model for comparative purposes. The components of the model are shown in Figure 3.1.

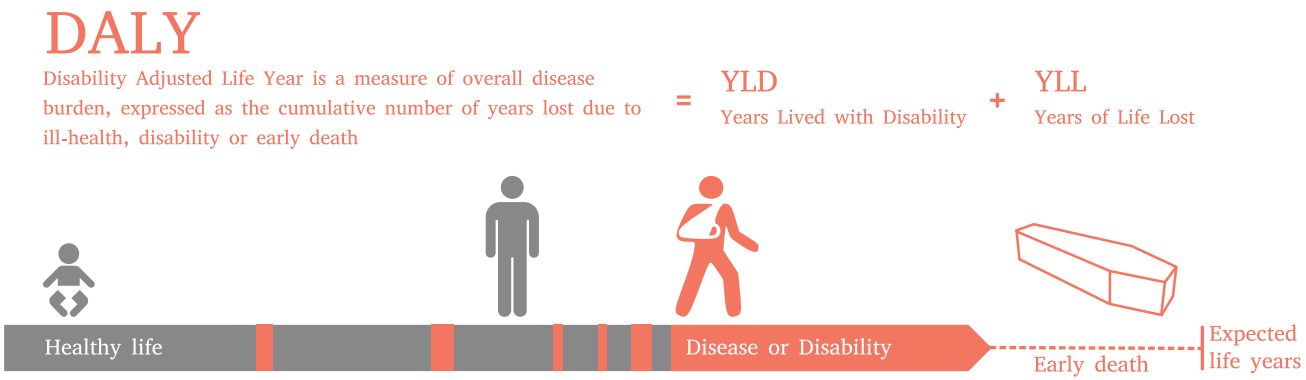


Figure 3.1 - Healthy and disabled life years and potential years of life lost
Source: Wikipedia[2]

Health system planning from a prudent or realistic approach requires an understanding of the changing patterns of both morbidity and mortality and DALYS are one method of capturing this. Figure 3.2 provides a useful graphical summary of the leading causes of death in Scotland, although not all of these deaths would require end of life care.

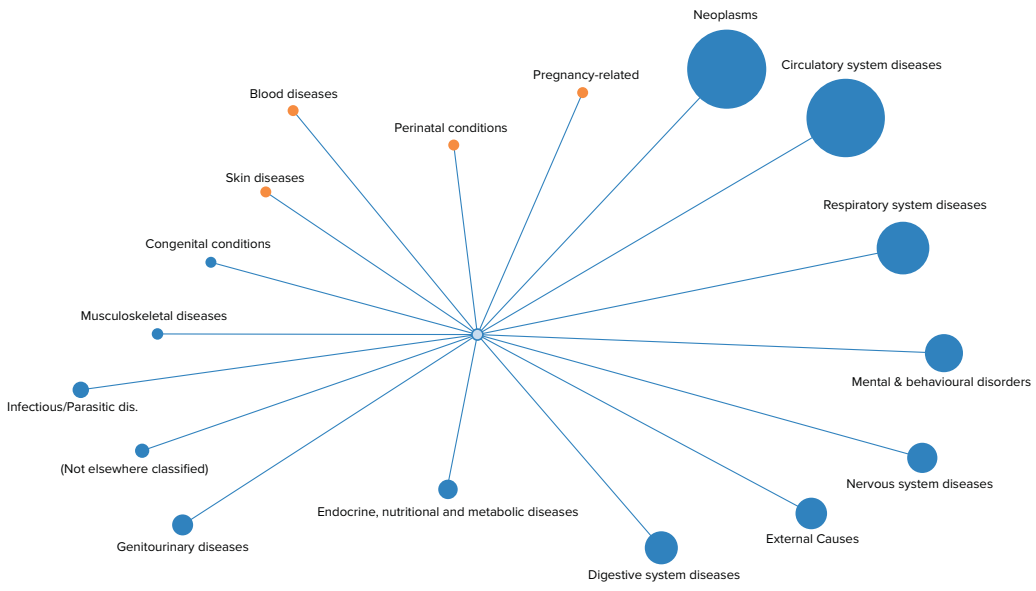
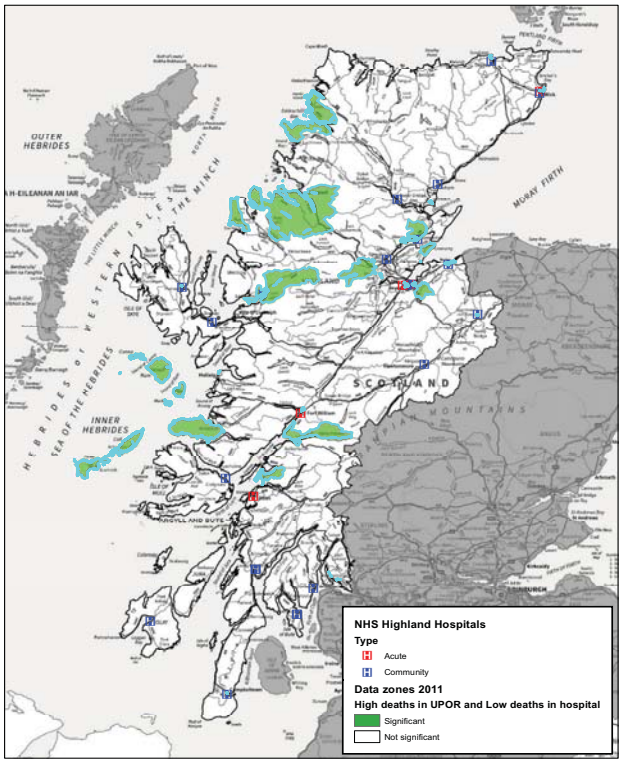


Figure 3.2 - Deaths by Cause in Scotland in 2016
Source: National Records of Scotland[3]

Place of death

Information on different aspects of mortality is provided below. The data that is initially presented relates to 'all causes of death', whereas data provided later in this report relates specifically to those causes of death where it can be anticipated that they will require end of life care.

There is significant variation in the rates of death at home and in hospital across both Scotland and NHS Highland. Areas with high rates of death at home and areas with high rates of death in hospital in NHS Highland are presented in Figure 3.3. Those areas highlighted in green have significantly higher rates of people dying at their usual place of residence (UPOR) and those areas in pink have significantly higher rates of people dying in hospital. The pattern is probably the result of a complex interplay between social and societal factors, GP practice catchments, district nursing services, care services, proximity to care home, nursing home, community hospitals and acute hospitals.



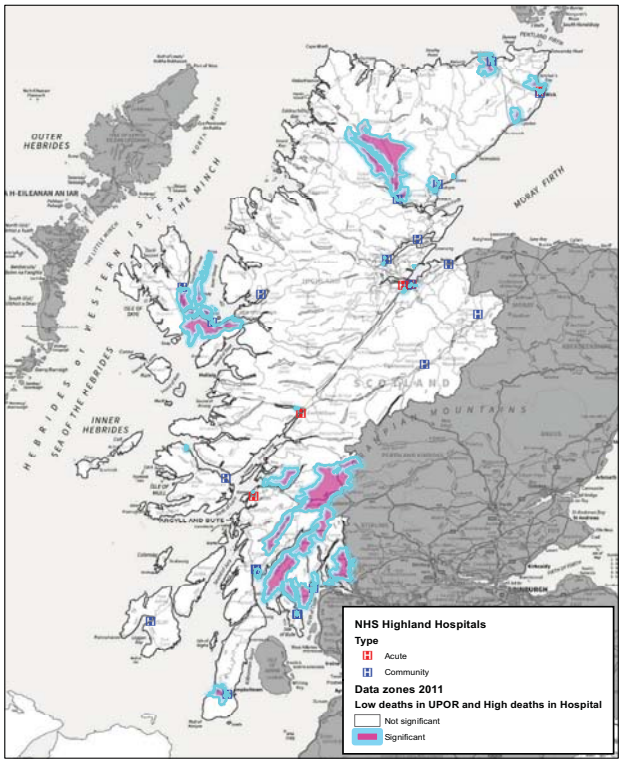


Figure 3.3 - Areas with high rates (>2 or >3 standard deviations from the mean) of all cause of death (i) at home, (ii) in hospital

The percentage of a person's last six months of life spent at home or in a community setting has been adopted in Scotland as a national quality outcome measure. This is to be monitored annually as part of the strategic framework for action on palliative and end of life care in Scotland. An increase in this measure is considered to reflect more people being offered their preferred place of death.

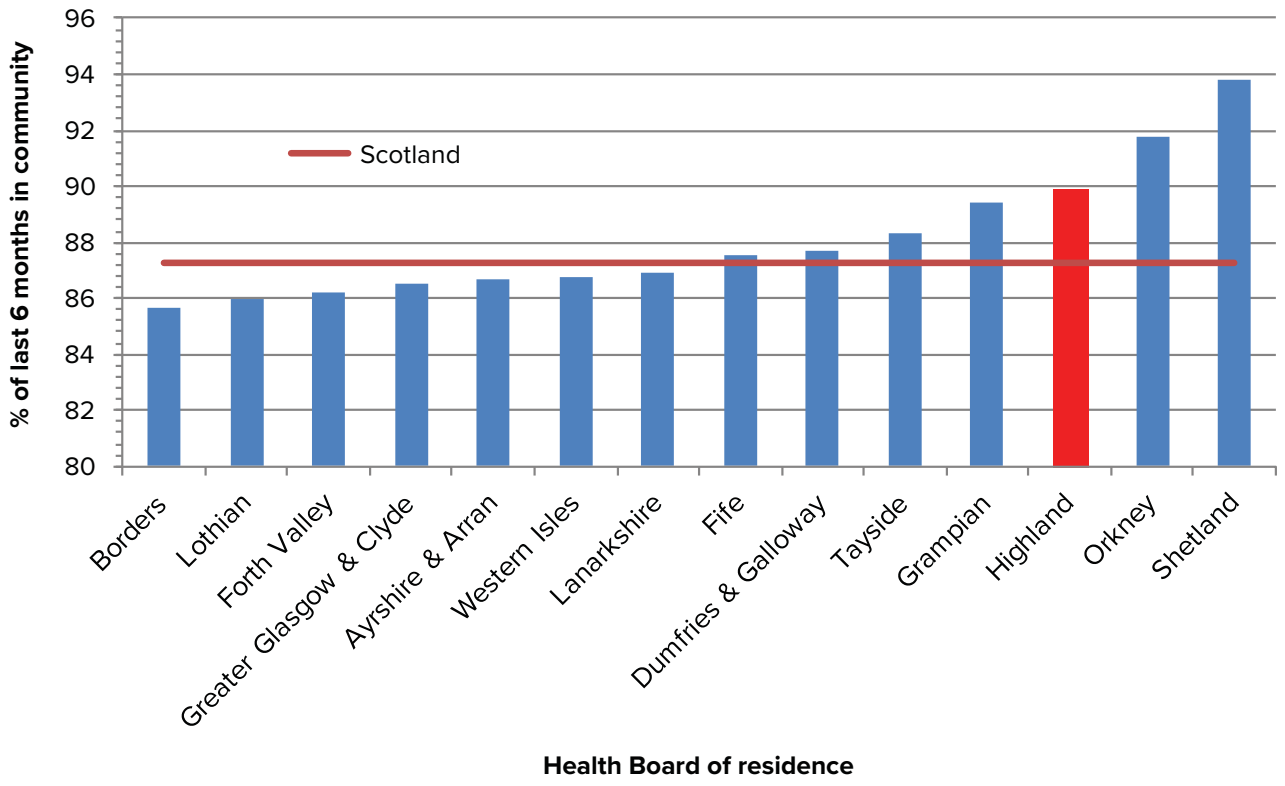


Figure 3.4 - Percentage of the last six months of life spent at home or in the community setting by Health Board of residence during 2016/17[1]
Source: SMR01, SMR04 and NRS Death Records: Health and Social Care Team, ISD: published 10/10/2017. Calculated as 100-% time in hospital in last six months of life

[1]2016/17 deaths are provisional and exclude those from external causes, such as accidents

During 2016/17, the chart represented in Figure 3.4 demonstrates that, for those who died in 2016/17, Highland has the 3rd highest percentage of time spent in the community rather than in a hospital during the last six months of a person's life.

Who needs end of life care?

The National Institute for Clinical Excellence (NICE)[4] has described end of life care as the care of those who are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with:

- Advanced, progressive, incurable conditions
- general frailty and coexisting conditions that mean they are expected to die within 12 months
- existing conditions if they are at risk of dying from a sudden acute crisis in their condition
- life threatening acute conditions caused by sudden catastrophic events.

The problem with defining a timeframe is that accurately estimating prognosis is innately difficult. In a review of 42 studies the accuracy of prognosis varied from 23% to 78% (see Figure 3.5)[5]. This means that when a doctor thinks that a person has a specified time to live, they are probably wrong at least half the time. There is evidence that nurses who have dealt with many terminal cases are more accurate in their prognosis when death is only a few hours away. The general inaccuracy of prognosis is a major challenge in the context of Realistic Medicine or Prudent Healthcare.

It is easy for a health professional to mistakenly think that further treatment for an individual is futile, beause the health professional thinks that the patient does not have many months or years to live. Many experienced health professional can recall incidents of patients where the general consensus was that the person only had days or weeks to live, but where the patient went on to live for another 10 or 20 years.

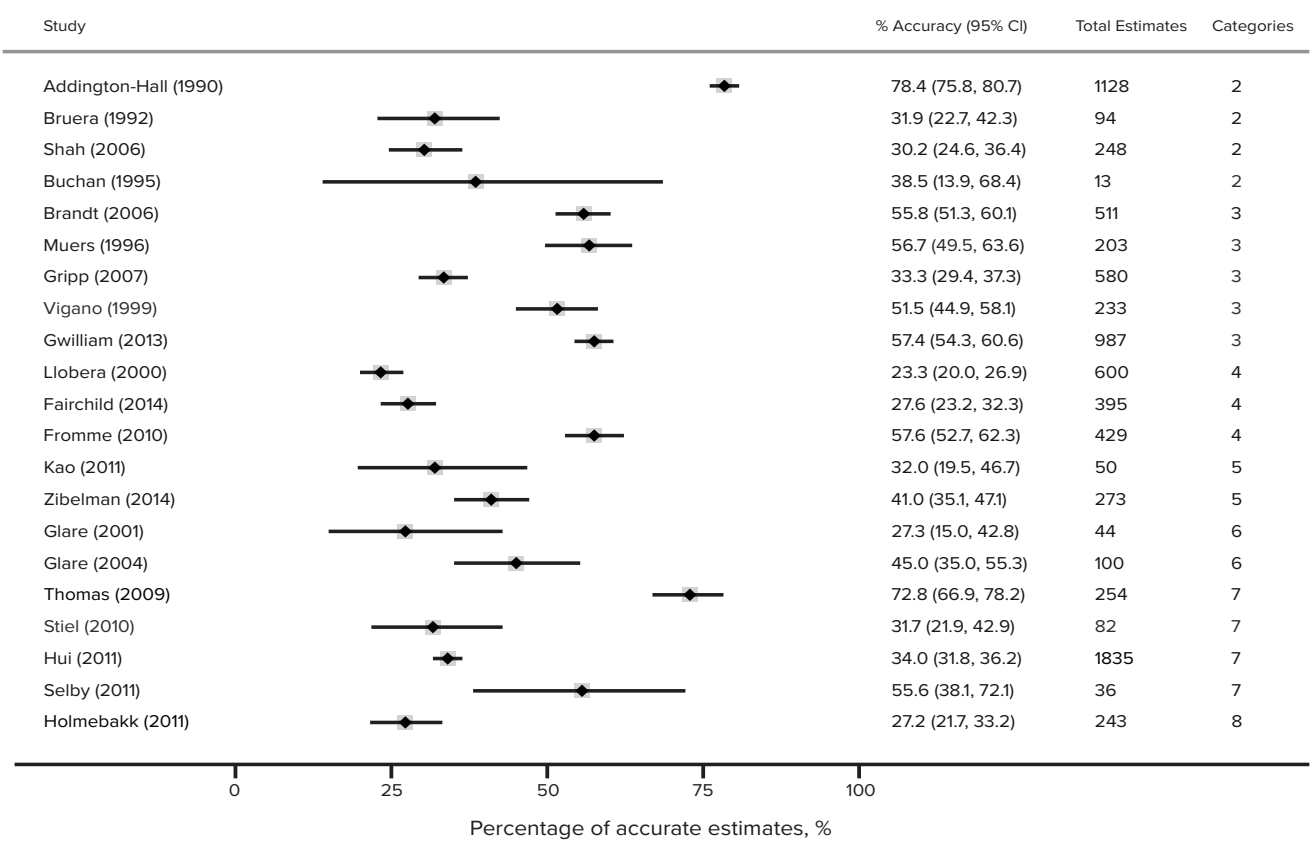


Figure 3.5 - Summary of studies demonstrating large variation in the accuracy of prognosis by clinical staff
Source: White N et al.[5]

Any palliative care provided within the last 12 months of life can be regarded as end of life care, although that is very much a retrospective definition, which is useful for epidemiological proposes but less useful when considering the needs of an individual. In addition to managing physical symptoms such as pain, breathlessness, nausea and increasing fatigue, it includes emotional, social and spiritual care.

It has been reported that the majority of people (56-74%) in their last year of life express home as their preferred place of death[6]. However, during the course of their illness, this preference may change. For example, it has been found that for those with terminal cancer, the percentage preferring home as their place of death decreased from 90% to 50% and the percentage preferring hospice, increased from 10% to 40%[6,7]. Changes in preference may be influenced by many factors including a desire not to be a burden to family members. The quality of the provision of care in the community, therefore, impacts on preference for place of death.

Population in NHS Highland likely to need palliative care

There is published research defining a set of diagnoses which are likely to require palliative care[8]. Analysis is presented in Figure 3.6, which applies these criteria to the population of NHS Highland. A report on this topic has been produced by the Public Health team[9]. Over the last three decades, an increasing number of deaths are observed from cancer and pre-senile/senile conditions and decreasing rates for circulatory conditions.

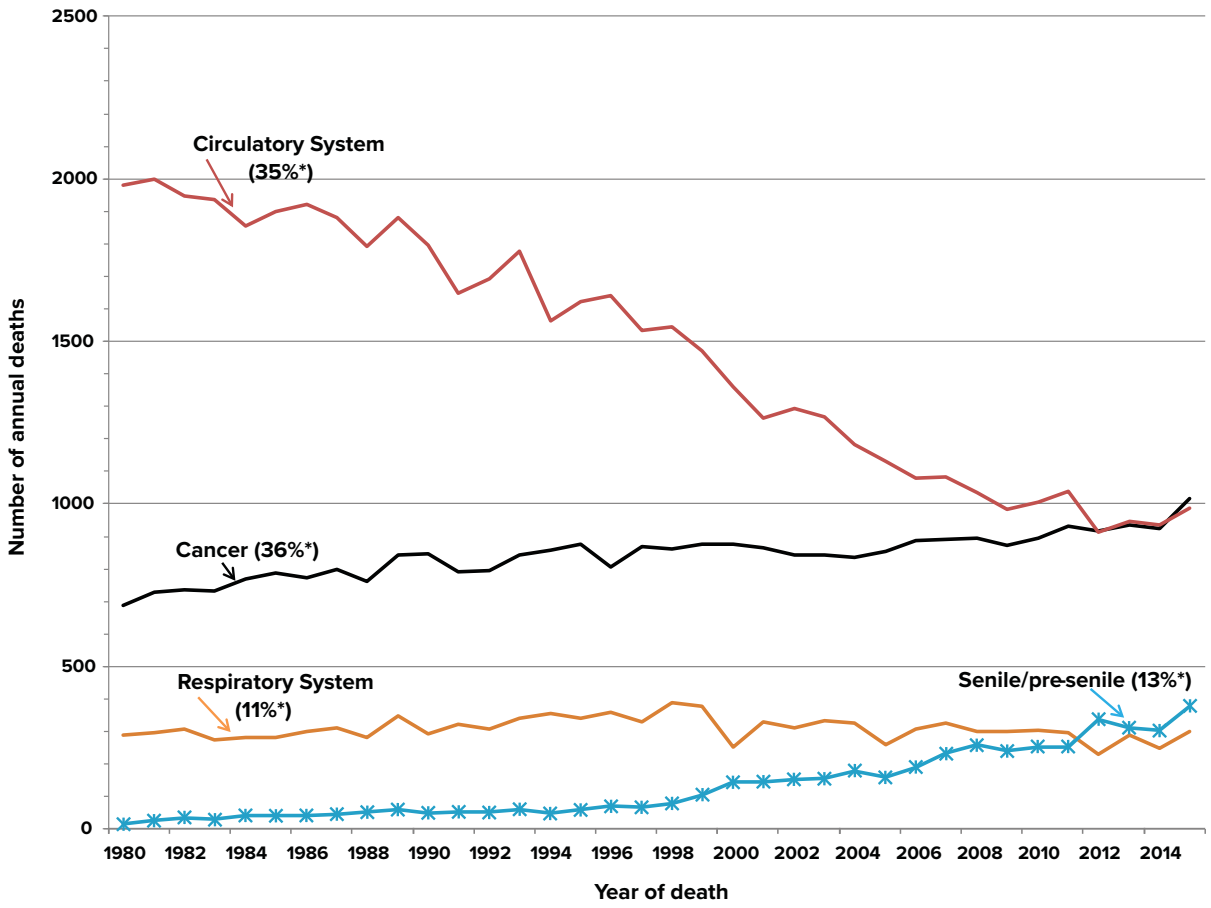


Figure 3.6 - Percent of death in NHS Highland residents from causes where end of life care would be expected, 1980 to 2015
Source: Analysis of Mortality data, (NRS) according to specific causes relevant to Palliative/End of Life care

[1] Proportions for other deaths were: Nervous system, 2%; Liver; 2%; Renal, <1%

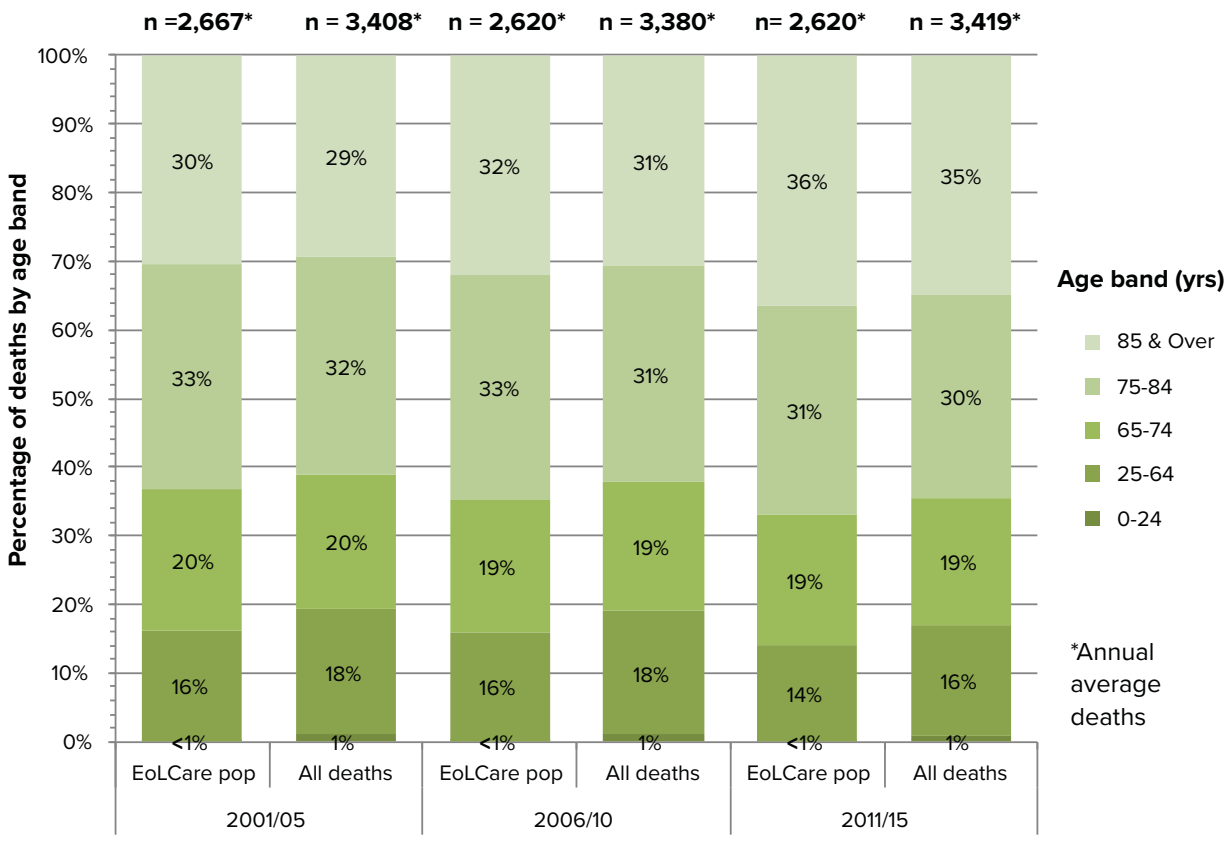


Figure 3.7 - Comparison of deaths by age group in five-year bands, 2001 to 2015, NHS Highland
Source: Analysis of mortality data (NRS)

The end of life care population, who had conditions that were likely to require palliative care, remained fairly constant over the last fifteen years making up around three quarters of all cause deaths in any given year (77%; 2,620/3,420). This percentage is within but at the higher end of the range previously estimated for 'high income' countries of 69% - 82%[8]. The proportion of patients requiring end of life care who are aged 85 years and older has increased over the last 15 years (Figure 3.7). Health and social care services will need to adjust the way that care is provided to take these changes into account over the next decade.

This trend is likely to continue and an ageing population will place increasing demands on palliative care services, suggesting that there needs to be closer collaboration between care of the elderly services and palliative care services.

Place of death for those with end of life care needs

The place of death also varied with time (Figure 3.8) where the percentage dying at home had decreased from 39% in 1980 to 29% in 2015. In contrast, the percentage dying in an acute hospital increased from 20% to 31% over the same period.

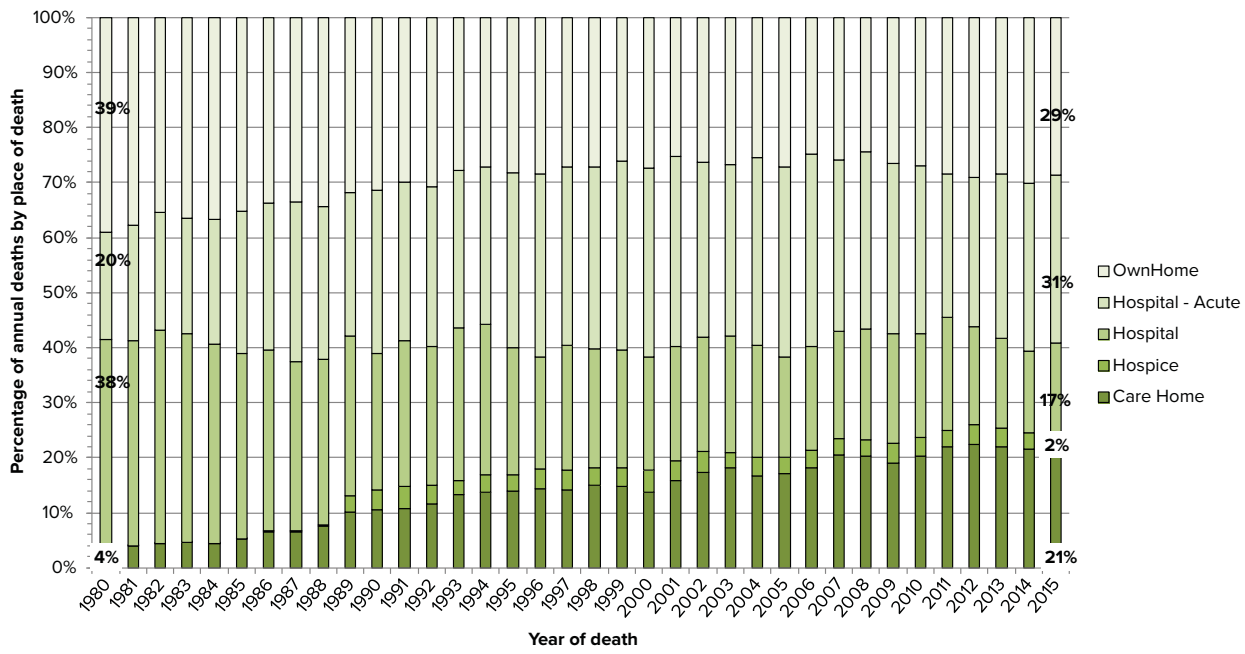


Figure 3.8 - Percent of annual deaths with potential end of life care needs by place of death, 1980 to 2015, NHS Highland
Source: Analysis of mortality data (NRS)

The place of death also varied with age group summed over the most recent five year period (Figure 3.9). The younger age group (0-24 years) was more likely to die in acute hospital, the 25 to 64 year age group was the most likely to die at home (45%).

The oldest age group was more likely to die in a homely setting rather than in a hospital. For the oldest group (85 years and over), 60% died at home or in a care home compared to 43-47% for those aged 65 -74 and 75-84 years. Highland Hospice has supported care homes and home care to provide end of life care and some examples of this work are considered in the following chapter. Approximately one third (31-35%) of the end of life care population aged 25 to 84 years died in an acute hospital. The proportion was lower (one quarter) in those aged 85 years and over.

The place of death also varied between men and women with men overall more likely to die in their own home[9]. This pertained to all conditions other than to renal or 'nervous & sensory' conditions, where women were more likely to die at home. The gender difference may reflect the longer life expectancy of women with the greater likelihood of them caring for husbands and partners. In turn these women are likely to be left living alone with no one to care for them to the same extent.

The place of death also varied according to the underlying causes of death (Figure 3.10). The highest percentage dying at home was with cancer (35%) and the lowest was with senile/pre-senile conditions (11%). Those dying from liver, renal or respiratory conditions were more likely to die in an acute hospital (43-59%). Less than 10% of those with cancer died in a hospice but among those dying from other causes, only those dying from kidney or nervous/sensory related conditions recorded deaths in a hospice.

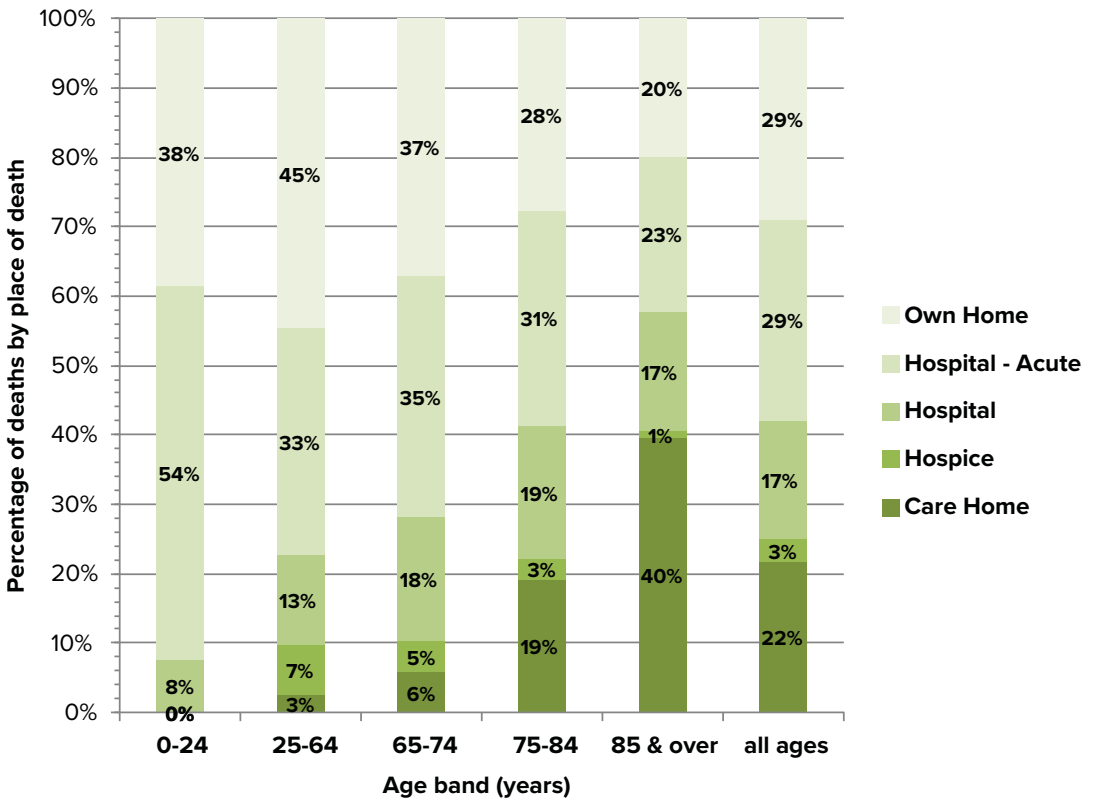


Figure 3.9 - Deaths from causes relevant to End of Life care by age group and place of death: NHS Highland[1]
Source: Analysis of mortality data (NRS)

[1]Summary data over the five years 2011 to 2015

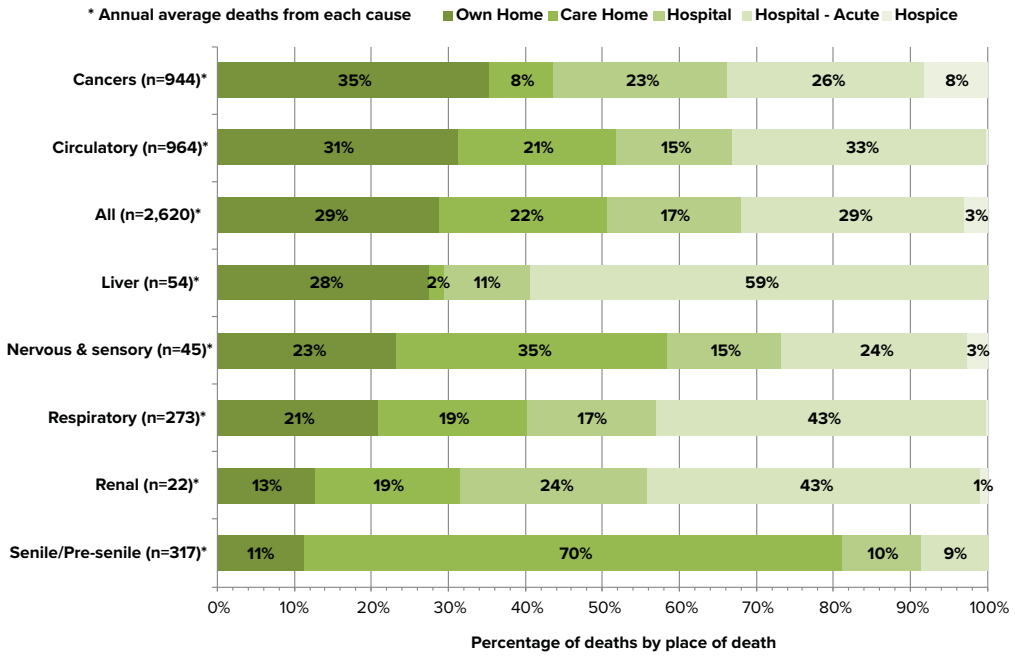


Figure 3.10 - Potential end of life care population by condition and place of death[1]
Source: Analysis of mortality data (NRS)

[1]Summary for five year period 2011 to 2015

Future need for end of life care in NHS Highland

Assuming that current rates of need for end of life care by gender and by age group apply over the next 10 to 20 years, future numbers can be predicted in NHS Highland. An almost two-fold increase in the number of deaths is expected. This is shown for the total end of life population and also by the different categories of conditions for which end of life care is needed, (Figure 3.11).

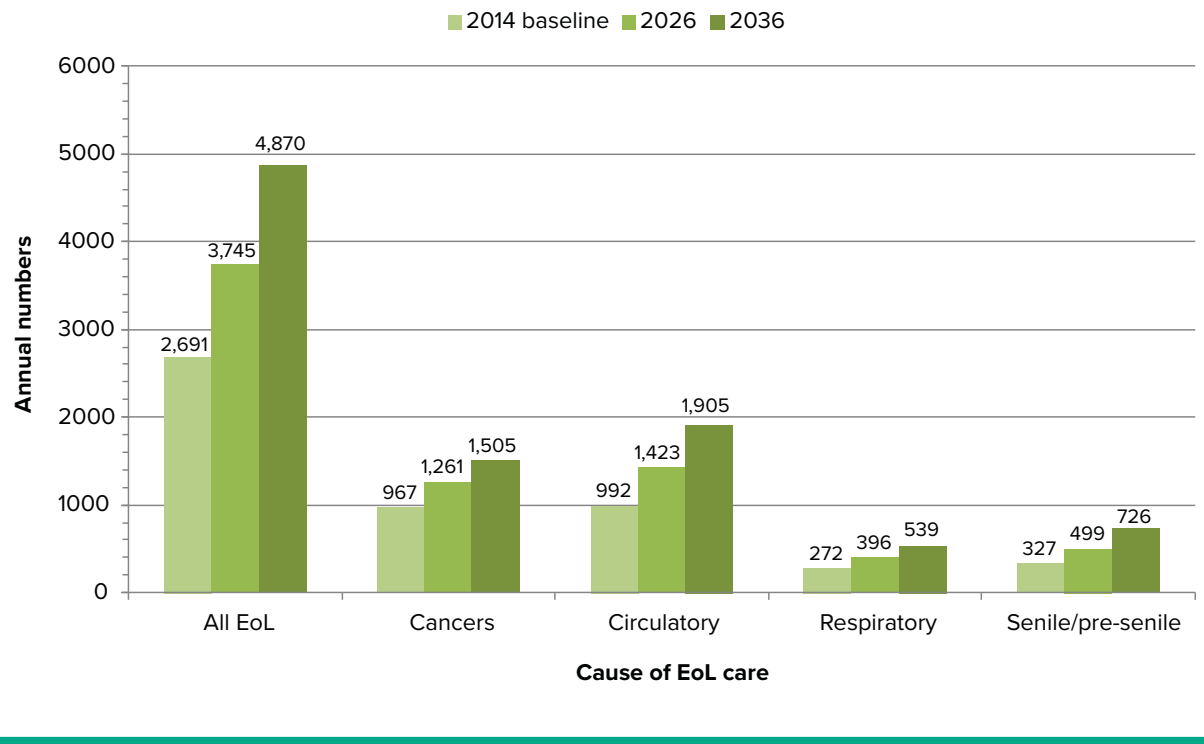


Figure 3.11 - Baseline and projected numbers[1] of the NHS Highland population with End of Life care need

[1]Actual age/sex End of Life annual death rates averaged for 2011-2015 applied to 2014-based mid year population projections for NHS Health Boards (National Records of Scotland)

Key points

- It is possible to estimate the number of people requiring palliative care or end of life care in a given population and the numbers used to plan services accordingly.
- The estimated number in NHS Highland who would potentially benefit from end of life care during a year is equivalent to around three quarters of all deaths.
- Decreasing numbers of patients are needing end of life care for circulatory system disorders, but increasing numbers are needing such care who have cancer, cognitive decline or dementia.
- Over the last 35 years there has been a fall in the proportion of patients dying at home and an increase in the proportion dying in acute hospitals and in care homes.
- On average during the last five years, over one half of those needing end of life care died in their own home or in a care home, and just under a third died in an acute hospitals.
- Those dying from dementia and related conditions or from conditions of the nervous/sensory system were the most likely to die in community settings and those dying from renal or liver or respiratory related conditions, more likely to die in an acute setting.
- Additional data[9] also indicates that men overall were more likely to die in their own home than women and this was the case for all conditions other than for renal or 'nervous & sensory' conditions where women were more likely to die at home. The gender difference may reflect the longer life expectancy of women with the greater likelihood of them caring for husbands and partners. In turn these women are likely to be left living alone with no one to care for them to the same extent.
- Projections based on current estimates predicts almost a doubling of the number requiring end of life care by 2036.

Chapter Four - Supporting high quality end of life care

Realistic Medicine or Prudent Healthcare includes effective palliative and end of life care from a clinical and a community perspective, both of which are considered in this chapter which considers the role of anticipatory care planning, compassionate communities and a range of related interventions.

Transitioning to palliative care

In 2014, the World Health Assembly passed a resolution requiring all governments to recognise and provide for palliative care in their national health policies. Against this backdrop, in 2015, the Scottish Government published its Strategic Framework for Action on Palliative and End of Life Care 2016-2021. Its vision is to ensure everyone in Scotland, irrespective of age or condition, will have access to palliative care if it will benefit them[1].

The Scottish Government define palliative care as more than care in the last days and hours of life, but include ensuring quality of life for both the person and their family at every stage of a life-limiting disease[1]. Similarly, the Scottish Partnership for Palliative Care describe end of life care as 'that which follows when it is clear a patient is entering the dying phase, whether or not they are in receipt of palliative care'[2].

The principles of palliative care and prudent or Realistic Medicine are well aligned. Both focus on a holistic approach and appropriate person centred treatment[3]. These principles are supported by a number of policies, tools and innovations in Scotland aimed at aiding the delivery of palliative and end of life care and improving patient outcomes.

Anticipatory care

A systematic review suggested that between 30% and 38% of patients near the end of life may received non–beneficial treatments[4] or end up dying in hospital rather than at home, which may have been their preference[5]. Anticipatory care plans (ACPs) recommended for those with palliative care needs, offer a means through which patient's can record their treatment preferences and enable health care professionals to plan appropriate clinical responses, as they evolve, over the course of an illness[6]. They encourage exploration of end of life preferences and clarification of a patients understanding of their prognosis, including preferred place of care and views about interventions, treatments and cardiopulmonary resuscitation (CPR)[7]. Key Information Summaries and shared electronic patient records, have also been pursued in Scotland[8], enabling anticipatory care plans to be written by GPs and shared electronically with secondary providers.

There is some evidence that anticipatory care planning may reduce futile invasive treatments and hospital admissions[9], Intensive Care Unit admissions and reduce length of stay[10,11,12]. Identifying an individual who may benefit from palliative care can be challenging[13]. A recent review of Anticipatory Care Planning implementation identified prognostic uncertainty as a key factor influencing the decision to initiate this discussion[6,12,14].

ReSPECT

ReSPECT stands for Recommended Summary Plan for Emergency Care and Treatment. It is an alternative to Advance Care Planning, which is perhaps more flexible.

As shown in Figure 4.1, it creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices.

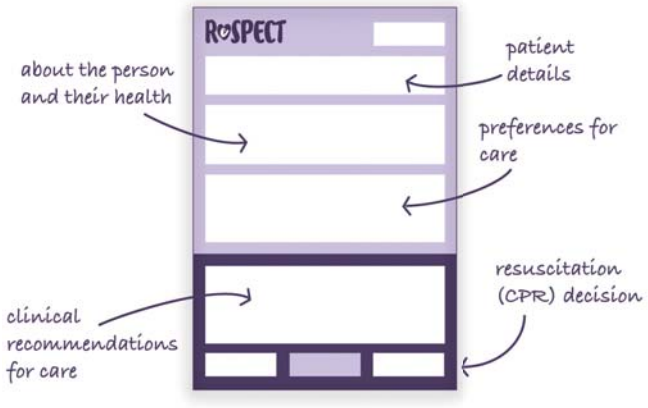


Figure 4.1 - ReSPECT template

Compassionate communities

Compassionate communities are a holistic, population health approach to palliative care beyond health and social care services. They were first described in 1999[15]. A 'compassionate community' is one which formally agrees to offer support, comfort and care to people who may be dying or suffering from a chronic condition such as dementia. A compassionate community recognises that we all experience loss and death. Given that these experiences are universal, there is a need for communities to help all of their members to care for each other.

The basis of compassionate communities is their reciprocal relationships with services. The community is therefore supported by professionals such as palliative care staff, dementia nurses, and other health and social care staff. There is a growing body of literature on their use.

Strong social relationships are one key to a healthier life. A meta-analysis showed that there was a 50% increased likelihood of survival for participants with stronger social relationships for both men and women[16]. Another study of people living with diabetes and heart disease[17] found that social involvement with a wider variety of people and groups supported personal self-management and physical and mental well-being, and significantly reduced the need for people to make use of hospital services. It is clear that increased levels of community engagement and the development of positive social relationships help to sustain the health of all[18].

There is some work underway in Highland to develop local Compassionate Community initiatives and it is included in the Highland Hospice three year strategy. Some supporting work in this direction includes:

Helping Hands – a service which trains and matches volunteers to support clients at home. Volunteers essentially do what a 'good neighbour' might do providing befriending, offer a 'sitting' service to allow carers to get out of the house for short periods of time, help with simple household tasks.

Last Aid – modelled on the format of First Aid training, this half day training session is designed for workplaces and community organisations. It covers practical support as well as supporting people to have a discussion about end of life and supporting people to talk about what they want from end of life care. Helping the public to understand the realities and choices around palliative and end of life care and bereavement will help our communities to build resilience and support each other at this difficult time in their lives.

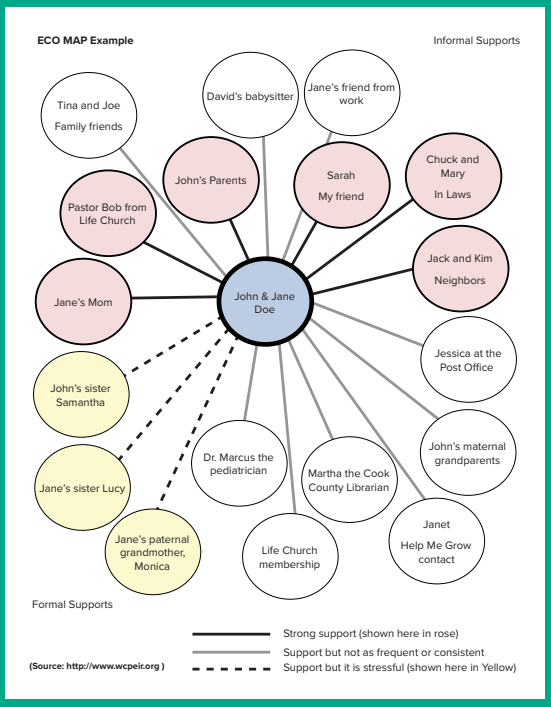
Project Echo – a telementoring system that connects care workers across the Highlands with each other and with the Hospice to provide mutual support as well as training and development in palliative and end of life care. This project is currently working with 35 care homes, community pharmacists, out of hours services and specialist nurses across the Highlands in support of compassionate communities.

The **Dementia Friendly Community project** that has been developed in Helmsdale is supporting development of 'compassionate communities' across Highland. With some additional funding from the Life Changes Trust, there are plans to roll out the model established in Helmsdale and learn from experiences there over the next five years.

Realistic Medicine Case Study

Eco-mapping to support personalised approach to discharge planning

The need for social and practical support in relation to maintaining health, disease management and supporting someone to stay in their own home is well known, but little is known about how to investigate support networks, particularly in a clinical setting[19]. Patients are not isolated beings; rather they will have a network of support which if understood by practitioners, may help to plan and co-ordinate efforts to ensure that patients have the right support to improve their health, manage their condition and maintain independence[20,21].



Eco-mapping is a tool that could help practitioners to plan what support patients might need by giving them the whole picture in relation to an individuals' network of support and therefore enhancing practitioners understanding of the care giving context[22]. Eco-mapping was developed in 1975 by Dr Ann Hartmann and has mainly been used by social workers in relation to understanding family networks in order to provide the most appropriate support to children and families[23].

An ecomap is a visual diagram that shows the social, personal, professional and organisational relationships that an individual or family has in their life. It is often depicted with the person or the family in a circle at the centre and the network of connections and support depicted with circles around the centre, like planets around the sun. It therefore quite literally puts the patient at the centre and builds a picture of their networks of support.

Ecomaps can provide useful information for practitioners and patients/clients and may be helpful in supporting development of care plans and discharge planning by identifying comprehensive networks of support for patients. They:

- provide a useful tool for assessment of relationships and networks and the quality and role of those relationships in supporting individuals in their day to day lives and supporting them to live independently and stay at home
- identify the network of support that an individual has, and can also be useful in identifying areas of need, disconnection or duplication
- identify connections to social support systems such as housing, fuel poverty or income maximisation
- describe connections to communities such as significant friends, neighbours, clubs, church etc.
- help to identify whether and how an individual's needs are being met and their reliance on professional agencies, friends and neighbours
- highlight where there may need to be enhanced communication and co-ordination between services
- help to analyse the level and type of support provided to an individual, and whether it is adequate and appropriate to meet their needs

A pilot of the use of ecomaps to support discharge planning is underway in NHS Highland. Initial feedback has been that the tool is easy to use and engages patients on identifying and thinking about the network of formal and informal support that they have around them. For some patients, it was useful in reaffirming the level of support that they have at home and the discussion with patients also revealed patient's wishes in relation to what kind of support they would like when discharged home, with patients often citing informal support as being the most important. Feedback to nursing staff after developing an ecomap with a patient has resulted in staff starting to identify local community based groups that could have a role in supporting patients when they go home, which they had previously been unaware of.

Realistic Medicine Case Study

Renal team's approach to building a personalised approach to care and managing risk better

Renal services have developed an approach that ensures that patients are at the centre of their care by having realistic conversations about treatment options which includes discussions about the disadvantages as well as the advantages of treatments so that patients and their families are supported with clear information to make decisions.

After discussion with the patient, family and the renal team, a treatment escalation plan is developed to guide future choices and treatment, always keeping the patient in charge of decisions. Whether patients are on a conservative care programme or on dialysis, patients and their families are supported with regular advice and information about what to expect.

Key points

- For healthcare practitioners identifying an individual who may benefit from palliative care can be challenging with prognostic uncertainty and/or communication difficulties identified as key factors influencing the decision to initiate a discussion around end of life care.
- Anticipatory care plans (ACPs) may be helpful in avoiding unnecessary and non beneficial treatment.
- Key Information Summaries (KIS) and shared electronic patient records, which were implemented in 2013 and widely used throughout Scotland[6], enable shared care plans written by GPs to be shared electronically and updated by providers of secondary and unscheduled care.
- A compassionate community is one which offers support, comfort and care to people who may be dying or suffering from a chronic condition such as dementia. The form compassionate communities take should be shaped through a participatory approach with communities.
- Compassionate communities are already forming in NHS Highland. Helmsdale has led the way with their Dementia Friendly Community project and Highland Hospice is developing a range of services to support a compassionate community approach to end of life care across volunteers and services.

Chapter Five - Frailty and its priority in Realistic Medicine

In this chapter, we consider frailty and examine its importance in relation to Realistic Medicine or Prudent Healthcare. One definition of frailty is "a distinctive health state related to the ageing process in which multiple body systems gradually lose their inbuilt reserves"[1]. Adverse outcomes include falls, hospitalisation, disability, or death and frailty is therefore an important condition. Being able to identify and assess frailty allows us to intervene to increase independence, slow progression and reduce risk of these adverse outcomes.

What is frailty?

Although age is the strongest risk factor for frailty, not all old or even very old people are frail. Predisposing factors can lead to a cycle of deterioration arising from relatively small adverse factors such as minor illnesses, the so-called 'domino effect'[2]. There is increasing evidence that impairment in the immune, endocrine, stress and energy response systems is involved in the development of frailty.

There are many tools for assessing frailty or dependence. Frailty can be defined as a cluster of symptoms (Table 5.1), by a frailty index, or as the outcome of a comprehensive geriatric assessment by a multi-disciplinary team. A frailty index is a broader measure than that derived from physical symptoms as it includes assessment of social and psychological aspects.

Table 5.1 - Characteristics of frailty

Characteristic	Measure criteria	
Shrinking	Unintentional weight loss of >10lbs (>4.5Kg) in prior year	
Weakness	Grip strength: lowest 20% distribution by gender & body weight	
Exhaustion	Self-report according to a depression scale (CES-D)	
Slowness	Walking time over 15ft within the slowest 20% of population by gender & height	
Low activity	Energy used per week, lowest 20% of population by gender	
Definitions	**Frail**	three out of the 5 criteria
	Intermediate (pre-frail)	one or two out of the 5 criteria

Source: Based on Fried LP et al.[3]

The current recommendation is that any interaction between an older person and health and social services should include an assessment of frailty. The British Geriatric Society suggests the use of gait speed, for example timing how long it takes to walk six meters, as criteria key assessment, and where this is not possible, the use of a seven item questionnaire with a cut off of three or over positive responses (Table 5.2).

Table 5.2 - PRISMA 7 frailty tool

1.	Are you more than 85 years old?	Yes = 1
2.	Are you male?	Yes = 1
3.	In general, do you have any health problems that require you to limit your activities?	Yes = 1
4.	Do you need someone to help you on a regular basis?	Yes = 1
5.	In general, do you have any health problems that require you to stay at home?	Yes = 1
6.	In case of need, can you count on someone close to you?	Yes = 1
7.	Do you regularly use a stick, walker or wheelchair to get about?	Yes = 1

Source: Based on British Geriatrics Society, 2014[1]

There is a sizable overlap between frailty, co-morbidity and disability. The overlaps between these three states are depicted in the Venn diagram below (Figure 5.1)[3]. Although nearly 70% of those with frailty have two or more long-term conditions (co-morbidity) less than 10% (249/2,576) who are co-morbid are frail.

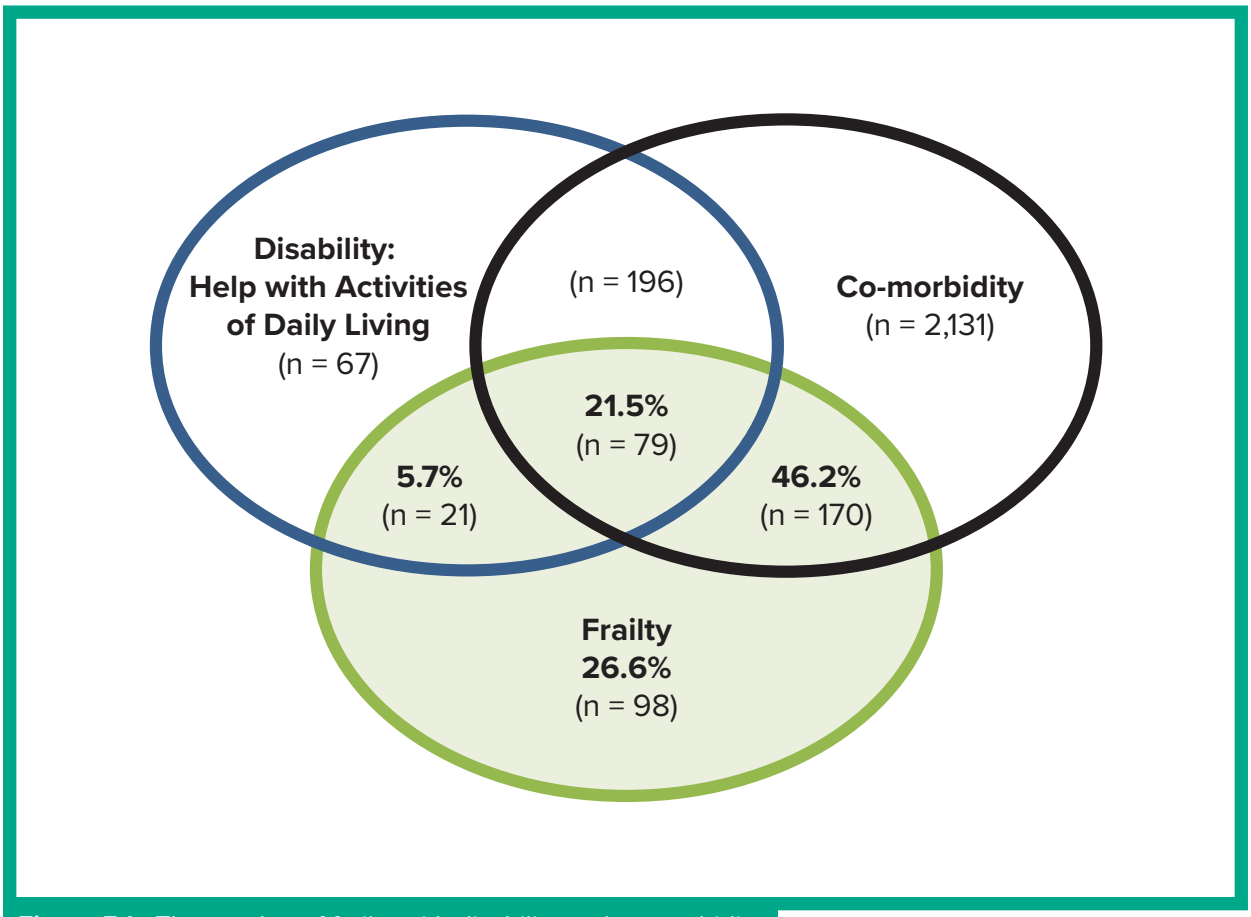


Figure 5.1 - The overlap of frailty with disability and co-morbidity
Source: Fried LP et al.[3]

Another approach to identifying frailty is based on five syndromes that raise the suspicion that a person may have frailty (Table 5.3). This is a relatively quick 'rule of thumb' method for use in a clinical practice.

Table 5.3 - Frailty syndromes

1.	Falls (e.g. collapse, legs give way, found lying on the floor)
2.	Immobility (e.g. sudden change in mobility, "gone off legs", "stuck in the toilet")
3.	Delirium (e.g. acute confusion, "muddleness", sudden worsening of confusion in someone with known dementia or known memory loss)
4.	Incontinence (e.g. change in continence-new onset or worsening of urine or faecal incontinence)
5.	Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants).

Source: Based on British Geriatrics Society, 2014[1]

For primary care, use of a recently available electronic Frailty Index, (eFI) may result in more individuals identified as frail and thus provides the opportunity to optimise care and slow decline[4]. The eFI is based on 36 different deficit variables that can be identified in GP computer systems. It provides a categorisation of mild, moderate or severe frailty. The eFI is available on primary care systems in England and is being tested in Scotland[5].

One review[6] has suggested frailty prevalence of 9.9% (and 44.2% for pre-frailty) amongst those over 65 years, 15.7% in those aged 80-84 years, and 26.1% in those aged 85 years and over, with a slightly higher prevalence in women.

Another systematic review of prevalence studies of frailty in nursing homes[7] indicates higher rates than the equivalent estimates amongst those in the community. Across nine studies, the rate for frailty was 52.3% and across seven studies for pre-frailty, 40.2%. It is interesting to note that approximately 48% of care home residents aged 60 years and over were found not to be frail. It is not known to what degree institutionalisation in itself affects frailty.

A study assessing frailty amongst those aged 75 years and over admitted as an acute medical admission to a district hospital in England, reported that 56% were frail[8]. Out of these, the majority (81%) presented with lack of mobility for over 24 hours, 70% were admitted with falls and nearly 50% were admitted with known dementia or delirium. Overall, 45% were admitted from a nursing home. Although this was a small study (n = 232) and did not include out of hours admissions, it does indicate that a substantial proportion of admissions of older individuals are related to frailty and raises the question as to whether earlier intervention could have been put in place which would have prevented admission in at least some cases.

The three year outcomes of frailty are shown in Table 5.4.

Table 5.4 - Three-year outcomes in those with or without frailty, aged 65 years & over[1]

Outcome	Incidence over 3 years		Hazard Ratio*		Relative Risk#	
	Not frail	Frail	HR	95% CI	RR	95% CI
Worsening ADLs	8%	39%	1.98	1.54-2.55	5.61	4.50-7.00
Worsening mobility	23%	51%	1.50	1.23-1.82	2.68	2.26-3.18
First fall	15%	28%	1.29	1.00-1.68	2.06	1.64-2.59
First hospitalisation	33%	59%	1.29	1.09-1.54	2.25	1.94-2.62
Death	3%	18%	2.24	1.51-3.33	6.47	4.63-9.03

[1] From the results of Fried LP et al[3]
* correcting for factors also know to predict frailty e.g. age & gender
# based on the incidence measure at 3 years

Electronic Frailty Index, (eFI)[4] which is based on Primary Care electronic records (see Table 5.5), predicts adverse outcomes . Identification using the eFI affords the opportunity to put in place evidence-based interventions to improve outcomes in a community setting.

Table 5.5 - Adverse outcomes in older patients identified as frail using the eFI in primary care

Frailty	Hazard Ratio over one year		
	Mortality	Hospital admission	N. Home admission
Mild	1.92 (1.81-2.04)	1.93 (1.86-2.01)	1.89 (1.63-2.15)
Moderate	3.10 (2.91-3.31)	3.04 (2.90-3.19)	3.19 (2.73-3.73)
Severe	4.52 (4.16-4.91)	4.73 (4.43-5.06)	4.76 (3.92-5.77)

Source: Clegg A et al.[4]

Prevalence of frailty across NHS Highland

On the basis of the published work considered in the previous sections, this section presents what can be inferred for the population of NHS Highland in terms of the likely numbers with frailty in different situations and settings.

Table 5.6 - Expected numbers of older frail persons living in the community by area in NHS Highland

	Prevalence of frailty		Expected numbers of persons with or without frailty					
			Argyll & Bute Council		Highland Council		NHS Highland	
Age group	Men	Women	Non-frail	Frail	Non-frail	Frail	Non-frail	Frail
60-69	6.0%	7.0%	12,341	860	30,416	2,117	42,757	2,977
70-79	10.5%	14.5%	8,235	1,189	18,692	2,700	26,927	3,889
80-89	24.0%	37.0%	2,989	1,394	7,163	3,324	10,152	4,718
90 & over	65.0%	57.5%	351	515	789	1,174	1,139	1,690
All	**12.0%**	**16.0%**	**23,916**	**3,958**	**57,059**	**9,316**	**80,975**	**13,274**

Source: Gale CR et al.[9] applied to 2016 mid-year population estimates

Overall, across NHS Highland there are an estimated 13,000 frail older people living in the community and around 1,100 in residential care homes.

Table 5.7 - Expected numbers of older frail, long stay residents of care homes in NHS Highland

Age (years)	Prevalence rate[1] (95% CI)	Estimated prevalent numbers (95% CI)		
		Highland Council	Argyll & Bute Council	NHS Highland
60-69	49.0% (23.1%-75.2%)	116 (55-178)	17 (8-26)	133 (63-204)
70-79	45.5% (32.0%-59.4%)	208 (146-271)	85 (60-112)	293 (206-383)
80 & over	61.8% (48.0%-74.6%)	545 (424-658)	165 (128-199)	710 (552-857)
All ages	52.3% (37.9%-66.5%)	824 (597-1048)	256 (185-325)	1,080 (783-1373)

[1]From Kojima G[7] prevalent rates applied to numbers of long-stay residents (defined as intended to be a permanent resident at time of admission plus any short-term resident who is a still a resident after 6 week) in older peoples (majority aged 65 years & over) Care Homes from the Scottish Care Homes Census, 2016.

During 2015/16, there were over 15,000 discharges of NHS Highland residents aged 65 years and over from Scottish hospitals after an emergency admission. The majority (82%) were in hospitals within NHS Highland. In turn, most of these admissions (82%) were to the four acute and rural general hospitals (Table 5.8).

Application of the prevalence rate of frailty, as per a reported Scottish study[10] to hospital emergency stays in Raigmore District General Hospital and the Rural General Hospitals across NHS Highland during 2015, provides an estimate of the number of emergency admissions involving older people with frailty during a year.

There were over 1,700 admissions to the main four hospitals (Table 5.8). However, there were a further 2,200 emergency admissions to our community hospitals and the prevalence of frailty amongst those are likely to have been much higher in comparison to our four main hospitals (Table 5.8). It should be noted that emergency admissions are approximately fifty percent of the total admissions.

Table 5.8 - Estimated emergency admissions, NHS Highland residents aged 65 years, 2015/16

Hospitals	Hospital admissions[1]	Estimated number with frailty[2]
	Number	
Acute and Rural General Hospitals		
Belford Hospital	700	119
Lorn & Islands Hospital	991	168
Caithness General Hospital	1,420	241
Raigmore Hospital	9,944	1,180
Total	**10,055**	**1,709**

[1] Continuous Inpatient Stays (admissions coded as 30-36 inclusive and 38 & 39)
[2] Average prevalence (17%) from Poots et al[10] applied to SMR01 extract of NHS Highland residents

Frail older people with an 'end of life condition' in their last year of life in NHS Highland have been estimated at around 2,500 (800 in Argyll & Bute and 1,700 in north Highland), 750 dying in an acute hospital, the same number in their own homes, and under 600 in care homes.

The following chapter will consider how we can respond to frailty through considering effective interventions and alternative models of care.

Realistic Medicine Case Study

Attend Anywhere service which reduces waste and variation in practice

"It is much more convenient to be able to have a private 1:1 conversation with a professional from the privacy of my own home."

Pilots are underway using Attend Anywhere, which is a web-based platform that helps healthcare providers offer video call access to their services as part of their 'business as usual', day-to-day operations. It is designed to make the system more efficient for clinicians, patients, carers and families by reducing travel time and the stress associated with attending a medical facility.

The Pharmacy Anywhere project started because of difficulties recruiting pharmacists in remote and rural areas, but initial experience suggests some patients prefer the service because it is more convenient than attending an appointment in person. The pilot involves connecting the pharmacist with the GP practice, where the pharmacist uses Vision Anywhere to remotely access the patient's medical records and connecting the pharmacist and the patient. The patient is given a choice of having an Attend Anywhere video consultation via their own computer/smartphone or a traditional telephone call.

Realistic Medicine Case Study

Allied Health Professionals (AHPs) support innovative interventions to reduce harm, manage risk and reduce variation

Occupational therapists across Highland are working to support people to live with, and manage their own conditions; often by delivering rehabilitation programmes alongside self management information that maximises independence in day to day activity. This includes provision of specific advice and support into workplace and leisure activity to promote health and wellbeing.

- Physiotherapists and public health specialists are working with Hi-Life Highland to further develop a range of targeted exercise programmes and making these available in local communities for people with a range of health conditions, including cardiac rehabilitation. This work builds on the Otago classes that are delivered to people at risk of falls and aim to reduce harm and manage risk more effectively in the community.
- Speech and Language Therapists are continuing to develop the use of video-conferencing technology to support the remote delivery of one to one therapy and reduce variation in access.
- Speech and language therapists and occupational therapists have worked alongside teachers in Highland to develop a programme to better support the development of literacy skills in primary one children, providing a firm foundation for children's education and reducing variation in literacy.
- AHPs in Argyll and Bute are working in partnership with 3rd sector organisations and community groups like Lorn Healthy Options and the Strachur Hub to refer people with long term health conditions or frailty to exercise classes in their community. These programmes have enabled participants to regain physical ability and have improved wellbeing. People taking part in the classes also benefit from peer support in group activities.
- Occupational therapists in Argyll and Bute work in partnership with community team support workers and homecare providers to help people regain independence in activities of daily living. This is called re-ablement and ensures people can regain as much ability as possible therefore minimising the need for ongoing care at home.

Realistic Medicine Case Study

ENT transformed service delivery model to improve their service, reduce waste and manage risk better

The ENT department has made improvements to their outpatients service making more effective use of time and reducing waiting lists. Nurse led clinics have increased capacity and utilised expertise within the service. Implementation of balance clinics lead by Allied Health Professional Service has also resulted in more efficient use of staff skills and expertise.

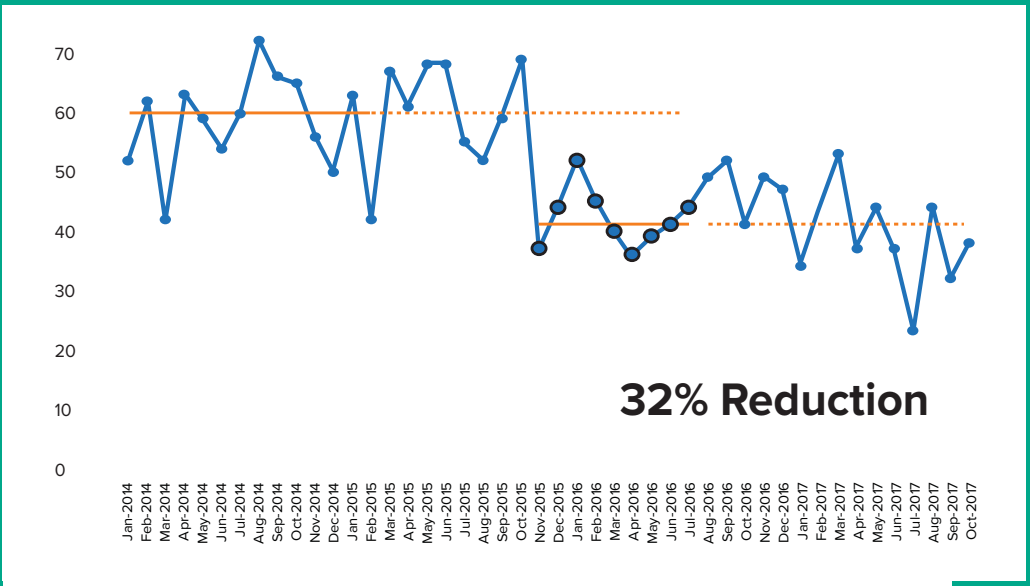
Provision of joint audiology and ENT clinics has reduced appointment times for patients and improved flow. This has reduced waste through unnecessary hospital visits. Referrals are now vetted electronically, which helps to streamline the service improves risk management and frees up capacity to deal directly with patient care. This transformation work was started in October 2016 and by August 2017 the number of patients waiting more than 12 weeks for their first clinic appointment had reduced from 965 to 84.

Realistic Medicine Case Study

Reducing falls and improving orthopaedic pathways

The Scottish Patient Safety Programme, with leadership by the Nurse Director and Senior Quality Improvement Lead (Patient Safety) have used a falls bundle, linked to quality improvement methods to substantially reduce the number of inpatient falls in NHS Highland.

New orthopaedic pathways have been developed for patients with foot and ankle problems, spinal, trauma conditions and post-operative arthroplasty care. This has reoriented the care provided to ensure that it is more patient-centred, uses the skills and abilities of the whole team and reduces variation in practice.



NHS Highland Inpatient Falls With Harm, All Ward Areas, Jan 2014 – July 2017
Source: Maryanne Gillies, Senior Quality Improvement Lead, NHS Highland

Key points

- The strongest risk factor for frailty is age but not all old or very old adults are frail, nor is it always associated with co-morbidity or disability.
- Frail individuals have up to ten times the rate of adverse outcomes such as falls, hospitalisation, care home admission, procedure complications, and are less able to adapt to stressors such as illness and trauma.
- Identification of frailty in older adults is important, as is a more structured approach to interventions in this group, and depends on agreement on assessment tools and methods.
- Estimated frail populations in NHS Highland are:
  - >13,000 living in the community
  - >1,000 living in older peoples care homes
  - ~2,000 admitted to NHS Highland hospitals per year
  - ~2,500 in their last year of life with a defined end of life care condition.

Chapter Six -
Responding to frailty

This section explores how we can respond to and manage frailty through specific interventions and models of care. Such interventions can reduce the likelihood of frailty leading to adverse outcomes such as loss of independence, falls and preventable hospital admissions.

Tackling muscle loss

Perhaps the biggest contributor to frailty is sarcopenia, that is loss of muscle mass and function. Most muscle loss does not seem to be an inevitable part of the ageing process but seems to be associated with a Western lifestyle, where retirement is seen as a time when one would expect to deteriorate physically and to undertake less activity. Hospitals have traditionally exacerbated muscle loss by restricting the extent to which patients (in the recovery phase) move around and are encouraged to act independently.

Perhaps one of the biggest challenges in terms of inpatient care in our current models is reducing muscle loss during admission. The recent Nottingham University Hospital social media #endPJParalysis campaign, endorsed in NHS Highland, has sought to increase the number of hospital inpatients who are encouraged to get out of bed and dress in day clothes, to support their rehabilitation and recovery[1]. Muscle mass and strength does peak in early adult life, but the rate at which it declines thereafter has a significant effect on the risk of frailty in old age (Figure 6.1).

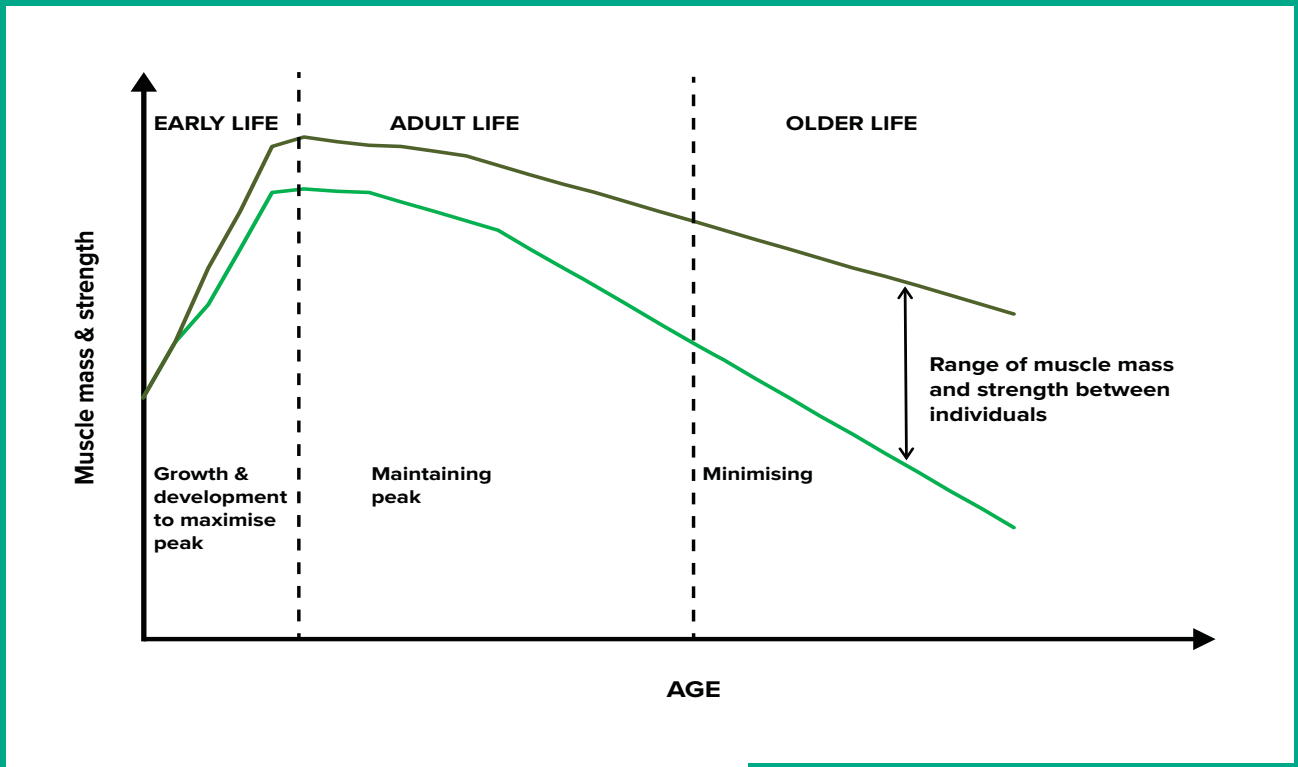


Figure 6.1 - Life course changes in muscle mass and strength
Source: Based on Sayer AA et al.[2]

A Cochrane Systematic Review[3] indicates that progressive resistance strength training (PRT) improves physical functioning in older people. This involves participants exercising against increasing external loads several times per week. Other types of exercise involving gait, balance, co-ordination and functional exercise have also been associated with decreased risk and rate of falls and with improvement of balance in older people[1].

Amongst the exercises associated with better clinical balance outcomes are those with three dimensional range including tai chi, qi gong, and dance[4]. Nutrition is also important, although the evidence for supplements is poor[1,5].

Models of specialist geriatric care

One method of responding to increasing levels of frailty is to consider alternative models of delivering specialist geriatric care, within hospitals, across the hospital-community interface, and in the community. A literature review of published evidence for different models by setting[6] found that in-hospital geriatric-specific rehabilitation is effective in increasing functionality and in reducing discharge to nursing home. This is particularly so for orthopaedic patients.

Hospitalised patients have better outcomes with care delivered by geriatric-specific and multi-disciplinary teams, particularly when these are delivered in designated units or wards. A local example of this approach has been the integration of geriatric and surgical care for patients with hip fractures. In 2017, the Ward 3A team in Raigmore Hospital, who have led on this work, won the Golden Hip award for meeting the most audit targets in fractured hip management.

Across the hospital-community interface, most of the evidence has come from the care in the post-acute phase. Models such as Geri-FITT include follow-up after discharge by telephone and by communication with primary care providers within 48 hours of discharge. Overall, there appears to be some evidence that patient outcomes may be improved across the hospital-community interface by such models, but it is not clear which specific health inputs produce the improvements.

In the community, Medical Day Hospitals, when compared to no treatment, are associated with better patient outcomes such as Activities of Daily Living and decreased use of hospital beds. There is a paucity of research evaluating the effectiveness of direct input of specialist Geriatric services to Care Homes, but assessment of people at risk of admission to nursing homes by a Geriatrician may reduce deterioration of functions, lower stress for carers, and reduce service contacts and costs.

Medication reviews may also have some benefit for patients in nursing homes as demonstrated in Hawaii, when undertaken by a geriatrician. This intervention resulted in reductions in poly-pharmacy, ineffective medications and potential drug-interactions. The evidence for the role of Geriatricians in Primary care is weak, although one study has demonstrated lower hospitalisations and costs for patients assessed by a Geriatrician.

There is evidence for the effectiveness of multi-dimensional preventative home services (out with discharge planning/rehabilitation/case management specific services) in improving functional status when a clinical examination was included. There may also be benefit in screening for frailty in the community. Further review of all of the above has been provided in a separate review by the NHS Highland Public Health team[6].

Examples of models of care in NHS Highland

The acute hospital setting is in many cases, not the most appropriate setting for older people who are frail or who have an end of life condition. Therefore a decrease in the rate of emergency admissions and the associated length of stay is desirable in this population. Assistance with self-management, urgent day care or ambulatory assessment, and a move towards more proactive, anticipatory care and support in the community are expected to facilitate this. Supporting people to be more confident in managing their long-term conditions and providing coordinated care and support at home when it is safe and appropriate are key aspects of the Scottish Government's healthcare 2020 vision and of a Realistic Medicine approach.

The extension of secondary care into the community by using hospital based Geriatricians to work directly with nine General Practices is being piloted in North Highland. The expectation is that in addition to enhanced patient care, this arrangement will result in a reduction in the rates of emergency admission to hospital for older people.

An initial evaluation of Geriatricians working with nine GP Practices in North Highland indicates improvements in some GP practices but not in others (Figure 6.2).

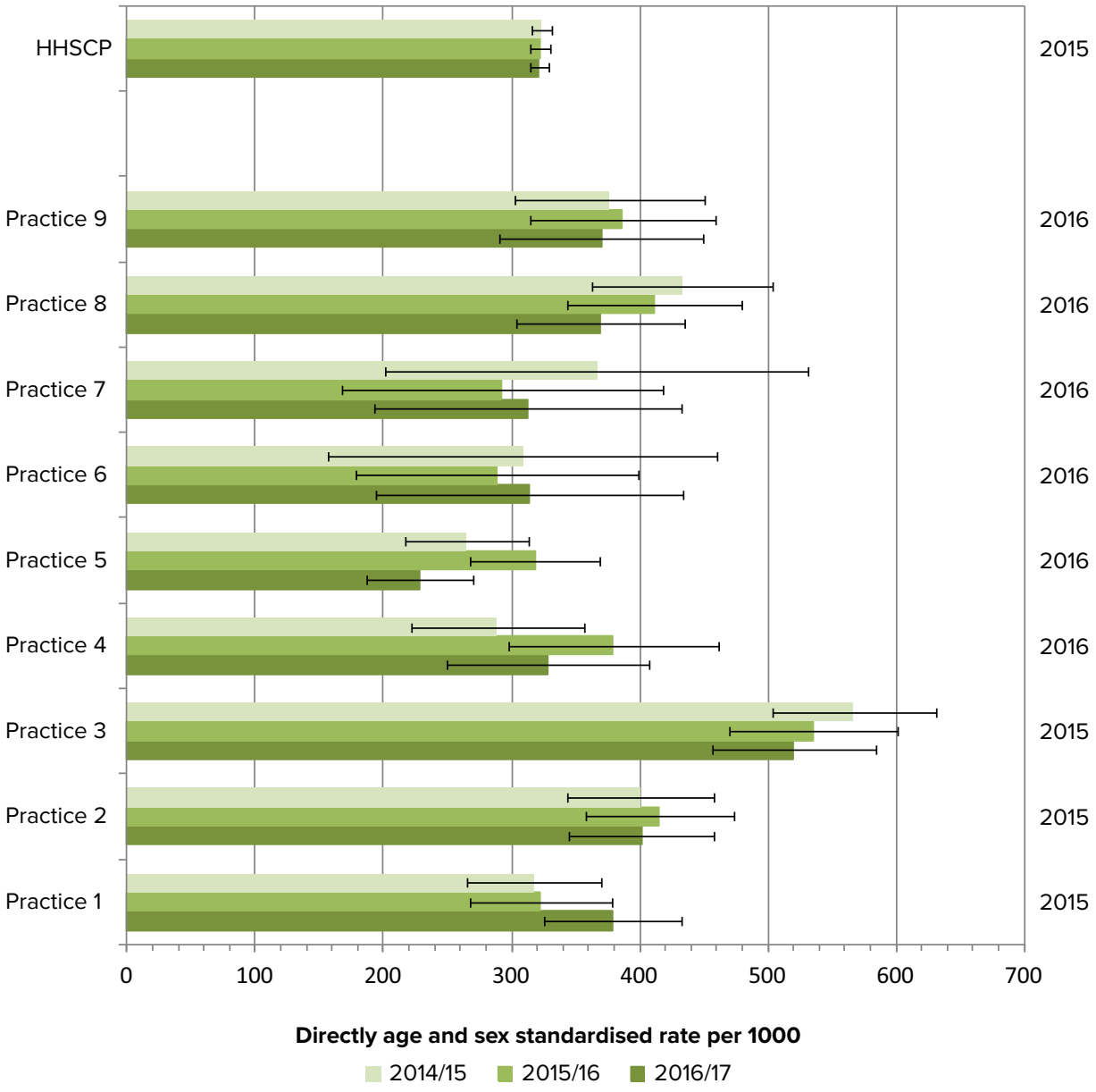


Figure 6.2 - Annual emergency admission rates, standardised for age and sex, in those aged 75 years and over by GP practices with Geriatrician involvement[1], 2014 - 17
Source: Hospital activity from PMS and CHI populations: directly standardised to European standard population 2013, provided by Public Health Intelligence, 2013

[1]The year of first involvement with the Geriatrician service in the GP Practices is shown in the right hand vertical axis

There is a wide variation in the rates of emergency hospitalisations of older people between GP Practices with or without Geriatrician input (Figure 6.3) and an understanding of the reasons for this may reveal what factors are involved in the lower and higher rates and lead to future areas of improvement.

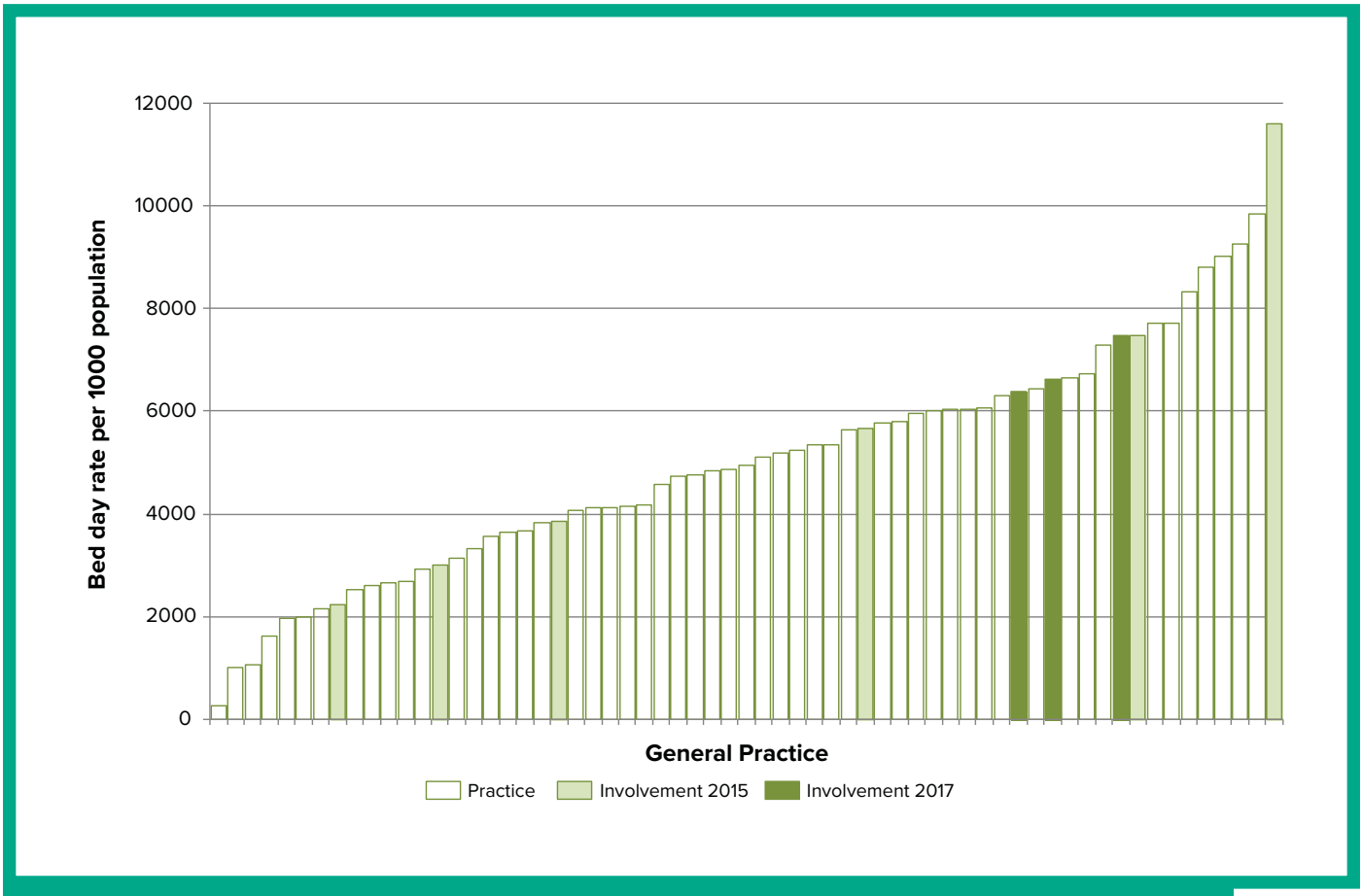


Figure 6.3 - Directly standardised rates of emergency bed days of those aged 75 years & over for General Practices in the Highland Health & Social Care Partnership: 1st April 2016 to 31st March 2017
Source: Hospital activity from PMS and CHI populations: directly standardised to European standard population 2013, provided by Public Health Intelligence, NHS Highland

Realistic Medicine Case Study

Joint working with GPs in Community hospitals

Geriatricians are now aligned to Community Hospitals in North Highland. General Practitioners provide the majority of medical care in community hospitals, particularly for older adults. Consultants now link in on a regular basis to our community hospitals to work alongside GP's, developing a hub and spoke approach to delivery of care, particularly in remote and rural areas.

This brings in specialist expertise when needed, and makes more efficient use of time as decisions about care can be made quicker and more efficiently. It also prevents patients having to travel long distances to attend acute hospital appointments. This approach has been developed in Invergordon Hospital, the Royal Northern Infirmary, Nairn and Ross Memorial hospitals.

Realistic Medicine Case Study

Multidisciplinary team reviews in care homes

The care home sector is vital to the overall health and well being of a large number of frail adults. On any given day, across Scotland, more adults are looked after by Care Homes than Hospitals.

To try and support adults and those caring for them in what is effectively their own home a programme of regular Multidisciplinary Reviews of adults in care homes is rolling out steadily across Highland. The teams involve Consultants, GP's, Care home staff and Allied Health Professionals who discuss and clarify medical and medication management on a planned basis.

Reducing unscheduled care admissions

Unplanned hospital admissions account for nearly 50% of all admissions to acute hospitals in NHS Highland and of these, 47% involve patients aged 65 years and over. A review of interventions to address this unscheduled care admissions has been undertaken by the NHS Highland Public Health team[7]. Some of the findings are summarised in Table 6.1.

Table 6.1 - Interventions involving older adults for which there is evidence of effectiveness in preventing admission to hospital

Intervention	
Community Health & Social Care Integration with generic case management[1]	
Telehealth Care in Long Term Conditions	
Discharge Planning: hospital to home	
Nurse-led units[2]	
Prevention of falls in community dwellers	Tai-Chi group exercise
	Multi-factorial
	Individualised, multi-component exercise at home
	Gradual withdrawal of psychotropic medication
	First eye cataract surgery
Vitamin D supplementation in care facilities	
Prevention of falls in hospital	Multi-factorial
	Supervised exercise
Case management of Heart Failure	
Ambulance call out to fallers/minor injuries (Emergency Care Practitioners/Paramedics)[3]	

[1]Involves assessment, planning and facilitation, usually by a case manager to obtain services to meet an individual's health needs.
[2]Based in community, acute or satellite hospitals, the care is managed by nurses and the lead therapy was nursing.
[3]Interventions included (i) specially trained paramedic attending older people with minor injury or illness for whom a 999 call had been made. (ii) Attendance by an Emergency Care Practitioner to older people who had fallen and received an ambulance call-out. This resulted in 50% fewer being transported to hospital and over 50% avoiding subsequent hospital admission within 72 hours.

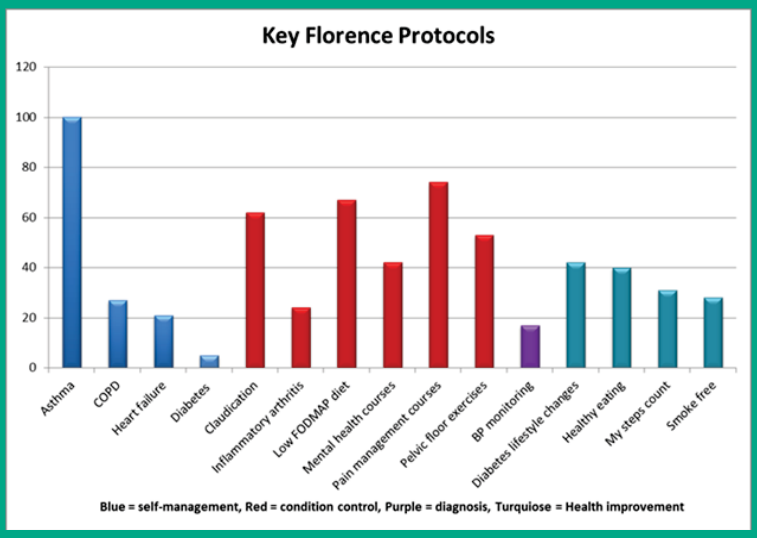
Source: Based on the report of the Review of the evidence for the effectiveness of interventions to reduce hospital admissions of older people (on NHS Highland internet site (http://bit.ly/2uKnL37))

The table indicates that some nurse-led units, tele-health care use in long-term conditions, discharge planning from hospital to home, case management in heart failure and integration with generic case management can reduce hospital admissions in those who are frail and elderly.

Realistic Medicine Case Study

Florence Tele-health Technology to reduce variation in access, reduce resource waste and support a personalised approach to care

Florence is an automated, interactive text messaging service, used to deliver a programmed series of text messages to patients, supporting people with a wide range of health conditions – including asthma, COPD, diabetes and heart failure.



Florence's messages provide tips, advice, reinforcement and reminders to patients, as well as prompting them to take readings such as peak flow, SATS, BP, blood glucose and weight, and smking cessation advice. In this way Florence promotes self-management, enabling patients to understand, monitor and manage their own health condition, while also giving healthcare staff the opportunity to monitor their progress remotely.

Since 2015, 1368 patients across NHS Highland have used Florence to manage chronic conditions or engage with health improvement techniques. The range of protocols Florence supports is shown in the graph.

Trials have also begun using the Florence automated texting service in the Invergordon Community Midwifery Team. Antenatal texts commence from 16 weeks, and include, reminders around appointments, foetal movements, maternity records, smoking and alcohol, and scans. Later prompts include information on baby's development, healthy start vitamins, diet, appointments, foetal movements, and what to do if concerned.

The text service concludes with five evaluation questions being sent to women in order to monitor satisfaction and includes; whether they would recommend Florence, whether it helped them to remember appointments, whether it helped increase their awareness around foetal movements, and whether they have any ideas for improving the service. Finally they are asked whether they are happy to be contacted further.

While no women have yet reached the end of the trial, initial feedback is very positive, with only a tiny minority who are offered the service choosing not to engage. Staff report that women appear to be more proactive in making and keeping appointments and that there are fewer appointments missed. Staff also report increased awareness and understanding of foetal movement, and reporting of issues. Overall feedback is positive with a view that Florence is another valuable tool in the overall aim of improving ante-natal care.

Florence combines the expertise of health care teams with the convenience of using the patient's own mobile phone. Using this service enables healthcare staff to offer a person-centred approach to healthcare while at the same time making best use of innovative healthcare resources.

Realistic Medicine Case Study

Video Conferenced Multidisciplinary Meetings to reduce variation in practice and minimise waste

Innovative approaches to care are being implemented in Ballachulish, Lochinver and Armadale where video-conferencing technology is being used for multidisciplinary patient reviews. This has allowed more efficient use of resources, particularly for some of the most remote practices where regular video conferencing meetings are held between primary care and other teams and professionals to discuss complex cases.

Realistic Medicine Case Study

Myth Busting Back Pain supports shared decision-making through information provision

Back pain is currently the largest reported reason for sickness absence in the UK and has the largest referral rate to physiotherapy service. The campaign explores and challenges beliefs about back pain and has created opportunities for conversations regarding back pain, reassuring people that short term back pain can be common and normal. This campaign also advises on self management of short term back pain.

Realistic Medicine Case Study

Supporting People Living with Chronic Pain

Long term conditions and ageing are often associated with chronic pain and this can be extremely debilitating for people. There is clear evidence that supporting people to self manage their health can reduce chronic pain and this approach is adopted in Argyll and Bute's partnership response to pain management. The Public Health Department has engaged Arthritis Scotland to deliver a contract with two aspects:

- Recruiting and training volunteers to deliver Tai Ch'i for Health in their communities.
- Training and supporting front line health professional in delivering the Pain Toolkit with the people they provide health and social care for. The toolkit has 12 sections including goal setting, prioritisation, getting involved, physical activity and relaxation.

Key points

- To reduce frailty we need to promote interventions that improve physical functioning by increasing muscle mass and strength, particularly progressive resistance strength training, exercise involving gait, balance, co-ordination, and encourage walking on a daily basis.
- The effectiveness of dietary interventions are subject to more uncertainty but a healthy diet is important in preventing and addressing frailty.
- A life-course approach to optimising peak muscle mass and strength in early life, maintaining this in adulthood, and reducing their rate of loss in older adulthood presents a strategy for reducing the rate of frailty in our population.
- For hospitalised patients, better outcomes for patients are associated with care delivered by geriatric-specific and multi-disciplinary teams, particularly when these are delivered in designated units or wards.
- Interventions that reduce hospitalisation include certain types of nurse-led unit, tele-health care for long-term conditions, discharge planning from hospital to home, case management in heart failure and integration with generic case management.
- We need to maximise the network of support around every patient using tools such as eco-mapping, so that they have the right support to improve their health, manage their condition and maintain independence.


Fire exit
ACTIVE

Chapter Seven - Sustainable solutions

We have seen that there are a range of related healthcare movements in the UK including Realistic Medicine, Prudent Healthcare and Choosing Wisely and that these movements can help create a more sustainable approach to health and social care over the next few decades. We have reflected on the six key elements in Realistic Medicine: shared decision-making; a personalised approach to care; managing risk well; reducing harm and waste; reducing unnecessary variation and improving and innovating.

Realistic Medicine primarily uses a lens that focuses on individual care and the public health challenge is to extend the principles of Realistic Medicine to decision making at the population level, particularly in relation to harm and variation. From a public health perspective variation often indicates inequality in access or health due to the wider socio-economic determinants of health.

Figure 7.1 shows a hierarchy of Realistic Medicine components which applies Realistic Medicine at a population level. Shared decision-making, a personalised approach to care and good management of risk can be considered as underlying principles in service design. Managing unnecessary variation, and reducing waste and harm are actions that contribute to good, safe, care delivery. Achieving all these actions also requires a focus on quality, improvement and innovation.

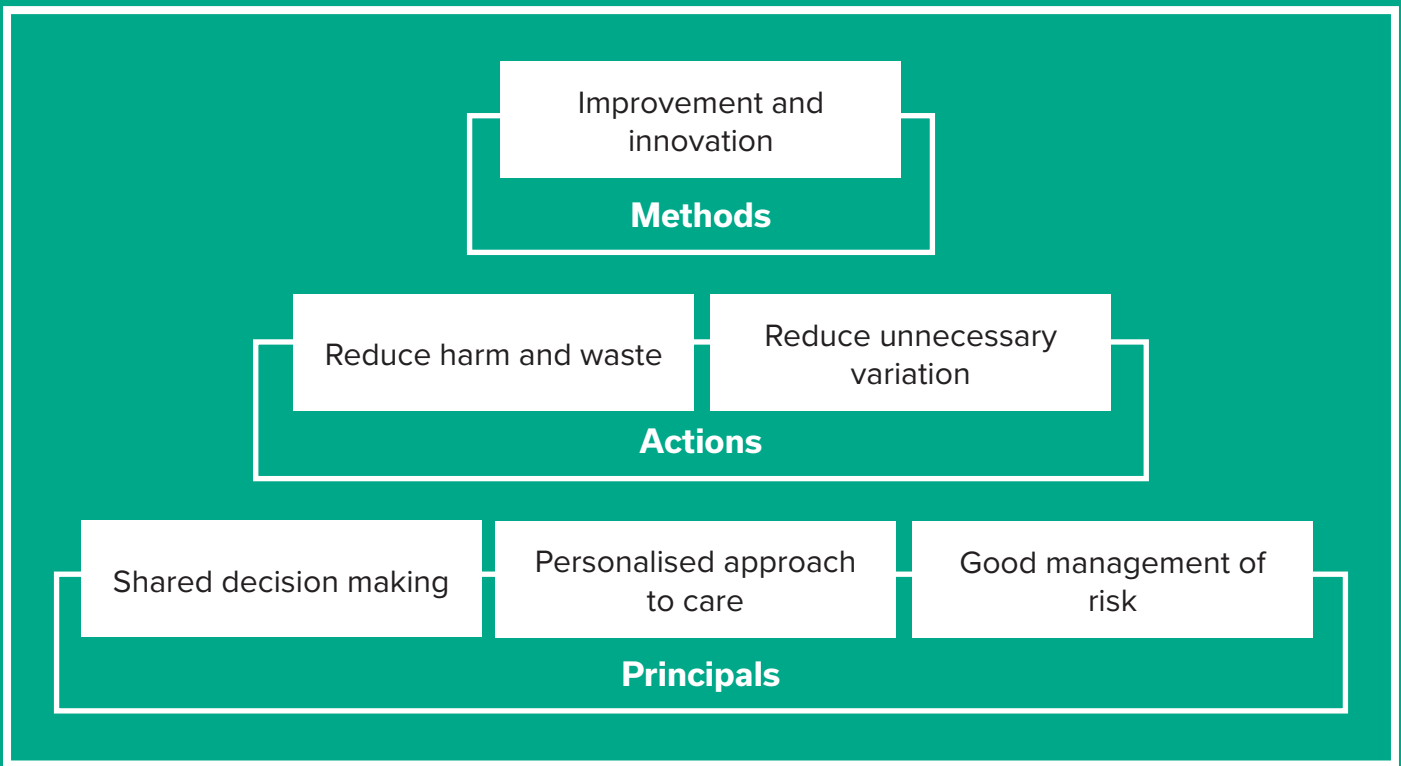


Figure 7.1 - Potential layers of Realistic Medicine from a population perspective
Source: Dr Cameron Stark, NHS Highland

Sustainable quality

NHS Highland has developed a Highland Quality Approach (HQA), see Figure 7.2 on page 66, as its basis for quality improvement. The HQA approach is based on methods used in business over the last 70 years and which have been adopted by healthcare organisations such as Virginia Mason, Bellin Health and ThedaCare.

Figure 7.2 - The Highland Quality Approach

The HQA triangle (Figure 7.2) puts care of the individuals at the top of its aims but also has a vision which is very population focused: "Better Health, Better Care and Better Value". It is important to acknowledge that there can be tensions between the principles of personalised care and shared decision making at an individual level and population level actions taken to plan services which minimise waste and harm and provides a sustainable service for a population as a whole. A holistic model, such as the HQA provides a basis for bringing these together.

NHS Highland has invested in strong quality improvement leadership, with a Director of Transformation and Quality Improvement, specialist improvement support staff, ownership of the approach at executive level and a training programme that has touched thousands of members of staff with key messages around a sustainable approach to quality: removing waste, harm and excess variation to both improve quality and reduce cost.

The organisation uses a large number of quality improvement tools including: Rapid Process Improvement Workshops, process mapping, visual controls, huddles to inform daily management, 5S (Figure 7.3) and a range of related techniques to improve and sustain quality. All of these have a key role in delivering the goals of Realistic Medicine or Prudent Healthcare.

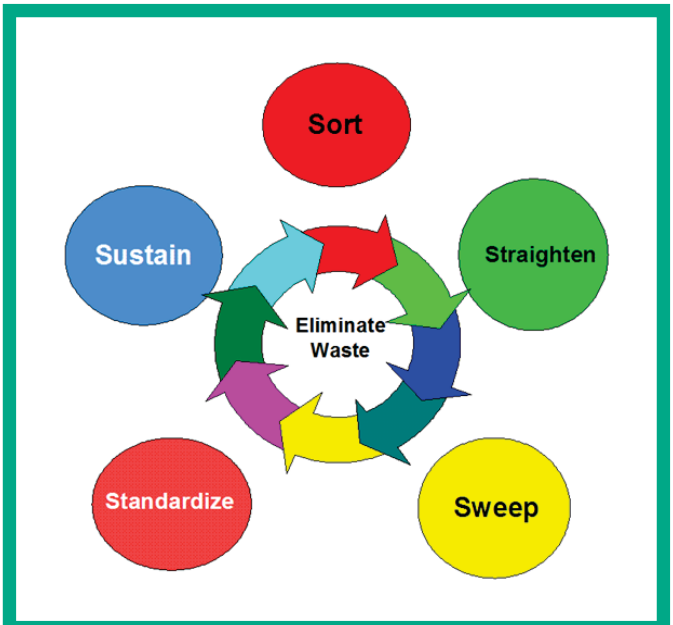


Figure 7.3 - The 5S approach to Quality Improvement
Source: http://bit.ly/2hSNTo7

Innovation is also a key component of sustainable quality. The Research and Development Department within NHS Highland is undertaking a large number of innovative projects that provide sustainable solutions based on the concepts within Realistic Medicine, for example, a capsule incorporating a camera that can be swallowed and which photographs the intestine, removing the need for an endoscopy, which is much more invasive and utilises greater NHS resources.

NHS Highland has strong academic links with a wide range of partner organisations. Joint working with local government colleagues in Highland, Argyll and Bute and increasingly at regional level, provide an opportunity to learn from each other. There is also the opportunity to benchmark performance using tools developed by National Services Scotland such as Source and Discovery databases.

The delivery of a quality service involves considering a number of factors including the 'opportunity cost'. This is, the principle that any use of a resource forgoes alternative uses of that same resource. For example, NHS Highland could prioritise one aspect of quality, the provision of specialist treatment close to home, but at significant cost. However, as the volume of such a treatment would be low, the technical quality would generally be less than that of a larger specialised centre and

the costs would generally be much higher. Funding such a service may not be in the best interests of the patients who receive it and may divert considerable resource from other patients, where it would yield better value. In such circumstances most people prefer to have better care further from home, even although this involves additional travel[1]. The language of 'opportunity cost' can be useful in assessing such tradeoffs.

A commonly used model which similarly expresses the balance of different factors required to deliver sustainable health service planning is the triangle of cost, quality and time (Figure 7.4). Additional emphasis on one corner of the triangle can only be uncertaken at the expense of the other two. Some of the trade-offs that need to be considered in delivering sustainable, prudent and realistic services across NHS are provided below. It should be emphasised that these are illustrative and that others could also have been chosen.

Sustainable Care

Care homes have traditionally been used to provide care for the frail and the elderly. However, there are major challenges in sustaining this model[2]. The reimbursement of places in care homes is based on a National Care Home Costing Model. This model appears to make the financial assumption that care homes have at least 48 beds, as care homes of this size have significantly reduced costs per person.

In rural areas such as NHS Highland, care homes can rarely be as large as this, as local demand is not sufficiently high to fill large care homes, and it is extremely difficult to get enough staff to support them. It is almost impossible for a commercial provider to deliver care in such an area, resulting in the public sector having to step in to provide this care at a far higher cost per person.

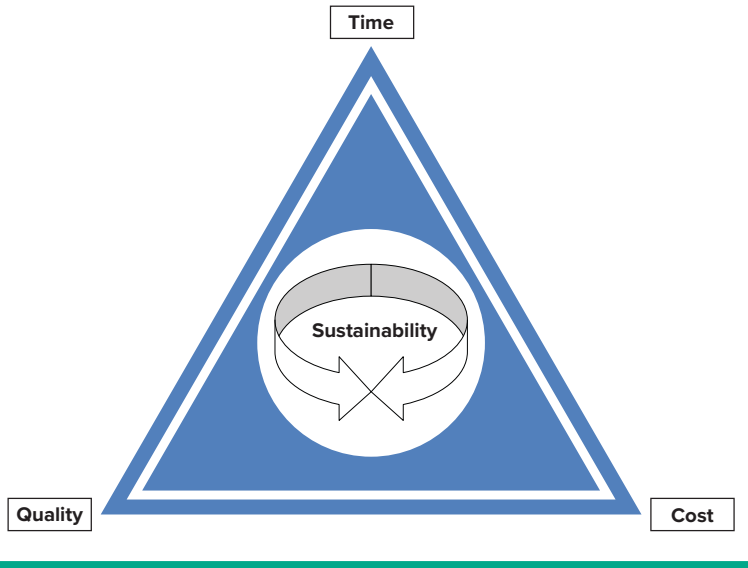


Figure 7.4 - Balancing Time, Quality and Cost to deliver sustainability

The consequence of spending money on high cost care in remote and rural areas is that there is an 'opportunity cost' involved and less money is consequently available to provide other services for other individuals. This trade off is widely recognised and it is generally accepted that rural areas have to be subsidised. However, what is particularly difficult is to differentiate a reasonable additional cost to ensure access in a remote or rural area from an unreasonable additional cost to make services available locally in such a context.

At its most extreme, few of us would build a care home for one person on an island which had only had five people. Doing so might cost 100 times as much as the average cost of a place in a care home. But should we provide a care home in a small community that costs four times as much per person as the average for a care home? What constitutes a reasonable additional subsidy for each incremental step in remoteness?

Sustainable Staffing

The ratio of people of working age to people of retirement age is changing, with fewer working age people relative to those above retirement age. In rural areas with low unemployment, other sectors compete with the care sector for staffing. This is particularly the case during the summer when tourism is at its height and there is a shortage of staff in the hospitality sector. This challenge is likely to worsen as the age structure of the population continues to move towards a reduced younger:older ratio (Figure 7.5).

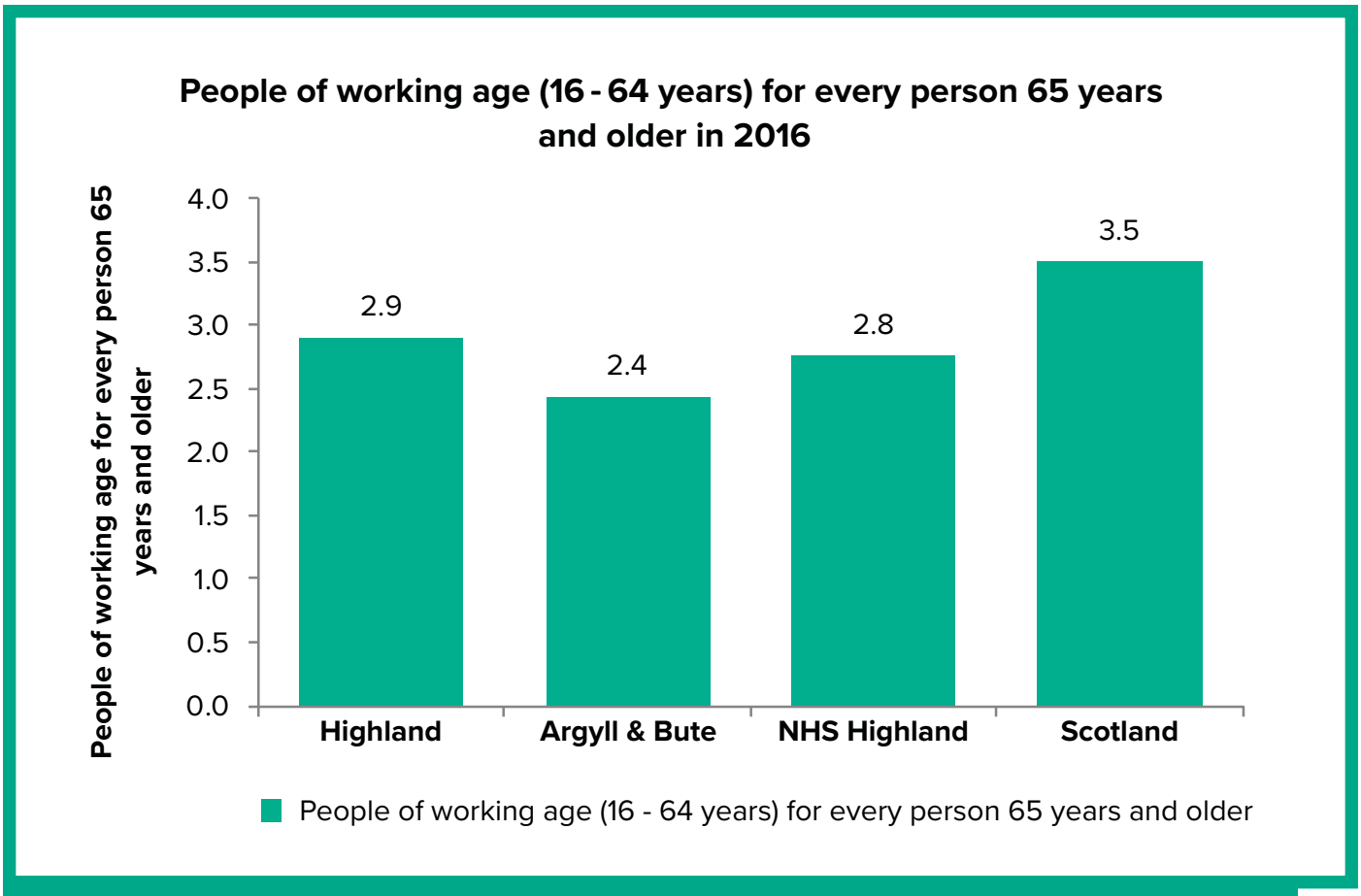


Figure 7.5 - People of working age (16-64 years) for every person 65 years and older in 2016
Source: National Records of Scotland, 2016 mid-year population estimates. Available at: http://bit.ly/2yZWfSd

Across Scotland there are 3.5 people of working age for every person aged 65 and over, this reduces to 2.4 people of working age for Argyll and Bute.

Long term solutions need to be found to the care needs of an ageing western population. New technological developments; examples of which include the use of robot companions in care homes or semi-automated living environments, may revolutionise the way in which we live, in sufficiently affluent societies. These are being piloted, particularly in Japan, but are still a number of years away[3]. We also need to empower communities to find local solutions to caring for those in their own communities and recognise that an approach which relies on the state to solve problems by funding more and more services is unsustainable. The Community Empowerment Act, 2015, has the potential to support such a societal change but will require significant support to ensure that it does not increase social inequity[4].

We need to recruit students locally and provide education locally, so that we train individuals who then stay to live and work in the community they know. There is a need to use workforce planning tools and work with local training providers, particularly the University of the Highlands and Islands (UHI), which uniquely provides both further and higher education, to recruit, train and continually professionally develop staff to undertake a range of health and social care roles. Remarkable

progress has been made in this regard with recent developments around a UHI School of Nursing, training of medical students via ScotGEM, work towards a Care Academy, and the possibility of training a range of Allied Health Professionals within the Highlands and Islands and Argyll and Bute.

Sustainable Financing

There are a range of challenges in delivering sustainable financial models in a health board with the geography of NHS Highland. Some of the challenges in creating a sustainable financial framework that expresses the principles of Realistic Medicine or Prudent Healthcare are addressed below.

Existing health and social care infrastructure across Highland and Argyll and Bute reflect historic rather than current or future need and creates distortions to expenditure contributing to large geographical variations in cost per case. The historic location and configuration of primary and secondary care buildings and facilities needs reviewed, particularly given the demographic changes anticipated in this report.

The increasing availability of expensive technological solutions, which have a small incremental benefit, presents a significant challenge in the context of Realistic Medicine or Prudent Healthcare. Most individuals requiring expensive technological solutions are not treated locally, but are reviewed and agreed by a local 'out of area referrals' process. Requests for treatment are considered by a multidisciplinary panel, chaired by the Director of Public Health, called the Clinical Advisory Group. There can be a mismatch between personal hope in an emerging treatment, and the evidence base. This is particularly the case when significant sums are required for a course of treatment that is highly experimental, with only a slim chance of success. Wherein such cases, the wishes of an individual, however understandable, need to be carefully assessed and balanced with the clinical evidence, endeavouring to provide the best possible care for each and every individual.

Figure 7.6 - Poster for 'Okay to ask' initiative

An excessive focus on cost can be harmful and result in a loss of compassion and a failure to do the best that can be done for each patient. On the other hand, there is an opportunity cost in providing very resource intensive care for one individual, or for a small group of individuals, which is associated with a more hidden but very real loss of an opportunity to treat other patients. Figure 7.6 provides an example of an initiative which encourages patients to question clinical staff from a Realistic Medicine perspective.

Health economic approaches have been developed to address the challenge of assessing new treatments against current options, using the concept of an incremental cost per Quality Adjusted Life Year (QALY). This approach is open to a range of major criticisms around the measurement techniques that are used by health economists, but the Incremental Cost Effectiveness Ratio (ICER) is widely used as one of a number of factors guiding resource allocation decisions[5].

It is not clear what ICER threshold should be used when considering new treatments. The National Institute for Health and Care Excellence has traditionally used a threshold of £20-30,000 per QALY. However, some research has suggested that an affordable threshold is probably around £13,000[6,7].

There are some odd anomalies in the way funding decisions are currently made, which do not sit well with either a Realistic Medicine or Prudent Healthcare approach. Some extremely expensive treatments are handled by the Specialised Services team in National Services Scotland, or at a UK level[8]. The ICERs in some of these contexts are very high. It may be helpful to illustrate the challenges by reference to a specific example:

> An Enzyme Replacement Therapy for a Lysosomal Storage Disorder called Idursulfase which was presented by a drug manufacturer for approval had an incremental cost per QALY of between £564,692 and £1,174,342, as it produced very little benefit to patients[9,10].

Current mechanisms for determining what the drug manufacturer can charge for such medicines are not fit for purpose[11]. There is little relationship between production cost and retail price, and some evidence to suggest exploitation by the pharmaceutical industry[12]. A shorter duration of patent or price caps could be used as part of a Realistic Medicine approach to addressing this issue.

Sustainable planning tools

Sustainable planning requires high quality data. There is a need for greater drivers to improve data quality. Although not without its problems, the National Tariff and Payment by Results scheme that operates in NHS England has driven up data quality and made it possible to benchmark services at the level of individual patients, and has created a driver to measure costs at a granular level. There is a case for considering an alternative approach in Scotland that might have a similar effect.

NHS Highland has had success with a tool called 'the box score', which has reduced costs at ward level in local hospital pilot work, while maintaining quality[13]. The tool provides a method for pulling together and visually managing quality, cost, and workforce capacity on a weekly basis. This example delivers on a number of the aspirations of Realistic Medicine and Prudent Healthcare and is now being shared widely.

Sustainable priorities

Health service planning always involves prioritisation. There are many tools for doing this, none of which are ideal and some approaches have indeed gone badly wrong[14]. Different frameworks take into account different factors when considering system level priorities; one model is shown in Figure 7.7. The model focuses on four helpful high level questions, but still involves judgements that have to be made by service planners.

Another method of prioritisation is to consider thresholds for treatment. This approach has been used more in England than in Scotland. and Figure 7.8 illustrates the effect of changing thresholds over time. The data comes from a study in Australia. The figure demonstrates a rise in the number of patients eligible for surgery from 660 patients in 1950. The rise in numbers in this example is due to changes in

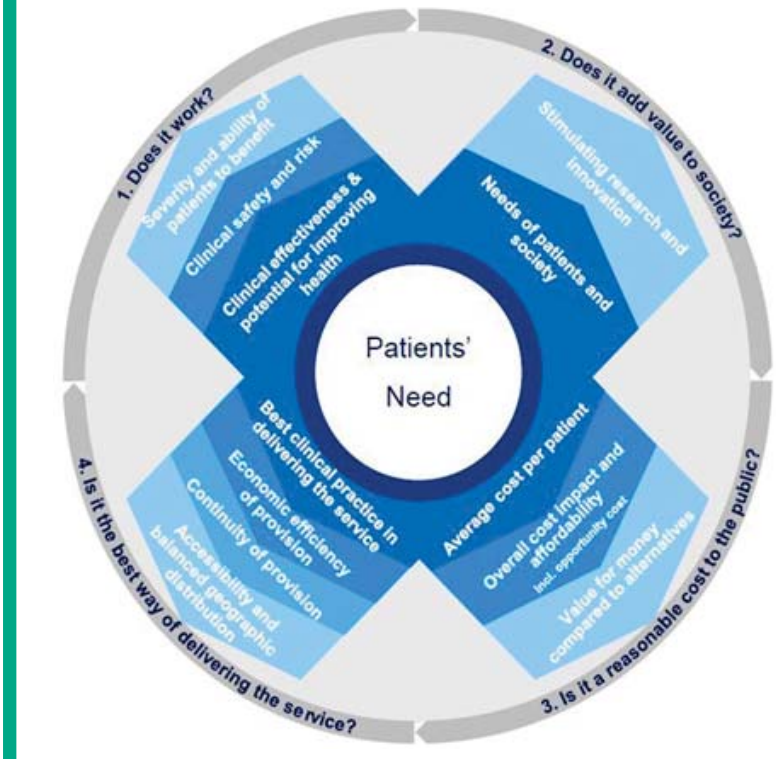


Figure 7.7 - Prioritisation model
Source: Specialised Services Workshop, Wales, 2011

visual acuity threshold and to demographic changes to an estimated 9,070 patients in 2020. The figure also indicates that if the 1950 threshold was maintained until 2020 the number eligible for surgery would only rise to 2,980 patients, as opposed to 9,070 patients. No one would suggest using the visual acuity threshold used in 1950 today, but the example illustrates the way in which technological changes and demographic changes combine to place increasing pressure on healthcare services.

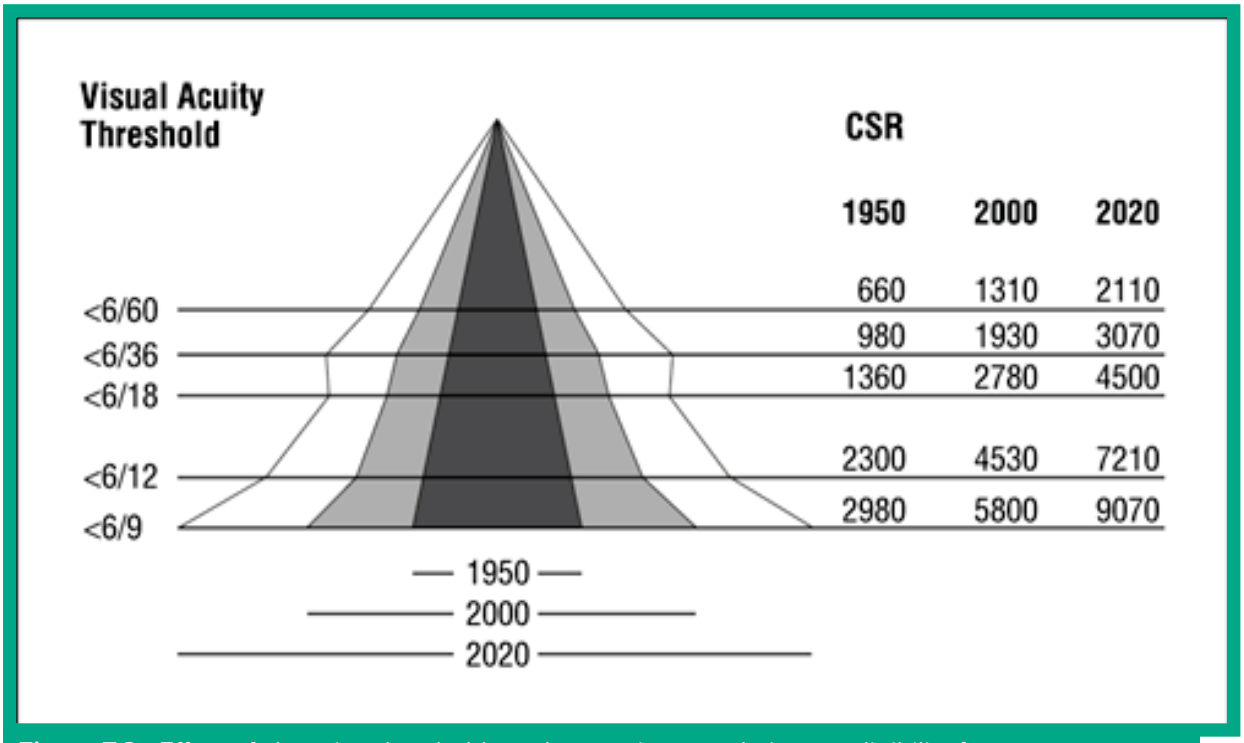


Figure 7.8 - Effect of changing thresholds and an ageing population on eligibility for cataract surgery
Source: Arch Ophthalmol. 2006;124(12):1750-1753. doi:10.1001/archopht.124.12.1750[15]

Decisions on treatment threshold can have significant effects on resource utilisation. It can be argued that in some cases thresholds have fallen too far, for example, as many as one in five patients who have a knee replacement regret having done so[16]. There is a question as to whether such patients represent excessive treatment.

Some of the care we provide can do more harm than good, exposing patients to unnecessary risks. This fact is compounded by the fact that the NHS has historically been poor at monitoring long term outcomes, except as part of formal research. Better long term measurement of patient related outcomes, combined with benchmarking would significantly aid a realistic or prudent approach to healthcare.

Pendulum swings

An emphasis on Realistic Medicine or Prudent Healthcare is welcome but there is a risk that, as the concept takes hold, the pendulum will swing too far in the direction of 'realism', and that some aspects of compassion and generosity may be lost[17]. The social contract underpinning a service free at the point of delivery, where some pay and others benefit to improve equity overall, can easily start to erode.

Totalitarian regimes in the past have argued that the best thing to do is to get rid of the weak and the vulnerable. Thankfully, we are far removed from that position as a society but it would not be too big a step for some in society to start to say that it is not 'realistic' to treat those individuals who do not contribute to economic generation and that we would all be better off if such people were not around.

Some of the harsh restrictions that have been introduced in parts of England, for example, around weight loss requirements before surgery for example, are an area for concern. We must ensure continue to value every member of our population and advocate for access to healthcare for all, regardless of the extent to which an individual may, or may not, have contributed to their condition.

This report has primarily focused on healthcare services however a truly holistic and realistic approach requires recognising the need for complementary upstream as well as downstream actions to reduce variation and inequality across the domains of health, social care, education and income.

Conclusion

Realistic Medicine, Prudent Healthcare and Choosing Wisely have important lessons for clinical service delivery. The underlying principles are also relevant to decision making at population level. Constructs such as social justice and inequality are not explicit in the Realistic Medicine model but have been adopted by the Scottish Government and are central to public health work.

Income equality is particularly a challenge to health at a global level, see Figure 7.9. The richest 85 people on the planet own as much as the poorest half of humanity; a degree of skew in the distribution of wealth that few of us would wish to condone and which must surely form part of any approach to Realistic Medicine.[18]

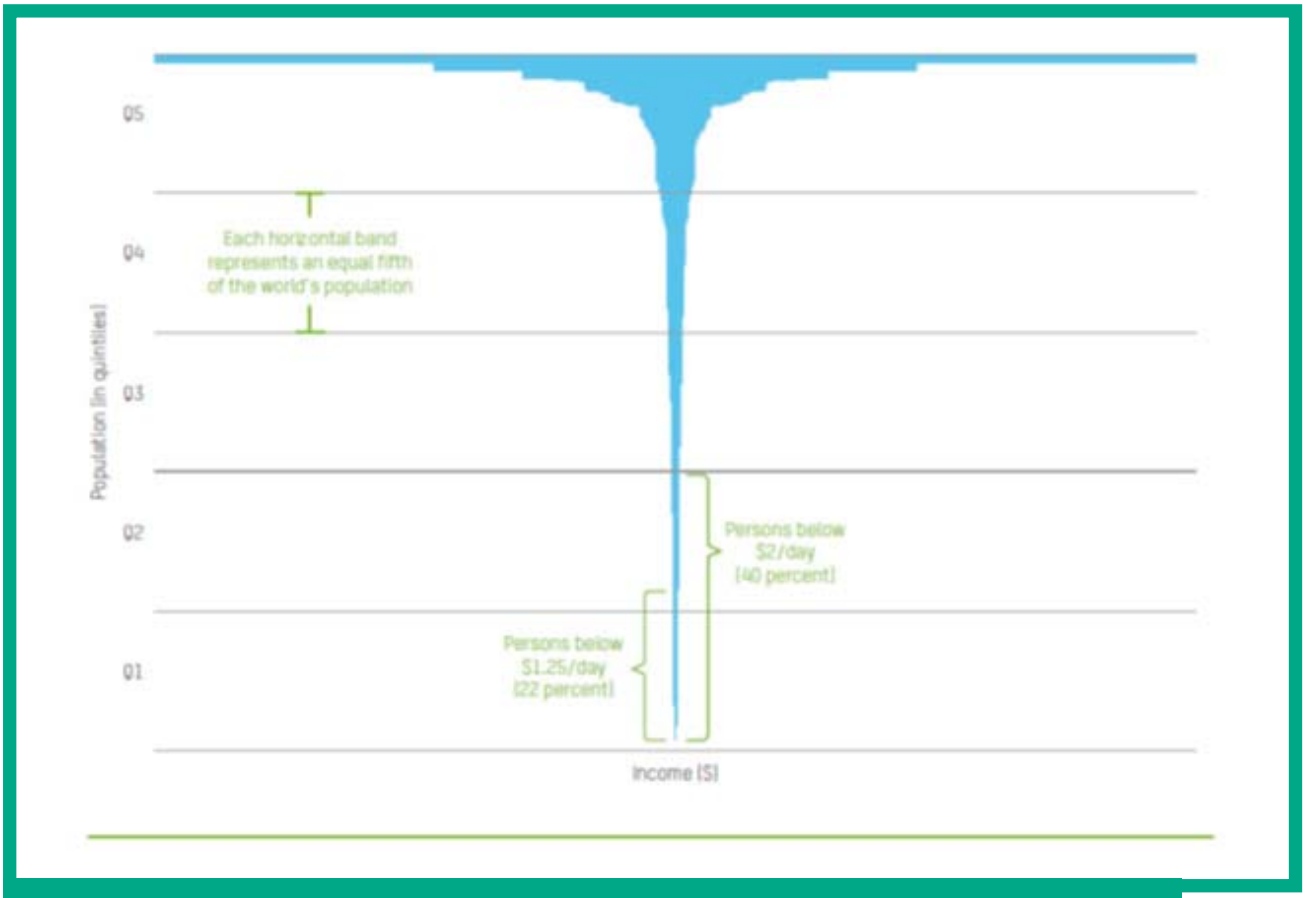


Figure 7.9 - Global income by percentile of population (population in quintiles)**Source:** Seery E, Caistor Arendar A. Even It Up: Time to end extreme inequality. London: Oxfam International; 2014

The value of Realistic Medicine could be enhanced by incorporating these wider dimensions of care and considering its application to population health as well as that to the individual. The approaches outlined in this report are not a panacea, but clearly have the potential to contribute to a more sustainability approach to health and social care in NHS Highland.

The challenges of Realistic Medicine are not new. There has always been a tightrope to walk and judgements to be made in providing healthcare free at the point of access. The concepts

encapsulated in the story of the Good Samaritan are perhaps an ancient example of Realistic Medicine. The story includes the idea of compassionate care, as someone risks their life to rescue a social outcast, provides free first aid, free transport and pays up front for treatment. However, the story also includes the concept of prudence as the payment is only for a fairly tight 'estimated length of stay' supplemented by a post hoc payment adjustment mechanism.

A tight length of stay gave the care provider an incentive to support rapid recovery, whilst recognising that the outcome at the point of admission was associated with a degree of uncertainty. In summary, the story exemplifies generosity and financial prudence. It balances altruism, compassion and courage. In many ways, the challenges we face in the health service today are just the same.

Realistic Medicine Case Study

Rapid Process Improvement Workshops

NHS Highland uses Rapid Process Improvement Workshops (RPIWs) as a quality improvement methodology. RPIWs are a way of bringing staff together to work on a number of related improvements. Wherever possible, service users take part in the event. The workshops use a range of methods including root cause analysis, problem solving, visual controls, focus on service flow, error proofing and Plan, Do, Study, Act cycles.

Examples of recent improvement work using these methods include:

- Delivery of meals at Campbeltown Hospital
- Assessment and allocation of mental health service referrals in Inverness
- Flow through the Emergency Department at Caithness General Hospital, Wick
- Management of people with respiratory problems at Raigmore Hospital, Inverness
- Patient flow at Lorn and the Isles Hospital, Oban
- Management of Long-Term staff absence, with work initially conducted in Invergordon

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Notes

Notes

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PUBLIC HEALTH

NHS Highland

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.3ii

Date of Meeting : 29 November 2017

Title of Report : Argyll & Bute Alcohol & Drug Partnership (ADP) Annual Report

Prepared by : Craig McNally, Argyll & Bute ADP Co-ordinator

Presented by : Alison McGrory, Health Improvement Principal

The Integration Joint Board is asked to :

Note the ADP Annual Report.

1. EXECUTIVE SUMMARY

This report has been produced by the Argyll & Bute Alcohol & Drug Partnership. It has been agreed and approved by the ADP Committee and the Community Planning Partnership before being sent to the Scottish Government.

The report is being presented to the IJB as both a key strategic partner and a major service provider across all ADP priorities.

http://www.argyllandbuteadp.info/img/ARGYLL--.pdf

2. INTRODUCTION

The Alcohol & Drug Partnership are required to present an Annual Report to the Scottish Government with details of:

1. Financial Framework
2. Ministerial Priorities
3. Additional Information

The requirements for the 2016/17 report were in line with the previous year, 2015/16, which were significantly reduced from those of earlier years.

The report was produced by the ADP support team with input from a range of ADP partners.

3. DETAIL OF REPORT

The report is split into three sections as follows:

Section 1: Funding
The report does not represent the total monies within the ADP budget but gives detail of the sum of the funding that the ADP is aware of being allocated by partners to meet the aims of the ADP. This is not an exhaustive list as not all partners provide details of external funding they have received.

The ADP budget for 16/17 was £1,351,200 which was made up of the £972,277 allocation received from the Scottish Government plus £257,923 allocated by NHS Highland to preserve the budget at 2015/16 levels plus an additional £103,000 carried forward from the previous year.

The £1.04m allocation from NHS Highland included the above mentioned £257,923.
In total Argyll & Bute spent £2,562,272 on alcohol & drugs work, including Hepatitis C treatment and services, in 2016/17.

Section 2: Ministerial Priorities
The Scottish Government identified twelve priorities for ADPs to report on.

Within these, three areas have been identified as needing further development in order to see the required level of change:

Priority 2: Alcohol Brief Interventions – Argyll & Bute did not meet the target of 1028 ABIs delivered with only 857 ABIs delivered. – Changes have been made to the ABI delivery model in Argyll & Bute in order to embed delivery within NHS and other services and give management responsibility for the target over to the localities.

Priority 3: Increasing Data Compliance Scottish Drugs Misuse Database – where the percentage of anonymous records was 76%. This will have a significant impact on the ability to implement the Drug & Alcohol Information System (DAISy) when it comes online in April 2018 (Priority 4).-The ADP is working with service delivery partners and ISD to prepare for the implementation of DAISy

Priority 6: Drug Related Death – there continues to be small but steady increase in drug related deaths in Argyll & Bute – a DRD working group has been re-established and is looking at ways to reverse this trend.

Section 3: Additional Information
This section provides details of services the ADP commissioned in 2016/17, the ADP's reporting arrangements and details of both the ROSC and workforce development plans.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

The ADP shares a number of strategic priorities with the IJB including the Alcohol Brief Interventions target and the waiting times target. The report highlights where we are with these and what plans are in place for the current financial year.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact
Financial performance is included within the report.

5.2 Staff Governance
Staff governance and performance against the relevant indicators is included in the report.

5.3 Clinical Governance
Clinical Governance is undertaken by the commissioned services, including the Argyll & Bute Addiction Team, however the ADP did invite all service providers to participate in a service evaluation exercise based around the Quality Principles and led by the Care Inspectorate.

6. EQUALITY & DIVERSITY IMPLICATIONS
The report does not require an EQIA scoping exercise.

7. RISK ASSESSMENT
Not applicable

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT
The report was coordinated by the ADP support team with the input of services. This did not include the explicit input of service users however the ADP is currently in the process of developing an involvement strategy which will cover service users, families, carers and other interested parties.

9. CONCLUSIONS
The Argyll & Bute Alcohol & Drug Partnership 2016/17 Annual Report indicates that the ADP is continuing to progress towards all of the strategic priorities set out by the Scottish Government.

The ADP recognises that there are local priorities which run parallel to the national priorities and continues to work in partnership across Argyll & Bute to ensure these all remain within our strategic aims.

STANDARD REPORTING TEMPLATE - ARGYLL & BUTE ADP ANNUAL REPORT 2016-17

Document Details:

ADP Reporting Requirements 2016-17

1. Financial Framework
2. Ministerial Priorities
3. Additional Information

The Scottish Government copy should be sent by 23 October 2017 for the attention of Amanda Adams to:

Alcoholanddrugdelivery@gov.scot

August 2017

1. FINANCIAL FRAMEWORK -- 2016-17

Your report should identify all sources of income that the ADP has received (via your local NHS Board and, where relevant, Integration Joint Board), alongside the monies that you have spent to deliver the priorities set out in your local plan. It would be helpful to distinguish appropriately between your own core income and other expenditure on alcohol and drug prevention, treatment and support, or recovery services which each ADP partner has provided a contribution towards. You should also highlight any underspend and proposals on future use of any such monies.

Total Income from all sources

Income	Substance Misuse (Alcohol and Drugs)
Earmarked funding from Scottish Government	972,277
Funding from Local Authority	447,625
Funding from NHS (excluding funding earmarked from Scottish Government)	1,039,370
Funding from other sources – carry forward of 15/16 underspend	103,000
Total	**2,562,272**

Total Expenditure from sources – Please note A&B Council figures to be confirmed and added to draft

	Substance Misuse (Alcohol and Drugs)
Prevention (include community focussed, early years, educational inputs/media, young people, licensing objectives, ABIs)	
Alcohol Brief Interventions (ABI) – GP Practices	69,760
ABI Admin Support	2,786
ABI Supplies	555
Children & Young People (C&YP) – Direct Intervention	30,000

C&YP – prevention, early intervention, education and needs assessment	55,000
Training – Multi Agency & Staff Development	5,763
NHS – Public Health	57,168
NHS – Health Promotion / Health Education	5,272
Treatment & Support Services (include interventions focussed around treatment for alcohol and drug dependence)	
Argyll & Bute Addiction Team (A&B ADP / NHS / A&B COUNCIL)	977,693
ADDACTION	88,852
NHS – Blood Borne Virus (Argyll & Bute Addiction Team)	10,000
NHS – Hepatitis C (Argyll & Bute Addiction Team)	46,378
NHS – Methodone Prescribing	119,178
NHS – Drug Misuse Retainer & Maintenance (GPs)	84,802
NHS – Hepatitis C drug costs (Hervoni)	320,070
NHS – Waverley Care for Hepatitis C Support Service	45,000
Naloxone Prescribing	5,076
A&B Council – Residential Placements	16,758
A&B Council – Maxie Richards Foundation – Supported Living	7,362
Recovery	
Engagement of Service Users	39,775
A&B Council – Addictions Recovery Services	244,068
Dealing with consequences of problem alcohol and drug use in ADP locality	
Other	
ADP Support	109,203
A&B ADP Independent Chair	13,890

Partnership Development	84,623
3rd Sector Travel Reimbursement	715
A&B ADP Website Hosting	600
3rd Sector Transition	3,000
Local Forum Support & Service Development	44,074
A&B Council – Miscellaneous Services	74,851
Total	**2,562,272**

2016-17 End Year Balance for Scottish Government earmarked allocations

	Income £	Expenditure £	End Year Balance £
Substance Misuse	**972,277**	**972,277**	**0**

2016-17 Total Underspend from all sources

Underspend £	Proposals for future use

Support in kind

Provider	Description

August 2017

2. MINISTERIAL PRIORITIES

ADP funding allocation letters 2016-17 outlined a range of Ministerial priorities and asks ADPs to describe in this ADP Report their local Improvement goals and measures for delivering these during 2016-17. Please outline these below.

PRIORITY	*IMPROVEMENT GOAL 2016-17	DELIVERY MEASURES	ADDITIONAL INFORMATION
1. Compliance with the Drug and Alcohol Treatment Waiting Times LDP Standard, including, increasing the level of fully identifiable records submitted to the Drug and Alcohol Treatment Waiting Times Database (DATWTD)	• 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. • No one will wait longer than 6 weeks to receive appropriate treatment • 100% data compliance is expected from services delivering tier 3 and 4 drug and alcohol treatment in Scotland	• We continue to sustain performance to meet waiting times local improvement target and LDP standard. • This will be managed through existing service redesign, service user pathway, and process for managing waiting times through routine monitoring of activity and feedback loop. • A&B are attempting to reduce the number of anonymous records prior to the implementation of DAISy. • Quarterly Waiting Times report ensures all stakeholders are aware of current and past performance, enabling improved monitoring.	In 16/17, 94% of drug misuse clients and 91.5% of alcohol misuse clients were seen within 3 weeks, overall 92.75% across both types of service. 99.5% of drug misuse clients and 99.25% of alcohol misuse clients were seen within 6 weeks, overall 99.38% across both types of service.
2. Compliance with the LDP Standard for delivering Alcohol Brief Interventions (ABIs)	• Achieve 100% of the ABI target for 15/16. • Increase delivery of ABIs in deprived communities and across Argyll & Bute as a whole. • Increase the number of GP practices signed up to the programme.	• The short life working group have redesigned the ABI service and this will hopefully improve the numbers of delivered within priority and wider settings. • Implementing ways to increase training capacity.	The target for ABI delivery in the ADP for 16/17 was 1028. There were 857 ABIs carried out across Argyll & Bute during this period, 839 in a GP setting, 0 in non-GP priority setting (A&E) and 18 in a wider setting. This equates to having achieved 83.37% of the target. In 15/16 79% of the target was achieved.

3. Increasing Data Compliance Scottish Drugs Misuse Database (SDMD) both SMR25 A and B.	• Sustain levels of reporting & submission to SDMD • Improve % of identifiable records in DATWT database and in turn SDMD. • Maintain staff knowledge and awareness regarding the process of submitting SMR25 records to ISD.	• Encourage service providers to increase data compliance and act on any feedback received. • Address issues & concerns regarding confidentiality.	The SDMD initial completeness rate for Argyll & Bute ADP is 66% for 2015/16. Service Managers in Argyll &Bute continue to support staff to increase data compliance. The percentage of anonymous records remains too high at 76%.
4. Preparing Local Systems to Comply with the new Drug & Alcohol Information System (DAISy)	• Ensure compliance with SMR25 • Increase the level of identifiable records in DATWT database.	• Continue to raise awareness of DAISy and ROW locally • Support and advise providers	Continuing to work as part of the national process to implement DAISy. Working closely with service providers to ensure staff, service users and systems are ready for DAISy implementation.
5. Increasing the reach and coverage of the national naloxone programme for people at risk of opiate overdose, including those on release from prison.	• Comment on kit distribution • Comment on awareness and training	• Monitor, sustain and increase levels of kit distribution	There were 6 first supply Naloxone kits distributed across Argyll & Bute in 16/17. 7 staff and 10 users were trained
6. Tackling drug related deaths (DRD)/risks in your local ADP.	• Reduce numbers of Drug Related Deaths across Argyll & Bute • Target support & resources to areas most in need	• Further establish and maintain links between Procurator Fiscal & other key partners. • Ensure all DRD meetings are well informed with all relevant parties in attendance and engaging with the process. • Ensure the ADP is represented at the DRD national coordinators meetings held by ISD and act upon learning gained through this forum. • Ensure all deaths are recorded in the National DRD database.	In 2016 there were 10 Drug Related Deaths where the deceased was either resident in or where the death occurred within Argyll & Bute. Drug related deaths in Argyll and Bute more than doubled from 2013 (5) to 2015 (11) and seem to have stabilised in 2016. DRD meetings are now taking place regularly and actions have been taken back to the wider ADP.

7. Implementing improvement methodology including implementation of the *Quality Principles*: *Standard Expectations of Care and Support in Drug and Alcohol Services.*	• Develop a ROSC with support from SDF • Raise Awareness of Quality Principles and embed within the ROSC	• Develop a joint working protocol to increase collaborative working	ADP has worked in partnership with SDF to establish two ROSC pilot areas. A ROSC tool has been developed in one of the localities with a view to cascading across Argyll & Bute. Work has been done in partnership with Highland ADP to look at re-running a Self Assessment exercise with all service deliverers in Argyll & Bute.
8. Responding to the recommendations outlined in the 2013 independent expert group on opioid replacement therapies.	• Ensure local ORT services are in line with ORT recommendations, clinical guidance and best practice	• Address ORT review recommendations through ROSC. • In turn, develop ORT action plan informed by improvement methodologies within the Quality Principles.	Access to prescribing services is in place throughout A&B.
9. Ensuring a proactive and planned approach to responding to the needs of prisoners affected by problem drug and alcohol use and their associated through care arrangements, including women	• Ensure pre/post release care arrangements consider relevant prisoners needs.	• Develop links between community based services and services within local prisons. • Review extent of women in prison from the ADP and look at their needs.	ADP Coordinator has met with Community Justice Lead with a view to increasing partnership approaches and attended Criminal Justice Planning Event and The joint Argyll, Bute and Dunbartonshire's Criminal Justice meeting before it was disbanded in March 2017.
10. Improving identification of, and preventative activities focused on, new psychoactive substances (NPS).	• Raise local awareness of NPS & new law surrounding these. • Examine & assess local drugs trends via a prevalence study and ascertain NPS use locally	• Targeted social media posts regarding the legality and potential effects of NPS. • Continue to work in conjunction with Police Scotland to raise awareness & identify prevalence. • Once study complete, convene short life working group to create action plan.	NPS prevalence has not yet been established. CREW delivered a Train the Trainers course for local Third Sector Partners who then delivered sessions to other staff across Argyll & Bute. Initial discussions have taken place with Police Scotland re looking at prevalence of NPS in A&B

11. On-going Implementation of a Whole Population Approach for alcohol recognising harder to reach groups, supporting a focus on communities where deprivation is greatest.	• Focusing on children, young people & families, undertake initial work around needs assessment & mapping exercise across this group.	• Link SFAD report with national research (including Lloyds PDI 'Everyone has a story' & other local available findings) and use to develop robust proposal for service provision. • Working group will report on findings and give recommendations.	Work completed in conjunction with SFAD examining the extent of local issue within the children & young people age group. Whole population approach for young people implemented and developed in conjunction with Education department and a range of service delivery partners.
12. ADP Engagement in improvements to reduce alcohol related deaths.	• Reduce levels of alcohol related deaths & monitor trends	• DRD group to review DRDs where alcohol was also involved. • Ensure the ADP is represented at the DRD national coordinators meetings held by ISD and act upon learning gained through this forum.	The ADP Information, Research and Performance Officer attended the national ADP Drug related Death Review in Edinburgh in the Coordinators absence.

* SMART *(Specific, Measurable, Ambitious, Relevant, Time Bound)* measures where appropriate

3. ADDITIONAL INFORMATION 1 APRIL 2016 – 31 MARCH 2017

1	**Please <u>bullet point</u> any local research that you have commissioned in the last year.**	• The ADP commissioned SFAD to produce a Children & Young People's Needs Analysis Report, completed in May 2016. • Figure 8 Consulting were commissioned early into 16/17 to produce a Service User Involvement Framework & Strategy • The Scottish Drugs Forum will assist in the development of a ROSC and a detailed work plan has been agreed. • The Scottish Drugs Forum have been funded to coordinate and deliver an education and training programme for the ADP. • Collaborative work planned on collective approach to children and young peoples' services in A & B
2	**What is the formal arrangement within your ADP for working**	• The ADP report to the A & B Community Planning Partnership Management group re the annual report and other relevant published documents. • The independent chair of the ADP sits on a local Chief Officers group and is

	with local partners to report on the delivery of local outcomes?	developing closer links with the IJB, • At a local level the ADP has seven forums, the chairs of these forums meet bi-monthly at an ADP Locality Chairs Meeting to share practice and developments. Each forum is also represented on the DAP Committee by their chairs
3	**A person centered recovery focus has been incorporated into our approach to strategic commissioning.** **Please advise on the current status of your ROSC?**	• In Development in conjunction with local partners and SDF • ROSC is being piloted in two localities with a view to this being rolled out across A&B in 2017/18
4	**Is there an ADP Workforce Development Strategy in Place, if <u>not</u>, are there plans to develop? What additional supports have you leveraged to facilitate this and are you working with our NCOs?**	• Workforce Strategy in place Yes Developed and managed in partnership with Scottish Drugs Forum.

APPENDIX 1

Please provide any feedback you have on this reporting template.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.4

Date of Meeting: **29 November 2017**

Title of Report: **West of Scotland Regional Health and Social Care Delivery Plan**

Presented by: **Stephen Whiston, Head of Strategic Planning & Performance**

The Integration Joint Board |(IJB) is asked to:

- Note the issue of the West of Scotland Regional Delivery Plan position paper and associated appendices covering.
- Consider the impact and expectation on the Argyll and Bute HSCP relating to shaping and influencing the Regional Delivery plan.
- Note the next steps.

1. Introduction

This paper sets out the requirement for the West of Scotland to produce a first Regional Delivery Plan for March 2018 and seek the support of Health Boards and Integrated Joint Boards to work collaboratively to achieve the best outcomes delivered sustainably for the citizens across the West.

The position paper is framed by the following:

- Our guiding principles
- The leadership of the Programme
- The national policy context
- The regional context
- The case for change
- The emerging common purpose
- Early thinking on new models of care
- The regional plan to take this work forward to March
- Next steps
- Statements of intent

There is a clear expectation that in the west of Scotland that the future care models will be developed in four ways as illustrated below:

Understanding the needs of different segments of the population	Addressing as much care as possible proactively and locally	Designing hospital care to deliver safe and sustainable services	Putting in place the key enablers
• Use ISD data to have fact-based discussion on population segments • Identify specific patients and segments to make targeted interventions to care plans and care models	• Integrated services covering primary care, community care, social care, mental health, access to specialist diagnostics • Services integrated and co-ordinated from patient view • Increased funding and capacity outside hospital • Effective multi-disciplinary team working	• Establishing clear standards for safe delivery of services – Interdepend-encies – Workforce – Volumes • Establishing different levels of hospital services • Networking hospitals for sustainable high-skilled services	• Digital • Workforce • Estates • Organisational development • Financial Allocation Model • Governance • Communications & engagement

2 Next steps

The production of the Regional Delivery plan by the end of March 2018 is to be informed from the statement of intent leading to a variety of programme actions to deliver the plan:

- Develop and publish a clinical case for change.
- Come together as regional leaders of our health and care system and set out a comprehensive programme to deliver our vision and common purpose.
- Develop a region-wide planning process that will describe what will be planned and delivered by whom at national, regional and local level.
- Assess the care needs of our population, taking into account the different needs of Individuals and segments of the population.
- Develop local care models for the highest priority population segments and model the impact of these interventions on future acute capacity requirements.
- Develop a stratified model of local and acute care setting out the different levels of service provision in the different facilities across the region; understanding the implications for future service configuration.
- Hold engagement sessions with our population, frontline staff and policy-makers to inform them of the regional delivery plan and allow them to shape and coproduce it with us.
- Develop a view of the impact of this plan on the future capital investment requirements for the region, including hospital and out-of-hospital infrastructure.
- Assess the impact of this plan on our workforce and outline our future workforce strategy;
- Informing future training and education requirements.
- Evaluate the impact of the implementation of this strategy on finance and activity and outline a financial plan to support implementation.

The HSCP is an important stakeholder in this work to ensure the developing care models are influenced by and take account of the rural health and care needs of Argyll and Bute's communities both mainland and Island.

Representatives from the HSCP senior management and clinical leadership are members of the programme board and various work streams.

The Governance and approval processes of the developing regional plan requires the consideration and consultation of the Argyll and Bute HSCP IJB as it proceeds through to March 2018.

3 Governance Implications

3.1 Contribution to IJB Objectives

The Regional Health and Social Care Delivery plan aligns with the IJB objectives as detailed in its strategic plan.

3.2 Financial

There are a number of significant capital and revenue implications in producing and subsequently implementing the plan which will require the IJB to factor into its financial planning and management going forward

3.3 Staff Governance

The workforce requirements will require extensive and ongoing staff partnership involvement in shaping the plan for the future workforce and subsequent implementation.

3.4 Planning for Fairness:

A fundamental approach to planning at regional level is ensuring health inequalities are identified and addressed and assessment and impacts will be on-going.

3.5 Risk

Actions to mitigate any risk with regards to services, safety and finance will be incorporated in the programme but will also require IJB risk identification for mitigation and action.

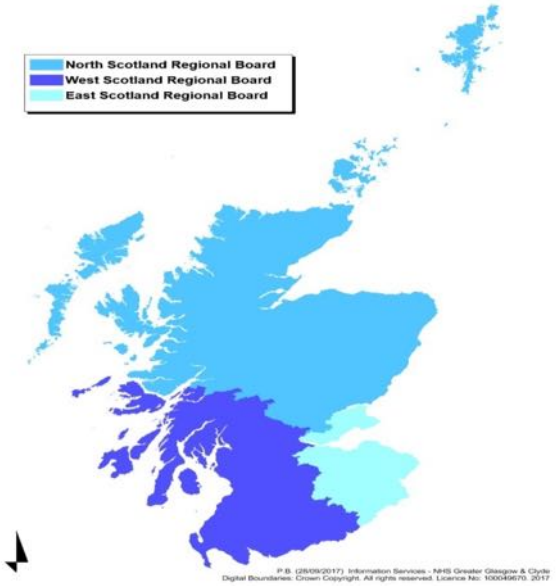
3.6 Clinical and Care Governance

Clinical and care safety is seen to be at the core of the Regional planning taking account of service demand, sustainability, capability, infrastructure and resources.

3.7 Public Engagement and Communication

An extensive public engagement and involvement programme will require to be conducted over the next few months across the West of Scotland and the HSCP will be asked to support this.

West of Scotland



Developing a Regional Plan

Position Paper and Discussion Document
September 2017

1. Introduction

This paper describes the collective ambition of the West of Scotland to improve the health and care for people across the Region. It has a particular focus on keeping people well, early intervention and developing better, more integrated care organised around the individual needs of the patients we serve. It builds on the many examples of excellent care already provided across the Region and reflects our local aspiration to deliver the *National Health and Social Care Delivery Plan* providing better health, better care and better value.

The paper is structured as follows:

- Summary of our overall approach
- Our guiding principles
- The leadership of the Programme
- The national policy context
- The regional context
- The case for change
- The emerging common purpose
- Early thinking on new models of care
- The regional plan to take this work forward to March
- Next steps
- Statements of intent

Delivering this vision will require action at every level of the health and care system across the Region. Our starting point is to recognise that circa 90%of care is provided in an out of hospital setting. Our approach will therefore build first and foremost on the needs of local communities whilst also recognising the need to plan for the most seriously ill who will require more specialised hospital based services.

Our approach is to collectively plan to improve the health and wellbeing of our 2.7m population, reducing inequalities and improving health outcomes for our citizens. It will be grounded in effective and meaningful partnership between health care, local authority services, primarily social care, the third sector, patients and communities. The Regional Delivery Plan will support both the Local Delivery and Health and Social Care Strategic Commissioning Plans and taken together with these plans will describe a strategy for the health and social care for the Region's population as a whole.

2. Executive Summary

Regional planning in the West of Scotland with the focus on acute and tertiary services has served us well for many years. These arrangements are no longer fit for purpose, as the task to prepare a Regional Delivery Plan requires a different and more inclusive approach. Therefore, we are putting in place new arrangements to co-ordinate planning across the Region.

The NHS in the West of Scotland has demonstrated significant improvements over the last 20 years; however there is further work to be taken forward to meet the challenges of the next 20years. Preventable illness is widespread and health **inequalities deep-rooted**.

New technologies and treatment options are emerging, and **patients' needs are changing**. We face particular pressures in providing care to an increasingly older population recognising they will need more joined up integrated care to stay well and lead a full life.

In the West of Scotland, we have a shared understanding of the challenges we face and have developed a **compelling Case for Change** as a basis for action.

We have developed a **shared vision and a common purpose** which describes our future offer for our patients and communities. Our ambition is to join up care around the patient breaking down traditional barriers in how care is provided between family doctors and hospitals, between physical and mental health and between health and social care. This future will see far more care delivered locally nearer to people's homes but with some services in specialist centres.

We are committed to **Local Care Models** based on a deep understanding of the different needs of segments of the population, a consistent set of clinical standards and with services integrated and co-ordinated from a patient view.

Whilst most people can be cared for by better more joined up local care, we recognise the most seriously ill need more specialised hospital care. We are committed to developing a region-wide framework to support the development of **New Models of Acute Care** based on a stratified network of services.

To deliver this vision we have put in place comprehensive programme arrangements including **System Leadership through a Regional Programme Board** and have set out a **Forward Programme Plan** (October to March) to deliver the first strategic plan in March 2018.

3. Guiding Principles

In drafting this document and developing the plan, we are proposing to apply the following principles:

- Prevention is better than cure
- Care should be designed around the needs of the whole population removing boundaries in planning and delivering care
- Focus on reducing health inequalities by working together on the wider determinants of health
- Care should be provided as locally as possible and only centralised where absolutely necessary
- Care should be integrated across health and social care working in true partnership with patients, carers and the voluntary sector
- We should make the best possible use of resources achieving value for patients, communities and the tax payer.

4. Leadership of the Programme

The West of Scotland comprises a number of partner organisations supporting the provision of health and care services including 5 Territorial Boards, 15 Health and Social Care Partnerships, 16 Local Authorities, 5 National Boards and a number of Third Sector Organisations.

West of Scotland Partners

Health and Social Care Partnerships (15) / Local Councils (16)[1]	• Inverclyde • East Renfrewshire • West Dunbartonshire • North Ayrshire • North Lanarkshire • Dumfries &Galloway • Falkirk • Glasgow City	• Renfrewshire • East Dunbartonshire • East Ayrshire • South Ayrshire • South Lanarkshire • Stirling & Clackmannanshire[1] • Argyll and Bute
NHS Territorial Boards (5)	• Ayrshire & Arran • Forth Valley • Lanarkshire	• Dumfries & Galloway • Greater Glasgow &Clyde
NHS National Boards (5)	• Scottish Ambulance Service • NHS 24 • Golden Jubilee Foundation	• National Education Scotland • National Shared Services

1 Local Councils are typically 1:1 with HSCPs with the exception of Stirling and Clackmannanshire which has 2 Councils and 1 HSCP
Source: Regional Team

Recognising the importance of all the key stakeholders in developing a plan for the future in the West of Scotland work, we began working with Boards and their executive and non executive members, the Integrated Joint Board chief officers and their voting members, and other senior managers and senior clinical leaders' to begin to create a shared agenda. We recognise that we have further work to do engage with and include Local Authorities, Integration Joint Boards and the third sector in the development of this plan, particularly around the social care element of this work. This will be progressed over the next few months.

Some of this work has been facilitated by external organisations to encourage a more transformational approach both to developing the regional delivery plan and the ways in which we will need to work across the different parts of the system to achieve success, learning from experience both within the United Kingdom and across other parts of the world.

Stakeholder Engagement

Our first set of meetings aimed to set out the question we believe we needed to answer as a region. This can be described as:

How do care services need to be configured in the West of Scotland to be safe, sustainable, equitable, effective and affordable to meet the needs of the 2.7m population going forward to 2035 and support the delivery of the Health and Social Care Plan?

The workshop engaged more than 65 people in shaping approach




An engagement session on the 20th September 2017 saw representatives from the NHS Boards, the Integrated Joint Boards come together to consider the emerging story for the region. The session set out for consideration and discussion:

- the key messages arising from the population needs assessment;
- the key messages from the gap analyses on workforce, demand and performance analyses, finance and infrastructure;
- the case for change;
- the common purpose that unites us as a region
- the potential interventions in care models and a stratified model for designing services
- the programme structure to support the development of the Regional Delivery Plan
- the approaches we need to adopt to communication and co-production as we go forward to prepare the first regional delivery plan for March 2018, including the approach to governance and sign off prior to submitting the plan at the end of March 2018.

This session allowed key regional stakeholders to come together to consider and agree the vision for the region and the guiding principles and behaviours that will be crucial to develop and maintain the relationships across the region and to create the arrangements and necessary conditions to engender a whole system approach to achieve the collective goal.

5. National Policy Context

Over the past eighteen months 2 key documents – the Health and Social Care Delivery Plan and the National Clinical Strategy- have been published providing the policy direction and setting out the way forward in Scotland in terms of health and care of our population on top of the existing Quality Strategy that sets out an ambition for quality.

National Health and Social Care Delivery Plan[1], launched in December 2016, describes the approach to be followed to ensure that Health and Social Care is transformed in the next few years. It is action orientated, and sets out a significant list of deliverable objectives which include a focus on regional and national planning of services where appropriate. The delivery plan draws on preceding strategies, pulling them together and setting out the direction of travel and expectation of a modern health and care system to achieve the aspirations mentioned in the strategies.

- 2020 Vision – people live longer, healthier lives at home or in a homely setting
- Health and Social Care Integration[2] which promotes prevention, anticipation and supported self management; working across health and social care to improve patient care
- Daycase treatment as the norm
- Highest standards of quality and Safety (Quality Strategy 2010)
- Person centred care
- Health and Social Care Workforce Plan[3]– considering workforce planning and development
- Investment - matched to reform and transformation
- Digital Strategy[4] - promoting technology and information supporting both patients and care professionals to provide modern models of care

The National Clinical Strategy[5]published in February 2016 set out areas for change:

- 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/ availability of appropriately skilled workforce paradigm
- Providing high value, proportionate, effective and sustainable healthcare (linked with Realistic Medicine)
- Transformational change supported by investment in eHealth and technological Advances

The National Clinical Strategy also calls for regional planning of many hospital services to improve patient outcomes; to make maximal use of highly trained clinicians; to fully utilise complex services supported by expensive technology such as robotic surgery; to standardise care to avoid unwarranted variation; and to make services financially sustainable for the future.

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[1] http://www.gov.scot/Resource/0051/00511950.pdf
[2] www.shiftingthebalance.scot.nhs.uk/downloads/1305042182-Integration(Summary position paper)
[3] Integration across Health and Social Care Services in Scotland – Progress, Evidence and Options: www.gov.scot
[4] http://www.ehealth.nhs.scot/strategies/the-person-centred-ehealth-strategy-and-delivery-planstage-one/
[5] www.gov.scot/Publications/2016/02/8699

The King's Fund has considered the evidence of benefit from reconfiguration of acute services and notes that while reconfiguration can lead to improvements in services:

> *"Reconfiguration is an important but insufficient approach to improve quality. It should be used alongside other measures to strengthen delivery of care and to instil an organisational culture of improvement."*[6]

Other national policies and strategies influencing the development of the regional delivery plan include:

- Best Start *(Maternity and Neonatal Services Strategy – 2017)*
- Primary Care Transformation
- Implementing the GP contract
- Mental Health Strategy
- Cancer Strategy (March 2016)
- Getting it Right for Every Child (GIRFEC)
- Realistic Medicine
- Review of Health and Social Care Targets
- Public Health Strategy

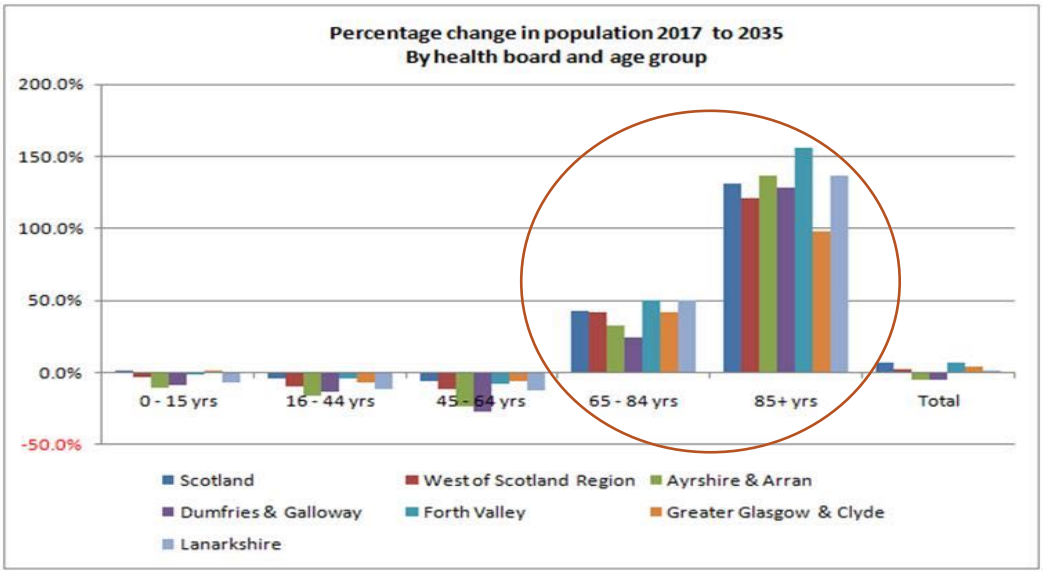
[6] The King's Fund: *Reconfiguration of Clinical Services: What is the evidence?* Candice Imison. November 2014

6. Regional Context

6.1. Understanding the Population

The West of Scotland serves a population of circa 2.7m, covering a wide geographic area of 8,777 square miles, consisting of urban, rural and island communities. A Health Needs Assessment for the West of Scotland is currently being progressed. A significant number of analyses have been identified and undertaken which will support the work over the coming months to consider the service model and provision for health and care services for the region. Beyond the work to consider the population age, gender, deprivation levels and the implications of this both in relation to health and social care provision, use and funding levels, work is considering the use of services, life expectancy and health outcomes; reviewing the trends in this over the last decade or longer.

Population Changes in West of Scotland



Population Needs Assessment: Emerging Findings

- The West of Scotland has some of council areas with highest proportions of oldest residents in terms of population percentage over 65.
- It also has most of the most deprived council areas in terms of summary SIMD score (Glasgow city, West Dunbartonshire, Inverclyde, Renfrewshire, North Lanarkshire, East Ayrshire) and the bulk of the population residing in the most deprived deciles and quintiles.
- Both social deprivation and agedness of the population place major demands on the health and care systems
- The challenges of equitable service provision based on need rather than demand in a geographic area that also has considerable sized areas of affluence results in smaller National Resource Allocation Committee (NRAC) and Scottish Allocation Formula (SAF) shares for hospital & community services.
- Hospital admission rates are observed to be higher in the West of Scotland based on the crude rates. Work is underway to age, sex, deprivation adjust this position to assess the

level of over-utilisation. This poses the question - does the proximity to hospital facilities encourage access particularly where they are relatively well provided for in terms of hospital beds and consultant provision?

- Plateauing of the life expectancy at birth is seen for Scotland as a whole, which is particularly clear for Scottish males, and evidence of unexpected downward shifts in the life expectancy trajectory are visible in some areas within the region. Stalling of rises in life expectancy defying the expectation of ongoing improvements in longevity. This is likely to be multi-factorial
  - including the effects of the high prevalence of obesity, the rising prevalence of Type 2 Diabetes, the stalling decline of smoking prevalence, the contribution made by the rise in alcohol-related deaths, etc
  - the role of austerity and level of investment in health and social care may be impacting, as well as the current organisational model that may hinder the achievement of optimal efficiency.
  - falling access to primary and secondary health services, and social care, for some sections of the population in both remote/ rural areas and urban areas.

  All of these threaten to reverse the progress made by improving structural determinants of health over the past century and increased health service provision over the past 15 years.
- Consistently clear improvements in most health parameters, as well as preservation of, or improvement in, the relative position in the national health league table, are being seen for the residents of the most deprived health board in the West of Scotland, namely Greater Glasgow & Clyde, in terms of standardised death rates from all causes, and standardised mortality ratio for all causes, SMR for cancer mortality for all types, and specifically for the commonest cause of death, namely heart disease.
- Despite having less social deprivation than GG&C, Lanarkshire's relative position in the standardised mortality (all causes) league table has worsened somewhat in recent years and its relative position in the cancer mortality league table for all types combined and for lung cancer in females has also worsened.
- Perhaps more surprisingly, more rural areas in the West of Scotland, even those characterised by relative affluence such as Dumfries & Galloway and Argyll & Bute, have unexpectedly lost ground and those with historical health deficits, such as parts of Ayrshire & Arran, appear to have deteriorated further in very recent years. Age/sex standardised death rates (all causes), standardised mortality ratios (all causes of death), and/or SMR for cancer (all types combined) appear to be rising in recent years, for these three board/council areas, the starting points of the rises varying with the area. Even the more affluent Forth Valley, appears to have lost ground with respect to its relative position in the cancer (all types) SMR league table, since its enviable position before 1990.

To ensure that the limited resources available are used equitably, that is, determined by genuine need, and fairly distributed against both geographical and socio-economic gradients, it will be important to consider the service provision across the region.

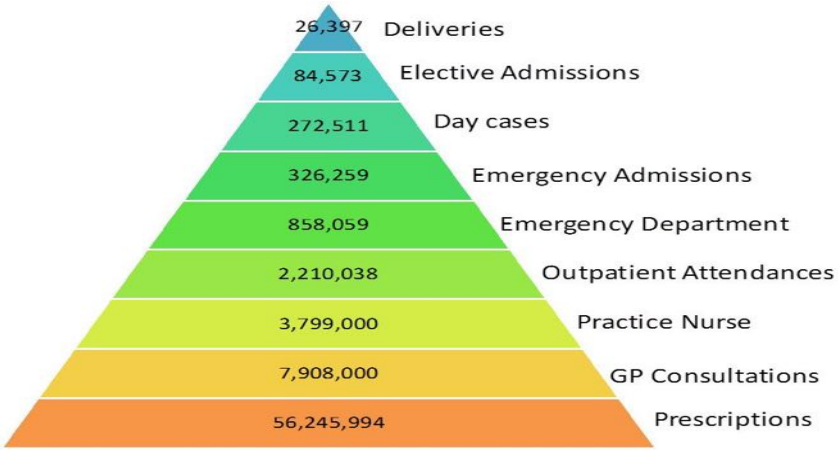
6.2. Demand Capacity Review

As with the Health Needs Assessment, analyses are being undertaken to consider the demand for and use of services. The focus to date has been primarily on health but this will be extended to include the social care provision for the plan submitted in March. This work has been reviewing a number of areas including analyses of: activity by admission category and by specialty; changes in activity; beds, bed days used and length of stay; projected position by 2020, 2025 and 2035; performance data including waiting times and waiting list information, outpatient measures and day case rates.

Information setting out the position for the West of Scotland is available in a supporting paper however some of the high level messages of this work to date are set out below:

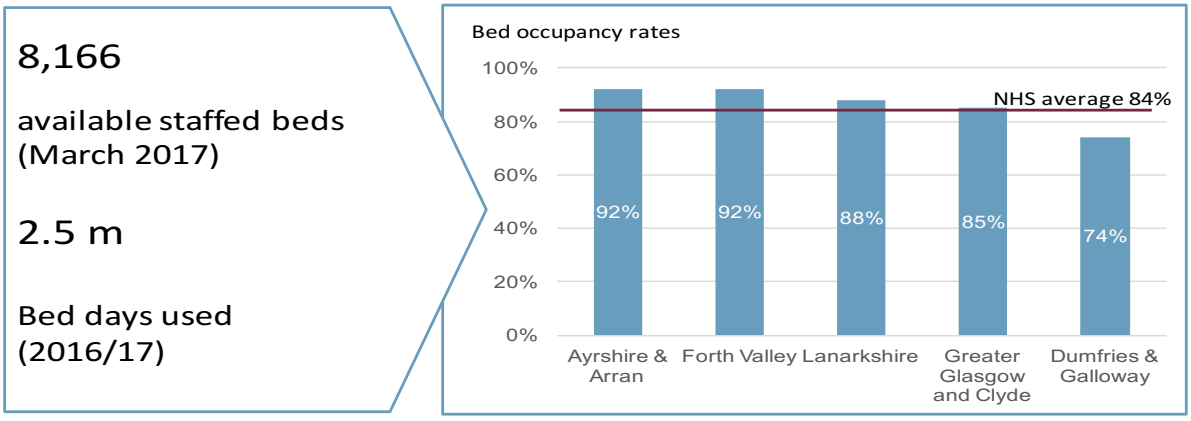
West of Scotland Activity

The diagram below sets out some of the key areas of activity, indicating the different levels of activity, providing some context in terms of where the services are provided.



Work has also been undertaken to consider the bed numbers and bed days being used to support the hospital service provision across the region. The inserted information below shows the current position based on the expected percentage growth of the population based on how the current service is used by different age bands of the population and the potential future scenarios if there is no change.

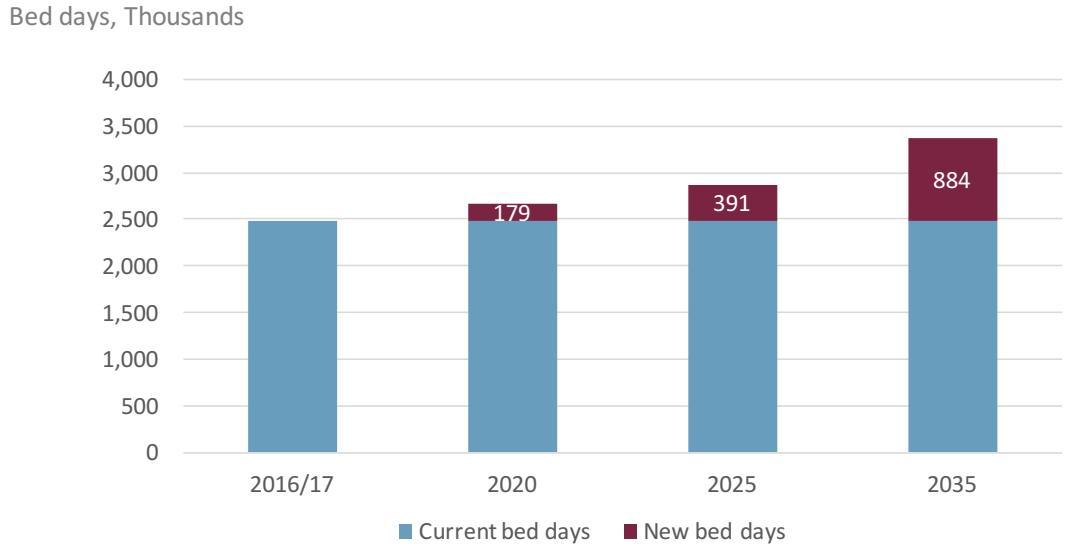
Current acute bed status in West of Scotland



Projected changes in activity and bed days, based on demographic growth only

Of particular note is the rise in bed days in addition to the 200,000 currently to be saved. With the current model of care, we expect there to be demand for an additional 880,000 acute bed days by 2035– 2,850 beds assuming an 85% occupancy rate.

Projected changes in occupied bed days due to demographic changes only



Source: Regional team analysis

6.3. Workforce Challenges

The NHS in Scotland must adapt its workforce models to be in the best position to deliver excellent and sustainable treatment and care in a rapidly changing Health and Social Care landscape. Workforce planning must take account of the national workforce planning work and consider the workforce challenges across the health and social care sector. West of Scotland Health Boards have been working together to develop a position which accurately describes the workforce within the region and identifies the principle workforce issues which must be addressed in order to deliver new regional models of clinical care:

- Workforce availability
- Workforce adaptability

- Workforce affordability

The West of Scotland Health Boards currently employ 62,630 wte / 72,620 head count, which accounts for approximately 45% of the NHS workforce in Scotland. Each Board has reviewed the ISD dataset to identify specific factors, where applicable, in terms of risks and challenges, opportunities and options to create an overall high level regional workforce position.

A supporting paper on the work to date is attached in the appendix. The high level message is that there are five key 'hot spot' job families/professions across the region:

- Medical – challenges in demand, supply and sustainability across a spectrum of grades, specialties and including general practice;
- Nursing – specifically challenges in smaller branches/cohorts associated with the overarching demography of the workforce and the potential risk this presents in terms of retirement profiles e.g. health visitors, district nurses, paediatrics, midwifery, mental health and associated issues with demand and supply. The demand for Advanced Nurse Practitioners (ANPs) was also specifically flagged. This mirrors the medical position both in acute settings but also increasingly within GP practices. There remain questions about the capacity of higher education institutes to meet demand;
- Radiographers – mismatch in supply of radiographers compounded by the increasing demand for services and existing problems with radiology staffing;
- Pharmacy technicians – significant increase in demand not being matched by supply;
- Healthcare science – demographics of the workforce, particularly in senior roles, are influencing the current provision couples with longstanding national issues with supply;

Issues informing the need for change are currently being quantified in terms of medical staffing as this proves challenging in providing equitable access to specialist opinion to support care in a number of Boards and specific specialties within the region. Currently there are circa 269 vacancies at consultant level (119 vacant for 6 months or more). This exercise will in time cover all staff groups.

It is recognised that the workforce of the future will not be "more of the same". The workforce will be older and have a greater reliance on Advanced Practitioners and roles with extended scope. All staff groups will be required to work to the "top of their licence" with work aligned to their skills. It is likely that the workforce may require to be re-profiled to match the increased workload demand in the community and the higher acuity in acute care. The Directors of Nursing are leading work through the West of Scotland Advanced Nurse Practitioner Academy to ensure consistency of competency and level of practice across the West of Scotland, sharing resources where appropriate. This is enabling the West of Scotland to get assurance with regard to growth of this important senior group. They are also looking at non-medical care models to develop new and extended Advanced NMAHP roles such as caseload holders, clinical leads as alternatives to medical models for particularly hard to fill specialties.

As part of the development of the first plan for March 2018 work will be undertaken to understand the total workforce supporting health and care services within the West of Scotland.

6.4. Infrastructure

Based on the report prepared by Health Facilities Scotland the West of Scotland faces significant challenges in relation to the infrastructure within health. The Report indicates that

around 50% of the estate is modern, offering good functional accommodation however 50% of the estate has significant challenges. This is summarised below:

Modern estate

- Queen Elizabeth University Hospital & Royal Hospital for Children
- Stobhill and Victorla ACHs Glasgow
- New Dumfries and Galloway Hospital
- Forth Valley Royal Hospital
- 2 PFIs / PPP facilities – Hairmyres, Wishaw (Lanarkshire)
- Golden Jubilee Hospital
- New community care estate such as Eastwood Health and Care Centre and other similar primary care facilities

Estate with significant challenges

- Backlog maintenance around 1/3rd of national total
- Physical condition, age and functional suitability challenges a number of sites
- 3 similarly sized hospitals south west of Glasgow, with a growing need for investment RAH, Crosshouse Hospital and Ayr Hospital
- East side of Glasgow - GRI and Monklands will struggle to provide functionally appropriate accommodation. There are also challenges around the need to improve engineering services infrastructure to support these sites.
- Outlying areas of the region need investment in buildings and engineering services; specifically IRH, Vale of Leven and Falkirk Community Hospital
- Some GP practices

The current position offers both a challenge and an opportunity to build the future infrastructure based on the needs of the population organizing care in the most appropriate setting and using the workforce to best effect to provide the right care level within the hospital or community settings.

- £1bn - £2.5bn investment required
- Investment strategy combining replacement, refurbishment and rationalisation likely to offer most effective and affordable solution
- Health and Care Facilities and requirements as well as national work on primary care being undertaken by Health Facilities Scotland will also be included in the March 18 plan
- Medical Equipment and technology investments are currently being reviewed
- Offers new opportunities to consider different infrastructure to support future services

  The Regional Delivery Plan must bring a co-ordination to the planning of and investment in infrastructure that supports the care models developed.

6.5. Finance

The financial plans submitted by the West of Scotland Health Boards for 2017/18 show a combined recurring deficit of £237m.

	Greater Glasgow & Clyde £m	Ayrshire & Arran £m	Forth Valley £m	Lanarkshire £m	Dumfries & Galloway £m	Total £m
New Resources:						
Baseline increase	31.1	10.0	7.3	23.5	4.2	76.1
Social Care Fund	(23.7)	(7.7)	(5.3)	(13.4)	(3.0)	(53.1)
New Medicines Fund	(7.9)	(2.6)	(1.5)	(3.7)	(1.8)	(17.5)
Income from other Boards	2.4					2.4
Other (including NRAC)	0.0	1.5	5.4		1.7	8.6
Total new resources	**1.9**	**1.2**	**5.9**	**6.4**	**1.1**	**16.5**
Additional Expenditure:						
Recurring over/(under) commitment b/fwd	29.6	17.7	7.5	9.5	4.8	69.1
Pay inflation estimate	20.0	4.8	3.3	7.2	3.6	38.9
Other Costs (incl medical staffing)	6.0	3.1	4.4	8.7	4.5	26.7
Supplies inflation estimate	6.0	5.0	4.7	4.8	0.4	20.9
Primary Care prescribing	8.5	5.6	2.9	1.4	1.2	19.6
Acute prescribing	21.0	0.3	2.4	8.6	0.7	33.0
Other prescribing			2.5			2.5
Capital charge inflation	1.0					1.0
Apprentice levy	8.0	1.5		2.0	0.8	12.3
Rates revaluation	11.0	0.3	1.2		0.5	13.0
Pension cost (RRL to AME)	3.5					3.5
National services	1.5	0.4	0.1	0.3		2.3
Premises costs	3.2	0.9				4.1
Out of Hours and other regional costs	5.0	0.4	0.9			6.3
Total additional expenditure	**124.3**	**40.0**	**29.9**	**42.5**	**16.5**	**253.2**
Financial gap to be closed	**(122.4)**	**(38.8)**	**(24.0)**	**(36.1)**	**(15.4)**	**(236.7)**

Work is currently under way to complete a forward look for the next three years but this is difficult given uncertainties around future funding assumptions regarding Scottish Government funding uplifts and pay policy. To set a context for the financial parameters of the regional plan, a three year forward projection is being developed based on the following assumptions:

- **Annual Scottish Budget allocations** – assumes that the basis in which funding was allocated for 2017/18 continues for 2018/19 and 2019/20 (annual uplift to meet cost pressures <1%).
- **Transfer resource** – share of the transfer of £250m from Acute to IJBs in line with national target to reduce bed days by 400,000. This will also provide 50% of the commitment to increase primary care funding by £500m by the end of the current parliamentary term. The other 50% being funded directly by Scottish Government Commitment to 50:50 split between primary / community care and acute costs by end of the current parliamentary term also factored into three year forward projections.
- **Projected Cost Base** – assumes 10% inflationary increase (3%pa) on 2016/17 budgets over the next three years (conservative estimate).
- **Earmarked allocations** – assumes that these will be spent of new commitments and therefore no net benefit to overall financial position.
- **New medicines and diagnostic costs** - assume increase for secondary care medicines and diagnostics in line with recent historic patterns.

- **Capital**– no change in formula funding allocation to be prioritised towards backlog maintenance and essential equipment replacement.
- Changes to pay policy will impact future modelling

7. Case for change

Everyone deserves to lead a full and healthy life and to receive the best possible care when they become ill. The West of Scotland has many areas of excellent care of which we should be proud of but we know that we could do more both to prevent ill health and to improve outcomes.

Over the last few years we have seen improvements in the services and infrastructure for patient care. For example:

- We opened the Queen Elizabeth University Hospital and Royal Children's Hospital in Glasgow. We will shortly open a new hospital in Dumfries and Galloway.
- We have reorganised our community services, placing responsibility for local health and social care services under the joint leadership of the NHS and Local Authorities.
- We have successfully provided a number of regional services such as interventional cardiology, based in 2 facilities at Hairmyres in Lanarkshire and the Heart and Lung Centre at the Golden Jubilee Foundation; Forensic medium-secure care at Rowanbank Clinic, Glasgow. The Beatson West of Scotland Cancer Centre on the Gartnaval Campus in Glasgow which we have recently extended by developing a satellite cancer unit at Monklands in Lanarkshire; and most recently the Regional Robotic Prostatectomy Service at the Queen Elizabeth Hospital.
- There is ongoing work to reorganise and improve specialist services across the West of Scotland including major trauma, systemic anti-cancer therapy, urology and ophthalmology. Each of these services seeks to improve patient outcomes by organising care in the most effective way; providing the timely access to specialist care and through standardising approaches to optimise care.
- Integrated Joint Boards have progressed change in local care through the Integrated Care Fund and Primary Care Transformation.

Staff work hard so that we can continue to care for people under greater and growing pressures on the services. Despite all of this work, there is an emerging set of facts that we believe will not make it possible for the care services to stay on the current path without causing significant issues for our patients and staff as well as circumstances which we believe will make the current service model unsustainable even in the short term. This set of emerging facts, tested with senior colleagues involved in leading care services in the West of Scotland, who have confirmed their support for this, can be grouped around 8 major themes:

- **Our population is changing and so are their care needs** - Our population is getting older quicker, partially as a result of work we have done to improve how long people live. This brings its own challenges as older people generally need more health and social care. Particularly of significance is the growth in over 85's albeit we are seeing that life expectancy is remaining flat and for some areas reducing.

- **We need to improve people's health** – In the West of Scotland we have high levels of obesity, smoking, drinking and drug use. There is also widespread poverty in parts of the Region. There is strong evidence that these factors contribute significantly to people's need for care, in how long people live and in how many of these years are lived in good health.

- **Hospital is not always the best place for care** – People are currently in hospitals who need care that would be better provided outside of hospitals. There is strong evidence that people staying in hospital longer than necessary makes them deteriorate and lose their independence. In some parts of West of Scotland we lack co-ordination of care for people who require multi professional input, particularly those with long-term conditions, mental health and older people and this also results in unnecessary visits or admissions to hospitals. Our care staff in the community do not have access to specialised services and this means they have no choice but to refer people to hospitals.

- **We want to provide the best possible care**– There are differences in how we deliver care across the region and variation in practice. It is important that we use the learning from each part of the service to support us to deliver the best care models and address variation in morbidity and mortality rates. This is partially because our most experienced and highly specialised staff are spread too thinly across the West of Scotland reducing the experience given to junior staff in the management of complex cases that allow them to build up the skills to provide the most appropriate level of support in emergency care. Hospitals are also struggling with waiting times for operations and treatments. This is in part because due to emergency care pressures which can impact on the provision of planned care in the same hospital resulting in elective cancellations reducing the capacity available to support planed care.

- **We need to use our workforce effectively** - There are difficulties in recruiting and retaining staff at all levels and settings of care making it hard to provide the best levels of care. The age profile of our staffing in some professions and general practice also gives cause for concern in terms of maintaining sustainable services. Some local organisations already have high levels of vacancies and are using temporary staff which is proven to cause clinical risks as well as costing the care services more.

- **Our buildings are not fit for purpose**– About half of the hospital buildings in the West of Scotland need major repair work or replacement that would cost somewhere between £1-2.5 billion. At the same time, much of the care that could be provided in the community does not have suitable locations or accommodation to provide these services.

- **Opportunities afforded by technology** – Technology has changed many industries for the better and there are many opportunities for the West of Scotland to use technology to improve our service, both in terms of how we organise and deliver care and in the interventions we offer.

- **We need to make the best possible use of available health and social care funding –** This year we expect to have a deficit of £237m across the West of Scotland. Whilst some Boards will manage this in 2017/18 we must address the underlying issues and transform our service model to deliver quality and sustainable services.

In bringing these 8 themes together it is clear that status quo is not an option in terms of providing sustainable and safe services across the region. Leaders of the

West of Scotland care systems believe we must make radical changes in how we provide care or we will fail our population and our staff. There is recognition that regional working across Board boundaries with our citizens to develop service models that meet the populations' needs is essential. This approach will be important to make most effective use of the resources, particularly workforce, if we are to ensure the population have access to the appropriate level of care and to use the funding available to best effect.

Evidence from other systems demonstrates the need to have upfront investment to support delivering the service transformation. In considering the way forward the region recognises the importance of: developing digitally enabled services to modernise how care is delivered; and ensuring adequate capital investment is available to create the most effective configuration of facilities across the health and care system to provide the right models of care to support transformation.

Recognising the existing governance arrangements and accountabilities of the NHS Boards, the Health and Social Care Partnerships/ Integrated Joint Boards and Local Authorities, work will be progressed to consider how each of the organisations can work effectively together to deliver their local plans but also to optimise the opportunities from working regionally to create sustainable care models for the local populations. To achieve this ambition a common purpose has been developed. The next section sets out what our common purpose might be as region to address this case for change.

8. Developing the Way Forward

8.1. Shared Vision and Common Purpose

We are working together as a region towards four aims:

- Improving health and wellbeing;
- Increasing care and quality;
- Delivering on finance and efficiency; and
- Better workplace with a focus on staff.

In the submission in March, we will set out a shared vision and common purpose for the West of Scotland to achieve these aims and directly address our case for change. Our current draft of this is:

While we will be united as a region in addressing this common purpose, not all of the work to plan or deliver these objectives will be done at a regional level. For example, the Integration Joint Boards (IJBs) have primary responsibility for joining up health and social care in their communities, while there are national programmes who are planning for shared services across the nation. Existing Board Strategies and Health and Social Care Strategic Commissioning Plans set out work that will continue to be progressed locally. This work will influence and be influenced by the development of the regional delivery plan. By March we will define how this common purpose will be planned and delivered at local, regional and

national levels with a guiding principle that we should be as local as possible and as regional as necessary where there is a compelling case for regional or national work.

In developing this plan, one of the challenges will be defining the role of the region in care that is delivered outside of hospital. From discussions amongst leaders of the care system we believe there will be a regional role in facilitating sharing of best practices, developing common and consistent elements of care models across the region, determining how best to ensure the money is available to implement these new ways of care, and making sure the IJBs are supported with the necessary workforce, facilities and technology to do their work.

Inevitably there will be tension between organisations within the region as we try to balance achieving individual organisation goals and regional goals that may sometimes pull in opposite directions. If we are to achieve this common purpose as a region, our service leaders will need to role model behaviours that will support the different organisations to work together successfully. Our workshop participants on the 20th identified behaviours they felt would be important including trust, respect, acting with principle and integrity, acting collegiately and ultimately working for the best interests of all the 2.7m people who live in the West of Scotland.

8.2. Care Models

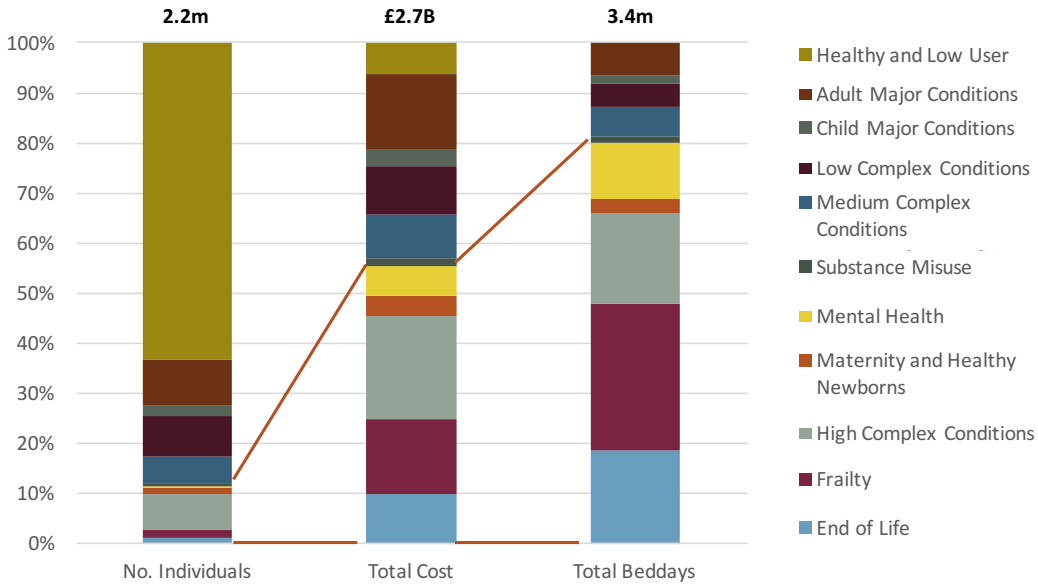
In the West of Scotland we intend to develop our future care models in four ways, outlined in the exhibit below.

Understanding the needs of different segments of the population	Addressing as much care as possible proactively and locally	Designing hospital care to deliver safe and sustainable services	Putting in place the key enablers
• Use ISD data to have fact-based discussion on population segments • Identify specific patients and segments to make targeted interventions to care plans and care models	• Integrated services covering primary care, community care, social care, mental health, access to specialist diagnostics • Services integrated and co-ordinated from patient view • Increased funding and capacity outside hospital • Effective multi-disciplinary team working	• Establishing clear standards for safe delivery of services – Interdependencies – Workforce – Volumes • Establishing different levels of hospital services • Networking hospitals for sustainable high-skilled services	• Digital • Workforce • Estates • Organisational development • Financial Allocation Model • Governance • Communications & engagement

Understanding the needs of different segments on the population

ISD Scotland have developed data that shows how different segments of the population use the care services in very different ways. For example, people with serious mental health needs are estimated to cost £19k in hospital care per person per year, people with frailty issues cost £11K per person per year while mostly healthy people cost £115 per person per year.

In the West of Scotland 12% of the population consume over 55% of the health spend and 80% of beddays



Source: ISD

Individuals and groups of our population clearly have very different needs and we in the West of Scotland are committed to organise the system around these different needs.

Addressing as much care as possible proactively and locally

Integration Joint Boards have primary responsibility for this area and are making progress in developing and delivering on their plans. At a regional level we are exploring the potential for some common elements of care models that can be described regionally and delivered locally. For example, one region in England made this offer of local care to its older population with complex needs:

- **Care planning and navigation** – People will be supported to develop a personalised care and wellbeing plan. Dedicated professionals from a variety of health and social care backgrounds will co-ordinate the care and support from the rest of the multi-disciplinary team (MDT) and the wider health, social care and voluntary sector.

- **Supporting people to improve their health and wellbeing** - Supporting people and carers to improve and maintain health and wellbeing by building knowledge and changing behaviours through proactive prevention / engagement.

- **Healthy living environment** – Ensuring a healthy living environment to preserve long-term health & wellbeing (e.g. falls prevention, housing improvements and alterations).

- **Integrated health and social care multi-disciplinary team** – Providing person-centred, coordinated multi-disciplinary care services, wrapped around GP practices and community services providing care to people who have personalised care plans based on their needs.

- **Single point of access** – A number called by the person, the GP, community services and acute staff, or indeed any other professional, to support people with their care by gaining more efficient, coordinated access to services.

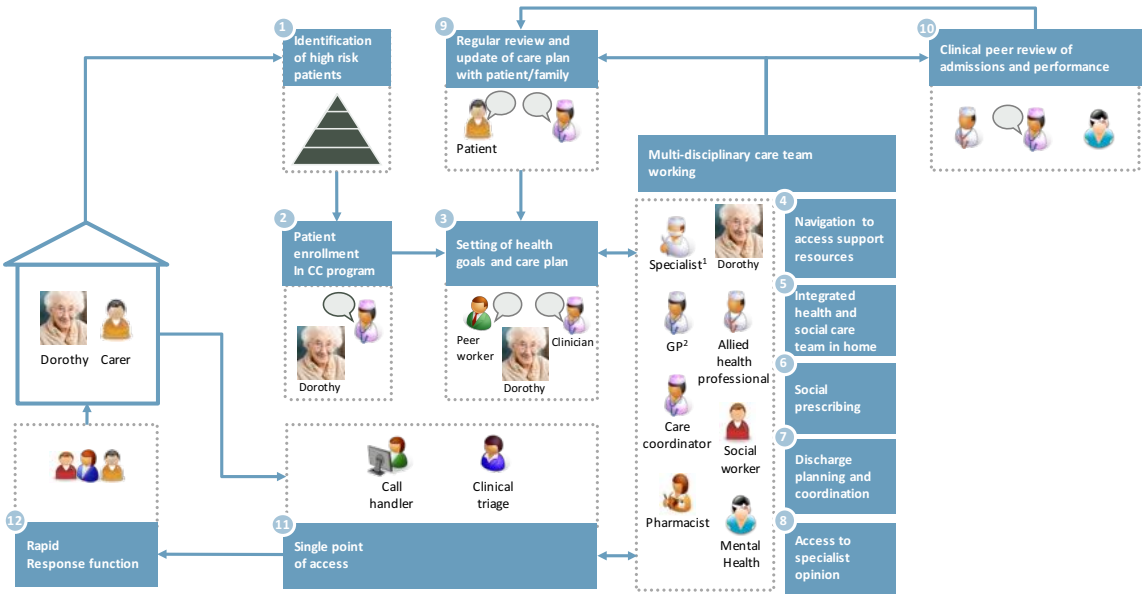
- **Rapid response** – The ability within an MDT to respond rapidly to people with complex needs who are experiencing urgent health or social care needs that left unattended would result in a hospital admission.

- **Discharge planning and reablement** – A pro-active, anticipatory service designed to target those people who are medically optimised for discharge, no longer requiring an inpatient bed, but still needing some level of care to prevent their health from deteriorating and to support their recovery.

- **Access to expert opinion and timely access to diagnostics** - The ability for primary care professionals to access a specialist opinion in the community setting and where appropriate, a specialist triage for diagnostics. Access to full and timely diagnostic services and diagnostic results will reduce the need for multiple outpatient appointments.

Such a model for anticipatory care could look like the following chart:

Example flows of an anticipatory Local Care model

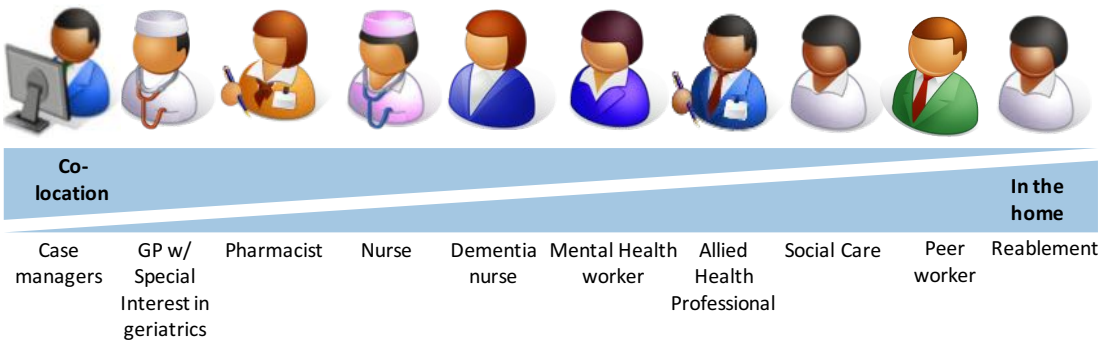


1 Specialists in both inpatient or outpatient settings
2 Includes primary care physicians, advanced practice nurses, physicians assistants
Source: Carnall Farrar

It is important to recognise that this type of local care model will require a mix of different primary care professionals working as a multidisciplinary team and is in part designed to make best and most sustainable use of the GP as the expert generalist to improve outcomes. The chart below draws out the range of skills that may be needed.

We are exploring ways to strengthen the teams around GPs, particularly for population segments that need coordinated care in the community

Multi-disciplinary team model for older people with complex needs



In the regional workshop, we agreed that we would seek to put a model or models like this in place across the West of Scotland recognising that there could be significant variation in how we might implement it locally. As a region, we intend to as a minimum:

- Share best practice across Integration Joint Boards
- Estimate the impact of local care models so that we can design the future need for beds
- Agree on the regional need for investment to make the business case together
- Ensure the enablers of local care in place, including workforce, technology and facilities
- Communicate to the population of West of Scotland an expectation of what can be provided locally and where hospital care is needed.

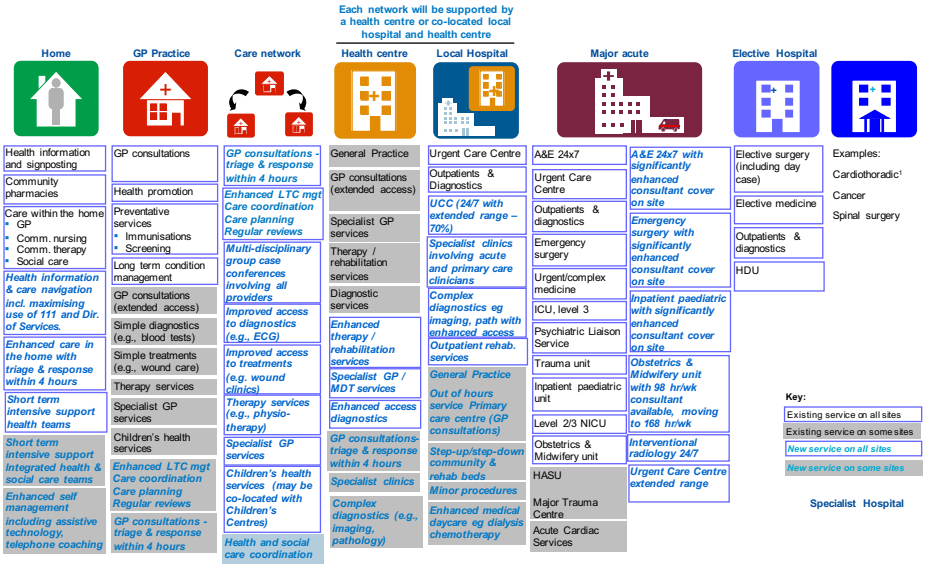
Designing hospital care to deliver safe and sustainable services

As a region, we have explored taking a tiered approach to hospital care, with clearly defined services at each site based on the needs of the population, meeting clinical standards, having the minimum volumes needed to build and maintain staff skills, and the availability of skilled staff for each specialty.

In practice, this would mean moving low volume specialties around different hospital sites; with some higher level hospitals will specialist services. Other hospitals would not have every service but would work through networks.

An example of how a tiered approach might look in the acute sector, as well as how some care services currently provided in acute may move to other models or setting of care models is outlined in the exhibit below.

Illustration of region-wide framework for local and acute care models



In the engagement workshop, it was agreed to explore this approach for the March submission and detail the factors and process that would be considered in such a decision, including assessing different options for clinical safety, availability of workforce, the amount of time it would take patients and families to get to services, capital investment needed, and operating costs.

Putting in place the key enablers

To deliver these care models, many enablers will need to be in place. The exhibit below outlines our early thinking on the different enablers that will need to be planned for in our March plan:

1 Workforce	People will be at the heart of the system that we are building, they are our greatest asset. The new care model will require staff and partners to work differently and will also require new roles to be developed.
2 Organisational development	Training, upskilling and behavioural change are crucial to enable leaders, professionals and teams to work together differently to deliver the new care model.
3 Estates	Estates resources need to be understood. The new care model will be enabled by the creation of a regional capital strategy, considering additional space required; repair, repurposing or disposal of existing space. Exploration of estate and infrastructure for both health and local authorities will be essential to optimise use of facilities and capital funding investment.
4 Information	The new care model will need to be enabled by integrated patient data to allow clinicians and care professionals to plan, and deliver the care needed for our population. Information is also crucial to enable long term, innovative solutions and drive productivity improvements.
5 Financial model	The current financial models and service level agreement arrangements across organisations within the region require to be reviewed as they contribute to the fragmentation in the system, and do not support integrated population based care. A new approach is needed to align organisations around a common purpose, provision of services across the region, nurture collaboration, drive cost savings and support system-wide decision making.
6 Governance	To support the integrated system and achieving a shared vision, appropriate governance is essential to enable the organisations to work together effectively as the system transitions into a new delivery model. This will require clear roles and responsibilities, with engagement from the right stakeholders.
7 Comms and engagement	The public and staff need to be engaged throughout and consulted appropriately. A detailed and robust internal and external communications and engagement plan is required, backed up by the resources to execute it.

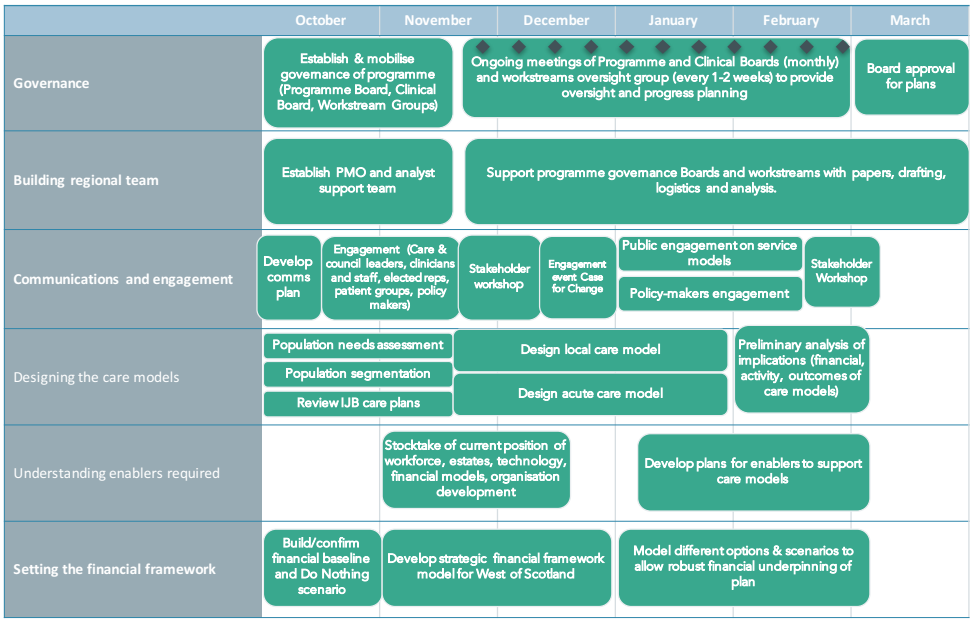
Taken together, we believe these proposals for designing our care models are consistent with the National Clinical strategy, particularly when planning local services around individuals, population segments and their communities, and planning hospital networks at the appropriate level recognising availability of skilled workforce.

9. West of Scotland Structure and Planning Approach to Deliver the Regional Plan

To deliver our regional plan by end-March, we have developed a workplan that covers:

- Governance
- Building the regional team
- Communications and engagement
- Designing the care models
- Understanding enablers required
- Setting the financial framework

This work and the timeline is illustrated below and detailed further in the rest of this section.



9.1. Governance

We are putting in place the following governance arrangements:

- NHS Board Chairs form an assurance and scrutiny group. It is anticipated that this group will develop to include representation from IJB chairs.
- West of Scotland Health and Social Care Delivery Group. This group is chaired by the Regional Implementation Lead. Membership includes CEOs, Chief Officers, Partnership, Employee Director Rep, and leads for Nursing, Medical, HR. We are also engaging with COSLA/SOLACE on including representation from Local Authorities.
- We are exploring the establishment of a Clinical Board/Senate whose scope could include: 1) deepening and owning the case for change, 2) providing clinical input into care model decisions and 3) providing clinical leadership to the process and signal clinical backing of the regional work.

9.2. Building the regional team

Developing the plan and preparing for implementation is going to require building a regional team to support this, the scale of which will depend upon the final scope of work agreed for the region.

The overall effort will be led by the Lead Chief Executive (John Burns) and the Director of Regional Planning (Sharon Adamson). We will be mobilising 5 strategic work streams led by a Chief executive or joint leadership with a Chief Officer to develop detailed plans for each area:

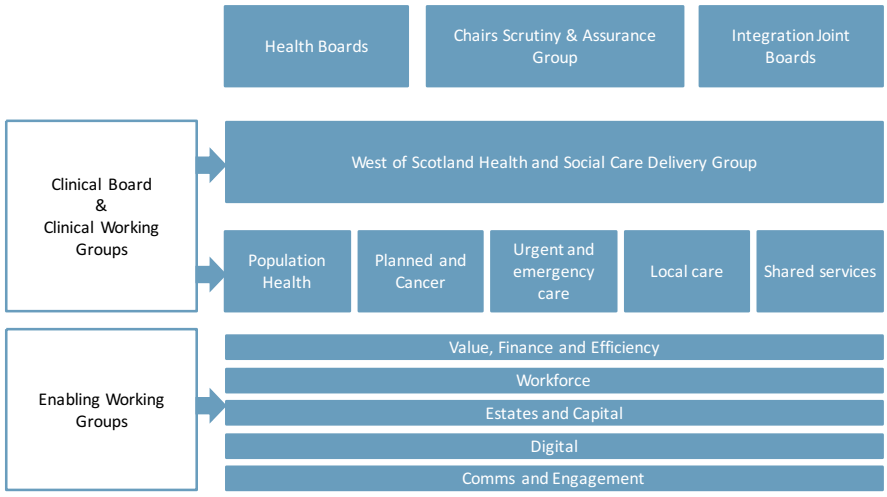
- Population Health
- Planned and Cancer Care
- Urgent and Emergency Care
- Local care
- Shared Services (including links to National Work e.g., Once for Scotland)

Supporting this work is a number of enabling work groups:

- Finance
- Workforce
- Estates and Capital
- Digital
- Communications and Engagement

The chart below maps out our current thinking on the arrangement of governance and workstreams for the West of Scotland:

West of Scotland Region – Programme Structure



Furthermore, there is work underway from the previously agreed regional priorities that will continue and will inform the new regional delivery arrangements, including reviews of:

- Urology
- Ophthalmology
- Trauma and Orthopaedics

- Major Trauma
- Maternity and Neonatal
- Systemic Anti- Cancer Therapy Provision
- Interventional radiology

9.3. Communications and Engagement

All of the areas outlined above need to inform the change in conversations across the system with the public, with the various staff involved, the different organisations and the roles that we all need to play in achieving this, thereby setting the expectations of how we will behave and act to encourage success.

There has been considerable engagement work undertaken by the Health and Social Care Partnerships in developing their Strategic Commissioning Plans. Engagement findings from the National Clinical Strategy and through the National Conversations work also offer views that can inform the approach we are taking and can be built upon as we develop the regional delivery plan.

Critical to success is describing the functional relationships required to progress this and achieve success, recognising the importance of conversations rather than plans in driving change. As part of this we need to provide an environment that supports the enacting of change.

Initial Engagement will look at:

- Developing and sharing key messages around regional planning and the case for change; considering what Scottish Government will lead and what will be regional and local
- Ongoing Engagement
  - Identifying key stakeholders – internal and external, targeting our approaches to support different stakeholders needs
  - Setting out the messages around the population health need, considering service models and the views of the public on service requirements
  - Setting out the emerging thinking on the future service models and implications to provision

9.4. Designing the Care Models and Understanding the Enablers Required

As outlined in section 8.2 above we believe there are four elements to designing interventions that will be transformative and allow us to meet our four aims as a region:

- Understanding the needs of different segments of the population (both now and how it will change over time) in order to identify those that need targeted interventions to care models.

- Addressing as much care as possible proactively and locally in primary, community and social care.
- Designing our acute and community hospitals around the need for safe and sustainable acute care following the local care intervention.
- Putting in place the enablers to allow these interventions to be successfully implemented.

We have quite rich data from ISD around population segmentation and are working with public health colleagues on a population needs assessment for the region. Based on this work, we propose to do a quick effort to prioritise population segments where we would look for better care models to improve their care.

We will then look to produce with IJB colleagues, informed by their existing plans as well as local and international best practice, the common elements of local care models that the population of the West of Scotland can expect to be delivered by IJBs. We expect to have by end-March a clear description of how local care models will be experienced by people in the West of Scotland, an analysis of activity shifts between acute and local care, a business case for the system from these investments, as well as an implementation plan for these models of care.

In parallel with this local care model work, we will be building activity and financial models that will allow us to understand the implications of local care models on the bed requirements and service configuration in the acute sector. By end-March, we expect to have a view on what this will mean in terms of:

- Centres of excellence, particularly for low-volume, high-complexity care
- Organisation of elective and emergency services
- A model for different levels of hospitals and the services they will provide
- An alternative model for providing excellent urgent and emergency care

When designing care models, we will also develop a view on the implications for enablers of these care models, including:

- The implications for estates and infrastructure across the public services, including how best to use the existing estate across hospital sites, primary care and social care.
- Understanding the skills and competencies, as well as numbers, of staff required to support the emerging models, creating a position to influence training and education for the future.
- Understanding of how the future developments in technology might influence the care and models required to better inform the planning beyond 2025 and the potential impact on the different parts of the system. This will consider the opportunities digital health offers, linking with national work.

9.5. Setting the financial framework

In parallel with the care model work, we intend to build a regional financial framework that will:

1) set out the current baseline for the region and the do nothing scenario over a longer period than we have currently projected.
2) allow us to model the impact of care model interventions and changes to key revenue and cost assumptions.
3) Determine a different approach to the finance models to support more effective cross system working
4) outline the business case for interventions at a locality level, board level and regional level.

10. Next steps

With the other regions and the National Boards, we have identified a set of next steps that we should also address collaboratively which the national boards will lead to support the development of the regional delivery plans.

10.1. Collaborative Contribution from the National NHS Boards

As part of developing our regional delivery plans we will also consider the services, functions and support that are best delivered on a national basis; and which can contribute towards the management of demographic financial and workforce pressures. To that end we will work closely with the National Boards over the next few months to refine, develop and prioritise the initial propositions that they have set out.

10.2. Service Transformation – Demand Management

With NHS24 and the Scottish Ambulance Service we will develop plans to

- implement, at scale, the proposals for practice level GP Triage
- reduce the volume of out of hour callers to NHS24 and 999 callers requiring further support from primary and secondary care;
- develop a triage service for return appointment patients and outreach telehealth clinics;
- roll out computerised CBT and improved pathways for those contacting NHS24 and the Scottish Ambulance Service in mental distress.

10.3. Supporting Recruitment, Retention and Improving the Employment Experience

We will work with NES, NSS and others to co-ordinate national and international campaigns to promote careers in health and care in Scotland and to link careers advice and marketing support to the new NHSScotland national recruitment system.

We will also continue to work to improve the employment experience for all our workforce; including rolling out the arrangements to reduce the number of employers of Doctors and Dentists in Training.

We will work with NES, NSS, SSSC, the Care Inspectorate and others to develop an accessible, user designed data platform which provides access to data on the existing and the 'in-training' workforce and to analytical tools which can help to inform the development of different workforce scenarios supporting local, regional and national planning.

10.4. Digital Transformation

It is essential that we transform our digital landscape to enable the public and healthcare staff to access information, resources and services from smart phone technology in the same way as they access retail, transport, and similar services in other spheres of their lives. Part of the work we will progress is to ensure that we can use technological advances in robotics and artificial intelligence to meet the challenges that face us now, and in the future.

Working with the National Boards we will seek to create clarity about technical and usability standards that will support intuitive applications that are capable of delivery across boundaries and which support the scale up and spread of proven innovations to ensure the benefits of technology are accessed across the whole system at pace.

10.5. Once for Scotland

We will continue to work with the National Boards to develop new models of delivery for services such as procurement, radiology, aseptic pharmacy, laboratories and clinical engineering.

We will also work with the National Boards to implement the strategy for NHSScotland Business Systems, which is predicated on moving to Cloud based, Software as a Service models for a joined up approach to Finance, HR and Payroll (moving away from legacy systems and from managing these systems in individual silos). This will provide a core infrastructure which will facilitate the development of shared business services in our regional structures.

11. Statements of Intent

In advance of the submitting the regional delivery plan in March 2018, we intend to:

1. Develop and publish a clinical case for change.
2. Come together as regional leaders of our health and care system and set out a comprehensive programme to deliver our vision and common purpose.
3. Develop a region-wide planning process that will describe what will be planned and delivered by whom at national, regional and local level.
4. Assess the care needs of our population, taking into account the different needs of individuals and segments of the population.
5. Develop local care models for the highest priority population segments and model the impact of these interventions on future acute capacity requirements.
6. Develop a stratified model of local and acute care setting out the different levels of service provision in the different facilities across the region; understanding the implications for future service configuration.
7. Hold engagement sessions with our population, frontline staff and policy-makers to inform them of the regional delivery plan and allow them to shape and coproduce it with us.
8. Develop a view of the impact of this plan on the future capital investment requirements for the region, including hospital and out-of-hospital infrastructure.
9. Assess the impact of this plan on our workforce and outline our future workforce strategy; informing future training and education requirements.
10. Evaluate the impact of the implementation of this strategy on finance and activity and outline a financial plan to support implementation.

Appendices

1. Population Health Needs Assessment Summary Information
2. Demand and activity
3. Workforce
4. Communications and Engagement Plan

Appendix 1

Population Health Needs Assessment Summary Information

Understanding the Population

A Health Needs Assessment for the West of Scotland is currently being progressed; a significant number of analyses have been identified and undertaken which will support the work over the coming months to consider the service model and provision for health and care services for the region. Beyond the work to consider the population age, gender deprivation levels and the implications of this both in relation to health and social care provision, use and funding levels, work is considering the use of services, life expectancy and health outcomes; reviewing the trends in this over the last decade or longer.

Population Needs Assessment: Emerging Findings

- West of Scotland has some of the council areas with the highest proportions of oldest residents in terms of population percentage over 65; as a whole it differs significantly from the Rest of Scotland (RoS) by having a slightly greater percentage of young people aged 0-15 years and a considerably smaller percentage of the very elderly aged 90+ (appendix Table1).

  Table1: Age distribution for a recent year, 2016, for Scotland, NWoS, RoS, and component areas of the NWoS. Source: NRS.

	% of population by age group				
	0-15 yrs	16-64 yrs	65+ yrs	75+ yrs	90+ yrs
Scotland	16.9%	64.6%	18.5%	8.2%	0.76%
GG&C	16.7%	66.8%	16.4%	7.6%	0.72%
FV	17.4%	64.1%	18.5%	8.0%	0.70%
Lan	18.0%	64.3%	17.7%	7.6%	0.59%
D&G	15.8%	59.5%	24.7%	11.0%	0.98%
A&A	16.8%	61.5%	21.7%	9.4%	0.85%
A&B	15.2%	60.1%	24.7%	10.7%	0.99%
NWoS	17.0%	64.6%	18.4%	8.2%	0.73%
RoS	16.9%	64.5%	18.6%	8.2%	0.79%
RoS/NWoS ratio	99.1%	99.9%	101.1%	100.6%	108.9%
NWoS/NoS ratio	**100.9%**	100.1%	98.9%	99.4%	**91.8%**

- It also has most of the most deprived council areas in terms of summary SIMD score (Glasgow city, West Dunbartonshire, Inverclyde, Renfrewshire, North Lanarkshire, East Ayrshire) and the bulk of the population residing in the most deprived deciles and quintiles. Appendix Table 2 and Figure 1.

Figure 1: Map of Scotland, showing the three regions and the distribution of 2016 SIMD quintiles, by datazone. Source: P Barton, NHS GG&C.

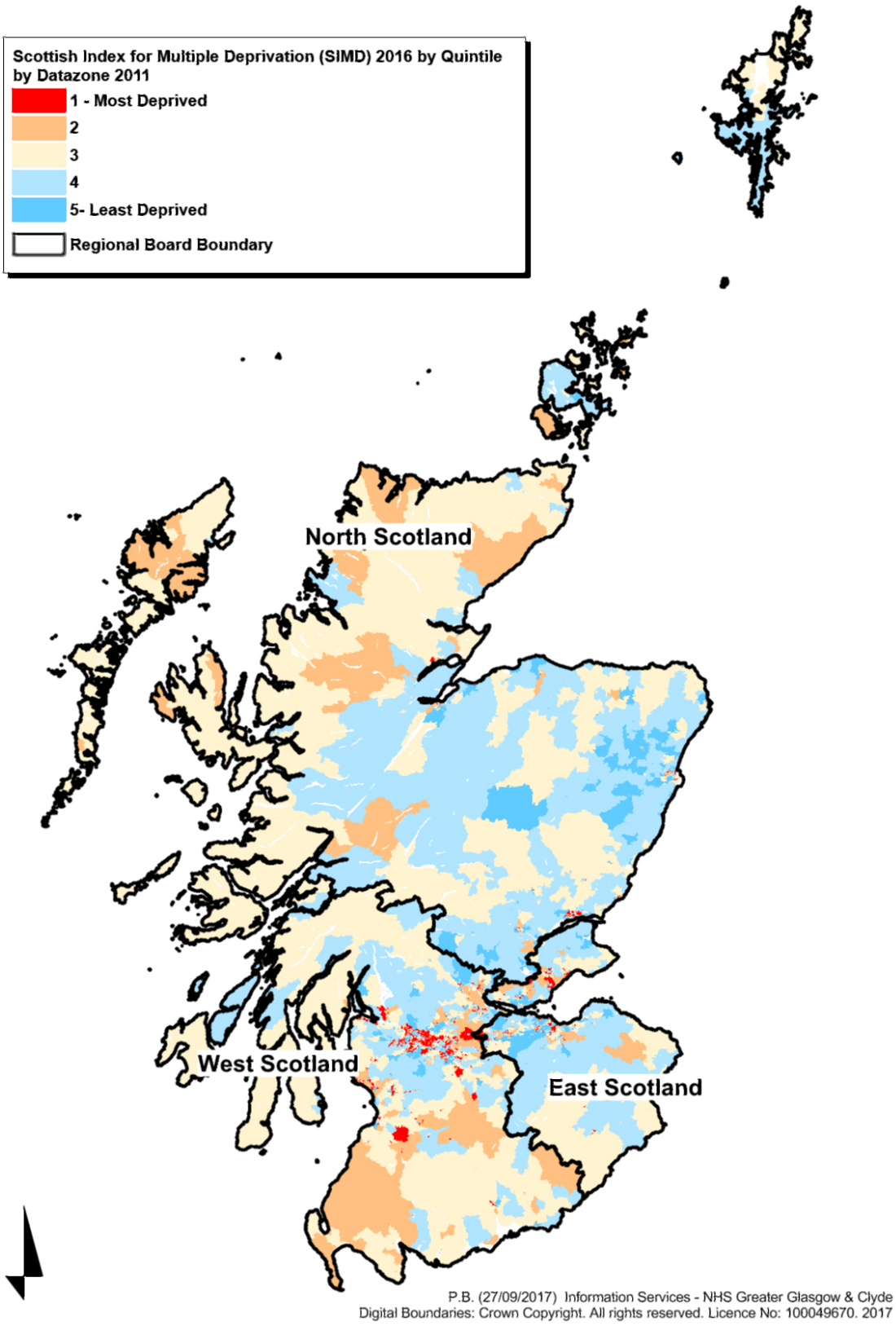


Table 2: Distribution of the Scottish population by SIMD decile and region using ISD weighted population. All figures are based on SAPE 2016 and SIMD 2016. Source: M Grimmer, NHS GG&C.

	Total Population				Percentage of Area Population			
Decile	East Scotland	North Scotland	West Scotland	Scotland	East Scotland	North Scotland	West Scotland	Scotland
1 (most deprived)	72,238	47,996	420,087	540,321	5.3	3.7	15.4	10.0
2	121,262	64,881	352,690	538,833	8.9	5.0	12.9	10.0
3	137,275	93,302	307,082	537,659	10.1	7.1	11.3	9.9
4	136,167	110,211	292,832	539,210	10.0	8.4	10.7	10.0
5	142,166	145,656	249,297	537,119	10.4	11.1	9.1	9.9
6	131,921	167,475	241,106	540,502	9.7	12.8	8.8	10.0
7	141,408	198,350	204,901	544,659	10.4	15.1	7.5	10.1
8	120,668	191,247	230,667	542,582	8.8	14.6	8.5	10.0
9	139,257	149,726	254,340	543,323	10.2	11.4	9.3	10.1
10 (least deprived)	222,498	141,446	176,548	540,492	16.3	10.8	6.5	10.0
Total	1,364,860	1,310,290	2,729,550	5,404,700	100.0	100.0	100.0	100.0

- Both social deprivation and agedness of the population place major demands on the health and care systems. Analysis of the SMR01 dataset for hospital activity shows that the elderly, who are also deprived, are particularly high users of unscheduled services and considerably outnumber the elderly affluent in key board areas such as GG&C.
- The challenges of equitable service uptake and provision, based on need rather than demand in a geographic area that also has considerable sized areas of affluence, results in smaller National Resource Allocation Committee (NRAC) and Scottish Allocation Formula (SAF) shares for hospital & community services and GMS services, respectively. The challenge to meet the level of the need with the level of the service provided will exacerbate the falling historical and projected crude population share of the region as whole and those of the WoS health boards individually to ensure a considerable drop in the equivalent target shares to 2039. Figure 2 shows the projected population estimates for the WoS and the RoS and Figure 3 shows the falling crude population share for the WoS and the rising crude population share for the Rest of Scotland). The WoS is projected to expand only modestly over the next 20 years whereas the percentage rise in the population of the Rest of Scotland will be 6 times greater. ASHD of the SG has agreed to our request to calculate all NRAC parameters, including historical and projected target shares, for the WoS, EoS and NoS.

Figure 2: Projected populations for the NWoS and the RoS, between the baseline, which was 2014, and 2039. Source: NRS. (Breakdown by Board available)

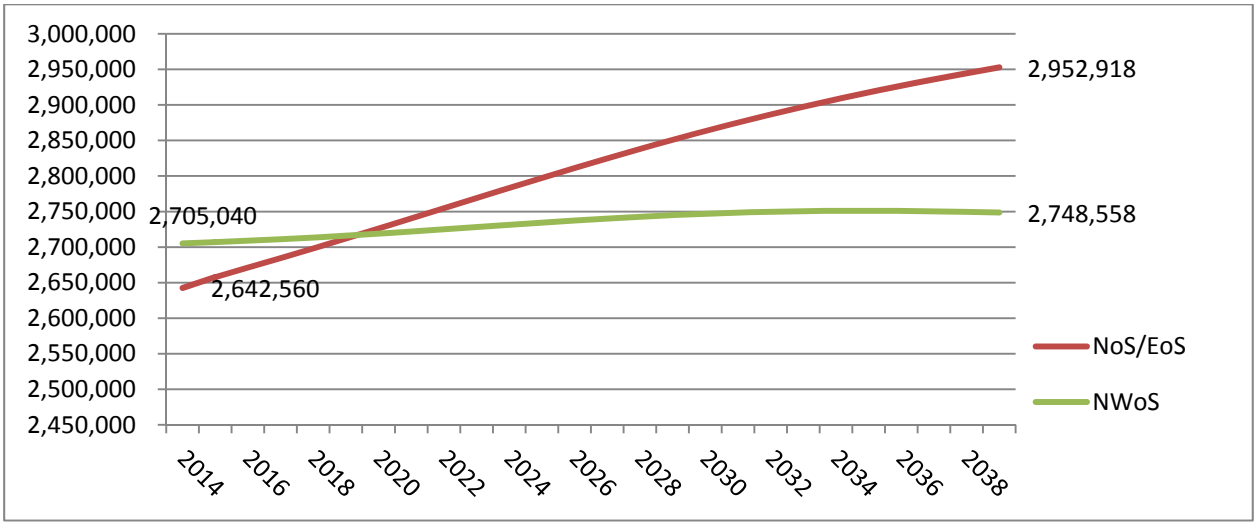
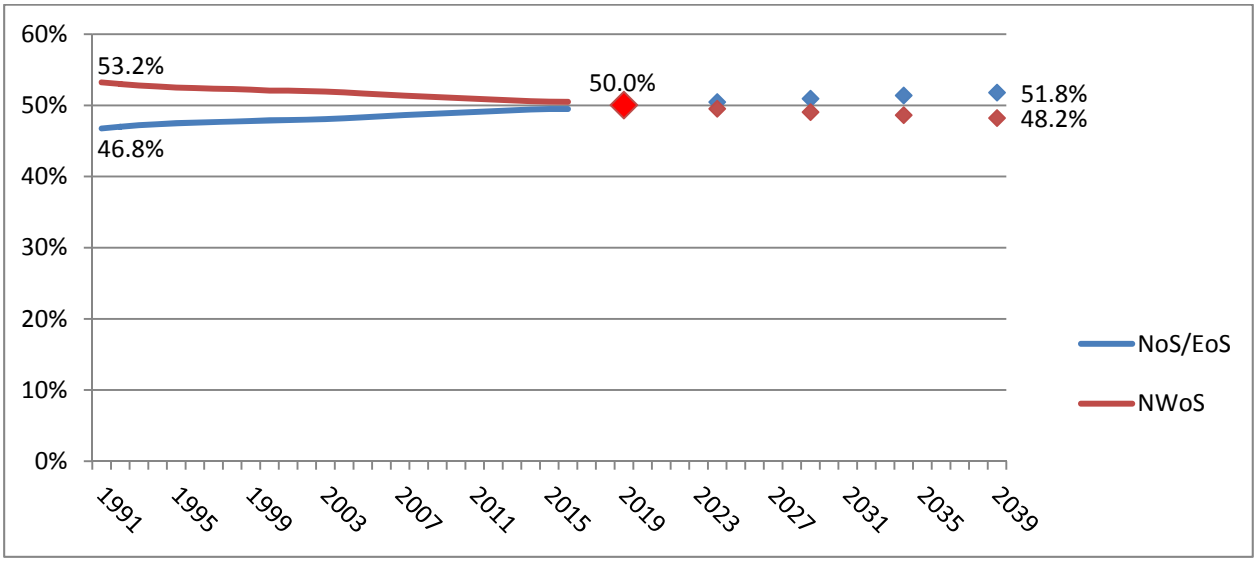


Figure 3: Historical (solid line) and projected (diamond datapoints) for the New West of Scotland Region and the Rest of Scotland (NoS/EoS), 1991-2039. Source: NRS Scotland. (Breakdown by Board available)



- Plateauing of the life expectancy at birth is seen for Scotland as a whole, which is particularly clear for Scottish males (see red arrow in Figure 4), and evidence of unexpected downward shifts in the life expectancy trajectory are visible in some areas within the WoS region (see downward red arrows in Figure 5, which relates to females, which are unprecedented in scale or duration over the entire study period).
- Life expectancy for those who reach 85 years of age appears to have declined since 2009/11, for both genders, but particularly for females (Figure 6). This drop appears to

have occurred earlier for D&G males (after 2009), after 2011 for Lanarkshire males and very recently for A&A, FV and GG&C males (Figure 7).

Figure 4: Life expectancy at birth for Scottish males and females, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.

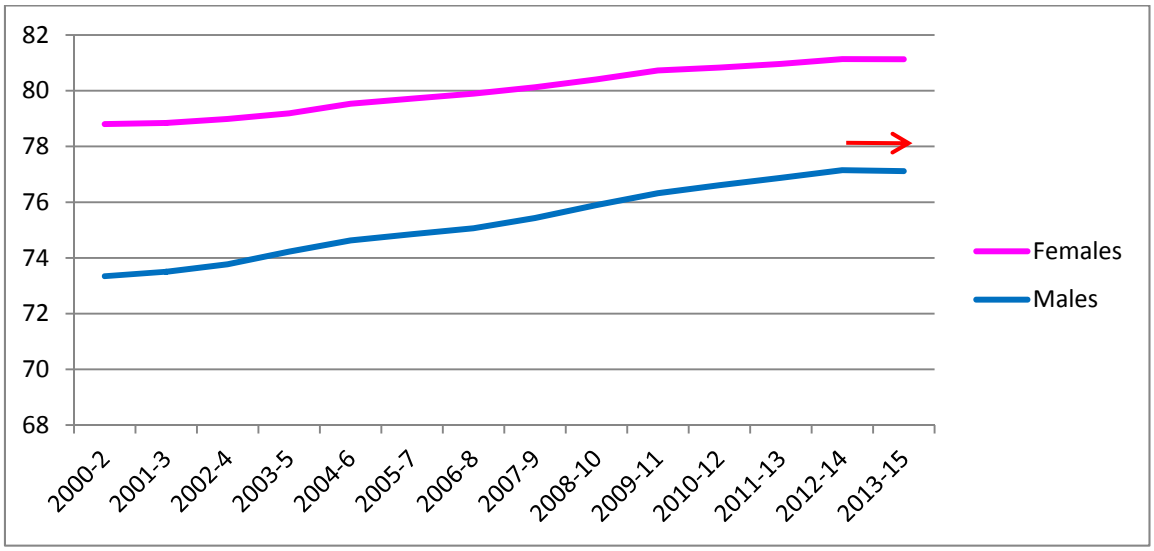


Figure 5: Life expectancy at birth for females by area, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.

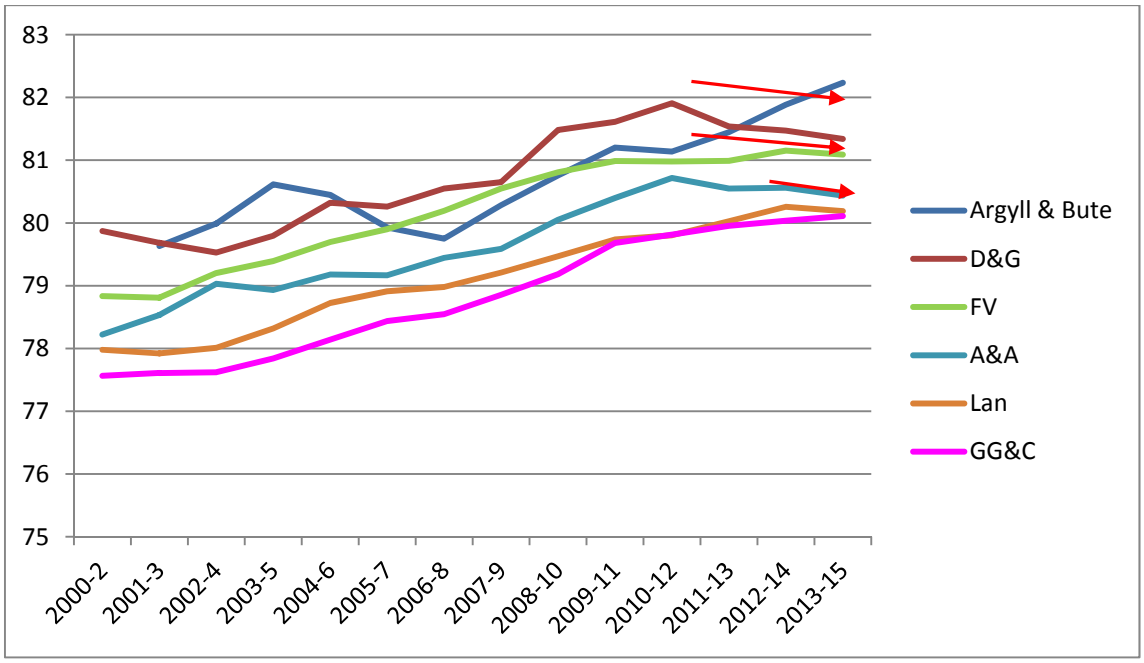


Figure 6: Life expectancy at age 85 years for Scottish males and females, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.

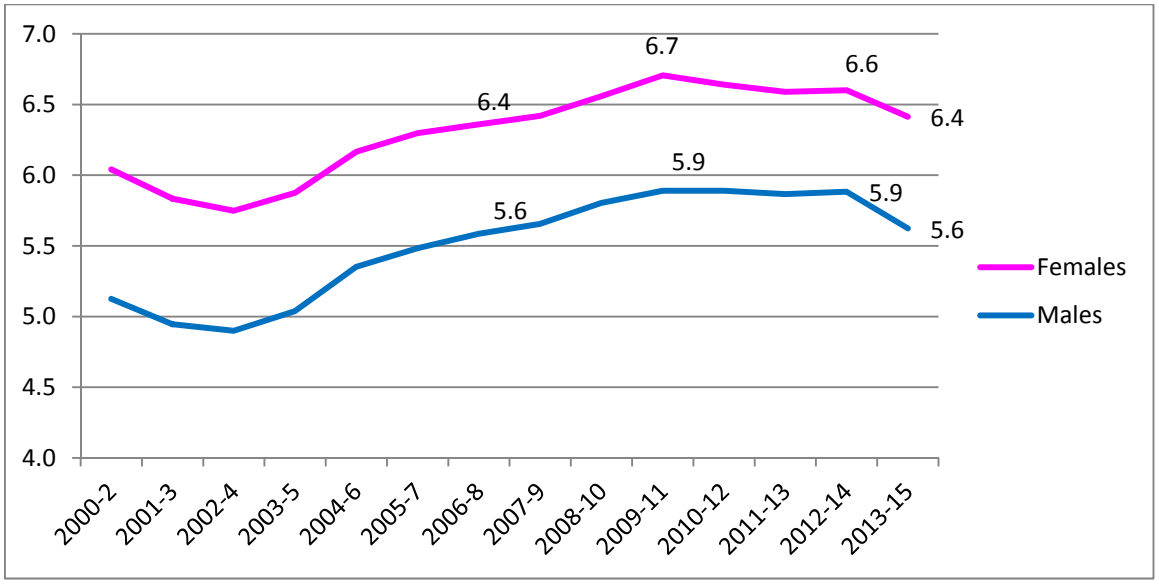
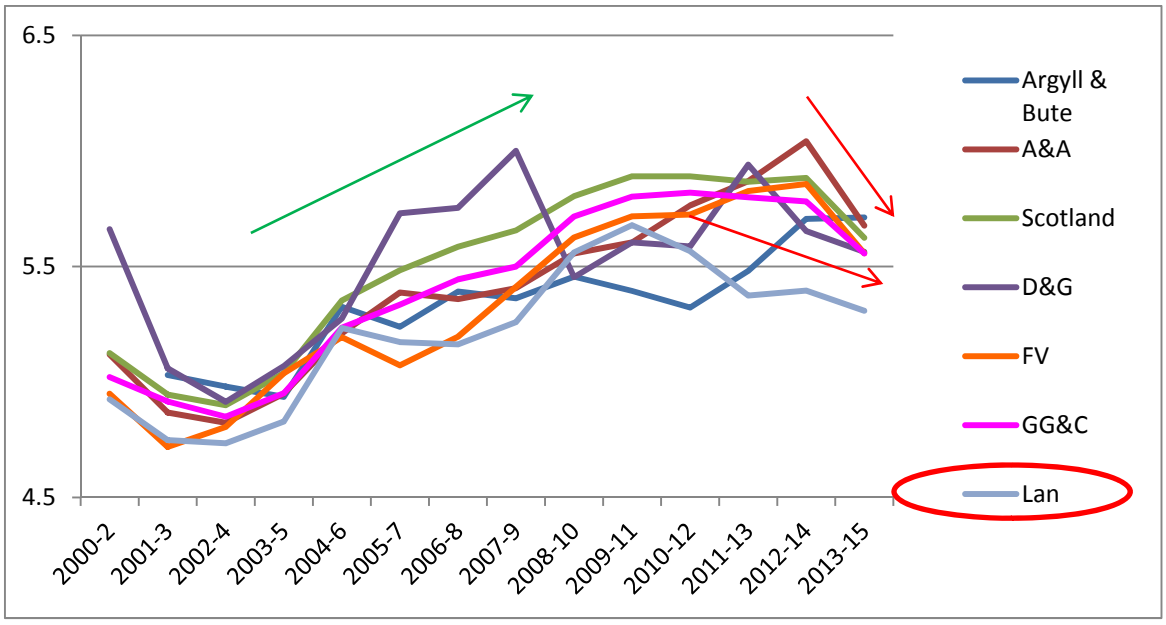


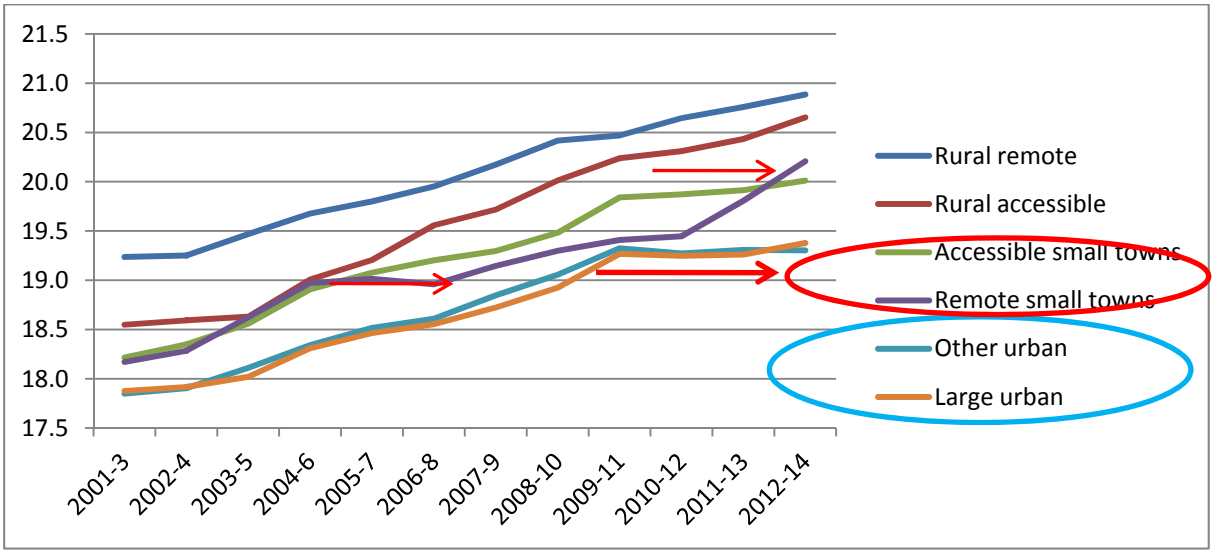
Figure 7: Life expectancy at 85 years for males by area, within the WoS, 2000/2 to 2013/15. Y axis truncated. Source: NRS Scotland.



- Furthermore, when the life expectancy of Scots who reach 65 years of age are categorised using the urban rural classification, some trendlines appear to experience a lengthy plateau including those living in accessible and remote small towns, but also the lines for those living in large and other urban areas, as shown for females at age 65 (Figure 8). This raises the possibility that some of the drop in life expectancy in A&A and D&G as a whole is due to a stalling of LE in older people in accessible (more recent) and remote small towns (after 2004-6). It is interesting to note that the LE is highest and still

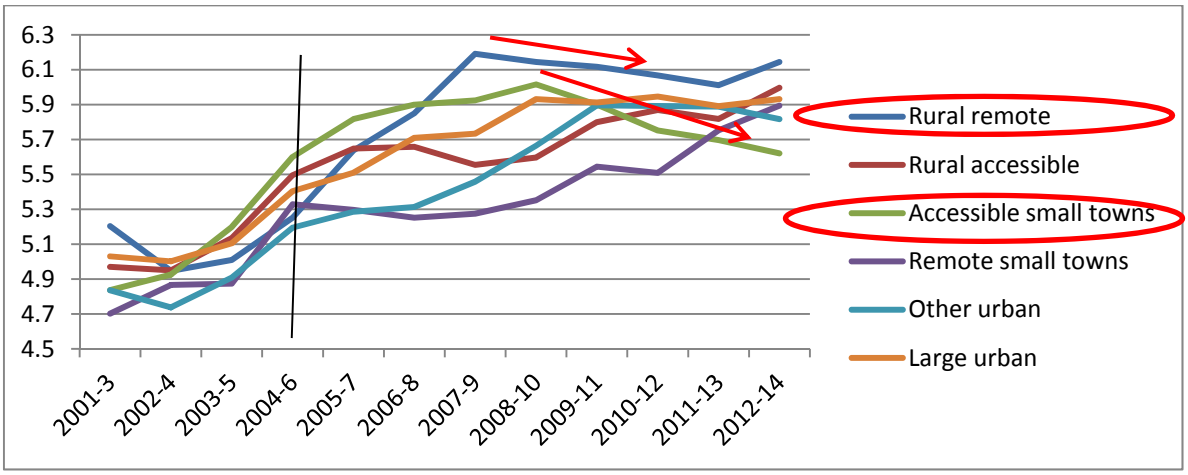
rising for females at age 65 who live in both rural remote and rural accessible areas, suggesting a self-selection effect.

Figure 8: Life expectancy at 65 years, for females, by urban rural classification. Y axis truncated. Source: NRS Scotland.



Nevertheless, any advantage conferred by being elderly and living in rural Scotland appears to diminish for those males in Scotland who reach 85 years of age as shown in Figure 9. There appears to be a prolonged stalling of the previous rise in LE for males at age 85 years living in rural remote areas after 2007-9, despite 7 years of steady improvement.

Figure 9: Life expectancy at 85 years, for males, by urban rural classification. Source: NRS Scotland.



- The stalling of rises, or even clear declines in life expectancy, defy the expectation of ongoing improvements in longevity which are seen in other parts of the world. The cause is likely to be multi-factorial

  - the role of the recession in 2008 and exacerbated by recent austerity measures, mediated by
  - life style related diseases which include the effects of the high prevalence of obesity, the rising prevalence of Type 2 Diabetes, the stalling decline of smoking prevalence, the contribution made by the rise in alcohol-related deaths, etc
  - the relative level of investment in health and social care,
  - as well as the current organisational model that may hinder the achievement of optimal efficiency of the current use of resources,
  - falling access to primary and secondary health services, and social care, for some sections of the population in both remote/ rural areas and urban areas, as a result of centralisation of acute hospital services, closure/downgrading of community hospitals, falling access to a GP principal who knows the patient (loss of continuity in primary care).

  All of these threaten to reverse the progress made by improving structural determinants of health over the past century and increased health service provision over the past 15 years.

- Consistently clear improvements in most health parameters, lesser degree of deterioration, and preservation of, or improvement in, the relative position in the national health league table, are being seen for the residents of the most deprived health board in the West of Scotland, namely Greater Glasgow & Clyde, in terms of standardised death rates from all causes, and standardised mortality ratio for all causes (Figure 10), SMR for cancer mortality for all types (Figure 11a), and specifically for the commonest cause of death, namely heart disease (see Health Needs Assessment report).
- Despite having less social deprivation than GG&C, Lanarkshire's relative position in the standardised mortality (all causes) league table has worsened somewhat in recent years (Figure 10 in Appendix) and its relative position in the cancer mortality league table for all types combined (Figure 11b) and for lung cancer in females has also worsened (Figure 14).
- Perhaps more surprisingly, more rural areas in the West of Scotland, even those characterised by relative affluence such as Dumfries & Galloway (Figure 11c) and Argyll & Bute (Figure 11d), have unexpectedly lost ground and those with historical health deficits, such as parts of Ayrshire & Arran (Figure 11e), appear to have deteriorated further in very recent years. Age/sex standardised death rates (all causes), standardised mortality ratios (all causes of death), and/or SMR for cancer (all types combined) appear to be rising in recent years, for these three board/council areas, the starting points of the rises varying with the area. Even the more affluent Forth Valley, appears to have lost ground with respect to its relative position in the cancer (all types) SMR league table, since its enviable position before 1990 (Figure 11f).

Figure 10: Trends in standardised mortality ratios (all causes of death) for the component parts of the NWoS, 2000 to 2016. Source: NRS Scotland.

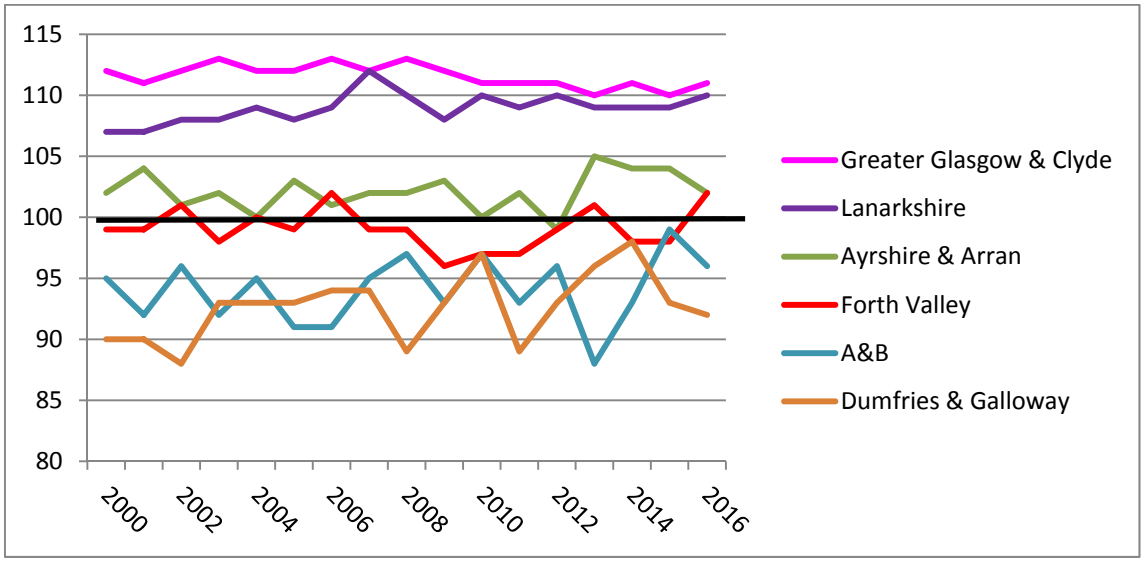
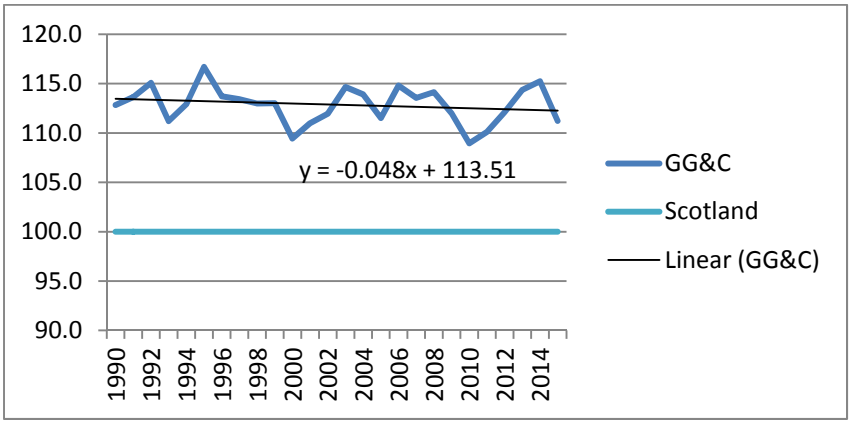
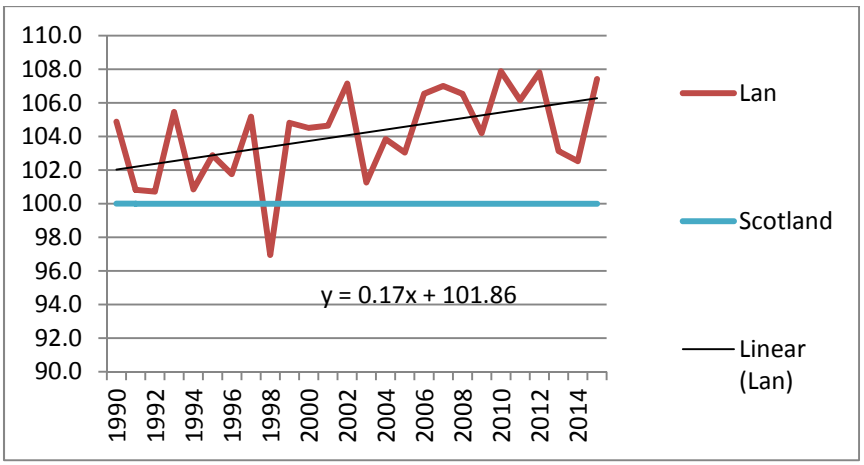


Figure 11: Trends in standardised mortality ratios for cancer (all types combined) for the component parts of the NWoS, 2000 to 2016. Source: NRS Scotland.

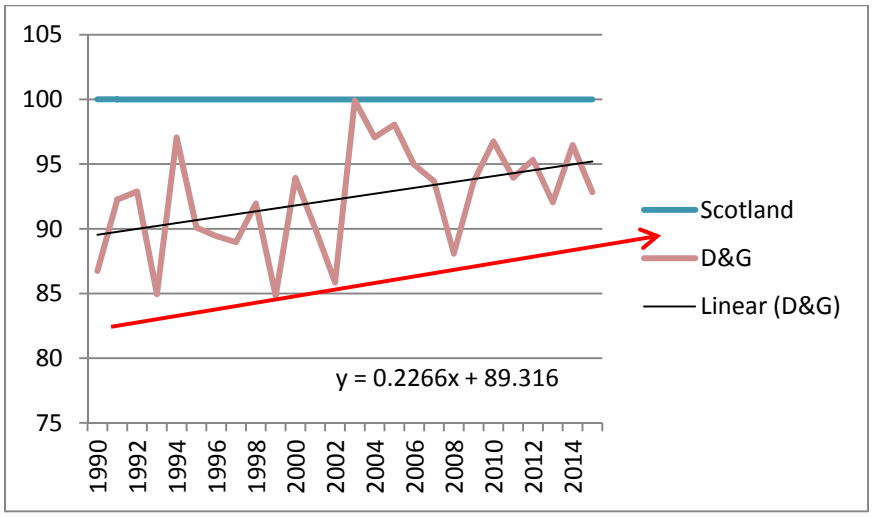
a) GG&C



b) Lanarkshire



c) D&G


105
100
95
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85
80
75
1990
1992
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1996
1998
2000
2002
2004
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2008
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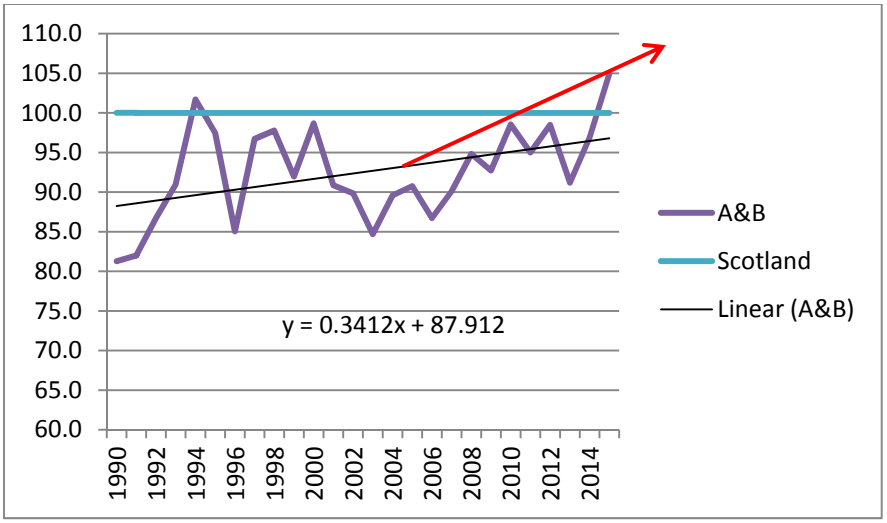
2014
y = 0.2266x + 89.316
Scotland
D&G
Linear (D&G)

d) A&B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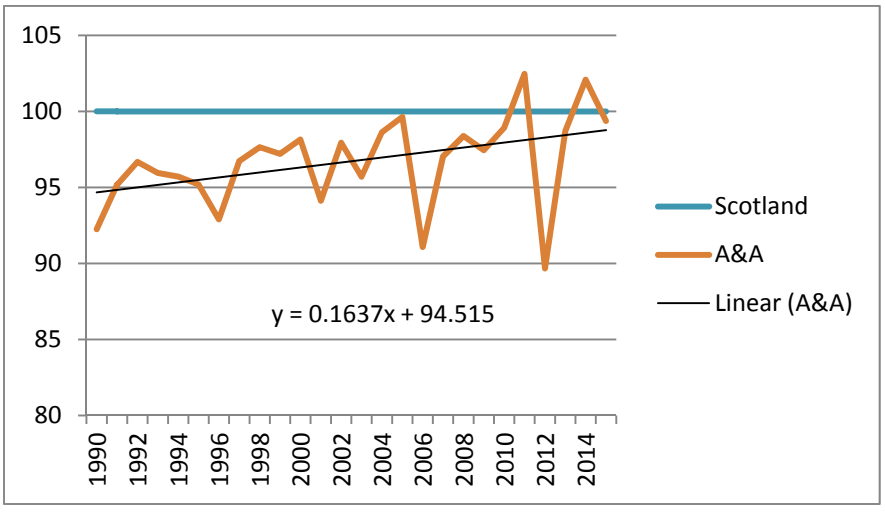
y = 0.3412x + 87.912
A&B
Scotland
Linear (A&B)

e) A&A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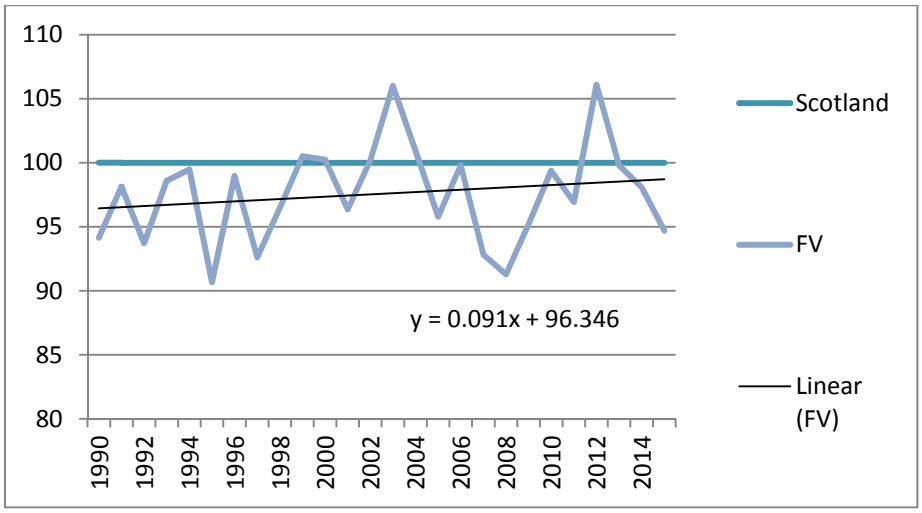
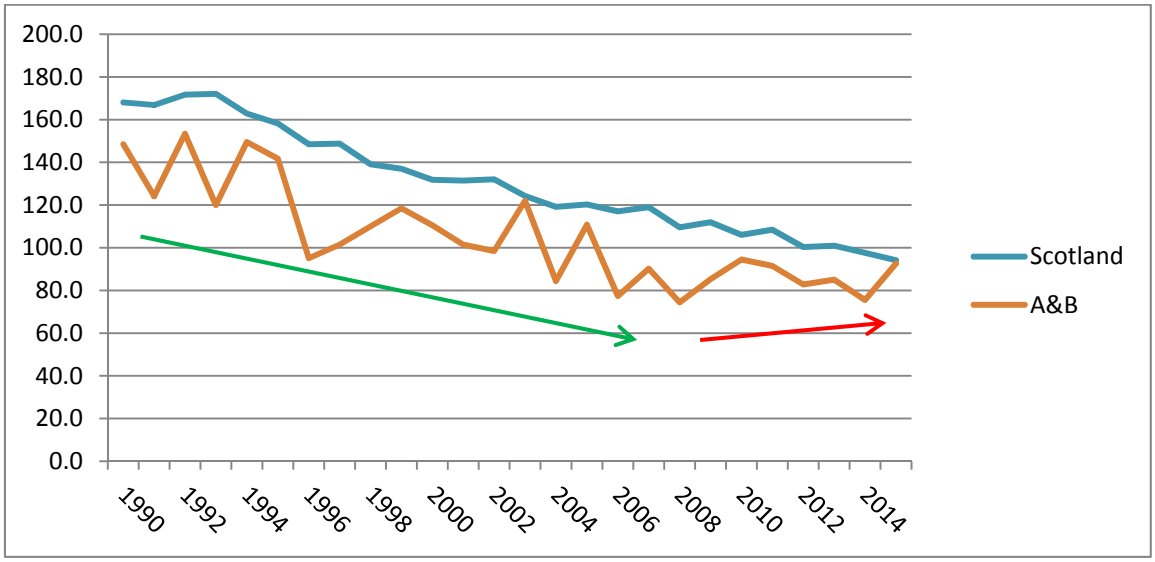
y = 0.1637x + 94.515
Scotland
A&A
Linear (A&A)

f) FV



- For Argyll and Bute males, the age/sex standardised death rate for lung cancer actually increased between 2008 and 2015, at a time when most observers are seeing dramatic declines in such deaths throughout the western world. By 2015, it had reached the national rates, something it had only achieved once before in 26 years (Figure 12).

Figure 12: Trend in age/sex standardised lung cancer mortality per 100,000 person years, in Argyll and Bute males, using the European Standard Population (2013), by year, 1990-2015.



- For Lanarkshire females, the age/sex standardised death rate for lung cancer increased more rapidly than did the Scottish rates such that by 2015, there was a 10.0 point gap opening up between the two trends (shown with the red arrow) (Figure 13). Meanwhile, GG&C females managed to reduce this gap slightly over this time period, emphasising that GG&C either held its ground or improved on it and rarely lost ground regardless of the parameter under study. This converging picture for GG&C vs Lanarkshire, with

respect to lung cancer mortality in females, is highlighted in Figure 14. By 2015, their lines are coming close to touching for the first time (red circle in Figure 14).

Figure 13: Trend in age/sex standardised lung cancer mortality per 100,000 person years, in Lanarkshire females, using the European Standard Population (2013), by year, 1990-2015.

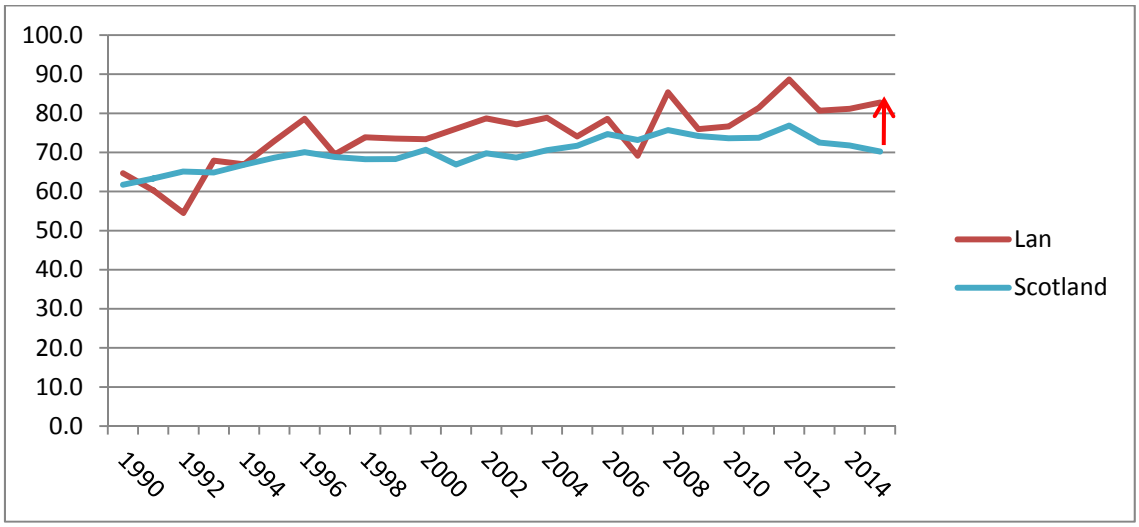
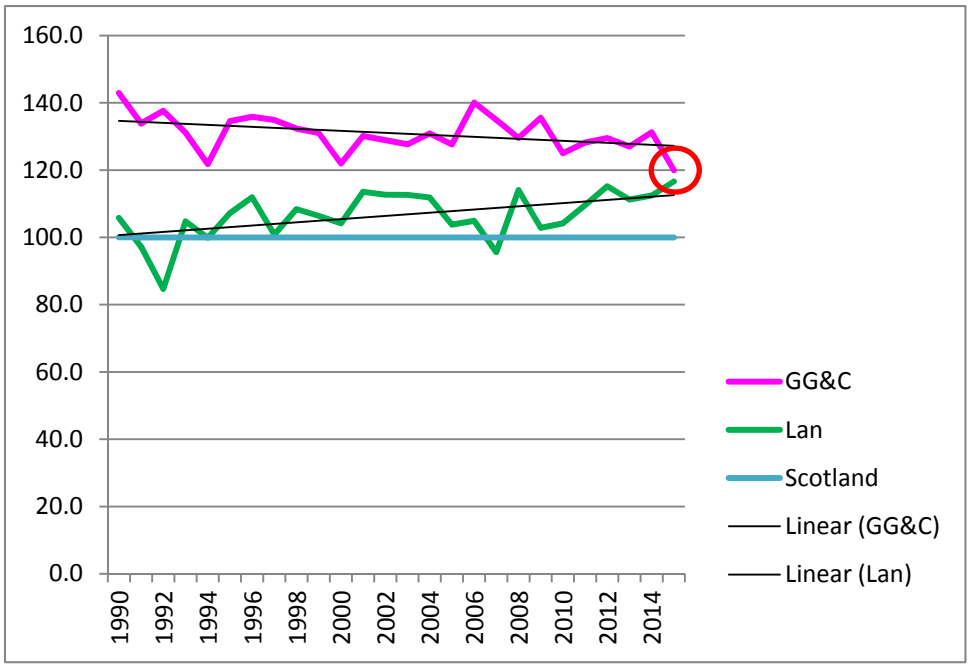


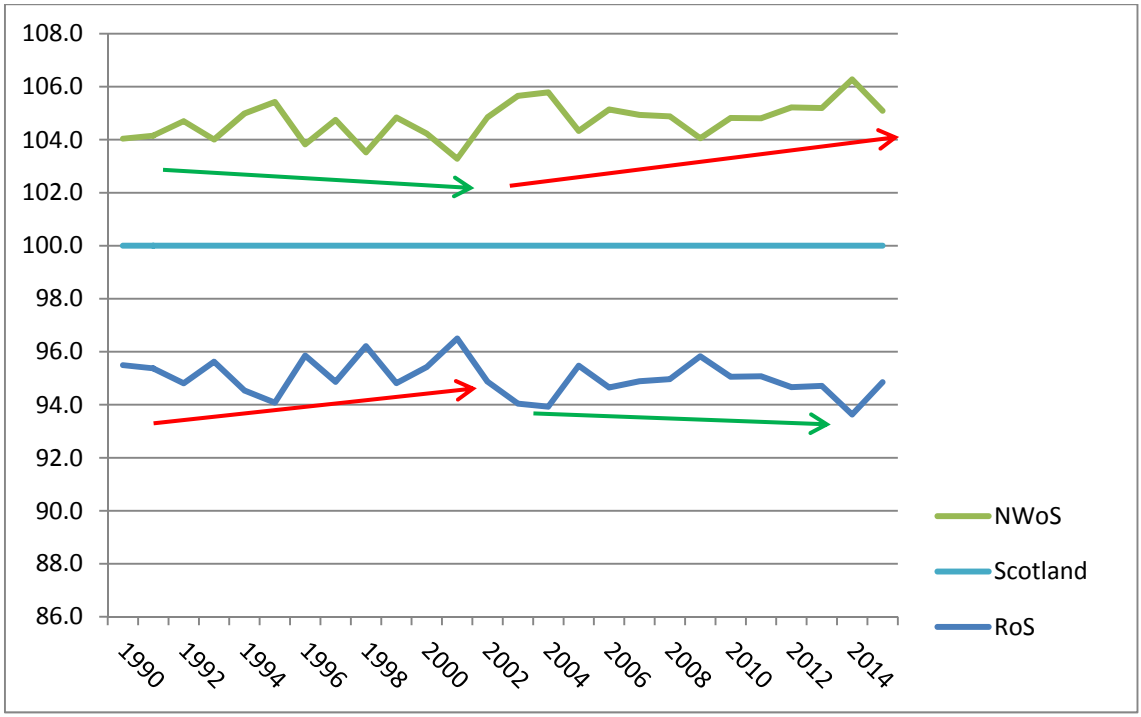
Figure 14: Trend in standardised mortality ratios for lung cancer in females for GG&C and Lanarkshire, showing the relative position compared to the national average (100% for Scotland) by year, 1990-2015.



- A comparative study of the trends of the standardised mortality ratios for cancer (all types combined) for the WoS and the RoS suggests that these changed direction after 2001, starting an upward, worsening trajectory for the NWoS (apart from GG&C

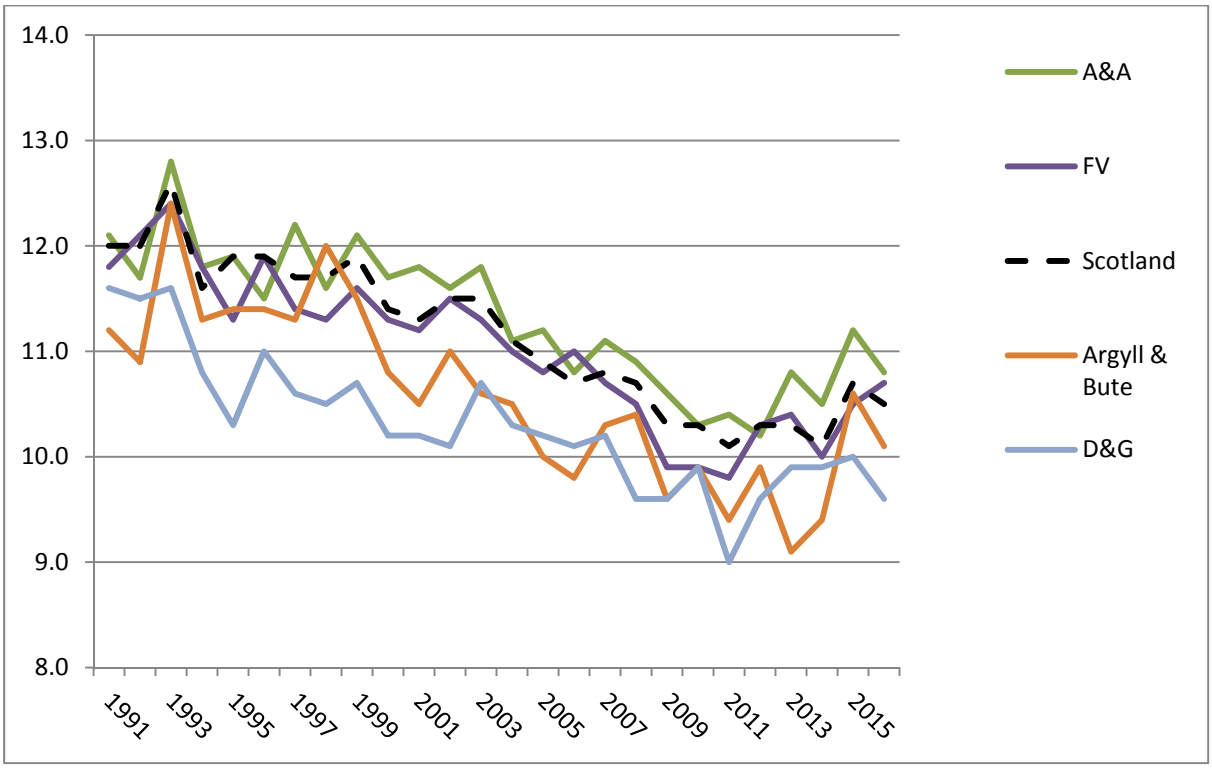
as described above) and a flat or perhaps slightly improving trajectory for the RoS. Identifying what happened after 2001 to cause this worsening relative picture for cancer mortality in 5 of the WoS areas under study is an important aim of the health needs assessment and therefore of any regional plan aimed at improving the targeting and efficiency of service provision (Figure 15).

Figure 15: Trends in standardised mortality ratios for cancer (all types combined) for the NWoS and the RoS, 1990 to 2015. Source: ISD Scotland.



- The only part of the WoS that has improved on virtually every parameter examined is GG&C, well studied for its concentrated social deprivation, and the two obvious mitigating factors to consider are its ability to attract economic investment and its ready access to/supply of health care. The one parameter that showed some loss of ground in GG&C was the age/sex standardised mortality rate for all causes combined, which rose by 2.6% between 2011 and 2016. However, the equivalent rises for the West of Scotland and Rest of Scotland as whole were 4.7% and the 2.1%, suggesting that GG&C behaved more like the Rest of the country (the east half of the country) than its immediate neighbours in the west side of the country . In contrast, the equivalent percentage rises for FV, A&B, D&G, A&A and Lanarkshire for the same 5 year time period were, in decreasing order, 9.2%, 7.4%, 6.7%, 3.8% and 3.6% respectively. The actual trends for the four rural areas that experienced higher percentage rises after 2011 are shown in Figure 16.

Figure 16: Trend in age/sex standardised death rate per 1,000 population, FV, D&G and A&A, both genders combined, using Scotland as the standard population, by year, 1991-2016.



- Extensive analysis (pending) of routinely collected data on the prevalence, incidence, mortality and hospitalisation for both coronary heart disease and all heart disease combined suggests a similar picture, although with ongoing improvements in both GG&C and Lanarkshire and recent small deterioration in the other rural areas under study. The other finding of note is that the overall decline in incidence and mortality for cardiovascular disease in both the WoS and the RoS is only accompanied by a fall in hospitalisation in the RoS. Although higher rates of hospitalisation in the WoS are in keeping with its greater level of social deprivation, a trajectory that is travelling in the opposite direction, ie rising, is difficult to justify.
- Hospital admission rates, for all ICD10 codes (all illnesses and diseases) and types (emergency, elective inpatient and elective day case) are observed to be higher in the West of Scotland than in the Rest of Scotland, based on the crude rates (Figures 17 to 19). The trends are rising for both halves of the country for emergency and elective day case but falling overall for both halves of the country for elective inpatient, in keeping with national directives to move to day case activity. The divergence in the trend lines between the WoS and the RoS over time was greatest for emergency admissions. The temporary plateau in rates for elective inpatient in the RoS between 2011/12 and 2014/15 (Figure 19) was matched with a clear rise in the WoS, which will have exacerbated the ongoing rise in emergency admissions in terms of pressure on what are declining bed numbers.

Figure 17: Emergency inpatient admissions: Crude rate per 100,000 population for NWoS, RoS and Scotland. Source: ISD Scotland.

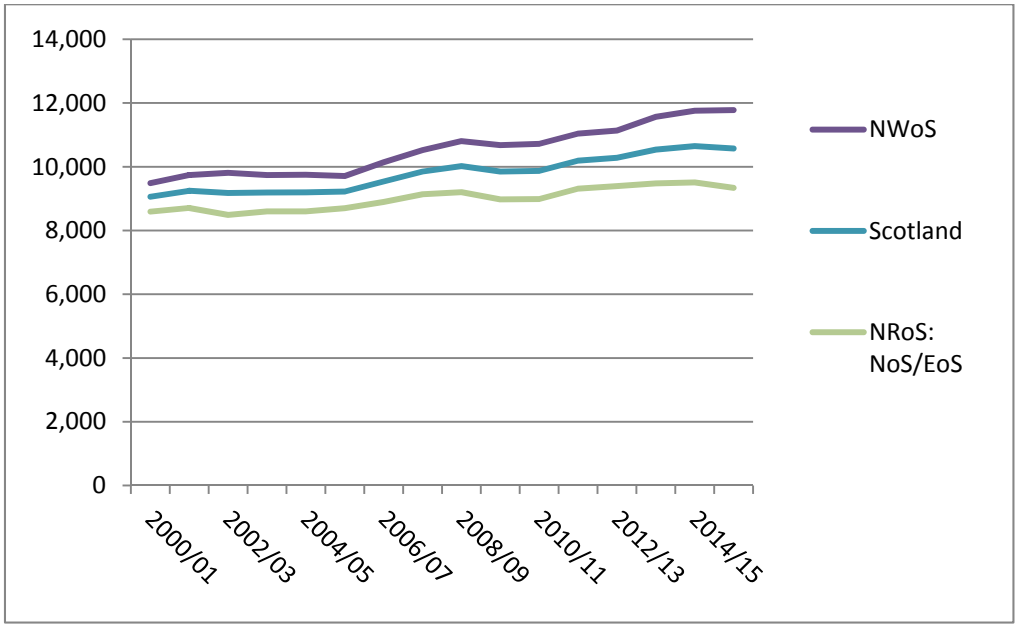


Figure 18: Elective day case activity: Crude rate per 100,000 population, for NWoS, RoS and Scotland. Source: ISD Scotland.

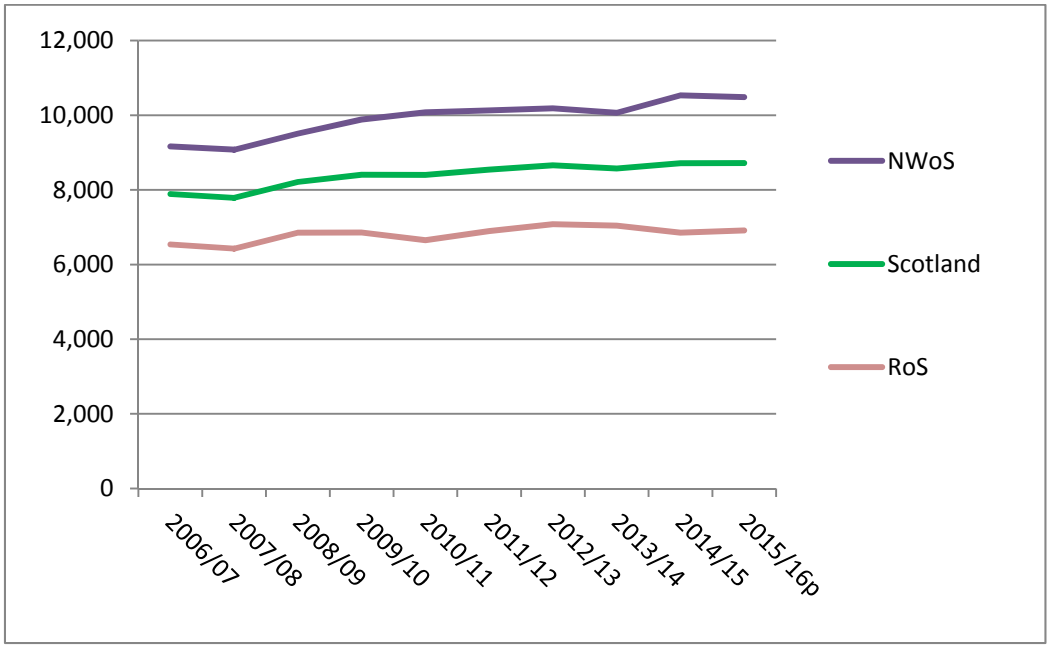
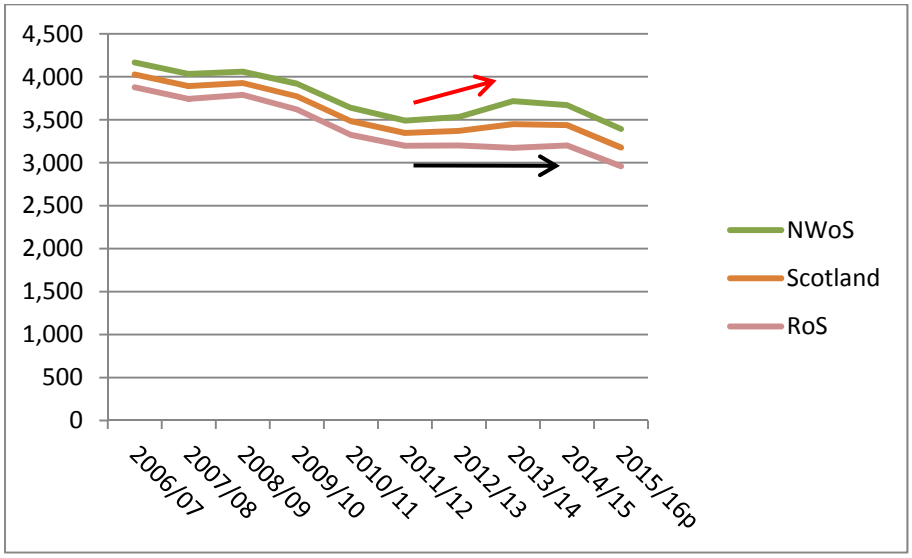
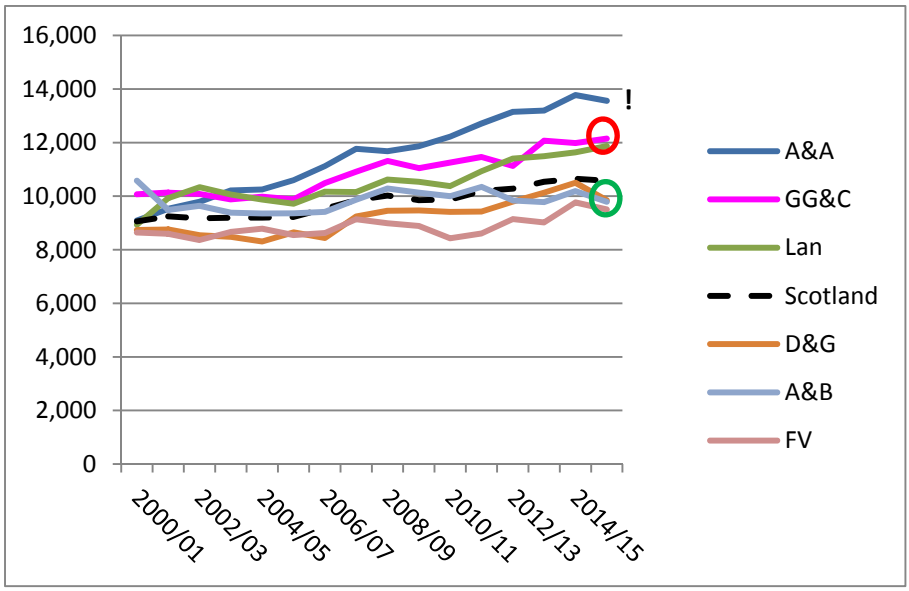


Figure 19: Elective inpatient admissions: Crude rate per 100,000 population, for NWoS, RoS and Scotland. Source: ISD Scotland.



- Furthermore, within the WoS there is considerable variation in rates of emergency inpatient admission with the range expanding significantly over the past 15 years (Figure 20). Work is underway to age, sex, deprivation adjust this position to assess the level of over utilisation in the WoS. This poses several questions - does the proximity to hospital facilities encourage access particularly where they are relatively well provided for in terms of A&E sites, hospital beds and consultant provision? Are there historical cultural factors that lead to increasing dependency on A&E services leading to higher reliance on emergency inpatient admission? Does falling provision of GP principals, and related continuity of care, in primary care have an impact on use of unscheduled hospital care. Do redirection policies at A&E make a real difference to the use of unscheduled care?

Figure 20: Emergency inpatient admissions: Crude rate per 100,000 population, for Scotland and the 6 study areas within the NWoS. Source: ISD Scotland.



- Although the use of elective care varies to a lesser extent within the WoS, based on crude rate trends (Figures 21 and 22), additional questions are raised about why some health board and council areas within that region have such high rates and others have such low rates, even after standardisation for age, sex and deprivation (based on fully adjusted analyses for 2016/17 and age/sex standardised analyses using European standard population for 2013, analyses pending). Why are FV elective day case rates static and equivalent A&A rates falling over time whilst those of the other areas tend to be rising (Figure 21)? Why are A&B rates for elective inpatient admission, though falling, so much higher than elsewhere in the WoS and can this excess be legitimately attributed to its remoteness and rurality, its agedness and the level of deprivation it conceals in its rural neighbourhoods (Figure 22)?

Figure 21: Elective day case activity: Crude rate per 100,000 population for Scotland and the 6 study areas within the NWoS. Source: ISD Scotland.

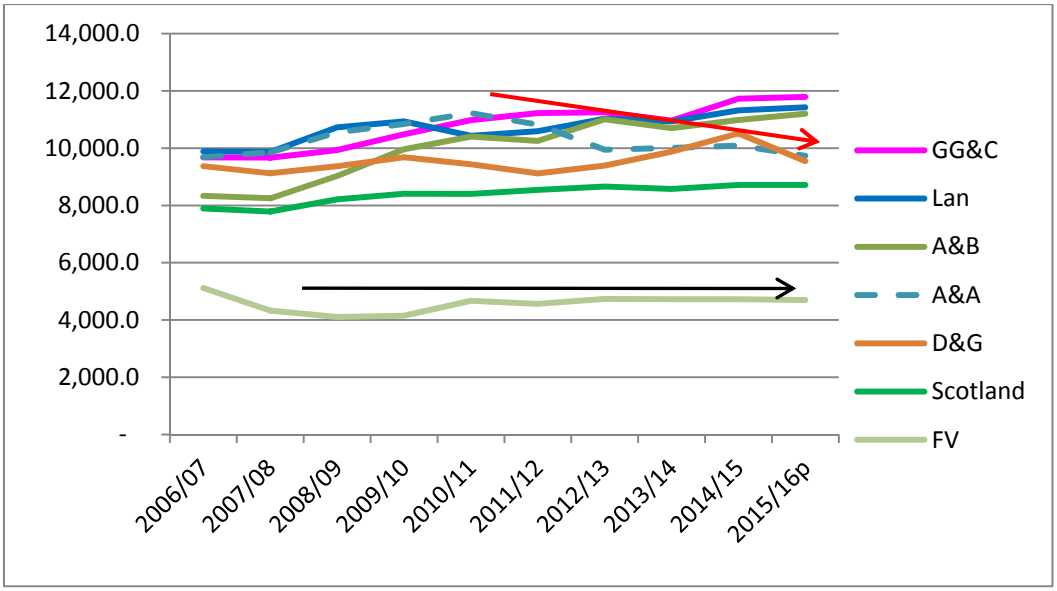
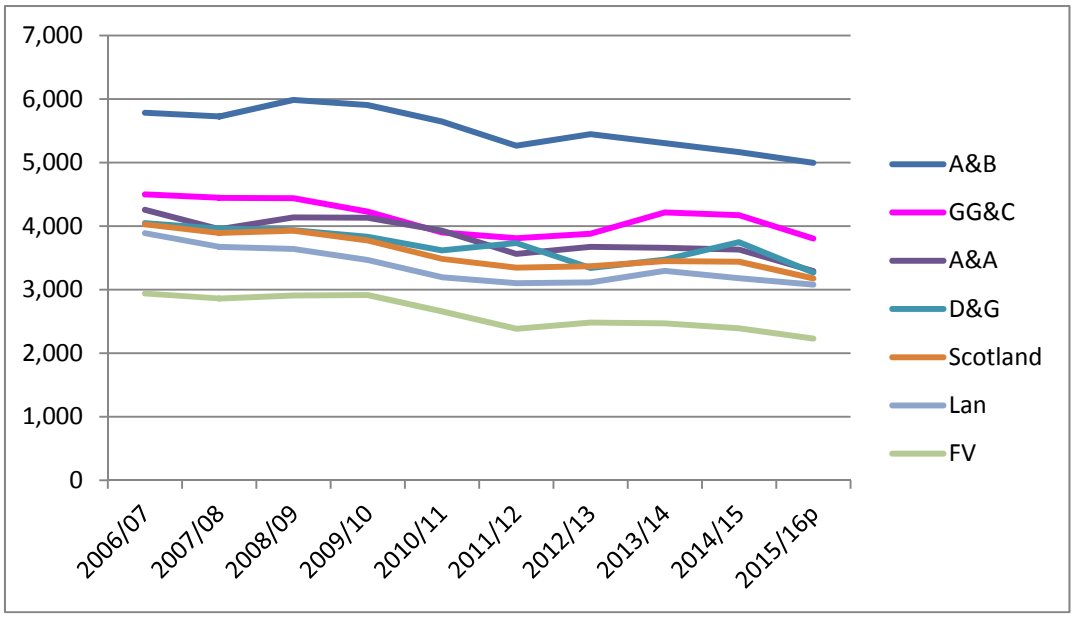


Figure 22: Elective inpatient admissions: Crude rate per 100,000 population for Scotland and the 6 study areas within the NWoS. Source: ISD Scotland.

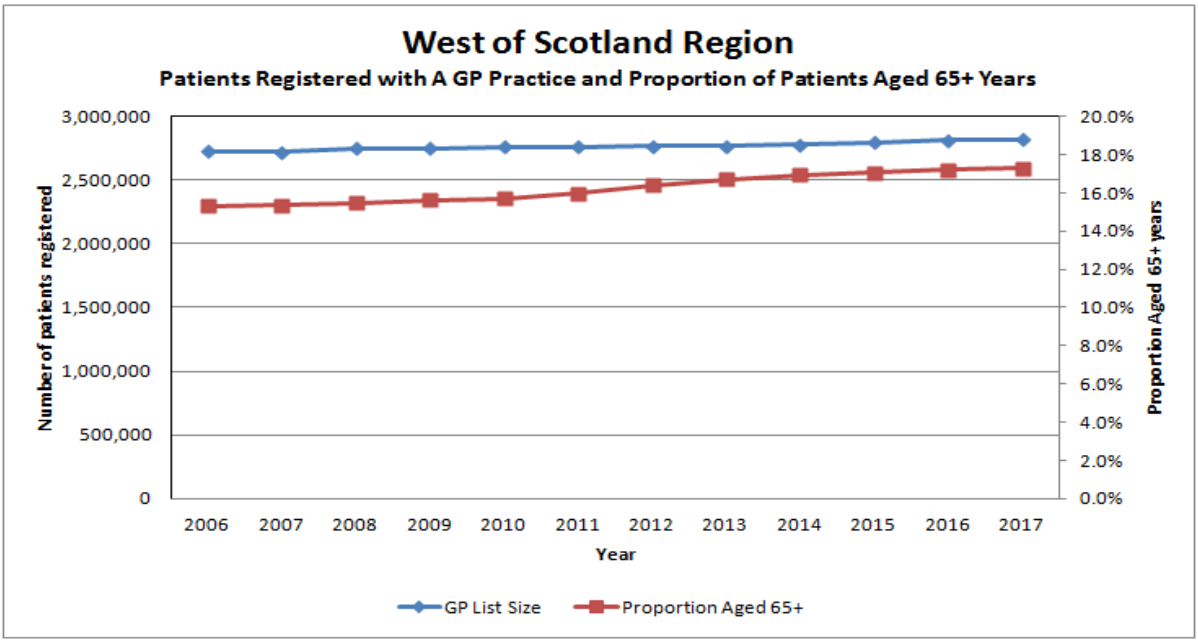


These largely unexplained variations require to be explored with a view to better understanding the drivers of consumption of hospital care and the degree to which current provision is meeting, or indeed exceeding, the needs of the residents of the WoS Region. To ensure that the limited resources available are used equitably, that is, determined by genuine need, and fairly distributed against both geographical and socio-economic gradients, it will be important to consider the service provision and service uptake across the region.

Appendix 2: Demand and Activity

This paper sets out supporting information contained within the West of Scotland Submission. This work was prepared by J Gomez.

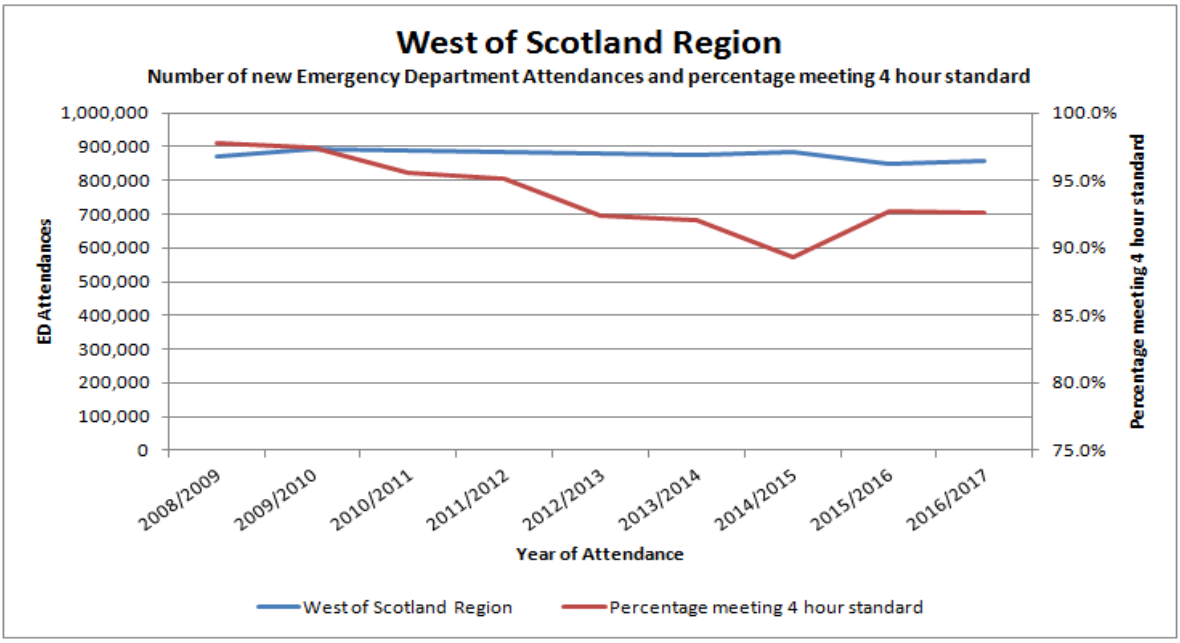
General Practice



- Between 2006 and 2017 the number of patients registered with a West of Scotland GP increased by 3.5 per cent, from 2,725,912 to 2,820,944.
- This represents an average annual increase of 0.3 per cent.
- At the same time the proportion of patients aged 65+ years have increased by 12.9 per cent, an average annual increase of 1.1 per cent.
- ISD have estimated that per annum there would be approximately 7,908,000 GP consultations and 3,799,000 Practice Nurse consultations with 56,245,994 prescriptions dispensed.

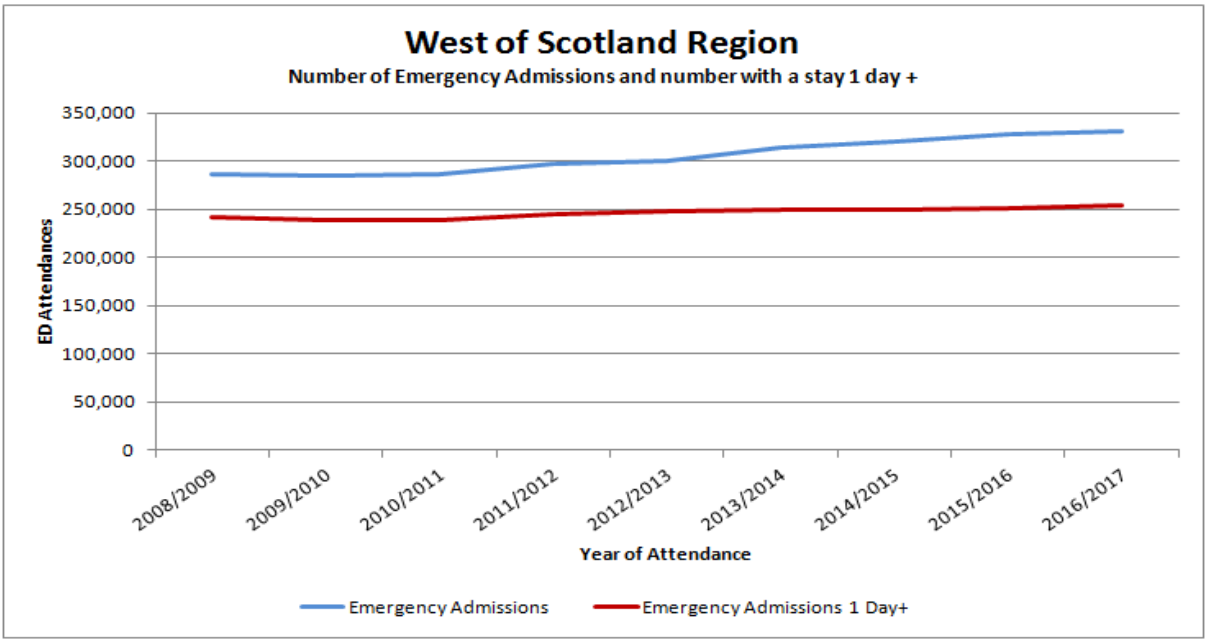
Emergency Care

Emergency Department Attendances



- Between 2008/2009 and 2016/2017 the number of New Emergency department attendances decreased by 1.4 per cent, from 869,960 to 858,059, since 2014/2015 it has decreased by 3.1 per cent.
- This represents an annual average of a 0.2 per cent decrease.
- The percentage of patients meeting the four hour standard decreased by 5.3 per cent, reducing from 97.6 per cent in 2008/2009 to 92.6 per cent in 2016/2017.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population attended Emergency Departments 7.8 per cent more than expected.

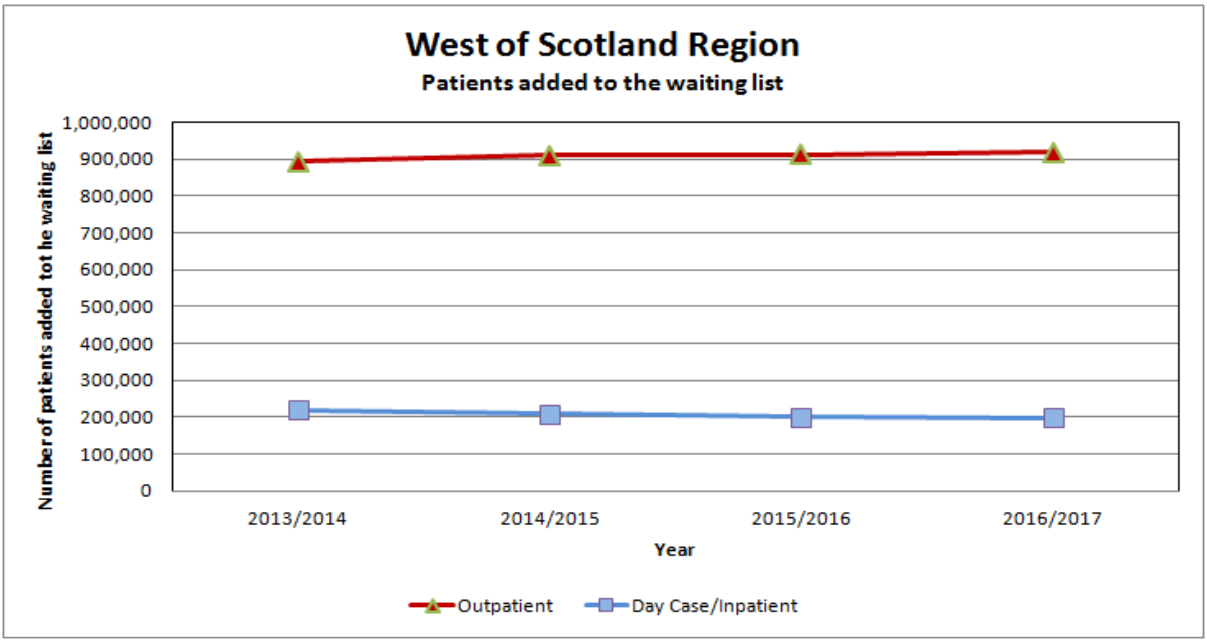
Emergency Admissions



- Between 2008/2009 and 2016/2017 the number of emergency admissions increased by 15.7 per cent, increasing from 286,478 to 331,318, since 2014/2015 it has increased by 3.3 per cent..
- Emergency admissions with a stay of one day or longer increased by 5.1 per cent whilst short stays with no overnight stay increased by 71.8 per cent.
- Zero stay admissions accounted for 15.8 per cent of all emergency admissions in 2008/2009 increasing to 23.4 per cent in 2016/2017.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population were admitted as an emergency 6.3 per cent more than expected.
- In 2016/2017 the case mix adjusted average length of stay was 0.96 which was 0.02 better than NHS Scotland.
- The emergency re-admission rate within 7 days in 2016/2017 was 4.7 per cent compared to NHS Scotland at 4.8 per cent and within 28 days it was 10.1 per cent compared to NHS Scotland at 10.4 per cent.
- Emergency admissions are projected, based on demographic changes alone, to increase by 3.3 per cent (11,250 admissions) by 2020, 8.3 per cent (26,135 admissions) by 2025 and 18.2 per cent (57,494 admissions) by 2035.

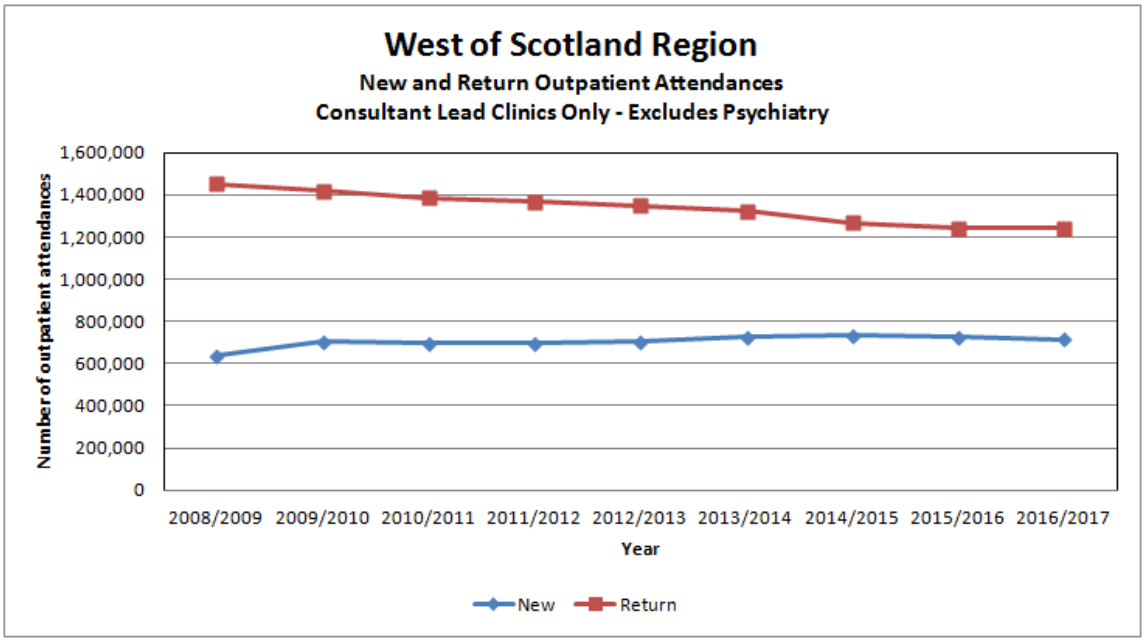
Elective Care

Additions to Waiting Lists



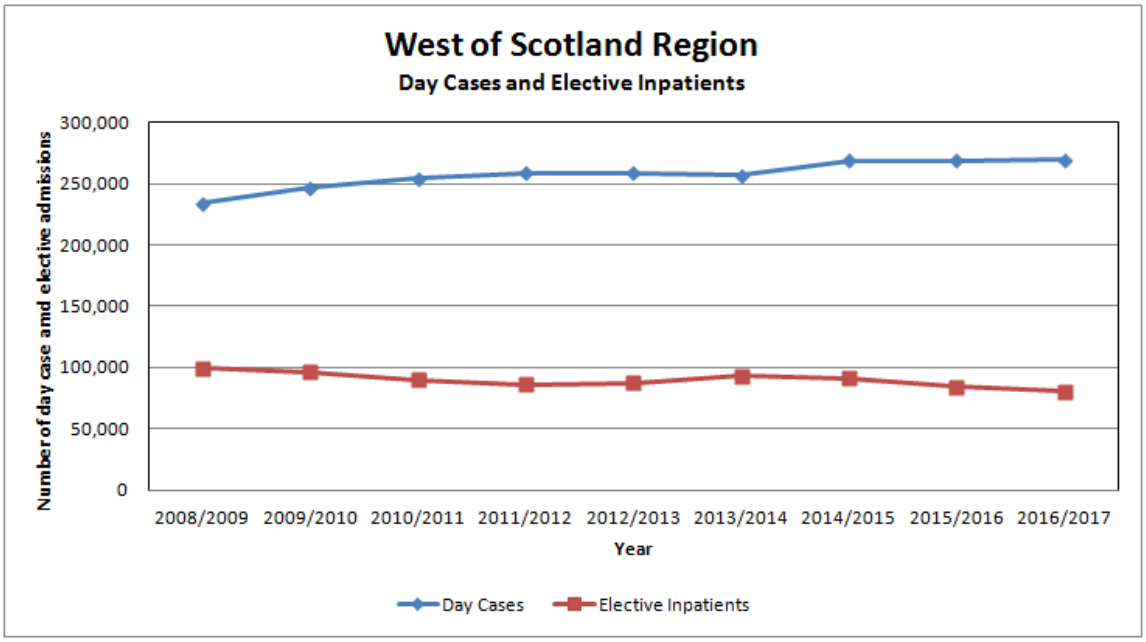
- Between 2013/2014 and 2016/2017 the number of additions to the new outpatient waiting list has increased by 3.0 per cent from 892,805 to 919,244
- This represents an average increase of 1 per cent.
- Patients on the outpatient waiting list have increased by 27.2 per cent from 125,053 in March 2014 to 159,018 in March 2017. Over sixty per cent of this increase occurred in the past year.
- The number of additions to the inpatient or day case waiting list decreased by 9.7 percent, from 219,371 in 2013/2014 to 198,080 in 2016/2017.
- This represents an average annual 3.3 per cent decrease
- Patients on the inpatient or day case list have increased by 37.2 per cent from 24,348 in March 2014 to 33,408 in March 2017. The increase is spread more regularly across the period than the increase in the outpatient waiting list.

Outpatient Attendances



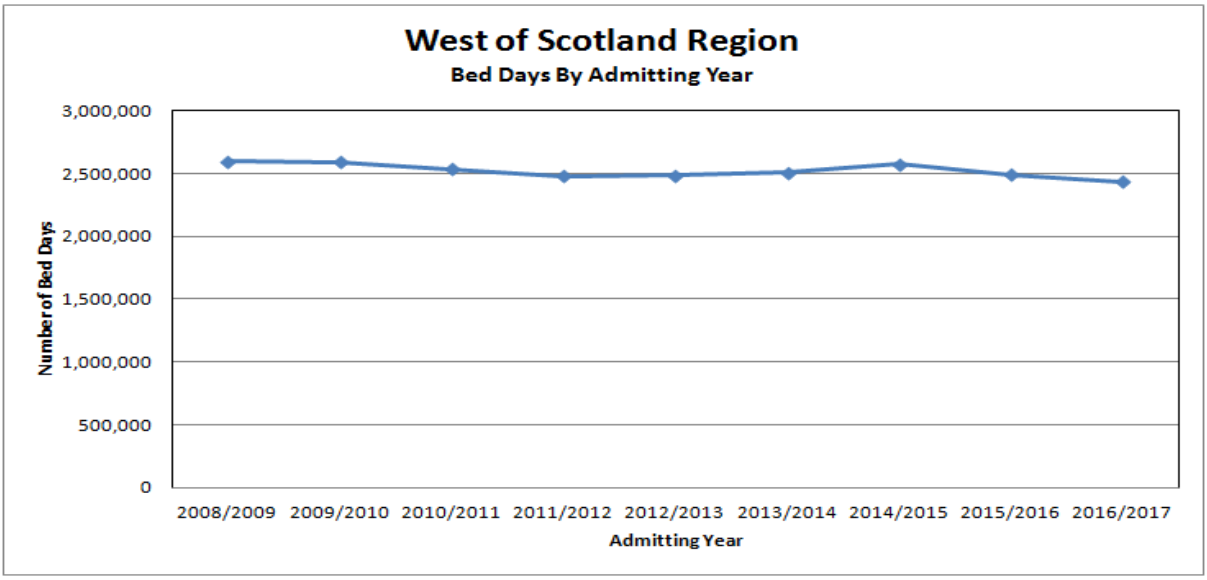
- Between 2008/2009 and 2016/2017 the number of new outpatient attendances at consultant led clinics (excluding psychiatry) increased by 12.1 per cent, increasing from 638,212 to 715,441, since 2014/2015 it has decreased by 2.5 per cent. Over the same period return outpatient attendances decreased by 14.6%.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population attended an outpatient appointment 1 per cent more than expected.
- The percentage of outpatients seen within 12 weeks in 2016/2017 was 83.2 compared to NHS Scotland at 81.5 per cent.
- In 2016/2017 the new outpatient DNA rate was 10.3 per cent compared to NHS Scotland which was 9.4 per cent., the DNA rate for return outpatients was 7.1 per cent for West of Scotland and 8.7 per cent for NHS Scotland.
- The return to new outpatient ratio in 2016/2017 was 1.8 compared to 2.0 for NHS Scotland
- Outpatients are projected, based on demographic changes alone, to increase by 1.9 per cent (14,222 attendances) by 2020, 4.1 per cent (31,105 attendances) by 2025 and 7.4 per cent (56,473 attendances) by 2035.

Elective Admissions



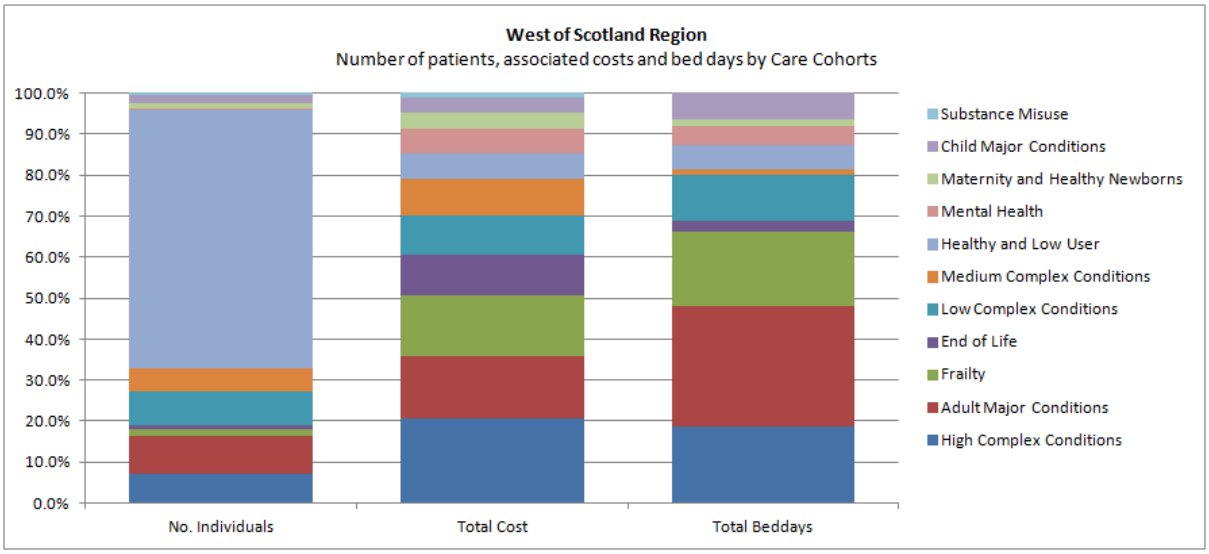
- Between 2008/2009 and 2016/2017 the number of day cases increased by 15.1 per cent, increasing from 233,984 to 269,386, since 2014/2015 it has increased by 0.3 per cent.
- Between 2008/2009 and 2016/2017 the number of elective inpatients decreased by 19.2 per cent, decreasing from 99,530 to 80,437, since 2014/2015 it has decreased by 11.2 per cent.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population were admitted as a day case 16.5 and as an elective inpatient 3.6 per cent more than expected.
- The percentage of day case or inpatients seen within 12 weeks in 2016/2017 was 87.7 compared to NHS Scotland at 87.4 per cent.
- In 2016/2017 the BADS day case rate was 87.0 per cent compared to NHS Scotland which was 85.4 per cent. The overall day case rate for West of Scotland Region was 77.0 per cent and for NHS Scotland 73.9 per cent.
- In 2016/2017 the case mix adjusted average length of stay was 1.03 which was 0.04 poorer than NHS Scotland.
- Day case and elective admissions are projected, based on demographic changes alone, to increase by 3.3 per cent (11,835 admissions) by 2020, 6.9 per cent (24,601 admissions) by 2025 and 12.0 per cent (42,815 admissions) by 2035.

Bed Days



- Between 2008/2009 and 2016/2017 the number of bed days decreased by 6.2 per cent, increasing from 2,597,377 to 2,478,550, since 2014/2015 it has decreased by 5.3 per cent.
- The West of Scotland population indirectly standardised for age, gender and deprivation to Scotland suggests that in 2016/2017 the West of Scotland population used 3.2 per cent more bed days than expected.
- During the period between 2008/2009 and 2016/2017 the average available staffed bed decreased by 8.7 per cent.
- Bed days are projected, based on demographic changes alone, to increase by 7.2 per cent (178,931 days) by 2020, 16.1 per cent (390,837 days) by 2025 and 36.5 per cent (884,006 days) by 2035.

Activity and Costs for Cohorts of Patients



- Four cohorts, High Complex, Adult Majors, Frailty and End of Life account for 19.1 per cent of individuals but 60.6 per cent of costs and 68.8 per cent of bed days.

NHS Dumfries & Galloway

NHS Forth Valley

NHS Greater Glasgow and Clyde

NHS Lanarkshire

Golden Jubilee Foundation
Patients at the heart of progress

West of Scotland

Developing a Regional Workforce

1. Introduction

West Region Workforce size and scope

The NHS West Region employs approximately 62,630 WTE (72,619 headcount) NHS staff, within five territorial Boards (the Golden Jubilee Foundation being a national Board), representing circa 45% of the entire NHS Scotland workforce as illustrated in the charts below:

Chart 1 – Regional workforce contrast

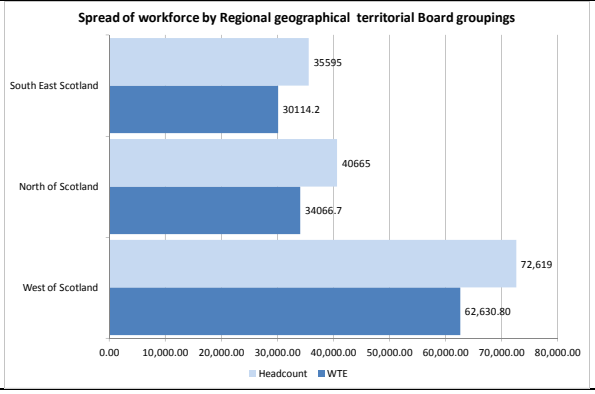
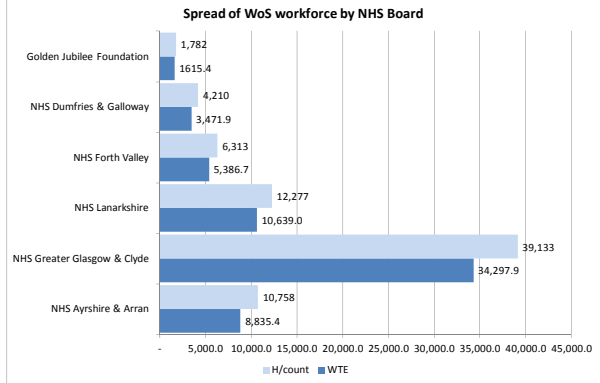


Chart 2 – Workforce within region



In this chapter, the focus is on the NHS workforce as workforce information is more developed. Workforce data from social care will be available from the the Health and Social Care Partnerships as we refine Phase 2 of the national workforce plan.

2. Drivers of Change

2.1. Healthcare treatment and provision is constantly advancing and changing, and our workforce must adapt in order to deliver modern, patient quality focused treatment and care. All staff groups at all levels have an important part to play in shaping and delivering future models of care. Staff need to be supported and developed to ensure they can fully engage and commit to new service delivery models.

2.2. The future workforce cannot be "more of the same". The future workforce will need to be based on multi-skilled teams rather than individual practitioners, this will facilitate skill focused effective multi-disciplinary team working.

2.3. Hospital based staff will work more closely with community teams and both will need to have a clear understanding and appreciation of each other's roles to create a culture which supports people with long term conditions and their carers to be the lead partners in decisions about their health and wellbeing.

2.4. New developments across the West Region, such as the development of a Regional Elective Centre at the Golden Jubilee National Hospital will bring career opportunities and new work environments which are attractive to staff and may potentially destabilise the staffing in existing and established units.

Workforce planning for new developments must include a risk assessment of unintended consequences for workforce supply and demand.

2.5. The ageing population is not the only factor which will impact on service demand; more young people are surviving with long term conditions, the provision of services for people with chronic conditions in mid life, and the increased demand for mental health services for all ages will all impact on the shape of the future workforce.

2.6. Changing treatments, interventions and diagnostics will bring opportunities for brand new roles and career pathways.

2.7. Sustainability and workforce availability in remote and rural settings is a continuing challenge across all job families but particularly medical , nursing and Allied Health Professions.

3. Regional Pressure Points

Boards have already undertaken work to identify pressure points within the West Region. Common themes which have emerged across the West of Scotland are as follows:

- The Medical Workforce – challenges in demand, supply and sustainability across the spectrum of grades and specialities but significantly at Consultant grade within specialties in acute hospital settings; see Appendix 1 case study examples

- Nursing – an ageing workforce, a significant element of which will retire in the next decade presents particular challenges in key job areas e.g. health visitors, district nurses, paediatrics, midwifery and mental health practitioners. The demand for Advanced Nurse Practitioners (ANPs) is likely to increase, as medical recruitment and retention both in acute and primary care creates additional workforce pressures. New educational programmes and pipelines need to be created to supply this workforce, although recruitment of ANPs will come form an increasingly scarce nursing resource .

- Radiology – demand and supply issues connected to the current radiologist/reporting radiographer position in addition to increasing service demand and enhanced technical solutions requiring different ways of working.

- Pharmacy technicians – a significant increase in demand which is not being matched with supply.

- Healthcare science – demography of the workforce, particularly in senior and specialist roles, as well as longstanding national issues with supply.

Further work is required to expand on the detail of these pressure areas and potential solutions. For the purposes of this discussion paper, the focus is on medical workforce.

4. Medical Workforce Availability

Recruitment and retention of medical staff within acute and primary care services is increasingly a challenge across Scotland. The available labour market is competitive at inter/intra regional, national, and international levels.

With a growing elderly population and a consequent increase in complex healthcare needs, it is recognised that the current workforce model, with its heavy reliance on a traditional medical model of care is becoming fragile and in some specialties unsustainable in the long term. New workforce models must consider a mixed economy of professions within the workforce working alongside medical staff i.e. advanced practice roles from varying professional backgrounds e.g. Nursing, Allied Health Professionals, Pharmacy, Healthcare Science and Physician Associates.

The charts below illustrate the age profile of the consultant workforce across the West Region and the gender split:

Chart 3 – WoS Consultant age profile

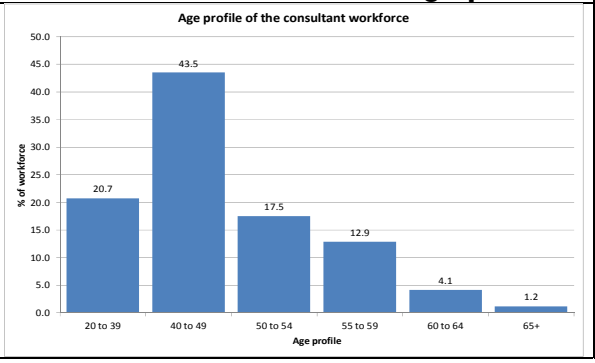
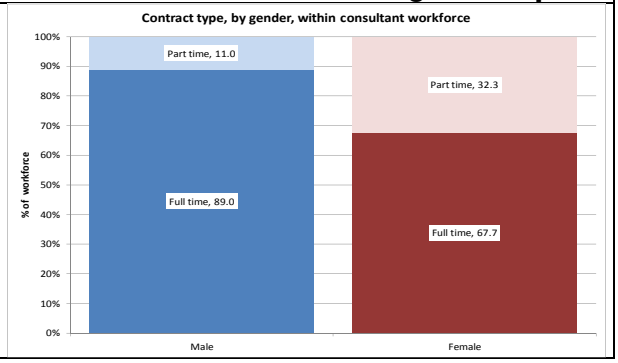


Chart 4 – WoS Consultant gender split



Approximately 126 (headcount) consultants in the West Region are aged over 60. 60.6% of the consultant workforce is male however this is changing as the number of females in the medical workforce continues to expand. This is likely to change the working patterns of the medical workforce as females currently work part time more frequently than males. This will be an important workforce planning consideration in terms of workforce numbers and service capacity.

Table 1, below, illustrates the scale of the challenge faced by the West Region in terms of consultant vacancies, with 46% of all vacancies being vacant 6 months +:

Table 1 – West Region Consultant Vacancies as at 31st March 2017

	Total Vacancies WTE	Vacant 6 months or more
All specialties	**260.0**	**119.8**
All medical specialties	**254.9**	**117.8**
Emergency medicine	9.0	6.0
Anaesthetics	26.0	9.0
Intensive care medicine	2.0	-
Clinical laboratory specialties	**53.0**	**25.0**
Histopathology	13.0	5.0
Chemical pathology	2.0	-
Haematology	5.0	2.0
Medical microbiology & virology	2.0	1.0
Clinical radiology	31.0	17.0
Medical specialties[R]	**78.5**	**41.4**
General (internal) medicine	12.0	9.0
Cardiology[R]	3.0	3.0
Infectious diseases	3.0	1.0
Dermatology	7.9	2.0
Endocrinology & diabetes	4.0	3.0
Gastroenterology	13.0	7.0
Genito - urinary medicine	3.6	0.6
Geriatric medicine	7.0	3.0
Renal medicine	2.0	1.0
Neurology	5.8	4.8
Palliative medicine	1.0	-
Rehabilitation medicine	2.6	1.0
Respiratory medicine	8.0	5.0
Rheumatology	2.6	-
Clinical neurophysiology	1.0	-
Clinical oncology	2.0	1.0
Public health medicine	1.3	1.3
Occupational medicine	2.0	2.0
Psychiatric specialties	**30.4**	**9.1**
General psychiatry	23.7	6.8
Child & adolescent psychiatry	1.8	-
Old age psychiatry	3.3	2.3
Psychiatry of learning disability	0.6	-
Psychotherapy	1.0	-
Surgical specialties	**35.7**	**19.0**
General surgery	3.7	1.0
Otolaryngology	6.0	5.0
Neurosurgery	1.0	-
Ophthalmology	8.0	6.0
Trauma & orthopaedic surgery	6.0	1.0
Plastic surgery	2.0	-
Urology	8.0	5.0
Oral & maxillofacial surgery	1.0	1.0
Obstetrics & gynaecology	4.0	-
Paediatrics specialties	**13.0**	**5.0**
Paediatrics	13.0	5.0

Attached at Appendix 1 is a case study analysis of three medical specialties with significant staffing challenges for illustrative purposes – clinical radiology, histopathology and gastroenterology.

Across all Boards there are also significant supply challenges at the Trainee doctor level, resulting in either trainee vacancies or appointments of less senior trainee doctors, which present real challenges to Boards across the region to sustain current services and plan for future service provision and contributes to the wider Scotland wide challenges of a lack of future supply of trained doctor for both the secondary and primary sectors.. The changing demography of the medical workforce coupled

with individuals wanting to improve work life balance and/or work part time means that for many it takes longer to complete training, which compounds current fragility of rotas and longer term supply challenges. This will be a key element of the March 2018 Workforce Plan.

Recruitment & Retention

The West Region health boards recognise the importance of being an Employer of Choice which attracts and retains staff, supported by robust implementation of the Staff Governance Standards and the implementation of the Everyone Matters 20/20 Workforce Vision with its five priorities (A Healthy Organisational Culture, A Sustainable Workforce, A Capable Workforce, An Integrated Workforce and Effective Leadership & Management). All health boards have local action plans in place which support the priorities and ensure ongoing engagement with staff.
All boards remain committed to reducing expenditure on agency, bank and locum staff and a number of strategies are currently in place in boards to support this aim.

5. Workforce Affordability

Improve efficiency

To maximise the efficiency of service delivery, several factors should be taken into account in designing the workforce of the future:

- **Avoid duplication** – opportunities to integrate and streamline patient pathways will be considered and where possible generic support workers introduced both across health and health / social care (AHP, nursing, social care).

- **Reduce utilisation of high cost agency staff** – all Boards are committed as far as practicably possible to reduce/eliminate the utilisation of high cost agency staff within nursing and medical job families. The West Region continues to develop its medical bank to not only attract doctors in training but also those seeking additional work at retirement.

- **Work to "top of licence"** (registered and support staff) – roles require to be reviewed with staff supported and developed to work to the "top of their licence". This offers the potential to increase staff numbers and redistribute the workload to lower banded but appropriately trained staff, thus avoiding an increase in cost.

- **Extended scope** – to streamline the patient journey, certain roles will extend their scope to provide additional care elements and avoid referral to a different healthcare provider or into acute services e.g. community nurses developing Intravenous (IV) therapy skills to allow patients to be cared for in the community; extending psychological care approaches, growing the resilience of people using services to effectively self-care and supporting

concordance with agreed personalised treatment plans reducing demands on unscheduled care.

- **Roles appropriate to skill** – to ensure efficiency, appropriately skilled staff should undertake roles e.g. admin staff undertaking admin roles, not clinicians. Staff developed to conduct proactive engagement with patients, their families and carers about what matters to them and how they feel better supported to access services and to self care when they are able; staff empowered to promote healthy lifestyles and provide support to patients and carers to meet social challenges such as financial security and employment.

In addition, there are other opportunities for efficiency which will support the workforce of the future:

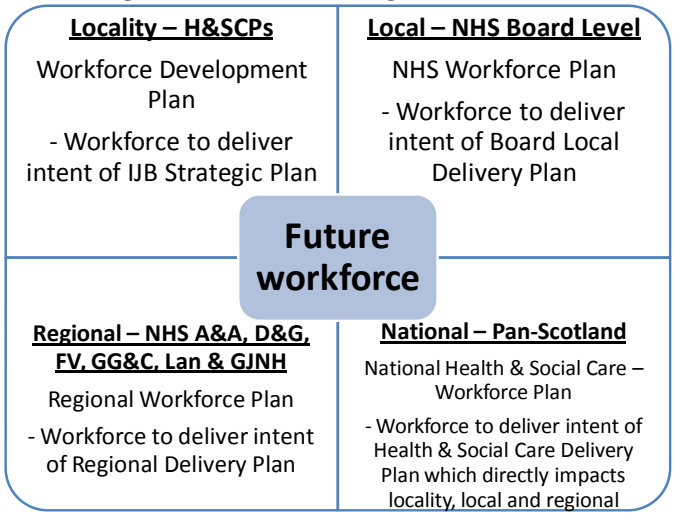
- Agile working arrangements which will support and enable the concept of working across boundaries
- Improvements in technology such as electronic patient records, mobile technology (tablet computers), etc. would support greater workforce productivity and efficiency and will require the workforce to work differently
- Innovative practice using existing technology based platforms (e.g. NHS Inform MATS) and developing other web-based access to services for early advice and self management, influencing a culture of self-efficacy which deflects demand away from healthcare services and into upstream services e.g. leisure, voluntary and third sector services.
- West Region health boards and their partner HSCPs will continue to work with third sector colleagues to focus on supporting and testing out new approaches for the delivery of community-based support for people with complex and multiple conditions.
- Integrate more closely all contractor disciplines such as community pharmacists, dentists, optometrists and care providers to enable patients to better access appropriate care and advice
- Introduce pharmacists in GP practices with advanced clinical assessment skills to support the care of patients with long term conditions and better manage their medications

The workforce of the future will not be “more of the same”. The workforce will be older and have a greater reliance on Advanced Practitioners and roles with extended scope. All staff groups will work to the “top of their licence” with work aligned to their skills. The workforce may require to be re-profiled to match the increased workload demand in the community and the higher acuity in acute care.

6. Regional Workforce Planning

All NHS Boards within the West Region have extant Workforce Plans at required by CEL32(2011) and the new regional approach should robustly complement existing plans as illustrated in Figure 1 below:

Figure 1 – Planning continuum



Critical will be balancing the unique, but mutually dependent, workforce requirements and needs arising from each of the four levels. The key workforce planning considerations required at all levels are the same:

- Detailed qualitative and quantitative profile the current workforce
- Skill profile of current workforce
- Need for a current and future service profile
- Labour market intelligence for staff group/speciality/geographic distribution

The Regional Delivery Plan will present the profile of the West of Scotland population and will recognises significant cross boundary flow from areas of Highland and the Island Boards, and Scotland as a whole due to the provision of some specialist tertiary services for NHS Scotland as a whole within the West Region.

7. Regional Workforce Planning – Way Forward

7.1. Standardised data collection – workforce information and numerical data should be gathered in a consistent regional format to allow for aggregation into regional documents.

7.2. Additional workforce planning capacity – additional resources should be identified for Regional workforce planning, identifying the limitations of the current Board workforce planning capacity.

7.3. Quantitative data needs to be augmented with soft, qualitative data to enable decision making and risk assessment to be made with a full picture including gathering information from the frontline.

7.4. There is a need for work at national level, via NES and NSS, in partnership and collaboration with the regions to ensure appropriate information and

intelligence is sourced, used and understood consistently in a 'Once for Scotland' manner.

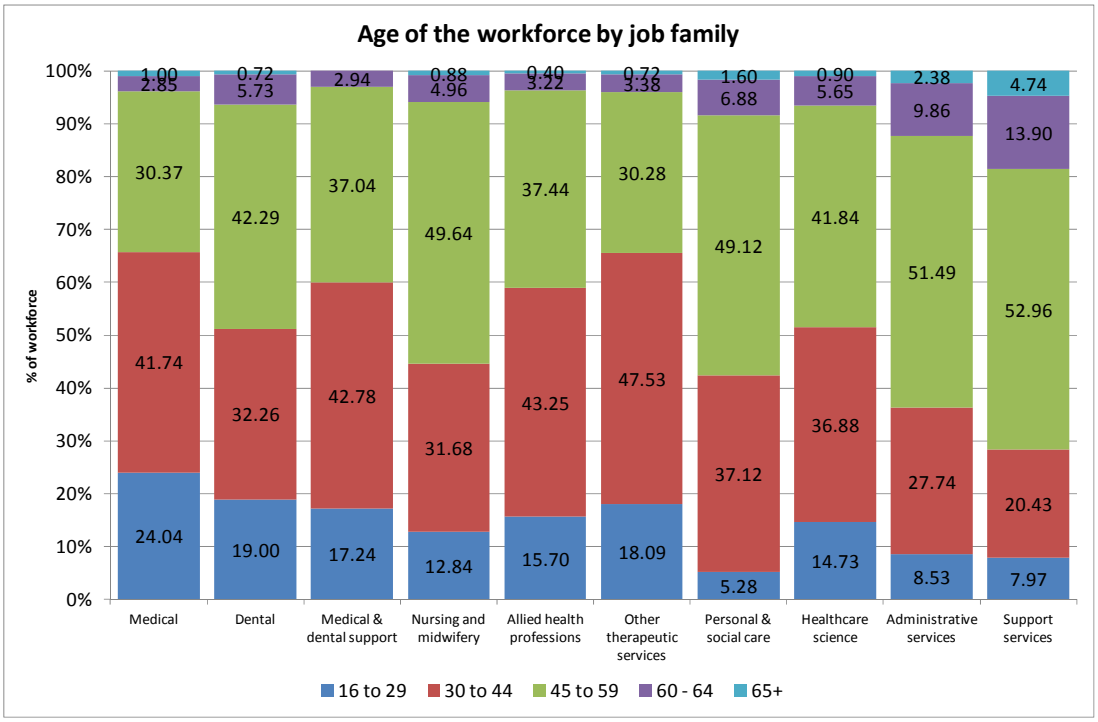
7.5. HR Recruitment teams should establish real time labour market intelligence at Board, Regional and National level, which will enable recruitment processes to be intelligence driven and will help inform education need.

7.6. Interventions to develop the West Region workforce should be skill focused and matched to the SCQF Framework so each intervention is matched to an education level.

7.7. West Region should undertake detailed multi-professional workload and workforce planning to support service redesign and change. Effective use of existing resources will be essential as will gaining an understanding of current utilisation of the workforce and the ongoing implications of retaining and up skilling the existing workforce, many of whom will remain part of the workforce for the next 5-10 years.

The age of the West Region workforce, by job family, is shown in Chart 5:

Chart 5 – Age of WoS Workforce by Job Family



7.7.1. The older population is also reflected in our workforce profile, this will affect the availability and fitness of the West Region workforce. An older workforce will bring both challenges and opportunities and all the West Region health boards are developing new approaches which will support older staff to remain in employment longer e.g. less physically demanding roles, reduced hours and flexible working.

7.7.2. Labour markets are changing, this includes the length of service, of our workforce influenced by changing pension provision; for example an employee born in 1981 will not draw their state pension until they are 68 years old (on the assumption there is no change to the state pension age of 68 being introduced by 2039), if they start work or education at 17 this makes their potential working life 51 years long. There are also now five generations in the workplace, ensuring the strengths and skills of each generation is capitalised on will be a core part of regional planning, whilst acknowledging the changing personal circumstances of such a diverse workforce.

With any intervention planning the length of time to train the required workforce should be factored in to preparation timelines, as well as backfill requirements, location and availability of training.

7.7.3. A similar approach will be required to define the generic support worker role and the education needs of this worker. It may not be possible to determine the exact numbers of each role required and so an initial estimate of need should be agreed and used for the purposes of development. Professions should be able to define their unique professional contribution and identify tasks which can be delegated and carried out effectively by support workers.

7.7.4. In a rapidly changing care environment with continual advances in care, there needs to be a cultural shift to accept that there will be a need for roles which may not have existed before. Listening to the workforce and understanding the detail of challenge will support appropriate intervention on careers, development and education. This further strengthens the need for qualitative and consultative intelligence on workforce and labour market availability, skill requirements and career satisfaction.

7.8. West Region health boards should work with Regulators, Scottish Government and Higher and Further Educational Institutions to ensure that the development of education programmes and curriculum are in line with the future healthcare needs, and have sufficient focus on community care. Future skills and treatment interventions will inform education need.

7.9. It is envisaged that Advanced Practice roles will be an integral part of building capacity and capability within the West Region workforce. The development of extended roles and initiatives such as intravenous therapy, advanced practice, non medical prescribing and the extension of the health care support worker role will require engagement with HEIs and the GP community. West Region health boards are fully engaged in the national agenda to develop the roles of community practitioners, ensuring new models meet the needs of people using services.

End.

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Radiology

Challenges
Vacancies are a growing trend, with a sustained inability to fill advertised posts, of which in some of the West Region Boards these have been enduring vacancies over many years. This mirrors the position across wider NHS Scotland and the UK as a whole

In terms of sub-specialisation within radiology specific pressure points across the region include: GG&C - Neuro Radiology and Neuro Interventional Radiology; Breast Radiology is flagged as a challenge across all West Region Boards.

Predicted CCT, as illustrated in the charts, for 2018 could be absorbed solely by the West of Scotland Region. Attraction and retention is the key issue across all Boards where there is an inability to replace retirees, without considering additionality arising from service development.

The largest pressures are in D&G, FV and A&A as illustrated in the vacancy charts.

Demand
Radiology services in the UK are described by the Royal College of Radiologists as being in crisis. There is a highly competitive labour market, making job design critical to attraction. The ever increasing role of imaging in modern clinical care has led to a high increase in demand, particularly in complex imaging including CT and MR scans which has outstripped the ability of current services to cope.

Existing models of mitigation
- Plain film reporting contracted out in some Boards
- Retired Consultants providing locum / bank capacity however this is limited by SPPA limitations on hours that may be worked (up to 16 hours per week)
- Collaboration on capacity across Boards

Potential future mitigation of risk
- Expansion of Radiographer clinical reporting and initial commenting – further development of Advanced Practice roles to support the service
- Regional concept of model of delivery
- Networks of expertise supporting the West Region
- National Radiology Shared Services implementation and impact

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Gastroenterology

Challenges
There is a trend of increasing vacancies, compounded by a number of impending vacancies particularly at a lower retirement than may have been expected (mid-50s) have been reported by some Boards.

There are insufficient numbers going through training; in 2018 there is only one expected CCT, in addition to the current number of 13 wte vacancies, a further 8 wte are expected to retire in 2018.

Demand
There is an increased demand for diagnostic gastroenterology, the rollout of Bowel Screening has been the greatest contributor to the increase, as such this demand could have been anticipated.

Media campaigns have increased public awareness of bowel cancer, increasing referrals. Changes in demography and disease incidence is also attributable

National UK studies anticipate a 40% increase in demand, from 2016 to 2020

Existing models of mitigation

- Nurse Endoscopists / Consultant Nurse Specialists / Specialist Nurses
- Planned care review under taken by Advanced Nurse Practitioners
- Direct to test vetting to improve efficiency
- Specialist Nurses

Potential future mitigation of risk

- Review the model of service delivery across the West Region to best capitalise upon economies of scale with existing resource
- Increase Advanced Nurse Practitioner / range and scope of specialist nursing roles to better support delivery of gastroenterology services
- Physician Associate roles open up a new labour market which has as not yet been systematically utilised within the West of Scotland region unlike other regions. The lead in time for Pas being 2 years.

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

Histopathology

Supply
The vacancy rate has increased significantly with workforce demand currently outstripping supply – a number of Boards have had several rounds of advertising with limited success e.g. A&A have had four rounds of recruitment with only one Consultant recruited

There are currently 13 wte vacancies, with a further 2 wte expected in 2018, this is set against a CCT 2018 supply of 6 headcount, effectively the West Region could subsume the entire CCT output and this would still result in a staffing deficit.

Demand
Pathology is involved in 70% of all diagnostics. Rising disease prevalence and increased incidence of cancer is the primary driver for the demand increase.

The demand is anticipated to steadily increase, with the predicted pattern of retirement there will be a shortage of Consultant Pathologists.

Existing models of mitigation

- Bio-medical scientists undertaking dissection
- Out-sourcing of some reporting

Potential future mitigation of risk

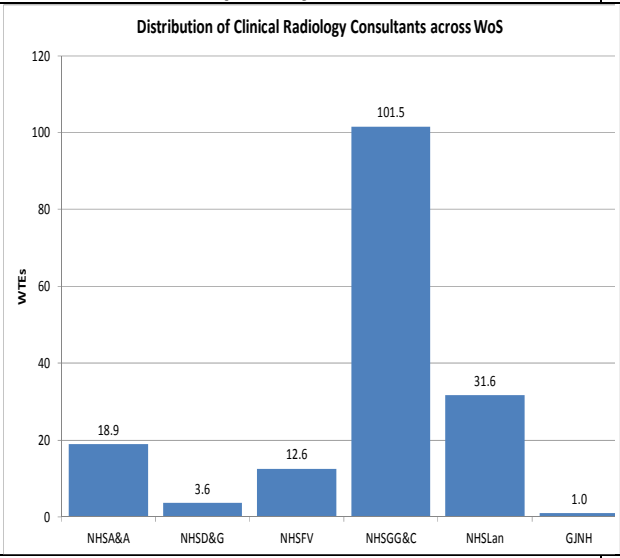
- Out-sourcing of service
- SLA with other Boards in the West Region
- Physician Associate roles open up a new labour market
- Bio-medical science reporting – in its infancy at a national level
- Roles for clinical scientists

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

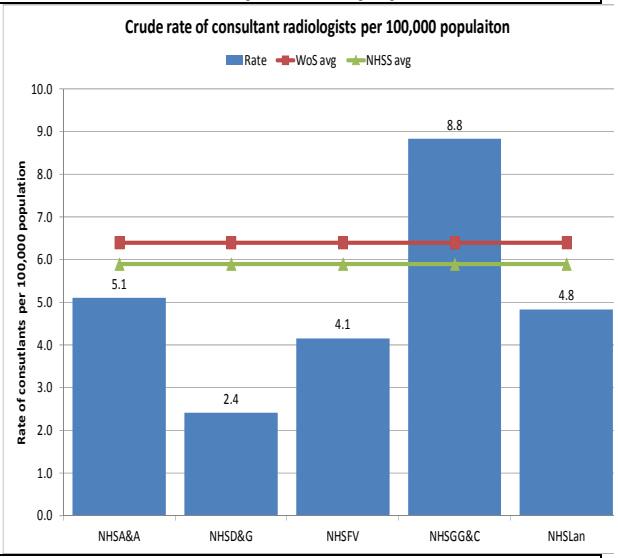
Clinical Radiology detail

Total WoS Radiologists = 169.2 WTE / 179 headcount

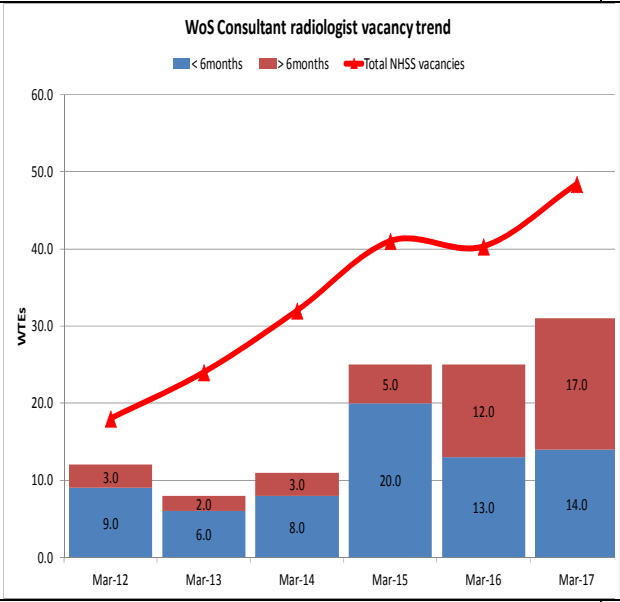
In post by Board



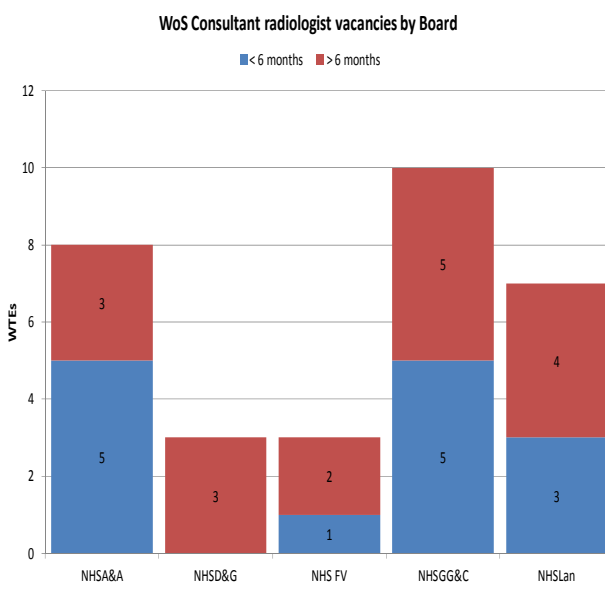
Consultants per 100k population



Vacancy trend - WoS

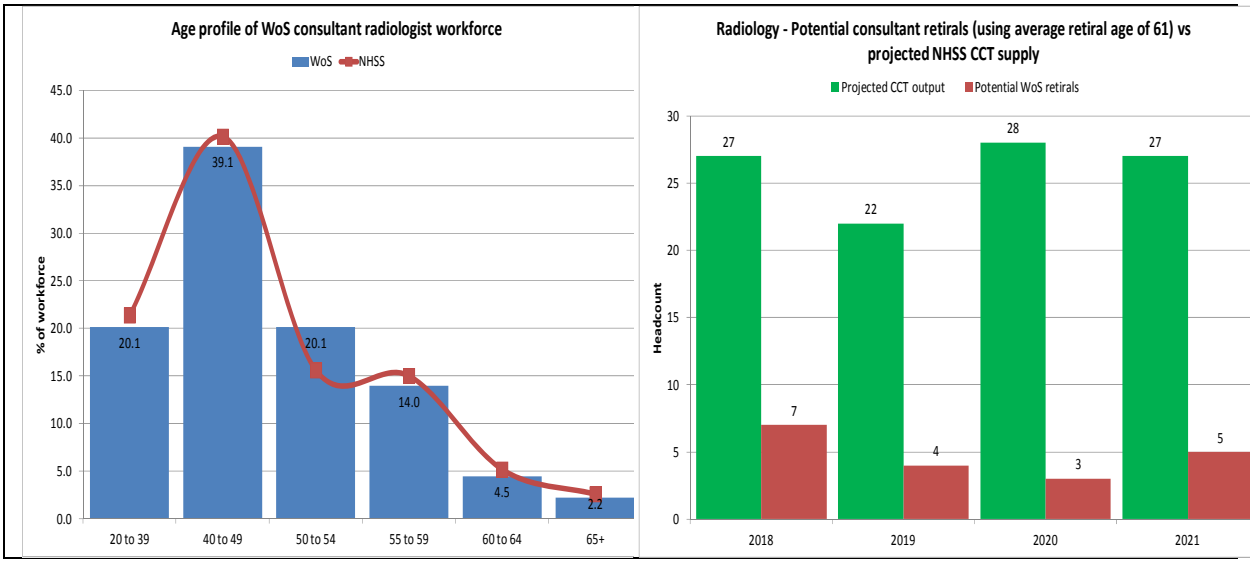


Vacancy distribution by Board



Age profile

Projected retiral v projected CCT output



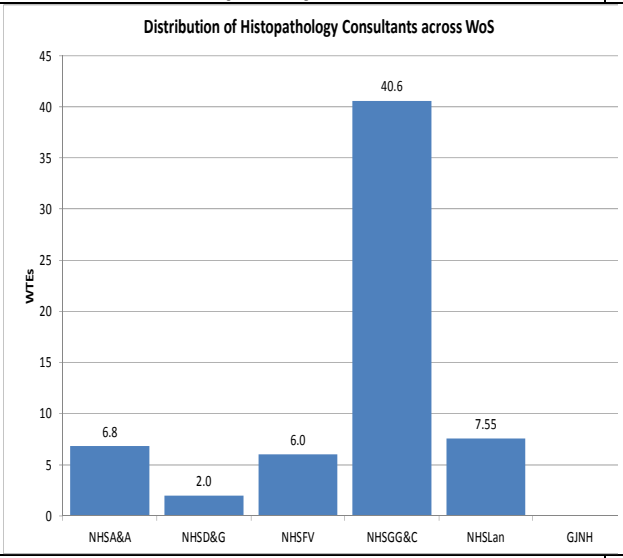
Clinical radiology – narrative summary

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

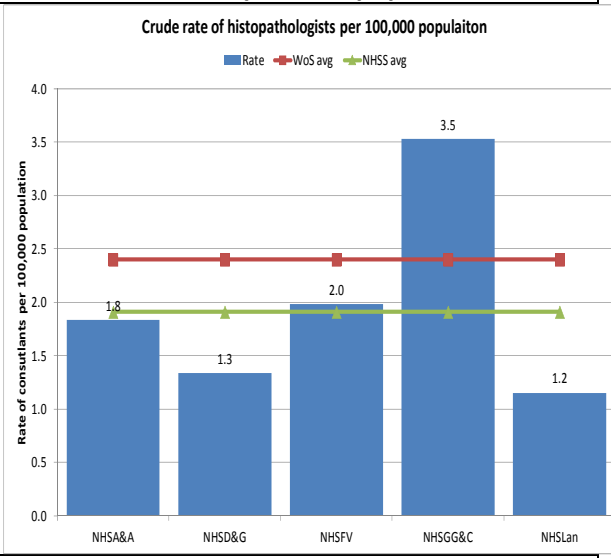
Histopathology detail

Total WoS Histopathologists = 63.0 WTE / 68 headcount

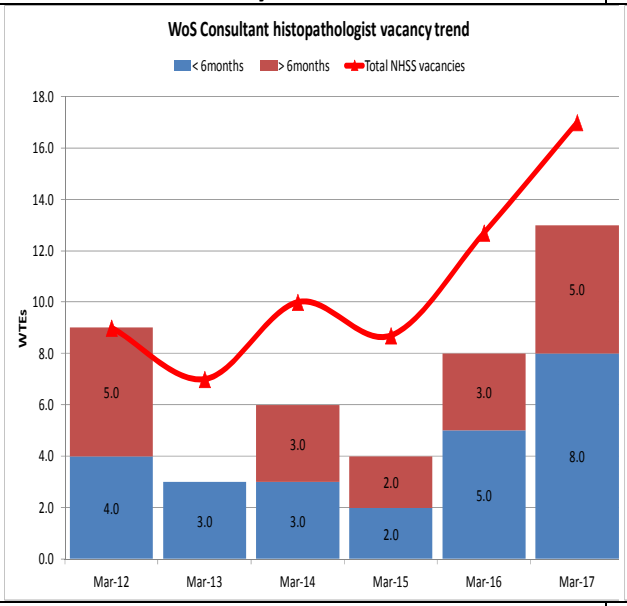
In post by Board



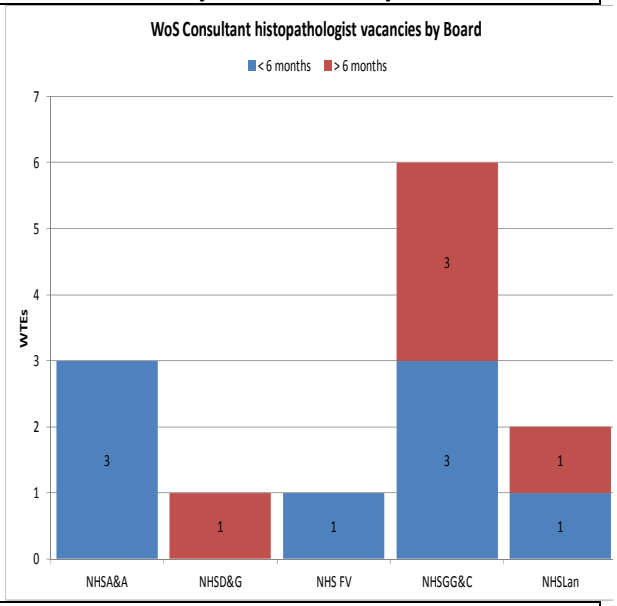
Consultants per 100k population



Vacancy trend - WoS

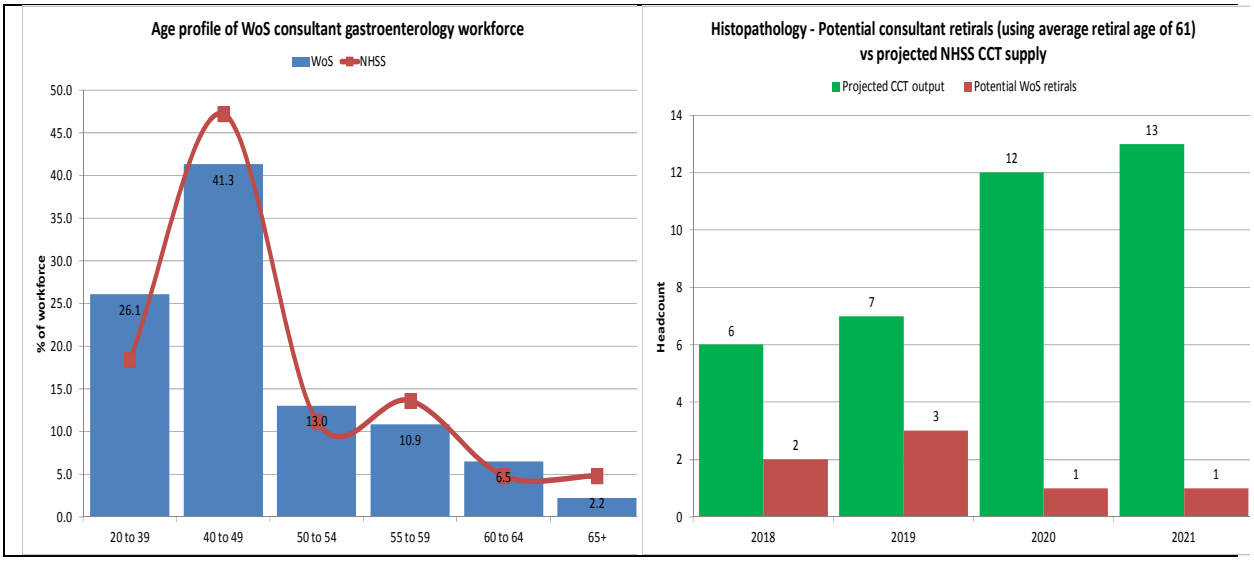


Vacancy distribution by Board



Age profile

Projected retiral v projected CCT output



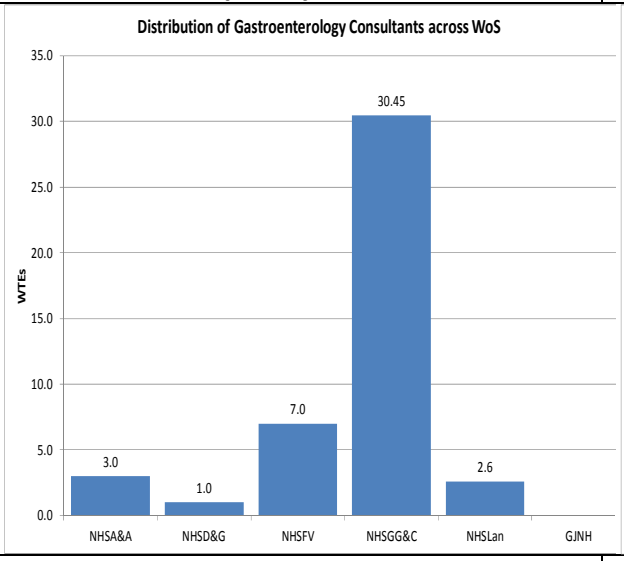
Histopathology – Narrative summary

Appendix 1: West Region Workforce Planning Case Study – Medical Workforce

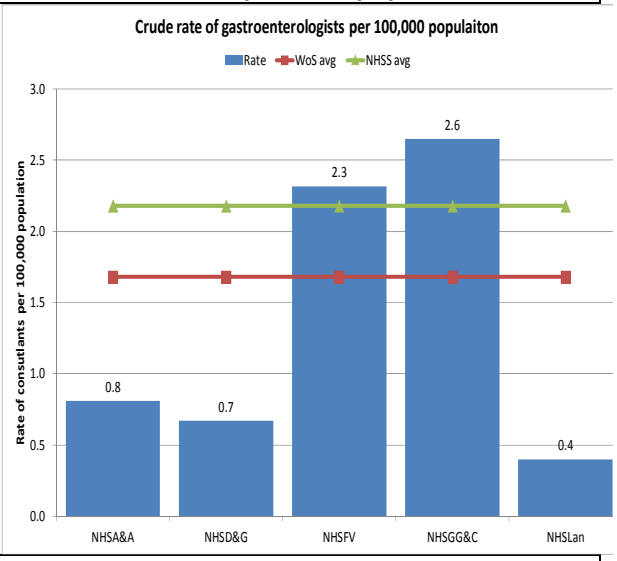
Gastroenterology detail

Total WoS Gastroenterologists = 44.1 WTE / 46 headcount

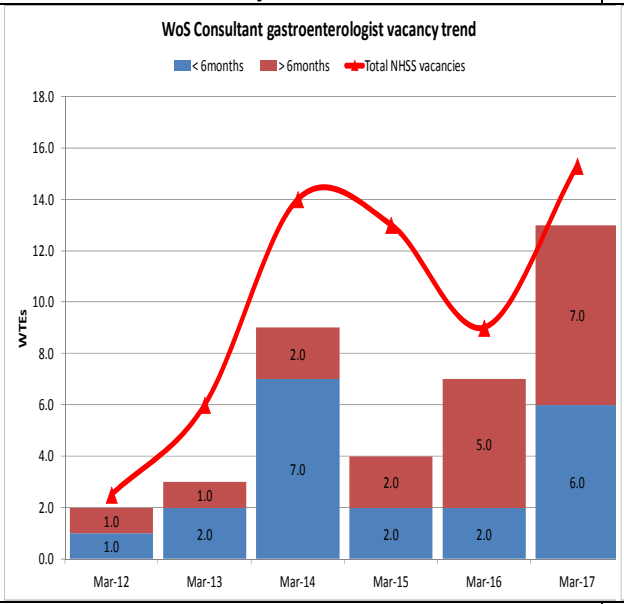
In post by Board



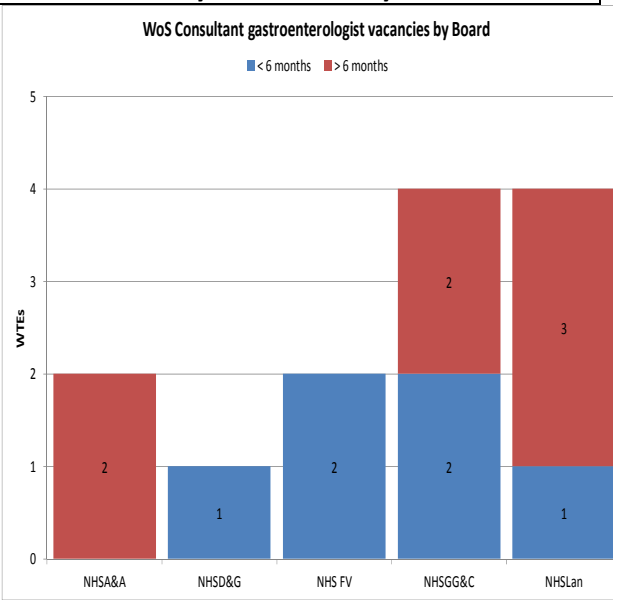
Consultants per 100k population



Vacancy trend - WoS



Vacancy distribution by Board



Age profile

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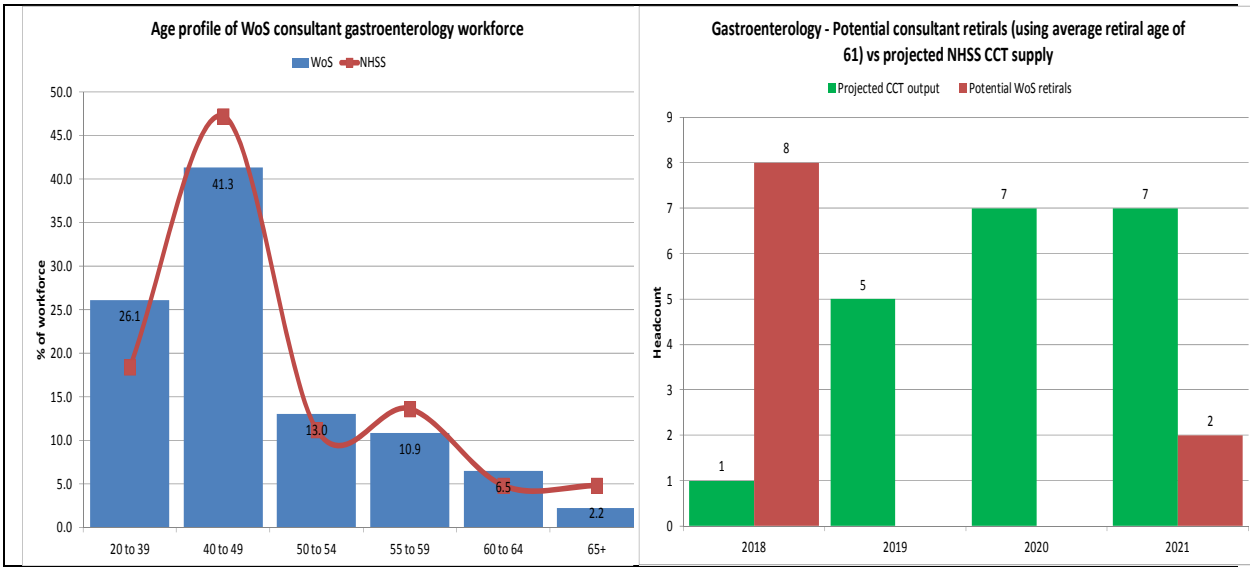


Gastroentertology – narrative summary

Appendix 4

Planning and delivering care and treatment across the West of Scotland

Communications plan

1. Introduction

1.1 This communications plan has been developed to support the implementation of the West of Scotland Delivery Plan. It sets out the approach that will be taken to engage with key stakeholders on the plan, to communicate the national and historical context within which the plan has been developed and to highlight the benefits that will be realised for patients, communities and staff.

1.2 It also outlines the measures that will be taken by the West of Scotland Communications Teams to ensure consistency of message, co-ordination of timescales and a single 'once for the West of Scotland' approach to maximise effective use of resources and avoid duplication.

2. Background

2.1 The Scottish Government published the Health and Social Care Delivery Plan in December 2016, which sets out the importance of delivering:

- better care;
- better health; and
- better value.

2.2 The Health and Social Care Plan outlines the need to look at services on a population basis and to plan and deliver services that are sustainable, evidence-based and outcome-focussed. By working more collaboratively, NHS Boards, Integration Joint Boards and other partners can plan and deliver services more effectively, so as to provide better patient outcomes and more efficient, consistent and sustainable services.

2.3 At regional level, the Scottish Government has commissioned Regional Delivery Plans to be developed, encompassing a whole-system approach to the delivery of health and social care for each of the three regions (North, East and West).

2.4 For the West of Scotland, this involves planning for the population of 2.7 million, which is covered by five NHS Boards, 16 Local Authorities and 15 Health and Social Care Partnerships, as well as the Golden Jubilee Foundation.

2.5 The national NHS Boards are also developing a single plan that sets out the national services where improvement should be focused, including, where appropriate, a 'Once for Scotland' approach in areas such as digital services, clinical demand management and support services.

2.6 To take forward the national and regional approach, five Chief Executives have been appointed to the role of National or Regional Implementation Lead.

2.7 The West of Scotland partners are required to produce a first Regional Delivery Plan by March 2018, and seek the support of Health Boards and Integrated Joint Boards to work collaboratively to achieve the best outcomes delivered sustainably for everyone across the West of Scotland.

3. Positioning our communications: national and historical context

3.1 The one constant in the NHS is change. The 70th anniversary of the NHS is a fitting backdrop to demonstrate to our communities just how much change has already taken place and how modern healthcare will continue to evolve, providing better care and better outcomes.

3.2 This is a key theme within the communications and engagement strategy created by the Scottish Government to support the delivery of the National Delivery Plan. That strategy provides a national framework to which all regional activity can be aligned.

3.3 All our communications will reflect the language and positioning of change as recommended within the national communications strategy, including:

- the use of language of evolution and development to explain change rather than the terms 'radical' or 'transformational';
- acknowledging people's affection for their NHS and mentioning the things that are important to them;
- emphasis on the benefits/advantages for people; and,
- change and development to be framed within the continuation and improvement of a much loved service.

3.4 The regional plan will also be based on the values and principles of the national strategy:

- Meaningful engagement with our staff - where our staff will be our primary audiences, learning first-hand about the Regional Delivery Plan as it affects them
- Meaningful involvement of our communities from the outset as plans develop
- Inclusiveness – reflecting the full diversity of our workforce and our communities
- Openness and transparency
- Collaborative

3.5 Key messages shared by everyone involved in the dialogue will be essential for clarity. Our key messages are:

- Working so the people of West of Scotland can live longer, healthier lives at home or in a homely setting and we have a health and social care system that:
    - is integrated;
    - focuses on prevention, anticipation and supported self-management;
    - will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
    - focuses on care being provided to the **highest standards of quality and safety, whatever the setting**, with the person at the centre of all decisions; and
    - ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.
- Healthcare / health and social care / the NHS in Scotland has been **continually evolving over the years** as new treatments, technology and service developments have emerged. Our health and social care system **will always evolve to deal with society's health challenges and to provide excellent care**.
- Health and social care provision is different in Scotland. We have found our own solutions to the challenges we face which give us a solid foundation from which to build. We must **continue to develop to provide the highest quality of health and social care** to the people of Scotland.

3.6 These messages will continue to develop as the regional delivery plan evolves.

4. Our audiences

4.1 The following audiences have been identified although this may be further segmented when the messages evolve.

- **Internal:**
  - NHS Boards - Chairs, Non-executive members and Employee Directors
  - Chief Executives and executive teams - Medical Directors, Nursing Directors, Directors of Finance, Directors of Public Health, Chief Operating Officers, HR Directors, Workforce and Planning Directors
  - Integrated Joint Boards
  - Area Partnership Forum, Trades unions,
  - GPs, Pharmacists and Dentists
  - Staff directly affected by the changes
  - All other staff

- **External:**
  - Patients and carers
  - Third sector organisations
  - Elected members: local councillors, MSPs and MPs
  - Community Planning Partners
  - Media
  - General Public

5. Our approach

5.1 Within the West of Scotland we have a well-established Communications Group which works collaboratively to deliver effective communications across a range of issues. This removes duplication and makes best use of the resources available. We will take the same approach with this communications plan. A single point of contact will liaise with the Regional Implementation Lead to develop content and regular updates for use across the region by all boards.

5.2 The Regional Implementation Lead will agree with his fellow Chief Executives on a 'once for the region' approach to communications, with a single authorisation for all communications.

5.3 The Group will collaborate to produce a range of resources that can be used by all boards to help communicate the plan including:

- Case studies – case studies and people stories will be crucial to evidence that changes is constant and successful and is benefitting patients across the west of Scotland
- FAQs
- Digital resources including animations and infographics

- Core content as newsletters and as editorial copy to be used in local communications

5.4 Each board will use its existing and well-established channels to communicate the regional updates with its own audiences:
- Staff communication channels
- External communications channels:
  - Print publications
  - Public websites
  - Social media
  - Third sector organisations
  - Patient groups
  - Media releases, editorial, events

5.5 As far as is practical, all boards will co-ordinate the publication of updates so that information is being shared with audiences within the same timescales.

5.6 Engagement activity with communities will be co-ordinated locally by each board with their established networks and in conjunction with Health and Social Care Partnerships. This will build on the work that the HSCPs have undertaken to inform their Strategic Commissioning Plans which is informing the development of the Regional Delivery Plan. The expectation is that the Boards and HSCPs will be responsible for gathering feedback to inform the draft plan.

5.7 All boards will keep a record of communications activity, including engagement activity, as evidence of engagement and consultation.

6. Budget and costs

This has yet to be determined

7. Timeline

This has yet to be finalised.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.5

Date of Meeting: **29 November 2017**

Title of Report: **Argyll & Bute HSCP- Performance Report- National Health and Well Being Outcome Indicators**

Presented by: **Stephen Whiston, Head of Strategic Planning & Performance**

The Integration Joint Board |(IJB) is asked to:

- Note the HSCP performance against National Health and Well Being Outcomes 5&6 for FQ2 17/18
- Note the actions identified to address deficiencies in performance as detailed in the exception reports
- Note the performance against Integration Authorities Performance Indicators- September 2017

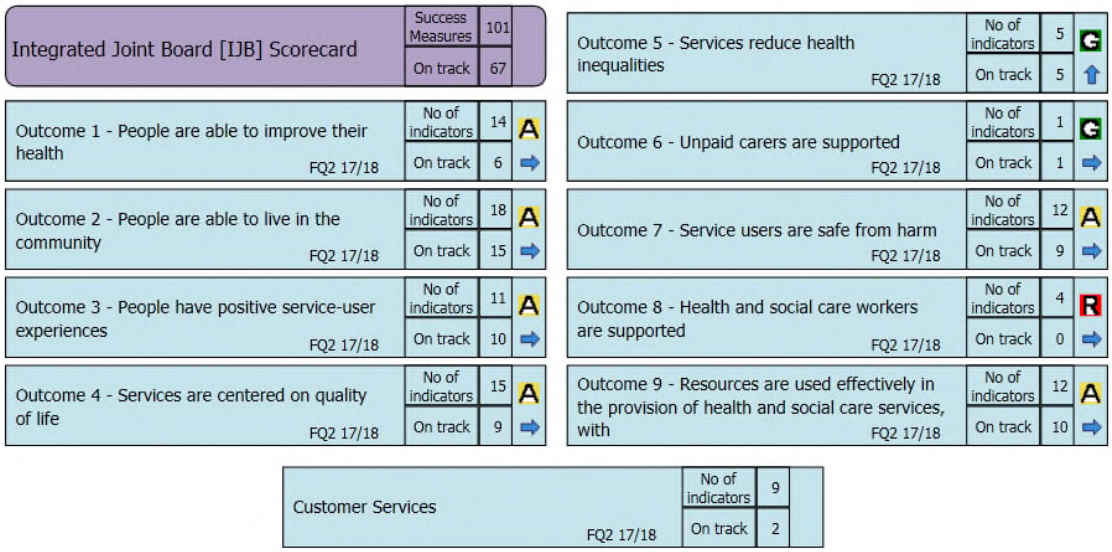
1. Background

The national health and wellbeing outcomes provide a strategic framework for the planning and delivery of health and social care services. These suites of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families. These outcomes focus on improving how services are provided, as well as, the difference that integrated health and social care services should make, for individuals.

Currently there are 9 key National Health and Wellbeing Outcomes (NHWBO) and 23 sub-indicators which form the basis of the reporting requirement for the HSCP

2 HSCP Performance against the NHWB outcomes for Financial Quarter 2 17/18

Figure 1 below provides a summary of the performance on the pyramid reporting system, noting the 101 scorecard success measures and of these 67 are currently reported as being on track for FQ2 17/18



Outcome 5: 5 of 5 measures are all reporting on track.

Outcome 6: 1 of 1 measure showing as on track.

3 Detailed Performance Report Outcome Indicators 5 & 6 (FQ2 17/18)

Outcome 5 – Services reduce health inequalities

- Rate of emergency admissions per 100,000 population for adults
- Rate of premature mortality per 100,000 population
- AC21 <=3 weeks wait between SM referral & 1st treatment
- No of treatment time guarantee completed waits >12 weeks
- No of treatment time guarantee ongoing waits >12 weeks

Outcome 6 – Unpaid carers are supported

- % of carers who feel supported to continue in their caring role

4 Integration Authorities Performance Indicators- FQ2 17/18 (Jul - Sep 2017)

Measures	Sub-Indicators	Target	A&B/ GG&C	Bute	Cowal	H &L	Islay & Jura	Kintyre	Mid Argyll	Mull, Iona, Coll, Tiree and Colonsay	Oban & Lorn	Total FQ2	FQ1 17/18
Unplanned Admissions	Total number of admissions	Reducing unplanned admissions by 10%	**A&B**	29	53	0	14	40	58	16	112	**322**	**322**
			GG&C	26	80	168	5	21	22	7	19	**348**	**372**
	A&E conversion rate	Remain at current performance	**A&B**	0	33.3	0	0	50	60	45.8	22.6	**38.8**	**66.1**
			GG&C	55.6	59	25.4	75	70.6	61.3	60	56	**74.4**	**48.4**
Unplanned bed days	Total number of bed days acute specialities	Reducing bed days by between 1-10%.	**A&B**	149	334	0	41	291	310	142	571	**1838**	**1766**
			GG&C	128	465	686	44	235	142	13	25	**1738**	**1778**
	Total number of bed days mental health specialities		**A&B**	210	277	0	5	310	679	0	298	**1779**	**2277**
			GG&C	53	139	1082	0	0	0	0	0	**1274**	**1082**
A&E performance	Number of attendances *	Remain at current levels of performance	**A&B**	NK	NK	NK	NK	NK	NK	NK	443	**443**	**560**
			GG&C	36	83	544	4	17	31	5	25	**745**	**768**
	% seen within 4hrs		**A&B**	NK	NK	NK	NK	NK	NK	NK	98%	**97.9**	-
			GG&C	94%	90%	93%	75%	94%	90%	100%	100%	**93.2**	-
Delayed discharges	Total number of bed days occupied * Sep 2017	Reducing delayed discharges occupied bed days by 10%.	**A&B**	24	45	2	0	60	46	32	324	**533**	**369**
			GG&C	0	0	53	0	0	0	0	0	**53**	**127**
			Total	**24**	**45**	**55**	**0**	**60**	**46**	**32**	**324**	**586**	**496**

Note:
**** NK - Excludes Community hospital A&E activity at present only RGH and GGC units***
 # includes all patient delayed discharge reasons

In the three areas the HSCP is aiming to improve performance improvements are evidenced in reducing unplanned admissions in both Argyll and Bute and NHSGG&C hospitals and delayed discharges occupied bed days in NHS GG&C between the 2 quarters.

However, there is a worsening performance in Delayed discharge occupied bed days in Argyll and Bute and in Reducing acute and mental health occupied bed days. Operational Managers will be preparing exception reports for these measures as they have just been included on Pyramid as at 9th November.

5 Governance Implications

5.1 Contribution to IJB Objectives

The PPMF is in line with the IJB objectives as detailed in its strategic plan.

5.2 Financial

There are a number of NHWBO indicators which support the quality and financial performance of the HSCP including productivity, value for money and efficiency.

5.3 Staff Governance

A number of indicators under outcomes 5& 6 are pertinent for staff governance purposes

5.4 Planning for Fairness:

The NHWBO indictors help provide an indication on progress in addressing health inequalities.

5.5 Risk

Ensuring timely and accurate performance information is essential to mitigate any risk to the IJB governance, performance management and accountability.

5.6 Clinical and Care Governance

A number of the NHWBO indicators support the assurance of health and care governance and should be considered alongside that report

5.7 Public Engagement and Communication

A number of the NHWBO indicators support user and patient experience/assessment of the HSCP services and planning processes

Argyll & Bute Health and Social Care Partnership

Performance Exception Report for Integrated Joint Board
Outcomes 5 & 6 (FQ2-17/18) - September 2017

Performance & Information Team

"People in Argyll and Bute will live longer, healthier, happier, independent lives"

Exception Reporting & Briefing Frequency

The Integrated Joint Board will receive this performance and exception report on a 6 weekly basis, this will be taken from a live snapshot of the current overall HSCP performance; focussing on those measures showing as below target performance. The layout of the report is designed to give IJB members a quick easy-read overview of exception across the IJB Scorecard, the format of the report uses the key aspects of the Pyramid Performance Management System in order to ensure continuity and consistency. Trend indicators are included within the report to ensure that performance variance and movement is reflected against the most recent reporting episodes.

This exception report format will be used to communicate performance across the HSCP and key stakeholders including its host bodies. The table below notes the groups and briefing frequency:

Group	Briefing Frequency
Integrated Joint Board	Quarterly
Local Area Committees	Quarterly
NHS Board	Quarterly
Community Planning Partnership *	Quarterly
Locality Planning Groups	Quarterly
East & West Operational Management Teams	Quarterly

Exception Reporting FQ2 (17/18)

Outcome Indicators – 5 & 6

Outcome 5 – Services reduce health inequalities

Outcome / Performance Indicator		Target	Actual	Trend	Period	Responsible Manager
5	Rate of emergency admissions per 100,000 population from adults	12,265	12,009		FQ2 17/18	James Littlejohn
5	Rate of premature mortality per 100,000 population	440.0	418.0		FQ2 17/18	Lorraine Patterson
5	AC21 <=3 weeks wait between SM referral & 1st treatment	255	176		FQ2 17/18	Lorraine Paterson
5	No of treatment time guarantee completed waits >12 wks	0	0		FQ2 17/18	Lorraine Paterson
5	No of treatment time guarantee ongoing waits >12 wks	0	0		FQ2 17/18	Lorraine Paterson

Outcome 6 – Unpaid Carers are supported

Outcome / Performance Indicator		Target	Actual	Trend	Period	Responsible Manager
6	% of carers who feel supported to continue in their caring role	41%	41%		FQ2 17/18	Lorraine Paterson

FQ2 17/18 Other NHWBO indicators currently off track presented for IJB reference

Outcome/Performance Indicator	Target	Actual	Trend	In charge
Outcome 1				
AC1 - % of Older People receiving Care in the Community	83%	74%	↑	James Littlejohn
AC15 - No waiting more than 12 weeks for homecare service - assessment authorised	6	7	→	James Littlejohn
A&B - % of LD Service Users with a PCP	90%	88%	↓	James Littlejohn
No of alcohol brief interventions in line with SIGN 74 guidelines	510	341	↑	Lorraine Paterson
NHS-H7 - Proportion of new-born children breastfed - STANDARD	33.3%	30%	→	Alex Taylor
No of ongoing waits >4 wks for the 8 key diagnostic tests	0	82	↓	Lorraine Paterson
% >18 type 1 Diabetics with an insulin pump	12%	7%	→	Lorraine Paterson
Outcome 2				
Falls rate per 1,000 population aged 65+	22	26	→ ↑	Lorraine Paterson
AC5 - Total No of Delayed Discharge Clients from A&B	12	20	↑	James Littlejohn
CPC01.4.4 - % Waiting time from a patient's referral to treatment from CAMHS	90%	88%	↑	Alex Taylor
Outcome 3				
No of patients with early diagnosis & management of dementia	890	847	↑	Lorraine Paterson
Outcome 4				
Falls rate per 1,000 population aged 65+	22	26	→	Lorraine Paterson
CA72 - % LAAC >1yr with a plan for permanence	81%	67%	↓	Alex Taylor
No of outpatient ongoing waits >12 wks	0	303	↓	Lorraine Paterson
% of outpatients on the waiting lists with medical unavailability	0.1	0.2	↓	Lorraine Paterson
% of patients on the admissions waiting lists with social unavailability	15.7%	18.2	↑	Lorraine Paterson

Outcome/Performance Indicator	Target	Actual	Trend	In charge
Outcome 7				
Falls rate per 1,000 population aged 65+	22	26		Lorraine Paterson
CP16 - % of Children on CPR with a completed CP plan	100%	92%		Alex Taylor
CP17 - % of CP investigations with IRTD within 24 hours	95%	91%		Alex Taylor
Outcome 8				
Social Work staff attendance	3.8	4.5		James Littlejohn
% of NHS sickness absence	4%	5.28%		Lorraine Paterson
Health & Social Care Partnership % of PRDs completed	90%	62%		Alex Taylor
Outcome 9				
Falls rate per 1,000 population aged 65+	22	26		Lorraine Paterson
% of SMR1 returns received	95%	91.3%		Lorraine Paterson

Argyll & Bute Health & Social Care Partnership

Integrated Joint Board

Agenda item: 5.6

Date of Meeting: **29 November 2017**

Title of Report: **Argyll & Bute HSCP**
- Consultant Outpatient Waiting Times Update and Forecast 2017/18

Presented by: **Stephen Whiston, Head of Strategic Planning & Performance**

The purpose of this paper is to:

- Update the IJB on both current and forecasted consultant service waiting times position for Argyll & Bute HSCP up to March 2018
- Note that it is likely that further breaches in the waiting times target will occur across the HSCP and within NHSGG&C unless there is funding allocated to Argyll & Bute to support additional clinics and service redesign
- Outline the action planned and service redesign areas to utilise this additional funding, to meet patients needs, ensure equity of provision and improve performance achieving waiting time targets
- Confirm the funding expectation and associated service and financial risk to Argyll & Bute HSCP if its NRAC share is not provided

1. BACKGROUND – ACCESS TO CONSULTANT OUTPATIENT SERVICES

Patients from within Argyll & Bute usually access consultant outpatient secondary care services in the following ways:-

1) Within NHS GG&C – the number of Argyll & Bute patient attendances in NHS GG&C in 2015/16 was 53,359*. These patients are captured on NHS GG&C waiting lists. This includes patients referred to local services who may be vetted as requiring more urgent care, diagnostics or particular sub specialism's not delivered locally.

2) Local 'in house' service provision – includes General Medicine, General Surgery, and the Pain Clinic covering the West of Argyll and Psychiatry across the whole of Argyll, with the exception of Helensburgh & Lomond. Orthotics is outsourced to an external provider on a regional basis.

3) Local Outreach from NHS GG&C – these services are usually delivered at local hospital sites within Argyll & Bute at varying frequencies and cover a range of specialties as outlined in Appendix 2. Given NHS GG&Cs current waiting times and SLA position most patients now wait for a local appointment if that specialty or sub specialty is provided as

outreach. The HSCP works closely with NHSGG&C to balance local capacity and demand. However NHS GG&C are clear that waiting times are not, on their own, a reason to refer to NHS GG&C. In this circumstance Argyll & Bute HSCP require to commission further service provision, often at premium rates.

Outreach clinics are fundamentally about reducing inequality for rural communities and hard to reach groups in accessing these specialist services. Cessation or centralization of these outreach services will increase inequity for patients as the old, young and infirm may elect not to travel.

Patients who are referred to locally provided services (including 'in house' and outreach services delivered by NHS GG&C as per points 2 & 3 above) are captured on NHS Highland Waiting Lists. In 2016/17 there were 1988 clinics held within in Argyll & Bute with the number of patient attendances approximately 30,000*.

** Figures from ISD Outpatients SMR00 – return patient figures are not a mandatory collected item and will be under recorded.*

2. PERFORMANCE AGAINST WAITING TIME TARGETS

2.1 Treatment Time Guarantee - Lorn and Islands Hospital

As at the end of September 2017, General Surgery and Oral Surgery both continue to meet the treatment time guarantee. However there remains a 0.5 wte vacancy in general surgery consultant establishment which may impact on our ability to maintain this if we cannot appoint or, in the interim, source and afford to fund locums to sustain the service.

2.2 Current Outpatient Waiting Times - Argyll and Bute HSCP

The number of Outpatient 12 week month end breaches reported have increased from 532 in 2015/16 to 1120 in 2016/17, an increase of 111%. It is forecast that in 2017/18 this will rise to 4719, an increase of 787% from 2015/16 and 320% from 2016/17.

The current length of outpatient clinics waits exceeding 12 weeks or more is detailed in table 1 below.

Table 1: Argyll and Bute Outpatient waiting times exceeding 12 weeks at 28th September 2017

Locality / Speciality	No of Weeks Wait as at 28/09/2017	Frequency of Clinic
Cowal Community Hospital		
ENT	17	Monthly
General Surgery	24	Weekly
Victoria Hospital Rothesay		
General Surgery	12	Monthly
Lorn & Islands Hospital		
Opthalmology	12	Weekly
Pain – Anaesthetics	19	3 per month
Dermatology	22	3 per month
ENT	32	Monthly
Orthopaedics	33	3 per month
Respiratory	21	Monthly

Oral Surgery	19	Monthly
Campbeltown Hospital		
Dermatology	12	Monthly
ENT	30	6 per year
General Medicine	12	Monthly
General medicine	20	6 per year
Paediatrics	15	6 per year
Islay Hospital		
Paediatrics	17	Quarterly

In addition to the above it should be noted that within Ophthalmology, there is an extensive follow up appointment waiting list of 737 patients waiting for a return appointment (as at 25th September 2017) with the longest wait 881 days. This is potentially a clinical risk to patients. Additional clinics are required to address this as well as a need to prioritise return patients within current planned clinics. This will be at the expense of new routine appointments for a number of months and will have an adverse impact on waiting times for new patients as indicated in the forecast below.

The current number of reportable breaches are recorded in Table 2 below.

Table 2: Number of Reportable Breaches on New Outpatient Waiting List at 21st September 2017

Hospital	Specialty	Number on List	Number in Breach	% of List in Breach
Campbeltown Hospital	Dermatology	41	1	2.4%
	Ear Nose and Throat	30	14	46.7%
Campbeltown Hospital Total		**163**	**15**	**9.2%**
Cowal Community Hospital	General Surgery	35	8	22.9%
Cowal Community Hospital Total		**203**	**8**	**3.9%**
Lorn and Islands Hospital	Cardiology	24	3	12.5%
	Chronic Pain Management Service	53	30	56.6%
	Dermatology	192	66	34.4%
	Ear Nose and Throat	137	34	24.8%
	Medical Endoscopy*	24	1	4.2%
	Oral Surgery	198	48	24.2%
	Orthopaedics	234	102	43.6%
	Respiratory Medicine	45	21	46.7%
	Surgical Endoscopy*	46	1	2.2%
Lorn and Islands Hospital Total		**1257**	**306**	**24.3%**
Mid Argyll Community Hospital	Ear Nose and Throat	47	16	34.0%
Mid Argyll Community Hospital Total		**183**	**16**	**8.7%**
Mull And Iona Community Hospital	Ophthalmology	4	1	25.0%
Mull And Iona Community Hospital Total		**12**	**1**	**8.3%**
HSCP Total		**1869**	**346**	**18.5%**

*Endoscopy subject to 4 week target

There are also a number of patients currently on this lists with unavailability applied due to local appointment requested.

Table 3: Number of Reportable Entries on New Outpatient Waiting List with Local Appointment Requested Unavailability at 21st September 2017

Hospital	Specialty	Number on List	Number with Local Appointment Requested	% of List with LAR Unavailability
Campbeltown Hospital	Dermatology	41	4	9.8%
	Medical Paediatrics	10	2	20.0%
Campbeltown Hospital Total		**163**	**6**	**3.7%**
Cowal Community Hospital	Ear Nose and Throat	53	43	81.1%
	General Surgery	35	17	48.6%
Cowal Community Hospital Total		**203**	**60**	**29.6%**
Islay Hospital	General Surgery	2	1	50.0%
	Medical Paediatrics	7	1	14.3%
Islay Hospital Total		**12**	**2**	**16.7%**
Lorn and Islands Hospital	Ear Nose and Throat	137	29	21.2%
Lorn and Islands Hospital Total		**1257**	**29**	**2.3%**
Mid Argyll Community Hospital	Ear Nose and Throat	47	2	4.3%
	Medical Paediatrics	2	1	50.0%
Mid Argyll Community Hospital Total		**183**	**3**	**1.6%**
HSCP Total		**1869**	**100**	**5.4%**

Most specialties are no longer offering NHS GG&C as an alternative due to their own waiting times pressures and their stated SLA position, unless there are specific issues with outreach service delivery.

Unavailability rates due to local appointment requested is therefore reducing and there is a consequent increase in reported waiting times.

2.3 Forecasted Outpatient Waiting Times in Argyll & Bute – up to 31st March 2018

The table overleaf shows the forecasted waiting times position for Argyll & Bute's pressure areas based on no additional funds to provide additional clinics for 2017/18. This will be reported within NHS Highland's overall waiting times position.

Table 4: Forecasted breaches over 12 and 26 weeks by specialty at month end up to March 2018

DERMATOLOGY			ENT			GYNAECOLOGY			OPTHALMOLOGY		
Month	Month end 12 week Breaches	Month end 26 week Breaches	Month	Month end 12 week Breaches	Month end 26 week Breaches	Month	Month end 12 week Breaches	Month end 26 week Breaches	Month	Month end 12 week Breaches	Month end 26 week Breaches
Oct-17	41	0	Oct-17	25	0	Oct-17	3	0	Oct-17	4	0
Nov-17	43	0	Nov-17	27	6	Nov-17	4	0	Nov-17	27	0
Dec-17	45	0	Dec-17	30	15	Dec-17	4	0	Dec-17	79	0
Jan-18	48	0	Jan-18	32	13	Jan-18	4	0	Jan-18	131	3
Feb-18	50	0	Feb-18	35	14	Feb-18	5	0	Feb-18	183	18
Mar-18	52	0	Mar-18	37	24	Mar-18	5	0	Mar-18	235	70
ORAL SURGERY			**ORTHOPAEDICS**			**PAIN MANAGEMENT**			**RESPIRATORY**		
Month	Month end 12 week Breaches	Month end 26 week Breaches	Month	Month end 12 week Breaches	Month end 26 week Breaches	Month	Month end 12 week Breaches	Month end 26 week Breaches	Month	Month end 12 week Breaches	Month end 26 week Breaches
Oct-17	100	0	Oct-17	101	17	Oct-17	32	18	Oct-17	16	3
Nov-17	111	0	Nov-17	107	23	Nov-17	33	19	Nov-17	18	4
Dec-17	121	0	Dec-17	113	29	Dec-17	33	20	Dec-17	19	5
Jan-18	132	0	Jan-18	118	35	Jan-18	34	21	Jan-18	20	6
Feb-18	142	0	Feb-18	124	41	Feb-18	34	22	Feb-18	21	7
Mar-18	153	0	Mar-18	130	47	Mar-18	35	23	Mar-18	23	8

The Demand Capacity Activity & Queue (DCAQ) analysis of the main pressure specialties below also clearly demonstrates that capacity is consistently not meeting demand.

Table 5: DCAQ Outputs for New & Return Activity

	Actual Clinic Statistics Jan16 - Jun17	**DCAQ Projections Jan16 - Jun17 ***				
Specialty	Average Slots per Month	Average Slots per Month	Optimum Capacity	Required Yearly Clinics Based on Average (variance)	Required Yearly Clinics Based on Optimum (variance)	extra slots per month (based on average variance)
Ophthalmology	327	364	446	205 (21)	251 (67)	37
Dermatology	153	169	203	65 (6)	78 (19)	16
ENT	81	125	147	73 (26)	85 (38)	44
Gynaecology	119	135	148	113 (13)	124 (24)	16
Orthopaedics	250	272	341	140 (11)	176 (47)	22
Pain Management	55	52	102	78 (+4)	152 (70)	-3
Oral Surgery	43	87	115	71 (36)	94 (59)	44
Respiratory Medicine	51	58	67	69 (8)	80 (19)	7

If this trend continues without significant action and investment the DCAQ analysis has identified that Orthopaedics, Ophthalmology, ENT, Pain Management and Respiratory will breach the outpatient waiting times target consistently with some specialties exceeding 26 weeks from September 2017. There is also a real risk that Dermatology breaches could exceed 26 weeks due to current gaps in service provision and reduced clinic capacity due to recruitment and funding challenges.

3. FINANCE

3.1 Current SLA Values

The total value of Argyll & Bute HSCPs Main Patient SLA with NHS GG&C in 2016/17 was £54.4 million. The 2017/18 value is awaited and is expected to be in the region of the 2016/17 value plus 0.4% nationally agreed uplift.

Preliminary discussions with NHS GG&C have indicated that, in addition to the main patient SLA value, their expectation is to receive all or a significant proportion of Argyll & Bute's NRAC share (£925,000) of NHS Highlands allocated waiting times funding in 2017/18. The rational for this is that the majority of the population of Argyll & Bute access secondary care services within NHS GG&C or delivered as outreach.

The NHS GG&C outreach SLA is in addition to the Main Patient SLA. The 2016/17 value of the outreach SLA is £916,648 and is detailed in the table below:

Table 6: Outreach SLA Values by Locality 2016/17

	2016/17 Cost of Outreach Services from NHS GG&C			
Locality	**SLA £**	**Dermatology £**	**Respiratory £**	**Total £**
Childrens Services	101,000			101,000
Oban, Lorn & Isles	335,276	48,576	53,315	437,167
Mid Argyll	68,956	18,313		87,269
Campbeltown	78,925	19,649		98,574
Islay	3,823			3,823
Helensburgh	72,872			72,872
Cowal	68,303			68,303
Bute	47,640			47,640
Total	**776,795**	**86,538**	**53,315**	**916,648**

The reference to Dermatology and Respiratory separately in the above table is due to Argyll & Bute having to incur additional non resident consultant sessions covering clinic

administration and cross cover to maintain these outreach services as it has not proved possible to recruit to these posts in NHSGG&C to date and consequently is clearly unaffordable going forward.

It is becoming increasing difficult for Argyll & Bute HSCP to secure ongoing specialist local access for patients. This is due to the recruitment challenges in NHS GG&C, which are known and replicated within NHS GG&C it's self and is further complicated by this rural dimension.

3.2 Additional Cost Pressures

In addition to the above Argyll & Bute HSCP anticipates potential further cost pressures in the following specialties:-

- Dermatology – the local provision of the service is fragile due to an imminent vacancy and NHS GG&Cs difficultly in sourcing cover. Therefore the HSCP is required to pay for more sessions as referenced above in order to maintain an outreach service. The current costs for 2017/18 are anticipated to be in the region of £131,000, giving rise to a cost pressure of £51,000. However this is for significantly reduced clinic provision and capacity compared with previous years. To maintain equitable access to the service, further additional clinics at these extra costs s are required over and above the current provision for 2017/18 or patients will be required to travel to NHS GG&C to access services, compounding their own waiting lists pressures.

- GI Endoscopy - There is potential that there may be a gap in long term locum medical cover for Lorn & Isles Hospital disrupting the provision of GI Endoscopy should there be an inability to source cover with this specialism. Scoping work is underway to identify alternative provision should there be a need to enter contingency. On the current scale of activity the baseline benchmarked costs are in the region of £100,000 per annum. However given that other boards, notably NHS GG&C, are under considerable pressure within Gastroenterology it is therefore anticipated that if we enter contingency it will likely require premium rates far exceeding the £100,000 baseline.

The HSCP also incurs an additional cost relating to the Urology service. As reported nationally there are significant challenges in recruiting surgeons, there are currently 5 vacancies in NHSGG&C for urologists.

This has seen the cessation of the basic local outpatient and treatment service at Lorn and Islands Hospital in Oban due to service sustainability and patient safety concerns. NHS GG&C have only been able to accept this transfer of activity by planning to recruit an additional surgeon. This has required a step cost investment in NHSGG&C which the HSCP has had to fund at a cost pressure of £204,000 per annum.

4. UTILISATION OF SGHD WAITING TIMES FUNDING ALLOCATION

In June 2017 the Scottish Government announced that £50 million will be targeted towards tackling waiting times in 2017/18. Boards were provisionally allocated their NRAC share of the £50 million with the remaining 25% being allocated once the detailed plans are agreed. The NHS Highland NRAC shared based on 100% allocation of this funding in 2017/18 is £3.2 million of which Argyll & Bute HSCP's NRAC share is £925,000

With its NRAC share of £925,000 the HSCP will undertake the following action:

- Source consultant support to undertake waiting list initiatives in the pressure specialties – this is unavoidable due to the non recurring nature of the funding and premium rates payable to NHS GG&C for local service delivery.
- Negotiation with NHS GG&C board regarding funding for:
    - Conversion impact - additional day case or inpatient treatment in NHS GG&C.
    - Redesign and DCAQ remodelling of service provision locally supporting the HSCP commissioning intentions.
    - Direct patient flows
- Progress and enhance our plans to redesign service delivery models, meet waiting time targets both within Argyll and Bute and for residents accessing services in NHSGG&C including centralising appointments in Argyll and Bute.
- Continue to develop and implement new delivery models such as specialist nurses, tele-consultation and direct or follow up referral to primary care and/or Nurse or AHP specialists.
- Centralise patient access team single appointment service and expand Skype for business system into records system, requires investment in IT system and staff training to improve efficiency and free up resource on a recurring basis.
- Further DCAQ analysis in partnership with NHS GG&C and medical records and waiting list initiative clean up of return appointment lists. This will ensure only patients with a clinical need are remaining on the clinic list and that avoidable travel for return appointments is reduced - the focus being on maximising access to local clinics including virtual, nurse specialist, pre op etc to prevent flows into Glasgow.

Appendix 1 provides further details on the service plans to be implemented. Table 7 below details the current budget and costs for the service:

Table 7: Service Redesign/Waiting times cost pressures 2017/18

Service	Budget £	Estimated Cost £	Funding Shortfall £
Urology	204,000	204,000	0
Respiratory Outreach	53,300	54,000	(700)
Dermatology Outreach	80,800	131,300	(50,500)
GI	0	100,000	(100,000)
Waiting List Sessions including medical, nursing and admin staff	0	391,700	(391,700)
Locum GP costs 6 week Gyn	0	15,000	(15,000)
Nurse Led Visual Fields	0	3,000	(3,000)
Agency Physio ESP Backfill & First Contact Pilot	0	85,000	(85,000)
Pain Management Programme LIH	0	6,600	(6,600)
0.5 additional Pain Nurse	0	13,000	(13,000)
0.6 additional Community Dental/Oral Surgery	0	20,000	(20,000)
Negotiation with NHS GG&C re service delivery model, direct flows and outpatient to treatment conversion costs.	0	**To Be Confirmed**	**To Be Confirmed**

Service	Budget £	Estimated Cost £	Funding Shortfall £
Total	**338,100**	**1,023,600**	**(685,500)**

The impact of implanting these plans are captured in Table 8 below using DCAQ projections of average required yearly clinics.

Table 8: Forecasted breaches over 12 and 26 weeks by specialty at month end up to March 2018 (based on planned action from NRAC allocation to Argyll & Bute HSCP)

DERMATOLOGY			ENT			GYNAECOLOGY			OPTHALMOLOGY		
Month	Month end 12 week Breaches	Month end 26 week Breaches	Month	Month end 12 week Breaches	Month end 26 week Breaches	Month	Month end 12 week Breaches	Month end 26 week Breaches	Month	Month end 12 week Breaches	Month end 26 week Breaches
Oct-17	52	0	Oct-17	0	0	Oct-17	0	0	Oct-17	0	0
Nov-17	25	0	Nov-17	0	0	Nov-17	0	0	Nov-17	0	0
Dec-17	20	0	Dec-17	0	0	Dec-17	0	0	Dec-17	0	0
Jan-18	15	0	Jan-18	0	0	Jan-18	0	0	Jan-18	0	0
Feb-18	10	0	Feb-18	0	0	Feb-18	0	0	Feb-18	2	0
Mar-18	5	0	Mar-18	0	0	Mar-18	0	0	Mar-18	17	0
ORAL SURGERY			**ORTHOPAEDICS**			**RESPIRATORY MEDICINE**					
Month	Month end 12 week Breaches	Month end 26 week Breaches	Month	Month end 12 week Breaches	Month end 26 week Breaches	Month	Month end 12 week Breaches	Month end 26 week Breaches			
Oct-17	40	0	Oct-17	83	0	Oct-17	12	0			
Nov-17	25	0	Nov-17	60	0	Nov-17	0	0			
Dec-17	20	0	Dec-17	45	0	Dec-17	0	0			
Jan-18	5	0	Jan-18	30	0	Jan-18	0	0			
Feb-18	0	0	Feb-18	15	0	Feb-18	0	0			
Mar-18	0	0	Mar-18	0	0	Mar-18	0	0			

** Pain Management revised forecast does not appear due to planned action not being an increase in clinic provision and unable to calculated by DCAQ model. Capacity will be focused on tacking return patients and discharge strategies to allow for re-profiling of clinic slots to accommodate new patients with expected reduction in waiting times.*

4.1 Assessment and Risk to Service Argyll & Bute HSCP

It is clear that the current demand on the outreach outpatient clinics, aligned with NHSGG&C difficulties in meeting its own targets mean we will undoubtedly see waiting times routinely exceeding the 12 week target for the remainder of the year and those in key pressure specialties such as Orthopaedics, Ophthalmology, ENT, Pain Management and Respiratory exceeding 26 weeks. The IJB has acknowledged that within current resources it is not possible to meet waiting time targets and patients will breach both locally and in NHS GG&C.

There are a number of potential clinical risks to elements of service provision which require mitigation and action as outlined. The need for additional clinics to address this demand and support maintenance of the targets in these areas is clear. There is also a demonstrated potential risk of increasing inequity of access and outcome to rural communities if outreach services are not increased.

The additional cost pressure incurred by the HSCP in 2016/17 to sustain services beyond the baseline SLA value is not affordable or best value for money. This will be exacerbated by a potential increase in dermatology costs and fragility of GI Endoscopy provision with potential for further significant cost pressure to ensure continued access for patient and appropriate waiting times. It is unlikely the HSCP can maintain this in 2017/18 without additional funding.

In addition, from preliminary discussions it is expected that NHS GG&C will require to incorporate a proportion of Argyll & Bute's NRAC share of additional funding to the SLA value for 2017/18 to ensure continued improvement of waiting times performance for Argyll & Bute residents within NHS GG&C and delivered as outreach.

These significant risks require additional funding to put in place a range of service initiatives to mitigate risks relating to clinical and patient safety, service sustainability and cost. These risk are recorded on the HSCP strategic risk register.

5. CONCLUSION

Current demand on outpatient clinics, aligned with NHS GG&C difficulties in meeting its own targets will mean that waiting times in Argyll & Bute will routinely exceed the 12 week target in 2017/18. The waiting times for a number of pressure specialties such as Orthopaedics, Ophthalmology, ENT, Pain Management and Respiratory are expected to exceed 26 weeks.

The IJB has acknowledged that within the current service profile and financial resources it is not possible to meet waiting time targets and patients will breach both locally and in NHS GG&C. This will result in clinical risk to patients.

The announcement of additional waiting times funding by the Scottish Government is welcomed and Argyll & Bute HSCP's NRAC share of additional funding in 2017/18 will allow it to mitigate clinical risk to patients, and improve waiting times performance. It will also allow the HSCP to accelerate progress on transforming the way local services are delivered by supporting redesign of services so future demand can be better managed.

This funding will also facilitate the negotiations with NHS GG&C regarding the outpatient to treatment conversion requirement and facilitate redesign of models of service delivery for patients within Argyll & Bute to better meet demand and modernise services going forward. Without additional funding not only will Argyll & Bute's waiting times performance deteriorate further, but it will be exposed to greater financial risk affecting its plans to deliver a balanced budget.

The funding has however, not yet been released by NHS Highland and there is a risk that a delay will not allow the HSCP to put in place the plans and actions to address the waiting times breaches detailed and projected.

Appendix 1: Pressure Specialties & Planned Action

The following is a list of key pressure specialties within Argyll & Bute along with the main actions planned with additional funding to reduce waiting times.

1) Ophthalmology
   - Immediate waiting list sessions to address the clinical risk to patients
   - Service redesign utilising a mixture of hospital based and independent sector optometrist support.
   - Increased hospital optometry support in Lorn & Isles with an additional investment of £27,000 from the access support team to pump prime this service. However, this is likely to be a difficult role to recruit to and it is therefore expected that this will be at high cost sessional rate.
   - Potential to formalise a pilot of shared care to rebalance the demand. This will also make best use of the independent sectors diagnostic equipment, promoting greater local access and reduced travel without the need for significant investment in hospital based equipment for relatively low usage.
   - Nurse led visual field training and clinics to reduce unnecessary consultant appointment slots and clinic throughput.
   - Exploration of virtual pre op assessment as being trialled by GJNH.

2) Orthopaedics
   - Backfill to release ESP trained staff to fully commit their time to orthopaedic triage. Due to the non recurring nature of funding this would be via agency staff. In the longer term recruitment or training to additional ESP level posts is essential to support the successful model of orthopaedic triage rolled out in Argyll & Bute and allow for a complete change of pathway for orthopaedic referrals to ESP as the first point of contact. The model is currently fragile with lone practitioners in each locality and there is continued risk of sudden and unplanned pressure on consultant waiting times.
   - Exploration of enhanced local nurse and AHP led services to support pre and post op assessment reducing travel into GGC
   - A pilot of first contact practitioner with a large GP practice. Evidence from North NHS Highland shows that a practice with a first contact practitioner makes only 4 referrals per 1000 patients in comparison with an average of around 16.

3) Dermatology
   - Additional consultant sessions to support local delivery of this service and increasing cost pressure due to consultant vacancies and recruitment challenges.
   - Support the expansion of established tele-vetting service with further training in primary care on condition management, virtual consultation and advice only referrals.
   - Redesign work to explore appropriate service delivery modes i.e. specialist nurse, GP with special interest.

4) Ear Nose and Throat
   - Additional consultant sessions within A&B and GGC. Current consultants unwilling to carry out WLI sessions due to the additional capacity required/conversion costs of increased throughput and activity into GGC being unfunded.
   - Exploration of ongoing service models for rural service provision and access.

5) Obstetrics & Gynaecology

- Potential short term clinical project support (nurse specialist/GP) to scope and review the availability of local sexual health services, developing a wider clinical network and training program, maximizing opportunities for management in primary care, and reducing referrals into consultant led gynecology services.
- Training program to up-skill midwives to provide basic sexual health services.
- Explore opportunities for triage processes within the Gynecology services to ensure timely referral and access to sub-specialisms.
- Roll out of existing 'attend anywhere' pilot to support Obstetric Redesign. This involves virtual consultant and midwife consultations from patients own home/device or from GP practice. This will support further redesign of the service supported by Technology Enabled Care (TEC) reducing travel for patients, and supporting more coordinated Multi Disciplinary Team planning, and make the best use of local obstetric scanning services. More virtual consultations for obstetric patients would free up capacity and resource for gynecology and assist with sustainable service provision and job planning.

6) Respiratory

- Review of current service in conjunction with NHS GG&C due to pressures both in NHS GG&C and within A&B. There is a need to review the model of service provision exacerbated by the need to succession plan for an A&B wide specialist nurse role which will become vacant in the next year.
- Additional initiative clinics whist this work is underway.
- DCAQ analysis to support ongoing review of the service model.

7) Pain Management

- Further pilot Pain Management Programme run by Physio and Specialist OT to triage, treat and manage appropriate patients to allow discharge from the consultant caseload.
- Promote self management tools such as TEC initiatives, the use of Florence (a self management texting service) to self motivate patients to manage their pain and increase independence rather than medicine management.
- Increased dedicated chronic pain nurse hours to support the self management programme. This strategy promotes equity across West Argyll since patients in more remote areas would find it very difficult to access any pain management programme.
- Rollout of Pain Education Sessions for new referrals as the initial step on the pathway and other educational initiatives.
- Potential to fund access to NHS GG&C only initiatives such as dedicated 12 week Pain Management Programme, Pain Psychology, Pain specific Mindfulness Programme. There is potential that patients who were suitable and willing to attend in NHS GG&C could access these programmes as an Extra Contractual Referral. There may also be scope to explore whether NHS GG&C could offer virtual services or assist with developing local alternatives.

8) Oral Surgery

- Further DCAQ work to examine the requirements
- The service is predominantly provided by a single handed retired community dentist supported by visiting consultants from NHS GG&C. There is potential for increased dentistry hours whilst we explore longer term service provision and succession plans.

Appendix 2 – NHSGG&C Consultant Outreach Clinic Schedule in Argyll & Bute - as at March 2017

Area / Specialty	**Oban & Mull** (Lorn & Isles Rural General Hospital)	**Mid Argyll** (Community Hospital – Lochgilphead)	**Campbeltown** (Community Hospital)	**Islay** (Community Hospital)	**Cowal** (Community Hospital – Dunoon)	**Bute** (Community Hospital – Rothesay)	**Helensburgh** (Victoria Integrated Care Centre)
Audiology					Fortnightly (aprox) 24 visits 96 sessions *SLA 58*	Fortnightly (aprox) 24 visits 24 sessions *SLA 58*	
Biochemistry	Fortnightly (aprox) 20 visits p.a. 20 sessions p.a.						
Clinical Oncology	Monthly 12 visits p.a. 36 sessions p.a.						
Dermatology	Fortnightly (aprox) 24 visits p.a. 79 sessions p.a. *clinical sessions only*	Monthly 13 visits p.a. 26 sessions p.a. *clinical sessions only*	Monthly 13 visits p.a. 26 sessions p.a. *clinical sessions only*				
Diabetic – Paediatric	Quarterly (aprox) 3 visits p.a. 18 sessions p.a.						
Diabetic Nurse					Fortnightly 24 visits p.a. 48 sessions p.a.	Monthly 12 visits p.a. 17 sessions p.a.	
Endocrinology - Diabetes					Quarterly 4 visits p.a. 4 sessions p.a.	Quarterly 4 visits p.a. 4 sessions p.a.	
ENT	Monthly 12 visits p.a. 24 sessions p.a.	Monthly (aprox) 9 visits p.a. 18 sessions p.a.	Bi-Monthly 6 visits p.a. 12 sessions p.a.	6 Monthly 2 visits p.a. 2 sessions p.a.	Monthly 12 visits p.a. 12 sessions p.a.	Monthly 12 visits p.a. 12 sessions p.a.	
ENT Nurse						Monthly 12 visits p.a. 12 sessions p.a.	
General Medicine			Monthly (aprox) 10 visits p.a. 20 sessions p.a.				Monthly (aprox) 10 visits p.a. 10 sessions p.a.

Area / Specialty	**Oban & Mull** (Lorn & Isles Rural General Hospital)	**Mid Argyll** (Community Hospital – Lochgilphead)	**Campbeltown** (Community Hospital)	**Islay** (Community Hospital)	**Cowal** (Community Hospital – Dunoon)	**Bute** (Community Hospital – Rothesay)	**Helensburgh** (Victoria Integrated Care Centre)
General Medicine - Cardiology			6 monthly 2 visits p.a. 2 sessions p.a.				
General Surgery – Vascular			6 monthly 2 visits p.a. 4 sessions p.a.				
General Surgery			6 monthly 2 visits p.a. 4 sessions p.a.		Monthly 12 visits p.a. 24 sessions p.a. *Service disruption – reduced clinics*	Monthly (aprox) 9 visits p.a. 9 sessions p.a.	
Geriatric Medicine					Monthly 12 visits p.a. 12 sessions p.a.	Monthly 12 visits p.a. 12 sessions p.a.	
Haematology	Fortnightly 25 visits p.a. 50 sessions p.a.						
Microbiology	Monthly 12 visits p.a. 12 sessions p.a.						
Obstetrics & Gynaecology	Weekly 44 visits p.a. 66 sessions p.a.	Monthly 13 visits p.a. 26 sessions p.a.	Monthly 13 visits p.a. 26 sessions p.a.	Bi-Monthly 6 visits p.a. 6 sessions p.a.	Monthly 13 visits p.a. 26 sessions p.a.	Monthly 13 visits p.a. 26 sessions p.a.	Weekly (aprox) 44 visits p.a. 44 sessions p.a. *Service disruption – reduced clinics*
Obstetrics Midwife							Weekly 52 visits p.a. 260 sessions p.a.
Ophthalmology	Weekly (Aprox) 40 visits p.a. 120 sessions p.a.	Monthly 12 visits p.a. 48 sessions p.a.	Monthly 12 visits p.a. 72 sessions p.a.		Fortnightly (aprox) 22 visits p.a. 44 sessions p.a.	Monthly 12 visits p.a. 24 sessions p.a.	
Ophthalmology – Nurse						Monthly 12 visits p.a. 24 sessions p.a.	

Area / Specialty	**Oban & Mull** (Lorn & Isles Rural General Hospital)	**Mid Argyll** (Community Hospital – Lochgilphead)	**Campbeltown** (Community Hospital)	**Islay** (Community Hospital)	**Cowal** (Community Hospital – Dunoon)	**Bute** (Community Hospital – Rothesay)	**Helensburgh** (Victoria Integrated Care Centre)
Oral Surgery	Quarterly 4 visits p.a. 8 sessions p.a.						
Orthopaedics	Weekly (aprox) 32 visits p.a. 128 sessions p.a.	Monthly 12 visits p.a. 24 sessions p.a.	Monthly 12 visits p.a. 48 sessions p.a.		Fortnightly (aprox) 20 visits p.a. 40 sessions p.a. *Includes staff grade*	Monthly 12 visits p.a. 12 sessions p.a.	Fortnightly (aprox) 20 visits p.a. 20 sessions p.a.
Orthoptics	Monthly 17 visits p.a. 68 sessions p.a. *Includes sessions for Mull*	Monthly 14 visits p.a. 40 sessions p.a.	Monthly 13 visits p.a. 36 sessions p.a.	Yearly 2 visits p.a. 5 sessions p.a.	Fortnightly (aprox) 24 visits p.a. 60 sessions p.a. *SLA 60*	Monthly 13 visits p.a. 16 sessions p.a. *SLA 60*	Bi-Monthly 6 visits p.a. 25 sessions p.a.
Pacemaker	Quarterly (aprox) 3 visits p.a. 6 sessions p.a.						
Paediatrics		Monthly 12 visits p.a. 24 sessions p.a.	Bi-Monthly 6 visits p.a. 12 sessions p.a.	Quarterly (aprox) 3 visits p.a. 3 sessions p.a.	Monthly 12 visits p.a. 24 sessions p.a.	Monthly 12 visits p.a. 12 sessions p.a.	Weekly (aprox) 42 visits p.a. 63 sessions p.a.
Paediatric Respiratory Care	*Home Visits - A&B wide as required*	*Home Visits - A&B wide as required*	*Home Visits - A&B wide as required*	*Home Visits - A&B wide as required*	*Home Visits - A&B wide as required*	*Home Visits - A&B wide as required*	*Home Visits - A&B wide as required*
Rehab Medicine	Quarterly (aprox) 3 visits p.a. 9 sessions p.a.	6 monthly 2 visits p.a. 2 sessions p.a.	Quarterly (aprox) 3 visits p.a. 6 sessions p.a.		Quarterly (aprox) 3 visits p.a. 3 sessions p.a.	Quarterly (aprox) 3 visits p.a. 3 sessions p.a.	
Respiratory Medicine	Monthly 12 visits p.a. 48 sessions p.a. *Includes premium rates and cost for activity in NHS GGC*						

Argyll & Bute Health & Social Care Partnership

Integration Joint Board **Agenda item : 5.7**

Date of Meeting : 29 November 2017

Title of Report : Staff Governance Report – Quarter 2 (end-Sept 2017)

Prepared by : Sandy Wilkie, Head of HR (HSCP) & Jane Fowler, Head of Improvement & HR (A&B Council)

Presented by : Stephen Whiston, Head of Strategic Planning & Performance

The Integration Joint Board is asked to :

Note the content of this quarterly report on the staff governance performance in the HSCP.

1. EXECUTIVE SUMMARY

This paper sets out performance data and current key issues for staff governance in the Health & Social Care Partnership. As the IJB is aware the HSCP does not employ staff, this remains the statutory responsibility of Argyll and Bute Council and NHS Highland respectively.

The elements detailed in this paper provide the IJB with information on the staff governance issues which the HSCP and its respective employer bodies are addressing to:

- Support staff in their work and development.
- Assess workforce performance and identify issues
- Establish staff partnership and trade union relationship and operation
- Ensure compliance with terms and condition and employing policies
- Adopt best practice from both employers
- Identify service change implications for the workforce and compliance with the above.

2. INTRODUCTION

This report provides an overview of the staff governance issues identified above as raised and discussed at the Strategic Management Team and Joint Partnership Forum. This report will be presented to the IJB on a quarterly basis. This report includes updates on:

- iMatter (NHS)
- Workforce Planning
- Update on Integrated HR issues
- Organisational Change & Service Redesign issues
- Recruitment & Redeployment activity
- Statutory & Mandatory Training
- Workforce performance trends; attendance management, costs of sickness absence, fixed-term contracts, turnover, employee relations, performance management.
- Plans for next quarter (Q3 2017)

The majority of the data in this report relates to Quarter 2 (July to Sept 2017).

3. iMatter (NHS)

iMatter is a continuous improvement tool designed with staff in NHS Scotland to help individuals, teams and Boards understand and improve staff experience. This is a term used to describe the extent to which employees feel motivated, supported and cared for at work. It is reflected in levels of engagement, motivation and productivity. Understanding staff experience at work is the first step to putting in place measures that will help to maintain and improve it. It will benefit employees, and the patients, their families and other service users that they support.

Between 29th May and 26th June 2017, HSCP staff (Council and NHS) were asked to participate in the iMatter survey either via a short online or paper questionnaire that was anonymous and treated confidentially. We were one of the first HSCPs within Scotland to run iMatter across both employing organisations.

For teams of 5 and above, where 60% of members or more completed the questionnaire, a Team Report including an Employee Engagement Index (EEI) Score was generated (100% for teams with 4 staff or less). Argyll & Bute HSCP achieved a 61% response rate which was good for our first involvement with iMatter. This enabled the HSCP and 114 A&B teams to receive their own report.

From mid July there was a 12 week period ending 13th October for Managers and Team Leaders to be discussing the Team's reports and agreeing an Action Plan for improving staff experience in their work area. This identifies what the team do well and 1-3 improvement actions can be added. This can be with the whole team or team representatives if it was not possible to get all the team together.

If the team did not achieve a response rate to get their own report they could use the Directorates' (HSCP). It is the action plan element that is key to identifying and managing change and improvements in the workplace. Action plans can continue to be added to iMatter beyond the 12 week period and we have been working to maximise uptake across the HSCP before the cut-off date (30 Nov) for inclusion in the Annual NHS Staff Experience Report 2018.

4. WORKFORCE PLANNING

The national iHub improvement team (http://iHub.scot/) have been working with the HSCP to support workforce planning. They provided consultancy support from Red Hen to develop a workforce planning tool that has almost been completed in Oban, Lorn and the Isles locality, a final session was held in mid September. The tool could help a locality see visually how changes in various dynamics including turnover, recruitment and skills development will help to deliver the Locality Plan. Key learning was that strong local leadership was essential as well as the articulation of workforce data at locality level to develop an accurate model.

Discussions have taken place with Gareth Adkins, Head of Improvement Support at Healthcare Improvement Scotland to see how iHub can further support roll out of the model to the rest of the HSCP. This will now be more of a knowledge transfer approach from ihub, and the next 3 phases will be evaluated in terms of impact and learning from using this 'systems dynamic' approach to workforce planning.

The phased roll-out is below and two workshops are arranged for the localities, with a follow on workshop to be planned for end of February/early March for all localities to come together to consolidate learning, use of outputs of the model, actions at locality and across A&B, and evaluation:

Phase 2 – End of November/January - Cowal & Bute
Phase 3 – December/January – Helensburgh & Lomond
Phase 4 – December/January – Mid Argyll, Kintyre and Islay

A Programme Board is set up to govern the work and will be chaired by the Head of Strategic Planning & Performance, the first meeting is planned for 23rd November. This will help to bring together key elements of work as part of developing a workforce plan for the HSCP to ensure we achieve the workforce needed. This is a workforce that can deliver the transformation of care delivery and healthcare needs of the people in Argyll & Bute.

Part 1 of the Scottish Government's *National Health and Social Care Workforce Plan was launched in June, and Pa*rt 2 is due to be published in the autumn, and proposals are underway for safe and effective staffing legislation**.**

5. UPDATE ON INTEGRATED HR ISSUES

The Staff Liaison Group and Organisational Change Group are operating to ensure consistent application of NHS & Council organisational change and redesign policies. We have active staff-side involvement on both groups.

The Council HR team has been undertaking a re-organisation. Next quarter (Q3), a similar process will commence with the HSCP HR team to ensure we have sufficient alignment and resilience to support service changes across the HSCP.

The new Head of Human Resources for the HSCP has now started employment and interviews for the Workforce, Organisational Development and Staff Engagement Manager are arranged for December 2017.

The NHS Lease Car Policy, Standard Dress Policy and Annual Leave Policy have been reviewed and approved at Highland Partnership Forum in September 2017. The review of the Management of Employee Capability Policy is being finalised and is due to be submitted to the next Highland Partnership Forum in December 2017 for approval.

6. ORGANISATIONAL CHANGE & SERVICE REDESIGN ISSUES

The Mental Health Admin Review was approved at Staff Liaison Group and progressed to Organisational Change Group. It is now near completion with one vacancy still to be recruited to.

Work to progress the new Neighbourhood teams has commenced this month will be reported in the next (Q3) report.

7. RECRUITMENT & DEPLOYMENT ACTIVITY

NHS Vacancies

Posts Advertised

	July	Aug	Sept
A&B Adult Services – East Total	9	2	5
A&B Adult Services – West Total	9	13	25
A&B Children & Families Total	10	3	6
Corporate Services Total	9	8	14
Totals	**37**	**26**	**50**

Council Vacancies

Posts Advertised

	July	Aug	Sept
A&B Adult Services – East Total	1	2	4
A&B Adult Services – West Total	7	2	7
A&B Children & Families Total	0	2	5
Totals	**8**	**6**	**16**

Redeployment

There were 40 staff on the NHS primary redeployment register (a reduction of 3) and 26 on the secondary register (no change from June 2017).

No Social Work staff are currently on the redeployment register.

Locality Management arrangements

At the Locality Manager (LM) and Locality Area Manager (LAM) levels, we have some vacancies & interim cover arrangements which affect the resilience of our operational leadership structures.

Adult Services (West) have an Interim LM for OLI, Interim LAMs in place for Oban Community and Mull & Kintyre and a LAM vacancy for Islay. Adult Services (East) have an LM covering two areas while the LM for Helensburgh is serving as Interim Head of Service. Finally, Children & Families and Criminal Justice have an Interim LM in place for Cowal & Bute.

8. STATUTORY & MANDATORY TRAINING

A new project is underway to implement the learnPro Course Booking System (CBS) to allow line managers and employees to manage both classroom and elearning training in one intuitive and familiar system – learnPro NHS. The objectives of the project are to:

- Make it easier for employees and line managers to:
    - Book onto classroom based courses electronically
    - Create an online training plan, which can be a blend of elearning and classroom training
    - Monitor and report progress against the training plan

- Provide an overview of organisational compliance with statutory and mandatory training.

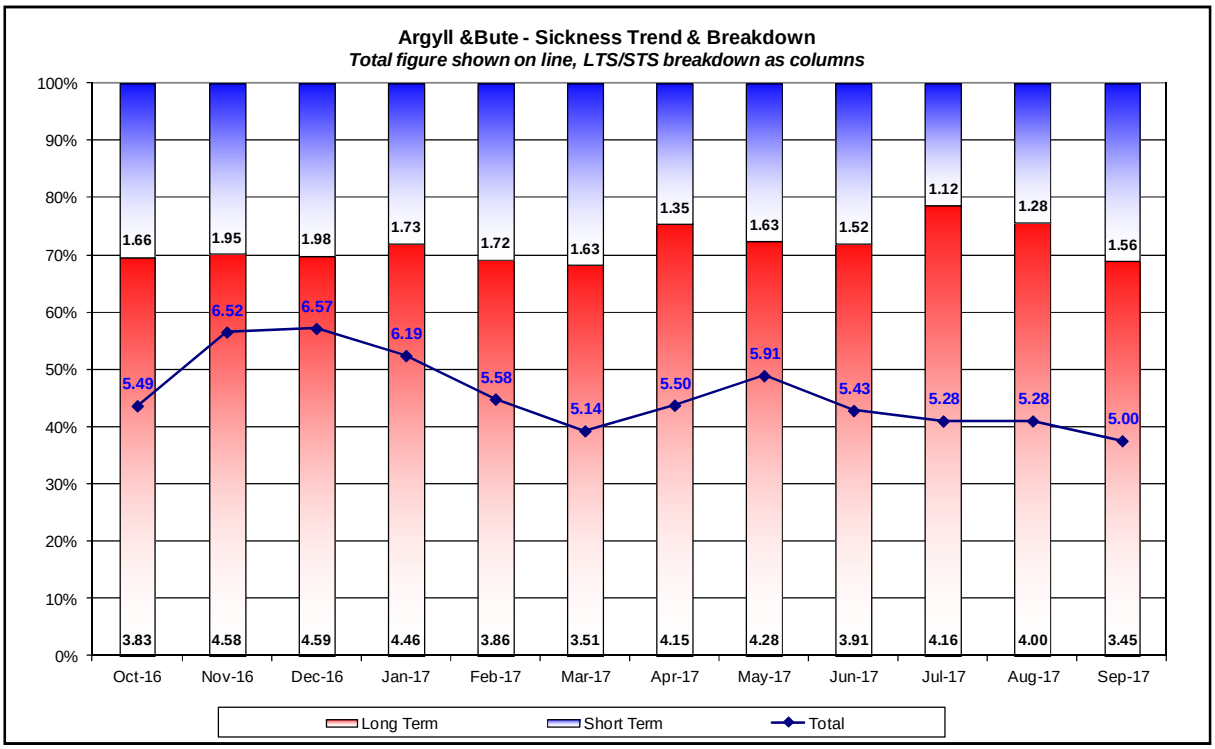
A range of training options will be available to help staff and Managers use the new course booking system; short videos, quick guides, Webinars and FAQs.

A full update on Statutory & Mandatory Training compliance will be provided in next quarters report (Q3) once information has been obtained from Health & Safety.

9. WORKFORCE PERFORMANCE TRENDS

9.1 Attendance Management

Most NHS Management Units remain above the national target of 4%. Sickness absence stabilised over July and August before reducing again in September to its lowest level (5.00%) since September 2016. This is encouraging news.



September 2017	STS	LTS	Total
Adult West	1.41%	3.62%	5.03% ↓
Adult East	1.54%	3.82%	5.36% ↓
Children's & Families	1.21%	0.80%	2.02% ↓
Corporate (incl Dental)	2.28%	3.15%	5.43% ↑
A&B Total	**1.56%**	**3.45%**	**5.00% ↓**

STS = Short Term Sickness, LTS = Long Term Sickness

At the IJB Joint Partnership Forum in October 2017 it was agreed to establish a Health & Wellbeing Short Life Working Group to meet in November to explore and agree actions in partnership on how the organisation can reduce and maintain lower levels of sickness absence. Preventative measures such as Healthy Working Lives, and encouraging flu vaccination for all Council and NHS staff are in place. In conjunction with Occupational Health Services, the group will also consider whether there are any trends in regard to reasons for absence.

A Rapid Process Improvement Workshop (RPIW) took place in North Highland on long term sickness absence to look at improvements around the process and to address high sickness absence levels. The outcome of the RPIW including any new standard work has been spread and shared with Argyll & Bute HR to implement across the HSCP.

The Council measures sickness absence as working days lost as per the required SPI for local government. The data available for this report is for Quarter 2 ending in September 2017. In Q2 the total number of working days lost per FTE employee was **4.50** against a target of **3.78.**

The percentage of Return to Work Interviews completed in this month is considerably below the Council's target of 100% and a number of RTWIs are taking more than 10 days to complete.

September 2017	**% RTWI Completed**	**Average time taken to complete (days)**
Adult West	29%	3.25
Adult East	35%	7.5
Children and Families	32%	3.9
Strategic Planning and Performance	n/a	n/a
GRAND TOTAL	**31%**	**4.9**

9.2 Costs of Sickness Absence

At the IJB meeting in September, a request was made to provide costs of HSCP sickness absence. Total sick pay costs for both Q1 and Q2 are shown below:

Employer	**Q1 £k**	**Q2 £k**	**Total £k**
Council	217	334	551
Health	825	763	1,588
Total	**1,042**	**1,097**	**2,139**

The costs above represent the total estimated sick pay costs for the absent members of staff and do not include any additional costs of cover or backfill where this is required.

The sick pay cost for Council employees includes the sick pay element of pay and does not include any salary on-costs, this figure is an accurate cost of the payment to all staff groups. The cost for Health staff includes all staff costs, however this cost is an estimate of the total cost of sick pay based on the overall health staff pay bill and the levels of absence, as detailed information is not recorded separately in the health financial ledger for sick pay costs.

Further work would be required to develop more sophisticated reports to produce more detailed information, however these figures do provide a high level estimate of the financial cost of sickness absence across the HSCP.

9.3 Fixed Term contracts

NHS employees

There are 33 staff currently on fixed term contracts (a decrease of 4).

Adult Care West	**16**
Adult Care East	**12**
Corporate	**6**
Children & Families	**3**
TOTAL	**37**

Breakdown per locality

Cowal & Bute	**6**
Helensburgh & Lomond	**6**
Mid Argyll, Kintyre & Islay	**3**
Oban Lorn and Isles	**13**
Corporate	**6**
Children & Families	**3**

Council employees

Adult Care West	**51**
Adult Care East	**7**
Children and Families	**29**
Strategic Planning & Perf	**1**
TOTAL	**88**

9.4 Turnover, Employee Relations Cases & Performance Management

Information on these themes will be provided for both NHS and Council employees in the Q3 report

10. PLANS FOR NEXT QUARTER (Q3)

- The national 'Dignity at Work' survey for all NHS staff will run 6-17 November and our NHS staff within the HSCP will each receive a questionnaire
- A&B Council are planning a Wellbeing Survey for their staff in November, we hope to extend this to NHS staff in December so that we can obtain benchmarking data across the whole of the HSCP that will inform resilience interventions
- We will be attending a **'**Workforce Planning in Health and Social Care' event on 22 November at Holyrood. This will provide HSCPs with an opportunity to learn more about the policy landscape of health and social care workforce planning in Scotland.
- Practical sessions will be held for Line Managers and Administrators in November 2017 for the LearnPro Course Booking System (CBS) and the go live date is scheduled for December 2017
- A meeting is planned to explore the feasibility of joint placements across the Council/NHS to give Modern Apprentices the opportunity to experience a range of roles across the HSCP
- We will be reviewing our reporting against Wellbeing Outcome Indicator 8 to ensure a more holistic approach (e.g. including staff engagement measures)

11. CONTRIBUTION TO STRATEGIC PRIORITIES

The staff governance paper sets out the issues relating to staff that support or have an effect on the delivery of the HSCP strategic priorities.

12. GOVERNANCE IMPLICATIONS

12.1 Financial Impact – N/A

12.2 Staff Governance – this is the staff governance report.

12.3 Clinical Governance – N/A

13. EQUALITY & DIVERSITY IMPLICATIONS

These issues are picked up within the NHS and Council HR departments as appropriate when policies and strategies are developed.

14. RISK ASSESSMENT

Risk assessment will be addressed at individual project level. There are HR issues flagged up in the A&B HSCP Strategic Risk Register.

15. PUBLIC & USER INVOLVEMENT & ENGAGEMENT – N/A

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.8

Date of Meeting : **29 November 2017**

Title of Report : **Climate Change Report**

Presented by : **Lorraine Paterson, Head of Adult Services (West)**

Compiled By : **David Ross, Estates Manager**

The Integration Joint Board is asked to :

- Note the progress towards submission of an IJB Climate Change report to Scottish Government by 30th November 2017
- Approve the principles of completion.
- Approve the establishment of an Argyll & Bute HSCP Climate Change Group
- Approve submission of the report.

1. INTRODUCTION

This paper summarises the Integration Joint Board's (IJB) responsibility to produce a Climate Change report under the Climate Change (Scotland) Act 2009.

2. EXECUTIVE SUMMARY

In 2009 the Scottish Parliament passed the Climate Change (Scotland) Act. Part 4 of the Act states that a *"public body must, in exercising its functions, act: in the way best calculated to contribute to the delivery of (Scotland's climate change) targets; in the way best calculated to help deliver any (Scottish adaptation programme); and in a way that it considers most sustainable"*.

As a public body the IJB has a responsibility to produce a Climate Change Report under the Climate Change (Scotland) Act 2009 to the Scottish Government by 30 November 2017, independent from the parent bodies of NHS Highland and Argyll & Bute Council.

As Argyll & Bute Health and Social Care Partnership (HSCP) Integration Joint Board has no responsibility for staff, buildings or fleet cars the report does not contain a great deal of detail and aspects related to staff, buildings or fleet cars will be contained within constituent authorities reports.

3. DETAILS OF THE REPORT

The Scottish Government's guidance for the completion of the report clearly states that this should be seen as a baseline assessment of progress towards meeting the Government's targets for climate change.

Argyll & Bute Health and Social Care Partnership appointed David Ross, Estates Manager as its Climate Change Lead, to represent the HSCP on the Argyll & Bute Council Climate Change Board. Liaison is also ongoing with NHS Highland Estates Department in developing a similar arrangement.

The *Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015* came into force in November 2015 as secondary legislation made under the Climate Change (Scotland) Act 2009. The Order requires bodies to prepare reports on compliance with climate change duties. This includes 'An integration joint board established by order under section 9(2) of the Public Bodies (Joint Working) (Scotland) Act 2014(c)'

The three elements of the public bodies climate change duties are:

- **Mitigation - Reducing Greenhouse Gas Emissions**
    - The first element of the duties is that, in exercising their functions, public bodies must act in the way best calculated to contribute to delivery of the Act's greenhouse gas emissions reduction targets. Reducing emissions is referred to as climate change *mitigation*.
    - The Act has set an interim target of a 42% reduction in greenhouse gas emissions by 2020 and an 80% reduction in greenhouse gas emissions by 2050, on a 1990 baseline. The long-term targets will be complemented by annual targets, set in secondary legislation.
- **Adaptation - Adapting to the Impacts of a Changing Climate**
    - The second element of the duties is that public bodies must, in exercising their functions, act in the way best calculated to deliver any statutory adaptation programme. The first statutory adaptation programme – Scotland's Climate Change Adaptation Programme (SCCAP) – was published in 2014. While public sector bodies will have varying degrees of influence in relation to adaptation, all public bodies need to be resilient to the future climate and to plan for business continuity in relation to delivery of their functions and the services they deliver.

- **Acting Sustainably - Sustainable Development as a Core Value**

    - The third element of the duties places a requirement on public bodies to act in a way considered most sustainable. This element of the duties is about ensuring that, in reaching properly balanced decisions, the full range of social, economic and environmental aspects are taken into account, and that these aspects are viewed over the short and long term.

The report to the Scottish Government requests information under the following 5 categories :

1. Confirmation of Board/Group set up to deal with Climate Change issues.
2. Polices specific to Climate Change.
3. Emission records.
4. Plans for adaptations to mitigate risks associated with climate change.
5 Procurement policies which take account of Climate Change.

This is the first request from the Scottish Government for the HSCPs in Scotland to complete a climate change report and as such there is a degree of uncertainty as to what information to provide. It is understood that completion of reports will be on basis that the parent organisations are responsible for climate change as the IJB has no responsibility for property, vehicles or staff.

Discussion with NHS Highland's Climate Change leads agreed the principle of the above approach but further suggested that this be accompanied by information on the Health & Social Care Partnership's current position on climate change

As such the Argyll & Bute document is completed where appropriate on a similar basis with the following standard statement.

"As Argyll & Bute Health & Social Care Partnership Integration Joint Board has no responsibility for staff, buildings or fleet cars the responsibilities are limited. We would refer readers to the two constituent authorities climate change reports"

https://www.keepscotlandbeautiful.org/sustainability-climate-change/sustainable-scotland-network/climate-change-reporting/201617-reporting/

https://www.keepscotlandbeautiful.org/media/1557908/argyll-and-bute-council-ccr-2016.pdf

The statement is accompanied by additional narrative on the HSCP's current climate change position specific to the data required and on how we will work towards establishing our own governance arrangements to allow us to collect the required data, develop climate change adaptation strategies, action plans and risk management procedures, and any climate change adaptation policies

In addition, other relevant areas of work/good practice within the HSCP are highlighted.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

The report is in line with Government Climate Change strategy.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

Currently none. The HSCP undertakes efficiency improvements to facilities, services and vehicles as and when funds allow.

5.2 Staff Governance

Staff are encouraged to exercise good energy efficiency practices.

5.3 Clinical Governance - not applicable

6. EQUALITY & DIVERSITY IMPLICATIONS – not applicable as this is a statutory duty to be carried out by the IJB.

7. RISK ASSESSMENT required by end of December 2017

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT - not applicable

9. CONCLUSIONS

The submission of the report should be seen as the first move by the Scottish Government to ensure that IJBs independently take forward the Government's policies in this area.

Public Sector Climate Change Duties Report Template

Introduction

Welcome to this online reporting portal to submit your annual reports under the Climate Change (Duties of Public Bodies: Reporting Requirements) (Scotland) Order 2015.

Please submit your 2016-17 Climate Change Report through this system on or before **30th November 2017.**

Technical guidance notes on the system can be accessed here.

Detailed guidance notes on how to complete the sections can be accessed on the SSN support for reporting webpages here

Please note that access to **Q3A & Q3B** is only currently available to bodies reporting on either a Financial year (01/04/16 – 31/03/17) and Calendar Year (01/01/2016 – 31/12/2017). Bodies using the academic reporting year (both fiscal and financial) will be able to access Q3A & 3B following the publication of the 2017 Greenhouse gas emissions factors by BEIS, expected on or around 30th June 2017. All other questions on the form will be able to be completed in the meantime

The recommended reporting section follows on at the bottom of the form following the declaration which allows you to provide information on the wider impact and influence of your organisation on GHG emissions.

Please note that there is a limit set on your session time which expires after 10 minutes and any work that has not been saved will be lost. To ensure you do not lose any entries, please remember to save the form after each entry.

Required section

1 Profile of reporting body

1a Name of reporting body

Provide the name of the listed body (the "body") which prepared this report.

Argyll and Bute

1b Type of body

Integrated Joint Boards

1c Highest number of full-time equivalent staff in the body during the report year.

0

1d Metrics used by the body.

Specify the metrics that the body uses to assess its performance in relation to climate change and sustainability.

Metric	Units	Value	Comments
Please choose from the list below...			The Integrated Joint Board does not monitor its performance in relation to
Please choose from the list below...			

1e Overall budget of the body (£).

Specify approximate £/annum for the report year

£259,137,000

Comments

Overall budget for 2016/17

1f Specify the report year type.

Financial (April to March)

1g Context

Provide a summary of the body's nature and functions that are relevant to climate change reporting.

The Integrated Joint Board is responsible for the services as outlined in the Public Bodies (Joint Working) Scotland Act 2014

2 Governance, Management and Strategy

Governance and management

2a How is climate change governed in the body?

Provide a summary of the roles performed by the body's governance bodies and members in relation to climate change. If any of the body's activities in relation to climate change sit outside its own governance arrangements (in relation to, for example, land use, adaptation, transport, business travel, waste, information and communication technology, procurement or behaviour change), identify these activities and the governance arrangements.

As Argyll & Bute Health & Social Care Partnership Integration Joint Board has no responsibility for staff, buildings or fleet cars the responsibilities are limited. We would refer readers to the two constituent authorities climate change reports

However in recognition that the Argyll & Bute Health & Social Care Partnership is required to provide its own data the following has been actioned

1. Argyll and Bute health & Social Care Partnership has appointed a Climate Change Lead

2. Argyll and Bute Health & Social Care Partnership is an invitee to Argyll & Bute Councils Climate Change Board and alongside NHS Highland is working towards, in the next 12 months, establishing its own Climate Change Group to collect the required data to populate the below return

Provide a diagram / chart to outline the governance structure within the body (JPEG, PNG, PDF, DOC)

Browse...

2b How is climate change action managed and embedded by the body?

Provide a summary of how decision-making in relation to climate change action by the body is managed and how responsibility is allocated to the body's senior staff, departmental heads etc. If any such decision-making sits outside the body's own governance arrangements (in relation to, for example, land use, adaptation, transport, business travel, waste, information and communication technology, procurement or behaviour change), identify how this is managed and how responsibility is allocated outside the body.

Argyll and Bute health & Social Care Partnership's, Climate Change Lead reports to Strategic Management Team and Integrated Joint Board

Provide a diagram to show how responsibility is allocated to the body's senior staff, departmental heads etc. (JPEG, PNG, PDF, DOC)

Browse...

Strategy

2c Does the body have specific climate change mitigation and adaptation objectives in its corporate plan or similar document?

Provide a brief summary of objectives if they exist.

Wording of objective	Name of document	Link

2d Does the body have a climate change plan or strategy?

If yes, provide the name of any such document and details of where a copy of the document may be obtained or accessed.

The body currently doesn't have a climate change strategy but will in the coming 12 months be working through its Climate Change Group to develop

2e Does the body have any plans or strategies covering the following areas that include climate change?

Provide the name of any such document and the timeframe covered.

Topic area	Name of document	Link	Time period covered	Comments
Adaptation				
Business travel				

Staff Travel				
Energy efficiency				
Fleet transport				
Information and communication technology				
Renewable energy				
Sustainable/renewable heat				
Waste management				
Water and sewerage				
Land Use				
Other (state topic area covered in the comments)				

2f What are the body's top 5 priorities for climate change governance, management and strategy for the year ahead?
Provide a brief summary of the body's areas and activities of focus for the year ahead.

As Argyll & Bute Health & Social Care Partnership Integration Joint Board has no responsibility for staff, buildings or fleet cars the responsibilities are limited. We would refer readers to the two constituent authorities

Argyll & Bute health & Social care Partnership does not currently have 5 priorities

2g Has the body used the Climate Change Assessment Tool (a) or equivalent tool to self-assess its capability / performance?

If yes, please provide details of the key findings and resultant action taken.

(a) This refers to the tool developed by Resource Efficient Scotland for self-assessing an organisation's capability / performance in relation to climate change.

Argyll & Bute Health & Social Care Partnership has not used the Climate Change or equivalent Assessment Tool

Further Information

2h Supporting information and best practice

Provide any other relevant supporting information and any examples of best practice by the body in relation to governance, management and strategy.

None at present

3 Emissions, Targets and Projects

Emissions

3a Emissions from start of the year which the body uses as a baseline (for its carbon footprint) to the end of the report year.

Complete the following table using the greenhouse gas emissions total for the body calculated on the same basis as for its annual carbon footprint /management reporting or, where applicable, its sustainability reporting. Include greenhouse gas emissions from the body's estate and operations (a) (measured and reported in accordance with Scopes 1 & 2 and, to the extent applicable, selected Scope 3 of the Greenhouse Gas Protocol (b)). If data is not available for any year from the start of the year which is used as a baseline to the end of the report year, provide an explanation in the comments column.

(a) No information is required on the effect of the body on emissions which are not from its estate and operations.

(b) This refers to the document entitled "The greenhouse gas protocol. A corporate accounting and reporting standard (revised edition)", World Business Council for Sustainable Development, Geneva, Switzerland / World Resources Institute, Washington DC, USA (2004), ISBN: 1-56973-568-9.

Reference Year	Year	Scope 1	Scope 2	Scope 3	Total	Units	Comments
Baseline carbon footprint						tCO2e	

3b Breakdown of emission sources

Complete the following table with the breakdown of emission sources from the body's most recent carbon footprint (greenhouse gas inventory); this should correspond to the last entry in the table in 3(a) above. Use the 'Comments' column to explain what is included within each category of emission source entered in the first column. If, for any such category of emission source, it is not possible to provide a simple emission factor(a) leave the field for the emission factor blank and provide the total emissions for that category of emission source in the 'Emissions' column.

If providing consumption data for Water – Supply, please also include the Emission Source and consumption data for Water – Treatment.

If providing consumption data for Grid Electricity (generation), please also include the Emission Source and consumption data for Grid Electricity (transmission & distribution losses).

(a) Emission factors are published annually by the UK Government Department for Environment, Food and Rural Affairs (Defra).

Emission Source	Scope	Consumption data	Units	Emission factor	Units	Emissions (tCO2e)	Comments
					Total	0.0	

3c Generation, consumption and export of renewable energy

Provide a summary of the body's annual renewable generation (if any), and whether it is used or exported by the body.

	Renewable Electricity		Renewable Heat		
Technology	Total consumed by the	Total exported (kWh)	Total consumed by the	Total exported (kWh)	Comments

	organisation (kWh)		organisation (kWh)		

Targets

3d Targets

List all of the body's targets of relevance to its climate change duties. Where applicable, overall carbon targets and any separate land use, energy efficiency, waste, water, information and communication technology, transport, travel and heat targets should be included.

Name of Target	Type of Target	Target	Units	Boundary/scope of Target	Progress against target	Year used as baseline	Baseline figure	Units of baseline	Target completion year	Comments

Projects and changes

3e Estimated total annual carbon savings from all projects implemented by the body in the report year

If no projects were implemented against an emissions source, enter "0".
If the body does not have any information for an emissions source, enter "Unknown" into the comments box.
If the body does not include the emissions source in its carbon footprint, enter "N/A" into the comments box.

Emissions Source	Total estimated annual carbon savings (tCO2e)	Comments
Electricity		
Natural gas		
Other heating fuels		
Waste		
Water and sewerage		
Business Travel		
Fleet transport		
Other (specify in comments)		
Total	0.00	

3f Detail the top 10 carbon reduction projects to be carried out by the body in the report year

Provide details of the 10 projects which are estimated to achieve the highest carbon savings during report year.

Project name	Funding source	First full year of	Are these savings figures	Capital cost (£)			Primary fuel / emission source saved	Estimated carbon	Estimated costs	Behaviour change aspects	Comments

		CO2e savings	estimated or actual?		Operational cost (£/annum)	Project lifetime (years)		savings per year (tCO2e / annum)	savings (£/annum)	including use of ISM	

3g Estimated decrease or increase in the body's emissions attributed to factors (not reported elsewhere in this form) in the report year

If the emissions increased or decreased due to any such factor in the report year, provide an estimate of the amount and direction.

Emissions source	Total estimated annual emissions (tCO2e)	Increase or decrease in emissions	Comments
Estate changes			
Service provision			
Staff numbers			
Other (specify in comments)			
	Total	0.00	

3h Anticipated annual carbon savings from all projects implemented by the body in the year ahead

If no projects are expected to be implemented against an emissions source, enter "0".

If the body does not have any information for an emissions source, enter "Unknown" into the comments box.

If the body does not include the emissions source in its carbon footprint, enter "N/A" into the comments box.

Emissions Source	Total estimated annual carbon savings (tCO2e)	Comments
Electricity		
Natural gas		
Other heating fuels		
Waste		
Water and sewerage		
Business Travel		
Fleet transport		
Other (specify in comments)		
Total	0.00	

3i Estimated decrease or increase in the body's emissions attributed to factors (not reported elsewhere in this form) in the year ahead

If the emissions are likely to increase or decrease due to any such factor in the year ahead, provide an estimate of the amount and direction.

Emissions source	Total estimated annual emissions (tCO2e)	Increase or decrease in emissions	Comments
Estate changes			
Service provision			
Staff numbers			
Other (specify in comments)			
	Total	0.00	

3j Total carbon reduction project savings since the start of the year which the body uses as a baseline for its carbon footprint

If the body has data available, estimate the total emissions savings made from projects since the start of that year ("the baseline year").

Total savings	Total estimated emissions savings (tCO2e)	Comments
Total project savings since the baseline year		

Further information

3k Supporting information and best practice

Provide any other relevant supporting information and any examples of best practice by the body in relation to its emissions, targets and projects.

As Argyll & Bute Health & Social Care Partnership Integration Joint Board has no responsibility for staff, buildings or fleet cars the responsibilities are limited. We would refer readers to the two constituent authorities.

However in recognition that the Argyll & Bute Health & Social Care Partnership is required to provide its own data the following has been actioned

1. Argyll and Bute health & Social Care Partnership has appointed a Climate Change Lead

2. Argyll and Bute Health & Social Care Partnership is an invitee to Argyll & Bute Councils Climate Change Board and alongside NHS Highland is working towards, in the next 12 months, establishing its own Climate Change Group to collect the required data to populate the below return

4 Adaptation

Assessing and managing risk

4a Has the body assessed current and future climate-related risks?

If yes, provide a reference or link to any such risk assessment(s).

None at the moment. It is intended that the Health and Social Care Partnership's Climate Change Group will undertake a Risk Assessment exercise prior to the end of December 2017

4b What arrangements does the body have in place to manage climate-related risks?

Provide details of any climate change adaptation strategies, action plans and risk management procedures, and any climate change adaptation policies which apply across the body.

None at the moment. It is intended that the Health and Social Care Partnership's Climate Change Group will undertake a Risk Assessment exercise prior to the end of December 2017. This will in conjunction with working with Argyll & Bute Council and NHS Highland allow the development of change adaptation strategies, action plans and risk management procedures

Taking action

4c What action has the body taken to adapt to climate change?

Include details of work to increase awareness of the need to adapt to climate change and build the capacity of staff and stakeholders to assess risk and implement action.

None at moment

4d Where applicable, what progress has the body made in delivering the policies and proposals referenced N1, N2, N3, B1, B2, B3, S1, S2 and S3 in the Scottish Climate Change Adaptation Programme(a) ("the Programme")?

If the body is listed in the Programme as a body responsible for the delivery of one or more policies and proposals under the objectives N1, N2, N3, B1, B2, B3, S1, S2 and S3, provide details of the progress made by the body in delivering each policy or proposal in the report year.

(a) This refers to the programme for adaptation to climate change laid before the Scottish Parliament under section 53(2) of the Climate Change (Scotland) Act 2009 (asp 12) which currently has effect. The most recent one is entitled "Climate Ready Scotland: Scottish Climate Change Adaptation Programme" dated May 2014.

Objective	Objective reference	Theme	Policy / Proposal reference	Delivery progress made	Comments
Understand the effects of climate change and their impacts on the natural environment.	N1	Natural Environment			
Support a healthy and diverse natural environment with capacity to adapt.	N2	Natural Environment			
Sustain and enhance the benefits, goods and services that the natural environment provides.	N3	Natural Environment			
Understand the effects of climate change and their impacts on buildings and infrastructure networks.	B1	Buildings and infrastructure networks			
Provide the knowledge, skills and tools to manage climate change impacts on buildings and infrastructure.	B2	Buildings and infrastructure networks			

Increase the resilience of buildings and infrastructure networks to sustain and enhance the benefits and services	B3	Buildings and infrastructure networks			
Understand the effects of climate change and their impacts on people, homes and communities.	S1	Society			
Increase the awareness of the impacts of climate change to enable people to adapt to future extreme weather events.	S2	Society			
Support our health services and emergency responders to enable them to respond effectively to the increased pressures associated with a changing climate.	S3	Society			

Review, monitoring and evaluation

4e What arrangements does the body have in place to review current and future climate risks?

Provide details of arrangements to review current and future climate risks, for example, what timescales are in place to review the climate change risk assessments referred to in Question 4(a) and adaptation strategies, action plans, procedures and policies in Question 4(b).

None available till 4a and 4b are in place

4f What arrangements does the body have in place to monitor and evaluate the impact of the adaptation actions?

Please provide details of monitoring and evaluation criteria and adaptation indicators used to assess the effectiveness of actions detailed under Question 4(c) and Question 4(d).

None at moment

Future priorities for adaptation

4g What are the body's top 5 priorities for the year ahead in relation to climate change adaptation?

Provide a summary of the areas and activities of focus for the year ahead.

None at moment

Further information

4h Supporting information and best practice

Provide any other relevant supporting information and any examples of best practice by the body in relation to adaptation.

As Argyll & Bute Health & Social Care Partnership Integration Joint Board has no responsibility for staff, buildings or fleet cars the responsibilities are limited. We would refer readers to the two constituent authorities

5 Procurement

5a How have procurement policies contributed to compliance with climate change duties?

Provide information relating to how the procurement policies of the body have contributed to its compliance with climate changes duties.

As Argyll & Bute Health & Social Care Partnership Integration Joint Board has no responsibility for staff, buildings or fleet cars the responsibilities are limited. We would refer readers to the two constituent authorities

5b How has procurement activity contributed to compliance with climate change duties?

Provide information relating to how procurement activity by the body has contributed to its compliance with climate changes duties.

As Argyll & Bute Health & Social Care Partnership Integration Joint Board has no responsibility for staff, buildings or fleet cars the responsibilities are limited. We would refer readers to the two constituent authorities

Further information

5c Supporting information and best practice

Provide any other relevant supporting information and any examples of best practice by the body in relation to procurement.

As Argyll & Bute Health & Social Care Partnership Integration Joint Board has no responsibility for staff, buildings or fleet cars the responsibilities are limited. We would refer readers to the two constituent authorities

6 Validation and Declaration

6a Internal validation process

Briefly describe the body's internal validation process, if any, of the data or information contained within this report.

The report and associated cover paper will be presented to the Argyll & Bute Health & Social Care Partnership Integration Joint Board on 29th November 2017 for approval and has been consulted on with colleagues across the two constituent authorities

The report will be presented to the Argyll & Bute HSCP Integration Joint Board on xxxx for approval to submit to Sustainable Scotland Network

6b Peer validation process

Briefly describe the body's peer validation process, if any, of the data or information contained within this report.

The report and associated cover paper will be presented to the Argyll & Bute Health & Social Care Partnership Integration Joint Board on 29th November 2017 for approval and has been consulted on with colleagues across the two constituent authorities

6c External validation process

Briefly describe the body's external validation process, if any, of the data or information contained within this report.

Not Applicable

6d No Validation Process

If any information provided in this report has not been validated, identify the information in question and explain why it has not been validated.

6e Declaration

I confirm that the information in this report is accurate and provides a fair representation of the body's performance in relation to climate change.

Name:	David Ross
Role in the body:	Estates Manager
Date:	22-11-2017

Recommended Reporting: Reporting on Wider Influence

Wider Impact and Influence on GHG Emissions

1 Historic Emissions

Table 1a

Sector	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Units	Comments
Total Emissions													

2a Targets

Please detail your wider influence targets

Table 2

Sector	Description	Type of Target (units)	Baseline value	Start year	Target Saving	Target / End Year	Saving in latest year measured	Latest Year Measured	Comments

2b Does the organisation have an overall mission statement, strategies, plans or policies outlining ambition to influence emissions beyond your corporate boundaries? If so, please detail this in the box below.

None at the moment

3 Policies and Actions to Reduce Emissions

Table 3:

Sector

Start year for policy/action implementation	Year that the policy/action will be fully implemented	Annual CO2 saving once fully implemented (tCO2)	Latest Year measured	Saving in latest year measured (tCO2)	Status

Metric / indicators for monitoring progress

Delivery Role	During project/policy design and implementation, has ISM or an equivalent behaviour change tool been used?

Please give further details of this behaviour change activity

Value of Investment (£)	Ongoing Costs (£/year)

Primary Funding Source for Implementation of Policy/Action

Comments

Please provide any detail on data sources or limitations relating to the information provided in Table 3

None at the moment

4 Partnership Working, Communications and Capacity Building

Please detail your Climate Change Partnership, Communication or Capacity Building Initiatives below.

Table 4

Key Action Type	Description	Action	Organisation's project role	Lead Organisation (if not reporting organisation)	Private Partners	Public Partners	3rd Sector Partners	Outputs	Comments

Other Notable Reportable Activity

5 Please detail key actions relating to Food and Drink, Biodiversity, Water, Procurement and Resource Use in the table below

Table 5

Key Action Type	Key Action Description	Organisation's Project Role	Impacts	Comments

6 Please use the text box below to detail further climate change related activity that is not noted elsewhere within this reporting template

None at the moment

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item : 5.9

Date of Meeting : **29 November 2017**

Title of Report : **Pharmacy Team Report**

Presented by : **Fiona H Thomson, HSCP Lead Pharmacist**

The Integration Joint Board is asked to :

Note the national policy relating to the pharmacy profession and the implementation of this within the HSCP.

1. EXECUTIVE SUMMARY

Prescription for Excellence[1] (PfE) published in 2013 set out the Scottish Government (SG) vision for pharmacy focusing on providing direct clinical care to patients with pharmacists working in or closely with GP practices. This year Achieving Excellence in Pharmaceutical Care[2] aligns the strategic direction for pharmacy with the direction of policy set out in the Health and Social Care Delivery Plan, the National clinical strategy, Pulling together, the Modern Outpatient Collaborative, Realistic Medicine, the Mental Health Strategy, and the six essential actions to improve unscheduled care. The SG vision is for pharmacy as an integral and enhanced part of modern NHS in Scotland.

Within Argyll & Bute Health and Social Care Partnership (HSCP) pharmacy services have been developed in line with the SG strategic direction. A range of pharmacy services to support GP practices have been introduced with the primary care investment funding and pharmacists delivering more direct patient care. The Pharmaceutical care being provided is person-centred and promotes safe, effective use of medicines.

2. INTRODUCTION

The report provides an overview of the strategic direction for pharmacy set out in Achieving Excellence in Pharmaceutical Care[2] and outlines the developments made to pharmacy services to date in Argyll & Bute and future plans for the service. Within the report there are examples of the pharmaceutical care being delivered by the team working with other health and social care practitioners to improve health of the population.

3. DETAIL OF REPORT

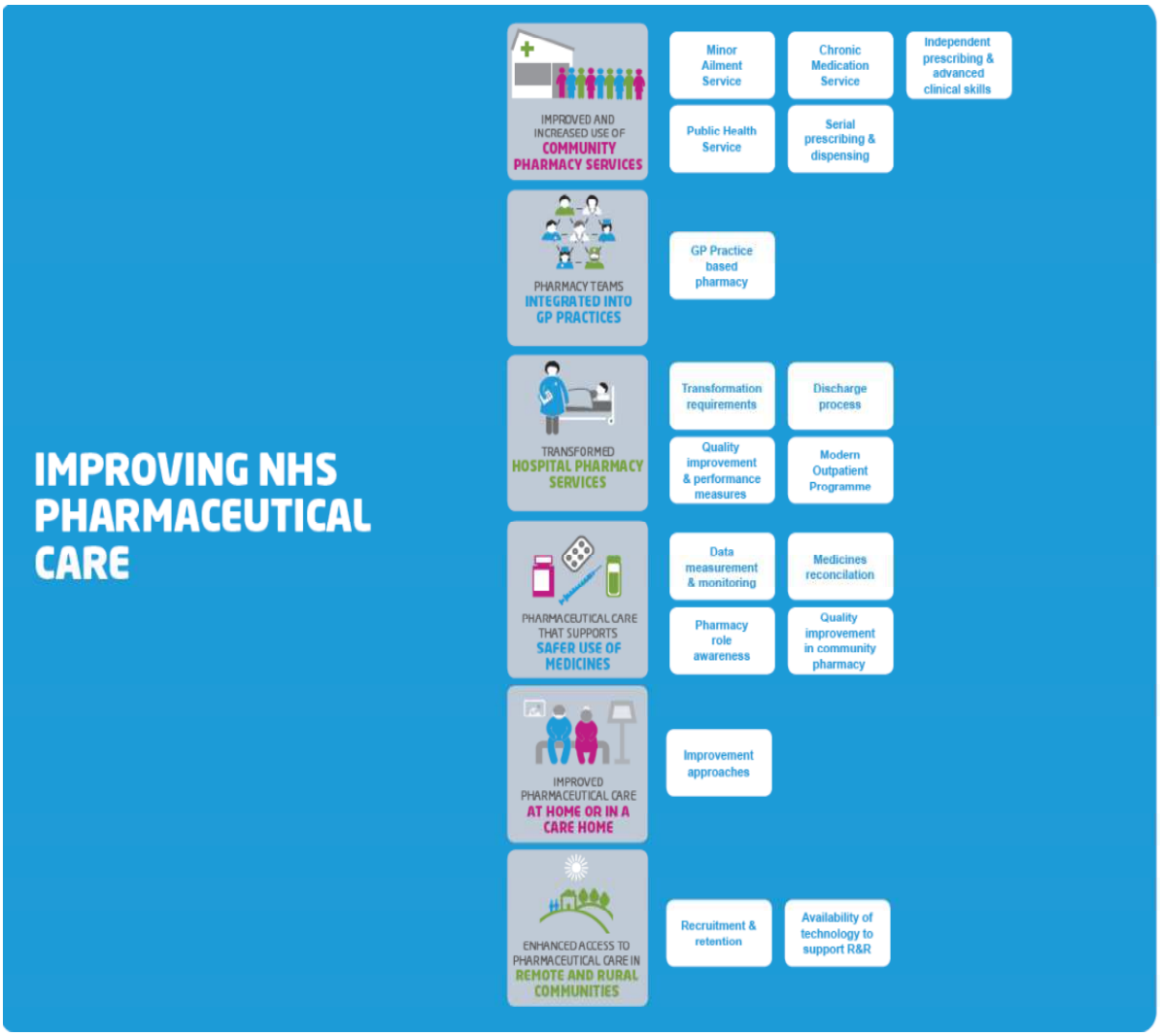
Achieving Excellence in Pharmaceutical Care

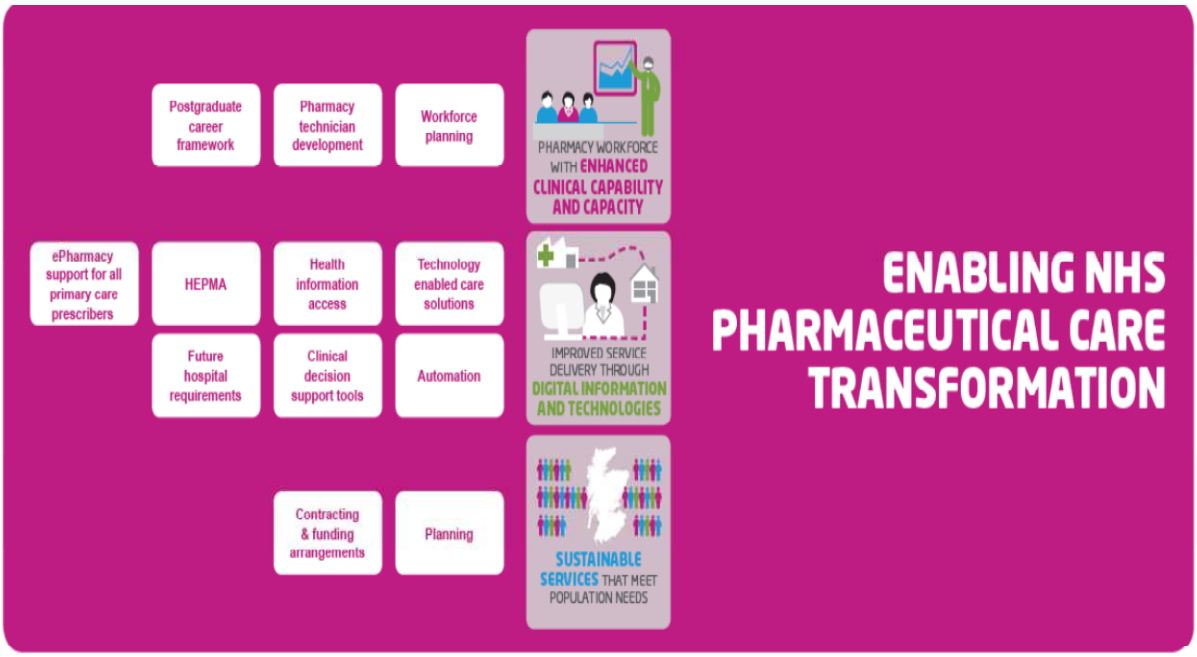
Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland aims to transform the role of pharmacy across all areas of pharmacy practice, increase capacity, and offer the best person-centred care. It sets out the priorities, commitments and actions for improving and integrating pharmacy and pharmacy services in Scotland.

Achieving Excellence in Pharmaceutical Care describes how pharmaceutical care will evolve in Scotland and the crucial contribution of pharmacists and pharmacy technicians, working together with other health and social care practitioners, to improve the health of the population and impact on health outcomes, especially for those with multiple long term and complex conditions.

Two main priorities are identified: Improving NHS Pharmaceutical Care and Enabling NHS Pharmaceutical Care Transformation. These priorities are supported by 9 commitments and 29 actions which focus on integrating and enhancing the role of pharmacy across all areas of pharmacy practice, increasing capacity, and offering the best person-centred care.

The diagram below is a summary of the 9 commitments and 29 actions.


IMPROVING NHS PHARMACEUTICAL CARE
IMPROVED AND INCREASED USE OF COMMUNITY PHARMACY SERVICES
Minor Ailment Service
Chronic Medication Service
Independent prescribing & advanced clinical skills
Public Health Service
Serial prescribing & dispensing
PHARMACY TEAMS INTEGRATED INTO GP PRACTICES
GP Practice based pharmacy
TRANSFORMED HOSPITAL PHARMACY SERVICES
Transformation requirements
Discharge process
Quality improvement & performance measures
Modern Outpatient Programme
PHARMACEUTICAL CARE THAT SUPPORTS SAFER USE OF MEDICINES
Data measurement & monitoring
Medicines reconcilation
Pharmacy role awareness
Quality improvement in community pharmacy
IMPROVED PHARMACEUTICAL CARE AT HOME OR IN A CARE HOME
Improvement approaches
ENHANCED ACCESS TO PHARMACEUTICAL CARE IN REMOTE AND RURAL COMMUNITIES
Recruitment & retention
Availability of technology to support R&R


Postgraduate career framework
Pharmacy technician development
Workforce planning
PHARMACY WORKFORCE WITH ENHANCED CLINICAL CAPABILITY AND CAPACITY
ePharmacy support for all primary care prescribers
HEPMA
Health information access
Technology enabled care solutions
Future hospital requirements
Clinical decision support tools
Automation
IMPROVED SERVICE DELIVERY THROUGH DIGITAL INFORMATION AND TECHNOLOGIES
Contracting & funding arrangements
Planning
SUSTAINABLE SERVICES THAT MEET POPULATION NEEDS
ENABLING NHS PHARMACEUTICAL CARE TRANSFORMATION

Pharmacy Services to support to GP practices

In June 2105 the Scottish Government announced three year funding to support primary care services including £16.2 million for investment in clinical pharmacists to support GP practices and an additional £4.2m is available to boards up to period 9 of 2017, based on actual costs incurred.

To utilise the primary care funding, introduce skill mix to the team the recruitment of a 1 wte Clinical Pharmacy Technician and 4.2 wte Clinical Pharmacists were agreed. The Clinical Pharmacy Technician took up their post on 1st of August 2016 and is supporting practices with savings, medicines reconciliation and will be undertaking post discharge visits. To date 3.2 wte Clinical Pharmacist have been recruited. Recruiting pharmacists to some areas has been challenging and the full time post for Cowal & Bute remains vacant. Allocating the available resources to GP practices across the large geographical area has also presented challenges and some practices do not currently have access to the services available. When the team is at full complement and training completed for pharmacists new into these roles, services will be rolled out to all practices.

These are some examples of the services being provided by the pharmacy team:

Medication reconciliation is the process of ensuring patients are prescribed the correct medicines, in the correct doses appropriate to their current clinical presentation and avoidable harm from medicines is reduced. This process is carried out when patients move between care settings. Pharmacist approach this task differently, undertaking additional checks and have increased patient and interface communication e.g. between hospital, GP practice and community pharmacies.
As well as pharmacy involvement in the process with hospitals in A&B, the primary care clinical pharmacists are undertaking this process in GP practices for patients with complex medication regimes. The clinical pharmacy technician has also been assisting with medicines reconciliation. During August and September 2017 the primary care pharmacists have undertaken 53 complex medication reconciliations.

Pharmacists have particular knowledge and skills in conducting **medication reviews** in people with multiple co-morbidities and/or polypharmacy, examples being:

- People with specific pharmaceutical care needs e.g. care home residents
- People with high numbers of repeats - use Scottish Therapeutics Utility (STU) to identify and review
- High cost, complex combinations of medicines.People with significant non concordance with medicines - use STU to identify and review

Medication reviews have been classified into four levels:

Level 0 - an **ad-hoc review** is not really a proper medication review (hence level 0) and is opportunistic and unstructured. It is usually something like a clarification of a dose or formulation, perhaps by a practice receptionist or community pharmacist.
Level 1 - a **prescription review** examines technical aspects of a prescription such as dose optimisation, brand to generic switches, and resolving quantity issues. It is not a clinical review and might be conducted by a trained member of practice staff, a community pharmacist or pharmacy technician.
Level 2 - **Treatment reviews** are the first level to require access to a patient's notes. They involve checking therapy is appropriate and adjusting doses. Treatment reviews should be conducted by a doctor, pharmacist or nurse.

Level 3 - **Clinical medication reviews** are the gold standard of medication reviews. They comprise a complete review of a patient's medication (including over-the-counter medicines) with the patient's input and access to the patient's notes. The aim is to evaluate the efficacy of all the patients' medicines, monitor progress, consider patient's preferences and expectations, compliance and address unmet needs. Such reviews should be conducted by a doctor, pharmacist or nurse. **Polypharmacy reviews** are level 3 reviews carried out using the polypharmacy guidance and should be conducted by doctor, pharmacist or nurse.

During August and September 2017 the team carried out:

9 complex medication reviews undertaken in clinic (patient are referred by clinicians)

45 medication reviews for patients prescribed high risk medication

20 care home patient medication reviews plus 223 level 1 reviews (pharmacy technician)

64 polypharmacy reviews

The pharmacist reviews a patients medication to ensure correct dosages, indications and for any interactions between medicines which may cause. Discussions with the patients focus on their understanding of their medicines and how to take them to get maximum benefit from them.

Pharmacist Prescribing

The regulations allowing pharmacists to be independent prescribers came into effect in 2006 and all pharmacists within Argyll & Bute undergo training to become prescribers. Currently six out of eleven pharmacists are prescribers and five are undertaking the course. Since 2006 the oncology pharmacist in the Lorn & Islands Hospital has been prescribing for this group of patients and both pharmacists within the hospital are prescribing for inpatients as part of the multi-disciplinary team. Within GP practices pharmacists are utilising their prescribing skills in clinics for hypertension, cardiovascular heart disease, diabetes and medication review.

Two senior pharmacists have completed an advanced clinical skills course to develop clinical skills in history taking, clinical assessment and examination. The course enables the pharmacist to identify and respond to new ways of working within a multi-professional team and across traditional boundaries. Currently in Oban as part of a multi-disciplinary frailty project, one of the pharmacists is using their clinical skills to review patients, carry out assessments and management of chronic conditions. Plans are being developed for the other pharmacist to utilise their skills within the Lochgilphead Medical Practice.

Post Discharge Visits

In August and September 2017 33 post discharge visits were undertaken by the pharmacy technicians, the purpose of the visits is to support patients at home with managing their medication following discharge from hospital. The types of intervention made are rationalisation of medication e.g. three times day to once daily, demonstration of inhalers, explanation of how to take medication, disposal of medication no longer required, and referral to GP practice for drug monitoring, blood pressure or blood tests.

Community Pharmacy

There are 26 community pharmacies in Argyll & Bute HSCP and they have an important role in the provision of NHS pharmaceutical care, providing highly accessible services for people both in-hours and out-of hours. The **Chronic Medication Service** (CMS) is one of the core pharmaceutical services provided by pharmacies. One aspect of CMS is **serial prescribing and dispensing**. A GP can issue prescriptions for up to a year to patients with long term conditions on stable medication regimens. Dispensing over the period of the prescription is arranged between the patient and their community pharmacist. Community pharmacists can monitor patient response to medicines over that time and report any concerns to GPs.

Although serial prescribing and dispensing has been part of the core community pharmacy contract for a number of years the uptake is low and the full benefits of the service are yet to be realised. Setting up serial prescribing and dispensing requires an investments in time to transfer patients onto the system and there are clear links it can reduce GP workload when fully implemented. One of the actions in Achieving Excellence in Pharmaceutical Care[2] is to maximise the use of this service to benefit people, utilise community pharmacy more effectively and ease workload on GPs.

In September 2017 funding has been provided by the SG to roll out the **Pharmacy First** initiative across Scotland. Pulling Together[3], the report of the independent review of the Primary Care Out of Hours Services highlighted that community pharmacists make an essential contribution to care both in daytime and during out of hours periods and they should have a greater profile and urgent care role going forward. The review recommended the extension of community pharmacy Patient Group Directions (PGDs) to enable assessment and management of a broader range of common clinical conditions. Based on work originally started in NHS Forth Valley, Pharmacy First enables community pharmacists to treat uncomplicated urinary tract infections in women and impetigo in children under PGDs. NHSH have plans to have the PGD for treatment of uncomplicated urinary tract infections to be in place for winter 2017.

Prescribing Efficiency

The pharmacy team continues to provide advice on cost effective rational prescribing and support practices to undertake projects to help the HSCP achieve finance balance in the prescribing budget.

4. CONTRIBUTION TO STRATEGIC PRIORITIES

Delivery of pharmaceutical care and the pharmacy service meets the following priorities:

- Promote healthy lifestyle choices and self-management of long term conditions;
- Reduce the number of avoidable emergency admissions to hospital and minimise the time that people are delayed in hospital;
- Support people to live fulfilling lives in their own homes for as long as possible;
- Support unpaid carers, to reduce the impact of their caring role on their own health and wellbeing;
- Efficiently and effectively manage all resources to deliver Best Value.

The pharmacy team use quality improvement methodology to review and improve services. Feedback and advice is also provided to prescribers to reduce variation and waste.

5. GOVERNANCE IMPLICATIONS

5.1 Financial Impact

Funding from Primary Care Investment funding is utilised to provide the service.

5.2 Staff Governance

Staff are employed by NHS Highland to provide service.

5.3 Clinical Governance

Service provided to set standards and using standard operating procedures. Staff work in line with NHSGGC medicines formulary and policies.

6. EQUALITY & DIVERSITY IMPLICATIONS

Not applicable as paper does not propose a change to patient services.

7. RISK ASSESSMENT

Not applicable as paper does not propose a change to patient services.

8. PUBLIC & USER INVOLVEMENT & ENGAGEMENT

Not applicable as paper does not propose a change to patient services.

9. CONCLUSIONS

This report gives an overview of the pharmacy services being provided in GP practices and the implementation of the national strategic direction for pharmacy within Argyll & Bute HSCP. Progress has been made in implementing new ways of providing person-centred care and will continue to evolve to ensure pharmacy is an integrated part of the services within the Argyll & Bute HSCP.

References:

1. Prescription for Excellence: A Vision and Action Plan for the right pharmaceutical care through integrated partnerships and innovation. Scottish Government September 2013 www.gov.scot/Resource/0043/00434053.
2. Achieving Excellence in Pharmaceutical Care: A Strategy for Scotland. Scottish Government August 2017. http://www.gov.scot/Publications/2017/08/4589
3. Pulling Together: transforming urgent care for the people of Scotland December 2015 http://www.hub.careinspectorate.com/media/268698/sg-report-of-independent-review-of-primary-care-out-of-hours-services.pdf.

Argyll & Bute Health & Social Care Partnership

Integration Joint Board

Agenda item: 5.10

Date of Meeting: **29 November 2017**

Title of Report: **Chief Officer Report**

Presented by: **Christina West**

The Integration Joint Board is asked to :

Note the following report from the Chief Officer

Lorn & Islands Hospital Open Day

Lorn & Islands hospital held an Open Day on Saturday 28th October to provide an opportunity for members of the public in Oban and surrounding areas to find out more about the wide range of hospital and community services that the HSCP provides for the local community.

There were a wide range of stalls and displays on the day and the public had an opportunity to meet health and social care professionals as well as representatives from partner organisations.

The Open Day was very successful with well over 100 members of the public coming along. A range of photographs from the day, as well as some short video clips, can be viewed on the HSCP Facebook page at www.facebook.com/abhscp

Evidence to Scottish Parliament Committees

The HSCP was invited to give evidence to 2 Scottish Parliament Committees in October and the Head of Strategic Planning and Performance attended both committees on behalf of the HSCP. A short summary of the topics discussed is included below.

Rural Economy and Connectivity Committee - evidence provided on the specific requirement regarding "Island Impact Assessment or Island Proofing" with respect to Health and Care Services.

Health and Sports Committee – evidence provided on Technology and Innovation in Health and Social Care.

New Head of Human Resources Department

Sandy Wilkie has been appointed as Head of HR for the HSCP. Sandy has 20 years of HR experience across both the private and public sector and has worked for a wide range of organisations including the MOD, Scottish & Newcastle Breweries, Standard Life and the University of St Andrews.

Drama Used to Highlight Issues Affecting Young People in Argyll and Bute

Young people in all Council secondary schools in Argyll and Bute have been benefiting from an innovative and stimulating drama performance. The play, called 'You are not alone' was held to promote 'Smoke Free' messages to students in S3. The powerful performance also used comedy to address a range of issues identified as relevant by young people and staff working with young people.

Following the performance there were workshops supported by staff from local services such as: school nursing teams, stop smoking staff, youth work, sexual health and cool2talk (an online health information service for young people 12-26).

There was also close partnership working between health staff, education, youth service and teachers to produce the drama project and develop lesson plans. This will help direct young people to where they can go for information, advice and support when they are faced with challenging life experiences.

Be Mouthaware: 45 Seconds Could Save Your Life

Mouth Cancer Action Month takes place throughout November and is organised by the Oral Health Foundation. With around 7,000 people across the UK diagnosed with mouth cancer last year, the disease is one of the UK's fastest increasing cancers, with cases rising by a third in the last decade alone.

The HSCP has been supporting Mouth Cancer Action Month to raise awareness of mouth cancer across Argyll and Bute and to make people more Mouthaware and recognise the early warning signs of mouth cancer.

With awareness of the disease remaining alarmingly low, a simple 45 second check is often all that's needed to identify anything unusual and be able to then seek professional guidance.

Early diagnosis transforms the chances of beating mouth cancer from 50 per cent to 90 percent so it is crucial that we know what to look out for and that we do not hesitate in seeking advice from a health professional.

Integration Joint Board Webpage Developments

The current Integration Joint Board webpage provides a range of information about the IJB including details of forthcoming meetings, minutes from previous meetings and a list of IJB members.

This page is being developed further so that members of the public from across Argyll and Bute can find out more about the role and remit of IJB members. This new page will be operational by the end of the year and will include a short biography of each member, an individual photograph of each member and also a short video clip from members outlining their role on the IJB.

Annual Learning Awards Ceremony

The Chief Officer and Interim Head of Service (East) attended the Annual Learning Awards Ceremony on the 3rd November in the Council Chambers in Kilmory to recognise employees from across Argyll and Bute Council who had achieved a professional, academic or vocational qualification linked to their role.

Included in the awards ceremony were 21 social work staff who had achieved a range of qualifications.

Cowal GP Wins Doctor Award

Cowal GP, Dr Glen Hall, was one of the winners at the Scottish Health Awards which were held at the beginning of November in Edinburgh. Dr Hall was nominated as Doctor of the Year by one of his patients.

Mid Argyll Hospital Macmillan Coffee Morning

On Friday 27th October the administration staff at Mid Argyll Hospital, along with the local Macmillan Cancer Support Group, held a coffee morning and sales table. This event is held annually to raise funds for Breast Cancer Pink Day and Macmillan Cancer Support. The day is a popular event on the social calendar and is always extremely well supported by staff, patients and members of the public.

The fantastic sum of £2100 was raised on the day and was split between the 2 charities. Over the 11 years since this event started £22,577 has been raised which is an amazing achievement. Thanks are extended to all.

Feedback from the 'The Country Council' Series

There has been a wide range of positive feedback from 'The Country Council' programme which was broadcast recently on BBC One. This programme highlighted a wide range of HSCP, Council and partner agency services from across Argyll and Bute and not only did it outline the dedication that employees have to their local communities but it also highlighted the attractiveness of Argyll and Bute as a place to live and work.

Health and Care Experience Survey

The 2017 Health and Care Experience Survey was launched by the Scottish Government in November. The survey is designed to help support the national health and wellbeing outcomes and will include questions about aspects of care, support and caring as well as gathering views about local primary health services.

The survey is sent to a sample of people who are registered to a GP Practice and the last survey attracted over 100,000 responses nationally. The results of this latest survey will be published in the Spring of 2018. Further information can be accessed at: www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey.