AGENDA ITEM NO: 7

Report To:	**Inverclyde Integration Joint Board**	**Date: 26th January 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership (HSCP)**	**Report No: IJB/07/2016/HW**
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Subject:	**BUSINESS UPDATE**	

1.0 PURPOSE

1.1 The purpose of this report is to update the Integration Joint Board on a number of key workstreams that are currently underway or are projected to require HSCP or IJB action.

2.0 SUMMARY

2.1 The integration landscape and requirements of Integration Joint Boards are still evolving. As Scottish Government Policy is shaped around this agenda, it is important the IJB members are advised of emerging policies, issues or HSCP workstreams that are responding to specific situations. This paper provides a brief summary of such workstreams that are currently or soon to be live.

3.0 RECOMMENDATION

3.1 That the Integration Joint Board notes the business update report and advises the Chief Officer if any further information is required.

Brian Moore
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Inverclyde Health & Social Care Partnership

4.0 BACKGROUND

4.1 This report highlights current and emerging reports and workstreams that IJB Members should be alert to.

4.2 Pulling Together: Transforming Urgent Care for the People of Scotland

This Scottish Government report relates to the independent review of Primary Care out of hours services, published at the end of November 2015. The report considers access to urgent primary medical services outwith normal GP surgery hours, and options for future delivery in the context of HSCPs, Scotland's ageing population, and the NHS 2020 Vision.

4.3 It is timely to consider future options, as HSCPs will have responsibility for planning unscheduled care across all local health and social care services, including hospital and out of hours.

4.4 The Scottish Government is considering its response to the report, and is expected to publish its intentions in late January or early February 2016, after which a further update will be brought to the IJB. The key areas the Scottish Government will focus on are likely to be:

- Care at night and at the weekend
- Current best practice
- High quality and safe experience (both patients and staff)
- Agreeing core service requirements out of hours, including roles and skills needed
- Agreeing national and local standards
- Testing new models.

This is in line with the strategic commissioning themes that underpin our Strategic Plan, so we anticipate that the Review will become a core reference document over the next few years. The review can be found at:
http://www.gov.scot/topics/health/services/nrpcooh

4.5 Strategic Plan Update

Since the last meeting of the IJB, the Strategic Planning Group has been working on further developing the substantive Three-Year Strategic Plan. Since the last IJB update, the Strategic Needs Assessment, which is an important companion document to the Plan, has been considerably advanced in response to stakeholder comments. The level of participation in both the Plan and the Needs Assessment has been extremely helpful in providing assurance that the process has been truly inclusive. We are still on schedule for the full draft to be presented to the March 2016 meeting of the IJB.

4.6 Primary Care New Ways of Working

General Practice is under considerable pressure from the compounding problems of a workforce shortage and an increasing workload. It is recognised that one of the major concerns in the health and social care system at present is that few of the professionals involved are truly working to 'the top of their licence' i.e. many are engaged in a significant proportion of tasks/activity that can be more effectively done by others.

The role of the General Practitioner and other professionals in Primary Care, in future must be able to make best use of the unique experience and skills of each, if we are to successfully address the health needs of individuals and communities, and achieve the intended outcomes of the Scottish Government's 2020 vision.

In order to improve outcomes, GPs needs to be freed up from activities that do not

require GP involvement but which will require other health and social care professionals to become more accessible.

Inverclyde HSCP is at the early stages of working with the Scottish Government, the BMA and the RCGP to pilot changes and inform the development of a new GP contract. As the project develops further updates will be provided in due course.

4.7 Audit Scotland Report: Health and Social Care Integration

In November 2015 Audit Scotland published a report on their view of progress in integrating health and social care across Scotland. The report notes the difficulties across the country in agreeing budgets, and highlights that the uncertainty around future funding levels is creating difficulties in developing meaningful Strategic Plans.

The report also recognises some of the pressures introduced by the legislation, such as that the required governance arrangements are complex and there is potential uncertainty as to how they will work in practice and that the range of plans required will be difficult to deliver to short timescales.

The purpose of the report is to provide a progress report during the transitional year (2015/16) and an indication of the emerging arrangements across the country. All areas apart from Highland have chosen to follow the body corporate model.

The key findings reported are:

- The scope of services being integrated varies widely across Scotland, and most IJBs will oversee more than the minimum requirement.
- Ten Authorities (including Inverclyde) will also integrate children's social work services.
- All authorities will integrate children's health services.
- Half (16) of the authorities will integrate criminal justice social work services.
- Two authorities (Argyll & Bute and Dumfries & Galloway) will integrate planned acute health services.
- Councils and NHS Boards are finding it difficult to agree budgets, and the report recognises that the results of the UK spending review were not announced until November 2015, and that the Scottish Government only published its financial plans on 16 December 2015. The implications of these need to be fully scoped and analysed before budgets can be finalised.
- At the time of the report there was still considerable uncertainty about set-aside budgets for acute services, how these would be calculated, and how control would be transferred to Integration Authorities.
- The financial issues are noted as being compounded by different planning cycles for NHS and local authorities, in that they agree budgets at different times.
- The report recognises that across the country it has not been possible to develop Strategic Plans that set a blueprint for the redesign of future service delivery. Instead they simply reflect existing arrangements. The most significant gaps noted in the report are in relation to budgets and workforce resources, but it is recognised that these will take time to accurately identify.
- Another important gap in strategic planning across the country relates to what level of acute services will be needed in each area, and how to shift resources out of acute and towards preventative and community-based care.
- The identification of performance measures that directly relate to the national outcomes is also proving difficult.
- Other challenges include meaningful locality planning; GP and clinical engagement; and service user and voluntary organisations engagement.

A number of these issues have also been identified in Inverclyde, however the publication of this report should support a national approach to resolving them. The full report can be found at:
http://www.audit-scotland.gov.uk/report/health-and-social-care-integration-0

4.8 Facilitating the Journey of Integration

The Scottish Government has issued a toolkit to support IJB members in understanding their roles and responsibilities so that they can oversee HSCPs and ensure that they will make a transformative difference to the outcomes of people who rely on health and social care services. The toolkit is called "Facilitating the Journey of Integration" and is appended to this report. In response to earlier discussions between IJB members and officers, a development session is being set up for early February 2016, to consider the detail of how the IJB should function. Members might wish to consider using the toolkit as a framework for some of the discussions at that session.

4.9 NHSScotland Chief Executive's Annual Report 2014/15

This Annual Report was published in December 2015 and re-states the NHS 2020 Vision for Health and Social Care, in that by 2020 everyone is able to live longer, healthier lives at home, or in a homely setting.

This is entirely in line with the HSCP vision and values, and the report goes on to focus on some of the issues that have also been identified in Inverclyde. For example, it highlights that there has been a steady reduction in premature deaths, but also that there is still much to be done – a position that is echoed by our strategic needs assessment. Some important reductions in service waiting times are highlighted, noting that by reducing waiting times, treatment can often be more effective, and the patient experience of the service is generally more positive.

The report emphasises a commitment to ensure that patient complaints and feedback are used to influence change, and this is an ambition that Inverclyde HSCP also shares.

Although the report focuses mainly on community and hospital health services, the principles underpinning it are entirely in line with Inverclyde HSCP's commitment to improving lives through joined up and integrated services that make sense to the people who use them.

4.10 Scotland's National Action Plan for Human Rights

Scotland's National Action Plan for Human Rights proposes that organisations are enabled and accountable to put human rights into practice. This infers that the IJB should agree a strategic priority to increase local people's understanding of human rights and their confidence in claiming those rights.

The Scottish Government has asked that public bodies support and promote the human rights awareness raising plans, and has produced a campaign toolkit (appended) to support a consistent approach.

The Government has also expressed a keenness to explore ways in which to build a positive human rights culture in Scotland, in the context of the Public Service Reform agenda. Whilst this campaign is targeted at members of the public, the Government has invited all public bodies to support and promote it through their own networks and channels. The Report can be found at:

http://www.gov.scot/Resource/0049/00490412.pdf .

5.0 PROPOSALS

5.1 The content of this report is for noting only, and to ensure that IJB Members are informed about the business of the HSCP.

6.0 IMPLICATIONS

Finance:

6.1 There are no financial implications in respect of this report.

Financial Implications:

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
N/A					

Legal:

6.2 There are no legal implications in respect of this report.

Human Resources:

6.3 There are no human resources implications in respect of this report.

Equalities:

6.4 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO - This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

7.0 LIST OF BACKGROUND PAPERS

7.1
- Health and Social Care Integration
- Scotland's National Action Plan for Human Rights
- Pulling Together: Transforming Urgent Care for the People of Scotland
- NHSScotland Chief Executive's Annual Report 2014/15
- Facilitating the Journey of Integration

The Scottish Government
Riaghaltas na h-Alba

Health and Social Care Integration

Public Bodies (Joint Working) (Scotland) Act 2014

Facilitating the Journey of Integration

A Guide for those supporting the formation of Integration Joint Boards

HEALTH AND SOCIAL CARE INTEGRATION

Contents

1. Introduction

1.1 The public sector reform agenda

In 2011, Campbell Christie produced a report, commissioned by the Scottish Government on the future delivery of public services. The Christie Commission, called for organisations delivering public services to work together and integrate in order to provide a more efficient and effective service to people. Amongst his key recommendations he urged that "public service providers must be required to work much more closely in partnership, to integrate service provision and thus improve the outcomes they achieve"; and that "our whole system of public services – public, third and private sectors – must become more efficient by reducing duplication and sharing services wherever possible".

1.2 Health and social care integration

The integration of health and social care is part of the Scottish Government's ambitious programme of public sector reform. It embodies the recommendations of the Christie Commission in that it aims to improve outcomes for those who use health and social care services by requiring those services to integrate.

The Public Bodies (Joint Working) (Scotland) Act 2014 came into force on 1 April 2014. It provides the legislative framework for the integration of health and social care in Scotland. It requires local integration of adult health and social care services, with Health Boards and Local Authority partnerships deciding whether to include other services in their integrated arrangements.

The vision for Health and Social Care Integration in Scotland

Ensuring better outcomes for people where users of health and social care services can expect, for themselves and those that they care for, to be listened to; to be involved in not just in deciding upon the care they receive, but to be an active participant in how it is delivered; and to enjoy better health and wellbeing within their homes and communities as a result.

Shona Robison, Cabinet Secretary for Health and Wellbeing and Sport has stated that:

"We want those who use health and social care services to have integrated care – services that work together to give the best outcomes based on that person's personal circumstances."

1.3 The wider context

It is important to remember that health and social care integration is part of a wider agenda of public sector reform. These reforms are vital to ensure the sustainability of our public services and to deliver better outcomes for those that use them.

The reforms are focused on joining up public services, organisations working together and improving outcomes for the most vulnerable people in our society. Success will ensure the sustainability of health and social services and wider public services not just for now, but also for years to come.

Integration Joint Boards need to pursue the principles of reform as a fundamental part of their role. They must work closely with other public services and also the third, independent and private sectors, to integrate service provision, use resources effectively and direct spend towards prevention and early intervention.

In this context community planning partnerships provides a pivotal vehicle for achieving effective public service reform at local level. By working with partner bodies in Community Planning Partnerships, Integration Joint Boards (IJBs) can build close connections with local communities, and shape and target the collective use of local public service resources towards integrated and efficient approaches.

This change and will require clear and cohesive leadership across all levels of the partnerships involved and confident and focused governance arrangements will be critical to getting this right.

1.4 Who is this guide for?

This guide is designed for use by a broad audience of those helping to support Integration Joint Boards as they establish themselves and begin to formulate their shared strategic vision for the partnership.

In considering the unique support requirements of Integration Joint Boards and their members, it is important to recognise that individual members will bring a variety of different skills, knowledge and understanding of particular issues to the Board. As a result, some material within the guide may be of more use to some members than others.

It is recommended that to support development approaches, IJBs start to collect data and insights that allow for the establishment of individual and collective development programmes. This will help to ensure that IJB members have the skills, knowledge and support to carry out their roles and ensure that they effectively scrutinize the governance arrangements which are in place.

The approaches detailed in this document are suggestions that can be used to begin the process of data collection, however, there is no requirement to

undertake the activities outlined and those providing support to Boards are free to pursue alternative approaches should they wish.

The majority of partnerships have implemented the 'body corporate' model of integration and therefore have an Integration Joint Board, but this resource could equally be of use for those in a governance role in partnerships based on the 'lead agency' model. However, for ease of use, the resource will refer to the Integration Joint Board throughout.

1.5 The aim of this guide

The resource highlights the important roles that are required to make the integration of health and social care a success. It is structured around providing key pieces of information followed by 'development exercises' that can be used to support the effective development of an Integration Joint Board, either individually or collectively. .

This guide focuses on three main areas:

1. How can an Integration Joint Board make a difference to people's lives in delivering integrated health and social care services through the principles of integration?
2. What may be different about being a member of an Integration Joint Board?
3. How can members make a difference on an Integration Joint Board? What skills and experience do members bring from their respective backgrounds?

1.6 How to use this guide?

This resource works at an individual and collective level and can be used to stimulate discussion, affirm purpose and create conditions for effective team working. It can be used to help create a development plan for the Integration Joint Board or as an on-going reflective resource to support the strategic vision.

It aims to help develop reflective thinking in order to support:

- Identification of the collective and individual roles required to carry out the responsibilities of an Integrated Joint Board;
- Reflection on how an Integration Joint Boards will exercise collaborative leadership to achieve the outcomes for integration;
- The principles of integration being visible throughout all Integration Joint Board work;
- Discussion on how Integration Joint Boards can make a difference;
- Acknowledgment that all Integration Joint Board members come with rich but sometimes differing experience and perspectives; and
- The development of a shared understanding and appreciation of integration and how collective thinking can contribute to improving outcomes for people.

There may be times where the responses to some of the questions and development exercises create a range of different and opposing thoughts from board members. Acknowledging and working through these areas of difference will be important and could provide the greatest opportunities for learning for an Integration Joint Board as it navigates its way through new ways of working.

It is important to recognise that things will change as integration progresses. Using this guide at different points along the path of integration may illicit different responses to areas. Integration Joint Board may therefore want to revisit discussions over time to assess where members are at with their thinking.

DEVELOPMENT EXERCISES

DEVELOPMENT EXERCISE 1 - MAPPING OUR INTEGRATION JOINT BOARD

MAPPING OUR INTEGRATION JOINT BOARD

This exercise is to highlight where the key relationships are between the Health and Social Care Partnership and the other planning and delivery organisations that contribute to health and social care.

Given that the Integrated Joint Board sits within a complex system with different relationships with other organisations, this exercise has been developed to explore what that may mean to the Integration Joint Board members.

Activity

Ask the Integration Joint Board members to work in small groups to draw the partnership and where it sits in relation to the NHS Board, the Local Authority, the Community Planning Partnership and any other significant delivery organisations.

Use discs or other shapes to represent the organisations or draw them freehand. Then using tracing paper put a layer over the shapes and then draw in the relationships, reporting and communication channels between the partnerships and the other organisations.

- What does this map look like?
- Is there agreement in the group and across the groups?
- Is there a common perspective that emerges?
- How does this relate to me as an Integration Joint Board member?

Notice how much agreement there is on the relationships and where organisations sit, discuss different perspectives. Is there a common perspective that emerges?

DEVELOPMENT EXERCISE 2 -NATIONAL HEALTH AND WELLBEING OUTCOMES

Successful health and social care integration will be measured against the nationally agreed outcomes.

These outcomes, set out below, should be the focus for all the work of the Integration Joint Board.

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

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

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

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

5. Health and social care services contribute to reducing health inequalities.

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

7. People who use health and social care services are safe from harm.

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

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

The National Health and Wellbeing Outcomes Framework has been published and can be accessed here.

The accompanying measurement framework which supports the Integration Joint Board to identify the indicators that are appropriate to them can be accessed here.

DEVELOPMENT EXERCISE 2 - NATIONAL HEALTH AND WELLBEING OUTCOMES

NATIONAL HEALTH AND WELLBEING OUTCOMES

The use of outcomes in measuring success will be familiar to some Integration Joint Board members and not so familiar to others. Each Integration Joint Board will select the indicators that they will use to show whether an outcome is being achieved or worked towards.

It is crucial that Integration Joint Board members understand what the outcomes are and how they will be achieved, but also that they should be the focus of the partnership.

- Are Integration Joint Board members comfortable about the difference between an outcome, input, output and process?

- How do Integration Joint Board members know if the indicators the Integration Joint Board are using let them know the real extent to which national outcomes are being met?

- How are these high level outcomes translated into something meaningful for your Integration Joint Board to tackle?

DEVELOPMENT EXERCISE 3 - THE PRINCIPLES OF INTEGRATION

The integration planning and delivery principles are the lens through which all integration activity should be focused to achieve the national health and wellbeing outcomes. They set the ethos for delivering a radically reformed way of working and inform how services should be planned and delivered in the future.

The principles also set a clear tone for both the national guidance and local implementation of the Public Bodies (Joint Working) (Scotland) Act 2014.

The main purpose of the integration planning and delivery principles is to improve the wellbeing of service-users and to ensure that those services are provided in a way which:

- Are integrated from the point of view of service-users
- Take account of the particular needs of different service-users
- Takes account of the particular needs of service-users in different parts of the area in which the service is being provided
- Take account of the particular characteristics and circumstances of different service-users
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- Respects the rights of service-users
- Take account of the dignity of service-users
- Take account of the participation by service-users in the community in which service-users live
- Protects and improves the safety of service-users
- Improves the quality of the service
- Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care)
- Best anticipates needs and prevents them arising
- Makes the best use of the available facilities, people and other resources

Guidance on the planning and delivery principles which describe how integrated care should be planned and delivered and how the principles will work in tandem with the National Health and Wellbeing Outcomes can be accessed here – Integration Planning and Delivery Principles.

DEVELOPMENT EXERCISE 3 – THE PRINCIPLES OF INTEGRATION

PRINCIPLES OF HEALTH AND SOCIAL CARE INTEGRATION

The following statements have been developed to help Integration Joint Boards consider how well they are embedding the principles of integration.

As an Integration Joint Board , each member should indicate where they feel t board sits on the following statement with 1 strongly agree and 5 strongly disagree

The Integration Joint Board should collectively look at the responses and;

- consider the differences and similarities
- reflect on what they might mean
- identify potential areas and opportunities for improvement

Please give a rank to the domains below in terms of the development required by the Integration Joint Board	**Scale: 1 = Strongly agree to 5 = Strongly disagree**				
Focus on service users The Integration Joint Board is assured that the needs of individual service users are met with respect, dignity and safety.	**1**	**2**	**3**	**4**	**5**
Focus on communities The Integration Joint Board is assured that the services developed and delivered within their localities reflect full engagement with their communities and will deliver improved outcomes for local people.					
Resources and accountability The Integration Joint Board is confident that it will deliver on its strategic priorities, effectively manage associated risks and that it makes the best use of available resources.					
Board dynamics Integration Joint Board members are motivated individuals who have the right blend of skills and experience to help deliver the strategic intent. Board members work constructively together in a climate characterised by informed trust, involvement and robust dialogue.					
Leadership The Integration Joint Board is confident that it has the conditions to support collaborative leadership and that every member's voice is heard and valued.					

DEVELOPMENT EXERCISE 4 – THE ROLE OF AN INTEGRATED JOINT BOARD AND ITS MEMBERS

The principles and outcomes that have been developed for integration are designed so that the people in your communities have the best possible services which are tailored to local circumstance and deliver high quality results. The role of Integration Joint Board member is to ensure that this is central to the decision-making process.

Making decisions about how integrated health and social services are planned and delivered for communities both now and in the future presents Integration Joint Boards with their most significant challenge but it also has huge opportunities for all parties. Working with complex multi-faceted problems will require a collective wisdom and approach that seeks to draw on all the assets of the Integrated Joint Board members and the communities and groups they serve. There will be difficult decisions to be made on the journey of integration and how the Integration Joint Board approaches these will be crucial in defining its success.

It is important to acknowledge that with so many different stakeholders and interests represented on the Integration Joint Board it is likely that there will be times of disagreement from respective organisational points of view. It is therefore important to remember that when members sit on an Integration Joint Board they are representing the interests of the Integration Joint Board. They will have been nominated by their parent organisations and must act in the best interests of the Integration Joint Board. This may at times mean decisions are made that do not sit easy with colleagues in their parent organisations or indeed with communities and members of the public. It is therefore important that the principle of collective decision making is reinforced and Integration Joint Board members accept that once decisions have been agreed, they may need to function as a community leader to make sure the changes which have been agreed happen.

Constructive challenge and discussion within Integration Joint Boards is imperative. Rigorous scrutiny of proposals that are put before the Integration Joint Board will help to justify potentially difficult and unpopular decisions .Integration Joint Boards should ensure that appropriate professional advice from your fellow Integration Joint Board members and others is sought as appropriate. Adopting this approach as individuals and as a collective will enable the successful redesign of pathways of care and ensure that the co-productive nature of the Integration Joint Board is maintained.

DEVELOPMENT EXERCISE 4 – THE ROLE OF AN INTEGRATED JOINT BOARD AND ITS MEMBERS

INTEGRATION JOINT BOARD - DECISION-MAKING ARRANGEMENTS

The following issues for consideration have been developed to help Integration Joint Board discuss and reflect on decision-making arrangements. It will help clarify how Integration Joint Boards will engage with and ensure that all members contribute to the business of the board. The purpose is to generate discussion and reflection on 'how' the Integration Joint Board works together. Exploring different perspectives will enrich how the Integration Joint Board works together and forms their own ways of reaching agreement

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Issues for consideration

- How do we as an Integration Joint Board make decisions around areas where members may have different opinions?
- As an Integration Joint Board member you may be in a position where the decisions that are agreed by the board do not reflect your own views. How will you provide effective leadership in these circumstances?
- As an Integration Joint Board member you may at some point have a conflict between the goals of the Integration Joint Board and that of your parent organisation. What preparation and support can you draw on to work this through, when it occurs?
- How do we, as an Integration Joint Board, ensure transparency in our decision-making?
- How do we ensure the Integration Joint Board works collectively and 'corporately' to achieve best improved outcomes across the Health and Social Care Partnership?
- How will the Integration Joint Board hold itself to account for its decisions?
- How do we ensure the Third and Independent sectors in the Integration Joint Board feel included and involved in deliberations. How do we evidence this?
- How will we ensure engagement with relevant stakeholders not on the Integration Joint Board, and facilitate their contribution?
- How will we ensure the voices and perspectives of all members are equally considered in our decision-making processes
- How do we know if the Integration Joint Board strategy, vision and principles are collaborative and integrated?
- What difference will we notice when the Integration Joint Board vision, strategy and principles of integrations are upheld or implemented?

DEVELOPMENT EXERCISE 5 - MEMBERSHIP OF THE INTEGRATED JOINT BOARD

The job of the Integration Joint Board is to help shape the development of integrated arrangements and decide how best to plan and oversee the delivery of the functions that have been delegated to it. The Integration Joint Board is made up of voting and non-voting members. It is important to understand the following:

- Voting membership must have parity in terms of membership, the Local Authority and the Health Board who make up the voting cohort must agree on the same number of representatives to sit on the Integration Joint Board.
- The Integration Joint Board must have a minimum membership which is outlined in the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014.
- The Integration Joint Board can add additional non-voting members to the Board if there is agreement.

It will be important for Integrated Joint Board members to have a clear understanding of the the role they hold and those of other members of the Integration Joint Board. Below is a description of the varying roles that must make up the membership of an Integration Joint Board

Local Authority and NHS Members (Voting members)

These members are nominated in equal numbers by the Health Board and Local Authority. Their role is to bring the perspectives of their parent organisation onto the Integration Joint Board and help shape the strategic direction of the Integration Joint Board to improve outcomes for their communities.

Advisory Members (Non-voting)

The non-voting members of the Integration Joint Board are there to provide advice and support to ensure that the integration of services makes a difference for the people using them and being supported by them

- **Chief Officer** of the Integration Joint Board is the single point of accountability for integrated services. They are appointed by the Integration Joint Board and are responsible for the development, delivery and oversight of the Integration Joint Boards Strategic Plan.
- **The Section 95 Officer (Chief Financial Officer CFO)** of the Integration Joint Board is statutorily responsible for the financial assurance and accountability of the Integration Joint Board.
- **The Chief Social Work Officer** of the constituent Local Authority has the statutory responsibility with regards to the governance of social care services.
- **A General Practitioner**, appointed by the Health Board, is required to provide advice to the Integration Joint Board on matters relating to primary care services and represent the GP and primary care communities.
- **A Secondary Medical Care Practitioner**, employed by the Health Board is required to provide advice to the Integration Joint Board on matters relating to the Secondary Medical Care and represent Secondary Medical Care Practitioner more broadly.

- **A Nurse representative**, employed by the Health Board; is required to provide advice to the Integration Joint Board on matters relating to nursing and represent the views of the nursing community more broadly.
- **A staff-side representative** is expected to provide advice on staff issues to the Integration Joint Board and to report to their membership on the topics discussed at meetings. These individuals are non-voting members of the Integration Joint Board.
- **A Third Sector representative** is required to provide advice to the Integration Joint Board on matters relating to Third Sector and represent the views of the Third Sector more broadly.
- **A carer representative**; is required to provide advice to the Integration Joint Board on matters relating to carers and represent the views of the carers community more broadly.
- **A service user representative**; is required to provide advice to the Integration Joint Board on matters relating to service users and represent the views of the service users more broadly

DEVELOPMENT EXERCISE 5 - MEMBERSHIP OF THE INTEGRATED JOINT BOARD

BUILDING RELATIONSHIPS

The following issues for consideration have been developed to help the Integration Joint Board discuss and reflect on how they will develop and build effective relationships to deliver the vision and principles of integration. They can be used in a variety of ways, through paired discussions, group discussion or whole board reflection. However they choose to use them, the purpose is to build trust, communication and understanding between Integration Joint Board members.

- What do we value about working in partnership?
- What is important to us in working together, what do we need to be present?
- How do we demonstrate the principles for integration in how we work?
- What might get in the way of this and how would we deal with these situations?
- What people skills are important for us in these roles?
- What does effective collaboration look and feel like as an Integration Joint Board member?
- How will we build trust across the Integration Joint Board, what are our /my roles in this?
- How will we work with challenge, difference or disagreement to reach decisions that improve outcomes for people?
- If we get ‘stuck’ how will we notice this and move forward?
- Where will we seek help and support to help us to continually develop?
- How will we recognise and celebrate success?

DEVELOPMENT EXERCISE 6 - ORGANISATIONAL CULTURE

Bear in mind that all Integration Joint Board members will come from different organisations, some with political backgrounds and alliances.

The issues that an Integration Joint Boards will face will be challenging and it is essential that in taking this forward the business of the Integration Joint Board it is conducted in line with the Ethical Standards in Public Life etc. (Scotland) Act 2000.

CULTURE OF THE INTEGRATION JOINT BOARD

Public, Third and Independent Sector services have very different; ever changing and evolving cultures

The culture of Integration Joint Board will be different from members 'parent' organisations in that it will be bringing together a variety of cultures. The challenge for the Integration Joint Boards will be to bring the best from these existing cultures and establish the essential elements within Integrated Joint Boards as they plan and commission integrated services.

There are lots of different elements that shape culture. The following questions have been developed to prompt discussion across the Integration Joint Board membership to help them to acknowledge culture differences, celebrate what is good already about culture and how they can help to shape new culture.

- What are the symbols which mark a healthy work culture?
- What do we want to highlight as important now?
- What are the aspects of our culture that we wish to focus on?
- How do we model these aspects in our leadership role?
- Do we understand our informal culture creators?

DEVELOPMENT EXERCISE 7 - LEADERSHIP

The leadership role of a member of the Integration Joint Board is complex; invariably requiring members to juggle competing demands and deal with complex situations. Some of the skills required to successfully fulfil the role of an Integration Joint Board member include collaborative and collective working, self-awareness and astute governance.

In relation to meeting governance and accountability expectations, maintaining a focus on the national outcomes for people will enable these commitments to be met. In working this way as an Integration Joint Board will be able to have confidence in knowing that people's needs are clearly at the centre of service design and delivery rather than services driving activity. This guide provides a focus for Integrated Joint Board members to consider what skills they may have and need to contribute, in order to support the Integration Joint Board to work in this way.

To achieve the vision of integration, where people are at the centre of delivery, leadership is required at all levels. It is crucial that the Integration Joint Board are able to lead by example and model the kind of inclusive, collaborative and person-centred behaviour expected from practitioners and organisations. It is recognised in research that the focus and priorities of the board will have an impact on the quality and delivery of care. The role of an Integration Joint Board member is fundamental in establishing the future vision and culture change required to support integration.

It is important to understand people, what matters to them and why. Being self-aware will enable Integrated Joint Board members to first understand their strengths and what drives them, how they relate and react to others personally and professionally, how they process information and the ways in which this informs how they reach conclusions and take action.

DEVELOPMENT EXERCISE 7 - LEADERSHIP

LEADERSHIP

To enable effective relationships it is important that you consider the following questions:

- What do individual members bring to Integration Joint Board?
- What do the other Integration Joint Board members bring?
- What will the Integration Joint Board do together that will make a difference to people?

Effective relationships are at the heart of effective organisations. The core of developing relationships is building trust and understanding across the members of the Integration Joint Board.

The space for listening to what is important to individuals may seem like a luxury or indulgence, however it has the potential to pay dividends in terms of time saved and problems avoided through the Integration Joint Board having a high degree of trust. Working together with other Integration Joint Board members to deliver effective leadership and create resilient relationship is crucial and requires building trust through honest relationships and maintaining clarity of role and purpose.

DEVELOPMENT EXERCISE 8 -WORKING TO SUPPORT LOCALITIES

One of the key components of the Public Bodies (Joint Working) (Scotland) Act 2014 is that it requires the establishment of localities, so what does establishing localities mean for the Integration Joint Board?

Within each Health and Social Care Partnership there will be at least two localities, although partnerships can have more if they wish. Localities will be shaped differently across Scotland; however the guiding principle that Integration Joint Board members must remember is that localities are in place to enable services to be tailored to local circumstance.

Integration Joint Boards must ensure that the rationale for identifying localities is sound and robust. Localities should relate to natural communities and take account of clusters of GP practices and levels of deprivation and health inequalities. The key to the success of localities is the involvement of different participants: GPs primary care, secondary care, social care and most importantly local communities all have a role to play. Therefore, members of Integration Joint Boards must ensure that the rationale for developing localities is sound, it is even more important that skills and insights of these key groups are successfully heard. Drawing on the expertise of the professional advisors to the Integration Joint Board and having close links with Community Planning Partnerships will support Integration Joint Boards to do this.

Localities and partnerships need to develop in tandem with decisions about local resource being made as close to the locality as possible. Localities should have the ability to allocate resources and enable close community and workforce involvement to support innovation and service design to meet local needs. Engagement of professionals, including primary care will be a key element of in developing thriving and effective locality working.

In addition, the establishment of localities puts in place certain legal requirements and Integration Joint Board members should make themselves aware of these as localities are developed.

For further information in relation to localities, Integration Joint Board members can refer to the All Hands on Deck, the think piece previously published by the Scottish Government on the importance of localities.

DEVELOPMENT EXERCISE 8 -WORKING TO SUPPORT LOCALITIES

WORKING ACROSS LOCALITIES

The reflective questions and issues for consideration below are designed to support a discussion across the Integration Joint Board. Notice what is similar and different in perspectives. What does this mean for the Integration Joint Board? What are the agreed areas for development?

Reflective questions

- Although each locality will be unique, are there common priorities across them all?
- How does the Integration Joint Board respect different locality needs in our decision-making?
- Does the Integration Joint Board have effective engagement with primary care and the wider workforce within our localities? How is this being evidenced?
- What conditions will enable decision-making and resource transfer to localities?
- What does it mean for the Integration Joint Board if priorities in the localities are widely different and conflicting?
- How can the principles for integration help us be flexible and adaptive?
- How flexible/responsive are we able to be if priorities change locally?
- How confident do Integration Joint Board members feel about their knowledge and understanding of the communities in the partnership area?
- How does the Integration Joint Board ensure that engagement with the communities is effective in each locality?

DEVELOPMENT EXERCISE 9 - STRATEGIC COMMISSIONING PLANS

The Act places a duty on Integration Authorities to develop a “strategic plan” for integrated functions and budgets under their control. The strategic plan is the output of what is more commonly referred to as the “strategic commissioning” process.

Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place[1].

Each Integration Authority must produce a strategic commissioning plan that sets out how they will plan and deliver services for their area over a three year rolling period. All members of the Integrated Joint Board must be fully engaged in the preparation, publication and review of the strategic commissioning plan, in order to establish a meaningful co-productive approach, to deliver the national outcomes for health and wellbeing, and achieve the core aims of integration.

By developing new strategic commissioning plans for all adult care groups, Integration Joint Boards have an opportunity to design and commission services in new ways in collaboration with their partners. Strategic commissioning plans should incorporate and leverage informal, community capacity and assets to deliver more effective preventative and anticipatory interventions.

Services cannot continue to be planned and delivered in the same way. The current situation is neither desirable in terms of optimising wellbeing, nor financially viable. The focus should be less about how it is done now and more about how it should be done in the future. This might mean, through a robust option appraisal process, that the Integration Authority makes decisions about disinvesting in current provision of services in order to reinvest in other services and supports that are required to meet on-going and changing demand.

[1] Joint Strategic Commissioning – A Definition: Strategic Commissioning Steering Group, June 2012

DEVELOPMENT EXERCISE 9 - STRATEGIC COMMISSIONING PLANS

STRATEGIC COMMISSIONING PLANS

The reflective questions and issues for consideration below are designed to support a discussion across the Integration Joint Board. Members may find it useful to reflect on their own perspective then share this with others. Notice what is similar and different in how you see things. What does this mean for the Integration Joint Board? Where are your agreed areas for development?

- How will we assure ourselves that the strategic commissioning process is robust and reflects a new way of working?
- How will the Integration Joint Board negotiate amongst itself if there are areas of disagreement about the strategic commissioning process or outcome?
- Where there are areas of disinvestment, what will the process be for this and how will the Integration Joint Board communicate this message to stakeholders?
- How do the values and principles of health and social care integration challenge traditional commissioning and planning – what impacts will these have, what skills might Integration Joint Board members need to bring about positive change and outcomes?
- How will the Integration Joint Board ensure an outcomes approach to commissioning is implemented?
- How might procurement processes need to change?
- What support do we require as an Integration Joint Board to achieve this?

DEVELOPMENT EXERCISE 10 - BOARD DEVELOPMENT

Each Integration Joint Board is required to produce a Board Development Plan which sets out how the Integration Joint Board plans to develop a continuous improvement approach to how it operates.

The Board Development Plan will pull together the themes and areas for improvement as well as detail actions required and monitoring process. This exercise is just one example of these and the questions that may assist with the process of creating the plan.

ASSESSING CONTINUOUS IMPROVEMENT

The Integration Joint Board should collectively review and discuss the themes and questions and from the discussion the themes for improvement should emerge.

Themes	**What are we doing well?**	**What do we need to change in the way we are working to improve our effectiveness as an** Integration Joint Board**?**	**What action do we need to take to make this improvement?**
Focus on service users			
Focus on localities			
Resources and accountability			
Board Dynamics			
Leadership			

APPENDIX 1

PERSONAL DEVELOPMENT

This section is for Integration Joint Board members to work though on their own. The additional tools and resources are freely available. The questions are designed to help members reflect on their own leadership style and role.

There is a personal action plan to help Integration Joint Board members to develop a personal leadership journey and sources of support and further reading. You may choose to use an existing or alternative PDP format. The key point is to invite Integration Board members to reflect on what they bring to the Integration Joint Board and capture the actions which would support their development in this role.

Those who are supporting the formation and development of the Integration Joint Board will need to clarify the process by which the specific and general development needs stemming from the personal development plans will be addressed. This should be negotiated with the Chair or Chief Officer of the Integrated Joint Board.

What do individual members bring in relation to Integration Joint Board?
Each member of the Integration Joint Board is a unique person with their own set of values and beliefs. Knowing what is important to them and how they communicate with others and listen to their ideas and perspectives is vital in developing the Integration Joint Board and individual members leadership role. Essentially the more members pay attention to the behaviours needed to fulfil the tasks they are asked to fulfil, the better they will be able to provide authentic leadership when serving on the Integration Joint Board.

Questions to stimulate personal reflection by Integration Joint Board members

Question	Reflection	Actions based on reflection
What are my values?		
Would those around me recognise that I am living these values?		
What skills, knowledge, and attributes do I bring to the role?		
How do I operate when I am at my best?		
What do I need to watch out for when under pressure or stressed?		
What or who inspires me?		
Who is supporting me in my leadership role?		
How does this differ from other roles/positions I possess?		
What is different about how I need to operate as a member of an Integration Joint Board?		

Useful tools and resources

Psychometric assessments to help me understand my preferences and character	Individual developments to help me gain perspective and new insights	Board or group developments to improve collaborative working and functioning
e.g. 360 degree feedback, Behavioural profiles e.g. MBTI, 16 PF, Insights, Disc	e.g. coaching, mentoring, eLearning on specific leadership qualities or technical skills (e.g. finance, data analysis, appreciative inquiry skills, critical thinking/systems thinking), creative thinking approaches, personal resilience, mindfulness, leadership exchanges, paired learning, action learning	e.g. facilitated Board development workshops on group dynamics, Board dialogue on critical issues, locality visits to confirm realities and impact of decisions made, regional or national networking events (profession specific or whole system)
These can generally be accessed through: Organisational Development leads in NHS or Local Authorities	These can generally be accessed through: Organisational Development leads in NHS or Local authorities Coaching Collaborative via Workforce Scotland http://www.scottishleadersforum.org/public-service-collaborative-learning	These can generally be accessed through: Organisational Development leads in NHS or Local Authorities National organisations which provide support to Integration Joint Board SSSC - http://www.sssc.uk.com/ JIT http://www.sssc.uk.com/ NES http://www.nes.scot.nhs.uk/ Improvement Service

What do other Integration Joint Board members bring?

When considering the role and responsibility of the Integration Joint Board it is important to understand what other Integration Joint Board members bring. Appreciating different perspectives and ideas is important and adds strength to a group and helps them to develop ideas and work more comfortably with ambiguity and complexity.

Much has been written in leadership and organisational development research about how groups function, the roles of group members and group processes. The majority of groups work best when there is a group environment where all members feel listened to, valued, are able to contribute to debate and discussion, where different opinions are aired and respect for members is a core aspect for how the group works. It is also important for groups to be able to identify where they may have gaps in their knowledge or skills and seek to continually improve and build on their ways of working.

Questions to stimulate personal reflection by Integration Joint Board members

Question	Reflection	Actions I may take as a result of reflection
How do I know what others bring?		
How do I ensure that I operate on facts and not assumptions?		
How do I ensure that I value difference?		
What do I value about partnership working?		
What is the difference between cooperation and collaboration – where are we?		
What annoys me about working in partnership and what is in my ability to change?		
Is there shared and equal power amongst other Integration Joint Board members?		
How do I know what other Integration Joint Board members' priorities are?		
How will we make new Integration Joint Board members welcome?		

PERSONAL ACTION PLAN

This section is for you as an Integration Joint Board member to capture learning and insights and create a plan to build on these.

What are my key insights and learning from using this guide?	What are my next steps to develop myself in this role?	What support do I need to do this?

APPENDIX 2
KEY MESSAGES FOR INTEGRATION JOINT BOARD MEMBERS

General messages about why we are integrating health and social care services	
1	Health and Social Care Integration is the Scottish Government's ambitious programme of reform to improve services for people who use health and social care services.
2	It will ensure that health and social care provision across Scotland is joined-up and seamless, especially for people with long term conditions and disabilities, many of whom are older people.
3	The Public Bodies (Joint Working) (Scotland) Act 2014 was granted Royal Assent on 1 April 2014. This means changes to the law which requires Health Boards and Local Authorities to integrate their adult health and social care services.
4	One of the main aspects of the Act is to create statutory Integration Authorities which will replace existing Community Health Partnerships.

Overarching national core messages	
1	People can expect to be supported to live well at home or in the community for as much time as they can.
2	People can expect to have a positive experience of health and social care when they need it, with services planned and delivered in ways that are joined-up and person-centred.
3	People can expect to experience the same high quality of care wherever they live in Scotland.

Key messages for all stakeholders	
1	Health and Social Care Integration will enable people to maintain their health and wellbeing for longer and to live independently and safely for as long as possible.
2	There will be a better understanding of an individual's whole needs to allow for earlier interventions and prevention before problems arise.
3	There will be better and fairer use of resources, as services and networks are used more efficiently.

4	Services will be co-produced with the communities they serve. They will be built on people's assets and will support the health and wellbeing of the whole person and their family.
5	Individuals using services will have a stronger voice in their treatment and care. This voice will be listened to and respected and will help to shape health and social care services for the future.

Key messages for people who use care and support services

1	Individuals can expect health and social care services to work in a co-ordinated way with them, to understand what matters most in their lives, and to build support around achieving the outcomes that are important to them.
2	The necessary joined-up health and social care support will be provided to help individuals, their carers and families to better manage their conditions on a day-to-day basis; formalising networks within the community; and working with individuals as true partners, rather than just as patients or people who use services.
3	Individuals can expect to be supported to live not just longer, but healthier lives and will receive locally based services and support that best meets their needs and which are organised around them, their family and their informal support network.
4	People with care and support needs should have the same choice, control and freedom as every other citizen.

Key messages for the general public

1	The general public can expect family members, someone that they are caring for, or themselves at some point in the future to receive a coordinated, seamless system of care and support that recognises their individual needs and aspirations whenever they need it.
2	Depending on their previous experience of health and social care services, individuals will notice a change if they ever require similar care and support in the future.

Key messages for those delivering services – the workforce

1	At its heart, health and social care integration is about enabling services to work together effectively to support people achieve the outcomes that matter to them.
2	This is a transformational change most likely to be achieved by actively engaging with people who are delivering services.
3	Workers need to be supported to feel engaged in the work that they do and to

	continuously improve the information, care and support that they provide
4	Workers and organisations need to build on what is already working well locally, drawings on resources and assets that already exist.
5	Workers and organisations need to further develop the skills focused on what matters to the person; creating networks, making connections, building shared values and working with people and communities to produce shared solutions.

APPENDIX 3
A BRIEF HISTORY OF INTEGRATION

1999	Seventy nine **Local Health Care Cooperatives** established across Scotland to bring health and social care practitioners together to deliver a range of primary and community health services and promote joint working with councils and the voluntary sector.
2000	Scottish Government adopts recommendations from the **Joint Futures Group**, a collection of senior figures from the health service and local Government. These include shared assessment procedures, information sharing, joint commissioning and joint management of services.
2002	**Community Care and Health (Scotland) Act** includes powers, but not duties, for NHS Boards and local authorities to work together more effectively.
2004	**NHS Reform (Scotland) Act 2004** requires Health Boards to establish one or more Community Health Partnerships (CHPs) in their local area to bridge gaps between primary and secondary healthcare, and health and social care. Between 2004 and 2006 each local area established a partnership which is a subgroup of the health board with strong local representation.
2010	Scottish Government launches the **Reshaping Care for Older People Programme** to prepare for a projected rise in older people and drive improvements in support and services. The programme and arrangements for the related Change Fund both require closer collaboration between Health Boards and Local Authorities and with the third and independent sectors.
2011	All major political parties include commitments to integrate health and social care in their **Scottish Parliament Election manifestos**.
2012	Scottish Government consults on its **proposals for the integration of adult health and social care**.
2013	Publication of the **Public Bodies (Joint Working) (Scotland) Bill** proposing the creation of 32 Health and Social Care Partnerships, one in each Local Authority area, to replace CHPs/CHCPs.
2014	**Public Bodies (Joint Working) (Scotland) Act 2014** receives Royal Assent on 1 April.


NHS
SCOTLAND
NHSScotland
Chief Executive's
Annual Report
2014/15
healthier
scotland
SCOTTISH GOVERNMENT


We are improving the
quality of care and outcomes
for the people of Scotland.

Calum

To see Calum's story see the online report at:
www.nhsscotannualreport.scot

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Foreword

Quality is at the heart of our 2020 Vision – it drives our approach to improving the health of the population and to developing new models of safe, person-centred and effective health and social care.

Paul Gray

Foreword

I am very pleased to present this, my second NHSScotland Chief Executive's Annual Report.

Once again, the achievements outlined in this year's report are a tribute to the outstanding commitment of all NHSScotland staff and their focus on improving the quality of care that we deliver to the people we serve.

Quality is at the heart of our 2020 Vision – it drives our approach to improving the health of the population and to developing new models of safe, person-centred and effective health and social care.

This focus on quality means that Scotland is internationally recognised for its record on patient safety.

Our most recent data shows a 15.7 per cent reduction in Hospital Standardised Mortality Ratios since the implementation of the Scottish Patient Safety Programme in 2008; and during this reporting year, cases of *Clostridium difficile* in patients aged 65 and over were at their lowest level since monitoring began.

Through the integration of health and social care, services are being empowered to work in a co-ordinated way with patients, their families and carers, to understand what matters most in their lives, and to support them to achieve the outcomes that are important to them.

Satisfaction with NHSScotland remains high. Eighty-nine per cent of hospital inpatients who participated in the Scottish Inpatient Patient Experience Survey 2014 reported overall care and treatment to be good or excellent and 87 per cent who responded to the Health and Care Experience Survey 2013/14 rated the overall care provided by their GP practice as good or excellent.

The staff I meet strive day and night, day in, day out, to deliver person-centred, compassionate care, in partnership with a whole range of ancillary and supporting services from estates to procurement to catering.

At the same time as delivering this high level of care, NHSScotland continues to operate within an increasingly challenging context, facing ongoing pressures of poor patterns of health and health inequalities, an ageing population, and continuing tight finances.

We are addressing these challenges as we work towards our 2020 Vision, but at the same time we need to look to a longer horizon to develop new ways of improving the health and wellbeing of the population.

We must address how we will deliver high quality, patient-focused, local health and social care services in the future.

Effective partnership working with all our stakeholders, together with engagement through the Healthier Scotland national conversation will continue to be the trademark of our approach.

We are on the verge of real, fundamental change within our NHS in Scotland, and I am proud to be leading the exceptional people who will contribute to that change.

Paul Gray
Chief Executive of NHSScotland and
Director-General Health and Social Care

Chapter 1
High Quality Health and Care for Scotland

Our focus on quality has secured for Scotland an internationally-strong record in health outcomes and patient safety improvements.

Dr Alex Connan, Portobello Surgery

To see Dr Connan's story see the online report at: www.nhsscotannualreport.scot

Improving the health and wellbeing of the people of Scotland is one of the Scottish Government's five strategic objectives.[1] Helping people, especially those in disadvantaged communities, to sustain and improve their health and ensure better and faster access to healthcare locally is a key priority and gives strategic direction to both the policy and delivery landscape for health and social care in Scotland.

We have articulated through our 2020 Vision for Health and Social Care (2020 Vision) what we want care to look like by the year 2020.

Our 2020 Vision for Health and Social Care

Our vision is that by 2020 everyone is able to live longer, healthier lives at home, or in a homely setting.

The healthcare system will have integrated health and social care and a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day-case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Quality continues to be at the heart of all we do in pursuing our 2020 Vision and is our key operating principle for developing new policy. Quality drives our approach to improving the health of the population and developing new models of compassionate, safe, person-centred and effective health and social care provision.

1 Further information on the Scottish Government's Strategic Objectives can be found at: www.gov.scot/About/Performance/scotPerforms/objectives

This approach, described in our *Healthcare Quality Strategy for Scotland*,[2] continues to underpin improvements in the care people receive. Our Quality Ambitions for person-centred, safe and effective care remain the guiding light for work undertaken at national and local levels, transforming care and improving performance against the *Triple Aim* of:

- improving the quality of the care we provide;
- improving the health and wellbeing of the population; and
- securing the value and financial sustainability in the health and care services we provide.

Our focus on quality has secured for Scotland an internationally-strong record in health outcomes and patient safety improvements. We nevertheless face unprecedented longer-term challenges, including:

- poor patterns of health and health inequalities across the population;
- changing demography, including a rapidly ageing population;
- high levels of preventable diseases and other conditions among those growing older; and
- continuing tight finances, despite our record £12 billion of health resource spending in 2015/16.

We will start to address these challenges as we move toward 2020, but we also need to look to a longer horizon, over 10 to 15 years, to develop new ways of improving the health and wellbeing of the population and deliver high quality, efficient, appropriately integrated and locally-delivered health and social care services.

NHSScotland cannot, of course, address the challenges or develop new approaches to the future on its own. Effective partnership working with people, staff and partners across the public, third and private sectors and industry will continue to be the hallmark of our approach.

To this end, at the beginning of April 2014, the Scottish Parliament unanimously passed the Public Bodies (Joint Working) (Scotland) Act 2014.[3] The Act, which came into effect from April 2015, will transform the way health and social care services are provided in Scotland and drive real change that improves people's lives. It puts in place a framework to make sure that health and social care services are planned, resourced and delivered together by NHS Boards and Local Authorities to improve outcomes for people using services, their carers and families.

Under the new arrangements, newly-formed Integrated Health and Social Care Partnerships – involving NHS Boards and Local Authorities – will be responsible for delivering national outcomes for health and wellbeing. Through its emphasis on effective strategic commissioning, underpinned by a shared understanding of the population's needs, services will be planned and delivered in a co-ordinated way; listening to what people tell us matters most to them in their lives as we build support around achieving the outcomes that are important to them. There will also be a strong role for the third and private sector, clinicians, social workers, other professionals and local service users and communities.

Our health and social care workforce will play a vital role in ensuring the successful achievement of the 2020 Vision, working across boundaries and delivering services in new ways with the creation of new roles and models of care. We are committed to all staff being empowered to influence the way they work, leaders who show by example and managers who have the skills to manage well, with all being held to account for what they do and how they do it. We want to see all staff being fairly treated and supported to do the best job they can, as evidence shows staff who are motivated and valued deliver better quality care for patients.

2 The Healthcare Quality Strategy for NHSScotland, Scottish Government, May 2010. Access at: www.gov.scot/resource/doc/311667/0098354.pdf

3 Public Bodies (Joint Working) (Scotland) Act. Access at: www.legislation.gov.uk/asp/2014/9/contents/enacted

Our 2020 Workforce Vision is: We will respond to the needs of the people we care for, adapt to new, improved ways of working, and work seamlessly with colleagues and partner organisations. We will continue to modernise the way we work and embrace technology. We will do this in a way that lives up to our core values. Together we will create a great place to work and deliver a high quality healthcare service which is among the best in the world.

Our shared values, developed through extensive engagement with staff and stakeholders and described in *Everyone Matters: 2020 Workforce Vision*[4] are: care and compassion; dignity and respect; openness, honesty and responsibility; and quality and teamwork. We expect everyone in NHSScotland to live by these shared values.

We will continue to ensure people are at the centre of decisions about the care they receive and the shape of our health and social care services in the future. While Integrated Health and Social Care Partnerships are now engaging with their communities about what matters to them locally, in August 2015 the Cabinet Secretary for Health, Wellbeing and Sport launched a forward-looking national conversation – Creating a Healthier Scotland – to gather views on how we might improve the health of the population and on how health and social care services should evolve over the next 10 to 15 years.[5]

The conversation is wide-ranging and will help us define an ambitious programme of work to:

- create a culture in which healthy behaviours are the norm, founded in the early years and supported by changes in institutional, social and physical environments;
- ensure that users and providers of services are jointly responsible for a healthier population, with high quality services matched by individuals promoting their own health and wellbeing;
- develop new models of compassionate care appropriately tailored to individuals' needs, with success measured by improved patient outcomes;
- further support the integration of health and social care, with more care and support provided at home or close to home where possible and blurring of the boundaries between Primary and Secondary Care and mental and physical support;
- redesign Primary Care services in a collaborative and inclusive way, transforming and invigorating the workforce, creating new roles and supporting communities to innovate so that services are available where people need them; and
- develop new ways of delivering care across the Primary/Secondary Care boundary, including multi-disciplinary teams being sited in local community hubs (physical or virtual), with centres of expertise for some acute services and regional centres to provide greater capacity for planned surgery and procedures – all, of course, focused on high quality care and improved health outcomes.

The conversation will run until the early part of next year. We will produce a report on the key themes emerging from the conversation, and our responses to them, by next spring. We will use the Our Voice framework (see Chapter 3) beyond then to continue to engage with the people of Scotland on any future service change and on continued service improvement.

4 Everyone Matters: 2020 Workforce Vision, Scottish Government, June 2013. Access at: www.gov.scot/resource/0042/00424225.pdf

5 You can find out more and join in the conversation by accessing: www.healthier.scot/

Chapter 2
Delivering Outcomes for People – Our Story of Achievement

This chapter sets out some of the achievements staff within NHSScotland and its partners have delivered during 2014/15. The achievements need to be seen in the context of the challenges faced over the winter,[6] including increased and prolonged pressures from influenza and respiratory illness (see Chart One).

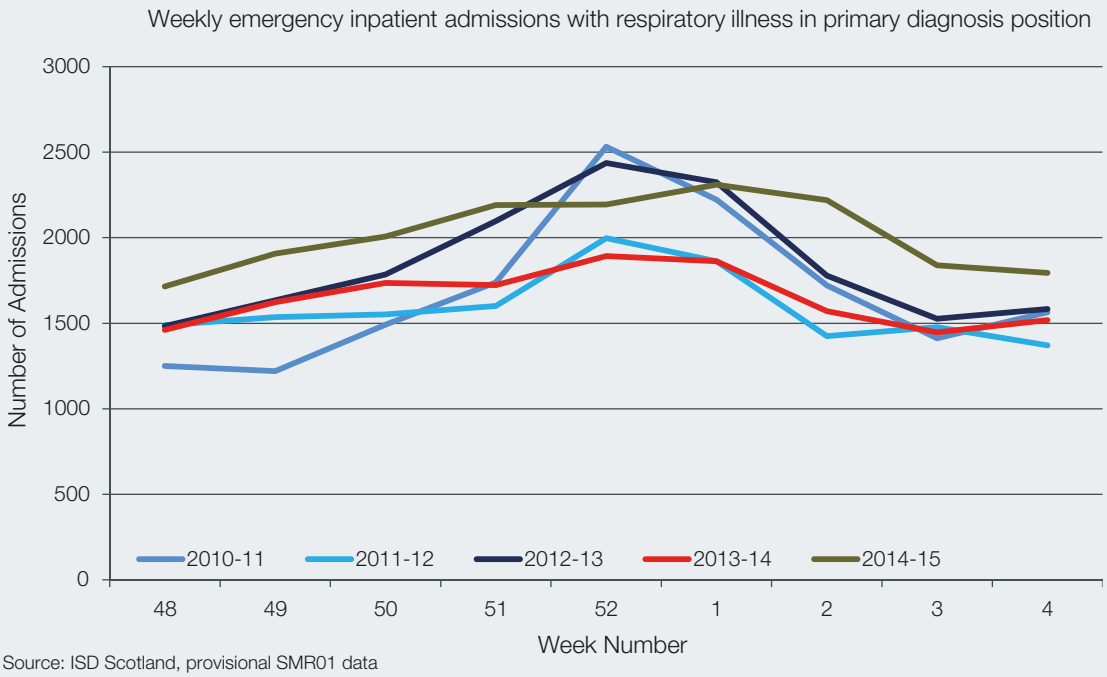
In future, the NHS will work with partners across the public sector to manage pressures and ensure the effective and efficient use of resources.

Gregor

To see Gregor's story see the online report at: www.nhsscotannualreport.scot

6 Health & Social Care: Winter in Scotland in 2014/15, Scottish Government, August 2015. Access at: www.gov.scot/Publications/2015/08/4912

Chart One:
Weekly Emergency Inpatient Admissions with Respiratory Illness as a Primary Diagnosis, by Week 2010/11 to 2014/15



Source: ISD Scotland, provisional SMR01 data

The Scottish Government has taken steps to strengthen preparedness for winter 2015/16[7] which are based on integrating health and social care, the £100 million being invested to improve delayed discharge and the fresh approach to improving unscheduled care across Scotland – in winter and all year round – based on six essential actions.[8] Winter is defined here as the months of October to March, inclusive.

You can read more about our approach to improving unscheduled care across Scotland in Chapter 3 – Effective Care.

Capacity and Activity

Between March 2014 and March 2015, the NHSScotland workforce increased by 1,977.8 whole time equivalents (WTE) (or 1.5 per cent). This included an additional 224.8 WTE medical and dental consultants and 1,001.8 WTE nursing and midwifery staff (including interns).[9] In future, the NHS will work with partners across the public sector to manage pressures and ensure the effective and efficient use of resources.

NHS Boards plan and manage the number of acute medical beds required throughout the year to take account of seasonal pressures. The number of acute medical beds increased throughout this winter from 10,979 in quarter ending December 2014 to 11,275 in quarter ending March 2015 (excluding Highland, for which data is not available). This was on top of an increase of 149 between quarter ending September 2014 and December 2014.[10]

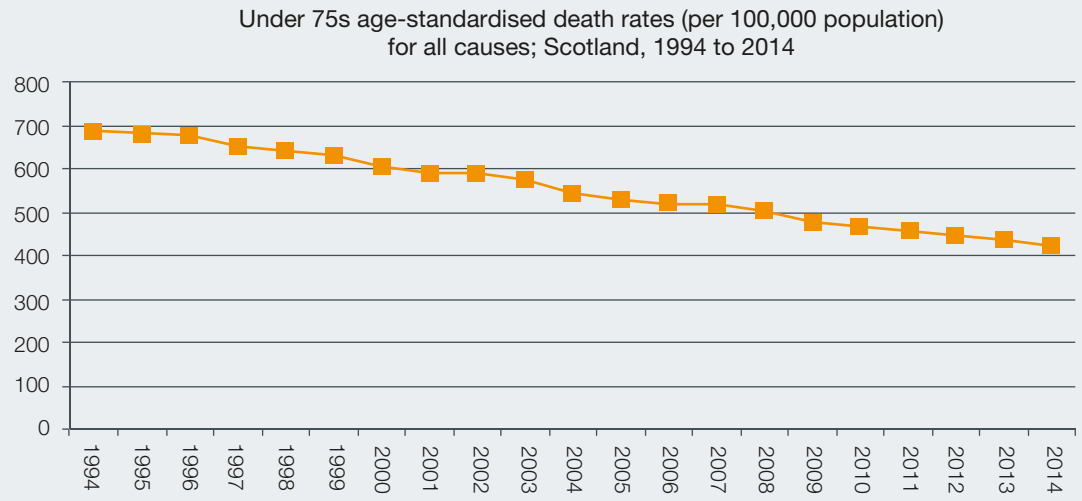
7 Health & Social Care: Preparing for Winter 2015/16 guidance, Scottish Government, August 2015. Access at: www.sehd.scot.nhs.uk/dl/DL(2015)20.pdf

8 Scottish Government: 6 Essential Actions. Access at: www.qihub.scot.nhs.uk/quality-and-efficiency/unscheduled-care-/6-essential-actions.aspx

9 ISD Scotland: NHSScotland Workforce Information – Quarterly Update of Staff in Post, Vacancies and Turnover. Access at: www.isdscotland.org/Health-wTopics/Workforce/Publications/index.asp

10 ISD Scotland: Acute Hospital Activity and NHS Beds Information. Access at: www.isdscotland.org/Health-Topics/Hospital-Care/Publications/index.asp

Chart Two:
Premature Mortality, Under 75s Age-Standardised Death Rates per 100,000 Population for All Causes, 1994 to 2014



Source: National Records of Scotland

The number of calls answered by NHS 24 increased by 115,574, or 17 per cent, compared to last winter. This year's increase may be partly attributable to the introduction of the free-to-call 111 number. Overall Scottish Ambulance Service emergency demand (by incidents) (Categories A, B and C)[11] increased by 17,499 (or 3.8 per cent) compared to last winter.[12]

Hospital activity was also at an increased level compared to winter 2013/14. Accident and Emergency (A&E) attendances were up 3,924, or 0.5 per cent; provisional emergency and transfer inpatient discharges up over 12,000, or 2.6 per cent this winter; and provisional elective inpatient and day case discharges up almost 1,500, or 0.5 per cent. Based on the most recently published information, the average annual increase in emergency admissions between 2009/10 and 2013/14 is 1.1 per cent.

Across Scotland, the rate of emergency bed days per 1,000 population aged 75 and over decreased significantly by a provisional 11.4 per cent, from 5,422 in 2009/10 to 4,805 in 2014/15, against the planned reduction of 12 per cent.[13]

Premature Mortality

Premature mortality (deaths among those aged under 75 years) has reduced substantially, down 23 per cent since 2004 to a death rate of 423 deaths per 100,000 population in 2014. Once again, some causes of premature mortality have seen a sharper fall during this time. Early deaths due to cancer – the leading cause of death – have reduced by 15 per cent over the last decade. Deaths due to heart disease and due to a stroke are each down by almost half, at 47 per cent and 46 per cent respectively, while deaths due to diseases of the respiratory system have reduced by 15 per cent (see Chart Two).

11 www.scottishambulance.com/WhatWeDo/Howdowerespondtoyourcall.aspx

12 www.scottishambulance.com/TheService/BoardPapers.aspx
www.nhs24.com/aboutus/nhs24board/agendasandpapers/

13 ISD Scotland: Acute Hospital Activity and NHS Beds Information. Access at: www.isdscotland.org/Health-Topics/Hospital-Care/Publications/index.asp

Cancer

Detect Cancer Early

There have been recent improvements in the early detection of cancer, the biggest cause of early death (under 75 years) in Scotland. The sooner that cancer is diagnosed and treated, the better the survival outcomes. In the combined calendar years of 2013 and 2014, 24.7 per cent of lung, breast and colorectal cancers were diagnosed at the earliest stage, an increase of 6.5 per cent on the baseline combined calendar years of 2010 and 2011.[14]

Cancer Waiting Times

Over 2014/15, NHSScotland also continued to deliver shorter waits for specific procedures.[15] While the 31 Day Decision to Treat to Treatment cancer waiting time Standard was met in each of the quarters in 2014/15, some challenges remain for the 62-day urgent referral with suspicion of cancer to treatment waiting time measure. In the period January to March 2015, 96.5 per cent of patients began cancer treatment within 31 days of a decision being taken to treat and 91.8 per cent of patients began cancer treatment within 62 days of urgent referral with suspicion of cancer. For each measure, the national standard is 95 per cent. You can read more about our approach to the early detection and treatment of cancer in Chapter 3.

For the financial year 2014/15 (using data from 2014 Quarters 2, 3 and 4, and 2015 Quarter 1), 93.8 per cent of patients began cancer treatment within 62 days of urgent referral with suspicion of cancer. The corresponding figure for 2013/14 for the 62-day standard was 93.1 per cent. The 31-day standard was met in both of the financial years.

The Scottish Government continues to work with NHS Boards to ensure prospective management information is used for the proactive scheduling of patient diagnosis and treatment.

14 ISD Scotland: Detect Cancer Early. Access at: www.isdscotland.org/Health-Topics/Cancer/Publications/index.asp

15 ISD Scotland: Cancer Waiting Times. Access at: www.isdscotland.org/Health-Topics/Waiting-Times/Cancer/

Smoking

The proportion of adults who smoke cigarettes declined from 31 per cent in 1999 to 20 per cent in 2014.[16] The decline between 2013 and 2014, from 23 per cent to 20 per cent, is the sharpest year-on-year reduction over the series (see Chart Three).

Although the pattern is broadly similar to that of previous years, prevalence has reduced in all deprivation quintiles[17] in the last year, most notably from 39 per cent to 34 per cent in the 20 per cent most deprived areas.

Of 39,746 quit attempts made with the support of NHSScotland smoking cessation services, in the most deprived areas of Scotland in 2014/15, 7,017 were still not smoking at three months, a 'quit rate' of 18 per cent.[18] This represents 58 per cent of the NHSScotland HEAT target to achieve at least 12,005 three-month quits in the most deprived areas.

The number of quit attempts made with the support of NHSScotland smoking cessation services has dropped by 39 per cent since 2012. The reason for this decrease is not completely clear, but the rise in use of electronic cigarettes as an alternative to smoking is possibly part of the explanation.

The *Scottish Health Survey 2014* report[19] shows that just under two-thirds (64 per cent) of recent ex-smokers and current smokers who had attempted to quit said they used a nicotine replacement therapy (NRT) product or e-cigarettes in a recent quit attempt. The most common items used as part of a recent quit attempt were nicotine patches (36 per cent) and e-cigarettes (32 per cent).

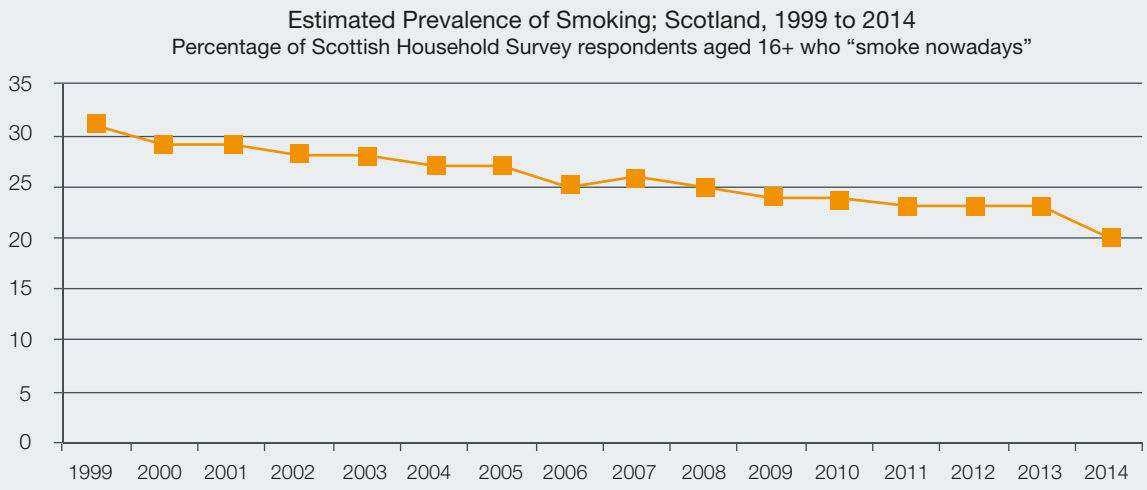
16 Scottish Government: Scottish Household Survey 2014 Annual Report. Access at: www.gov.scot/Publications/2015/08/3720

17 Results are presented by breaking DataZones down into five 'quintiles'. Quintile 1 represents the 20 per cent most deprived DataZones in Scotland, Quintile 2 the next most deprived 20 per cent and so on, until Quintile 5 represents the 20 per cent least deprived DataZones.

18 ISD Scotland: NHS Smoking Cessation Service Statistics (Scotland). Access at: www.isdscotland.scot.nhs.uk/Health-Topics/Public-Health/Publications/2015-10-06/2015-10-06-SmokingCessation-Report.pdf?30511111022

19 Scottish Government: Scottish Health Survey 2014. Volume 1: Main Report, Scottish Government, September 2015. Access at: www.gov.scot/Publications/2015/09/6648

Chart Three:
Estimated Prevalence of Smoking; Scotland 1999 to 2014



Source: Scottish Household Survey, 2014; ["Do you smoke cigarettes nowadays?"]

Alcohol

The *Scottish Health Survey 2014* report shows that prevalence of drinking outwith the government guidelines for weekly and/or daily drinking declined significantly from 2003 to 2014, both for men (from 53 to 46 per cent) and women (from 42 to 36 per cent).[20]

Alcohol Brief Interventions (ABIs) contribute to the Scottish Government's overall objective of reducing alcohol-related harm by helping individuals to cut down their drinking. In 2014/15, NHSScotland delivered almost 100,000 Alcohol Brief Interventions to help prevent the increased morbidity, mortality and social harm that result from excessive alcohol consumption.[21]

You can read more about our approaches to reducing smoking and alcohol consumption in Scotland in Chapter 4.

Eighteen Weeks Referral to Treatment

When NHS treatment is needed, shorter waiting times lead to earlier diagnosis and better outcomes, minimising unnecessary worry and uncertainty for patients.

The 18 Weeks Referral to Treatment (RTT) standard does not focus on a single stage of treatment, such as the time from referral to first outpatient appointment, or the time from being added to the waiting list until treatment starts: the 18 weeks standard applies to the whole pathway from referral up until the point where each patient is actually treated. This means that the RTT is dependent on stage of treatment and diagnostics performance.

For the financial year 2014/15, 88.9 per cent of almost 2.5 million patients (2,491,898) were seen within 18 weeks of referral to treatment (against a standard of 90 per cent). The corresponding figures for 2013/14 showed that 90.5 per cent of 2,479,708 patients were seen within 18 weeks of referral.[22]

20 Scottish Government: Scottish Health Survey 2014. Access at: www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey

21 ISD Scotland: Alcohol Brief Interventions, 2014/15. Access at: www.isdscotland.scot.nhs.uk/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2015-06-30/2015-06-30-ABI2014-15-Report.pdf?70946902037

22 ISD Scotland: 18 Weeks Referral to Treatment (RTT). Access at: www.isdscotland.org/Health-Topics/Waiting-Times/18-Weeks-RTT/

Treatment Time Guarantee

The Scottish Government continues to support NHS Boards to deliver the 12 weeks legal treatment time guarantee for inpatient and day cases set out in the Patient Rights (Scotland) Act 2011. The legal guarantee is that patients requiring inpatient and day case treatment must be treated within 12 weeks from the patient and consultant agreeing to such treatment.

There were increased challenges over the winter, with NHS Boards reporting that they were experiencing increased levels of cancellations for routine treatment. Over 316,000 inpatients and day cases have benefited from the 12 weeks legal treatment time guarantee in 2014/15, meaning that 96.5 per cent of patients were seen within 12 weeks. The corresponding figures for 2013/14 showed that 97.8 per cent of patients were seen in 2013/14 with over 337,000 patients benefiting from the 12 weeks legal Treatment Time Guarantee.[23]

The Scottish Government has announced its intention to invest £200 million to build six new elective treatment centres at Aberdeen Royal Infirmary, Edinburgh Royal Infirmary, St John's Livingston, Ninewells Hospital in Dundee, Raigmore Hospital in Inverness, and a new centre at the expanded Golden Jubilee National Hospital. This network of new centres will address changing demographics over the next 20 years, and the likely increased demand in hospital care from a growing elderly population. It is expected that the new facilities will be completed and delivered by 2021.

Outpatients

On 31 March 2015, 92.2 per cent (236,079) of new outpatients had been waiting 12 weeks or less for a first outpatient consultation. The corresponding figure on 31 March 2014 is 96.9 per cent, with 233,098 new outpatients waiting 12 weeks or less.

A number of NHS Boards have experienced capacity issues in relation to outpatient waits across a number of specialties. To help improve performance we have announced the *Delivering Outpatient Integration Together* (DO IT) programme to support delivery and identify sustainable solutions. The programme will be focusing firstly on redesigning dermatology and gastroenterology services, particularly for follow-up appointments, as well as optimising use of technology before moving on to all outpatient services. The Scottish Government has made available an additional £2.7 million in 2015/16 specifically to address outpatient waits, with the objective of achieving 95 per cent of outpatients seen within 12 weeks in 2016/17.

Drug and Alcohol Treatment – Referral to Treatment

Those needing treatment to help tackle problem drug and alcohol use benefited from NHSScotland support, with 95 per cent of the 11,881 people beginning treatment within three weeks of referral during January to March 2015.[24] For alcohol treatment, 95.7 per cent of 7,544 people waited three weeks or less between January to March 2015, and for drug treatment, 93.9 per cent of 4,337 people waited three weeks or less in the same quarter.

In Vitro Fertilisation Waiting Times

Improving access to In Vitro Fertilisation (IVF) by reducing waiting times for patients will potentially improve the chance of a successful outcome from the treatment and will increase equity so that all those eligible for NHS IVF will have a waiting time of 12 months or less. During the quarter ending March 2015, 397 eligible patients were screened at an IVF centre in Scotland.[25] Of these, around 96 per cent of eligible patients were screened for IVF treatment within 365 days (12 months). This compares to 80 per cent in the quarter ending December 2014. The Scottish Government target for IVF waiting times is that the target should be delivered for at least 90 per cent of patients, as for some patients, it may not be clinically appropriate for treatment to begin within the target's time.

23 ISD Scotland: Waiting Times Data Warehouse

24 ISD Scotland: Drug and Alcohol Treatment: Referral to Treatment. Access at: www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/

25 ISD Scotland IVF Waiting Times. Access at: www.isdscotland.scot.nhs.uk/Health-Topics/Waiting-Times/IVF-Waiting-Times/Publications/2015-05-26/

Child and Adolescent Mental Health Services and Psychological Therapies Waiting Times

Timely access to healthcare is a key measure of quality that applies equally in respect of access to mental health services. Early action is more likely to result in full recovery and, in the case of children and young people, will minimise the impact on other aspects of their development such as education, so improving their wider social development outcomes.

Demand for services has increased significantly. We have seen an increase in demand for mental health services through better identification of those requiring treatment, better diagnosis and more people being prepared to come forward. In addition, waiting times have decreased significantly despite a rise in the number of people seeking help.

During the quarter ending March 2014, 3,601 children and young people started treatment at Child and Adolescent Mental Health Services (CAMHS) in Scotland and 83.9 per cent were seen within 18 weeks. During the quarter ending March 2015, 4,269 children and young people started CAMHS treatment, an increase of 18.6 per cent on the same period last year. Of these, 78.9 per cent were seen within 18 weeks.[26]

During the quarter ending March 2015, around 11,659 patients started their treatment for psychological therapies in Scotland, an increase of 2,253 people or 24.0 per cent on the same period in 2014. Of these, 82.8 per cent were seen within 18 weeks.[27]

The Scottish Government will continue to work with NHS Boards to support Boards to improve waiting times for mental health services and deliver the HEAT standard of 90 per cent of patients being seen within 18 weeks. To that end, the Scottish Government committed to invest an extra £100 million in mental health over the next five years. This funding will be targeted at improving access to services, supporting responses to mental health in Primary Care, promoting wellbeing through physical activity, and improving patient rights, one of the elements of the Mental Health (Scotland) Bill.

Hospital Standardised Mortality Ratios

As well as providing timely access to services, it is also vital that NHSScotland delivers the highest standard of quality and safety when providing treatment. Hospital Standardised Mortality Ratios (HSMR) compare observed deaths to predicted deaths. The Hospital Standardised Mortality Ratio for Scotland has decreased by 15.7 per cent between October to December 2007 and January to March 2015.[28] Overall, hospital mortality at Scotland level had been falling prior to the baseline period.

The Scottish HSMR for January to March 2015 is currently 0.90. Compared to an index of 1.0, this means there were 10 per cent fewer deaths than predicted in the period. Hospital mortality has fallen for all types of admission; non-elective medical patients consistently account proportionately for the majority of deaths within 30 days of admission. Patients from the least deprived areas of Scotland consistently have lower levels of crude 30-day mortality than those from more deprived areas.

Clostridium difficile

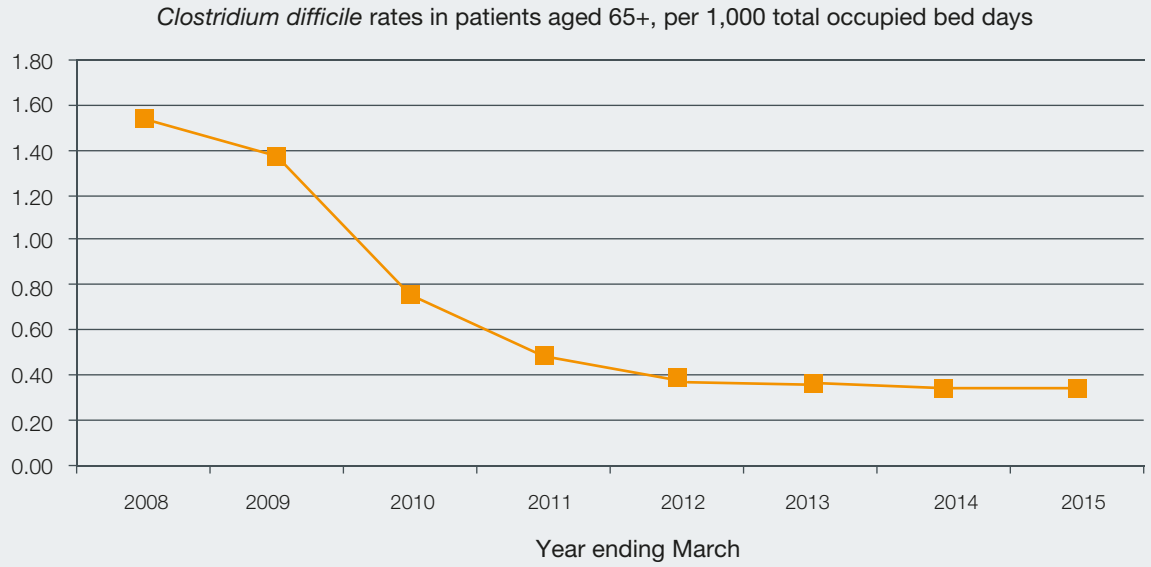
For the year ending March 2015, the rate of identifications of *Clostridium difficile (C.diff)* across NHSScotland was 0.34 per 1,000 occupied bed days among patients aged 15 and over, maintaining the improvement seen in previous years. The standard NHSScotland was aiming for was a rate of 0.32 cases or less per 1,000 total occupied bed days among patients aged 15 and over (see Chart Four).

26 ISD Scotland: Child and Adolescent Mental Health Waiting Times. Access at: www.isdscotland.org/Health-Topics/Waiting-Times/Child-and-Adolescent-Mental-Health/

27 ISD Scotland: Psychological Therapies Waiting Times. Access at: www.isdscotland.org/Health-Topics/Waiting-Times/Psychological-Therapies/

28 ISD Scotland: Hospital Standardised Mortality Ratios. Access at: www.isdscotland.org/Health-Topics/Quality-Indicators/Publications/index.asp

Chart Four:
Clostridium difficile Rates Amongst Patients Aged 65+ per 1,000 Total Occupied Bed Days, Year Ending March 2008 to Year Ending March 2015



Source: Health Protection Scotland: Quarterly Epidemiological Commentaries – *Clostridium difficile* infection (CDI) and *Staphylococcus aureus* bacteraemias (SAB)

Staphylococcus aureus bacteraemia

Recent improvements in *methicillin-resistant Staphylococcus aureas* (MRSA), *methicillin-sensitive Staphylococcus aureus* (MSSA) and new Staphylococcus aureus bacteraemia (SAB) were sustained.

For the year ending March 2015, the rate of MRSA/MSSA cases across NHSScotland was 0.31 per 1,000 acute occupied bed days. The standard NHSScotland was aiming for was a rate of 0.24 cases or fewer per 1,000 acute occupied bed days (see Chart Five).

Accident & Emergency (A&E) Activity and Waiting Times

NHSScotland has again worked hard to tackle A&E waiting times over the past year. Increased and prolonged pressures over winter contributed to the reduced whole system four hour A&E waiting times performance in December, January and February. This winter, performance in Scotland[29] (88.8 per cent) was marginally above that in England[30] (88.2 per cent) and significantly above the performance in Northern Ireland[31] (72.4 per cent) and Wales[32] (79.3 per cent), based on 'core' (Scotland), 'Type 1' (England and Northern Ireland) and 'Major' (Wales) A&E. This is different from winter in the previous year, where England's performance was marginally above that of Scotland.

The National Unscheduled Care Action Plan, which was previously launched in 2013, has now moved to an improvement-orientated approach to sustainability improving unscheduled care, focusing on six essential actions. This new approach was

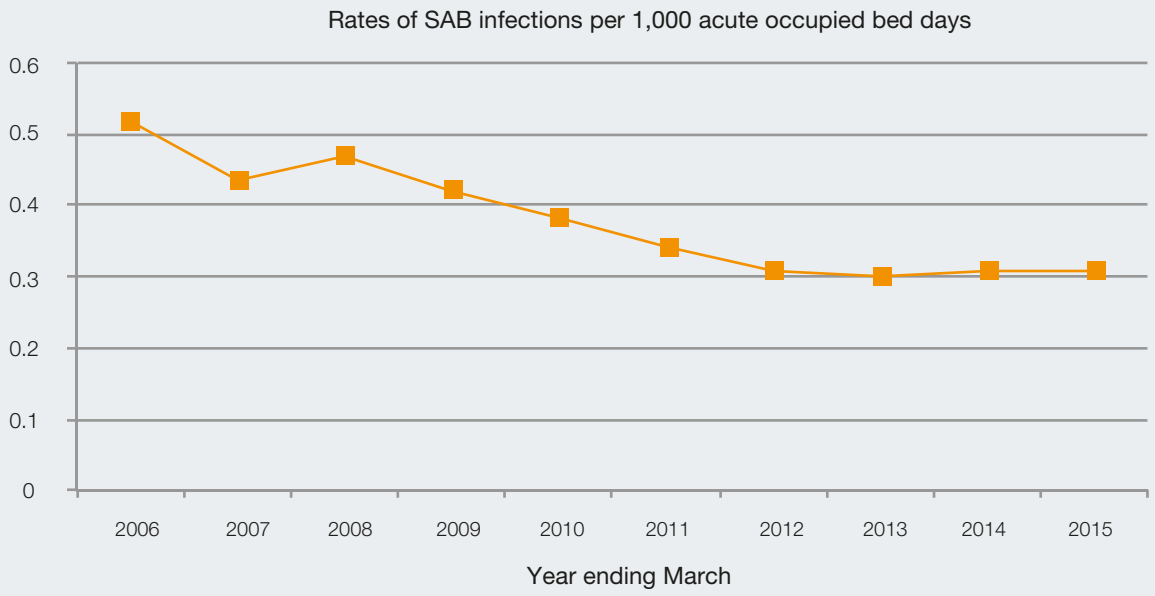
29 ISD Scotland: Emergency Department Activity & Waiting Times. Access at: www.isdscotland.org/Health-Topics/Emergency-Care/Publications/index.asp

30 NHS England, A&E Attendances and Emergency Admissions Weekly: www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/04/2015.06.28-AE-TimeseriesBaG87.xls Monthly: www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/statistical-work-areasae-waiting-times-and-activityae-attendances-and-emergency-admissions-2015-16-monthly-3/

31 NHS Northern Ireland, Statistics on Emergency Care Waiting Times by Department & Month. Access at: www.dhsspsni.gov.uk/index/statistics/hs-nitws-ecwt-tables-2008-2015.xls

32 Time Spent in NHS Wales Accident and Emergency Departments: Monthly Management Information. Access at: www.infoandstats.wales.nhs.uk/docopen.cfm?orgid=869&id=270705

Chart Five:
Rates of *Staphylococcus aureus bacteraemia* (SAB) infections per 1,000
Acute Occupied Bed Days, Year Ending March 2006 to Year Ending March 2015



Source: Health Protection Scotland

launched in May 2015 and is a two-year programme aiming to improve outcomes for people who are using services. The programme recognises, however, that this is a multi-disciplinary issue requiring commitment across every part of the health and social care system to ensure better care on a sustainable basis, joining up several work strands to ensure a much more strategic approach. Integration of health and social care is therefore at the heart of the solution to the problems of unscheduled care. Strategic planning across the whole pathway of care – health and social care – is being taking forward under integration.

A new website, NHS Performs,[33] was developed to bring together information on how hospitals and NHS Boards are performing. It includes new statistics on weekly A&E waiting times, monthly delayed discharges and cancellations. NHS Performs will be developed further during 2015/16.

Delayed Discharge

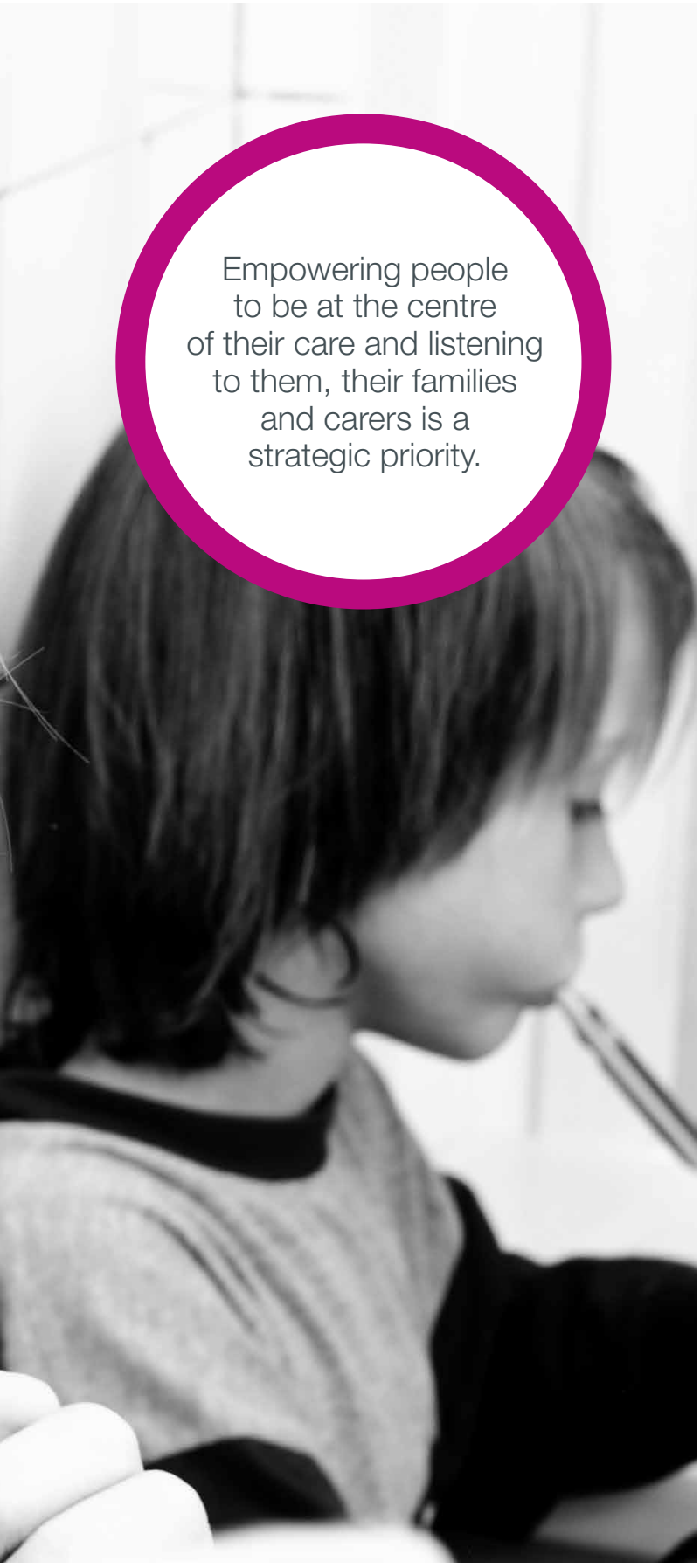
Tackling delayed discharge is one of the Scottish Government's key priorities for NHSScotland in improving the quality and experience of care and people's outcomes. Joined up health and social care will allow people to be timeously discharged and receive care at home or in a homely setting.

In January 2015, a £100 million investment over three years was announced to help local partnerships to tackle the issue of delayed discharge. During the quarter January to March 2015, 151,098 bed days were occupied by delayed discharge patients.[34] This represents a reduction of 10 per cent compared to the previous quarter (168,526 during the quarter October to December 2014), but an increase of 2 per cent compared to the equivalent quarter in 2014 (148,079 during the quarter January to March 2014). At the April 2015 census, 357 patients were waiting over 14 days to be discharged from hospital. By comparison, at the January 2015 census, 517 patients were delayed and 418 were delayed at the April 2014 census.

33 You can access NHS Performs at: www.isdscotland.org/Products-and-Services/NHS-Performs

34 ISD Scotland: Delayed Discharge. Access at: www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/

Chapter 3
Improving Quality of Care



The *Healthcare Quality Strategy for Scotland* sets three clearly articulated and widely accepted ambitions based on what people say they want from their NHS: care that is person-centred, safe and effective.

The Quality Ambitions

Person-centred

Mutually beneficial partnerships between patients, their families and those delivering healthcare services that respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.

Safe

There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate clean and safe environment will be provided for the delivery of healthcare services at all times.

Effective

The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

PERSON-CENTRED CARE

Empowering people to be at the centre of their care and listening to them, their families and carers is a strategic priority for public services, including NHSScotland, and the Scottish Government. NHSScotland is committed to developing a culture of openness and transparency that actively welcomes feedback and uses it to inform and drive continuous improvement.

Healthcare Improvement Scotland continued to work across NHSScotland and with third sector partners in 2014/15 to test and spread best practice in person-centred care. Building on the successes of the Person-Centred Health and Care Collaborative, national quality improvement support for person-centred care was refocused early in 2015 to help NHS Boards and Integrated Health and Social Care Partnerships gather and use feedback to improve experience of services, integrate person-centred care into other national quality improvement programmes and share evidence and best practice.

Improving Responses to Feedback, Comments, Concerns and Complaints

The Patient Rights (Scotland) Act 2011[35] introduced the right for people to give feedback, comments, concerns and complaints about the services they receive from NHSScotland. It places a duty on the NHS to actively encourage, monitor, take action and share learning from the views they receive.

In 2014/15, in line with one of the recommendations of the Scottish Health Council's report *Listening and Learning: How Feedback, Comments, Concerns and Complaints Can Improve NHS Services in Scotland*,[36] the Scottish Government asked the Scottish Public Services Ombudsman's Complaints Standards Authority to lead the development of a revised NHS complaints procedure. This will build on the requirements of the Patient Rights (Scotland) Act 2011 and the *Can I Help You?* good practice guidance for handling and learning from feedback, comments, concerns or complaints.[37]

The aim is to further improve outcomes for people by introducing a more standardised and person-centred complaints process, with a sharper focus on local ownership and early resolution. A working group that includes representation from NHS Boards, the independent Patient Advice and Support Service, the Scottish Health Council, Healthcare Improvement Scotland and NHS Education for Scotland has been convened to take this forward.

There were 22,417 complaints made about NHS services in Scotland in 2014/15[38] – the equivalent of 0.05 per cent of all NHS activity. This figure includes all hospital visits and GP, outpatient, dental and ophthalmic appointments, and represents a 9 per cent increase since 2013/14.

NHS Boards must listen to, and act, on every complaint made about the services they provide, using the information to identify changes or improvements that could be made to further improve quality of care and treatment. NHS Boards once again published annual reports this year showing where lessons have been learned and describing actions taken to improve services as a direct result of feedback, comments, concerns and complaints.

Satisfaction with NHSScotland – National Surveys

Satisfaction with NHSScotland remains high, with 89 per cent of hospital inpatients who participated in the *Scottish Inpatient Patient Experience Survey 2014*[39] reporting overall care and treatment to be good or excellent and 87 per cent who responded to the *Health and Care Experience Survey 2013/14*[40] rating the overall care provided by their GP Practice as good or excellent.

35 Patient Rights (Scotland) Act 2011 can be found at: www.gov.scot/Topics/Health/Policy/Patients-Rights

36 Listening and Learning: How Feedback, Comments, Concerns and Complaints Can Improve NHS Services in Scotland, Scottish Health Council/Healthcare Improvement Scotland, April 2014. Access at: www.scottishhealthcouncil.org/publications/research/listening_and_learning.aspx

37 Can I Help You? Scottish Government, updated April 2012. Access at: www.gov.scot/Publications/2012/03/6414/0

38 NHSScotland Complaints Statistics. Access at: www.isdscotland.org/Health-Topics/Quality-Indicators/NHS-Complaints-Statistics/

39 Scottish Inpatient Patient Experience Survey 2014, Scottish Government, August 2014. Access at: www.gov.scot/Topics/Statistics/Browse/Health/InpatientSurvey/inpatients2014

40 Health and Care Experience Survey 2013/14, Scottish Government, May 2014. Access at: www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/Survey1314

The Scottish Government published results from a new survey of NHSScotland radiotherapy patients in November 2014.[41] The survey found that the large majority had a positive experience: 97 per cent rated their overall care as excellent or very good, with patients particularly positive about staff.

Building on this work, the then Cabinet Secretary for Health and Wellbeing, Alex Neil, MSP, announced in August 2014 that a new national survey of cancer patients would be launched in autumn 2015. Scotland's first national cancer patient experience survey will aim to provide high quality national and local data on patients' experiences of cancer treatment and care to inform ways to enhance and improve services in Scotland. It will focus on elements such as diagnosis and treatment, information provision and the quality of care and support. Patients are expected to receive their questionnaires in October 2015, with results expected to be published in June 2016.

Development of Our Voice

In June 2014, the then Cabinet Secretary for Health and Wellbeing, Alex Neil, MSP, announced that: "We must do more to listen to, and promote, the voices of those we care for. We need the voices of our patients, those receiving care and their families, to be heard in a much clearer and stronger way."

This is a key part of improving quality and integrating services to meet people's needs. It will help to ensure services are person-centred and reflect the lived experience of patients and carers, and that services are designed and delivered with, rather than designed for and delivered to, patients.

The Scottish Government worked in partnership with the Scottish Health Council, the ALLIANCE, the Convention of Scottish Local Authorities, Healthcare Improvement Scotland and its public partners throughout the autumn of 2014 to develop high-level proposals for a new framework for hearing the voices of citizens in health and social care.

This aimed to find out what really mattered to people using services, families and carers, and the staff working with them. A wide range of methods, including national events, small focus group sessions, surveys, Twitter chats and virtual events, were used to gather views from individuals and groups across every Local Authority and NHS Board area in Scotland. The views were considered alongside key themes that emerged from desk research and fed into the Our Voice framework, which was launched at the NHSScotland Event in June 2015. Work is now underway to develop key elements of the framework, which is designed to support citizens' involvement in local engagement, improvement and planning processes, and in national policy issues.[42]

Increased Use of Patient Opinion to Drive Change

The Scottish Government continued to support NHS Boards' engagement with Patient Opinion,[43] an independent website that provides an online route for people to share their experiences of care – whether good or bad – directly with NHS Boards and engage in constructive dialogue with them about how services can be improved.

In 2014/15, 1,305 stories were shared on Patient Opinion, representing a 96 per cent increase on the same period in 2013/14. The vast majority (98 per cent) received a response, and 43 service changes to NHS services were made (or are being planned) as a direct result of the stories.

The Scottish Government has signed a contract with Patient Opinion that provides for each Territorial NHS Board and relevant Special NHS Boards, including NHS Education for Scotland, the Golden Jubilee Foundation, NHS 24, the Scottish Ambulance Service, NHS National Services Scotland and Healthcare Improvement Scotland, to be fully registered with Patient Opinion for up to three years from April 2015. A comprehensive package of support is available to NHS Boards to support them to engage effectively with the site.

41 Scottish Radiotherapy 2014 National and Local Results, Scottish Government, November 2014. Access at: www.gov.scot/Topics/Statistics/Browse/Health/RadiotherapySurvey/results2014

42 You can access the Our Voice website at: www.scottishhealthcouncil.org/patient__public_participation/our_voice/our_voice.aspx

43 You can access the Patient Opinion website at: www.patientopinion.org.uk/

Third Sector Partnerships

The NHSScotland strategic partnerships with third sector organisations continued in 2014/15 as part of the drive to improve care through active participation. The ALLIANCE brought together a number of workstreams involving third sector partners with expertise in delivering person-centred care to enable people with lived experience to contribute to the co-design of services and support local teams to make their services more person-centred. This reflects the partnership approach adopted to improving the whole system: it recognises the value of partnership and, indeed, patients and service users in the health and social care system.

The ALLIANCE has directed work with three early adopter sites (NHS Tayside, NHS Greater Glasgow and Clyde, and NHS Lothian) and two further sites (NHS Ayrshire and Arran and NHS Lanarkshire) to take forward the 'House of Care'[44] approach to collaborative care and support-planning. This approach, which has an internationally recognised evidence base, puts people and their families in the driving seat of their care.

Funded by the Scottish Government and delivered in partnership with the ALLIANCE, ALISS (A Local Information System for Scotland) continued to map assets across the community to enable people to more effectively self-manage by connecting them with local sources of support. ALISS is now being rolled out across all Community Pharmacies in Scotland.

Work continued to support people to have the knowledge, understanding, skills and confidence they need to use health information, to be active partners in their care, and to navigate health and social care systems. A demonstrator programme as part of the *Making it Easy: a Health Literacy Action Plan for Scotland*[45] was initiated in NHS Tayside in March 2015. It is examining a range of tools and approaches to enable staff to recognise and cater for the health literacy needs of their patients.

Carers

Funding of nearly £34 million is being provided between 2008 and 2016 to NHS Boards and the Scottish Ambulance Service for direct support to carers, of which £5 million was allocated in 2014/15 to take forward a wide range of initiatives to support carers[46] and young carers. NHS Boards were asked to continue to support previous priorities for 2014/15, including funding carers' centres that provide a range of services such as advocacy and advice, training for carers and the workforce, and short breaks.

The Carers (Scotland) Bill,[47] which was introduced in March 2015, will extend the rights of carers and young carers. It will make a meaningful difference to unpaid carers and will contribute towards the improvement of their health and wellbeing, ensuring they can continue to care but also have a fulfilling life. It will also reflect the importance of carers in improving care and quality. The Bill, which is currently in Stage 1 of Parliamentary consideration, is an important part of the wider programme of health and social care reform.

A new official statistics report was published in March 2015. *Scotland's Carers*[48] gives one of the clearest and most detailed pictures of the caring population ever produced, covering issues such as gender, carers' health, employment and deprivation.

Self-directed Support

The Social Care (Self-directed Support) (Scotland) Act 2013[49] has directly put eligible people from across Scotland at the centre of shaping their own care and support, enabling them to exercise greater choice and control and access more flexible support. The Act is helping more people to live more independent, fulfilling lives.

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44 Delivering Better Services for People with Long-term Conditions. Building the House of Care, King's Fund, October 2013. Access at: www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

45 Making it Easy: a Health Literacy Action Plan for Scotland, Scottish Government, June 2014. Access at: www.gov.scot/Publications/2014/06/9850

46 Carer Information Strategies. Access at: www.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/CarerInformationStrategies

47 Further information on the Carers (Scotland) Bill can be found at: www.scottish.parliament.uk/parliamentarybusiness/Bills/86987.aspx

48 Scotland's Carers, Scottish Government, March 2015. Access at: www.gov.scot/Publications/2015/03/1081

49 The Social Care (Self-directed Support) (Scotland) Act 2013. Access at: www.legislation.gov.uk/asp/2013/1/contents/enacted

At the core of self-directed support is a support-planning conversation that identifies personal outcomes and ways in which they can be achieved. The Scottish Government has invested £7.5 million since 2012 in independent information and support to ensure everyone can participate in their support planning. Aggregated learning from 42 independent projects shows that people and carers now have clearer information about self-directed support, more opportunities for choice and control, and are better able to make informed choices. This evidence has led to a Scottish Government commitment to provide a further £2.4 million across 34 organisations in 2015/16 to build the capacity of independent support and information for people.

Innovative service design and delivery is essential to providing sufficient flexibility for people to achieve the personal outcomes they define during support-planning. Employment can feel like a distant goal for many people who require support. That is why the Scottish Government funded projects like Pilotlight in Moray,[50] in which a team of people who access social care services, commissioners and providers of social care and employment support services used co-design to deliver practical solutions and tools. These have enabled people who access self-directed support to set up their own small businesses.

The Scottish Government has invested £6.3 million since 2012 in over 30 third and private sector providers to support innovative service delivery. A further £1.1 million is being invested in 21 organisations during 2015/16 for building the capacity of providers and workforce development.

Self-directed support is most successful when independent information organisations, third and private sector providers of care services and support, community groups, Local Authorities, Integrated Health and Social Care Partnerships and people, families and carers work together in partnership.

50 Further information on Pilotlight, can be found at: www.pilotlight.iriss.org.uk/sds/business

Palliative and End-of-life Care

The Scottish Government established a new Palliative and End-of-life Care National Advisory Group in 2014 to strengthen governance and leadership in this area. Membership is drawn from across the health, independent hospice and care sectors, and is supported by a stakeholder group. This group is supporting the development of a strategic framework for action to provide a focus for, and support the delivery of, high quality palliative and end-of-life care.

The Scottish Government engaged widely throughout the early part of 2015, including with people working in health, social care and the third and private sector and members of the public, about What matters to them about the future of palliative and end-of-life care.[51] This inclusive approach to the development of the framework will help ensure that people can identify with the actions required to deliver change. The strategic framework will be published at the end of 2015.

Health Information Services

NHS 24[52] continued to develop and make available key health and care information for people during 2014/15, using a range of platforms and services that includes NHS Inform, the national health and care information service, along with Care Information Scotland, Smokeline,[53] Know Who To Turn To[54] and the NHS 24 website.[55] These platforms received 2.9 million contacts through internet, telephone and user-engagement sessions during the year. NHS 24 also provided five special helplines, including a UK helpline, as part of its service provision during 2014/15.

Other developments included the relaunch of Care Information Scotland as a new website and service for all carer groups, the redevelopment of NHS 24's web-based self-help guide, the launch of the Fit for Work website and the start of an evaluation process to scope the future direction of the Smokeline service.

51 What Matters to You about the Future of Palliative and End Of Life Care in Scotland? Engagement Document, Scottish Government, June 2015. Access at: www.rcpsych.ac.uk/pdf/SFA%20Engagement%20Document.pdf

52 NHS Inform is the national health and care information service. Access at: www.nhsinform.co.uk

53 Further information on Smokeline can be found at: www.canstopsmoking.com

54 Further information on Know Who To Turn To can be found at: www.knowwhototurnto.org

55 Further information on NHS 24 can be found at: www.nhs24.com

SAFE CARE

The Quality Ambitions articulate clearly the aim to ensure there is no avoidable injury or harm to people from the health care they receive, and that clean and safe environments will be provided for the delivery of healthcare services at all times.

The internationally acclaimed Scottish Patient Safety Programme[56] was launched in January 2008, focusing at that time on acute adult care. Its aim is to reduce avoidable harm to patients by improving the safety of care provided across NHSScotland. The Programme now has six strands – Acute Adult, Healthcare Associated Infection (HAI), Maternity and Children, Medicines, Mental Health, and Primary Care – and continues to drive improvements across a number of key areas of healthcare.

The Scottish Patient Safety Programme seeks to engage frontline staff in improvement work by promoting the application of a common set of tested, evidence-based interventions and a common improvement model based on the plan-do-study-act (PDSA) model. A key element is that the changes are led by staff who are directly involved in caring for patients. Staff can monitor improvements through the collection of real-time data at individual unit level.

Work to reduce Healthcare Associated Infections, implement electronic prescribing via the ePharmacy Programme and to support improved care for older people in hospital also continues. These developments demonstrate the breadth of effort in Scotland to provide safer outcomes for people accessing healthcare services.

Examples of key achievements of the quality improvement work across NHSScotland are set out here.

Reduction in Mortality from Sepsis

Sepsis is a life-threatening condition triggered by an infection. It is a whole-body inflammation that occurs when the body's response to infection damages its own tissues and organs. Sepsis continues to be one of the world's biggest killers, with incidence continuing to rise.

Sepsis is extremely dangerous because of its rapid onset. If it can be diagnosed and treatment with the appropriate antimicrobials and intravenous fluids offered within the first hour, survival rates can be higher than 80 per cent.

Someone dies of sepsis every 3-4 seconds[57] and is one of the harms being addressed by the Scottish Patient Safety Programme, which has developed the Sepsis Collaborative and supported NHS Boards to deliver its aims.

The Collaborative's initial aim was to reduce mortality in acute care settings by 10 per cent through early identification of patients and completion of the Sepsis 6 Care Bundle within one hour. The Collaborative exceeded its aim of a reduction in mortality from sepsis with data showing a relative reduction in mortality of 21 per cent over the period from January 2011 to March 2015[58]. Eighty per cent of patients identified as having sepsis now receive antibiotics within one hour[59]

Safety in Inpatient Mental Health

The Scottish Patient Safety Programme for Mental Health[60] aims to reduce the harm experienced by people in receipt of mental health care so that both staff and patients within services feel, and are, safe. The work is delivered through a four-year programme running to September 2016, with the Scottish Government providing funding of over £245,000 in 2014/15.

The Programme enjoys a very high level of engagement from NHS Boards. Through collaboration and innovation from staff, service users and carers, and through the development and use of quality improvement interventions and processes, it has helped cultivate learning among those delivering and in receipt of care to improve the safety and quality of care delivered in mental health inpatient settings.

56 Access at: www.scottishpatientsafetyprogramme.scot.nhs.uk/

57 World Sepsis Day fact sheet, 2013: www.world-sepsis-day.org

58 ISD Scotland referencing codes A40 and 41

59 Kumar A, et al. Initiation of inappropriate antimicrobial therapy results in a fivefold reduction of survival in human septic shock. Chest. 2009;136(5):1237–48. See more at: www.biomerieux.co.uk/clinical-diagnostics/solutions/sepsis#sthash.Z6k9MfV1.dpuf

60 Access at: www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/mental-health

As a result, significant reductions in the number of patients who self-harm (up to 57 per cent), reductions in rates of violence and aggression (up to 54 per cent), and reductions in restraint (up to 63 per cent) are now beginning to be seen across a number of areas in Scotland. Nationally aggregated data gives a baseline and a route to comparison, but it is the individual ward data that is showing real improvement.

Recognition of the pivotal role of service users, carers and the third sector in the Programme has ensured that they have been involved in every step of the process. For example, the Patient Safety Climate Tool (PSCT),[61] developed by mental health service users and carers, has seen over 400 patients across Scotland given the opportunity to participate in a facilitated survey designed to enquire about environmental, relational, medical and personal safety. It is a Scottish innovation that is leading the way in person-centred and safe delivery of care.

Examples of themes from completed PSCTs have included the requirement for more information about medication and possible side-effects and positive comments about staff, particularly their ability to deconstruct and help to explain and interpret difficult situations such as being restrained or witnessing a restraint.

Reducing Harm in Primary Care

The Primary Care strand of the Scottish Patient Safety Programme aims to reduce the number of events which could cause avoidable harm from healthcare delivered across the wide range of Primary Care settings. Launched with an initial focus on General Practice, a range of tools and resources has been developed to support those working within Primary Care to improve the quality of care to patients, developing the patient safety culture within their teams and making higher-risk processes reliable. The work has now spread to Community Pharmacy, where a collaborative is currently testing approaches for national adoption in this setting, and recruitment to a similar dental collaborative has also commenced.

Within General Practice, the current GMS contract supports two principal pieces of work: reflective review of case notes by trigger tool; and a practice Safety Climate Survey.

The trigger tool review, using the NHS Education for Scotland Primary Care Trigger Tool, allows GP Practices to analyse a sample of case notes to determine whether any safety events, or near misses, have taken place. The resultant reflective report is discussed within the Practice before being shared with the NHS Board so that themes may be developed and further improvement activity undertaken taken if appropriate.

The Safety Climate Survey is a validated tool for all Practice staff, clinical and non-clinical, to express their views in six key areas of safety climate. This data can then be used by Practices to determine strengths and areas for development through the formation of a reflective report which is shared with the NHS Board where learning across the system may again be aggregated.

In addition to each of these areas, NHS Boards have commissioned a range of local enhanced services to improve areas of care that are recognised as being of higher risk to individuals; examples of these include warfarin therapy, disease modifying anti-rheumatic drugs, medicines reconciliation and laboratory results handling.

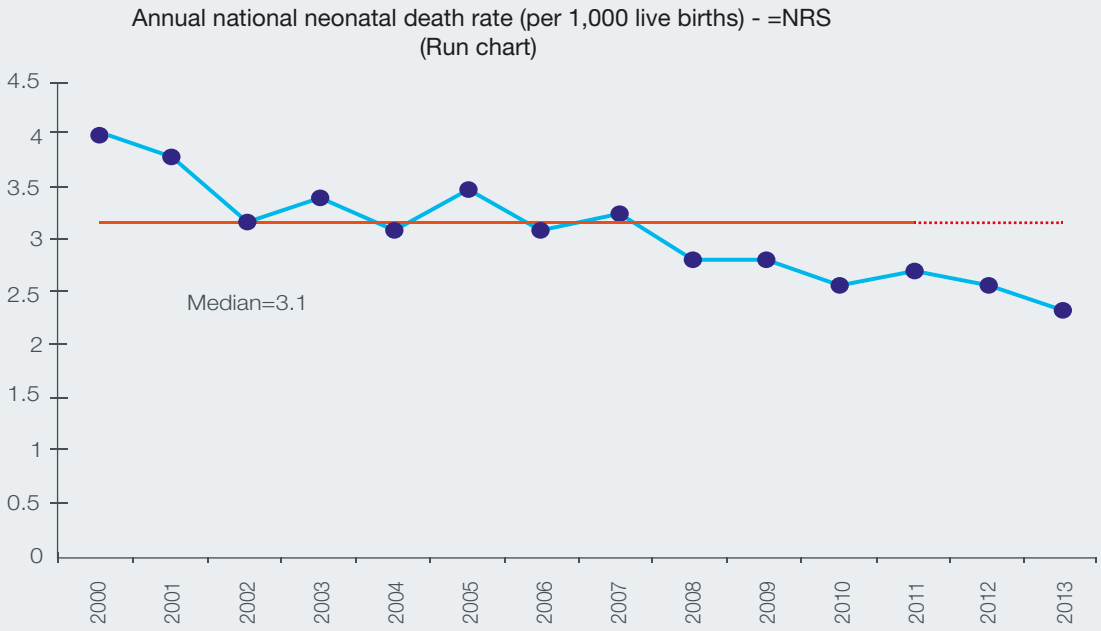
Improving the Care Experience for all Women, Babies and Families in Scotland

The maternity, neonatal and children's strand of the Scottish Patient Safety Programme is continuing to improve care and reduce inequalities in healthcare outcomes by providing a safe, high quality care experience for all women, babies and families in Scotland.

The Scottish Government is committed to ensuring that every child has the best possible start in life. To support this endeavour, a Midwifery Champion has been funded for every Territorial NHS Board to facilitate capacity-building and implementation of the Maternity and Children Quality Improvement

61 See: www.scottishpatientsafetyprogramme.scot.nhs.uk/programmes/mental-health (under 'Tools and Resources').

Chart Six:
Annual National Neonatal Death Rate (per 1,000 live births) – NRS (Run chart)



Source: Healthcare Improvement Scotland using NRS data

Collaborative. Champions work alongside national programme leads and local improvement colleagues to engage relevant multi-professional and multi-agency stakeholders from acute and Primary Care in the Collaborative's work and build capability and capacity in improvement science in local communities. They also facilitate introduction of care bundles and other initiatives and support data collection and dissemination.

The Collaborative has achieved:[62]

- a 14.4 per cent reduction in the annual national stillbirth rate from 2012 to 2014;
- a 5.3 per cent reduction in the annual neonatal death rate from 2012 to 2014 (see Chart Six); and
- 93 per cent of women being offered carbon monoxide monitoring at booking.

Reducing Healthcare Associated Infections

Reducing Healthcare Associated Infections (HAI) remains a priority for Scottish Government Ministers and NHSScotland. People should be able to have confidence in the quality of the care they receive and be assured that work continues to reduce HAI and improve outcomes.

The commitment to this priority is demonstrated by the reduction of cases of *methicillin-resistant Staphylococcus aureas* (MRSA) from 88 per cent from January to March 2007 to April to June 2015.[63] Cases of *Clostridium difficile* infection in patients aged 65 years and older reduced by 84 per cent in the same period.[64]

Tackling the rise of antibiotic resistance is another priority and the Scottish Antimicrobial Prescribing Group report on *Antimicrobial Use and Resistance*

62 National Records of Scotland data: www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/vital-events-reference-tables/2013/section-4-stillbirths-and-infant-deaths

63 Quarterly Surveillance Report on the Surveillance of Epidemiological Data on *Staphylococcus aureus* (*S. aureus*) Bacteraemia Infection in Scotland, Health Protection Scotland, October 2015.

64 Health Protection Scotland Quarterly Surveillance Report on the Surveillance of *Clostridium difficile* Infection (CDI) in Scotland, Health Protection Scotland, October 2015.

in Humans 2014[65] shows that the use of systemic antibacterials in Primary Care was 1.9 per cent lower in 2014 than in 2013 and the rate of prescribing in 2014 has reduced to the same level as 2005.

The Vale of Leven Hospital Inquiry concluded and published its report on the 2007/08 *Clostridium difficile* outbreak in November 2014.[66] The report identified system-wide failings and the occurrence of at least 34 deaths between 2007 and 2008 in which *Clostridium difficile* infection was a causal factor, but acknowledged the significant work taken forward in Scotland to prevent such a tragedy occurring again. Work progressed during the year (including with the families of those affected) to develop the Scottish Ministers' response to the report,[67] learn lessons and continue to make improvements.

The Healthcare Environment Inspectorate's annual report (published in February 2015)[68] highlighted 51 inspections in 34 hospitals in 14 Territorial and two Special NHS Boards in the period October 2013 to December 2014. The Inspectorate made 143 requirements and 61 recommendations. Requirements and recommendations have reduced significantly since the Chief Inspector's first annual report, demonstrating the improvements and progress that continue to be made by staff across hospitals in NHSScotland.

The ePharmacy Programme and Electronic Prescribing

Over 100 million prescription items were dispensed in the community in 2014/15, with over 90 per cent prescribed by GPs.[69] The ePharmacy Programme is revolutionising the way GP prescriptions are issued, dispensed at Community Pharmacies and processed for payment by the NHS, using the Electronic Transmission of Prescriptions system. The system increases patient safety by avoiding transcription errors and increases the accuracy and efficiency of drug reimbursement payments to Community Pharmacies.

Over 98 per cent of GP prescriptions are now issued electronically. Approximately 88.3 per cent of those dispensed at Community Pharmacies are claimed electronically, with 87.8 per cent of claims automated for pricing purposes.[70] The automation of claim-processing delivers a more efficient payment process, enabling back-office costs to be saved and diverted to frontline NHS services.

The ePharmacy platform leads the way in electronic prescribing systems in other parts of the UK.

Care for Older People in Hospitals

Healthcare Improvement Scotland led the Chief Nursing Officer Directorate-funded Improving Care for Older People in Acute Care workstream, which focused on two key areas:

- care co-ordination – identification and immediate management of frailty; and
- cognitive impairment – identification and immediate management of delirium.

65 Report on Antimicrobial Use and Resistance in Humans 2013, NHS National Services Scotland, October 2015. Access at: www.isdscotland.scot.nhs.uk/Health-Topics/Prescribing-and-Medicines/Publications/2015-10-06/2015-10-06-SAPG-2014-Report.pdf?87571352721

66 The Vale of Leven Hospital Inquiry Report, The Vale of Leven Hospital Inquiry, November 2014. Access at: www.valeoflevenhospitalinquiry.org/Report/j156505.pdf

67 The Scottish Government's Response to the Vale of Leven Hospital Inquiry Report, Scottish Government, June 2015. Access at: www.gov.scot/Publications/2015/06/4333

68 The Healthcare Environment Inspectorate Annual Report 2013/14, Healthcare Environment Inspectorate, February 2015. Access at: www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/hei_annual_reports/hei_annual_report_2013-14.aspx

69 Prescription Cost Analysis 2014/15, NHS National Services Scotland, Practitioner Services Division, June 2015. Access at: www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Community-Dispensing/Prescription-Cost-Analysis/

70 Management Information provided by NHS National Services Scotland, Practitioner Services Division, Service Improvement Team.

Patients identified as frail on admission to acute care settings receive comprehensive assessment and input from a specialist team on the day of admission. Evidence shows that appropriate and timely screening and assessment can reduce length of hospital stay and improve patient experience.

Healthcare Improvement Scotland published a case study report on innovations in identifying and managing frailty in four acute sites in NHSScotland in April 2011.[71] The case study's overall conclusion, under the heading 'Demonstrating Outcomes', included the following: "This report highlights significant improvements and outcomes for frail elderly people coming into hospital. These outcomes include reduction in admissions and re-admissions to hospital, reduction in length of stay, reduction in discharge to care home and reduction in mortality".

Managing Falls for Older People in Care Homes

The Up and About in Care Homes Improvement Collaborative was established in January 2014 with the aim of reducing falls in participating care homes by 50 per cent by the end of 2015. It recognises and reflects the need to reduce 'avoidable' hospital admissions where it is known that outcomes will worsen and problems linked to frailty are likely to increase during a hospital stay.

The Collaborative has developed a number of resources and tools covering education, information and advice to support daily practice in the management of falls and fractures in care homes. Reductions in the total number of falls and the number of those resulting in injury has been reported in care homes that have taken a proactive approach to improvement, with one care home achieving a 74 per cent reduction.

EFFECTIVE CARE

Many of the areas for improvement prioritised over 2014/15 make a direct contribution to achieving the Quality Ambition of more effective healthcare services. A focus has been to identify improvements for which there is clear and agreed evidence of clinical and cost-effectiveness, then support the spread of these practices (where appropriate) to ensure reductions in unexplained and potentially wasteful or harmful variation.

Primary Care

Transforming Primary Care

Primary Care remains the place where people interact with NHSScotland on a day-to-day basis. Pharmacists, Dentists, Optometrists and GPs, along with their Community Nursing and Allied Health Professional colleagues, provide enormously valued services at the heart of local communities. They work with all parts of the community and play a significant role in ensuring excellent service delivery.

This is a key component of integrating health and social care. As the 'front door' to services, Primary Care will shape pathways of care, reflecting closer and joined-up working with other professionals, including those in social care.

Challenges continue to exist, including those related to health inequality and rurality. As the population grows and people are living longer, they need different Primary Care services to manage their long term conditions in the community. GP practices working in clusters and as part of multi-disciplinary teams are needed to support individuals in a holistic and person-centred way, delivering care at home or in a homely setting.

We are committed to transforming Primary Care services, and increasing training posts is one of many initiatives needed to achieve this. This has to be combined with making a career as a GP more appealing and work to do this is progressing through our reforms to Primary Care; such as abolishing the outdated Quality and Outcomes Framework rewards from GP contracts.

71 Improving the Identification and Management of Frailty: a Case Study Report of Innovation on Four Acute Sites in NHSScotland, Health Improvement Scotland, April 2014. Access at: www.healthcareimprovementscotland.org/our_work/person-centred_care/opac_improvement_programme/frailty_report.aspx

We need to be more innovative and flexible in our recruitment efforts and are working closely with stakeholders on this. This includes looking at the way in which GP trainees are recruited, and enhancing the potential roles for GPs including working in new models of care, such as one-year fellowships in a community hub.

The contract status of GPs was stabilised on a three-year basis in 2014 after years of annual fluctuation, and work began in earnest with the British Medical Association (BMA) on proposals for a new GP contract from 2017 that will be based on quality, leadership and person-centred care. The introduction of Integrated Health and Social Care Partnerships means GPs must play a key role in locality planning. GPs understand their communities and are often the key decision makers regarding care pathways, so they need to be actively engaged in shaping local services and have responsibility for how best to spend the money to deliver services that improve outcomes.

The crucial role of GP out of hours services was recognised when Professor Sir Lewis Ritchie was asked to chair a review of out of hours Primary Care in January 2015. Sir Lewis, whose approach has been inclusive and wide-ranging, will present his recommendations later in 2015.

Building Clinical Capacity

The Prescription for Excellence (PfE) Programme is working towards building clinical capacity in Primary Care as a key priority to improve access to high quality pharmaceutical care and ensure all patients get the best possible outcomes from their medicines, while avoiding waste and harm.

Delivery of Primary Care Fund activities complements key PfE workstreams and aims to develop Primary Care pathways. The Primary Care Fund has allocated £16.2 million over the next three years to recruit up to 140 additional Pharmacist Independent Prescribers with advanced clinical skills training to work as part of multi-disciplinary teams in GP Practices. These pharmacists will manage caseloads, carry out medicines reviews and support the care of patients with long term conditions, consequently freeing-up GP time to spend with other patients.

Independent Prescribing by Physiotherapists and Podiatrists

It is increasingly recognised that services need to care for the whole person, rather than expecting people to fit into historic structures and arrangements that have more to do with administrative convenience and professional boundaries. Non-medical prescribing is at the forefront of changing professionally defined boundaries and shifting the focus to what people need to promote their wellbeing.

Physiotherapists and Podiatrists have been able to train as independent prescribers since May 2014. Prescribing rights enable these professionals to fully treat and support patients by, for example, prescribing appropriate pain killers as part of a treatment plan.

Unscheduled Care

NHSScotland faced some very challenging times last winter with crowding in Accident and Emergency (A&E) Departments, mainly due to unprecedented levels of activity, bed days lost to delayed discharge and people awaiting care in their communities.

Substantial funding was invested during 2014/15 to alleviate these issues at central and local levels and to support sustained improvements. Over £9 million was allocated to building on local unscheduled care action plans, £10 million to supporting improvements in relation to delayed discharge, and £10 million for winter resilience, with a focus on delayed discharge.

As outlined to in Chapter 2, Scotland's unscheduled care performance last winter deteriorated in line with other parts of the UK and, indeed, similar health systems across the world. Scotland's core A&E performance was nevertheless almost 1 per cent better than England's in winter 2014/15, having been almost 1 per cent worse in winter 2013/14. Although Scotland's performance continues to be the best in the UK, more needs to be done, particularly in certain NHS Boards and sites.

Health and social care integration is key to this. While only in the implementation phase, integration presents great opportunities for preventative and anticipatory care planning, joined-up services that prevent unnecessary admission, and alternative care-based services. This will require a joint approach through Integrated Health and Social Care Partnerships in which all partners are involved and, importantly, Local Authorities and NHSScotland are jointly responsible.

The £50 million national unscheduled care action plans have delivered significant benefits since their launch in 2013, including the introduction of weekend discharge teams, widespread introduction of patient safety and planning huddles, enhanced use of discharge lounges and the introduction of models of care for frail older people. It was nevertheless recognised that something drastically different needed to be done to ensure patients arriving at A&E departments received the quality of care they deserve.

The Cabinet Secretary for Health, Wellbeing and Sport announced in January 2015 the move to an improvement-focused approach to unscheduled care based on six fundamental actions developed in partnership with the Academy of Royal Colleges. The '6 Essential Actions to Improving Unscheduled Care' are:

- clinically-focused and empowered hospital management;
- realignment of hospital capacity and patient flow;
- operational performance management of patients presenting at A&E and progressing through the acute system;
- medical and surgical processes arranged to take patients from A&E through the acute system;
- seven-day services targeted to increase weekend and earlier-in-the-day discharges; and
- ensuring patients are cared for in their own homes or a homely setting.

This new approach, which was launched in May this year, is a two-year programme that aims to improve outcomes for people using services. It is multi-disciplinary in nature and requires commitment across every part of the health and social care system to ensure better care on a sustainable basis, joining up several work strands to ensure a much more strategic approach is adopted. National and local teams dedicated to progressing the 6 Essential Actions have been recruited.

While steady and significant improvements have been made in A&E over the spring (and beyond), ongoing challenges persist. NHSScotland and its partners are committed to addressing these to bring about sustained improvements for the people of Scotland.

Delayed Discharge

Tackling delayed discharge is one of the Scottish Government's key priorities for NHSScotland and its partners. We invested an additional £18 million in 2014/15 to tackle delayed discharges by supporting the development of intermediate care and other services aimed at supporting people to remain healthy and independent at home or in a homely setting. Local partnerships increased the number of step-down Intermediate Care beds by 200 during 2014/15, with 700 such beds now in place across Scotland.

Alongside these additional resources, Scottish Government officials worked closely with those partnerships facing the most significant challenges to identify areas of improvement. These discussions took place under the new shadow integration arrangements, with local partnerships starting to think in terms of shared resources and shared solutions.

As a consequence of this targeted investment, delays of over three days reduced by over 30 per cent, from 947 in October 2014 to 633 in April 2015.[72] During the same period bed days occupied reduced by over 16 per cent (from 56,122 at October 2014 to 46,890 in May 2015)[73] (see Chart Seven).

Excellent progress has been made by a number of partnerships during 2014/15, in particular, by increasing the use of Intermediate Care, and their focus on a discharge to assess policy.

In January, a £100 million investment, over three years, was announced to help Integrated Health and Social Care Partnerships tackle delayed discharges.

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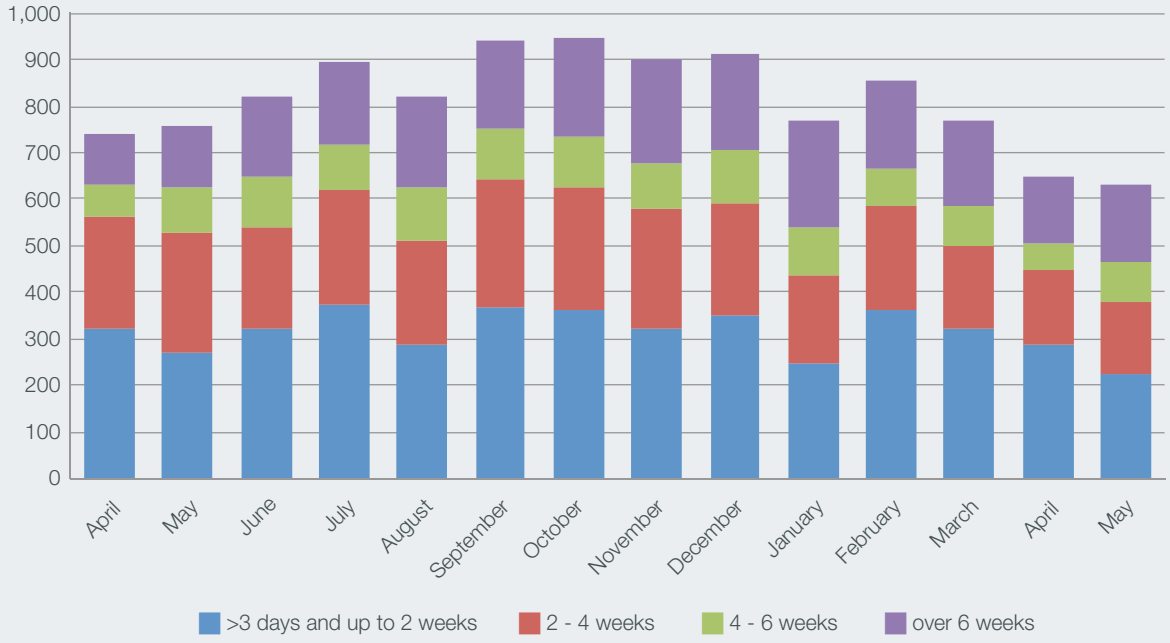
72 Delayed Discharges in NHSScotland, ISD Scotland, September 2015. Access at: www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/

73 ISD Scotland: Delayed Discharge www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/

Chart Seven:
Delayed Discharge April 2014 - May 2015



Move to New 111 Telephone Number

NHS 24 changed its telephone number to the new free-to-call 111 number in April 2014. The NHS 24 service remains unchanged, with people seeking help and advice during the out of hours period receiving the same high quality, safe and effective national unscheduled care service.

The switch to the free-to-call number was carefully planned to ensure a successful service transition. It was launched by the then Cabinet Secretary for Health and Wellbeing, Alex Neil MSP, and was supported by a public campaign using a mixture of public relations, social media and press, radio and outdoor advertising across the summer months.

Within eight weeks of introduction, 85 per cent of calls to NHS 24 were being made via the 111 telephone number. NHS 24 received 1,441,483 calls in total in 2014/15 (including 08454 and 111 numbers), a 16.7 per cent rise on 2013/14. The busiest day for the service since 111 was introduced was 2 January 2015, when it received 12,519 calls.[74]

Dementia

It is important that everyone in Scotland who has dementia has an early diagnosis and receives person-centred, safe and effective care at all stages of the illness and in all care settings – at home, in hospital and in residential care. Latest diagnosis information (from 2014) shows that between half and two-thirds of people with dementia are being diagnosed (depending on which prevalence model is applied).[75]

We are working with partners to support delivery of our world-leading service offer of a minimum of a year's worth of dedicated post-diagnostic support by a named Link Worker. Delivery is underpinned by a Local Delivery Plan Standard, with performance data to be published in spring 2016. We are also testing Alzheimer Scotland's proposed model of home-based support for people with

74 NHS 24 Management Data

75 Evaluating the Impact of the Alzheimer Scotland Dementia Nurse Consultants/Specialists & Dementia Champions in Bringing about Improvements to Dementia Care in Acute General Hospitals: Independent evaluation by Blake Stevenson, NHS Education for Scotland, April 2014. Access at: www.nes.scot.nhs.uk/media/2711493/impact_evaluation_-_final_report.pdf

dementia whose symptoms have advanced to the extent that they need intensive care and support to stay at home. We are working with five test sites – North Lanarkshire, Midlothian, Highland, Moray and Glasgow City – and the usefulness and impact of the service model is being independently evaluated, with a report scheduled for 2016.

The national approach to up-skilling and developing the dementia workforce continues, backed by around £500,000 per annum. Over 500 healthcare and social care staff have been trained as Dementia Champions to support joint working with people with dementia (this is expected to increase to over 600 in the next two years) and around 800 Dementia Ambassadors in Social Care have been trained.

The Quality and Excellence in Specialist Dementia Care Programme was developed in 2014/15 to extend work in improving standards of dementia care in general hospitals to other hospitals and NHS settings (including specialist dementia mental health units providing care and treatment for people with progressed-stage dementia).

Driving Up Standards of Dementia Care in Hospitals

The three-year strategy to improve dementia care[76] includes a 10-point action plan to drive up standards of care in hospitals. The actions focus on improvements in leadership, person-centred care, the environment and discharge planning.

The Dementia in Acute Care Settings improvement programme, launched in July 2014, concentrates on leadership, workforce development, working as equal partners with families and minimising and responding to stress and distress. NHS Education for Scotland has produced resources to support staff working with people who have dementia, including in acute care.

An evaluation report looking at the impact of Alzheimer Scotland Dementia Nurse Consultants and Dementia Champions was published in June 2014.[77] The report states that: “Improving experiences and outcomes for people with dementia care in acute general hospitals is recognised in Scotland’s Dementia Strategies as requiring significant cultural change and service development. Despite the enormity of the task and the relative small scale and immaturity of the initiatives, a significant amount of change and improvement work has been initiated by the two roles, and would likely not have happened without them”.

Improving Mental Health Services

Psychological Therapies and Child and Adolescent Mental Health Services

Data published by Information Services Division (ISD) Scotland indicates that the total number of people starting treatment in the quarter ending 31 March 2015 increased 24 per cent for psychological therapies and 18.5 per cent for Child and Adolescent Mental Health Services over the same period last year (see Table 1).

76 Scotland’s National Dementia Strategy: 2013–16, Scottish Government, May 2013. Access at: www.gov.scot/Topics/Health/Services/Mental-Health/Dementia/DementiaStrategy1316

77 Evaluating the Impact of the Alzheimer Scotland Dementia Nurse Consultants/Specialists & Dementia Champions in Bringing about Improvements to Dementia Care in Acute General Hospitals: Independent evaluation by Blake Stevenson, NHS Education for Scotland, April 2014. Access at: www.nes.scot.nhs.uk/media/2711493/impact_evaluation_-_final_report.pdf

Table 1: Starting treatment with psychological therapies and child and adolescent mental health services, 2014/15

	Psychological therapies	CAMHS
March 2014	9,4061[78]	3,6012[79]
March 2015	11,6593[80]	4,2694[81]
Difference	+2,253	+668
As a percentage of March 2014	+24% (23.9%)	+19% (18.55%)

Suicide Prevention

The Scottish Government has continued to work with a range of cross-sectoral partners to improve mental health services and the diagnosis of depression and other mental health problems. More support is now available for those affected and much has been done to improve safety for patients experiencing mental health problems and tackle the stigma of mental ill-health.

Suicide rates in Scotland over the rolling periods 2000 to 2004 to 2010 to 2014 fell by 17.8 per cent, with the number of deaths by suicide in 2014 the lowest in a single year since 1977.[82, 83] The welcome continuing downward trend in the suicide rate suggests that suicide is preventable and that having the right support available can make a big difference.

Breathing Space

The NHS 24 national mental health support service, Breathing Space, reached its 10th anniversary in November 2014. The service has taken more than 525,000 calls since it was established. Key milestones include the development of a national website in 2005, the launch of an annual awareness-raising day ('Breathing Space Day') in 2007 and the introduction of an award-winning British Sign Language (BSL) service in 2010. A new website was also launched to mark the 10th anniversary year.[84]

Vocational Rehabilitation

Allied Health Professionals are leading on the implementation of the Individual Placement and Support (IPS) model of vocational rehabilitation, which can support up to 66 per cent of users to gain paid employment, producing 50 per cent cost savings for every individual in work.[85]

An increasing number of service users now have access to IPS, with more models in development. Evaluation using the Fidelity Review has resulted in improved client outcomes.

78 Psychological Therapies Waiting Times in Scotland: Quarter Ending 31 March 2014, ISD Scotland, May 2014. Access at: www.isdscotland.scot.nhs.uk/Health-Topics/Waiting-Times/Publications/2014-05-27/2014-05-27-WT-PsychTherapies-Report.pdf?14344424010

79 Child and Adolescent Health Services Waiting Times in Scotland: Quarter Ending 31 March 2014, ISD Scotland, May 2014. Access at: www.isdscotland.scot.nhs.uk/Health-Topics/Waiting-Times/Publications/2014-05-27/2014-05-27-CAMHS-Report.pdf?14344424010

80 Psychological Therapies Waiting Times in Scotland: Quarter Ending 31 March 2015, ISD Scotland, May 2015. Access at: www.isdscotland.org/Health-Topics/Waiting-Times/Publications/2015-05-26/2015-05-26-WT-PsychTherapies-Report.pdf?

81 Child and Adolescent Health Services Waiting Times in Scotland: Quarter Ending 31 March 2015, ISD Scotland, May 2015. Access at: www.isdscotland.org/Health-Topics/Waiting-Times/Publications/2015-05-26/2015-05-26-CAMHS-Report.pdf?

82 Probable Suicides: Deaths which are the Result of Intentional Self-harm or Events of Undetermined Intent, National Records of Scotland, 2014. Access at: www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/suicides/main-points

83 Suicide: Key Points, Scottish Public Health Observatory, 2014. Access at: www.scotpho.org.uk/health-wellbeing-and-disease/suicide/key-points.

84 Breathing Space website can be accessed at: www.breathingspace.scot/

85 Briefing 41: Commissioning –What Works, Sainsbury Centre for Mental Health, 2009. Access at: www.centreformentalhealth.org.uk/briefing-41-commissioning-what-works

Cancer

Detect Cancer Early Programme 2014/15

As outlined in Chapter 2, the Scottish Government launched the Detect Cancer Early Programme in February 2012 to address the poor quality of life and poor survival rates resulting from late diagnosis. Early detection offers people the best chance of cure and possibly an opportunity to join clinical trials. Even in cases of advanced or incurable disease, early detection increases the chances of being able to offer treatment that prolongs life or allows more time to manage symptoms better and improve quality of life.

The Programme has successfully carried out five social marketing campaigns to help people spot the signs and symptoms of cancer earlier, encourage them to seek advice from their health professional and provide information to allow them to make an informed choice about participating in cancer screening programmes.

Fundamental to success is the need to address people's deep-rooted attitudes about cancer and ensure they understand the disease is not what it used to be – it can be survived, and early detection is worthwhile.

The Programme reached its three-year milestone in February 2015, producing a short film highlighting achievements in 2014/15.[86]

A new regional campaign was launched in autumn 2014 to emphasise the benefits of breast screening in areas of low uptake. The campaign included a short film starring the actress Elaine C Smith that aimed to demystify the process of breast screening and the distribution of over 55,000 'thingymaboob' keyrings. The bowel screening campaign helped contribute to an 80.6 per cent increase in the number of replacement bowel screening kits requested during campaign periods and over 4,300 extra test kits returned each month.

The lung cancer campaign was refreshed to include a 'three-week cough message'. This resulted in a significant increase in the proportion of people aged 55 years and over who disagreed strongly with the idea that they would 'feel silly' going to the doctor with any small changes they thought could indicate lung cancer – up from 24 per cent to 36 per cent. In addition, 93 per cent of the core Detect Cancer Early target audience (those most at risk of cancer and least likely to take part in screening) agreed that: "The earlier lung cancer is detected, there's more that doctors can do to treat it".

A two-year Primary Care initiative in which GPs are recognised for their role in supporting informed uptake of screening was supported by the large majority (83 per cent) of participating GP Practices across Scotland. The choice of whether to participate in screening programmes is a personal one, and those who are eligible are provided with information on the benefits and risks to enable them to make an informed choice.

Healthcare Improvement Scotland published refreshed *Scottish Referral Guidelines for Suspected Cancer*[87] in August 2014 and a mobile app is in development for late 2015 to ensure timely referral and diagnosis for all suspected cancer patients.

Building on this work, the 'wee c' strategy[88] was launched by the Cabinet Secretary for Health, Wellbeing and Sport, Shona Robison MSP, in August 2015. This strategy is a joint venture involving the Detect Cancer Early Programme in partnership with Cancer Research UK that aims to reduce the fear typically associated with cancer and push the message that: "Together, we can turn the Big C into the wee c".

Development of National Cancer Quality Performance Indicators

National Cancer Quality Performance Indicators (QPIs)[89] have been developed to drive continuous quality improvement in cancer care and ensure consistency and quality in treatment across NHSScotland. The indicators are proxy measures of the quality of cancer care and have been developed for 18 tumour types including breast, lung and colorectal.

86 You can access the film at: www.youtube.com/watch?v=llOJGc0_QO4

87 Scottish Referral Guidelines for Suspected Cancer, Healthcare Improvement Scotland, August 2014. Access at: www.healthcareimprovementscotland.org/our_work/cancer_care_improvement/programme_resources/scottish_referral_guidelines.aspx

88 Information on the 'wee c' is available at: www.theweec.org/

89 Cancer Quality Performance Indicators, Healthcare Improvement Scotland, August 2013. Access at: www.healthcareimprovementscotland.org/our_work/cancer_care_improvement/cancer_qpis/quality_performance_indicators.aspx

The QPI Programme aims to foster a culture of continuous quality improvement in which data is reviewed regularly at multi-disciplinary team/unit level and issues are quickly addressed. This ensures that activity is focused on the areas that are most important in relation to improving survival and enhancing patient experience while ensuring the most effective and efficient delivery of care.

NHS Boards are required to report against the QPIs as part of a mandatory publicly reported national programme.[90] Reports for breast, upper-gastrointestinal, lung and colorectal cancers have already been published and more will be released over the coming year.

Out-of-Hospital Cardiac Arrest Strategy

The Out-of-Hospital Cardiac Arrest (OHCA) Strategy for Scotland[91] was launched on 27 March 2015. This five-year plan aims to ensure that Scotland becomes a world leader in OHCA outcomes by 2020 by increasing survival rates by 10 per cent across the country. Increasing bystander cardiopulmonary resuscitation (CPR) is the cornerstone of improving outcomes: it can double or even triple the likelihood of survival.[92] The strategy aims to equip an additional 500,000 people with CPR skills by 2020.

The Strategy has been co-produced by a broad coalition of stakeholders, including emergency services, primary and secondary healthcare providers, third and private sector groups and academics. The commitment to improve OHCA outcomes is a collaborative effort, the success of which will depend on contributions and actions from many individuals and organisations. It will also require concerted clinical and political leadership and a change in culture around OHCA.

Increasing Access to Orphan, Ultra-orphan and End-of-life Medicines

More patients than ever are benefiting from access to new medicines for the treatment of orphan, ultra-orphan[93] and end-of-life conditions following the implementation of policy changes designed to increase patient access. Around 500 patients in Scotland were treated with medicines in these categories in 2014/15[94] ahead of the positive impact of decisions from a new approach being implemented by the Scottish Medicines Consortium. The changes were supported by the Scottish Government's New Medicines Fund.

Increasing Access to Insulin Pumps

Following the Ministerial Commitment in 2012 to increase access to insulin pumps as an effective person-centred treatment for type 1 diabetes, more people than ever now have access to this potentially life-changing therapy.

A quarter of young Scots with type 1 diabetes had access to insulin pump therapy in 2014/15,[95] exceeding the overall commitment to increase the total number of insulin pumps available to people of all ages to more than 2,000. Having met this commitment for Scotland as a whole, work with NHS Boards continues to ensure that insulin pump therapy is fully embedded and delivered as a core part of diabetes services, and that improvements in access are sustained.

ScotSTAR Service

The Scottish Ambulance Service launched a world-class national specialist transport and retrieval service for critically ill patients on behalf of NHSScotland on 1 April 2014.

With an annual investment of £9.5 million, ScotSTAR provides a single integrated national service involving a sustainable multi-disciplinary team to make best use of road and air transport resources. It brings the three transport and retrieval services – the Scottish Neonatal Service, the Transport of Critically Ill and Injured Children Service, and the Emergency Medical Retrieval

90 National reports can be found at: www.isdscotland.org/Health-Topics/Quality-Indicators/Cancer-QPI/

91 Out-of-Hospital Cardiac Arrest: a Strategy for Scotland, Scottish Government, March 2015. Access at: www.gov.scot/Publications/2015/03/7484/downloads

92 Hasselqvist-Ax I, et al. Early cardiopulmonary resuscitation in out-of-hospital cardiac arrest. N Engl J Med 2015;372:2307–15: DOI: 10.1056/NEJMoa1405796

93 Orphan and ultra-orphan drugs are those developed to treat very rare illnesses and conditions. They tend to be costly due to pharmaceutical companies' development investment and the relatively small numbers of patients for whom they are appropriate, meaning individual treatment courses can be very expensive.

94 NHS Board individual patient treatment requests and New Medicines Fund data.

95 Access at: www.sehd.scot.nhs.uk/mels/CEL2012_04.pdf

Service – together with the Scottish Ambulance Service, which co-ordinates the teams and road and air ambulances.

ScotSTAR delivers a centralised and co-ordinated approach that will create opportunities for greater shared working, training and education for staff. The new service transferred 2,654 of the most seriously ill patients to specialised treatment in 2014/15.[96]

Early Years

NHSScotland continues to be involved in the work of the Early Years Collaborative,[97] which is picking up pace across the 32 Community Planning Partnerships.

Eight Early Years Collaborative Key Change themes were agreed in 2014/15 and tests are helping to identify the high-impact interventions that are most likely to improve outcomes for children in their early years and achieve the stretch aims, which are ambitions aims that set out to challenge and stretch the service to achieve them. Highlights include tests that are supporting local improvements in: increasing the uptake of Healthy Start vouchers; joining up midwifery and addiction services for vulnerable families; increasing attendance at the 27- to 30-month child health review; and finding new person-centred ways to identify specific child health and wellbeing needs.

The number of tests across the Key Change themes continues to grow, with opportunities now being identified to spread interventions that have been proven to work across Community Planning Partnerships. This includes an income maximisation model that involves midwives identifying and referring vulnerable families to local welfare benefits advice services. The model has been spread to four Community Planning Partnership areas so far and is increasing the number of families receiving such advice and support.

Workforce

As Chapter 1 explains, the NHSScotland workforce is the key to delivering high quality healthcare. A healthy organisational culture is not about what we do, but how we do it. NHS Boards ensure everyone is clear about the values and behaviours expected of them. Local feedback from patients, staff and service users inform how well the values are embedded.

Recruitment

Recruitment of staff remains the responsibility of individual NHS Boards, but the Scottish Government has been able to help them with their recruitment challenges. For example, officials worked with NHS Boards to gather evidence of shortages across medical specialties and submitted evidence to the Migration Advisory Committee in December, resulting in the UK Government making additions to the UK-wide and Scotland-only Shortage Occupation lists. NHS Boards seeking to recruit specialists from this list should now find it quicker and less expensive to do so from abroad.

In January 2014, the Scottish Government announced a 6 per cent increase in pre-registration student nursing and midwifery intakes for the 2014/15 academic year. This follows a 4 per cent rise in 2013/14 (this equates to 2698 recommended training places for student nurses and midwives, up from 2530 in 2013/14). In February 2015, a further 3 per cent increase was announced for the 2015/16 academic year – a third successive rise.[98]

In February 2015, we also announced investment of £450,000 over three years to encourage former nurses and midwives back into the profession. This will enable around 75 former nurses and midwives to retrain each year and re-enter employment from April 2015.

The Scottish Government also worked with European Recruitment Services (EURES) and the Government of the Netherlands to promote NHSScotland as an employment option. EURES (UK) attended a medical careers fair in Amsterdam, returning with a number of expressions of interest in working within NHSScotland. The Scottish Government is building on this work as it continues to support NHS Boards' efforts to recruit the staff they need.

96 SCOTSTAR – Critical Care Anywhere. Annual Report 2014-15, Scottish Ambulance Service, 2015. Access at: www.scottishambulance.com/UserFiles/file/TheService/Publications/ScotSTAR%20AR%20WEB.pdf

97 Access at: www.gov.scot/Topics/People/Young-People/early-years/early-years-collaborative

98 Access at: http://news.scotland.gov.uk/News/Student-nurse-levels-increase-by-3-per-cent-15de.aspx

Workforce Planning

Work to strengthen workforce planning began in 2014/15, with the Scottish Government working closely with NHS Boards through their Human Resource Directors to implement the recommendations of the Pan-Scotland Workforce Planning report.[99] Two data-quality improvement exercises were completed in 2014/15, resulting in more accurate data collection to better inform future workforce supply and demand forecasting. Midwifery and neonatal nursing sub-job family titles have been reviewed and staff have been re-categorised, where appropriate, into the correct sub-job family; community nursing, particularly district nursing, health visiting and school nursing, has also been reviewed, with guidance prepared for users and staff being re-categorised where appropriate.

Further progress will be made in 2015/16 through the establishment of a Vacancy Short-life Working Group to look at workforce planning for Integrated Health and Social Care Partnerships and the establishment of a Workforce Observatory.

NHS Pay and Conditions

NHS Pay Review Bodies' recommendations for 2015/16 have been implemented in full. This means that all NHSScotland staff on Agenda for Change pay points over £21,000 received a 1 per cent pay increase from 1 April 2015. Staff earning under £21,000 received a flat rate increase of £300. Executive and senior managers had a 1 per cent pay rise in line with other staff.

NHS Boards delivered an overall reduction in senior management posts of 437.0 WTE between 2010/11 and 2014/15: this reduction of 33.1 per cent exceeded the target by 8.1 percentage points.[100]

A new NHS pension scheme was introduced from 1 April 2015 following communication with all staff. The new scheme includes a later pension age and work on developing support for staff continues through the UK-wide Working Longer Review.

Together, these achievements improve efficiency and support staff in the continued delivery of quality services.

Sustainability and Seven-day Services

The aim of the Sustainability and Seven-day Services Programme is to ensure that people who require healthcare have timely access to high quality care whenever they need it, on a basis that is sustainable in the long term. The Sustainability and Seven-day Services Taskforce, which was established to drive this work, published an interim report in March 2015[101] that defined seven-day services, set out the Taskforce's findings to date and clarified actions that would be undertaken in the next phase of work. The actions include a review of the 29 sites that undertake acute general surgery, considering new models for diagnostic imaging and interventional radiology, and looking at new models of care, such as community hubs.

The Scottish Government, NHS employers, staffside partners and healthcare professionals are working together in taking this forward, demonstrating commitment to a partnership approach in NHSScotland.

Workforce Integration

The workforce is vital to the successful delivery of integrated health and social care services and efforts to identify key workforce issues arising as a result of integration continue. As part of this, the second event in the successful Strengthening the Links series was held on 30 October 2014, with a focus on practical examples of workforce challenges.

This collaborative series of events forms a key part of continuous learning and networking processes around workforce issues. The events bring together those responsible for strategic human resources across health and social care, including representatives from the third and private sector, and staffside partners.

The Human Resources Working Group on Integration continued its work to address strategic-level workforce issues and advise on the practical human resource implications.

99 Pan Scotland Workforce Planning Assessment and Recommendations, Scottish Parliament, March 2014. Access at: www.scottish.parliament.uk/S4_HealthandSportCommittee/SGDocs/PanScotlandWorkforcePlanning.pdf

100 25% Reduction in Senior Management Posts Target – National Progress Towards 25% Reduction as at 31st March 2015, Scottish Government, August 2015. Access at: www.gov.scot/Publications/2015/08/9870

101 Sustainability and Seven Day Services Taskforce. Interim Report, Scottish Government, March 2015. Access at: www.gov.scot/Resource/0047/00472724.pdf

Youth Employment

NHS Boards continue to deliver against youth employment targets. Over the reporting year 2014/15, Boards created 96 new Modern Apprentice opportunities and delivered 3,050 new employment opportunities for young people (aged 16 to 24), making a positive contribution to building a sustainable workforce for NHSScotland.[102]

Over 8,000 opportunities have been offered to young people by NHS Boards over the past three years, with levels of activity measured through an annual survey. A new target of creating 500 Modern Apprenticeship opportunities between August 2014 and August 2017 was set for NHSScotland in the summer of 2014. Progress is being monitored and reported back to NHS Boards on a quarterly basis to manage delivery of the target.

eHealth

eHealth is the key to how information is accessed, used and shared within and across NHS Boards and with partner organisations to deliver integrated health and social care and, as such, is a prime enabler of the delivery of the 2020 Vision for Health and Social Care. eHealth supports patients and their carers to make informed decisions to manage their health and wellbeing and also enables health data to be used appropriately to improve the effectiveness of services and treatments and make significant advances in medical research.

The latest eHealth Strategy,[103] published in March 2015, was developed collectively with the support of NHSScotland Chief Executives. Current major strands of work include the use of portal technology to incrementally continue to build an Electronic Health Record (EHR) and make summary views from the EHR increasingly available to health and care professionals wherever and whenever they need them. These views will also be accessible across NHS Board boundaries. A Hospital Electronic Prescribing and Administration System was procured this year to enable NHS Boards to fill an important gap in the electronic information they hold (funded with an additional £1 million investment this year with further significant funding in following years as NHS Boards roll it out).

Another major strand of work that uses portal technology is progressively giving patients access to information held in the EHR so they can manage their health and wellbeing, order repeat prescriptions and book appointments online, and use secure two-way digital communication with their health and social care providers. Those with appropriate needs will also have access to a portfolio of proven technology enabled care solutions, such as Telehealth home-based health monitoring.

Significant initiatives this year include the Technology Enabled Care Programme, which aims to scale-up and embed Telehealth and Telecare solutions (funded with an additional £10 million annual investment over three years), and the Digital General Practice Programme that focuses on providing a broader and deeper set of digital services offered by GPs across Scotland (funded with an additional £2 million investment per year over three years).

Telehealth and Telecare

The NHS 24 Scottish Centre for Telehealth and Telecare continues to expand and embed digital health services across a number of NHS Boards. Innovations in mental health have been expanded to adults with mild to moderate depression and/or anxiety in a further four NHS Boards (NHS Shetland, NHS Grampian, NHS Lanarkshire and NHS Fife), transferring the learning from two early adopters in Scotland (NHS Forth Valley and NHS Tayside) and wider European experience.

MasterMind is a three-year European programme using clinically proven computerised Cognitive Behavioural Therapy (cCBT) to support a significant number of patient referrals from GPs and other mental health and care professionals. Provision of cCBT services aims to improve patient access to psychological therapies while providing additional treatment choice and early intervention. Commencing in January 2015, the trial has seen 1,117 patients start treatment up to the end of August 2015. MasterMind's cCBT services are being delivered at home or in community locations such as libraries, supporting greater flexibility and accessibility for patients while enabling better targeting of specialist health resources.

102 NHSScotland Youth Employment Returns, Scottish Government

103 eHealth Strategy 2014–2017, Scottish Government, March 2015. Access at: www.gov.scot/Publications/2015/03/5705

Science and Research

Engagement with Leading Medical Research Charities to Co-fund Large-scale Research Projects and Fellowships

The Chief Scientist Office (CSO) co-funded six research projects and four clinical fellowships in 2014/15 with the following charities: Action Duchenne, Alzheimer's Research UK, Breast Cancer Campaign, British Lung Foundation, MND Association, MND Scotland, Muscular Dystrophy UK, Pancreatic Cancer UK, Scottish Huntington's Association and the Stroke Association.

The total amount of research funding made available through these collaborations was £3.2 million, with over 50 per cent being contributed by the third and private sector. A further four collaborations have been signed off and are awaiting announcement.

These collaborations are a vital component of CSO's strategic aim of maximising research capacity in NHSScotland in areas of clinical importance and need. Increased effectiveness in health and social care depends on evidence gained from research, and this initiative helps build future research capacity within NHSScotland in a cost-effective manner.

NHS Research Scotland/Universities Scottish Senior Clinical Academic Fellowship Scheme

This new Clinical Academic Fellowship Scheme is funded jointly by the Scottish Government Health and Social Care Directorates, with universities playing a valuable role in providing medical training. The Scheme will recruit 15 senior fellows over a five-year period, with the first round advertised in January 2015.

Clinical academics are a valuable resource for Scotland and complement NHSScotland's capacity-building activity. As university employees who spend at least half of their working week delivering and developing clinical services for the NHS, clinical academics undertake research that not only improves Scotland's health and healthcare, but also drives economic growth. Without this scheme, there would be a significant risk that carefully nurtured early career clinical academics would be attracted to long-term career posts outside Scotland.

The Scottish Improvement Science Collaborating Centre

The Scottish Improvement Science Collaborating Centre (SISCC) is a Scotland-wide research initiative that aims to develop and promote evidence-based, integrated, sustainable ways of working in and across health and social care that consistently prioritise the needs of service users, carers and the public. It was established during 2014/15 and is being led by the University of Dundee and NHS Tayside through a collaboration involving eight universities and nine NHS Boards, national NHS and Social Care organisations, third and private sector and community groups, Local Authorities and the Scottish Government.

SISCC is supported by £3.75 million investment over five years from the Scottish Funding Council, Chief Scientist Office, NHS Education for Scotland and the Health Foundation, with matched investment from partner organisations.[104]

The Centre is building a large Scotland-wide collaboration that provides a firm foundation to support its mission to overcome the barriers that can exist between:

- research, practice and policy;
- acute and Primary Care;
- healthcare and public health;
- health and social care and the third sector;
- different professional groups; and
- those who provide services and those who use them.

Increasing Opportunities to Participate in Research for Patients in Scotland

The number of research study sites opened through NHS Research Scotland increased by 11.8 per cent over the preceding year, with the number of patients recruited to publicly funded research studies increasing by 4.6 per cent in the same period.[105]

104 Further information can be found on the SISCC website at: www.siscc.dundee.ac.uk

105 NHS Board activity returns.

Chapter 4
Improving the Health of the Population

Graham

To read Graham's story see the online report at: www.nhsscotannualreport.scot

Overall, health in Scotland is improving. This can be seen in the underlying trends for Life Expectancy (LE) and Healthy Life Expectancy (HLE)[106] at birth, which both show a general improvement over recent years.

It is recognised, however, that considerable variations in LE and HLE exist among the people of Scotland. In 2011/12, for example, male LE at birth ranged from 81.7 years in the least deprived populations to 71.3 years in the most deprived populations. The figures for male HLE at birth were 69.1 and 48.3 years respectively (a difference of 20.8 years). For females, LE at birth ranged from 84.0 years in the least deprived quintile to 77.2 years in the most deprived quintile (a difference of 6.9 years), while the figures for HLE at birth were 71.9 and 51.5 years respectively (a difference of 20.4 years).

Tackling inequalities in health has been a focus for NHSScotland for many years and is not without its challenges. The complexity of resolving health inequalities is widely acknowledged: as the Health and Sport Committee of the Scottish Parliament recognised in its report published at the beginning of 2015,[107] this is not a problem the NHS can solve alone.

The fundamental drivers of inequality need to be addressed to effectively tackle health inequalities. The emphasis needs to shift from dealing with the consequences to tackling the underlying causes, such as ending poverty, providing fair wages, supporting families and improving physical and social environments. A Scotland that is both prosperous and socially just needs to be built to get to the root of inequalities in health.

Inequalities in health are neither inevitable nor irreversible, and there is nothing inherently unhealthy about people living in Scotland. Harnessing the power of the entire NHSScotland workforce through working together can make a difference.

106 Life Expectancy (LE) is an estimate of how many years a person might be expected to live, while Healthy Life Expectancy (HLE) is an estimate of how many years they might live in a 'healthy' state. HLE is a key summary measure of a population's health.

107 1st Report, 2015 (Session 4): Report on Health Inequalities, Health and Sport Committee of the Scottish Parliament, January 2015. Access at: www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/85035.aspx

Public Health Workforce

People in Scotland's public health community are seen as pioneers not only within the UK, but also across the world. The workforce is diverse, which ensures the public health voice is heard across the broad determinants of health through working with partners and within the NHS.

Scotland continues to see progress and success in improving the population's health and wellbeing across a broad range of activities, from influencing lifestyle choices, through providing support within the workplace, to working with partners in the wider public and third and private sectors to impact positively on people's lives.

Smoking

Tobacco remains the primary preventable cause of ill health and premature death. It is associated with 56,000 hospital admissions and over 13,000 deaths each year in Scotland – around a quarter of all annual deaths. Annual costs to NHSScotland associated with tobacco-related illness are estimated to exceed £300 million and may be higher than £500 million.[108]

Reducing the number of people who take up smoking, supporting those who do smoke to quit and protecting people from second-hand smoke have long been clear public health priorities.

The Scottish Government's *Tobacco Control Strategy – Creating a Tobacco-free Generation*[109] was published in 2013. This sets a bold and ambitious target to reduce smoking rates to 5 per cent or lower by 2034.

As outlined in Chapter 2, the results of the *2014 Scottish Household Survey*[110] were published in August and reveal encouraging progress towards achieving this goal. It showed that 20 per cent of adults now smoke – only one in five adults in Scotland. This is a drop of three percentage points on the previous three years and the sharpest year-on-year decline in smoking rates since 1999. Encouragingly, smoking rates in the most deprived areas have dropped from 40 per cent in 2010 to 34 per cent in 2014, although this figure remains significantly higher than the 9 per cent found among those in the least deprived areas.

NHSScotland continues to play a key role in tobacco control efforts. NHS Boards exceeded the Scottish Government target of helping people quit tobacco for at least one month between 2011 and 2014. A new target was set for NHSScotland to support at least 12,000 people to quit for at least three months in the most deprived areas between April 2014 and March 2015. This target presented a challenge to NHS Boards, as reflected in recently published figures that show NHSScotland achieved 58 per cent of the target.

It is important to view this in the context of around a 40 per cent drop in people accessing NHS cessation services since their peak in 2012. This is likely to be due to a number of factors, including the rise in the popularity of e-cigarettes as a means of stopping smoking. Supporting people in deprived communities to stop smoking, particularly given the high smoking prevalence in this group, remains a challenge but will continue to be a priority for tobacco control activity in the NHSScotland.

NHSScotland also rolled out a nation-wide smoke-free policy for all its outdoor grounds as of April 2015. This built on the range of policies already in place across NHS Boards to deliver one Scotland-wide approach and was supported by a national campaign that recognised the efforts of people who smoke in trying to comply with the policy. The Scottish Government is taking forward legislation to help support implementation of smoke-free grounds.

It is not just people who smoke who are affected by the health impact of tobacco. Second-hand smoke also affects children who are exposed to it. Recent Scottish research shows that harmful chemicals from tobacco can linger in a room for up to 5 hours. The Scottish Government's Take it Right Outside campaign,[111] launched in 2014, was developed with the support of NHS Boards to raise awareness of the risks of smoking indoors and supports people to not smoke in the homes of children.

108 ScotPHO Smoking Ready Reckoner –2011 Edition, Scottish Public Health Observatory (ScotPHO), January 2012. Access at: www.scotpho.org.uk/downloads/scotphoreports/scotpho120626_smokingreadyreckoner.pdf

109 Tobacco Control Strategy – Creating a Tobacco-free Generation, Scottish Government, March 2013. Access at: www.gov.scot/Publications/2013/03/3766

110 Scotland's People Annual Report: Results from 2014 Scottish Household Survey, Scottish Government, August 2015. Access at: www.gov.scot/Publications/2015/08/3720

111 You can access the campaign website at: www.rightoutside.org/

Help continues to be provided for those who want to quit. GPs provide expert advice and will direct people to a range of local services on their doorstep. Pharmacists have become a convenient frontline smoking cessation service for many people, providing smoking cessation products to help people quit with ongoing advice and follow-up support. Further information and advice is also provided through services such as Smokeline (0800 84 84 84)[112] and the Take it Right Outside campaign.

Alcohol

Scotland is also seen as a world-leader in addressing alcohol-related harm. It was recognised several years ago that Scotland's relationship with alcohol had become unbalanced, and bold action has been taken to tackle alcohol misuse.

A whole-population approach is at the heart of Scotland's Alcohol Framework,[113] which includes a package of over 40 measures to reduce alcohol-related harm by helping to prevent problems arising in the first place. It also addresses improving support and treatment for those who are already experiencing problems.

Alcohol-related harm has an impact not only on individuals, but also on families and communities. Alcohol Brief Interventions (ABIs) play an important preventative role in tackling this as part of a wider strategic approach to addressing problem alcohol use.

The ABI Programme has focused delivery on three priority settings: Primary Care, A&E and antenatal services. In 2014/15, 99,252 ABIs were carried out, exceeding the target of 61,081 by 62 per cent.[114] The target has continued into 2015/16 to support the long-term aim of embedding ABI delivery into routine practice, with broadened delivery opportunities in wider community settings to increase coverage of harder-to-reach groups. If people feel better supported to live well within their community and to self-manage, they are more likely to avoid reaching crisis point, which can mean ending up in hospital.

Obesity

The Scottish Government is committed to addressing Scotland's obesity crisis, but there is no simple solution and we have to maintain activity across a broad front that makes it easier for people, including children and their families, to be more active, to eat less, and to eat better.

In 2010, the Scottish Government published *Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight* which sets out both national and local governments' respective long-term commitment. The Programme for Government 2015/16 contains a commitment to update the Route Map. It includes an aim to identify and adopt new actions and highlight the developing link with inequalities.

Since 2008, the Scottish Government has directly funded NHS Boards to deliver Child Healthy Weight Interventions. Between 2011 and 2014, there were 16,820 Interventions completed, 12.8 per cent higher than the agreed HEAT target.[115] Three classes of intervention have been run – one-to-one, family group and school-based – supported by annual funding of £2 million which continues into 2015/16.

A further annual £1.76 million funds services for adults including the internationally-recognised Football Fans in Training in conjunction with the Scottish Professional Football League Trust.

Diet

Poor diet and excessive consumption of food and drink remains one of the main contributors to poor health in Scotland, with around two-thirds of Scots overweight or obese[116] and one in 25 diagnosed with type 2 diabetes.[117]

Rebalancing our diet is a shared responsibility between individuals, communities, industry and government, but changing established habits is neither easy nor quick. The most recent Scottish Health Survey showed only one in five adults and 14 per cent of children aged 2-15 are currently meeting the five-a-day recommendation for fruit

112 You can access the Smokeline website at: www.canstopsmoking.com

113 Changing Scotland's Relationship with Alcohol: a Framework for Action, Scottish Government, March 2009. Access at: www.gov.scot/Publications/2009/03/04144703/0

114 Alcohol Brief Interventions 2014/15, ISD Scotland, June 2015. Access at: www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2015-06-30/2015-06-30-ABI2014-15-Report.pdf

115 Child Healthy Weight Interventions 2013/14, ISD Scotland, July 2014 Access at: www.isdscotland.scot.nhs.uk/Health-Topics/Child-Health/Publications/2014-07-29/2014-07-29-ChildHealthyWeight-Report.pdf?24651736022

116 Scottish Health Survey 2014. Access at: www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey

117 Scottish Diabetes Survey 2014, Scottish Diabetes Survey Monitoring Group. Access at: www.diabetesinscotland.org.uk/Publications/SDS2014.pdf

and vegetable consumption.[118] We need to change the way people think about food and make it easier for people to make healthier food choices.

Through our *Supporting Healthy Choices Voluntary Framework*, we are engaging with the food and drink industry, the public and third sectors to take action to support people to eat more healthily. Key areas of action include: rebalancing promotions; the responsible marketing of food; and reformulation of products to reduce salt, sugar and fat content.

The Scottish Government's Eat Better Feel Better social marketing campaign promotes healthier eating as a simple, affordable choice for everyone in Scotland. It offers practical hints, tips, offers and recipes to help families eat more healthily at home.

Food Standards Scotland (previously Food Standards Agency Scotland) continues to play a key role in supporting the Scottish population to eat a healthier diet through the provision of healthy eating information and resources for both consumers and businesses.

Fit for Work

Good work is a key driver of health. Sustained unemployment and worklessness frequently leads to poor and declining health. The longer someone is out of work, the harder it is for him or her to return to it. For those still in work, prolonged sickness absence without access to support often leads to job loss and a move onto benefits.

Fit for Work Scotland[119] was launched in 2014. It is being delivered in Scotland as a collaboration between the Scottish Government and the Department for Work and Pensions through NHSScotland.

A free and confidential advice service is currently being rolled out across Scotland, with an assessment service to provide detailed support for returning to work. Access to occupational health expertise will enable people to get back to work sooner and will reduce the risk of job loss, a move onto benefits and poorer health outcomes.

Acting as a Role Model and Making the Healthier Choice the Easier Choice

NHSScotland has a key responsibility for promoting health and wellbeing in the population it serves, but it has recognised in recent years that it should also be seen as an organisation that values and promotes health among its workforce and those that engage with the NHS. This is being realised through the Health Promoting Health Service (HPHS).[120]

HPHS is about promoting healthier behaviours and discouraging detrimental ones in NHSScotland and is aimed at staff and anyone visiting NHS premises. It seeks to achieve this by ensuring that healthier choices are readily available and that appropriate support and encouragement is in place to help people make better choices.

Improvements in the hospital environment have been particularly evident over the last year, with healthier food choices on offer in staff canteens and visitor cafes, an increase in the number of sites with well-designed, usable green spaces for therapy and to encourage physical activity, and a ban on smoking in NHSScotland grounds.

NHS Boards achieved the Healthyliving Award Plus in all 123 NHS-operated sites, with a further 60 in the third and private sector. The Healthyliving Award rewards caterers from across the length and breadth of Scotland for making it easier to eat healthily when eating out. Award criteria are based on the general principles of a healthy balanced diet and have been developed to reflect Scottish dietary targets, so aim to ensure that healthier ingredients and cooking methods are used to keep fat, salt and sugar to a minimum and options such as water, low-fat dairy products and fruit and vegetables are always available. NHS Boards are asked to ensure that all caterers (such as tea bars, restaurants and cafes) who sell food or drinks in healthcare premises work to maintain the Healthyliving Award Plus, ensuring a consistent approach among food service providers across the NHS: 70 per cent of all food provision must meet Healthyliving criteria.

118 Scottish Health Survey 2014. Access at: www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey

119 You can access the website at: www.fitforworkscotland.scot/

120 You can find out more about the HPHS at: www.knowledge.scot.nhs.uk/home/portals-and-topics/health-improvement/hphs.aspx

Physical Activity

Regular physical activity of at least moderate intensity provides general health benefits across a range of diseases and for all ages. There is strong evidence that the greatest health benefits are accrued when the least active people become moderately active.

Physical activity reduces the risk of coronary heart disease, cardiovascular disease and stroke and is an effective treatment for peripheral vascular disease and high blood pressure. It is also associated with a reduction in the risk of colon and breast cancer. Active people have a 30 to 40 per cent lower risk of developing type 2 diabetes compared to inactive people: for people who have already developed type 2 diabetes, the risk of premature death is much lower for active and fit patients than for those who are inactive and unfit.

Physical activity promotes strength, co-ordination and balance. This is particularly important for older people, as it helps to reduce their risk of falls and helps them to maintain their capacity to carry out common activities. As a result, physical activity can help older people sustain an independent lifestyle for longer.

Employees who are physically active have fewer days of sick leave, lower staff turnover and fewer industrial injuries. In relation to mental health, physical activity reduces the risk of depression and cognitive decline in adults and older adults.

The health risks of inactivity are stark: inactivity contributes to over 2,500 premature deaths in Scotland each year and costs NHSScotland over £94 million.[121] It is estimated that getting Scotland more active would increase life expectancy by more than a year, given current inactivity levels.

In recognition of the substantial benefits to health that being physically active offers, a 10-year Physical Activity Implementation Plan[122] was launched in February 2014, followed by the Active Scotland Outcomes Framework[123] for physical activity in December 2014. Promotion of physical activity in the NHS forms a core element of the Health Promoting Health Service.

NHS Boards have been tasked with increasing opportunities for staff, patients and visitors to be more physically active by, for instance, encouraging stair use and setting up walking groups, as well as greening the NHS estate (through setting up community gardens or creating new walking paths around the estate, for example). NHS Boards have also been asked to encourage staff and visitors to make more active, green travel choices by providing more information about active travel options available and putting initiatives such as the bike purchase scheme in place. They are also encouraged to improve the infrastructure to support active travel to hospital sites, where possible.

Childsmile

Childsmile is an innovative Scottish Government initiative that provides free daily supervised tooth-brushing for every child attending nursery in Scotland. Specially trained dental nurses assist nursery staff to deliver daily supervised tooth-brushing with fluoride toothpaste.

In a major study funded by Scottish Government and undertaken by the University of Glasgow, the full impact of the programme in terms of the number of dental extractions and fillings saved has become apparent. Importantly, fewer children needed general anaesthetics. The study looked at the period 2001/02 to 2009/10, estimating that nearly £5 million a year was saved through treatment costs avoided in 2009/10.[124]

These savings are ongoing and show the significant financial impact of preventive health programmes. Very simple health interventions can have a major effect in terms of patient care and savings to the NHS.

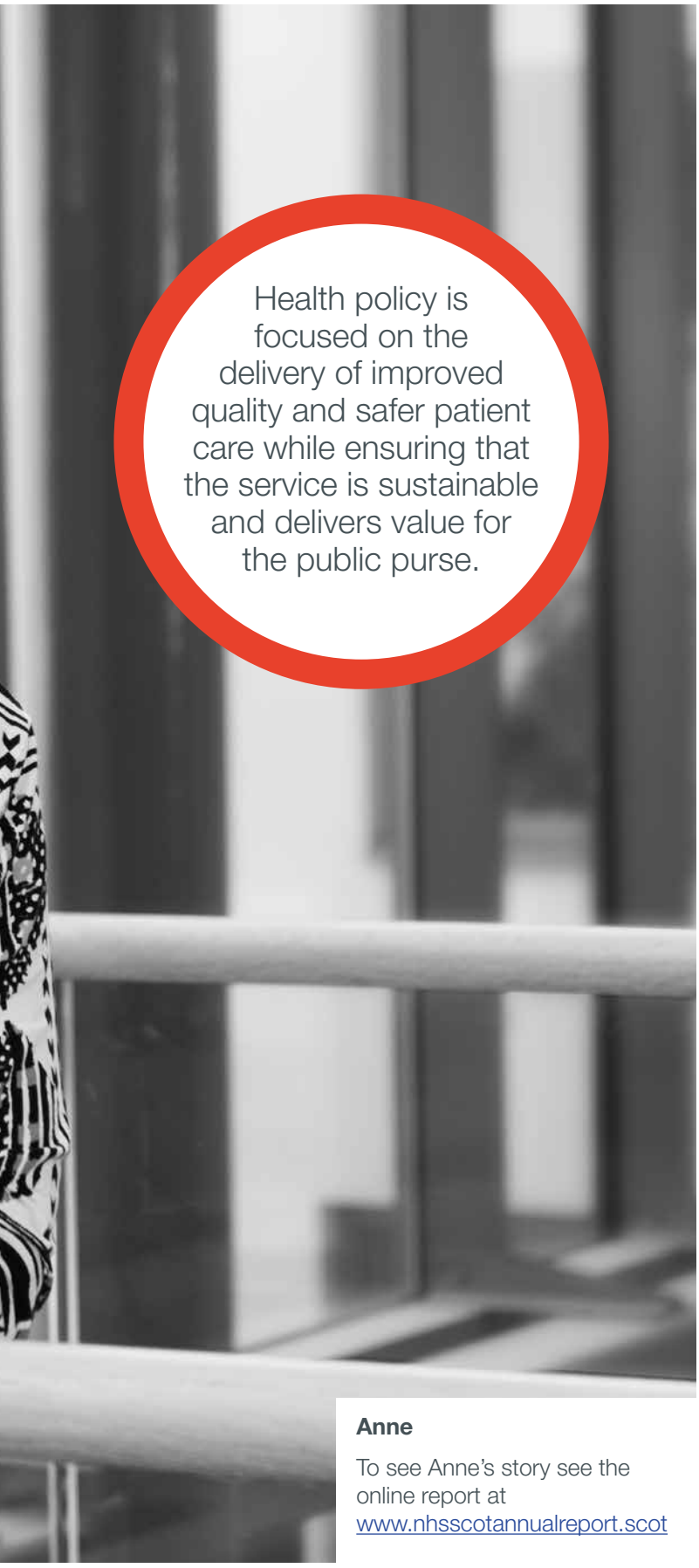
121 Costing the Burden of Ill Health Related to Physical Inactivity for Scotland, NHS Health Scotland, August 2012. Access at: www.healthscotland.com/uploads/documents/20437-D1physicalinactivityscotland12final.pdf

122 You can find out more about the Physical Activity Implementation Plan at: www.gov.scot/Topics/ArtsCultureSport/Sport/MajorEvents/Glasgow-2014/Commonwealth-games/Indicators/PAIP

123 You can find out more about the Active Scotland Outcomes Framework at: www.gov.scot/Topics/ArtsCultureSport/Sport/Outcomes-Framework

124 Nursery Toothbrushing Reduces Decay, University of Glasgow, November 2013. Access at: www.gla.ac.uk/schools/dental/aboutus/news/archive2013/headline_296200_en.html

Chapter 5
Securing Value and Financial Sustainability



Health policy is focused on the delivery of improved quality and safer patient care while ensuring that the service is sustainable and delivers value for the public purse.

Anne

To see Anne's story see the online report at www.nhsscotannualreport.scot

FINANCIAL OVERVIEW

Health had an overall resource and capital budget of £12.0 billion in 2014/15 and spent in full the cash available for services and infrastructure. There was an underspend of less than 0.1 per cent of the budget relating entirely to non-cash budgets such as depreciation and asset impairments that therefore could not have been spent on services.[125] All of the money available was used to provide services and invest in health infrastructure across Scotland. This underlines the sound financial stewardship of NHS Boards and the Scottish Government Health and Social Care Directorates.

As in each year since 2010/11, the NHS frontline resource budget has been protected. The 14 Territorial NHS Boards received above-inflation baseline resource increases of 3.1 per cent in 2014/15.[126] Owing to the contributions of all those involved in the running of the NHS, all NHS Boards met their financial targets in 2014/15 and remained within budget for the seventh year in a row.

The health resource budget has increased by £409 million in 2015/16, taking spending to a record level. Resources allocated to Territorial NHS Boards have increased by 3.8 per cent,[127] an above-inflation increase that has ensured all Territorial NHS Boards have received above-inflation increases in each year since 2010/11.

How the Budget was Spent

The Scottish Government allocated £10.1 billion directly to the 14 Territorial NHS Boards. The seven Special NHS Boards and Healthcare Improvement Scotland received £1.3 billion, and the remaining £0.6 billion was used to provide funding for national public health programmes such as tackling health inequalities, improving access to services, eHealth initiatives and medical research.

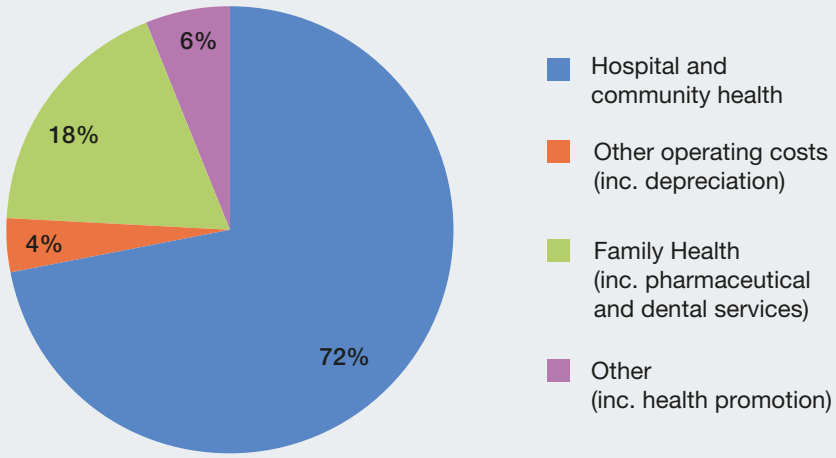
Resource spending by NHS Boards can be categorised as shown in Chart Eight.

125 Annual report of consolidated financial results of the Scottish Government, its Executive Agencies and the Crown Office, prepared in accordance with IFRS published 2 October 2015. Access at: www.gov.scot/Publications/2015/10/3786/0

126 Parliamentary Question S4W-19644: Aileen McLeod, South Scotland, Scottish National Party, Date Lodged: 06/02/2014. Access at: www.scottish.parliament.uk/parliamentarybusiness/28877.aspx?SearchType=Advance&ReferenceNumbers=S4W-19644&ResultsPerPage=10

127 Parliamentary Question S4W-24353: Bob Doris, Glasgow, Scottish National Party, Date Lodged: 05/02/2015. Access at: www.scottish.parliament.uk/parliamentarybusiness/28877.aspx?SearchType=Advance&ReferenceNumbers=S4W-24353&ResultsPerPage=10

Chart Eight:
NHS Expenditure 2014/15



Investing in the Future

In terms of capital investment, and as part of the Scottish Government's commitment to providing modern, state-of-the-art NHS facilities, the new £842 million Queen Elizabeth University Hospital campus in south Glasgow was delivered on time and on budget. This investment provides patients of all ages with access to services on a single site and ensures better continuity of care.

The contract was signed for the new NHS Dumfries and Galloway's Royal Infirmary in March. The new Infirmary is due to open in the final quarter of 2017.

Other projects completed included NHS Grampian's Forres Community Health and Care Centre (£6 million), NHS Fife's Glenwood Health Centre (£5 million) and NHS Highland's Tain Health Centre (£4 million).

In future, spending for community health will be the responsibility of Integrated Health and Social Care Partnerships and will focus on improving outcomes across traditional health and social care boundaries.

Efficiency Savings

Scottish Government health policy is focused on the delivery of improved quality and safer patient care while ensuring that the service is sustainable and delivers value for the public purse.

Complementing the record levels of investment in NHSScotland, all NHS Boards are required to deliver planned efficiency savings each year for reinvestment into patient care. These savings amounted to more than £285 million in 2014/15.[128]

128 NHS in 2015, Audit Scotland, October 2015. Access at: www.audit-scotland.gov.uk/uploads/docs/report/2015/nr_151022_nhs_overview.pdf

Among the wide range of support that the Scottish Government provides to NHS Boards, the Quality and Efficiency Support Team (QuEST) has been at the heart of innovative good practice. QuEST has enabled the service to test, spread and embed innovation over a range of clinical and non-clinical areas through directly delivering specific programmes, supporting local initiatives and providing robust methodologies for knowledge capture and experience sharing.

NHS Boards achieve efficiency savings through a wide range of areas, such as procurement, facilities management and prescribing. In addition to cash savings, many initiatives lead to improvements in productivity, consequently avoiding additional cost.

Quality, Efficiency and Value

The Scottish Government approach to improvement was set out in its *2020 Framework for Quality, Efficiency and Value*.[129] Launched in June 2014, the Framework included lots of examples of improvement, many of which were supported through the QuEST portfolio approach.

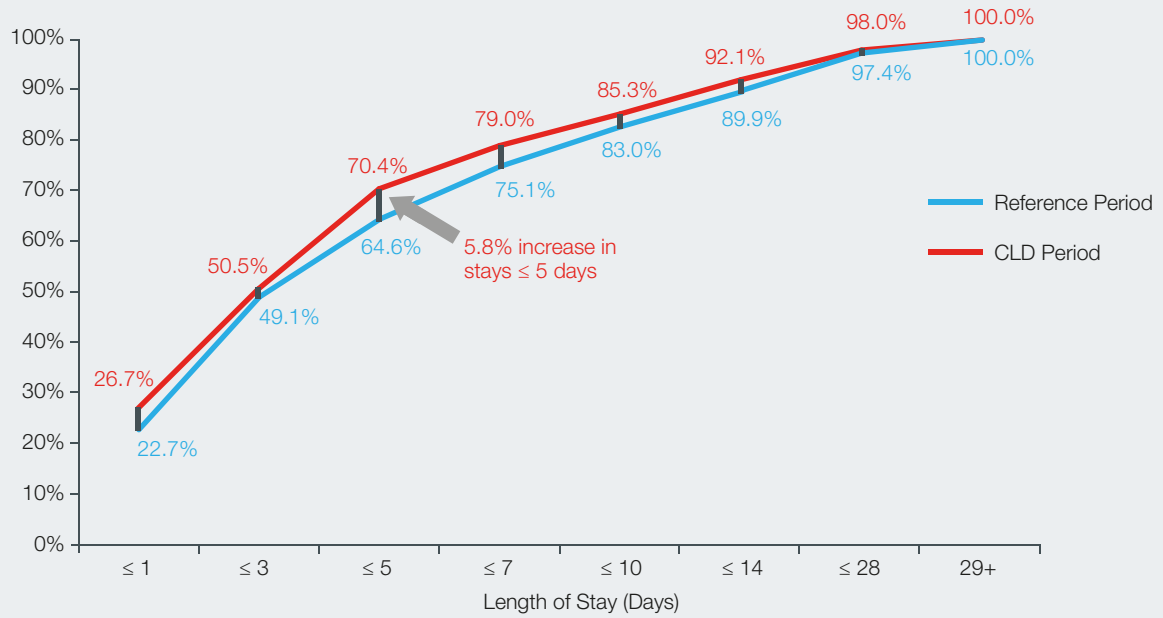
A primary objective of QuEST is to support NHS Boards to develop their own capacity and capability for continuous improvement. Staff at the sharp end of delivery are often best placed to identify ways to improve, as evidenced by more than 120 examples of improvement formally reported by QuEST in the past three years.

Cash savings and cost avoidance are often at the forefront of decision making when individual NHS Boards review business cases for change. The return on investment and the payback period are critical measures when resources are under pressure. QuEST provides support to NHS Boards who may require additional help to identify and release efficiencies.

In addition to programmes related to support services such as procurement, human resources and facilities, QuEST also supports major clinical improvement programmes. The Whole-system Patient Flow Programme includes the Safety Flow Huddle Project. Working collaboratively with the Scottish Patient Safety Programme, unscheduled care and person-centred health and care, the team supports the implementation, improvement and spread of effective hospital safety flow huddles across NHSScotland. The safety flow huddles provide an opportunity for multi-disciplinary teams to collectively discuss, prioritise and action issues of flow and safety. This provides a timely, proactive review and mitigation of clinical risks as part of a 24/7 system.

129 2020 Framework for Quality, Efficiency and Value, Scottish Government, June 2014. Access at: www.qihub.scot.nhs.uk/media/607430/2020framework_12062014_final.pdf

Chart Nine:
Ward Length of Stay Cumulative Distribution



A whole-system patient flow project that exemplifies partnership working and utilising resources effectively across health and social care piloted a criteria-led discharge tool in specific wards in three NHS Boards in August 2014. Delays in discharge are a key blockage identified within the hospital system. They cause a reduction in performance against the Emergency Department Activity and Waiting Time standard, specifically producing 'wait for bed' breaches. This impacts on patient safety and quality of care, with patients' length of stay in hospital extended due to delays in decision making, and the development of a 'wait culture' across the system. The purpose of this project is to create a tool to facilitate more effective and timely discharge planning. Criteria-led discharge enables delegated decision making by members of the multi-disciplinary team, ensuring discharge from an acute hospital at the optimum time and day for patients and the prevention of unnecessary delays.

All pilot wards realised benefits in the form of productive gain and quality improvement, including increased discharges before mid-day, increased discharges at weekends, improved patient flow, improved patient experience and reduction in length of stay.

The pilot NHS Boards are at different stages of implementation, but the ward in NHS Ayrshire and Arran that has gained the most momentum has achieved a shift to shorter lengths of stay with an increase of 5.8 per cent in stays of five days or less (see Chart Nine).

Away from the acute hospital setting, the Outpatients, Primary and Community Care Programme delivers projects to support the overall aim of moving care closer to home, enabling more people to receive the right care from the right person, at the right time, in the right place.

One change concept in the Transforming Outpatients Services Project was to implement patient reminder services to reduce appointment non-attendance and therefore release additional capacity for patient appointments. The result of pilots indicates a significant productive opportunity and an improvement in patient experience through reduced waiting times. Capacity release, reduction in non-attendance rates and cancellations resulted in a measured productive opportunity in pilot NHS Boards of up to 5,000 appointments per annum. Extrapolated across NHSScotland, this could be worth up to £5 million annually.

In addition to supporting quality and efficiency in specific areas, QuEST also supports the co-ordination of emerging innovation and best practice across programmes. The portfolio office approach (QPO) provides benchmarking, data development and associated toolkits and shares these through national partnerships such as the Quality Improvement Hub. QPO also provides funding and monitors innovations that do not fit existing programmes.

The Future

The then Cabinet Secretary for Health and Wellbeing, Alex Neil MSP, announced in Parliament in 2014 that there would be an integrated improvement resource for NHSScotland to bring together the improvement aspects of QuEST with the Joint Improvement Team (JIT) and Healthcare Improvement Scotland. This new integrated improvement resource will harness and build on the unique and common capacities, capabilities and experience of the three teams and will be hosted within Healthcare Improvement Scotland.

QuEST support services programmes will transition to NHS National Services Scotland under the Shared Services Portfolio. The transition plan will ensure the new integrated improvement resource will be fully functional with governance in place by 1 April 2016.

Appendices

HEAT Target Performance 2014/15

The HEAT Target Performance for 2014/15[130] is provided in the table below.

Health Improvement

HEAT Targets Due for Delivery in 2014/15	
Target	**Outcome**
NHSScotland to deliver universal smoking cessation services to achieve at least 12,000 successful quits, at 12 weeks post quit, in the 40 per cent most deprived within-board SIMD areas (60 per cent for island health boards) over one year ending March 2015.	Of 39,746 quit attempts, 7,017 were still not smoking at three months, a 'quit rate' of 18 per cent, similar to the overall Scotland quit rate. This represents 58 per cent of the HEAT target of around 12,000 three month quits in the most deprived areas.
At least 80 per cent of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation by March 2015 so as to ensure improvements in breastfeeding rates and other important health behaviours.	For the year ending March 2013, the worst-performing SIMD quintile at the national level was 74.6 per cent. Awaiting data for period up to March 2015.
HEAT Targets Due in Future Years	
Target	**Latest Results**
To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25 per cent by combined calendar years 2014 to 2015.	In Scotland, there was a 6.5 per cent increase in the percentage of people diagnosed at stage 1 for breast, colorectal and lung cancer (combined) between the baseline of combined calendar years 2010 and 2011 and combined calendar years 2013 and 2014.

Efficiency and Governance

HEAT Targets Due for Delivery in 2014/15	
Target	**Outcome**
NHS Boards are required to operate within their Revenue Resource Limit (RRL), their Capital Resource Limit (CRL) and meet their Cash Requirement.	All NHS Boards met their 2014/15 financial targets.
NHSScotland to reduce energy-based carbon dioxide (CO_2) emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.	Between 2009/10 and 2014/15, NHSScotland secured a 6.8 per cent reduction in carbon dioxide (CO_2) emissions and a 4.6 per cent reduction in energy consumption.

130 Scottish Government HEAT Targets 2014/15 to Local Delivery Plan (LDP) Standards. Access at: www.gov.scot/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance

Access to Services

HEAT Targets Due in Future Years	
Target	**Latest Results**
Eligible patients will commence IVF treatment within 12 months by 31 March 2015.	During the quarter ending March 2015, 397 eligible patients were screened at an IVF Centre in Scotland. The initial estimates from data at this early stage of development indicate that around 96 per cent of eligible patients were screened for IVF treatment within 365 days.
Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013; reducing to 18 weeks from December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014.	During the quarter ending December 2014, 86.0 per cent of children and young people were seen within 26 weeks for CAMHS. During the quarter ending March 2015, 78.9 per cent of children and young people were seen within 18 weeks for CAMHS. During the quarter ending March 2015, 82.8 per cent of people were seen within 18 weeks for Psychological Therapies.
95 per cent of patients will wait less than 4 hours from arrival to admission, discharge or transfer for accident and emergency treatment by year ending September 2014.	The percentage of patients waiting less than 4 hours for the year ending September 2014 was 93.4 per cent.

Treatment Appropriate to Individuals

HEAT Targets Due for Delivery in 2014/15	
Target	**Outcome**
Further reduce healthcare-associated infections so that by March 2015 NHS Boards' *Staphylococcus aureus* bacteraemia (including MRSA) cases are 0.24 or less per 1,000 acute occupied bed days; and the rate of *Clostridium difficile* infections in patients aged 15 and over is 0.32 cases or less per 1,000 total occupied bed days.	For the year ending March 2015, the rate of MRSA/MSSA cases across NHSScotland was 0.31 per 1,000 acute occupied bed days. For the year ending March 2015, the rate of identifications of CDI across NHSScotland was 0.34 per 1,000 occupied bed days among patients aged 15 and over.
No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015.	There were 357 people waiting over 14 days to be discharged from hospital in April 2015.
Reduce the rate of emergency inpatient bed days for people aged 75 and over per 1,000 population by at least 12 per cent between 2009/10 and 2014/15.	Across Scotland, the rate of emergency bed days per 1,000 patients aged 75 and over has reduced by a provisional 11.4 per cent from 5,422 in 2009/10 to 4,805 in 2014/15. This figure will remain provisional until summer 2016 when a final figure will be published.

HEAT Targets Due in Future Years	
Target	**Latest Results**
To deliver expected rates of dementia diagnosis and by 2015/16, all people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support co-ordinated by a link worker, including the building of a person-centred support plan.	Data systems and definitions are currently under development.

It should be noted that the Local Delivery Plan (LDP) Standards for 2015/16 have since replaced the system of HEAT targets and Standards, with the vast majority of LDP Standards being former HEAT targets.

Further information is available on the Scotland Performs webpages of the Scottish Government website.[131]

131 Access at: www.gov.scot/About/Performance/scotPerforms

Territorial NHS Boards

NHS Ayrshire and Arran	www.nhsaaa.net
NHS Borders	www.nhsborders.org.uk
NHS Dumfries and Galloway	www.nhsdg.scot.nhs.uk
NHS Fife	www.nhsfife.scot.nhs.uk
NHS Forth Valley	www.nhsforthvalley.com
NHS Grampian	www.nhsgrampian.org
NHS Greater Glasgow and Clyde	www.nhsggc.org.uk
NHS Highland	www.nhshighland.scot.nhs.uk
NHS Lanarkshire	www.nhslanarkshire.co.uk
NHS Lothian	www.nhslothian.scot.nhs.uk
NHS Orkney	www.ohb.scot.nhs.uk
NHS Shetland	www.shb.scot.nhs.uk
NHS Tayside	www.nhstayside.scot.nhs.uk
NHS Western Isles	www.wihb.scot.nhs.uk

Special NHS Boards

National Waiting Times Centre Board (NWTCB)	www.nhsgoldenjubilee.co.uk
NHS Education for Scotland (NES)	www.nes.scot.nhs.uk
NHS Health Scotland	www.healthscotland.com
NHS National Services Scotland (NSS)	www.nhsnss.org
NHS 24	www.nhs24.com
Scottish Ambulance Service	www.scottishambulance.com
The State Hospital Board	www.tsh.scot.nhs.uk

Healthcare Improvement Scotland

Healthcare Improvement Scotland	www.healthcareimprovementscotland.org

The Scottish Government
Riaghaltas na h-Alba

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Human Rights awareness raising campaign

#FlyTheFlag for your human rights

The Scottish Government is launching a social media and public relations campaign on Wednesday 18 November to raise awareness of the benefits of human rights for people in their everyday lives.

#FlyTheFlag for your human rights celebrates the benefits of human rights in the hope more people will understand how rights relate to them and feel empowered to claim them.

Why is an awareness campaign needed?

The Scottish Government is running this campaign as a contribution to the objectives of Scotland's National Action Plan for Human Rights, where evidence demonstrates that people are insufficiently aware of their rights and do not feel empowered to claim their rights.

Human rights have an image problem. They are taken for granted, misunderstood and misrepresented by the press and public.

Recent research reveals that one in five people (22%) think that human rights are designed to protect minority groups, rather than everybody. There is also limited understanding of how relevant human rights are, with over two in five people (44%) believing they have little bearing on their everyday life.

But whilst there's some misunderstanding around human rights, positivity overall is riding high with 67 per cent agreeing human rights are more of a positive thing than a negative.

#FlyTheFlag will demonstrate the relevance of human rights by showing tangible, down to earth examples of how they impact our everyday lives.

What are we telling people?

Campaign key messages:

- People in Scotland exercise their human rights every day, they're just not aware of it.
- We all have rights and it's important to know how we can claim them if they are misused to ensure we're fairly treated and have our place in society.
- If you think you or someone you know is being poorly treated, get advice from onescotland.org and find out where you stand.

When will the campaign run?

The campaign will run from Wednesday, 18 November until International Human Rights Day on Thursday, 10 December.

Our ambition

To create a groundswell in awareness and understanding of what human rights are, why they exist, who they are for and how a claim can be made if a breach has taken place.

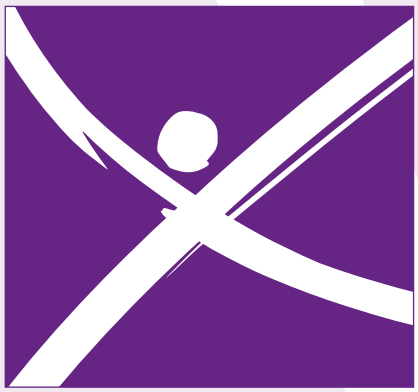
How can you get involved?

This note is to keep you informed about the #FlyTheFlag for your human rights campaign, but we'd also be very grateful if you would like to get involved to help spread the word.

A number of organisations including the Scottish Human Rights Commission, Amnesty International, Equality Network, ALLIANCE for Health and Social Care, Human Rights Consortium Scotland, Children and Young People's Commissioner Scotland and the Care Commission have all pledged their backing and agreed to share materials and we'd be extremely grateful and appreciative for any support you can lend.

From 18 November, you can:

- Use the campaign hashtag #FlyTheFlag on Facebook and Twitter posts
- Follow us on **Twitter @EqualScotland**
- Like **Equal Scotland** on Facebook
- Fly the flag for human rights by visiting **onescotland.org/flytheflag** and changing your organisation's Facebook profile
- Share/re-tweet our campaign images, tweets, posts
- Signpost our website **onescotland.org**



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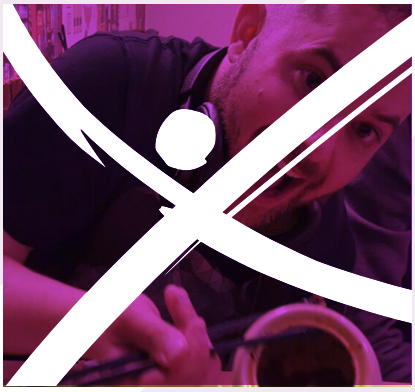
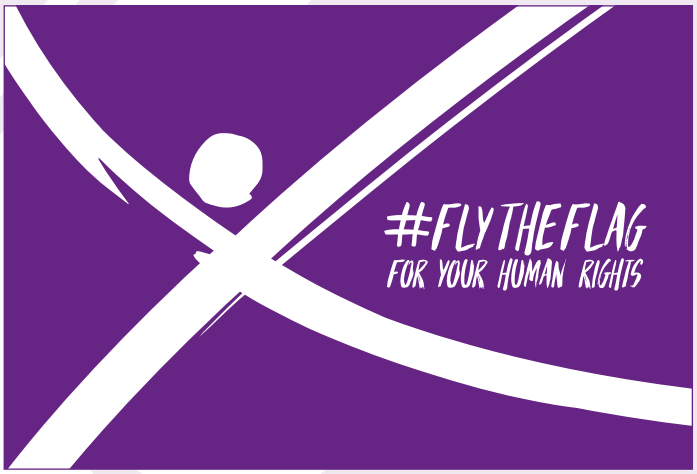


Suggested tweets/posts

- #FlyTheFlag in support of your human rights.
  Visit **onescotland.org/flytheflag** and add our flag to your profile picture
- Scotland exercises its human rights positively every day, we should be proud of this. #FlytheFlag at **onescotland.org/flytheflag**
- We're showing support for human rights by choosing to #FlyTheFlag! Make sure you do the same! Go to **onescotland.org/flytheflag**
- Are you aware of your basic human rights? #FlyTheFlag and visit **onescotland.org** for more info
- Human rights help us live in a free and fair world.
  Visit **onescotland.org and #FlyTheFlag**

Materials

- Distributing campaign information via your own internal channels – website, newsletters, intranet etc.
- A number of small #FlyTheFlag handwavers and large (5ft x 3ft) flags have been produced specifically for this campaign. You can order a number of these by emailing julie.watt@consolidatedpr.com or calling 0131 240 6420.
- Using #FlyTheFlag handwavers and flags in any related roadshows/event you're organising
- Share images of staff, service users waving their #FlyTheFlag handwavers or the large #FlyTheFlag flags on buildings



For any questions or requests, please contact Julie Watt at Consolidated PR at julie.watt@consolidatedpr.com or call 0131 240 6420.

Alternatively, please contact Gillian Howell at the Scottish Government Marketing team on Gillian.Howell@scotland.gsi.gov.uk or call 0131 244 2755.