INVERCLYDE HSCP
Health and Social Care Partnership

Agenda 2016

Inverclyde Integration Joint Board

For meeting on:

26	January	2016

Municipal Buildings, Greenock PA15 1LY

Ref: SL/AI

Date: 14 January 2016

A meeting of the Inverclyde Integration Joint Board will be held on Tuesday 26 January 2016 at 3pm within the Municipal Buildings, Greenock.

Gerard Malone
Head of Legal and Property Services

BUSINESS

**** Copy to follow**

1.	**Apologies, Substitutions and Declarations of Interest**	**Page**
2.	**Minute of Meeting of Inverclyde Integration Joint Board of 10 November 2015**	**p**
3.	**NHS Greater Glasgow & Clyde Clinical Services Strategy 2015** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership **NB** There will also be a presentation on this item	**p**
4.	**Overview of Development of Governance Arrangements** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
5.	**Membership of the Inverclyde Integration Joint Board** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
6. **	**Health & Social Care Partnership – Financial Report 2015/16** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
7.	**Business Update** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**

8.	**HSCP Complaints Annual Report** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
9.	**Inverclyde Alcohol and Drug Partnership's Annual Report (Self-Assessment) 2014/15** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
10.	**Freedom of Information Annual Report** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
11.	**Reshaping Care for Older People and Delayed Discharge Performance** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
12.	**Community Justice Transition Plan** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
13.	**Inverclyde Alliance Tobacco Strategy and Action Plan** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
14.	**HSCP Internal Services Care Inspectorate Gradings Annual Report 2015** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership	**p**
The documentation relative to the following item has been treated as exempt information in terms of the Local Government (Scotland) Act 1973 as amended, the nature of the exempt information being that set out in paragraph 6 of Part I of Schedule 7(A) of the Act.		
15.	**Governance of HSCP Commissioned External Organisations** Report by Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership providing an update on matters relating to the HSCP governance process for externally commissioned Social Work Services	**p**

Enquiries to - **Sharon Lang** - Tel 01475 712112

Inverclyde Integration Joint Board

Tuesday 10 November 2015 at 3 pm

Present: Councillors V Jones, S McCabe, J McIlwee and L Rebecchi, Mr S Carr, Dr D Lyons, Mr A MacLeod, Mr R Finnie, Dr H MacDonald, Ms C Roarty, Dr C Jones, Mr B Moore, Ms R Gacha (for Mr R Taggart), Ms D McCrone, Ms M Telfer, Mr I Bruce, Ms S McCready (for Mr A Black) and Ms S McLeod.

Present also: Mr A Robertson, Chairman, NHS Greater Glasgow & Clyde.

Chair: Councillor McIlwee presided.

In attendance: Ms H Watson, Head of Planning, Health Improvement & Commissioning, Ms B Culshaw, Head of Health & Community Care, Ms S McAlees, Head of Children & Families and Criminal Justice, Ms D Gillespie, Head of Mental Health, Addictions and Homelessness, Ms A Edmiston (for Chief Financial Officer), Ms V Pollock (for Head of Legal & Property Services), Ms S Lang, Legal & Property Services and Ms K Haldane, Executive Officer, Your Voice, Inverclyde Community Care Forum.

Prior to the commencement of business, Councillor McIlwee welcomed to the meeting, Mr Andrew Robertson, Chairman of NHS Greater Glasgow & Clyde.

13 Apologies, Substitutions and Declarations of Interest **13**

Apologies for absence were intimated on behalf of Mr R Taggart (with Ms R Gacha acting as proxy) and Mr A Black (with Ms S McCready acting as proxy).

Declarations of interest were intimated as follows:

Agenda Item 7 (Business Update) – Dr D Lyons.
Agenda Item 12 (Governance of HSCP Commissioned External Organisations) – Councillors S McCabe and J McIlwee, Mr S Carr and Ms S McLeod.

14 Minute of Meeting of the Inverclyde Integration Joint Board of 10 August 2015 **14**

There was submitted minute of the Inverclyde Integration Joint Board of 10 August 2015.
Decided: that the minute be agreed.

15 Membership of the Inverclyde Integration Joint Board **15**

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership advising the Board of a change in its voting membership arrangements.
Decided:
(1) that the resignation of Mr Ken Winter as Vice-Chair of the Inverclyde Integration Joint Board be noted;
(2) that the appointment by Greater Glasgow & Clyde NHS Board of Mr Simon Carr as a voting member of the Inverclyde Integration Joint Board be noted; and

(3) that the appointment by Greater Glasgow & Clyde NHS Board of Mr Ross Finnie as Vice-Chair of the Inverclyde Integration Joint Board be noted.

16 Inverclyde Integration Joint Board – Audit Arrangements **16**

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership on proposals for the audit arrangements for the Inverclyde Integration Joint Board including the establishment of a Financial Performance and Audit Committee.

Decided:

(1) that consideration be continued to the next meeting of the Board for clarification of the remit of the proposed Financial Performance and Audit Committee; and

(2) that it be noted that the Council representatives on the Committee when established will be Councillors McCabe and Rebecchi with Councillor McCabe as Vice-Chair.

17 Schedule of Reports **17**

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership seeking approval of a cycle of reports to be presented at future meetings of the Inverclyde Integration Joint Board.

It was noted that as the Board had previously agreed to continue consideration of the item on audit arrangements, no decision could be taken at this time on the proposed meeting cycle for the Financial Performance and Audit Committee.

Decided: that approval be given to the proposed schedule of reports to be submitted to future meetings of the Inverclyde Integration Joint Board as set out in the report.

18 Health & Social Care Partnership – Financial Report 2015/16 as at Period 5 to 31 August 2015 **18**

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership on the Revenue and Capital Budget current year position as at Period 5 to 31 August 2015.

Decided:

(1) that the current year Revenue Budget projected overspend of £168,000 for 2015/16 as at 31 August 2015 be noted;

(2) that the current projected capital position showing a projected Social Work capital slippage of £288,000 in the current year be noted;

(3) that the current earmarked reserves position be noted;

(4) that the position on prescribing be noted; and

(5) that the Social Work budget virements as detailed at Appendix 7 be noted.

19 Business Update **19**

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership providing an update on a number of key workstreams which are currently underway or are projected to require Health & Social Care Partnership or Inverclyde Integration Joint Board action.

Dr Lyons declared a non-financial interest in this item as a Member of the Scotland Committee of the Equality and Human Rights Commission. He also formed the view that the nature of his interest and of the item of business did not preclude his continued presence in the Chamber or his participation in the decision making process.

Decided: that the report be noted.

20 Update on Plans for Replacement Greenock Health Centre **20**

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership on the progress of the new Greenock Health and Care Centre proposals.
Decided: that the Board note the progress to date and that this will be the subject of a report to each future meeting of the Board and also to the appropriate Council Committee.

21 Communication Framework **21**

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership on a proposed communication framework designed to deliver key messages about the purpose and activity of the Integration Joint Board and Health & Social Care Partnership to staff, partners and the general public.
Decided:
(1) that approval be given to the communication framework detailed in the report as an interim arrangement; and
(2) that proposals for a more wide-ranging communication framework be submitted to a future meeting of the Board.

22 Delayed Discharge Performance and Winter Planning 2015/16 **22**

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership on performance towards achieving the target for delayed discharge and arrangements for co-ordinated winter planning in Inverclyde.
Decided: that the Board note the progress towards achieving the target for delayed discharge, including the winter plan, and the ongoing work to maintain performance.

23 NHS Greater Glasgow & Clyde Clinical Services Strategy 2015 **23**

It was noted that this item had been withdrawn from the agenda.

The documentation relative to the following item has been treated as exempt information in terms of the Local Government (Scotland) Act 1973 as amended, the nature of the exempt information being that set out in paragraph 6 of Part I of Schedule 7(A) of the Act.

24 Governance of HSCP Commissioned External Organisations **24**

There was submitted a report by the Chief Officer, Inverclyde Health & Social Care Partnership on performance and progress relating to the HSCP governance process for externally commissioned Social Care Services covering the period 1 July to 30 September 2015.
Non-financial interests in this item were intimated as follows:
Councillor McCabe as a Member of the Board of River Clyde Homes;
Councillor McIlwee as a Member of the Board of River Clyde Homes and as a Director of Inverclyde Association for Mental Health;
Mr Carr as a Member of the Board of the Richmond Fellowship; and
Ms McLeod as a member of the staff of River Clyde Homes.

All of the Members formed the view that the nature of their interests and of the item of business did not preclude their continued presence in the Chamber or their participation in the decision making process.

Decided: that the governance report covering the period 1 July to 30 September 2015 as set out in Appendix 1 to the report be noted.

AGENDA ITEM NO: 3

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**26th January 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/04/2016/HW**
Contact Officer:	**Helen Watson Head of Planning, Health Improvement and Commissioning**	**Contact No:**	**01475 715285**
Subject:	**NHS Greater Glasgow & Clyde Clinical Services Strategy 2015**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board of the NHS Greater Glasgow & Clyde Clinical Services Strategy.

2.0 SUMMARY

2.1 In 2011, the Scottish Government set out its strategic vision for achieving sustainable quality in the delivery of healthcare services across Scotland, in the face of the significant challenges of Scotland's public health record, our changing demography and the economic environment.

The 2020 Vision provides the strategic narrative and context for taking forward the implementation of the Quality Strategy, and the required actions to improve efficiency and achieve financial sustainability.

The Scottish Government's 2020 Vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting, and that we will have a healthcare system where:

- We have integrated health and social care
- There is a focus on prevention, anticipation and supported self-management
- 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.

2.2 In response to the challenges of the 2020 Vision, in February 2012 NHS Greater Glasgow and Clyde (NHSGGC) agreed to establish the Clinical Services Fit for the Future Programme to review services and prepare a single clinical strategy for NHSGGC for 2015 onwards. In establishing the Review the Health Board recognised the need to:

- Integrate acute services across the whole Board area and ensure that there is equity of

access to this level of care across NHSGGC.

- See acute services as part of a wider system of care including primary and community care that also requires to be considered to meet the challenges of the 2020 Vision and to deliver the integrated health and social care changes from 2015 onwards.
- Recognise the changing landscape of health care with the developments in technology and treatments.

2.3 The former Community Health & Care Partnership Sub-Committee was consequently briefed on the review's emerging conclusions at its October 2013 meeting.

2.4 At its meeting of 20th January 2015, the Health Board was presented with the final output of that clinical service review process by its Medical Director; and then approved it as a clinical strategy to provide the basis for future service planning. This Clinical Services Strategy was then launched in April 2015 (attached).

3.0 RECOMMENDATION

3.1 It is recommended that the Integration Joint Board note the NHS Greater Glasgow & Clyde Clinical Services Strategy.

Brian Moore
Corporate Director (Chief Officer)
Inverclyde HSCP

4.0 MAIN ISSUES

4.1 The key aims of the Strategy are to ensure that:

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

4.2 The Strategy provides a framework to ensure that best clinical outcomes are achieved for patients and that services are:

- Safe and sustainable.
- Patient centred.
- Integrated between primary and secondary care.
- Efficient, making best use of resources.
- Affordable, provided within the funding available.
- Accessible, provided as locally as possible.
- Adaptable, achieving change over time.

4.3 In approving this Strategy, the Health Board's intention has been to continue to engage with stakeholders, including the new Integration Joint Boards within the Greater Glasgow & Clyde area as they are each established – the latter to specifically:

- Seek their support in adopting this as a shared clinical strategy.
- Seek to work together on planning service changes.
- Seek to engage on the refresh of the Health Board's Primary Care Strategy and the further development of primary and community services.

5.0 IMPLICATIONS

FINANCE

5.1 Financial Implications:

One of the drivers for the Strategy is the reality that the health service is facing a period of rising demand resultant from demographic pressures at the same time as facing a period of significant financial constraint. It is therefore important that in planning for future services the funding available is spent effectively to ensure the best outcomes for patients. It should be noted that that imperative equally holds true for social care services as it does for the health care services described within the Strategy.

One off Costs – no one-off costs associated with this report have been identified at this time.

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

Annually Recurring Costs/ (Savings) - no annually recurring costs or savings associated with this report have been identified at this time. Any future change to the assessment of costs or savings will be brought to the IJB for further discussion.

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

LEGAL

5.2 There are no legal issues within this report.

HUMAN RESOURCES

5.3 The Strategy recognises the importance of supporting the workforce to meet these future changes; and that effective implementation will require strong clinical leadership and commitment as well as a significant cultural shift across NHSGGC.

EQUALITIES

5.4 An acknowledged theme of the services model within the Clinical Services Strategy is the imperative on them to support and comply with the relevant duties under the Equality Act 2010.

Has an Equality Impact Assessment been carried out?

X	YES an Equality Impact Assessment has been carried out on the Clinical Services Strategy.
	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.

6.0 CONSULTATION

6.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with the senior management team and the CSS implementation team.

7.0 LIST OF BACKGROUND PAPERS

7.1 N/A

Greater Glasgow and Clyde NHS Board

Board Meeting

Tuesday 20th January 2015 **Board Paper No. 2015/02**

Medical Director

CLINICAL SERVICES FIT FOR THE FUTURE: APPROVING THE CLINICAL STRATEGY

Recommendation:

The Board is asked to:

- **approve the clinical strategy developed from the clinical services review process**

1. INTRODUCTION AND PURPOSE

1.1 In February 2012 NHS Greater Glasgow and Clyde agreed to establish the Clinical Services Fit for the Future Programme to review services to prepare a single clinical strategy for NHS GGC for 2015 onwards. The purpose of this paper is to bring the output of the clinical service review process to the Board to enable it to be approved as a clinical strategy which will provide the basis for future service planning.

1.2 The key aims of the strategy are to ensure:

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

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

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

- accessible, provided as locally as possible;
- adaptable, achieving change over time.

1.4 Board approval of this paper will enable:-

- the publication of the strategy providing a further opportunity to engage all stakeholders;
- engagement with the new Integration Joint Boards to adopt this as a shared clinical strategy and to work together on planning service changes;
- a platform for the development of implementation plans, including delivering changes to reflect the output of the Paisley development programme across the Board area;
- engagement with GPs, wider primary care contractors and with the new Health and Social Care Partnerships to refresh the Board's Primary Care Strategy and plan the further development of primary and community services.

2. SETTING THE SCENE: NHS SCOTLAND POLICY CONTEXT

2.1 In 2012 the Cabinet Secretary for Health, Wellbeing and Cities set out her strategic narrative and vision for achieving sustainable quality in the delivery of healthcare services across Scotland.

2.2 This vision for NHS Scotland is:

> **"By 2020 everyone is able to live longer healthier lives at home or in a homely setting with a healthcare system.**
>
> **There will be integrated health and social care, 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 patient 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 possible, with minimum risk of re-admission."**
>
> ***Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision***

2.3 This vision provides the context for taking forward the implementation of the Healthcare Quality Strategy for Scotland and the required actions to improve efficiency and achieve financial sustainability and for the development of our approach to planning clinical services fit for the future.

2.4 The actions outlined for NHS Scotland which drive the requirement to reshape our services are:

- We need a shared understanding with everyone involved in delivering healthcare services which set out what they should expect in terms of support, involvement and reward alongside their commitment to strong visible and effective engagement and leadership which ensures a real shared ownership of the challenges and solutions.

- We need to develop a shared understanding with the people of Scotland which sets out what they should expect in terms of high quality healthcare services alongside their shared responsibility for prevention, anticipation, self management and appropriate use of both planned and unscheduled/ emergency healthcare services, ensuring that they are able to stay healthy, at home, or in a community setting as long as possible and appropriate.

- We need to secure integrated working between health and social care, and more effective working with other agencies and with the Third and Independent Sectors.

- We need to prioritise anticipatory care and preventative spends, e.g. support for parenting and early years.

- We need to prioritise support for people to stay at home/in a homely setting as long as this is appropriate, and avoid the need for unplanned or emergency admission to hospital wherever possible.

- We need to make sure people are admitted to hospital only when it is not possible or appropriate to treat them in the community - and where someone does have to go to hospital, it should be as a day case where possible.

- Caring for more people in the community and doing more procedures as day cases where appropriate will result in a shift from acute to community-based care. This shift will be recognised as a positive improvement in the quality of our healthcare services, progress towards our vision and therefore the kind of service change we expect to see.

2.5 The direction underpinning this vision sees further focus on improving the quality of services, with expanded primary and community care, a focus on multi-morbidity and improving unscheduled and emergency care out with hospital where clinically appropriate. National work is currently underway between Boards and the Scottish Government to set out the steps which will need to be taken to deliver the 2020 Vision. This strategy provides our local basis to develop those changes.

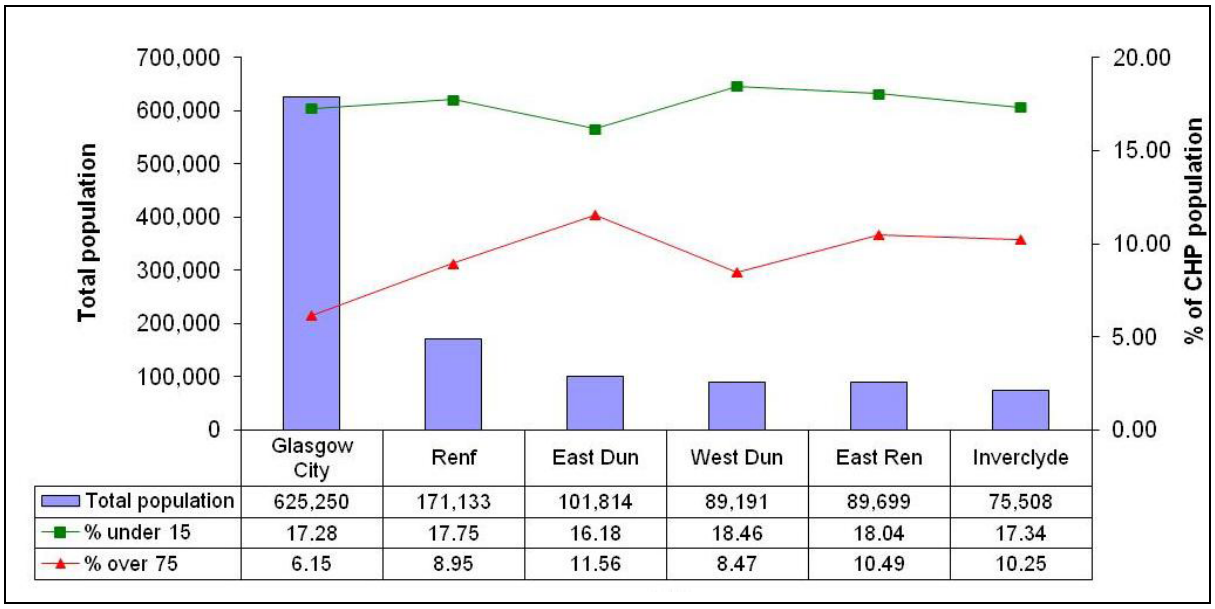
2.6 In addition to this context, a further important point of context for this clinical strategy is the establishment from April 201 of Integrated Health and Social Care Partnerships. Successful development of the new integrated partnerships will be key to the achievement of all of the strategic priorities and service models set out in this strategy which will frame our joint working with the Partnerships with shared responsibility for the strategic planning of acute services.

3. THE NHS GREATER GLASGOW AND CLYDE POPULATION HEALTH

3.1 In bringing forward this outcome of the CSR it is also important to restate the local context in which the CSR has been developed.

3.2 The Population of NHSGGC: Demographics

3.2.1 The current population and age profile is shown below. Our population is relatively young compared to other parts of Scotland, although this varies significantly between local authority areas. Women predominate in the older age groups.



	Glasgow City	Renf	East Dun	West Dun	East Ren	Inverclyde
Total population	625,250	171,133	101,814	89,191	89,699	75,508
% under 15	17.28	17.75	16.18	18.46	18.04	17.34
% over 75	6.15	8.95	11.56	8.47	10.49	10.25

3.2.2 The population of the NHS Greater Glasgow and Clyde area in 2010 was 1,203,870. This population is expected to increase overall by 2.4% by 2020. (See table below)

Age Group	Population 2010	Population 2015	% change by 2015	Population 2020	% change by 2020	Population 2025	% change by 2025
0-14	194,562	197,268	1.4	202,876	4.3	199,911	2.7
15-24	166,320	150,265	-9.7	137,743	-17.2	139,286	-16.3
25-34	176,434	193,672	9.8	184,614	4.6	166,623	-5.6
35-44	167,002	156,647	-6.2	172,422	3.2	187,458	12.2
45-54	177,130	177,566	0.2	159,827	-9.8	149,426	-15.6
55-64	136,201	147,198	8.1	164,852	21.0	165,878	21.8
65 & over	186,221	197,206	5.9	210,174	12.9	233,297	25.3
All Ages	1,203,870	1,219,822	1.3	1,232,508	2.4	1,241,879	3.2

3.2.3 During this time, the age profile of the population will continue to change. In common with much of Scotland, in most areas there will be a steep rise in the numbers and proportion of older people. The over 65 population will increase by 12.9% by 2020. This will impact differently across Greater Glasgow and Clyde with areas like East Dunbartonshire and East Renfrewshire already experiencing significant rises in numbers of older people, whilst Glasgow City is projected to see a short term decline in the numbers of older people, before following the same longer term trends. A small increase in the number of children together with a larger decrease in the number of people aged 15-29 will result in an overall reduction in the 0-19 age group.

3.2.4 It is a population with high levels of deprivation compared to the rest of Scotland. 30.4% of people in NHS Greater Glasgow and Clyde live in the 15% most deprived data zones (Scottish Index of Multiple Deprivation). This ranges from 3.1% in East Dunbartonshire, to over 50% North and East Glasgow.

3.2.5 Summary of key trends:

- The **top 10 causes of death** in Scotland account for 44% of all deaths. Each of the causes of death are amenable to prevention by not smoking; being a healthy weight; being physically active; drinking within recommended levels of alcohol and maintaining a healthy diet.

- **Population projections** estimate that Glasgow City is due to have a modest rise in population to 2033, whereas, all other local authorities in NHSGGC will have a decrease in population. This will be most marked in Inverclyde and East Dun.

- **Our population is ageing**. Between 1911 and 2008 there has been an increase in the number of people aged over 65 years in Scotland of 221%. However, NHSGGC is ageing at a markedly slower rate than the rest of Scotland.

- There are **wide variations within NHSGGC**. East Dumbarton experienced a 47% increase in people aged 65+ and Glasgow city a 25% decline between 1982-2007.

- **Forecasts predict the under 50's will shrink** from 70% in 2008 to 62% in 2033; whereas the over 50's will expand from 30% to 38%. The biggest increase is expected in the over 65's age group.

- **Dependency ratios are due to increase** to 2040 across NHSGGC. Within NHSGGC there are marked variations. Current dependency ratios vary from 44% in Glasgow City to 60% in East Renfrewshire by 2031 these are predicted to increase to 51% in Glasgow City to 91% in East Dunbartonshire and 89% in East Renfrewshire. A male born in East Glasgow can expect to live in a healthy state for 15 years less than a male born in East Dunbartonshire.

- **Older single person households are expected to increase**. It is anticipated these will account for 54% of households by 2031.

- Life expectancy and healthy life expectancy is lower in NHSGGC than the rest of Scotland. People living in NHSGGC can expect to have the **longest period of unhealthy life at 10.5 years.**

- Aging is associated with an increased burden on long term conditions and chronic disease.

- There will be a significant growth in the numbers of people with dementia as the population ages. There will be an estimated 18% increase in dementia in GGC by 2020. One in three people aged over 65 will die with a form of dementia and one in four hospital inpatients will have dementia (Alzheimer's Research Trust 2010)

3.2.6 In recent years across NHSGGC, there have been some significant improvements in health. Overall life expectancy has risen; rates of premature mortality have fallen, with particular improvements for Coronary Heart Disease. Cancer survival has improved significantly across a range of cancers. However, there remain many significant health challenges and marked inequality across NHS Greater Glasgow and Clyde. Overall,

average life expectancy in NHS Greater Glasgow and Clyde is well below the Scottish average (see below). Again, there is considerable variation between different parts of NHS Greater Glasgow and Clyde.

3.2.7 *Healthy* life expectancy in NHS Greater Glasgow and Clyde is even lower compared to the Scottish average. People in NHS Greater Glasgow and Clyde live for many years in ill health, with the consequent impact on quality of life, economic and societal contribution and need for services. Over the past 10 years, the gap in healthy life expectancy between the 20% most deprived and the 20% least deprived areas has increased from 8 to 13 years.

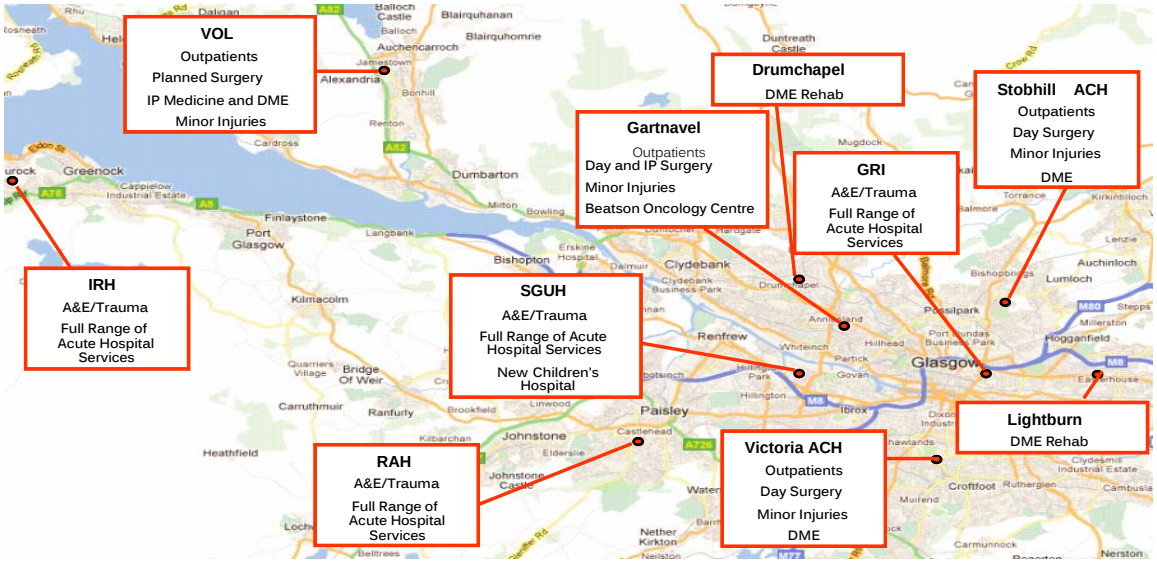
Life Expectancy at Birth by Gender 2007 - 2009 Source: NRS (formerly GRO(S))

CH(C)P	Male	Female
Glasgow City	71.1	77.5
East Dunbartonshire	78.3	83.1
East Renfrewshire	77.8	82
Renfrewshire	73.7	79.2
Inverclyde	73.1	79
West Dunbartonshire	72.5	78.4
NHSGGC	**73.1**	**78.9**
Scotland	**75.4**	**80.1**

4. THE CONTEXT OF ACUTE SERVICES PROVISION IN NHSGGC

4.1 Prior to the CSR NHSGGC had two separate approved acute strategies - one for Greater Glasgow, the Acute Services Review (ASR) agreed in 2002 and the other for Clyde (South Clyde in 2006/7 and North Clyde in 2009). The Clyde strategy has already been fully implemented and the Greater Glasgow ASR will be delivered during 2015. At that point the Acute Services Provision across NHS GGC will be as follows:

2015 GGC
Delivery of the Acute Services Review



4.2 In establishing the CSR the Board recognised the need to:

- integrate acute services across the whole Board area and ensure that there is equity of access to this level of care across NHSGGC;
- see acute services are part of a wider system of care including primary and community care that also requires to be considered to meet the challenges of the 2020 Vision and to deliver the integrated health and social care changes from 2015 onwards;
- recognise the changing landscape of health care with the developments in technology and treatments and the requirement to ensure care is provided in a patient centred way.

4.3 The following sections describe the approach we took to review the organisation of clinical services and to consider what would be required to achieve the best health outcomes for patients. The critical characteristics of the review work were clinical leadership, whole system clinical engagement and intensive patient and public engagement

5. THE CASE FOR CHANGE AND CHALLENGES THIS STRATEGY NEEDS TO ADDRESS

5.1 The first stage in the CSR was to establish the case for change. This part of the process was also based on the views of a wide range of clinicians on what is currently affecting the clinical services and what is likely to impact on services in the future, as well as the opinions of patients of what they value in the current service and what they would want of future services.

5.2 Following extensive engagement with stakeholders the Case for Change was published in December 2012. This identified 9 key themes:

1. The health needs of our population are significant and changing.
2. We need to do more to support people to manage their own health and prevent crisis.
3. Our services are not always organised in the best way for patients[i].
4. We need to do more to make sure that care is always provided in the most appropriate setting;
5. There is growing pressure on primary care and community services.
6. We need to provide the highest quality specialist care[ii].
7. Increasing specialisation needs to be balanced with the need for co-ordinated care which takes an overview of the patient.
8. Healthcare is changing and we need to keep pace with best practice and standards.
9. We need to support our workforce to meet future changes.

5.3 Together these issues paint a picture of health services which need to change to make sure that we can continue to deliver high quality services and improve outcomes. As outlined in the earlier sections the years ahead will see significant changes to the population and health needs of NHS Greater Glasgow and Clyde. It is clear that not enough focus on prevention and support for people at an early stage in their illness can lead to poorer health outcomes, and to people accessing services and support at crisis points or at later stages of illness. The growing complexity of need, including multi morbidity and a wide range of care and support needs, mean that users and carers can feel inadequately supported and services can feel complex and fragmented. This poses significant challenges to the way we deliver health services and work with partner agencies, to ensure that our services adapt to these changing needs.

5.4 The health service is facing a period of rising demand resultant from demographic pressures at the same time as facing a period of significant financial constraint. It is therefore important that in planning for future services the funding available is spent effectively to ensure the best outcomes for patients. A more consistent and joined up approach is required across all parts of the system, targeting interventions and support where they are most needed. The case for change tells us that we need to improve outcomes by organising and delivering services differently to prevent ill health in the first place, to support patients with multiple conditions more effectively and to enable older people to live more independently. We also need to change our hospitals to ensure that high quality care is consistently available, that there is timely access for all to specialist care and that we have 24 /7 access to specialised emergency care.

The full case for change is at http://www.nhsggc.org.uk/content/

5.5 The core of this clinical strategy is based on the case for change and the detailed work done in eight workstreams to consider how we can address these challenges. These workstreams, to determine the service strategy for 2015-2020 and identify the future clinical service provision, cover:

- Population Health
- Emergency Care and Trauma
- Planned Care
- Child and Maternal Health
- Older People's Services
- Chronic Disease Management
- Cancer
- Mental Health

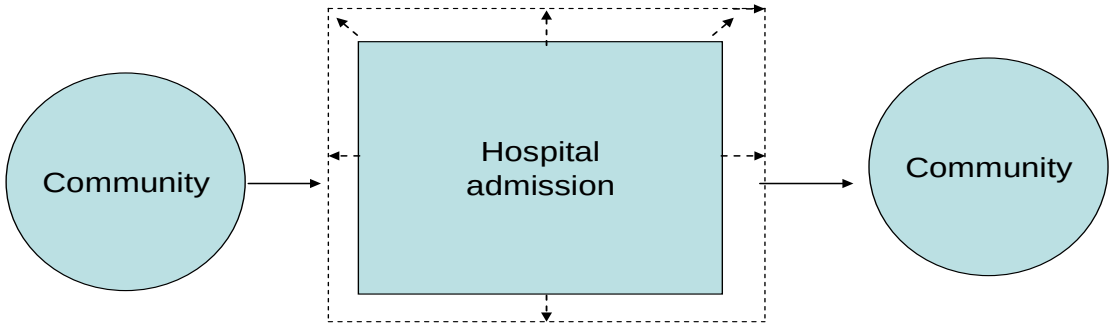
5.6 The detailed conclusions of this service models work are set out later in this paper

5.7 Meeting the challenge across the whole system

The diagrams below show the challenge we face across NHSGGC and the system we need to move towards in the future.

The current position is one where we face challenging demand pressures across a system in which 'hospital' and 'community' services are largely seen as separate, with often poor communication and joint planning across the system. While there are some good examples of joint working, these are not systematic and often on a small scale. The future demand pressures we face as a result of demographic and health changes mean that if we continue with the system as it is now, we would need an additional 500 acute beds by 2020. In an environment of constrained resources, the investment required for this would result in a vicious circle, with growing expenditure in acute hospital admissions and less money for investment in community services, which in turn reduces our ability to support people at home.

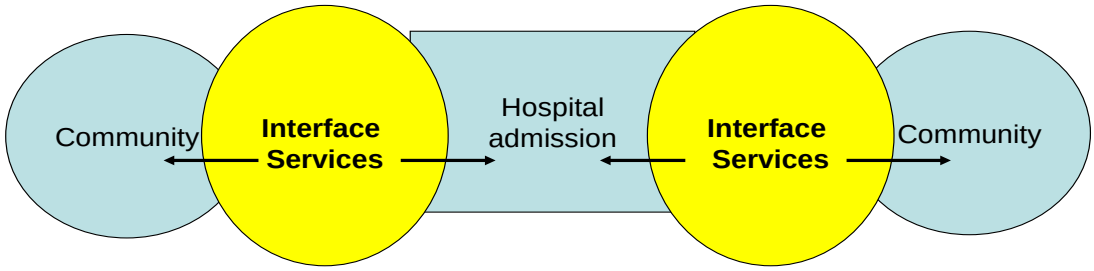
Figure 2



The system of care we want to move to sees a significant change focusing on providing care where it is most appropriate for the patient. This is based on strengthened 24/7 community services, acute services focused on assessment and management of acute episodes, and a range of services being developed at the interface including shared management of high risk patients and a range of alternatives to face to face hospital visits.

Working differently at the interface (represented by the yellow circles below) may involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system.

Figure 3



It is recognised that to change the system will require strong clinical leadership and commitment as well as a significant cultural shift across the organization to undertake this size of system change. To achieve this we require to:

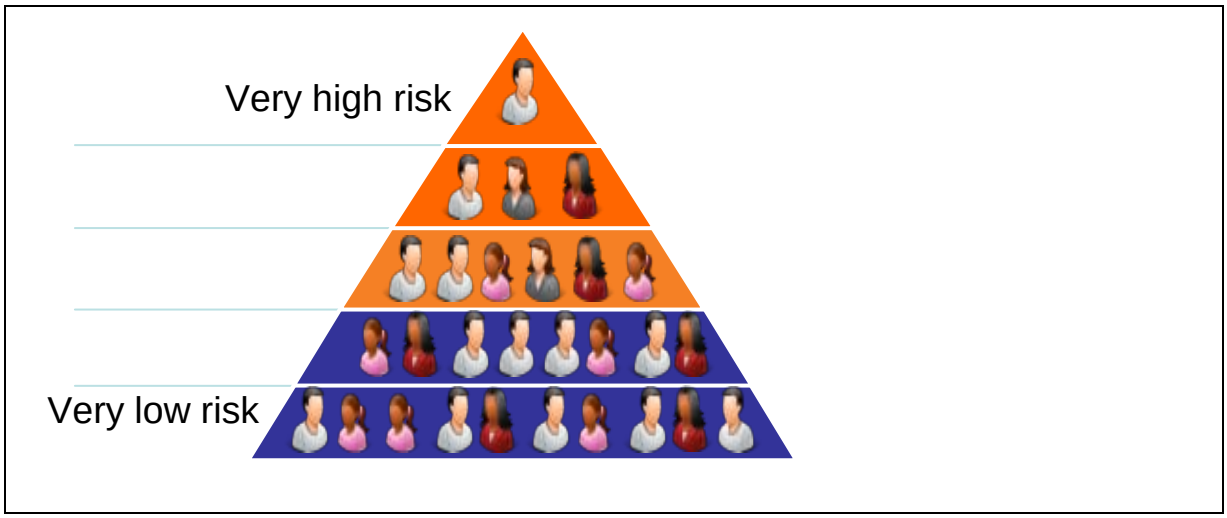
- think beyond artificial boundaries of 'hospital' and 'community';
- focus on patient pathway and needs at each stage;
- change the delivery of acute care: assess and direct to appropriate place of care;
- change the provision and accessibility of community services;
- create different ways of working at the interface.

5.8 This needs to build on the work of bringing clinical teams together to consider the problems and challenges facing the services, to jointly problem solve and plan services across the organisation for the future with shared responsibility for delivery of the new service models to maximise success.

5.9 <u>Core components of the future health system</u>

The overarching aim of this clinical strategy, based on the service models work, is to provide **a balanced system of care where people get care in the right place** from people with the right skills, working across the artificial boundary of 'hospital' and 'community' services.

At the heart of this approach is the requirement to understand our population and provide care at the most appropriate level. Getting this right will enable more intensive support for those most in need, and supported self management with rapid access into services when required for the majority of the population.



This approach relies on a strong emphasis on prevention. It is therefore important that as part of the strategy we continue to emphasise the importance of health improvement and disease prevention. We need to encourage the population to improve their health and prevent disease, recognising that lifestyle choices in modifiable behaviours are responsible for around 80% of our current LTC disease burden. This requires all health care professionals to promote healthier lifestyles and to support the population to take responsibility for improving their own health by adopting healthier lifestyles.

The key characteristics of the clinical services required to support this approach are:

1. A system underpinned by timely access to **high quality primary care** providing a comprehensive service that deals with the whole person in the context of their socio-economic environment:

   - Building on universal access to primary care.
   - Focal point for prevention, anticipatory care and early intervention.
   - Management where possible within a primary care setting.
   - Focus for continuity of care, and co-ordination of care for multiple conditions.

2. A comprehensive range of **community services,** integrated across health and social care and working with the third sector to provide increased support at home:

- Single point of access, accessible 24/7 from acute and community settings.
- Focused on preventing deterioration and supporting independence.
- Multi-disciplinary care plans in place to respond in a timely way to crisis.
- Working as part of a team with primary care providers for a defined patient population.

3. Co-Coordinated care at **crisis / transition** points, and for those **most at risk**:

   - Access to specialist advice by phone, in community settings or through rapid access to outpatients.
   - Jointly agreed care plans with input from GPs, community teams, specialist nurses and consultants, with shared responsibility for implementation.
   - Rapid escalation of support, on a 24 / 7 basis.

4. **Hospital assessment** which focuses on early comprehensive assessment driving care in the right setting:

   - Senior clinical decision makers at the front door.
   - Specialist care available 24/7 where required.
   - Rapid transfer to appropriate place of care, following assessment.
   - In-patient stay for the acute period of care only (see Fig 4).
   - Early supported discharge to home or step down care.
   - Early involvement of primary and community care team in planning for discharge.

5. **Planned care** which is locally accessible on an outpatient / ambulatory care basis where possible:

   - Wider range of specialist clinics in the community, working as part of a team with primary care and community services.
   - Appropriate follow-up.
   - Diagnostic services organised around patient needs.
   - Interventions provided as day case where possible.
   - Rapid access as an alternative to emergency admission or to facilitate discharge.

6. **Low volume and high complexity care** provided in defined units equipped to meet the care needs:

   - Driven by clear evidence of the relationship between volume and outcome.

The service models which follow at section 6 onwards consider what needs to be in place to deliver these core components of care for specific groups of patients.

5.10 Enablers

Changing the system on this scale will require a significant cultural shift and clinical commitment across the organisation. In order to achieve this, services will have to be underpinned by a series of enablers and improvements to supporting systems, including:

- Supported leadership and strong clinical engagement across the system to develop and implement the new models.
- Building on the clinical portal to enable shared IT systems and records which are accessible to different professionals across the care system.
- Jointly agreed protocols and care pathways, supported by IT tools.
- Stratification of the patient population to ensure that care is targeted at the appropriate level with supporting anticipatory care plans in place.
- Ensuring that access arrangements enable all patients to access and benefit from services
- Increasing the education and information shared with patients and the public to support people to take more responsibility for their own care.
- Involvement of patients and carers in care planning and self management.
- Shared learning and education across primary, community and acute services.
- Governance and performance systems which support new ways of working.
- Information systems which enable us to gather the information we need to monitor whether the changes are working, including disaggregated data on activity and outcomes for equality groups.
- Integrated planning of services and resources.
- Ensuring that contractual arrangements with independent contractors support the changes required.

5.11 Benefits

It is anticipated that a successful move towards this system of care would result in:

- Patients being in control of their care and empowered to share decisions about it;
- A system of care which is easier to navigate for patients and professionals.
- Clinicians and other staff at all stages having the necessary information about the patient, with care better tailored to the patient's needs.
- Better patient experience and patient safety, and improved health outcomes with a particular improvement for patients with multi-morbidity.
- A reduction in health inequalities as the most vulnerable patients receive better access to holistic person centred care.
- Care which is provided in the most appropriate setting, relative to the patients needs.
- More cost effective use of resources with care focused on early intervention, better management of complex multi morbidity and a reduction in duplication of care.

Figure 4

What is Acute Care? Who needs to be admitted for inpatient care?

The definition of Acute Inpatient Care we propose is:

"Acute care is where people receive specialised support in an emergency or following referral for surgery, complex tests or other things that cannot be done in the community. Acute care usually provides treatment for a short period, until the person is well enough to be supported in the community again."

The European Appropriateness Evaluation Protocol Approach has been developed and used in a number of countries to support this definition. This considers admission criteria in relation to both severity of illness and intensity of service required:

Admission criteria – intensity of service

- Surgery or other procedure in 24 hours requiring general/ regional anaesthesia or equipment or other facilities only for inpatients.
- Vital signs monitoring at least every 2 hours.
- Intravenous medications and or/ fluid replacement
- Continuous or intermittent (at least every 8 hours) respiratory assistance.

Admission criteria – severity of illness

- Severe electrolyte or blood gas abnormality.
- Acute loss of sight or hearing (within 48 hours of admission).
- Acute loss of ability to move any body part (within 48 hours of admission).
- Persistent fever >38 for more than 5 days.
- Active bleeding.
- Pulse rate <50 or >140 per minute.
- Blood pressure systolic <90 or >200, diastolic <60 or >120.
- Sudden onset of unconsciousness (except transient unconsciousness).
- ECG evidence of acute ischaemia, suspicion of new myocardial infarction.

Experience of applying this tool indicates:

- The most influential factor determining the appropriateness of bed utilisation is how the care system in place manages the patient, rather than the characteristics of the patient.
- Therefore it is important to consider the service configuration and care delivery to effect change.

Significant additional and different capacity is required if patients are to be treated more appropriately:

- A shift away from acute inpatient setting to provide a wide spectrum of home and community based care.
- Improved assessment and diagnosis.
- Non acute beds with therapy support.

Going forward we need to determine where the threshold for acute inpatient care is set

- ***Too high: difficult to implement, risk of readmission, significant impact.***
- ***Too low: won't be radical enough to address the problems we face.***

We need to develop a more comprehensive range of services in community settings based on the services we currently have. This will require us to determine what capacity is needed to ensure that core primary care and community services are accessible when required. It will require us to test the alternatives to ensure they are safe and cost effective.

5.12 The next section of this document sets out the high level service models to support the delivery of care in a more balanced system as we go towards 2020, indicating the areas where services should be further developed and the core components to underpin the health care provision.

6. SERVICE MODELS

6.1 The groups which developed the service models were clinically led and were formed with representatives of the hospital, primary care and academic clinicians. The clinical working groups included patient representatives and were supported by wider patient reference groups, involving patients, carers and voluntary organisations. The process was also supported by a series of cross-cutting events to consider specific issues across the groups, including primary care and the third sector. In addition work has been undertaken in relation to tertiary services which has been fed into the work of the different clinical groups where indicated.

6.2 The groups focused on:

- Reviewing current services, future changes and possible models of care;
- Looking at evidence from research, good practice and innovation;
- Thinking about what needs to change – and what doesn't;
- Reviewing feedback from the engagement sessions with the patient reference groups.

6.3 Underpinning each work stream was a core set of activities to consider current pathways, delivery models, workforce requirements and the relationship between primary and secondary care to ensure efficient and effective patient pathways.

6.4 The outputs from each of the groups were brought together into a discussion paper and summary document in June 2013, which set out how the models developed by all of the groups come together into a series of changes to the overall system of care in NHSGGC, as well as highlighting specific service models from individual groups.

6.5 The discussion paper was shared widely across NHSGGC, with partner organisations and with patients and third sector organisations. This included:

- Presentations and discussions with groups of clinicians, including Medical Staff Associations, Senior Nurses and AHPs
- Through each of our Directorates in the Acute Division, and all six of our Community Health (and Care) Partnerships
- Discussions with GPs through locality groups
- A session with all Patient Reference Groups
- A dedicated session for third sector organisations
- Discussions with West of Scotland Regional Boards and other partner organisations.
- Discussion at joint planning groups with Local Authorities
- Information in StaffNews and through papers available on the intranet
- Discussion with the Area Partnership Forum and Staff Partnership Forums across GGC
- Regular updates to the Area Clinical Forum and advisory committees

6.6 The general feedback was very supportive of the direction of travel set out in the service models paper and welcomed the approach being taken to involve the whole system. The approach described in the service models paper was considered an appropriate response to the issues raised in the case for change. Issues raised in the feedback included:

- Interface services require to be further defined: there was some concern about what it might mean for specific services and seeking details about how it will be taken forward
- The need for more emphasis on the role and implications for primary care.

- The need for explicit mention of health and social care integration, and effective working with social care.
- Request for inclusion of some patient stories to illustrate the proposed changes more clearly.
- Lots of examples of good practice, where services are already moving towards the sorts of models set out in the paper.
- Strong support for the emphasis on assessment and senior decision makers.
- Strong support for the focus on multi-morbidity
- The need to make sure that the service models recognise the different needs and approaches required for frail elderly patients, and younger patients with multiple chronic diseases.
- Respondents were keen to see the approach tried out before it is fully implemented, particularly to test out the affordability of the model.
- An appreciation of the level of engagement so far, and a request for reassurance that all parties will be involved in working through the details to understand the implications and the detailed models.
- An emphasis on the need for increased engagement and involvement of social care going forward, particularly to consider the interrelationship with the integrated health and social care agenda.
- Patients were keen to stay involved with and informed about the process

6.7 The comments received were incorporated into the final version of the Service Models paper which forms the basis of this clinical strategy. The detail of the outputs of the service models work is set out later in this paper but it is particular important to highlight a number of key consistent themes.

6.7.1 Equalities

- In addition to this, future service models will have to support NHSGGC to comply with its duties under the Equality Act 2010 to remove discrimination, close the health gap as a consequence of poverty and social class, and address the needs of marginalised groups.

6.7.2 Overarching principles

- Focus on what care the patient needs
  - care provided based on need and individual circumstance
  - care delivered in the best way
- Focus on improving clinical outcomes and delivering a good patient and carer experience.
- Locally accessible on an outpatient / ambulatory care basis where possible
- In-patient care only where necessary.
- Low volume and high complexity care provided in defined units equipped to meet specialist care needs.
- Consistently meeting core standards of care: patients should be able to access the same standard of care wherever they are in Greater Glasgow and Clyde.
- Continually evolving to ensure the most appropriate treatment / intervention is offered.
- Care should be focused on reducing inequalities by ensuring access for the most disadvantaged
- Services should be provided in a non-discriminatory manner
- Supporting patients to have the best health possible.
- Research should be strongly supported and fostered.
- Services should be sustainable, both clinically and financially.

6.7.3 Issues for patients

- Concern about lack of joined up care, particularly for those with multiple conditions receiving support from different teams across primary care, community services and hospital outpatients and / or inpatients.
- Lack of communication between teams and with patients
- A desire to be able to manage conditions better themselves, with appropriate support
- The need for patients and carers to be valued as partners in care
- The importance of access to services, in terms of both time and physical location
- A broad range of issues impacting on people's health and ability to benefit from services, including the impact of the recession and welfare reform
- The challenge of ensuring that changes to services add up to real benefits for
- individual patients

6.7.4 The following comments reflect a view of what success would look like from a patient perspective:

"I know who the main person in charge of my care is. I have one first point of contact. They understand both me and my condition."

"The professionals involved with me talk to each other. I can see that they work as a team."

"There are no big gaps between seeing the doctor, going for tests and getting the results."

"I am as involved in decision making as I wish to be."

"I understand my condition and am supported to manage my care."

"Having someone identified to help coordinate my care is important."

"Understanding who can help and support me, not just with my clinical care, is important."

"Receiving care in a specialist unit is fine as long as I can access local services for follow up and advice."

7. FRAIL ELDERLY AND CHRONIC DISEASE

7.1 Core Elements of Service Models

7.1.1 There is significant overlap in the models emerging for frail elderly patients, and for those with chronic diseases. However, there are also areas where a dedicated focus on frailty, distinct from single or multiple long term conditions, is essential. And there is a clear group of younger patients, particularly in deprived areas, who experience multiple long term conditions long before they would be defined as 'older'. The common approaches and specific requirements are set out below, followed by the areas where separate emphasis or approach is required.

7.1.2 The evidence suggests that getting the basics right – integrated, multifaceted and coordinated primary, secondary and social care are much more important than any single tool approach. The following interventions are supported by consistent evidence

(http://library.nhsgg.org.uk) and should be linked into a coherent whole as part of a future strategic approach to change in NHSGGC:

- Shared, high-quality protocols across care settings
- Collaborative relationships between specialists and generalists
- Planned systems of collaborative care involving case management, systematic follow-up
- Improved integration of primary and secondary care
- High quality primary care
- Effective coordination of care and use of IT to support communication
- Effective self management/supported self care
- Multi-professional teams
- Explicit care planning
- information sharing with patients and among care providers
- Reliable methodology and application of risk stratification
- Ensuring that all health professionals ask about diet, smoking and physical activity in their consultations with patients
- Ensuring that all health professionals can direct people towards appropriate computerised decision support tools to ensure coherent protocols available and used by clinical staff
- Use of a range of professional specialists nurses (e.g. Specialist nursing has demonstrable benefits for asthma, COPD and heart failure and may be replicable for analogous long term conditions).

7.1.3 The core elements of the service model to deliver this include:

- **Anticipatory care planning** enables patients and professionals to plan for a change in health or social status, particularly for those at high risk of crisis.

  Plans need to be developed by multi-disciplinary teams including primary care, community services and hospital specialists.

  Successful implementation of plans require the ability to mobilise a wide range of support in community, including home care, aids and adaptations, housing, befriending and carer support in a timely manner, based on a 7 day model that can also support care in the evening and overnight.

- **High Quality Primary Care** Age and chronic diseases represent a significant proportion of patient contacts in primary care, and the majority of care is managed in a primary care setting. General practice and the services it connects to are critical to a focus on prevention, management of risk factors and continuity of care for those with long term conditions.

- **Front door assessment model** will require early comprehensive assessment with senior decision makers at the front door, identifying specialist input and appropriate management plans guiding treatment and care packages in all settings, to support chronic disease management and / or frailty.

- **Non-acute beds may have a place as alternative to admission or to enable step down care** – this model requires a smaller ‘acute’ element of care with more non-acute and community infrastructure. The non acute beds would need to have rigorous standards for patient throughput and clear outcomes. Further work is required to define this approach.

- **Managing multi-morbidity** -better integration of services across specialties within hospital, between hospital and the community, and between health and social services are crucial to the management of multi morbidity.

- **Inpatient Care focused on acute episode of care, with planning for rehabilitation and return home** – ensuring rehabilitation is available dependent on need not age, focused on ensuring return home at the earliest opportunity by supporting rehab care in the community.

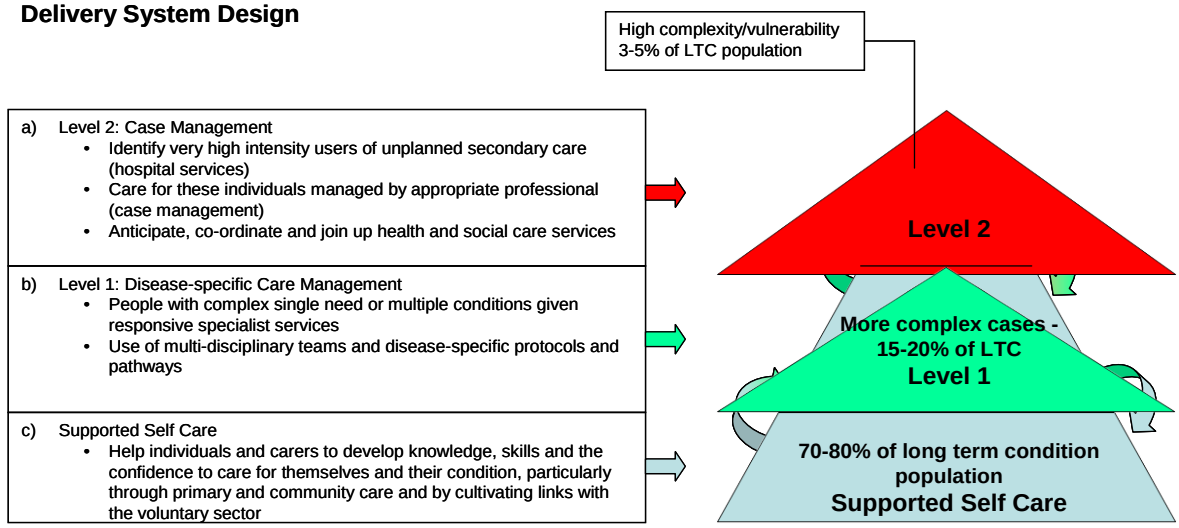
7.1.4 These are considered in more detail below in relation to both Chronic Disease and Frail Elderly pathways.

7.2 Chronic Disease

7.2.1 Overall approach

The proposed approach is based on risk stratifying the population by complexity and vulnerability, and providing care accordingly:

Figure 5



The key building blocks to support these models are listed below. A number of these are already in place, however the challenge is to ensure that they are consistently in place across the system, based on a 24/7 model, addressing the timing and volume issues currently facing many of these services.

Tailored Care - Care assistant - Physiotherapist/ OT - District Nurse - Community Pharmacy - Advanced Nurse Practitioner (generic) - Specialty Liaison Nurse - GP - Hospital Physician - Clinical Psychologist	**Advice** - Expert patient - GP - Nurse Specialist - Hospital Specialist - Acute Physician - Specialty Physician
	Access to Hospital facilities and outpatients
	Intermediate care
	Out of hours advice and assessment - Nurse provided - Expert Patient - 'Buddy system
Communication: Portal; e referral / direct referral	

These services need to work together effectively to provide both routine care, and to escalate support in response to a crisis or significant change in condition. These pathways are shown below at figures 6 and 7.

Fig 6: Chronic Disease Routine Care

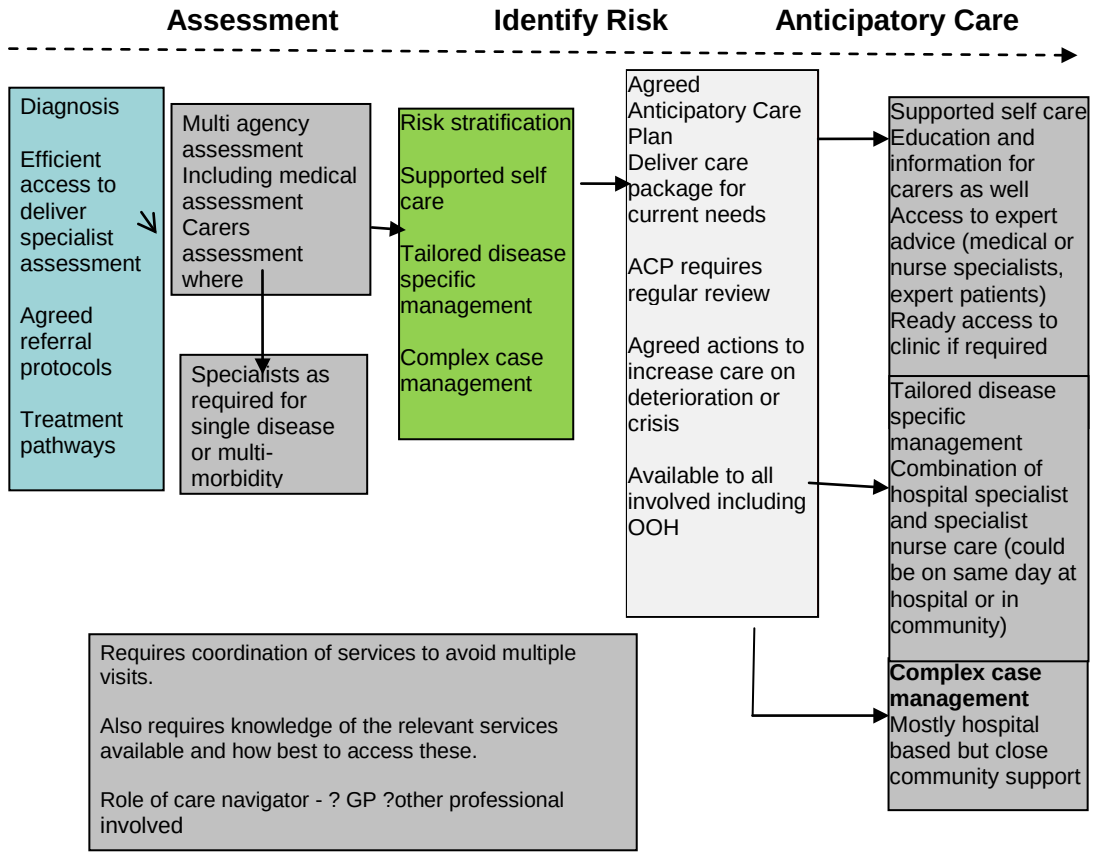
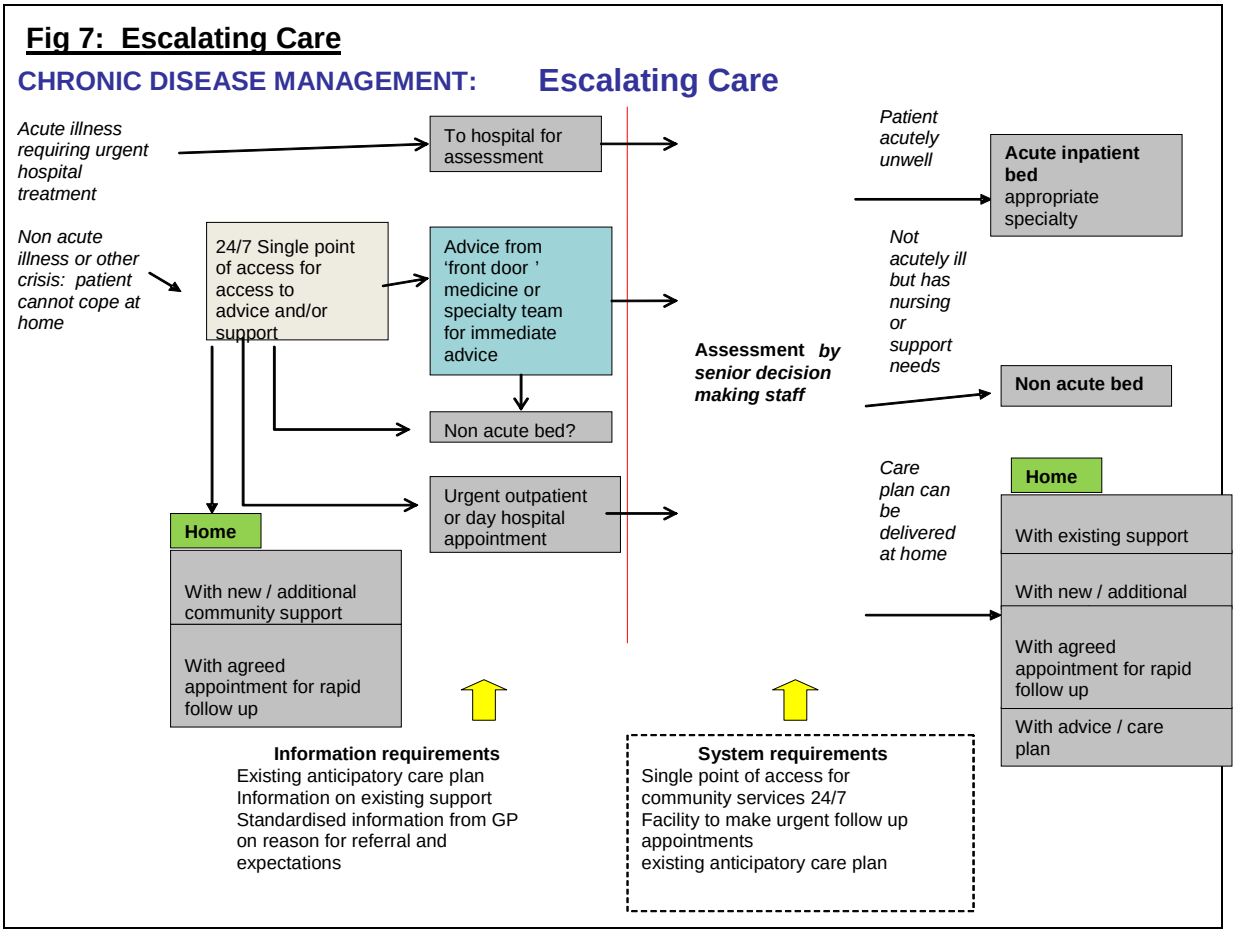


Fig 7: Escalating Care



7.2.2 Anticipatory care

A clear and responsive anticipatory care plan, which follows the patient and informs care in all settings, is a core part of this approach. While anticipatory care planning has been in development in NHSGGC in recent years, it is not yet a systematic multi-disciplinary approach focusing on those who would most benefit.

The agreed definition of anticipatory care in MHSGGC is "An integrated programme of defined preventive interventions delivered to individuals, operating across the continuum of primary, secondary and tertiary prevention. Its overall aim is to shift focus of service provision from reactive to preventive care, by adopting a whole population perspective across all aspects of service planning and delivery"

Anticipatory care planning is, by definition, planning of the above. It can be considered at an individual or population level. In both cases, it involves planning appropriate interventions that are i) evidence based; ii) connected to other interventions and services; and iii) applied across the entire continuum of disease, not just the latest stages.

Anticipatory care planning should be undertaken as early as possible – needs to start with diagnosis. Effective interventions relevant to that patient's needs should be delivered across the anticipatory care continuum, from primary prevention to end of life care. At each point along the continuum of primary, secondary and tertiary prevention, the objective is to control the underlying condition and prevent or delay progression of disease. Each stage of intervention in this process has a preventive component, a clinical management component and a self care component.

Health related behaviours, life circumstances and psychosocial factors all play an equally important role at each stage, not solely in primary prevention.

There are some good existing examples within NHSGGC of effective anticipatory care planning, including:

The Heart Failure Liaison Nurse Service cares for a well defined population of patients with chronic heart failure. These are referred from hospital and risk stratified to community or clinic care by the HFLNS. The HFL nurse will communicate with both the GP and the cardiologist about aspects of the care.

We would seek to roll out models such as this across GGC.

7.2.3 Multi morbidity

Developing better approaches to multi-morbidity has been a key theme of this Clinical Services Review. Within the pathways described above, the following elements will need to be developed further to establish a better approach to multi-morbidity:

- Continuing the work on QOF and Enhanced Services within primary care to bring together the management of different chronic diseases into a combined approach focusing on individual patient needs.

- Developing a better 'combined approach' to providing specialist input where patients are currently attending multiple outpatient clinics. This would focus on co-ordinating investigations, treatment and management so that any specialist input is managed in the context of the whole person and their environment not just narrow disease specific guidelines. This could be done through:

    - Shared clinics where there are common co-morbidities
    - Access to additional specialist input at chronic disease clinics (for example, specialist nurse input)
    - Improved access for GPs to specialist advice and opinion.

- Development of care navigator or case management roles to co-ordinate care and minimise visits and duplication, as well as improving co-ordination In some cases, this could be the GP, district nurse or specialist nurse as long as some form of designation occurs. There may be a need for another individual or care navigator in complicated cases. As with anticipatory care planning case management has been in development in NHSGGC in recent years, but is not as yet systematically in place focusing on those who would most benefit.

- Improving the identification and management of co-morbidities in emergency and inpatient settings. Co-morbidities are often a major reason for prolonged stays in hospital. Early generalist assessment to establish a comprehensive treatment and care plan for an individual will support better management of co-morbidities. Where a patient's care is transferred to a specific single condition specialist, we need to find better ways to enable input from generalist and / or other specialist, including the patient's general practitioner.

- Polypharmacy is often associated with multi-morbidity and carries with it a number of risks to patients. Medication reviews should be available on a regular basis to all

patients experiencing polypharmacy, and should be triggered by any acute or emergency episode of care.

- We know that multi-morbidity occurs is strongly linked to deprivation, occurring 10-15 years earlier in areas of high deprivation and encompassing both physical and mental health. Approaches to multi-morbidity therefore need to take account of a range of wider complex and challenging life circumstances which may act as barriers to patients' participation in new service models. Approaches to multi morbidity also need to focus on the changes in practice and behaviour required to take account of this.
- Multi-morbidity is a particular feature of patient contact in primary care, and we need to ensure that there is both sufficient capacity and support for effective approaches to managing multi-morbidity in a primary care setting, learning from current research activity in this area.

Illustration: for a patient, moving to the new model of care described might look like this:
Patient story

58 year old woman with diabetes, hypertension, chronic kidney disease and rheumatoid arthritis, is overweight and smokes and is unable to work.

Now: Has frequent appointments at hospital diabetic clinic, GP chronic disease reviews, podiatrist, renal clinic, hypertension clinic, rheumatology clinic. Frequent DNA because forgets appointments, doesn't see the point or doesn't have the bus fare to get there. This results in several acute admissions per year.

Future: Risk stratification flags up patient as high risk due to multi-morbidity; case review highlights multiple teams involved in care – case manager identified to develop a co-ordinated care plan involving the GP and appropriate specialists. Routine outpatient review minimized and clear triggers in place for return. Targeted support put in place and advice on diet and weight loss, smoking and benefits maximisation.

7.3 Frail Elderly

7.3.1 Overview

The older people group focused on 'frailty' as distinct from older people with other single conditions or multiple chronic diseases, with no additional functional problems. This reflects the fact that older people are cared for across all services, that amongst older people there is wide variety in terms of health and function, and that treatment should be needs based and not age based.

The main premise of the group is that specialist geriatric input should be focused on the frail elderly or those with 'frailty syndromes'. Stroke pathways are described in section 7.

What is frailty?

Frailty can be defined as a syndrome of multi-system reduction in physical capacity as t result of which an older person's function may be severely compromised by min environmental challenges, giving rise to the condition of 'unstable disability'.

Older people tend to present to clinicians with non-specific presentations or frailty syndrome

in contrast to the classical presentations seen in younger people. The reasons behind the nc specific presentations include the presence of multiple co-morbidities, disability a communication barriers. The ability to recognise and interpret non-specific syndromes is ke as they are markers of poor outcomes:

- ***Falls***
- ***Immobility***
- ***Delirium and dementia***
- ***Polypharmacy***
- ***Incontinence***
- ***End of life care***

These indicators should be the basis of simple assessment tools adapted to all settings – community, hospital 'front door' and inpatient.

The core pathways and components of care for frail elderly are set out in the diagrams below (figures 8-10):

Figure 8: Community support

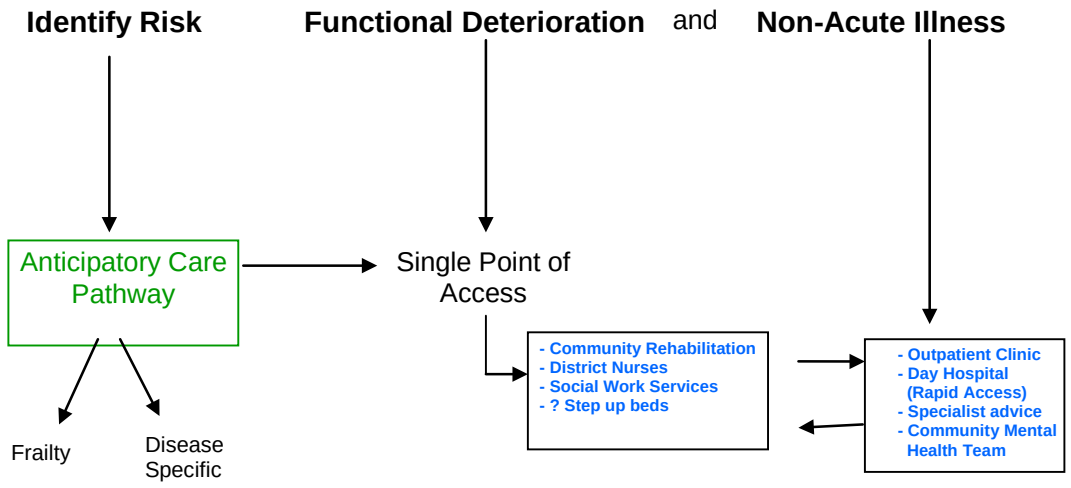


Illustration: For a patient, moving to the new model of care described might look like this:

Patient story

80 year old man with mild dementia and mobility problems, lives alone, has daily home care visits. Daughter lives 10 miles away, works full time and has small children but tries to visit several evenings a week.

Arrives one evening to find her father has an upset stomach and has been unable to get to the toilet quickly enough, and has fallen.

Now: Daughter unsure of where to get help, so phones NHS24. GP arrives, suggests admission to hospital. Patient admitted, investigated and treated for stomach bug. Confusion increases in strange environment, and mobility decreases as he stays in bed until his stomach is better. Stays in hospital for several weeks and now doubt about return home.

Future: Patient has been identified at risk due to mobility issues, dementia and living alone and has anticipatory care plan, informed by Comprehensive Geriatric Assessment, which sets out steps to take if he is ill or needs additional support. Daughter is able to see on the plan who to contact. Crisis team responds quickly, assesses father and helps to clean up and get him to bed. Arrangements made for GP to visit in the morning. Additional support put in place for a few days to ensure he is drinking enough and to support mobility until he is better. Care needs are reassessed and patient is given an alarm and increased support, with planned ongoing review.

Figure 9: Front door/hospital pathway

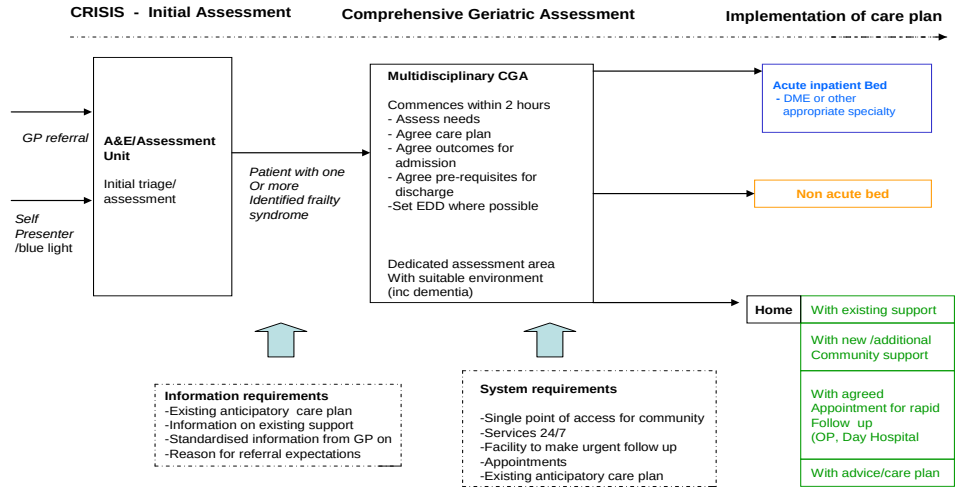
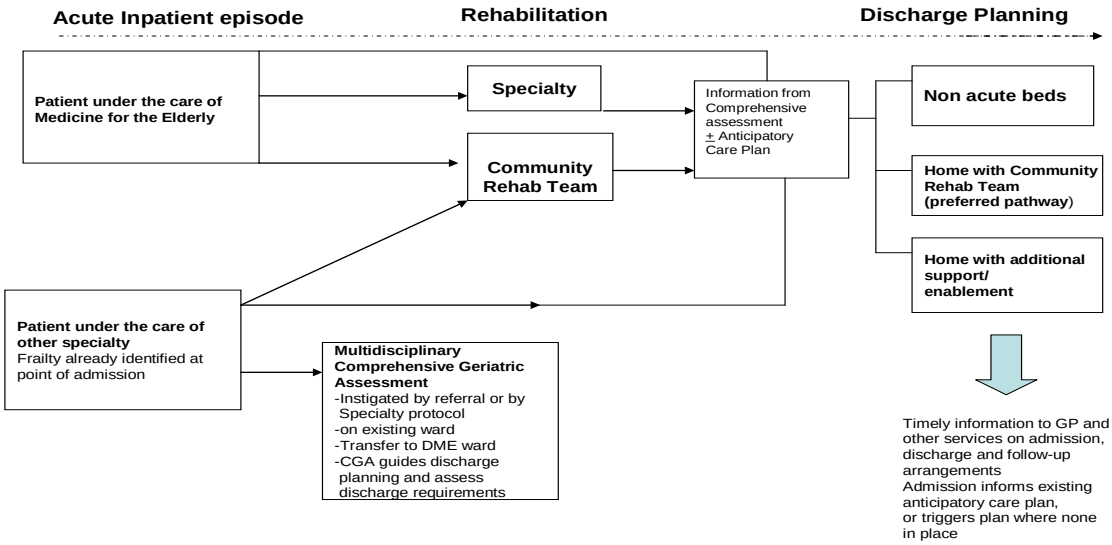


Figure 10: Inpatient Pathway (Frailty)



7.3.2 Anticipatory care

Anticipatory care plans must include frailty as well as chronic disease management. This includes consideration of social care needs, carer support, isolation, function and ability to manage the activities of daily living, supported by the multi agency single shared assessment process. It should explicitly include consideration of options for when carers are unwell or unable to provide support for any reason. The plans must enable rapid escalation of support from health, social care and third sector agencies supported by a 24/7 single point of access.

7.3.3 Comprehensive Geriatric Assessment (CGA)

CGA is strongly evidence based and drives the model for frail elderly. The pathways set out above enable CGA to be carried out in a community setting with specialist input through geriatric outpatients and day hospital services, and in acute settings with the presence of senior geriatric specialists at the front door.

Figure 11: The evidence base for comprehensive geriatric assessment

There is robust evidence to support multidimensional assessment and multi-agency management of older people leading to better outcomes, including reduced readmissions, reduced long term care, greater satisfaction and lower costs.

Comprehensive Geriatric Assessment (CGA) is defined as 'a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up'.

While integrating standard medical diagnostic evaluation, CGA emphasises a quality of life and functional status, prognosis, and outcome that entails a workup of more depth and breadth. The hallmarks of CGA are the employment of interdisciplinary teams and the use of standardised instruments to evaluate function, impairment, and social support.

Comprehensive Geriatric Assessment should be available to patients with one or more identified frailty syndrome within 2 hours of A&E attendance (14 hours overnight) and should drive the treatment and care plan both within hospital and in the community. CGA needs to be available within the community, at the hospital front door and in inpatient settings. It is a key requirement that information which may inform CGA, and the outcome of the assessment, is passed through the system consistently and is easily accessible and useable in a fast paced environment.

Delivering CGA in an emergency environment is challenging, and will require access to a separate quieter area (such as a medical assessment unit) with an appropriate environment.

Patients who have been admitted as inpatients (either emergency or elective) to any specialty, may subsequently exhibit frailty syndromes and require access to Comprehensive Geriatric Assessment. This should be available in all settings and specialties, as an assessment which drives a care or discharge plan, or to consider the appropriateness of transfer to specialist Geriatrics.

Figure 12: Falls

Falls are a common trigger of an emergency episode, and a key indicator of frailty. Falls must be a core part of broader approaches to risk assessment and care planning. This approach should include the following components, with timescales in line with the National Falls Bundles:

- Primary prevention based on falls assessment as part of general frailty assessment and anticipatory care planning, including self assessment
- Secondary prevention based on rapid notification of falls in both community and inpatient settings, leading to:
  - Falls assessment as part of more comprehensive frailty assessment
  - Individualised plan agreed with patient and actioned within 6 weeks. The plan should cover a range of interventions to prevent future falls taking account of related clinical needs, mobility issues, home and social environment and medication.
- Inpatient treatment where required (e.g. fracture) with access to Comprehensive Geriatric Assessment 7 days a week for Orthopaedic patients.
- Rehabilitation. Transfer to Geriatric Orthopaedic Rehabilitation Unit where appropriate. Multi-disciplinary discharge planning and discharge to community rehab teams for ongoing falls assessment and intervention.

Review and follow up. Review of plan within 6 months of commencement to update or close the plan

7.4 Dementia

Dementia is a syndrome caused by a number of illnesses in which there is a progressive functional decline in memory, reasoning, communication skills and the ability to carry out daily activities. It is increasingly present in patients presenting for a range of other health needs. Alongside this decline, individuals may also develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering. These cause problems in themselves, complicate care, and can occur at any stage of the illness. Dementia was reviewed jointly by the Older People and Mental Health groups and is considered further in section 8, but assessment and response to dementia and associated symptoms must be a core part of assessment throughout the older people's pathways described above, in all settings of ca

7.5 Implementation challenges for this model

- Defining the alternative models to admission such as advice service to support patients in the community non-acute beds to enable step down care considering the how this might impact to create a smaller 'acute' element of care with more non-acute and community infrastructure. This will require further definition of categories of 'non-acute' patients and support required including the risk of change and deterioration in patients, level of nursing care required and any ongoing diagnostic requirements.

- Front door model – general assessment with quick access to specialist care for treatment where required and the staffing model to support.

- Sizing the different groups and input required, for example likely numbers with frailty syndromes will drive front door geriatric staffing model. This will be based on assessment of known demographic changes, assumptions re potential for avoiding admissions, and an assessment of the current proportion of admissions with frailty syndromes.

- Work to assess further potential for home based rehabilitation / re-ablement.

- Particular consideration needs to be given to end of life care and supporting alternatives to acute hospital admission, particularly where patients wish to die at home or supported in a community setting (see figure 13).

Figure.13: End of Life Care

A key group where acute admission may not be desirable is for end of life care. The approach to palliative and end of life care should be based on:

- Palliative care needs being identified as soon as possible with more effective use of the **Gold Standards Framework** (GSF) in primary care, the use of the **Support and Palliative Care Indicators Tool** (SPICT) in in/outpatient settings and the use of the **Support and Palliative Action Register** (SPAR) in care home/continuing care settings. This would allow appropriate, timely engagement in the process of **Anticipatory Care Planning** (ACP).
- Ongoing holistic assessment being undertaken by professionals with good communications skills and a knowledge and understanding of the disease process, likely symptomatic issues and an appreciation of where these needs could be met, in order that the ACP process can be engaged with in a realistic way by the patient and family. This may be the GP, District Nurse, Consultant, disease specific specialist nurse, ward staff, care home staff or any of this combination in partnership.
- Effective communication of priorities of care. Conversations could be initiated using the My Thinking Ahead and Making Plans (MTA&MP) communication tool and further details placed on **Key Information Summary** (KIS) or the **electronic Palliative Care Summary** (ePCS) which can be accessed by unscheduled care areas, the Out of Hours Services and the Scottish Ambulance Service.

The preferred place of care is influenced by many factors. Options should include:

- **Care at home**, with the facility for patients to be assessed at any time in a 24hour period with rapid access rehabilitation teams, increased home care provision or equipment. The need for an appropriately skilled, well coordinated multi agency service in the community with effective communication systems is essential to this.

- Patients, who need less acute interventions sometimes simply observed care, may be suitable for rapid admission to **non acute bed**.

- There will be an ongoing need for Acute Admission for patients with symptom issues that cannot be managed at home. There is also a need for a “wider team” (or “virtual team”) assessment of patients on admission

so that their palliative care needs are assessed promptly, their co-morbidities are taken into account and prioritised and a plan is made for that individual based on the above assessment. This could include referring patient immediately for Hospice admission or being able to get the patient home with enhanced community care.

- Rapid access to **hospice beds** for assessment, complex symptom control and end of life care may be appropriate for those with more complex care needs, not needing or wishing admission to an acute bed.

7.6 Mental Health

7.6.1 Introduction

The mental health clinical groups focused on the models of care required for:

- Adult Mental Health
- Dementia
- Drug and Alcohol Services

The overall approach which applies across these services is set out below, with condition specific examples given where appropriate.

7.6.2 Overview of the approach

The purpose of prevention, treatment and care activity in mental health is to deliver health outcomes, a positive user and carer experience from contact with services, and to contribute to user's progress towards recovery/living well with their illness.

Achievement of that purpose requires:

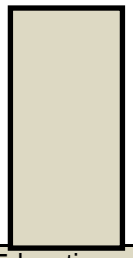
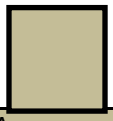
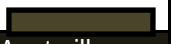
- A needs led structure of service delivery based on condition and frailty
- Interventions which are organised and delivered by condition
- Levels of intervention determined by the intensity and severity of the condition
- Interventions which are systematically delivered based on agreed condition specific care pathways consistent with evidence based/ best practice standards
- Users to be able to see their place on the care pathway
- Operational and team processes, practice, culture and pathways within and between teams which are organised and delivered to ensure:
    - Clinical interventions are systematically delivered based on the condition specific care pathways
    - Positive user experience in which carers and users are partners in care and feel well supported
    - Services are "easy in and easy out"
    - Interventions provide "everything you need and nothing more"
    - Patients with multiple morbidities receive coordinated rather than fragmented care
    - Care planning supports personal outcome based progress towards recovery/living well with the condition

7.6.3 Clinical framework for prevention, treatment and care

As with the approach described for physical chronic conditions, the overall approach is based on a stratified system of care, identifying need and responding at the most appropriate level of intensity.

The diagram (figure 17) below describes the overarching framework for mental health services. The Framework will be populated for each major clinical condition to set out the condition specific interventions and care pathway for that condition.

Figure 17

Numbers					
Need for help	Education and promotion of well being Targeted prevention for groups at risk	Anyone concerned about their own health or other peoples health	A prompt response for people who develop symptoms associated with a condition	Progress towards recovery whilst living with ongoing mental health problems	Acute illness
Type of Intervention	Information, screening, self-help	Education, self-help, peer support, group classes	"Low intensity" work: brief interventions, psychological therapies, guided self-help	Longer-term psychological therapies; community rehabilitation;	Risk management, physical health care
Access	Everyone	Open, self-referral	Self-referral and GP referral	GP or secondary care referral	GP or secondary care referral
Care level	Public	Open access /supported self care	ERBI: early response, brief intervention	Ongoing care and support	Intensive treatment

7.6.4 Personal outcomes for service users and carers

In their contact with services Service Users can expect:

- To define recovery goals together with the service
- Services support progress towards recovery /living well with their condition

People with mental health problems should be able to say that they have a positive experience of their contact with services and through this contact:

- I get the treatment and support I need when I need it
- Accessing services is straightforward
- I was diagnosed early
- I & those around me and looking after me feel well supported
- I am actively involved in decisions about my care
- I am treated with dignity and respect
- My care plan focuses on my recovery as I have defined it
- I have meaningful occupational interests and social involvement

7.6.5 Changes required to deliver the model

Moving towards this model will require the following changes:

1. Cease age based exclusions from access to service supports such as psychological interventions/crisis services and liaison psychiatry.

2. Shift from age based service configuration of adult and older people mental health services to needs based configuration of:

    - Mental Health 18+ (no upper age cut off, needs led transition based on physical frailty).
    - Dementia and Functional mental health combined with physical frailty service.

3. Consideration of service models for people with dementia given apparent commonality of health needs of people in acute wards and Older People Mental Health acute wards.

4. Address service gaps within the dementia care pathway:

    - Memory assessment service for early diagnosis of 2300 new patients per year in community setting.
    - Post diagnostic support services.

5. Review the functionality of services and teams to ensure their detailed operational processes are aligned to deliver the principles set out in sections 3, 4 & 5 above & in particular:

    - Systematic interventions of agreed condition specific care pathways.
    - Health outcomes.
    - Positive user and carer experience.
    - Recovery/living well with your condition.
    - “Easy in easy out”.
    - Coordinated management of multiple morbidities.

7.6.6 Implementation challenges for this model

Mental Health 18+

- Components of comprehensive service system are in place and no major service gaps per se
- Modest incremental further acute bed closures/balance of care shifts.

- Need to scope & size operational implications of shift to 18+ service for inpatient and community services.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

Dementia services

Resolve service model and relationships between mainstream acute and specialist dementia services to determine:

- Configuration of dementia services as integrated mainstream acute service or specialist dementia service.
- Size the dementia cohort and the challenging behaviour cohort to model workload implications of the configuration options for both acute and community services.
- Rework the bed model and site alignments between acute and MH sites to reflect the eventual agreed model and configuration of dementia services.
- Develop detailed service model and configuration of community based memory assessment services & post diagnostic support services.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

Drug and alcohol services

- Improve management of co morbidity between addictions and MH.
- Improve alignment between day services and community services.
- Improve access and support to substitute prescribing.
- Improve alignment of operational processes and recovery outcomes for service users.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

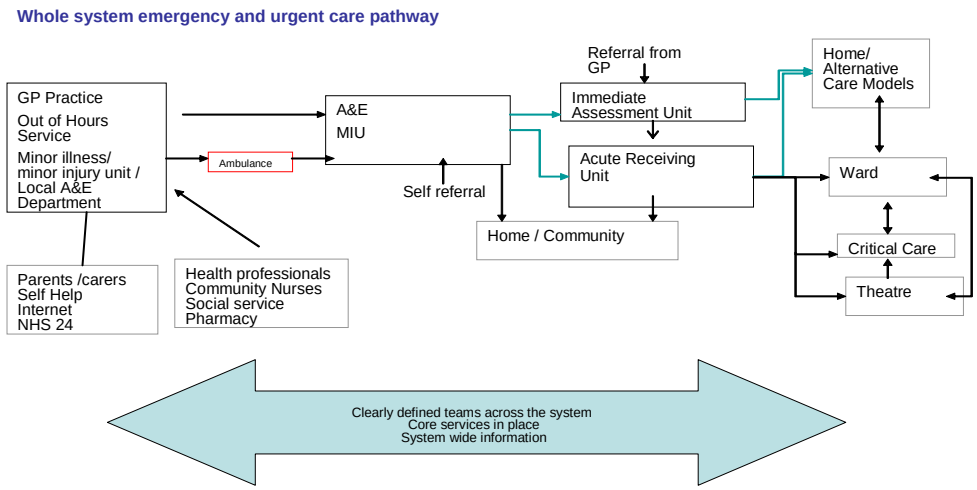
8. EMERGENCY CARE AND TRAUMA

8.1 Overview

Emergency services have to be able to respond appropriately to all patients who present. This section describes the proposed overall model for emergency services to meet standards and requirements for all patients and the changes to emergency services required to respond to the chronic disease and frailty pathways set out above (which form the majority of emergency admissions).

The overall pathway is summarised in the following diagram

Figure 14: Whole system emergency and urgent care pathway



8.2 Accessing emergency care

The key routes in to emergency care are set out below.

In-hours patients may:

- Call GP for an emergency appointment
- Call NHS 24 for advice and onward referral as appropriate
- Call other community service for an emergency appointment (e.g. Dental, Ophthalmology; Mental Health)
- Go to their pharmacy
- Call the Scottish Ambulance Service – who may treat on site, take to the Emergency Department or refer to another service (e.g. GP)
- Go directly to the Emergency Department/Minor Injury Units

Out of Hours patient may:

- Call NHS24 for advice with onward referral as appropriate and may be offered either GP OOH telephone advice, GP Out of Hours appointment; Minor Injury Unit or Emergency Department.
- Patients may choose to go directly to Minor Injury Unit, Emergency Department or walk-in to the GP Out of Hours service.
- Call the Scottish Ambulance Service – who may treat on site, take to the Emergency Department or refer to another service (e.g. GP)
- Call the Out of Hours District Nursing Service or other Community Services

8.3 Response to emergency assessment in all settings

When a patient is assessed in an emergency at any of the entry points above, a more flexible range of responses is required. A number of studies support the position that a much greater proportion of work could be undertaken as an outpatient or in an ambulatory setting including many acute medical emergencies. This requires our services to develop a

more “planned” urgent clinic approach to manage medical emergencies. Some examples are set out below:

Figure 15

Respiratory	Cardiology	Gastroenterology
- Community acquired pneumonia with a low CURB-65 score - Small pneumothorax - Asthma following British Thoracic Society guidance - Chronic obstructive pulmonary disease with supported home care - Asymptomatic pleural effusion	- Cardiac failure - Atrial fibrillation	- Upper gastro intestinal bleed with Rockall score of 0 - Lower gastro intestinal bleed with no haemodynamic compromise - Painless obstructive jaundice - Non-acute abdominal pain - Diarrhoea and vomiting
Endocrinology	**Infectious Diseases**	**General Medicine**
- Hyperglycaemia without ketosis - Hypoglycaemia with full recovery - Type 1 diabetes without ketosis - Electrolyte imbalances	- Cellulitis - Osteomyelitis	- DVT - Pulmonary embolism - Anaemia with no haemodynamic compromise - Syncope with low cardiac risk - Urinary tract infection

Based on the above position a number of services to support ambulatory emergency care are identified. These could be services that sit as part of the interface service model.

- Chronic obstructive pulmonary disease outreach
- Pleural disease clinics
- Rapid access chest pain clinics
- Transient ischaemic attack /stroke clinics
- Epilepsy clinic
- Pain management service
- Functional assessment teams and support teams
- Falls clinic
- Nurse specialists - diabetes, cancer, palliative care etc.
- Outpatient parenteral antibiotic teams
- Endoscopy services
- Heart failure team

A pre-requisite to changing how urgent and emergency care is provided is to ensure that there is quick and reliable access to GP appointments. This will allow patients to connect into the relevant services through their GP thus supporting patients accessing care in the right place at the earliest appropriate opportunity.

For most patients, the GP practice will be the first port of call for help or advice. Moving forward, we need to ensure that we have the right capacity in primary care to provide timely access to appointments for those who need to see a GP, and to build on the work of the access toolkit and productive general practice to provide a range of options for patients, including telephone advice where appropriate. This includes supporting GPs to free up

appointments by understanding and addressing the growing demand on primary care from multiple sources.

In addition to the disease specific approaches set out above, additional support to manage patients appropriately in the community could be provided through:

- Urgent access to specialist advice, for GPs to be able to discuss patients in an emergency situation.
- Urgent access to outpatient clinics (e.g. within 24 hours), directly bookable, where an immediate admission is not required.
- Single point of access to health and social care community services to provide immediate support at home where required.
- Access to step up beds where a patient requires additional support which cannot be provided at home, but does not require an acute admission.

It is also important that all services where people present as emergencies, work to the same common protocols with access to a consistent range of support services across GGC to ensure there is equity of access to care and that care is not escalated beyond the lowest level required.

To support this it will be important that all parts of the system can access the information about the patient, their ongoing care, e.g. their anticipatory care plan where applicable, to ensure the right intervention can occur.

8.4 Hospital Assessment and Admission

Once at hospital it is important to have clear patient pathways through each of the services. The major components of hospital emergency services are described below:

- Minor Injury Service
- Emergency Department
- Immediate Assessment Unit
- Acute Receiving Unit

8.4.1 Minor Injury Service

Nurse led Minor Injury Service led by Emergency Nurse Practitioners (ENPs) to provide treatment for a wide range of conditions including:

- Fractures of nose, shoulder, upper arm, elbow, forearm, wrist, hand (inc. fingers), knee, lower leg, ankle, foot and toes.
- Soft tissue injury including strains and sprains.
- Dislocations.
- Wounds.
- Burns.
- Minor head and neck injuries.
- Eye injuries and conditions.

This may be provided as part of a standalone Minor Injury Unit, or as an integral part of the Emergency Department, where the ENPs will work with medical staff as part of the wider emergency team.

8.4.2 Emergency Department

The Emergency Department provides care to patients with:

- Acute injury or illness associated with physiological derangement or threats to life or limb
- Acute undiagnosed illness or injury that requires time critical intervention to prevent long term impairment, disability or death
- Acute illness or injury resulting in acute severe pain until once made comfortable, they can have appropriate investigations or additional treatment before being directed to definitive care.

The Emergency Department does not provide services for:

- Minor non-urgent illnesses that can be better managed in a non time critical manner by other community or primary care services both in and out of hours
- Non acute exacerbations of chronic conditions that are under the management of specialist inpatient or outpatient services
- Non acute complications, enquiries or requests for advice following elective surgical procedures (including urology, orthopaedics, ENT, maxillofacial surgery, obstetrics and gynaecology etc).

The key role of the Emergency Department is to assess and treat quickly, and ensure that patients receive care in the most appropriate setting. Destinations from the Emergency Department will include home, home with community support which can be arranged directly from the Emergency Department, move to the Immediate Assessment Unit for a further assessment period, or admission to the Acute Receiving Unit.

8.4.3 Immediate Assessment Unit

GP referred patients will go directly to the Immediate Assessment Unit (IAU). The purpose of the unit is to provide rapid assessment of patients by senior decision makers.

The focus of the IAU will be to pursue appropriate alternatives to admission including: urgent out patient clinic appointments, rapid access to diagnostics, access to Comprehensive Geriatric Assessment by specialist multi disciplinary teams, initiating specialist care and opinion by the relevant specialty team and prioritising the timely admission of acute patients into the Acute Receiving Unit. Specific pathways will support patient management through this unit. Inter hospital transfers should not pass through Immediate Assessment Unit but should go directly to a specialty bed by agreement with the relevant specialty senior decision maker.

Care will be provided on a 24/7/365 basis. It is envisaged that the consultant input within the IAU for medicine will be predominantly from acute care physicians and the geriatric specialist team and will be supported by junior medical trainees and medical nurse practitioners.

The surgical model of care sees general surgery GP referrals, undiagnosed urology and undiagnosed vascular patients directed into the IAU.

The surgical receiving team under the control of the senior decision maker will provide opinion and admission or diagnostic decision making to the IAU 24 hours a day every day.

Orthopaedic, ENT and diagnosed vascular and urology patients should be directed from the Emergency Department for the relevant surgical specialist team to take the decision to discharge or admit to downstream wards or treatment facilities as appropriate.

It is proposed that all necessary imaging and diagnostic work is commenced in the IAU this should be available 24 hours a day 365 days a year; recognizing that these patients have the same diagnostic and imaging requirements as those within the ED.

8.4.4 Acute Receiving Unit

The Acute Receiving Unit (ARU) provides the initial period of acute management for patients assessed in the Emergency Department or Immediate Assessment Unit as requiring admission.

The ARU will enable senior decision makers to manage the patient's assessment with fast access to diagnostic tests and the ability to discharge home or for suitable patients for return to the emergency department outpatient department. The ability to care for patients in the ARU for periods over 24 hours will allow complex diagnostic investigations to be completed without the need to admit to a downstream ward. The aim is for all imaging of patients within the ARU to be completed whilst the patient is in ARU.

8.5 Principles and standards

8.5.1 For patients requiring attendance and or admission to hospital for emergency care the following principles and standards are proposed:

8.5.2 Principles

- Patients are managed in an area designated for their acuity of illness by a 'generalist' (this includes Emergency Department or Acute Care Physician, Care of the Elderly Physician, Intensive Care Medicine Physician or General Physician) with early input from a specialist where required to ensure the most effective treatment plans are put in place as quickly as possible
- Consistent standards of care are in place across the systems which maximise patient outcomes.
- Prompt commencement of time critical treatment.
- Prompt access to appropriate imaging (CT, U/S, plain radiography) to allow immediate diagnosis of life threatening conditions.
- Availability of appropriate critical care expertise and skills across the system.
- Early informed decision making regarding patient disposition.
- An extended presence of senior clinicians providing expert direct patient care, leadership and supervision.
- Timely, planned discharge to an appropriate setting and with appropriate support.

8.5.3 Process standards

- Emergency admissions should be seen promptly by someone who is appropriately trained to make an assessment of their care needs, and with prompt consultant input where required. The different needs of medical and surgical patients should be managed appropriately.
- The Assessment Unit approach is a core component of emergency care, providing protocolised periods of investigation, observation, and review for patients who would otherwise be admitted to scarce and expensive hospital beds or discharged potentially unsafely.

- Ambulatory care- care should be instigated in the Emergency Department / Immediate Assessment Unit / Acute Receiving Unit and continued in the community where clinically appropriate.
- A comprehensive 24-hour interventional radiology service should be available.
- To maximise patient outcomes, where specialist care is required, it should be provided by senior clinicians undertaking high volumes of cases/ operations in line with national guidelines.
- Emergency day case surgery should be available where clinically appropriate.
- Patients should be provided with any necessary care, treatment and support in the most appropriate setting and environment, compatible with the delivery of safe and effective care, including the community where appropriate.

8.5.4 Disease/condition specific standards

- Frail elderly patients should have early access to comprehensive geriatric assessment to support effective management.
- Appropriate and timeous access to mental health services should be in place for people with mental health needs.
- Patients suffering major trauma injuries should be taken directly to a major trauma centre.
- Patients suffering from chest pain should have timeous access to angiography services.
- Patients suffering from a stroke should be taken directly to a specialist centre (see figure 16)
- Acute hospitals providing care for patients with GI bleeding should meet the national recommendations and provide 7 days a week access to out-of-hours endoscopy services; within 1-2 hours of admission for severe bleeding and within 12 hours for moderate bleeding. Appropriate assessment systems should be in place in all sites, with appropriate care pathways in place to treat patients or to transfer patients to the appropriate site for definitive treatment.
- National guidelines should be met where available; for example in the care of patients with myocardial infarction, head injury, bleeding in early pregnancy, suicide prevention and child protection.

8.5.5 Diagnostics

- Underpinning the new models will be a heavy focus on access to diagnostics to support the assessment of patients. This will require changes to how the services are currently organised to support early investigation to support decision making without the need to admit patients to organise tests.

Illustration: for a patient, moving to the new model of care described might look like this:

Now: Present to A&E and is admitted to hospital

Future: assessed by a consultant, not acutely unwell requiring admission, sent home with an appointment for a diagnostic test the following day with an outpatient appointment. GP informed, community team informed where indicated. Patient has information on what to do if condition changes / warning signs to look for.

Figure 16: Example of future models: Stroke

- **Prevention:** Primary prevention and management of risk factors [Rapid assessment of high risk TIA patients within 1 day of referral. All GPs using rapid assessment service; cardiac and vascular services resourced to meet demand from stroke.

- **Hyper acute stroke service (HASS):** Scottish Ambulance Service take patients with FAST +ve suspected stroke directly to hospital with HASS beds; early specialist stroke team assessment; immediate imaging and investigations; treatment commenced (including thrombolysis where indicated); rehab commenced in HASS; 35% patients discharged home from HASS bed.

- **Integrated acute/rehab stroke unit:** transfer from HASS at average of 2.5 days post admission; 7 day stroke specialist Multi Disciplinary Team assessment and rehab (AHPs, nursing, medical); planning for discharge and support for carers; average length of stay in unit 21 days.

- **Early Supported Discharge within Community Stroke Team:** 6/7 day stroke specialist rehab; multiple visits per day to support early discharge from hospital; close links with re-ablement care services; time limited intervention with review/follow up.

- **Support in the Long Term:** local community and voluntary sector services with awareness of stroke; GP Enhanced Service for stroke.

8.6 Implementation challenges for this model

- How we can consistently support a model of the 'generalist' as first line approach supported by specialist rotas allowing timely intervention. It will also consider the implications of this model across Glasgow and Clyde in terms of:

    - Activity and patient flows
    - The staffing model of generalist and specialists required to support the model
    - Accommodation requirements to allow for the effective components of the models to manage patient flows as described.
    - Assessment / Decision Unit approach and availability of urgent outpatient service across GGC.
    - Contact system for GPs to discuss patients prior to referral to hospital.
    - Develop a more detailed position on key areas identified for a change in specialist approach:
        - Stroke
        - Angiography / angioplasty
        - GI bleeding
        - Vascular
    - Develop the major trauma centre in line with regional and national planning, considering the critical clinical adjacencies to support this.

9. PLANNED CARE

9.1 Key Components of the approach

9.1.1 Local provision of outpatient and ambulatory care facilities

It is proposed that wherever possible outpatients, investigations, day surgery and short stay surgery should be provided as locally as possible across NHS GGC. This would provide a full range of core clinical services locally to meet the majority of patient needs with patients travelling only where clinically required to other sites.

9.1.2 Outpatient model modernisation

Outpatient model of referral and attendance at outpatient clinic needs to be modernised to provide alternatives to clinic consultation. This should include telephone consultation, telephone advice services for GPs to manage patients without referral to hospital; direct to test approach where appropriate.

Return appointment models should be reviewed with the aim to reduce the return appointments where appropriate and to facilitate alternative follow-up arrangements where possible. This should include telephone follow up; discharge with patient driven return initiation. The recent cancer services group and the work on Quality Performance Indicators suggest that the follow up arrangements could be reduced. For chronic disease management, different approaches to ongoing management and follow-up are also being considered with both groups considering how community based follow –up and patient initiated follow up could be part of the future models.

9.1.3 Community based service provision

Care should be provided within the community wherever possible. This could include:

- Further development of local phlebotomy services and monitoring of patients in community.
- Nurse/AHP led clinical services in the community or in hospital where applicable. This would build on the currently available services such as the diabetes and respiratory services. Some of the areas currently proposed to be developed could include:
  - Lower urinary tract and incontinence service;
  - Raised PSA clinic – Nurse led triage clinic where TRUS biopsy is provided;
  - Chronic pain service.
- Specialist clinics in community settings, working with GPs and community teams to develop joint care plans for patients.

9.1.4 Consolidation of low volume/ high complexity care

The evidence suggests that there is a case for improving outcomes by providing complex investigations and treatments in only a few specialist centres. This applies in particular to cancer care, which is covered in the next section.

9.1.5 Maximisation of ambulatory care including day surgery and the development of short stay surgical models within Ambulatory Care Hospital type facilities

There is scope to improve the use of Greater Glasgow and Clyde's inpatient beds for planned care. This is in part by maximising day case surgery / day treatment but also by

managing the time patients spend in hospital after elective care, which can be quite variable across sites.
This variation is caused by a number of factors, including availability and the quality of home and community support as well as the surgical techniques used.

Programmes such as the Enhanced Recovery after Surgery (ERAS) should be in place to ensure that patients spend no longer than they need in hospital. These programmes also encourage active participation of patients in the care plan and recovery process. This type of approach should be encouraged across surgery. Similarly, less invasive techniques should be used where clinically appropriate to improve the patient experience and the speed of recovery.

Reducing length of stay, where clinically appropriate, will be important to improve the patient experience and to bring financial benefit to allow investment in other parts of the service.

9.1.6 Planned 'urgent' care clinics

Through the work of the Emergency Care work stream there are a number of areas being identified to develop a more planned approach to care to avoid emergency admissions. This was detailed in the earlier part of this report and requires the service to consider different approaches.

9.1.7 New service models

New service models to better support the management of patients are being considered such as the digestive diseases service combining gastroenterology and upper and lower GI surgery to provide a single coordinated service for GGC.

Illustration: for a patient, moving to the new model of care described might look like this:

Patient Story
70 year old woman lives in Argyll and Bute, 4 hour travel time to services in Glasgow, main carer for husband. She attends outpatient clinic once a year for specialist follow up.

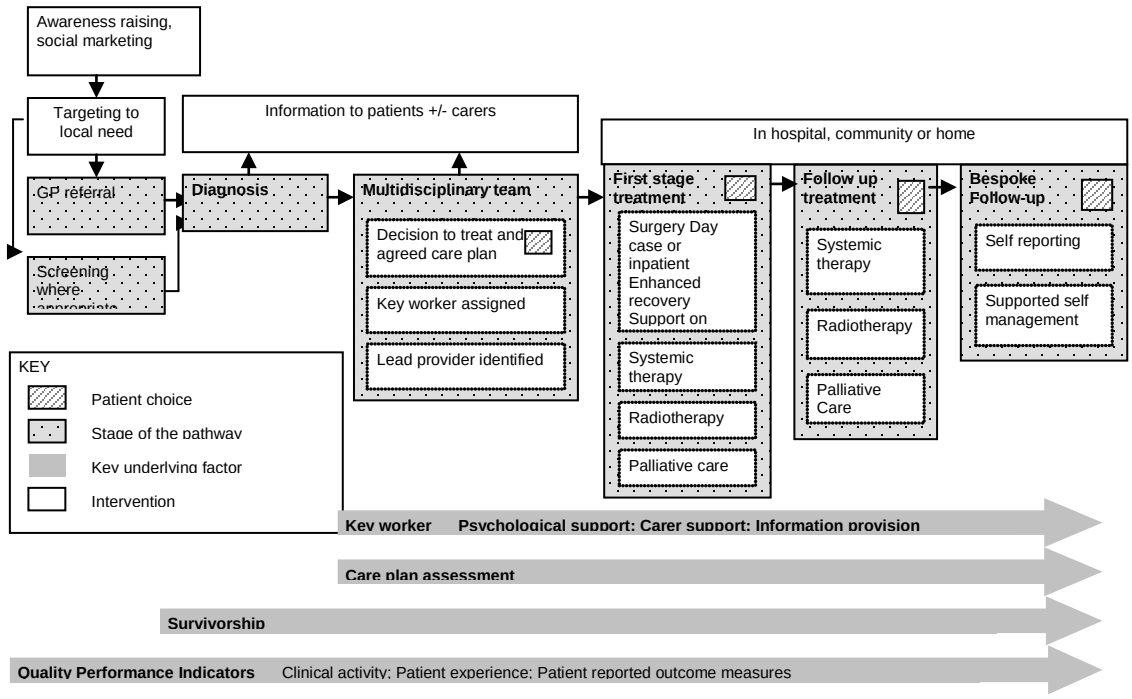
Now:
Sent an appointment for 9am, has to change to a time she can travel for
Makes arrangement for husband to be cared for
Travels all morning for rearranged early afternoon appointment
Has bloods taken and sees consultant for 5 minutes to be told everything is fine
Travels 4 hours home again – arriving late evening

Future:
Blood tests done locally, OP only arranged if indicated from results. Phone consultation or via telemedicine link for follow up where clinically appropriate.

10. CANCER

10.1 Key Components of Approach

Figure 18: Cancer Pathway



The key aspects of the care pathway identified to enhance survival and quality of life are shown on figure 18 above. In general the cancer pathways are considered to be well established and working well. Some areas were identified as areas where further consideration and development is required which are discussed below. Clinical evidence suggests that common cancer care such as systemic anti cancer therapy and patient follow-up should be provided as locally as possible and where possible outside the hospital setting. The evidence also makes the case for improving outcomes by providing complex investigations and treatments in only a few specialist centres.

10.2 Cancer surgery

The number of site(s) providing cancer surgery should be based on numbers of patients and outcomes achieved. The proposed model of care recommends some further consolidation of surgical services for both common and rarer cancers. This will ensure that clinical teams and environments are in place to provide high quality care and improved outcomes for patients across Greater Glasgow and Clyde.

10.2.1 Impact for Common Cancer Surgery

- **Breast cancer surgery**

  Breast cancer surgery can be delivered as a day case, with surgeons using less invasive techniques so that patients do not have to stay in hospital unnecessarily. Guidelines suggest that 60-70% of breast surgery should be day case.

To improve outcomes and experience, day case breast services should be available locally to all patients who require less complex surgery.

Patients undergoing more complex surgery should have the opportunity to discuss their breast reconstruction options and have immediate breast reconstruction if appropriate.

- **Colorectal surgery**

  The number of patients being seen and patient outcomes from cancer audit results should determine the number of sites. Where clinically appropriate this should be delivered locally. Complex colorectal surgery with plastic surgical involvement should be delivered in a specialist unit.

10.2.2 Impact for rarer cancers

Over recent years NHS Greater Glasgow and Clyde has consolidated services into single sites for some rarer cancers such as upper gastrointestinal cancer. For a number of cancers this has also resulted in supporting other boards within the region to provide a tertiary level service such as ovarian cancer. However there are still some areas where we are providing care on a number of sites for relatively small numbers of cases. Consolidating services into fewer hospitals would create and maintain complete clinical environments that can enable the delivery of best practice providing improvements and benefits for patients by focusing experience in limited areas within services.

There are a number of rarer cancers where volumes mean that the service can only be provided from a single site.

- **Rarer urological cancers**

  As with other small volume cancers urological cancers need to be provided from a specialist urology team. General urology services should be able to refer patients with complex needs to the specialist team. To ensure the best outcomes and experience, rarer urological services should have access to all of the requirements of a high quality service such as 24 hour access to interventional radiology, appropriate consultant cover and resident surgical juniors. NHS GGC needs to consider creating a centralised specialist team and unit to support the provision of complex urological cancer care. Currently there is ongoing work with other Boards within the region to realign small volume surgery into one service within NHS GGC.

10.3 Changes to Treatment

10.3.1 12.3.1 Systemic Anti-Cancer Therapy (SACT)

Guidelines recommend that to provide patient centred care the inpatient delivery of systemic anti-cancer therapy (SACT) should be minimised. Over recent year's local provision has developed in many areas linked to the central unit at the Beatson to provide more convenient treatment to patients where it is safe and clinically appropriate to do so. As therapies evolve with the development of oral preparations it will be important to develop the service to increase the care delivered locally and where possible and clinically appropriate out with the hospital setting.

10.3.2 Managing emergency care

For patients admitted as an emergency the guidelines indicate that arrangements should be in place to assess cancer patients immediately when they arrive at hospital to expedite care.

It is proposed to provide an acute oncology assessment unit (OAU) and 24 hour phone to provide a dedicated service for all adult oncology /haematology patients who are currently receiving /or have received treatment (chemotherapy /radiotherapy) in the past 6 weeks at the cancer centre, or are at risk from disease / treatment related immuno-suppression.

It will also support all patients attending the cancer centre who are identified to be at risk of developing malignant spinal cord compression (MSCC) as per the National Institute for Clinical Effectiveness (NICE) and the West of Scotland Cancer Network Guidelines.
It is expected that this will prevent unnecessary hospital admissions, and where hospital admission is required, ensure patients are seen /and or admitted to the right facility to support the care they require, improving patient outcomes and care.

10.3.3 Haematological cancers

The management of haematological (blood) cancers is increasingly dependent on the detection of particular genetic changes within the cancer cells. These require highly specialised molecular techniques and many new agents are being developed. These genetic changes are important for determining both prognosis and appropriateness of therapies, including the need for stem cell transplants. Molecular techniques can be used to monitor response to treatment.

Access to modern diagnostic techniques is critical to ensure appropriate use of therapies and to monitor effectiveness.

10.3.4 Follow up and Support

The follow-up of most cancer patients is done on a routine basis in hospital outpatient departments. Recent regional and national work through the Managed Clinical Networks (MCNs) indicates that there is a requirement to change the follow-up arrangements for many areas. This includes providing monitoring and follow–up within the community where possible including patient blood tests.

With changes to survivor rates it is recognised that the approach needs to be altered to offer more individualised aftercare services and more responsive to patient needs as some patients can become ill again between outpatient appointments and not feel able to see a specialist until their next scheduled visit. Changing the method of follow-up will improve outcomes and quality of life for patients and could free up specialists' time to continue to improve quality of care for all patients across GGC in other ways and could support a more person-centred interaction with the clinical team. To support this it will be important that patients are given the relevant information to make an informed choice on their preferred model of follow-up.

10.3.5 Supportive and palliative care

This is a key part of care, especially with the changes in survivor rates, and so needs to meet the needs of patients both living with cancer as well as to support advanced care planning for the end of life. Across NHS GGC the Gold Standard Framework has been

implemented as has the use of advanced care pathways. This has helped improve both palliative care and end of life care planning. See figure 13 on End of Life Care.

As future services are planned it is recognised that there is a need to ensure that holistic assessments are part of the patient pathway including assessment of psychological needs and the support requirements of carers with advanced care plans in place consistently across GGC to support patient care.

10.4 Implementation challenges for this model

- Modelling of the capacity required to meet the future predicted increase in cancer patient numbers.
- Consolidation of complex / low volume surgery / care – impact on patient activity changes / clinical team and infrastructure changes required.
- Front door model to support emergency care of patients with cancer.
- Provision of increased chemotherapy in the community – estimating the impact of chemotherapy changes and the community / local service capacity requirements or changes.
- Service requirements in primary care to support monitoring and follow up including links with the 3rd Sector to support patients and carers.
- Requirements to support palliative care and end of life care out with hospital with effective advanced care planning – this is linked to other work in relation to long term condition management and management of the frail elderly to consider alternatives to hospital care.

11. CHILDREN SERVICES

11.1 The emerging models from the Children's Services group in some respects mirror the developments in other work streams, such as emergency care and the management of patients with complex care needs, particularly in relation to the development of primary care, community services and better working at the interface. The specific drivers and proposed changes for children's services are set out in this section.

11.2 The Children's Group focused primarily on services provided to the NHSGGC population rather than on the wide range of regional and tertiary services provided by the Royal Hospital for Sick Children (RHSC). This acknowledges the national and regional planning fora which cover these more specialist areas, as well as the significant amount of work and redesign going into the planning for the new RHSC.

11.3 The work of the group focused on general paediatrics, long term conditions, links to the community and providing support in an emergency, as well as on effective transition between children's and adult services. These were the priority areas highlighted during the development of the Case for Change.

11.4 Core principles

- Care should be focused on the needs of children and families.
- Care should be provided in dedicated child friendly environments.
- The approach to care in settings should uphold the Rights of the Child
- There should be a focus on co-ordination of care and clear points of contact.
- There should be an appropriately trained, skilled and senior workforce: complying with relevant standards.
- Information should be shared and available across the system to inform care.

- There should be robust child protection systems in place.
- Emotional support has to be central.
- Clear transition arrangements should be in place when children move to adult services.
- Standards of care and access to range of children's services should apply equally across the whole of Greater Glasgow and Clyde.
- Care should be focused on reducing inequalities by ensuring access for the most disadvantaged and supporting children to have the best start in life.

11.5 Key components of approach

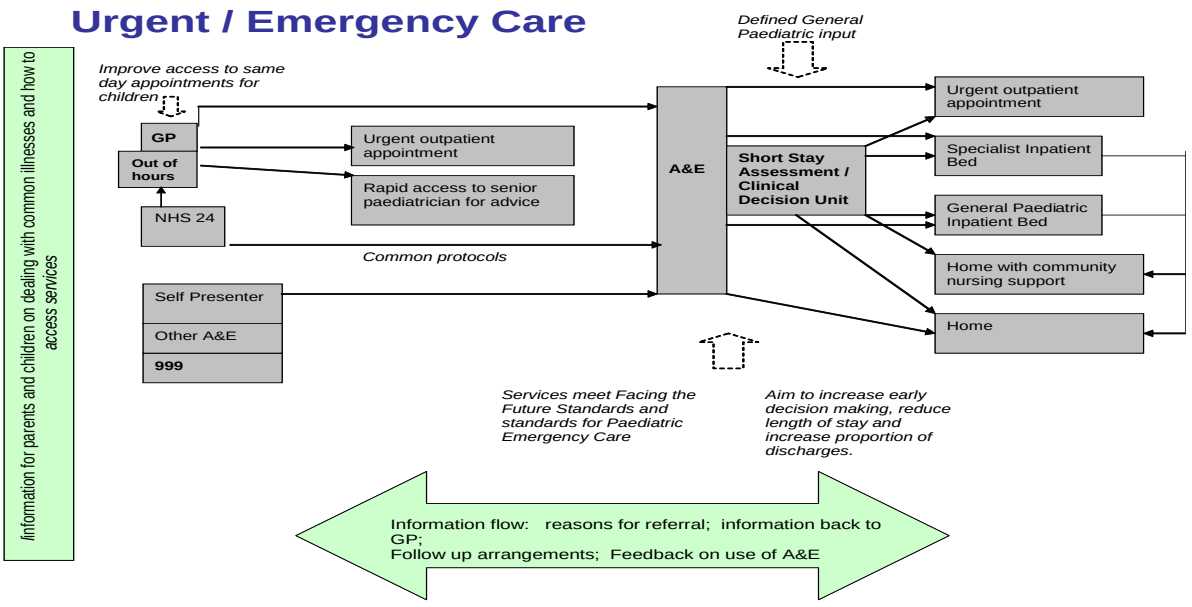
11.5.1 Emergency care

As with the model for adult emergency care there are a number of ideas being proposed to provide a range of alternatives to admission, which are accessible from the Emergency Department such as urgent outpatient appointment and community nursing support to enable earlier discharge.

This needs to be underpinned by the effective flow of information from the GP to the hospital and vice versa, supported by clear follow-up arrangements and feedback to practices on Emergency Department attendances and outcomes.

Where there are admissions for exacerbation of chronic disease this needs to prompt review of the care plan. The diagram below sets out the urgent / emergency care pathways.

Figure 19



This model requires a greater focus on the development of dedicated General Paediatric input as a focal point for the management of emergencies and alternatives to emergency admission. It also requires further development of nursing roles and closer working across acute and community services, facilitating earlier discharge and ensuring children can be supported at home were possible.

The 'Facing the Future' standard and Standards of Care for Paediatric Emergencies set out clear expectations for the skills, expertise and specialist opinion which should be available for children in all emergency settings. We need to ensure that we can provide this required range of specialist paediatric services to all children presenting as emergencies and those requiring inpatient care.

Key elements of this pathway will be implemented as part of the move to the new Royal Hospital for Sick Children on the South Glasgow Hospitals site. This move will enable all 'blue light' emergency cases for children in Glasgow to come to the dedicated paediatric unit which represents a gold standard in terms of access to the definitive place of care with specialist treatment, a dedicated child friendly environment and dedicated paediatric staff across a range of services and disciplines, including triple co-location between children's, adult and maternity services.

The changes described above will support that move and we need to consider further the pathways for 'blue light' emergencies and inpatient care, as well as minor injuries and self-presenters, across Greater Glasgow and Clyde to ensure that patients can access the right level of care as quickly as possible.

While this diagram focuses on access to urgent and emergency care from the community to hospital settings, we recognise that neonatal services also deal with a significant emergency workload with a pathway to urgent care from maternity units to neonatal units and that this is an additional route into emergency care. As such, it needs to be supported by clear criteria for identifying and transferring sick newborns both in maternity wards and in the early days following discharge home.

11.5.2 Planned care and long term conditions

The emerging service model seeks to establish local **Integrated Children's Centres.** This supports:

- Local provision of a range of services, enabling better joint management of patients across services and agencies, with locally accessible specialist care.
- Promote different way of working: not current hospital activity in a different place but rather a focus on effective joint care planning across primary care, community services and specialist paediatrics.
- Point of contact for families with long term conditions / complex disabilities, including being a focal point for transition.

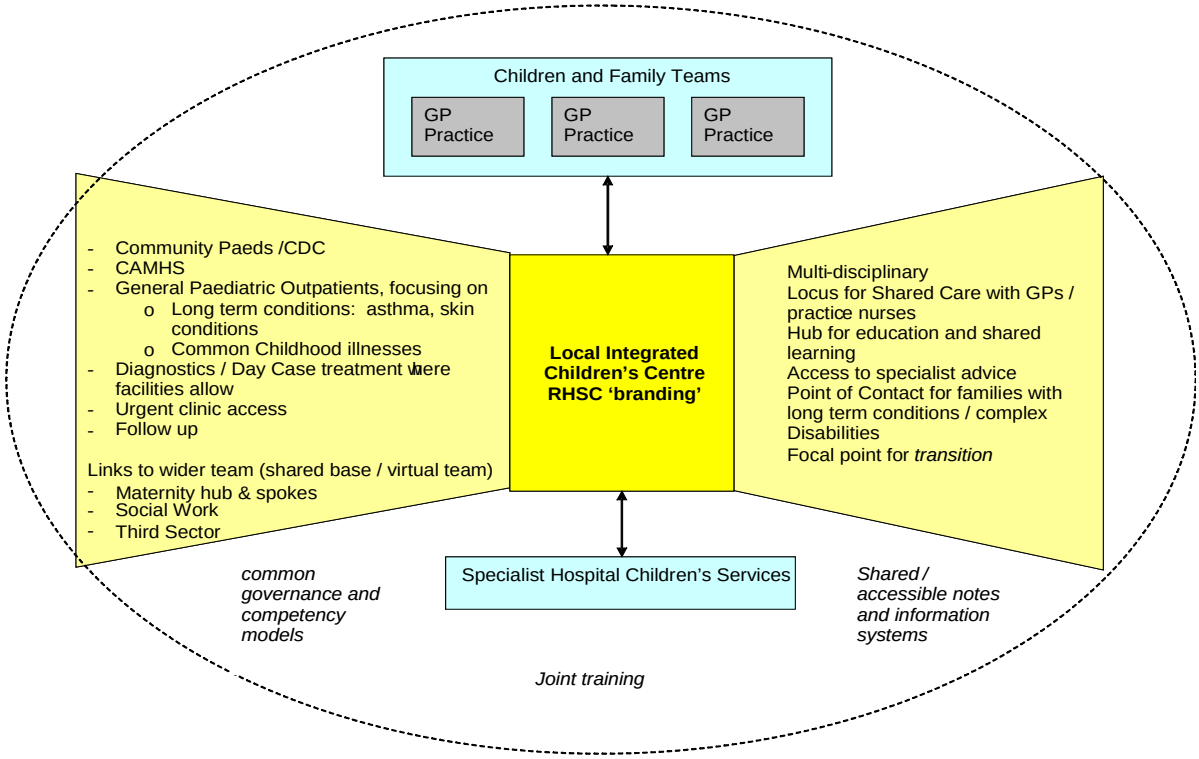
Core components of the **Integrated Children's Centres** would include:

- Community Paediatrics / Child Development Centres
- Child and Adolescent Mental Health Services
- General Paediatric Outpatients, focusing on
    - Long term conditions: asthma, skin conditions
    - Common childhood illnesses
- Diagnostics / Day case treatment where facilities allow
- Urgent clinic access
- Follow up
- Links to wider teams and services (shared base / virtual team)
    - Maternity hub and spokes
    - Social Work
    - Third Sector
- Link to localities / clusters of GP practices

- Locus for Shared Care with GPs / practice nurses
- Hub for education and shared learning
- Local point of access for specialist advice

This model will only work if it is seen as a very different way of doing things, rather than providing the same services in a different location. The real potential of integrated children's centres is to enable services and families to work together in a different way, across current service boundaries. The Royal College of Paediatrics and Child Health estimate that 50% of paediatric outpatients could be seen in a community setting, and that a greater community focus will lead to better long term conditions management and a more holistic social and behavioural approach. The centres also offer the opportunity to look at different ways of working to support children and families at home, and to set the foundations for effective chronic disease management for a lifetime. This includes using new technologies and making the most of opportunities for home monitoring and supported self care.

Figure 20: Integrated Children's Centres



11.5.3 Transition

Transition has been a recurring them of discussions with patients and professionals. The model described above will support effective transition through the integrated children's centres, enabling a clear point of contact and co-ordination for families, and by involving GPs at an earlier stage in the management of long term conditions and complex care packages for children which will give greater continuity into adulthood. In addition to this, good practice in the approach to transition has been identified as including the following components:

- Transition should be viewed as a process, not an event. Services need to view transition as a period of at least 2 years, which starts in early adolescence, and allows gradual, coordinated transfer of care to primary care and adult health services. The aim of the transition process is therefore to enable and empower young people and their families to confidently access adult services.

- A key worker should be identified to coordinate the transition from paediatric to adult health services.

- In order to develop workable transition care pathways, there should be good communication and cooperation between paediatric and adult services and GPs.

- Joint transition clinics for paediatric and adult health services would help support the transition of young people with more complex needs and/or those requiring ongoing active management. The future co-location of adult and paediatric hospital services at the South Glasgow Hospitals site might help to facilitate this joint working for some hospital-based teams.

- The collation and sharing of information between health professionals needs to be improved to ensure effective transfer of health information to adult services. This sharing of information may be facilitated by improved IT systems. The use of a patient-held health record should also be considered.

12. MATERNITY SERVICES

12.1 Principles

- Focus on providing safe, accessible and effective care which improves outcomes for women and babies and reduces inequalities.
- Care focused on the health and social needs of women and families.
- Promotion of normal childbirth and reduction of interventions.
- Appropriately trained, skilled and senior workforce: complying with national workforce recommendations.
- Strengthen communication and collaboration between services which include other key NHS services and local authorities.
- Women are able to make informed decisions about their care.
- Use women's experience of care to drive service improvements.

12.2 Key components of approach

The key components of the approach of the service model for maternity care are set out below:

- Pre-pregnancy advice and health promotion.
- Early booking.
- Comprehensive assessment as early as possible, informed by shared information.
- Early identification of red / green pathway: midwife led care where possible, with regular review and ability to move between pathways when required. Identification of risk and appropriate support is critical to successful outcomes, and to defining future service and workforce needs both for maternity and neonatal services.
- Early pregnancy assessment service available 7 days a week.

- Increased support for vulnerable women and families in pregnancy: identification of vulnerability based on broad assessment of individual family and social circumstances.
- Supporting access to wider services including financial inclusion, welfare advice, and family support.
- Health visitor involvement as early as required, especially for vulnerable families: co-ordination of care and handover between midwife and health visitor.
- Team based approach with a central role of midwives as autonomous practitioners of normal pregnancies, working as a team with obstetricians, anaesthetists and paediatricians, in the care of women with complex and complicated pregnancies.
- Delivery suites meet required staffing standards: Midwife, Obstetrician and Anaesthetic cover. Move to 24 hour consultant obstetrician presence. Increasingly this will require to be covered by dedicated Obstetricians, with the increasing specialisation of gynaecology.
- 'Timely' discharge from hospital: reducing length of stay.
- Neonatal units which comply with Neonatal Quality Framework standards, with clearly defined pathways to ensure that babies are identified in post-natal settings and transferred in a safe and timely manner.

13. UNDERPINNING SYSTEM CHANGE

13.1 As we move to develop implementation plans for this strategy there are a number of areas of work which need to underpin system change. These include:

- Diagnostics and diagnostic Systems
- Information and Information Systems
- Communications
- New Ways of Working - appointment systems / technology
- Ways we deliver care – person centred care. Equalities sensitive practice

13.2 There are also implications for Other NHS Organisations including the SAS, NHS 24 and other territorial health Boards.

14. PUBLIC AND PATIENT ENGAGEMENT

14.1 There has been extensive engagement through the development of this clinical services review which has been referenced throughout this document. Formal approval of the Clinical Strategy is a further opportunity for that wide engagement. As we develop specific change proposals engagement will continue to be fundamental.

14.2 The Scottish Health Council (SHC) have been involved in this process from the start, attending the ongoing engagement events with the patient reference groups and the third sector as well as attending the event at Hampden in April when the emerging service models work was shared with the wider clinical group. In addition they have met with Board Officers to discuss the programme and to share thinking on the approach being taken, feedback on their observations and to support planning for the ongoing engagement. As the planning to develop service change proposals follow this strategy this close engagement will be continued to ensure the approach taken is in line with SHC guidance in relation to engagement, pre consultation and consultation, where this is indicated. The fill SHC commentary on the review is attachment one to this paper.

15. CONCLUSION

15.1 The clinical service review has enable us to develop this clinical strategy to provide a basis for the development of detailed service change proposals working with Integration Joint Boards and with the emerging national approach to clinical strategy and delivering the 2020 Vision. We need to work together to deliver:

- Improving health and prevention of ill health; empowering patients and carers through the development of supported self care.
- Developing primary care and community service models; simplification of community models; focus on anticipatory care and risk stratification to prevent crisis.
- Improving the interface between the community and hospital to ensure care is provided at the right time in the right place; Community and primary care services inward facing and hospital services outward facing; focused on patient and carers needs.
- Developing the ambulatory approach to hospital care, with inpatient hospital care focused on those with greatest need ensuring equitable access to specialist care.
- Redesign of specialist pathways to establish a consistent service model delivering the agreed clinical standards and good practice guidelines.
- Developing the rehabilitation model based on need not age; working across the service within primary and secondary care and with partner organisations to provide rehabilitation in the home setting where clinically appropriate.
- Changing how care is delivered - patient centred care; shifting the paradigm to deliver care differently for patients particularly for patients who have multiple conditions; helping patients and the public to develop and understand the new approaches to care

[i] London Health Programmes: A framework for action, 2011.

[ii] Better cancer care: an action plan (2008). Edinburgh: Scottish Government.

Attachment 1

Board consideration of clinical services review

Clinical Services Review

21 February 2012	Board Meeting	Clinical Services Fit for the Future paper to the Board for agreement for agreement to progress
02 October 2012	Board Seminar	Briefing on Clinical Services Review
18 December 2012	Board Meeting	Case for Change to Board for Approval
07 May 2013	Board Seminar	Emerging Service Models (presentation)
07 August 2013	Board Seminar	Service Models (presentation)
20 August 2013	Board Meeting	Service Models Paper to Board for approval
6 December 2013	Board Away Day	Clinical Services Review Update (presentation)
17 December 2013	Board Meeting	Clinical Services Review Update - Development of the Renfrewshire Development Programme for approval
14 February 2014	Board Away Day	Clinical Services Review Update (presentation)
21 October 2014	Board Meeting	Clinical Services Review Renfrewshire Development Programme update paper to Board
09 December 2014	Board Away Day	Clinical Services Review Update (presentation)

9th

Attachment 2

scottish health council

making sure your voice counts

Ms Catriona Renfrew
Director of Corporate Planning & Policy
NHS Greater Glasgow and Clyde
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Date: August 2013

Our Ref: J B Russell House

Enquiries to: Louise Wheeler

Direct Line: 0141 429 7545
Email: louise.wheeler@scottishhealthcouncil.org

Dear Catriona

Clinical Services Review Fit for the Future

The Scottish Health Council has welcomed the exchange of information that's taken place between ourselves and board officers over the past 18 months. We consider that this has been helpful in enabling us to have a dialogue to ensure that the process, as it develops, observes the principles of openness and transparency, contained within national guidance.

As well as providing comment on the board's early process of engagement and information, we have also used these meetings to provide feedback on our observations from the meetings hosted by the board and share the findings of our recent survey on participants' experience of involvement.

Scottish Health Council staff attended most of the Patient Reference Group sessions held during the period March 2012 to April 2013; Third Sector events held in January and June 2013; the Combined Clinical Group workshop in April 2013; and the Combined Patient Reference Group meeting held in June 2013.

We also note that there was patient and public representation on each Clinical Steering Group and that an Overarching Patient Reference Group met several times throughout the process. In addition we are aware that NHS Greater Glasgow and Clyde officers took the opportunity to discuss this review process with Public Partnership Forums and some community groups across the Board area.

For each meeting between the Scottish Health Council and board officers we prepared a "feedback paper" to inform our discussions. Our most recent meeting was held on 25th July 2013. The feedback on the board's review process for June and an extract from the May feedback is provided as an appendix to this letter.

Some of the key themes from the engagement so far have included:

- Participants appear to support the general direction of travel (anticipatory care and early intervention) and some acknowledge that difficult decisions may be needed in order to deliver new models of care.
- Some people have expressed concerns around the interface between acute services and primary care (including access to and capacity of GPs), discharge planning and community support.
- Some participants at the Patient Reference Group sessions have whether there are sufficient links with local authorities, other public agencies and the Third Sector to support multi-agency pathways of care.
- Challenges have been identified around how some of the aspirations can be implemented eg staff training, finance and resources.
- Some participants at the Combined Patient Reference Group session in June 2013 noted that it was difficult, at this stage to see anything coherent within the draft service model discussion paper and referred to the challenge of articulating the emerging models of care, with the inclusion of the proposed 'interface services'.
- Consideration should be given to continued discussion and engagement with neighbouring Boards

and their patients/public involvement structures in any proposed service development and change. As part of the Scottish Health Council's survey to capture participants' experience of involvement to date, we issued130 questionnaires (70 by hand, 47 by post and 13 by email) and received 36 completed questionnaires giving a response rate of 28%. Responses included:

- 29 people (81% of respondents) felt they'd been able to contribute to the emerging models and 24 people (73%) felt that the models reflected previous group discussions.
- 25 people (69% of respondents) felt they'd been able to influence the process
- 32 people (89%) indicated that they intend to continue their involvement in the process

In response to some of the issues raised, the Scottish Health Council would encourage NHS Greater Glasgow and Clyde to:

- Consider how patients, carers, the public and voluntary sector may continue to be meaningfully involved in further engagement.
- Ensure that information is accessible for a wide range of people and that acronyms and technical language is kept to a minimum. Information and communications should be developed with patients, carers and public representatives to ensure that the language and content supports peoples' understanding of any proposals.
- Seek to address the issues and concerns that have been raised by patient and public representatives and staff during this early phase of engagement to inform the next steps.
- As the detail of the review emerges, demonstrate the 'contrasts' between existing and proposed new services. The paper makes reference to "support to maintain people at home, when clinically appropriate", "need to do more to stop people being admitted to hospital" and "help people leave hospital more quickly". However it may not be clear to people whether this drive is to maintain existing structures and services or may result in disinvestment or changes to service configurations. The use of case studies may also help people to appreciate the impact of change.
- Work in partnership with special and neighbouring NHS boards, public agencies, the Third Sector and others as more detail around service models emerges.
- Continue to develop the equality impact assessment, with additional elements from health inequalities.
- Evaluate its process and structure of engagement (March 2012 – June 2013) to identify any learning and areas for improvement.

At our meeting on 25th July, representatives from the board acknowledged that the service models developed do not currently contain the necessary detail required for public consultation. We agreed that the timescales in the draft discussion paper did not reflect the further work required to develop specific models/proposals in order for or a wider group of people to then be engaged. T This should include option development and appraisal which should assist in identifying any preferred options. Where the proposal, or elements of th his, may be considered 'major' the guidance "Informing, Engaging and Consulting People in D Developing Health and Community Care Service" (CEL 4 (2010)) indicates that the board should not move to consultation until they have confirmation from the Scottish Health Council on the public c involvement process to date. Finally, we would like to acknowledge t e the scope of involvement work conducted to d date and encourage this to be carried forward as the process develops. We would be happy too continue our dialogue with NHS Greater Glasgow and Clyde as planning is progressed and look f forward to hearing from you in due course.

Yours sincerely

Louise Wheeler
Service Change Adviser

Appendix

Extract from Feedback on process for Clinical Services 'Fit for the Future'
May 2013

Emerging themes from PRGs from discussions

- Numbers have remained consistent at each of the workshop sessions (suggesting that people have stayed involved in the process)
- Participants at the PRGs have questioned the 'links' with local authorities, public agencies and the Third Sector to support multi-agency pathways of care
- Participants have had the opportunity to respond to the issues/themes raised from earlier PRG sessions. Clarity was sought on shared understanding at the start of each session.
- At several of the workshops, participants have questioned buy-in to the review from GPs and the primary sector
- Concerns around how some of the aspirations can be implemented eg staff training, finance/resource (Unplanned care/Chronic Disease)

Information

- Note that information from the first two PRGs is available on the Board's website.
- Information and presentations do not appear to be shared consistently with participants in advance of meetings
- The presence of a clinician has enabled participants to ask, and get immediate response, to some probing and specific questions.
- To date, lay participants appear to be content with the review process and their involvement with some representatives speaking supportively of it at sessions.
- Some people noted that there were too many acronyms in some of the presentations (Planned care, Cancer). Where possible the use of these should be eliminated or reduced.
- In Mental Health, some participants found the papers difficult to understand. The content, detail and format of these should be considered for future participation.
- Participants raised an impression that there may be reluctance by NHS staff to refer to third sector services. This point was agreed upon as something requiring further investigation by the Board officer present.

Next steps

- Participants have suggested that it would be helpful to bring all the public representatives together for the next round of discussions, given the cross-over/ entire patient pathways
- With patient flows between services across neighbouring Boards – have discussions taken place to engage these Boards and their patients/public involvement structures?
- The Scottish Health Council welcomes the development of the EQIA for the review process – we would encourage the Board to consider how people with protected characteristics may be involved in considering service models and engagement and consultation processes.

- Gauge impact re specialist tertiary care – have other Boards and patients been involved in this work? Board officer stated that the Tertiary Care Clinical Group has been informed from discussions of other PRGs and the service models will be shared at event in June – will relevant Boards/ patients/ public representatives be invited to this session?
- Discussion around the Scottish Health Council's survey questionnaire (June 2013).

Feedback on process for Clinical Services 'Fit for the Future' July 2013

The comments below come from the Scottish Health Council's attendance at the Third Sector event on 24th June, the Combined Patient Reference Group session on 26th June, the Scottish Health Council's feedback survey and consideration of the Clinical Services Review discussion paper. It is also informed by reviewing footage of interviews conducted by NHS Greater Glasgow and Clyde with six members of the Overarching Patient Reference Group.

Information

- The Scottish Health Council welcomes the ongoing exchange of information and communication that's taken place with board staff and the Scottish Health Council and their response to feedback.
- Three people in NHS Greater Glasgow and Clyde's interviews advocated the use of plain language, without acronyms, to support understanding.
- From the Scottish Health Council's survey, 29 people (85% of respondents) said they'd received enough information and 32 (91% of respondents) said that information had been shared in a timely manner.
- The events in June were planned to share the emerging service models with patient and public representatives and the Third Sector. Although Board officers presented an overview there was little detailed discussion or interrogation of the discussion paper that was sent in advance of the meeting
- At the Combined PRG session, some people felt that there was too much information to take in and that it was difficult to see how this had evolved from PRG involvement.
- Some participants highlighted that they felt the presentations were comprehensive and provided a good overview.
- Some participants noted that it was difficult to see anything coherent within the discussion paper and that it was difficult to articulate the emerging models of care, with the inclusion of the proposed 'interface services'.
- One group at the Combined PRG session noted that there was not enough information for people to understand what the models mean. The Scottish Health Council notes that public representatives sit on the Clinical Groups as well as the Patient Reference Groups.
- Two respondents to the Scottish Health Council survey suggested that more detail would be needed to engage with the public.

Implementation and themes

- It was suggested that there may be challenges to collaboration within the Third Sector as each organisation seeks to:
- o Preserve their own identity and empowered budget
- o Successfully compete for the same pot of money
- Most participants at both events appeared to support the general direction of travel (anticipatory care and early intervention) and recognised that some difficult decisions would be needed around disinvestment in acute care.
- Some people are concerned around GP interface, discharge planning and community support.
- Three people (through the Overarching PRG interviews and Scottish Health Council survey) commented that work to date appears to have been mainly led by medical professionals – participants suggested that the Board extend involvement to other staff groups
- Participants suggested that further engagement is needed with social work, education etc.

Process

- Some participants at the Combined PRG session noted that they had welcomed the Board's openness and opportunities for discussion
- The Scottish Health Council notes that there were fewer people at the Third Sector event in June (around 35) compared with that held in January (around 100).
- • Responses to the Scottish Health Council survey indicated:
- o 32 people (89%) intend to continue their involvement in the process (note that Board advised that the PRG work has now drawn to a close).
- o 29 people (81% of respondents) felt they'd been able to contribute to the emerging model and 24 people (73%) felt that the models reflected previous group discussions.
- o 25 people (69% of respondents) felt they'd been able to influence the process
- • Some additional comments from the Scottish Health Council survey (not covered elsewhere):
- o Exciting and ambitious project
- o Continue to engage with service users and the public
- o Aim to recruit more young people/identify gaps in representation

Scottish Health Council's Survey Responses

The Scottish Health Council issued 130 questionnaires (70 by hand, 47 by post and 13 by email) and received 36 completed questionnaires giving a response rate of 28%.

Half of the respondents indicated which workstream they were involved in – but all workstreams had a response from at least one representative (highest was Older People with six responses).

Most people indicated that they were representing a group or structure eg Public Partnership Forum (12), community/voluntary group (12), Third Sector (11). Note that the Third Sector is also involved through a separate process.

Clinical Services Review Discussion Paper

- The Scottish Health Council is unaware of any discussions with lay representatives around the detail and content of the board's discussion paper though there has been lay representation in the development of service models through the Clinical Groups. We acknowledge that people have indicated general support for the direction of travel for the process to date. However, some people have commented on the lack of detail about what is being proposed.
- We acknowledge the scale of the Clinical Services Review project and the board's attempts to provide a comprehensive overview – and this is reflected in the length of the discussion paper. However, this may be to the detriment of making the paper accessible to lay participants. Consideration should be given to some of the terms used such as polypharmacy and co-morbidity and whether a glossary would assist with this.
- We welcome the Board's production and distribution of a more succinct four page summary. It may be helpful if this format is used as the process progresses and the details emerge.
- As the detail of this review work emerges it would be helpful to demonstrate the 'contrasts' between existing and proposed new services. The paper makes references to "support to maintain people at home, when clinically appropriate", "need to do more to stop people being admitted to hospital" and "help people leave hospital more quickly" however it may not be clear to people whether this drive is to maintain the existing structures or may result in disinvestment or changes to service configurations.

Next steps

- The Scottish Health Council notes that the service change models are still at a high level and give a general direction of travel. The paper and Board officers have acknowledged that more work involving stakeholders is needed to develop these further.
- The Scottish Health Council would suggest that in future information should aim to communicate the impact of change perhaps through the use of case studies or 'contrasts' (comparing existing service with the new service). Information and communication should be developed with patients, service users and carers to ensure that the language and content supports people's understanding.
- Consider how existing patient representatives may be further involved in the engagement process.
- It will be helpful to clarify what stage NHS Greater Glasgow and Clyde has reached in their review process in terms of the Informing, Engaging and Consulting guidance, CEL 4 (2010)and discuss expectations and next steps.

In particular we note the timescale outlined in section 13 of the board's discussion paper. The timescales do not appear to indicate further work may be required to develop more robust models/proposals that a wider group of people can then be engaged. This engagement should include option development and appraisal in order to identify any preferred options. This review process, or elements of this may be considered 'major' change. In such cases, the guidance indicates that the board should not move to consultation until they have confirmation from the Scottish Health Council on the public involvement process to date.

AGENDA ITEM NO: 4

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**26th January 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/10/2016/HW**
Contact Officer:	**Helen Watson: Head of Planning, Health Improvement & Commissioning**	**Contact No:**	**01475 715285**
Subject:	**OVERVIEW OF DEVELOPMENT OF GOVERNANCE ARRANGEMENTS**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board (the IJB) of the progress in developing Inverclyde Health & Social Care Partnership's (HSCP) governance arrangements. Integral to this is compliance with the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act); the Inverclyde HSCP Integration Scheme Commitments, and Scottish Government guidance (statutory and non-statutory) on Health and Social Care integration.

2.0 SUMMARY

2.1 This report is produced to give the IJB assurance that progress is being made to meet the legislative and other commitments required to ensure sound governance arrangements for full implementation of integrated health and social care services. Appendix 1 highlights current status on planned activity around engagement and consultation with stakeholders and partners in co-producing the strategic plan. It also includes an update on the development of localities in line with the statutory timescale of 1st April 2016.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board notes the current status of compliance with statutory and other timescales and the planned activity around the key legislative and other commitments necessary to achieve sound governance arrangements for Inverclyde's Health and Social Care Partnership from 1 April 2016.

Brian Moore
Corporate Director
(Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) and subsquent national guidance require all HSCPs to produce an Integration Scheme to be approved by the Scottish Government. The Inverclyde HSCP Integration Scheme was formally approved on 27th June 2015.

4.2 The Integration Scheme - an operationally significant document - sets the context within which the IJB is constitued as a legal entity. It goes on to set out its commitments and compliance with the Act, and the implementation of operational and financial governance arrangements within a legally prescribed timeframe.

4.3 The intention of this paper and attached appendix is to provide the IJB with assurance that planned activity is on course to meet the legal and national guidance within the anticipated timeframe and IJB reporting cycle.

4.4 **Governance Arrangements**

Appendix 1 provides the overview of the legal and other commitments required to be in place within the agreed timescales. This document provides details of the following:

- Governance of non-financial arrangements;
- Communication and Engagement;
- Strategic Planning;
- Performance Management;
- Delivering for Localities;
- Workforce Planning & Development;
- Clinical & Care Governance;
- Finance & Audit; and
- Information Sharing & ICT

4.5 **Governance of non-financial arrangements**

4.5.1 As appendix 1 indicates, the majority of requirements in this section are met. The first meeting of the legally constituted IJB was 10 August 2015.

4.5.2 Formal arrangements for hosted services within the Greater Glasgow and Clyde Health Board area are on track to meet the 31st March 2016 target date.

4.5.3 The IJB will consider approval of the aligned HSCP complaints procedure at its 26th January 2016 meeting.

4.5.4 It is a legal requirement of the Equalities & Human Rights Commission that the HSCP develop Equality Outcomes to reflect the needs of the people of Inverclyde. The Strategic Planning Group anticipates the consultation on these outcomes will take place during our planned Engaging Our Localities event to be held in early February 2016.

4.5.5 An Equality Impact Assessment (EQIA) is required to be undertaken on the Inverclyde HSCP Strategic Plan.

4.5.6 An equalities sub-group has been initiated by the Strategic Planning Group to undertake the EQIA of the Strategic Plan prior to the public consultation scheduled for February and March 2016.

4.5.7 The guidance suggests that a streamlined statement on equalities is inserted into the Strategic Plan. However, the Strategic Planning Group agreed at its December 2015 meeting that an equalities focus should be a key theme reflected in all of the sections

of the Strategic Plan rather than one standalone statement of intent.

4.5.8 It is anticipated that full delegated responsibility for the agreed Health Board and Council functions, as detailed in the Integration Scheme, will transfer to the IJB on 1st April 2016.

4.6 Communication and Engagement

4.6.1 The IJB has adopted the former CHCP People Involvement Framework, on the proviso that this will be reviewed and updated to reflect our new arrangements in the first year of operation as an HSCP.

4.7 Strategic Planning

4.7.1 The development of the Strategic Plan for 2016 – 2019 is progressing to meet the 1st April 2016 implementation date. Our Strategic Planning Group is actively driving forward the development of the Plan and anticipates that formal consultation by stakeholders on the final draft will commence from 15th February 2016.

4.7.2 The finalised draft Plan will be presented to the IJB on 15th March 2016 for approval, following the outcome from the formal stakeholder consultation. Thereafter the parent organisations will be formally updated on the outcome of the consultation and finalised Strategic Plan 2016-2019.

4.8 Performance Management

4.8.1 The legislation requires that every HSCP reports performance to its IJB on a number of key areas.

Reports on financial planning and performance must include information about:

- the total amount spent by the HSCP on each of the delegated functions
- the total amount paid to or set aside for the HSCP by the Health Board and the Council
- any underspend or overspend against the planned spending, the amount of underspend or overspend and an assessment of the reasons for this.

Reports in respect of localities must include an assessment of performance in planning and carrying out functions, including:

- a description of the arrangements made for consultation and involvement
- an assessment of how the locality arrangements have contributed to improved provision of services
- the total amount paid to or set aside for the locality during the reporting year.

In addition to these statutory requirements, Inverclyde IJB will receive regular Performance Exceptions Reports linked to the national outcomes, in line with the reporting schedule agreed at the November 2015 meeting.

4.9 Delivering for Localities

4.9.1 Following an engagement event in April 2015 on developing localities, further discussion and consultation took place with the Alliance Single Outcome Agreement Programme Board on how the HSCP could best engage with established community planning and learning community structures.

4.9.2 The Inverclyde Alliance Programme Board has approved the HSCP's intentions to share three Wellbeing Localities, common across all partners, for the planning of local health and social care provision (Inverclyde East, Central and West). This will maximise the use of existing networks and reduces additional demand on the time of

those community members who wish to be part of the process.

4.10 **Workforce Planning & Development**

4.10.1 A Workforce Planning and Development sub-group has been established by the Strategic Planning Group to progress development of a "People Plan". This plan will consider the entire workforce available in Inverclyde to deliver integrated health and social care, including staff employed by the statutory, independent and third sector staff and unpaid carers. It will also consider the number of people (both paid and unpaid), and skill mix required to implement the future vision of health and social care.

4.10.2 The People Plan will encompass an Organisational Development Plan, as required by the legislation. Inverclyde's Organisational Development arrangements will have a different focus to most of the plans across Scotland because we have had integrated service and management arrangements since 2010. The policy intent of this requirement is to support partnerships in the transition from separate entities to single integrated partnerships, and we have already undergone much of this change. However we propose using the requirement as an opportunity for the IJB to consider its options for the future culture of the HSCP, in the contexts of:

- planning and delivering for outcomes
- planning for acute hospital services
- strengthening links to the housing sector through the Housing Contribution Statement.

4.11 Clinical & Care Governance

4.11.1 This strategic governance requirement is on track to meet the target implementation date, and will be detailed in a separate report to the March 2016 meeting of the IJB.

4.12 Finance & Audit

4.12.1 This strategic governance requirement is on track to meet the target implementation date, and will be reported to a subsequent meeting of the IJB.

4.13 Information Sharing & ICT

4.13.1 The legal requirement for this delegated area is currently in place and fully met.

5.0 IMPLICATIONS

FINANCE

5.1 Financial Implications:

One off Costs: None identified

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

Annually Recurring Costs/ (Savings)

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

LEGAL

5.2 There are no legal issues within this report.

HUMAN RESOURCES

5.3 There are no human resources issues within this report.

EQUALITIES

5.4 There are equality issues within this report as set out in 4.5.4.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
X	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.

6.0 CONSULTATION

6.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with the Strategic Planning Group.

Appendix 1: IJB Legal Requirements and Commitments

The tables below detail the legislative requirements and commitments in relation to Inverclyde Health and Social Care (HSCP) Integration as set out in the Public Bodies (Joint Working) (Scotland) Act 2014 and Inverclyde HSCP's Integration Scheme.

Requirement / commitment source:	Key
Act & supporting Regulations	Act
Inverclyde HSCP Integration Scheme	IS
Scottish Government guidance	SG
Established governance arrangements for parent bodies	Gov

1. Governance (non-financial) arrangements				
Legal requirement /commitment	**Type**	**Legal deadline**	**Target date**	**BRAG**
Integration Scheme approved and published and Integration Joint Board (IJB) legally established	Act	27/06/15		
1st meeting of the legally constituted IJB	Act		10/08/15	
Ratify the remit and constitution of the IJB including its voting and non-voting members, chair and vice chair.	Act		10/08/15	
The Procedural Standing Orders of the IJB agreed	Act		10/08/15	
IJB ratify the appointment of the Chief Officer, Chief Finance Officer and establish the Strategic Planning Group (including governance arrangements and Terms of Reference)	Act		10/08/15	
Risk policy, strategy, and procedures approved by IJB	IS		10/08/15	
Key strategic risks approved by IJB	IS		15/03/16	
Arrangements for Hosted Services agreed amongst the IJBs in the GG&C area.	IS	31/03/16	31/03/16	
Health and Safety policy and procedures in place	IS	31/03/16	10/08/15	
Complaints policy and procedures in place	IS	31/03/16	26/01/16	

FOI policy and procedures in place	Act	31/03/16	15/03/16	
FOI Publications Scheme in place	SG		31/08/16	
Business continuity arrangements in place	IS	31/03/16	Work has been completed by HSCP. Awaiting final sign-off from CCS.	
Equalities scheme and EQIAs completed for Partnership (in line with IJB requirements under the Equalities Act)	IS	31/03/16	30/04/16	
Parent organisations agree the provision of support services for the IJB	IS	31/03/16	19/02/15	
CO confirms all governance arrangements in place (IJB Report) for functions to be delegated from parent organisations to the IJB	IS	31/03/16	10/08/15	
Functions delegated to IJB	Act	01/04/16	01/04/16	

Key:		Complete		On target		Risk of delay		Significant Issues

2. Communication and engagement				
Legal requirement /commitment	**Type**	**Legal deadline**	**Target date**	**BRAG**
IJB agrees its participation and engagement strategy	IS	27/12/15	10/08/15	

Key:		Complete		On target		Risk of delay		Significant Issues

3. Strategic Plan (the order of Strategic Plan activities are prescribed in the Act but not specific individual deadlines for each stage)				
Legal requirement /commitment		**Legal deadline**	**Target date**	**BRAG**
IJB agree the initial Establishment Plan			10/08/15	
IJB agree its proposals for the process of development of the full Strategic Plan	Act	-	10/08/15	
SPG feedback on the proposals for the Strategic Plan content	Act	-	27/07/15	
SPG feedback on the Establishment Plan and begin the process for developing the full Strategic Plan	Act	-	06/10/15	
Formal consultation with prescribed stakeholders including SPG, Health Board and Council	Act	-	15/02/16	
Update report on consultation and final draft of Strategic Plan prepared for the IJB	Act	-	18/02/16	
IJB agree the final draft of Strategic Plan, taking account of SPG and wider stakeholder feedback		-	15/03/16	
Health Board updated on the outcome of the consultation and the draft Strategic Plan	Gov	-	HB and HSCC April 2016	
Council updated on the outcome of the consultation and the draft Strategic Plan	Gov	-	HB and HSCC April 2016	
Strategic Plan published along with financial statement and statement of action taken by IJB under section 33 of the Act (consultation and development of the Strategic Plan).	Act	31/03/16	31/03/16	

Key:		Complete		On target		Risk of delay		Significant Issues

4. Performance Management				
Legal requirement /commitment		**Legal deadline**	**Target date**	**BRAG**
Parties prepare a list of delegated and non-delegated functions	IS	27/06/15	27/06/15	
Council and Health Board develop proposals for 2015/16 interim performance framework to be submitted to IJB	IS	27/06/16	26/01/16	
SPG develop reporting arrangements proposed performance framework for 2016/17, for IJB approval	Act	-	18/02/16	
IJB agree the proposed reporting arrangements and performance framework for 2016/17, taking account of localities, reporting arrangements and plans to publish the annual performance report.	IS	27/06/16	15/03/16	

5. Delivering for Localities				
Legal requirement /commitment		**Legal deadline**	**Target date**	**BRAG**
IJB agree locality arrangements (in line with SG guidance), based on stakeholder engagement, which will be reflected in the Strategic Plan	IS	-	15/03/16	

Key:		Complete		On target		Risk of delay		Significant Issues

6. Workforce Planning and Development				
Legal requirement /commitment		**Legal deadline**	**Target date**	**BRAG**
Workforce plan	Act	01/04/17	01/04/17	
Organisational development Plan	Act	01/04/17	01/04/17	
Learning and development of staff; and	Gov	01/04/17	01/04/17	

7. Clinical and Care Governance				
Legal requirement /commitment		**Legal deadline**	**Target date**	**BRAG**
The IJB agrees appropriate clinical and care governance arrangements for their duties under the Act.	IS	31/3/16	10/08/15	
Clinical and Care Governance Group established	IS	31/03/16	15/03/16	
Chief Social Work Officer provides annual report to IJB (Section 5.15 of IS)	IS	31/03/17	30/11/16	

8. Finance and Audit				
Legal requirement /commitment		**Legal deadline**	**Target date**	**BRAG**
IJB Audit arrangements agreed	IS	31/03/16	15/03/16	
Insurance arrangements (claims handling) in place	IS	31/03/16	10/08/15	
IJB agree procedure with other relevant integration authorities for any claims relating to Hosted Services		31/03/16	31/03/16	
IJB sign off financial governance arrangements as per the national guidance	IS	31/03/16	15/03/16	
IJB report on due diligence on delegated baseline budgets moving into 2016/17	IS	31/03/16	15/03/16	

Draft proposal for the 2016/17 Integrated Budget based on the Strategic Plan approved by IJB	IS	31/03/16	15/03/16	
Draft proposal for the Integrated Budget based on the Strategic Plan presented to the Council and the Health Board for consideration as part of their respective annual budget setting process	IS	31/03/16	15/03/16	
Financial statement published with the Strategic Plan	Act	31/03/16	15/03/16	
Resources for delegated functions transferred to IJB from parent organisations	Act	31/03/16	31/03/16	
Audit arrangements established	IS	31/03/16	15/03/16	

9. Information sharing and ICT				
Legal requirement /commitment	**Type**	**Legal deadline**	**Target date**	**BRAG**
Information Sharing Protocol ratified by parent organisations	IS	31/03/16	10/08/15	
Information Sharing Protocol shared with IJB	Gov	31/03/16	10/08/15	
Appropriate Information Governance arrangements are put in place by the Chief Officer	IS	31/03/16	10/08/15	

Key:		Complete		On target		Risk of delay		Significant Issues

AGENDA ITEM NO: 5

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**26 January 2016**
Report By:	**Brian Moore, Corporate Director (Chief Officer), Inverclyde Health & Social Care Partnership**	**Report No:**	**VP/LP/010/16**
Contact Officer:	**Vicky Pollock**	**Contact No:**	**01475 712180**
Subject:	**Membership of the Inverclyde Integration Joint Board**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Inverclyde Integration Joint Board ("IJB") of a change in its non-voting membership arrangements.

2.0 SUMMARY

2.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 sets out the arrangements for the membership of all Integration Joint Boards.

2.2 Membership of the IJB was approved at its first meeting on 10 August 2015. Since then, the Inverclyde Council staff representative member on the IJB, Mr Robin Taggart, has intimated his resignation from the IJB. It is proposed to appoint Ms Robyn Garcha in his place.

2.3 This report sets out the revised non-voting membership arrangements for the IJB.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Inverclyde Integration Joint Board:-

(1) notes the resignation of Mr Robin Taggart as the Inverclyde Council staff representative non-voting member of the Inverclyde Integration Joint Board; and

(2) agrees the appointment of Ms Robyn Garcha as the Inverclyde Council staff representative non-voting member of the Inverclyde Integration Joint Board.

Vicky Pollock
Legal & Property Services

4.0 BACKGROUND

4.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 ("the Order") sets out the arrangements for the membership of all Integration Joint Boards.

4.2 Membership of the IJB was approved at its first meeting on 10 August 2015. Since then, the Inverclyde Council staff representative member on the IJB, Mr Robin Taggart, has intimated his resignation from the IJB with effect from 18 December 2015. It is proposed to appoint Ms Robyn Garcha in his place.

4.3 In terms of the Order, the IJB is required to appoint stakeholder members who are non-voting members. These must comprise at least one staff representative.

5.0 PROPOSALS

5.1 It is proposed that the IJB agree the revised IJB non-voting membership arrangements as set out in Appendix 1 Section C.

6.0 IMPLICATIONS

Finance

6.1 None.

Financial Implications:

One Off Costs

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

Annually Recurring Costs/ (Savings)

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

Legal

6.2 The membership of the IJB is set out in the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

Human Resources

6.3 None.

Equalities

6.4 None.

Repopulation

6.5 There are no direct implications in respect of repopulation.

7.0 CONSULTATIONS

7.1 The Chief Officer of the Inverclyde Health & Social Care Partnership has been consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

8.1 N/A

Inverclyde Integration Joint Board Membership

SECTION A. VOTING MEMBERS		
		Proxies (Voting Members)
Inverclyde Council	Councillor Joe McIlwee (Chair) Councillor Stephen McCabe Councillor Ciano Rebecchi Councillor Vaughan Jones	Councillor Gerry Dorrian Councillor Jim Clocherty Councillor Kenny Shepherd Councillor Ronnie Ahlfeld
Greater Glasgow and Clyde NHS Board	Mr Ross Finnie (Vice Chair) Dr Donald Lyons Mr Allan MacLeod Mr Simon Carr	
SECTION B. NON-VOTING PROFESSIONAL ADVISORY MEMBERS		
Chief Officer of the IJB	Brian Moore	
Chief Social Worker of Inverclyde Council	Brian Moore	
Chief Finance Officer	Vacant	
Registered Medical Practitioner who is a registered GP	Inverclyde Health & Social Care Partnership Clinical Director Dr Hector MacDonald	
Registered Nurse	Professional Nurse Advisor Ms Cathy Roarty	
Registered Medical Practitioner who is not a registered GP	Chief Medical Officer Dr Chris Jones	
SECTION C. NON-VOTING STAKEHOLDER REPRESENTATIVE MEMBERS		
A staff representative (Council)	Ms Robyn Garcha	
A staff representative (NHS Board)	Ms Diana McCrone	
A third sector representative	Mr Ian Bruce Manager CVS and Chief Executive Inverclyde Third Sector Interface	
A service user	Ms Margaret Telfer Chair Inverclyde Health and Social Care Partnership Advisory Group	

A carer representative	Mr Alistair Black	
SECTION D. ADDITIONAL NON-VOTING MEMBERS		
Representative of Inverclyde Housing Association Forum	Ms Sandra McLeod, Director of Housing & Customer Services, River Clyde Homes	

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**
Contact Officer:	**Helen Watson Head of Service Planning, Health Improvement & Commissioning**	**Contact No: 01475 715285**
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
Corporate Director (Chief Officer)
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
-
- 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

.

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

Contents

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).

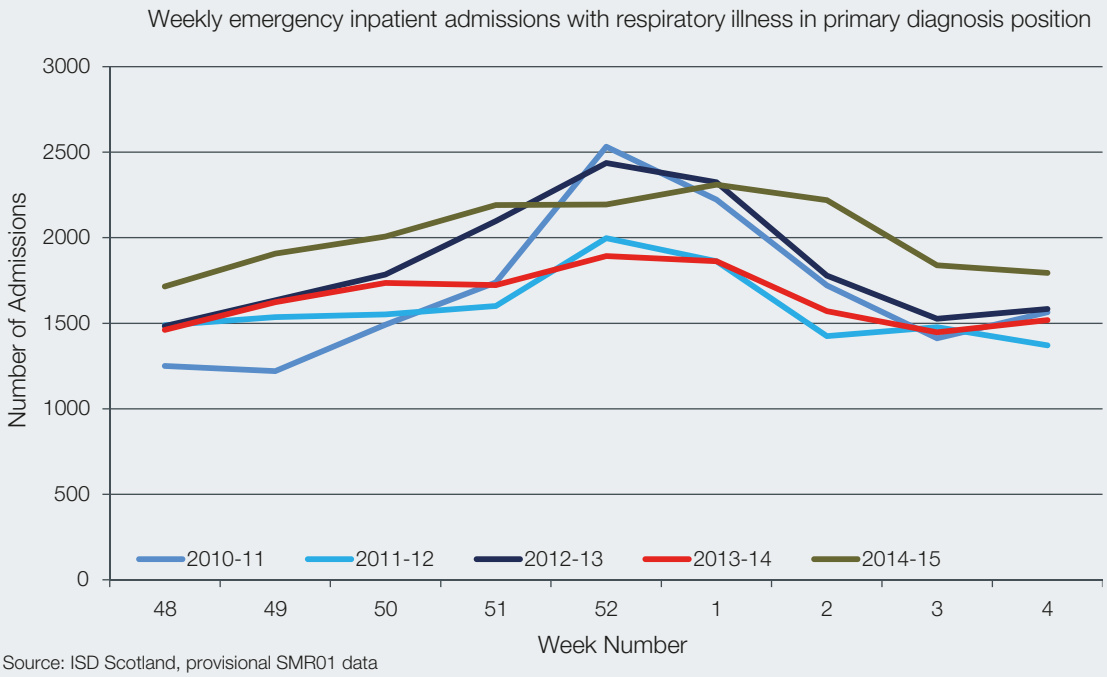
In future, the NHS will work with partners across the public sector to manage pressures and ensure the effective and efficient use of resources.

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]

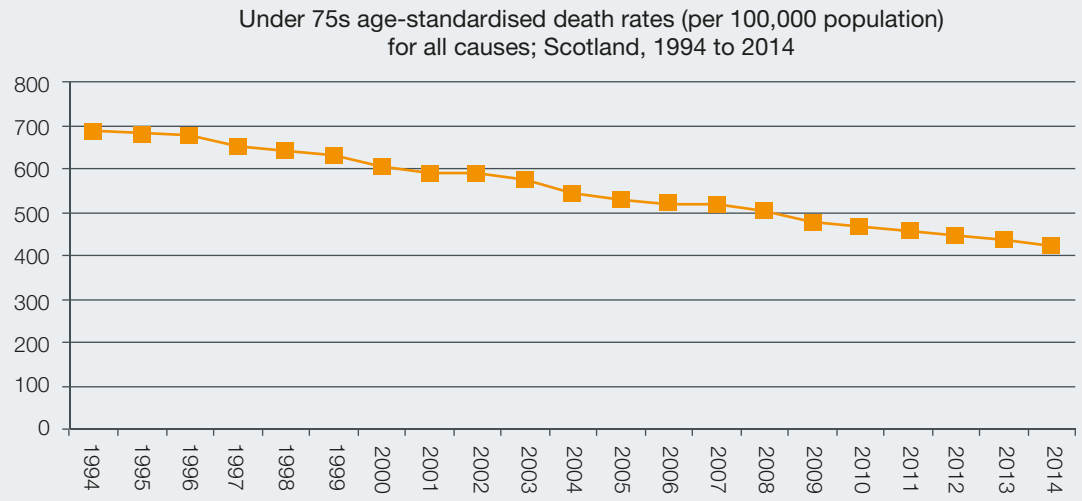
7 Health & Social Care: Preparing for Winter 2015/16 guidance, Scottish Government, August 2015. Access at: www.sehd.scot.nhs.uk/dl/DL(2015)20.pdf

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).

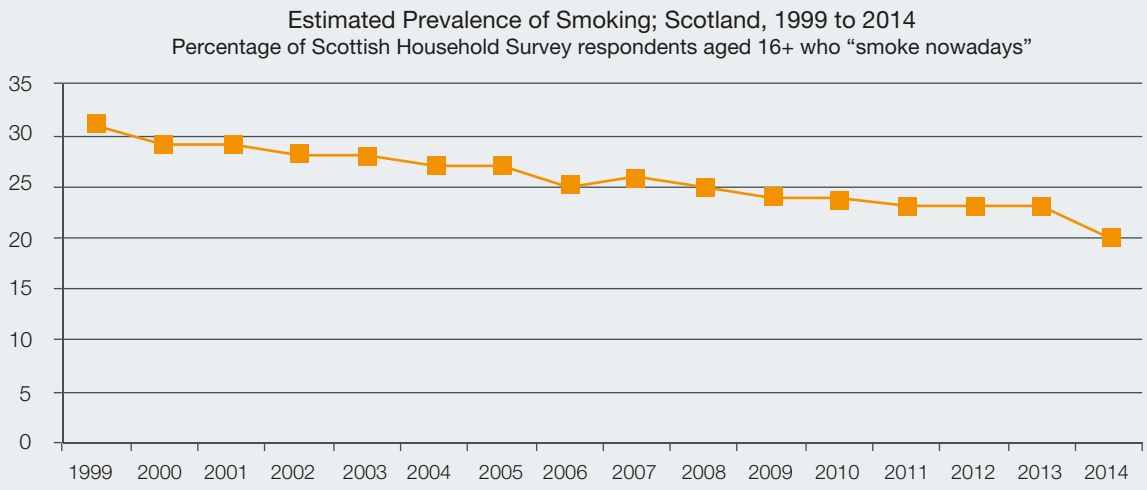
16 Scottish Government: Scottish Household Survey 2014 Annual Report. Access at: www.gov.scot/Publications/2015/08/3720

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

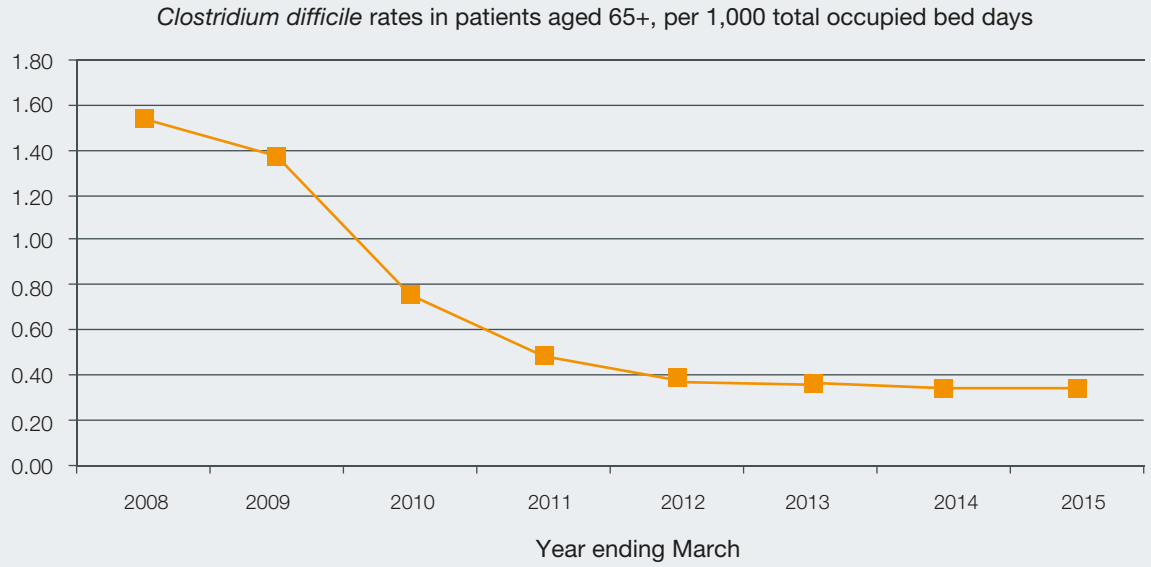
For the year ending March 2015, the rate of identifications of *Clostridium difficile (C.diff)* across NHSScotland was 0.34 per 1,000 occupied bed days among patients aged 15 and over, maintaining the improvement seen in previous years. The standard NHSScotland was aiming for was a rate of 0.32 cases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

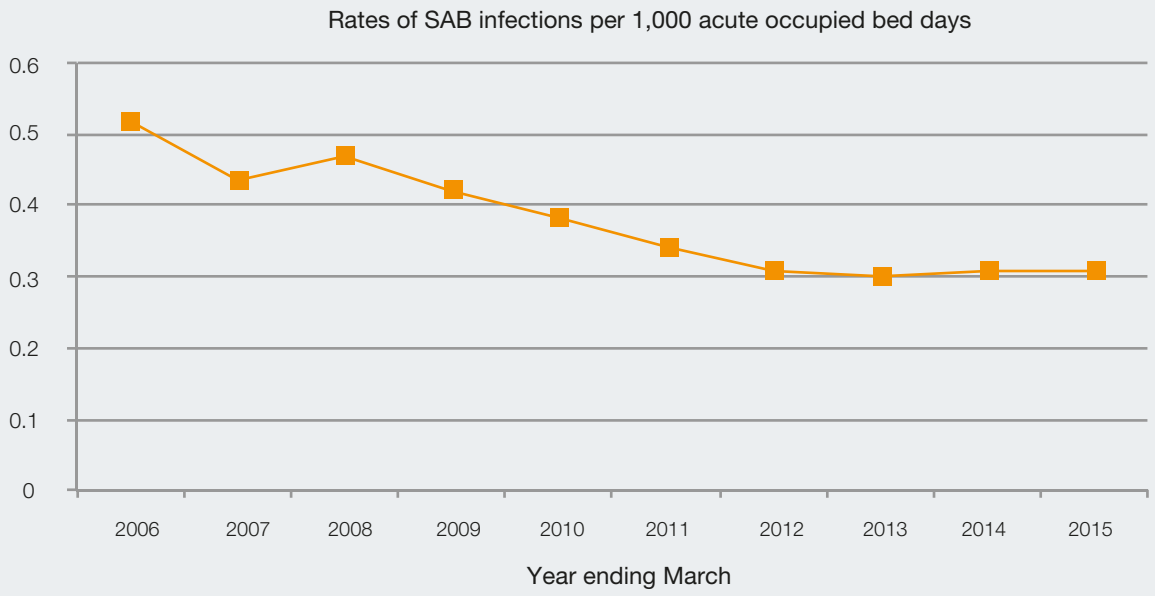
29 ISD Scotland: Emergency Department Activity & Waiting Times. Access at: www.isdscotland.org/Health-Topics/Emergency-Care/Publications/index.asp

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

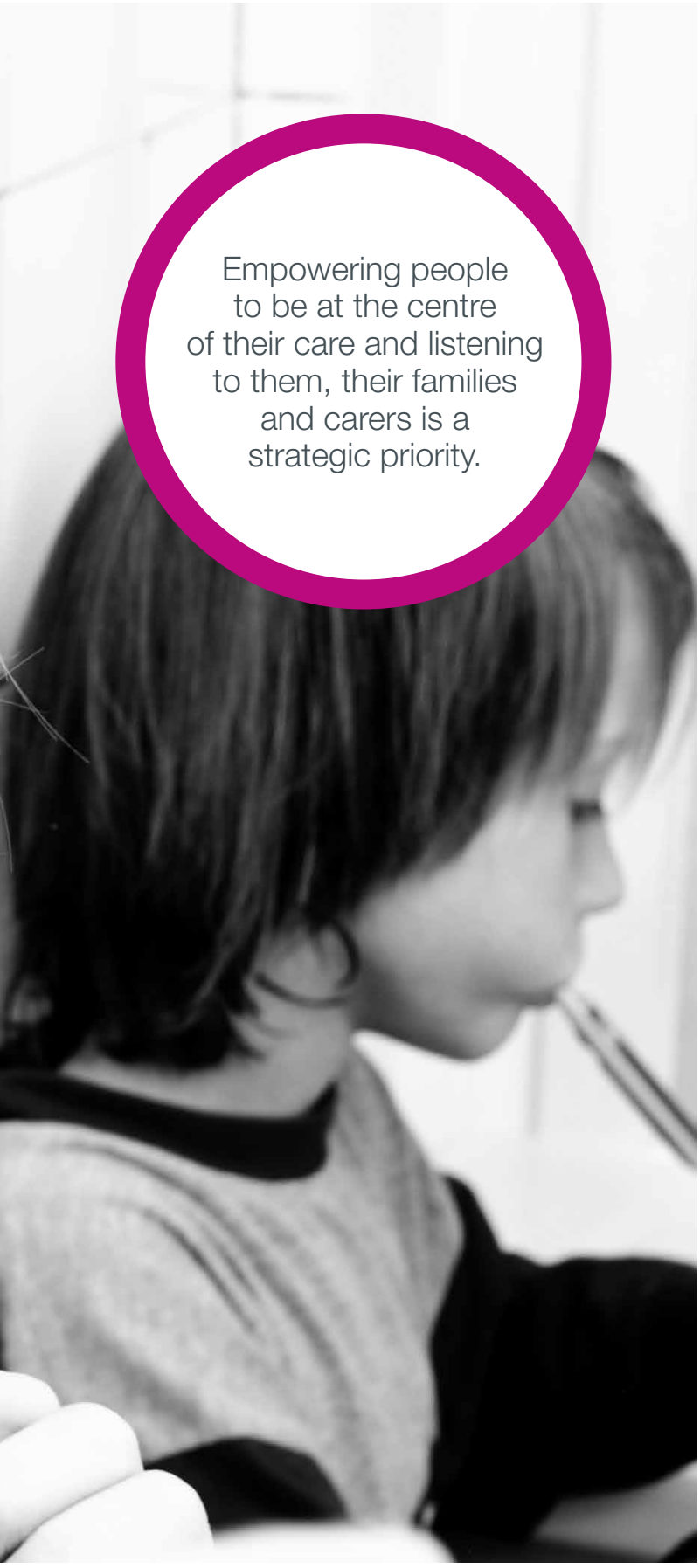
Tackling delayed discharge is one of the Scottish Government's key priorities for NHSScotland in improving the quality and experience of care and people's outcomes. Joined up health and social care will allow people to be timeously discharged and receive care at home or in a homely setting.

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.

---

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.

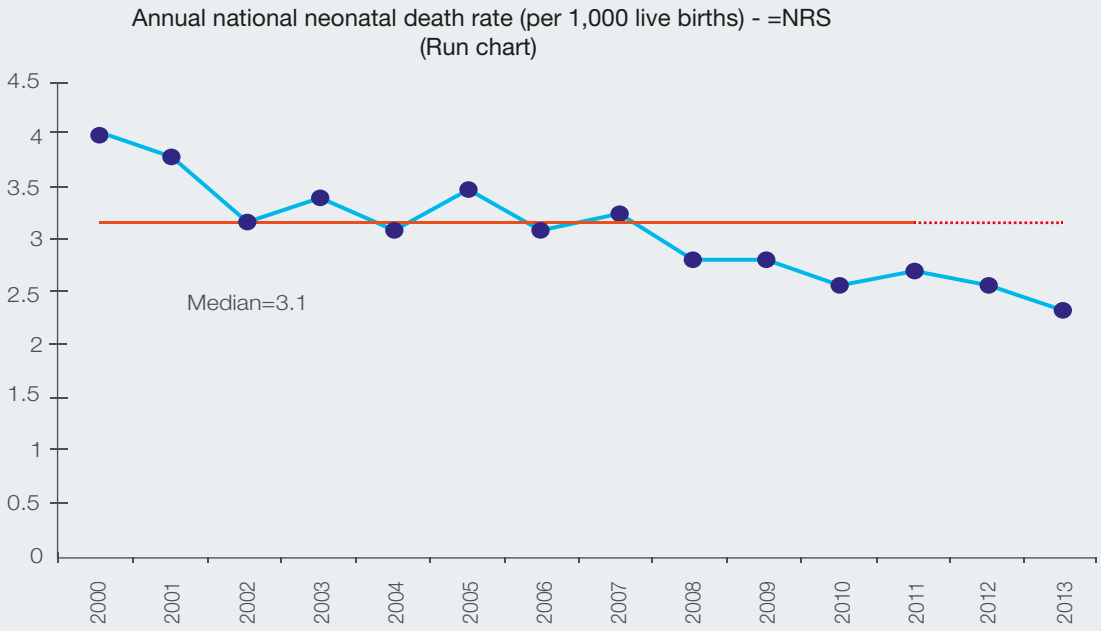
Improving the Care Experience for all Women, Babies and Families in Scotland

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.

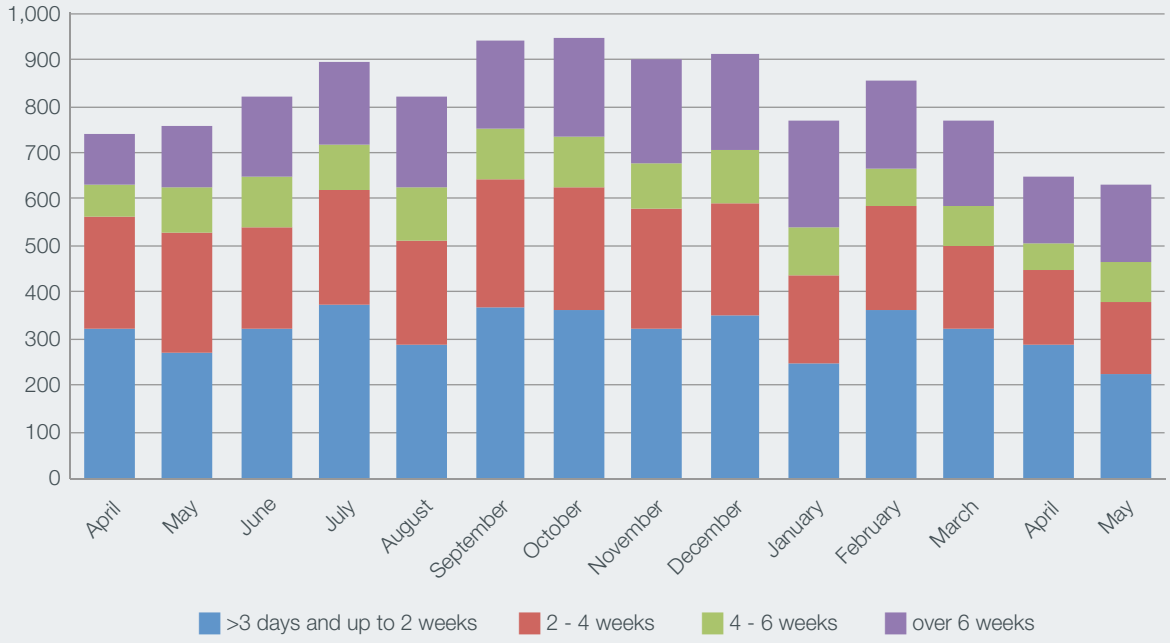
In January, a £100 million investment, over three years, was announced to help Integrated Health and Social Care Partnerships tackle delayed discharges.

---

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.

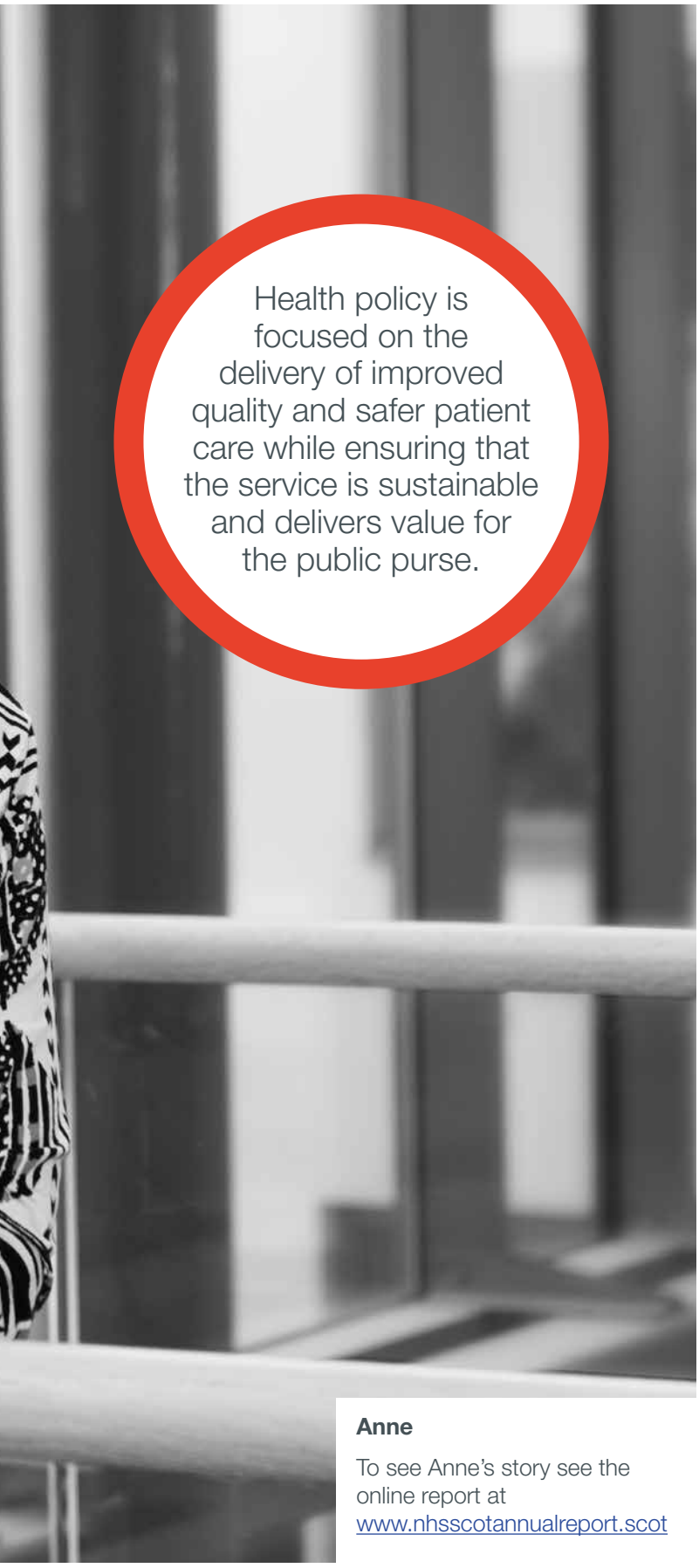
121 Costing the Burden of Ill Health Related to Physical Inactivity for Scotland, NHS Health Scotland, August 2012. Access at: www.healthscotland.com/uploads/documents/20437-D1physicalinactivityscotland12final.pdf

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.

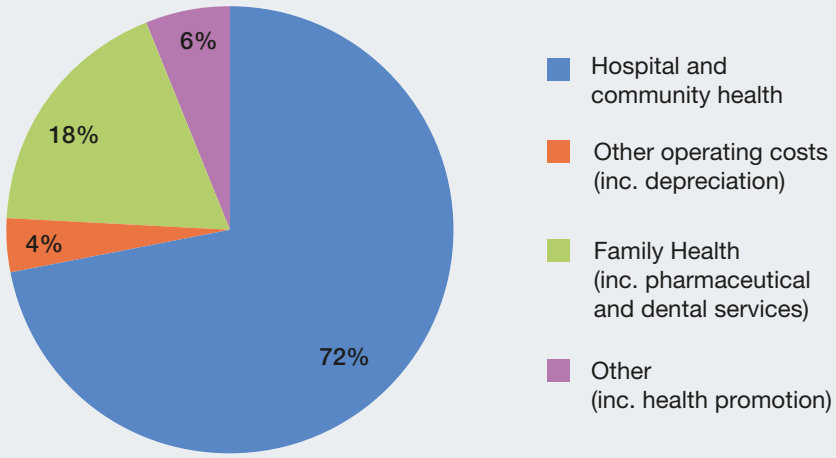
Resource spending by NHS Boards can be categorised as shown in Chart Eight.

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.

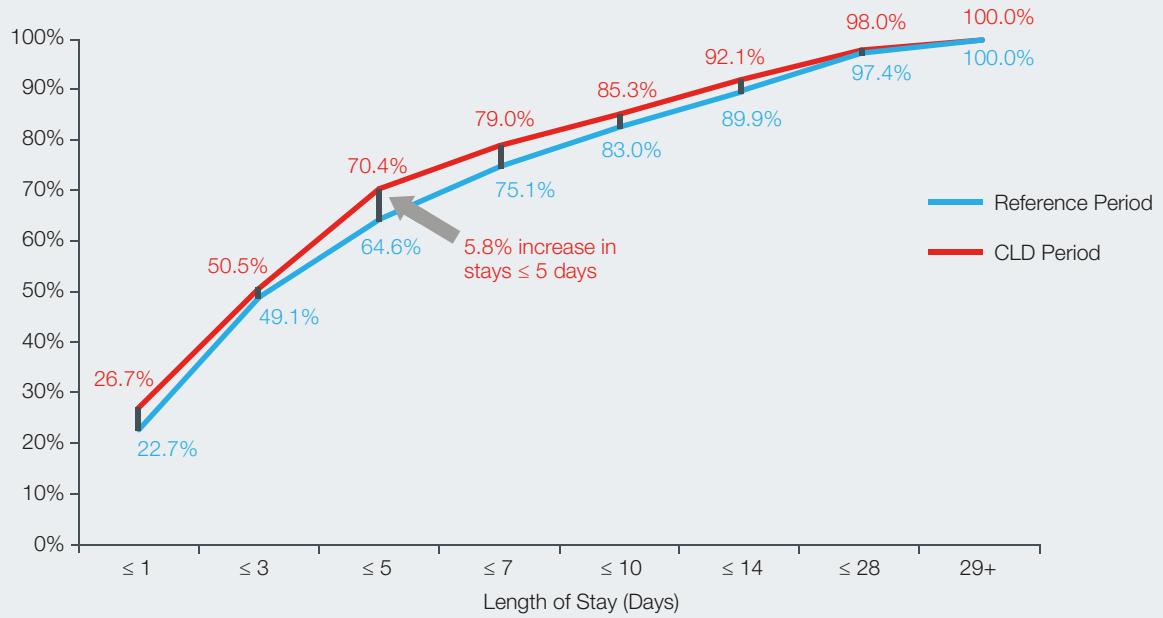
A primary objective of QuEST is to support NHS Boards to develop their own capacity and capability for continuous improvement. Staff at the sharp end of delivery are often best placed to identify ways to improve, as evidenced by more than 120 examples of improvement formally reported by QuEST in the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

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

First published by The Scottish Government, December 2015
ISBN: 978-1-78544-793-8 (web only)

E-book in EPUB format first published by The Scottish Government, December 2015
ISBN: 978-1-78544-794-5 (EPUB)

E-book in MOBI format first published by The Scottish Government, December 2015
ISBN: 978-1-78544-795-2 (MOBI)

Published by The Scottish Government, December 2015

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS56473 (12/15)

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.

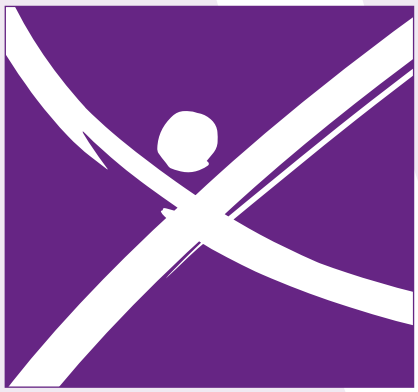
How can you get involved?

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.

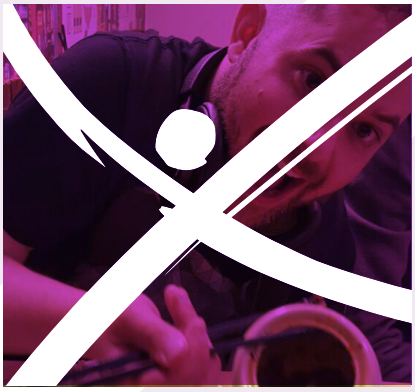
From 18 November, you can:

- 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**



+

=

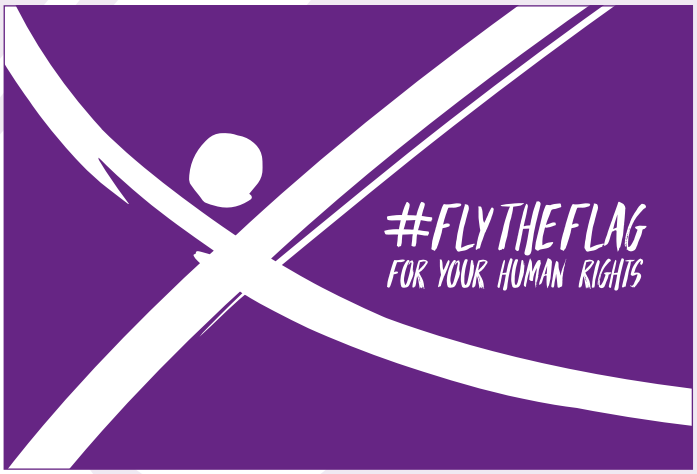


Suggested tweets/posts

- #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.

AGENDA ITEM NO: 8

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**26th January 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/01/2016/HW**
Contact Officer:	**Helen Watson Head of Service Planning, Health Improvement & Commissioning**	**Contact No:**	**01475 715285**
Subject:	**HSCP COMPLAINTS ANNUAL REPORT**		

1.0 PURPOSE

1.1 The purpose of this report is to inform the Inverclyde Integration Joint Board (IJB) of the annual performance of the Health & Social Care Partnership (HSCP) with regard to the operation of complaints procedures in respect of health and social work functions in Inverclyde. The statutory procedures are determined by the Scottish Government Guidance and Directions (SWSG5/1996) and health service procedures are determined by the policies of Greater Glasgow and Clyde NHS Board.

1.2 This Integrated Annual Report provides the analysis of complaints received by Inverclyde HSCP for the period 2014 – 2015.

2.0 SUMMARY

2.1 The annual report provides the following information:

i. Performance Information
ii. Analysis of complaints activity
iii. Update of learning from complaints.

3.0 RECOMMENDATIONS

3.1 It is recommended that the IJB note the annual performance of the HSCP statutory and integrated complaints procedures.

3.2 It is recommended that the IJB approve the revised integrated complaints procedures for Inverclyde HSCP (as per appendix 2)

Brian Moore
Corporate Director
(Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The purpose of this report is to inform the Inverclyde Integration Joint Board (the IJB) of the annual performance of the NHS and Statutory Social Work complaints procedures.

4.2 The Integrated Complaints Procedure is issued by the Chief Officer of the Inverclyde HSCP and supports the Scottish Government's Policy of Health and Social Care Integration and its Public Bodies (Joint Working) (Scotland) Regulations 2014 in respect of the integration of Health and Social Care complaint handling processes. This document brings alignment with the requirements of the NHS Patients' Rights (Scotland) Act 2011 (Health Complaints); the NHS Greater Glasgow & Clyde Complaints Policy, and the Statutory Social Work (Representation and Procedures) (Scotland) Directions 1996 (SI 1990/2519) hereafter referred to as Social Work Complaints. It applies to all services managed by the HSCP.

4.3 The Quality & Development Service has the lead responsibility for managing, co-ordinating and recording complaints across the HSCP. The Contracted Health & Social Care Services also fall under this function.

4.4 The appendix to this report includes details of the following:

- Annual Performance of Frontline Resolution & Investigated Complaints
- Analysis of complaints in respect of:
    - Health and Community Care
    - Children's Services and Criminal Justice
    - Mental Health, Addictions and Homelessness
    - Planning, Health Improvement and Commissioning
- Learning from Complaints, Compliments, Comments and Thanks.

5.0 PROPOSALS

5.1 Public Sector Scrutiny and Complaints Handling

The Scottish Government endorsed the recommendations made in The Fit-for-Purpose Complaints System Action Group, The Scottish Government, Sinclair Report, (November 2008). The Public Services Reform (Scotland) Act 2010 was introduced to streamline, simplify and invoke a consistent complaint handling system as good practice in all Public Services in Scotland. Work is ongoing by the Scottish Government and SPSO to streamline the Social Work Complaint Procedure into a simplified three stage process as set out in NHS Complaints Procedures. Inverclyde Social Work Services previously operated a 5 stage complaint process.

5.1.1 Stage 3 - Review by the Chief Social Work Officer (CSWO)

The Chief Social Work Officer Review was incorporated into Inverclyde social work complaint procedure process in late 1996. This additional stage gave a further opportunity to scrutinise Social Work practice and resolve complaints prior to an appeal by the complainant to the Complaint Review Committee (CRC). This 3rd stage in the procedure is a non-statutory requirement of the process and does not comply with the principles of the streamlining of complaints as set out in the Fit-For-Purpose Crerar and Sinclair reviews. IJB members are asked to note that from 1st April 2015 this interim stage has been removed from the Integrated /aligned HSCP complaint procedure.

5.1.2 **Stage 4 – Social Work Complaint Review Committee (CRC)**

The Fit for Purpose review of complaint handling identified that a barrier to achieving the streamlining of Social Work Complaints was the appeal stage of the process. It is the view of the Scottish Government, in consultation with the 32 Local Authorities in Scotland, that the Complaint Review Committee (CRC) function is no longer fit for purpose and it recommends its removal from the statutory framework to be replaced by adjudication of the SPSO. However, as this function is set out within the statutory complaint procedure legislative change is required prior to the transfer of this function to the SPSO. Discussions are ongoing and the Scottish Government proposal is currently out for public consultation, with a closing date of 14th December 2015. We await the results of this process.

5.2 **Integrated/Aligned Complaints Procedures**

In line with the aforementioned legislative reforms and principles, the HSCP has developed a single integrated/aligned complaints handling procedure which has streamlined the stages in the process across all services.

This new procedure incorporates a three stage process with the caveat of the statutory inclusion of CRC for Social Work related complaints. This has included an alignment of procedural guidance and response timescales. The Quality & Development Service liaised with the SPSO Complaint Standards Authority (CSA) in developing the process to ensure compliance with the current legislative framework and anticipated changes to existing NHS model complaint handling procedures.

5.3 **Complaint Handling Training**

5.3.1 **Frontline Resolution**

The Quality & Development Service developed and delivered 4 half day training session events in June 2015 for administration and frontline HSCP staff. This training incorporated the overview of the complaint landscape, understanding of the complaint procedure, first contact skills, frontline resolution process, de-escalation techniques and unacceptable behaviour.

5.3.2 **Complaint Investigation**

The HSCP developed the procedure in consultation with the Scottish Public Services Ombudsman (SPSO) and jointly developed and produced a bespoke package of training for employees who will investigate complaints on behalf of the HSCP.

The focus of this training was on the

- ✓ Procedures, timescales and processes,
- ✓ Early resolution,
- ✓ Investigation,
- ✓ Analysing information,
- ✓ Providing a written response,
- ✓ Learning and service improvement and,
- ✓ Managing unacceptable behaviours.

80 training places were offered over 4 full day sessions during April and May 2015. The overall feedback from participants was positive and the relevance and support to their operational roles was recognised and well received. Further training sessions will take place as identified and delivered by the Quality & Development Complaint Team Leader.

6.0 GOVERNANCE

6.1 The HSCP has a corporate governance process for complaint handling and reporting of complaints activity as follows:

- Inclusion in the Inverclyde Council Corporate Complaints Steering Group
- Weekly Senior Management Team meetings (SMT)
- Bimonthly Clinical & Care Governance meeting
- Quarterly Performance Service Reviews (QPSR)
- Biannual Organisational Performance Report (OPR)
- Parent organisational corporate Complaint Reporting.

7.0 FUTURE PLANNING 2015-2016

7.1 Integration of Complaint Process

The HSCP will use the next reporting period to embed the new complaint handling procedure across services. The Quality & Development Service will continue to offer guidance and support to the services as the new process develops.

7.2 Learning From Complaints/Quality Assurance

The HSCP will fully implement the Learning and Service Improvement Action Planning process as part of the new Integrated Complaints Procedure. This essential part of the complaint process will be shared and monitored through the Clinical and Care Governance Group to ensure learning is shared across the organisation.

Contracted Health & Social Care providers will also continue to submit quarterly complaint performance information. Further, they will now be required to demonstrate to the HSCP how they are learning from such activity.

8.0 IMPLICATIONS

FINANCE

8.1 Financial Implications:

Any costs associated with this report will be met from existing budgets.

One off Costs

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

Annually Recurring Costs/ (Savings)

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

LEGAL

8.2 There are no legal issues within this report.

HUMAN RESOURCES

8.3 There are no human resources issues within this report.

EQUALITIES

8.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
X	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.

9.0 BACKGROUND PAPERS

9.1 Government Response to Crerar Review, The Report of the Independent Review of Regulation, Audit, Inspection and Complaints Handling of Public Services in Scotland, The Scottish Government, (January 2009).

9.2 Inverclyde Community Health and Care Partnership Aligned Complaint Procedure.

9.3 Scottish Executive Circular – SWS56/1996.

9.4 The report of the independent review of regulation, audit and Inspection and complaints handling of Public Services in Scotland, Crerar Review (September 2007).

9.5 The Fit-for-purpose Complaints System Action Group, The Scottish Government, Sinclair Report, (November 2008).

9.6 The Public Services Reform (Scotland) Act 2010.

10.0 CONSULTATION

10.1 Consultation on Draft Order to revise the procedures for complaints about social work (September – December 2015).

Appendix 1

Inverclyde Health & Social Care Partnership
Annual Complaints Report
2014 – 2015

Contents

1. Introduction

1.1 Inverclyde Health & Social Care Partnership (HSCP) has 1,666 members of staff and serves a population of 79,860. We aim to deliver high quality health and social care services and to use the views and experiences of the people who use our services as part of the process of continuous improvement.

1.2 The HSCP values complaints, comments and compliments as a vital part of gaining feedback from the people who use our services. The Quality & Development Service captures complaint activity and coordinates those which can be dealt with quickly or those which require further investigation. As a learning organisation, the HSCP takes every opportunity to learn from the feedback received from the people who use our services. As part of the Quality Assurance Framework, this information provides opportunities to identify gaps in systems, performance or processes which may require review or improvement. Such continuous learning ensures we have a consistent, accountable and transparent approach in the delivery of health and social care to the residents of Inverclyde.

1.3 Governance arrangements are in place to facilitate reporting and analysis of complaints within the HSCP as well as feeding into the partner organisations NHS Greater Glasgow & Clyde (NHSGG&C) and Inverclyde Council reporting systems and processes.

1.4. This report contains performance information in respect of complaints, comments and compliments across our services from **1st April 2014 to 31st March 2015**.

2. Summary of Performance

2.1 Number of Complaints

2.1.1 For the purposes of this report, complaints are subdivided into Frontline Resolutions or Investigations.

2.1.2 **Frontline Resolution:** relates to complaints which are not regarded as complex, and can be resolved immediately or relatively quickly by those individuals directly involved in delivering the service.

2.1.3 **Investigation:** relates to complaints which are required to have a more detailed review or regarded as complex.

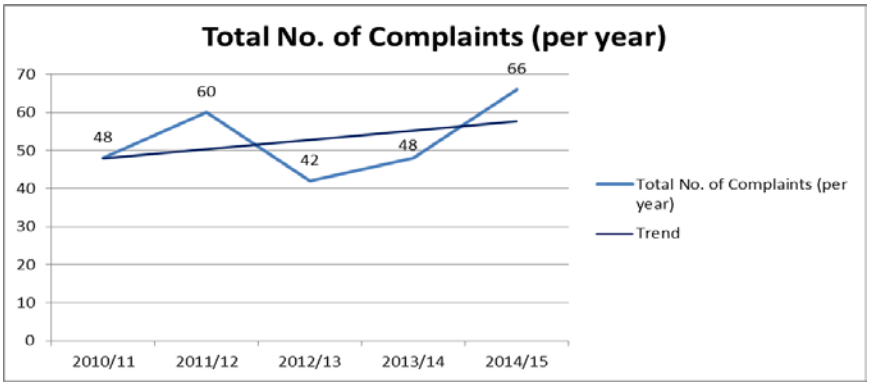
2.1.4 The HSCP received a total of **82** complaints during the reporting period. **64** related to Social Care and **18** in respect of health services. Of these, 66 were investigated and 16 were resolved at source. Comparison with the previous year's figures show that there has been a slight decrease in the overall number of complaints (from 85 in 2013/14 to 82 in 2014/15), but a higher proportion have required formal investigation (going from 48 to 66). This is disappointing given that we always try to resolve any issue at the front line if at all possible.

Table 1 – Number of Complaints 2014-2015

	Number of Investigated Complaints 2014/15	Number of Front Line Resolutions 2014/15	Number of Investigated Complaints 2013/14	Number of Front Line Resolutions 2013/14
Social Work	51	13	36	32
NHS	15	3	12	5
Total	**66**	**16**	**48**	**37**

2.1.5 Complaints received and investigated since the formulation of the Community Health & Care Partnership (CHCP) from April 2010, indicate an average of 52 complaints per year are received and investigated.

2.1.6 There is a higher than average level of complaint activity in this reporting period than in previous years. Analysis indicates that this is due to multiple complaints from a small number of complainants. Chart 1 below illustrates this trend.



2.2 Targets for Investigated Complaints

2.2.1 Health and Social Care have different statutory target timescales in responding to investigated complaints. These are outlined in Table 2 below along with our performance in meeting these targets.

Table 2 – Complaint Timescale Reporting

		2014/15		2013/14	
		Timescale Met	**Timescale Not Met**	**Timescale Met**	**Timescale Not Met**
Social Work	Acknowledged within 5 calendar days	48	3	35	1
	Completed in 28 days or agreed timescale.	34	17	35	1
NHS	Acknowledged within 5 calendar days	15	0	12	0
	Completed in 28 days or agreed timescale.	11	4	10	2

Social Care Services

2.2.2 In comparison to the previous reporting period (2013/14), in which a total of **36** complaints were investigated, there is a decrease in performance of **4%** of complaints acknowledged within the 5 day target and a decrease in performance of **34%** for complaints completed within the statutory 28 day target timescale.

Community Health Services

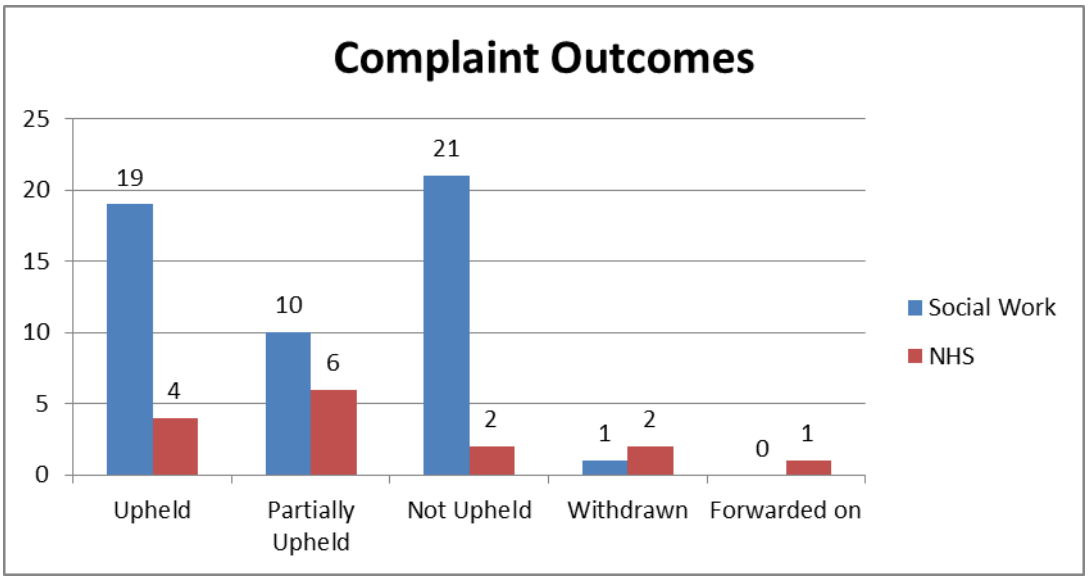
2.2.3 In comparison to the previous reporting period (2013/14), in which a total of **12** complaints were investigated, 100% of were acknowledged within the 3 day timescale. However, there is a decrease in performance of **10%** for complaints completed within the 20 working day target.

2.2.4 The analysis of these trends identified that the decrease in performance of complaints falling outwith the target response dates is primarily as a direct consequence of individual complainants submitting multiple complaints during the period of investigation. Due to the volume and frequency of the complaints, it had taken time to screen for any duplicated issues which had previously been investigated and responded to.

2.3 Complaint Outcomes

2.3.1 Within a complaint response, complainants have a right to know the outcome of the findings from the investigation. This is important in the interests of being open and transparent, and to enable the individual to decide whether to progress their complaint to the appeal stage of the complaint procedure. Chart 2 details the outcome of investigated complaints.

Chart 2 – Outcomes



2.4 Appeals

2.4.1 If complainants are dissatisfied with the outcome of the investigation, they have a right to appeal this decision. All complainants have ultimate recourse to the Scottish Public Services Ombudsman (SPSO) when appealing the outcome of their complaints.

2.4.2 The NHS complaint system has a two stage process for complaint investigation. These stages are:

- Investigation and written response.
- Appeal to the Scottish Public Services Ombudsman.

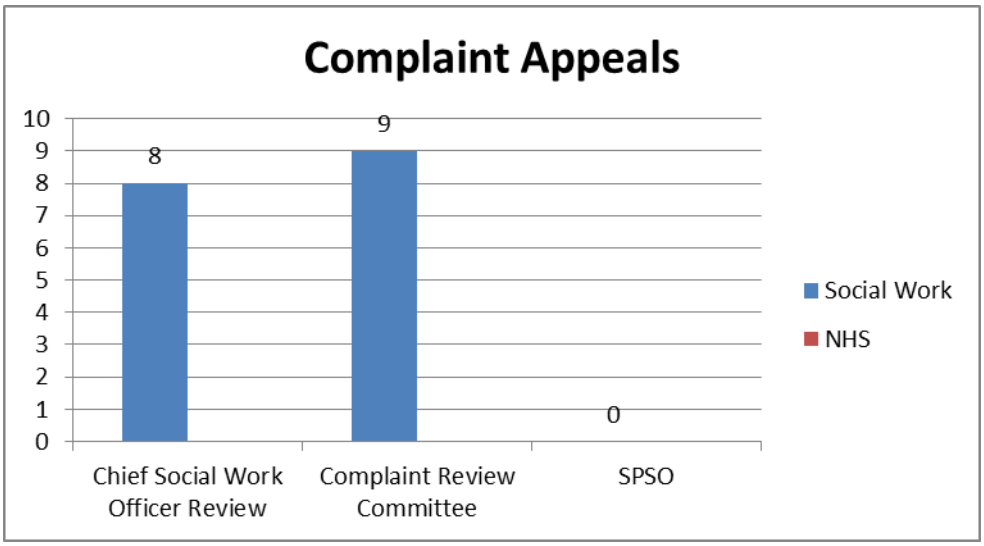
2.4.3 However, under the Statutory Complaint Procedure for Social Work Services, there are a further two interim stages of appeal prior to the Ombudsman review. These are:

- Review by Chief Social Work Officer
- An Independent Review by the Social Work Complaints Review Committee

It should be noted that the Scottish Government is currently consulting on the future of the Social Work Complaints Review Committee through the "Consultation on Draft Order to revise the procedures for complaints about social work", which runs until 14th December 2015.

2.4.5 The table below sets out the number of complaints progressed to the complaint appeal stages. HSCP staff are usually unaware if complainants decide to progress their complaint to the SPSO until this scrutiny body make direct contact with the offices of either the Council or NHS Board's Chief Executive.

Chart 3 – Number of appeals 2014-2015



2.4.6 One complaint which progressed to the Social Work Complaint Review Committee had been carried forward from the previous reporting period. The analysis of 14/15 reporting period demonstrates a **75%** increase of complaints progressed to the Social Work Complaint Review Committee appeal stage (from **2** in 2013/14 to **9** in 2014/15). The majority of these appeals were made by complainants who had made multiple complaints at various times over the year.

2.4.7 It is noted that out of these **9** appeals, **2** were carried forward to the next reporting period, **2** were withdrawn and **5** were not up-held.

2.4.8 To comply with the principles of streamlining public sector complaints as outlined in the Scottish Government Complaints Handling of Public Services in Scotland, the Chief Social Work Officer Review stage has been removed from the procedure. From 1st April 2015 complainants who remain dissatisfied with the outcome to their complaint will now make a single appeal to the Complaint Review Committee prior to its escalation to the SPSO.

2.5 Learning from Complaints

2.5.1 Inverclyde HSCP is committed to delivering quality services and strives to ensure continuous improvement and learning from complaints. As such, following investigation of a social work complaint, where it has been upheld or elements are partially upheld, recommendations may be made in a Service Improvement Action Plan. This process will be extended to include Health Service complaints.

2.5.2 Of the **twenty nine** social work complaints that were upheld or partially upheld, in most cases the service itself had taken immediate action to address the issue so a service improvement action plan was not required.

2.5.3 There were **twelve** Service Improvement Action Plans issued during the period 2014/15, where **twenty** recommendations were made. The twelve Service Improvement Action Plans in the reporting year represents a significant increase from the four that were put in place during 2013/14.

2.5.4 This may be an indication of the increasingly complex nature of complaints. Table 3 below outlines the common themes.

Table 3 – Theme of Improvements

Theme of Recommendation	Number	Percentage
Practice Standards	4	20%
Internal Processes*	5	25%
Communication**	6	30%
Quality Assurance***	5	25%

2.5.5 *This included developing a new process; reviewing an existing system or general tightening of procedure.

2.5.6 **Communication includes with service users, as well as between HSCP internal services.

2.5.7 ***This involved developing monitoring systems to ensure certain tasks are being done, for example, service user and carer engagement.

2.5.8 Service Improvement Action Plans are monitored to ensure all recommendations have been addressed appropriately and that learning has been used to improve the quality of service delivery.

3. Summary of Private and Voluntary Sector Complaints

3.1 Number of Private and Voluntary Sector Social Care Complaints

3.1.1 The HSCP Quality & Development Service gathers and monitors complaint activity relating to private and voluntary sector social care organisations contracted to provide care and / or support on behalf of the HSCP. This equates to approximately **140** services (an increase of 20) from different organisations providing a broad range of services.

3.1.2 During 2014 / 15 there were a total of **48** complaints received by private and voluntary sector providers. Of these:

- 25 (52%) were in relation to Older People's services;
- 23 (48%) related to Adult services.

3.2 Outcomes of Private & Voluntary Sector Complaints

3.2.1 Table 4 details the outcomes of Independent Sector complaint investigations. Comparison with 2013/14 shows that there has been a notable reduction in the overall number of complaints, going from 74 to 48. Proportionately the outcomes have been similar so there is still much learning to be gleaned from this sector.

Table 4 – Private & Voluntary Sector Social Care Outcomes

Outcome	Number 2014/15	%	Number 2013/14	%
Upheld	22	46%	64	45%
Partially Upheld	6	13%	22	16%
Not Upheld	15	31%	47	33%
Withdrawn	4	8%	1	1%
Ongoing	1	2%	8	5%
Total	**48**	**100%**	**74**	**100%**

3.2.2 The overall themes from these complaints focused on:

- Staff Conduct – **15** (31%)
- Care Practice – **8** (16%)
- Policy and Procedure – **7** (15%)
- Service Standards – **18** (38%)

3.2.3 The HSCP Quality & Development Service uses this complaint information to analyse themes and inform contract monitoring processes as well as liaison with the Care Inspectorate for regulated services.

3.2.4 This is part of our approach to assist the provider to update practice, improve systems or identify contractual service improvements.

3.2.5 Over the next reporting period, contracted services will be required to provide information on learning from complaints.

3.3 NHS GG&C Contracted Health Services

3.3.1 NHS private providers such as GPs, Pharmacists, Optometrists and Dental Practitioners are contracted to deliver NHS community health services.

3.3.2 The level of complaint activity is monitored and reported through the Clinical and Care Governance process.

3.3.3 There were **46** complaints received by GP practices during the 2014/15 reporting period (Quarters 1 to 3). **44** (96%) were responded to within timescales. There were no complaints received from Pharmacy, Dental or Optometry.

3.3.4 The themes of the GP complaints were:

Prescription Issue	2
Communication Issue	10
Clinical Care	9
Access / Appointment Issue	9
Results Handling	2
Attitude of Staff	4
Medical Records	1
Administration	3
Lab Results	3
Complaint Sent to Other Service	1
No Descriptor	2
Total	**46**

3.3.5 The Independent Contractors respond to their own complaints and have their own arrangements for service improvement in response to complaints. However the Clinical and Care Governance Group will make recommendations as and when required.

3.4 Learning from Complaints - A Case Study

Background

3.4.1 Ms M made a complaint on behalf of her 80 year old father (Mr M) who had a diagnosis of dementia but was assessed as able to live on his own with a package of support provided by a contracted external agency.

3.4.2 The HSCP had arrived at Mr M's home in place of the external agency to support him to bed which caused him agitation and distress. There were two elements to the complaint raised:

- The HSCP service arrived unannounced and at an unreasonable time
- When Ms M was contacted she was unhappy with the communication she had received and the manner in which she was spoken to.

Listening and Learning

3.4.3 It was ascertained that the external agency worker had an accident on their way to Ms M's father. His planned appointment was for 21.45. The HSCP support service was informed by the agency of the accident at 22.16. As this was unexpected the

support service were asked to include a home visit to Mr M in place of the agency By the time the support workers had arrived it was 22.55.

3.4.4 On receipt of the complaint, the Team Leader from the support service visited Ms M and her father at home to listen to the concerns and distress they had experienced. The Team Leader also used this time to provide them with feedback on the findings of the investigation.

3.4.5 The Team Leader listened and agreed with Ms M's concerns and gave an explanation of the events surrounding the home visit. It was explained that visit was allocated to two support workers as Ms M's father could not be left to take has medication and get himself into bed. However due to their planned rota and distance from the house, the support workers did not arrive at the house until almost 11pm.

3.4.6 Ms M advised that her father was distressed when the two workers arrived because the agency worker had not arrived and the workers were unfamiliar to him. The staff had contacted Ms M to advise of what had happened and her father's reaction.

3.4.7 Ms M felt that there should have been better communication with her and the support service could have contacted her to advise of the situation and she might have been able to attend to help. When Ms M tried to express this to the support worker who had called her, she felt they were abrupt in their manner toward her.

3.4.8 It was accepted and agreed that better communication could have prevented the situation from occurring. Ms M was advised that there would be a review of the communication process with the agency and the HSCP support service in reporting issues in good time to provide an alternative. But it was also agreed that the support service could have contacted Ms M as soon as they were aware of the incident as unfamiliar people arriving at her father's home would have caused him worry and distress. It was agreed that Mr M's support plan would be updated to clearly reflect this.

3.4.9 The Team Leader also advised that the way Ms M had been spoken to was unacceptable and this had been addressed. The support worker would be asked to reflect on their handling of the situation and identify ways they could have handled the events differently.

3.4.10 Ms M and her father were given an apology by the Team Leader for the anxiety and distress this situation had caused to both of them. Ms was also advised that the complaint was upheld. Ms M was happy that the Team Leader had dealt with the issues quickly and met with her to discuss the matter.

3.4.11 Ms M was provided with a written apology and confirmation of the outcome of the investigation together with a summary of the events, the discussion and lessons learned from the situation. As with all complaints, Ms M was provided with information about how she could take her complaint to the next stage of the complaint procedure is she remained dissatisfied with the overall outcome.

<u>3.4.12 Action planning and service improvement</u>

- A meeting took place between the agency and the support service to look at the events and to agree a more appropriate communication strategy based on this incident.

- A meeting took place with the support worker to reflect and learn from the incident and consider any further training which would support their learning from the incident to avoid similar issues in the future.

3.4.13 This situation occurred because of a breakdown in communication which resulted in Mr M being distressed and disappointment by his daughter Ms M. There was great value in meeting with Ms M and her father to listen to their experience and feedback how they felt we had performed as an organisation. This information is vital to help us evaluate the standard or quality of our service. However, this feedback is less useful if the information gained is not shared as a reflective and learning opportunity on our practice and approach across the service and to minimise the chance of a similar incident happening in the future.

4. Feedback, Compliments and Thanks

4.1 Some brief examples of feedback, compliments and thanks we have had in the reporting period are as follows. These examples do not include the vast array of examples of feedback we receive via the People Involvement Network, which is in place to deliver our responsibilities in respect of involving people in the business of the HSCP.

4.1.1 ‘Thanks for being there for me and thanks for listening to me’

4.1.2 ‘Thanks for your kindness and support’

4.1.3 ‘Just a wee thanks for all your hard work’

4.1.4 ‘Just wanted to say thanks for all the help and support I received during a difficult time’

4.1.5 ‘I have found the Team to be very helpful and efficient in regards advice and direct input into complaints’

4.1.6 ‘you have been Very helpful and informative’

4.1.7 ‘Very sad news, I am sorry to say, my brother passed away at around 3am on Sunday morning. As you know he had been fighting cancer for nearly a year, I know he wished to thank you both for your help. Also for your efforts to change procedures which would ensure that what happened would be prevented in the future from occurring again. Unfortunately due to his health he was unable to do this himself. So on his behalf I wish to pass on his thanks. The very best regards’

5. Conclusion

5.1 This report highlights the performance of the HSCP in undertaking its commitment to providing the highest possible quality of care and services within its financial resources.

5.2 The information contained demonstrates that feedback from complaints is welcomed and used as a vital service quality improvement tool. It further demonstrates that the HSCP takes responsibility when we fail to deliver best quality services or meet the expectations of patients, service users, their representatives or other members of the public in delivering its duties, responsibilities and services.

Inverclyde Health and Social Care Partnership (HSCP)

Integrated Complaints Procedure 2016

Appendix 2

Date complaints procedure approved by Integration Joint Board:	**January 2016**
Date complaints procedure to be reviewed:	**January 2019**
Responsible Officer	**Helen Watson** **Head of Service: Planning, Health Improvement and Commissioning**

Inverclyde Health and Social Care Partnership (HSCP)

Integrated Complaints Procedure 2016

Introduction

The Inverclyde Health and Social Care Partnership (HSCP) is a Partnership between Inverclyde Council and NHS Greater Glasgow and Clyde (NHSGG&C) bringing together both NHS and Local Authority responsibilities for community-based health and social care services within a single, integrated structure. The HSCP is committed to providing quality, effective and efficient services.

This Guidance is issued by the Chief Officer of the Inverclyde HSCP and supports the Scottish Government's Policy of Health and Social Care Integration and the Public Bodies (Joint Working) (Scotland) Act 2014, and its associated Regulations, in respect of the integration of Health and Social Care complaint handling processes. This document brings alignment with the requirements of the NHS Patients Right (Scotland) Act 2011 (Health Complaints); the NHS Greater Glasgow & Clyde Complaints Policy, and the Statutory Social Work (Representation and Procedures) (Scotland) Directions 1996 (SI 1990/2519). It applies to all services managed by the Inverclyde Health and Social Care Partnership.

Our aim is to reduce barriers to making complaints as part of a streamlined approach to delivering sensitive care and support and promoting equality of opportunity for the residents of Inverclyde.

Application of these operational procedures must ensure the organisation complies with the duties placed on it by equalities legislation to treat all individuals on an equitable basis, with an understanding of issues relating to age, disability, gender, race, religion, sexual orientation, or socio-economic status in accordance with the equality legislation. In practice, this will include:

- Making all information accessible in appropriate formats.
- Identifying any additional individual support that the complainant or their representative may need to assist them to progress a complaint.
- Whenever possible, the HSCP should resolve any complaints immediately without the necessity to enter into the complaints investigation process.
- Being open and transparent subject only to the appropriate preservation of confidentiality and data protection.

This procedure and guidance seeks to support these key aims.

Health and Social Care Integration

The Patient's Rights (Scotland) Act 2011 supports the Scottish Government's vision for a high quality, person-centred NHS. The Act gives patients a legal right to give feedback on their experience of healthcare and treatment and to provide comments, or raise concerns or complaints. The 1968 Social Work (Scotland) Act places duties on Local Authorities with regard to Social Work complaint procedures. The act is supported through guidance and directions which can be found in SWSG5/1996 circular. NHS GG&C revised its complaints policy and processes to reflect the requirements of the Patient's Rights (Scotland) Act 2011 and launched this during 2012. The HSCP procedure and guidance for staff aligns these requirements. Complaints can be made by patients, service users and customers or their nominated representatives using a range of methods including an online form, face to face contact, in writing and by telephone.

Inverclyde Health and Social Care Partnership (HSCP)

Integrated Complaints Procedure 2016

The Scottish Government is currently reviewing the Social Work complaints process at national level. Once recommendations have been made regarding this, the procedures will be amended if required.

Definition of a complaint

A "complaint" is defined as an expression of dissatisfaction about an action or lack of action or standard of care provided or commissioned by the Health and Social Care Partnership that requires a response.

Who can make a complaint?

A complaint can be made by:

- Anyone who has had or is receiving a service provided directly or commissioned on behalf of the HSCP for care, treatment or intervention has a right to make a complaint if they are dissatisfied with any aspect of the service provision.
- In some cases a third party might make a complaint on behalf of the service recipient, but this must be with the explicit and recorded consent of the service recipient.
- Anyone likely to be affected by a decision taken by the HSCP.
- In the case of a deceased person, the right to pursue a complaint might rest with the executor.

Who is not entitled to make a complaint?

- Individuals who are not in receipt of HSCP services or are not likely to be affected by our decisions.
- Individuals who are raising a complaint on behalf of a patient or service user without consent and are not in possession of Power of Attorney or Guardianship or a written certificate of authorisation.
- Those using the process for political purposes.
- Those wishing to use the process as part of a legal action or compensation claim.

If a concern is identified as one of the following it should be dealt with through other channels:

- as a review of a service decision i.e. re financial assessment/service charges;
- an investigation of a criminal offence;
- a possible claim for negligence;
- Freedom of Information Request;
- Subject Access Request;

Response timescales

Inverclyde HSCP has combined the requirements of the NHS response targets and those of Social Work and has agreed the following formal process:

- Acknowledgement in 3 working days.
- An outcome letter should be issued within 20 working days from receipt of the complaint. Further extension to the target response date can be negotiated and agreed with the complainant where the issue is complex and a response is not going to be achievable within the 20 days.

- Social Work only – if the complainant is dissatisfied with the outcome of the investigation findings s/he can appeal the decision to the Complaints Review Committee within 28 days. The Committee will be convened within 56 days, with a response to be issued within 42 days of the Committee meeting.

Where a complaint concerning NHS services is expected to extend beyond 40 days (in total) there must be a review at Chief Officer level of the handling of the complaint to date to ensure that any delay is for good reason. The complainant will be kept informed in writing of progress throughout the process and agree to any extensions of timescales.

There will usually be a time-bar placed on the complaint process. Complaints should be submitted within 6 months of the date of the incident or circumstances leading to the complaint unless there are significant reasons why a complainant has delayed making the complaint or where serious issues are raised.

The time-bar is in place because the passage of time may prevent full and fair investigation taking place.

Any submission of a complaint outwith the 6 month timescale should be discussed with the Head of Service and HSCP Chief Officer to determine whether the complaint should be investigated and if an investigation would provide a meaningful outcome before activating the complaint procedure.

Independent Support and Advice

Where an individual is raising a complaint in relation to NHS services they should be made aware of The **Patient Advice and Support Service.** This is an independent service managed by the Citizens Advice Bureau that provides free, accessible and confidential information, advice and support to patients, their carers and families about NHS healthcare.

This service can be accessed from any Citizens Advice Bureau in Scotland. www.cas.org.uk or under CAB in the local phone book.

The Local Advocacy Service can also provide support to individuals raising a complaint. It can assist complainants to make complaints or advocate on their behalf. Circles Network, Advocacy Service Inverclyde, 21 Grey Place, Greenock. PA15 1YF. 01475 730797.

Confidentiality / Anonymity

Complainants may request that their identity is not disclosed when a complaint is made. However, they must be advised that this anonymity may restrict the activity of the investigating officer to fully investigate the matters raised or that an indication of who the complainant is may become evident during the investigation. This will allow the complainant to consider their position in this respect.

Data Protection

The complainant should be reminded that they have no right of access to personal information held on files about a third party, unless the third party has given written (or equivalent) consent in line with Data Protection legislation.

Complaints Handling Process

The aim of the complaints handling procedure is to provide a quick, simple and streamlined process with a strong focus on local, early resolution by empowered and well trained staff. This enables the complainant to have their issues or concerns dealt with as close to the event which gave rise to the complaint.

This model provides organisations with two opportunities to deal with complaints internally: frontline resolution and investigation.

Frontline Resolution

Where possible, the complainant should be actively and positively engaged within the process from the outset. Clarity should be sought where appropriate on the grounds of the complaint and expected or desired outcome. Unrealistic expectations must be managed appropriately.

Frontline resolution should be attempted where the issues involved are straightforward and potentially easily resolved, requiring little or no investigation.

Examples of issues suitable for frontline resolution:

- A service that should have been provided has not been provided.
- A service has not been provided to an appropriate standard.
- A request for service has not been actioned
- An error has been made when applying charging.
- Where a staff member has been rude or unhelpful.
- A staff member failed to attend a scheduled appointment.

The focus of frontline resolution is to take action to resolve the complaint as quickly as possible. This may take the form of an immediate resolution, quick apology or explanation for service failure where this is evident.

People receiving complaints should consider the following four key questions:

- What is the complaint?
- What does the service user wish to achieve by complaining?
- Can an explanation be provided that answers the complaint?
- If the person is unable to resolve the issue, do they know where to refer the complaint on to?

Frontline resolution should be completed within 5 working days.

These complaints should be recorded along with the date of receipt, nature of the complaint and date of resolution or response.

Investigation

Not all complaints are suitable for frontline resolution and not all complaints will be resolved at this stage, with some requiring further investigation.

For issues that have not been resolved and that are complex, serious or high risk, a thorough investigation of the points raised will be undertaken.

Responses will be signed off by the Head of Service or a senior manager who has this function delegated to them by the Head of Service. Each Head of Service will ensure that information gathered from complaints about their area of responsibility will be used to improve services.

Examples of issues suitable for investigation:

- Frontline resolution was attempted, but the service user remains dissatisfied
- The service user refuses to engage with the frontline resolution process
- The issues raised are complex and will require detailed investigation
- The complaint relates to issues that have been identified as serious or high risk/high profile
- Involves major delays in service provision or repeated failure to provide a service

Complaints handled by investigation are typically those that are complex or require a certain amount of examination to establish the relevant facts before the service provider can state their position.

The investigating officer will prepare a response that will be:

- Open and honest
- Explain the nature of the investigation undertaken
- Address all the issues raised
- Offer an apology in appropriate circumstances
- Identify the actions taken to prevent a recurrence where appropriate
- Invite the person to make further contact if they remain unhappy

A leaflet will be enclosed with any outcome letter to the complainant detailing the next stage of the complaints process.

The Complainant should be offered the opportunity to discuss the outcome of the investigation for clarity if they wish.

Complaint Review Committee – Social Work Complaints only

If the complainant is dissatisfied with the response to their complaint, they can appeal the outcome of the investigation to the Complaints Review Committee (CRC).

The CRC is made up of a panel of 3 independent persons to Inverclyde Council. These panel members are responsible for reviewing the evidence presented in an objective and independent manner and to offer an opportunity for the complainant to present and discuss their case. The CRC also enables the Chief Social Work Officer or Head of Service to make a case on behalf of the Service.

The complainant must request a review by CRC in writing within 28 days of receiving the complaint investigation response.

The Complaints Review Committee must meet within 56 days of having received the appeal. The Complaints Review Committee will forward a response to the Chief Executive of Inverclyde Council outlining its outcome and if necessary any recommendation and remedial action to be taken if the complaint outcome is overturned.

The role of the Complaints Review Committee is to objectively and independently examine the facts of the complaint. Although the Complaints Review Committee can express disagreement with policies, priorities, resources and professional judgment it only has the

power to make recommendation to the appropriate local authority committee. It is the local authority committee which effectively takes the final decision on the complaint.

The Local Authority must within 42 days of receiving the recommendations notify the complainant in writing about what actions it intends to take in response to the Complaints Review Committee recommendations. The Chief Executive will provide a written outcome to the Complainant.

Once the above processes have been completed, if the complainant is still not satisfied, the complaint can be raised with the Scottish Public Services Ombudsman.

Review by the Scottish Public Services Ombudsman (SPSO)

Both organisations within the HSCP are required to inform complainants of the role of the SPSO in reviewing a complaint if the complainant is dissatisfied with the outcome of an investigation.

When the complaint procedure has been exhausted and a final outcome provided, the complainant will be advised in writing of their right to seek independent review of the complaint by the Scottish Public Services Ombudsman. The SPSO is not normally able to investigate matters where the issue raised is over 12 months old.

Complaints Involving Multiple Services or Agencies

Where a complaint concerns another Partnership, or the Acute Services Division as well as Inverclyde HSCP, it is anticipated that each Partnership/Division will investigate the matters relating to its services but the Chief Officer, or other appropriate officer, will sign off a combined response.

The weighting of the complaint will determine which department will take the lead for coordination of the written response.

Complaints about Commissioned Services

Anyone receiving a registered care services commissioned by HSCP has the right to complain either directly to the Care Inspectorate or to Inverclyde Health and Social Care Partnership (HSCP).

In line with good practice, the Care Inspectorate and the HSCP encourage complainants to make contact with the service, care agency or provider in an attempt to resolve the issue quickly in the first instance.

When a complainant contacts only the HSCP about a commissioned service, the HSCP will contact the provider and agree with them an appropriate investigation and action, and will notify the Care Inspectorate of the complaint.

The Care Inspectorate's contact details can be found on their website:
http://www.scswis.com/
or: telephone 0845 600 9527
fax 01382 207 289
complete an online complaints form at http://www.scswis.com, or
email enquiries@careinspectorate.com

What Cannot be Considered

- Any complaint about private care and treatment or services including private dental care or privately supplied spectacles.
- A complaint about an Independent Contractor such as a GP or NHS Dentist – there are separate complaints procedures, displayed within the Practices.
- A complaint about services not provided or funded by the local authority or NHS.
- A complaint about another NHS body or for an NHS service that is not the responsibility of the Health and Social Care Partnership (e.g. acute inpatient services for general medicine or surgery).
- Any complaint that is being or has been investigated by the SPSO.
- Any complaint about which a complainant has stated in writing that they intend to take legal action.
- Any complaint that has already been investigated under the current or a former complaints procedure.

Unacceptable Behaviour by Complainants - Persistent and Unreasonable Complaints.

The HSCP is committed to dealing fairly, appropriately and consistently with all complaints and believes that complainants should have the right to be heard, listened to and understood and be treated with respect and dignity. They should not experience disadvantage as a result of expressing dissatisfaction with a service or making a complaint. Each complaint will be treated by the HSCP on an individual basis and on its own merit. However the HSCP believes that respect should also be afforded to its employees.

It is acknowledged that people may act out of character in times of distress.

Complainants who behave in an angry, aggressive, demanding or persistent manner in their pursuit of a complaint, may be viewed by the HSCP as unreasonable. The HSCP will aim to manage this behavior under the respective “Management of Violence and Aggression” (NHSGG&C) or “Violence to Staff” (Inverclyde Council) Policies.

Complainants may be deemed as being unreasonably persistent or vexatious in their actions and the HSCP reserves the right to restrict or alter the contact the complainant has with its employees.

If it is viewed that a complainant is acting in an unreasonable manner, this will be discussed with the Head of Service with responsibility for Quality and Development who will liaise with the appropriate parent organisations, HSCP Chief Officer and Local Authority Legal Services to determine the appropriate action to be taken.

In relation to Social Work Complaints procedures, Inverclyde Council’s Legal and Administrative Services will be responsible for advising and reporting to the Complaint Review Committee (CRC) of instances of unreasonable or repetitive complainants and the decision to manage such behavior in a particular way.

If it is deemed that the complainant is acting in an unreasonable manner, they will be formally advised of this in writing and informed that their complaint should be referred to the Scottish Public Services Ombudsman (SPSO) to review the decision.

The HSCP reserves the right to seek arbitration by the SPSO in any future or ongoing dispute with such complainant(s).

Further complaints from an individual deemed to be unreasonable or repetitive will be carefully screened and reviewed to ensure that no new issues are expressed which might require a separate investigation and response before a decision not to act is taken.

Role of the Investigating Officers

Each HSCP service has trained Investigating Officers. Their primary role is to communicate with complainants where appropriate, process complaints and support managers in responding to complaints.

The HSCP has a role to develop and oversee the complaints process including:

- Providing a central point for receipt of complaints, coordination of timed responses and supporting staff with complex complaints.
- Ensuring appropriate arrangements are in place for tracking and monitoring of complaints and responses.
- Monitoring and analysing themes from complaints and feeding trends into the quality improvement process.
- Development of relevant training and guidance notes for staff.
- Production of an Annual Review Report in respect of complaints.

Monitoring, Governance and Improvement

Complaints received by the HSCP should be logged within one working day onto the Complaints System by the Complaints Administration Officer. All complaints information should be handled in a way that satisfies Data Protection requirements, with staff being trained and aware of the expectations of the public in respect of their personal information.

Information recorded about complaints (both informal and formal) should, as a minimum include:

- The category and nature of the complaint.
- The service area complained about.
- In what way the complainant wishes the complaint to be handled – frontline resolution or investigation.
- What action was taken to resolve the complaint.
- Whether the service user was satisfied with the outcome.

Where necessary an appropriate investigating officer will be identified by the Head of Service and they will be responsible for completing an investigation and writing a draft response outcome letter to be issued to the Head of Service for consideration within 15 working days of receipt of the complaint.

A copy of the joint open complaints register will be issued to Senior Managers on a weekly basis for overview and monitoring.

If an extension to the response time is required, the complainant should be actively and positively engaged with to reach mutual agreement of an amended date. This should be recorded in the joint complaints register and respective complaints management systems.

All complaints activity and learning opportunities are monitored through the HSCP Clinical and Care Governance process.

Regular reporting of complaints will be made in quarterly service reviews, with the content being viewed and used to improve service delivery.

The complaints handling process should ensure a culture within the organisation that values and learns from complaints.

Learning from Complaints

As an integral part of the HSCP Quality Assurance and audit processes, all complaints are used as a method of public experience feedback about service delivery and engagement. Issues, themes or patterns of complaints are used as opportunities to share learning. In doing so, the HSCP demonstrates its commitment to continuous development and performance of its services as well as preventing future recurrence of issues.

A service improvement or learning action plan should be completed by the designated investigating officer to identify areas of practice which:

- contributed to the complaint being raised or
- prevented effective working or engagement, leading to the complaint.

Elements of the complaint should be analysed by the investigating officer to identify any improvements in practice, process or behaviour required to prevent a similar experience or occurrence in the future.

The Investigating officer should forward the completed learning and improvement plan to the Head of Service and Service Manager for comment and action. A copy of the action plan should then be forwarded to the Quality and Development Service to identify themes and trends from complaints across all sections of the organisation.

The identified learning will be cascaded by the Head of Service or Service Manager to staff to ensure performance or quality improvement as appropriate to the circumstances in such forums as:

- Management meetings;
- Team meetings;
- Quarterly Service Reviews;
- Clinical & Care Governance meetings;
- Individual, One to One / Supervision sessions;
- In-house service training or development events;
- Appraisals.

The Quality and Development Service will report progress and completion of the plans to the Chief Officer and Heads of Service as required and produce an Annual Complaints Report for the Integration Joint Board.

Further information is available on the following links:

Links to NHS Complaints procedurehttp://www.staffnet.ggc.scot.nhs.uk/Corporate%20Services/Complaints/Pages/NHSComplaints.aspx

Links to Social Work (Representation & Procedures) (Scotland) Directions 1996
www.scotland.gov.uk/Publications/2011/12/21143818/1

AGENDA ITEM NO: 9

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**26th January 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/05/2016/DG**
Contact Officer:	**Deborah Gillespie Head of Service Mental Health, Addictions & Homelessness**	**Contact No:**	**715284**
Subject:	**INVERCLYDE ALCOHOL AND DRUG PARTNERSHIP'S ANNUAL REPORT (SELF-ASSESSMENT) 2014/15**		

1.0 PURPOSE

1.1 To advise the Integration Joint Board of the Inverclyde Alcohol and Drug Partnership's Annual Report (Self - Assessment) for the period 2014/15.

1.2 To inform the Board of key areas of progress over 2014/15 and areas of focused development for the Alcohol and Drug Partnership (ADP) in 2015/16.

1.3 To ask the Board to note details of the ADP's performance framework and benchmarking report, which form part of the Scottish Government's performance monitoring arrangements for assessing the partnerships progress towards meeting National Outcomes for ADPs.

1.4 To advise the Integration Joint Board of direction from Scottish Government which requires that ADPs have arrangements for linking into local decision-making processes including Health and Social Care Partnerships.

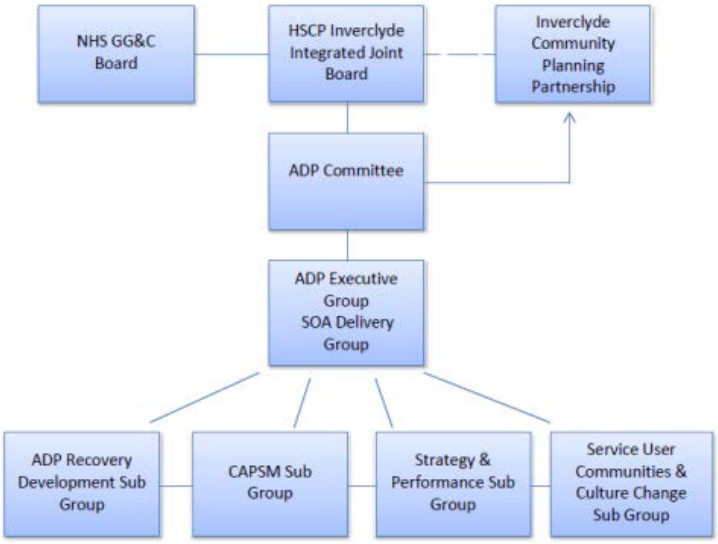
1.5 To raise awareness of alcohol and drug issues informing local priorities, ensuring strategic and delivery plans for alcohol and drug outcomes are embedded within integrated Health and Social Care arrangements.

2.0 SUMMARY

2.1 The work of the ADP is directed by the commitments outlined within the ADP Delivery Plan. The Plan provides details of arrangements for meeting priorities within the context of ADP National Outcomes, Ministerial Priorities for ADPs (set by Scottish Government) and local priorities. The Plan provides the focus for partnership working across Inverclyde ADP partners. This work is monitored by the ADP performance framework.

2.2 Inverclyde ADP's governance arrangements provide a framework within which the alcohol and drug policy agenda can be taken forward. This framework provides a mechanism for linking with wider planning structures including the Community Planning Partnership (CPP) and Health and Social Care Partnership (HSCP). The structure has been reviewed over the past few years as the ADP partnership has

evolved to better reflect identified need and the range of activities undertaken. The ADP Executive group has a dual function acting also as a Single Outcome Agreement Delivery Group for alcohol within the Community Planning Partnership.
Inverclyde ADP is a specific client planning group within the Inverclyde HSCP governance arrangements. The ADP reports to the HSCP Integrated Joint Board.
Figure 1 ADP Governance Structure



(CAPSM: Children Affected by Parental Substance Misuse)

2.3 The annual report provides an update on the ADP's progress towards meeting the ADP Delivery Plan commitments including reporting on performance against targets within the ADP performance framework.

2.4 The annual report identifies the ADP priorities for further development in 2015/16. The five key commitments for 2015/16 following this self-assessment have been identified as:

1. Continue to embed Recovery Orientated Systems of Care (ROSC) across services.
2. Implementing National Quality Standards for Drug and Alcohol Services.
3. Implementation of the new National Drug and Alcohol Information System (DAISy).
4. Reduce drug related deaths.
5. Workforce development.

3.0 RECOMMENDATIONS

3.1 That the IJB note the ADP Self-Assessment (Annual Report) for 2014/15.

3.2 That the IJB note the progress of the ADP across the self-assessment criteria and take cognisance of areas for future development within the self-assessment criteria including priority areas for development in 2015/16.

3.3 That the IJB note the ADP performance reporting across ADP outcomes and the action being undertaken across partners to work towards meeting targets and outcomes.

Brian Moore
Corporate Director
(Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The Scottish Government's governance framework for Alcohol and Drug Partnerships is outlined within '*Updated Guidance for Alcohol and Drug Partnerships on Planning and Reporting Arrangements (Scottish Government July 2015)'*. This details the reporting requirements which support the embedding of outcomes based planning and reporting at a local level, helping ADPs to self-assess their performance (including benchmarking against other ADPs) and to articulate their contribution to their local SOA/health and social care plans in supporting joint improvements. This also contributes to a national picture of our overall progress in supporting alcohol and drug prevention, treatment and recovery.

4.2 Alcohol and Drug Partnerships are asked to evidence their delivery, activities, and progress against a range of themes within an Analyse, Plan, Deliver and Review framework. The self-assessment process includes a traffic light coding system (RAG score) to rate performance where: *RED* – reflects not yet started or being considered for the future. *AMBER* – reflects work in progress but not yet completed or still some development needed. *GREEN* - indicates work either completed or a pattern of work fully established to the ADP specification and now an on-going piece of work which includes further enhancements.

4.3 Of the 20 assessment themes which were subject to RAG scores, no theme was assessed as having a RED RAG score and ten areas had AMBER and GREEN RAG scores.

Areas with **Green** RAG scores included progress across the following themes:

- An ADP joint strategic needs assessment process is in place.
- An outcomes based ADP Joint Performance Framework is in place.
- We have a shared vision and joint strategic objectives for people affected by problem substance use, and our work is aligned with our local partnerships, e.g. child protection committee, violence against women, community safety, and prevention programmes including with education.
- Our planned strategic commissioning work is clearly linked to Community Planning and local integrated health and social care plans.
- Service Users and carers are embedded within the partnership commissioning processes.
- We adhere to statutory requirements regarding Equality Impact Assessments.
- We can evidence a range of prevention, treatment, recovery & support interventions (including early intervention) commissioned by the ADP which have been delivered in the reporting period.
- A schedule for service monitoring and review is in place, which includes statutory provision.
- We evidence that the ADP and partners are contributing to delivery of a whole population approach for alcohol.

4.4 Areas with an **Amber** RAG scores included areas of work which continue to be progressed across the following themes:

- Integrated Resource Framework Process: Requires broader capture of finance information across partner agencies. An integrated resource framework across all partner agencies requires development.
- A person centered recovery focus has been incorporated into our approach to strategic commissioning. Our Recovery Orientated System of Care (ROSC) is in development.
- We are working to deliver Joint Workforce plans which are based on the needs of our population, as outlined in 'Supporting the Development of Scotland's Alcohol and Drug Workforce' statement. We are being supported by the Scottish Drugs Forum (Workforce Development Team) to take this work forward.

- We continue to develop support to communities across a range of dimensions: prevention of developing problem alcohol/drug use; community safety including violence against women, and reducing reoffending where substance misuse is a feature; collaborating with interventions for children affected by parental substance misuse; and supporting people in moving on from treatment and care services for ongoing recovery (e.g. self-directed support, mutual aid/recovery communities).
- The ADP Delivery Plan is reviewed on a regular basis, which includes a review of the provision of prevention activity, recovery, treatment and support services (ROSC).
- Progress towards outcomes focussed contract monitoring arrangements being in place for all commissioned services.
- Service Users and their families play a central role in evaluating the impact of our statutory and third sector services.
- The ADP is working towards setting in place a framework for a quality assurance system which governs the ADP and evidences the quality, effectiveness and efficiency of services within the framework of requirements of the *National Quality Principles: Standard Expectations of Care and Support in Alcohol and Drug Services.*
- The ADP is working towards meeting the recommendations from the Independent Expert Review of Opioid Replacement Therapies in Scotland.

4.5 Performance Framework:

The ADP performance framework links ADP national and local outcomes with indicators and targets and includes benchmarking with National data and other ADPs within NHS Greater Glasgow and Clyde. The performance framework also illustrates the range of actions undertaken across the seven National ADP Outcomes.

4.6 Drug and alcohol issues within Inverclyde are profound and pervasive and benchmarking gives some indication of this across a number of key reporting areas. The performance framework provides a mechanism for measuring the impact of actions undertaken to address the impact of alcohol and drug misuse and to support prevention strategies. The ADP continues to work on identifying meaningful targets across all indicators.

4.7 A sample of performance against targets met and those where the target was not met are provided below:

Targets met:

- Reduced Alcohol related hospital admissions
- Reduced Alcohol related mortality
- HEAT target for alcohol and drug services waiting times –waiting three weeks or less for treatment
- Increased referrals with acute liaison services for alcohol and drug
- Increasing reach to these needing drug services demonstrating an increased referral rate
- Decrease in prevalence of injecting among those in drug services
- Retention of people in treatment demonstrated by the increase in the number of problem drug users still in treatment 3 months after treatment commencing
- A reported reduction in mean number of units of alcohol consumed by young people who are weekly drinkers (15 years) – SALSUS
- HEAT Target for delivery of alcohol brief Interventions has been met.
- All ADP Partner agencies have had access to training on New Psychoactive Substances
- Reduction in the number of Domestic Fires where alcohol/drug is suspected to be a contributory factor including where there were casualties or fatalities
- % of people perceiving rowdy behaviour very/fairly common in neighbourhood lower than national level
- Number of licensed premises in force per on trade, off trade and personal

licenses in force per 10K population, is lower than national rate

ADP targets were not met across the following indicators:

- Drug related hospital admissions
- Drug related mortality, i.e. drug deaths
- The estimated prevalence of problem drug use
- Percentage of 15 year old pupils who have used illicit drugs in the last month or last year
- Proportion of 15 year olds drinking on a weekly basis
- Criminal Offences: Numbers of serious assaults, vandalism, breach of the peace

4.8 Actions to Address Ministerial Priorities:

The ADP funding allocation letter for 2015-16 outlined a range of Ministerial priorities and asks ADPs to describe in the annual report their measures for delivering these during 2015/16. Ministerial priorities and our commitments to deliver these are as follows:

- *Implementing improvement methodology, including implementation of the Quality Principles: Care and Support in Drug and Alcohol Services and the recommendations outlined in the independent expert group on opioid replacement therapies (ORT).*

We will continue to analyse our practice and develop service responses in partnership with users and other partners. We will embed 'Outcome Star' and relevant outcome measurement tools to assure performance measurement. We will manage risk in relation to ORT, promote alternative treatments to methadone and place recovery at the heart of all service provision. We will continue to support and promote our Intensive Family Response Service to address whole family needs and support training and development of Addiction staff.

- *Improving data compliance with the Drug and Alcohol Treatment Waiting Times Local Delivery Plan (LDP) Standard, including, increasing the level of fully identifiable records submitted to the Drug and Alcohol Treatment Waiting Times Database (DATWTD). Increasing compliance with the Scottish Drugs Misuse Database.*

We will work effectively to ensure that targets are met in respect of DATWTD. We will ensure full staff capacity and the development of low threshold approaches to access care. We will ensure that all relevant staff are trained and supported to ensure efficient and effective recording and practice.

- *Preparing local systems to comply with the new Drug & Alcohol Information System (DAISy) which is expected to be operational by Autumn 2016.*

All staff involved in delivery will be trained and supported to use the new system. We will refine our processes and maximise the effectiveness of organisational information systems.

- *Ensuring a proactive and planned approach to responding to the needs of prisoners affected by problem drug and alcohol use and their associated through care arrangements.*

We will implement the NHS GG&C Prison Healthcare New Substance Misuse Strategy which includes a recovery focused model for delivery of substance misuse services including bespoke Addiction Nurse Service in SPS. The Persistent Offenders Partnership [POP] will continue to work into prisons. Throughcare Support Officers Services will continue to work across NHS services in prison and the community to support suitable release plans including arrangements with GP

prescribers and support services being in place prior to release from custody.

- *Compliance with the Alcohol Brief Interventions (ABIs) Local Delivery Plan (LDP) Standard.*

We will deliver extensive training, modify reporting systems and support effective reporting of ABIs.

- *On-going implementation of a Whole Population Approach for alcohol: recognising harder to reach groups, supporting a focus on communities where deprivation is greatest.*

We will sustain our existing comprehensive input to all school aged children in Inverclyde. We will continue to engage with our community in respect of alcohol awareness and education and develop further our input to people who are homeless and to prisoners.

- *ADP engagement in improvements to reduce alcohol related deaths.*

We will continue to develop services which prevent and divert people from dangerous consumption and ensure effective services for those who require them.

- *Increasing the reach and coverage of the national naloxone programme and tackling drug related death.*

We will support the development of alternatives to methadone and promote and sustain our significant recovery developments including the wider coverage of Naloxone uptake.

- *Improving identification of, and preventative activities focused on, new psychoactive substances (NPS).*

We will deliver tailored inputs to every school which highlight the risks attached to NPS. We will deliver bespoke training on NPS. We will continue to monitor NPS impact upon statutory services linking actively with the Drug Trend Monitoring Group.

5.0 IMPLICATIONS

FINANCE

5.1 Financial Implications: None

One off Costs

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

Annually Recurring Costs/ (Savings)

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

LEGAL

5.2 There are no legal issues within this report.

HUMAN RESOURCES

5.3 There are no human resources issues within this report.

EQUALITIES

5.4 There are/are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
No	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.

6.0 CONSULTATION

6.1 The ADP Annual Report is produced in collaboration with partners and is approved by the ADP Committee.

7.0 BACKGROUND PAPERS

7.1 **Inverclyde HSCP ADP Annual Report**
http://www.inverclydeadp.org.uk/GetAsset.aspx?id=fAAzADMAOQA2ADIAfAB8AEYAYQBsAHMAZQB8AHwANgAxAHwA0

Changing Scotland's Relationship with Alcohol: A Framework for Action, March 2009: http://scotland.gov.uk/Publications/2009/03/04144703/0

The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem, May 2008: http://www.scotland.gov.uk/Publications/2008/05/22161610/0

Scottish Government (2014) Updated Guidance for Alcohol & Drug Partnerships (ADPs) on Planning & Reporting Arrangements 2014-15. Available from : http://www.gov.scot/Resource/0045/00453380.pdf

Delivering Recovery - Opioid Replacement Therapies in Scotland-Independent Expert Review. Scottish Government 2013.
http://www.gov.scot/Publications/2013/08/9760

Supporting the Development of Scotland's Alcohol and Drug Workforce: Scottish Government 2010. http://www.gov.scot/Publications/2010/12/AandD

The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services: Scottish Government 2014.
http://www.gov.scot/Publications/2014/08/1726

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**26th January 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/08/2016/HW**
Contact Officer:	**Helen Watson Head of Service Planning, Health Improvement & Commissioning**	**Contact No:**	**715285**
Subject:	**FREEDOM OF INFORMATION ANNUAL REPORT**		

1.0 PURPOSE

1.1 The purpose of this report is to inform Integration Joint Board Members of the number, themes and sources of Freedom of Information requests from October 2014 to November 2015, and our performance with regard to response timescales.

2.0 SUMMARY

2.1 The Freedom of Information (Scotland) Act 2002 (FOISA) came into force on 1st January 2005. The Act provides a statutory right of access to information held by Scottish public bodies and requires us to respond appropriately to requests for information made under the terms of the Act. Responses should normally be completed and issued within 20 working days of receipt of the request. Information is available through the Council and NHS Board's Publication Schemes, located at www.inverclyde.gov.uk and www.nhsggc.org.uk . Requests for access to information can be made by anyone, whether resident in the UK or not, and can be made for information held prior to enactment of the Act. The right of access to information is subject to a number of exemptions within FOISA.

2.2 During the year from 1st October 2014 to 30th November 2015, we received 200 requests under the terms of the Act, and of these 195 (98%) were responded to within 20 working days.

3.0 RECOMMENDATIONS

3.1 Board members are asked to review our Freedom of Information Annual Report, and comment as required.

Brian Moore
Corporate Director
(Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The Freedom of Information (Scotland) Act 2002 ('the Act') imposes a number of obligations on Scottish public authorities, including NHS Greater Glasgow and Clyde (NHSGG&C) and Inverclyde Council. The Act gives a general right of access to recorded information held by public authorities, subject to certain exemptions. The Act also imposes additional responsibilities:-

(a) to produce a Publication Scheme which is subject to approval by the Scottish Information Commissioner. Publication schemes are high level, strategic documents in which a public authority makes binding commitments to make information available to the general public. Such schemes:-

- provide clear evidence to the public that an authority is meeting its obligations under the Act to be accessible, open & transparent;
- enable the public to see what information is already published, and to access it without having to make a formal request for information;
- give employees clear guidance about the information that they can and should give out to the public so they can respond to information requests efficiently;
- help reinforce leadership messages about openness and accountability to staff at all levels in the organisation;
- are to be easily accessible and designed to be easy to understand and to use by everyone (including those with no internet access).

(b) to respond to requests (which must be in writing or some other permanent form) made by anyone for information held by the authority within set timescales (normally 20 working days) regardless of when it was created, by whom, or the format in which it is now recorded.

(c) to advise an applicant if information is not held.

(d) to specify within the terms of exemptions set out in the Act if the authority refuses to release the requested information.

(e) to charge for the provision of information only in accordance with regulations made under the Act and to decline to provide information if the cost of doing so exceeds a specified level.

(f) to make applicants aware of their right to seek a review of any decision on a request for information and of the right to pursue an appeal to the Scottish Information Commissioner if dissatisfied with the decision of the authority.

4.2 Given that the HSCP is part of both Inverclyde Council and NHSGG&C, there are two different processes in place. We have worked to streamline the system in that we receive FOIs through a central office and comply with the correct organisational procedure which in turn gives an overall picture of FOIs received. It is important to note that while there are slight variations in the detail of organisational processes, the legislation that covers both parent organisations is the same, as are the response timescale requirements.

5.0 REQUESTS RECEIVED

5.1 During the specified time-frame there were 200 FOI requests. Table 1 below outlines our performance in relation to timescales.

Quarter	*Total FOI Requests*	*Completed within Timeframe*	*Timeframe not met*
Oct - Dec 2014	41	41 (100%)	0
Jan - Mar 2015	40	39 (98%)	1
Apr - Jun 2015	46	45 (98%)	1
Jul – Sep 2015	40	38 (95%)	2
Oct – Nov 2015	33	21*	1

Table 1 – Performance in respect of timescales
**7 requests currently within timeframe for response.*

All of the above have come through the Council FOI system. Health requests are centrally co-ordinated at the Health Board, and generally relate to the whole Board area, rather than Inverclyde specifically.

5.2 Table 2 and Figure 1 provide a breakdown of the source of requests for information in respect of Freedom of Information. This shows the majority of requests came from individuals (28%), followed by requests from journalists and media organisations (22%).

Indicative source of request	**October 2013 – November 2014**	**October 2014 – November 2015**
Charity/Campaign/Voluntary organisations	15 (10%)	25 (13%)
Commercial organisations	30 (20%)	37 (19%)
Education/research	5 (3%)	10 (5%)
Journalist/Media organisation	31 (20%)	43 (22%)
Legal Organisations	5 (3%)	4 (2%)
Individuals	35 (23%)	56 (28%)
MSP/Scottish Parliament/other elected official	20 (13%)	24 (12%)
Other Public Body	12 (8%)	0 (0%)
Trade Union/Professional Representative body	0 (0%)	1 (<1%)
Total	**153**	**200**

Table 2 – Source of requests

Figure 1 – the chart below shows indicative source of requests from 2014 – 2015 alongside comparator data from 2013/14.

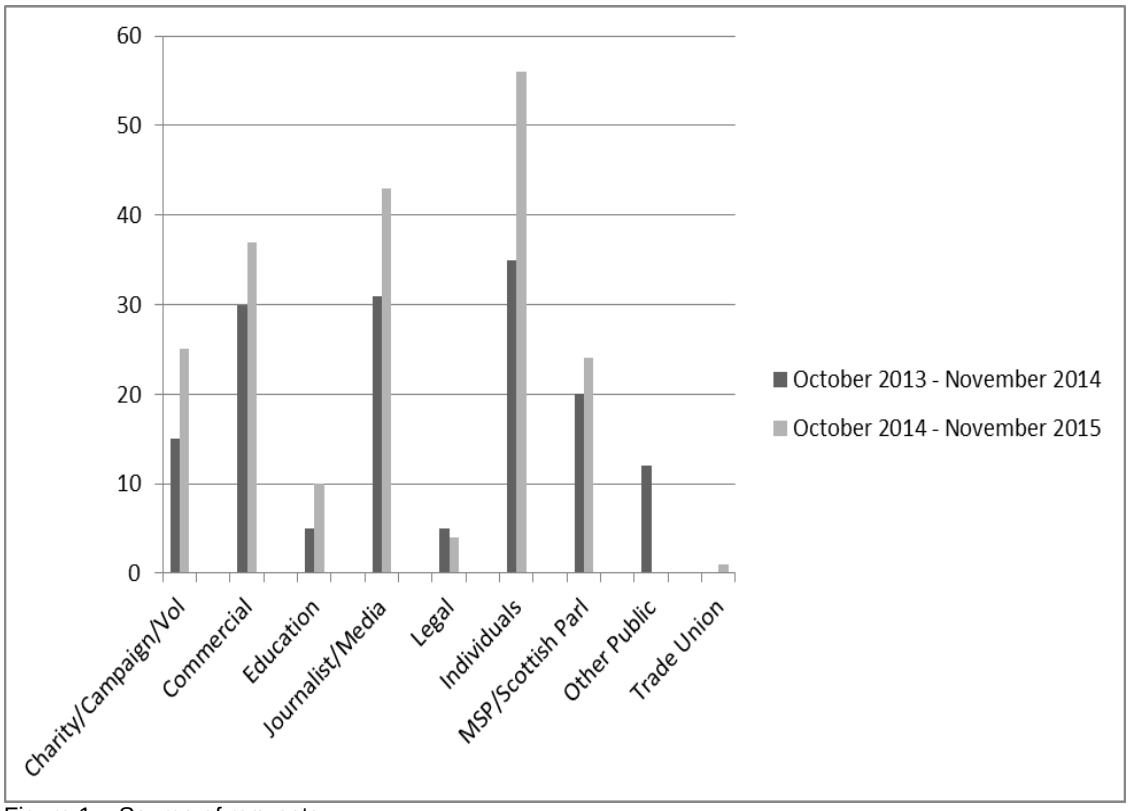


Figure 1 – Source of requests

5.3 The information shows a 24% increase in the number of FOIs received, going from 153 in 2013/14 to 200 in 2014/15. The increase is most notable in the amount of requests received from individuals, going from 35 in 2013/14 to 56 in 2014/15 which is an increase of 38%.

6.0 TYPE OF INFORMATION REQUESTED

6.1 A number of recurring themes were identified in the subject matter of requests for information. These are listed below together with a flavour of the detail of what was asked in relation to each key theme.

Themes	October 2013– November 2014	October 2014 – November 2015
Finance	9 (5%)	17 (9%)
Social Work Staffing	20 (13%)	16 (8%)
Adult Services – Social Care Fees/ Care Home Info.	25 (16%)	49 (24%)
Learning Disability Services	5 (3%)	4 (2%)
SDS Personalisation	1 (1%)	13 (6%)

Children & Families	59 (39%)	54 (27%)
Occupational Therapy	8 (5%)	2 (1%)
The Travelling Community	4 (3%)	2 (1%)
Housing & Homelessness	5 (3%)	11 (5%)
Criminal Justice	2 (1%)	6 (3%)
Mental Health & Addictions	4 (3%)	9 (5%)
Corporate Policies & Reports/ Complaints	10 (7%)	17 (9%)
Welfare/ Financial Advice Service	1 (1%)	0
Total	**153**	**200**

Table 3 – Themes of requests

Fig 2 – Themes are shown below between October 2014 – November 2015 along with comparator data from 2013/14, with detailed analysis showing an increase in FOI requests around Adult Services, with a reduction noted in respect of Children and Families.

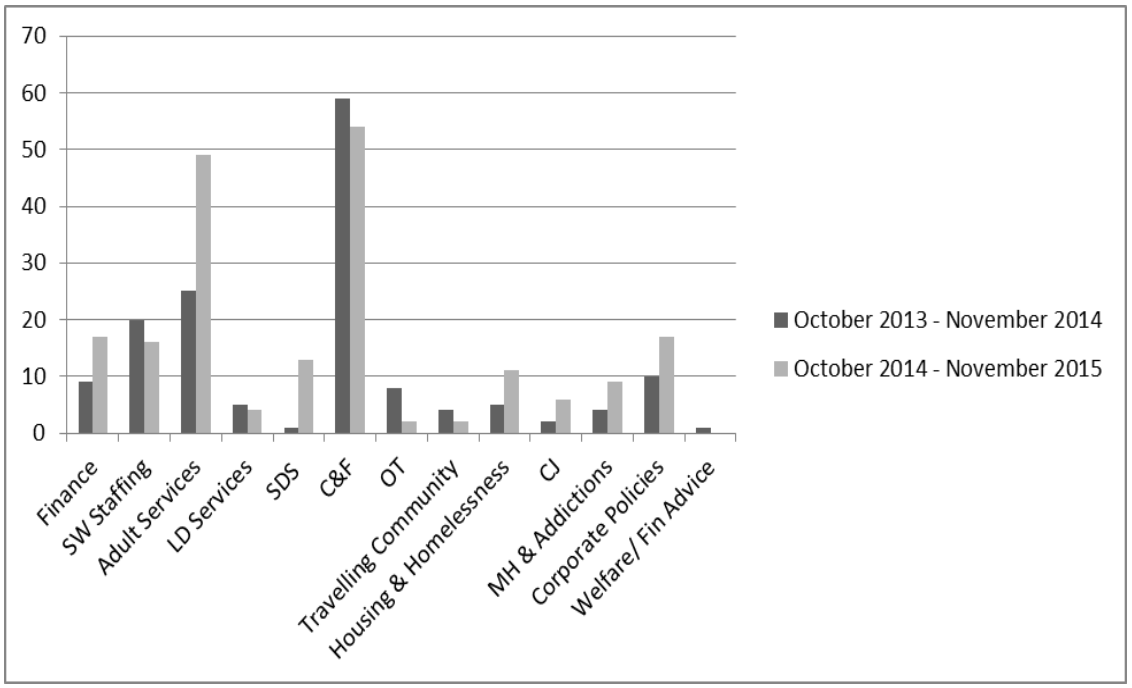


Figure 3 – Themes of requests

6.2 The biggest increases in relation to the themes are noted around information requests about Adult Services, SDS provision, Criminal Justice and Housing and Homelessness. We will review the information on the Publication Scheme relating to these aspects to see if it can be improved, to reduce the need for future FOI requests and responses.

7.0 CONCLUSION

7.1 Whilst we embrace the spirit of the Act, it should be noted that there is significant demand on staff with 200 requests from October 2014 to November 2015. We have issued 16 exemption notices during this period, these being in respect of time and financial limits as this would have involved an excessive amount of staffing resource including front line practitioner resource to gather and return the information. To date no applicant has requested information which has been deemed exempt due to staff time and resource, therefore no charge for information has been issued by Inverclyde HSCP.

7.2 The majority of requests to Inverclyde HSCP come from individuals, journalists and commercial organisations, which we seek to address by working with the corporate functions of the Council to further develop the Publication Scheme to help interested members of the public, and to reduce the amount of time required to respond to requests.

7.3 The Council has developed a Freedom of Information Working Group, which will:-

- Oversee the implementation of local guidance based on the Scottish Ministers Code of Practice on the discharge of functions by public authorities under the Freedom of Information (Scotland) Act 2002.
- Review current arrangements and make suggestions for better working and streamlining processes and consistency across the Council, in line with the commitments of the Council's Records Management Plan.
- Provide a forum for all staff with FOI remit to come together to share knowledge and expertise.
- Discuss the volume and types of requests received by the Council, and amend the Publication Scheme as indicated.
- Monitor significant changes in access legislation and update each other on developments in the law.
- Make recommendations relating to the legislation when necessary and/or appropriate.
- Discuss performance of FOIs.
- Report to the Information Governance Steering Group on progress.

7.4 Members are asked to note this updated report on the operation of the Freedom of Information (Scotland) Act 2002 within Inverclyde HSCP and give any comments or views on the format of the report or on any area with regard to the Act.

8.0 IMPLICATIONS

FINANCE

8.1 Financial Implications:

One off Costs

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

Annually Recurring Costs/ (Savings)

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

LEGAL

8.2 There are no legal issues within this report.

HUMAN RESOURCES

8.3 There are no human resources issues within this report.

EQUALITIES

8.4 There are no equality issues within this report.

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.

9.0 CONSULTATION

9.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP).

10.0 BACKGROUND PAPERS

10.1 None.

AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**26th January 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/06/2016/BC**
Contact Officer:	**Beth Culshaw Head of Health and Community Care**	**Contact No:**	**01475 715283**
Subject:	**Reshaping Care for Older People and Delayed Discharge Performance**		

1.0 PURPOSE

1.1 The purpose of this report is to advise the Integration Joint Board of progress in Inverclyde's performance in relation to Delayed Discharges, set in the wider context of the range of initiatives in place responding to the national strategy of Reshaping Care for Older People.

2.0 SUMMARY

2.1 The Delayed Discharge target reduced from 4 weeks to 2 weeks from April 2015. Local efforts to achieve this target are informed by the Reshaping Care for Older People strategy, with the overarching aim to provide integrated, planned, person-centred care close to or within people's own homes.

3.0 RECOMMENDATIONS

3.1 Members are asked to note the progress towards achieving the Delayed Discharge target and the ongoing work to maintain performance.

Brian Moore
Corporate Director (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 The 10 year strategy Reshaping Care for Older People - A Programme of Change 2011- 2021 and the subsequent refresh 'Getting On' (2013), set out the vision that "Older people in Scotland are valued as an asset, their voices are heard and older people are supported to enjoy full and positive lives in their own home or in a homely setting".

4.2 Our local intentions are contained in the Joint Strategic Commissioning Plan for Older People (2013) and associated delivery plan; the purpose being to promote involvement, empowerment, enablement and recovery-focused planning and delivery which shift the balance of care from residential to community-based services.

4.3 Change Fund monies were available for a three year period to March 2015. This funding enabled us to trial a range of initiatives to address the demographic challenges of an increasingly frailer, elderly population with the key aim of avoiding unnecessary hospital admission and promoting safe, effective discharge.

4.4 **Home First**

Partnership working across the HSCP and Inverclyde Royal Hospital has recently focussed on improving our discharge processes and is informed by the Joint Improvement team.

Team 'Home First' policy. Home First complements the Reshaping Care for Older People strategy by recognising that safe, effective care should wherever possible be provided in the community and that prolonged periods of hospitalisation can contribute to detrimental outcomes for older people. Wherever possible, we reduce the length of time older people spend in hospital and that, at discharge, older people return to their own home.

We continue to utilise and update our Home First Strategic Action Plan, which is monitored at the monthly Strategic Discharge meeting attended by senior managers of the HSCP and Inverclyde Royal Hospital.

There is robust evidence to support the effectiveness of early assessment and the diagnosis of frailty in older people. Within the hospital environment this approach can have major improvements in outcomes including: positive effects on mortality rates; reduction in readmissions and safe discharge of the individual back to their own home.

In November we held a joint workshop to consider the advantages of the comprehensive geriatric assessment model recently introduced to the Royal Alexandra Hospital, Paisley and how we might utilise resources to achieve this locally. This includes jointly developing the role and remit of the new Elderly Care Assessment Nurse (ECAN) who provides early assessment to older people in hospital in order to identify those who can be discharged home quickly and those who would benefit from rehabilitation within the Larkfield Unit, Inverclyde Royal Hospital.

4.5 **Review of specialist nurses**

We have undertaken a review of all specialist nurses with a remit around discharge based within Inverclyde. This has provided a greater clarity of roles and assisted us to establish processes which ensure appropriate access to information and services to support timely discharge. It is our intention to broaden the scope of this work within both Inverclyde Royal Hospital and the community to include other services supporting discharge such as:-

- Home Care

- Discharge Social Work Team
- Allied Health Professionals
- Care Home Liaison Nurses

4.6 **Delayed Discharges**

From April 2015 the target for Delayed Discharge, which had been in place since 2013, decreased from 4 weeks to 2 weeks. NHS Greater Glasgow and Clyde also reports on the number of bed days lost due to Delayed Discharges, as this provides a more complete picture of the impact of hospital delays (Appendix 1).

There is a proposal for a new target to discharge a higher proportion of patients within 72 hours of being ready for discharge. We have therefore started to measure the number of patients discharged within 72 hours of being ready.

Work with colleagues at Inverclyde Royal Hospital continues to demonstrate the effectiveness of early commencement of assessments regarding future care needs in achieving an appropriate, timely and safe discharge. The result is that the majority of individuals are assessed and discharged home as soon as they are deemed medically fit for discharge, including those requiring a home care package or residential care placement.

We have consistently achieved zero delays of more than 4 weeks since February 2015 and zero delays more than 2 weeks since April 2015. In November the census data showed that we again had no service users waiting longer than 14 days, with 4 service users awaiting support packages to be arranged.

This performance is set against a background of increasing referrals for social care and community supports following discharge. Between April and October 2015 we have received a 15% increase in referrals compared to the same period in 2014.

In common with other areas across Scotland, we continue to see an increasing number of emergency admissions with an overall reduction in the number of bed days occupied (Appendices 2 and 3). This performance indicates positive outcomes for service users who are returning home or moving on to appropriate care settings earlier and spending less time inappropriately in hospital.

4.7 **Step Up Beds (Intermediate Care)**

To further develop our range of community-based options to avoid unnecessary hospital admission, we have engaged with local care home providers to establish step up beds.

During this winter, we will utilise short term placements in care homes to provide 24 hour supervision and intensive rehabilitation. This offers an additional service which can respond at times of crisis where it is not practical for someone to remain at home but for whom hospital admission is not required. We will monitor the effectiveness of this service in reducing the number of emergency admissions to IRH.

Placements will be short term, and may be from as little as a few days up to a maximum of 6 weeks; thus focussing on recovery, reablement and rehabilitation, to enable a return home.

This service will be funded through existing budgets and use of the Integrated Care Fund to provide additional Allied Health Professionals capacity, including physiotherapy and occupational therapy.

Engagement sessions have taken place with providers and representatives of Scottish Care, and we will closely monitor activity over the winter to inform the future specification of the service. There is an intention then to begin a tender process which will enable the development of a 6-bed step up unit within a local care

home(s). The unit will allow provision of dedicated rehabilitation space and an environment focussed on equipping people to return home.

4.8 **Care Home Activity**

In recent years we have been monitoring the average length of stay of clients in care homes, and are pleased to report an ongoing reduction (Appendix 4). This reflects the changing demographic of the care home population; improved assessment and community resources have ensured that those admitted more recently have more acute needs reflecting a greater period of support whilst still in their own home.

4.9 **Providers Forums**

Inverclyde HSCP is committed to working in partnership with social care providers to ensure the best possible services are provided, and that mutually beneficial relationships are sustained with a range of Providers Forums now in place. Working in this way informed the recent development and introduction of the new Homecare Framework as well as the development of proposals relating to step up beds in care homes.

Feedback from providers demonstrates that they find the opportunity to get together in this way invaluable, not only for the information that they receive but also for the ability to network with other providers.

4.10 **My Home Life**

Local care home managers have participated in the 'My Home Life' leadership programme with support provided by Inverclyde HSCP and Scottish Care. This is a UK-wide initiative promoting quality of life for older people living and dying in care homes, and for those visiting and working with them, through relationship-centred and evidence-based practice. The programme highlights include: Improving health & healthcare; Sharing Decision-making**;** and Keeping the Workforce Fit for Purpose. This has also led to increased collaborative working, particularly with District Nurses and Care Home Liaison Nurses (CHLN).

4.11 **Role of Social Work Review Team and Care Home Liaison Nurses**

In March 2015 the HSCP set up a Long Term Care Social Work Review Team whose remit is to ensure regular reviews of residents within care homes, better liaison with care home managers and staff, and monitoring of the care and support residents funded by the HSCP receive. The review team works closely with the CHLN.

As well as offering professional nursing support to nursing homes within Inverclyde, the CHLN are involved in an exercise to review all admissions to hospital from long term care placements. The CHLN are assisting in identifying where admission may have been avoided as well as facilitating timely discharge.

4.12 **Integrated Care Plan**

Since April 2015 and the end of the Change Fund, we have developed our local Integrated Care Plan (ICP) which is supported by the associated Integrated Care Fund. Whilst not solely directed at older people, the themes within the plan continue to deliver on the Reshaping Care for Older People outcomes, and have widened to pay particular reference to individuals with long term conditions.

In particular, the focus continues to be on supporting older people to stay in their own homes for as long as possible by further developing supported self care, anticipatory care, reablement and access to Telecare. A full report on the progress of the ICP will be brought back to a future IJB meeting.

4.13 **Integrated Palliative Care Development Plan**

As part of the partnership approach to care of older people, we have developed a multi-agency Palliative Care Development Plan. This has led to a range of initiatives in line with the aim to embed palliative care in our day to day practice.

The Inverclyde GP Palliative Care Facilitator has led an initiative to increase awareness of palliative care services and support GPs in their care of patients. This has included visits to all local GP surgeries to foster links between the community and Ardgowan Hospice services. This has also led to providing each GP surgery with a copy of the Palliative Care Resource Packs which includes pharmacy advice and prognostication tools.

Following an educational needs assessment survey of local GPs in 2014, GPs are offered regular Palliative Care evening education sessions which include discussion around all these topics and again foster good team working and networking within Inverclyde.

The District Nursing Teams have supported the roll-out of the Supportive and Palliative Care Action Register (SPAR). This tool assists with recognition of deterioration in the health and wellbeing of palliative care patients.

All partners across Inverclyde have been encouraged to be involved in SPAR and this has been particularly successful within care homes and is now being rolled out to care at home services.

4.14 **Day Care Review**

Inverclyde Day Care Services were last fully reviewed in 2003 and it was recognised that a review was necessary in recognition of the ageing population, as well as policy directives such as the Reshaping Care for Older People agenda, Self-Directed Support legislation and the Inverclyde Joint Strategic Commissioning Plan for Older People.
A review of all day care provision for older people across Inverclyde is nearing completion. This will inform the future development of day services across both the HSCP and our partners.

4.15 **Reablement and Homecare**

Reflecting the complexity and increasing needs of our older population we continue to see increasing demands upon both our reablement and homecare services. Homecare is a high volume, complex service interfacing with over 1200 discreet service users each week, many several times per day, and given the need to meet fluctuations in demand has to be able to flex service delivery at short notice.

We are now seeing some consistency in the level of referrals to reablement at around 80 per month and, on average, achieving full independence for a third of these. If this performance continues it places us in a stronger position for the future. However, of the hours transferring, we continue to see increasing demand in both evening and weekend service delivery.

Additional pressure monies are being considered as part of the current process of budget proposals.

5.0 PROPOSALS

5.1 As outlined above, it is intended to continue to utilise the range of initiatives currently underway to achieve the objectives outlined in the Reshaping Care for Older People strategy with the implicit aim of maintaining and improving upon our current performance in relation to Delayed Discharges.

6.0 IMPLICATIONS

FINANCE

6.1 Financial Implications:

One off Costs

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

Annually Recurring Costs/ (Savings)

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

LEGAL

6.2 There are no legal issues within this report.

HUMAN RESOURCES

6.3 There are no human resources issues within this report.

EQUALITIES

6.4 There are no equality issues within this report.

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 CONSULTATION

7.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP).

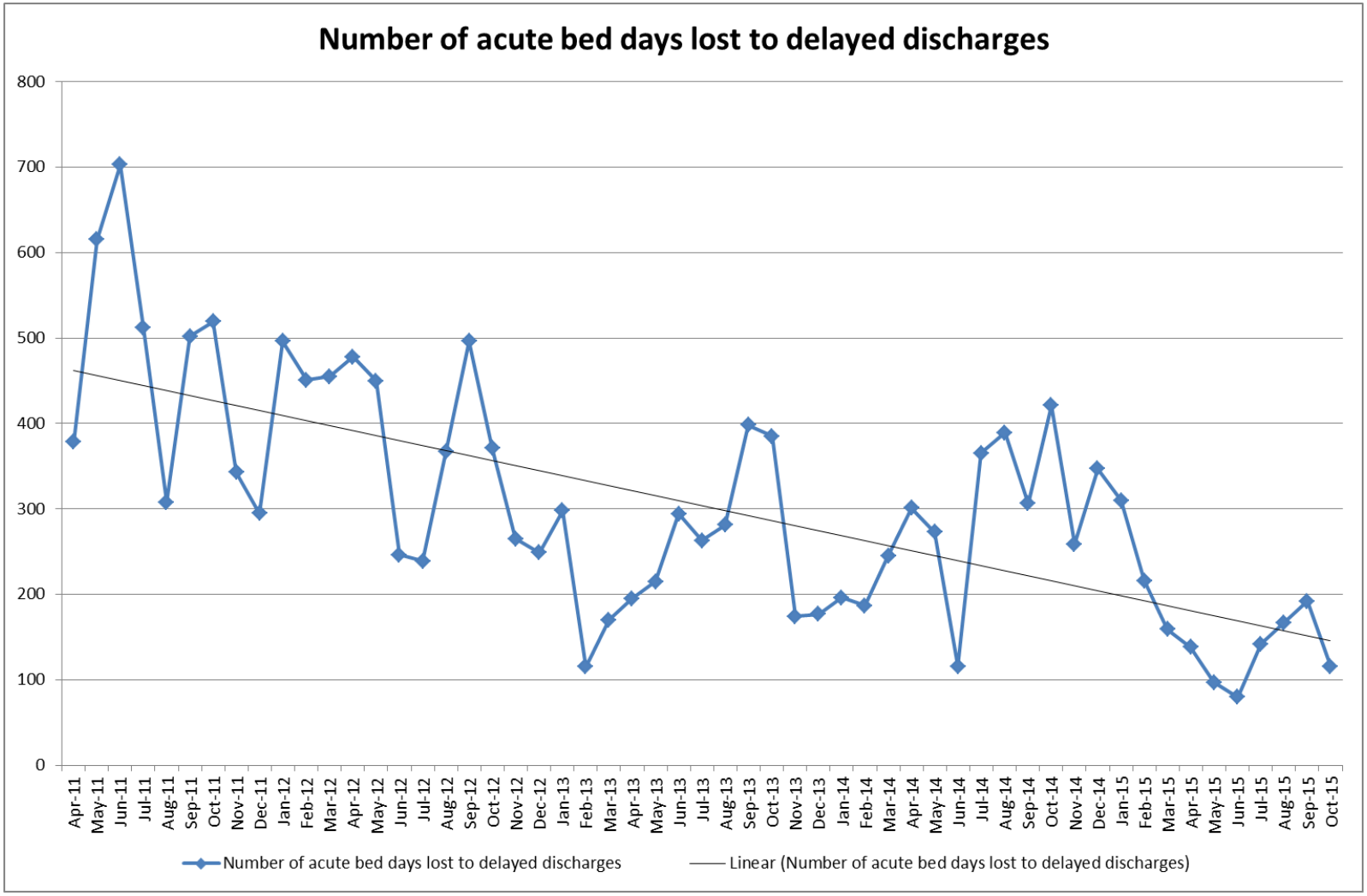
8.0 LIST OF BACKGROUND PAPERS

8.1 Reshaping Care for Older People Strategy – A Programme of Change 2011-2021.

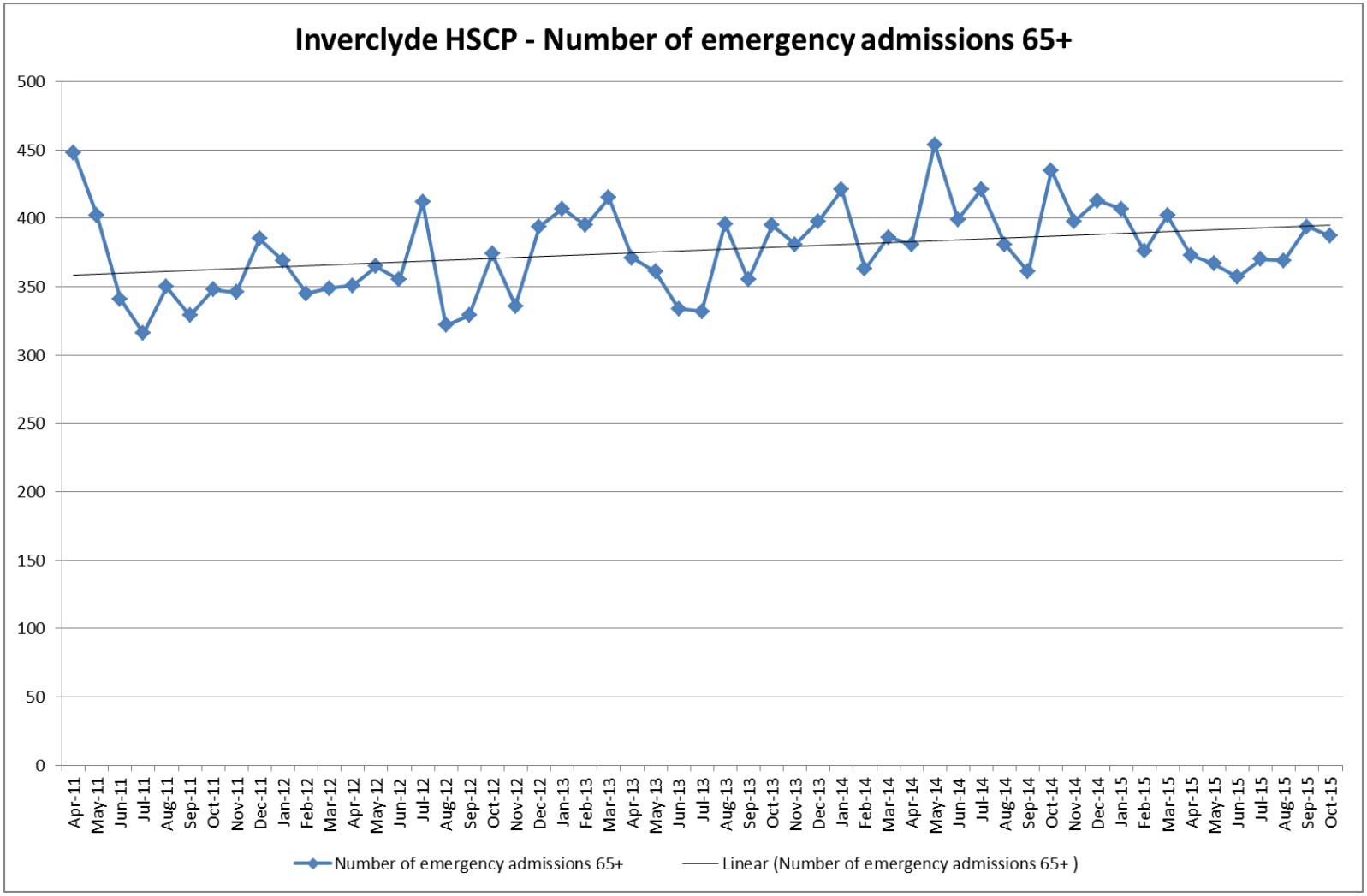
8.2 Reshaping Care for Older People Strategy – Getting On 2013.

8.3 Inverclyde Joint Strategic Commissioning Plan for Older People 2013.

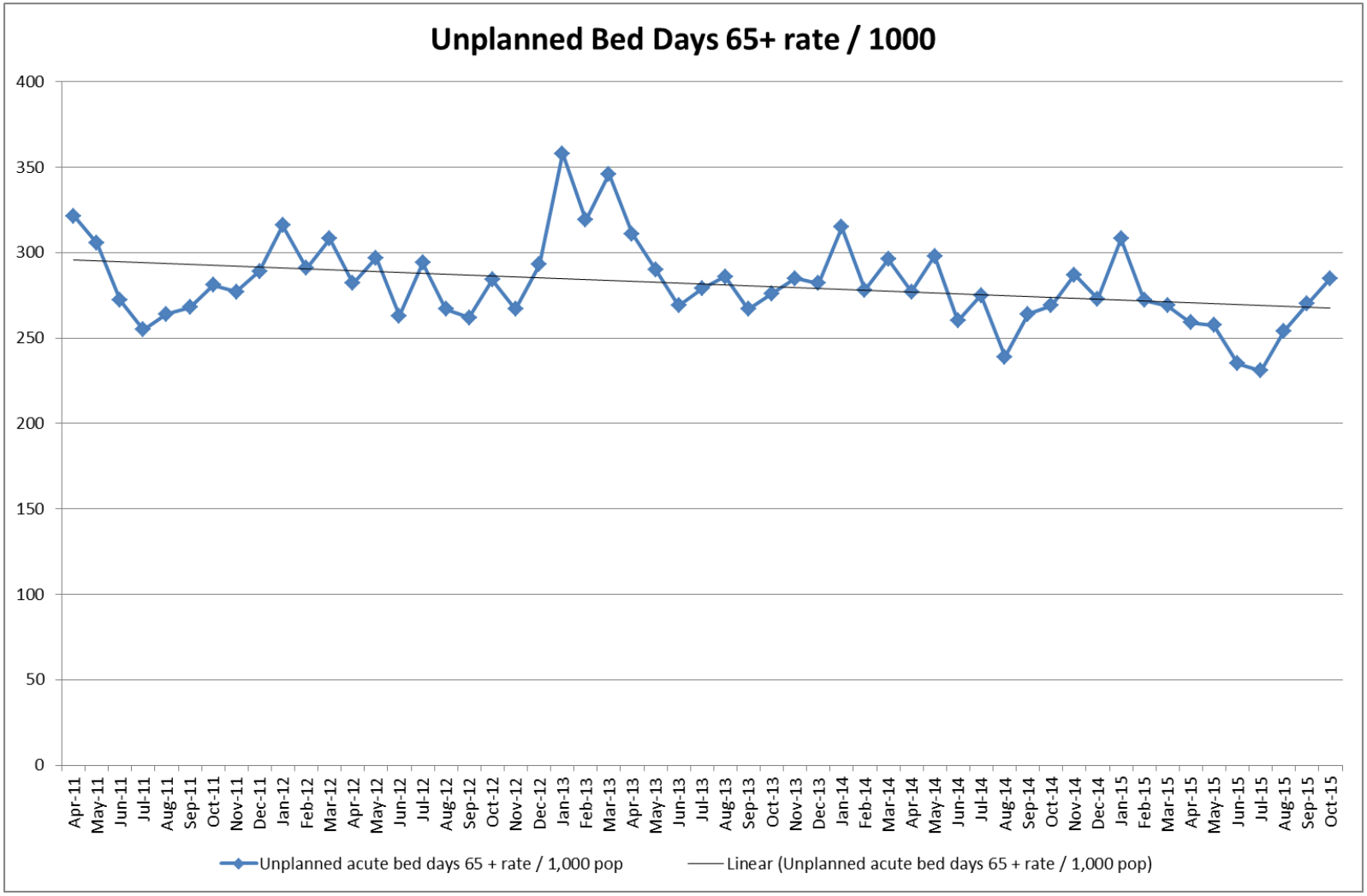
Appendix 1


Number of acute bed days lost to delayed discharges
800
700
600
500
400
300
200
100
0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Number of acute bed days lost to delayed discharges
Linear (Number of acute bed days lost to delayed discharges)

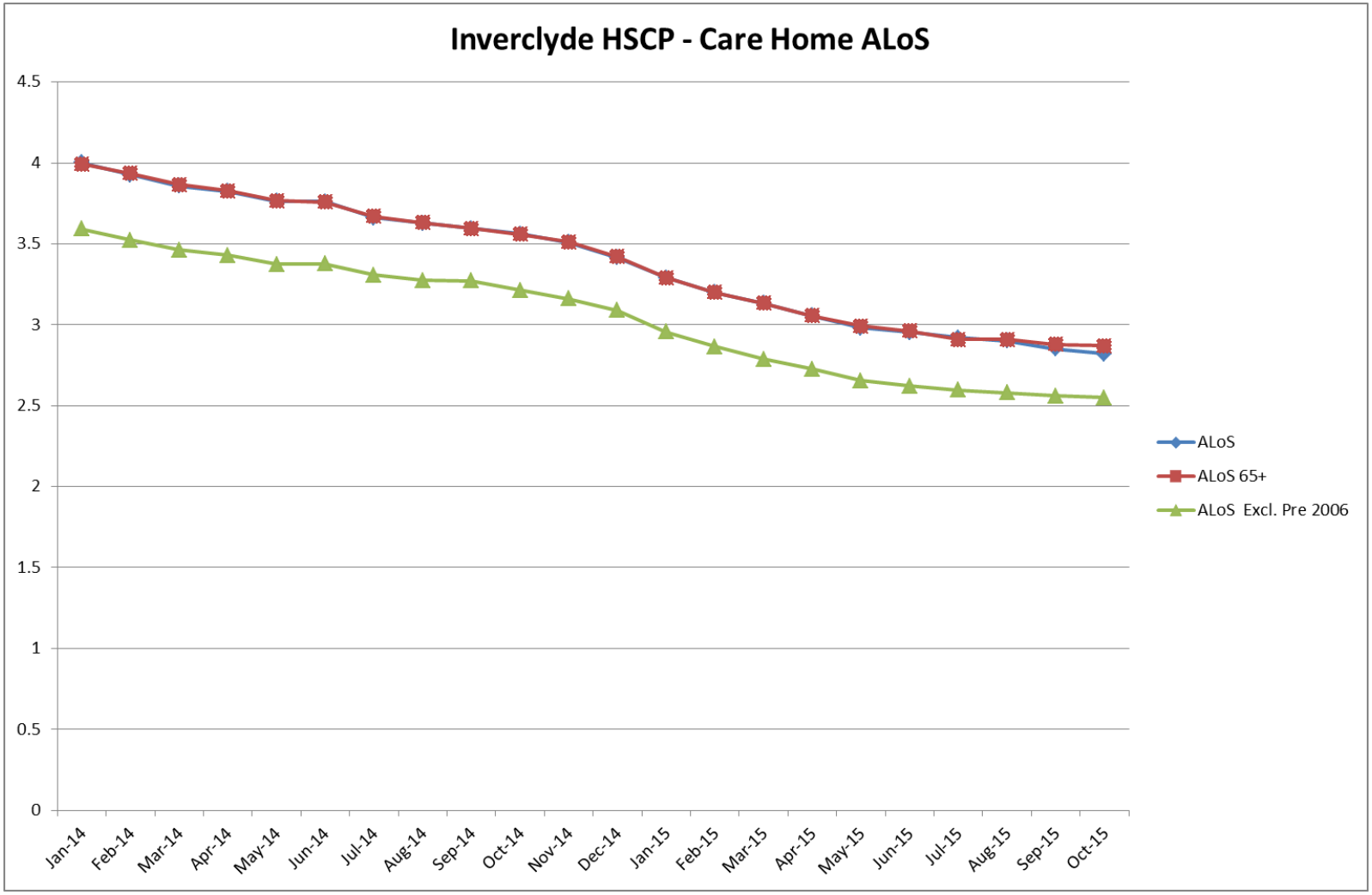
Appendix 2


Inverclyde HSCP - Number of emergency admissions 65+
500
450
400
350
300
250
200
150
100
50
0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Number of emergency admissions 65+
Linear (Number of emergency admissions 65+)

Appendix 3


Unplanned Bed Days 65+ rate / 1000
400
350
300
250
200
150
100
50
0
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Apr-13
May-13
Jun-13
Jul-13
Aug-13
Sep-13
Oct-13
Nov-13
Dec-13
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Unplanned acute bed days 65 + rate / 1,000 pop
Linear (Unplanned acute bed days 65 + rate / 1,000 pop)

Appendix 4


Inverclyde HSCP - Care Home ALoS
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Jan-14
Feb-14
Mar-14
Apr-14
May-14
Jun-14
Jul-14
Aug-14
Sep-14
Oct-14
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
ALoS
ALoS 65+
ALoS Excl. Pre 2006

AGENDA ITEM NO: 12

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**26th January 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health and Social Care Partnership (HSCP)**	**Report No:**	**IJB/02/2016/SMcA**
Contact Officer:	**Sharon McAlees Head of Criminal Justice and Children's Services**	**Contact No:**	**715282**
Subject:	**COMMUNITY JUSTICE TRANSITION PLAN**		

1.0 PURPOSE

1.1 The purpose of this report is to present to the Integration Joint Board the draft Inverclyde Community Justice Transition Plan for the period 2016-2017.

2.0 SUMMARY

2.1 The Community Justice (Scotland) Bill was introduced to the Scottish Parliament on 7th May 2015.

2.2 Stage 1 evidence sessions concluded on 6th October 2015 and it is anticipated that enactment of the Bill will be in June 2016.

2.3 A number of Working Groups have been established by the Community Justice Division to develop a national Community Justice Strategy, including a National Performance Framework.

2.4 Locally, a Community Justice Lead Officer was appointed in September 2015. This post is funded by the Community Justice Transitional funding monies.

2.5 A Transition Group has been established and includes both the statutory partners outlined in the Community Justice (Scotland) Bill and other key partners from the third sector.

2.6 The Community Justice Division has provided an outline of what is required in local Transition Plans and these are to be submitted by 31st January 2016.

2.7 The Inverclyde Community Justice Transition Plan (Attached Paper) has followed this outline as well as giving a broader local context.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board note and comment on the draft Inverclyde Community Justice Transition Plan.

Brian Moore
Corporate Director
(Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

NATIONAL CONTEXT

4.1 The Scottish Government's Future Model for Community Justice in Scotland consultation paper (2014) defined community justice as:

"The collection of agencies and services in Scotland that individually and in partnership work to manage offenders, prevent offending and reduce reoffending and the harm that it causes, to promote social inclusion, citizenship and desistance."

Inverclyde submitted a response to this consultation paper on 13th August 2015 in respect to a call for evidence from the Justice Committee.

4.2 The new model will allow for:

- Local strategic planning and delivery of community justice services.
- Duties on a defined set of statutory Community Justice Partners to engage in this local strategic planning and delivery with accountability for planning and performance residing at a local level.
- The creation of Community Justice Scotland to provide leadership for the sector; enhanced opportunities for innovation, learning and development; independent professional assurance to Scottish Ministers and Local Government Leaders on the collective achievement of community justice outcomes across Scotland.
- A focus on collaboration, including the opportunity to commission, manage or deliver services nationally where appropriate.

4.3 The statutory Community Justice Partners include:

- Local Authorities
- Health Boards
- Police Scotland
- Scottish Fire and Rescue Service
- Skills Development Scotland
- Integration Joint Boards
- Scottish Courts & Tribunal Service
- Scottish Ministers (Scottish Prison Service)

4.4 The statutory Community Justice Partners are required to engage and involve the Third Sector in the planning and delivery of services.

4.5 The statutory Community Justice Partners have been chosen because of their role, individually and collectively, in delivering services that will improve community justice outcomes. It is for a local area to identify the needs and priorities of their community. The collaborative identification of these needs will allow partners to contribute and plan services according to local need. While planning will be done at a local level, if benefits can be realised that allow for wider partnership delivery then these can be established and this will be for local areas themselves to decide together.

4.6 The Community Justice Division has established four work streams that reflect the suggested pillars of the national Community Justice Strategy that is currently being progressed. These include:

- Empowering communities to participate in community justice matters and support those who have offended or have been affected by offending.
- Improving partnership, planning and performance to ensure community justice bodies deliver services effectively.
- Improving access to services to ensure there is equality of access to all

based on need.
- Effective use of interventions to ensure people who have offended receive the most suitable intervention at the appropriate time.

4.7 The key milestones in the establishment of the new Community Justice model are:

Timescale	Milestones
2015-2016	Partners will commence their collective planning and capacity-building activities in the community planning context.
31st January 2016	A local Transition Plan to be submitted to Scottish Government.
1st April 2016	Partners will assume their responsibilities under the new model as a shadow year alongside the current Community Justice Authorities.
Summer 2016	The enactment of the Community Justice Bill is anticipated.
Summer 2016	Scottish Government will publish the National Community Justice Strategy; the National Community Justice Performance Framework and guidance on the implementation of the new Community Justice model.
Summer 2016	Community Justice Scotland will be established.
December 2016	Partners will produce their first plan for Community Justice.
31st March 2017	Community Justice Authorities (CJA's) are formally dis-established.
1st April 2017	The new model for Community Justice comes fully into effect.

LOCAL CONTEXT

4.8 On 31st July 2015 the Depute Director, Community Justice Division, wrote to Community Planning Chairs to clarify what is required in the shadow year Transition Plans that CPP's are required to submit by 31st January 2016. This includes:

- How CPPs plan to build links with and between Community Justice Partners.
- How CPPs plan to involve the Third Sector, service users, people with convictions, and communities in their local arrangements, planning and delivery in 2016 / 2017.
- How CPPs intend to work with CJAs to ensure that community justice issues that are led on by CJAs are picked up, where appropriate, by the relevant CPPs in 2016 / 2017.
- Looking to 2016 / 2017 and beyond, what the local governance arrangements will be for:
    - Community justice, including accountability lines;
    - Which organisations and individuals will be involved across the statutory, non-statutory and community sectors;
    - How community justice arrangements will link into the wider CPP, and
    - How links will be made from broader community planning themes to the community justice agenda and vice versa.
- How partner resources will be leveraged to support change and innovation locally, making the most effective use of transition funding.

4.9 A Transition Group has been established and includes the statutory Community Justice Partners, national Third Sector representation and the local Third Sector Interface representative. The Transition Group has developed a Terms of Reference which informed the governance arrangements detailed in the Transition Plan.

4.10 It should be noted that further work is required within the terms of reference regarding the governance arrangements. Specifically to reflect that each agency will

retain their respective accountability structures whilst having delegated functions within the community justice partnership. A memorandum of understanding will be developed to consolidate this.

4.11 The Transition Plan provides an articulation of the key areas of activity over the coming year in laying a sound foundation in developing a local Community Justice Model.

5.0 IMPLICATIONS

FINANCE

A review of the funding arrangements for those monies currently allocated to CJAs for the planning and delivery of services, most notably Criminal Justice Social Work Services, is currently underway. While no decisions have been made, there is growing consensus that the current funding formula is not fit for purpose. This work is being taken forward under the auspices of Reducing Reoffending Programme 2 (RRP2). However, under the new model it is proposed that the Scottish Government will retain responsibility for the allocation of funding, with advice from the new national body as appropriate.

The Scottish Government's transition funding allocation of £50,000 to Inverclyde will be used in taking forward this plan. A Community Justice Lead Officer was appointed in September 2015 and will support the co-ordination of activity and the Community Justice Transition Group. Any further expenditure will require to be contained within the overall budget allocation.

5.1 Financial Implications:

One off Costs

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

Annually Recurring Costs/ (Savings)

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

LEGAL

5.2 It is anticipated that the Community Justice (Scotland) Bill will be enacted in June 2016. This will provide the legal framework to support the new model.

HUMAN RESOURCES

5.3 There are no human resources issues within this report.

EQUALITIES

5.4 There are no equality issues within this report.

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.

6.0 CONSULTATION

6.1 This report has been prepared by the Chief Officer, Inverclyde Health and Social Care Partnership (HSCP) after due consultation with statutory and third sector partners. It is also the intention to hold a series of consultation events during 2016 as outlined in the Transition Plan.

7.0 BACKGROUND PAPERS

7.1 There are no background papers associated with this report.

Inverclyde Community Justice Transition Plan 2016 - 2017

Version	1.0
Date	11.11.15
Review Date	(Draft)
Produced by	Ann Wardlaw

Contents

Introduction

Welcome to the Community Justice Transition Plan for Inverclyde. This is in response to the legislative requirements proposed in the Community Justice (Scotland) Bill as it is introduced. The plan covers the transitional period of shadow arrangements alongside the North Strathclyde Community Justice Authority (NSCJA) to the point where Community Justice Authorities are dis-established and the new model of Community Justice is implemented on 1st April 2017.

The plan adopts Inverclyde Alliance vision of "Getting it Right for Every Child, Citizen and Community (GIRFECCC)" and developing a Nurturing Inverclyde approach. While we are at the early stages of laying a strong foundation for Community Justice in Inverclyde' this plan will make a significant contribution towards delivering the wellbeing outcomes where we want all our children, citizens and communities to be safe, healthy, nurtured, active, respected, responsible and included. These aspirations reflect the proposed national Community Justice Strategy vision that

> "Scotland is a safer, fairer and more inclusive nation where we reduce reoffending by addressing its underlying causes, while safely and effectively managing those who have committed offences, to help them integrate into the community and realise their potential for the benefit of all citizens."

This plan is outcome focused and will strengthen partnership working, community capacity, engagement and involvement of a full range of stakeholders. This plan sets out a clear pathway to ensure a smooth period of transition for Community Justice.

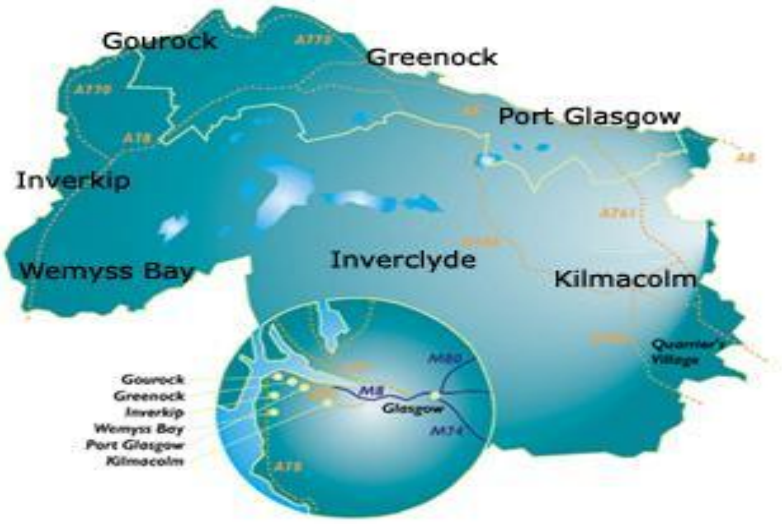
I am confident that this plan includes all the necessary building blocks for a robust and successful local model of community justice and I look forward to working with all the partners and wider stakeholders to bring this into fruition.

Sharon McAlees,

Chair of Inverclyde Community Justice Transition Group

2. Demographic Profile of Inverclyde

Inverclyde is located in West Central Scotland covering 61 square miles stretching along the south bank of the estuary of the River Clyde. Inverclyde is one of the smallest local authorities in Scotland with the main towns of Greenock, Port Glasgow and Gourock sitting on the Firth of the Clyde. The towns provide a marked contrast to the small coastal settlements of Inverkip and Wemyss Bay, which lie to the South West of the area, and the picturesque rural villages of Kilmacolm and Quarrier's Village which are located further inland, offering a further dimension to the area's diversity.



A strong sense of community identity exists in Inverclyde and local residents are proud of the area and its history, which is steeped in centuries of maritime and industrial endeavour. There is also a strong community spirit and opportunity to further enhance this with the Community Justice agenda and the aim of building on local capacity to co-produce local responses.

Inverclyde is going through a period of transformation with improvements taking place in the physical infrastructure including further improvements in the existing well developed transport links to Glasgow and the rest of Scotland, new residential developments, leisure and retail facilities, cultural and arts centres and a new and refurbished schools estate being established that will help further renew and regenerate Inverclyde and more importantly, its communities. Inverclyde is also strengthened with West College Scotland situated over two local campuses. With regards to health facilities, Inverclyde is served with Inverclyde Royal Hospital and sixteen GP practices. Inverclyde also has HMP Greenock that includes both male and female prison population. These are all considered as key assets within Inverclyde and in meeting the aspirations of how Community Justice is developed locally.

The 2014 mid-year population estimate for Inverclyde according to the National Statistics of Scotland (NRS Mid-Year Estimate) is 79,860; this accounts for 1.5% of the total population of Scotland. By 2037 the population of Inverclyde is projected to be 65,014, a decrease of 18.6% (based on the 2012 population estimate).

There is a significant gap between our more affluent areas and those which experience high levels of poverty and deprivation. In our most deprived and disadvantaged areas, people face multiple problems such as ill-health; high levels of worklessness; poor educational achievement/attainment; low levels of confidence

and low aspirations; low income; poor housing and an increased fear of crime. In addition, Inverclyde has particular issues relating to alcohol.

The Scottish Index of Multiple Deprivation rank's the 6,505 zones of Scotland from most to least deprived using data on 7 domains. 50 of the 110 Inverclyde zones rank among the 20% most deprived in Scotland. Inverclyde has the second highest (42.7), next to Glasgow (44.4), proportion of datazones that are within the 15% most deprived in Scotland.

There is increasing research that demonstrates the strong links between mental health and material deprivation. The poorest fifth of adults are at double the risk of experiencing a mental health problem as those on average incomes. The impact of welfare reform has compounded this further where 98% of respondents in a recent report **Worried Sick: Experience of Poverty and Mental Health Across Scotland** (2014) indicated their mental health had suffered.

Mental Health in Focus: A profile of mental health and wellbeing in Greater Glasgow & Clyde, (2011) produced by the Glasgow Centre for Population Health states in the Inverclyde Profile.

"In Inverclyde perceptions of local crime were 36% higher than the Scottish average (an estimated 78% of Inverclyde adults reported that crime was "very or fairly common in their area" compared to 57% in Scotland). This contrasted with the relatively low level of both acquisitive crime (170 in Inverclyde versus 238 per 10,000 in GG&C) and offenders and victims of violent crime (30% and 22% lower in Inverclyde compared to GG&C)... Across the intermediate zones in Inverclyde, a picture of polarised communities is presented."

The estimated number of individuals with problem drug use and the corresponding prevalence rates for 2012 / 2013 indicates the council areas with the highest prevalence rates of problem drug use in Scotland are Inverclyde 3.20%, Dundee City 2.80% and Glasgow City 2.76% - For Scotland as a whole the figure is 1.68%. (Percent of populations aged 15-64). **Inverclyde ADP Strategic Plan 2014-2015.**

Alcohol misuse is a particular problem in Inverclyde, particularly amongst the more disadvantaged population, where deaths and hospital admissions related to alcohol misuse are more than double the national average. In a Citizens' Panel survey carried out in Spring 2012, 87% of respondents thought that excessive alcohol consumption is a particular problem in Inverclyde. **Inverclyde Alliance SOA 2013-2017.**

Alcohol plays a major part in relation to crime and the fear of crime in Inverclyde. 85% of people who are arrested for disorder related offences are under the influence of alcohol, and in about 80% of violent crime cases in Inverclyde, alcohol has been a contributing factor, whether consumed by the victim, perpetrator or both. **Drugs Strategy: Tackling Drugs in the Community, ACPOS, 2009-2012.** Domestic violence also demonstrates a significant level of alcohol involvement. Women's Aid highlight that whilst the number of incidents of domestic abuse reported to the Police have fallen, their data has shown an increase in the last year. **To Reduce Violence Against Women, Inverclyde CSP, Co-ordinating Group, October 2009.**

Parental substance misuse is also a significant factor in Child Protection concerns. **Inverclyde Alliance SOA 2013-2017.**

Two thirds of young offenders were under the influence of alcohol at the time of committing their offence and a significant number of prisoners report having problems with alcohol and drugs outside prison. **Alcohol and Inverclyde: Impact, Services and Strategy, Report prepared for the Inverclyde Alliance Board, 2007.**

The Scottish Fire and Rescue Service in Inverclyde believe there may be a link between the consumption of alcohol and the types of fire-related anti-social behaviour incidents encountered by their officers. **http://www.strathclydefire.org/pdfs/Scotland_Together_07_09_09.pdf**

A significant proportion of Inverclyde residents presenting at emergency homeless services have alcohol and drug problems. **Inverclyde Alliance SOA 2013-2017.**

All of these criminogenic conditions impact on community justice and highlight the multi-layered and complex nature of issues facing our community. Importantly the profile also speaks to the variety of community assets that may be utilised in developing community capacity to facilitate the desistance of offenders.

3. Community Justice

National Context

The Scottish Government's Future Model for Community Justice in Scotland consultation paper (2014) defined community justice as:

> "The collection of agencies and services in Scotland that individually and in partnership work to manage offenders, prevent offending and reduce reoffending and the harm that it causes, to promote social inclusion, citizenship and desistance."

The Community Justice (Scotland) Bill outlines the meaning of community justice as:

a) "Giving effect to community disposals and post-release control requirements."
b) "Managing and supporting offenders in the community with a view to reducing reoffending by them."
c) "Arranging general services in ways which facilitate offenders in the community accessing and using them."
d) "Preparing offenders for release from imprisonment or detention in a penal institution."

Following Stage 1 evidence sessions as part of the parliamentary process of the Bill; it is anticipated there will be an amendment to the definition of community justice that reflects a more holistic approach. Karp and Clear (2000) state that

> "Community Justice broadly refers to all variants of crime prevention and justice activities that explicitly include the community in their processes and set the enhancement of community quality of life as a goal."

The Community Justice Division has established four work streams that reflect the suggested pillars of the national Community Justice Strategy that is currently being progressed. These include:

- Empowering communities to participate in community justice matters and support those who have offended or have been affected by offending.
- Improving partnership, planning and performance to ensure community justice bodies deliver services effectively.
- Improving access to services to ensure there is equality of access to all based on need.
- Effective use of interventions to ensure people who have offended receive the most suitable intervention at the appropriate time.

It is anticipated that the national Community Justice Performance Framework will also reflect these outcomes.

Local Context

The Inverclyde Alliance Single Outcome Agreement 2013-2017 enshrines three pivotal approaches that will be interwoven in progressing community justice in Inverclyde. These include:

1. Community Capacity building and Co-production.

   The core values underpinning this are:

   - Recognising that people have assets, not just problems.
   - Redefining work so that unpaid activities are valued and supported.
   - Building reciprocity and mutual exchange.
   - Strengthening and extending social networks.

2. Focus on Prevention and Early Intervention.

   The Report on the Future Delivery of Public Services (2011) emphasised the need for public services to focus on prevention and early intervention which included a move towards preventative spend.

3. Getting it Right for Every Child, Citizen and Community (GIRFECCC): A Nurturing Inverclyde.

   Inverclyde Alliance has applied the GIRFECCC approach and has adapted the wellbeing outcomes as outlined below as a whole population approach.

Safe	Protected from abuse, neglect or harm and supported when at risk. Enabled to understand and take responsibility for actions and choices. Having access to a safe environment to live and learn in.
Healthy	Achieve high standards of physical and mental health and equality of access to suitable health care and protection, while being supported and encouraged to make healthy and safe choices.
Achieving	Being supported and guided in lifelong learning. Having opportunities for the development of skills and knowledge to gain the highest standards of achievement in educational establishments, work, leisure or the community.
Nurtured	Having a nurturing place to live and learn, and the opportunity to build positive relationships within a supporting and supported community.
Active	Having opportunities to take part in activities and experiences in educational establishments and the community, which contribute to a healthy life, growth and development.
Respected & Responsible	Respected and share responsibilities. Citizens are involved in decision making and have an active role in improving the community.
Included	Overcoming social, educational, health and economic inequalities and being valued as part of the community.

The Inverclyde Alliance Single Outcome Agreement 2013-2017 outlines eight local strategic outcomes as detailed below.

Outcome 1	Inverclyde's population is stable with a good balance of socio-economic groups.
Outcome 2	Communities are stronger, responsible and more able to identify, articulate and take action on their needs and aspirations to bring about an improvement in the quality of community life.
Outcome 3	The area's economic regeneration is secured, economic activity in Inverclyde is increased, and skills development enables both those in work and those furthest from the labour market to realise their full potential.
Outcome 4	The health of local people is improved, combating health inequality and promoting healthy lifestyles.
Outcome 5	A positive culture change will have taken place in Inverclyde in attitudes to alcohol, resulting in fewer associated health problems, social problems and reduced crime rates.
Outcome 6	A nurturing Inverclyde gives all our children and young people the best possible start in life.
Outcome 7	All children, citizens and communities in Inverclyde play an active role in nurturing the environment to make the area a sustainable and desirable place to live and visit.
Outcome 8	Our public services are high quality, continually improving, efficient and responsive to local people's needs.

4. Community Justice Partners

The diagram below outlines both statutory partners (highlighted in blue) and non-statutory partners (highlighted in white). At this stage there have been discussions with the majority of these partners exploring their potential role to progress the community justice agenda.

As an interim measure a Community Justice Transition Group has been established. This has the aim of ensuring a smooth transition into shadow arrangements on 1st April 2016. This will operate alongside NSCJA and ensure we are ready for the introduction of the new model for Community Justice on 1st April 2017.

The Transition Group includes involvement of all of the statutory partners and representation from Action for Children and Turning Point Scotland who both deliver local services; CVS Inverclyde who form one part of Inverclyde's third sector interface; local Community Safety and Wellbeing Manager, ADP Co-ordinator and NSCJA Policy Officer.

The main consideration when opting for the development of the Transition Group was that the transition period required the expertise of various sectors while also recognising the SOA is being revised during 2016 and this will impact on future governance structures. The Transition Group will be able to remain focused on community justice at this crucial time while the SOA is being revised.

It is anticipated that while the statutory partners will remain static; there can be a degree of fluidity with regards to non-statutory partners dependent on the various stages and priorities at any given time. While there are partners who may not directly be involved in the Transition Group, this is not under-estimating the role they may have in progressing community justice. Several meetings have already taken place and will continue with other community partners to ensure a whole systems approach is taken and a wide range of community assets are fully utilised in community justice.

5. Involvement of Stakeholders

Inverclyde Alliance Community Engagement Strategy mirrors the National Standards for Community Engagement as outlined below:

1. **Involvement:** we will identify and involve the people and organisations who have an interest in the focus of the engagement.

2. **Support:** we will identify and overcome any barriers to involvement.

3. **Planning:** we will gather evidence of the needs and available resources and use this evidence to agree the purpose, scope and timescale of the engagement and the actions to be taken.

4. **Methods:** we will agree and use methods of engagement that are fit for purpose.

5. **Working Together:** We will agree and use clear procedures that enable the participants to work with one another effectively and efficiently.

6. **Sharing Information:** we will ensure that necessary information is communicated between the participants.

7. **Working With Others:** we will work effectively with others with an interest in the engagement.

8. **Improvement:** we will develop actively the skills, knowledge and confidence of all the participants.

9. **Feedback:** we will feed back the results of the engagement to the wider community and agencies affected.

10. **Monitoring And Evaluation:** we will monitor and evaluate whether the engagement achieves its purposes and meets the national standards for community engagement.

There is an opportunity to build capacity and strengthen community resilience through promoting maximum participation in a programme of engagement events commencing in January 2016. This will be wide ranging and inclusive of those considered to be at the furthest distance from services such as people who have committed offences in a variety of settings including those who have an alcohol or drug problem; mental health issues; or are homeless; and those who are currently serving a community order or a prison sentence. Particular effort will also be given to ensure we capture the views of women who have committed offences and young people.

Other key stakeholders are the victims of crime and their families as well as the families of those people who have committed an offence.

A variety of methods will be used including one-to-one interviews; focus groups and questionnaires. The primary focus of this engagement will be to learn from people's own stories of both what has worked for them, what has had less impact, what are the gaps in service delivery and how services individually and collectively can improve to make the greatest impact for individuals, their families and wider community.

Engagement events will include tailored sessions for providers including national third sector organisations; PSP providers; local third sector organisations; and community organisations. This will provide an opportunity to both strengthen local networks and map the wide range of services. It will also assist in identifying any duplication of effort as well as informing future planning of services.

A further element of engagement will be at a community level using existing mechanisms developed as part of community planning partnership wellbeing localities and Health and Social Care Partnership Integrated Joint Board locality planning. This will include involvement of Community Councils, community groups and the general public. This will be about enabling community conversations to capture information about what really matters to people in the various geographical localities and to understand the outcomes they would wish to achieve as part of community justice. A range of methods will be used including attending meetings, arranging events, focus groups and using the Citizen's Panel.

6. Governance Arrangements

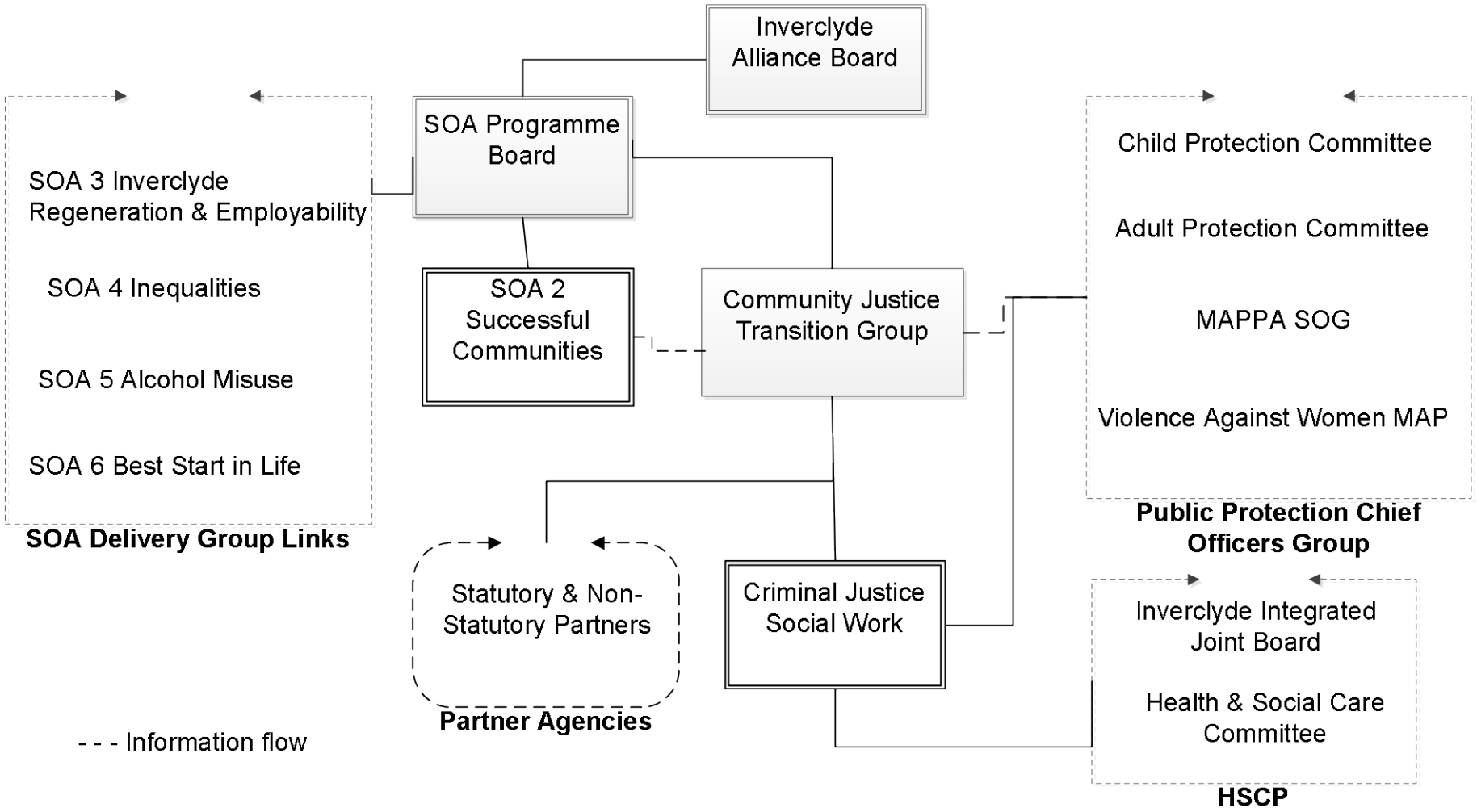
Before reaching agreement with regards to the governance arrangements for community justice; various options were considered and a SWOT Analysis was undertaken to inform the decision.

It was agreed as an interim measure to support the immediate period of transition, that a Community Justice Transition Group be established. The Transition Group has developed a Terms of Reference (Appendix 1) that details the remit and focus of the group. Final governance arrangements will be considered following the revision of Inverclyde SOA and implemented during 2017.

The Community Justice Transition Group is aligned to the SOA Delivery Group "Successful Communities" and will report to the SOA Programme Board and Inverclyde Alliance. Each partner will also report within their respective organisational governance structures. In addition; information sharing and collaborative working will also be developed with SOA Delivery groups and other fora including Inverclyde Public Protection Chief Officers Group; Inverclyde Integrated Joint Board and the Health & Social Care Committee as well as the Inverclyde Alcohol and Drug Partnership and Community Safety Partnership.

The Structure Chart below outlines the governance arrangement.

Governance Structure



Planning Structure

With a view to simplifying the planning structure in line with various locality planning drivers and the Community Empowerment (Scotland) Act 2015; it was agreed at Inverclyde SOA Programme Board on 6th November 2015 that there will be three "Wellbeing Localities" in Inverclyde. These will be known as Inverclyde East, Inverclyde Central and Inverclyde West. The concept of "wellbeing localities" reinforces the GIRFECCC approach and the role of the wellbeing indicators across Inverclyde's planning structure.

Below each "Wellbeing Locality" there are "Wellbeing Communities", followed by "Wellbeing Neighbourhoods". All of these have been mapped with Community Council and Ward boundaries. Both Police Scotland and the Scottish Fire and Rescue Service use Ward boundaries in their planning structures. Inverclyde HSCP intends to adopt the Wellbeing planning structure.

With regards to implementing Community Justice the locality planning arrangements will be applied. This will enable a common language to be used by all partners around wellbeing, while also considering data specific to Inverclyde as a whole, right down to individual ward information where partnership resources can be targeted to ensure they make the maximum impact and services can be localised and flexible.

Appendix 2 details the planning structure.

7. Transition / Shadow Arrangements

As outlined in Appendix 3; the North Strathclyde Community Justice Authority Area Plan 2014 – 2017, local and partnership actions will remain a primary focus during the transition period and beyond. The NSCJA is a key partner represented on the Transition Group where they will be able to share their knowledge and expertise.

Inverclyde has an active role in NSCJA and has close working relationships with both the NSCJA Chief Officer and NSCJA Policy Officer. The NSCJA have developed a Transition Plan and are scheduled to give a presentation to Inverclyde Alliance on 14th December 2015 to provide information on this. The NSCJA is also intending to produce Local Authority Level Offender Profile and Strategic Assessment.

There are regular meetings between NSCJA and Inverclyde in preparation for the transition that take cognisance of national developments within community justice and how this relates to the local context of Inverclyde.

8. Going Forward

Much of the focus and activity during 2016 will be on developing the local model for community justice alongside partners and stakeholders from our local communities. A key focus of Inverclyde Alliance is in tackling inequalities including health, housing and employability. These all impact on criminogenic conditions and in tackling them will support desistance.

The pathway to desistance is an individual one and in planning services it is recognised that “one size fits all” will not work. Community justice as an approach needs to be outcome-focused and person-centred. There are good practice developments that can be adapted and applied to community justice. One aspect is in recognising and building on personal strengths and resources including positive social networks and developing a positive identity within their local neighbourhood.

As previously outlined there is a programme of engagement events planned for January – March 2016. Information from these will be used to inform future planning of services.

An Inverclyde Community Justice Logic Model will be developed that will be used to identify short-term, medium term and long-term outcomes. As part of this exercise there will be a mapping exercise of all the local resources available to progressing community justice.

A comprehensive data collection and analysis will also be undertaken at the various levels described in the planning structure. This will help to identify the range of data available, as well as informing any gaps and future developments of local indicators.

9. Resources

The Scottish Government’s transition funding allocation of £50,000 to Inverclyde will be used in taking forward this plan. A Community Justice Lead Officer was appointed in September 2015 and will support the co-ordination of activity and the Community Justice Transition Group.

By developing close partnership working, identifying all available resources, (not just financial resources) whether staff, expertise or premises and services; partner resources will be leveraged to support change and innovation locally.

In undertaking benchmarking there will also be opportunity to consider cost analysis and preventative spend options.

A key resource that partners may share is around learning and development opportunities. This may include sharing training opportunities and expertise, sharing facilities or developing peer support and shadow opportunities.

References

Community Justice (Scotland) Bill, (2015), Scottish Government

Community Justice: A Conceptual Framework, (2000), Karp & Clear, Criminal Justice Journal, Volume 2 pg 323 - 368

Consequences, Risk Factors and Geography of Young People Not in Education, Employment or Training (NEET), (2015), Social Research, Scottish Government

Designing and Evaluating Interventions to Reduce Crime and Reoffending, (2015), Social Research, Scottish Government

Evaluation of Sixteen Women's Community Justice Service in Scotland, (2015), Social Research, Scottish Government

How and Why People Stop Offending: Discovering Desistance, (2012), IRISS Insights 15

Inverclyde Local Policing Plan 2014 – 2017, Police Scotland

Mental Health in Focus: A profile of Mental Health and Wellbeing in Greater Glasgow & Clyde (Inverclyde Profile), (2011), Glasgow Centre for Population Health

The Scottish Public Health Observatory: Deprivation Data http://www.scotpho.org.uk/life-circumstances/deprivation/data

Preventing Homelessness and Reducing Reoffending, (2015), Shelter Scotland

Inverclyde Alliance Single Outcome Agreement 2013 - 2017

Inverclyde CHCP Chief Social Work Officers Report 2014 – 2015

Inverclyde Health and Social Care Partnership Strategic Plan Establishment Plan 2015 – 2016

Local Fire and Rescue Plan for Inverclyde 2014 – 2017, Scottish Fire and Rescue Service

Management Information Council Area Report: Quarter 1 2015 – 2016, (2015), Police Scotland

North Strathclyde Community Justice Authority Area Plan 2014 – 2017

Online Statistics Local Authority Breakdown (Inverclyde), (2015), Scottish Children's Reporter Administration
http://www.scra.gov.uk/publications/online_statistical_service.cfm

Scottish Prison Service – HMP Greenock
http://www.sps.gov.uk/

The Report of the Ministerial Group on Offender Reintegration, (2015), Scottish Government

The Ideals of Community Justice, (2015), Jean Hine, British Journal of Community Justice Vol 13(1) pg 1-6

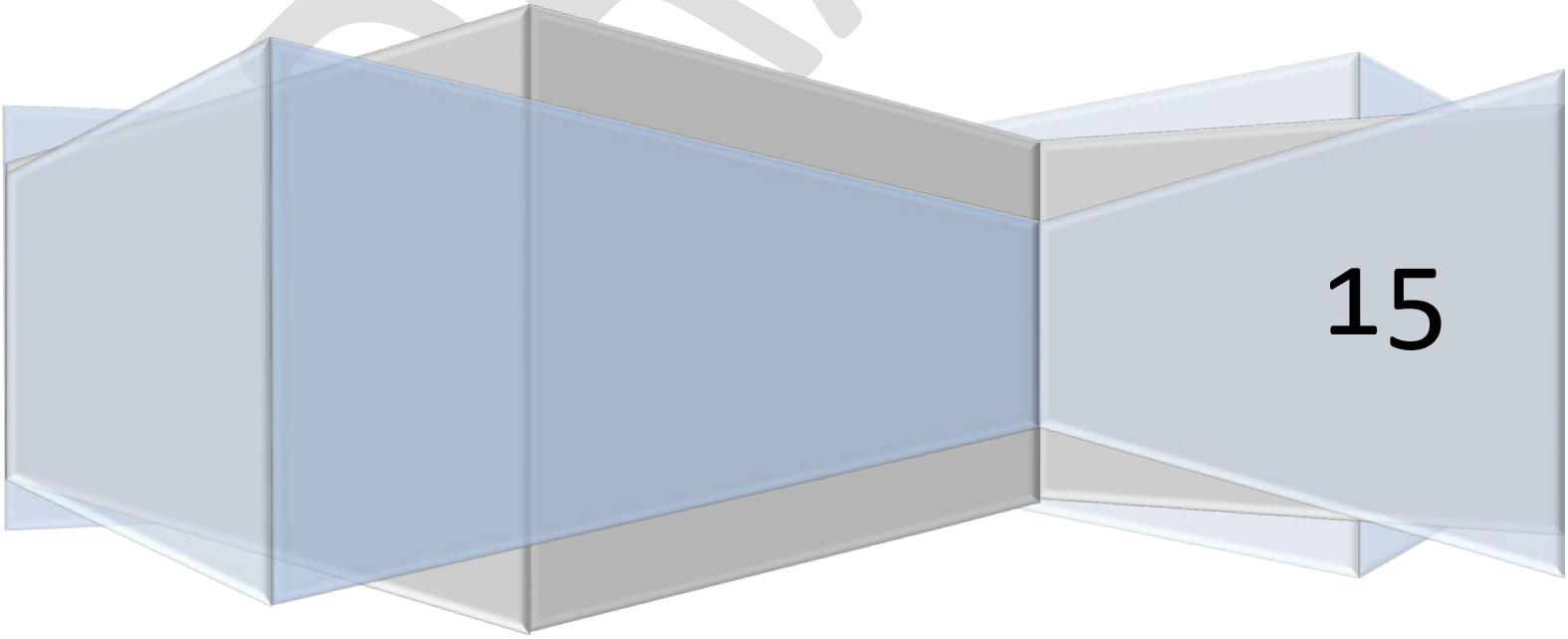
What Works to Reduce Reoffending: A Summary of the Evidence, (2011), Justice Analytical Services, Scottish Government

Appendix 1

Community Justice Transition Group

Terms of Reference

Sharon McAlees



Introduction

The Scottish Government's Future Model for Community Justice in Scotland consultation paper (2014) defined community justice as:

> "The collection of agencies and services in Scotland that individually and in partnership work to manage offenders, prevent offending and reduce reoffending and the harm that it causes, to promote social inclusion, citizenship and desistance."

The Community Justice (Scotland) Bill is the legislative vehicle for implementing this new model whereby responsibility will transfer to local strategic planning and delivery while disbanding the current Community Justice Authorities.

The Community Justice Division has established four work streams that reflect the suggested pillars of the national Community Justice Strategy that is currently being progressed. These include:

- Empowering communities to participate in community justice matters and support those who have offended or have been affected by offending.
- Improving partnership, planning and performance to ensure community justice bodies deliver services effectively.
- Improving access to services to ensure there is equality of access to all based on need.
- Effective uses of interventions to ensure people who have offended receive the most suitable intervention at the appropriate time.

It is anticipated that the national Community Justice Performance Framework will also reflect these outcomes.

These terms of reference define the remit and focus of the Transition Group in preparing for local implementation of the Community Justice (Scotland) Bill.

Aim

The aim of the Community Justice Transition Group is to ensure a seamless period of transition whereby a model of community justice is developed that reflects both the needs and strengths of Inverclyde.

The Community Justice (Scotland) Bill details statutory partners to include:

- Local Authorities
- Health Boards
- Police Scotland
- Scottish Fire & Rescue Service
- Skills Development Scotland
- Integration Joint Boards
- Scottish Courts and Tribunal Service
- Scottish Ministers (Scottish Prison Service)

In addition there are key non-statutory partners including the third sector. The Community Justice Transition Group has representation from all of the statutory partners and key non-statutory partners.

Underpinning the emerging model of community justice in Inverclyde are the principles of Best Value; efficiency, effectiveness and equity of service provision across all partners.

Group Membership

Name	Designation	Service
Sharon McAlees	Head of Children's Services & Criminal Justice	HSCP Integrated Joint Board
Helen Watson	Head of Planning, Health Improvement and Commissioning	HSCP Integrated Joint Board
Andrina Hunter	Health Improvement, Inequalities and Personalisation Service Manager	NHS Greater Glasgow & Clyde
Audrey Howard	Service Manager	HSCP Criminal Justice
Ann Wardlaw	Community Justice Lead Officer	Community Justice Partnership
Miriam McKenna	Corporate Policy & Partnership Manager	Inverclyde Council
Fraser Jarvie	Legal Services Manager	Inverclyde Council
Willie Kennedy	Planning Officer	NSCJA
Anne Glendinning	Service Manager	HSCP Youth Justice
Lisa Davies		Scottish Court Service
Stuart Cassisdy		Procurator Fiscal

Mary Flynn	Team Leader	SDS
William Stuart	Governor, HMP Greenock	SPS (Representative for Community Justice)
Andy Lawson	Chief Superintendent	Police Scotland
Ian Bruce	Executive Officer	CVS Inverclyde
Paul Nelis	Group Manager	Scottish Fire & Rescue
Janine Ryan	Service Manager	Action for Children
Christine Buntrock	Operations Manager	Turning Point
Drew Hall	Community Safety and Wellbeing Manager	Housing, Safer & Inclusive Communities, Inverclyde Council
Margaret McConnachie	ADP Co-ordinator	Inverclyde ADP

Other members will be co-opted onto the group for specific projects as appropriate.

Scope and Methodology

The group will work across a wide range of partners and stakeholders in Inverclyde and will use the following to inform methodology:

- Community Justice (Scotland) Bill
- Consultation Events by Criminal Justice Division
- Local Community Justice Engagement Events
- Community Justice Strategy (when published)
- Community Justice Performance Framework (when published)
- Community Justice Guidance (when published)
- Community Empowerment (Scotland) Act 2015
- Best Value Toolkits
- GIRFECCC approach across Inverclyde and SHANARRI Wellbeing Indicators
- Logic Modelling Toolkits
- Benchmarking
- Research on good practice examples
- Research on desistance and reducing re-offending
- The values of holding the people and communities of Inverclyde as the primary focus; recognising partners work better together; that all partners strive to improve and each partner individually and as a collective ensure transparency and accountability.

Reporting

The group will report to the SOA Programme Board and Inverclyde Alliance. Each partner will also report within their respective organisational governance structures.

Meetings

The group will meet on a six-weekly basis and the quorum required will be that a minimum of three different agency partners are in attendance.

There is a clear expectation that this group will be required to make decisions and each partner has a responsibility to have an appropriate representative in attendance who can contribute to this process. Where there are occasions where a partner is unable to have representation in attendance at a meeting; that partner has responsibility for ensuring they have submitted their feedback on matters being taken forward.

Data Analysis

Data will be shared and collated across all partners in order to undertake all aspects of logic modelling and benchmarking, as well as being able to identify the impact of service delivery.

Dispute Resolution

Where there is a disagreement on a particular matter, in the first instance attempts should be made to resolve this within the group. Where this is not possible it may be necessary for the respective partner(s) and the chair of the group to meet out with the meeting to attempt resolution. A further option would be for the respective partners and the chair of the group to identify and agree to approach an independent person to act as a mediator. The final stage where all other steps have been fully exhausted is that the matter is considered at the SOA Programme Board for arbitration, whereby a final decision will be reached. An appropriate partner with expertise regarding the specific matter may be co-opted onto the SOA Programme Board for this purpose.

Recommendations

- That the terms of reference are used to steer the group during the transition period.
- As the legislation is progressed the terms of reference may need periodic review.

Timescales

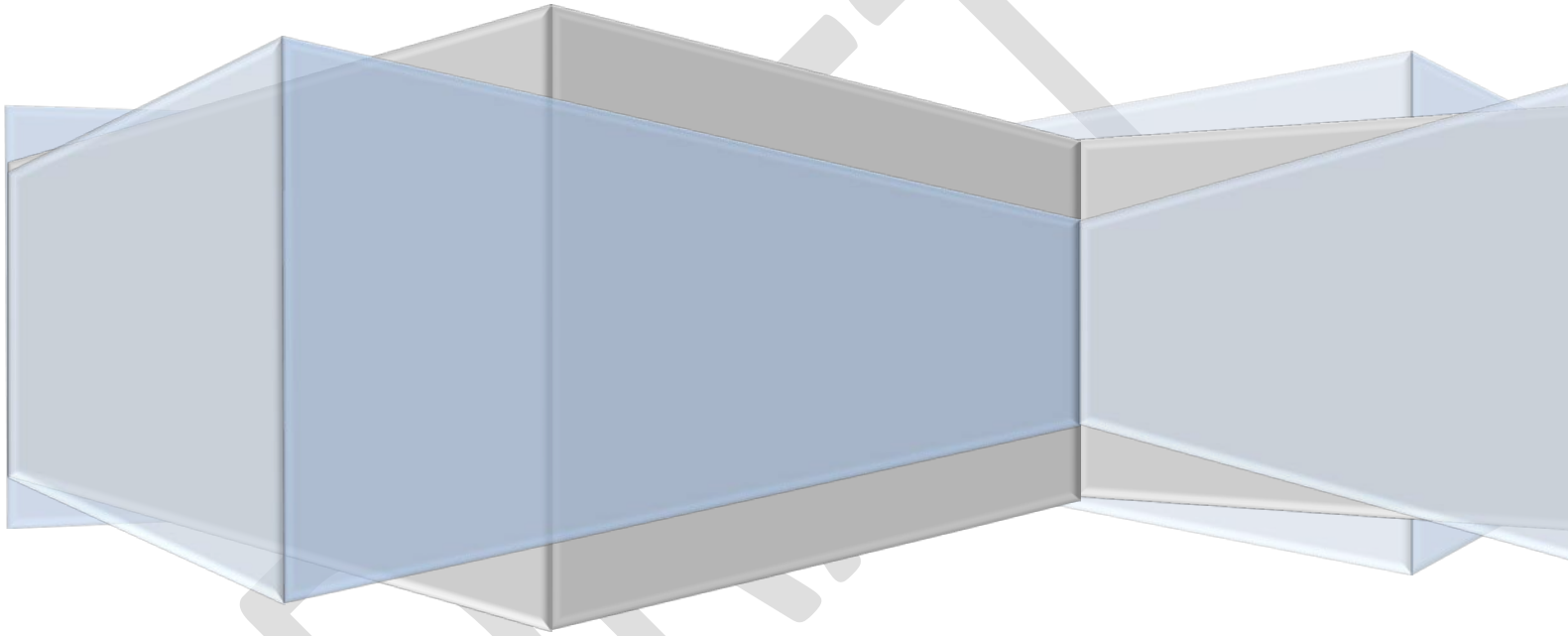
The following milestone dates have been identified:

Timescale	Milestones
2015-2016	Partners will commence their collective planning and capacity-building activities in the community planning context.
31st January 2016	A local Transition Plan to be submitted to Scottish Government.
1st April 2016	Partners will assume their responsibilities under the new model as a shadow year alongside the current Community Justice Authorities.
Spring / Summer 2016	The enactment of the Community Justice Bill is anticipated. Following this the Community Justice Strategy; Community Justice Performance Framework and Community Justice Guidance will be published.
December 2016	Partners will produce their first Community Justice Outcomes Improvement Plan.
31st March 2017	Community Justice Authorities are formally dis-established.
1st April 2017	The new model for Community Justice comes fully into effect.

How will we know we are getting there?

As well as by meeting the milestones identified, qualitative achievements would include:

1. There is an enhanced understanding among statutory and non-statutory partners of the concept of community justice and their role in progressing this within the communities of Inverclyde.
2. The model of community justice in Inverclyde is outcome-focused and person-centred.
3. The communities of Inverclyde are recognised as having a wide range of strengths on which to build on.
4. The foundations of effective partnership working are established with regards to community justice.



Appendix 2 – Wellbeing Localities

Wellbeing Locality	Wellbeing Community	Wellbeing Neighbourhood	LEARNING COMMUNITY CLUSTER	COMMUNITY COUNCILS	WARD
Inverclyde East Wellbeing Locality	Kilmacolm & Quarriers Village	• Kilmacolm • Quarriers Village	Port Glasgow High/Joint Campus	Kilmacolm	Ward 1 (Inverclyde East)
	Port Glasgow	• Devol • Slaemuir • Oronsay • Woodhall/Kelburn • Park Farm • Parkhill • Clune Park • Lilybank • Town Centre • Chapelton • Kingston Dock		Port Glasgow East Port Glasgow West	Ward1 (Inverclyde East) Ward 2 (Inverclyde East Central)
Inverclyde Central Wellbeing Locality	Greenock Central and East	• Gibshill • Strone • Weir Street • Cartsdyke • Bridgend • Greenock Town Centre • Well Park • Drumfrochar • Broomhill • Propecthill	Inverclyde Academy	Greenock East Greenock Central	Ward 2 (Inverclyde East Central) Ward 3 (Inverclyde North)
	Greenock South and	• Bow Farm	Inverclyde	Holefarm &	Ward 4

Wellbeing Locality	Wellbeing Community	Wellbeing Neighbourhood	LEARNING COMMUNITY CLUSTER	COMMUNITY COUNCILS	WARD
	South West	• Grieve Road • Neil Street • Whinhill • Overton • Pennyfern • Peat Road • Hole Farm • Cowdenknowes • Barrs Cottage • Fancy Farm • Branchton • Braeside • Larkfield	Academy	Cowdenknowes Greenock South West Larkfield, Braeside & Branchton	(Inverclyde South) Ward 6 (Inverclyde South West)
Inverclyde West Wellbeing Locality	Greenock West and Gourock	• Greenock West End • Cardwell Bay • Midton • Gourock Town Centre • Ashton • Levan • Trumpethill	Clydeview Academy	Greenock West and Cardwell Bay Gourock	Ward 3 (Inverclyde North) Ward 5 (Inverclyde West)
	Inverkip & Wemyss Bay	• Inverkip • Wemyss Bay	Inverclyde Academy	Wemyss Bay & Inverkip	Ward 6 (Inverclyde South West)

Appendix 3

NSCJA Area Plan 2014-2017 – What we plan to achieve locally

NSCJA Plan	Inverclyde
1. A continued reduction in the 1 year reconviction rate in the NSCJA area.	Continue at a local level.
2. The effective provision of person centred, evidence led support services and interventions for women offenders as recommended by the Commission on Women Offenders in both community and in-custody settings.	Continue at a local level.
3. Effective and enhanced support services and interventions for high risk offenders including sex offenders and perpetrators of domestic abuse, whilst ensuring the 'victim's voice' is heard in the NSCJA area	Continue at a local level.
4. An increased focus on alternatives to custody and community sentences where appropriate, including diversion; community payback order (CPO); Drug Treatment and Testing Orders (DTTO); the use of electronic monitoring, where suitable; and alternatives to remand.	Continue at a local level.
5. Continue to support a prison culture where the maximisation of opportunities for prisoners to work towards positive destinations is the norm, addressing the cross cutting issues that contribute to offending and re-offending.	Continue at a local level.
6. A collaborative approach with our partners in Health and Alcohol and Drug Partnerships to address Health Inequalities.	Continue at a local level.
7. A smooth and efficient transition into the new Structure for Community Justice.	Continue at a local level.

NSCJA Area Plan 2014-2017 – What actions we will do as a partnership

NSCJA Actions	Inverclyde
1. We will continue to work effectively in partnership to ensure the coordination of plans/strategies, interventions and workforce learning and development to reduce reoffending.	Continue at a local level.
2. We will agree an Action Plan each year with our partners and others, which will set out specific actions that we will manage and monitor through regular progress reports to NSCJA.	Continue via agreed local structure.
3. We will be responsive to developing policy initiatives by including these within our existing partnership structures or establishing new structures where required to implement at a local level.	Continue at a local level and in line with the development of the national Community Justice Strategy and Performance Framework alongside any new guidance.
4. We will take into account the recommendations of the Commission on Women Offenders and ensure all resources are utilised effectively across a multi-agency and multi sector approach to addressing the needs of women offenders in the NSCJA area coordinated through the NSCJA Women's Services Steering Group.	Continue at a local level.
5. We will ensure the effective roll out of 'Moving Forward, Making Changes' in the NSCJA area, as well as continuing to work in collaboration with a wide range of partners to develop effective interventions for domestic abuse perpetrators as well as support for victims.	Continue at a local level.
6. We will continue to support the increased, appropriate use of all forms of community sentences and alternatives to custody. We will progress any appropriate actions arising from the current review of Community Payback Orders and the unit cost of CPO's and review the delivery of Drug Treatment and Testing Orders across the NSCJA area.	Continue at a local level.

7. We will continue to support the Scottish Prison Service; in particular taking advantage in the opportunities presented by the developing estate within the NSCJA area, whilst continuing to offer support to the innovative initiatives that have already been introduced.	Continue at a local level.
8. We will continue to support the National; Local and exemplar Public Social Partnerships and through these we will communicate examples of good practice and success to our wider partnership group. We will work with key public sector bodies to secure sustainable funding for successful PSPs.	Continue at a local level as part of a local Community Justice Commissioning Strategy.
9. We will work with NHS GG&C and other partners to pursue innovative initiatives that incorporate a 'Whole Family Approach' to address health inequalities experienced by offenders and their families.	Continue at a local level.
10. We will work in partnership with local Alcohol and Drug Partnerships to improve equity of service access and reduce the instances of drug related deaths and alcohol related deaths in the NSCJA area.	Continue at a local level.
11. We will work with Scottish Government Community Justice Division; Community Planning Partnerships and other partners and stakeholders to ensure the smooth and efficient transition of duties and functions to the new structure for Community Justice.	Continue at a local level.
12. We will use flexibility and innovation in the way that we allocate funding whilst keeping a focus on 'What Works' and interventions that have the most impact on reducing reoffending.	Continue at a local level.

AGENDA ITEM NO: 13

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/03/2016/HW**
Contact Officer:	**Andrina Hunter Service Manager Health Improvement and Inequalities**	**Contact No.**	**01475 715285**
Subject:	**Inverclyde Alliance Tobacco Strategy and Action Plan**		

1.0 PURPOSE

1.1 The purpose of this report is to present a comprehensive Tobacco Strategy and Action plan for Inverclyde for the period 2015 – 2017, developed through Inverclyde's Community Planning Partnership, the Inverclyde Alliance.

2.0 SUMMARY

2.1 The Scottish Government's National Strategy (Creating a Tobacco Free Generation; A Tobacco Control Strategy for Scotland) is a 5 year strategy aimed at addressing tobacco use across Scotland. The overarching aim is to create a tobacco-free generation by 2034, defined as a smoking prevalence of 5% or less.

The Strategy and actions are agreed under the following high level themes:

- Prevention: creating an environment where young people choose not to smoke
- Protection: protecting people from the harmful effects of second hand smoke
- Cessation: providing help for those who want to stop smoking.

2.2 The Scottish Government's Tobacco Control Strategy has placed responsibility on local authorities and its partners to drive forward the tobacco control agenda through the development of local tobacco plans.

2.3 There has been considerable progress in addressing tobacco use within Inverclyde. Smoking prevalence has reduced by 11% over the last six years; less young people have tried smoking; there has been a reduction in adult exposure to second-hand smoke; smoking in pregnancy has reduced over the last two years.

2.4 Whilst this is welcomed, effort needs to continue as smoking continues to be a leading preventable cause of ill health and premature death within Inverclyde.

2.5 The Inverclyde Tobacco Strategy and Action Plan will aim to address tobacco with our Inverclyde Alliance partners. This strategy sets the detail for the introduction of a local implementation group, consisting of Inverclyde Alliance partners, to set local policy as well as deliver upon a unified agreed action plan.

2.6 The role of the HSCP in implementing the Inverclyde Tobacco Strategy is important. The Health Improvement Team (HIT) promote and deliver specialist intensive stop smoking services across Inverclyde with a particular focus on the 40% most deprived; support prevention work e.g. within schools and youth organisation; promote Smokefree environments across various settings and deliver tobacco awareness and training sessions.

All pharmacies in Inverclyde provide smoking cessation support and direct access to stop smoking medications.

Other HSCP staff and services have a role in raising the issue of smoking and supporting health behaviour change, promoting local stop smoking services and referral and promoting smoke free environments. This includes children, maternity, looked after and accommodated children and young people, mental health, addiction, older people and homeless services as well as GP practices.

2.7 This multi-facetted and collaborative approach is required to have a meaningful impact to reduce smoking prevalence, in particular within our more deprived communities.

2.8 In consideration of the national outcomes that are part of the Public Bodies (Joint Working) (Scotland) Act 2014, and are also part of the Inverclyde Integration Scheme, the Tobacco Strategy and Action Plan will contribute to our aim of *Improving Lives*. They will do this by supporting people to look after and improve their own health and wellbeing and live in good health for longer, which is the very first requirement of the national outcomes.

2.8 Inverclyde Tobacco Strategy and Action Plan will support the Inverclyde Alliance in achieving the wellbeing outcomes set out in the Community Planning Partnership Single Outcome Agreement (SOA), to ensure that every child, citizen and community in Inverclyde is safe, healthy, achieving, nurtured, active, respected, responsible and included.

3.0 RECOMMENDATIONS

3.1 The HSCP Integration Joint Board is asked acknowledge progress that has been made to reduce smoking prevalence in Inverclyde and the importance for this work to continue.

3.2 The HSCP Integration Joint Board is asked to note and endorse the Inverclyde Tobacco Strategy and Action Plan and its role in continuing to addressing tobacco use within Inverclyde. This will contribute towards the Scottish Government's vision of a tobacco-free generation by 2034 within Inverclyde by working towards a smoking prevalence of 5%.

Brian Moore
Corporate Director (Chief Officer)
Inverclyde HSCP

4.0 BACKGROUND

4.1 Addressing tobacco is a public health priority for Scotland and Inverclyde. Smoking continues to be a leading preventable cause of ill health and premature death.

4.2 In Inverclyde (2012), there were 163 smoking attributable deaths, 225 lung cancer deaths and 180 COPD deaths, the incidence rate for all are greater than the Scottish average.

4.3 Men are more likely to smoke than women and smoking is associated with life expectancy, within Inverclyde male life expectancy is 6 years less than female (73.7 and 79.9 years respectively).

4.4 Smoking is a key contributory factor towards inequalities in health and healthy life expectancy between the most affluent and poorest within Scotland and within Inverclyde. Across Scotland, there is an incremental increase in smoking prevalence with increased deprivation, SIMD 1 (most deprived) 39% smoke compared to SIMD 5 (least deprived) 11% smoke.

4.5 There has been considerable progress in reducing adult smoking prevalence within Inverclyde, 35% of adults in 2008, reported as smoking either every day or some days, this reduced to 23% in 2011 and increased slightly to 24% in 2014. This equates to an 11% reduction in smoking prevalence over the last 6 years.

4.6 There is promising increased trend in the proportion of smokers within Inverclyde who intend to stop smoking. According to the most recent Inverclyde Health and Wellbeing Survey (2014), intention to stop smoking has increased to 39%.

4.7 Children and Young People

Promising data from Inverclyde Child and Youth Health and Wellbeing survey reported that overall 82% of young people had not tried smoking. However the proportion who had not tried was less when age was taken into account. 93% of S1 and S2 pupils had not tried smoking compared to 69% of S5 and S6 pupils (see figure 1 below). Currently, S1/S2 1%, S3/S4 7% and S5/S6 9% report as currently smoking, this has gradually reduced since 2006, (see figure 2 below)

Figure 1 Proportion never smoked

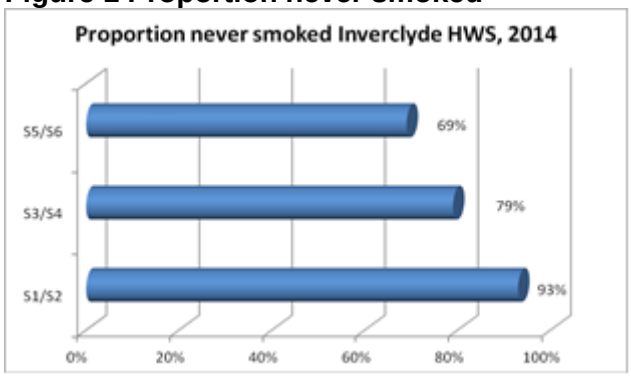
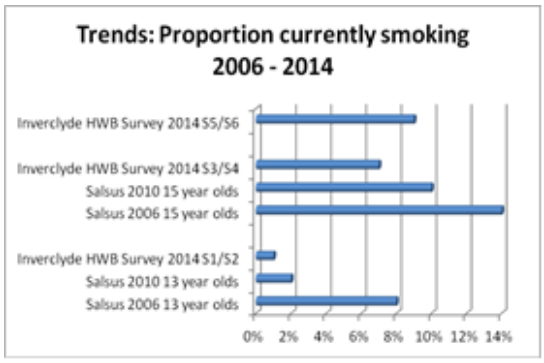


Figure 2 trends in smoking prevalence



4.8 In addition, according to the Inverclyde Child and Youth Health and Wellbeing Survey (2013), 45% of young people, who smoke, want to stop smoking.

4.9 Pregnancy

Smoking in pregnancy continues to be a very real issue and is linked to low birth weight

amongst other conditions. Positive trends in relation to this can be seen in figures 3 and 4 below.

Figure 3: Trend smoking pregnancy

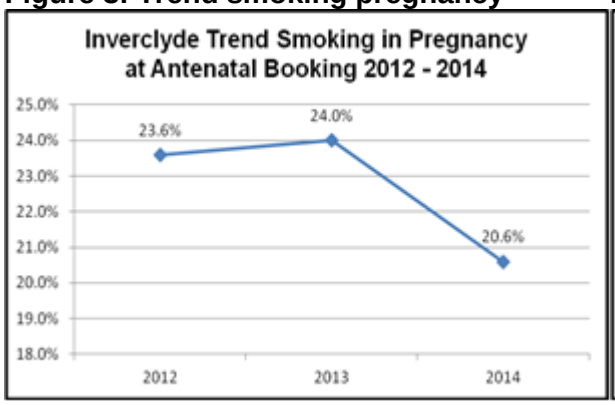
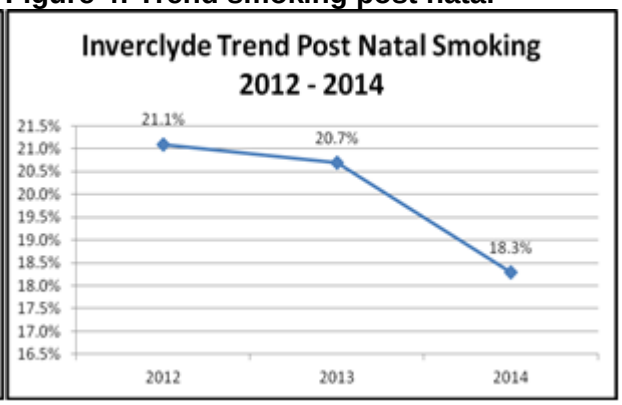


Figure 4: Trend smoking post natal



4.10 Tobacco Purchasing

Since 2007 it is now an offence to sell tobacco products to young people under the age of 18 years, and for someone else to buy tobacco products for them (proxy sale). Findings from the Inverclyde Child and Youth Health and Wellbeing Survey (2014) reported that young people are still accessing cigarettes either purchasing cigarettes themselves or purchased by others, (see table 1). In addition 17% of those who smoke purchased single cigarettes and 43% said they would know where to go for "cheap" tobacco.

Table 1: Access to cigarettes

- I get them from someone I know - e.g. friends or family (52%, 97 pupils)
- I ask an adult I don't know to buy cigarettes/tobacco from (28%, 53 pupils)
- I buy them myself from a shop - e.g. supermarket, newsagent (23%, 43 pupils)
- I buy them myself from a van - e.g. ice cream van or burger van (12%, 23 pupils)
- I ask someone else under the age of 18 to buy me cigarettes/tobacco from a shop (11%, 21 pupils)
- I take them from my parents or other adults (without them knowing) (9%, 16 pupils)
- I get cigarettes/tobacco in some other way (8%, 15 pupils)

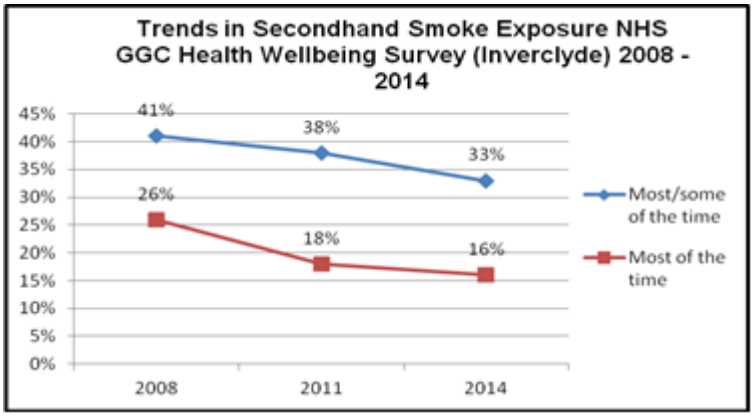
4.11 Second-hand Smoke (SHS)

Despite the successful introduction of The Smoking, Health and Social Care (Scotland) Act 2005 that no longer permitted smoking in enclosed public spaces, exposure to SHS still presents a challenge.

4.12 Exposure to SHS causes harm and children are particularly vulnerable to the effects.

4.13 There has been a reduction in adult SHS exposure within Inverclyde over the last 6 years. 41% were exposed to SHS some or most of the time in 2008 this has reduced to 33% in 2014, a reduction of 8%. In addition the proportion that are exposed most of the time has also reduced from 26% in 2008 to 16% in 2014 (see figure 5).

Figure 5: Trends in adult SHS exposure



4.14 According to the Inverclyde Child and Youth Health and Wellbeing survey (2014) 78% reported that they were exposed to SHS at some point. 7% reported they were exposed every day, 14% often, 56% rarely and 22% never. 42% of children reported that someone smoked at home and when asked where the person smoked:

- 53% (793 pupils) said they smoked outside
- 22% (321 pupils) said they smoked in a particular area in the house
- 20% (296 pupils) said they smoked in one room
- 17% (250 pupils) said they smoked anywhere in the house
- 10% (151 pupils) said they smoked in the car

4.15 **E Cigarettes**

Electronic Cigarettes or e-cigarettes are battery-powered devices that heat a liquid, often containing nicotine and flavourings, into a vapour that is inhaled. A national review on the safety of e-cigarettes concluded that no safety concerns emerged in the short to mid-term use (2 years or less).

4.16 The use of e-cigarettes as a means to stop smoking is increasing however their use in particular with young people needs to be monitored. The Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill will introduce various restrictions on the sale (young people under the age of 18 years) and promotion of nicotine vapour products, such as e-cigarettes, thus reducing availability.

5.0 STRATEGY

5.1 The Scottish Government's National Strategy (Creating a Tobacco Free Generation; A Tobacco Control Strategy for Scotland) is a 5 year strategy aimed at addressing tobacco use across Scotland. The overarching aim is to create a tobacco-free generation by 2034, defined by a smoking prevalence of 5% or less.

5.2 The Strategy sets out required actions for the Scottish Government, Local Authorities, NHS Scotland and the third sector, both individually and in partnership. It also requires individuals, families and communities in Scotland to share and contribute to the vision of a tobacco-free generation. The Strategy builds on the multi-faceted approach, set out in previous tobacco control strategies, balancing a range of national and local actions that complement and reinforce each other.

5.3 The Scottish Government's Tobacco Control Strategy has placed responsibility on local authorities to drive forward the tobacco control agenda through the development of a local

tobacco plan.

5.4 The Inverclyde Tobacco Strategy and action plan will aim to address tobacco with our Inverclyde Alliance partners. This strategy sets the detail for the introduction of a local implementation group, consisting of Inverclyde Alliance and HSCP partners, to set local policy as well as deliver upon a unified agreed action plan.

5.5 The overall aim of the Inverclyde Tobacco Strategy is to improve the health of local people by addressing health inequality and promoting positive lifestyles by reducing the harmful effects of tobacco.

5.6 The Strategy and actions are agreed under the following high level themes:

- Prevention: creating an environment where young people choose not to smoke
- Protection: protecting people from the harmful effects of second-hand smoke
- Cessation: providing help for those who want to stop smoking.

5.7 A number of key objectives contribute to this aim and set the devolved nature adopted both in approach and ambition:

- Tackling health inequalities is regarded as a key component of reducing smoking prevalence through targeted resources within areas of greatest need.
- Tobacco control measures focus on anti-smoking and refrain from anti-smoker in approach and outcome.
- Non-smoking is promoted as socially normal across Inverclyde.

5.8 In addition, the following core principles support the above and raise the awareness of the work required across partners and professional work streams:

- All non-smokers have a fundamental right not to be exposed involuntarily to second-hand smoke.
- Children and young people have the right to be free from tobacco related advertising and promotion.
- All smokers have the opportunity to access stop smoking advice and support across the local area in a time-efficient and convenient manner.
- Inverclyde is regarded as an area of good practice regarding tobacco control activities

5.9 It is important that actions taken locally address all three high level themes to ensure a meaningful impact within Inverclyde. The impact of tobacco within Inverclyde is significant in relation to healthy life expectancy and its contribution towards health inequalities needs to be addressed. This can only be achieved through effective collaboration with Inverclyde Alliance partners through a unified agreed tobacco strategy and action plan.

6.0 WIDER HSCP ROLE

6.1 The wider HSCP has a role in addressing tobacco by supporting and implementing key actions within the Inverclyde Tobacco Strategy and will including areas of work that will prevent uptake of smoking, protect from the harm associated with second-hand smoke and the provision of stop smoking services. The Inverclyde Health Improvement Team have a significant role in delivering tobacco control activities however others within the HSCP can further enhance this agenda.

6.2 Inverclyde HSCP Health Improvement Team (HIT) support and deliver all aspects of tobacco control. This includes:

- Carry out asset based approaches to increase local awareness of Inverclyde Smokefree Services.

- Deliver specialist intensive stop smoking services across Inverclyde with a particular focus on SIMD 1 & 2 areas. Stop smoking services are delivered in Health Centres, all 19 pharmacies, Family Centres, Community Centres, Addiction Services, Maternity services, within Inverclyde Royal Hospital with strong links to community services following discharge, Mental Health Services, Health and Homeless services, within West College Scotland and workplaces including the HSCP.
- Deliver training and information sessions to HSCP staff to increase capacity in promoting smoke free environments, HSCP Smoking Policy and Smokefree Policies within other settings e.g. Youth Organisations. This will equip staff to talk about smoking and second hand smoke, support health behaviour change and refer to stop smoking services.
- Focussed second hand smoke activities with a focus on protecting children within the home and car. This includes training and information sessions and an intervention using a Dylos machine which involves measuring and providing feedback on levels of fine particulates in homes where smoking occurs.
- Support the delivery of smoking prevention within schools and youth organisations.

6.3 Local HSCP implementing and compliance with NHS GGC Smoking Policy. This has now been extended beyond NHS premises to include NHS grounds. Staff can support patient adherence to the policy by providing information and referral to local stop smoking services. In the case where the patient does not want to stop smoking however are experiencing acute nicotine withdrawal, provision of nicotine replacement therapy is arranged. HSCP staff also have a role in ensuring they comply with organisational Smoking Policies. All Mental Health premises will be completely smoke free by 7th March 2016. Briefing sessions are in place to support this transition.

NHS and Inverclyde Council staff share premises however the employers have different Smoking Policies. Plans are underway with Inverclyde Council HR and the Health & Safety service to review this discrepancy.

6.4 Smokefree Policies are in place with Looked After and accommodated Children and Young People (LACYP) services. LACYP nurse has a carbon monoxide monitor and will discuss smoking during heath checks.

6.5 Health and Homeless Nurse has attended specialist smoking cessation training. This will allow localised information about stop smoking support for those who want to stop smoking.

6.6 Smoking cessation and second hand smoke information and training sessions for Children and Family and Maternity services. This will facilitate delivery of health behaviour change interventions and referral to stop smoking services. Midwives carry out routine carbon monoxide testing and automatic referral to pregnancy stop smoking services and will implement a tailored package of care for women who continue to smoke during pregnancy. This is recommended through the Maternity and Children Quality Improvement Collaborative (MCQIC). Continuation of support can be provided in the post natal period to prevent relapse for those who stopped during pregnancy, information and referral for partners and encourage Smokefree homes and cars. The Family Nurse Partnership have a role in delivering smoking cessation and second hand smoke interventions during pregnancy and into the post natal period. In addition, small tests of change will be considered through the Early Years Collaborative.

6.7 Other Health and Social Care services e.g. Older People's services, Dementia services, GP practices all have a role in raising awareness and referring into Inverclyde Smokefree Services.

7.0 PROPOSALS

7.1 It is proposed that the Inverclyde Integration Joint Board notes the contents of this report and approve the Inverclyde Tobacco Strategy and Action Plan for the period of 2015 – 2017 for

publication and implementation.

7.2 That the Board acknowledge what has been achieved to reduce smoking related harm in Inverclyde and see the importance of continuing this work through a multi-faceted and collaborative approach in doing so, ensuring Inverclyde has a future generation who are tobacco-free.

7.3 That Inverclyde Integration Joint Board agrees to participate in the multi agency group to ensure progress is made against the action plan.

7.4 That the Board receive and review a quarterly activity and progress report relating to the Inverclyde Tobacco Strategy Implementation. A reporting template will be developed.

8.0 IMPLICATIONS

Finance

8.1 In order to refocus efforts directed towards reducing tobacco related harm it may be necessary for Inverclyde Integration Joint Board to redistribute resources in line with greatest need.

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

8.2 None at the time of this report.

Human Resources

8.3 None identified at the time of this report.

Equalities

8.4 To ensure the Inverclyde Tobacco Strategy and Action Plan complies with the Equality Act, 2010, an Equality Impact Assessment has been carried out. Smoking is a direct cause of continued inequalities in health. The Strategy and Action Plan will ensure that those who are more likely to smoke are not discriminated against. The EQIA of the Strategy will ensure the needs of those who are more likely to smoke are addressed.

Has an Equality Impact Assessment been carried out?

√	YES (see attached appendix 2)
	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.

9.0 CONSULTATIONS

9.1 Consultation with Inverclyde Alliance and HSCP partners from the start of development of the Strategy.

9.2 Your Voice agreed to take a summary of the Inverclyde Tobacco Strategy to sub-groups of the Inverclyde HSCP Advisory Group, feedback was supportive and positive. There is a consensus that the work needs to continue, in particular preventing young people from starting to smoke and the use of e-cigarettes. See appendix 3 for more information.

10.0 CONCLUSIONS

10.1 Although progress to address tobacco in Inverclyde continues, the impact of tobacco continues to be a leading, preventable cause of morbidity, premature mortality and inequalities in health. In order to address this we need to implement a multi-facetted and collaborative approach if we are to achieve the Scottish Government's ambition of a tobacco-free generation by 2034. Establishing a Tobacco Strategy and Action Plan that is relevant to Inverclyde will aim to address the impact tobacco has towards our local population.

11.0 LIST OF BACKGROUND PAPERS

11.1 Scottish Government, (2013). Creating a Tobacco-Free Generation, A Tobacco Control Strategy for Scotland. http://www.scotland.gov.uk/Publications/2013/03/3766/0

11.2 Inverclyde Tobacco Strategy and Action Plan appendix 1

Appendix 1 strategy and action plan Inver

11.3 List of Partner organisations – appendix 2

Appendix 2 List of Inverclyde Alliance Pa

11.4 Equality Impact Assessment – appendix 3

Appendix 3
Inverclyde HSCP Tob

11.5 Your Voice, Inverclyde Community Engagement Forum feedback from sub-groups of the Inverclyde HSCP Advisor Group, appendix 4

Appendix 4 HSCP
Tobacco Strategy Re

Inverclyde Alliance

INVERCLYDE HSCP Health and Social Care Partnership

Inverclyde Tobacco Strategy

2015 - 2017

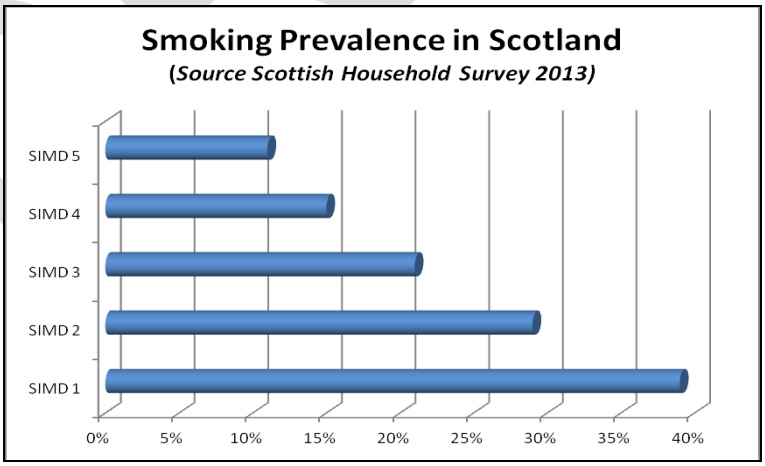
Inverclyde Tobacco Strategy

1. Introduction

Addressing tobacco is a public health priority for Scotland and Inverclyde. Smoking continues to be a leading preventable cause of ill health and premature death. In Scotland smoking is associated with 13,000 deaths, around 56,000 hospital admissions and is estimated to cost £300 to £500 million pounds every year. In addition exposure to secondhand smoke causes harm, children are particularly vulnerable to the effects.[1]

There has been considerable progress in addressing tobacco use within Inverclyde. Smoking prevalence has reduced by 11% over the last six years;[2,3,4] less young people have tried smoking; [5,6] there has been a reduction in adult exposure to secondhand smoke; [2,3,4] smoking in pregnancy (at antenatal booking) has reduced by 3% and maternal smoking prevalence (10 days post natal) has reduced by 2.8% over the last two years.[7] Effort needs to continue to further reduce the impact of tobacco within Inverclyde. The Inverclyde Tobacco Strategy will aim to further enhance this positive progression.

Figure 1 Smoking and deprivation



1.2 Smoking Prevalence in Scotland

Currently it is estimated that 23% of adults in Scotland currently smoke.[8] Overall prevalence is reducing in Scotland however this is less so within areas of deprivation. Figure 1 demonstrates differences in smoking prevalence in relation to

deprivation.[9] There is an incremental increase in smoking prevalence with increased deprivation. As a consequence smoking is a key contributory factor towards inequalities in health and healthy life expectancy between the most affluent and poorest within Scotland and Inverclyde.

1.3 Tobacco Control Scotland

The Scottish Government's National Strategy, (Creating a Tobacco Free Generation; A Tobacco Control Strategy for Scotland), is a 5 year strategy aimed at addressing tobacco across Scotland.[1] The overarching aim is to create a tobacco-free generation by 2034, this is defined as a smoking prevalence of 5% or less. The strategy adopts a multi faceted approach to tobacco control and is laid out under the themes of:

- Prevention – creating an environment where young people choose not to smoke.
- Protection – protecting people from the harmful effects of secondhand smoke.
- Cessation – help for those who want to stop smoking.

Reducing inequalities, partnership working, and assets based approach are key cross cutting themes within the Strategy. The Scottish Government's Tobacco Control Strategy has placed responsibility on local authorities to drive forward the tobacco control agenda through the development of a local tobacco plan. The Inverclyde Tobacco Strategy and action plan will aim to address tobacco with our Inverclyde Alliance partners. This strategy sets the detail for the introduction of a local implementation group, consisting of Inverclyde Alliance partners, to set local policy as well as deliver upon a unified agreed action plan.

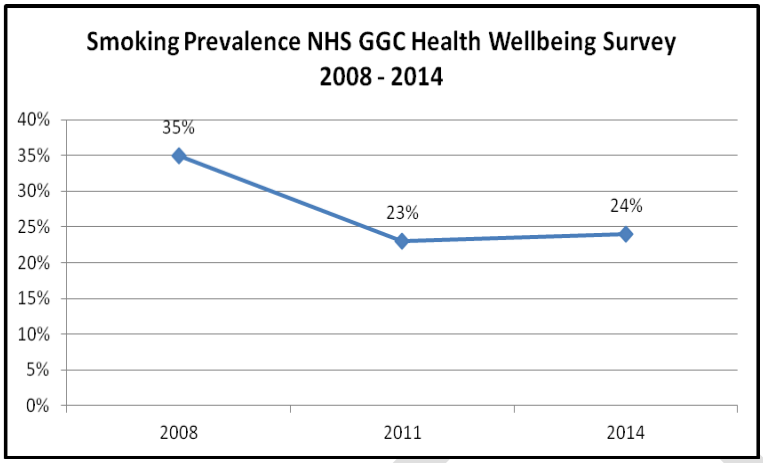
2. Smoking and secondhand smoke exposure Inverclyde

2.1 Adult smoking prevalence

There has been considerable progress in reducing adult smoking prevalence within Inverclyde.[2,3,4] 35% of adults in 2008, aged 16 years and older, reported as smoking

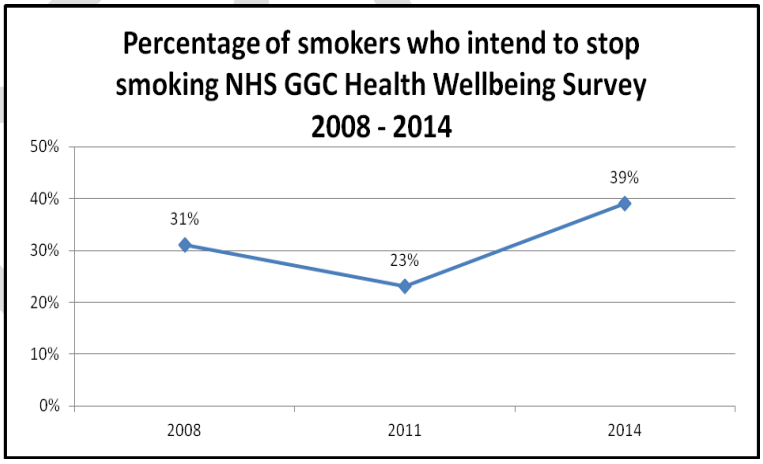
either every day or some days, this reduced to 23% in 2011 and increased slightly to 24% in 2014, (see figure 2).

Figure 2 Trends in Adult Smoking Prevalence



In addition, there had been a downward trend in the proportion of smokers who want to stop smoking however, in the most recent Inverclyde Health and Wellbeing Survey the proportion who intend to stop smoking has increased to 39%, (see figure 3). [2,3,4]

Figure 3: Trends in intention to stop smoking

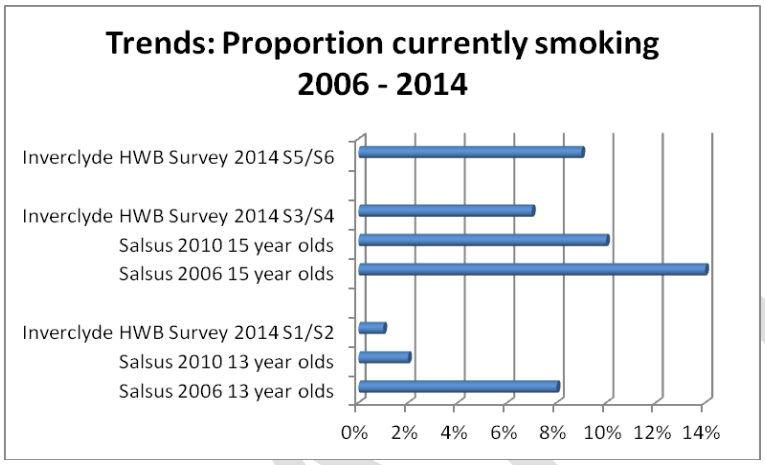


2.2 Smoking Prevalence and young people

According to the 2012 Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS), there has been a notable decline in the proportion of 13 year olds who regularly smoke (8% in 2006 to 2% in 2010), however no statistically significant change to the proportion of 15 year olds (14% to 10%).[6] According to the Inverclyde

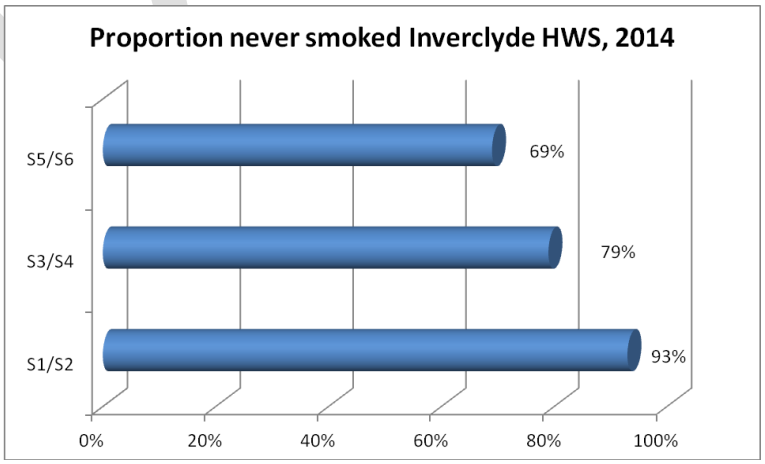
Child and Youth Health and Wellbeing Survey (2013), there is evidence of a further reduction in proportion of S1 – S4 pupils smoking, S1/S2 1%, S3/S4 7% and S5/S6 9% (see figure 4).[5] Note that questions asked about smoking status varies between each survey so cannot be subject to comparison. In addition, current smokers were asked if they wanted to stop smoking 45% yes, 32% said possibly and 23% said no.

Figure 4 Trends in Smoking Prevalence: S1 – S6 Pupils



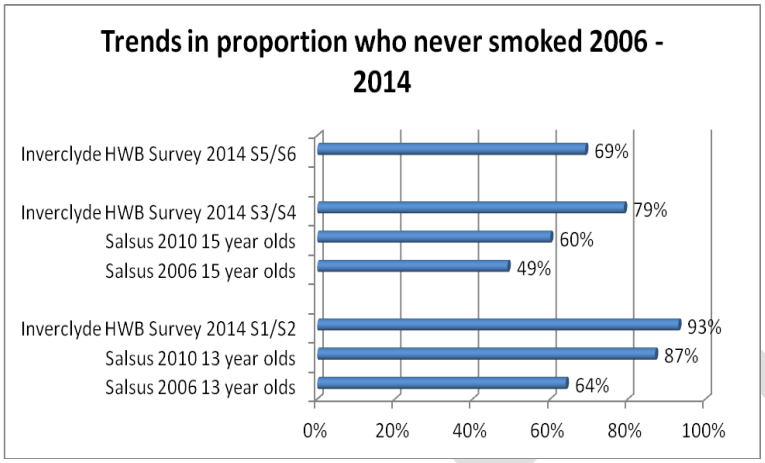
Promising data from Inverclyde Child and Youth Health and Wellbeing survey reported that overall 82% of young people had not tried smoking. However the proportion who had not tried was less when age was taken into account. 93% of S1 and S2 pupils had not tried smoking compared to 69% of S5 and S6 pupils, (see figure 5).[5]

Figure 5 Proportion never smoked: Inverclyde 2014



Comparing this to SALSUS, there some evidence of a reduction in the proportion of young people ever smoking, (figure 6), however, note that the variables differ, the Inverclyde Child and Youth Health and Wellbeing survey reports S1/2, S3/4 and S5/S6 data,[5] SALSUS reports S2 (13 years old) and S4 (15 year old).[6]

Figure 6 Trends in proportion who never smoked 2006 – 2014



2.3 Young People: Access to cigarettes

Since 2007 it is now an offence to sell tobacco products to young people under the age of 18 years, for them to tobacco products if they under the age of 18 years and for someone else to buy tobacco products for them (proxy sale).[10] Findings from the Inverclyde Child and Youth Health and Wellbeing Survey (2014) reported that young people are still accessing cigarettes either purchasing cigarettes themselves or purchased by others, (see table 1). In addition 17% of those who smoke purchased single cigarettes and 43% said they would know where to go for "cheap" tobacco.[5]

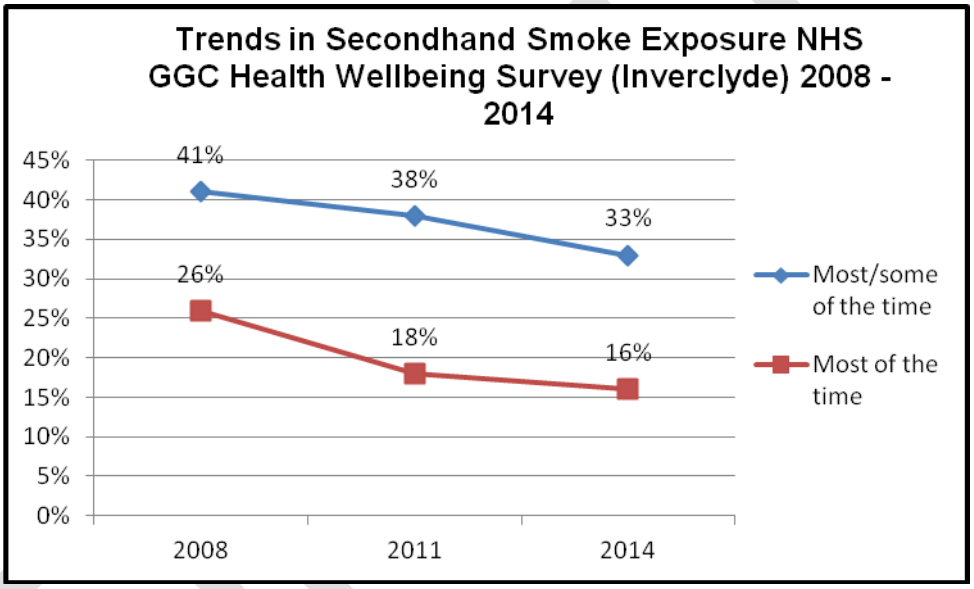
Table 1: access to cigarettes

- I get them from someone I know - e.g. friends or family (52%, 97 pupils)
- I ask an adult I don't know to buy cigarettes/tobacco from (28%, 53 pupils)
- I buy them myself from a shop - e.g. supermarket, newsagent (23%, 43 pupils)
- I buy them myself from a van - e.g. ice cream van or burger van (12%, 23 pupils)
- I ask someone else under the age of 18 to buy me cigarettes/tobacco from a shop (11%, 21 pupils)
- I take them from my parents or other adults (without them knowing) (9%, 16 pupils)
- I get cigarettes/tobacco in some other way (8%, 15 pupils)

2.4 Exposure to secondhand smoke

Despite the successful introduction of The Smoking, Health and Social Care (Scotland) Act 2005 that no longer permitted smoking in enclosed public spaces, exposure to secondhand smoke still presents a challenge.[11] There has been a reduction in adult exposure to secondhand smoke exposure within Inverclyde over the last 6 years. [3,4,5] 41% were exposed to secondhand smoke some or most of the time in 2008 this has reduced to 33% in 2014. In addition the proportion that are exposed most of the time has reduced from 26% in 2008 to 16% in 2014 (see figure 7).

Figure 7: Trends in Adult Exposed to Secondhand Smoke



According to the Inverclyde Child and Youth Health and Wellbeing survey (2014) 78% reported that they were exposed to SHS at some point.[5] 7% reported they were exposed every day, 14% often, 56% rarely and 22% never. 42% of children reported that someone smoked at home. Table 2 provides further information on what young people say where people smoke at home.[5]

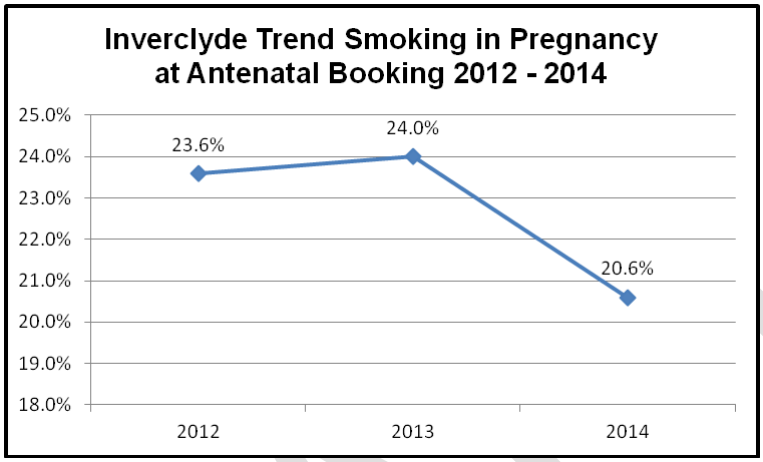
Table 2: Where people smoke in the home

- 53% (793 pupils) said they smoked outside
- 22% (321 pupils) said they smoked in a particular area in the house
- 20% (296 pupils) said they smoked in one room
- 17% (250 pupils) said they smoked anywhere in the house
- 10% (151 pupils) said they smoked in the car

2.5 Smoking in Pregnancy

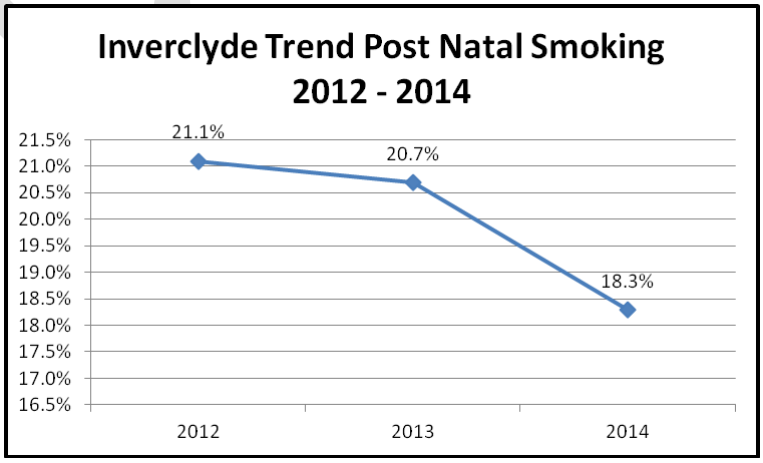
January to December 2014, electronic antenatal booking data reports that 20.6% of pregnant women, within Inverclyde, are still smoking at antenatal booking, this will not include those who stopped prior to their antenatal booking, this has reduced by 3% (23.6%) since 2012.[7] (see figure 8).

Figure 8: Inverclyde Trend Smoking in Pregnancy



Further to this, post natal smoking status is recorded as part of the Child Surveillance Programme. 18.3% are still smoking at first post natal visit (10 days post natal), 27.2% within the most deprived areas.[9] Again, more resent data suggests a downward trend in the proportion still smoking in the post natal period, 21.1% in 2012 to 18.3% in 2014, a reduction of 2.8% (see figure 9).

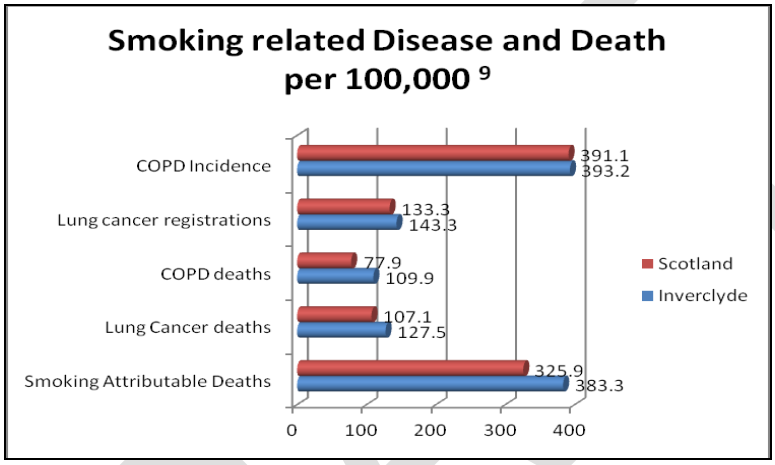
Figure 9: Inverclyde Trend Post Natal Smoking



2.6 Smoking Related Harm and Hospital Admissions

In 2012, there were 5,293 smoking attributable hospital admissions in Inverclyde, a rate of 2,740.6/100,000 in Inverclyde compared to 3,149/100,000 across Scotland. All measures in relation to smoking attributable diseases, such as Chronic Obstructive Pulmonary Disease incidence and mortality, Lung Cancer registration and death and smoking attributable deaths within Inverclyde are greater than the Scottish average, (see figure 10).[12]

Figure 10: Smoking Related Disease and Death in Inverclyde



2.7 Electronic Cigarettes (E-cigarettes)

Electronic Cigarettes or e-cigarettes are battery-powered devices that heat a liquid, often containing nicotine and flavourings, into a vapour that is inhaled.[13] A Cochrane Review on the safety of e-cigarettes concluded that no safety concerns emerged in the short to mid-term use (2 years or less).[14] Overall e-cigarettes are considered 95% less harmful than cigarettes.[15]

Awareness and use of e-cigarettes has increased across Scotland (ASH).[13] According to the NHS GGC Health and Wellbeing Profile (Inverclyde), 2014, 13% of adults in Inverclyde used e-cigarettes in the last year.[4] In addition 50% of respondents agreed or strongly agreed that e-cigarettes encourage people to stop smoking. According to a study in England, approximately 30% of all attempts to stop smoking in the past year involved e-cigarettes, this is higher than any other stop smoking aid.[16] There is also some evidence of increased success in stopping smoking using an e-cigarette when compared to using no help or over the counter

nicotine replacement therapy. The most common reason for using e-cigarettes is to reduce health risks of smoking by either stopping smoking completely and or reducing smoking.

There is a concern that e-cigarettes are a gateway to smoking for young people who would have otherwise never smoked.[13,16] According to the 2013 SALSUS, 6% of 13 year olds and 13% of 15 year olds have either tried or have used e-cigarettes.[6] A recent study in England has explored e-cigarette use among young people.[17] 88% of pupils were aware of e-cigarettes, this increased with age, 80% of 11 year olds and 93% of 15 year olds. 22% of pupils reported that they had used e-cigarettes on at least one occasion. This varied by cigarette smoking status, with regular smokers (89%) more likely to have used e-cigarettes than those who had never smoked cigarettes (11%). Again, e-cigarettes use increased with age, 5% of 11 year olds compared to 35% 0f 15 year olds said they had used e-cigarettes at least once. In addition boys (23%) were more likely than girls (20%), to have used e-cigarettes. The use of e-cigarettes with young people needs to be monitored. The Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill has been circulated for comment.[18] The Bill will introduce various restrictions on the sale (young people under the age of 18 years) and promotion of nicotine vapour products, such as e-cigarettes, thus reducing availabilty.

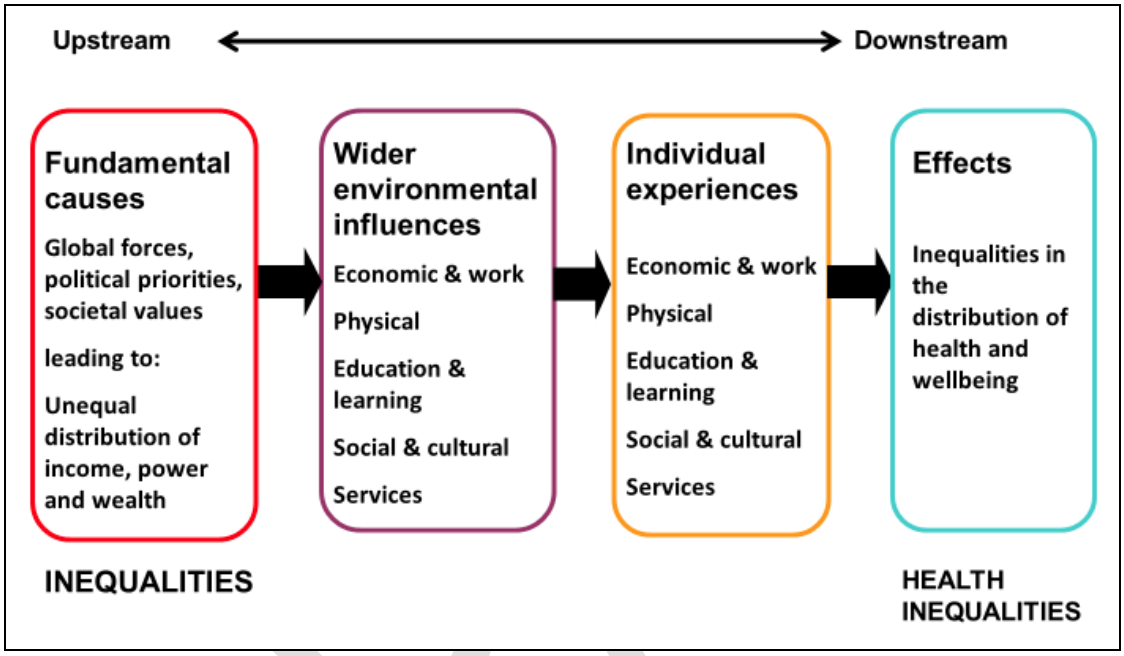
2.7 Smoking and Inequalities in health

Inequalities and inequalities in health remain a significant challenge for Scotland and Inverclyde. Smoking is a direct cause of continued inequalities in health with clear correlation between area deprivation, smoking prevalence and life expectancy.[1] In Inverclyde one in three residents live in areas considered to be within the most deprived 15% in Scotland.[19] Smoking prevalence, including smoking in pregnancy is higher than the Scottish average and life expectancy, in particular for men is less than the Scottish average.[8,12] In addition, smoking related hospital admissions and smoking related conditions such as lung cancer and Chronic Obstructive Pulmonary Disease (COPD) are greater than the Scottish average.[12]

Although focused work on specific risk factors is important, there is evidence that this alone will not reduce inequalities in health. The Ministerial Task Force on Reducing

Health Inequalities reconvened to consider the latest evidence on health inequalities in Scotland and from this a summarised theoretical account of upstream and downstream causes of inequalities and their effect on health inequalities was presented (Figure 11).[20]

Figure 11 Health Inequalities: Theory of Causation *(reproduced with permission from NHS Health Scotland: this info is © NHS Health Scotland.*



In addressing inequalities action is required at all three levels, fundamental, wider and individual level. Inverclyde's Single Outcome Agreement (SOA), delivered through the Inverclyde Alliance, aims to address these determinants, by improving quality of life and wellbeing of people who live in Inverclyde, whilst tackling the inequalities which exist across the area. Inverclyde Tobacco Strategy and Action Plan will contribute to the overall aim of reducing inequalities in health by working closely with partners within the Inverclyde Alliance and assets based approaches.

The priorities outlined within this strategy will assist in the delivery of two of the Single Outcome Agreement (SOA) outcomes:

- The health of local people is improved, combating health inequality and promoting healthy lifestyles

- A nurturing Inverclyde gives all our children and young people the best possible start in life.

The strategy will also help the Alliance to achieve the wellbeing outcomes set out in the SOA, to ensure that every child, citizen and community in Inverclyde are safe, healthy, achieving, nurtured, active, respected, responsible and included, this is summarised in the Nurturing Inverclyde Wheel, (see figure 12).

Figure 12: Nurturing Inverclyde Wheel

2.8 Conclusion

There has been good progress in reducing smoking prevalence for adults, pregnant women and young people within Inverclyde. However the impact of tobacco continues to be a leading, preventable cause of morbidity, premature mortality and inequalities in health. Reducing smoking prevalence with key priority groups is important, in particular young people, pregnant women, those living within areas of deprivation and marginalised members of society, if we are to achieve a tobacco-free generation in Inverclyde by 2034. Inverclyde continues to have clear health inequalities, with smoking prevalence higher across our most deprived communities. However in order to have a real impact on reducing inequalities and inequalities in

health measures to tackle poverty and unemployment can have a bigger impact on tackling this by improving life circumstances for people, rather than just specific, targeted services at individual level. To make the difference we need both, and the wider inequalities can be out with the scope of services' influence.

3. National Policy

3.1 National Tobacco Policy Scotland

There have been a number of national tobacco control initiatives, backed up with local enforcement, including a ban on tobacco advertising since 2002, the introduction of smokefree legislation in 2006, increasing the age for tobacco sales from 16 to 18 in 2007, overhauling tobacco sale and display laws as well as ongoing investment in NHS smoking cessation services.[10,13,21,22]

In 2014, the Scottish Government launched a *'Consultation on Electronic Cigarettes and Strengthening Tobacco Control in Scotland'.*[15] This calls for views on a range of measures to protect young people, including an age restriction on the sale and purchase of e-cigarettes; additional action to control the advertising and promotion of the devices; and legislation to prohibit smoking in vehicles with children on board.[23] This is now progressed to a consultation of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill.[18]

In 2013, the Scottish Government launched their new tobacco strategy for Scotland, Creating a Tobacco-Free Generation; A Tobacco Control Strategy for Scotland.[1] This is five year strategy and aspires to create a tobacco-free generation by 2034, defined as a smoking prevalence among the adult population of 5% or lower, and with a clear focus on those communities at greatest risk of unequal health outcomes. Reducing inequalities, partnership working, and assets based approach are key cross cutting themes within the Strategy.

The Scottish Government's Tobacco Control Strategy has placed responsibility on local authorities to drive forward the tobacco control agenda through the development of a local tobacco plan. The Inverclyde Tobacco Strategy and action plan will aim to address tobacco with our Inverclyde Alliance partners. This strategy

sets the detail for the introduction of a local implementation group, consisting of Inverclyde Alliance partners, to set local policy as well as deliver upon a unified agreed action plan.

3.2 Progress within Inverclyde

There has been a great deal of progress and activity, within Inverclyde, to address tobacco, the following is examples of local activity:

- Availability of smoking cessation services, delivered by trained smoking cessation practitioners, within the community, hospital and maternity settings.
- Inverclyde was the first local authority in Scotland to successfully pilot Smokefree play parks with this initiative being rolled out across the full local authority area.
- A specific smokefree policy has been developed for Looked After and Accommodated Children (LAAC) following good practice evidence base developed by NHS Greater Glasgow and Clyde (NHSGGC).
- Inverclyde was the first local authority to initiate smokefree family events with the first of these taking place at the 2012 Gourock Highland Games.

3.3 Strategic Context

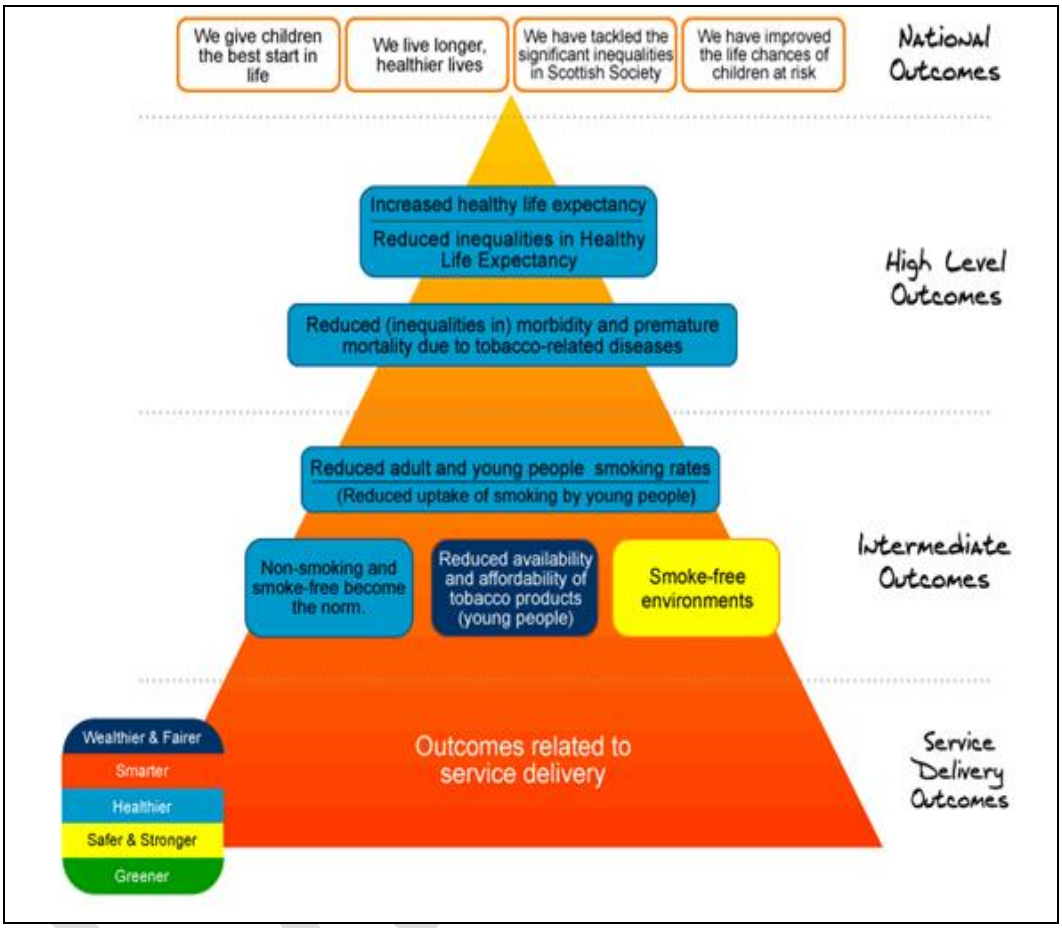
Over recent years a number of key strategic documents have been developed to further highlight the importance of a partnership approach to tackling tobacco. Successive Governments have recognised the importance of this issue through consistent strategic publications. These are noted within appendix 1.

Historically tackling the issue of tobacco and its associated problems has fallen within the remit of health services. Inverclyde Alliance recognises that in order to successfully embed work across prevention, cessation and protection it is crucial to cement this strategy within the working remit of partner agencies. This approach is supported by relevant research which encourages a combination of measures across a multitude of respective organisations and departments.

Implementation of the Inverclyde Tobacco Strategy forms a key component of the Inverclyde Alliance Single Outcome Agreement and Community Planning Framework. NHS Health Scotland has produced outcome framework tools that assist local community planning partners to clarify links between outcomes of services

provided and the shared health improvement outcomes that they are working with partners to achieve. They are designed to assist community planning partners in developing outcomes-focused approaches to planning and performance, figure 13 presents the Tobacco Health Outcomes Triangle.

Figure 13: The Tobacco Health Outcomes Triangle



NHS Health Scotland (2012) – Tobacco Health Outcomes Triangle
http://www.healthscotland.com/OFHI/tobacco/content/outcomes_triangle.html

4. Inverclyde Tobacco Strategy

4.1 Aims, Objectives and core principles of the Inverclyde Tobacco Strategy

The overall aim of the Inverclyde Tobacco Strategy is to improve the health of local people by addressing health inequality and promoting positive lifestyles by reducing the harmful effects of tobacco. A number of key objectives contribute to this aim and set the devolved nature adopted both in approach and ambition:

- Tackling health inequalities is regarded as a key component of reducing smoking prevalence through targeted resources within areas of greatest need.
- Tobacco control measures focus on anti-smoking and refrain from anti-smoker in approach and outcome.
- Non smoking is promoted as socially normal across Inverclyde.

In addition, the following core principles support the above and raise the awareness of the work required across partners and professional work streams:

- All non smokers have a fundamental right not to be exposed involuntarily to secondhand smoke.
- Children and young people have the right to be free from tobacco related advertising and promotion.
- All smokers have the opportunity to access stop smoking advice and support across the local area in a time-efficient and convenient manner.
- Inverclyde is regarded as an area of good practice regarding tobacco control activities.

4.2 Equalities Act, 2010

To ensure the Inverclyde Tobacco Strategy and Action Plan complies with the Equality Act, 2010, an Equality Impact Assessment has been carried out.[24] Smoking is a direct cause of continued inequalities in health. This is evident across Inverclyde where the smoking prevalence, including smoking in pregnancy is higher than the Scottish average, life expectancy, in particular for men is less than the Scottish average and the incidence of smoking related hospital admissions and conditions such as lung cancer and Chronic Obstructive Pulmonary Disease (COPD) are greater than the Scottish average. In addition there are others with certain protected characteristics who are more likely to smoke. For example, people with severe and enduring mental health problems, people who are homeless, Gypsy/Travellers, gay and bisexual men, prisoners and certain age groups e.g. 40 – 64 years of age, are more likely to smoke.[8,12] The Strategy and Action Plan will ensure that those who are more likely to smoke are not discriminated against. The EQIA of the Strategy will

ensure the needs of those who are more likely to smoke are addressed. The EQIA of the Inverclyde Tobacco Strategy is available to view online.[17]

4.3 Targets and Key Performance Indicators

Targets for Inverclyde focus on smoking cessation activity and outcomes for community, pregnancy, hospital and pharmacy stop smoking services. The former HEAT targets and standards have been replaced by a suite of Local Delivery Plan (LDP) standards. These have been grouped as strategic priorities identified in the 2015-16 Strategic Direction / Local Delivery Plan. A smoking cessation LDP standard for 2015/16 has been agreed as follows:

> *NHS Scotland to sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas (60% SIMD areas for island Boards).*

The smoking cessation LDP standard for 2015/16 is measured on 12 week outcomes from the 40% most deprived. At the time of writing this Strategy, Inverclyde specific trajectories have still to be agreed.

4.5 Implementation of Strategy

This strategy has been led by Inverclyde Alliance (Inverclyde Community Planning Partnership), and is supported by Inverclyde Council, the HSCP and NHS Greater Glasgow and Clyde. The collective approach taken confirms a responsive and shared approach which offers the greatest opportunity for sustained success. Contributions from a range of partners have been paramount to the overall coordination and development of this strategy.

Establishing strong community engagement channels will support the work of partners to not only promote services but enact proactive and preventative measures. Involving our local communities in decisions which impact upon them is essential in order to gain a full understanding of their individual needs. Local community engagement networks offer an ideal pathway for this work to be highlighted as well as promote a positive forum for the delivery of future outcomes.

4.6 Monitoring and Evaluation of Strategy

Monitoring of this strategy will inform progress and future direction, and the allocation of both local and wider resources. Progress will be reported primarily through the Inequalities Outcome Delivery Group as a conduit to the wider Inverclyde Alliance Single Outcome Agreement Programme Board. A report will be available quarterly informing progress across all outcomes and will be compiled by partners involved in the delivery of this strategy.

4.7 Funding

In order to refocus efforts directed towards reducing tobacco related harm it will be necessary for Inverclyde Alliance Partners to distribute resources in line with greatest need. This means we will have to ensure we have enough staff to deliver services and enough resources to support them.

Partners will be required to invest their time in supporting action from the Strategy, for example facilitate and attend training, supporting prevention work, referral into the stop smoking services and time required for Tobacco Strategy Local Implementation Group meetings. Support may be required to identify future investment opportunities in order to address the significant tobacco related health inequalities evident across Inverclyde. NHSGGC tobacco prevention budget is a non recurring budget which, at time of writing, is available as a support mechanism for preventative work.

4.8 Action Plan

The action plan developed to support this strategy outlines three key themes for future work:

- Prevention – creating an environment where young people choose not to smoke
- Protection – protecting people from the harmful effects of secondhand smoke
- Cessation – help for those who want to stop smoking

The actions identified that will meet the needs of this strategy have been detailed below with corresponding strategic outcomes. The related performance indicators

are noted within the accompanying action plan which has also been informed by NHSGGC Tobacco Planning and Implementation (PIG) Group.

Each strategic outcome is linked to key actions as follows:

Strategic Outcome	This is the required high level result of the actions and related performance measures. This will detail the difference the strategy will make to the Inverclyde area and its people.
Actions	These are the individual high level actions to be taken in order to address the strategic outcomes. These indicate what needs to happen.
Indicator	Detailed performance indicators which require to be specific, measurable and associated with the strategic outcome.

The following highlights the agreed outcomes with subsequent actions; more detail is included within the Tobacco Action Plan.

1. Smoking Prevention

Strategic Outcome

Actions:

1. 1. Hard to reach groups will be engaged within Inverclyde including those who are not in employment, education or training or who are in settings, occupations or minority groups with higher than average smoking levels.

1. 2. Inverclyde will actively involve children and young people in the planning and delivery of tobacco services and programmes to ensure their perspectives are fully reflected in the approaches adopted and to encourage active citizenship.

1. 3. Organisations and agencies who come into contact with children and young people are encouraged to develop a health leadership role by:

- adopting and enforcing clear no smoking policies.

- reinforcing messages concerning the addictiveness and health risks associated with smoking and secondhand smoke.

1. 4. Training on tobacco will be promoted and facilitated for staff working with young people most at risk from taking up smoking.

There will be fewer people who smoke, particularly within more disadvantaged population groups such as those who are not in employment, education or training or who are in settings, occupations or minority groups with higher than average smoking levels.

2. Stop Smoking Services

Strategic Outcome

Inverclyde will continue to develop and provide comprehensive, integrated and intensive stop smoking services based on the evidence of effectiveness and targeted to the needs of the population, this will include e-cigarettes. This will be guided by national recommendations for stop smoking services and practices and monitored and reviewed in line with national requirements.

Actions:

2.1. Inverclyde will continue to develop and provide comprehensive, integrated and intensive stop smoking services based on the evidence of effectiveness and targeted to the needs of the population.

2.2 The performance of local stop smoking services will be monitored and reviewed in line with national requirements and within the required time frame to inform the targeting of service delivery.

2. 3. All strands of stop smoking services are effectively promoted through awareness raising with the public and health professionals including: Smokefree Community, Pharmacy, Pregnancy, Acute and Butt Out services.

2.4 Stop Smoking services will be vigorously promoted within other services (e.g. debt counselling, housing, social services) which tackle the broader social issues that contribute to smoking behaviour and create barriers to stopping smoking and throughout NHS Contractors and ancillary NHS services.

2.5 Ensure the provision of stop smoking services to young people throughout Inverclyde.

3. Protection (protecting people from secondhand smoke

Strategic Outcome

Individuals exposure to secondhand smoke and the wider harm associated with smoking will be reduced within Inverclyde

Actions:

3.1 Individual exposure to secondhand smoke (SHS) and the wider harm associated with smoking will be reduced within Inverclyde.

3.2 Inverclyde will develop and sustain capacity in relation to tobacco control, building upon strong community infrastructure.

Appendix 1

Relevant policy documentation which support the development of tobacco strategy both locally and nationally:

Creating a Tobacco-free Generation – A Tobacco Control Strategy for Scotland (2013) (pdf, 258kb)
http://www.scotland.gov.uk/Publications/2013/03/3766

Schools (Health Promotion and Nutrition) Scotland Act (2007)
http://www.scotland.gov.uk/Topics/Education/Schools/HLivi/foodnutrition

A Guide to Smoking Cessation in Scotland (2010)
http://www.healthscotland.com/documents/4661.aspx

National Institute for Health and Clinical Excellence (2013)
http://www.nice.org.uk/search?q=smoking+harm+reduction

State of the Nation: Measuring progress towards a tobacco free Scotland (2010)
http://www.ashscotland.org.uk/media/3405/ASH%20Scotland%20STATE%20OF%20THE%20NATION150910.pdf

HEAT (Health Efficiency Access and Treatment) Health Improvement Targets (2013)
http://www.scotland.gov.uk/Publications/2013/11/4395/8

Inverclyde Tobacco Strategy

Action Plan

The following action plan template is designed to provide an overview of tobacco control work directed by national and local targets.

Timescale:

It is anticipated that this work will span the next 2 years and will link directly with the work of the Inverclyde Alliance Single Outcome Agreement. (we use those questions within our planning to reflect an element of self evaluation in the process, and they appear in the action plans for the Directorate Improvement Plans. You don't have to include them, but I thought it might help join the Council and CHCP planning processes up a bit?)

Strategic Outcome	This is the high level result of the actions and related performance measures. This will detail the difference the strategy has made to the Inverclyde area**. This is where we want to be**.
Actions	These are the individual high level actions to be taken in order to address the strategic outcomes. These indicate what needs to happen. **This is how we will get there.**
Indicator	Detail performance indicator which require being specific, measurable and associating with the strategic outcome. **This is how we will know we are getting there.**

1. Smoking prevention

Outcome: There will be fewer people who smoke, particularly within more disadvantaged population groups such as those who are not in employment, education or training or who are in settings, occupations or minority groups with higher than average smoking levels.

Action	Indicator	timescale	Partners
1. 1. Hard to reach groups will be engaged within Inverclyde including those who are not in employment, education or training or who are in settings, occupations or minority groups with higher than average smoking levels.			
1.1.1 Develop partnership working to address potential interactions between tobacco and wider health behaviours with a focus on vulnerable young, specifically young people in care.	a. Number of tobacco awareness sessions for young people in LAAC settings b. Number of CPD training sessions and number of staff trained in tobacco awareness and effective tobacco policy. c. Number of LACYP engaging with stop smoking services.	2017	Health and Social Care Partnership (HSCP) Health Improvement Team, LAAC Nurse, Children & Families Team, staff in Looked After Children and Young People,(LACYP) residential units, Foster Carers, Kinship Carers, adoptive carers. Young carers, Education.
1.1.2 Develop and implement strategies for young people in custody or within the youth justice system	a. Number of tobacco awareness sessions for young people b. Referral activity report	2017	Criminal Justice Services (Youth), Health Improvement Lead for prisons
1.1.3 Ensure joint working with local Alcohol and Drug Partnership (ADP) in relation to potential interactions between tobacco and wider health behaviours including Cannabis use.	a. Progress report on joint activity b. Number of training and awareness sessions delivered c. Referral activity report	2017	HSCP Health Improvement Team, Alcohol and Drugs Partnership, Addiction Services.

Action	Indicator	timescale	Partners
1. 2. Inverclyde will actively involve children and young people in the planning and delivery of tobacco services and programmes to ensure their perspectives are fully reflected in the approaches adopted and to encourage active citizenship			
1.2.1. Ensure continued implementation and development of effective tobacco control education in Inverclyde schools through curriculum for excellence	a. Number of schools signed up for: Name the Teddy, Tradewinds and Smokefree for Me a. Number of CPD sessions delivered to teachers. b. Number of teachers attending relevant CPD training c. Record of relevant discussions / planning outcomes with Health and Wellbeing Steering Group (Education Services)	2017	HSCP Health Improvement Team, Education, NHSGGC Smokefree Services.
1.2.2 Support local authority to deliver the enforcement programme in relation to underage sale of tobacco. Specifically, by supporting the recruitment of young people to become test purchasers.	a. Number of young people recruited each year b. Number of test purchases delivered each year c. Number of training sessions delivered to community wardens.	2017	CHCP HI, Trading Standards Team, young people.
1.2.3 Ensure appropriate engagement of young people in the development of tobacco prevention programmes ensuring a targeted, neighbourhood approach**.**	a. Number of young people involved b. Activity and outcome report with young people c. Report of attendance at Inverclyde Health and Wellbeing Conference on 25th March, involving young people and addressing risky behaviours.	2017	Young people, youth groups, Education Health and Wellbeing Development Officer, Smokefree Services, education, West College Scotland, CHCP HI, CLD, NHSGGC SFS, Weigh to go – Your Voice, More Choices, More Chances.

Action	Indicator	timescale	Partners
1. 3. Organisations and agencies which come into contact with children and young people are encouraged to develop a health leadership role by: • **adopting and enforcing clear no smoking policies** • **reinforcing messages concerning the addictiveness and health risks associated with smoking and secondhand smoke**			
1.3.1. Support the development of Smokefree policies with organisations working with young people aged 16-24.	a. Record of work with relevant organisations b. Number of organisations with Smokefree policy	2017	NHSGGC SFS, CHCP HI, Youth organisations, CVS Inverclyde, Inverclyde Council Community Learning and Development, West College Scotland, Schools, Inverclyde Community Development Trust.
1.3.2 Deliver tobacco awareness sessions with young people, young people aged 16-24 and support Inverclyde Colleges achieving Healthy Body Healthy Mind award by delivering smoking prevention activities.	a. Number of awareness sessions delivered. b. Report on organisations participating. c. Number of young people 16-24 receiving tobacco awareness sessions. d. Number of smoking prevention activities delivered in colleges e. Number of young people engaging with smoking cessation.	2017	NHSGGC SFS, CHCP HI, Youth Providers, West College Scotland, education, Get Ready to Work programmes, Inverclyde Community Development Trust, CVS Inverclyde, Inverclyde Council Community Learning and Development, More Choices, More Chances.
1.3.3 Implement NHS GGC Youth Smokefree Policy guide with identified youth organisations	a. Record of work with local youth organisations b. Number of local youth organisations with a Smokefree Policy in place.	2017	NHSGGC SFS, CHCP HI, CLD-Youth Work Sub Group, Youth organisations, West College Scotland, CVS Inverclyde Life, Uniformed organisations, More Choices, More Chances.

Action	Indicator	timescale	Partners
1. 4. Training on tobacco will be promoted and facilitated for staff working with young people most at risk from taking up smoking			
1.4.1 Ensure tobacco awareness, young people and tobacco and Smokefree policy training is delivered to projects and services working with young people.	a. Number of training sessions delivered. b. Report on organisations participating	2017	NHSGGC SFS, CHCP HI, CLD-Youth Work Sub Group, Youth organisations, West College Scotland, CVS Inverclyde Life, Uniformed organisations, Criminal Justice (Young People), More Choices, More Chances.

2. Stop Smoking

Outcome: Inverclyde will continue to develop and provide comprehensive, integrated and intensive stop smoking services based on the evidence of effectiveness and targeted to the needs of the population, this will include e-cigarettes. This will be guided by national recommendations for stop smoking services and practices and monitored and reviewed in line with national requirements.

Action	Indicator	timescale	Partners
2.1. Inverclyde will continue to develop and provide comprehensive, integrated and intensive stop smoking services based on the evidence of effectiveness and targeted to the needs of the population			
2.1.1 Smokefree Services to continue to deliver current Local Deliver Plan Standard for Smoking Cessation.	a. Numbers engaging b. Numbers setting a quit date c. Numbers successfully stopping smoking in relation to current target.	2017	Community, Pharmacy, Pregnancy, Mental Health, Youth and Hospital Smokefree Services
2.1.2 Ensure the stop smoking services is in line with national recommendations	a. Recommendations implemented b. Service activity report	2017	Community, Pharmacy, Pregnancy, Mental Health, Youth and Hospital Smokefree Services
2.1.3 Cessation services that support the needs of people living in deprived areas and other groups where tobacco use plays a key role in unequal health outcomes (unemployed, homeless, those with mental health issues, LACYP, alcohol and drug dependency, BME, LGBT).	a. Number of priority groups engaging b. Number of priority groups setting a quit date c. Number of priority groups successfully stopping smoking d. Reduction in adult prevalence in SIMD 1 and 2	2017	Inverclyde Smokefree Services, NHS GGC Smokefree Services, Health and Social Care Services, Voluntary Organisations, Prison Service, CLD, CVS, Your Voice, Care Organisations/Homes, Local Community (volunteers), Homeless, Addiction services, River Clyde

			Homes, Family Centres, LACYP, Fostering & Adoption training, Women and Children's Services.
2.1.4 Ensure all Smokefree Service providers are appropriately trained to national standards	a. All practitioners to be trained in Health Related Behaviour Change level one b. All practitioners to be trained in Maudsley / PATH c. All practitioners to be working towards level two health related behaviour training	December 2013 April 2011 March 2014	NHS GG&C Training Quality Group; HSCP training section

Action	Indicator	timescale	Partners
2.2 **The performance of local stop smoking services will be monitored and reviewed in line with national requirements and within the required time frame to inform the targeting of service delivery**			
2.2.1 Local targets specific to each Smokefree Service will be agreed. Data will be collected locally and Board level through data collection services and also recorded through the Organisational Performance Review structure.	For each Service and all services collectively activity is measures against agree targets: a. Numbers engaging b. Numbers setting a quit date a. Numbers successfully stopping smoking in relation to current target.	Ongoing	Community, Pharmacy, Hospital, Mental Health, Youth and Pregnancy services, NHS GG&C data collection services and HSCP planning and performance team.
2.2.2 To increase local awareness and uptake of the Smokefree Pregnancy	a. Numbers setting a quit date b. Numbers successfully stopping	2017	Smokefree Pregnancy service, NHS GG&C data collection services and

Service.	smoking in relation to current target c. Smoking prevalence at antenatal booking and 10 days post natal d. Outcome PDSA Early Years Collaborative.		CHCP planning and performance team, voluntary organisations e.g. Barnardos, Women and Children's Services.

Action	Indicator	timescale	Partners
2.3. All strands of stop smoking services are effectively promoted through awareness raising with both the public and health professionals including: Smokefree Community, Pharmacy, Pregnancy, Acute and Butt Out services			
2.3.1 Campaign to increase uptake of stop smoking services, including dual tobacco and e-cigarette users: community, Butt Out, Acute Pregnancy and Pharmacy	a. Number of promotional campaigns and events delivered b. Number of community engagement sessions delivered c. Number of people engaged via No Smoking Day d. Monitoring report on efficacy of promotional campaigns in relation to service activity.	2017	HSCP Health Improvement Team, Education, Colleges, NHSGGC SFS (Acute, Pregnancy, Community and Pharmacy Services), Corporate Communications.

Action	Indicator	timescale	Partners
2.4 Stop Smoking services will be vigorously promoted within other services (e.g. debt counselling, housing, social services) which tackle the broader social issues that contribute to smoking behaviour and create barriers to stopping smoking and throughout NHS Contractors and ancillary NHS services			
2.4.1 Ensure engagement of service	a. Monitoring report of source of	2017	Inverclyde Tobacco LIG partners,

leads in promotion of stop smoking services	referral b. Number of information sessions delivered to services c. Referral pathways agreed		Service leads and staff from debt counselling, credit union, Health and Social Care Services, Voluntary Organisations, Prison Service, CLD, CVS, Your Voice, Care Organisations, Local Community (volunteers), Homeless, Addiction services, River Clyde Homes CLD, Family Centres. LAAC, Fostering & Adoption training.
2.4.2 Ensure engagement of HSCP and council staff with Smokefree services.	a. Number of staff engaging b. Number of staff setting a quit date c. Number of staff successfully stopping smoking	2017	Health Working Lives, corporate Communications.
2.4.3 Provide training on best practice smoking cessation (particularly brief interventions) to a range of health professionals (drug and alcohol workers, mental health) and other relevant groups including non-health sector professionals who work with disadvantaged populations	a. Number of training sessions delivered b. Numbers trained c. Number of organisation receiving training	2017	Inverclyde Smokefree Services, NHS GGC Smokefree Services, Health and Social Care Services, Voluntary Organisations, Prison Service, CLD, CVS, Your Voice, Care Organisations, Local Community (volunteers), Homeless, Alcohol and Drug Services.
2.4.4 Ensure pathways into Smokefree Services are available to all professionals and potential referring services	a. Referral pathways agreed b. Monitoring report of source of referral c. Number of information sessions delivered to services	2017	GPs, practice staff; dental staff; nursing and midwifery staff (acute, primary care and community), social work, Alcohol and Drug Partnership, money advise services, Inverclyde Corporate Communications.

Action	Indicator	timescale	Partners
2.5 Ensure the provision of stop smoking services to young people throughout Inverclyde			
2.5.1 Deliver Butt Out stop smoking service for young people under 24 years	a. Number of referrals b. Number of young people setting a quit date c. Number of young people successfully stopping smoking	2017	NHSGGC Smokefree Services, Inverclyde Smokefree Services, Youth organisations, CLD, education, West College Scotland, Education Health and Wellbeing Development Officer, More Choices, More Chances.
2.5.2 Take account of the views of young people from Inverclyde Health and Wellbeing Survey in relation to their preferred source of support to stop smoking.	a. Feedback report from Health and Wellbeing Conference on 25th March	2017	Inverclyde Smokefree Services, Youth organisations, CLD, education, West College Scotland, Education Health and Wellbeing Development Officer.
2.5.3 Implement a stop smoking programme for 16-24 year olds in West College Scotland.	a. Number of referrals b. Number of 16 – 24 year olds setting a quit date c. Number of 16 – 24 year olds successfully stopping smoking	2017	NHSGGC SFS, SFS Community and Youth Services, West College Scotland, Inverclyde Community Development Trust, CVS Inverclyde, Inverclyde Council Community Learning and Development.
2.5.4 In support of Inverclyde Smokefree Care Placements Policy for Looked After and Accommodated Children and Young People, deliver tobacco awareness for young people, Butt Out stop smoking service and tobacco awareness training for residential unit staff	a. Number of awareness sessions with LACYP b. Number of awareness sessions with residential unit staff c. Number of referrals d. Number of LACYP setting a quit date e. Number of LACYP successfully stopping smoking	2017	NHSGGC SFS, SFS Youth Service, LACYP Nurse, LACYP Unit staff

3. Protection (Protecting people from secondhand smoke)

Outcome: Individual exposure to Secondhand smoke and the wider harm associated with smoking will be reduced in Inverclyde

Action	Indicator	Timescale	Partners
3.1 Individual exposure to Secondhand Smoke (SHS) and the wider harm associated with smoking will be reduced within Inverclyde			
3.1.1 Support the Government proposed campaign to raise awareness of the harm caused by SHS in enclosed places such as homes and cars and support people to reduce the harm it causes	Local implementation of indicators to be provided by Scottish Government	2017	Inverclyde Smokefree services, Inverclyde Tobacco LIG partners, NHS GGC Smokefree services.
3.1.2 Implement smoke-free grounds across all local authority and NHS localities by, using a partnership approach to share learning and experiences of policy development. • Smokefree hospital grounds within acute settings (March 2015) • Smokefree Mental health grounds (October 2015).	a. Local implementation report b. Number of NHS and Local Authority staff receiving Smokefree Policy training. c. Number of Inverclyde family events are designated Smokefree environments. d. Progress report of implementation of joint NHS and local authority Smokefree policies within the wider context of the integration of adult health and social care	2017	SFS Community Services; SFS NHSGGC; Health & Safety Forum; Inverclyde Smokefree Policy Representatives for, Acute Services, Mental Health Services, Local Authority and HSCP staff, Inverclyde hospitals – management and facilities.

3.1.3 Drive the adoption of smokefree policies in organisations working with vulnerable people	a. Youth smokefree policies (*see prevention section)* b. Residential care homes for the elderly: Scope out issues with staff and residents, including support for people with dementia who smoke.	2017	Inverclyde Smokefree Services, LACYP Nurse, LACYP, Residential Care Homes, Fostering and Adoption Services, Mental Health Services, Residential Care Homes, River Clyde Homes (Sheltered Homes), Care Scotland, Fire Safety, Homeless organisations.

Action	Indicator	timescale	Partners
3.2 Inverclyde will develop and sustain capacity in relation to tobacco control, building upon strong community infrastructure			
3.2.1 Ensure partners within the community voluntary sectors are provided with opportunities to protect people from SHS by working together to reduce exposure to SHS	a. Activity report of jointly promoted local tobacco campaigns b. provide resources to ensure people are protected from SHS and harm	2017	CVS, CLD, Health Improvement, Your Voice, Smokefree Community Services, Inverclyde Carers, ICOD, Inverclyde Community Development Trust, British Lung Foundation.
3.2.2 Ensure all antenatal and postnatal services and adoption, foster, kinship and residential care services support new parents to create a Smokefree home and car by local implementation of NHS GGC Smoking in the Home training and use of resources for relevant professionals and carers.	a. Number of courses delivered b. Number of staff receiving training c. Number of families using the Dylos Machine intervention	2017	Child and Maternal Services, Inverclyde Smokefree Services, Your Voice, Inverclyde Carers, ICOD, Inverclyde Community Learning and Development, LACYP services, Family Nurse Partnership.

3.2.3 Using a co-production model, implement an approach to reduce the availability of and demand for illicit tobacco by developing a toolkit to increase community engagement to address illicit tobacco and continue partnership action to address illicit supply of illicit tobacco.	a. Number of surveys returned c. Number of focus groups held d. Final report and recommendations	2014 2014 2015	NHSGGC and Inverclyde Smokefree Services, Your Voice, CLD.

References

1. Scottish Government,(2013). Creating a Tobacco-Free Generation, A Tobacco Control Strategy for Scotland. http://www.scotland.gov.uk/Publications/2013/03/3766/0

2. NHS Greater Glasgow and Clyde Inverclyde Health and Wellbeing Survey, (2008). http://www.phru.net/rande/Health%20and%20Wellbeing%202008/2008%20Inverclyde%20Final%20Report%20(2).pdf

3. NHS Greater Glasgow and Clyde Inverclyde Health and Wellbeing Survey, (2011). http://www.nhsggc.org.uk/media/225756/nhsggc_ph_nhs_greater_glasgow_and_clyde_2011_health_and_wellbeing_survey_inverclyde_report.pdf

4. NHS Greater Glasgow and Clyde Inverclyde Health and Wellbeing Survey, (2014). (Unpublished)

5. Inverclyde Child and Youth Health and Wellbeing Survey (2013). http://www.nhsggc.org.uk/media/232366/nhsggc_public_health_inverclyde_child_and_youth_health_and_wellbeing_survey_2013.pdf

6. SALSUS (2008-2013). Smoking, Drinking and Drug Use among 13 and 15 year olds in Inverclyde. Available from: http://www.isdscotland.org/Health-Topics/Public-Health/SALSUS/

7. NHS GGC Central Information Centre, accessed July 2015.

8. Scottish Public Health Observatory Health and Wellbeing Profiles (2014). Accessed January 2015 https://scotpho.nhsnss.scot.nhs.uk/scotpho/profileSelectAction.do

9. The Scottish Government; Scottish Household Survey 2013, http://www.scotland.gov.uk/Resource/0045/00457570.pdf

10. Tobacco and Primary Medical Services (Scotland) Act 2010 http://www.scotland.gov.uk/Resource/0039/00398197.pdf

11. The Smoking, Health and Social Care (Scotland) Act 2005 http://www.clearingtheairscotland.com/faqs/index.html

12. Tobacco Control Profile (Inverclyde) (2013), Accessed January 2015 https://scotpho.nhsnss.scot.nhs.uk/scotpho/profileSelectAction.do

13. Ash Scotland Briefing on E-Cigarettes, (2014). http://www.ashscotland.org.uk/media/6675/E-cigarettes.pdf Accessed 28/07/2015

14. McRobbie H, Bullen C, Hartmann-Boyce J, Hajek P, (2014). Electronic cigarettes for smoking cessation and reduction. The Cochrane Collaboration. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD010216.pub2/abstract;jsessionid=96654CE36A1E2218855FE5DE52A16D69.f01t02 accessed 28/-7/2015

15. David J. Nutt, Lawrence D. Phillips, David Balfour, H. Valerie Curran, Martin Dockrell, Jonathan Foulds, Karl Fagerstrom, Kgosi Letlape, Anders Milton, Riccardo Polosa, John Ramsey, David SweanorNutt et al (2014) Eur Addict Res Estimating the Harms of Nicotine-Containing Products Using the MCDA Approach 20:218–225

16. West R, Hajek P, Mcneill A, Brown J, Arnott D (2015) Electronic cigarettes: what we know so far. A report to UK All Party Parliamentary Groups. www.smokinginengland.info/reports/ accessed 28/07/2015

17. Smoking, drinking and drug use among young people in England in 2014, (2015). Health and Social Care Information Centre. http://www.hscic.gov.uk/catalogue/PUB17879/smok-drin-drug-youn-peop-eng-2014-rep.pdf Accessed 05/08/2015

18. The Health (Tobacco, Nicotine etc. and Care) (Scotland) Bill http://www.scottish.parliament.uk/parliamentarybusiness/Bills/89934.aspx

19. Inverclyde Alliance Single Outcome Agreement (2013). Accessed February 2015. http://www.inverclyde.gov.uk/council-and-government/community-planning/inverclyde-alliance-single-outcome-agreement/

20. Beeston C, McCartney G, Ford J, Wimbush E, Beck S, MacDonald W, and Fraser A. Health Inequalities Policy Review for the Scottish Ministerial Task Force on Health Inequalities. NHS Health Scotland. Edinburgh. 2014 http://www.healthscotland.com/uploads/documents/23047-1.%20HealthInequalitiesPolicyReview.pdf Last accessed 12/06/2015

21. Tobacco Advertising and Promotion Act 2002. http://www.legislation.gov.uk/ukpga/2002/36/pdfs/ukpga_20020036_en.pdf

22. Scottish Government; Tobacco Display Regulations 2013. http://www.gov.scot/Resource/0041/00415587.pdf

23. A Consultation on Electronic Cigarettes and Strengthening Tobacco Control in Scotland, 2014. http://www.gov.scot/Publications/2014/10/5471

24. Equalities Act, 2010. http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

25. Equality Impact Assessment: Inverclyde Tobacco Strategy. http://www.staffnet.ggc.scot.nhs.uk/EQIA/EQIAList/AllItems.aspx

26. EQIA Inverclyde Tobacco Strategy, 2015 – 2016. http://www.nhsggc.org.uk/your-health/equal-access-to-health/equality-impact-assessments/2015-2016/

List of Inverclyde Alliance Partners who support the Inverclyde Tobacco Strategy
Alcohol and Drugs Partnership
Children Families
Community Learning & Development (Youth groups)
Community safety
Criminal Justice Services (Youth)
CVS Inverclyde
Early Years Collaborative Programme Manager
Education Health & Wellbeing Development Officer
Family Nurse partnership
Health and Homeless
Healthy Working Lives
Inverclyde Community Development Trust
Inverclyde Council Corporate Policy
Inverclyde HSCP Health Improvement
Inverclyde Integrated Drug Service
Looked After & Accommodated Nurse
Mental Health Services
NHS GGC Public Health Directorate
Prison Services
Quality and Development Service (Care Homes)
River Clyde Homes
Scottish Fire and Rescue Service
Trading Standards
West College Scotland
Your Voice
More Choices, More Chances

Equality Impact Assessment Tool: Policy, Strategy and Plans

(Please follow the EQIA guidance in completing this form)

1. Name of Strategy, Policy or Plan

Inverclyde Tobacco Strategy

Please tick box to indicate if this is: Current Policy, Strategy or Plan ☐ **New Policy, Strategy or Plan** ☒

2. Brief Description – Purpose of the policy; Changes and outcomes; services or activities affected

The Scottish Government's Tobacco Control Strategy has placed responsibility on local authorities to drive forward the tobacco control agenda through the development of a local tobacco plan. The Inverclyde Tobacco Strategy and action plan will aim to address tobacco through Inverclyde Alliance partners with the establishment of a Local Implementation Group.

The Inverclyde Tobacco Strategy aims to support the Scottish Government's ambitious plan to reduce smoking prevalence to 5% by 2034. Reducing inequalities, partnership working, and assets based approach are key cross cutting themes within the Scottish Government Tobacco which we aim to implement across Inverclyde. The strategy is directed by three main headings:

1. **Prevention:** To prevent uptake of smoking by young people
2. **Protection:** To protect people from the harmful effects of secondhand smoke
3. **Cessation**: The provision of stop smoking services

The Strategy will have agreed outputs and outcomes and will be developed and overseen by partners from the Inverclyde Alliance.

3 Lead Reviewer

Brenda Friel, Health Improvement Lead, Inverclyde CHCP

4. Please list all participants in carrying out this EQIA:

Louise McVey, Inverclyde Early Years Collaborative Programme Manager
Rosin Lynch, Health Improvement Senior, Public Health Directorate
Sara McLaughlin, Health Improvement Senior, Inverclyde CHCP
Ian Hanley, Inverclyde Community Safety
Fiona Knox, Inverclyde Trading Standards
Angela Montgomery, Senior Officer, Extra Care, River Clyde Homes
Lynn Cawley, LACYP Nurse
Brenda Friel, Health Improvement Lead
Maureen O'Neill Craig, Health Improvement Lead
George Simmonds, Equalities Officer
A copy of the drafted EQIA was emailed to the Inverclyde Tobacco Strategy Local Implementation Group for comment.

5. Impact Assessment

A Does the policy explicitly promote equality of opportunity and anti-discrimination and refer to legislative and policy drivers in relation to Equality
Smoking is a direct cause of continued inequalities in health. This is evident across Inverclyde where smoking prevalence, including smoking in pregnancy is higher than the Scottish average, life expectancy, in particular for men is less than the Scottish average and the incidence of smoking related hospital admissions and smoking related conditions such as lung cancer and Chronic Obstructive Pulmonary Disease (COPD) are greater than the Scottish average. There are some protected characteristics where uptake and continuation of smoking is more likely. For example, people with severe and enduring mental health problem, people who are homeless, Gypsy travellers, gay and bisexual men, prisoners and certain age groups e.g. 16 – 39 years and 40 – 64 years, are more likely to smoke. The Strategy and Action Plan will ensure that those who are more likely to smoke are not discriminated against. The EQIA of the Inverclyde Tobacco Strategy will ensure the needs of those who are more likely to smoke are addressed.

B What is known about the issues for different equalities groups in relation to the services or activities affected by the policy?		
		Source
All	• There is a close correlation between smoking prevalence and deprivation. Across Scotland, smoking is lowest with the most affluent and incrementally increases with increasing levels of deprivation (SIMD 1 (most deprived) 38% and SIMD 5 (least deprived) 12%. (1) • Lung cancer and Chronic Obstructive Pulmonary Disease (COPD) mortality are significantly higher than the Scottish average, lung cancer registration and COPD incidence is higher than the Scottish average. (2)	(1) Tobacco Control Strategy – Creating a Tobacco-Free Generation, A Tobacco Control Strategy for Scotland, (2013).

	• There are gender differences in smoking prevalence within Inverclyde, more men smoke, women are more likely to engage with stop smoking services however are less likely to stop smoking. (2) • In Inverclyde, smoking can affect all ages, children can be exposed to secondhand smoke, young people will start smoking while they are still at primary or into secondary school, smoking prevalence is highest age groups 16 – 39 years and 40 – 64 years. (2) • Nationally, smoking prevalence is higher with individuals who have a severe and enduring mental health problem. (3) • Smoking is a risk factor for certain types of Dementia (4) • National information informs us that those undergoing or have undergone gender reassignment experience higher reported rates of smoking (5) • Nationally and within Glasgow, smoking prevalence is higher within some Ethnic Minority Groups, for example Eastern European immigrants and Pakistani males. GGC data on ethnicity and smoking in pregnancy Polish and Slovakian women are more likely to continue smoking in pregnancy. (7 & 8) • Nationally, those with a reported a disability were significantly more likely to smoke than those who did not, 34% of those with a limiting long-term condition smoked, compared with only 23% and 22% of those with a non-limiting condition or with no condition. (6) • Roman Catholics and those who did not belong to any religion were most likely to be smokers whilst Muslims and Other Christians were least likely to smoke. (6)	(2) Tobacco Control Profile (Inverclyde) (2013) (3) ASH Scotland Tobacco use and people with mental health problems (2011) (4) Smoking and Dementia (ASH Scotland 2013) (5) NHS Health Scotland Equality issues (6) Scottish Health Survey, Equality Group (2012) (7) Smoking Cessation Assessment Report of BME Population living

	• Self-identified bisexual (27%) and gay and lesbian respondents (28%) had a slightly higher smoking prevalence than heterosexuals, but the difference was not significant. Those who self-identified as having an 'other' sexual orientation were significantly more likely to smoke than heterosexual respondents (36% compared to 24%). Those who preferred not to answer the question on sexual orientation also had significantly higher smoking prevalence (33%). (6) • Within Inverclyde, approximately 20 – 30% of pregnant women continue to smoke during their pregnancy and find it difficult to stop. (8)	in South East Glasgow CHCP (2010) (8) NHSGGC Smoking in Pregnancy Antenatal Booking Data
Sex	There are gender differences in smoking prevalence within Inverclyde, 31.8% men smoke compared to 24.7% of women, both are greater than the Scottish average of 24.6% and 21.5% respectively. High smoking prevalence correlates to lower life expectancy, in Inverclyde smoking prevalence is higher and life expectancy is lower than the Scottish average, in particular men (women 79.9 years, men 73.7 years).	ScotPHO, Tobacco Control Profile (Inverclyde) (2013) ScotPHO, Health and Wellbeing profile (Inverclyde) (2013)
Gender Reassignment	Those who have or are planning to undergo Gender Reassignment are more likely to smoke. Gender reassignment training for staff and other partners to ensure inclusive language is used and being respectful of individual identity.	NHS Health Scotland Equality issues
Race	97% of the Inverclyde population are White Scottish/British/Irish, 1.3% is Asian, Asian Scottish, Asian British and other ethnic groups and 0.1% is Polish. 5.4% of Inverclyde households where not all persons are in same ethnic group category. Whilst Inverclyde has a small ethnic population the Strategy is designed to inclusive, access to translators is available, literature will be inclusive, accessible and available in other	CENSUS 2011

	languages and in Plain English formats as required.	
Disability	Nationally, those with a reported a disability were significantly more likely to smoke than those who did not, 34% of those with a limiting long-term condition smoked, compared with only 23% and 22% of those with a non-limiting condition or with no condition. In Inverclyde 34.1% of the population have one or more long-term health condition and 7.8% have a physical disability. Work is currently being implemented within Inverclyde to support people who have a long term condition or disability, this will include tobacco control measures (1 & 2) Smoking is around twice as common among people with mental health disorders, and more so in those with more severe disease. Smoking rates are reducing however less so among those with mental disorders. Smokers with mental disorders are just as likely to want to quit as those without, but are more likely to be heavily addicted to smoking and are less likely to successfully stop. Within the Inverclyde population 6.4% report as having a mental health condition. Tobacco control measures to include activities for people with a mental health condition (2, 3 & 4). People with a learning disability, Deaf Community and British Sign Language (BSL) users smoke and want to stop smoking. Within Inverclyde population, 8.3% are deaf or have partial hearing loss and 0.6% has a learning disability. Communication pathways and information provision needs to meet their needs and understanding. (2 & 5) Stop smoking practitioners have attended learning disability and Deaf awareness training. Stop smoking practitioners and Strategy partners know how to access BSL interpreters. Literature will be inclusive, accessible and available in other languages and in Plain English formats as required. Other forms of communication such as text messaging will be used. Smoking prevention work within schools will include special needs schools, activities will be adapted to suit their learning requirements.	(1) Scottish Health Survey, Equality Group (2012) (2) CENSUS 2011 (3) ASH Scotland Tobacco use and people with mental health problems (2011) (4) Smoking and Mental Health, Royal College of Physicians, 2013. (5) Tobacco and alcohol use in people who have a learning disability: giving voice to their

		health promotion needs 2009.
Sexual Orientation	Self-identified bisexual (27%) and gay and lesbian respondents (28%) reported a slightly higher smoking prevalence than heterosexuals, but the difference was not significant. Those who self-identified as having an 'other' sexual orientation were significantly more likely to smoke than heterosexual respondents (36% compared to 24%). Those who preferred not to answer the question on sexual orientation also had significantly higher smoking prevalence (33%). (1) Gay and bisexual men are more likely to smoke at some point in their life. Higher levels of smoking are thought to be due to daily stress caused by homophobia and discrimination. A gap was identified in raising the issue of smoking within organisations which provide support for members of the LGBT community, eg voluntary organisations for those living with HIV. (2) We will identify and make links with local groups who connect with the LGBT community to increase tobacco awareness and local stop smoking and prevention services. Training for staff and other partners to ensure inclusive language is used and being respectful of individual identity.	(1) Scottish Health Survey, Equality Group (2012) (2) ASH Scotland Tobacco use and LGBT communities March 2011
Religion and Belief	In Inverclyde 33% are Church of Scotland, 37% Roman Catholic, 0.2% Muslim, almost 5% are other, 19.2% no religion. (1) Nationally, Roman Catholics and those who do not belong to any religion are more likely to smoke, Muslims and Other Christians were least likely to smoke. (2) Equality and diversity training and awareness programmes has been undertaken by Smokefree services staff and other partners to ensure culturally sensitive practice for example, confidentiality of service provision was critical to encourage attendance	(1) CENSUS 2011 (2) NHS Health Scotland Equality issues (3) Smoking Cessation

	(particularly amongst female South Asian smokers). (3)	Needs Assessment of the BME communities within South East Glasgow CHCP 2010
Age	Smoking can affect all ages, children can be exposed to secondhand smoke, young people will start smoking while they are still at primary or into secondary school. (1 & 2) In Inverclyde smoking prevalence is highest for age groups 16 – 39 years (30.2%) 40 – 64 years (28.2%). (3) A significant amount of tobacco control work is carried out to prevent young people form starting to smoke and reduce the attractiveness and availability of smoking. Targeted work involved Inverclyde alliance partners is included in the strategy.	(1) Inverclyde Child and Youth Health and Wellbeing Survey (2013) (2) Tobacco-Free Generation, A Tobacco Control Strategy for Scotland, (2013). (3) ScotPHO, Tobacco Control Profile (Inverclyde) (2013)
Pregnancy and Maternity	Within Inverclyde, approximately 20 – 30% of pregnant women continue to smoke during their pregnancy and find it difficult to stop. Smoking in pregnancy in Inverclyde	(1) NHSGGC Smoking in Pregnancy

	is higher than the Scottish average. The impact of smoking during pregnancy affects the mother and the baby impacting the child's health into adulthood. There is a gradient in the proportion who continue to smoke during their pregnancy within SIMD groups. SIMD 1 (most deprived) 34.2% continue to smoke in pregnancy compared to 5.4% (least deprived) SIMD 5. The strategy aims to work with partners to support more pregnant women to stop smoking during pregnancy.	Antenatal Booking Data (2) Tobacco Control Profile (Inverclyde) (2013) (3) NHS Health Scotland Equality issues
Marriage and Civil Partnership	N/A	
Social and Economic Status	Smoking is a direct cause of continued inequalities in health with clear correlation between area deprivation, smoking prevalence and life expectancy. (1) In Inverclyde one in three residents live in areas considered to be among the most deprived 15% in Scotland, and the incidence of poverty and deprivation mirrors the stark inequalities in health outcomes. (2) In Inverclyde, smoking prevalence, including smoking in pregnancy is higher than the Scottish average and life expectancy, in particular for men, is less than the Scottish average. (3 & 4) Across Scotland, smoking is lowest with the most affluent and incrementally increases with increasing levels of deprivation (SIMD 1 (most deprived) 38% and SIMD 5 (least deprived) 12%, this will be reflected within Inverclyde. (1)	(1) Tobacco-Free Generation, A Tobacco Control Strategy for Scotland, (2013). (2) Inverclyde Single Outcome Agreement 2013-2017 (3) NHSGGC Smoking in Pregnancy

	The same applies to the proportion who continue to smoke in pregnancy, SIMD 1 33.7% continue to smoke in pregnancy compared to 5.6% SIMD 5. (4) The strategy includes actions that will target the most deprived in Inverclyde. The Smoking Cessation Health Improvement, Efficiency, Activity and Treatment (HEAT) target is an inequalities focussed target.	Antenatal Booking Data (4) Tobacco Control Profile (Inverclyde) (2013)
Other marginalised groups (prisoners, homelessness, addictions, travellers, asylum seekers and refugees etc)	UK data estimates that 77% of homeless people smoke. There are 147 – 179 people per quarter who are homeless within Inverclyde. Actions with this strategy are included in the Health and Homelessness Action Group's Action Plan. (1 & 2) Based on English studies within Gypsy or Irish Traveller groups, 49% and 46% for males and females respectively smoke. Plans are to connect with Health Visiting teams who work with Travellers. 76% of Scottish prisoners said they smoke, around 46% reported that they shared a cell with someone who smokes. Around 56% of those who smoked expressed a desire to stop smoking. Actions within the strategy include working with Prison services, rehabilitation service users and the criminal justice team. (3) In Inverclyde, 4% of 13 year olds and 19% of 15 year olds had tried cannabis (SALSUS). Inverclyde Schools Survey, 9% of pupils said that they had ever used drugs or legal highs from this, the most commonly used drug was cannabis (89%). Actions within the strategy include working with Drug and Alcohol services and service users. (4 & 5) Looked After Children and Young People (LACYP) are more likely to smoke and have poorer health outcomes. In Inverclyde, 18% of young people are in care, this is higher than the Scottish average. Actions within the strategy include working with LACYP, have established connections with local LACYP staff. (6)	(1) Homeless Link (Registered Charity) (2) Inverclyde Planning and Performance homeless data (2014) (3) ASH Scotland Tobacco use, ethnicity and health, 2014 (4) Adolescent Lifestyle and Substance Use Survey (SALSUS)

		(5) Inverclyde Child and Youth Health and Wellbeing Survey (2013) (6) ScotPHO, Health and Wellbeing profile (Inverclyde) (2014) (7) The Director of Public Health Report: Building Momentum for Change (2013/15)

C Do you expect the policy to have any positive impact on equalities or on different equalities groups?

	Highly Likely	Probable	Possible
General	A reduction in smoking prevalence across Inverclyde will have positive impact on health for all protected		

	characteristics and reduce smoking related inequalities.		
Sex		If we do more targeting work to address the differences in health outcomes for this protected characteristic, linking in with the third sector, work places.	
Gender Reassignment	If we are conscious of inclusive language and being respectful of identity then we are more likely to engage with people with a trans history.		
Race	Inverclyde has a small ethnic minority population, the Strategy is designed to be inclusive, to include access to translators, inclusive literature that is available in other languages and in Plain English format as required.		
Disability	Actions within the strategy and staff training and awareness of this protected characteristic will have a positive impact. An EQIA of the stop smoking services within the community, pregnancy and hospital have been carried out.		

Sexual Orientation	If we are conscious of inclusive language and being respectful of individual sexual orientation then we are more likely to engage with people regardless of their sexual orientation.		
Religion and Belief	Awareness and delivery of culturally sensitive practice and prevention work by Smokefree Services and wider partners will address this protected characteristic.		
Age	Awareness of and focussed work for specific age groups for example 16 – 24 year olds, with support from various partners will have a positive impact.		
Marriage and Civil Partnership	**N/A**		
Pregnancy and Maternity		Collaboration and focussed work to address smoking in pregnancy have a probable impact.	
Social and Economic Status	Focussed neighbourhood working, collaboration with partners and including the wider social determinants of that affect health and reason		

	for continuing to smoke will have a positive impact.		
Other marginalised groups (prisoners, homelessness, addictions, travellers, asylum seekers and refugees etc)	Awareness of marginalised groups within Inverclyde, working collaboratively with partners who have good links with marginalised groups and ensuring information and support is relevant to their needs will have a positive impact.		

D Do you expect the policy to have any negative impact on equalities or on different equalities groups?			
	Highly Likely	**Probable**	**Possible**
General			If we do not understand our population within Inverclyde and work collaboratively with our partners and

			local people, this could result in a negative impact towards all protected characteristics and increase smoking related inequalities.
Sex			If we do not carry out more targeting work to address the differences in health outcomes and smoking prevalence for this protected characteristic.
Gender Reassignment			If we are not conscious of inclusive language and being respectful of identity then it is possible that we will have a negative impact towards people with a trans history due to their non-participation.
Race			If we do not use available resources such as translators or ensure information is available in different formats for example in different languages or in plain English format then it will be possible to have a negative impact. Non-English speakers will not be aware of services and will feel excluded.
Disability			If we are not aware of the needs of people with a disability, make reasonable adjustments based upon individual needs or do not work collaboratively with our partners then we could have a negative impact.

Sexual Orientation			If we are not conscious of inclusive language, being respectful of individual sexual orientation and prevent feeling of being excluded then we could have a negative impact.
Religion and Belief			If we are not mindful of and do not deliver culturally sensitive practice and prevention work by Smokefree Services and wider partners then we could have a negative impact.
Age			If we are not aware of the needs of specific age groups in relation to their participation and non-participation in prevention programmes and engagement in stop smoking services as well as working collaboratively with service users and partners we could have a negative impact.
Marriage and Civil Partnership			N/A
Pregnancy and Maternity			If we do not work collaboratively with our partners and service users and focus our work to address smoking in pregnancy then we could have a negative impact, because pregnant women will continue to smoke during pregnancy.

Social and Economic Status			If we do not focus our work within certain neighbourhood, do not work in collaboration with partners and do not include the wider social determinants of health then we could have a negative impact by excluding smokers from our most deprived communities, who will continue to smoke thus contributing towards smoking related inequalities in health.
Other marginalised groups (prisoners, homelessness, addictions, travellers, asylum seekers and refugees etc)			If we are not aware of marginalised groups within Inverclyde, if we do not work collaboratively with partners who have good links with marginalised groups and we do not ensure information and support is relevant to their needs then we could have a negative impact by excluding smokers from marginalised groups, who will continue to smoke thus contributing towards smoking related inequalities in health.

E Actions to be taken		
		Responsibility and Timescale
E1 Changes to policy	Include information on mental health, homeless, cannabis, drugs and Alcohol, LGBT	BF, March 2015

E2 action to compensate for identified negative impact	Designing all aspects of service delivery to be as inclusive and respect individual needs across protected characteristics With support from the voluntary sector, obtain views of the strategy from the local community within Inverclyde.	Inverclyde Tobacco strategy Local Implementation Group (LIG) - Ongoing for the duration of the policy until 2017 May 2015
E3 Further monitoring – potential positive or negative impact	There will be a time lapse in relation to impact Monitoring from early stage/continual monitoring of equalities information Some protected characteristics are collected when clients engage with stop smoking services, this is a Scottish National Minimum Dataset, there are plans being considered to include all protected characteristics Evidence base interventions that ensure inclusiveness Any new information will be used to revise the policy	Inverclyde Tobacco strategy LIG - Ongoing for the duration of the policy until 2017
E4 Further information required	Include information on mental health, homeless, cannabis, drugs and Alcohol, LGBT	BF, March 2015

6. Review: Review date for policy / strategy / plan and any planned EQIA of services

A monitoring framework will be agreed and implemented in place this will include protected characteristics. This will ensure that the strategy will have a positive impact towards smoking related health inequalities. Agreed quarterly/annual reports are planned.

Lead Reviewer: **Name: Brenda Friel**
Sign Off: **Job Title: Health Improvement Lead**

Signature 
Date:

Please email copy of the completed EQIA form to eqia1@ggc.scot.nhs.uk

All other enquiries please to:

Alastair Low, Planning & Development Manager, Corporate Inequalities Team, NHS Greater Glasgow and Clyde, JB Russell House, Gartnavel Royal Hospital Tel: 0141-201-4817.

TOBACCO STRATEGY ENGAGEMENT

your voice

Inverclyde Community Care Forum

One voice brings thought.

Background

Your Voice and Inverclyde Health & Social Care Partnership (HSCP) are committed to ensuring that service users, carers and their families' views are taken into account when developing and planning services, to ensure that services are responsive to the needs of the people who use them.

Partnership working with officers from both Inverclyde Council and NHS Greater Glasgow & Clyde has enabled the establishment of Inverclyde HSCP Advisory Group. This enables us to ensure that meaningful community engagement is facilitated in Inverclyde. To this end the Your Voice Network enables local people to collectively bring real issues forward on behalf of the wider community. See below for the Sub Groups/Strategy Groups linked to Inverclyde HSCP Advisory Group.

SUB GROUPS OF INVERCLYDE CHCP ADVISORY GROUP

- Addictions
- Adult Protection
- Carers
- Children & Young People
- Disability including Physical and Learning
- Healthier Lifestyles & Health Inequalities
- Housing & Homelessness
- Long Term Conditions & Self Care
- Mental Health & Wellbeing including Dementia
- Older People
- Secondary Care inc Hospital Discharge & Palliative/End of Life Care

The diagram below shows the structural processes for Inverclyde's CHCP and how this connects with Inverclyde Alliance and the Single Outcome Agreement.

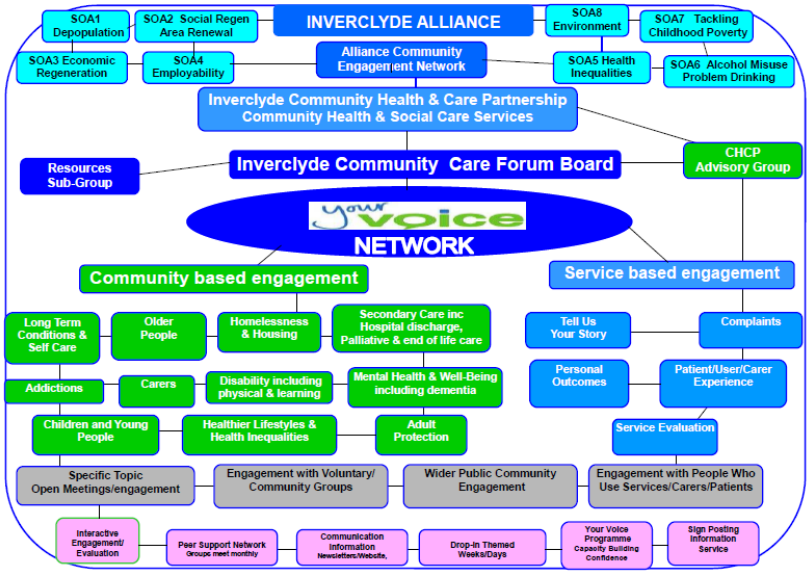


Table 1: Inverclyde Community Health & Care Partnership Engagement Network

On the following dates the Your Voice Team engaged with the following groups on the Tobacco Strategy.

Date	Group Name
14/05/2015	Men's Group
19/05/2015	The Debaters
02/06/2015	COPD Group
03/06/2015	Family Response Group
04/06/2015	Stroke Matters Group
18/05/2015	Mental Health & Wellbeing Sub Group
25/05/2015	HL&HI sub group
14/05/2015	Long Term Conditions Sub Group
04/05/2015	Older Peoples Sub Group
13/05/2015	Disabilities Sub Group
25/05/2015	Carers Sub Group
2005/2015	Secondary Care Sub Group

The Engagement Process

Community engagement with service users, carers and communities of interest was undertaken to raise awareness and ascertain people's knowledge of and thoughts on:

The importance of involving people in the above process is very much the ethos of Your Voice and the HSCP Advisory Network. Your Voice has built capacity and provide appropriate opportunities, encouragement and support to service users, carers and communities of interest in relation to promoting their autonomy, independence and community involvement and:

- Provide service users, carers, communities of interest with appropriate ongoing information
- Encourage and support service users, carers, communities of interest, or those acting on their behalf, to understand the information
- Ensure that service users, carers, communities of interest are enabled to express their views and to make, or participate in decision making processes relating to a wide range of areas and projects
- Collate feedback and relay this information to the relavant bodies

The Tobacco Strategy

The overall aim of Inverclyde Tobacco Strategy is to:

Prevent young people from starting to smoke

- Work with schools / colleges / organisations &community groups that work with young people e.g. Community Learning and Development, Inverclyde Community Development Trust, Children in Care, Youth Justice
- Ensure children under the age of 18 years are not able to buy cigarettes or buy counterfeit cigarettes
- Involve Young People in the work we do

Protect everyone in Inverclyde from the harmful effects of secondhand smoke

- Increase awareness of the dangers of secondhand smoke
- Increase awareness of the benefits of not smoking in the **home and car**
- Work with the local community, voluntary organisations, nurseries, schools, workplaces and youth organisations to create smokefree environments

Help people, who want to stop smoking - stop smoking for good

- Increase awareness of local stop smoking services in Inverclyde
- Provide training about how to talk to someone to find out if they are ready to stop smoking, if they are, provide information on where to get

help. The training is for all health service staff, community workers, voluntary organisations, local authority staff, workplaces, youth organisations.

About the feedback

The following feedback was gathered and has been placed in themes to harness a clear picture of what people said in response to:

1. What are your views on this as a priority for Inverclyde?

- Education is a good priority for Inverclyde
- Think it is a priority in Inverclyde and elsewhere as it is the number one killer and more needs to be done to prevent young people from denial e.g. “I won’t get addicted “or “I must give up before that happens to me”
- Yes it is a priority, people are trying to give it up, and now end up on E cigs - educate young people against smoking
- Shocked at the sale of E cigarettes in the town I feel they are not safe and not enough study has been done to ensure that they are
- E-Cigs – some felt that using e cigarettes have helped them to cope with not smoking
- Important and relevant. Issues with E cigarettes, pipes – anything to do with / associated with smoking
- It seems more and more young ones are smoking – more emphasis should be on photos of cancer on cigarette packets
- Anything that helps young people to see the health risks of smoking is a good idea
- I don’t smoke, I don’t mind others smoking
- People have to want to stop smoking
- Not as important as getting people to stop buying alcohol

2. What do you think will work well from the strategy?

- Better education for everyone
- Parents who smoke may be likely to continue / children as young as 3 should be educated not to
- Prevention through education for/with young people
- Involve young people / communities in anti-smoking campaigns etc.
- Empower children, to say no to smoking. Primary school kids would be assertive – proactive approach against smoking
- Education – children at primary school age, involving young children maybe influence their parents, influence grandparents to stop
- More hard hitting advertisements to help educate young people about the harmful effects on smoking
- More youngsters might take notice off the photos and think twice before lighting up
- Smoke free environments get the message across
- Fine people who smoke in doorways of hospitals/health centres.
- Stopping people smoking near doorways/buildings

3. What do you think could be improved with the strategy?

- Young people's long term health – screening to check if they are prone to diseases such as heart conditions, cancer etc.

- Bring people into schools (anyone inspiring for the kids) – e.g. footballers to speak to the boys and women who have smoked to show others the ageing process and the effects on their teeth, hair and skin

- The Tobacco Strategy is doing a good job at the moment - local schools are delivering skills for life such as the
    - Benefits of Health & Fitness
    - Dangers of Alcohol & Drugs

- Future generations will know the danger. Highly addictive, nature of addiction is denial

- Need to get it into people's heads that smoking is a killer, although it is **never too late to stop**

- Highlight the benefits to life – these are the things you can do if you are a non-smoker

- Show how saving money otherwise spent on cigarettes can be used for something more enjoyable… holidays, clothes etc.

- Electronic Cigarettes – concerns re the lack of research on these items. People are concerned about businesses jumping on the band wagon and selling these products with bright attractive colours and flavours akin to sweeties – children / young people might think this is cool and want to take up 'smoking' e cigarettes

- Stop making E cigarettes attractive to young people. They come out with all these different flavours which are designed to get young people to buy them. I.e. Cherry, vanilla and cola flavours!

- Better advertising – show imagery of lung diseases, pictures of children affected by passive smoking

- Make the packaging plain

- Raising the age limit to 25 for young people purchasing cigarettes - as they mature they can make more informed choices as adults, whether they wish to smoke or not

- 'Social responsibility tax' Nicola Sturgeon has quoted this for beer, perhaps this could also be used for cigarettes

- Double the tax on cigarettes

- Changing the terminology from tobacco to smoking – to broaden strategy to be all encompassing

- Stop selling cigarettes!

4. Do you have any other comments or thoughts?

- Emphasis should be made as to just how **unglamorous** smoking is

- As an ex-smoker, I think smoking should be banned outside pubs and if it would work, no smoking in any public places, parks etc.

- Lack of maturity, people think it is adult and grown up

- Homecare workers / teachers etc, people who work with people, and share confined spaces - smelling of smoke to a non-smoker can be off putting. Also, if people are unwell and have to receive some form of intimate care, the smell of smoke can be offensive to them.

INVERCLYDE HSCP Health and Social Care Partnership

AGENDA ITEM NO: 14

Report To:	**Inverclyde Integration Joint Board**	**Date: 26th January 2016**
Report By:	**Brian Moore Corporate Director (Chief Officer) Inverclyde Health & Social Care Partnership**	**Report No: IJB/11/2016/HW**
Contact Officer:	**Helen Watson Head of Service Planning, Health Improvement & Commissioning**	**Contact No: 01475 715285**
Subject:	**HSCP Internal Services Care Inspectorate Gradings Annual Report 2015**	

1.0 PURPOSE

The purpose of this report is to update the Integration Joint Board on Inverclyde HSCP Internal Services Care Inspectorate (CI) Gradings.

1.1 The reporting period is 1st November 2014 to 31st October 2015.

2.0 SUMMARY

2.1 During the reporting period 1st November 2014 to 31st October 2015 there were 10 Care Inspectorate (CI) inspections carried out across Inverclyde HSCP's 13 internal services.

2.2 Three Inverclyde HSCP internal services were not inspected during the reporting period. This was because their inspection schedule did not fall in the reporting period.

2.3 Five Inverclyde HSCP internal services increased in one or more theme grade.

2.4 Five Inverclyde HSCP internal services maintained the same theme grade(s) as their previous inspection.

3.0 RECOMMENDATION

3.1 That the Integrated Joint Board note the attached CI Grading report for the period of 1st November 2014 to 31st October 2015 (Appendix 1).

Brian Moore
Corporate Director (Chief Officer)
Inverclyde Health & Social Care Partnership

4.0 BACKGROUND

4.1 This report is based on Inverclyde HSCP Internal Services Care Inspectorate gradings on inspections carried out over the reporting period 1st November 2014 to 31st October 2015.

4.2 The Care Inspectorate regulates care services in Scotland; it ensures that registered services abide by the law as set out in the Public Services Reform (Scotland) Act 2010. Prior to 1st April 2011, this function was carried out by the Care Commission. Care services in Scotland cannot operate unless they are registered.

The Care Inspectorate inspects services to the National Care Standards. They award grades and set out improvements if/when required by making recommendations and/or requirements or enforcements which the service has to comply with.

The National Care Standards are produced by the Scottish Government and set out the standards of care people should expect. Care services should meet these standards so that everyone receives high quality care. Each type of care service has its own set of National Care Standards.

Further information in relation to all care services can be found on the Care Inspectorate website at: http://www.careinspectorate.com/index.php. A consultation is currently underway by the Care Inspectorate to inform the next generation of National Care Standards.

4.3 The Care Inspectorate grades are assessed on areas of performance and quality in the following 4 themes:

- Quality of Care & Support
- Quality of the Environment
- Quality of Staffing
- Quality of Management & Leadership

And are graded as follows:

- Grade 6 Excellent
- Grade 5 Very Good
- Grade 4 Good
- Grade 3 Adequate
- Grade 2 Weak
- Grade 1 Unsatisfactory

Further information on how the Care Inspectorate inspect can be found on: http://www.careinspectorate.com/images/documents/168/How%20we%20inspect%20care%20services%20and%20what%20goes%20into%20insp%20reports.pdf

4.4 There are 13 HSCP internal services registered with the Care Inspectorate, 5 Children and Family Services, 4 Learning Disability Services, 3 Older People Services and the Homelessness Service.

4.5 All 5 Children & Family services were inspected during the reporting period; all services either increased in grade or maintained previous inspection grades. All Children & Family services have received grades of 4 Good to 5 Very Good. No Children & Family services decreased in grade(s).

4.6 Three Learning Disability services were inspected during the reporting period. Outreach & Community Support Service was not inspected. All 3 inspected services either increased in grade or maintained previous inspection grades. All Learning Disability services have received grades of 4 Good to 5 Very Good. No Learning

Disability services decreased in grade(s).

4.7 Two Older People services were inspected during the reporting period. The 2 inspected services maintained previous inspection grade(s). All Older People services have received grades of 4 Good to 6 Excellent. No Older Peoples services decreased in grade(s).

4.8 The Homelessness Service was not inspected during the reporting period.

5.0 Reporting Period 1st November to 31st October 2015 Updates

5.1 Children & Family Services

5.1.1 Crosshill Children's Residential Unit was inspected on 2nd December 2014. The Quality of Care & Support and Quality of Management & Leadership themes increased from Grade 4 – Good, to Grade 5 - Very Good. The Quality of the Environment and Quality of Staffing maintained Grades of 5 - Very Good.

5.1.2 Kylemore Children's Residential Unit was inspected on 15th May 2015. The Quality of Care & Support theme increased from Grade 4 – Good, to Grade 5 - Very Good. The Quality of the Environment, Quality of Staffing and Quality of Management & Leadership maintained Grades of 5 - Very Good.

5.1.3 Neil Street Children's Residential Unit was inspected on 30th August 2015. The Quality of Management & Leadership theme increased from Grade 4 –Good, to Grade 5 - Very Good. All other themes maintained Grade 5 - Very Good.

5.1.4 Inverclyde HSCP Adoption Service was inspected on 8th January 2015. The Quality of Management & Leadership theme increased from Grade 4 – Good, to Grade 5 - Very Good. All other themes maintained Grade 5 - Very Good.

5.1.5 Inverclyde HSCP Fostering Service was inspected on 8th January 2015 and maintained grades across Quality of Care & Support, Quality of Staffing and Quality of Management & Leadership themes at Grade 5 - Very Good. The Quality of the Environment is not inspected.

5.2 Learning Disability Services

5.2.1 Inverclyde HSCP Fitzgerald Centre was inspected on 20th November 2014 and maintained grades across Quality of Care & Support, Quality of Staffing and Quality of Management & Leadership themes at Grade 5 - Very Good. The Quality of the Environment was not inspected.

5.2.2 Inverclyde HSCP Learning Disability Care and Support at Home Service was inspected on 26th January 2015 and maintained grades across Quality of Care & Support, Quality of Staffing and Quality of Management & Leadership themes at Grade 4 - Good. The Quality of the Environment is not inspected.

5.2.3 Inverclyde HSCP's McPherson Resource Centre was inspected on 20th August 2015. The Quality of Care & Support, Quality of Environment and Quality of Staffing and Quality of Management & Leadership themes increased from Grade 4 – Good, to Grade 5 - Very Good. The Quality of the Management & Leadership maintained Grade 4 - Good.

5.2.4 The Outreach and Community Support Service was not inspected during this reporting period.

5.3 **Older People Services**

5.3.1 Inverclyde HSCP Care and Support at Home was inspected on 29th May 2015 and maintained grades across Quality of Care & Support, Quality of Staffing and Quality of Management & Leadership themes at Grade 5 Very Good. The Quality of the Environment is not inspected.

5.3.2 Inverclyde HSCP Respite Unit was inspected on 5th November 2015 and maintained grades across Quality of Care & Support, Quality of Environment, Quality of Staffing and Quality of Management & Leadership themes at Grade 5 - Very Good.

5.3.3 Inverclyde HSCP Day Services was not inspected during this reporting period. The previous Care Inspectorate inspection on 23rd January 2013 graded the Quality of Care & Support, Quality of Staffing and Quality of Management & Leadership at Grade 5 – Very Good. The Quality of the Environment was graded at Grade 6 - Excellent.

5.4 **Homelessness Service**

5.4.1 The Homelessness Service was not inspected during this reporting period.

6.0 PROPOSALS

6.1 There are no proposals contained within this report.

7.0 IMPLICATIONS

Finance:

7.1 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:

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

Human Resources:

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

Equalities:

7.4 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.

Repopulation:

7.5 The HSCP Joint Commissioning Strategies take into account demographic trends to inform current and future plans for services living in Inverclyde.

8.0 LIST OF BACKGROUND PAPERS

8.1 Inverclyde HSCP Internal Services Care Inspectorate Grading's Report Appendix 1 – Reporting Period 1st November 2014 to 31st October 2015.

Appendix 1

Last Updated: **30th November 2015**

No C I Inspection during reporting period
↑ = Increase in grade
↓ = Decrease in grade

Provider	Type of Provision	Registration Number	Date of Care Inpectorate Inspection	Quality of Care & Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Care & Support at Home	Home Care & Housing Support	CS2004078042	29 May 2015	5	-	5	5
Crosshill Home	Care Home - Children & Young People	CS2003001104	2 December 2014	5 ↑	5	5	5 ↑
Fitzgerald Centre	Day Care - Adults	CS2003016286	20 November 2014	5	-	5	5
Homelessness Team	Housing Support	CS2004078039	25 April 2014	4	-	4	4
Inverclyde Council Adoption Team	Adoption Service	CS2005087048	8 January 2015	5	-	5	5 ↑
Inverclyde Council Fostering Service	Fostering Service	CS2005087054	8 January 2015	5	-	5	5
Inverclyde Day Services	Day Care - Older People	CS2003001082	23 January 2013	5	6	5	5
Inverclyde Learning Disability Support & Care at Home	Home Care & Housing Support	CS2004078035	26 January 2015	4	-	4	4
Kylemore	Care Home - Children & Young People	CS2003001106	15 May 2015	5 ↑	5	5	5
McPherson Resource	Day Care - Adults	CS2003001085	20 August 2015	5 ↑	5 ↑	5 ↑	4
Neil Street Children's Home	Care Home - Children & Young People	CS2003001105	30 August 2015	5	5	5	5 ↑
Outreach & Community Support	Support Service	CS2007164625	24 March 2014	5	5	5	5
Respite Unit	Respite (variety of support needs covered)	CS2003001081	05 November 2015	5	5	5	5