TO: ALL MEMBERS, ELECTED MEMBERS AND OFFICER REPRESENTATIVES OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

(See Distribution List attached)

Clerk and Standards Officer:
Roger Mennie
Head of Democratic and Legal Services
Dundee City Council

Assistant to Clerk:
Willie Waddell
Committee Services Officer
Dundee City Council

City Chambers
DUNDEE
DD1 3BY

12th December, 2017

Dear Sir or Madam

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

I would like to invite you to attend a meeting of the above Integration Joint Board which is to be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 19th December, 2017 at 2.00 pm.

Apologies for absence should be intimated to Willie Waddell, Committee Services Officer, on telephone 01382 434228 or by e-mail willie.waddell@dundeecity.gov.uk.

Yours faithfully

DAVID W LYNCH

Chief Officer

A G E N D A

1 APOLOGIES FOR ABSENCE

2 DECLARATION OF INTEREST

Members are reminded that, in terms of the Integration Joint Board's Code of Conduct, it is their responsibility to make decisions about whether to declare an interest in any item on this Agenda and whether to take part in any discussions or voting.

3 MINUTE OF PREVIOUS MEETING - Page 1

The minute of previous meeting of the Integration Joint Board held on 31st October, 2017 is attached for approval.

4 PERFORMANCE AND AUDIT COMMITTEE

(a) MINUTE OF MEETING OF 28TH NOVEMBER, 2017 - Page 7

(Copy attached for information and record purposes).

(b) CHAIR'S ASSURANCE REPORT - Page 13

(Report No DIJB60-2017 by the Chair of the Peformance & Audit Committee, copy attached).

5 MENTAL HEALTH AND WELLBEING

(Presentation by Arlene Mitchell, Locality Manager, Dundee Health & Social Care Partnership and Christina Cooper, Healthcare and Wellbeing Team Manager, Dundee Voluntary Action).

6 MENTAL HEALTH & LEARNING DISABILITY SERVICE REDESIGN TRANSFORMATION PROGRAMME – CONSULTATION FEEDBACK REPORT - Page 15

(Report No DIJB49-2017 by the Chief Officer, copy attached).

7 JOINT SENSORY SERVICES STRATEGY & COMMISSIONING PLAN - Page 51

(Report No DIJB52-2017 by the Chief Officer, copy attached).

8 SUBSTANCE MISUSE STRATEGIC & COMMISSIONING PLAN UPDATE - Page 93

(Report No DIJB55-2017 by the Chief Officer, copy attached).

9 GENERAL PRACTICE AND PRIMARY CARE - Page 97

(Report No DIJB51-2017 by the Chief Officer, copy attached).

10 CHIEF SOCIAL WORK OFFICER ANNUAL REPORT 2016/17 - Page 197

(Report No DIJB53-2017 by the Chief Social Work Officer, copy attached).

11 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2016/17 – TRANSFORMATIONAL PUBLIC HEALTH - Page 241

(Report No DIJB54-2017 by the Director of Public Health, copy attached).

12 IMPROVING SCOTLAND'S HEALTH: A HEALTHIER FUTURE – ACTIONS AND AMBITIONS ON DIET, ACTIVITY AND HEALTHY WEIGHT - Page 313

(Report No DIJB59-2017 by the Chief Officer, copy attached).

13 WINTER PLANNING ARRANGEMENTS - Page 353

(Report No DIJB58-2017 by the Chief Officer, copy attached).

14 FINANCIAL MONITORING AS AT OCTOBER 2017 - Page 385

(Report No DIJB50-2017 by the Chief Finance Officer, copy attached).

15 TRANSFORMATION PROGRAMME – UPDATE - Page 395

(Report No DIJB56-2017 by the Chief Finance Officer, copy attached).

16 PROGRAMME OF MEETINGS 2018

It is proposed that the programme of meetings for the Integration Joint Board over 2018 be as follows:-

DATE	TIME	VENUE
Tuesday, 27th February 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee
Tuesday, 24th April 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee
Tuesday, 26th June 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee
Tuesday, 28th August 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee
Tuesday, 30th October 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee
Tuesday, 18th December 2018	2.00 pm	Committee Room 1, 14 City Square, Dundee

17 DATE OF NEXT MEETING

The next meeting of the Integration Joint Board will be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 27th February, 2018 at 2.00 pm.

DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD
DISTRIBUTION LIST

(a) DISTRIBUTION - INTEGRATION JOINT BOARD MEMBERS

(* - DENOTES VOTING MEMBER)

Role	**Recipient**
Elected Member (Chair)	Councillor Ken Lynn *
Non Executive Member (Vice Chair)	Doug Cross *
Elected Member	Councillor Roisin Smith *
Elected Member	Bailie Helen Wright *
Non Executive Member	Judith Golden *
Non Executive Member	Munwar Hussain *
Chief Officer	David W Lynch
Chief Finance Officer	Dave Berry
Registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978(b)	Frank Weber
Registered medical practitioner employed by the Health Board and not providing primary medical services	Cesar Rodriguez
Registered nurse who is employed by the Health Board	Sarah Dickie
Chief Social Work Officer	Jane Martin
Third Sector Representative	Christine Lowden
Staff Partnership Representative	Raymond Marshall
Trade Union Representative	Jim McFarlane
Director of Public Health	Drew Walker
Person providing unpaid care in the area of the local authority	Martyn Sloan
Service User residing in the area of the local authority	Andrew Jack

(b) DISTRIBUTION – FOR INFORMATION ONLY

Organisation	**Recipient**
NHS Tayside (Chief Executive)	Lesley McLay
Dundee City Council (Chief Executive)	David R Martin
Dundee City Council (Head of Democratic and Legal Services)	Roger Mennie
Dundee City Council (Members' Support)	Jayne McConnachie
Dundee City Council (Members' Support)	Dawn Clarke
Dundee City Council (Members' Support)	Fiona Barty
Dundee Health and Social Care Partnership (Chief Officer's Admin Assistant)	Arlene Hay
Dundee City Council (Communications rep)	Steven Bell
NHS Tayside (Communications rep)	Jane Duncan
NHS Tayside (PA to Director of Public Health)	Linda Rodger
NHS Fife (Internal Audit) (Principal Auditor)	Judith Triebs
Audit Scotland (Senior Audit Manager)	Bruce Crosbie

Dundee Health & Social Care Partnership

ITEM No …3……..

At a MEETING of the **DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 31st October, 2017.

Present:-

Members	**Role**
Ken LYNN *(Chairperson)*	Nominated by Dundee City Council (Elected Member)
Doug CROSS *(Vice-Chairperson)*	Nominated by Health Board (Non-Executive Member)
Roisin SMITH	Nominated by Dundee City Council (Elected Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
David W LYNCH	Chief Officer
Dave BERRY	Chief Finance Officer
Cesar RODRIGUEZ	Registered Medical Practitioner (not providing primary medical services)
Sarah DICKIE	Registered Nurse
Jane MARTIN	Chief Social Work Officer
Drew WALKER	Director of Public Health
Raymond MARSHALL	Staff Partnership Representative
Christone LOWDEN	Third Sector Representative
Andrew JACK	Service User residing in the area of the local authority
Martyn SLOAN	Person providing unpaid care in the area of the local authority

Also in attendance:-

Name	**Organisation**
Diane McCULLOCH	Dundee Health and Social Care Partnership
Jenny HILL	Dundee Health and Social Care Partnership
Alexis CHAPPELL	Dundee Health and Social Care Partnership
Sheila ALLAN	Dundee Health and Social Care Partnership
David SHAW	Dundee Health and Social Care Partnership
Douglas LOWDON	NHS Tayside
Douglas GENTLEMAN	Honorary Consultant, Neuro Rehabilitation, NHS Tayside

Ken LYNN, Chairperson, in the Chair.

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Judith GOLDEN, Nominated by Health Board (Non-Executive Member); Munwar HUSSAIN, Nominated by Health Board (Non-Executive Member); Frank WEBER, Registered Medical Practitioner (whose name is included in the list of primary medical performers); Jim MCFARLANE, Trade Union Representative.

II DECLARATION OF INTEREST

Christine Lowden declared a non-financial interest in the item of business at Article XVI of this minute by virtue of her employment with Dundee Voluntary Action.

III MINUTE OF PREVIOUS MEETING

The minute of previous meeting of the Integration Joint Board held on 29th August, 2017 was submitted and approved.

IV PERFORMANCE AND AUDIT COMMITTEE

(a) MINUTE OF MEETING OF 12TH SEPTEMBER, 2017

The minute of meeting of the Performance and Audit Committee held on 12th September, 2017 was submitted and noted for information and record purposes.

(b) CHAIR'S ASSURANCE REPORT

There was submitted Report No DIJB49-2017 by the Chair of the Performance and Audit Committee outlining:-

- Delegated Decisions taken by the Committee
- Performance Against Workplan
- Any Other Major Issues to highlight to the Integration Joint Board

The Integration Joint Board agreed to note the content of the report.

The Integration Joint Board further agreed to note that information on the performance on waiting time targets was submitted to public meetings of NHS Tayside Board and that discussions would take place towards making this information more accessible to the public.

V TACKLING HEALTH INEQUALITIES IN DUNDEE: AN INTEGRATED APPROACH

There was submitted Report No DIJB36-2017 by the Chief Officer informing the Integration Joint Board of dedicated work taking place at a community and city-wide level to help tackle health inequalities, and the improved focus and opportunities that were arising from bringing together the different health inequalities strands.

Sheila Allan, Dundee Health and Social Care Partnership gave a presentation in supplement to the report.

The Integration Joint Board agreed:-

(i) to note the content of the presentation;

(ii) to note the content of the report including the positive health inequalities activity taking place in the city as detailed in paragraph 4.2 of the report;

(iii) to note the purpose of the decidated service redesign/expansion and the opportunities arising from this as detailed in paragraph 4.3 of the report; and

(iii) to note the potential impact on service delivery and strategic reporting requirements during the change process as detailed in paragraph 4.4 of the report.

VI CITY PLAN FOR DUNDEE 2017/2026

There was submitted by the Chief Officer Report No DIJB35-2017 presenting the City Plan for Dundee 2017-26 as agreed by the Dundee Partnership.

The Integration Joint Board agreed to endorse the City Plan for Dundee 2017-2026 a copy of which was attached to the report as Appendix 1.

VII PROPOSED MODEL OF CARE FOR OLDER PEOPLE – BUSINESS CASE

Reference was made to Article XIII of the minute of meeting of this Integration Joint Board held on 27th June, 2017 wherein the report on Remodelling of Care for Older People was agreed.

There was submitted Report No DIJB37-2017 by the Chief Officer providing the business case for the proposed model of care for older people that was outlined in the report on the remodelling of care for older people.

The Integration Joint Board agreed:-

(i) to note the content of the report; and

(ii) to approve the four phased transformational plan as outlined in paragraph 4.8 of the report and the associated financial framework which was attached to the report as Appendix 1.

VIII RESHAPING NON-ACUTE CARE IN DUNDEE

There was submitted Report No DIJB38-2017 by the Chief Officer updating the Integration Joint Board in relation to the work of the Reshaping Non-Acute Care Programme in Dundee and to seek approval to proceed to the next phase of the programme. The report described a future outline operational plan for non-acute care in Dundee, ideally in partnership with other localities. It also outlined the future impact on property in relation to the wider transformation of the property portfolio across Dundee and Tayside.

The outline operational plan described in the report fully supported relevant national and local strategies, specifically Dundee Integration Joint Board's Strategic and Commissioning Plan, the emerging NHS Tayside Transformation Board's Integrated Clinical Strategy and its Property Strategy.

The Integration Joint Board agreed:-

(i) to approve the proposed future model of non-acute care for Dundee in principle as described in paragraphs 4.2 – 4.6 of the report;

(ii) to instruct the Chief Officer to prepare a fully costed business case and present this to a future meeting of the Integration Joint Board; and

(iii) to note the level of engagement and consultation undertaken to date as set out in paragraph 4.7 of the report and commit to a continuation of this approach over the next phases of the proposed development.

IX DUNDEE AND ANGUS COMMUNITY EQUIPMENT LOAN SERVICE

There was submitted Report No DIJB44-2017 by the Chief Officer providing information about the Dundee and Angus Community Equipment Loan Service.

The Integration Joint Board agreed:-

(i) to note the content of the report; and

(ii) to note the progress in merging the Dundee and Angus Community Equipment Loan Service and in particular the performance and quality indicators detailed in paragraphs 4.2.6 and 4.2.7 of the report which demonstrated an improved service delivery model.

X A CARING DUNDEE: A STRATEGIC PLAN FOR SUPPORTING CARERS IN DUNDEE/VALUING, SUPPORTING AND INVOLVING CARERS: DUNDEE CARERS CHARTER 2017-2020

There was submitted Report No DIJB47-2017 by the Chief Officer seeking approval of a Caring Dundee: A Strategic Plan for Supporting Carers in Dundee (the Strategic Plan) and Valuing, Supporting and Involving Carers: Dundee Carers Charter 2017-2020 (the Charter).

The Integration Joint Board agreed:-

(i) to note the content of the report and in particular the involvement of carers in developing the Strategic Plan and the Charter as detailed in paragraph 4.2.1 of the report;

(ii) to approve the document entitled "A Caring Dundee: A Strategic Plan for Supporting Carers in Dundee" which was attached to the report as Appendix 1;

(iii) to approve the document entitled "Valuing, Supporting and Involving Carers: Dundee Carers Charter 2017-2020" accompanying the Strategic Plan which was attached to the report as Appendix 2 and to sign up to the pledges detailed in the Charter as outlined in paragraph 4.1.4 of the report; and

(iv) to request the Chief Finance Officer to bring a further report detailing financial and resource implications of the Carers (Scotland) Act 2016 to a future meeting of the Integration Joint Board once confirmed.

XI NOT JUST A ROOF: HOUSING OPTIONS AND HOMELESSNESS STRATEGIC PLAN 2017-2020

There was submitted Report No DIJB48-2017 by the Chief Officer providing information about Not Just A Roof: Housing Options and Homeless Strategic Plan 2017-2020 (the Plan).

The Integration Joint Board agreed:-

(i) to note the content of the report and in particular the collaborative approach to developing this Plan as detailed in paragraph 4.1.1 of the report; and

(ii) to approve Not Just A Roof: Housing Options and Homelessness Strategic Plan which was attached to the report as Appendix 1.

XII DUNDEE SMART HEALTH AND CARE STRATEGY 2017-2020

There was submitted Report No DIJB42-2017 by the Chief Officer seeking approval of the Dundee Smart Health and Care Strategy 2017-2020 which described the strategic approach to developing and embedding the use of healthcare and technology within Dundee to improve outcomes for individuals. This was the first Smart Health and Care Strategy to be published in Dundee.

The Integration Joint Board agreed:-

(i) to note the content of the report and in particular the three strategic outcomes detailed in paragraph 5.1.3 of the report; and

(ii) to approve the Dundee Smart Health and Care Strategy which was attached to the report Appendix 1.

XIII FINANCIAL MONITORING POSITION AS AT SEPTEMBER, 2017

There was submitted Report No DIJB40-2017 by the Chief Finance Officer providing the Integration Joint Board with an update of the projected financial monitoring position for delegated health and social care services for 2017/18.

The Integration Joint Board agreed to note the overall projected financial position for delegated services to the 2017/18 financial year end as at 30th September, 2017 and associated risk assessment as outlined in the report and set out in the appendices which were attached to the report.

XIV CLINICAL, CARE & PROFESSIONAL GOVERNANCE REPORT

There was submitted Report No DIJB41-2017 by the Chief Officer providing clinical, care and professional governance performance information and reporting on the work of the Clinical, Care and Professional Governance Forum (R2 Forum).

The Integration Joint Board agreed:-

(i) to note the contents of the report and the performance report which was attached to the report as Appendix 1;

(ii) to note the ongoing work to progress to a fully integrated clinical, care and professional governance performance reporting arrangement as described in paragraphs 4.2.2 and 4.2.3 of the report; and

(iii) to note the recent considerations of the R2 Forum as outlined in paragraph 4.3 of the report.

XV WOMEN'S COMMUNITY CUSTODY UNIT

There was submitted Agenda Note DIJB46-2017 reporting that on 14th September, 2017 the Cabinet Secretary for Justice announced that the Scottish Prison Service intended to build one of the first two Community Custody Units for women in Scotland within the city of Dundee, with a specific site yet to be identified.

The Integration Joint Board agreed:-

(i) to note the position as outlined in the note;
(ii) to note that a full report would be submitted to a meeting of this Integration Joint Board describing planning and consultation arrangements, opportunities and risks when more detailed information was available.
(iii) to note that Dr Drew Walker, Director of Public Health would welcome the opportunity for both he and his service to be involved in the planning of this facility.

XVI TERM OF OFFICE – CHAIRPERSON AND VICE CHAIRPERSON

Reference was made to Article XI of the minute of meeting of this Integration Joint Board held on 29th August, 2017 wherein it was agreed that notification be submitted to Dundee City Council and NHS Tayside proposing that the term of office for the Chairperson and Vice-Chairperson respectively be for a period of two years and that this be effective from 25th October, 2016.

It was reported that this matter was considered by the constituent parties of Dundee City Council and NHS Tayside and that they had agreed that the term of office for the Chairperson and Vice-Chairperson respectively be for a period of two years and that this be effective from 25th October 2016.

The Integration Joint Board agree to note the position as outlined in the note.

XVII DATE OF NEXT MEETING

The Integration Joint Board noted that the next meeting of the Integration Joint Board would be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 19th December, 2017 at 2.00 pm.

Ken LYNN, Chairperson.

ITEM No …4(a)……..

At a MEETING of the **PERFORMANCE AND AUDIT COMMITTEE OF THE DUNDEE CITY HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** held at Dundee on 28th November, 2017.

Present:-

Members	**Role**
Doug CROSS *(Chairperson*)	Nominated by Health Board (Non Executive Member)
Roisin SMITH	Nominated by Dundee City Council (Elected Member)
Helen WRIGHT	Nominated by Dundee City Council (Elected Member)
David W LYNCH	Chief Officer
Dave BERRY	Chief Finance Officer
Jane MARTIN	Chief Social Work Officer
Cesar RODRIGUEZ	Registered Medical Practitioner (not providing primary medical services)

Also in attendance:-

Judith TRIEBS (for Tony GASKIN)	(Chief Internal Auditor)
Arlene HAY	Dundee Health and Social Care Partnership
Alexis CHAPPELL	Dundee Health and Social Care Partnership
Lynsey WEBSTER	Dundee Health and Social Care Partnership
Diane McCULLOCH	Dundee Health and Social Care Partnership

Doug CROSS, Chairperson, in the Chair.

I APOLOGIES FOR ABSENCE

Apologies for absence were submitted on behalf of Judith GOLDEN, Nominated by Health Board (Non Executive Member), Raymond MARSHALL, Staff Partnership Representative and Tony GASKIN, Chief Internal Auditor.

II DECLARATION OF INTEREST

No declarations of interest were made.

III MINUTE OF PREVIOUS MEETING

The minute of meeting of this Committee held on 12th September, 2017 was submitted and approved.

IV DUNDEE HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE REPORT (QUARTER 2)

There was submitted Report No PAC32-2017 by the Chief Finance Officer providing an update on Quarter 2 performance against the National Health and Wellbeing Indicators and Measuring Performance Under Integration interim targets.

The Committee agreed:-

(i) to note the content of the report;

(ii) to note the performance of Dundee Health and Social Care Partnership against the Measuring Performance Under Integration interim targets as outlined in Appendix 1 and section 4.8 of the report; and

(iii) to note the performance of Dundee Health and Social Care Partnership against the National Health and Wellbeing Indicators as outlined in Appendix 2 and section 4.9 of the report.

V PERFORMANCE REPORT – CARE INSPECTORATE GRADINGS FOR DUNDEE REGISTERED CARE SERVICES FOR ADULTS (EXCLUDING CARE HOMES) – 2016/17

There was submitted Report No PAC34-2017 by the Chief Finance Officer summarising the grading's awarded by the Care Inspectorate to Dundee registered care services for adults (excluding care homes) for the period 1st April 2016 to 31st March 2017.

The Committee agreed:-

(i) to note the content of the report including the gradings awarded as detailed in the Performance Report which was attached to the report as Appendix 1 and highlighted in paragraph 4.3 of the report; and

(ii) to note the Care Inspectorate requirements as detailed in Appendix 2 of the report.

VI DISCHARGE MANAGEMENT PERFORMANCE UPDATE (INCLUDING CODE 9 ANALYSIS)

Reference was made to Article XI of the minute of meeting of this Committee held on 12th September 2017 wherein it was agreed that information on actions by which performance could be improved be provided.

There was submitted Report No PAC39-2017 by the Chief Officer providing an update on Discharge Management performance in Dundee. The report also provided detailed information about the current discharge management position for complex delays (code 9s) and practical actions being undertaken in response to current pressures as requested by the Performance and Audit Committee at its meeting on 12th September 2017.

The Committee agreed:-

(i) to note the content of the report and the current position in relation to discharge management performance as outlined in paragraph 5.2 of the report and Appendix 1 of the report and in particular sections 2.2 and 2.3 of that document;

(ii) to note the current position in relation to complex delays as outlined in paragraph 5.3 of the report and Appendix 1 of the report and in particular section 2.4 of that document; and

(iii) to note the improvement actions planned to respond to areas of pressure identified as outlined in paragraphs 5.2 and 5.4 of the report.

VII DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN 2017/18

There was submitted Report No PAC37-2017 by the Chief Finance Officer the purpose of the report was to consider the proposed Dundee City Health and Social Care Integration Joint Board's 2017/18 Internal Audit Plan.

The Committee agreed to note the content of the report and approve the proposed Dundee Integration Joint Board 2017/18 Internal Audit Plan as outlined in Appendix 1 of the report.

VIII DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT CHARTER

There was submitted Report No PAC35-2017 by the Chief Finance Officer the purpose of the report was to consider a proposed Internal Audit Charter for Dundee City Health and Social Care Integration Joint Board which set out the responsibility for and approach to internal audit activity.

The Committee agreed to note the content of the report and approve the proposed Dundee City Health and Social Care Integration Joint Board Internal Audit Charter as outlined in Appendix 1 to the report.

IX INTERNAL AUDIT OUTPUT SHARING PROTOCOL

There was submitted Report No PAC36-2017 by the Chief Finance Officer the purpose of the report was to consider a proposed protocol for the sharing of Internal Audit work across the Tayside Integration Joint Boards, Tayside local authorities and NHS Tayside.

The Committee agreed to note the content of the report and approve the proposed Sharing of Audit Outputs Protocol as outlined in Appendix 1 of the report, subject to approval by all relevant parties.

X DUNDEE INTEGRATION JOINT BOARD INTERNAL AUDIT PLAN PROGRESS REPORT

There was submitted Report No PAC38-2017 by the Chief Finance Officer the purpose of the report was to provide a progress update in relation to the current Internal Audit Plan.

The Committee agreed to note the content of the report and the progress of the current Internal Audit Plan as detailed in Appendix 1 of the report.

XI SERVICES FOR OLDER PEOPLE IN EDINBURGH INSPECTION REPORT (MAY 2017) – DUNDEE POSITION STATEMENT

There was submitted Report No PAC42-2017 by the Chief Finance Officer appraising of the published inspection report of older people's services within the Edinburgh Health and Social Care Partnership. It was reported that as part of the continual improvement process, the report highlighted learning to be gained for the Dundee Health and Social Care Partnership.

The Committee agreed:-

(i) to note the content of the report and the Edinburgh inspection report produced by the Care Inspectorate/Health Improvement Scotland which was attached to the report as Appendix 1;

(ii) to note the Dundee position as assessed against the Edinburgh report as detailed in Appendix 2 of the report;

(iii) to note the areas for consideration by the Performance and Audit Committee as detailed in paragraphs 4.2 and 4.3 of the report; and

(iv) to instruct the Chief Finance Officer to provide the Performance and Audit Committee with an action plan setting out the actions and timescales to address any highlighted areas for improvement and that this be submitted to the meeting of this Committee to be held on Tuesday 29th May 2018.

XII PROGRAMME OF MEETINGS 2018

The Committee agreed that the programme of meetings of the Committee over 2018 be as follows:-

Date	**Time**	**Venue**

Tuesday, 13th February, 2018	2.00 pm	Committee Room 1, 14 City Square
Tuesday, 27th March, 2018	2.00 pm	Committee Room 1, 14 City Square
Tuesday, 29th May, 2018	2.00 pm	Committee Room 1, 14 City Square
Tuesday, 31st July, 2018	2.00 pm	Committee Room 1, 14 City Square
Tuesday, 25th September, 2018	2.00 pm	Committee Room 1, 14 City Square
Tuesday, 27th November, 2018	2.00 pm	Committee Room 1, 14 City Square

XIII DATE OF NEXT MEETING

The Committee noted that the next meeting of the Committee would be held in Committee Room 1, 14 City Square, Dundee on Tuesday, 13th February, 2018 at 2.00 pm.

Doug CROSS, Chairperson.

ITEM No …4(b)…….

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19 DECEMBER 2017**

REPORT ON: **PERFORMANCE & AUDIT COMMITTEE CHAIR'S ASSURANCE REPORT**

REPORT BY: **CHAIR, PERFORMANCE & AUDIT COMMITTEE**

REPORT NO: **DIJB60-2017**

Delegated Decisions taken by the Committee

The Committee approved the following:

- the proposed 2017/18 Internal Audit Plan;
- the proposed Dundee IJB Internal Audit Charter;
- the proposed Sharing of Audit Outputs Protocol, subject to approval by all relevant parties.

Performance Against Workplan

- This was the fifth meeting of the Performance and Audit Committee. The Committee considered the Partnership Performance Report for Quarter 1 (2017/18); the Care Inspectorate Gradings for Dundee Registered Care Services for Adults (excluding Care Homes) 2016/17. It also considered an update report on Discharge Management Performance including Code 9 Complex Cases; and a position statement on the Partnership's self-assessment against the findings of the joint Care Inspectorate / Healthcare Improvement Scotland inspection of Services for Older People in Edinburgh. The Committee also considered a number of reports relating to Internal Audit matters including the 2017/18 Internal Audit Plan; an Internal Audit Charter; an Audit Output Sharing Protocol; and a progress report against the Internal Audit Plan.

Any Other Major Issues to highlight to the Integration Joint Board

- The Committee noted the Partnership had performed well against four of its nine targets (in the areas of emergency admissions, emergency bed day rates and overall delayed discharges). However, it performed less well against its targets in complex delayed discharges. Data was not available for three of the nine indicators (number of days spent in the last 6 months of life in the community; number of days spent in a hospice / palliative care unit; and number of days spent in a large hospital) due to other pressures within the NHS Tayside Business Unit. The Committee also considered the Partnership's performance against the national indicators. It noted there was significant variation across the Local Community Planning Partnership

(LCPP) areas and sought assurance that health and social care inequality issues were being addressed, particularly in the areas of Lochee, East End and Coldside where performance was below the Dundee average in all five national indicators.

- The Committee were pleased to note 82% of the registered services inspected by the Care Inspectorate were graded overall from good to excellent, while 16% were graded adequate and 2% were graded weak. The Committee recorded its thanks to the staff and management who provided an excellent service to the benefit of patients and their families / carers, however it expressed its view that adequate was not the required standard and all services should aim to be excellent or very good if possible.

- The Committee remain concerned about the level of Discharge Management performance, in complex (Code 9) cases. It received an update on the excellent work being undertaken to reduce “non-Code 9” cases and received assurance that significant efforts were being made to apply a similar analytical methodology, where appropriate, to reduce Code 9 delays and requested further updates be provided on progress made.

- The Committee were pleased to note the self-assessment exercise carried out by officers indicated the Partnership was well placed in respect of the findings of the joint Care Inspectorate / Healthcare Improvement Scotland joint inspection of Services for Older People in Edinburgh. It also noted however there were identified areas for further improvement and the Committee requested an updated self-assessment be carried out and reported to the May 2018 PAC meeting.

- The reports relating to internal audit matters was noted including approval of the 2017/18 Internal Audit Plan; progress against the current Internal Audit Plan; approval of the proposed Dundee IJB Internal Audit Charter; and approval of the proposed Sharing of Audit Outputs Protocol, subject to approval by all relevant parties.

Doug Cross
December 2017

ITEM No …6……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19 DECEMBER 2017**

REPORT ON: **MENTAL HEALTH & LEARNING DISABILITY SERVICE REDESIGN TRANSFORMATION PROGRAMME – CONSULTATION FEEDBACK REPORT**

REPORT BY: **MENTAL HEALTH PROGRAMME DIRECTOR AND FINANCE MANAGER, NHS TAYSIDE**

REPORT NO: **DIJB49-2017**

1.0 PURPOSE OF REPORT

1.1 The purpose of this report is to present the findings of the Mental Health and Learning Disability Service Redesign Transformation (MHLDSRT) Programme Consultation and subsequent recommendations to the Dundee Health & Social Care Integration Joint Board.

1.2 This report will be presented to NHS Tayside Board and the Angus and Dundee Integration Joint Boards to note and comment before seeking approval from the Perth and Kinross Integration Joint Board on 26th January 2018.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of this report, the Consultation Feedback Report (attached as Appendix 1).

2.2 Notes the process followed in undertaking the three month formal consultation on the preferred option for future General Adult Psychiatry and Learning Disability services.

2.3 Notes and comments on the Consultation Feedback Report content and recommendations.

3.0 FINANCIAL IMPLICATIONS

The financial implications associated with the options being considered were captured in summary in Section 12 of the June 2017 – MHLDSRT Programme Option Review Report and detailed further in Appendices Six. These will be further refined following approval and further modelling work required to progress preferred option to identify any potential areas for reinvestment

4.0 MAIN TEXT

4.1 Most people who access General Adult Psychiatry and Learning Disability services receive treatment in the community, living at home or in residential care supported by a General Practitioner. Community services help people recover from and live with the effects of their mental illness. They improve the experience of service users while helping them to engage with services. They improve clinical outcomes and enable people to live as full and meaningful lives as possible.

4.2 General Adult Psychiatry and Learning Disability inpatient services provide for approximately 6% of the population who come in contact with our Mental Health and Learning Disability services across Tayside.

4.3 The MHLDSRT Programme Option Review Report presented to the Dundee IJB in June 2017 (Article XI of the minute of the meeting refers) outlined the current issues facing provision of Mental Health Inpatient services for both General Adult Psychiatry and Learning Disability services and examined in detail four potential options that seek to ensure provision of safe, sustainable and person centred services for the future which meet the needs of all our stakeholders across Tayside.

4.4 The Option review report identified a preferred option for future Mental Health and Learning Disability inpatient services and approval to move to public consultation was requested and approved in June 2017 by the Perth & Kinross IJB following presentation to NHS Tayside and the Angus and Dundee IJBs for noting and comment.

4.5 The formal consultation period began on 3rd July 2017 and ran to 4th October 2017. This period was agreed in keeping with best practice guidance which recommends a three month public consultation period.

4.6 The main objectives of the consultation on the preferred option for in-patient General Adult Psychiatry and Learning Disability inpatient service redesign across Tayside were:

- To identify, share information and gain feedback on the preferred option with all stakeholders including the general public;
- To record all feedback, comments and discussions held and respond to consultees' questions about the preferred option;
- To identify consultees' concerns about the impacts and effects of the preferred option and, where practical, identify ways to address those concerns or to mitigate the impacts and effects;
- To assure decision makers, including NHS Tayside, Angus, Dundee and Perth & Kinross Integration Joint Boards and Scottish Government that the views of affected parties have been adequately canvassed and considered during process.

4.7 The Consultation Report seeks to reflect the culmination of a significant informing, engaging and consultation process which has been undertaken since January 2016. The report attached presents a brief background to the Programme and the preferred option, an overview of the consultation process, an overview of the consultation findings and thereafter potential solutions which will be required to support implementation.

4.8 The number of people reached through the use of social media and other approaches was significant.

- Facebook recorded 70,250 and Twitter recorded 30,904 people reached.

- 1250 people had face to face conversations or were involved in group meetings at 76 events

- 363 people completed the feedback questionnaire. This was less than 1% of those reached through social media and less than 30% of those who attended consultation events.

- Most people who answered the questionnaire had read some or all of the information available but 1 in 10 reported not having read any information prior to giving their response.

- 207 of those who completed the questionnaire did not support the change to General Adult Psychiatry inpatient services compared to 113 people who did support the change.

- 214 did not support the change to Learning Disability inpatient services while 91 people did support the change.

- Whilst just over half of those who filled in the questionnaire did not support the proposed changes two thirds understood the reasons why change was being proposed.

- All feedback received during the process has been reviewed and collated to highlight the key themes/concerns raised and are presented in the report attached. A breakdown of the detailed feedback is included in the supporting appendices and via links to the MHLDSRT Programme website.

4.9 The recommendation of the Mental Health and Learning Disability Services Redesign Transformation Programme team is that the preferred option is approved. This is because it will provide safe, sustainable and better quality inpatient services for this group of patients. It is patient safety which has been given highest priority in arriving at this recommendation.

4.10 We can no longer safely staff three acute admission units in Tayside. The aim is for people living with a mental illness or learning disability to be able to access inpatient treatment promptly when they need it. It is also important that the quality of care and treatment received is of the highest possible standard and is delivered in modern, fit-for-purpose single bedroom en-suite accommodation.

4.11 The attached report seeks to outline:

- the main reasons for the review
- the process leading to identification of a preferred option
- an overview of the consultation process detailing the approach and methodology used
- an overview of the consultation findings
- the key themes highlighted during the consultation
- the approach to developing solutions required to address or reduce the impact of concerns raised
- the recommendation to approve the preferred option and a draft key milestone implementation plan.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. The EQIA can be found at the following link: http://www.nhstaysidecdn.scot.nhs.uk/NHSTaysideWeb/idcplg?IdcService=GET_SECURE_FILE&Rendition=web&RevisionSelectionMethod=LatestReleased&noSaveAs=1&dDocName=prod_280838

6.0 RISK ASSESSMENT

The Integration Joint Board is being asked to note and comment on this report and not to undertake specific action in relation to recommendations in the report. As a consequence a risk table has not been completed.

7.0 CONSULTATIONS

The Chief Officer, Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

Consultation Feedback – Supporting Appendices.

Lynne Hamilton DATE: 27 November 2017
Mental Health Programme Director & Finance Manager

Mental Health and Learning Disability Services Redesign Transformation Programme

Consultation Feedback

December 2017

Document Control Information	
Control Status	MH&LDSRT Programme Team – Scheduled 02/11/2017 MH&LDSRT Programme Board – Scheduled 06/11/2017 Clinical Care Governance Committee – Scheduled 14/12/2017 Area Partnership Forum – Scheduled 09/01/2018 Dundee Integration Joint Board – Scheduled 19/12/2017 Angus Integration Joint Board – Scheduled 10/01/2018 Tayside NHS Board – Scheduled 16/01/2018 P&K Integration Joint Board – Scheduled 26/01/2018
Date Last Printed	07/12/2017
Version Number	1.23
Authors	Lynne Hamilton, Mental Health Programme Director & Finance Manager Keith Russell, Associate Nurse Director for Mental Health & Learning Disabilities Stuart Doig, Interim Clinical Director for Mental Health

Foreword

This report represents the outcome of a significant programme of public consultation and engagement to gather feedback on the preferred option for the future shape and delivery of inpatient mental health and learning disability services in Tayside. Our aim is to ensure that people who need specialist care because of their mental ill health or learning disability get the best care possible to support their recovery or long term well-being. The recommended option remains the only clinically viable and sustainable model of delivery.

However it is fully recognised that for many people and groups this would not be their preferred approach. Therefore, it was essential that the consultation offered people a comprehensive range of opportunities to express their views on the preferred option. These views have been listened to and are reflected in the report.

We have had a wide range of consultation events and opportunities for people to share their views through an extensive consultation programme. We commend those who have undertaken this programme and particularly the service users, carers, staff, stakeholders and the wider public. It is important to reflect how this will influence the way in which we take forward the next steps into the decision making process, implementation and beyond.

What we have heard, after carefully reviewing all of the views, are a number of key issues and themes that individuals and groups have raised in response to the preferred option. In considering the next steps, NHS Tayside and each of the health and social care partnerships will be considering ways of addressing the issues raised which include:

• Improving access	• Securing and sustaining a workforce for the future
• Building a refreshed leadership and culture	• Designing improved and aligned community services
• Creating centres of excellence	• Improving the physical environments

The active involvement of service users, carers, staff, stakeholders and the wider public will be critical to delivering the required changes.

If the preferred option is approved, NHS Tayside and the health and social care partnerships are committed to working in collaboration with service users, carers, staff, stakeholders, groups and local communities to implement the proposed model and create centres of excellence for adult mental health and learning disability services. We recognise that the hospital care aspect has been a critically important, challenging and, at times, controversial issue. However, for the vast majority of people experiencing mental health problems or living with a learning disability it is the wide range of care and support arrangements that enable people to live well in the community.

Professor John Connell
Chairman, NHS Tayside

Mrs Linda Dunion
Chair, Perth & Kinross Health & Social Care Partnership

Title

The title of the programme described in this document is ""Mental Health and Learning Disability Service Redesign Transformation (MHLDSRT) Programme".

Purpose of this Report

This Report sets out the findings from the Mental Health and Learning Disability Service Redesign Transformation (MHLDSRT) Programme public consultation which commenced on 3rd July 2017 till 4th October 2017. The consultation sought feedback on a preferred option for future General Adult Psychiatry Acute admission and Learning Disability inpatient services which had been identified following a detailed process of option appraisal and option modelling.

This consultation sought to:

- Identify, share information and gain feedback on the preferred option with all stakeholders and the general public;
- to record all feedback, comments and discussions held and respond to consultees' questions about the preferred option
- identify consultees' concerns about the impacts and effects of the preferred option and, where practical, identify ways to address those concerns or to mitigate the impacts and effects
- assure decision makers, including NHS Tayside, Angus, Dundee and Perth & Kinross Integration Joint Boards and Scottish Government that the views of affected parties have been adequately canvassed and considered during process

The Consultation Report seeks to reflect the culmination of a significant informing, engaging and consultation process which has been undertaken since January 2016 and will focus primarily on the findings of the three month public consultation period. The report attached presents a brief background to the Programme and the preferred option, an overview of the consultation process, an overview of the consultation findings and thereafter potential solutions which will be required to support implementation.

All feedback received during the process has been reviewed and collated to highlight the key themes/concerns raised and are presented in the report attached. A breakdown of the detailed feedback is included in the supporting appendices and via links to the MHLDSRT Programme website.

Following approval of the preferred way forward, a number of work streams need to be established to support the implementation process and the supporting solutions required to mitigate or reduce the impact of concerns raised during the consultation. These work streams will look to progress the work required to support - access, quality improvement, workforce planning, building design work, enhanced community and day treatment services, and co-design/partnership working. Initial work undertaken in respect of building design and cost implications are articulated in the earlier MHLDSRT Programme Option Review

Report documentation http://www.nhstayside.scot.nhs.uk/OurServicesA-Z/MentalHealthServiceRedesignTransformationProgramme/PROD_280788/index.htm and will be further refined during the implementation phase described above.

Background

Mental Health Services in Tayside have undergone significant change following the Mental Health Review in 2005-06 which allowed for an initial shift in the balance of care and substantial investment in community based services through a reduction in inpatient bed numbers at that time. However the decision to retain inpatient services within each locality of Tayside has meant the majority of mental health resources (both workforce and budget) remains within inpatient Services and the level of inpatient spend in Tayside is still substantially higher than the Scottish average when benchmarked against other Board areas. Tayside's health spend on community services is currently equivalent to the Scottish average spend per head of population for both Mental Health and Learning Disability services.

In keeping with the ambitions and actions in the Mental Health Strategy 2017 - 2027, the balance of care has already moved to predominately community-based services with a greater focus on prevention, early intervention and co-production. 94% of those who come in contact with mental health services currently do so in a community based setting. To further shift the balance we must always ensure that people who need in-patient care do so in environments where they can be provided with the specialist, high quality care that they need to support their recovery. In particular, in conjunction with the three local Health and Social Care Partnerships, with their focus on community-based services, we seek to re-model adult in-patient mental health and learning disability services in a way that makes the best use of our skilled workforce to provide patients with the right care in the right place at the right time.

Due to problems associated with recruitment and retention of staff, it has proved increasingly difficult to maintain the inpatient services across the current number of hospital sites. To ensure safe and effective services there has been an increasing need to use supplementary nursing staff and locum medical staff at significant financial cost.
In addition the accommodation on the Strathmartine site is no longer in good physical condition and due to the layout of the accommodation would not lend itself to meet modern accommodation requirements (i.e. single bedrooms with en-suite facilities) even with significant investment. This fact requires a sustainable solution to be found that can provide safe and suitable accommodation for learning disability service users.

The work of this programme including the option appraisal and option modelling exercises (which have been progressed following initial option scoping work presented to the Board in March 2016), have identified a preferred option for future services. It is anticipated this option will provide safe, high quality healthcare which is both sustainable and affordable now and into the future.

This document presents the findings of the public consultation, sets out the key recommendations and describes the next stages in the process.

.

TABLE OF CONTENTS –

SEPARATE APPENDIX DOCUMENT -

List of Contributors – Programme Board & Programme Team

Full list of stakeholder groups who participated in the Consultation listed in the Calendar of Events in the Appendices of report (Appendix Two link)

1. INTRODUCTION

Perth & Kinross Integration Joint Board (as the host of inpatient Mental Health & Learning Disability services) and NHS Tayside in partnership with the Integration Joint Boards (IJBs) of the Angus and Dundee Health and Social Care Partnerships have undertaken a strategic review of the General Adult Psychiatry (GAP) and Learning Disability (LD) inpatient services within Tayside.

Like all Health Boards in Scotland, NHS Tayside is facing significant challenges, and cannot keep delivering services the way we have in the past. We need to adapt our services to ensure they meet the future needs of the population.

Patient safety is our overriding priority. It is important that people can access specialist mental health assessment and treatment promptly. It is also important that the quality of care and treatment received is of the highest possible standard and for inpatients that this is delivered in modern fit for purpose single bedroom en-suite accommodation.

This report seeks to outline:

- the mains reasons for the review
- the identification of a preferred option
- an overview of the consultation process detailing the approach and methodology used
- an overview of the consultation findings
- the key themes highlighted during the consultation
- the identification of any solutions required to address or reduce the impact of concerns raised
- the recommendation to approve the preferred option and a draft key milestone implementation plan

2. MAIN REASONS FOR THE REVIEW

Most people who access General Adult Psychiatry and Learning Disability services receive treatment in the community to help them recover from the effects of their mental illness. This enables people to live as full and meaningful lives as possible. The role of a GP and primary care services is important in working collaboratively with mental health services such as community mental health teams, psychological services and substance misuse services. Third Sector, voluntary and self help organisations also have an important role to play as well as social housing and supported accommodation.

Admission to hospital however is required for a small number of people (approx 6% of population) when the nature and severity of their mental disorder cannot be managed safely or appropriately in the community. In these situations specialist care in an acute inpatient unit is necessary.

Certain groups of patients require specialist inpatient services such as those with a Learning Disability. Other specialist services provide for those with a severe eating disorder, those requiring inpatient rehabilitation for substance misuse and mentally disordered offenders who require assessment and treatment in hospital.

It is fundamental that all inpatient mental health units are safe, sustainable, and provide therapeutic, modern, fit for purpose environments.

Doing nothing is not an option.

This review was undertaken at the request of NHS Tayside Board to address concerns about:

- the ability to safely maintain three General Adult Psychiatry acute admission inpatient units in Tayside and two Learning Disability inpatient sites.

- the hospital environment at Strathmartine Centre not meeting the needs for people with complex needs and learning disabilities who are in hospital for often years at a time.

As highlighted in the Mental Health and Learning Disability Service Redesign Option Review report, the key area of concern for the first of these issues is current and future availability of both mental health and learning disability staff to safely and sustainably manage the services across multiple sites.

For the second issue the main driver is the need to urgently upgrade physical environments for Learning Disability inpatients which cannot be achieved in the current accommodation on the Strathmartine site.

It is recognised however that the Learning Disability inpatient services could be relocated within the overall existing NHS Tayside hospital estate with the potential to improve patient experience and make more efficient use of all current mental health accommodation and resources.

3. IDENTIFICATION OF THE PREFERRED OPTION

The Programme followed a detailed process of option appraisal and option modelling which led to the identification of a preferred option in June 2017.

Details of the full process undertaken to identify and present options for the reconfiguration of GAP and LD inpatient services, and the resulting consultation on the preferred option, are available in the Mental Health and Learning Disability Service Redesign Transformation Programme Option Appraisal, full report, appendices

and Option Review Report, Appendices 1-6, Appendices 7-12

These reports were presented to NHS Tayside governance committees, the NHS Tayside Board and the Angus and Dundee Integration Joint Boards before Perth & Kinross Integration Joint Board granted approval to move to public consultation on the 3rd July 2017.

Board members are directed to the previous reports referred to above for the detailed description, content and outcome of the Option Appraisal and process leading to the identification of the preferred option.

The preferred option (Option 3A) describes the provision of a single site solution for acute General Adult Psychiatry admission inpatient beds on the Carseview Centre in Dundee and a single site for Learning Disability inpatient services (alongside all other Tayside wide specialist services) from the Murray Royal Hospital site in Perth.

The Tayside wide Intensive Psychiatric Care Unit (IPCU) would continue to be provided from the Carseview Centre in Dundee alongside the relocated acute admission beds to provide a single site for the most acutely unwell General Adult Psychiatry inpatients from across Tayside.

The Tayside wide Complex Care, Rehabilitation, Substance Misuse and Forensic Mental Health inpatient units would remain on the Murray Royal Hospital site in Perth, Child and Adolescent Mental Health inpatient unit will remain in the Centre for Child Health, Dudhope Terrace in Dundee and Psychiatry of Old Age inpatient services would continue to be provided in each locality

WHAT CHANGES?

General Adult Psychiatry services

Mulberry Ward in Susan Carnegie Unit in Angus (25 beds) and Moredun Ward in Murray Royal Hospital, Perth (24 beds) relocate to Carseview Centre in Dundee to two refurbished wards.(44 beds in total)

Carseview site becomes the single centre for all acute General Adult Psychiatry admissions with four acute admission wards (84 beds) and the IPCU (10 beds). All out-of hours emergency assessment are carried out at Carseview Centre by the Crisis Response Home Treatment Team. This will improve the coordination of pre hospital assessment, acute inpatient treatment and early supported discharge. It will also remove the need for transfer of acutely unwell patients between hospitals after assessment by the CRHTT.

Learning Disability Services

The Learning Disability Assessment unit which is in the Carseview Centre and the Behavioural Support and Intervention Unit and Forensic Learning Disability units at the Strathmartine Centre, Dundee will relocate to Murray Royal Hospital in Perth. Murray Royal Hospital would therefore become the centre for specialist inpatient mental health services in Tayside.

Forensic Mental Health Services

The Tayside wide low secure unit at Rohallion Clinic currently provides assessment and treatment for men who have a mental illness that is closely related to offending behaviour. This change will mean instead of three wards (35 beds) for men with mental illness there will be two wards (25 beds) for men with a mental illness and one ward (10 beds) for men with Learning Disability

Overview of Preferred Option

As outlined in the MHLDSRT Programme Option review report the preferred option provides the safest most sustainable service model for the future. By ensuring sufficient medical cover, nursing, Allied Health Professionals and psychology workforce, professionals can share learning and experiences across specialities. The option allows for the remodelling and enhancement of the community services which are provided to the majority of population who access services and prevent unnecessary admissions to GAP and LD inpatient services. By shifting the balance of care and providing centralised specialist services it will reduce variation and provide ease of acute care pathways.

The creation of a centralised service provides the opportunity to provide “Centres of Excellence” for synergistic learning through close contact with professionals, service users and carers who would otherwise have been in separate services with different goals and potentially different quality standards.

By contrast travelling time for professionals, service users and carers will be significantly increased in some cases. Further exploration of the impacts on service users, carers, friends and families (time/cost/accessibility/availability) have been raised and considered throughout the consultation period and will require to develop further during option implementation.

4. CONSULTATION PROCESS

In the absence of National guidance for joint service planning across NHS Boards and Health and Social Care Integration Joint Boards, guidance has been sought from the Scottish Government to ensure clarity throughout the process.

The content and detail of the Option Appraisal report presented in August 2016 was noted by the Scottish Government to be of an extremely high standard. The Scottish Health Council (SHC) has been invited by the Programme Team throughout the process to share experiences and provide advice and guidance to the programme. Representatives from the SHC have attended all Option Appraisal events, Option Modelling events and public consultation events. A midpoint review meeting requested by the Programme Team was held in August 2017 to support a review of the consultation progress to ensure optimum feedback of views was being achieved. Positive feedback was received and detail of the meeting held was presented to the Perth & Kinross Integration Joint Board in November 2017 to provide assurance regarding the work being undertaken (attached in Appendix One)

Although the CEL 4 (2010) guidance http://www.sehd.scot.nhs.uk/mels/CEL2010_04.pdf does not apply under the new Integration agenda, the Programme team have followed CEL 4 guidance and sought Scottish Health Council advice as a best practice guide and although not required have worked to meet the requirements formally associated with a programme which would be seen as major service change.

CONSULTATION PLANNING

The formal consultation period began on the 3rd July 2017 and ran to the 4th October 2017. This period was agreed in keeping with best practice guidance which recommends a three month public consultation period.

The MHLDSRT Programme team commenced a programme of information sharing during the month of June 2017 whilst Boards considered the approval of the Option Review report and the draft consultation plan. The information sharing programme in June 2017 helped to inform the public of the forthcoming consultation period and explained how people would be able to get involved.

The MHLDSRT Programme communications and engagement work stream developed a detailed consultation action plan and programme for the three month formal consultation period, building on the engagement work undertaken to that point and information gathered from an initial planning workshop held with wider stakeholder representatives.

The stakeholder workshop was held on 4th July 2017 and 31 individuals and organisations including the Scottish Health Council were invited to attend to support the planning of the three month formal consultation period. The aim of the workshop was to seek suggestions, feedback and views on the proposed consultation approach and materials prepared. 14 individuals from voluntary, service user and carer organisations and staff from across Tayside attended and participated in group work which provide valuable information and suggestions which was then used to inform and shape the planning of events, approach taken and materials shared.

The MHLDSRT Programme team agreed to utilise a wide range of different approaches to gather the views and feedback on the preferred option from service users, their carers and families, staff, third sector and voluntary organisations, the public and any other interested parties. Due to the complexity of the MHLDSRT Programme and wider implications of the options being considered, it was agreed that "face-to-face" methods (such as staff briefings, focus groups, presentations to meetings, discussion groups and public events) would be particularly helpful in enabling people (particularly Mental Health and Learning Disability service users) to feel comfortable to ask questions, raise concerns and receive immediate feedback.
A detailed consultation action tracker plan and detailed calendar of events was prepared to support the planning of the consultation period which noted the tasks to be undertaken, action required, timescale and lead officers (calendar of event is available in Appendix Two)

RAISING AWARENESS

All initial consultation materials were prepared immediately after the approval by P&K IJB on the 30th June to move to a formal 3 month consultation period, and were available online for the consultation launch on 3rd July 2017. The Programme had its own designated external website, internal staffnet page, email, freepost address and freephone number to support the recording of all feedback received and the sharing of information

The website provided a range of supporting materials which were also distributed in hard copies (on request) and handed out at all events held across Tayside. The link to the website and these supporting materials is attached http://www.nhstayside.scot.nhs.uk/OurServicesA-Z/MentalHealthServiceRedesignTransformationProgramme/index.htm

The range of supporting materials included:

- a short easy read summary version of the Board Paper (Option Review Report)
- a more detailed shortened easier read full report (reduced version of the full Option Review Report presented to the Boards)
- Frequently Asked Questions (and a subsequent FAQ2 which was added following a number of questions raised at a Perth & Kinross event)
- a Glossary of all terminology used
- links to all Board reports and stakeholder bulletins/updates
- a short video supported by subtitles and sign language
- further supporting materials such as the poster advertising the consultation and the Equality Impact Assessment (EQIA)
- a link to the online survey monkey questionnaire to provide feedback. The feedback questionnaire was prepared to ensure consistent recording of feedback and support identification of main themes of feedback coming through the various categories of key stakeholder groups. .
- an evaluation questionnaire provided by the Scottish Health Council
- Supporting easy read pictorial materials for Learning Disability service users provided by specialist Speech and Language Therapy staff. These

were used to support face to face meetings, focus groups and to allow families, carers and staff to share information and gain feedback.
- dates of all public sessions, times and venues across Tayside
- A tri-fold pamphlet highlighting key messages and contact information

These materials were shared with some of the key stakeholder groups to ensure they were easily understood and met the needs of all who would participate in the consultation period.

Links to the website were also made available via Local Authority webpages and shared through social media (facebook recorded 70,250, twitter 30,904 people reached) and through local third sector and voluntary organisations websites.

CONSULTATION METHODS

The MHLDSRT Programme utilised a full range of methods to raise awareness of the consultation period and process which included:

Internal

- Information available on staffnet
- Article in NHS Tayside INBOX
- Rolling notice boards on websites
- Staff Bulletins/Newsletters
- Direct distribution of consultation materials through service and clinical leads
- Posters to all services
- Pop up banners in main entrances to Murray Royal Hospital, Susan Carnegie Centre, Carseview Centre, Rohallion Clinic and Strathmartine sites.

External

- Media releases to local newspapers to launch the consultation
- NHS Tayside facebook page updates and Twitter profiles
- Associate Medical Director interviewed on Radio Tay
- Update bulletins to stakeholders list (over 460 individuals/organisations on list)
- Rolling notice boards on NHS Tayside internet page
- Posters advertising the dates of the public events being provided across Tayside were distributed widely by email through the programme stakeholder list, and over 250 printed copies of posters were mailed to all post offices, GP surgeries, pharmacies, libraries, rural library vans, community centres, leisure centres, SPARs, CO-OPs, Tescos, Asdas, Aldis, Lidls, Morrisons etc across Tayside to signpost for further information (email/Website/freephone)
- Information on MHLDSRT Programme website /NHST internet page/Local Authority websites /Partner agency websites

- Direct distribution of update bulletins to key stakeholders identified (stakeholder list included service users, carers, voluntary and third sector organisations, community councils, minority ethnic groups, Public partner forums, NHS Grampian etc and all those who registered an interest)
- All materials prepared were able to be made available in large print, Braille, audio, sign language, and interpreted in the main ethnic community languages on request
- Scottish Health Council also supported distribution through its local communication networks.

A large contribution to the sharing of information and planning of the consultation came from the stakeholder workshop held with third sector/voluntary organisations, staff, service users and carer representatives. In addition members of the Programme's communications and engagement group (clinical leads, Scottish Health Council and engagement officers from across Tayside) provided significant local intelligence to identify key stakeholder groups and contacts.

STAFF EVENTS

A number of staff events were held across both mental health and learning disability hospital sites in each of the three localities. These events (as previous MHLDSRT Programme Events) were offered three times a day to co-coincide with current shift pattern arrangements to support staff attendance. Initial interest indicated that evening sessions would not be attended and therefore two sessions were held on each site. (8 sessions in total) All staff events/presentations were supported by two Programme Team leads and a Staff Side and Human Resources representative, to support staff and answer any queries or concerns raised.

These meetings were held at the beginning of July 2017 to avoid key two week local holiday periods and additional visits to ward areas were then undertaken late September/October to provide information to ward staff that had been unable to be released to attend sessions.

Additional drop in events were also undertaken in foyer areas at Murray Royal, Carseview, Ninewells and Whitehills sites at the end of the consultation period to provide further opportunities for staff (as well as service users and members of the public) to gain information and ask questions/express concerns. The detailed feedback from staff who attended the July sessions is available by locality and attached in Appendices Three, Four and Five

FOCUS GROUPS

Twenty focus groups with service users and carers from across both GAP and LD services were undertaken and supported by the programme leads, staff, third sector and voluntary organisations to gain service user and carer views. These focus groups were essential to ensure those most affected by any

proposed changes to current inpatient services had the opportunity to understand the rationale behind proposed changes and raise any concerns they may have. Some examples of these are: Angus Voice, Advocating Together Dundee, Centre for Independent Living P&K focus group, Wellgate Day Centre Carers, current Strathmartine inpatients and day hospital service users etc. A full list of groups is provided in the calendar of events (Appendix Two)

Learning Disability services utilised the many existing relationships with service user and carer groups to support focus groups. Some groups requested support through presentations from the programme team and then undertook their own focus groups to support feedback. Staff also ran a number of focus groups with current inpatients, community and day services to help support people to participate and have views heard. Speech and Language specialists supported the production of a pictorial easy read version of the consultation presentation to support focus group sessions with Learning Disability service users

Forensic patients were consulted as part of a scheduled meeting of the Rohallion Users Group facilitated by Independent Advocacy.

PUBLIC EVENTS

Ten public events were arranged across Tayside to enable the wider public the opportunity to participate in the consultation, provide feedback and support further information sharing. Events were held in Arbroath, Auchterarder, Blairgowrie, Crieff, Dundee, Kinross, Kirriemuir, Montrose, Pitlochry and Perth in central venues such as town halls, community campuses, church halls etc.

It was agreed that the public sessions would be held in a format which allowed for members of the public to have “one to one” conversations with key members of the programme team and local service managers and clinicians. This format allowed mental health and learning disability service users and their families the opportunity to share sometimes personal stories/experiences, and facilitated private conversations in a way in which the traditional approach of presenting on stage and following questions and answers session would not have allowed for. At the events the public were directed to the consultation stand which presented information displays, consultation banners and provided the opportunity to ask and answer questions, hear people’s concerns and their personal stories and allow sharing of summarised printed materials, questionnaires and record views in a comments box.

In addition to the Mental Health and Learning Disability consultation stand, a whole range of local mental health and learning disability community based service providers supported the events by providing information stalls. This provided the opportunity to raise public awareness of the range of current mental health and learning disability services available locally which support

the majority of the population in their own homes. These events had an excellent response of between 10-20 organisations willing to support most of the public events across Tayside. Feedback received from organisations that supported the events was positive and felt events provided a great opportunity to promote services to the public.

The comments received from each event (in the comments box) are available in detail by locality in Appendices Three, Four and Five.

In addition the programme Team also provided four additional drop in style events in the last two weeks of the consultation period where Programme leads manned an information stand with the pop up banners, boards and information leaflets in the main footfall foyer areas of Whitehills Community Resource Centre, Forfar, Ninewells Hospital, Dundee, Murray Royal in Perth and Carseview Centre in Dundee. These events were attended by members of the public, service users, carers and staff and comments received in the comments box are again available in detail by locality in Appendices Five to Seven.

ATTENDANCE AT KEY GROUPS AND COMMITTEES

A list of key stakeholder local groups and committees were identified and members of the Programme Team provided presentations and Question and Answer sessions at scheduled meetings of these groups held during the consultation period.

Some examples of the groups attended were:

- Angus HSCP locality Improvement groups
- Friends of Stracathro
- Dundee Mental Health and Learning Disability Management Team meetings
- Perth & Kinross Learning Disability Strategy Group
- Dundee Learning Disability/Autism Strategic Planning Group
- Dundee Learning Disability Provider Forum
- Angus Mental Health Reference Forum
- Perth & Kinross Mental Health Strategy Group
- Angus Clinical partnership group

The full list of meetings attended is available in the calendar of events attached in Appendix Two.

SUMMARY

In total 76 events were held during the three month consultation period and approx 1250 face to face/group conversations held. All these meetings and events provided the opportunity to discuss the proposals at both an individual and stakeholder group level.

5. CONSULTATION FINDINGS

The detailed feedback received from all stakeholders has been recorded in the supporting appendices and all feedback comments submitted/extracts of minutes, focus group discussions, emailed submissions etc are available in full via links to the MHLDSRT Programme website (Appendix Three, Four and Five)

The feedback received has been reviewed and themed into a summary report for each of the three local areas, Angus, Dundee and Perth and Kinross by key interest groups i.e. service users, carers, locality/focus groups, staff and members of the public.

The survey monkey feedback questionnaire recorded completed questionnaires from 363 people, which was a relatively small % of the total people reached by social media (0.36%) and who participated/attended the consultation events (29%). These were completed online or by paper copy which was then subsequently entered online and retained for files.

SUMMARY OF QUESTIONNAIRE RESPONSES

- The majority of people who completed the questionnaires read some or all of the materials, with only 10% having not read any information. This question was asked to review which materials were read/most popular to support future engagement and consultation planning.

- Of the people who completed the questionnaire 64% (232) felt the materials they had read helped them understand the reasons for the changes proposed to future GAP inpatient services and 60% (218) understood the reasons for changes to future LD inpatient services.

- 31% (113 responses) either fully supported or partly supported the single site option for GAP and 25% (91 responses) for a single site option for LD with 11% and 15% (40 & 54 responses) respectively of those who responded were unsure.

- Of the people who completed the questions which asked whether they supported the single site option for GAP inpatient services 57% (207 responses) were not supportive of the option and 59% (214 responses) of those who completed questionnaires were not supportive of a single site option for LD inpatient services.

- Only approx 30 to 40 % (109 – 145) of those who participated felt that current mental health and learning disability services met the needs of people across the range of community and inpatient services listed.

- Of the total responses received 29% (105) were from GAP and LD service users, 22% (80) from the public, 18% (65) from carers/families of service users, 19% (69) were staff, 6% (22) from Voluntary/third sector organisations and 6% (22) unknown.

- Over half of responses received were from people aged 46 to 65 (53%), 32% aged 26 – 45, 5% 18-24 and 10% over 65% and 94% of responses were from white Scottish/British people.

- 41% (149) of responses were from people who had a physical or mental health condition or disability.

- The geographical split of responses gathered was 43% (156) from Angus residents, 37% (134) Perth & Kinross, 16% (58) Dundee and 4% (15) from outwith Tayside.

The detailed comments received on the questionnaires are available in the survey monkey summary and detailed reports in Appendix Six and the Scottish Health Council letter and completed forms are attached in Appendix Seven

6. WHAT WE HEARD - KEY THEMES

There are six key themes which have been raised by stakeholders when considering the impact and implementation of the preferred option. These themes were consistent throughout the consultation process, from the one to one conversations, the focus group discussions, the comment box feedback, the survey monkey comments and the emailed correspondence received.

This section of the report will look at each of these key themes in turn, note the feedback recorded and highlight the main concerns raised.

The six key themes from the consultation feedback are:

1. **ACCESS**
2. **QUALITY/CULTURE**
3. **WORKFORCE**
4. **ENHANCED COMMUNITY SERVICE**
5. **CO DESIGN/PARTNERSHIP APPROACH**
6. **IMPROVED ENVIRONMENTS**

The analysis and identification of these key themes can be viewed in Appendices Three, Four and Five and throughout the detailed feedback available via the Programme website.

Following collation of all the consultation feedback and identification of the areas of key concerns in relation to the progression of the preferred option, the programme team commenced a further process to look at what potential solutions are available to reduce/remove any negative concern or impact. Work has begun and will continue throughout the proposed implementation programme to review each of the key themes raised as below

6.1 KEY THEME - ACCESS

Access is undoubtedly the main theme which has been highlighted throughout the whole process as a major source of concern for carers, families and service users, particularly in the more rural areas of Tayside for both General Adult Psychiatry and Learning Disability service users, carers, friends and family

The relocation of all GAP Acute admission inpatient services to Carseview Centre in Dundee will mean the loss of the local GAP inpatient ward in Angus and in Perth. Having to travel to another hospital site outwith the local area is a concern for people not just in terms of how they would get there as inpatients but as a concern regarding how families and carers would be able to visit them during their inpatient stay. For Learning Disability services this is a particular concern for Dundee and Angus populations who currently access services in Dundee and would require to travel to Murray Royal in Perth.

Transport time and cost as well as availability and accessibility are concerns for people, particularly if required to travel across the region to access inpatient services from more rural areas with poor public transport links.

Bed availability was also a concern expressed regarding access and whether sufficient beds will be available or whether the option will mean more patients are admitted outwith Tayside due to demand.

Transport accessibility for people with physical disabilities was raised and current public transport difficulties for those with different wheelchairs, walking aids and electric scooters were also identified.

Communication barriers were also highlighted as a concern particularly for those who may not speak English, are deaf or blind and have mental health needs or a learning disability. This can be particularly difficult if presenting Out of Hours in crisis.

Transport time and cost was also highlighted by third sector and voluntary organisations that currently provide services into inpatient areas in their local areas. Particular concerns were highlighted from small services (often reliant on grant funding etc) and how they will be able to meet the additional cost/time

implications if services are relocated outwith their current local catchment area. Examples of services affected would be advocacy services.

Other partner organisations and service providers such as local authority Mental Health Officers, small local teams of Allied Health Professionals, Psychology services, Pharmacy also raised similar concerns regarding their ability to cover the additional travel time required and cost implications from within finite small team resources. Concerns were also highlighted in relation to the ability to assess current inpatients homes and community settings as part of their discharge planning and care plans if service users are relocated outwith their local area.

6.1.1 WHAT WE NEED TO DO - ACCESS

All the information gathered through the consultation period is currently being used to help inform the programme team regarding where current main areas of concern are, what likely solutions would be possible, what the likely demand for additional support may be and where any additional potential supports and solutions may be required.

While NHS Tayside and local Integration Joint Boards are not transport providers they need to seize the opportunities presented by the redesign of all services (not just mental health and learning disabilities) to improve transport links and access issues where recognised as a concern across the region.

People must be able to access all of our facilities whether as a service user, carer, relative or member of staff. The consultation feedback highlighted real concerns from people (particularly those living in the most rural areas of Tayside) that travel time, cost and current availability of public transport services (which can be very limited) would present real issues if no longer able to access local inpatient services.

Conversations with individuals highlighted that people do not want to be in hospital, they want to be at home and as near their families and friends as is possible. This has obviously highlighted that steps need to be taken to reduce admissions and support more people at home and therefore have fewer people having to travel to receive services. By supporting the enhancement of local community based services and ensuring the right community/home based treatment and wellbeing services are in place alongside inpatient services which are adequately resourced, people will spend less time in hospital.

As part of the workforce modelling, future roles need to be developed to provide support to service users to ensure they can access their home communities as part of their care plans and recovery.

It is recognised that for a minority of the population the preferred option will mean they will have to travel further. Therefore work has commenced to look at existing transport links and how these can be enhanced to reduce the

impact of access concerns for those people who require an inpatient stay when acutely unwell. Carers, families and friends all support recovery and therefore the ability to maintain these relationships is essential.

Some preliminary scoping work has been undertaken to review current available transport links, modes of transport and their availability/accessibility and their cost and time.

Appendix Eight sets out a map of the current estimated example transport links, time and cost from a number of the main population areas across Tayside. Preliminary discussions have been held with council transport planners, local transport companies, volunteer driver services, Scottish ambulance services and Police regarding the potential impact and solutions required to accommodate any relocation of services from one locality to another.

There are a number of local transport solutions/supports currently in place and further work is required to look at how these can be built upon to address access concerns highlighted.

An audit of visitor patterns and postcodes has been undertaken over an initial two week period and this will continue to be monitored to allow for the identification of current visitor trends and identify main areas of demand to support the planning of solutions where this is possible.

The Programme Team have highlighted throughout the consultation that all plans require to be realistic and not over promise and under deliver on potential supports which can be made available. It will not be possible to offer everyone assistance with access but where there are pockets of demand NHS Tayside and the three local health and social care partnerships will require to work together with partner organisations to identify any potential solutions which can be supported.

An Access and transport work stream would therefore require to be developed as part of the implementation stage of the process. The work commenced by the programme team will be progressed and shared through a joint work stream to support and co-ordinate the current range of proposed model changes by both NHS and Local authority services from across Tayside. Transport and access issues are wider than mental health and learning disability properties and therefore a wider partnership approach to finding solutions is required.

Examples of options which could be considered could be: allocation of funding to existing organisations providing volunteer drivers (initial discussion with current service providers has indicated a willingness and ability to meet any additional demand if resources were made available), improved transport links with local bus companies, links from other sites/areas to the existing X7/X8 service between PRI and Ninewells/Carseview etc

From initial review of current visitor logs and feedback from volunteer driver services the demand for support to access services is not as high as would expect. One approach could therefore be to consider piloting services in particular areas for a period of time and then monitoring to review demand.

A need for increased training of transport providers and raised awareness of peoples differing needs on public transport has also been highlighted. Discussion with transport contacts in Local authority services noted work which has already been undertaken in specific areas which could be rolled out. Particular concerns were noted during the consultation in relation to Learning Disability service users who may require to travel to Murray Royal in Perth. Use of technology is another potential solution to support contact with families which could also be explored. Some current nursing home accommodations and other services use IT devices such as ipads, laptops, computers and phones to facetime, messenger and skype families and friends to maintain relationships and contact when travel presents a significant issue. Again these are areas which can be further explored through the establishment of an Access work stream.

Transport and access for small organisations and teams also requires to be reviewed to look at how this can be supported or services remodelled locally to support provision across the localities by restructuring how these are currently provided to meet future demand and need.

6.2 KEY THEME - ENHANCED COMMUNITY SERVICES

The consultation highlighted the need to ensure robust links are established between local community services/day treatments and inpatient services particularly where beds are relocated outwith a locality. . Feedback again highlighted the impact the preferred option proposed could have on third sector and other partner organisations. Additional travel time/cost was raised as a key issue for smaller services with small teams and low staff numbers etc. Local Health and Social Care Partnerships are key to supporting the remodelling of community services to ensure robust links are in place.

The potential social isolation factor for service users and carers also needs to be considered as there is growing evidence around the negative impacts they can have on health and wellbeing.

Learning Disability services/service users and their carers and families raised specific concerns in relation to future provision of day services and day treatments currently accommodated on Strathmartine Centre in Dundee for people from across Tayside. Main concerns were whether the preferred option would require people from across Tayside to travel to Perth for day treatments and whether the Murray Royal site could accommodate workshops etc currently provided from Craigmill skill centre. Issues regarding access to Tayside wide therapy and support groups such as sex offender treatments, child health management, service user and carers forums etc were also

highlighted as a concern in relation to travel and access if these groups would be required to relocate from Strathmartine to Murray Royal in Perth.

6.2.2 WHAT WE NEED TO DO - COMMUNITY REMODELLING

Evidence shows that improving primary mental health care support can reduce the use of secondary care services and improve quality of care.

A suite of interventions require to be established to promote an understanding to people that they can take much of the control over their own physical and mental health e.g. health behaviour change coaching.

Health and social care integration has required us to think differently about how we plan services. The partnerships provide opportunities to redesign services and supports for people more widely across a range of care including improving the physical health of people with mental health problems.

The NHS Tayside Health Equity Strategy supports co-production, helping people to be involved in the planning of their services and to take back elements of services which do not need to be delivered by health professionals. Services are therefore co-produced by communities and the Statutory sector.

This promotes the concept of social capital which highlights the importance of a connected and caring society and the move away from institutions.

We need to ensure that future services promote more service user and community enablement and not an increased dependency on specialist NHS services. Simply moving the location of care without redesigning it is not enough. Existing services should not simply be relocated and then replicated in new settings. Developments should look to make a significant move away from a system in which the needs of the patient were determined and met by the system, towards one in which patients are given an increasing role in self –determination and where the service user's experience is part of evaluating success.

The impact of complex, co-morbid health problems on outcomes for people with mental health and/or learning disability issues is a huge underlying factor in health inequalities. The Mental Health Strategy for Scotland sets out the ambitions to achieve a parity of esteem between mental health and physical health problems

NHS specialist Mental Health and Learning Disability services can be represented as only two small pieces in a much larger jigsaw puzzle of mental health and wellbeing services which look after and support the majority of the population to stay well at home.

The core principles of community specialist mental health care are highlighted as:

1. Recovery – working alongside patients to enable them to follow their own recovery path
2. Personalisation – meeting the needs of individuals in ways that work best for them
3. Co –production and partnerships (delivering services with...rather than for)
4. Collaboration– working with people as experts in their own mental health. Collaborative working across sectors, with engagement of people/communities themselves being at the heart of this.
5. Promoting social inclusion/advice citizenship i.e. human rights/community empowerment acts
6. Preventions through public health strategies and earlier interventions
7. Promotion of mental health and Wellbeing
8. Pathway working – building on a stepped care approach from primary care and viewing mental health services as a system rather than a series of isolated services.

Throughout this the GP remains at the heart of a person's care and about one third of people with a serious and enduring mental illness are managed solely by GPs in primary care.

There is currently no standard model nationally for the commissioning and provision of community specialist mental health care services.

Each of the three health and social care partnerships in Tayside are at different stages in the planning and development of their local strategic and commissioning plans around their community based learning disability and mental health and wellbeing services. The redesign of inpatient services allows for resource release and an opportunity to remodel and enhance current community provision across Tayside to ensure there is a consistency of access and quality across all community services.

A key theme from the consultation was the need to further develop and remodel local community services to support the preferred option and ensure that more people can be supported at home both in and outwith working hours. People identified the need for robust links between inpatient and community services, primary care and third sector/voluntary organisations.

The design of future community services is the responsibility of each of the local health and social care partnerships and is being developed to meet the needs of the local populations.

Detailed information regarding community redesign across Tayside for both GAP and LD services is contained in Appendix Nine

6.3 KEY THEME - QUALITY / CULTURE

A key theme raised by service users throughout the consultation was the need to improve the current mental health service provision across services and Tayside. Quality of service provision, culture and a more recovery focused approach to care, supported by Peer Workers (people with personal experiences of mental health problems, employed to explicitly use those experiences in supporting patients) was raised by service users and carers/families who want reassurance that any changes to services will not negatively impact on the quality of service received and will improve outcomes for people. Feedback highlighted the need and appetite for service user involvement in planning their own care and in the future development of services.

Feedback highlighted current perceptions of reduced quality service provision in some areas and a need to review current models and create consistent high quality inpatient services for the future which were more recovery focused and provided the highest quality of care for the people of Tayside.

The consultation conversations highlighted current negative public perceptions of the Carseview Centre and current quality of services provided from the facility. This was also raised by members of the public to the Health Minister at the NHS Tayside Annual review meeting. There has been significant negative media attention in and around both the Mental Health services, the programme and the consultation process itself. Conversations held with members of the public at the consultation events allowed members of the programme team the opportunity to hear the range of experiences people have had both positive and negative. These also provided the opportunity to discuss individuals concerns surrounding the option being considered, the work of the programme and the robust process followed. There is however a recognition that in order to improve we need to address perceptions and issues around current service provision and work in partnership with a wide range of people to improve the models, quality of care and culture within our Mental Health and Learning Disability services for the future

Discussions also highlighted the limited provision of physical care for people with mental health problems and the current lack of parity between physical and mental health services

6.3.3 WHAT WE NEED TO DO - QUALITY IMPROVEMENT WORKSTREAM

Our shared ambition is to have services that work together to have a consistent focus on quality.

The Healthcare Quality Strategy for NHS Scotland outlines that people in Scotland want;

- Caring and compassionate staff and services
- Clear communication and explanation about conditions and treatment

- Effective collaboration
- A clean and safe environment
- Continuity of care
- Clinical excellence

These quality statements underpin our ambition for Mental Health and Learning Disability Services.

We want to extend this further to ensure that our services provide the highest quality learning and development environments for patients and staff to ensure that every person has the opportunity to maximise their potential.

The preferred option proposed will provide NHS Tayside with the opportunity to completely remodel its current inpatient services for both Mental Health and Learning Disability across Tayside. By striving to create a change in culture and create "centres of excellence" on both Carseview and Murray Royal sites, people who require specialist inpatient services will receive these in improved environments with safe and sufficient staffing resources. These new centres for both GAP and area wide specialist services will support shared learning, teaching, cross cover of staffing and therefore reduce variation and provide a consistency of care and outcome for people who require an inpatient stay. Through these opportunities it is envisaged this will reduce the length of stay required in inpatient wards and therefore people will return to care in their own locality as soon as is possible.

It is no longer possible to sustain local inpatient beds in each area so the option proposed must now ensure that when people require an inpatient stay it is in a safe, well resourced, highly skilled appropriate environment for as short a time as is possible.

It is recognised that work is required to improve and build on our current mental health and learning disability service models and these require ongoing engagement with the public, service users, carers, staff and all statutory and non statutory partner organisations to help shape and design them to meet the needs of the local population now and into the future.

6.4 KEY THEME - WORKFORCE

Another key topic raised throughout all events and focus groups was in respect of the current pressures faced in staffing the current and future mental health and learning disability services. The programme team was asked numerous questions seeking information about what is currently being done to ensure there is sufficient workforce for the future, what is being done to recruit and retain staff and why we weren't doing more to address the issues raised by the forecast retirements and workforce issues.

The face to face presentations and conversations allowed for the opportunity to share information regarding:

1. the national context in terms of national shortages of key staff groups
2. the impact of Brexit on recruitment from the European Union
3. more registered nurses leaving the Nursing and Midwifery Council (NMC) register than joining
4. the local context regarding current training opportunities and the impact of national recruitment to these training places
5. the national and international work opportunities for registered Nurses and Doctors
6. the current age profile of staff and forecast retirements (impact of early retirement status at 55 in mental health)
7. the current patterns of recruitment and Newly Qualified Practitioner preferences.

A repeated question asked was why current staff or newly qualified staff were not being required to work in the geographical area in which they had completed their undergraduate training. The programme team noted the merit of this question and encouraged people to raise this with their local MSP. People also asked why current or newly qualified staff were not assigned to areas where problems in recruitment were being experienced. The programme team were able to explain that the risk of placing a staff member in a specialty and geographical area they don't want to work in is that they move post at the earliest opportunity.

6.4.4 WHAT WE NEED TO DO - WORKFORCE PLANNING

The Associate Nurse Director and Associate Medical Director for Mental Health and Learning Disability services continue to engage with local and national colleges and universities to attract staff into Tayside.

In Nursing there is a range of recruitment initiatives in place locally with the University of Dundee and the University of Abertay. Examples include the joint NHS Tayside and University of Dundee return to nursing programme, one day a week contacts for Mental Health 4th year Nursing Students at the University of Abertay which leads to a substantive appointment on graduation, the Healthcare Support Worker HNC Programme and attendance at job fairs.

New Clinical Academic Nursing posts have been created with Edinburgh Napier University and the University of Abertay to help bridge the gap between academic and clinical practice. All newly qualified practitioners join action learning sets for their first 6 months in post which has received very positive feedback and evaluation. Regular liaison takes place with the Universities to continue to build the reputation of NHS Tayside as the employer of choice for newly qualified nurses.

The Royal College of Psychiatrists undertakes a biennial survey of NHS organisations and private independent providers who employ psychiatrists in the UK. There is an ongoing rise in the number of vacant consultant psychiatrist posts in the UK, up from 5% (2013), 7% (2015) to 9% (2017).

There are also increasing difficulties in recruitment to other non training grade medical posts such as Specialty Doctors.

The long anticipated increase in retirement numbers as a result of pension changes has not yet become an eventuality.

The majority of vacancies in consultant posts occur in the three largest specialties; general, child and adolescent and old age psychiatry. There are major challenges in recruiting permanent consultant staff is underlined by the increasing reliance on locum consultants. The number of full time locum working in psychiatry reported by the NHS organisations across England has risen by 60% in the last four years.

This national picture is mirrored in Tayside. Excluding university appointments NHS Tayside employs 50 consultant psychiatrists who work across the range of psychiatric sub specialities. Most of these subspecialties have long-term vacant consultant posts but General Adult Psychiatry has a particular challenge with a significant number of vacant posts across all three geographical areas in Tayside.

As of the end November 2017 the position in General Adult Psychiatry (including Liaison Psychiatry and CRHTT) was

	Funded whole time equivalent (wte) consultant posts	Number of consultants in post (wte)	Number of locum consultants employed (wte)
Perth & Kinross	5.4	4 (3.5)	2 (1.6)
Dundee	12.0	7 (6.4)	6 (5.1)
Angus	5.0	3 (3.0)	3 (2.4)

There unfortunately has been the downward trend in doctors undertaking training in general psychiatry. In Tayside there are nine funded posts for higher training in general psychiatry but at present only three of these are filled. National data suggest that for every 100 doctors who train in general psychiatry only 80 take up a consultant post in this speciality.

There is an improving picture in core psychiatry training in Tayside. All nine core psychiatry training posts are filled for February 2018 and because of unfilled posts in higher training additional funding has been made available to keep 2 core psychiatry trainees in post to hopefully gain their postgraduate examinations and progress to higher training.

It takes about 14 years to train a consultant psychiatrist when time at medical school is taken into account. From leaving medical school it takes at least eight years. Improving recruitment of trainees is an important part of addressing the medical workforce challenges but it will also require other recruitment approaches and looking at models of care. As part of the Mental Health & Learning Disability Service Redesign Transformation Programme there is a need to develop medical workforce plans to address the reality of

fewer consultant psychiatrists being available and the need to develop systems of care that are not reliant upon a large number of doctors in training.

6.5 KEY THEME – CO-DESIGN / PARTNERSHIP APPROACH

The final key issue raised though out the consultation was the requirement for all stakeholders' views to be considered to support service redesign across both GAP and LD services. It was clear from the consultation that people want to be involved in shaping future service models, accommodation, pathways and their or their family member's recovery.

People have felt that there has been a lack of engagement and partnership approach to the way services have been designed historically and are clear that they wish and need to be involved in planning of future GAP and LD services.

6.5.1 WHAT WE NEED TO DO – CO-DESIGN/PARTNERSHIP APPROACH

There is a connection between the priorities of people and the values of staff who work within services. NHS Tayside's aim is to be 'the best at getting better' and it is clear that co-design, collaboration and communication must underpin service development. A partnership approach will reflect a fundamental change in the traditional planner versus client relationship and ensure that people are active participants in their care. The co-design approach enables a wide range of people to make a creative contribution in the planning of services and resolving of concerns. Through health and social care partnership arrangements and ensuring the public and stakeholders maintain a continued engagement in the MHLDSRT Programme future service redesign can then maximise the opportunities of this approach.

This approach goes beyond consultation by building and deepening equal collaboration between those people affected by, or attempting to, resolve a particular challenge. A key tenet of co-design is that users, as 'experts' of their own experience, become central to the design process.

The immediate benefits of employing a co-design approach include:

- Generation of better ideas with a high degree of originality and user value
- Improved knowledge of service user needs
- Immediate validation of ideas or concepts
- Higher quality, better differentiated services
- More efficient decision making
- Lower development costs and reduced development time
- Better cooperation between different people or organisations, and across disciplines

The longer-term benefits include:

- Higher degrees of satisfaction of service users
- Increased levels of support and enthusiasm for innovation and change
- Better relationships between the service provider and service users

The Consultation process and earlier engagement around the option appraisal and option modelling work has proved invaluable in terms of the feedback and information received to support the options being considered and the Programme to date. The Programme team has found the one to one conversations and listening to people's stories a significant source of information and learning and has highlighted areas across the organisation where changes and improvements are required. The consultation cannot now end at the point of decision and the programme team leads feel strongly that the consultation has provided the opportunity to start these conversations and that they must now continue throughout the process and beyond to ensure a full partnership approach to planning of future services.

6.6 KEY THEME - IMPROVED ENVIRONMENTS

A key theme emerging from discussions with Learning Disability services was the need for improved environments and that any relocation of services would not reduce the current level of access to activities and work type day treatments currently available. Service users, carers, families and staff highlighted the current facilities available through the Craigmill centre and garden areas on Strathmartine site which were important to support Learning Disability service users and their treatment. Concerns were raised that the Murray Royal site could not replicate these and that patients would require to travel to Perth from across Tayside if these were only provided alongside inpatient services as per current service model.

6.6.1 WHAT WE NEED TO DO – BUILDING DESIGN WORKSTREAMS

Feedback received regarding the preferred option has highlighted that people have concerns regarding how the relocation of inpatient services will ensure improved inpatient environments.

It is recognised that the Carseview Centre in Dundee requires refurbishment which has been outstanding for a number of years. This refurbishment must be planned and designed with full stakeholder involvement in shaping the improvements required to the wards and site as a whole, including access to outdoor space, activity space and shared living accommodation. There were a number of initial drawings and design work undertaken between 2005 and 2011 for various refurbishment and extensions to the wards on the site which can be utilised to support the design process.

A number of concerns have been raised regarding the ability to ensure adequate activity space is available on the Murray royal site for Learning Disability services within the Moredun ward area. Initial design work

undertaken as part of the Option Review process looked at combined areas for Learning Disabilities and following consultation feedback Architects have commenced a review with the programme team to present a range of options utilising accommodation at Murray Royal to ensure sufficient space is made available to meet the needs of all inpatient services. High level initial footprints will then be shared with stakeholder to undertake the detailed design work required to ensure areas meet needs and provide sufficient and appropriate indoor and outdoor spaces required

7. SUMMARY AND RECOMMENDATIONS

It is clear from the consultation the majority of people would prefer to receive their health care close to where they live. The challenge to mental health services is balancing this with the need to provide safe inpatient services which are high quality and provide best value for money.

The public consultation process CEL 4 guidance section 14 notes that:

"*It will…look to the Board… to provide evidence that the views of potentially affected people and communities have been sought, listened to, and acted on: and treated with the same priority (unless in exceptional circumstances e.g patient safety) as clinical standards and financial performance*.

The above report seeks to assure the Boards that the views of the people of Tayside potentially affected by the changes proposed have been sought, listened to, collated, themed and potential solutions identified to be acted upon to reduce the impact of all concerns heard.

The current and future vacancies in the medical and nursing workforce puts at risk the sustainability of services over the next five to ten years. We need to change the way we currently provide services. Doing nothing is not an option.

It is necessary to ensure that inpatient services are both safe and sustainable now and into the future. This option will allow for resource release to support the remodelling and reinvestment work required by each local health and social care partnership to support more people in and around their own home (in keeping with feedback from the consultation). Relocating specialist acute inpatient services places them further away for some people but closer for others. The ongoing work to improve community based services from early intervention to prevention of admission to acute hospitals will go some way to mitigate concern about access for those who may have to travel further.

Future inpatient service models should be reviewed and remodelled to ensure provision of the best possible care for as short a period as necessary before people are supported back into their local communities.

The Perth & Kinross Integration Joint Board is asked to recognise the travel and access concerns raised and work with partner organisations to reduce the impact on people and ensure services are accessible when required.

The three Health and Social Care Partnerships will continue to work with local partners and mental health and learning disability services to further refine and develop local implementation plans for enhanced community based services as defined above.

The programme team therefore recommend that ***the preferred option (Option 3A) is approved taking cognisance of the key themes that emerged from the feedback gathered during the consultation process to ensure successful implementation of the preferred option*.**

8. NEXT STEPS – DRAFT TIMELINE

Following approval of the preferred option a suggested programme of next steps are set out in the attached high level draft key milestone programme plan below which provides an indicative programme of works with estimated timeline for work required. These work streams are only indicative at this stage to support an estimated programme of works – these will require to be formulated in partnership and therefore subject to change.

Programme of Works	Deadline
Approval of preferred option	End of Jan 2018
Mobilisation of implementation programme and suggested work streams to progress work required (to be agreed in partnership with stakeholders) : 1. Access – Transport/Technology 2. Service Improvement 3. Workforce planning 4. Learning Disability inpatient Service modelling 5. General Adult Psychiatry inpatient service modelling 6. Secure care inpatient service modelling 7. Carseview building Design Team 8. Murray Royal building Design Team 9. Logistics planning team 10. Ongoing Communication and engagement	February 2018 to November 2018
Engagement sessions with public/key stakeholder – update of decision	February 2018
Detailed design and approval process	March 2018 to September 2018
Approval of variation to contract	October 2018
Refurbishment Commence	November 2018
Programme completion	June 2020

ITEM No …7……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19 DECEMBER 2017**

REPORT ON: **JOINT SENSORY SERVICES STRATEGY & COMMISSIONING STATEMENT**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB52-2017**

1.0 PURPOSE OF REPORT

To seek approval of the Joint Sensory Services Strategy and Commissioning Statement for 2017 – 2020.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the contents of this report, particularly in relation to the engagement of the population of Dundee who have specific sensory requirements.

2.2 Notes the role of the different elements of provision and creation of specific social work support within the joint sensory community.

2.3 Approves the Joint Sensory Services Strategy & Commissioning Statement (attached as Appendix 1) as the vehicle for the planning and development of services in the next three years.

3.0 FINANCIAL IMPLICATIONS

The commissioning intentions outlined in this report will be funded from existing budgets and funding streams.

4.0 MAIN TEXT

4.1 Within the context of the Strategic Planning framework, it was identified that there was a need for a specific Joint Sensory Services Strategic Planning Group (SPG) which brought together the range of sensory service needs across the City. The creation of the Strategic Plan and Commissioning Statement began in 2016 and has been completed this year to take account of the need for a co-ordinated and collaborative approach to the delivery of quality sensory services across Dundee.

4.2 The delivery of services for those with specific sensory needs had been provided in a sporadic manner by a range of providers, with very little communication and collaboration across the City. The blind community and the deaf community, both providers and those using services, had little connection and planning was not linked to need.

4.3 A Strategic Needs Assessment was carried out and identified a range of issues that required to be addressed

- Dundee has approximately the same rate of people who are blind, deaf or have sight or hearing loss as the Scottish average (23.5 people per 1,000 population).
- There are differences across Localities.
- There is a strong correlation between sensory deficit and age.

- Older people are more likely to be known to social work.
- In general, men are more likely than women to identify themselves as having a sensory loss.
- There is some correlation between the level of deprivation in a locality and the prevalence of deafness and partial hearing loss.
- There is some correlation between deprivation and the prevalence of sensory needs in children and young people.
- It is not possible to identify the underlying reason for the correlation between deprivation and sensory needs.
- Having a sensory impairment means you are less likely to be in work or study.
- Having a sensory impairment means you are more likely to be in social rented accommodation.

4.4 The Joint Sensory Services SPG Strategy and Commissioning Statement is a result of the joint working and collaboration in the planning and delivery of services to meet identified need, and has involved a wide range of stakeholders in both the sensory service population and the general population across the City.

4.5 A range of seven key areas for action have been identified:

- Partnership working
- Joint Sensory Social Work Service
- Governance & Legislative Compliance
- Staff Learning and Skill Development
- Care Pathways
- Engagement & Involvement
- Communications

4.6 The Joint Sensory Services SPG has responsibility for the development of services and support for children and young people, and will therefore also have a role in helping to design and develop some services that will continue to be provided by NHS Tayside and Dundee City Council. This makes it even more important to have a strategic framework for the delivery and commissioning of identified services based on needs assessment.

4.7 The creation of a Joint Sensory Social Work Service was an outcome that has been managed and procured within the framework of the Needs Assessment and has recently become established as the first joint service within the City providing both sight and hearing support to the population of Dundee. This was commissioned through a procurement process and was awarded to North East Sensory Services (NESS), based in Dundee Voluntary Action (DVA).

4.8 There had been initial challenges, and many continue, in the engagement and collaborative working of providers within the sensory community and the Strategy & Commissioning statement supporting the work of the Sensory SPG provides a framework for services to be developed around an identified need.

4.9 There have been recent issues on a Tayside level around the support of a project called Hear to Help, provided by the national charity Action on Hearing. This project was previously funded by the Scottish Government, and latterly a one year funding commitment from NHS Tayside. At the end of that funding period an active campaign has been in place across Angus, Perth & Kinross and Dundee to persuade the three local partnerships to provide funding to continue this project. The project replaces batteries, cleans and replaces tubes on hearing aids and sign-posts people who use hearing aids towards assistive technology. It does this through community based drop in services once a month in 6 locations in Dundee and can visit people in their own homes where necessary. Currently the Joint Sensory SPG are looking at the level of service currently delivered by Hear to Help and considering all options to ensure that people who use hearing aids in Dundee can access the maintenance services they need. This work is being taken through a specific short life working group and includes the project manager for Hear to Help.

4.10 The establishment of the working groups and the engagement programme around the issues identified in the Joint Sensory Services SPG Strategy & Commissioning Statement provide a forum to ensure that the needs of the population of Dundee are met on the basis of the strategic needs assessment and services are developed in areas prioritised across the City.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. An EQIA is attached. It supports the Scottish Government's See Hear and A Fairer Scotland policy initiatives.

6.0 RISK ASSESSMENT

Risk 1 Description	The services are delivered by disparate organisations around their priorities and not the identified needs of the community as identified in the Strategic Needs Assessment resulting in duplication and disjointed services.
Risk Category	Operational
Inherent Risk Level	9 - High
Mitigating Actions (including timescales and resources)	The SPG and this strategic statement provide the structure and key stakeholders to mitigate this risk.
Residual Risk Level	3 - Low
Planned Risk Level	3 - Low
Approval recommendation	Given the low level of planned risk, the risk is deemed to be manageable.

7.0 CONSULTATIONS

The Strategic Statement was devised following a significant period of consultation across Dundee with all stakeholders. The Chief Finance Officer and Clerk were also consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 24 November 2017

Beth Hamilton
Locality Manager

Dundee
Health & Social Care
Partnership

Joint Sensory Services SPG
Strategy and Commissioning Statement
2017 – 2020

Joint Sensory Services Dundee

Version B16
November 2017

CONTENTS

INTRODUCTION

The Joint Sensory Services Strategic Planning Group (SPG) is responsible for developing a strategic approach to address the needs of people with sensory needs within Dundee. To help guide this work, the SPG has developed this, the first Dundee Joint Sensory Services Strategy.

The Joint Sensory Services strategy has been co-produced in partnership with a range of local people and local organisations. It will provide the strategic direction for developing services and support for people with sensory requirements over the next three years. It sets out the overall vision and key areas for action that will provide an overall structure of this work, and the main action points that need to be achieved.

The Health and Social Care Partnership has produced an overarching Strategic and Commissioning Plan, which sets out the overall vision for Dundee, and a series of Strategic Priorities. The vision and priorities have helped inform the development of this strategy. This strategy was commenced in 2016, and acknowledgement is provided to the previous Chair, Avril Smith Hope.

The Joint Sensory Services SPG has responsibility for the development of services and support for children and young people, and will therefore also have a role in helping to design and develop some services that will continue to be provided by NHS Tayside and Dundee City Council.

The strategy highlights the service changes that will be required, the commissioning intentions, the rationale for those decisions, the methods of implementing and delivering the required changes, and the way these actions will be achieved, monitored and reported.

The Joint Sensory Services SPG will contribute to the priorities and actions of the Health and Social Care Partnership, and other statutory and voluntary organisations in Dundee. In doing so, the SPG will ensure that people with sensory needs can receive the care, support information and access to services and support that they require in order to live fulfilled lives within Dundee.

This strategy sets out how we will make this happen.

Beth Hamilton
Christina Cooper
Co-Chairs, Dundee Joint Sensory Services SPG

Executive Summary

- The **strategic needs assessment** highlights that there is a strong correlation between age and the prevalence of sensory impairment. There is also a correlation between the age of people with sensory impairment, and the level of support they require.
- Longer life expectancy means the number of older people in Dundee is predicted to increase significantly. As a result, the number of people with sensory needs will increase, and the **level of demand** is liable to significantly increase. Many of the people requiring support will be older people who have not experienced sensory impairment before.
- There is a significant amount of **legislation and guidance** that needs to be taken into account. As well as the principals of health and social care integration, there are the recommendations outlined in See Hear, the national strategy for sensory impairment, and the requirements of the new British Sign Language (Scotland) Act.
- The See Hear strategy set out a series of recommendations.. To address these, the Joint Sensory Services Strategic Planning Group has developed **four principal workstreams** that will be responsible for implementing the recommendations.
- There is a need to develop clear, integrated **care pathways** that put the person at the centre of the care journey and promote independent living, self-management, early diagnosis and intervention, and effective partnership working across statutory and third sector agencies.
- To support this, robust **staff learning and development** will be essential, both to raise awareness of sensory impairment, and to provide training in effective communication, early identification and making referrals, and providing appropriate support for people with sensory needs.
- There is a need for **strong engagement** to help develop the overall strategy, and to ensure that changes to services are developed in co-design and co-production with local people and third sector organisations.
- There is a need for local people with sensory needs to receive **effective communication** in a variety of formats. This will allow them to effectively participate in the development of services, and to receive information about what services are available and how to access them.
- To underpin and support all of these areas, there is a need for **robust governance** arrangements, to ensure that legislation and best practice is being implemented, that resources are used effectively and efficiently, and that there are appropriate and timely methods of monitoring and evaluating the provision of services.

Vision and Key Areas for Action

Vision

In line with the intentions of the national See Hear strategy and the Dundee Health and Social Care Strategic and Commissioning Plan, the vision of the Dundee Joint Sensory Services Strategy is to ensure that:

> **All people with sensory needs are able to access the information and support they require in order to live a fulfilled life.**

Key Areas for Action

In order to achieve this overall vision, the Joint Sensory Services Strategy sets out several key actions:

1. **Partnership Working:** Work in partnership with people with sensory needs, their families and carers, and relevant third sector organisations in order to ensure future services are co-designed and co-produced, and that they are designed to address the issues that are important to local people.

2. **Joint Sensory Social Work Service:** Develop an integrated joint sensory social work service that actively promotes opportunities for assessment and service delivery across the different types of sensory needs and provides a single point of access to service users whenever possible.

3. **Governance & Legislative Compliance:** Fully implement the See Hear Recommendations, prepare for the British Sign Language (BSL) (Scotland) Act 2015, and ensure compliance with all other relevant legislation and guidance.

4. **Staff Learning and Skills Development:** Identify ways to improve current staff knowledge and awareness of sensory impairment, including staff from health, social care and the third sector.

5. **Care Pathways:** Identifying ways to deliver joined up, integrated services that support the person at all stages of their journey. This includes ensuring universal services are accessible to people with sensory needs, ensuring basic sensory checks at appropriate times, and developing appropriate care pathways for people with multiple or complex conditions.

6. **Engagement & Involvement:** Ensure that local people and carers have the ability to contribute towards the development of local services.

7. **Communications:** Develop accessible information so that everyone in Dundee, including professionals and people with sensory needs are aware of what services are available to help support people with sensory needs. Ensure that there are robust systems for maintaining information about people with sensory needs, and sharing this between agencies when appropriate.

Strategic Needs Assessment

Purpose

The Sensory Services Needs Assessment is designed to provide a demographic and geographical profile of people with sensory needs who live in Dundee. It is intended to help project the anticipated needs and demand for health, social care and community services, both now and in the future.

This will help inform the development and commissioning of services for people with sensory needs, so that our services target those most in need of support, and provide the type of services that people require. Our intention is to ensure that whenever possible people with sensory needs are able to remain independent in their own homes or communities, whilst still able to access specialist treatment and intervention when required.

Summary of Findings

- **Dundee has approximately the same rate of people who are blind, deaf or have hearing or sight loss as the Scottish average.** 23.5 people per 1,000 population identified themselves as being blind or having a partial sight loss, and 67 people per 1,000 population identified themselves as being deaf or having partial hearing loss.

- **There are differences between localities**. Coldside has the highest rate of people with a sensory impairment: 28.4 people per 1.000 population identify themselves as having sight loss, and 79.3 people per 1.000 population identify themselves as having hearing impairment. In comparison, the West End has only 18.5 people per 1.000 population with sight loss, and 47.8 people per 1.000 population with hearing impairment.

  To some extent, this may be due to an unequal distribution of where older people live within Dundee. However, even when just considering the under 65 population, the West End still has a lower rate of people with visual or hearing impairment.

- **There is a very strong correlation between sensory deficit and age.** While the average rate of visual impairment is 23.5 people per 1,000 population, this increases to 96.7 in the over 75-84 population, and to 241.9 in the over 85 population. Similarly, while the average rate of hearing impairment is 67 people per 1,000 population, this increases to 308.7 in the over 75-84 population, and 484.8 in the over 85 population.

- **Older people are more likely to be known to social work.** Of the people recorded in the social work information system as having a sensory impairment, 79% are aged 65 or over, and 46% are over 85.

- **In general, men are more likely than women to identify themselves has having a hearing loss or sight loss.** It is not known what the underlying reasons for this are. It could be the result of environmental factors (e.g. a larger number of males working in heavy industry), but this cannot be confirmed.

- **There is some correlation between the level of deprivation in a locality and the prevalence of deafness and partial hearing loss**. Because age is the most significant predictor for somebody having sensory needs, it can be difficult to identify additional causal factors. However, when comparing prevalence rates in the over 65 population, people in the East End (one of the most deprived localities) are almost 20% more likely to be deaf or have hearing loss, and 25% more likely to be blind or partially sighted, than people in The Ferry, the most affluent locality.

- **There is some correlation between deprivation and the prevalence of sensory needs in children and young people**. Children and young people (aged 0 to 15) in the two most deprived localities are almost three times as likely to be deaf or have partial hearing loss as children and young people in the two most affluent localities, and twice as likely to be blind or partially sighted.

- **It is not possible to identify the underlying reasons for the correlation between deprivation and sensory needs.** Deprivation may help create factors that make sensory loss more likely, or sensory loss may result in less life opportunities, reduced employment opportunities and lower income.

- **Having a sensory impairment means you are less likely to be in work or study**. In Dundee, 66% of people aged 16 and over are employed, but only 45% of people with blindness or partial sight loss are employed. 12% of Dundee's overall population are students, but only 4% of people who are deaf or have partial hearing loss are students. Some of this discrepancy is likely to be due to the age factor, as people with sensory needs are older than the general population, but it is not possible to quantify to what extent this is the case.

- **Having a sensory impairment means you are more likely to be in social rented accommodation.** Compared to figures for the overall Dundee population, people with a sensory impairment are less likely to be privately renting. However, there are wide variances across localities, and in the type of sensory impairment people have. Indeed,

people who are blind or partially sighted have a higher level of home ownership that the general population.

Next Steps

The Needs Assessment helps to identify and analyse current and future need for services and support. In doing so, it forms a foundation that can be used to help plan and develop services in the future.

The findings from the Needs Assessment have been used to help develop key Areas for Action that the Joint Sensory Service SPG will be responsible for implementing, and to highlight key issues and immediate priorities. The Needs Assessment has also been used to help inform the local implementation of national legislation and strategies, for example by highlighting specific areas of importance or relevant to people in Dundee. This is discussed further in the next section.

Legal Requirements and Principal Guidance

It is necessary to consider the current legislation and guidance that applies to the provision of services for people with sensory impairment. This is to ensure that Dundee continues to meet their legal and political obligations, and to identify areas of best practice that should be incorporated into local services.

Key Legislation and Guidance

There are five broad areas of current legislation and guidance that have been particularly key to the development of the Joint Sensory Services Strategy, and to the provision of services for people with sensory needs in Dundee:

- Health and Social Care Integration
- See Hear: The National Strategy for Sensory Impairment
- The British Sign Language (Scotland) Act 2015
- Equalities and Human Rights
- The Social Care (Self Directed Support) Act 2013

Outcomes and Indicators

In addition to this, there are several sets of outcomes and indicators that Dundee Health and Social Care Partnership must achieve, including National Health and Wellbeing Outcomes, Local Outcomes and Indicators, and local Strategic Priorities.

Strategic Shift

The overall Strategic and Commissioning Plan explains that there is a need to achieve strategic shifts in how services are prioritised, accessed, organised and delivered. This will involve investing in some areas of service, and disinvesting in others, with the principle of deploying resources towards a more preventative and integrated community based approach.

Key Action 1: Partnership Working

Importance of Partnership Working

The Dundee Health and Social Care Strategic and Commissioning Plan notes the importance of not just consulting and engaging with individuals and communities, but in actively working with them to co-design and co-produce services that deliver the outcomes people in Dundee need, both now and in the future.

The Plan specifically highlights the importance of promoting and support initiatives designed to empower communities and to adopt co-productive methods of working. These principles have been actively embraced and taken forward by the Joint Sensory Services SPG.

Co-Production

Co-production refers to an asset-based approach to developing services. Asset-based approaches focus on developing the capacity, capability, and resources of individuals, communities and organisations, rather than focusing on problems and deficits. This type of approach is intended to empower individuals to be in control of their own lives.

In order to support a co-productive approach to developing services, the Joint Sensory Services SPG held a specific Learning and Development Event in September 2015, three months after the SPG was formed. This event was open to all members of the SPG, and other interested parties, including community representatives and members of voluntary organisations.

The event explained the overall purpose of the SPG, the principles of co-production, and discussed how these could be applied in practice by the Joint Sensory Services SPG.

Implementing a Co-Productive Approach

The SPG members believed that in order to have a fully co-productive approach, there was a need to share skills, promote best practice, learn from others and focus on how services can actually be improved. To apply these principals in practice, the SPG members agreed there was a need to:

- Consider everybody's point of view
- Build on existing strengths
- Ensure strong networking
- Value differences
- Ensure an inclusive and supportive culture

- Share information
- Be open and accessible.

Additional Partnership Working

Partnership working is not just about ensuring a co-productive approach to the development of services and supports. It is about establishing wider links and contacts, learning and considering what wider developments might have an impact on the provision of services for people with sensory needs, and about ensuring wider service redesign fully takes into account the specific needs of people with sensory needs.

Services for children and young people are not included within the Dundee Health and Social Care Partnership. However, the Joint Sensory Services SPG is responsible for the overall development of services for all people with sensory needs, including children and young people, and their families and carers.

The Dundee Multi-Sensory Service helps to support sensory impaired children and young people in Dundee, and to enable them to develop to the best of their ability, intellectually, socially, emotionally and cognitively. The Service supports both children who are accessing a special curriculum in mainstream schools, and pupils in special schools. This Service works closely with TayCAST and CVISTA, which are regional groupings of specialists and other organisations who are helping to support children with hearing impairment and visual impairment respectively.

The Service can provide a variety of support, from the provision of equipment to input from specialist staff. Multi-Sensory Service staff will also carry out visits to a child's home, and visits to their nursery or school to carry out assessments, develop programmes of work, provide tutoring, or carry out awareness-raising.

Summary of Actions

The Joint Sensory Services SPG will:

- Ensure that member of the SPG are aware of the principles of co-design and co-production, and how to apply them in practice.
- Work in partnership with other organisations and groups, both within and outside the Health and Social Care Partnership to highlight and address issues of importance to people with sensory needs.
- Build and maintain strong links with the Multi-Sensory Service

Key Action 2: Joint Sensory Social Work Service:

A Need for Integrated Services

The See Hear strategy specifically notes that one of the key factors to consider is the development of integrated service provision that actively promotes opportunities for assessment and service delivery across the different types of sensory loss and the different agencies involved.

Strategically, the formation of the Joint Sensory Services SPG allows for the planning and development of services across both statutory agencies and the third sector, and will allow for the co-production and co-development of services that genuinely meet the needs of local people in Dundee.

At an operational level, Dundee followed the commitment to the development of a joint statutory social work service for people with all sensory needs, including people who are Deaf, deafened, blind, partially sighted, and people with a dual sensory impairment. This was progressed through a commission programme and was successfully awarded to North East Sensory Services.

In common with other local authorities, Dundee has recognised that specialist services for people with sensory deficits are often best commissioned from external organisations.

Public Consultation Event

To support this work, a public consultation event was held, in order to provide information on the purpose and functions of the statutory joint sensory social work service, and to allow local people to provide their views of what aspects are most important to them, and what issues of the service would be most important to them. The feedback from this event was used to help inform the development of the statutory social work services, and also the development of this strategy and the work of the Joint Sensory Services SPG.

Provider Event

In addition to the public engagement event, a separate event was held for providers interested in tendering for the contract. This event provided background information around health and social care integration, and the current demographic profile of Dundee. It also provided more specific information about current procurement regulations, the previous contracts, and the tender timeline. Potential providers were also provided with an opportunity to ask questions around the tender process and the expectations around delivering the service.

Role of the New Service

The new joint statutory social work service is designed to:

- provide support to all children and adults with sensory needs who require a social work service, including deaf, deafblind, blind, partially sighted or who have a dual sensory impairment.
- ensure that all children and adults with sensory needs are supported to live as independently as possible in their local community and that their impairment impacts as little as possible on their experience and quality of life.
- promote the principle of maximum independence with minimum intervention
- assess a person's need, facilitate access to high quality rehabilitation services, and enable children and adults to access the full range of social work services when required.
- help integrate both the overall service and individual service users within the wider community

Summary of Actions

Dundee Health and Social Care Partnership will:

- Monitor and evaluate the performance of the new service on an ongoing basis.

Key Action 3: Governance

In terms of developing Joint Sensory Services for Dundee, Governance is about ensuring:

- relevant people are aware of the appropriate legislation and guidance, and are following them;
- there is a good understanding of the demographics of people with sensory needs in Dundee, including their age and geographical spread, and the type of needs that they have, and where people need services or support, what level of support is required;
- there is an understanding of what resources are available in Dundee, and how they are being used;
- that there are methods of monitoring the delivery of services; and
- that investment, allocation of resources and the planning and delivery of all activities are actively supporting people to achieve health and social care outcomes.

Governance Sub-Group

The Joint Sensory Services Strategic Planning Group formed a Governance Sub-Group to oversee and address these issues. This sub-group is responsible for:

- Evidencing that service planning reflects local need within Dundee.
- Considering the hierarchy of need within Dundee, including needs met by universal services, self management, integrated rehabilitation and enablement, and intensive specialist and multi-disciplinary support.
- Auditing current spend and service patterns on sensory impairment, including carers and elements of other service provision that impact on people with sensory needs.
- Ensuring that service planning appropriately considers options for service redesign in light of audit findings.
- Ensuring compliance with the Equality Act 2010 and the United Nations Convention on the Rights of People with Disabilities (UNCRPD) Article

Summary of Actions

The Governance Sub-Group will:

- Oversee the development and governance arrangements for the Joint Sensory Services SPG
- Audit and map current service delivery and spend across Dundee and the surrounding area.
- Consider the implications and requirements of all relevant guidance and legislation, including health and social care integration, the See Hear strategy, the BSL (Scotland) Act, and equalities legislation.

Key Action 4: Learning and Skills Development

It is essential that everyone who supports people with sensory needs is provided with the knowledge and skills they require to provide effective care and support. This does not just include staff providing specialist services, but also staff and volunteers from across the statutory and third sectors who have day-to-day contact with people with sensory needs, or who provide other types of services or support.

Learning and Skills Development Sub-Group

The Joint Sensory Services Strategic Planning Group has formed a dedicated Learning and Skills Development Sub-Group. This sub-group is responsible for:

- Mapping the range of training opportunities currently available within Dundee and the wider Tayside area, as well as the provision of nationally available training materials.
- Auditing the skills and awareness of current staff across the statutory and third sector, and taking steps to address any gaps or areas for improvement.
- Working with appropriate organisations to identify and explore opportunities to increase sensory impairment awareness and expertise.

Summary of Actions

Dundee Health and Social Care Partnership will:

- Develop a shared training program for frontline staff to support awareness and understanding of sensory impairment, including signposting, sensory health checks and support.

The Learning and Skills Development Sub-Group will:

- Develop an overarching sensory impairment training framework
- Map existing sensory training provision and opportunities within Dundee and the local area.
- Ensure delivery of the shared training program for frontline staff. The accessibility and effectiveness of this will be monitored, and further actions will be taken as required.

Key Action 5: Care Pathways

The National Health and Wellbeing Outcomes and the See Hear strategy both emphasise the importance of integrated, joined-up care pathways putting people at the centre of their care journey:

Pathways Sub-Group

The Joint Sensory Services Strategic Planning Group formed a Pathways Sub-Group to take responsibility for developing and improving care pathways in line with these principles. The sub-group is responsible for:

- Considering options for introducing basic sensory checks, for example for people of a certain age, or at agreed times in their care pathway.
- Developing care pathways for people with a sensory impairment,
- Assessing performance against the care pathways, and use this as the basis for further service improvement.
- Identifying relevant responsibilities across agencies for the delivery and improvement of care pathways.
- Considering the implications of the Doran Review, the Scottish Government response to the Doran Review, and the Children and Young People (Scotland) Act 2014, and make suggestions for further service development as appropriate.

The Pathways Sub-Group is responsible for developing pathways in line with these component parts, assessing performance against these pathways, and making recommendations for further improvement.

Summary of Actions

The Pathways Sub-Group will:

- Initially focus on the development of adult sensory impairment pathways.
- Consider methods of identifying training requirements and providing appropriate training and awareness raising with the aim of increasing staff awareness of sensory impairment and knowledge of how to access current sensory pathways.
- Raise awareness and use of vision and hearing questionnaires.

Key Action 6: Engagement & Involvement

The Need for Engagement

The development of the Joint Sensory Services strategy needs to be reflective of the wishes and priorities of people with sensory needs and the wider community within Dundee. This has involved finding out what services and support people currently use, what they would like to see in the future, and any difficulties or issues they have accessing or using the current services. This approach is in line with the aims of the overall Strategic and Commissioning Plan.

Capturing Personal Experiences

Every individual person has a different personal experience of their diagnosis, their use of services and supports, and their life management and adjustment, and it is important to identify, recognise and capture these different experiences in order to ensure that future services can meet the demands of a wide and varied population of people with sensory needs.

Identifying and Addressing Barriers

People experiencing sensory impairment face a number of challenges with traditional communication methods, and as a result they can find accessing information difficult. The Joint Sensory Services SPG will continue to seek the views of all people with sensory needs in Dundee to ensure that communication methods are fully accessible.

Engagement plays a vital role, not just in terms of developing and improving specialised sensory services, but also to understand the barriers that can prevent people from accessing universal and general services, and how these barriers can be addressed and overcome. Ensuring a co-productive approach for people with sensory needs involves considering ways that all services in Dundee, including both statutory and third sector services, are provided.

Engagement Officer

A dedicated Sensory Services Engagement Officer has been appointed to oversee all aspects of engaging with local people and organisations. The Engagement Officer's responsibilities include:

- Planning, organising and carrying out a range of engagement activities across Dundee, with a view to engaging with as wide a range of people as possible.
- Developing a range of accessible information materials that can be used to inform people with sensory needs about Health and Social Care Integration and the development of Joint Sensory Services

- Ensuring that local people with sensory needs and their carers have the ability to contribute towards the development of local services.
- Identifying key issues and actions that are important to local people and that can be taken forward to by the SPG.
- Signposting and supporting people to access services when any issues are identified during engagement activity.

Issues and Barriers to Engagement

The Engagement Officer noted multiple barriers to initial engagement, which needed to be addressed in order to ensure the consultation and engagement process was successful. These barriers included:

- A lack of general awareness about the provision of services and health and social care integration.
- A need to provide and utilise multiple different communication methods.
- The time required to translate information into different formats.
- Seasonal variations in the ability and willingness of people to engage, due to competing priorities such as holiday time.

Key Findings

The Engagement Officer has carried out a wide range of engagement activities, including surveys, public engagement events, and 1-to-1 consultations. To date, over 30 public engagement events have been held, and 60 surveys returned. Multiple other engagement channels have also been utilised, including being interviewed by a talking newspaper, sending information out with BSL videos and DVDs, and holding additional events in care homes, sheltered housing complexes and hospitals.

From this work, the Engagement Officer has identified a range of key finding and issues. These include:

- Some reported difficulties in accessing health and social care services and receiving referrals to specialist services.
- A need to ensure more robust information and signposting to all services, including equipment services, maintenance services, social work and advocacy.
- Current information about services is often provided online. There are some exclusion issues for people with sensory needs, particularly for people who are digitally excluded, or when websites are accessed via a smart phone or tablet.
- A need for more accessible versions of the information provided, including a need for shorter textual explanations, clearer fonts, and more accessible formats.

- A need for all public-facing staff and volunteers to have awareness of sensory needs and appropriate methods of communication.
- A desire for better sharing of information across organisations about people's preferred communication methods.
- Challenges around the provision of services for people with dual sensory impairment. Because of the very specialised nature of the work, there are a small number of interpreters and guide communicators, meaning they are not always available when required.
- Wider community services, including leisure, cultural and sporting facilities are often not fully accessible to people experiencing sensory impairment. This can include a lack of working loop systems, lack of tactile signage, lack of interpreted displays, subtitles or audio descriptions, and obstructed or blocked passageways.
- Identification of best practice from across Scotland in terms of accessing public buildings, including leisure and cultural facilities. These have included ideas such as accessible travel routes and building access, BSL interpretation via handheld tablets, tactile and audio displays, use of non-echoing building materials and integrated loop systems.

Next Steps

The Joint Sensory Services SPG is continuing to receive regular updates on the Engagement activities, and the key findings and issues that are identified. There is an ongoing effort to ensure that the findings from the engagement work are used to actively improve services and the experiences that people have. In order to do this, the Joint Sensory Services SPG will use the findings from the engagement work to identify specific actions or pieces or work that can be taken forward by the SPG or within the individual sub-groups as appropriate.

Some of the main issues that have been reflected in the SPG's action and the work of the sub-groups to date directly links into the achievement of the Dundee Strategic Priorities, including:

- A need to build capacity and the range of services and supports that are available;
- A need to ensure the provision of strong person-centred care and support, that takes into account a person's individual wishes and needs
- A move towards more preventative approaches and early intervention.

Communications and Engagement Sub-Group

In order to support the work of the Engagement Officer, and to take the key consultation findings forward, a Communications and Engagement Sub-Group has been created. The work of the sub-group is discussed further in the next section.

Summary of Actions

The Engagement Officer will:

- Continue to consult and engage with a wide range of local people with sensory impairment, their carers and relevant local organisations.
- Identify and address any barriers to engagement
- Identify and collate the key issues and main findings from the consultation events.

The Communications and Engagement Sub-Group will:

- Provide all necessary support to the engagement officer.
- Develop an action plan to take forward the issues identified through the engagement process.
- Take responsibility for reporting and raising awareness of the key issues identified through the engagement process.

Key Action 7: Communication

Accessible Information

As previously acknowledged, there is a need to ensure that people with sensory needs are able to receive clear accessible information about the provision of relevant services and support in Dundee, including all health and social care services.

Ensuring Information is Accessible

To ensure that information is accessible, the Joint Sensory Services SPG needs to:

- Ensure that staff, volunteers, family members and carers are aware of what services are available to help support people with sensory needs, and how to make referrals or signpost people. This includes ensuring that people know how to access such information, and that they are able to do so.
- Ensure that all information provided is accessible and kept up to date.
- Ensure that information and correspondence is accessible and understandable to people with sensory needs. This includes information about appointments, onward referrals and diagnostic results. It will involve aspects such as staff awareness and the use of technological support.

Communications and Engagement Sub-Group

As noted in the previous section, a Communication and Engagement Sub-Group has been formed. The Sub-Group is responsible for:

- Developing accessible local information strategies.
- Ensuring that local information strategies include the provision of information on preventative measures and good self-care in retaining sensory health, and also information on how to access services.
- Providing advice on the development of robust systems for maintaining local information on people who have received a diagnosis of sensory impairment at any time from birth onwards.
- Advising on how to share such information between agencies when necessary.
- Supporting and advising on ongoing Engagement activities.

Summary of Actions

The Communications and Engagement Sub-Group will:

- Help develop accessible materials about engagement, health and social care integration and access to health and social care services.
- Consider methods of helping to promote and signpost people to available services in Dundee.
- Work with the Pathways and Learning and Skills Development Sub-Groups to ensure staff are aware of what services and support is available, and how they can access it. This includes local care and support services, training and awareness opportunities, equipment provision, and the Contact Scotland services.
- Work with the Governance Group to consider ways of gathering and sharing information about people with sensory needs, and how these needs can be addressed.

Conclusion

What Needs to Be Done

The strategic needs assessment indicates that with a growing population of older people in Dundee, the number of people with sensory needs is likely to also increase in the future. The increased numbers are mainly as a result of acquired impairment (often later in life), and these people will need new knowledge and skills to cope with their condition.

It is important that people maintain the optimum independence, and self-manage their condition whenever possible. It is therefore essential to ensure that appropriate services are available to support this growing number of people. This includes providing services for the full range of sensory needs, from the provision of information and advice, and early assessment and diagnosis through to the provision of integrated multidisciplinary support for complex cases.

However, it also involves ensuring that universal and general services, including GP surgeries, social work services and acute hospital wards are also fully accessible to people with sensory needs. People with sensory needs do not just have a sensory need: they also require the full range of other services that anyone else in Dundee may require.

How This Will Be Carried Out

This strategy has set out how the Joint Sensory Services SPG intends to meet these challenges.

- There will be a focus on developing integrated pathways that can provide the right support at the right time, in the right setting by the right person.
- There will be a need to provide training and support to a wide range of staff across both health and social care. Where appropriate, staff will be enabled to identify people with potential sensory needs, make referrals, communicate effectively and provide appropriate support.
- Information about sensory needs and about sensory services in Dundee will be provided in a variety of formats, so that people with sensory needs can understand their condition, how to manage it, and how to access support or services when required.
- The Joint Sensory Services SPG will also work with NHS Tayside and Dundee City Council to ensure that people with sensory needs are able to access general information and services as required.

What This Will Achive

Ultimately, the Joint Sensory Services SPG needs to lead a cultural change across the entire population of Dundee. There is a need to embrace the wide range of skills, knowledge and experiences provided by people experiencing sensory impairment, and to work with them to help improve access to services and support in Dundee.

All communities, organisations and services in Dundee must recognise they have individual responsibilities to ensure that their information, services and buildings are fully accessible to all people with a sensory need, regardless of the type or severity of the need. This includes ensuring that all community resources have skilled, knowledgeable staff, accessible information in a range of formats, and that services and supports can be adapted to meet the specific requirements of the individual person.

In doing so, the Joint Sensory Services SPG will help to create a future where all people with sensory needs can lead full and actives lives, where they are able to achieve their personal life goals, and are able to be part of the communities and groups of their choosing.

And in doing so, we intend to achieve our overall vision, of ensuring that:

> **all people with sensory needs in Dundee have access to the information and support they need to live a fulfilled life.**

Appendix 1: Sensory Services Strategic Action Plan

The following action plan sets out a summary of the action plan for the Joint Sensory Services SPG.. The four sensory sub-groups have their own individual action plans, so the overall action plan set out here does not include the sub-groups actions.

Establishing the "Golden Thread"

The last four columns of the Action Plan illustrate the "Golden Thread" of interdependencies between the various strategic priorities. These columns set out the key links to other Priorities. See the end of the Action Plan for more details. The column abbreviations are:

AfA = Sensory Strategy Areas for Action.
DSP = Dundee Strategic Priorities
SH = See Hear Recommendations
IP = Implementation Plan for the Strategic & Commissioning Plan

Name	Action	Status	Responsibility	Time-scales	AfA	SH	DSP	IP
Development of SPG	• Develop and agree remit of SPG. • Provide SPG members with training on strategic priorities, principles of co-production and co-design, and equalities. • Ensure that members of the SPG with sensory needs are provided with accessible papers and information as necessary.	**Completed/ Ongoing** Development of SPG completed. Learning & Development day was delivered in co-production with Dundee Voluntary Action. Additional sub-groups will be developed as required to address future priorities. Members of SPG with sensory needs will continue to be supported as required	SPG Co-Chairs Core SPG Governance Sub-Group Project Manager	Completed December 2015	2.1 4.1	4	5 8	6.1 6.3

Name	Action	Status	Responsibility	Time-scales	AfA	SH	DSP	IP
Development of Sub-Groups	• Agree membership and remit of sub-groups, and Sub-Group Leads • Agree formal reporting timescales and methods. • Develop and agree initial action plans. • Ensure that members of sub-groups with sensory needs are provided with accessible papers and information as necessary.	**Completed.** Initial Sub-Group Action Plans were formally approved in January 2016.	Core Group Sub-Group Leads Project Manager	Completed January 2016		6 8	5 8	6.1 6.3
Health and Social Care Integration	• Presentation given to Core SPG in March 2016 about the Vision and Strategic Priorities. • Included on Core SPG agenda as a standing item for updates.	**Ongoing**	SPG Co-Chairs Project Manager	Ongoing in line with Integration Joint Board timescales.	1		1 2 3	2.1 6.1

Name	Action	Status	Responsibility	Time-scales	AfA	SH	DSP	IP
Consultation & Engagement	• Engagement Officer Appointed • Carry out range of engagement activities with wide range of people with sensory needs, families and carers, and other interested parties. • Developed special logo to provide clear and specific “branding” for all engagement events.	**In Progress** Engagement officer is doing ongoing engagement. Pilot evaluation form has been development and is being consulted on.	Engagement Officer Senior Officer, Strategy & Performance	Ongoing.	1.1 7 7.1 7.4 8	4	1 2 3 4 5	6.1 6.3
Consultation & Engagement	• Gather information on people with sensory needs their conditions, needs and expectations. • Develop evaluation form for future events.							
Consultation Response & Next Steps	• Provide signposting and information to people who request help during engagement. • Identify and resolve any barriers to engagement or accessing services. • Summarise issues from engagement and identify key issues or ideas. • Take forward findings from engagement.	**In Progress** Interim engagement report was considered by SPG in January 2016. Communications & Engagement Sub-Group currently developing engagement action plan to take key findings forward.	Engagement Officer Communications & Engagement Sub-Group	Action plan to be developed by June 2016	2.2 7.2 7.3 7.5 7.6	4 4c 5	1 2 5 6 7 8	6.3

Name	Action	Status	Responsibility	Time-scales	AfA	SH	DSP	IP
Accessible Information	• Ensure engagement information and materials are available in a variety of formats. • Recommend and highlight ways that general information can be made more accessible to people with sensory needs.	**In Progress** Governance sub-group is considering methods of ensuring online resources such as the My Life portal are up to date and accessible.	Engagement Officer Governance Sub-Group	Ongoing	1.3 2.2 3.3 3.4 8.1 8.2	4c 5	1 2 3 8	2.1
Accessible Information **(cont)**	• Ensure accessible information on specialist sensory services (including NHS services and the joint sensory social work service) is available.							

Name	Action	Status	Responsibility	Time-scales	AfA	SH	DSP	IP
Mapping of Local Services	• Identify and map community based assets as part of engagement work • Project Manager has collated and circulated information from previous mapping exercise held at Kings Cross hospital. • Governance Sub-Group is mapping current spend and service delivery across Dundee, including the voluntary sector. • Learning & Skills Development sub-group is mapping existing training provision and opportunities within Dundee and Tayside. • Ensure staff are aware of what services and support are available and how to access it.	**In Progress**	Governance Sub-Group Learning & Development Sub-Group Pathways Sub-Group Communications & Engagement Sub-Group Project Manager Engagement Officer	Initial mapping by August 2016	4.2 5.3 8.3	2 4a	3 5 7 8	2.1 2.2 6.1 6.3

Name	Action	Status	Responsibility	Time-scales	AfA	SH	DSP	IP
Development of Joint Sensory Social Work Service	• Tender for new Joint Sensory Social Work Service. • Public consultation event about statutory social work services held in February 2016. • Engagement officer has carried out consultation on the development of the service and provided information on the service to local people.	**Completed** New Contact is due to be awarded May 2016.	Service Manager, Adult Services Social Work Contacts Engagement Officer	Tender completed May 2016 New service started October 2016	3 3.1 3.2 3.3 3.4	4 4b 5	1 2 3 7 8	1.1 2.1
Legislation & Governance	• Consider the implications and requirements of all legislation and guidance. • Ensure that services are developed in line with all relevant guidance, legislation, and best practice. • Prepare for Implementation of the BSL (Scotland) Act	**Ongoing** Initial mapping of legislation and guidance has been completed. Will continue to monitor for new developments, particularly around the BSL (Scotland) Act.	Governance Sub-Group Resource Manager Engagement Officer	Ongoing through to 2018+	1.2 3.1 3.3 4 4.1 4.3	4 4a 4b 5 6	7 8	

Name	Action	Status	Responsibility	Time-scales	AfA	SH	DSP	IP
Data Collection & Sharing	• Consider ways of gathering and sharing information about people with sensory needs. • Support development of new national blind & partially sighted form. • Consider information & data-sharing issues.	**In Progress** Engagement officer has reported significant local support for robust data sharing. Representatives on national See Hear Leads groups have been helping to advise on development of new blind & partially sighted form.	Governance Sub-Group Engagement Officer Communications & Engagement Sub-Group	Ongoing.	1.2 8.4	5	7 8	
Equality & Diversity	• Create Equalities Impact Assessment (EQIA) • Monitor and recording ongoing equalities issues. • Training Provided to SPG members at Learning & Development event.	**Ongoing.** Initial EQIA part of Joint Sensory Strategy. Equalities report considered by SPG every 6 months.	Senior Officer, Strategy & Performance Governance Sub-Group	Initial EQIA developed May 2016 Ongoing reporting.	4.3	6	1 3	
Staff Learning & Skills Development	• Develop a shared training program for frontline staff to support awareness and understanding of sensory impairment, including signposting, sensory health checks and support. • Develop an overarching sensory impairment training framework.	**In Progress** Sub-Group is currently finalising an electronic training package that can be used for all staff, in both statutory and voluntary organisations.	Learning & Skills Development Sub-Group. Pathways Sub-Group.	Initial pilot of package to commence in August 2016 Full roll out to commence by 2017.	5 5.1 5.2 6.2	2 3	7	2.3

Name	Action	Status	Responsibility	Time-scales	AfA	SH	DSP	IP
Staff Learning & Skills Development (cont)	• Consider further methods of identifying training requirements of staff.							
Care Pathways	• Consider options for developing adult sensory impairment pathways. • Develop action plan to implement improvements	**In Progress**	Pathways Sub-Group	Ongoing	6 6.1	1 4b 7	6 7	6.1 6.2 6.3 7.1 7.2 7.4
Partnership Working	• Consider methods of promoting and using the Contact Scotland service. • Presentation given to the Core SPG on the work of the Multi-Sensory Service. • Core SPG has discussed methods of engaging and contributing to Carers SPG and workstreams	**Ongoing** Core SPG will continue to monitor for partnership working opportunities.	Co-Chairs Resource Manager Core SPG	Ongoing	2 2.2 2.3 2.4	4 4a 4b	3 6	6.1 6.2 6.3 7.5

Appendix 2: Equalities Impact Assessment (EQIA)

Dundee City Council www.dundeecity.gov.uk CHANGING FOR THE FUTURE

EQUALITY IMPACT ASSESSMENT TOOL

Part 1: Description/Consultation

Is this a Rapid Equality Impact Assessment (RIAT)?	Yes ☒	No ☐
Is this a Full Equality Impact Assessment (EQIA)?	Yes ☐	No ☒

Date of Assessment: (dd/mm/yyyy) 20/05/2016	**Committee Report Number:**
Title of document being assessed:	Joint Sensory Services SPG Draft Strategy and Commissioning Statement
1. This is a new policy, procedure, strategy or practice being assessed (If **Yes** please check box) ☒	**This is an existing policy, procedure, strategy or practice being assessed?** (If **Yes** please check box) ☐
2. Please give a brief description of the policy, procedure, strategy or practice being assessed.	This is a plan by Dundee Health and Social Care Partnership and partners to improve outcomes for people affected by sensory deficit in Dundee.
3. What is the intended outcome of this policy, procedure, strategy or practice?	To develop a strategic approach to address the needs of people with sensory impairment and sensory needs within Dundee.
4. Please list any existing documents which have been used to inform this Equality and Diversity Impact Assessment.	As listed in Draft Strategy.
5. Has any consultation, involvement or research with protected characteristic communities informed this assessment? **If Yes please give details.**	An Engagement Officer for Dundee was employed by Dundee Voluntary Action.
6. Please give details of council officer involvement in this assessment. (e.g. names of officers consulted, dates of meetings etc)	Members of the Dundee Sensory Services Strategic Planning Group - 17/6/15, 7/8/15, 8/9/15, 16/9/15, 1/10/15, 30/10/15, 11/12/15, 21/1/16, 10/3/16.

7. Is there a need to collect further evidence or to involve or consult protected characteristics communities on the impact of the proposed policy? (Example: if the impact on a community is not known what will you do to gather the information needed and when will you do this?)	As plan develops there will be ongoing engagement with a focus of involving people with sensory needs.

Part 2: Protected Characteristics

Which protected characteristics communities will be positively or negatively affected by this policy, procedure or strategy?

NB Please place an X in the box which best describes the "overall" impact. It is possible for an assessment to identify that a positive policy can have some negative impacts and visa versa. When this is the case please identify both positive and negative impacts in Part 3 of this form.

If the impact on a protected characteristic communities are not known please state how you will gather evidence of any potential negative impacts in box Part 1 section 7 above.

	Positively	Negatively	No Impact	Not Known
Ethnic Minority Communities including Gypsies and Travellers	☒	☐	☐	☐
Gender	☒	☐	☐	☐
Gender Reassignment	☒	☐	☐	☐
Religion or Belief	☒	☐	☐	☐
People with a disability	☒	☐	☐	☐
Age	☒	☐	☐	☐
Lesbian, Gay and Bisexual	☒	☐	☐	☐
Socio-economic	☒	☐	☐	☐
Pregnancy & Maternity	☐	☐	☒	☐
Other (please state)	☐	☐	☐	☐

Part 3: Impacts/Monitoring

1. Have any positive impacts been identified? (We must ensure at this stage that we are not achieving equality for one strand of equality at the expense of another)	It is anticipated that the actions in this plan will benefir people with sensory defits who are part of all protected characteristic communities across Dundee. Again ?? use of sensory deficits ??
2. Have any negative impacts been identified? (Based on direct knowledge, published research, community involvement, customer feedback etc. If unsure seek advice from your departmental Equality Champion.)	No
3. What action is proposed to overcome any negative impacts? (e.g. involving community groups in the development or delivery of the policy or practice, providing information in community languages etc. See Good Practice on DCC equalities web page)	N/a
4. Is there a justification for continuing with this policy even if it cannot be amended or changed to end or reduce inequality without compromising its intended outcome? (If the policy that shows actual or potential unlawful discrimination you must stop and seek legal advice)	N/a
5. Has a 'Full' Equality Impact Assessment been recommended? (If the policy is a major one or is likely to have a major impact on protected characteristics communities a Full Equality Impact Assessment may be required. Seek advice from your departmental Equality lead.)	No (There will be ongoing monitoring of this plan and any planned actions that may risk negative impacts will be explored as well as identifying opportunities to take forward to promote postive impacts).
6. How will the policy be monitored? (How will you know it is doing what it is intended to do? e.g. data collection, customer survey etc.)	Via the Strategic Planning Group and Governance Sub Group

ITEM No …8……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19 DECEMBER 2017**

REPORT ON: **SUBSTANCE MISUSE STRATEGIC & COMMISSIONING PLAN UPDATE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB55-2017**

1.0 PURPOSE OF REPORT

This report informs the Integration Joint Board of the progress made with the development of the Strategic & Commissioning Plan for Substance Misuse and the development of governance arrangements for substance misuse.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of this report and, in particular, the progress that is being made with the development of a Strategic & Commissioning Plan for substance misuse

2.2 Approves the plans to launch the Strategic & Commissioning Plan in March 2018;

2.2 Notes and approves the progress made with restructuring the governance arrangements for substance misuse in Dundee;

2.3 Supports the proposal for the development of a Commission on drug misuse.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 Background

4.1.1 In April 2017 a report was presented to the IJB outlining proposals for future governance arrangements for the planning and commissioning of substance misuse to support the emerging relationship between the Alcohol & Drugs Partnership (ADP) and the IJB. This report also recommended that a Strategic & Commissioning (S&C) Plan be developed and signed off by both the ADP and the IJB.

4.1.2 The development of the S&C Plan would also include a review of current resources funded by the ADP and the IJB, and a shift of resources in line with strategic priorities, including the identification of services/supports which should be mainstreamed. This review will take account of any efficiency saving required by both the ADP and the IJB and should identify the level of resource available to continue further tests of change.

4.1.3 More specifically, the report further recommended:

- the establishment of a joint reporting arrangement between the ADP and IJB;
- replacing the ADP's Commissioning Group with a Strategic Planning group;

- the production of a joint ADP/IJB Strategic & Commissioning Plan for improving substance misuse services in Dundee;
- the development of work-streams / subgroups groups to support the implementation of the S&C Plan;
- the realignment of the ADP and IJB budgets to develop a single robust financial framework.

4.2 The Strategic & Commissioning Plan for Substance Misuse

4.2.1 An advanced draft of the S&C Plan has now been developed. This draft is based on consultations with individuals accessing services, with family members and carers, with local communities and service providers. This draft is also informed by the assessment of the wide-range of information available about the nature and extent of substance use in Dundee and the related harm. The assessment of information further includes the general demographics of Dundee, with a specific focus on the impact of poverty and deprivation on the adverse effects of substance misuse.

4.2.2 The newly formed Substance Misuse Strategic Planning Group (SPG) (see more detail at 4.4) contributed to the development of the strategic priorities outlined in the Plan and took a key role in developing the action plan. The SPG will also lead the implementation and monitoring of the action plan. It is proposed that the plan will be launched in March 2018.

4.3 Progress with the governance arrangements for substance misuse

4.3.1 The Alcohol & Drugs Partnership (ADP) continues to take overall strategic responsibility and leadership on all issues relating to substance misuse in the city. The ADP's Commissioning Group has been dismantled and the function will now be carried out by the structure outlined below.

4.4 Strategic Planning Group (SPG) for Substance Misuse

4.4.1 The Substance Misuse SPG has been established and is currently meeting on a monthly basis to ensure progress is being made. The Head of Service for Health & Community Care chairs the SPG and membership includes representation from all the substance misuse services (public and third sector organisations) as well as other key organisations/services, including Children & Families, Neighbourhood Resources and Housing, Violence Against Women, and carers' support. The SPG also includes representation from Carers' group and representation from individuals accessing services will be established. The SPG will report to the ADP and the IJB.

4.5 SPG Workstreams

4.5.1 The SPG has met three times and is currently focusing on contributing to the completion of the S&C Plan, including the development of an action plan. Once the S&C Plan is completed, the SPG will take responsibility to oversee, progress and monitor the implementation of the Plan. To support this work, four workstreams will be established. These will coincide with the four strategic priorities of the S&C Plan and will include: Children & Families/Prevention/Recovery system of care/Resilient Communities. It is planned that each workstream will be co-chaired.

4.6 Quality Assurance group

4.6.1 This group has been set up to provide oversight, scrutiny and governance of substance misuse services. The group is chaired by the Health & Social Care Partnership Locality Manager leading on substance misuse and will report to the SPG and the ADP. It is this group's remit to ensure that substance misuse services are accessible, safe, person centred, outcome focused and of excellent quality.

4.6.2 The group is currently developing a joint risk assessment system for Dundee and has started work to ensure that clinical, care and professional governance systems are in place and are effective throughout substance misuse services in Dundee. Following the principles of self-evaluation, and adopting the same approach undertaken by all the Protecting People partnerships/committees, the group is developing a Balanced Score Card for substance misuse services.

4.7 Finance Subgroup

4.7.1 Historically, ring-fenced substance misuse funding was allocated by the ADP's Commissioning Group (subject to approval from the ADP). The formation of the SPG provides an opportunity to develop a holistic approach to the allocation and monitoring of ring-fenced substance misuse funding.

4.7.2 The Finance Subgroup has been set up to review current/historical financial allocations in line with the strategic priorities outlined within the S&C Plan. The group will also identify ways to improve performance and monitoring arrangements - to ensure the reporting of Drug and Alcohol services is routinely embedded into the Dundee Health and Social Care Performance Framework.

4.7.3 The aim will be to support a performance framework which meets the needs of all partnership areas including the City Plan for Dundee and the Children's Services Plan. These reports will be tabled at the ADP and the IJB in accordance with current reporting arrangements.

4.8 Proposal to run a Commission on Drug Misuse

4.8.1 Following discussions between the Chair of the ADP and Elected Members, it is proposed to hold a Commission on drug misuse in Dundee. It is suggested that this Commission will adopt a similar approach to the recent Fairness Commission on poverty in the city. In the process of establishing the commission, discussions will take place regarding the following issues:

- There is a need to agree a clear remit, scope and purpose for the Commission;
- Should the Commission also consider issues relating to mental health, deprivation and social exclusion – all of which have an impact on drug misuse?
- The Commission should be conducted by an independent body. There is also a need to appoint a chair and a steering group;
- It is important to plan at the outset how the situation in Dundee will improve as a result of holding a Commission on drug misuse;
- It is useful to include a comparative element – identify best practice elsewhere in Scotland and compare Dundee to it.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	There is a risk that the Strategic & Commissioning Plan will not be completed and agreed before 31 March 2018.
Risk Category	Operational, Financial
Inherent Risk Level	9 - High
Mitigating Actions (including timescales and resources)	Work is progressing well and there is full engagement in the development of the Plan.
Residual Risk Level	4 - Moderate
Planned Risk Level	4 - Moderate
Approval recommendation	Given the moderate level of planned risk, it is deemed to be acceptable.

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None

David W Lynch
Chief Officer

DATE: 23 November 2017

ITEM No …9……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19 DECEMBER 2017**

REPORT ON: **GENERAL PRACTICE AND PRIMARY CARE**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB51-2017**

1.0 PURPOSE OF REPORT

This report outlines the current position for general practice in Dundee, outlines the progress made with the implementation of the primary care strategy, and highlights some of the opportunities and challenges that the new GP contract offer will bring.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the positive progress towards delivering solutions to a range of the challenges faced by primary care outlined in the paper and the Appendix 1 attached;

2.2 Notes the outline of the proposals and the implications of the proposed General Medical Services contract for the Health & Social Care Partnership (HSCP) attached as Appendix 2;

2.3 Notes the requirement for the HSCP to produce a primary care improvement plan by 1 July 2018.

3.0 FINANCIAL IMPLICATIONS

This report has no direct financial implications. However, the proposed changes to the GP contract are likely to have significant implications for both Dundee and Tayside as a whole. How and where services are provided in the future need time to be considered and reviewed collaboratively. This will be undertaken as an integral part of the Primary Care Development Plan for Dundee, working with all partners.

4.0 MAIN TEXT

4.1 Context

4.1.1 Health and care delivery is currently under significant pressure, with much of that pressure experienced in primary care. The majority of people interact with primary care professionals for their health care for the majority of the time. The increasing elderly and frail population being managed at home or in a homely setting require increasingly complex support from across sectors. A range of professions may work within this context but this report focuses on key aspects of general practice teams. An effective general practice team is a prerequisite for an effective healthcare system. This report will summarise some of the difficulties faced by General Practices in Dundee, and the actions available to and required of the HSCP to address them.

4.1.2 Around 90% of patient interaction with the NHS is with general practice with 1 in 10 of the population visiting their GP every week. There has been an 11% rise in consultations with GP teams in Scotland in the last 10 years, while the percentage of NHS funding received by General Practice has fallen from 9.8% of the total NHS resource in 2005/6 to 7.8% in 2012/13.

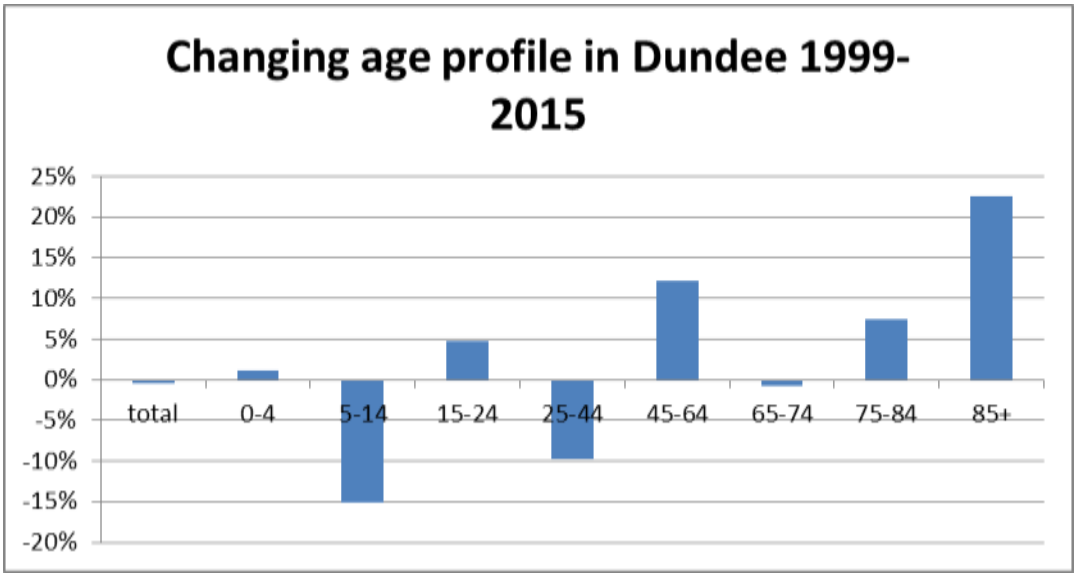
The whole time equivalent population of GPs in Scotland fell by 2.3% between 2013 and 2015. More than one third of GPs are over the age of 50, with new GPs preferring to work fewer hours than those who they have replaced. NHS Scotland has been unable to recruit its target number of GPs to training for the last six years, and fill rates in Tayside for the latest round of recruitment to the GP training programme are below 60%. Practice nurse numbers have remained broadly stable, with an increase of 2.8% between 2009 and 2015. There are however, concerns with regard to the stability of the workforce, with 53% of the 2015 practice nurse population over the age of 50.

4.1.3 Primary care services are hosted within Angus HSCP. These services are delivered in partnership with each of the local HSCPs with funding and contract management provided by the Primary Care Services Department. The Dundee component of the budget is £24.5 million for General Medical Services (GMS), with a further £20 million for other contracted primary care services such as dentistry, optician services and community pharmacy.

4.1.4 There are 65 practices in Tayside, with 25 in the Dundee HSCP area. Dundee practices have a total patient list of approximately 170,000 patients, of whom approximately 25,000 live in eastern Perth and Kinross and southern Angus in areas bordering on the Dundee City Council. With the exception of the Monifeith practice, very few patients who live in Dundee are registered to a non-Dundee based practice.

4.1.5 Most Dundee practices have wide practice boundaries, and as a consequence can have patients registered with them from a large part of the city. This means that unlike most market towns or more rural areas, people in Dundee have the choice of registering with many practices. This differs a little from other large cities in Scotland, where practices often have much tighter boundaries, covering only a selected locality within a city. Recently many Dundee practices have reduced their practice boundaries in an effort to reduce the workload associated in visiting patients who are located miles distant to the main surgery. While this has reduced the amount of choice available to patients, there is no part of Dundee that is not covered by at least six practices.

4.1.6 The population registered with Dundee practices is now almost identical to the population registered 20 years ago. However there have been substantial alterations in the age distribution in the patients registered with these practices as is shown in the graph below. Most marked has been a rise in the very elderly populations who because of their increased frailty require greater access to primary care services. The rise in this population has been balanced by a fall in younger adults (age 25-44) and older children (5-14 age group) who require relatively much less access to primary care services. It should be noted that the numbers of patients cared for by practices, and the age distribution of these patients has not altered in a uniform manner across the city – some practices have had significant population increases (in excess of 200% at Whitfield), while others have had population declines in excess of 20% in patient numbers. The result is that the increase in pressures associated with the ageing of the population of Dundee has been spread unequally amongst the practices caring for that population.



4.1.7 There are a number of key challenges which are being addressed currently, with varying degrees of success. These were outlined in “A Strategic Framework for Primary Care”. An update on the actions outlined in this are detailed at appendix 1, noting key areas of progress and some of the ongoing challenges. (NB This appendix is not an exhaustive list of progress and challenges, as some key areas are not detailed here as they are outwith the scope of this paper.)

4.2 Quality and cluster working

4.2.1 Dundee has four groups of practices, or clusters, which each have a cluster “lead”. Each practice has an identified quality lead. The key focus of these groups is to identify work where the clusters can review and improve the quality of care for issues relevant to their local population. They can also consider how to share learning, and provide support to each other. It is expected that as this progresses there will be greater “pooling” of resources, and as we move to increase locality working with local “hubs”, the clusters will be influential in shaping the services provided in this context. A number of areas of clinical care have been reviewed in each cluster with positive impacts, such as pain management and prescribing, and respiratory care. As locality planning for the HSCP develops to increasingly reflect the needs of the local population then these processes will become more integrated. This concept is emphasised in the proposed new GMS contract and GPs will, if the contract is agreed in January 2018, become central to this planning and delivery of care, with more services provided across clusters.

4.2.2 Plans are currently being developed to look at how we implement a cluster approach and locality working in local communities to support the delivery of care at home, or as close to home as possible. The need for care and treatment centres, in the context of wider community care centres, is being scoped. The range of services which will be provided from these centres will cover a range of areas of care which do not require the input of the GP directly. This will be tested in Dundee in one locality, building on work which has already been developed specifically around treatment and care of patients with leg ulcers. This test of change will then be rolled out as resources are secured to do so.

4.3 Workforce issues

4.3.1 As widely noted in the press there are national issues with GP recruitment and retention and the proposed contract has been introduced, at least in part, to address some of these issues. A number of successful local and national initiatives have been developed over the last two years to provide a degree of assistance (see appendix 1). However, as with the rest of Scotland, despite these initiatives, many practices in Dundee continue to have unfilled or vacant GP posts, which inevitably has an impact on patients, practices, the wider primary care system and the hospital care sector.

4.3.2 Difficulties in recruitment have resulted in a number of Dundee practices unable to manage their workload without closing their lists to new patients. The number of practices with closed lists is dynamic, altering from month to month. In response to the national pressures on General Practice, the Scottish Government has negotiated a new national GP contract with the profession, with a vote on whether to adopt this contract concluding in early January.

4.3.3 In addition to their GP complement, General Practice teams rely on a team of experienced non-medical clinical and non-clinical members. This wider non medical workforce within general practice is slightly more stable, but there are pressures on all roles and professions. A recent survey in Dundee shows that a high percentage of the practice nursing workforce will retire in the next five years. The proposed contract focuses on the GP as an expert medical generalist with other professions developing their role to release GP capacity to fulfil this role. Other professions may often be more appropriate in some areas of care and quality of care delivery should improve with this new model. However, there is a significant challenge as to how this workforce can be developed in the time frames proposed.

4.4 **Primary Care Transformation Programme and Fund**

4.4.1 The Scottish Government, in recognition of the pressures outlined above, are investing in the transformation of primary care, by investing £1.51million in Tayside in 2016-17. The funding has two streams; for primary care, and mental health, transformation, (£0.97m); and primary care unscheduled care (out of hours) (£0.54m). In Tayside these have been amalgamated. A Programme Manager for Primary Care Transformation has now been appointed and is working closely with the three Health and Social Care Partnerships and Out of Hours to progress developing and implementing multiagency models of care which meets the needs of the local population. An overarching programme plan has been developed in order to support this work. A scoping exercise aligned with the primary care strategy is also currently underway. A Tayside Primary Care Strategic Management and Transformation Board and Tayside Primary Care Senior Management Group have both been established as part of the IJB infrastructure with an R3 Care and Clinical Governance Group for Primary Care, and reporting lines flowing through current hosting arrangements in Angus.

4.4.2 Local plans are being developed in each of the HSCPs, taking cognisance of local priorities and linked to a wide range of work being progressed as part of wider service redesign and support. There are currently two key areas of development in Dundee.

4.4.3 Dundee has a well-established social prescribing link worker programme but it is currently only available in four practices. There is funding from Scottish Government to increase this to support the health of those in the most deprived practices across Scotland and Dundee will receive funding for nine staff. This will provide support to all of those practices with deprivation levels above the average for Dundee. Alongside this a review is underway of information systems that support patients to self care/manage and to promote prevention and early intervention. A wide range of sources of data is available, but there are a number of issues as to how comprehensive they are and if they are accurate and up to date. Work will be undertaken to review how both patients, carers, and professionals all access the information they need to support this wider agenda, including the signposting and referral aspects of social prescribing and prevention. The work undertaken to develop the My Life portal, and ongoing developments to support people's cancer journey, as well as a number of resources in the voluntary sector, will all feed into this. While this work may improve the overall patient experience, significant development will be required if it is to have any impact on patient demand for primary care service.

4.4.4 The development of local care centres is important to the delivery of services close to people. Some services which are currently provided in general practice may, longer term, best be delivered on a cluster or locality basis, to ensure equity of access and skill across practices. Centres may also provide more specialist support to patients which would previously have been provided in other settings. Elements of this work have already been tested with the development, by community nursing, of a clinic to improve wound care and healing for those with more complex wounds. This demonstrated that using a more locality focused approach improved outcomes for the patients involved, reduced referrals to secondary care, and reduced the staff resource required, mainly by decreasing the healing time. This model will be developed beyond the initial pilot work, and the approach used to develop other areas of care. A short life working group has been established to progress this work.

4.5 Proposed GMS contract

4.5.1 Nature of the contract

4.5.1.1 In view of the national difficulties faced by General Practice, the Scottish Government and the British Medical Association (BMA) have jointly negotiated a proposed new GMS contract. This contract is ambitious in its scope, and due to the extent of the changes envisaged, it will be implemented in two phases, one commencing in April 2018, with the second occurring from 2020/21. Both phases will be put to a vote of the profession prior to implementation.

4.5.1.2 The intent of the proposed GMS contract is to deliver for both patients and for practices. The aspiration expressed within the Memorandum of Understanding that underpins the contract is that the following seven outcomes would be achieved with this new contract:

- Improved patient safety

- Patient centred care which is appropriate, based on an assessment of individual needs and values; is outcome focused, demonstrates continuity of care, clear communication and decision making.
- Equitable care
- Outcome focused care
- Effective care
- Sustainable care
- Affordable, value for money care making the best use of public funds whilst retaining appropriate quality assurance processes.

The aspirations expressed by the GP contract negotiators were that the contract:

- Improve the nature of the job of being a GP
- Provide security of income to independent contractor GPs (a proportion of whom have a variable or reduced income due to the individual circumstances of their practice)
- Reduce GP workload
- Reduce the financial, legal and premises risks of being a GP
- Improve recruitment and retention to General Practice.

4.5.1.3 GPs will remain independent contractors, noting however the increasing number of salaried GP posts in a range of contexts. The intention is that there is less risk for practices than in the current contract and that GPs are embedded into wider health and social care services in their local community. They will play a critical role as “expert medical generalists” and senior clinical leaders within those services.

4.5.1.4 The contract is based on four guiding principles of primary care:

- Contact – accessible care for individuals and communities
- Comprehensiveness – holistic care of people – physical and mental health
- Continuity – long term continuity of care enabling an effective therapeutic relationship
- Co-ordination – overseeing care from a range of service providers

4.5.1.5 GPs will support a wide range of clinical professionals, working as an expert medical generalist and senior clinical decision maker within multi-disciplinary community teams.

4.5.1.6 Pay and expenses will be changed to support a core team to deliver services, including running costs for the practice.

4.5.1.7 The intention is to reduce GP practice workload and improve patient care.

4.5.1.8 A range of changes are proposed which will improve infrastructure for premises and information systems, including data sharing protocols.

4.5.1.9 Patients should receive better care both due to increased time for GPs to support and manage those patients who require the expert medical generalist support, and by increasing the number of people who will see another, more appropriate professional, as their first point of contact. The role of practice nurses, practice managers, and practice reception staff, will change to reflect this shift in care, as will the role of an extended multi- disciplinary team to include pharmacy, nursing, social care, and professions allied to medicine (including ambulance). Patients with complex needs will have more time with their GP or clinician when required.

4.5.2 The GP role

4.5.2.1 The proposed changes will allow GPs to have more time to focus where their expert medical generalist skills are most required. This includes:

- Undifferentiated presentations
- Complex care in the community
- Whole system quality improvements and clinical leadership.

4.5.2.2 The leadership role will be both at individual person level and across developing systems in their locality/cluster, recognising that the cluster will have a knowledge of their population and are able to influence this.

4.5.2.3 Practice funding will change in two phases. In the first phase, a new allocation formula will move funding to more closely match resource use. This will shift funding from rural practices to those with an elderly or deprived population. There is a guarantee that no practice will lose funding as a result of this new formula. There is also a minimum income guarantee that will increase the earnings of the bottom 20% of GPs. In the second phase, (starting from 2021) there will be a move towards the reimbursement of most practice expenses with a view to tracking a salary in line with that received by consultants while retaining the independent contractor status. This change will be in two phases as the data around GP numbers, hours worked and expenses incurred required to introduce the second phase is not currently available. This necessary information will be collected in the first phase.

4.5.2.4 In order to ensure a more manageable workload there are three key elements:

- Continuing to reduce contractual complexity
- Improving primary/secondary care interface working
- Building a wider primary care multi-disciplinary team.

4.5.2.5 Dundee has recently tested a primary/secondary care interface group which has been positively received and progressed a number of issues around communication, quality and safety. This group is likely to be replaced by a more formal group with a Tayside remit.

4.5.2.6 GPs and clusters will have a clear role in quality planning, quality improvement and quality assurance. The expectation of the contract is that GPs will employ fewer staff, but have a greater degree of advice and involvement in planning the services delivered together with NHS employed staff.

4.5.3 Service redesign

4.5.3.1 A redesigned service will be developed over the three year period for 2018 – 2021, and will reflect local priorities with an ability to change, building on assets and models locally. It will build on a number of developments already progressing locally, as described in appendix 1. However, it should be noted that this is a challenging timescale for delivery given the scale of the change, and the financial and workforce issues this redesign creates.

4.5.3.2 A primary care improvement plan will be developed by all HSCPs. The plans will involve a significant degree of consultation, particularly for the public, for whom this proposed model is likely to be a large cultural change, given people are used to seeing a GP within a few working days on most occasions, if not on the day of request. The HSCP is expected to produce its primary care improvement plan by 1st July 2018.

4.5.3.3 There is a requirement to focus on a number of key areas in relation to priority areas for redesign with the following areas developed prior to 2021:

- Vaccination services
- Pharmacotherapy services with a development of acute and repeat prescribing service; and a medicines management service led by practice pharmacists
- Community treatment and care services (including phlebotomy, wound dressing, chronic disease management amongst other roles)
- Urgent care services (e.g. the use of advanced non-medical practitioners as first responders for home visits)
- Additional professional services (clinical and non clinical) including musculoskeletal physiotherapy services, community mental health services and community link workers.

4.5.3.4 Each of these areas is a significant redesign in its own right, and when combined presents the HSCP with a challenging agenda over this period.

4.5.4 Infrastructure

4.5.4.1 The aim of these proposed changes is to reduce the risk associated with certain aspects of being an independent contractor. One of the most significant risks held by GPs is that of premises. The proposed new contract supports a reduction in the risk to practices that own their own premises through a supported loan mechanism that allows a smoother transfer of premises liabilities from retiring to joining partners, and which ultimately should allow GPs to cease their role as premises owners. The new contract also allows for premises which are leased to be transferred to NHS board management. The assumption of the NHS as the holder of most GP leases, and the potential removal of GPs as premises owners (over a period of the next two decades), allows the possibility of a longer term HSCP premises plan where GP surgeries are positioned more clearly within local communities, whilst reducing the risks to GP partnerships that are accrued by owning leases or premises.

4.5.4.2 Infrastructure around IT systems will be developed and a new information sharing agreement will reduce risk to GP contractors. The procurement of the next generation of GP clinical IT systems is already underway.

4.5.4.3 The risks of being an employer will be reduced longer term as new roles will be through a combination of NHS, Council or other partnership employment, and longer term plans are for practice reimbursement of costs for practices, which may include employed staff.

4.5.5 Resource Implications

4.5.5.1 In is anticipated that the changed GMS contract, alongside work that is well developed in Tayside to recruit and retain GPs, will have a positive impact on the GP workforce locally longer term. There are significant implications for developing an evolving workforce to work alongside GP and practice roles. This workforce will include amongst others advanced practice level pharmacists, nurses, Allied Health Professionals (AHP) and paramedics. There are a range of implications for the development of this workforce within the timescales envisaged. Particularly challenging is the expectation of the development of advanced level professional roles within the proposed three year timeframe. Pharmacy is a good example of where despite an increasing skill mix locally, and a strong pharmacy structure which already supports practices and localities, the competitive market, and numbers being trained are such that it will be difficult to deliver the ambitions set out in the contract document.

4.5.5.2 The Scottish Government have committed to the production of a further national health and social care workforce plan in early 2018 that will set out a range of options at national, regional and local level for the recruitment and retention of GPs and the expansion of the capacity and capability of the multi-disciplinary team. This will include plans for recruitment, training and development of specific professional groups and roles.

4.5.5.3 In terms of financial resource there is a commitment to funding which practices currently receive staying at practice level, and in fact in many cases increasing. There is an additional commitment from the Scottish Government to £250 million but it is not yet clear what the parameters of that funding will be. This should become clearer over the coming months but it is likely that a significant level of redesign of current services will be required to allow Dundee HSCP to deliver the expectations of this contract.

4.5.6 Process and timescales for the proposed contract

4.5.6.1 The first phase of the contract will be voted on by GPs from 7 December 2017 to 4 January 2018 and it is expected that a result will be known by the end of January. Further detail is likely to be forthcoming over the coming months. Given that NHS Tayside, and Dundee specifically, are already developing tests of changes in a number of areas that are now known to be in the contract we are in a positive place to progress this. However, the scale of the change is significant and will need a whole system approach to ensure its success. The Improvement Plan will detail priority areas, actions and timescales. This will be submitted to the IJB for approval.

4.5.6.2 Alongside this work the tests of change currently underway or being planned will progress, sharing learning and knowledge across the three Tayside Partnerships to inform effective implementation at scale.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues. A more detailed assessment will be required as part of the Primary Care Improvement Plan development.

6.0 RISK ASSESSMENT

Risk 1 Description	There is a risk that insufficient funding will be available to fund the health and social care community services infrastructure required to deliver the expectations of the new GMS contract.
Risk Category	Financial
Inherent Risk Level	16 (Extreme)
Mitigating Actions (including timescales and resources)	Continued engagement with all partners to develop the Primary Care Development Plan for Dundee.
Residual Risk Level	12 (High)
Planned Risk Level	9 (High)
Approval recommendation	Given the current stage of the Primary Care Development plan it is recommended that this risk is manageable and should therefore be accepted.

A more detailed risk assessment will be required as part of the development of the Primary Care Development Plan.

7.0 CONSULTATIONS

The Chief Finance Officer, Clinical Director, Associate Medical Director for Primary Care, General Manager for Primary Care, Head of Service - Health and Community Care, Lead Nurse, Lead AHP, Pharmacy Locality Team Leader, Head of Primary Care Development, Head of Service - Out of Hours, Senior Manager - Service Development and Primary Care and the Chief Officer of Angus HSCP were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 30 November 2017

Shona Hyman
Senior Manager
Service Development & Primary Care

David Shaw
Clinical Director

Michelle Watts
Associate Medical Director
Primary Care

1. Service Planning

1.1 GPs should work increasingly as part of an extended multidisciplinary team of health and social care professionals, and increasingly the patient and their carers, within a locality framework. NHS Tayside will support the formation and development of these localities.

Progress		Challenges
Locality groups have been agreed across Tayside with 4 clusters in Dundee MDT meetings are now established in practices, with wider team, focused on, but not solely for, older people. Models developed in other areas being reviewed to assess potential in Dundee		Mismatch in Dundee of locality working and GP clusters due to nature of practice boundaries and public expectations The MDT meetings are not as broad in terms of representation as they could be. Require further development to include specialists beyond MfE, and wider working practices ie so focus is on communication and not just on a meeting. Needs to include other professionals, eg mental health team. MDT meetings are time intensive and best value for that time needs to be achieved.

1.2 Support should be given to ensure that all practices in Tayside are engaged with the integration agenda, and have an active part in shaping it. This should be in accordance with the best available evidence and meet mutually agreed outcomes. They should help shape new and innovative models of care, supported by a new contractual framework which will have an emphasis on person centred care, safety and quality.

Progress		Challenges
Clusters in Dundee are established, with a cluster lead in place and with regular meetings. A number of areas of care delivery have been considered/progressed Cluster leads meeting with key H&SCP staff to ensure joint decision making around key service development		The proposed changes to GMS contract suggest that GP's are at the core of locality based work. Dundee H&SCP need to agree what that means locally, and if different to current model how that is progressed Practice quality leads and cluster leads do not feel they have adequate time currently to fulfil this role, giving issues in relation to degree of progress
1.3 There should be an established clear understanding of the roles and accountabilities of each member of the MDT, who will be expected to work "at the top of their licence" which needs to be underpinned by explicit professional governance arrangements.		
Progress		Challenges
A range of developments have been tested in Tayside with 2c practices, including new roles for physio, mental health staff, and nurses working at advanced practice level The role of pharmacists in both practice and community pharmacies is being developed, with governance frameworks to support this. A range of processes are being considered as part of the work to develop an ANP (and trainee) role for 2c practices, which can be used more widely		Expansion and development of this is key to the proposed GMS contract but timescales for this workforce development challenging (see workforce section) MDT team members need support to develop from their current to their new "top of licence" roles if this is to be done safely.
1.4 Local communities must be supported to contribute to the better management of their own care recognising and addressing inequity and being equal partners in co-producing services that meet their needs. They should "know who to turn to" and be offered alternatives to the traditional GP model.		

Progress		Challenges
Promotion of know who to turn to has progressed although relatively limited to date, although on going work around this Wider work within each H&SCP contributes to this more widely as each area agrees how it will enhance its co-production activity, and ensure a high level of communication and engagement with local residents Nationally NHS24 are progressing person centred care and support via their NHS Inform platform.		Better information systems required for both professionals and the public of where they can get advice, in a range of formats, and of “activities” that may help them. Plans to develop this in a number of ways developed under primary care transformation funding - waiting on approval Systems to allow patients to manage their own care without first needing to attend a GP need to be developed further.
1.5 Pathways of care should be co-produced, address inequity and focus on the whole patient journey, beginning with prevention. To empower the "prepared patient" there should be investment in self management, and access to a wide range of information, including early person centred care planning conversations.		

Progress		Challenges
Welfare Rights, the "Do you need to talk" service, and social prescribing link workers are available in some practices, but this is not consistent, with some practices having all 3 and others none. All 3 of these services are currently looking to expand in Dundee, although there are ongoing resource issues The House of Care model being implemented in some practices has a strong emphasis on self care and self management, shared decision making, and joint care and support planning. Anticipatory Care Planning is now much more widely implemented than has been in the past. A new national document has been launched (http://ihub.scot/anticipatory-care-planning-toolkit/#)		Even where resource available, eg roll out of more link workers, there is not always space in practices, and unclear if service as effective if locality based House of care is being delivered in a relatively small number of practices and is not used for all LTC's. We have ongoing challenges as to how to ensure a consistency of approach across patient pathways, with care and support planning conversations, personal outcomes, and anticipatory care planning. There are several competing anticipatory care plan mechanisms. A Tayside Anticipatory Care Plan (ACP) group has been set up to best manage the process of generating easily accessible, well designed ACPs.
1.6 The locality hub model should be tested, and spread if evaluation positive.		
Progress		Challenges
Leg ulcer work tested with positive outcomes. Plans to start a second site with a broader remit are underway. Looking at how can sustain longer term, and what can be added to this "service". SLWG set up to agree scope/plan for a local treatment centre/community care centre Opportunity to develop base in Lochee HC due to works planned Likely to be support from primary care transformation team/funding		Quantifying breadth of requirements challenging Agreeing a phased approach and priorities required Implications of proposed GMS contract need to be assessed in relation to impact on this model of delivery.

2 Service planning

2.1 The work to develop patient focussed, evidence based end to end pathways of care should be strengthened and made a Board priority. Initial pathways should focus on the areas of: frail elderly, dementia, management of complex or undifferentiated illness, and the deteriorating patient in the community. The economic and health impact of these pathways, and the shift into the community should be measured.

Progress		Challenges
Range of work building on ECS model with MfE ongoing Primary/secondary care interface group set up and building momentum Proposal to NHST Board in early 2018 re a formal interface group MCN groups are progressing pathways work which H&SCP linked to Work to establish the NEWS score for deteriorating patients progressing well and links across services		Impact of shifting work challenging to assess – process needs agreed (Tayside wide)

2.2 There must be a better understanding of access and demand across all parts of the system, supported by data and intelligence to inform and improve pathways of care. Service planning should be both whole system and supported at locality level, utilising integrated resources, and reflecting the needs of the local population. This should be reflected in locality level integrated resource frameworks.

Progress		Challenges
A range of work is underway to support this with a number of teams. The performance team have been developing locality profiles. The LIST team are now linking with clusters around their priorities and looking at how they can support improvement work. Data is starting to be extracted to SPIRE which will support improvement work Tableau data now available to support prescribing data – although not at cluster level generally.		Additional demands in Dundee for analysis as clusters require different data than locality does, even for same indicator Cluster leads have limited capacity to review data – need to consider how can support this work

2.3 In order to manage more complex care within the community, there must be rapid access to local diagnostics, named teams and readily available resources to support care at home.	
Progress	Challenges
Work to develop both Enhanced Community Support (ECS), and ECS Acute – is looking to progress this.	There are a number of issues related to developing capacity of skilled workforce to work at this level with all the resources in place to support this. (Not detailed here.)
2.4 There should be facilities and resource within each locality to support care within the local community - the current bed model should be reviewed as a priority, with resource freed to consider new and innovative models of providing step up and step down care supported by the whole MDT. This must include provision for end of life care.	
Progress	Challenges
Planning in relation to older people well developed to review bed base and community delivery, including GP practices MDT teams established around older/frail people in all Dundee practices and meet on a regular basis	Resource from older peoples services review of beds base being planned to redesign pathways delivery in communities across a range of areas
2.5 National reviews and recommendations relating to health visiting and district nursing should be implemented without delay.	
Progress	Challenges
Work in relation to health visiting and school nursing well progressed (http://www.sehd.scot.nhs.uk/mels/CEL2013_13.pdf) Review recently published for district nursing and plans being progressed locally	Outwith the scope of this paper to define and report in detail.

2.6 A new model of immunisation delivery must be developed and implemented as a strategic and public health priority.	
Progress	Challenges
Childhood immunisation programme now implemented. SG guidance on vaccination programme issued and being progressed by public health – key staff now in post Links made re locality delivery /treatment centre work Funding is available for this programme although plans already agreed to its use	New models for adult delivery not yet known nor any implications in detail
2.7 Develop a Primary Care Out of Hours Service based upon an MDT model of care operating in-hours with the emphasis upon achieving seamless transitions to support episodes of unplanned care	

Progress	Challenges
Out of hours service involved in planning and delivery of DECSA developments Increased support for both pharmacy and paediatrics being progressed within OOH Development of management structure with clinical leads as well as clinical director. Increased salaried GP's rather than sessional GP's with emphasis on OOH as a career choice. Introduced sessions in specialty areas to offer joint posts, with increased communication within these specialties and developed knowledge and learning in both OOH and the speciality. Increased MDT working and skill mix with a new health care assistant role, (including signposting redirection), enhanced nursing roles, and developing links with mental health nurses, (particularly for those in crisis.) and social work colleagues. On call chaplain delivering listening service and onwards referral to community listening team	Number of tests of change underway before rolled out to Dundee, including advanced paramedic practitioner Failure to recruit an OOH Clinical Director has reduced the ability of the existing OOH Clinical Leads to manage the OOH strategic agenda to the same level as previously.

3 Interfaces

3.1 Opportunities should be extended to developing more prospects for shared education and learning across the primary/secondary care interface. This should incorporate data for learning and improvement.	
Progress	Challenges
New unscheduled care board established Proposal for formal interface group to go to Directors in early 2018, supporting college recommendations	Time and resources.
3.2 GPs working as integral members of an extended team (*similarly to 2. Service Planning*) must be willing and engaged partners in the developing agendas of the new Integration Joint Boards. All Boards should support contractor engagement and recognise the resource required to enable this.	
Progress	Challenges
General practice input to Dundee IJB H&SCP cluster leads meeting to discuss jointly on relevant issues Teams across system have an increasing recognition of the role of clusters	Other independent contractors not represented on IJB
3.3 Contribute to the development of a local information system to successfully introduce the single electronic patient record.	
Progress	Challenges
Primary care IT group established National IT reprovisioning for general practice out to tender Data sharing protocols being developed nationally which will support local work	Will not be integrated with systems for social care such as MOSAIC
3.4 Patient safety and quality in Primary Care is recognised as the bedrock to delivering services within the multi-disciplinary team, and should be a priority for investment and development, utilising local and national clinical and academic expertise. This should inform clinical and care	

governance and include resource and support to implement clinical and care governance support systems such as Datix with clarity around how Primary Care will contribute to both existing and emerging governance structures		
Progress		Challenges
Work to increase use of Datix in general practice progressing and now more frequently used Work to analyse themes for datix relevant across whole pathways agreed and started Cluster groups involved in governance issues at that level and looking to share learning and progress Practice sustainability tool now tested and well used across Tayside NEWS scoring being widely promoted across disciplines in primary care, which is supporting professional to professional communications Primary /secondary care interface gives and opportunity to look at this issue on a regular basis		Much of this work is still reactive to issues rather than being able to plan
3.5 The opportunities and interfaces offered by new contractual frameworks are explored and actively developed. The opportunities offered by the new GP Contract and Prescription for Excellence must be explored, with a jointly agreed improvement agenda		

Progress		Challenges
Primary Care Strategy and Transformation Board developed Whole system Prescribing Management Group well established and working effectively to joint agenda Primary Care SMT established to coordinate primary care services and contractors delivery across Tayside, and ensure shared learning and decision making Prescription for Excellence has been superseded by Achieving Excellence in Pharmaceutical Care. http://www.gov.scot/Publications/2017/08/4589 A detailed report on progress in this context is outwith the scope of this paper.		Implications of proposed GMS contract still need worked through A primary care improvement plan will have to be developed
3.6 Supporting the recommendations of the Ritchie Report: A Tayside wide Out of Hours Strategic and Implementation Plan incorporating all Ritchie Report recommendations should be supported.		
Progress		Challenges
Development of nursing team with a view to outreach visiting e.g. within nursing homes; alignment with DECS-A model of nurses visiting frail elderly for assessment Development of paramedic practitioner roles Development of specialised paediatric and frail elderly clinics within OOH Development of HCA role within OOH service		Significant budgetary pressures within OOH Nursing development plan requires further work Developments dependent on continuation of transformation (or other) funding
4 Infrastrucutre		
4.1 A long term strategic capital plan for Primary Care should be developed. This must take account of PFI buildings, and consider new contracting opportunities.		

Progress	Challenges
Jenni Bodie has set up a group to consider infrastructure (premises and IT) National premises code recently published (http://www.gov.scot/Resource/0052/00527533.pdf)	GMS proposed contract changes likely to have a significant impact which needs considered in more detail once vote on contract known Pace of change likely to be such that it may not help support practices who have significant issues at the current time

4.2 Services and facilities must develop in places where demographic demand is growing. These must be planned and designed in partnership.

Progress	Challenges
Process for agreeing boundary changes developed and tested in Dundee clusters and now adapted more widely, which ensure people still have access to a number of practices Progress made with linking locally in relation to planning	As locality model matures in Dundee a way of integrating different aspects of planning, including for independent contractors, will need developed as this is not as well linked as it requires to be

4.3 The e-Health Strategy must take cognisance of not just the medical interface, but expand to consider the growing need for single record multiple interface freely mobile working. Patient access must be considered in this context. This will require significant and sustained investment and should be considered within the context of the Board's eHealth Local Delivery Plan.

Progress		Challenges
Primary care IT group looking at some of these issues Work to test a more linked model of delivery which works towards this is planned as part of the redesign of the Lochee building		A single person record within health, far less across agencies, is likely to be some way off. Access to their record for individuals is not currently being progressed
4.4 IT systems should be developed to support maximum data set extraction and sharing, supported by robust data protection and governance arrangements. Data sets should support whole system planning, and should increasingly reflect the integrated resource available within each locality.		
Progress		Challenges
SPIRE and Tableau are progressing although not yet at the stage of fully informing local planning activity The capacity created by the LIST team will give data that will help inform this agenda National progress with data sharing for what has been seen as general practice data will help this progress		GPs and clusters have not yet defined areas they would like to progress and therefore what data may support this. Protected time to review and act on data needs to be secured (may come from changes in workload resulting from alterations to the GP contract)
5 Workforce and Leadership		
5.1 A Tayside wide strategic package of initiatives should be put in place as a priority to support practices currently facing recruitment difficulties and to prevent other practices experiencing these difficulties. A specific Primary Care workforce plan should be considered.		

Progress		Challenges
A sustainability tool has been developed and implemented in Tayside to identify areas of risk for practices. National work is progressing looking at workforce across professions A number of models of GP employment have been developed and implemented with positive success • Career start GPs – more people have applied for these posts than there were posts available • Salaried model – annualised contract and regular hours • Leadership GPs A model for an advanced nurse practitioner, and trainee post, have been developed and being tested in one practice currently Training for nurses to work at advanced practice level being progressed nationally by NHS Education Scotland.		Workforce plan for primary care expected early 2018 A significant number of Dundee practices still have vacant GP posts despite this work Much of the focus has been on GP recruitment and not other professions. The new GP contract suggests that significant investment will be required in nursing, AHP and practice pharmacy roles. Failure to achieve this will defeat the contract objective of releasing GP time to act in the expert medical generalist role. Significant implications for NHST of the proposed GMS contract which creates challenges across the workforce Capacity to uptake this is unknown currently Increasing demand for pharmacy support for care delivery across a wide range of areas of delivery impacting with ongoing issues recruiting, despite an increasing skill mix
5.2 Put in place arrangements to support effective medical leadership and management development		
Progress		Challenges

A medical leadership structure is now in place Mentoring and development plans are progressing Benchmarking against national leadership competency framework In 2C practices there are now GP's with a leadership role established	At GP level continuing instability in the practice limits the time that the leadership GP's have to fulfil their role.
5.3 Primary Care should play an active part in the Academic Health Science Partnership.	
Progress	Challenges
AMD for Primary care is a member of this group A number of GPs who have an academic and clinical role have been recruited	
5.4 Models to support flow of staff and encourage learning and development across the interface should be developed. To support the patient journey across the interface, and support our staff to explore new ways of working, away from traditional models of hospital based to more community based care and prevention.	
Progress	Challenges
Medicine for elderly staff, and POA have reviewed and redesigned teams to work across interfaces in a more integrated way. ECS MDT is the most widely established model for this in all Dundee practices	Shared learning opportunities across interfaces requires to be explored further
5.5 We must support an improvement culture, with quality and safety - underpinned by clinical and care governance, at the heart of everything we do.	
Progress	Challenges

Clusters are focusing on data where can improve, and reduce, variation The LIST team are now in place and will have capacity to support the data analysis aspects of this work		Cluster working in early stages and not yet well developed to do this.

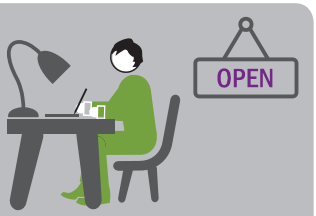
Appendix 2

THE 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND

A CLEAR ROLE FOR SCOTLAND'S GPs

BETTER CARE FOR PATIENTS

MANAGEABLE WORKLOAD



REDUCED RISK

INVESTING TO MAKE IT HAPPEN

BETTER HEALTH IN COMMUNITIES

BMA

Healthier Scotland
Scottish Government

THE 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND

The Scottish Government, Edinburgh 2017

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

ISBN: 978-1-78851-347-0

Published by The Scottish Government, November 2017

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS305366 (11/17)

FOREWORD

Shona Robison
Cabinet Secretary for Health
Scottish Government

Alan McDevitt
Chair
Scottish GP Committee, British Medical Association

We are delighted to attach a joint statement of policy that will underpin a new distinctively Scottish General Medical Services contract due to take effect in 2018.

This document is intended primarily to provide an accessible explanation to Scotland's GPs of the changes we propose to effect in the new contract. The proposed changes will complement the complex wider contractual framework that underpins the provision of General Medical Services in Scotland. It will also be of significant interest to those planning and managing General Medical Services.

This document is the result of significant constructive engagement, over an extended period, between the Scottish General Practitioners' Committee of the British Medical Association and the Scottish Government, as the parties authorised to negotiate the provision of General Medical Services. All the commitments made in this document and the ambitions for future change set out are shared and agreed.

We believe this is a landmark step on a journey already begun.

On 3 November 2016 we wrote to all general practitioners in Scotland[1] setting out our shared vision for general practice in Scotland. We restated our commitment to general practice, and the essential generalist care it provides, with Scotland's GPs supported to be the expert medical generalists in our communities.

We equally recognised the fundamental challenges faced by general practice, not least growing workload and increasing risk. Given these challenges, we emphasised the need to ensure stability as we transform through taking a measured, step-wise approach.

We have already taken substantial practical steps on that journey, not least the removal of the Quality and Outcomes Framework and introduction of GP cluster working, and this joint statement of policy sets out the next practical steps we will take to deliver on our shared vision and to meet the challenges facing general practice.

1 http://www.gov.scot/Publications/2016/11/7258/0

We believe that the policies set out in this document will provide the secure foundation that general practice needs. It recognises that general practice is an essentially collaborative endeavour, collaborative in terms of the enhanced multi-disciplinary teams that are required to deliver effective care; the joint working between GP practices in clusters; and, essentially, as part of the wider integrated health and social care landscape.

More effective sharing of information and sharing of responsibilities is essential to better manage the challenges of increasing workload and risk. And if we can better manage these challenges it will achieve our most fundamental aim, which is to provide the very best care for the people of Scotland.

Shona Robison
Cabinet Secretary for Health

Alan McDevitt
Chair, SGPC

EXECUTIVE SUMMARY

The contract offer proposes a refocusing of the GP role as expert medical generalists. This role builds on the core strengths and values of general practice – expertise in holistic, person-centred care – and involves a focus on undifferentiated presentation, complex care, and whole system quality improvement and leadership. All aspects are equally important. The aim is to enable GPs to do the job they train to do and enable patients to have better care.

This refocusing of the GP role will require some tasks currently carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. Integration Authorities[2], the Scottish GP Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services. GPs will retain a professional role in these services in their capacity as expert medical generalists.

The funding of general practice in Scotland will be reformed and a phased approach is proposed. In Phase one, starting from April 2018, a new funding formula that better reflects practice workload will be introduced. A new practice income guarantee will operate to ensure practice income stability. The new funding formula will be accompanied by an additional £23 million investment in GMS to improve services for patients where workload is highest.

In addition, the contract offer proposes to introduce a new minimum earnings expectation to ensure no GP partner earns less than £80,430 (including pension contributions) NHS income for a whole-time equivalent post from April 2019. Evidence indicates this will benefit approximately one fifth of GP partners in Scotland.

GP and GP practice workload will reduce and refocus under the proposals, as the wider primary care multi-disciplinary team is established and service redesign embedded. By the end of the planned transition period, for example, GP pharmacists will deal with acute and repeat prescribing and autonomously provide pharmaceutical care through medication and polypharmacy reviews - all tasks currently requiring GP time.

We will ensure that engagement with patients, and other professionals delivering primary care, is a key part of the development and delivery of any service redesign.

A Memorandum of Understanding (MOU), in development between Integration Authorities, SGPC, NHS Boards and the Scottish Government, will set out agreed principles of service redesign (including patient safety and person-centred care), ringfenced resources to enable the change to happen, new national and local oversight arrangements and agreed priorities.

---

2 Integration Authorities were established by the Public Bodies (Joint Working) (Scotland) Act 2014 and are the statutory bodies responsible for the planning, design and commissioning of primary care services in Scotland. These responsibilities are typically delivered through Health and Social Care Partnership (HSCP) delivery organisations.

The contract offer proposes significant new arrangements for GP premises, GP information technology and information sharing. The effect of these arrangements will be a substantial reduction in risk for GP partners in Scotland, and a substantial increase in practice sustainability. Sustainable general practice is critical for better care for patients.

Under the proposed contract offer, a new GP Premises Sustainability Fund will be established, with an additional £30 million investment over the next three years. The investment will support a long term shift that gradually moves towards a model which does not presume GPs own their own premises. A new National Code of Practice for GP premises sets out how the Scottish Government will achieve a significant transfer away from GPs of the risk of providing premises. By 2023, interest free secured loans – "GP Sustainability Loans" – will be made available to every GP contractor who owns their own premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases for GP practice premises.

New contractual provisions will reduce risk in information sharing by clearly setting out the roles and responsibilities of GP contractors and NHS Boards in relation to patient information held in GP patient records. The contract will recognise that GPs are not sole data controllers of the GP patient record, but are joint data controllers along with their contracting NHS Board. GP contractors will not be exposed to liabilities beyond their effective control. The proposals on information sharing have been developed with the support of the Information Commissioner's Office – Scotland.

Practice core hours will be maintained at 8am-6.30pm (or as previously agreed through local negotiation). Online services for patients will be improved and online appointment booking and repeat prescription ordering will be made available where the practice has the functionality to implement online services safely.

Service redesign, as set out in the MOU, will allow for longer consultations for patients where they are needed – in particular for complex care of patients with multi-morbidity, including co-morbidity of physical and mental health issues.

GP cluster quality improvement – introduced in the 2016/17 GMS contract in Scotland – will be further embedded. GP cluster core functions include an intrinsic function to improve care for their practice populations through peer led review and an extrinsic function to meaningfully influence the local system on how services work and on service quality. There will be a refreshed role for the GP Sub Committee in enabling this extrinsic function by facilitating the provision of combined professional advice to the commissioning and planning processes of Integration Authorities and NHS Boards.

GP clusters will have a clear role in quality planning, quality improvement and quality assurance. Existing analytical support from Information Services Division of NHS National Services Scotland will be further embedded. Practices will supply information on practice workforce and on demand for services to support quality improvement and practice sustainability.

The proposed contract offers new opportunities for clinical and non-clinical employed practice staff, including general practice nurses and practice managers and receptionists. The contract will support general practice nurses to focus on a refreshed role as expert nursing generalists providing acute and chronic disease management, supporting people to manage their own conditions where possible. Practice managers and receptionists will play an important role in supporting and enabling the primary care multi-disciplinary team to function smoothly, to the benefit of patient care.

1 INTRODUCTION

A strong and thriving general practice is critical to sustaining high quality universal healthcare and realising Scotland's ambition to improve our population's health and reduce health inequalities.

The 2018 Scottish General Medical Services (GMS) Contract has been developed by the SGPC and the Scottish Government to re-invigorate general practice and to re-energise its core values. It aims to create a dynamic and positive career for doctors and ensure that patients continue to have accessible, high quality general medical services.

The contract will be supported by a MOU between the Integration Authorities, SGPC, NHS Boards and Scottish Government. The MOU represents a statement of intent from all the parties to deliver the wider support and change to primary care services required to underpin the contract.

For the purposes of this document, we refer to Health and Social Care Partnerships (HSCP) as delivery agents of Integration Authorities, responsible for the planning and commissioning of primary care services.

NATURE OF THE CONTRACT

Since the inception of the NHS, general practice has developed as an independent contractor model. Some of the great strengths of general practice exist because of the independent nature of GPs under this model and their ability to prioritise and advocate for their patients.

After consideration and wide discussion, both the SGPC and the Scottish Government have agreed that the GMS contract will continue as an independent contractor model. In the BMA "The future of general practice" survey 2015, 82% of GPs supported maintaining the option of an independent contractor status for GPs.[3]

While the majority of general practice is intended to be delivered through the independent contractor model, we recognise there is an important, continuing role for non-GMS contractor GPs, often in salaried positions, in a wide range of circumstances. The new contract will continue to specify that salaried GP contracts should be on terms no less favourable than the BMA Model Contract.

Our vision is that GPs will continue to run their practices to deliver GP care to their list of patients. However, practices will now be expected to carry less risk compared to previous contracts and be more embedded in the wider health and social care services in their communities. GPs will play a critical role as expert medical generalists and senior clinical leaders within those services.

3 https://www.bma.org.uk/collective-voice/committees/general-practitioners-committee/gpc-surveys/future-of-general-practice

In *Distilling the Essence of General Practice*,[4] following in-depth consideration by RCGP Scotland on the future of general practice, the authors reflect consensus that "contracts should be used to enable rather than limit developments in general practice". The Scottish Government and SGPC agree with this consensus, and the aim of the proposed new contract is to be just such an enabling contract.

General practice – the context

"General practice provides continuing, comprehensive, coordinated and person-centred health care to patients in their communities.

GPs and GP-led multi-disciplinary teams manage the widest range of health problems; providing both systematic and opportunistic health promotion, diagnoses and risk assessments; dealing with multi-morbidity; coordinating long-term care; and addressing the physical, social and psychological aspects of patients' wellbeing throughout their lives. GPs are also integrally involved in deciding how health and social services should be organised to deliver safe, effective and accessible care to patients in their communities.

With general practice carrying out 90% of patient contacts in the health service, it is the bedrock of the NHS."[5]

GPs – Expert medical generalist

"GPs are expert medical generalists who provide the first point of contact with the NHS for most people in their communities. They may deal with any medical problem, 'from cradle to grave', and by providing continuity of care to their patients, families, and communities, they contribute hugely to keeping the nation healthy.

General practice is a unique discipline. Rigorous scientific and clinical medical training and the ability to apply the evidence appropriately in community settings, places general practice at the centre of the NHS. This knowledge and skill set – when combined with the discipline's holistic, relationship based philosophy and broad generalist practice, distinguish the discipline in large measure from other medical disciplines."[5]

This document is organised into a further seven chapters that set out the proposed changes to the GMS contract and our vision for the future of primary care services in Scotland.

4 Gillies, J. (et al) (2009) Distilling the Essence of General Practice: a learning journey in progress. *BJGP*

5 http://www.rcgp.org.uk/training-exams/becoming-a-gp/what-is-general-practice.aspx

THE ROLE OF GPS IN SCOTLAND - EXPERT MEDICAL GENERALISTS

Barbara Starfield's "four Cs"[6] of primary care acted as a guiding principle throughout the negotiations:

- contact – accessible care for individuals and communities
- comprehensiveness – holistic care of people - physical and mental health
- continuity – long term continuity of care enabling an effective therapeutic relationship
- co-ordination – overseeing care from a range of service providers

The 2018 Scottish GMS contract is intended to allow GPs to deliver these four Cs in a sustainable and consistent manner in the future.

These four pillars of primary care are also evident in the landmark Royal College of General Practitioners report on *Medical Generalism*.[7] The ethos of generalism described in this report includes comprehensiveness, co-ordination and continuity. Generalism, by definition, is a form of care that is person - not disease - centred. It is precisely the type of medicine needed to meet the challenge of shifting the balance of care, realising *Realistic Medicine*,[8] and enabling people to remain at or near home wherever possible.

The future will see general practitioners in Scotland fulfilling roles supporting a wide range of clinical professionals, working as an expert medical generalist and senior clinical decision maker within multi-disciplinary community teams. The key contribution of GPs in this role will be in:

- undifferentiated presentations
- complex care in the community
- whole system quality improvement and clinical leadership

Chapter two sets out this vision in more detail.

PAY AND EXPENSES

The GMS contract introduced in 2004 served a purpose for that time. No longer did GPs have individual contracts with the NHS. Contracts were with practices who were encouraged to provide a wide range of services outwith those provided directly by GPs. Alongside this came a structured attempt to promote quality improvement, the Quality and Outcomes Framework (QOF). Over time, QOF has been subject to much examination about whether its intended purpose was wholly achieved or brought about unintended consequences.[9]

---

6 Starfield, B. (1992) *Primary Care: Concept Evaluation and Policy.* OUP, New York.

7 http://www.rcgp.org.uk/policy/rcgp-policy-areas/medical-generalism.aspx

8 http://www.gov.scot/Resource/0049/00492520.pdf

9 http://www.SSPC.ac.uk/media/media-486342_en.pdf

The 2004 GMS contract also loosened the link between the income received by practices and the number of GPs. This has broadened the range of incomes of GPs in Scotland. While some have benefited from this (often as a result of entrepreneurial skills, hard work and long hours) others, despite all efforts, have found themselves financially compromised with difficulty recruiting new GPs, and keeping their practice viable. This is why underlying all the proposed changes is a key intention to improve the sustainability of practices.

Proposed changes to the way that practices are contracted and funded in Scotland are ultimately intended to re-establish the link between practice income and the provision of GPs to the community. Most of the payments to practices will be intended as income for the right number of GPs, for paying for a core team of employed staff, and for meeting the necessary expenses of running the practice. As change progresses, the intention is that GPs are paid to be GPs rather than to provide a wide range of other services. The proposed changes are also intended to reduce the transactional business elements of the relationship between GPs and the rest of the system. These elements have, at times, worked against the development of the collaborative relationships in health and social care necessary for good outcomes.

Chapter three sets out our proposals around pay and expenses, including a new workload formula and increased investment in general practice.

MANAGEABLE WORKLOAD

The consultation remains the foundation of general practice. It is where the values of compassion, empathy and kindness combine with expert scientific medical knowledge to the benefit of patient care and mental and physical health. The role of the modern GP, however, is wider than patient consultations. Repeat prescriptions, test results, home visits, telephone calls and other communication with patients and other services can all form a significant part of the GP day.

Chapter four sets out our proposals to provide additional primary care staff to work alongside and support GPs and practice staff to reduce GP practice workload and improve patient care. These additional staff will underpin a transformational service redesign over the next three years with the development of the multi-disciplinary team to support general practice.

IMPROVING INFRASTRUCTURE AND REDUCING RISK

As independent contractors running a practice, GPs are exposed to risk in a number of ways. This can be through the ownership and maintenance of practice premises, through acting as a data controller sharing information with the wider NHS, and through the risks of being an employer.

Chapter five introduces a number of significant new measures designed to manage and reduce these risks to GPs.

BETTER CARE FOR PATIENTS

With a focus on Barbara Starfield's four Cs, chapter six sets out the benefits the new contract will bring to patients. The proposals will help people access the right person at the right place at the right time, as described in the Scottish Government Primary Care Vision and Outcomes (see annex). In particular the chapter focuses on:

- maintaining and improving access (contact);
- introducing a wider range of health professionals to support the expert medical generalist (comprehensiveness);
- enabling more time with the GP for patients when it is really needed (continuity); and
- providing more information and support for patients (co-ordination).

In addition, the chapter sets out the critical role of meaningful patient engagement in ensuring services are designed in ways that meet the needs of individuals and communities.

BETTER HEALTH IN COMMUNITIES

Scotland's health and social care workforce continues to be at the forefront of a wide range of improvements in the safety, effectiveness and quality of care and treatment. General practice in Scotland took a distinctive path on quality improvement through the establishment of GP clusters in 2016/17 - enabling a peer-led, values-driven approach to quality improvement. The proposed new contract further embeds the cluster quality approach.

THE ROLE OF THE PRACTICE

The final chapter sets out the wider role of the practice and practice team, including general practice nurses, practice managers and practice receptionists.

Overall, the proposals represent both significant investment in primary care and significant change. At the heart of any change must be the core principle of patient safety. That is why our planned approach is of a three year transition with changes to services only taking place when it is safe, when it is appropriate, and when it improves patient care. By working together in this way we can build a GP service for the future, one that meets the changing needs and demands of the people of Scotland and enables GPs to do the job they train to do.

A range of supporting materials and evidence including the review of the Scottish Allocation Formula, the Premises Code of Practice and the Review of GP Earnings and Expenses will be published on the Scottish Government website. (http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract).

The next chapter sets out our vision of the role of the GP as an expert medical generalist.

2 THE ROLE OF GPs IN SCOTLAND – EXPERT MEDICAL GENERALISTS

Key Points

- The GP as expert medical generalist will focus on undifferentiated presentations, complex care and quality and leadership. All are equally important.
- GPs will lead and be part of an extended team of primary care professionals.
- GPs will have more time to spend with the people who need them most.

INTRODUCTION

The Scottish Government and the SGPC share a vision of the role of the GP as the expert medical generalist in the community. This is not a new role – generalism has always been at the heart of general practice: holistic care that sees the person as a whole in the context of their community is the very strength of general practice that we wish to enhance.

However, the context that GPs now work in is changing - multi-morbidity is more common; people are living longer and the demands on GPs have been growing. The challenge is ensuring GPs have the space and the time to carry out the expert medical generalist role that their communities need.

We intend to meet this challenge by focusing the role of the GP on activity that requires the skills of a doctor. The GP will be supported by an extended multi-disciplinary team that will be responsible for some of the activities currently being performed by the GP, where that is safe, appropriate and improves patient care. Practice workload will be more manageable, with patients consulting with the most appropriate professional in the team. Chapter four describes how we will tackle rising GP workload in more detail.

We anticipate that an enhanced role for the GP as senior clinical leader in the community will lead to greater professional esteem. It will remain a challenging role, and a rewarding one.

THE GP AS EXPERT MEDICAL GENERALIST

In the previous chapter we introduced Barbara Starfield's four Cs of primary care - contact, comprehensiveness, continuity and co-ordination. Her pioneering research clearly demonstrated the benefits of strong general practice for the population and for the wider health and care system. The international evidence is clear – health and care systems with strong primary care demonstrate better population health outcomes, more equitable outcomes and better cost efficiency than systems with relatively weak primary care. The aim of this contract – and wider primary care transformation – is to strengthen general practice for the benefit of all in Scotland.

Successfully addressing the health needs of individuals and communities requires an approach that makes the best use of the unique skills and experience of GPs and of other professionals in primary care. We expect that a modernised role for GPs will encourage recruitment and retention and strengthen the crucial role of general practice and primary care within the wider health and social care system.

We are proposing a refocused role for the GP from 2018. This will incorporate the core existing aspects of general practice and introduce a renewed focus on quality and the sharing of system wide clinical knowledge. It will acknowledge the GP's expertise as the senior clinical leader in the community, who will focus on:

- undifferentiated presentations
- complex care in the community
- whole system quality improvement and clinical leadership

A key change in the contract offer is the proposal that GPs become more involved in complex care and system wide activities, necessitating a refocusing of GP activity. As we refocus the GP role, we expect GPs to be less involved in more routine tasks, with these tasks being delivered by other health professions in the wider primary care multi-disciplinary team. To achieve this, the training needs of GPs and members of the wider primary care multi-disciplinary team will need to be considered, developed and delivered. The *National Health and Social Care Workforce Plan: Part 3 Primary Care* will set out plans for the development and training of GPs and this wider primary care multi-disciplinary team and is due to be published early 2018.

UNDIFFERENTIATED PRESENTATIONS

Seeing patients who are unwell, or believe themselves to be unwell, will remain a core part of general practice as it is the basis for the continuous development of the clinical skills required of a generalist and is essential for good patient care.

GPs are, however, a limited resource and their capacity to see patients is finite. There needs to be a balance between access to GP appointments, access to other health professionals where that is more appropriate, and encouraging patients to seek self-care advice, where appropriate. This will enable GP time to be available when really needed by patients.

The key direct clinical care role for the GP as expert medical generalist is in undifferentiated presentations which require the skills of a doctor trained in risk management and holistic care with broad medical knowledge. Often this care is delivered through the continuity of consultations over time.

People are often able to self-differentiate in their own presentations. For example, a person presenting with shoulder pain may choose to see a physiotherapist as a first point of contact if such a service is as responsive as their GP practice. This is also the case for minor illness and injury, where, if there is an advanced practitioner or other service available locally, patients may choose that practitioner rather than seek a GP appointment.

New models of care will require other health professionals to be more involved in meeting immediate patient needs as part of a wider team (see chapter four for further details). Working alongside GPs, other health professionals need to be able to efficiently assess and treat patients, within their clinical competence. It will be essential that they are able to complete episodes of care without recourse to the GP on a significant number of occasions.

GPs will retain oversight to ensure the service, as a whole, is working and patient needs are met. Other clinicians will work independently within their competencies as part of the extended team with mutual decision support.

GPs will be of particular importance in supporting and managing people with undifferentiated presentations especially in the context of multi-morbidity and complexity and will maintain longitudinal patient contact to support that role.

GP practices act as a patient gateway to ensure that people can access the right care. Patients should experience contacting the practice, either in person or remotely, as a way to obtain advice on how best to have their needs met safely, effectively and efficiently by services. GPs should oversee and manage this process to ensure it is effective and that patients can see the right person at the right place at the right time.

COMPLEX CARE IN THE COMMUNITY

As workload capacity is freed up, a key part of the GPs expert medical generalist role will be leading a primary care multi-disciplinary team to deliver care to patients with, for example, multiple co-morbidity, general frailty associated with age, and those with requirements for complex care (e.g. children or adults with multiple conditions, including mental health problems, or significant disabilities).

What do we mean by complex care?

Complex Care is most commonly the clinical care of patients who have multiple disease presentations. Such patients may have two or more diagnoses which, as they occur in the same individual, are therefore connected and interacting. Evidence based guidance and decisions which may be appropriate for one diagnosis may not be appropriate or may conflict with those for the other conditions. This uncertainty requires shared decision-making with patients and carers. Complexity can occur in the context of mental and/or physical ill health, at any age including end of life. The GP acts, as the expert medical generalist, giving advice on managing and treating these uncertainties to increase the likelihood of achieving the agreed outcomes.

The system, with the contribution of GPs and GP practices through cluster quality improvement, will be focused on knowing its population and assessing where there is potential to achieve better outcomes. GP clusters were introduced in Scotland with the 2016/17 GMS agreement between the SGPC and the Scottish Government. In professional groupings of five to eight practices, clusters enable peer-led, values-driven quality planning, improvement and assurance.

Each GP practice will be supported with appropriate information to proactively identify the cohort of patients requiring complex care and to then work with others to devise an appropriate care plan to ensure patients receive the optimum care and support.

One of the main aims of this change in focus is to provide care to patients with complex needs at home wherever this is appropriate. Where care at home is desirable and adequately supported it is better for patients. GPs spending more time on patients with complex needs would help to ensure that admission to acute care should only be to achieve a specific outcome, or for an assessment or treatment that can only be provided in a hospital setting.

GPs will also be involved in establishing care plans for patients with complex needs, including anticipatory care plans, which can be used by community teams to enable patients to be cared for in their own homes for as long as possible. As the expert medical generalist in the community, GPs will also support these community teams, when any expert GP input is required.

WHOLE SYSTEM ACTIVITY – QUALITY IMPROVEMENT AND LEADING TEAMS

Ultimately all GPs must have regular protected time to be able to develop as clinical leaders. The intended outcome is that they become fully involved in assessing and developing services intended to meet the needs of their patients and local communities. Currently, only Practice Quality Leads (PQL) have access to protected time, although different GPs in the practice can perform that role over time.

The next step in this journey is to create additional protected time for each practice, to enable GPs to develop their clinical leadership role. Therefore, from April 2018, each practice will receive resources to support one session per month for Professional Time Activities. There is a clear intention to achieve, over time, regular protected time for every GP.

GPs are senior clinical decision makers and leaders. As such, and with a clear focus on outcomes of relevance for patients, they will assess the overall performance of their own practice, practices within their cluster, and the wider community team, leading to suggestions for improvement that will in turn be evaluated by them and others. This will require GPs to have influence to direct change within the wider health and social care system. Indeed, for wider health and social care to be successful, meaningful involvement of GPs is required.

Whilst some GPs may not see themselves attracted to broader leadership roles and responsibilities, all will need to be involved in improvement activity in both their practice and the wider system through cluster working. Any significant improvements in patient outcomes are only likely to be achieved if every senior clinician is engaged in these activities at some level.

GP training

The evolution of primary care will require training for doctors wishing to become GPs to have a renewed focus on the skills required to be an expert medical generalist: in leadership, multi-disciplinary team working and peer-led quality improvement. Increased time and wider expertise may be required for training practices, with review of funding for training to ensure appropriate support for the necessary expansion of medical training in the community.

ESSENTIAL SERVICES, ADDITIONAL SERVICES AND ENHANCED SERVICES

The refocusing of the GP role to expert medical generalist has implications for the current contracted service elements of Essential, Additional and Enhanced Services.

We are proposing the following service refinements in the new contract:

Essential Services

Essential Services will remain unchanged in the proposed new contract. The fundamental core principles of general practice – care based on the registered practice list, generalist care of the whole person and sufficient consultation time for patients according to their clinical needs – align with Essential Services.

Additional Services

The agreed direction of travel is to reduce the over-specification of services in the contract wherever it is safe to do so. That will begin with the proposed new contract.

For instance, latest evidence[10] suggests there is no longer a requirement for a separate Additional Service for minor surgery. GPs may still provide treatments which would have previously fallen under the Additional Service at their clinical discretion under core services. The Enhanced Service for minor surgery will continue.

Out of Hours

There will be changes to arrangements for out of hours services. Instead of the current opt-out arrangement a new opt-in Enhanced Service will be developed for those practices that choose to provide out of hours services.

The new out of hours Enhanced Service will have a nationally agreed specification, building on the quality recommendations within Sir Lewis Ritchie's out of hours review *Pulling Together*[11] and covering areas such as record keeping, anticipatory care planning, key information summary, use of Adastra and NHS24.

This will contribute to a consistency of approach to the provision of unscheduled care services across Scotland where practice-based service level agreements are in place. There is also an opportunity to develop a nationally agreed quality and person-centred specification which could be used by all NHS Boards to test and benchmark their current local service level agreements.

---

10 https://cks.nice.org.uk/warts-and-verrucae#!scenaico

11 http://www.gov.scot/Resource/0048/00489938.pdf

Enhanced Services

We have agreed a general principle (with the exception of the new out of hours approach) against the expansion of the number of Enhanced Services under the proposed new contract.

Chapter four describes the Vaccination Transformation Programme which will transfer responsibility for the delivery of vaccinations from GPs to NHS Boards. On completion, to the satisfaction of the SGPC, Scottish Government and local delivery and commissioning partners, the relevant Additional and Enhanced Services for vaccinations will no longer be included in the Scottish GMS contract. In rare circumstances it may be appropriate for GP practices, such as small remote and rural practices, to agree to continue delivering these services through locally agreed contract options.

The current direction of travel on maternity medical services – where responsibility already largely lies with other parts of the community team – is expected to continue. Similarly, for contraceptive services, current provision by other professionals and teams is expected to continue.

There is, at this stage, no real alternative to delivering many of the current Enhanced Services provided by practices and no intention of reducing the funding to practices. Any further changes will need to be carefully planned with a rate of change that ensures patient safety, quality of service and practice stability.

The continuation of locally determined Enhanced Services is for NHS Boards and local practices to agree. The expectation nationally is that Enhanced Services funding is not removed from practices as services are transitioned to NHS Boards over 2018-2021, as doing so could be destabilising to the system. As mentioned previously, there is an intention to reduce the transactional business elements of the relationship between GPs and the rest of the system. These at times, have worked against the development of the collaborative relationships in health and social care necessary for good outcomes.

At the start of this chapter we set out our belief that the enhanced role of the GP as senior clinical leader in the community will lead to greater professional esteem and that while the role will remain challenging, it will be a rewarding one. The cornerstone of this enhanced role is the GP's skill and expertise in dealing with undifferentiated presentations, complex care in the community and whole system quality improvement and clinical leadership.

We also recognise that GPs should be appropriately remunerated for their work. Chapter three sets out our proposals for pay and expenses.

3 PAY AND EXPENSES

Key Points

- A new practice income guarantee will operate to ensure practice income stability.
- A new funding formula that better reflects GP workload will be introduced from 2018 with additional investment of £23 million.
- A new minimum earnings expectation will be introduced from 2019.

INTRODUCTION

The SGPC and the Scottish Government recognise that an appropriate and secure level of income is a key prerequisite to attracting GPs to the profession and ensuring the future viability of general practice. Existing GPs need to be adequately rewarded for the work they do. GP trainees and anyone considering a career as a GP needs to have a clear understanding about the rewards of the career.

THE NEW FUNDING MODEL AND A PHASED APPROACH

We recognise that the current funding arrangement is complex, leads to uneven funding allocations and needs to be reformed. We also recognise that practices require funding stability. To deal with these historical shortcomings of the current system, we are proposing:

From 1 April 2018:

- To introduce a new funding formula to better address practice workload (details are provided below)
- That new arrangements will include the correction factor (Minimum Practice Income Guarantee) and core standard payments (previously QOF payments) in a consolidated global sum. The funding associated with these elements of the 2004 GMS Contract will be subject to the new formula and would cease to exist as separate funding streams thereafter
- To make these changes in a protected manner so that no practice will lose funding. To maintain funding stability the Scottish Government has committed investment of an additional £23 million to fund the practices that receive a greater formula share and protect all other practices
- That seniority arrangements remain unchanged
- That there will be no out of hours opt-out deduction under the new arrangements. Nationally, 6% will be deducted from the 2017/18 Global Sum prior to applying the new funding formula. This will conclude the opt-out arrangements made under the 2004 GMS contract.

From 1 April 2019:

- The government will introduce a GP partner whole-time equivalent minimum earnings expectation. On current evidence around one-fifth of GP partners earn less than a whole-time equivalent income of £80,430 (inclusive of pension contribution), based on partner shares of total practice GP income. We agree that no GP should receive less than £80,430 (inclusive of pension contribution) for a whole-time post. This is a first step towards greater income security that will be further bolstered in the following years.

From 1 April 2020 we propose to:

- Introduce an income range that is comparable to that of consultants
- Directly reimburse practice expenses
- As these measures would again change GP practice funding and GP income they will be subject to negotiation and a second poll of the profession after specific details (including financial details) are available. Negotiations on this phase will include arrangements for the protection of GP income and practice expenses.

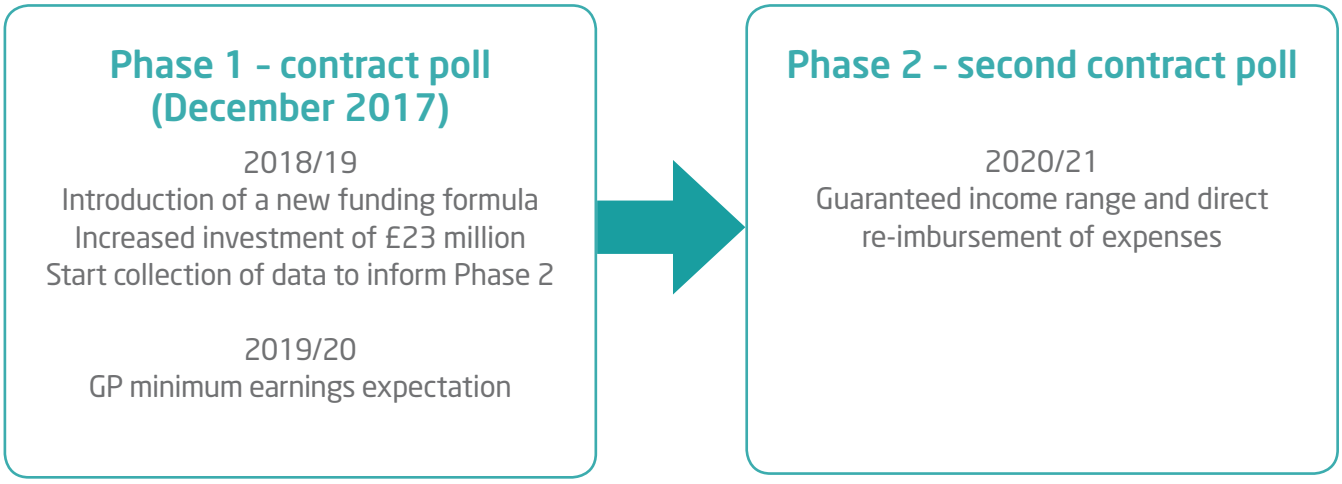
Underlying this investment are a number of key agreements:

- To invest £250 million in direct support of general practice by 2021/22
- To ensure that proposals stabilise practice income
- To ensure that an allocation mechanism better recognises the demand for GP and other staff time for any given practice population
- To develop a process that, at its endpoint, provides all GPs a guaranteed income on a range comparable to that of consultants and reduces risk through the direct reimbursement of premises and staff costs
- To ensure that there will be no loss of funding to general practice. Any disputes regarding funding will be ultimately reviewed by the Scottish Government and SGPC
- To ensure that practices can expect that support services they are provided with locally will continue

We have agreed that GP income should not be subject to arbitrary variation and should instead reflect the value of a GP's work as an expert medical generalist. Ultimately, this can only be achieved by providing practices with the necessary funding for expert medical generalist work and the necessary expenses to support this work.

To achieve this, we propose two separate phases of transition:

Figure 1: Two-phased approach to funding



PHASE 1 - INTRODUCTION OF A NEW FUNDING FORMULA

The current funding model under the 2004 GMS contract has led to a disparity of income and expenses between practices in Scotland because it is based on a methodology that performs two distinct functions simultaneously:

1. It allocates resources to GP practices according to population requirements and differences in costs; and
2. It determines GP partner pay as the difference between this funding and GP practice expenses.

While this arrangement incentivises GP partners to use their funds in the most efficient way to maximise their income, differences in local circumstances that are not captured adequately by the formula lead to differences in costs, income and provision of services.

Phase 1 sees the introduction of a new GP workload based resource allocation formula (the GP Workload Formula) to replace the existing Scottish Allocation Formula (SAF).

The new formula was developed as part of a 2016 review of the SAF.[12] It re-estimates the number of consultations per patient, dependent, in the main, on their age, sex and the deprivation status of the neighbourhood in which they live.

The new formula is a methodological improvement to the previous SAF. It is based on the best available evidence and as such it more accurately reflects the workload of GPs. Compared to the workload-related weightings of the original SAF, the new formula gives greater weight to older patients and deprivation.

The impact of deprivation on the workload of a practice is better reflected in the new workload formula than the previous SAF. Methodological improvements mean both deprivation in urban areas and isolated pockets of rural deprivation are better addressed by the new formula.

With the introduction of the new formula, GP practices will be protected from any potential funding losses. To this end, the Scottish Government has committed to invest an additional £23 million to fund the practices that receive a greater share under the new formula while protecting all other practices. This additional investment is to improve services for patients in areas where workload is highest.

We will monitor the impact of the funding formula during implementation.

Increased investment of £23 million

We have calculated the impact of the new formula on GP practice funding for each GP practice in Scotland. This information will be provided to your GP practice in a separate letter in November 2017.

---

12 http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-contract

The guarantee to protect GP practice income and expenses in Phase 1 will continue until there is a proposal acceptable to the profession for the introduction of Phase 2. Future funding uplifts will apply to all GP practices' share of the total, derived by the new formula during Phase 1, including the new income guarantee. Population increases will apply to the formula sum only.

PHASE 1 - MINIMUM EARNINGS EXPECTATION

In early 2017 the Scottish Government and SGPC commissioned a review of GP earnings and expenses in Scotland.[12] The review found significant differentials in income and expenditure in the sample of 109 practices, with around one-fifth of GP partners earning less than £75,000 (including any private work, excluding employer superannuation) in a whole-time equivalent post.

We propose that no GP partner should receive less than £80,430 (including employer pension contributions) NHS income pro-rata up to a whole-time equivalent (40 hours) from April 2019.[13] This extra income will be provided through NHS: National Services Scotland Practitioner Services on the basis of the income, hours and session information.

Start collection of data to inform Phase 2

We considered a single transition to an agreed income range with pay progression and direct re-imbursement of expenses (staff and premises), but there are a number of reasons why it is necessary to split the transition into two phases:

- We need time to develop the administrative capacity to enable the direct re-imbursement of expenses and payment of income.
- We need time to collect data to allow us to calculate the impact on individual partners if the funding model is replaced.
- We therefore cannot calculate the total cost and provide ministers. Parliament and the profession with the necessary assurance of the affordability of the preferred model.

In order to prepare for Phase 2 we need to fully understand the current expenses of running a GP practice, the income of salaried GPs and the income of GP partners as well as the hours worked by individual GPs.

This data is necessary to calculate partners' earnings entitlement and the total costs of introducing a consultant comparable income scale. We have agreed that all GP practices will be required to provide this data (earnings, expenses, hours/sessions) in a similar way to the data already provided for pension purposes.

---

13 Minimum earnings expectation is £80,430k per WTE GP in the practice, including employees and employers superannuation, and including all NHS practice income earned within practice opening hours, pro-rated to a WTE of at least 40 hours per week, and excluding all non-NHS income earned within practice opening hours.

To ensure confidentiality data will be held and processed by NHS National Services Scotland Practitioner Services (which currently handles GP income data for pension purposes) and only anonymised, non-identifiable data for the purposes of analysis will be provided to government, NHS Boards or the SGPC during Phase 1. In Phase 2 this data will be required to authorise payments and provide supporting information to ensure appropriate individual GP practice resourcing.

PHASE 2 - INCOME RANGE AND EXPENSES RE-IMBURSEMENT

In Phase 2, which is subject to further negotiations and another poll of the profession, an income range with pay progression for GPs (comparable to that of consultants) and direct re-imbursement of expenses (staff and premises) will be introduced. Negotiations will include the arrangements for protection of GP income and GP practice expenses.

Direct re-imbursement of expenses and an income range for GPs will remove the direct link between the new formula and practice funding. Instead, the new formula will act to define the GP input and an expenses 'norm' for a practice. This will guide the allocation of primary care resources across the country but will not be used to allocate money directly. The formula will indicate the necessary resources of individual practices to meet patient demand. The flexibilities that will be required under this proposal will be negotiated between the Scottish Government and the SGPC and presented to the profession before the poll for Phase 2.

Meeting the primary care needs of the people of Scotland

The intention of Phase 2 is that the new formula will inform the establishment of a baseline of the number of GPs required to meet the primary care needs of the people of Scotland. The determination of the baseline will be subject to negotiations and is also dependent on how much variability at a practice level is agreed to be allowed.

Once a baseline is determined, the new formula will help define the optimum GP supply required every year to deal with the workload generated by a growing and ageing population. This puts the onus on the Scottish Government to ensure sufficient training numbers and provide the necessary funding to enable the number of general practitioners to grow in line with overall workload. Further detail on initiatives to increase GP supply in Scotland will be contained in the forthcoming *National Health and Social Care Workforce Plan: Part 3 Primary Care*.

Phase 2 and GP pay

Under these proposals for Phase 2, GPs will have assured income and pay progression, providing stability. The allocation of GPs across GP practices will be informed (but not wholly determined) by the workload formula to allow for some flexibility while broadly ensuring the provision of GPs reflects population need.

In necessarily small remote GP practices, extra resources will continue to be made available to ensure long-term sustainability. Remote GP practices will, as they do now, continue to provide a broader range of services more appropriate to remote settings.

Phase 2 and GP Expenses

The composition and necessary amount of GP practice expenses will change over time in the context of the extra resources to be provided to the practice as part of the development of the wider multi-disciplinary approach.

We know that rural GP practices have, on average, higher expenses per patient than urban ones. Partly, these can be explained by the diseconomies of scale of small GP practices and the costs of dispensing, or having one or more site/branch surgeries and we recognise that these differences will need to be addressed by proposals for Phase 2.

We agree that GP practices need sufficient time to adjust their resources and that there needs to be sufficient flexibility to allow appropriate funding to account for exceptional circumstances.

This chapter started with a recognition that an appropriate and secure level of income is a key prerequisite to attracting GPs to the profession and ensuring the future viability of general practice. We believe that the proposals outlined deliver on these needs. We also recognise that as well as being rewarded financially for doing their work, GPs need to have a manageable workload. Chapter four explains how we plan to deliver this.

4 MANAGEABLE WORKLOAD

Key Points

- GP and GP Practice workload will reduce.
- New staff will be employed by NHS Boards and attached to practices and clusters.
- Priorities include pharmacy support and vaccinations transfer.
- Changes will happen in a planned transition over three years when it is safe, appropriate and improves patient care.
- There will be national and local oversight of service redesign and contract implementation involving SGPC and Local Medical Committees.

INTRODUCTION

We know that workload is currently one of the most challenging aspects of being a GP. We are introducing measures to address this by:

- continuing to reduce contractual complexity
- improving primary/secondary care interface working
- building a wider primary care multi-disciplinary team

Reducing contractual complexity

The process of reducing the contractual complexity of the Scottish GMS contract has already begun. In 2015 the Scottish Government and the SGPC announced that Scotland would become the first country in the UK to remove the Quality and Outcomes Framework (QOF). QOF no longer incentivised the direction of travel needed with respect to demographic change (an ageing population and increasing multi-morbidity), because the disease specific, procedural basis of QOF encouraged diseases to be viewed separately. This was counter to the holistic, person-centred care required for the increasing numbers of people with multiple long term conditions.

In April 2016, the remaining 659 QOF points were retired and transferred to the general practice core standard payments, signalling one of the first steps towards the development of the new contract, and a significant shift towards placing greater trust in the clinical judgment and professionalism of GPs. Transitional arrangements for quality assurance were introduced in the Statement of Financial Entitlements 2016/17 alongside the removal of QOF. These included early instructions for the creation of GP clusters in Scotland, setting the direction for the new contract.

Other arrangements have also been improved while the new contract was being developed. These include removing the discretionary element for parental leave and sickness leave locum cover payments so all eligible GP practices will receive these payments. We have also created an occupational health service that all GPs and GP practice staff can access, and improved the re-imbursement rate for appraisals.

The new contract will build on these improvements to further reduce contractual complexity. Some of the proposed simplification of the contractual landscape was set out in chapter two. Our proposed changes to the GMS regulations will include updates on dispute resolution, closing practice lists and defining the practice boundary. These changes are described more fully in chapter eight.

Improving interface working

- To ensure effective working between primary and secondary care, we will continue to implement the recommendations of the *Improving General Practice Sustainability Advisory Group* as set out in its report on November 2016.

Within the recommendations there are a number of broad themes including effective primary and secondary care interface working. Interface working will be better achieved through well-functioning primary and secondary care interface groups. These groups will support NHS Boards and HSCPs to reduce GP workload and provide a better patient experience by removing the need for GP involvement when it is not clinically necessary. The recommendations include:

- Improved processes for routine follow-up of hospital procedures and results of tests
- Allow the issuing of fit note certificates by secondary care providers at the time of discharge, where the condition being treated is the sole cause of a temporary disability
- More efficient use of the primary care multi-disciplinary team by ensuring secondary care staff request patient visits by the most appropriate professional for their condition e.g. social care or district nurse
- Changes to the referral pathway for patients who do not attend (DNA) hosptial appointments to remove the need for GP referrals

Building the primary care multi-disciplinary team

In line with commitments to be made in the MOU referred to in chapter one, HSCPs and NHS Boards will place additional primary care staff in GP practices and the community who will work alongside GPs and practice staff to reduce GP practice workload.

Practices will be encouraged to use the additional capacity created by reducing GP provided services to focus on activities that directly support GPs as expert medical generalists. We will increase protected time to allow GPs to maintain and develop their training and skills, and those of their practice teams.

SERVICE REDESIGN - 2018-2021

To enable and empower GPs to function as expert medical generalists, non-expert medical generalist workload needs to be redistributed to the wider primary care multi-disciplinary team, ensuring that patients have the benefit of the range of expert advice needed for high quality care.

Local areas are already beginning to reconfigure primary care by redistributing workload to the multi-disciplinary team as capacity becomes available.

An MOU between these local commissioning and delivery partners, the SGPC and Scottish Government is in development. It sets out agreed principles of service redesign, identified ring-fenced resources to enable the change to happen, national and local oversight arrangements, and the priorities for the transfer of responsibility for service delivery.

These agreed principles include patient safety and person-centred care. Patient engagement in the planning and delivery of new services will be critical to their success.

It is intended that GPs will become better embedded in HSCPs as senior clinical leaders working in collaboratively with managers to achieve better outcomes for patients.[14]

To help ensure sufficient, visible change in the context of a new contract, we have agreed to focus on a number of specific services to be reconfigured at scale across the country. These include:

- vaccinations services;
- pharmacotherapy services;
- community treatment and care services;
- urgent care services; and
- additional professional clinical and non clinical services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services.

To ensure the continued delivery of high quality, safe, person-centred care, the transition will happen over an agreed period of time.

Primary Care Improvement Plan

Each of the 31 HSCPs in Scotland will develop a Primary Care Improvement Plan which will outline how these services will be introduced before the end of the transition period in 2021. These Plans will be overseen by a GMS Oversight Group with representation from the Scottish Government, the SGPC, HSCPs and NHS Boards. This group will be formed to oversee implementation by NHS Boards of the Scottish GMS contract and implementation by the HSCPs of the Primary Care Improvement Plans. Plans will include clear milestones for the redistribution of GP workload and the development of effective primary care multi-disciplinary team working.

---

14 Don Berwick's concept of the need to move to an Era 3 of medicine was a guiding touchstone during the negotiations. https://www.advisory.com/daily-briefing/2016/04/12/berwick

As well as the requirements on the HSCPs to develop Primary Care Improvement Plans, NHS Boards with HSCPs will develop clear arrangements to deliver the commitments in respect of the new Scottish GMS contract. These arrangements include the priority areas of service redesign set out below and must be agreed with the local GP Subcommittee of the Area Medical Committee and the Local Medical Committee (LMC).

Leadership and management

Under the new contract GPs will be concentrating on their role as expert medical generalists with a focus on improving outcomes for patients. There is an explicit understanding that part of this role will be senior clinical leadership of the multi-disciplinary teams.

Line management of much of the primary care multi-disciplinary team staff will be provided through the employing authority (usually NHS Boards). This will include the provision of employee support, training, cross cover and cover for holidays and other absences. The purpose of the line management is to support staff in their role as a member of the primary care multi-disciplinary team attached to one or more practices and their patient lists.

While all professionals involved in patient care have a leadership role to play, the senior clinical leadership role of doctors will be outlined in the GP role in Primary Care Improvement Plans. Not all GPs will feel that they have all the skills to undertake this role, but training will be available and be part of core curricula in the future. Leadership which is intended to improve outcomes for patients will clearly require collaborative working with a wide variety of professionals who will be involved in primary care multi-disciplinary teams. Various members of these teams will also undertake leadership roles to achieve changes and improvements.

There are many examples of effective teams whose membership have different employers. Many GPs will have had experience of this with district nurses and other professionals not directly employed by their practice. The MOU is a clear statement of intent to deliver this form of team working. We have agreed shared principles to ensure these teams operate in optimum ways to the benefit of patient care.

Some of these primary care multi-disciplinary team members will be attached to individual practices but inevitably, in some cases, resources may have to be shared between different practices. GP clusters will have an important role in facilitating cross practice working including developing common working practices and pathways.

We believe that the best way to deliver relationship-based care to patients is through the effective relationships between the members of these primary care multi-disciplinary teams.

VACCINATION SERVICES

In 2017, as part of the commitment to reduce GP workload, the Scottish Government and SGPC agreed vaccinations would progressively move away from a model based on GP delivery to one based on NHS Board delivery through dedicated teams. The Vaccinations Transformation Programme is reviewing and transforming how we deliver vaccinations in Scotland. Delivery will move away from the current position of GP practices being the preferred provider of vaccinations on the basis of national agreements.

The vaccination services delivered by the programme will form part of the Primary Care Improvement Plan in each area. It is expected that each area will make meaningful progress over the first two years of transformation to demonstrate commitment to the change.

The aim of the programme is to reduce workload for GPs and their staff. This will mean that other parts of the system, with primary care multi-disciplinary teams, will begin to deliver vaccination services instead of GPs. This will be a step towards enabling GPs to focus their time on expert medical generalism, whilst ensuring that patients' needs are met through the reconfiguration of services which will make the best use of the mix of skills in primary care. How this programme is delivered will vary regionally, depending on local circumstances and factors.

The funding that was historically associated with the delivery of vaccinations will remain within general practice. An additional £5 million is being invested in 2017 to start the Vaccination Transformation Programme ahead of the delivery of the proposed new contract.

The Vaccination Transformation Programme will draw in expertise from across the NHS and will take three years to complete. Transition to the new model will be planned to ensure that it can operate safely and sustainably, and changes will be made only in line with an agreed process (detailed in the Primary Care Improvement Plans).

The Vaccination Transformation Programme can be divided into different work streams:

1. pre-school programme
2. school based programme
3. travel vaccinations and travel health advice
4. influenza programme
5. at risk and age group programmes (shingles, pneumococcal, hepatitis B)

We expect HSCPs and NHS Boards to have all of these programmes up and running by the end of the 3-year transition period - in April 2021. The order and rate at which HSCPs and NHS Boards make the transition may vary but progress is expected to be delivered against milestones in each of the 3 years.

1) **Pre-school programmes** in NHS Board areas such as Lanarkshire and Tayside are already established. This is a complex, time-critical programme and HSCPs and NHS Boards that do not currently provide this service will, early on in the transition period, prioritise the adoption of lessons learned from service delivery and workforce development in those areas that have already introduced the service.
2) The **school based programme** is already established across all areas delivering influenza vaccine and HPV vaccine to girls.
3) **Travel vaccinations and travel health advice** are currently a significant time burden on GP practices and the Vaccination Transformation Programme will prioritise optimal alternative options for re-provision in the first year.
4) The **influenza programme** will tackle the seasonal challenge of delivering to those in certain age categories and those at particular high risk. HSCPs will plan how they deliver vaccinations to the high volume over 65 category. Pre-school and school age children could have this vaccination delivered by their respective programmes. Consideration needs to be given to particular risk groups such as pregnant women and adult at-risk groups, and how vaccines can be provided in a way that is safe efficient and acceptable to patients.
5) For **at risk and age group programmes,** consideration needs to be given to providing relevant vaccines to eligible patients in a way that is safe, acceptable, and which maintains, or increases uptake.

PHARMACOTHERAPY SERVICES

Multi-disciplinary team working is crucial to reducing GP workload. The proposed contract includes an agreement that every GP practice will receive pharmacy and prescribing support.

The GP Pharmacy Fund has already enabled 160 pharmacists and 34 pharmacy technicians to be appointed to posts in over one third of GP practices across Scotland.

We are investing £12m in the GP Pharmacy Fund in 2017/18. We intend that investment in this service will continue under the new contract to allow more pharmacists and pharmacy technicians to work in general practice, reducing GP workload and improving patient care.

As part of the proposed contract, we would also introduce a new pharmacotherapy service to allow GPs to focus on their role as expert medical generalists, improve clinical outcomes, more appropriately distribute workload, address practice sustainability and support prescribing improvement work.

Case Study – Pharmacy support in Caithness

Pharmacists and pharmacy technicians are already developing an increased, specialised role within primary care multi-disciplinary teams. They are well placed to support GPs to focus on their role as expert medical generalists by ensuring workload is distributed more appropriately, undertaking prescribing improvement work, and providing medication reviews and specialised clinics.

In Caithness in NHS Highland, pharmacist prescribers are embedded in the primary care MDT. One pharmacist, who works in a GP practice with 5,447 patients, has taken over all the medication reviews that were previously provided by the practice GPs, and completed a total of 2,811 reviews in an 18-month period. This includes re-authorising repeat prescriptions and transferring suitable patients to serial prescribing. They also triage all daily acute requests, carry out all medicines reconciliation for hospital discharges and clinic letters and manage individual patients requiring more intensive medicines input, such as dose titration of a pain medicine. Caithness pharmacists also provide domiciliary medication reviews for patients in care homes and patients receiving care at home, reducing the number of visits required by GPs.

The pharmacist input has resulted in a marked reduction in GP time spent on medicines-related activities, enabling them to focus on other activities. Patient response has also been overwhelmingly positive.

"Having an in-house pharmacist has shown many benefits for patients including reducing polypharmacy, being able to monitor more closely patients on high risk medications, and supporting patients though medication changes after hospital discharge."

GP, Caithness

From April 2018, there will be a three year trajectory to establish a sustainable pharmacotherapy service which includes pharmacist and pharmacy technician support to the patients of every practice. This timeline will provide an opportunity to test and refine the best way to do this, and to allow for new pharmacists and pharmacy technicians to be recruited and trained.

In order to increase the pool of qualified pharmacists to provide the pharmacotherapy service, additional funding has been secured to increase the number of pharmacist training posts from 170 to 200 per year from 2018/19. This will ensure that there is sufficient capacity to deliver the pharmacotherapy service within the proposed timescales.

By April 2021, every practice will benefit from the pharmacotherapy service delivering the core elements as described below. Some areas will also benefit from a service which delivers some or all of the additional elements described below. The level of additional services available in different areas will be dependent on workforce availability which will build throughout the three years leading up to 2021 and beyond.

Figure 2: Core and additional pharmacotherapy services

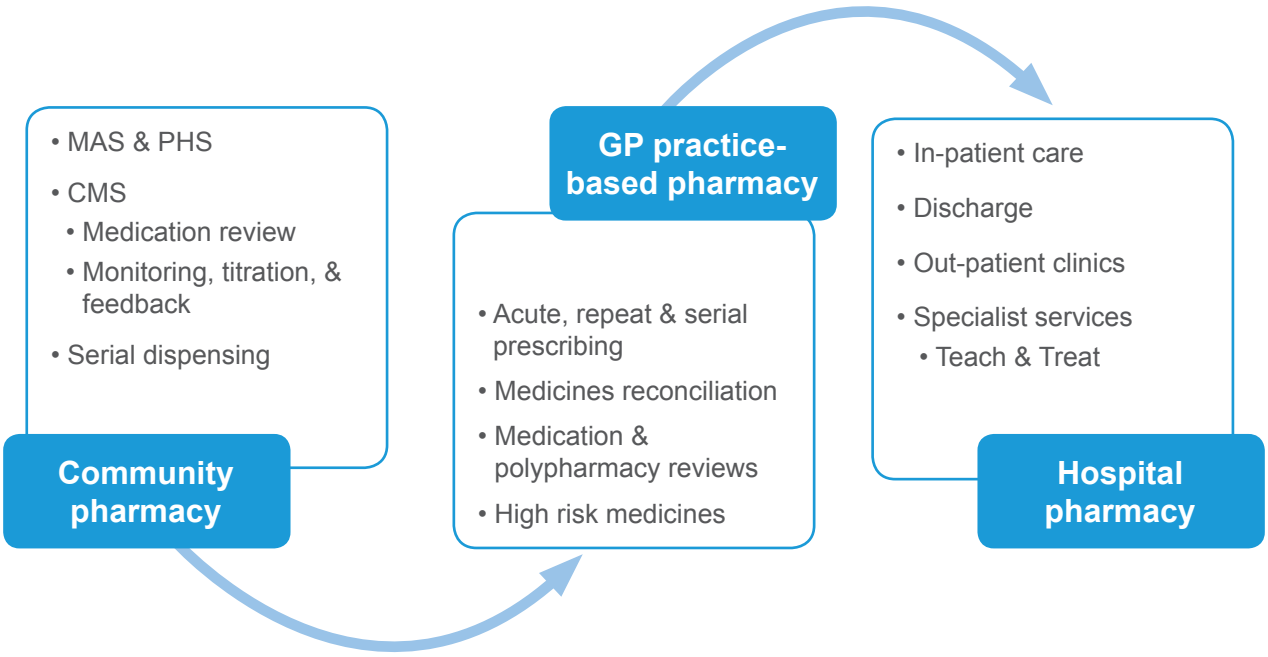
CORE AND ADDITIONAL PHARMACOTHERAPY SERVICES		
	Pharmacists	**Pharmacy Technicians**
Level one (core)	• Authorising/actioning[15] all acute prescribing requests • Authorising/actioning all repeat prescribing requests • Authorising/actioning hospital Immediate Discharge Letters • Medicines reconciliation • Medicine safety reviews/recalls • Monitoring high risk medicines • Non-clinical medication review Acute and repeat prescribing requests includes/ authorising/actioning: • hospital outpatient requests • non-medicine prescriptions • installment requests • serial prescriptions • Pharmaceutical queries • Medicine shortages • Review of use of 'specials' and 'off-licence' requests	• Monitoring clinics • Medication compliance reviews (patient's own home) • Medication management advice and reviews (care homes) • Formulary adherence • Prescribing indicators and audits
Level two (additional - advanced)	• Medication review (more than 5 medicines) • Resolving high risk medicine problems	• Non-clinical medication review • Medicines shortages • Pharmaceutical queries
Level three (additional - specialist)	• Polypharmacy reviews: pharmacy contribution to complex care • Specialist clinics (e.g. chronic pain, heart failure)	• Medicines reconciliation • Telephone triage

15 Pharmacist Independent Prescribers can action (instigate and sign) prescriptions, non-prescriber pharmacists can action prescriptions but they still require to be signed by a prescriber.

As outlined in the MOU, the pharmacotherapy service will evolve over the three year transition, with pharmacists and pharmacy technicians becoming embedded members of the core practice clinical teams. While not employed directly by practices, the day-to-day work of pharmacists and pharmacy technicians will be co-ordinated by practices. Pharmacists and pharmacy technicians will take on responsibility for:

a) Core elements of the service, including: acute and repeat prescribing, medicines reconciliation, monitoring high risk medicines
b) Additional elements of the service, including: medication and polypharmacy reviews and specialist clinics (e.g. chronic pain)

Figure 3: Integrated pharmacotherapy service



COMMUNITY TREATMENT AND CARE SERVICES

Community treatment and care services include many non-GP services that patients may need, including (but not limited to):

- management of minor injuries and dressings
- phlebotomy
- ear syringing
- suture removal
- chronic disease monitoring and related data collection.

There will be a three year transition period to allow the responsibility for providing these services to pass from GP practices to HSCPs. By April 2021, these services will be commissioned by HSCPs, and delivered in collaboration with NHS Boards that will employ and manage appropriate nursing and healthcare assistant staff. Phlebotomy will be delivered as a priority in the first stage of the Primary Care Improvement Plans.

Local circumstances and demand will determine where it is most appropriate to safely situate these services. It is expected that many of these functions will be provided in the GP practice premises for patient convenience and the benefits of having these services carried out with the close support of the wider practice team. This would also enable easier sharing of necessary data and the patient records.

In some areas, (for reasons of premises, practicality or geography) the NHS Board may operate these services from separate facilities. The principles agreed by the parties to the MOU will ensure that patient safety, person-centred care and sustainability remain at the heart of these services as they develop, wherever they are delivered.

Patients should be able to conveniently and confidently access community treatment and care services. In some circumstances it may be appropriate for certain GP practices, such as small remote and rural GP practices, to locally agree to deliver these services. If GP practices locally agree to deliver community treatment and care services, then support will be provided in the form of either expenses for the required practice employed staff capacity, or the deployment of NHS Board employed staff.

It is expected that community treatment and care services will be available for use by primary and secondary care. For example, pre-hospital clinic bloods could be carried out for a requesting consultant without having to involve the GP practice staff. The consultant's name would be on the test result to avoid unnecessary GP involvement.

It will be clear in the agreement represented by the MOU that local arrangements will determine how services will be provided. This will help to remove the responsibility for service provision away from GPs to the HSCPs, allowing GPs to focus upon their expert medical generalist role. NHS Boards and HSCPs will work with practices to plan and manage service transfers in a way that ensures patient safety and maximises benefits to patient care.

Delivery of the Vaccination Transformation Programme, pharmacotherapy service and community treatment and care service are priorities, and responsibility for these services will be transferred to HSCP by the end of the transition period in April 2021. Within that timeframe, delivery at a local level will vary based on local factors such as the extent to which comparable services are already in place, upon local geography, and prioritisation based on local demographics and demand.

URGENT CARE SERVICES

In addition to these priorities, the MOU will support the redesign of other services to reduce GP workload and free up GPs capacity to focus on their expert medical generalist role. These redesigned services will focus on urgent and unscheduled care, and developing the roles of other clinical and non-clinical professions, working in the practice, to support physical and mental health.

The Scottish Government and SGPC have agreed that another area of GP workload that needs to be addressed is urgent unscheduled care including the provision of advanced practitioner resource as first response for home visits.

A number of tests of change in Scotland over the last two years have focused on the role of Scottish Ambulance Service (SAS) paramedics in primary care. Evidence from pilots in Inverclyde, Hawick and Kelso shows that support (such as responding to urgent call out to patients) allows GPs to provide more appropriate patient care. Relevant support includes advanced practitioner resource, such as a nurse or a paramedic, for GP clusters and GP practices, serving as first response for home visits.

The MOU will support the implementation of sustainable advance practitioner provision in all HSCP areas, based on local service design. These practitioners will assess and treat urgent or unscheduled care presentations. This will allow GPs to focus on scheduled appointments with patients most in need of their skills as expert medical generalists. Where service models are sufficiently developed, advanced practitioners will also directly support GPs expert medical generalist work by carrying out routine assessments and monitoring of chronic conditions for vulnerable patients at home, or living in care homes.

It is expected that the workload for paramedics would mean that most GP practices would not have sole access to a paramedic. It is likely that paramedics would work across a number of GP practices to meet patient needs. GP clusters will play an important role in enabling this service to ensure effective working and good patient outcomes.

Paramedics and specialist paramedics can practice in all aspects of urgent, unscheduled, and emergency presentations as needed, underpinned by GP review and consultation with the GP and wider multi-disciplinary team where required. A specialist paramedic in urgent and emergency care is a paramedic who has undertaken, or is working towards a post-graduate certificate in Specialist Paramedic Practice. They will have acquired, and continue to demonstrate an enhanced knowledge base, complex decision making skills, and competent judgement in urgent and emergency care. Paramedics (as non-specialists) can also provide care and support to patients in primary care, both in and out of hours as part of a wider primary health and care team.

Case Study - Paramedic Support in Inverclyde

Part of the Inverclyde tests of change included SAS supported transformational change in GP clusters. Regent GP practice in Greenock piloted paramedic support in general practice using a Trainee Specialist and a Paramedic; and Gourock Health Centre retained a Specialist and a Paramedic.

Baseline data was collected for the month of June 2017. In that month, GPs carried out 102 home visits from Regent practice and 106 from Gourock. The average time taken for visits was 34 minutes. This includes travel time and updating patient records. In the first three months following paramedic support to practices being put in place, the percentages of home visits carried out by GPs reduced by over 60%. In addition to home visits, paramedics are also able to assess urgent presentations within the surgery. Referral rates to secondary care are very similar between GPs and paramedics. The most common conditions seen are acute respiratory illness, abdominal and back pain, UTIs and falls. Feedback from staff and patients so far has been positive. The GPs report they are happy with how the model is working and relationships between the professional groups continue to develop.

ADDITIONAL PROFESSIONAL SERVICES

Additional professional roles will provide services for groups of patients with specific needs that can be delivered by clinicians other than GPs, serving as first point of contact in the practice setting as part of the wider multi-disciplinary team. These include (but are not limited to) physiotherapy services, community mental health services and community links worker services.

Physiotherapy services focused on musculoskeletal conditions

Musculoskeletal problems frequently cause repeat appointments and are a significant cause of sickness absence in Scotland. The majority of a GP's musculoskeletal caseload can be seen safely and effectively by a physiotherapist without a GP referral. However the existing patient pathway often includes an unnecessary delay while initial non-physiotherapeutic solutions are attempted prior to access to a musculoskeletal physiotherapy service. There are variable waiting times across the country for access to face-to-face physiotherapy.

Physiotherapists are already well situated to work collaboratively with primary care multi-disciplinary teams and support the GP role as a senior clinical leader. Physiotherapists are an expert professional group. They have a high safety record and are trained to spot serious pathologies and act on them. Physiotherapists utilise their wider knowledge and skills as part of their assessment. A first point of contact service could also be seen in the context of the wider muscoloskeletal pathway.

Under the new contract, HSCPs will develop models to embed a musculoskeletal service within practice teams to support practice workload. In order to provide a realistic alternative for patients, access times must be comparable to those of general practice. Priority for the service, such as focusing on elderly care, will be determined by local needs as part of the Primary Care Improvement Plan.

Case Study - Physiotherapy services in Inverclyde

Inverclyde piloted the use of an Advanced Practice Physiotherapist (APP) as an alternative first point of patient contact within the GP practice. Since August 2016, an APP has worked in three GP practices with a total patient list of 14,000. Reception staff at each practice were trained to offer patients APP appointments where appropriate. To date the APP has provided over 1000 consultations, most of which would otherwise have been GP appointments. 94% of patients were seen once and did not need a further appointment with the physiotherapist.

GPs at one participating practice, Lochview practice in Greenock, noted a number of benefits. By seeing the majority of patients with musculoskeletal conditions the APP has freed up GP appointments. GPs are able to use their time more effectively by focusing on patients more in need of their expertise, and are spending more of their patient facing time on complex care needs. In qualitative evaluation, the pilot was rated highly by GPs, practice staff and patients, with patient feedback in particular being extremely positive.

'Of all the work that's ever been done in GP practices, this has been the one that feels like it has truly taken work away. Patients are safer - there is quicker access to the most appropriate intervention because triage assessment conducted by the physiotherapist gets people to the right place sooner'.
(GP, Greenock)

Community mental health services

Community clinical mental health professionals (eg nurses, occupational therapists), based in general practice, will work with individuals and families assessing their mental health needs, providing support for conditions such as low mood, anxiety and depression. The outcome sought is improved patient care through rapidly accessible, appropriate and timely mental health input.

Community Links Worker Services

A Community Links Worker (CLW) is a non-clinical practitioner based in or aligned to a GP practice or cluster who works directly with patients to help them navigate and engage with wider services. They often serve a socio-economically deprived community or assist patients who need support because of for example, the complexity of their conditions. As part of the Primary Care Improvement Plan, HSCPs will develop CLW roles in line with the Scottish Goverment's manifesto commitment to deliver 250 CLWs over the life of the Parliament. The roles of the CLWs will be consistent with assessed local need and priorities and function as part of the local models of care and support.

Rural support

The rural and remote GP shares much of the same generalist workload as their colleagues in urban areas. In many areas, being a rural GP means being the expert medical generalist providing the broadest range of skills because of their remoteness, because they usually have smaller primary care teams and because the locality services that may be available in areas with larger populations may not be available.

Many remote and rural GPs have chosen to work where they do in part because it fits with their desire to provide a more complete primary care service to their patients and see delivery of some services as welcome opportunities to engage with their patients. In some rural areas where there are larger list sizes, there will be the opportunity to move the responsibility for some services like immunisations to reduce workload pressures.

The service redesign described above requires practices to be involved via their GP clusters, so they have a say in how services will work locally.

Workforce

The introduction of the services described above relies on the establishment of a new workforce which will be part of practice teams but not employed by practices. These practice-attached staff will be largely employed by NHS Boards, embedded in practice teams with their day-to-day work co-ordinated by the practice.

Patient safety will be fundamental in delivering this workforce at scale. Taking the paramedic support service as an example, at all stages of the roll-out, we will ensure the capacity and capability of the workforce is sufficient. This means that the safety of patients requiring urgent unscheduled care is assured and core Scottish Ambulance Service performance is protected. This will require consistent and reliable provision of paramedic staff working in primary care teams, with appropriate training and education, supervision and support arrangements. Positive relationships between colleagues in the primary care multi-disciplinary teams will be crucial. This approach to attached staffing will be taken in the development and roll-out of all services – the principles for which are outlined in the MOU.

Further detail on delivering this new workforce will be set out in the Scottish Government *National Health and Social Care Workforce Plan: Part 3 Primary Care.*

As this chapter sets out, an expanded primary care multi-disciplinary team will bring substantial workload benefits to GPs and deliver better services and outcomes to patients. As well as improvements to workforce we will introduce measures to reduce risk and improve infrastructure in general practice. These are explained in chapter five.

5 IMPROVING INFRASTRUCTURE AND REDUCING RISK

Key Points

- The risks associated with certain aspects of independent contracting will be significantly reduced.
- GP Owned Premises: new interest-free sustainability loans will be made available, supported by additional £30 million investment over the next three years.
- GP Leased Premises: there will be a planned transition to NHS Boards leasing premises from private landlords
- New information sharing agreement, reducing risk to GP contractors.

INTRODUCTION

As independent contractors, many GP practices carry the responsibility for providing staff and infrastructure to support GPs and services to patients. With this responsibility can come risk which can include the risk of changes in funding. As outlined in chapter three, one of the overarching aims of reforming practice funding is to increase practice stability and reduce risk. As outlined in chapter four, proposals for the NHS Boards to largely employ the expanding primary care multi-disciplinary team are specifically intended to avoid increasing the clinical and administrative risks of being an employer.

This chapter describes new measures to improve infrastructure and reduce risk in areas such as ownership of premises, IT and information sharing.

PREMISES

Practice premises are increasingly perceived as an unwanted liability by potential GP partners; and this has become a barrier to recruitment, retention and retirement.

The Scottish Government and SGPC recognise and support a long-term shift that gradually moves towards a model which does not presume GPs own their practice premises.

To this end the Scottish Government and the SGPC have agreed a National Code of Practice for GP Premises ("the Code") which sets out how the Scottish Government will support a shift, over 25 years, to a new model in which GPs will no longer be expected to provide their own premises. The contract offer proposes that from 1 April 2018, the Code will be introduced and revised Premises Directions will take effect. The Code sets out how the Scottish Government will achieve a significant transfer away from GPs of the risks of providing premises.

To enable this transfer of risk, the Scottish Government will make available assistance of up to £30 million by 2021 (£10 million per year from 2018) to GPs with premises related liabilities. This will be through the establishment of a GP Premises Sustainability Fund. This represents a 24% increase in funding for supporting GPs with premises (compared to 2015/16, the latest available figures).

GP Owned Premises

The Code sets out the measures the Scottish Government will provide to assist GPs who own their premises. These measures include interest-free secured loans, known as GP Sustainability Loans, to be resourced through the new GP Premises Sustainability Fund.

These GP Sustainability Loans will be made available to every GP contractor who owns their premises by 31 March 2023. The loans will help stabilise general practice as a whole. They will allow partners to release capital without destabilising their practice, reduce the up-front cost of becoming a GP partner, and make general practice more financially rewarding. The loans will encourage GPs to become partners in practices which own their premises.

GP Sustainability Loans

All GP contractors who own their premises will be eligible for an interest-free loan, including those in negative equity.

The loans will be for an amount of up to 20% of the Existing-Use Value of the premises and they will be secured against the premises.

Loans will be funded from the GP Premises Sustainability Fund.

NHS Boards will have the power to top-up the amount of the loans where they decide that there are exceptional circumstances.

The loans will be repayable if the premises are sold or are no longer used by the GP contractor for the provision of general medical services under a contract with an NHS Board.

The loan will have no effect on Notional Rent or borrowing cost payments. There will be no abatements due to a loan.

A system for prioritising applications will be put in place to ensure that assistance is given first to those who need it most. However, all GP contractors who own their premises will be eligible to receive a GP Sustainability Loan by 31 March 2023.

The Scottish Government envisages that once the first cycle of GP Sustainability Loans is complete (2023) a further five year cycle will begin to further reduce the risk to GP practices which own their premises. The Scottish Government intends that these five year cycles of investment will continue until the transition to the new model where GPs no longer own their premises is complete (by 2043).

More information on GP Sustainability Loans can be found in the National Code of Practice for GP Premises.

GP Leased Premises

The Scottish Government's long term strategy is that no GP contractor will need to enter a lease with a private landlord for GP practice premises. NHS Boards will gradually take on the responsibility from GP contractors for negotiating and entering into leases with private landlords and the subsequent obligations for maintaining the premises. NHS Boards will ensure that GP contractors are provided with fit-for-purpose accommodation which complies with the standards set by the Premises Directions.

GP contractors who wish to continue to provide their own accommodation will be free to do so. They will continue to be eligible to receive rent re-imbursements under premises directions.

NHS Boards will support GP contractors who currently lease premises from private landlords. The Code sets out what GP contractors who lease their premises need to do to ensure that their NHS Board takes over the responsibility of providing their premises.

There are three ways in which NHS Boards can take on the responsibility of providing a GP contractor with practice premises. These are:

- negotiating a new lease for the GP contractor's current premises, with the NHS Board as the tenant
- accepting assignation of the GP contractor's current lease
- providing alternative accommodation for the GP contractor when its current lease expires

If a lease expires before 1 April 2023, the most likely course of action is for the NHS Board to negotiate a new lease or provide alternative accommodation.

If the lease expires after 1 April 2023, NHS Boards will take on the existing lease from GPs where:

- The practice has ensured that its premises are suitable for the delivery of primary care services and are sufficient to meet the reasonable needs of its patients
- The practice has met its statutory obligations regarding the premises
- The practice has provided all relevant information to its NHS Board
- The practice has given sufficient notice to its NHS Board of its need for assistance
- The practice has registered the lease with the NHS Board
- The practice has the agreement of the landlord to the assignation of the lease (and the other necessary conditions)
- The practice has complied with its obligations under its existing lease
- The rent represents value for money

Premises Survey

All premises used to provide GMS will be surveyed in 2018/19. This will provide the data which NHS Boards will require for their premises plans. Contractors will be contacted by the surveyor appointed by the Scottish Government to arrange a survey of their premises at a convenient time. This is essential if NHS Boards are to effectively support practices with premises issues in the future.

Risk of being an employer

Under the new contract GPs will be not be exposed to increased risks from being an employer as the joint intention of the negotiating parties is for the increased primary care team to be employed by NHS Boards and deployed in practices – details are outlined in chapter four.

Under Phase 2 of the funding changes it is proposed that practice expenses will be directly re-imbursed. This will include staff costs and those associated with staff sickness, maternity, paternity and adoption leave, including staff cover for long-term sickness and maternity leave.

GP CLINICAL IT SYSTEMS

NHS Boards have commissioned a procurement competition to provide the next generation of GP clinical IT systems for GPs in Scotland. This is being undertaken by NHS National Services Scotland.

The new systems will be more intuitive and user friendly. They will be quicker and more efficient, with increased functionality. They will be underpinned by strong service levels and performance management, with clear lines of responsibility and accountability, providing, overall, a more professional GP IT Service.

All GP practices will transition to the new systems by 2020. GPs will continue to have the right to choose a clinical IT system from those which have been approved by the Scottish Government.

The following groups will provide governance for Primary and Community Care eHealth:

Primary and community care e-health governance

GP IT Committee
Under the new contract, NHS Boards will remain responsible for providing integrated Information Management and Technology (IM&T) systems and telecommunications links within the NHS. However the Scottish Government will set national standards which will be developed with the assistance of a new GP IT Committee. The SGPC and RCGP will form this committee along with GPs and managers expert in information technology. These standards will be agreed between the Scottish Government and the SGPC.

The eHealth Strategic Assurance Board
The eHealth Strategic Assurance Board will provide strategic direction to the development of digital technology in NHSScotland and act as the senior governance group for the escalation of issues.

The Community Care Portfolio Management Group
The Community Care Portfolio Management Group will provide direction to the development of digital technology within the community and primary care sectors in line with the overall strategy set by the eHealth Strategic Assurance Board. It will also deal first with issues escalated to it by the governance boards of individual projects. It will escalate issues to the eHealth Strategic Assurance Board where appropriate.

Primary Care Contracts and Service Management Board
The Primary Care Contracts and Service Management Board will review the performance, financial status, and key issues and risks of the GP clinical IT system. This group will play the same role for the Community IT clinical system which is in an early stage of procurement.

INFORMATION SHARING

The proposed contract will set out the roles and responsibilities of GP contractors and NHS Boards in relation to information held in GP patient records. The contract will support adherence to the Data Protection Act 1998 and help prepare GP contractors and NHS Boards for the new General Data Protection Regulations (due to come into force in May 2018).

The new contractual provisions will reduce the risk to GP contractors of being data controllers. The contract will recognise that contractors are not the sole data controllers of the GP patient record but are joint data controllers along with their contracting NHS Board. The contract will clarify the limits of GP contractors' responsibilities. GP contractors will not be exposed to liabilities beyond their effective control.

The work of identifying the roles and responsibilities of GP contractors and NHS Boards has been carried out with the assistance of the Information Commissioner's Office in Scotland, and in collaboration with stakeholders who have provided expert guidance as well as practical experience of managing patient data. This includes the Caldicott Guardians Forum, SGPC, RCGP, Central Legal Office, NHS National Service Scotland, and relevant teams within the Scottish Government including the E-health Division and the Chief Medical Officer. The proposed new provisions are also consistent with the General Medical Council (GMC) Confidentiality guidance.[16]

16 http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

6 BETTER CARE FOR PATIENTS

Key Points

- **The principles of contact, comprehensiveness, continuity and co-ordination of care for patients underpin the proposals.**
- **GP time will be freed up for longer consultations where needed – improving access for patients.**
- **There will be a wider range of professionals available in practices and the community for patient care.**

INTRODUCTION

The joint Scottish Government/SGPC Memorandum published in November 2016, described the aim of the negotiations to develop a contract that helps to reinvigorate the core principles of general practice in primary care, and frees up more time for the role of the GP as expert medical generalist. The four C's of primary care, discussed in chapter one, are: contact, comprehensiveness, continuity, co-ordination.

GPs recognise these attributes as the qualities patients value most in general practice; they are the key strengths of general practice and the guiding values underpinning the negotiations.

This is why the focus of the transition over the next three years is to move away from the over-specification of services as described in chapter two – to progressively, though not entirely, move away from Additional and Enhanced Services – and to focus on the core role of the GP as expert medical generalist.

In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care, based on an understanding of patient's needs, life circumstances and experiences, it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. It is equally important that other health care professionals are part of the redesign process. We will therefore ensure that engagement with patients, and professionals delivering primary care, is a key part of the development and delivery of any service redesign.

This chapter is structured around the four Cs. The first section addresses how we will maintain and improve accessible contact.

The second section addresses comprehensiveness of care in the context of the multi-disciplinary team. The third and fourth sections address how patients will have continuity of care and how that care will be co-ordinated.

CONTACT – MAINTAINING AND IMPROVING ACCESS

Improving patient access to primary care and general practice is multi-faceted. Access in general practice is influenced by a range of issues: the location of the practice; when it is open; how easy it is to make appointments; and the speed of access to appropriate care.

Speed is not the only aspect of access that matters to people. Convenience – how easily people can make appointments; who those appointments are with; and when those appointments are – also matters. Being able to see a practitioner of choice also matters to some groups. The importance of these different aspects of access – ease of making appointment; time to appointment; time of appointment and choice – varies among different groups.

We have agreed that practice core hours will be maintained at 8am to 6.30pm (or as previously agreed through local negotiation), and that practices will continue to be required to provide routine services to patients during this period as appropriate to meet the reasonable needs of their patients.

More accessible information on surgery times within these practice core hours will be available to help patients easily identify when they can see a GP and/or other healthcare professionals.

The Extended Hours Directed Enhanced Service will be maintained. It will be clearer to patients when their local GP practice offers care in Extended Hours and when appointments with GPs and other practice staff are available within the Extended Hours period. Services provided by healthcare assistants may also be available during Extended Hours periods.

There will be improved convenience for patients in how they can access their local practice. Under the proposed new contract, GP practices will be required to provide online services to patients such as appointment booking and repeat prescription ordering, where the practice already has the existing computer systems and software required to implement online services safely.

COMPREHENSIVENESS – A WIDER RANGE OF HEALTH PROFESSIONALS WITHIN THE EXPERT MEDICAL GENERALIST CONTEXT

Ensuring patients have sufficient time with their GP when it is needed means recognising that not all patient needs at all times require the expertise of a doctor. The agreement on service redesign reflected in the Memorandum of Understanding will underpin the contract and allow GPs to have more time to deliver the type of care that only their skills and training can provide. At the same time, comprehensive patient care will be maintained within an expanded primary and community care team, with GPs having a more prominent clinical leadership role.

The discontinuation in Scotland of the single disease-focused approach to quality represented by the Quality and Outcomes Framework, has been a major step in creating a renewed focus on whole person and whole community health. This renewed commitment to a more holistic approach to quality and outcomes is being supported by the development of peer-led GP quality clusters. Clusters, in addition to improving quality and patient outcomes across GP practices, will have a leading role in advising on quality, patient experiences, and patient outcomes across the wider primary, community and social care landscape.

Significant new investment in expanded teams of clinical and non-clinical professionals working in practices and localities will widen patient choice and ensure that GPs are able to focus on their expert medical generalist role. As set out in chapter four, additional professionals will include pharmacy; nursing; allied health professionals (physiotherapy, and paramedics and other urgent care practitioners); and non clinical support workers (e.g. links workers).

Seeing the right person at the right place at the right time will sometimes mean not seeing a GP first, if this is appropriate. This might represent a significant change over time, both to how work is carried out and patients' experience. Emerging evidence from the testing of new models of care in Inverclyde indicates patients can adapt quickly and respond positively to improvements brought by this model. For example, high levels of patient satisfaction have been recorded among those people who have accessed new first point of contact acute musculoskeletal physiotherapy care in a group of practices in Inverclyde.

Realistic Medicine, Person Centred Care and Expert Medical Generalists

Scotland's Chief Medical Officer (CMO), Catherine Calderwood, published her first annual report *Realistic Medicine*[17] in 2016. The report explores whether improved healthcare can be achieved by combining the expertise of patients and professionals in a more equal relationship; through building a personalised approach to care; increasing shared decision making; reducing unnecessary variation in practice and outcomes; reducing harm and waste; managing risk better; and improving innovation. The CMO's second annual report, *Realising Realistic Medicine*[18], continued the debate - with widespread support and contributions from national and international clinicians, leaders in medicine and public health and stakeholders representing the public and patient voice.

The values of Realistic Medicine are wholly aligned with the values of general practice supported decision making; holistic care that focuses on the person - mind and body - not the disease; care that skilfully manages clinical risk with every encounter - these attributes of realistic medicine are already the hallmarks of general practice. Moreover general practice has a strong history of innovation, learning and collaboration and GP clusters offer an opportunity to revitalise and strengthen these traits over time.

Refocusing the GP role as expert medical generalist enables GPs to further pioneer the practice of realistic medicine among their medical colleagues. General practice provides just the right amount of medicine for the best possible outcome to individuals and populations. The principle of shared decision making extends to genuine discussion and engagement with the public about how care is best delivered. All four parties to the MOU are committed to public engagement in the development of Primary Care Improvement Plans.

17 http://www.gov.scot/Resource/0049/00492520.pdf
18 http://www.gov.scot/Publications/2017/02/3336

CONTINUITY - TIME WITH A GP WHEN IT IS REALLY NEEDED

Continuity of care – the development of lifelong therapeutic relationships between doctor and patient – is a distinctive hallmark of general practice. The aim of the workload reduction measures described in chapter four is to free up GP capacity for those times when only the expertise of a doctor is sufficient. Scottish Government and SGPC agree it is not appropriate to contractually define consultation lengths, as that will continue to be a matter for clinical judgement. Freeing up capacity, through the redesign of services over the next three years, will allow for longer GP consultations when required by patients, particularly for complex care.

We agree that the independent contractor model of general practice is a benefit to continuity of care as it encourages a strong and enduring commitment from GPs to their community of patients.

The new proposed contract reduces current risks to practice stability and sustainability, for example, by addressing some of the key risk factors relating to rising workload, premises ownership and employment of staff. This in turn will make the partnership model more attractive to newer generations of GPs.

CO-ORDINATION - INCLUDING MORE INFORMATION AND BETTER HELP TO NAVIGATE THE SYSTEM

The 2004 GMS contract requires each practice to make a practice leaflet available to patients. This requirement will remain and the practice leaflet will continue to include important information for patients about the practice and how they can access available healthcare services in their local surgery. This includes: the name of the contractor; partners and all healthcare professionals who deliver services; how to register with the practice; the practice area; and the opening time of the practice premises; as well as how to access services in core hours of 8am to 6.30pm.

The Scottish Government and SGPC have agreed to modernise access to, and provide a consistent platform for, the supply of this key information for patients. This will involve better use of NHS 24 - the national agency for health advice and information in Scotland.

NHS24 will develop a national standardised website for each practice in Scotland that will contain all the key information required in the practice information leaflet. It will also consistently signpost practice patients to reliable self-care information and to wider health and care services in the community. This website will be made available at no cost to individual GP practices. Once available, practices will be able to choose whether to use this service or another service, but all practices will be required to make practice information available to patients digitally.

In summary, ensuring continuity, comprehensiveness, accessible contact and co-ordination for patients lies at the heart of the proposed new contract. As well as treating the individual, the proposed new contract offers a better contribution by general practice to local population health and ensuring the needs of the community are met.

The next chapter will cover the wider role of GPs and GP Clusters in population health, planning of local services, quality planning, quality improvement and quality assurance, and supporting information for quality and sustainability at local, regional and national levels.

7 BETTER HEALTH IN COMMUNITIES

Key Points

- GPs will be more involved in influencing the wider system to improve local population health in their communities.
- GP clusters will have a clear role in quality planning, quality improvement and quality assurance.
- Information on practice workforce and activity will be collected to improve quality and sustainability.

INTRODUCTION

GPs, working with colleagues across health and social care, continue to be at the forefront of a wide range of improvements in the safety, effectiveness and quality of care and treatment.

For over 10 years, the Quality and Outcomes Framework (QOF) largely defined the approach to quality in general practice. It was introduced in the 2004 GMS contract with the intention of providing improved, or consistently high, quality of care, whilst offering GP practices an opportunity to increase funding via an incentivised payment scheme.

Whilst the quality of care delivered in general practice has undoubtedly improved since the beginning of the century, the extent to which QOF contributed to this improvement is contested. There is some evidence to suggest that in the early years it accelerated the pre-existing trajectory of improvement in managing those chronic diseases that were included, and achieved greater equality in the standard of care across practices. However over time, and for a variety of reasons, this effect became diluted and perhaps had the unintended consequence of crowding out other chronic conditions not included.

A systematic review published in The British Journal of General Practice[19] concluded that any replacement for QOF needs to consider the evidence of effectiveness of pay-for-performance in primary care, and the evidence of what motivates primary care professionals to provide high-quality care.

19 http://bjgp.org/content/early/2017/09/25/bjgp17X693077

IMPROVING TOGETHER

Improving Together[20] a new quality framework for GP clusters in Scotland offers an alternative route to continuously improve the quality of care that patients receive by facilitating strong, collaborative relationships across GP clusters and localities. At the heart is learning, developing and improving together for the benefit of local communities.

As described in chapter two, GP clusters are professional groupings of general practices that meet regularly, with each practice represented by their Practice Quality Leads (PQL). Each GP cluster has a Cluster Quality Lead (CQL) who performs a co-ordinating role and liaises with locality and professional structures. This requires supporting measures such as the existing contractual provision for protected time. It also requires: infrastructure to support leadership; data provision and analysis; and facilitation and improvement activity within local governance structures. Clusters may be of different sizes, influenced by local circumstances and geography, but as a principle, they should be viable for small group work.

Improving Together describes the agreed 'intrinsic' and 'extrinsic' functions of GP clusters in Scotland. The intrinsic function refers to the role of GP clusters in improving the quality of care in their cluster through peer-led review. The extrinsic function refers to the critical role GP clusters have in improving the quality of care in general practice and influencing HSCPs regarding both how services work and the quality of services. The dimensions of these intrinsic and extrinsic functions are set out in the table below.

Figure 4 - Intrinsic and extrinsic functions of clusters

INTRINSIC	EXTRINSIC
Learning network, local solutions, peer support	Collaboration and practice systems working with Community MDT and third sector partners
Consider clinical priorities for collective population	Participate in and influence priorities and strategic plans of Integration Authorities
Transparent use of data, techniques and tools to drive quality improvement - will, ideas, execution	Provide critical opinion to aid transparency and oversight of managed services
Improve wellbeing, health and reduce health inequalities	Ensure relentless focus on improving clinical outcomes and addressing health inequalities

20 http://www.gov.scot/Publications/2017/01/7911/10

As clinical leaders in the primary healthcare team, GPs will actively contribute to the clinical governance and oversight of service design and delivery across health and social care as part of the extrinsic GP cluster role.

CQLs will work in close collaboration with the already established medical advisory structure including: Medical Directors (Primary Care) (usually AMDs); Clinical Directors; Locality Strategic Planning Groups; and GP Sub Committees in NHS Boards.

The GP Subcommittee of the Area Medical Committee should be responsible and funded for local arrangements to ensure effective collaboration between the GP Subcommittee, NHS Board medical directors, and CQLs. The GP Subcommittee will be responsible for co-ordinating the agenda for this tri-partite collaboration and facilitating combined professional advice to the commissioning and planning processes of the HSCPs and NHS Boards.

GP Subcommittees need to be adequately funded to carry out these roles (as well as day-to-day advice to the Board and its representative committees). NHS Boards and HSCPs should be able to demonstrate to the Scottish Government that they are appropriately supporting these activities. It is recognised that, in many areas, the GP profession chooses to have the same members in the GP Subcommittee as from the LMC. Local discussion should enable the funding of the GP Subcommittee to be clearly seen as funding those activities separate to the LMC activities.

GP CLUSTER WORKING AND LOCAL POPULATION HEALTH

GP practices participate in cluster working through their PQL. The PQL engages with the CQL, the rest of the GP cluster and attends GP cluster meetings. The practice will provide agreed local and national data extractions to enable intelligence led quality planning, quality improvement and quality assurance.

Cluster working will contribute to the development of local population health needs assessments undertaken by public health and local information analysts. They will also provide professional clinical leadership on how those needs are best addressed.

The NHS National Services Scotland Local Intelligence Support Team (LIST) service has been supporting GP cluster working in Scotland since April 2017. This analytical support to clusters will continue and expand under the new contract.

Case Study - List analytical support for clusters

LIST analysts have already been working with clusters and practices across Scotland to help analyse data and introduce improved ways of working. These have included:

- safely reducing the number of home visits through the use of telephone triage
- analysis of appointment demand to inform staff scheduling
- analysis of data to create a health needs assessment for homeless patients
- gathering evidence to assist plans for GP services in relation to new housing development
- using data to help identify High Health Gain patients, to facilitate anticipatory care planning and additional preventative support measures

These initiatives help to both reduce GP workload and improve patient care.

"The main thing we want to take forward is a more in depth analysis of our frequent attenders, looking at who they are seeing, when, why and how often, and looking at interventions which may help them to better self-manage and use the service as appropriately as possible. We are hopeful that this could free up some capacity in the system and improve the right person right time goal". GP Inverclyde

"LIST have analysed our appointments data - we have now made some changes which has improved capacity and helped us to prioritise the patients. The DNA rate has also significantly reduced". Practice Manager - Lothian

There is enormous potential for improving local population health, including mental health, through GP clusters, better data on population health needs and better intelligence and facilitation through LIST analysts. The aim is for GPs to have a bigger impact on public health as an expert medical generalist than they do as service providers for services that can be safely delivered by other health professionals.

NHS Boards, as the lead agency for protecting health, will continue to be responsible for planning and responding to public health incidents. Operational management locally will remain the responsibility of NHS Boards, drawing on the expertise and support of a range of local partners, including GPs and NHS Board staff. NHS Board staff will support with screening, prescribing, prophylaxis and nursing as appropriate.

QUALITY PLANNING

Quality Planning is a structured process for designing and organising services to meet new goals and patient needs. This includes setting aims, identifying practice populations, identifying patient and carers' needs, developing plans to meet that need, and developing measures to ensure that the aim is met.

Agreement will be needed on the balance between local and national priorities for GP clusters to focus their quality improvement activity each year. GP clusters themselves will be critical in identifying priorities locally with the inclusion of regional/national priorities as required. The former will primarily lead the improvement agenda with the latter playing in on an as required basis only.

Thus GP clusters must decide the majority of their own clinical priorities in their own locale using both information gathered by analytical support and their own deep knowledge and understanding of the communities they serve.

GP clusters working and quality planning

GP practices will participate in cluster working and through cluster working will contribute to the development of cluster quality improvement plans.

Cluster quality improvement planning will be supported by training in quality improvement if required.

2018/19 – quality improvement planning and activity for many clusters will be based on existing Transitional Quality Arrangements (TQA)[21] information. This activity will be better enabled, as more analytic and public health support goes on line. Clusters will initially review comparative data between cluster practices on areas such as disease registers, referral, prescribing, access and use of unscheduled care to identify variation, peer-based learning, and areas for improvement supported by external resources. Maintaining comprehensive disease registers will remain critical to underpin activity in quality planning, quality improvement and quality assurance.

QUALITY IMPROVEMENT

Quality Improvement is a continuous process. On an individual level doctors have a professional responsibility to maintain their skills and knowledge and contribute and comply with systems to protect patients.[22] GPs will continue to be registered with the GMC, undergo annual appraisal, learn from Significant Adverse Events, contribute to confidential enquires and comply with NHS Complaints procedures and Duty of Candour legislation.

---

21 http://www.isdscotland.org/Health-Topics/General-Practice/Primary-Care-Information-and-TQA/

22 http://www.gmc-uk.org/guidance/good_medical_practice.asp

GP practices will engage in quality improvement activities as agreed through GP cluster quality improvement planning. Practices will supply information to HSCPs and NHS Boards on their workforce and demand for their services to improve sustainability and facilitate service redesign. GP clusters work with the wider system, in particular HSCPs, to achieve whole system quality improvement.

GP clusters and quality improvement

GP practices will engage, as agreed in GP clusters, in quality improvement activities, including providing comparative data[23] and sharing best practice.

GP clusters will work with the wider system, in particular HSCPs, to achieve whole system quality improvement for patients.

QUALITY ASSURANCE

GP practices will participate in a cluster quality peer review process, whereby their quality improvement activity and quality data will be reviewed by their local GP cluster. Support will be offered as appropriate.

The Healthcare Improvement Scotland Quality of Care Approach will involve an increased emphasis on local systems of assurance. Service providers will use the quality framework domains to evaluate the quality of care they provide and identify areas for local improvement work. As GP clusters mature, practices and clusters will be expected to take part in the peer-led values driven assurance process. The methodology for this will be negotiated by the Scottish Government and SGPC.

GP clusters and quality assurance

GP practices will participate in a cluster quality peer review process, whereby their quality improvement activity and quality data will be assessed by their local GP cluster and support will be offered as appropriate. That support could take the form of written advice and/or a supportive practice visit from peers and a local manager.

23 In normal circumstances, providing information means allowing appropriate electronic extraction of information where that is the preferred option by the GP practice.

SUPPORTING INFORMATION FOR QUALITY AND SUSTAINABILITY

GP clusters will need information to support their intrinsic role of peer-led quality work and their extrinsic role with wider systems. Some of the data for the new quality arrangements has already been identified in the TQA. To fulfil both intrinsic and extrinsic functions GP clusters will need a combination of nationally agreed information and locally agreed data.

The new quality arrangements will be supported by new technologies, such as the Scottish Primary Care Information Resource (SPIRE). Currently SPIRE software is being rolled out across practices in Scotland - this is expected to be complete by April 2018.

Nationally and locally agreed (by SGPC and the clusters respectively) datasets will be supplied by practices and the use of automated extraction tools, such as SPIRE, is recommended as good practice. Practices will not be contractually required to use SPIRE and may choose not to use it at all. In those circumstances, practices must still provide the information required by the national and local datasets.

The existing dataset for the TQA will be the starting point for an agreed national dataset under the new GMS contract. This will enable clusters to build on their experience under the TQA to date, and on the existing work by NHS National Services Scotland Information Services Division to develop easily accessible data dashboards to support quality improvement in general practice.

GP practices and clusters will continue to be supplied with information on prescribing, outpatient referrals and admissions to hospital to support quality activity in these areas.

To contribute to the sustainabillity of general practice and primary care, GP practices will engage in the collection or extraction of information on activity and capacity. This information will be used transparently to inform and influence the development of the extended primary care teams.

To support GPs to identify individuals with more complex needs and to deliver anticipatory care planning more consistently, practices will continue to be supplied with risk predictive information based on the current High Health Gain Potential predictive tool. Work is ongoing to assess the value and to improve the predictive power of this and other case finding tools.

GP practices have reported a considerable increase in workload over the last five years, with more patient contacts, more clinical letters, more results and a higher proportion of consultations with people who have very complex problems who require more time.

Since the cessation of the Practice Team Information survey in Scotland there has been a lack of comprehensive national information on changing rates and complexity of GP consultations.

This information needs to be made available to the practice, the cluster, the HSCP and collated nationally to support sustainability, planning and the evolution of the extended multi-disciplinary team.

In addition, practices will be required to supply regular information on the workforce employed in their practices. This dataset will be used to triangulate locally with other sustainability factors, such as GP vacancies, increasing deprivation, and local house building. The purpose is to support GP practices, GP clusters, NHS Boards and HSCPs to identify and address sustainability challenges using a whole system approach.

GP cluster working, data extracts, and supporting sustainability

GP practices will provide agreed information on consultation rates, consultation types, health care professional being consulted and complexity within consultations. This will be done using SPIRE electronic extraction unless the practice wishes to collect the information itself.

GP practices will participate in assessment of capacity using the third available appointment method. Support will be provided to allow this to be undertaken electronically[24].

GP practices, through cluster working, will be involved in discussions about, and provide advice on, sustainability issues using activity, demand and workforce data.

This chapter describes the proposed arrangements for continuous quality improvement in general practice in Scotland. The next chapter summarises proposed changes in the role of the practice and changes in other underpinning regulations.

24 It is acknowledged that those practices with open access arrangements will be supported with alternative arrangements.

8 THE ROLE OF THE PRACTICE

Key Points

- General practice nursing will continue to have a vital role under the proposed new contract.
- There will be new enhanced roles for practice managers and practice receptionists.
- In addition, a number of clarifications and improvements to the underpinning GMS and Primary Medical Services (PMS) regulations will be made.

INTRODUCTION

The table below sets out how the activities of the practice team might be expected to change in the next three years. The examples given below under the heading of each professional are indicative only, not exhaustive. More information on the services mentioned in the table is set out in chapter four.

Figure 5: Services in 2017 and 2021

2017

General practitioners
Independent contractor – based in the practice

- Default primary medical service provider
- Undifferentiated presentations- patients who are ill/believe themselves to be ill, who require diagnosis
- Complex care - including patients who have more than one diagnosis or medical issue
- Clinical leadership of the practice team to improve patient outcomes
- Home visits
- Delivery of chronic disease monitoring
- Chronic disease management
- Delivery of some nursing services (treatment room)
- Repeat prescribing, serial prescribing, 'specials', and polypharmacy reviews.
- Reviewing results (large Docman activity)
- Leading practice team/practice management

2021

General practitioners
Independent contractor – based in the practice

- Default responsibly for a reduced number of primary medical services
- Undifferentiated presentations- patients who are ill/believe themselves to be ill, who require diagnosis and cannot choose to see other health professionals
- Complex care - including more time with patients who have more than one diagnosis or medical issue
- Clinical leadership of extended primary care team to improve patient outcomes
- Fewer home visits but more complex and often as part of team assessment and support
- Oversight of chronic disease management
- Reduced volumes of Docman – outpatient and self-ordered test results
- Leading practice team / practice management
- Leading clusters
- Influencing local system

2017

General Practice nurses
Employed by the practice

- Treatment room services
- Chronic disease monitoring/management
- Vaccinations
- Minor injury, dressings

Practice manager
Employed by the practice

- Contract management
- Contract monitoring
- Business planning
- Contract and other regulatory compliance
- Staff management

Receptionists
Employed by the practice

- Organising patient appointments
- Managing communications to/from the practice
- Managing prescription requests/enquires
- Operating call/recall systems
- Administration

2021

General Practice nurses
Employed by the practice

- Minor illness management
- Chronic disease management
- Supporting GP to deliver care planning
- Monitoring lab results

Practice manager
Employed by the practice

- Contract management
- MDT co-ordination
- Contract monitoring
- Business planning
- Contract and other regulatory compliance
- Staff management

Receptionists
Employed by the practice

- Organising patient appointments
- Supporting patients with information on available services
- Managing communications to/from the practice
- Managing prescription requests/enquires
- Operating call/recall systems
- Administration

New for 2021

Pharmacotherapy services
HSCP/NHS Board Service

- Repeat prescribing, serial prescribing, 'specials', shortages
- Medication and polypharmacy reviews.
- Medicines reconciliation
- Medication enquiries
- Monitoring lab results for high risk medicines

Urgent Care Services
HSCP/NHS Board Service

- Assess and treat urgent and emergency care presentations
- Home visits
- Falls

Additional Professional Services
HSCP/NHS Board Service

- Acute musculoskeletal physiotherapy services
- Community mental health services
- Community link worker services

New for 2021

Community Treatment and Care Services
HSCP/NHS Board Service

- Management of minor injuries and dressings, phlebotomy, ear syringing, suture removal
- Chronic disease monitoring – routine checks, and related data collection
- Screening test results will go directly to requesting physician
- Monitoring lab results to pharmacist/general practice nurse
- Carrying out requests from secondary care

Vaccination Services
HSCP/NHS Board Service

- Provide all vaccinations previously provided by GP practices.
- Travel vaccines and travel health advice

Case Study - community treatment and care services in Lanarkshire

In Lanarkshire, most GP practices have access to a 'Treatment Room' (TR) service which enables a range of procedures, many of which were previously provided by a GP or GP employed-staff. The service provides core services which includes, amongst others, wound management, venepuncture, injections and ear irrigation.

For routine needs, patients are provided with appointments at health centres. However, both GPs and Board run treatment rooms have retained flexibility in how they provide services in order to deliver the best experience for the patient. For example, some GPs will take blood samples when the patient is in their practice if they have a view that there is an urgent need or to do so or it is clinically appropriate for the patient.

The service is also helpful in allowing a range of patients, where appropriate, who would previously have required a domicillary visit from a District Nurse to now receive such treatment in a more appropriate clinical setting. This is also more efficient than a domiciliary service with attendant travel time between visits.

TR services are staffed, where possible, with an appropriate skill-mix to reflect the range and quantity of interventions.

GENERAL PRACTICE NURSING

General practice nursing is an integral part of the core general practice team. The profession provides primary care services, mainly through GP independent contractor employment, including general nursing skills as well as extended roles in health protection, urgent care and support for people with long term conditions.

General practice nurses had a key role in the achievement of QOF points as part of the 2004 GMS contract. However, many in the profession felt that QOF greatly increased bureaucratic workload and had a negative impact on consultations, supporting "box ticking" rather than facilitating holistic and person-centred consultations. The new general practice landscape in Scotland will enable general practice nurses to have more meaningful person-centred consultations.

With dedicated community treatment and care services delivered through HSCPs the 2018 GMS contract will support GPNs to focus on a refreshed role in general practice as expert nursing generalists. They will provide acute and chronic disease management, enabling people to live safely and confidently at home and in their communities, supporting them and their carers to manage their own conditions whenever possible.

To fulfil the challenges associated with the increasing complexity and demand of primary care in Scotland the role and career pathway of general practice nursing will need to adapt and evolve. A 'one size fits all' approach may not be appropriate for all posts, but there will be a common pathway to lead general practice nurse or advanced nurse practitioner careers. At the present time variation in terms of both job titles and training is evident within general practice nursing.

To support an enhanced role safely integrated into general practice it is critical that there are agreed role definitions supported by a robust career and educational framework. The *Transforming Roles: General Practice Nursing Group* was established by the Scottish Government in 2017 to refresh the role and educational requirements of general practice nurses. This work will be taken forward jointly by the Scottish Government's primary care and Chief Nursing Officer Directorates in 2017/18.

GPNs require a significant breadth of knowledge and need to access appropriate structured education and training. Investing in general practice nurses provides a valuable opportunity to deliver a highly skilled 'fit for purpose' profession. The Scottish Government has invested £2 million in 2017/18 for additional training for general practice nurses in recognition of the importance of this role in the future delivery of care to patients in the primary care setting. This training will enhance the skills of general practice nurses so that they are better equipped to meet the increasingly complex needs of patients. This training enhancement will also make it easier for patients to access the right person at the right time.

The Transforming Roles: General Practice Nursing Group will oversee the continued funding of training for general practice nursing to enable the on-going development of this critical workforce during the three year transition period as outlined in the MoU.

Given the changes in service redesign in primary care, demand for nursing staff in the community will increase. We anticipate continued employment of the nursing workforce in primary care by both NHS Boards and Independent Contractors. There will also be opportunities, if individuals wish, to change roles to take on new opportunities in the community treatment and care services; in general practice nursing, and in advanced nursing practice.

PRACTICE MANAGERS AND PRACTICE RECEPTIONISTS

Practice Managers play a key role ensuring the smooth and efficient day-to-day running of practices and the long term strategic management and co-ordination of primary care, including supporting the development of the multi-disciplinary team.

The role of the primary care manager was introduced in the 1980s as a senior receptionist/office Manager role. With the introduction of the Red Book contract in 1990, which coincided with the introduction of the first IT systems into general practice including automated call and recall systems and electronic appointment systems, the role began to evolve and become more commonplace.

The 2004 GMS Contract formally recognised the contribution effective practice management has on reducing the administrative burden on clinical staff and included a core competency framework for practice management.

Since 2004 the role of practice managers has adapted to meet a number of new challenges such as the development of practice IT systems; larger practice employed clinical and administrative teams; the increasing complexity of the GMS contract; and payment processes including the management of regularly changing QOF criteria and Enhanced Services. Practice managers have had a key role as facilitators of many of these changes. Indeed, many practice managers are now in senior management roles, however there nevertheless remains large variation in practice managers' roles, responsibilities and skills from practice to practice.

General practice in Scotland has a highly skilled and experienced practice manager workforce. These managers have skills and experience which will be vital to ensure the success of the proposed new contract.

Practice managers already have a wide range of skills which will be essential for the future including financial management, IT management, HR management, contract management, leadership and facilitation, quality improvement skills, change management, communication and patient engagement skills. Work is ongoing with NHS Education for Scotland to identify and meet practice managers' training needs. Career development and succession planning will also be important considerations going forward.

The introduction of the proposed 2018 contract will increase the need for highly skilled practice managers with wide ranging, adaptable and versatile skills. In addition to continuing to manage the practice employed team, they will work more with the wider primary care system including GP clusters, NHS Boards, HSCPs, and emerging new services.

Alongside the changing role of practice managers, the roles of receptionists and other non-clinical staff in the practice have also evolved.

Practice receptionists have an important role supporting patients and enabling practices to run smoothly.

Opportunities to develop the skills of practice receptionists to support patients with information on the range of primary care multi-disciplinary team services available, or to increase their role in the management of practice documentation and work optimisation, are currently being explored with Healthcare Improvement Scotland (HIS). HIS will be working with GP clusters to develop training and resources to support these staff.

There is also a wide range of practice administrative staff carrying out a diverse number of tasks from prescription management, medical secretarial skills and IT management including call and recall, to documentation management, health and safety monitoring, and finance management. These staff are a highly skilled and adaptable workforce who will continue to have an important role in general practice in the future.

Strong leadership by practice managers supported by their teams, and by the practice GPs will be hugely important to the success of the proposed new contract and new ways of working.

IMPROVEMENTS TO REGULATIONS AND OTHER ISSUES

In addition to the proposals set out in previous chapters, a range of clarifications and improvements will be made to the underpinning regulations for General Medical Services contracts and Primary Medical Services contracts. These, and other issues not contained in underpinning regulations but pertinent to general practice, are set out below.

Indemnity

In the spirit of reducing risk for GPs, the Scottish Government and the SGPC are working collaboratively with Medical Defence Organisations to seek the best solution for indemnity in Scotland, following the announcement of changes to the discount rate in February 2017 and subsequent announcement by the UK Department of Health of its intention to introduce a state-backed scheme. The solution will take into account the indemnity needs of partners, locums and sessional GPs.

Temporary Residents

Practices are currently paid to treat Temporary Residents under the Temporary Patient Adjustment provisions of the Statement of Financial Entitlements. Before the 2004 contract this treatment was paid for by the temporary residents' fees, emergency treatment fees and immediately necessary treatment fees under the Red Book. All contractors currently receive a payment for unregistered patients as an element in their global sum allocation. The amount each contractor receives is generally based on the average amount that, historically, the contractor's practice claimed for treating such patients each year under the Red Book prior to 1 April 2003.

The Temporary Patient Adjustment leaves practices exposed to the risk of their number of Temporary Residents fluctuating while the resources to treat them remains constant. Under the new contract, practices will be required to report on numbers of Temporary Residents in 2018/19 to allow the Temporary Patient Adjustment to be reformed and uplifted on the basis that funding will follow activity as soon as practicable and by 2020/21.

Data also will be collected on activity around care homes to ensure that funding follows activity on a similar basis to Temporary Residents.

Dispensing

The current arrangements for dispensing in Scotland will not change under the proposed new contract. As part of the preparation for a Phase 2, we will establish a short-life working group to consider the current dispensing arrangements and look for any mutually beneficial improvements. Relevant interest groups will be consulted to ensure their views are incorporated.

Challenging Behaviour Scheme

All NHS Boards are required to establish a Violent Patients Scheme, the underlying purpose of which is to ensure that there are sufficient arrangements in place to provide general medical services to patients who have been subject to immediate removal from a GP's patient list of a general medical services contractor because of an act or threat of violence.

Under the new contract, this Directed Enhanced Service will be revised to introduce a greater degree of consistency across NHS Boards ensuring that practices and staff are protected from patients who have been violent or threatening.

Practice Areas

The current regulations provide limited information and guidance on practice areas beyond the need for practices to refer to their area by reference to a sketch diagram, plan or postcode in their practice leaflet. The new contract will clarify how practice areas should be agreed as part of the contract between NHS Boards and practices. The regulations will introduce processes for the formal variation of practice areas to ensure that NHS Boards do not make unilateral decisions and patient wishes are respected. This will enable practices to make changes in a timely fashion whilst ensuring that the interests of other practices in the vicinity are taken into account by NHS Boards.

Patients will retain the right to remain on the list of a practice if they live outwith a boundary which has been reduced. Not all patients will wish to remain on the list of a practice which no longer covers their area, and NHS Boards will be empowered to help practices rationalise their lists where patients are willing, even to the extent of assigning patients to practice lists which are otherwise closed where practices agree.

Practice List Closures

Under the current regulations practices must apply to their NHS Board to submit a notice to close their patient list. Closing a practice list is a last resort for a practice and the process for closing lists is intended to function as a failsafe to ensure that NHS Boards work with their contractors to keep lists open for patients wherever possible.

Under the new regulations, if NHS Boards have not completed discussions concerning support with practices within three months, a closure notice will be considered as accepted. Where assessment panels do not accept applications to close practice lists they should nonetheless agree the increase in terms of either a percentage of the current number of patients or an actual number of patients which would trigger a closure of the list.

Contract Disputes

The NHS Dispute Resolution procedure provides an inexpensive way for parties to the GMS contract to hold each other to account. Under the new contract the Local Dispute Resolution procedure will be formalised giving practices confidence that their disputes are recognised and are being taken forward within specified timescales. Local dispute processes will address practice boundary and list closures.

The constitution of local resolution panels will include: a representative from the NHS Board; a representative from the LMC; and an independent chair.

Certificates fees and charges

GPs are not always the best or only person to provide the various certificates prescribed in current regulations and this will be reflected in new regulations which will make alternative and routine providers clear.

The new regulations will provide a list of certificates which, through primary legislation, GPs are entitled to charge for providing. The regulations will be clear that other work falls outwith the GMS contract.

Emergency Responders

GPs have a professional duty to provide immediate and necessary treatment due to accident or emergency in their practice areas. However GPs should be understood as a last resort for these situations and the new regulations will reflect that.

Patient checks

The new regulations will clarify that while new patient checks will still be required, they can be conducted by members of the wider multi-disciplinary team.

All practices are currently required to offer patients who have not been seen within 3 years and patients aged 75 years and over (on an annual basis) appointments. Patients are not obliged to take up the offer. As all patients are entitled to request an appointment with their GP regardless of when they last attended, these specific provisions will be removed from the existing regulations.

New practices

The arrangements for Phase 2 will include developing proposals for creating new practices. This will usually be in areas where the population is growing rapidly and established practices are unable to expand their patient list further. The proposals will include specific financial support for new practices while their list size is growing, and a mechanism for establishing new premises. Additional funding for supporting new practices will not affect the funding of other practices as funding in Phase 2 will be practice specific.

Community hospitals

The current local arrangements for community hospitals in Scotland rest with HSCP and are unaffected by the proposed new contract. As part of the preparation for Phase 2, consideration will be given to reviewing the current arrangements and how they align with the proposed new contract and the role of the GP as expert medical generalist. Relevant interest groups will be invited to contribute to such a review process.

Primary Medical Services ("17C")

Alongside updating the NHS (General Medical Services Contracts) (Scotland) Regulations 2004 (17J), the Scottish Government and the SGPC have also agreed to update the NHS (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004. This will ensure that both contracts will support the transformation of primary care services and deliver significant benefits to patients, GPs and practice staff. The proposed changes outlined in this document will apply equally to both GMS contracts and 17C agreements. The intention is that practices in 17C and 17J will, in future, have equity of access to funding.

The revised sets of Regulations will not remove the right for any practice which currently operates under a 17C agreement to choose to revert to a 17J contractual status.

AFTERWORD

Much of the content of this document has focussed on improving the terms and conditions for GPs in Scotland – in particular, maintaining income stability, reducing workload and reducing risk. The ultimate reason behind all these proposals is to improve patient care. There is clear evidence to link workforce morale with better patient experience – with the new contract we have the opportunity to create a virtuous circle that delivers a thriving future for GPs and for patients.

In itself, a contract can never be the sole answer to the challenges facing primary care. However, the manner in which a contract is developed, agreed and implemented can demonstrate underlying common aims and purposes for mutual benefit. In complex and challenging times, a collaborative approach to a common vision certainly appears, based on our experience, far more productive and more likely to succeed.

We hope that the collaborative relationship which we have created to agree this contract will set the tone for the future of primary healthcare in Scotland. We have developed what could be called a Scottish Negotiating Approach which we agree has been essential to delivering this significant change. We set out initially to both develop and agree a vision for general practice and its place in the Scottish NHS of the future. We had no difficulty in agreeing that the very strengths of general practice are those core values which we wish to enhance and support to meet the needs of the people of Scotland. This is a bold statement of confidence that Scottish general practice is the right kind of medicine for the future.

Both the contract, and the surrounding support structures of the primary care multi-disciplinary team, are intended to enable GPs to be GPs. This approach will underpin delivery of the new contract as well as setting the direction for future development beyond the first three years.

This document describes a very significant degree of necessary system change. It is essential that patient safety and confidence is maintained during this change. Successful delivery will therefore require the support and commitment of all those in the health and care system. We all have a vested interest in the success of general practice and the primary care system for our patients, our families and our communities.

We all have to be active in managing our own care and health. To support this the contract is intended to ensure that GPs are available when needed to help the people of Scotland achieve the best agreed outcomes for their health. GPs will also have a clear role in assessing how well the health and care system delivers these outcomes and advising on how we might better improve on them. There will be better primary care services for patients, more time with a GP when it is really needed, quicker access to other healthcare professionals in the community and a more convenient, wider range of services.

We believe that these changes will enable the GPs of Scotland to make the best contribution possible to achieving better health outcomes. For those who are, or may aspire to become, GPs in Scotland, we invite you to join us in delivering, for the people of Scotland, better health and better care.

Shona Robison
Cabinet Secretary for Health

Alan McDevitt
Chair, SGPC

ANNEX

NATIONAL OUTCOMES Our children have the best start in life and are ready to succeed	We live longer, healthier lives	Our people are able to maintain their independence as they get older	Our public services are high quality, continually improving, efficient and responsive
We start well	**We live well**	**We age well**	**We die well**

PRIMARY CARE VISION Our vision is of general practice and primary care at the heart of the healthcare system. People who need care will be more informed and empowered, will access the right professional at the right time and will remain at or near home wherever possible. Multidisciplinary teams will deliver care in communities and be involved in the strategic planning of our services.

HSCP OUTCOMES	***People can look after own health***	***Live at home or homely setting***	***Positive Experience of Services***	***Services improve quality of life***
Services mitigate inequalities	***Carers supported to improve health***	***People using services safe from harm***	***Engaged Workforce Improving Care***	***Efficient Resource Use***

PRIMARY CARE OUTCOMES		
We are more informed and empowered when using primary care	***Our primary care services better contribute to improving population health***	***Our experience as patients in primary care is enhanced***
Our primary care workforce is expanded, more integrated and better co-ordinated with community and secondary care	***Our primary care infrastructure – physical and digital – is improved***	***Primary care better addresses health inequalities***

GLOSSARY

BMA – the British Medical Association, the registered trade union for doctors in the United Kingdom.

CQL – Cluster Quality Lead, a GP appointed by a NHS Board to coordinate a cluster.

EMG – Expert Medical Generalist, a GP when they are performing those GP roles and duties only a GP can do.

GMC – General Medical Council.

GMS – General Medical Services, the range of healthcare services that is provided by general practitioners under a General Medical Services contract with an NHS Board.

GMS contract – the national Scottish General Medical Services contract entered into under section 17J of the National Health Service (Scotland) Act 1978.

GP – General Practitioner, a doctor specialising in primary care and registered in the General Practitioner Register of the General Medical Council.

GP partner (as opposed to a GP) – a Partner in a GMS or 17C medical services practice.

GPN – General Practice Nursing.

HIS – Healthcare Improvement Scotland.

HSCP – Health and Social Care Partnership, the organisations formed as part of the integration of services provided by NHS Boards and Councils in Scotland.

IA – Integration Authority. Statutory body resposible for the planning design and commissioning of primary care services in Scotland.

LMC – Local Medical Committee, the local committees of the BMA representing general practitioners.

MDT – multi-disciplinary team, where primary care professionals work as an integrated team.

NHS – National Health Service.

PMS – Primary Medical Services.

PQL - Practice Quality Lead, the GP quality leadership role in practice.

PSD – Practitioner Services, the division of NHS National Services Scotland which, among other roles, processes payments for practices.

QOF – Quality and Outcomes Framework.

RCGP – Royal College of General Practitioners, the professional body for GPs.

2004 Contract– the national GMS contract prepared in accordance with the rules set out in The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004.

SAF – the Scottish Allocation Formula.

SGPC – the Scottish General Practitioners' Committee of the BMA.

TQA – Transitional Quality Arrangements.

Scottish Government
Riaghaltas na h-Alba
gov.scot

ISBN: 978-1-78851-347-0

This document is also available on The Scottish Government website:
www.gov.scot

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS305366 (11/17)

ITEM No …10…..……

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19 DECEMBER 2017**

REPORT ON: **CHIEF SOCIAL WORK OFFICER ANNUAL REPORT 2016/17**

REPORT BY: **CHIEF SOCIAL WORK OFFICER**

REPORT NO: **DIJB53-2017**

1.0 PURPOSE OF REPORT

This report brings forward for information the Chief Social Work Officer's Annual Report for 2016/17.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of this report and the Chief Social Work Officer's Annual Report for 2016/17 (attached as Appendix 1).

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 The requirement that every local authority has a professionally qualified Chief Social Work Officer (CSWO) is set out in Section 5 (i) of the Social Work (Scotland) Act 1968, as amended by Section 45 of the Local Government, (Scotland) Act 1994. The qualifications of the CSWO are set down in regulations which state that he/she should be a qualified social worker and be registered with the Scottish Social Services Council.

4.2 The role provides a strategic and professional leadership role in the delivery of social work services, in addition to certain functions conferred by legislation directly on the CSWO. The overall objective of the role is to ensure the provision of effective, professional advice and guidance to elected members and officers in the provision of social work and social care services. Although the Public Bodies (Joint Working) (Scotland) Act 2014 provides for the delegation of certain social work functions to an integration authority, the CSWO's responsibilities in relation to local authority social work functions continue to apply to functions which are being delivered by other bodies under integration arrangements. Responsibility for appointing a CSWO cannot be delegated and must be exercised by the local authority itself. The CSWO therefore has a role in providing professional advice and guidance to the Integration Joint Board (IJB).

4.3 National guidance requires that the CSWO produces and publishes an annual summary report for local authorities and, more recently, IJBs on the functions of the CSWO and that the approved report is forwarded to the Scottish Government to contribute towards a national overview of Social Work Services.

4.4 National guidance in relation to the role of the Chief Social Work Officer was revised in July 2016 in recognition of the diversity of organisational structures and the range of partnerships and organisations with an interest and role in the delivery of social work services. In addition to supporting local authorities to discharge their responsibilities, the guidance is also intended

to assist IJBs understand the role of the CSWO in the context of integration of health and social care. It particularly emphasises the role of the CSWO in professional and clinical and care leadership and clinical and care governance systems. The guidance also requires that the CSWO's annual report be considered by the IJB, alongside the local authority.

4.5 The attached report is the seventh CSWO report for Dundee. The report demonstrates that the service has continued to deliver quality support and services which improve lives and provide innovative responses to the challenges being experienced. The report provides information on how the CSWO discharged her responsibilities in 2016/17. It provides an overview of the social services delivery landscape across Dundee and the partnership structures. It provides information on the key trends, risks, achievements and challenges and outlines how resources have been deployed. The information provided complements other more detailed and service specific reports on social work and social care services which have been reported to members and the public in a range of other ways, including the IJB's Annual Performance Report 2016/17. It also provides details of the statutory functions carried out by the CSWO during the 12 month period. Information regarding complaints is also included in the report, referred to at Section 9 (previously reported to the Performance and Audit Committee – Article XII of the minute of the meeting held on 12 September 2017 refers). Specific achievements include:

- Good progress has been made in reducing the level of delayed discharge and there has been an increase in the uptake of direct payments.
- There has been a significant focus on user and carer involvement as evidenced by the Making Recovery Real partnership approach and the establishment of a Cancer Voices Panel.
- Significant work has been undertaken with carers in preparation for the implementation of the Carers (Scotland) Act.
- A new service user record keeping and information service, MOSAIC, was introduced across Social Work which required a significant focus on training and support to staff in order to assist them transition to the new system.
- Learning in relation to the protection of children and adults has remained a priority and a range of core programmes have been delivered.

4.6 The report is also forward looking and identifies the key challenges and opportunities for the coming year which include:

- The environment social work operates in is increasingly complex and there needs to be a continued focus on strengthening the interfaces across partnerships on issues such as domestic abuse, substance misuse and transitions from childhood to adulthood. The on-going review of Education Governance has the potential to significantly impact on the work of Children and Families Services across the City.
- There has been a shift towards more locality based services alongside a shift from reactive to preventative approaches in order to support people remain at home as long as possible and, wherever possible, avoid hospital admission. This has required the development of flexible services which are in line with the needs of service users and with the principles of self-directed support.
- In common with other services there will be major financial challenges which will continue to require new ways of working and active involvement of communities in service redesign and prioritisation of scarce resources. Increasingly there will be a focus on joint working with neighbouring authorities.
- The coming year will see further legislative changes including the introduction of the Carers (Scotland) Act.

4.7 The CSWO is of the view that good progress continues to be made and integrated arrangements are becoming increasingly embedded. The CSWO continues to have a role in ensuring the local authority fulfils their statutory responsibilities across the range of partnerships, including the Health and Social Care Partnership. This includes continuing to develop the CSWO governance framework to ensure appropriate arrangements are in place for the CSWO to discharge their function in relation to services delegated to the IJB.

5.0 POLICY IMPLICATIONS

5.1 This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

No risk assessment has been carried out as the CSWO Annual Report is submitted for information only.

7.0 CONSULTATIONS

The Chief Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

Jane Martin
Chief Social Work Officer

DATE: 13 November 2017

200

201

Appendix 1

Dundee City Council
www.dundeecity.gov.uk
CHANGING FOR THE FUTURE

Dundee City Council

Chief Social Work Officer Annual Report

2016-17

Dundee Health & Social Care Partnership

I am pleased to present the Chief Social Work Officer's (CSWO) Annual Report for Dundee City Council for the period 2016/17. My report has been written for all our stakeholders and provides a summary of key Social Work activities over the last 12 months. It includes information about the leadership of Social Work; work with partner agencies; statutory decisions made on behalf of the Council; financial information; the involvement of service users; and on performance across all service areas of Children's Services, Community Justice, Health and Social Care and Advice Services. The report is not intended to be exhaustive but gives an indication of key trends, challenges, opportunities and priorities over the past year and going forward.

Last year was a time of major change in all Social Work Services, as Children's and Community Justice Services combined with Education to form a single Children and Families Service. In partnership with NHS Tayside, Angus and Perth and Kinross Councils and other partners, there were also major developments in the planning of children's services across the region. For adults, the Dundee Integration Joint Board (IJB), established to oversee the planning and delivery of Health and Social Care, became embedded. In Justice, it was a transitional but equally significant year as we moved towards the disestablishment of Community Justice Authorities and the creation of a combined national and local model to reduce re-offending. The Service changed its title to Community Justice Services in recognition of the fact that the term criminal was stigmatising and did not reflect the breadth of work being undertaken.

As such, it was the first full year when the city did not have a single Social Work Service and the CSWO operated across multiple organisational and regional boundaries. Whilst this involved some complexities in carrying out the role, it also provided opportunities to contribute towards a more integrated approach towards the delivery of services whereby different partners, partnerships and local communities focus on jointly identified priorities. Similarly, although the financial climate continued to be demanding it provided incentives for re-design in order to ensure services focus on what matters most to children, young people and adults. In response, there were a wide range of developments relating to prevention, early intervention, locality working and engagement with service users.

Social Work has continued to play a key role in influencing the shape and delivery of services whilst ensuring a focus on providing high quality person-centred care and support; and by managing risks both to and from some of our most vulnerable citizens. I am confident that, as a Social Work Service within a wider partnership of statutory, third sector, private sector and community stakeholders, we have helped to build on increasingly shared foundations and continued to have a positive impact on people's lives.

The Social Work profession in Dundee continues to have a strong value base, involving the promotion of social justice, providing services to vulnerable groups, promoting human dignity and worth and acting with integrity at all times. Social Work staff carry out their roles in often difficult and demanding circumstances and need to be supported in their work. I am proud to be part of the Social Work profession and to recognise the significant contributions staff make towards protecting people and helping them to lead safe and fulfilling lives. I hope this report goes some way towards explaining all our services and the positive impact they have on the people of Dundee.

Jane Martin
Chief Social Work Officer

Contents

Introduction

1

1.1 This report details the arrangements within Dundee which enable the Chief Social Work Officer (CSWO) to fulfil their responsibilities as outlined in Section 5 (1) of the Social Work (Scotland) Act 1968, as amended by Section 45 of the Local Government (Scotland) Act 1994. The post is a senior one designed to promote leadership, standards and accountability for Social Work services, including commissioned services. Statutory guidance outlines requirements of the CSWO to:

- Report to Elected Members and the Chief Executive any significant, serious or immediate risks or concerns arising from his or her statutory responsibilities.
- Provide appropriate professional advice in the discharge of the Local Authorities functions as outlined in legislation, including where Social Work services are commissioned.
- Assist Local Authorities and their partners to understand the complexities and cross-cutting nature of Social Work, including corporate parenting and public protection.
- Promote the values and standards of professional Social Work, including all relevant National Standards and Guidance and adherence to Scottish Social Services Council Codes of Practice.
- Establish a Practice Governance Group or link with relevant Clinical and Care Governance Arrangements designed to support and advise managers in maintaining high standards.
- Promote continuous improvement and identify and address areas of weak and poor practice in Social Work services, including learning from critical incidents and significant case reviews.
- Workforce planning, including the provision of practice learning experiences for students, safe recruitment practice, continuous learning and managing poor performance.
- Make decisions relating to the placement of children in secure accommodation and other services relating to the curtailment of individual freedom.
- In cooperation with other agencies, ensure on behalf of the Local Authority that joint arrangements are in place for the assessment and risk management of certain offenders who present a risk of harm to others.

1.2 The statutory guidance also states that the CSWO must produce and publish a summary Annual Report for Local Authorities and Integration Joint Boards. This report therefore provides details on how the CSWO functions are being discharged within Dundee, including the systems and processes in place to ensure the safety of children and vulnerable adults and the management of those who present a risk to others, in the period 2016-17. The report ends with an outline of key priorities over the next 12 months.

2 Summary

In 2015-16, the Annual Report of the CSWO set out the focus for developments in the forthcoming year. The priorities were informed by a variety of factors, including opportunities and challenges afforded by new and anticipated legislative requirements, national or local structural changes, ongoing financial pressures, internal self-evaluation, external inspections and SSSC Codes of Conduct. We committed to:

- Further developing locality working.
- Build on the opportunities created through health and social care integration.
- Implement Community Justice reforms.
- Develop the first statutory Children's Services Plan.
- Continuing to develop and strengthen Corporate Parenting.
- Further shifting the balance of care from hospital to community provision.
- Implement the principles and practices of personalisation.
- Further promoting the fairness agenda.
- Improve self-evaluation and performance management.

This year's Annual Report describes how the CSWO supported the progression of each of these areas of work. It shows how there were a number of key achievements in each of our service areas, including developments in Children's Services on the joint completion of a Tayside Plan for Children, Young People and Families 2017-20; in Community Justice, the coordination of a Community Justice Outcome Improvement Plan; and in Health and Social Care a focus on rehabilitative pathways for vulnerable adults, reductions in delayed discharge from hospital and increases in the proportion of people who feel safe being supported at home. All service areas strengthened their approaches to locality working.

Partnerships Structures/Governance Arrangements

207 3

3.1 In Dundee the role of CSWO lies with the Head of Service for Integrated Children's Services and Community Justice, with the Head of Service, Health and Community Care deputising as required. The CSWO continues to have direct access to Elected Members, the Chief Executive, managers and front line practitioners in relation to professional Social Work issues. The following formal arrangements are also in place:

- Reporting to the Executive Director of Children and Families and regular meetings with the Chief Executive.
- Member of the Integration Joint Board and IJB Performance and Audit Committee.
- Member of the Tayside Clinical and Care and Professional Governance Forum.
- Member of 3 Executive Boards which oversee the implementation of community planning priorities.
- Member of the Adult Support and Protection Committee, providing advice on Social Work matters relating to vulnerable adults.
- Member of the Alcohol and Drug Partnership (ADP), providing advice on Social Work matters relating to substance misuse problems.
- Member of the Child Protection Committee, providing advice on Social Work matters relating to children and young people at risk of harm.
- Member of the Chief Officer Group for Protecting People, providing leadership and oversight on all child and adult protection matters.
- Member of the newly formed Tayside Strategic Collaborative Group as the representative of the CSWOs in all 3 local authority areas.

4 Partnership with Service Users, Carers and the Third Sector

As well as having a strong history of engaging with service users, carers and communities, each of which are outlined in Section 12, Social Work remains committed to working closely with Third Sector partners to develop and improve services. The City has a vibrant and diverse Third Sector and a shared focus on improving outcomes has enabled existing partnerships to be maintained or adapted to fit priorities and new partnerships to begin. Examples include:

Children's Services
In Children's Services, the last 12 months have seen a particular focus on partnership work with the Third Sector on the related priorities of early identification and intervention and work with Looked After Children. Firstly, this has involved agreement with Third Sector colleagues to develop and coordinate localised family support hubs. These hubs will provide triage services to children, young people and families identified as being in need of additional support.

Secondly, we have revised Looked After Children governance arrangements by extending membership of key decision-making groups to the Third Sector. This has facilitated creative discussions on how to maximise the use of local resources in order to support placements and retain children and young people locally.

Thirdly, working with Third Sector colleagues to increase the range of available local placements in order to either prevent external placements or enable the return of children and young people from such placements. Collectively, these developments are intended to prevent problems escalating towards statutory interventions; to enable Looked After Children and young people to remain in their local communities; to improve outcomes; and to reduce costs.

In the summer of 2016, a Food and Fun Programme was launched to provide lunches to children in deprived areas during school holidays. The purpose was to promote their health and wellbeing and contribute towards narrowing the attainment gap, with children experiencing 'holiday hunger' less likely to progress academically during the new school term. The programme has since been expanded to cover other holiday periods and delivered 23,100 lunches up to October 2016. It also provided 42 families with Farmfoods vouchers. The programme has continued to expand in 2017-18, when it has become a fully constituted charity known as Dundee Bairns, widened its scope from lunches to breakfasts and extended to offer low cost holidays. It is being extremely well received and many recipients are also Social Work service users.

Community Justice Service
In Community Justice, the service has worked with Third Sector partners on the ongoing delivery of services within the whole systems approach towards youth justice. This has included work with Third Sector partners in respect of Early and Effective Intervention arrangements and in respect of resettlement support following release from secure care or prison. The service has maintained regional services and developed locally specific services:

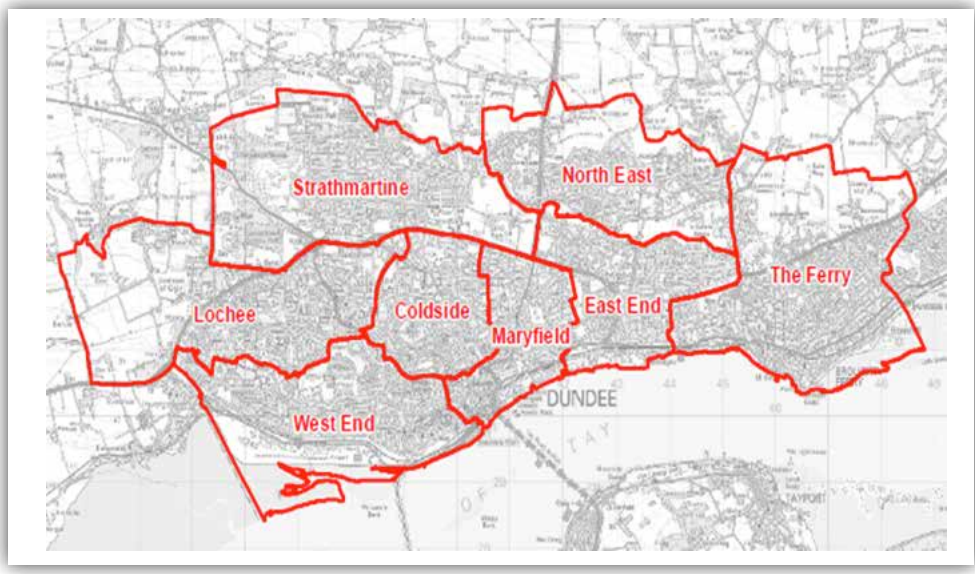
- ✔ Continued to work with Action for Children on the Tayside Arrest Referral Service (TARS) delivered across all 3 local authorities.
- ✔ Worked with Apex on employability support delivered across all 3 local authorities.
- ✔ Worked with Tayside Council on Alcohol (TCA) on mentoring services delivered across all 3 local authorities.
- ✔ Worked with SACRO to develop a new service involving restorative approaches with girls and young adult women at risk of secure care or custody.

Health and Social Care
The HSCP has continued to support the Safe Zone Bus which aims to provide a place of safety that meets the needs of any person whose wellbeing is threatened by their inability to get home safely due to alcohol misuse, emotional distress or any other risk of vulnerability. It is staffed by support workers and volunteers from Tayside Council on Alcohol and the British Red Cross. Over the last 12 months, it has provided people with advice and information, emotional support, first aid, warmth and facilitated safe contact with friends and family and/or a safe route home.

During the last year the Carers (Scotland) Act 2016 was passed by the Scottish Government. The Act will come into force in 2018 and we have embraced the legislation as an opportunity to build on, strengthen and further develop local systems of support for carers. A range of work has been carried out over the last year to prepare for the implementation of the Act, working to meet requirements whilst co-producing our approaches with carers wherever possible. Key activities included:

- ✔ The provision of manual handling training for carers to reduce their risk of injury as a result of caring.
- ✔ The provision of learning and development activities for our workforce to enhance their understanding of carers' needs and the Act.
- ✔ Testing new models for supporting carers within the service delivery area in which they live with the Carers Centre.
- ✔ A "What does a Carer look like?" campaign which ran for two months and celebrated Dundee Carers Week with a Carers Tea Party.

5 Social Service Landscape/Market



Map of 8 LCPP areas in Dundee

5.1 Dundee has a population of 148,000 with high levels of poverty, deprivation and inequality. This is accompanied by the range of related social, community and personal problems, including high levels of unemployment, substance misuse, mental health, physical health, domestic abuse, re-offending and morbidity. There are also more people with physical or learning disabilities than the Scottish average. Typically, there are over 9,000 users of social care services in the city at any time.

5.2 Over the next 25 years, the number of people aged over 75 years is also expected to rise by 45%. There will be similar increases in the number of people aged over 90 years. This is likely to lead to a greater prevalence of problems associated with older age which require health and social care, such as dementia, injuries resulting from falls, osteoarthritis, osteoporosis, immobility and other features of deteriorating mental and physical health.

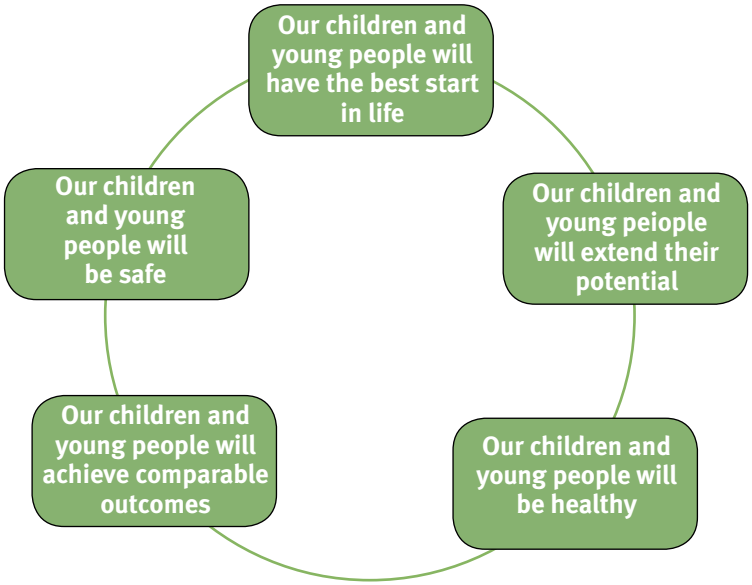
5.3 As a result, in the context of growing financial pressures, there are unusually high and ever increasing demands on health, social care and other relevant local services. It means services must work together and engage with communities to prioritise and address problems within existing, shared resources. As such, the Dundee Partnership has outlined an aspirational vision for the City which will be realised over the next 10 years. Our shared vision is that:

- We will have a strong and sustainable economy that will provide jobs for the people of Dundee, retain more graduates and make the city a magnet for new talent.
- We will offer real choice and opportunity in a city that has tackled the root causes of social and economic exclusion.
- We will be a vibrant and attractive city with an excellent quality of life where people choose to live, learn, work and visit.

5.4 To achieve this, we are focusing on 5 priorities of Work and Enterprise; Children and Families; Health, Social Care and Wellbeing; Community Safety and Justice; and Building Stronger Communities. This is supported by themes on Cultural Development, Sustainability, Public Protection and Substance Misuse. We will engage with localities, jointly resource, prevent problems occurring or escalating and reduce inequalities. Given its work with vulnerable groups, Social Work will play a major role.

5.5 During the last year Dundee's Fairness Commission published 56 recommendations for action in their report 'A Fair Way to Go' aiming to tackle issues of stigma and social inclusion, work and wages, reducing the education gap, benefits, advice and support, housing and communities (including food and fuel poverty) and improving health. These recommendations have informed a range of plans, including the Tayside Plan for Children, Young People and Families 2017-2020.

5.6 The Tayside Plan sets out the joint vision and priorities across the three local authorities, NHS Tayside and other local and national partners. It has been informed by the views and responses from children and families gathered through the Dartington Social Research Unit in 2014. It has a clear focus on reducing inequalities and improving outcomes for all of Tayside's children, with partners committed to working collaboratively in five priority areas:



5.7 The Plan also identifies a range of ways in which Children and Families will work with Health and Social Care Partnership to improve outcomes for children, young people and adults. These include developing shared strategies on joint priorities such as parenting, substance misuse and mental health, with a focus on prevention, early intervention, transitions and tiered responses to need. There is a shared commitment to self-evaluation across the workforce and community so we can understand strengths and address areas for improvement.

5.8 In 2016-17 the work of the Health and Social Care Partnership continued to be guided by the eight strategic priorities set out in The Strategic and Commissioning Plan. Under each of these priorities there are a range of strategic shifts that have been identified. A locality approach will provide the overarching framework for the development and implementation of the plan, including the allocation of resources to achieve the strategic shifts against the priorities identified. The 8 priorities are:

1 Health inequalities
2 Early intervention/prevention
3 Person centred care and support
4 Carers
5 Localities and engaging communities
6 Building capacity
7 Models of support/pathways of care
8 Managing our resources effectively

6 Finance

6.1 In 2016/17, the total Social Work budget of £119,120,000 was allocated across services as follows:

Service Area	2016/17 Budget £000
Children's Services	£34,794
Community Justice Services	£260
Adult Services*	£37,655
Older People*	£46,411
Total	**£119,120**

* Delegated to Dundee Integration Joint Board

Children's Services experienced significant financial pressures around Looked After Children due to national requirements for parity of payments between kinship carers and foster carers and the demands of new Continuing Care legislation. The Continuing Care entitlements have led to more young people staying for longer in Children's Houses and reduced local capacity to accommodate others. As a result, more children and young people have been accommodated in more expensive external placements.

In response, an action plan has been developed to reduce the overall numbers of Looked After Children and re-model the type and range of local placement options. This includes work with the Third Sector on preventative services; work to increase the number of foster carers; the new build of another Children's House; the development of satellite flats attached to Children's Houses; and additional, targeted support to more vulnerable placements at risk of breaking down.

The Community Justice budget continued to be supported by grant funding of £4,667,000 from the Scottish Government on a ring-fenced basis, for spending on matters relating to community justice only. The Council provided a further £260,000 in respect of human resources, finance, legal and related supports.

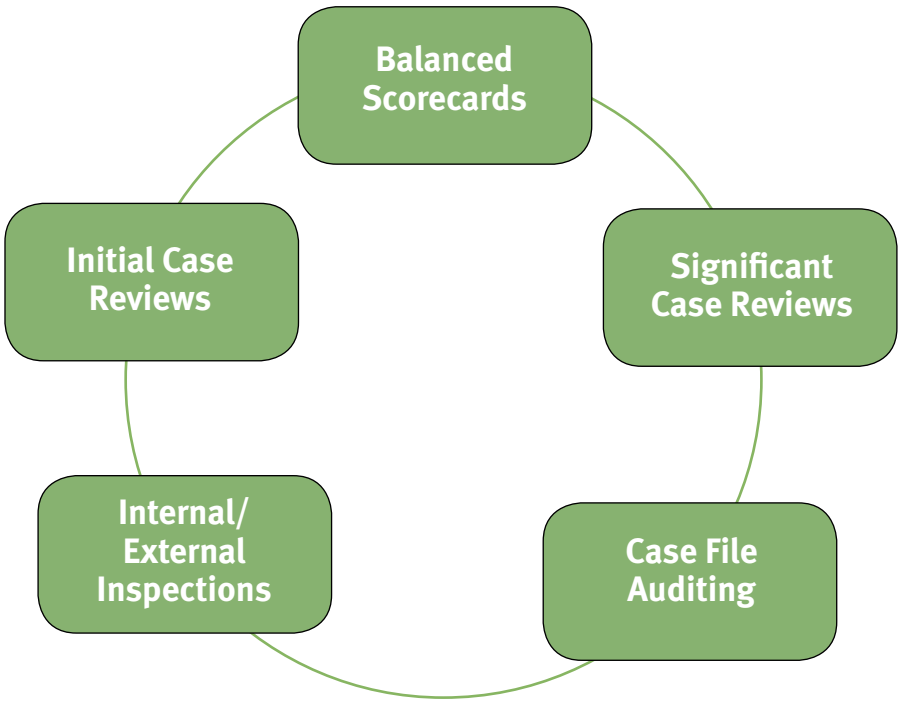
The budget to support the delivery of adult social work and social care services was formally delegated by the Council to the IJB for the first time in 2016/17. Substantial efficiency savings were required which meant that services and strategic priorities had to be delivered within a restricted budget. However, the IJB reported a £1.032m underspend against core social work and social care budgets, with a further £3.931m underspend within Integration Change Funding. This has been carried forward into 2017/18 to support the further development of new models of care.

7 Service Quality and Outcomes

7.1 Self-Evaluation

Social Work services lead and participated in a number of single and multi-agency self-evaluation activities focused on continuous improvement and improving outcomes for service users, carers and communities. These activities sit within the framework of the Care Inspectorate Performance Improvement Model and include case file audits, case reviews and audits of specific processes/documents. Self-evaluation activity is supported by the Learning and Organisational Development Service to ensure that learning is effectively shared and informs improvement plans at team and service level, as well as contributing to the development of strategic and commissioning plans for health and social care and children and families.

In 2016-17, the Protecting People grouping finalised a Learning and Continuous Improvement Framework which outlines a series of linked activities focusing on both quantitative and qualitative indicators of performance and improved outcomes. In recognition of the commitment to continuous improvement from the Chief Officers Group and the significant resource required to implement the framework during 2017/18 a specific post will be established to support the framework implementation across all agencies, including Social Work services. The elements are:



In 2016/17, Social Work also introduced a new service user record keeping and information system, known as MOSAIC. As well as supporting operational service delivery, the design of MOSAIC will promote easier data collation and analysis and help to further improve performance. Whilst the focus this year has been on transition to the new system and associated training and support for staff, the new system will have an important role within service self-evaluation and quality assurance activity in 2017-18.

The Child Protection Committee also commissioned its first Learning Together Significant Case Review in 2016/17 which identified a number of areas for improvement which have been developed alongside learning from a CELCIS Neglect Improvement Programme, into an overarching GIRFEC implementation action plan. Immediately following the conclusion of the SCR a range of single and multi-agency case file auditing, including a Children's Services Social Work audit, were undertaken to better understand the quality of provision to vulnerable children and young people and required improvement actions. Specific developments that have been progressed based on the findings of the review include:

- the development of a performance and quality assurance framework for the Multi-Agency Screening Hub;
- a review of the referral pathways for children and young people with disabilities; and,
- the development of a comprehensive learning and development programme to support implementation of GIRFEC, covering risk assessment, children and young peoples' plans, chronologies, and outcome measurement.

As part of the Chief Officers Group (COG) the CSWO has played an important role in overseeing the quality and impact of responses to children, young people and adults in need of protection, as well as interventions with perpetrators of abuse. Through their collective leadership the COG has supported the Independent Chairs / Convenors of the public protection committees to enable multi-agency co-operation and collaboration across all public protection issues. The CSWO has been an active participant in the regular Chief Officer Engagement Events over the last year have focused on responding to neglect and challenging stigma.

7.2 External Scrutiny

In 2016/17, there were no joint inspections of Social Work services undertaken in the Dundee area. Appendix 1 sets out the outcomes of external scrutiny of care services provided by the Council and the Health and Social Care Partnership. These grades have remained consistently high in the main and there is a process in place that any issues raised are quickly discussed with the appropriate service and improvement plans put in place. Comments from service users during inspections included:

Quotes from Service users:

"Yes I know I have a support plan, I remember discussing it with staff. They asked me the things I needed help with and we also talked about my interests."

"Staff help me cook my own meals - we go shopping too."

"I feel safe and can make choices about a range of things"

Commissioned Services 8

8.1 In 2016/17, Social Work services continued to be delivered through a mixed economy of local authority, private, independent and third sector provision. In total, there were 192 contracts with 101 suppliers of social care services. Of these, 133 were involved in the supply of regulated services, ranging from residential care to care at home. The remaining 59 contracts were for unregulated services, including lunch clubs, advocacy services and family support services.

8.2 The continued operation of a Social Care Contracts Team operating across Children and Families and the Health and Social Care Partnership has supported robust contract monitoring. In 2016/17, former Education and Social Work contracts were brought into a single Children and Families contractual process. Work also took place under Health and Social Care integration to bring a small number of contracts previously administered by NHS Tayside into the Social Care Contracts Team.

8.3 Partnership work with external providers has continued over the last year with a range of innovative and creative approaches in place to ensure the best use of local resources. Examples of this over 2016/17 include:

- A Family Support Framework has been established via an open tender exercise. Under this arrangement, 8 local providers can be commissioned individually or under a partnership arrangement to provide a holistic family support service tailored to suit individual families. A collaborative forum is in place where discussion and learning can take place to ensure the model continues to be fit for purpose.
- The Health and Social Care Partnership published Shaping the Adult Health and Social Care Market in Dundee 2017-2021; it's first market facilitation strategy. As well as facilitating a discussion between the Partnership, service providers, service users, carers and other stakeholders about the future shape of the local social care market the strategy sets-out our approach to good governance and management of services in order to support high quality and good outcomes for service users.
- A Dundee Learning Disability Provider's Forum aims to increase the capacity and skills of provider organisations in order to improve the quality of life for people with learning disabilities. It was the first public body in Scotland to sign up to a national charter ensuring that people with additional support needs have a say in the issues that affect them. The charter informs all commissioning relating to people with learning disabilities.
- In Children and Families work has continued to progress towards a Strategy and Commissioning policy that creates an outcome focussed framework with equity of access and strategic commissioning decisions that will inform commissioning work in the future. During 2016/17 a working group from the Strategy & Performance Team, Contracts and Third Sector partners have achieved an agreed shared set of commissioning principles. These principles include the following and will be used to inform commissioning decisions from 2018/19:

1. A commitment to multi-year funding for the Third Sector.
2. Outcome focussed decisions.
3. Focus on early intervention and prevention.
4. Focus on innovation.
5. Equality of access for big national and small local Third Sector organisations.

- In Justice, the Community Justice Outcome Improvement Plan was developed in collaboration with the Third Sector and includes a commitment to Third Sector provision in line with the priorities outlined in the plan. As the TCA Mentoring Service is funded by a temporary Change Fund budget until 2018, this includes an ongoing commitment to monitoring the impact of both this and other Third Sector services. Partners are committed to ensuring that all funding is targeted at those areas which have demonstrated a positive impact on reducing re-offending and related outcomes and/or are required on a statutory basis.

9 Complaints

9.1 In Dundee, the Social Work Complaints Procedure had up to 4 stages with different points of possible appeal against decisions. In 2016-17, the total number of statutory complaints received from service users was 77, compared with 56 the year before. There were 22 complaints relating to Children's Services, 40 in Community Care and 5 in Criminal Justice. The 5 remaining complaints related to financial charging. The outcomes were:

- **Upheld** – 28.5%
- **Partially upheld** – 17%
- **Not upheld** – 55.5%

9.2 Most of the complaints related to a failure to meet service standards or treatment by or attitude of a member of staff. Two of them progressed to the final stage of the appeal process or the Scottish Public Services Ombudsman. The agreed timescales for finalising investigations was met in 50% of cases, with delays usually caused by the complexity of the complaint and the investigation taking longer than expected.

9.3 Given the total number of Social Work service users of 9,000, the number of complaints is small however services do endeavour to use complaints to improve practice and improvement services. In 16/17, a total of 34 planned service improvements were implemented.

9.4 From the 1 April 2017 social work complaints will follow the Scottish Public Service Ombudsman (SPSO) Model Complaint Handling Procedures. Both the Dundee Health and Social Care Partnership and Social Work Complaint Handling Procedures have been developed during 2016/17. They have each been assessed as complying with the model complaint handling procedure by the SPSO. The CSWO will continue to monitor complaints across both of these procedures.

In addition to complaints, a range of compliments have also been received from service users and some examples are provided below:

Adult Care Physical Disabilities
'My brother passed away a little over 2 weeks ago and I wanted to send a note to let you know how well I and my family feel we were supported over the last 7 to 8 years by your team in Dundee'.

Community Response Team
'NHS 24 contacted the Community Response Team late last night after my wife had fallen to the floor and I was unable to assist her back up. We were both very grateful to the team that arrived to assist. They were very professional, friendly and supportive and we can't thank them enough for their help and good humour'.

Community Justice Unpaid Work Team
'Please can you pass our thanks to the team who painted our sensory garden. It is looking much better and is lovely and bright. Once the bedding plants are in it will look great. Just in time for the better weather and the summer holidays when the children get the most out of the garden'.

10 Performance

10.1 In Dundee, the CSWO reports statutory and local performance indicators through the Council Annual Performance Report and the Integration Joint Board Annual Report. This is supplemented by a range of separate reports to Elected Members, the Integration Joint Board and the various governance bodies relating to Children's Services, Criminal Justice and Health and Social Care. Further oversight is provided by the Chief Officer Group for Protecting People, including scrutiny of Balanced Scorecards. In 2016/17, trends included:

10.2 Children's Services

- The length of time children stayed on the register continued to reduce, with 87% de-registered after less than 12 months. This indicates that measures put in place reduced the level of risk and protected children from harm.
- A total of 45 Child Protection Orders were made, which continue to be higher than the Scottish average and represents a slight increase from the previous year. In partnership with the Children's Reporter, the service continues to scrutinise applications for CPOs and trends are considered at the Child Protection Committee.
- The number of Looked After Children is slowly reducing and is now consistently under 600 at any one time, with 570 on 31st March 2017. Over 90% of Looked After Children are cared for in the community, similar to the national average.
- There were a total of 13 Emergency Placements, which involve authorising an emergency move of children and young people subject to supervision requirements in cases of urgent necessity. This was slightly higher than the previous year.
- The attendance gap between looked after and non-looked after pupils is gradually narrowing and there has been significant reduction in exclusions for looked after pupils by almost 20%.
- The proportion of looked after children and young people living in Dundee or the outskirts of Dundee and attending Dundee schools is gradually increasing from 71.3% in 2015/16 to 71.9% in 2016/17.
- The proportion of care leavers aged up to 26 years old in education, training or employment was 41.2%. This continues to be a key priority, with a range of actions outlined in a Corporate Parenting Plan.
- The Through Care and Aftercare Team ensured all Care leavers aged 21 26 years were contacted to ensure they were aware of available supports in their transition into adulthood.
- There were 143 children and young people with complex needs supported by Social Work, with 25 receiving respite services at Gilburn Road.
- The service has also significantly enhanced collaborative working with Kingspark School, which provides a range of education and health services to pupils aged 5 to 18 years who have complex additional support needs. A Social Work lead officer now forms part of the school management team.
- The overall number of children and young people in secure accommodation continued to be low at 8 over the course of the year with the majority being girls.

- In respect of permanent alternative care and adoption, 33 Permanence Orders were made and of these, 18 were with authority to adopt.
- There continues to be a shortage of carers and adopters for some groups of children and young people, including adolescents, large sibling groups and children with complex additional support needs.
- Almost half a million pounds was generated in unclaimed benefits entitlements by the Council Advice Service for kinship carers as part of the approach to income maximisation in relation to achieving parity with foster carers.

10.3 Adult Support and Protection

- In 2016/17 918 adult protection referrals were received which is a decrease from 2015/16 when 1,246 referrals were received. 142 of these referrals resulted in adult protection activity, with 49 Adult Support and Protection Case Conferences taking place over the year. Most referrals (741 - 81%) continue to be made by Police Scotland.
- Of the 142 which resulted in adult protection investigations, financial and physical harm featured as the highest single areas of adult harm identified. In the other referral reason categories neglect by carer and risk associated with vulnerabilities due to age, disabilities or health concerns, domestic abuse, fire safety risk, harassment and welfare harm.
- During 2016/17, 500 referrals have been considered by the Early Screening Group providing opportunities for early intervention and prevention and contributing to the overall decrease in the number of adult support and protection referrals received.

10.4 Mental Health

- There were a total of 80 emergency detentions in hospital, compared with 90 the year before. There has been an average of 82 detentions a year in the last 5 years.
- There were a total of 152 short-term detentions in hospital, compared with 148 the year before. There has been an average of 146 short-term detentions a year in the last 5 years.
- There were 22 Compulsory Treatment Orders, compared with 39 the previous year. Following a four year period in which numbers have remained generally consistent, this represents a significant reduction in orders.
- The Mental Health Officer Service has established a positive trend over the last 3 years towards increasing the proportion of social circumstances reports (SCRs) provided to the Mental Welfare Commission following periods of short detention. In 2014/15 (the last year for which data is available) 50% of detentions were followed by submission of an SCR. As the service is in the process of transferring data from one system to another, figures are not yet available for 2016-17.
- There were 94 Local Authority and 131 Private Guardianship Orders granted in 2014/15 (the last year for which data is available), compared with 99 and 131 the year before. Within this there has been an increase in the proportion of orders granted on an indefinite basis. As the service is in the process of transferring data from one system to another, figures are not yet available for 2016-17.
- The service continued to promote the Power of Attorney Campaign during 2015/16 as a means through which to reduce the number of Guardianships and subsequent impacts on Social Work services. As the service is in the process of transferring data from one system to another, figures are not yet available for 2016-17.

- The number of people subject to Compulsion Orders with Restriction (12), and Treatment Orders (2) has remained stable in comparison with the year before. There has been a slight reduction in Transfer for Treatment Directions (1 in 2016/17) and a slight increase in Compulsion Orders (10 orders in 2016/17) and Assessment Orders (5 in 2016/17).

10.5 Criminal Justice

- A total of 656 Community Payback Orders were imposed, compared with 795 the previous year. This is the first time there has been a reduction in the number of CPOs since they were introduced in 2011.
- The total number of Unpaid Work hours carried out was 40,016, compared with 38,864 the previous year. This increase reflects requirements for people to start unpaid work earlier, work more often and complete sooner.

People said:

''I felt I was doing something worthwhile''

''I learned about staying out of trouble''

''I got motivation and into a routine''

- Over 79% of all Community Payback Orders were completed successfully, compared with 70% the year before. This means the person reached the end of the Order without re-sentence for non-compliance or further offences.
- In respect of Drug Treatment and Testing Orders, the Sheriff Court imposed 12 Orders compared with 6 the year before. These Orders are designed for people with the most chronic substance misuse problems related to offending.
- There were 154 Registered Sex Offenders subject to statutory supervision under MAPPA, with 3 assessed as high risk, 35 as medium risk and 116 as low risk. There was an increase in internet related offending.

One person said:

"Whilst I am not sure what the future holds I feel as though I am better suited to serve a more purposeful life. I hope that with the ongoing support I receive I learn to address my thoughts and feelings and this will allow me to progress throughout my life."

- There were 126 Community Payback Orders imposed on women compared with 147 the year before. A total of 67% of these Orders were completed successfully, compared with 70% the year before.
- There were 144 people serving prison sentences of more than 4 years who will be subject to statutory supervision on release, compared with 144 the year before. The service provides through care whilst they are in prison.
- There were 20 new Supervised Release Orders (SROs) compared with 18 the year before. In total, 18 were completed successfully compared with 12 the year before.

- The number of young people receiving a custodial sentence continued to be very low, with only 3 compared with 6 in the previous year. This success is attributed to the effectiveness of our whole systems approach.

Case Study: A Partnership between Dundee City Council, Advance Construction, Kilmac Construction and Robertson's Construction

This programme was aimed at supporting young people who have been through the Youth Justice System or from disadvantaged backgrounds. They were supported by employees and supervisors from the construction companies and Dundee City Council to participate. There were 6 young people involved in this programme and with the right support and intensive training they are all now in permanent employment, working in construction and earning salaries above the living wage. One of the most exciting elements of this programme is that it has become a preferred recruitment model for both Kilmac and Advance Construction. Both Kilmac and Advance have enough confidence in the programme that they approached Dundee City Council to run another programme for 6 young people.

As an example of an Unpaid Work project carried out in 2016-17, the Project Team were informed of a Sheltered Housing Complex which had an external space that was no longer accessible for people with mobility difficulties and no longer useable for congregating. Following a period of planning with residents and staff, a team of 5 people subject to Unpaid Work and their Supervisor worked on the project each day for 3 weeks. The team liaised with DCC Neighbourhood Services to access specialist equipment to build a concrete ramp to allow safe access from the flats in the Complex. A facing fence was built to improve the look of the existing boundaries and borders and planting pots were installed. Another team of individuals based in the Unpaid Work Project Indoor Workshop, constructed benches for the new patio. The residents now have an accessible, safe, low maintenance outdoor communal area in which they can gather or relax and they can also tend the plants in the pots.

The individuals on Unpaid Work undertaking the development had the opportunity to experience basic landscaping and construction work. They expressed a sense of satisfaction at being able to contribute to a worthwhile community based project. Before and after pictures are shown below:

10.6 Health and Social Care

- 93.9% of adults supported at home who participated in the Health and Care Experience survey agreed that they have been supported to live as independently as possible. Performance has therefore been maintained and is slightly above the Scottish average. A rehabilitative pathway has been developed in order to support people moving from the Centre for Brain Injury Rehabilitation into community settings. In partnership with Angus Health and Social Care Partnership a shared community equipment loan service has been launched for people with disabilities which delivers, installs, repairs, maintains and recycles a range of equipment to help people of all ages to live independently.
- The same survey found that an increasing proportion of adults (94%) receiving any care or support rate this as excellent or good. The same proportion of adults supported at home as in previous years (88%) agreed that their services and support had an impact in improving or maintaining their quality of life.
- The emergency admission rate (per 100,000 people aged 18+) declined in comparison with previous years (12,411 in 2016/17), however the emergency bed day rate (per 100,000 people aged 18+) improved (136,059 in 2016/17), although this remains above the Scottish average.
- There proportion of time in the last 6 months of life spent at home or in a community setting has been maintained at 87%, which is in line with the Scottish average.
- Over the last year the MacMillan Improving Cancer Journey project has established a Cancer Voices Panel made up of members who have had a cancer diagnosis or who have cared for someone with cancer that has helped to shape services. A new locality based model of support for people affected by cancer will be piloted in 2017/18.
- Good progress has been made in continuing to reduce the level of delayed discharge; the number of days people spend in hospital when they are ready to be discharged has reduced to 755 per 1,000 population and is now below the Scottish average. An integrated discharge hub at Ninewells Hospital has supported the implementation of the Home and Hospital Transition Plan. The Home from Hospital service is providing up to six weeks support to older people following discharge and step-down services are helping to support early, safe discharge.

- The proportion of carers who felt supported to continue in their caring role (44%) remained the same as in previous years. A wide variety of work has taken place over the last year in preparation for the implementation of the Carers (Scotland) Act 2016. As well as continuing public awareness raising and engagement with carers, a pilot scheme to support people who use mental health services and their unpaid carers to access new types of short breaks suited to their needs has been developed. In addition work has been undertaken to promote and embed carers' health checks through the Keep Well Team and Dundee Carers Centre.
- 85% of adults supported at home reported feeling safe. Work is continuing across adult protection (see above) and violence against women to support vulnerable adults to feel and be safer in their homes and communities. The Safe and Together approach to domestic abuse has been implemented in one Children and Families locality, with 41 staff having been trained to support changes in practice that keep children and their mothers together, support women experiencing domestic abuse and address the behaviour of perpetrators.
- The rate (per 1,000 population) of readmission to acute hospital within 28 days increased slightly from 121 to 125. Over the last year we have taken a collaborative approach to the use of technology enabled care to support service users to live independently in their own community. We have also significantly increased investment in home based care services, including funding the implementation of the living wage for care workers in this sector. Understanding the reasons for high rates of readmission and improving performance in this area is a priority for 2017/18.
- The falls rate for over 65s increased slightly to 26 falls per 1,000 population. We have expanded our falls service to ensure patients aged 65 and over are routinely screened by Allied Health staff if presenting with a fall and follow up interventions are put in place. This expanded service includes a single point of referral, triage by nurses, self referral option to Community Rehabilitation Team and improved information sharing practices. We have also introduced falls prevention care-home education and this has resulted in a reduction in falls in care homes. Otago falls classes are now well established in community venues contributing to improvements in clinical outcomes for those who have experienced a fall.
- Our Medicine for the Elderly (MfE) Consultant, Social Work teams, Community Rehabilitation Team, Community Nursing teams and Psychiatry of Old Age services have been realigned to enable them to work more closely with our GP clusters on community based service delivery. These teams have regular multi-disciplinary meetings with individual GP practices and with GP cluster areas to look at quality improvement.
- The number of people receiving a direct payment has been steadily increasing over the last three years, with 60 receiving this last year. The amount spent on delivering services and supports under options 1 and 2 has increased considerably from over £96k to over £308k. This relates to the increasing complexity of packages of care required by service users.

Maximising Potential and Making Every Moment Count

Mr B lives in sheltered housing. He has recently begun to struggle to take care of himself at home and to maintain his social contact with friends. He has a diagnosis of dementia. His family have become increasingly concerned that his symptoms of dementia are worsening and he is forgetting to eat properly and is becoming isolated and depressed.

Mr B was referred to the Community Mental Health Team for Older People for further support. He was visited at home where he discussed his current difficulties. Mr B identified he was struggling with activities of daily living and had lost his confidence to make his own meals, to deal with finances and to go out to visit his friends at the bowling club. Mr B stated looking after himself was not a priority, as he felt there was 'no need' anymore.

The team spent time getting to know Mr B, allowing time and space for him to share his wishes and hopes for the future. Mr B told them that the bowling club had been a big part of his life, especially after his wife died and he missed the support he received. The team worked with Mr B to support him to return to the bowling club. A volunteer driver was arranged to take him and to return him home. The visits also coincided with a regular meal provided at the bowling club. Once Mr B's confidence increased, his friends at the bowling club arranged transport themselves to allow him to attend twice a week.

In addition, Mr B attended a lunch group and bingo in the sheltered housing complex which provided further social support. A support worker from the team worked weekly with Mr B to attend appointments and to assist him to set up systems to manage his finances.

Statutory Functions

11

11.1 As outlined in the legislation and guidance, there are a number of duties and decisions that can only be made either by a CSWO, or by a professionally qualified Social Worker to whom responsibility has been delegated by the CSWO and for which the CSWO remains accountable. These relate primarily to the restriction of individual freedom and the protection of service users from themselves and others and the protection of the public from service users. It includes the following:

- Children and young people on the Child Protection Register.
- Looked After children and young people.
- Fostering and adoption.
- Placement in secure accommodation.
- Offenders assessed as very high or high risk of harm to others.
- Mental health statutory provisions.
- Adults with incapacity and welfare guardianship.
- Adult support and protection.

11.2 **Children's Services Plan** – the service contributed towards the development of the Tayside Plan for Children, Young People and Families 2017-20, which includes priorities and a range of actions relevant to Children's Services. These priorities and actions have since been reflected in the Local Outcome Improvement Plan and Corporate Plan. From a Social Work perspective, they include a key focus on providing effective support to parents and carers with 0-5 year olds who are at risk of significant harm; on corporate parenting for looked after children and young people; and on child protection arrangements.

11.3 **CJS Transition Plan** – in partnership with statutory partners and as outlined in legislation, the service coordinated the development of a Community Justice Transitions Plan. This involved the establishment of a new Community Justice Partnership, which carried out a strategic assessment to identify local needs and priorities. The partnership is linked with colleagues in Health and Social Care and they have jointly identified priorities on mental health, substance misuse and domestic abuse. This work has provided the platform on which the first Community Justice Outcome Improvement Plan (CJOIP) has been developed in 2016-17.

11.4 **Health and Social Care** – the Public Bodies (Joint Working) (Scotland) Act 2014 required NHS Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. The main purpose of integration is to use the available resources to improve the wellbeing of people who use health and social care services, including adult social work services, in particular those whose needs are complex and who require both health and social care support at the same time.

Following the establishment of the Dundee IJB, they became responsible for the planning and delivery of a wide range of adult social work and social care services. The CSWO's role in relation to these delegated functions continues and the CSWO has continued to play an important role in the leadership and governance of HSC integration over the last year, ensuring that adherence to social work values, principles and standards is central to developing the partnership.

12 User and Carer Involvement and Empowerment

12.1 Social Work has a strong tradition of engaging with communities and families to mutually explore and identify key risks, needs and strengths; agree plans which protect people and help them to realise their potential; and jointly implement, review and adapt those plans. Given the range and complexity of communities and individuals, the challenge is to find creative methods which best suit their needs and promote the best possible outcomes for them and others.

12.2 In Children's Services, it is essential that the views of children, young people and their families are represented at all stages of involvement including Team Around the Child Meetings, Child Protection Case Conferences and Looked After Children Reviews. Children can also be linked to independent advocacy services and the service is piloting a Child Protection Buddy Scheme in the West of the city. In 2016-17, specific examples included:

- Parents attended 79% of all Child Protection Case Conferences compared with 73% last year. Chairs of Conferences always hold a pre-meeting with parents.
- Following the success of CP buddy arrangements, this approach is now available for all children aged 5 years and over to ensure their views are heard.
- The Champions Board for Looked After Children and Care Leavers is well established and a new approach has been piloted in one school, with an intention is to role this out to other schools in the coming year.

In Community Justice, in partnership with Third Sector organisations, the service responded to feedback from women involved in a previous independent living skills programme to adapt and refine 2 subsequent 6 week programmes. Based on their feedback, these programmes focused on the preparation and sharing of a healthy meal. At the end of the programmes, all participants successfully gained a formal qualification and went on to receive further, individualised support.

In Health and Social Care, through service user consultation and working with other services the White Top centre has contributed to improving the quality of life for service users. This has been achieved in a number of different ways over the last year:

- A widely accessible activity programme for people with a profound and multiple learning disability has been created. This provides a platform for service users to engage in their chosen activities and experience new opportunities. Joint working has been undertaken with Promoting a More Inclusive Society (PAMIS) to promote the inclusion of people with a profound and multiple learning disability in their local and wider communities.
- An opportunity was created by PAMIS for service users to be involved in making an award winning film about having a profound learning disability. After this success some of the service users and staff were asked to feature in the up and coming PAMIS film called Profound.

- Joint working with PAMIS and Tayberry Enterprise has led to the introduction of Sensory Storytelling within the service. This has been well received by service users and has provided them with a regular opportunity to be involved and explore new tactile and audio experiences. Tayberry Enterprise has also opened up the opportunity to have their lead percussionist visit the White Top Centre to provide an inclusive drumming experience.

For the past two years the Making Recovery Real (MRR) partnership has been listening to people with mental health challenges and practitioners with the intention of transforming mental health supports and services. They have told us they want to see more roles for people with lived experience through peer support, peer education and learning. The response from people with lived experience has been such that we now have seven different groups locally (involving about 40 volunteers) and have employed a Peer Support Co-ordinator to co-ordinate this work. The plan is that these groups will generate 'stories' which will help improve services. MRR has provided an opportunity to open up wide ranging discussions about recovery and what it means for people and services. It has provided a platform for discussions, a safe space to bring together professionals and members of the community on equal terms, and a mandate for change. It has provided an opportunity to have a meaningful impact on the local agenda based on that discussion and given partners hope that recovery focused practice could finally be implemented.

We have also continued to undertake specific consultation around the development of the vision and priorities contained within the Strategic and Commissioning Plan for health and social care integration. In particular, we took our consultation out into local communities, through our network of community centres and libraries, to create opportunities for the voices of local people to be heard. We spoke to in excess of 50 people. We held focus groups with employees and other stakeholders, listening to their views and contributions and used this information to develop to content of our integration plan. We had 14 focus groups with over 65 people in total (including employees) choosing to attend one of the meetings.

13 Workforce

13.1 Social Work and Social Care Workforce Development

The Council's commitment to our employees is reflected within Our People Strategy and includes our approach to Workforce and Succession Planning, Talent Management and Developing the Young Workforce. Within Social Work, shared aims for learning and development are outlined in the Organisational Development Plan and associated strategies for Health and Social Care Partnership and the Tayside Plan. These plans highlight that there will be a collaborative approach to Learning and Workforce Development across all partners. The services have been able to engage with and contribute to a wide variety of collaborative leadership development programmes with partners from across the services and geographic areas. The Council is developing a strategic approach to succession planning.

We have invested significantly in our registerable workforce to ensure they are fully equipped with the occupational competencies to meet management and leadership standards and our statutory requirements. We have continued to deliver high quality qualifications across the SSSC registerable workforce groups. A feature of work in this area is recent merger of 3 different SQA centres within the Council to maximise opportunities for delivery of suites of qualifications. We have a key role working with national partners through the Social Work Scotland, Learning and Development Sub-Group to look at creative ways to collaborate on these challenges.

In 2016-17, specific learning programmes on protection of children and adults has remained a priority. We have developed and delivered core programmes of multi-agency training on Child and Adult Protection and provided a range of face to face and high quality e-learning programmes across the protection spectrum. These include Child Sexual Exploitation, Challenging Stigma, Children with Disabilities, Roles and Responsibilities in Adult Support and Protection. Our award winning Protecting People Learning and Development Framework and online portal provides a comprehensive overview of the range of learning opportunities available across all workforce groups.

Special programmes of support for courses including the Postgraduate Certificate in Child Welfare and Protection, the Mental Health Officer Award, Practice Learning Qualification are all in place and currently prioritised for funding support in relation to our statutory duties and SSSC work streams. In 2016-17, we have enhanced the proactive approach to recruitment to the MHO award to support regular and supported intake to the programme.

The Council has a strong commitment to Practice Learning which includes opportunities for students throughout the services. We continue to provide significant professional placements and work experience opportunities for a number of workforce groups. Our aspiration is for all SW services and many other teams to provide opportunities for SW students as there remains a gap nationally in the provision of statutory placements. In 2016-17 we have achieved excellent recommendations from the significant monitoring of the PDA Practice Learning (Social Services) Qualification which we lead on behalf of 6 local authorities. The leadership and quality of the programme along with the excellence in the partnership arrangements was commended.

It is recognised that Social Work staff can operate in difficult circumstances and can be subject to aggression and violence. In 2016-17, there were a total of 40 recorded violent incidents against Social Work staff compared with 41 recorded incidents the year before. While the number appears consistent there has been an increase in the number of incidents which were reported to Police Scotland. In response, services have lone working arrangements with very clear escalation procedures for staff to follow should they encounter difficulties or not return to their place of work within a stated time. Staff are also provided with conflict management training and staff in residential units are provided with CALM training to manage difficult incidents whilst ensuring residents continue to be safe. Where incidents occur, then where relevant and required staff are provided with support. Staff in the service have also received training in critical incident de-briefing.

13.2 Promoting Social Work Values and Standards

The CSWO has a duty to ensure Social Work values and standards as outlined in the SSSC Codes of Practice are promoted. For employers, the Codes include such requirements as making sure people understand their roles and responsibilities, having procedures in place relating to practice and conduct and addressing inappropriate behaviour. For employees, protecting the rights and interests of service users, maintaining trust and promoting independence. This includes the following:

- Recruitment and selection, including checking criminal records, relevant registers and references.
- Induction, training, supervision, performance management and a range of procedures on such things as risk assessment, records and confidentiality.
- Responding to internal or external grievances or complaints about the conduct or competence of staff.
- Ensuring line managers appropriately support staff and progress self-evaluation activities to identify strengths and areas for improvement.
- Ensuring health and safety policies are in place, including risk assessments and controls for identified hazards such as lone working and moving service users.
- Ensuring that staff required to register with the SSSC do so and are supported to meet the learning and development requirements associated with this.

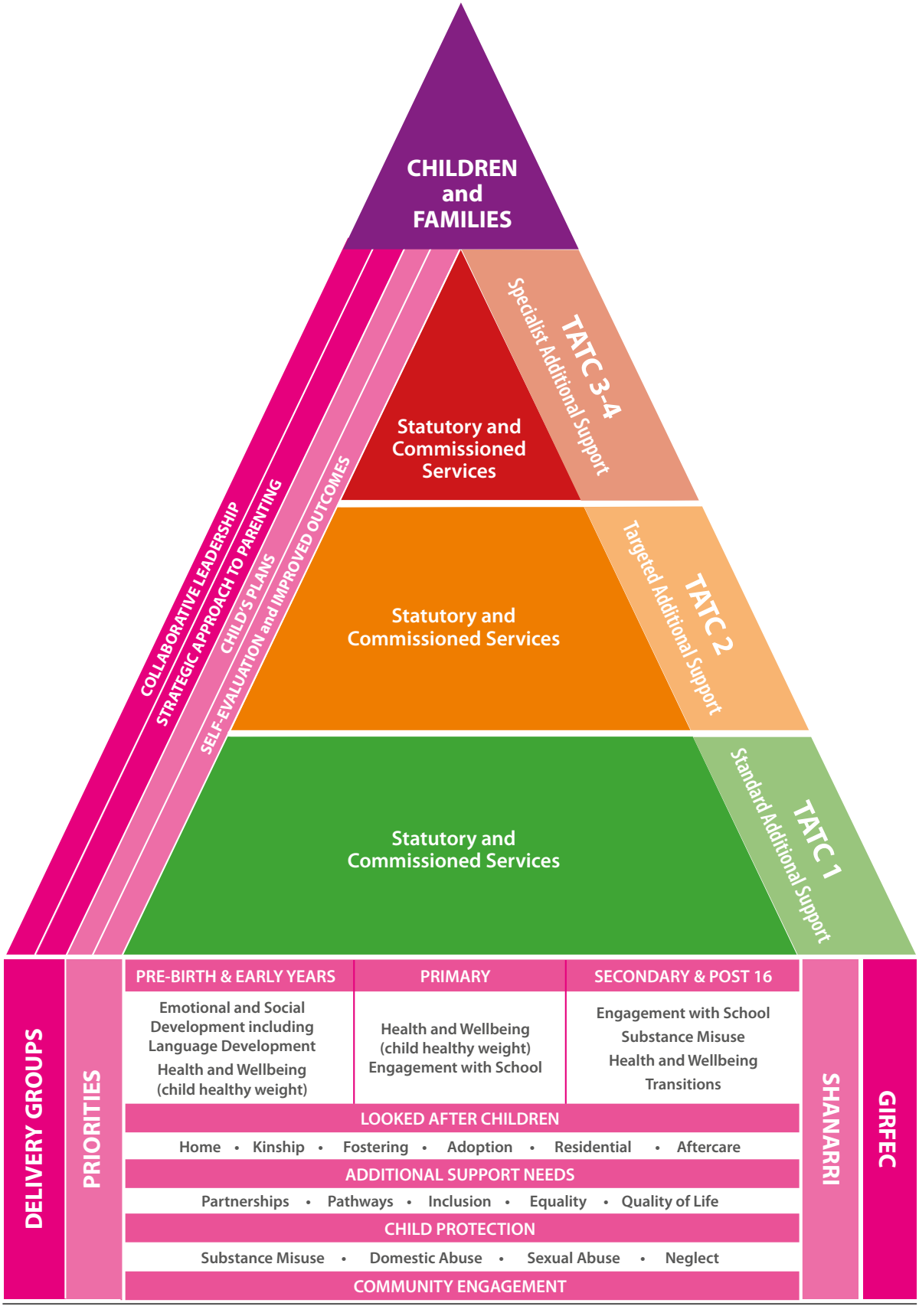
Within the Health and Social Care Partnership Workforce and Organisational Development Strategy (published in June 2016) a number of guiding principles to support the workforce to deliver on the ambitions of integrated health and social care were adopted. These locally created principles sit alongside existing legislative and clinical, care and professional governance requirements, as well as the SSSC Codes of Practice. The principles include: inclusivity and equality, visible leadership, collaborative co-production and reflective practice.

14 Improvement Approaches and Examples/Case Studies

14.1 Planning for Change

Following the publication of the Joint Inspection Report in March 2016, the Children and Families Service embarked with partner agencies to address the 4 areas for improvement relating to collaborative leadership, self-evaluation, parenting and child's plans. A new Children and Families Executive Board was established to oversee developments. The Board is supported by a new Strategy and Performance Team which includes representatives from different Council services, NHS Tayside and the Third Sector. The team provides targeted capacity and expertise for the development of integrated services within and between partner agencies and local communities. There have been a number of related developments:

- A partnership programme with the Centre for Excellence for Looked After Children (CELCIS) on approaches towards neglect. This has involved adopting new improvement methodologies with both senior leaders and front-line staff and has led to the remit for the initiative being expanded to encompass the effective implementation of GIRFEC as a whole. As such, the programme has identified 3 inter-related priorities on support to increase the capacity, confidence and competence of Named Person's to carry out their roles; new approaches towards the effective engagement of whole families, including parents/carers and siblings; and developing a shared culture and ethos
- This methodology is helping to address the areas for improvement on collaboration, parenting and child's plans. It also serves as a platform on which other improvement actions have been and will continue to be progressed, such as the 5 priorities outlined in the Tayside Plan and the 10 issues for consideration identified by the Significant Case Review which focused on a case involving neglect. A further, related development involves the creation of locality based family support hubs coordinated and delivered by the Third Sector. These hubs will act as triage centres for Named Person's or children, young people and families in need of additional resources and/or support.
- The approach towards self-evaluation has also been strengthened, with a new Protecting People Learning and Continuous Improvement Framework focusing on both quantitative and qualitative processes, measures and outcomes. In respect of Children's Services, the Significant Case Review led to an Improvement Plan which is being implemented by partners; a Child Protection Balanced Scorecard is continually helping to identify and address key areas for improvement; and a case file audit on a randomised sample of Social Work files identified significant improvements in the quality of assessments, chronologies and plans for children and young people whilst confirming further improvements are required. This approach is being expanded to include audits of universal services in 2017-18.
- To ensure that Dundee City Council and Dundee Health and Social Care Partnership can effectively meet its statutory obligations a review of the Mental Health Officer (MHO) Service has been completed. This identified 18 priorities around the themes of pursuing interventions with the minimal restriction on people's rights and freedoms, service responsiveness, workforce development and capacity and quality assurance. A three year MHO Service Action Plan has been developed and implemented over the last 12 months to maintain a focus on achieving the 18 priorities, National Standards for Mental Health Officers and Clinical, Care and Professional Governance requirements. Key achievements through 2016 – 2017 have included:


CHILDREN and FAMILIES
COLLABORATIVE LEADERSHIP
STRATEGIC APPROACH TO PARENTING
CHILD'S PLANS
SELF-EVALUATION and IMPROVED OUTCOMES
Statutory and Commissioned Services
TATC 3-4
Specialist Additional Support
Statutory and Commissioned Services
TATC 2
Targeted Additional Support
Statutory and Commissioned Services
TATC 1
Standard Additional Support
DELIVERY GROUPS
PRIORITIES
PRE-BIRTH & EARLY YEARS
PRIMARY
SECONDARY & POST 16
Emotional and Social Development including Language Development
Health and Wellbeing (child healthy weight)
Health and Wellbeing (child healthy weight)
Engagement with School
Engagement with School
Substance Misuse
Health and Wellbeing
Transitions
LOOKED AFTER CHILDREN
Home • Kinship • Fostering • Adoption • Residential • Aftercare
ADDITIONAL SUPPORT NEEDS
Partnerships • Pathways • Inclusion • Equality • Quality of Life
CHILD PROTECTION
Substance Misuse • Domestic Abuse • Sexual Abuse • Neglect
COMMUNITY ENGAGEMENT
SHANARRI
GIRFEC

- Last year the MHO Team members approached Making Recovery Real with a view to exploring how they could link in with the initiative to help them share their discussions on possible improvements with people who have experience of using the service, about areas for improvement and how best improvements can be achieved. An event was held where people with lived experience of mental health challenges and of using the MHO services and MHO team members identified key areas for improvement and how they would work together to develop and test new ways of working. It was agreed this should not be a one-off discussion but a dialogue where people with lived experience can be engaged in on-going discussions about areas for improvement and how best improvements can be achieved.
- Development of procedures relating to Adults with Incapacity and Mental Health Acts to support consistency of practice across the Partnership. It is planned to implement these procedures during 2017-2018.

14.2 Personalisation and Outcome Focused Practice

To date, much has been done to transform the way we commission and deliver services to focus more on personal outcomes or more simply put "what matters" to a person in their daily, weekly, annual lives.

The introduction of Outcome Focused Assessment and Reviewing is still an iterative process where ongoing review of the new tools, supporting IT systems and associated paperwork is ongoing. This will continue until the partnership is satisfied that it is fit for practice and is in line with the messages given out at National Training sessions 'Good Conversations'' facilitated by the Personal Outcomes Network.

A programme of training has been rolled out to all staff who have a role to play in assessment. This training has also been offered to our private and voluntary providers. To date, 468 staff have attended and feedback has been hugely positive. A further 3 workshops were delivered in March 2017 specific to Lead Professional Model for Homelessness (62 people across the partnership).

In 2017/18 we will be focusing on embedding outcomes at all levels of the partnership, focusing on integrated assessments, in the context of locality working and on reporting against high level outcome indicators to evidence the personal outcomes being achieved.

14.3 Self-Directed Support

Since the introduction of the Social Care Self-Directed Support (Scotland) Act (2013), there has been some progress in respect of the uptake of Options 1 and 2 but this has been slow, compared to the other 32 local authorities.

Work has been on-going with staff through focus groups and a survey. Findings revealed that 88% of staff are either confident of very confident using an outcomes approach. They highlighted some issues around process and paperwork being time consuming, which is currently being reviewed. There seemed to be a direct relationship between the people who said they had been trained and a higher level of confidence in offering self-directed options.

A local work-plan has been developed to take forward areas of work to allow more flexible and responsive systems to deliver SDS taking a community focused, asset based approach.

The Children with Disabilities Team have a designated worker whose role is to increase awareness of SDS across the service and develop consistent approaches. There have been 18 young people and their families where involvement has resulted in outcome focused plans with SDS options. The worker has also been involved with the Carer's Centre regarding the range of literature available to children and their families.

"Z is a 10 year old boy on the autistic spectrum who was socially isolated due to his disability and lack of awareness of danger. In discussion with the family, Z and his mother were keen for him to have opportunities with his peers with similar needs and abilities. His mum noted that community resources had been previously tried but never sustained. The worker spoke with a local after school club for children on the autistic spectrum and it was agreed that funding would be provided for him to attend the group 2 evening a week. In response, Z and his mother now say he is enjoying the opportunity for safe social interaction with his peers. His mother and his school have also noted improvements in his behaviour."

14.4 Challenges for the year ahead

- The environment social work operates within is increasingly complex with multiple reporting arrangements. Although this can be challenging it also affords opportunities for increased collaborative working across a range of partnerships. The next year will see a number of significant legislative changes which will have a direct impact on the work of the service. The outcome of the on-going review of Education Governance also has the potential to impact significantly on the work of the Children and Families Service across the City and from a social work perspective I believe it is important that any such reforms are based around a commitment to developing the whole child through the Getting it Right for Every Child approach.
- Given the complexities of the environment within which social work operates we continue to work to strengthen the range of joint working and interfaces across partnerships on issues such as substance misuse, domestic abuse and transitions from childhood to adulthood. Work from the Scottish Government's Fairer Scotland and local Fairness Commission Action Plan continue to inform our approaches especially around areas such as welfare, poverty and stigma.
- Building on developments over the last 12 months, the coming year will see locality based working and integration becoming increasingly embedded across the city. As part of this, the CSWO will continue to play an important role in ensuring the local authority fulfils its statutory responsibilities, particularly within delegated arrangements. Approaches to clinical care and professional governance will continue to be developed providing operational scrutiny and quality assurance.
- At the end of 2016 Audit Scotland published 'Social Work in Scotland' highlighting that current approaches to delivering social work services are not sustainable in the long-term, but that there also significant risks that further reducing costs will affect the quality of service delivery. In their report Audit Scotland emphasised the need to work closely with service providers, people who use services and carers to commission services that make the best use of local resources and expertise. They also promoted approaches that support community capacity building in order to better support vulnerable people to live independently in their own homes and communities. In Dundee all social work services will continue to face major challenges in respect of the financial environment which will continue to require new ways of working, including the involvement of communities in service redesign and the prioritisation of scarce resources. This also includes building on the joint working agenda with neighbouring councils, NHS Tayside and other agencies. The CSWO will have an important role in ensuring that any changes do not detract from the quality of care and are fair and equitable.

- In community justice we will work with partners to implement the Community Justice Outcome Improvement Plan and work with Scottish Prison Service on developing new approaches to women in custody.
- In Children's Services we will work with partners to implement the Tayside Plan for Children, Young People and Families. We will have a particular focus on our approaches to neglect, enhancing community capacity through locality based family support hubs and remodelling of local accommodation options for Looked After Children.
- Across Health and Social Care the priority is to develop a better understanding of reasons for hospital readmissions within 28 days and identify appropriate supports to enable people to remain at home safely; implement the requirements of the Carers Act and further develop the range of supports for carers to enable them to feel supported; improve access to mental health and wellbeing support and pathways between community, primary and acute services for people who face mental health challenges.

Appendix 1
Summary of Care Inspectorate Gradings – All Registered Services with the exception of Care Homes in Dundee

Organisation	Name of Service	Service Type	Category LA/Priv/ Vol	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Dundee City Council	White Top Centre	Adult Respite	LA	06/01/17	6	6	6	6
Dundee City Council	Mackinnon Centre	Adult Respite	LA	15/02/17	6	6	6	6
Dundee City Council	Oakland Centre	Support Service	LA	28/09/16	6	5	6	5
Dundee City Council	Weavers Burn	CAH/HS	LA	03/11/16	2	-	3	2
Dundee City Council	Craigie House	Care Home	LA	25/01/17	5	4	5	4
Dundee City Council	Menzieshill House	Care Home	LA	07/11/16	5	5	5	5
Dundee City Council	Turriff House	Care Home	LA	01/03/17	5	5	5	5
Dundee City Council	Janet Brougham House	Care Home	LA	27/10/16	5	6	5	5
Dundee City Council	Gillburn Road	Respite	LA	18/01/16 18/03/15	4 5	5 5	5 5	4 5
Dundee City Council	The Junction	Care Home	LA	25/02/15	4	5	4	4
Dundee City Council	Millview Cottage	Care Home	LA	08/02/16 16/03/15	4 4	5 5	4 4	4 4
Dundee City Council	Drummond House	Care Home	LA	21/01/16	4	5	5	4
Dundee City Council	Fairbairn St YPU	Care Home	LA	24/02/16	4	5	5	4
Dundee City Council	Fostering Services	Fostering	LA	04/09/15 03/04/15	4 4	n/a n/a	5 4	4
Dundee City Council	Adoption Services	Adoption	LA	04/09/15	4	n/a	4	4
Dundee City Council	Through-care & Aftercare Service	Housing Support Service	LA	17/03/16	4	n/a	5	3
Dundee City Council	Homecare Social Care Response Service	Care at Home and Housing Support combined	LA	01/09/16	5	n/a	5	5

Appendix 1 (continued..)

Organisation	Name of Service	Service Type	Category LA/Priv/ Vol	Inspection Date	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Dundee City Council	Home Care Locality Teams and Housing with Care – East	Care at Home and Housing Support combined	LA	24/03/17	5 5	n/a n/a	5 5	5 5
Dundee City Council	Home Care Locality Team and Housing with Care – West	Care at Home and Housing Support combined	LA	22/02/17	5 5	n/a n/a	5 5	5 5
Dundee City Council	Home Care Enablement and Support and Com-munity MH Older People Team	Care at Home and Housing Support combined	LA	08/12/16	5 5	n/a 5	5 5	5 5
Dundee City Council	Supported Living Team	Support Service	LA	22/12/16	6 6	n/a n/a	6 6	6 6
Dundee City Council	Dundee Community Living	Support Service	LA	04/11/16	6	n/a	6	6

- not assessed
n/a - no requirement to be assessed

Notes

2016

2016

Head of Integrated Children's Services and Criminal Justice/
Chief Social Work Officer
Children and Families Service
Dundee City Council
Floor 2
Dundee House
50 North Lindsay Street
Dundee DD1 1NF

t: 01382 436001
www.dundeecity.gov.uk

Dundee Health & Social Care Partnership

Dundee City Council
www.dundeecity.gov.uk
CHANGING FOR THE FUTURE

...you can do so much more ONLINE at...
dundeecity.gov.uk

Design by Communications, DCC FA/11/17

ITEM No …11…….

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19 DECEMBER 2017**

REPORT ON: **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2016/17 – TRANSFORMATIONAL PUBLIC HEALTH**

REPORT BY: **DIRECTOR OF PUBLIC HEALTH**

REPORT NO: **DIJB54-2017**

1.0 PURPOSE OF REPORT

This report brings forward the Director of Public Health's Annual Report 2016/17 for information.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of this report and the Director of Public Health's Annual Report (attached as Appendix 1).

2.2 Notes the progress made against 2015/16's recommendations (pages 4-7 of Appendix 1);

2.3 Supports the recommendations for 2017/18 (page 8 of Appendix 1).

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 Annually, the Director of Public Health in each territorial Health Board is required to publish an independent report on public health. In 2014 I was asked to produce a more focused and better illustrated Report covering fewer topics - feedback on the revised format has been extremely positive.

4.2 Over a three year cycle all our priorities are covered in my Report. This year's Report revisits 2013/14's topic areas (with the addition of Realistic Medicine) and comprises:

- A Population Profile of Tayside
- Health Protection
- Halting the Obesity Epidemic
- Realistic Medicine
- Sexual Health and Blood Borne Viruses
- Substance Use

Next year the Report will cover a different range of topics.

4.3 The Director of Public Health Annual Report is required to be taken to Tayside NHS Board and made public for use by local stakeholders, including individuals, committees, third sector, local authorities and NHS partners.

4.4 The Report focuses wherever possible on the health inequalities which surround us, and the

efforts being made in partnership to promote health equity. Transformational change in population health and wellbeing can be achieved by taking an explicitly public health approach, incorporating co-production, needs assessment, prevention, value for money, early intervention, putting evidence into practice, shifting the balance of care, having people formerly known as patients at the heart of all change, health and economic literacy, and asset based approaches with a resolute focus on equity.

4.5 It is sometimes said that public health is part of the solution. In my opinion a public health approach is the solution – not only to the challenges faced by NHS Tayside but also to those of its partners.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

No risk assessment has been carried out as the Director of Public Health's Annual Report is submitted for information only.

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

Drew Walker
Director of Public Health

DATE: 17 November 2017

Appendix 1

Population Profile

Health Protection

Halting the Obesity Epidemic

Realistic Medicine

Sexual Health and Blood Borne Viruses

Substance Use

Director of Public Health 2016/17 Annual Report

NHS Tayside

Transformational Public Health

Russell Goldsmith
Health Intelligence Officer
r.goldsmith@nhs.net

Carol Angus
Health Intelligence Analyst
carol.angus@nhs.net

Click here

Dr Daniel Chandler
Consultant in Public Health Medicine
d.chandler@nhs.net

Click here

Joyce Thompson
Dietetic Consultant in Public Health Nutrition
joycethompson@nhs.net

Click here

Sarah Donaldson
Specialist Pharmacist in Substance Misuse and
Trainee Pharmacist in Pharmaceutical Public Health
sarahrdonaldson@nhs.net

Andrew Radley
Consultant in Public Health Pharmacy
andrew.radley@nhs.net

Click here

Ann Eriksen
Executive Lead, Sexual Health and Blood Borne Virus
ann.eriksen@nhs.net

Donna Thain
Sexual Health and Blood Borne Virus MCN Manager
donnathain@nhs.net

Click here

Dr Emma Fletcher
Specialty Registrar in Public Health Medicine
emmafletcher1@nhs.net

Click here

Foreword

Welcome to my Annual Report for 2016/17. This is my 17th Report as the Director of Public Health in Tayside, and my 26th since I first became a director of public health. I hope you find it interesting and helpful. I would welcome any comments or suggestions for future Reports.

As in recent years, the Report only covers about one third of the topics which are currently a priority for us and our partners. This continues our recent pattern for Annual Reports, which means that all of our priorities are covered at least once every three years.

When I started work here 17 years ago NHS Tayside was under intense financial scrutiny related to a lack of financial control and a lack of sustainable models of care. The main outcome of that scrutiny was the financial overspend at the time being written off, but very little else changed. What followed was a period of unprecedented increase in NHS resources which were used in Tayside to develop a wide range of valued services, but also a significant number of unsustainable models of care, sometimes accompanied by suboptimal financial control.

As I write, NHS Tayside is once again under intense financial scrutiny. Whatever the outcome of that process, if we want to avoid history repeating itself, then this time something fundamental needs to change. I think we are all agreed that this change has to be transformational. I have been looking at a range of definitions of transformation, and the one I like best is as follows:

Transformation is a process of profound and radical change that orients an organisation in a new direction and takes it to an entirely different level of effectiveness.

Unlike 'turnaround' - which implies incremental progress on the same plane - transformation implies a basic change of character with little or no resemblance to the past configuration or structure.

Currently the word transformation is being bandied around and applied to almost any type of change. And while there are some very good examples of transformational change taking place in Tayside - recent progress towards the eradication of hepatitis C and the development of our gluten-free food scheme are outstanding examples - the majority of change taking place is incremental and/or transactional. Most of these current approaches are not going to take us to where we need to be.

It is no coincidence that these two outstanding examples of transformational change have taken an explicitly public health approach, incorporating population health intelligence, co-production, needs assessment, prevention, value for money, early intervention, putting evidence into practice, shifting the balance of care, having people formerly known as patients at the heart of all change, economic and health literacy, and asset based approaches with a resolute focus on equity.

It is sometimes said by people that public health is part of the solution. I take a different view. In my opinion the public health approach described above **IS** the solution - not only to the challenges faced by NHS Tayside but also to those of our partners. To that end, my public health colleagues and I are becoming increasingly

engaged in the transformation work taking place within the Board itself, and within our Health and Social Care Partnerships and our Community Planning Partnerships. That shift in our focus is very evident in all of the chapters in this Report.

It has become a bit of a cliché to say that the NHS is more of an illness service than a health service. While that might be understandable, there is no doubt that the single most important responsibility of the NHS is to improve population health, but it has been overly focused on treating disease while underinvesting in health improvement. Our NHS has prioritised technical approaches to the treatment of illness rather than preventing people becoming ill in the first place.

Addressing waste, variation and harm in the way we use the resources available to us has the potential to make a significant contribution to the transformation which is needed. The huge amount of money tied up in medicines when not used appropriately, is just one example of unacceptable waste. The disparity in the use of and outcome from services between our most and least affluent individuals and communities is just one example of unacceptable variation. Unnecessary admissions to hospital and the undermining of our natural resilience to adverse circumstances are just a couple of examples of unacceptable harm. There are many more examples of each of these. Addressing all of them in a transformational way will lead to better health and much greater cost effectiveness.

In addition to programmes which aim to improve the health of individuals and families, there is a need to change the environment in which we live. Much has been said in recent years about salutogenesis - the conditions which create health. I am starting to talk more and more about morbogenesis - the conditions which create ill health. These are the conditions in our environment which encourage people, for example, to over-consume high calorie, low nutritional value food, to become too sedentary and not take enough exercise, to make poor choices around their sexual health and wellbeing, and to use a range of substances - alcohol and other drugs - as self-medication to cope with the stresses and disappointments of life. By taking an explicitly public health approach we would focus on creating an environment where the healthy choice is the easy choice - whether that is in the food, alcohol and other drugs we consume, the relationships and mental resilience we develop, our sexual behaviour, accessing good housing and healthy, fulfilling employment, or the extent to which we are physically active. All of that is possible, but it will only happen if there is public, professional and political support.

Please let me know what you think.

As always, I am very grateful to a range of colleagues in my directorate and in partner organisations for the quality of the content and the impact of the work described. I am constantly aware how fortunate I am - and how fortunate Tayside is - to have such a high calibre of professional expertise available to us in tackling the public health and health equity challenges we face. My thanks go to Lesley Marley, Directorate Manager, Public Health, who has commissioned and coordinated this Report on my behalf. I would also wish to acknowledge Alistair McGillivray, Graphic Designer, who has designed and produced this year's Report.

Dr Drew Walker
Director of Public Health
June 2017

Recommendations Update

Below is a brief update on the work undertaken in 2016/17 to fulfill the recommendations from our topics in last year's Report, 2015/16

Early Years, Children and Young People

Evidence demonstrates the importance of prevention, early identification and intervention throughout the early years of life. We will:

Secure national support to progress Suit of Summaries (SOS) will be sought in 2016/17.

This was developed to a level where it can be held in abeyance until funds can be identified for it to be developed nationally.

Develop further the work to support improving outcomes in young people's mental health and emotional wellbeing.

The Early Years and Young People Team (EYYPT) remains engaged in the Child and Adolescent Mental Health Service (CAMHS) Mental Health Innovation Fund Project Advisory Group, working collaboratively with partners to support the progress of key areas within the project plan. The EYYPT has worked with the project team by supporting communication between CAMHS and the education departments in the three local authorities and providing advice and expertise as appropriate.

Develop further opportunities for young people participating in the A Stop Smoking in Schools Trial (ASSIST) programme to take forward health issues identified in their school and wider community.

Delivery of the ASSIST programme continues in Tayside secondary schools, and young people are encouraged routinely to continue to apply their learning to other health issues relevant to their school and wider community. As well as promoting remaining smoke free to their peers, young people have also indentified other health related concerns as a focus for further work, and have been supported by the wider EYYPT to extend their learning and the learning of others. Young people have further disseminated their knowledge at parents' evenings, health drop-ins and school assemblies. In 2016 ASSIST was delivered in 25 of the 26 local authority secondary schools in Tayside. The final year of the three-year pilot was completed on target in 2017. 'Process Evaluation Report of Implementation of ASSIST in Scotland' was published by Scottish Government in March 2017. http://www.gov.scot/Resource/0051/00515634.pdf

Work with partners, including education and other local authority services and local communities to agree and embed the smoke free homes initiatives and awareness of the issue of second hand smoke into ongoing work. We will also develop further opportunities to support individuals and families to make their homes smoke free.

Working in partnership with 'Shaper/Caper', the EYYPT has incorporated specific learning activities into the 'Well Good' one-day smoking and health workshops for children in Primary Six or Seven. The team has also built-in learning into the Storytelling Project which is currently being developed for engagement with children in Primary Five and Primary Two throughout Tayside and possibly beyond. Work to develop a specific secondhand smoke training session for colleagues working with children in early years' settings is ongoing and will be offered to schools as a test of change in the next academic year, 2017/18.

Identify further opportunities to develop cessation support for young people who have started smoking and want to stop.

Work within the EYYPT has focused on updating the current cessation support materials used to assist young people who express a desire to stop smoking. To ensure sustainability, multi-agency colleagues have been offered training to enable them to support young people giving up smoking.

Screening

Specialist public health involvement focuses on ensuring that the conditions required for successful screening are met operationally.

The national screening programmes will remain a priority for NHS Tayside in 2016/17. Maintain and where possible improve the uptake of screening programmes, especially in our more deprived communities.

Cervical screening uptake has been declining nationally. Scottish Government launched a national campaign in February 2017 to promote awareness of cervical screening and is supporting work locally to promote uptake, especially in young people in our more deprived communities.

In March 2017, the NHS Board Chief Executives approved a business case which will see cervical screening transition to primary high-risk human papilloma virus (hr-HPV) testing in future. Primary hr-HPV testing of the smear will be a more effective way to advise women whether they have any risk of developing cervical cancer.

Uptake in abdominal aortic aneurysm (AAA) screening has increased following a reconfiguration of services. Sixteen local screening sites in Tayside and six in Fife were consolidated into four sites in Fife and four in Tayside. The percentage of men attending screening clinics in the areas where sites were consolidated increased by 7.9%. The change in the service delivery model also resulted in a more efficient service, reduced screening risk and improved patient experience.

A new IT system to support diabetic retinopathy screening has been implemented recently.

Smoking

Smoking remains a major influence on ill health. Tobacco use is strongly associated with excess mortality and morbidity and is also a major influence on health inequalities and poverty. Reducing the harms created by tobacco use also means changing public opinion and working to de-normalise its use. To achieve this it was recommended that:

We work with local authority partners to identify opportunities to protect children and young people from the harms of tobacco smoke.

Work has continued in 2016/17 to provide incentives to pregnant smokers to encourage cessation. A consultation with cessation service users was carried out across Tayside; the majority of dients that responded were happy with services but provided suggestions as to developments that may increase uptake in communities.

Local authorities have worked with NHS Tayside to review and update their smoking policies for foster care and adoption placements.

We review our policies and practices to identify areas in which a harm reduction approach can be used to minimize the health problems caused by tobacco.

In line with the Tayside Tobacco Plan the smoking policies within statutory organisations in Tayside are being reviewed. This will enable these major employers in Tayside to give the same message i.e. that the provision of smoke free buildings and grounds contributes significantly to the health of employees and service users.

Training has been delivered to 25% of the mental health workforce in Tayside to enable them to support clients to be smoke free before and during a hospital admission. Two pilot wards have made this transition and have identified improvements in patients' health - particularly in weight reduction, increased physical activity and reduction in medication levels. The mental health service in Tayside will be smoke free from October 2017.

In October 2016 a law prohibited smoking in cars containing a person under the age of 18. Work with partners in within schools and nurseries to raise awareness is ongoing.

We identify ways in which we can make tobacco less available and a less desirable choice. We will work with partners to reduce the number of opportunities that people have to smoke tobacco and we will strive to create opportunities for smokers to choose healthier options.

The publication of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 has enabled us to work with partners to tighten controls around the sale of nicotine vapour products. To protect young people, restrictions on advertising will follow. The Act will allow us to look at the provision and overprovision of tobacco and work within communities to reduce access to tobacco and to promote external smoke free areas.

Physical Activity

We know that regular physical activity of at least moderate intensity provides general health benefits across a range of diseases and across all ages. We will:

Provide leadership for physical activity in health and social care integration.

Physical activity leadership event was held. As a result of good practice, Tayside was chosen as a national improvement site for the second 'test of change' for the application of a methodology that aims to promote a culture that makes physical activity a strategic priority. The presentations from Scottish Government as well as national and local speakers put into context the compelling evidence for change. The commitments generated were:

- *Physical activity should be a core component in planning structures in population health improvement.*
- *Consider all partners in how we deliver physical activity e.g. transport and leisure, Social Enterprise Network, private sector and public sector, third sector.*
- *Consider a physical activity discretionary budget targeted to increase action to the 20% least active in the population.*
- *Active Workforce/Active Travel; improve our active infrastructure - people and place.*
- *Communicate better physical activity messages/awareness within health promotion training for health and care staff.*

These commitments fall into three themes; environment, policy and workforce. The local Physical Activity Strategic Partnerships are now responsible for both developing tangible actions from the corporate commitments and leading on implementation. The proposal is to roll-out the learning across Scotland.

Via Healthy Working Lives (HWL) and Health Promoting Health Service (HPHS), embed the benefits of physical activity/active travel in workforce development to create an active health and social care workplace.

In 2016/17 the HWL programme has continued to encourage employees to be more physically active and travel more actively. Initiatives included; the annual virtual step count challenge, summer walks and healthy picnics, Join Us In July - walking a mile a day and the Swim the Tay Challenge at the Ninewells swimming pool. Travel smarter events and promotions at hospital sites provided sustainable travel information in partnership with local authorities and TACTRAN e.g. European Car Free Day, Cycle to Work Day, National Liftshare Week, the SUSTRANS Workplace Journey Challenge and the promotion of the workplace pool bikes and cycle skills training provided by a volunteer staff member. The Cycle to Work scheme was facilitated by the procurement department.

Small grants have been made available through the HWL programme to support staff-led physical activity initiatives at community hospitals and other sites.

The 2016 HWL Employee Wellbeing Survey indicated that 64% of 625 respondents were active at a moderate intensity level for 30 minutes or more each day. This is an increase on previous reported levels, however, work is still required and will be ongoing.

As part of a national improvement programme, Perth and Kinross Health and Social Care Partnership focused on enabling older people using care services to be less sedentary. Several local events will take place to bring people together to learn and share.

In Angus, care home residents are benefiting from a new activity programme called Video Active which broadcasts chair-based activity classes from local sports centers to care homes. This is available through the joint partnership of Angus Alive and Angus Health and Social Care Partnership

Work to maximize the use of NHS/local authority green space for physical activity.

Dundee has a wide range of nature based health promotion initiatives and nature based interventions which contribute to local health priorities and targets. The Directorate of Public Health is collaborating with local partners, communities and Scottish Natural Heritage to create the conditions for a Local Green Health Partnership. Nationally, the Scottish Government is encouraging development of these partnerships to mainstream approaches to increase physical activity and improve mental health through engagement with the natural environment.

In NHS Tayside many of our outdoor spaces are being utilised as an important healthcare resource. Joint funding from the Community Innovation Fund and Forestry Commission Scotland has resulted in the completion of a Leaf Room in Ninewells Hospital Community Garden. The Leaf Room is well used but would be enhanced by the installation of electricity, water and toilet facilities; discussions are progressing with NHS Tayside. Other gardens are now established on or near hospital sites and are flourishing through the dedication of volunteers.

In 2016/17 additional Ramblers Scotland Medal Route Hubs at Perth Royal Infirmary and Murray Royal Hospital were created. These routes provide a focus for walking at these sites. Cycling Scotland Cycle Friendly Employer Awards have been attained for the Perth Royal Infirmary and King's Cross sites.

In NHS Tayside 28 teams took part in the MacMillan Step Count Challenge. The Ninewells Intensive Care Team achieved top place in Scotland.

In Tayside the physical activity partnerships are working with the third sector to reduce inactivity. The wellbeing teams in leisure trusts are using the medium of sport and physical activity to improve the quality of life for a number of targeted groups - a priority area is to support people with long-term conditions to increase their levels of physical activity and to support families to be active together.

Therapeutic Nutrition

For Coeliac Disease:

The Scottish Government plans to develop a national Coeliac Disease Clinical Pathway. This work will be led by a member of Tayside Nutrition during 2016/17 as part of the Developing Out-patient Integration Together (DOIT) Programme (Scottish Government). A review of the local pathway is already underway which will feed into the national work. Once finalised, the national Coeliac Disease Clinical Pathway will be incorporated into the NHS Tayside local pathway.

NHS Tayside is one of four NHS Boards in Scotland to be allocated additional funding to test the new Scottish Coeliac Disease Clinical Pathway. This will see increased investment in nutrition and dietetics and the implementation of new technology enabled care tools to better support people to manage their condition themselves.

For Renal Disease:

Consider and understand better the demographics of the renal population of Tayside and identify health inequalities.

Work continues to better understand and identify health inequalities relating to nutritional care for renal patients in Tayside. Inequalities in clinical service delivery were identified for patients receiving haemodialysis.

Hold a stakeholder event to explore co-producing and developing nutritional care pathways for nutritional support (food first, oral supplements and enteral tube feeding); weight management; healthy eating; phosphate restriction; potassium restriction; sodium restriction; fluid management and diabetes.

A stakeholder event has not been held but work is underway with the development of nutritional care pathways specifically looking at phosphate, potassium, sodium and fluid management. This began with the development of first line intervention information aimed at patients attending 'low clearance' clinics. Consultation is underway with stakeholders and patient feedback is being sought via patient representative groups such as the Tayside Kidney Patients' Association and the Patient Liaison Committee.

Weight management has been identified as an area for pathway development with an initial focus on pre-transplant patients. We are liaising with the Adult Weight Management Service with a view to adapting its programme to make it suitable for adults with renal conditions.

Identify health inequalities in nutritional care and work with key stakeholders to use targeted approaches to reduce them.

Inequalities in clinical service delivery for patients receiving haemodialysis has been addressed with the establishment of regular sessions at renal units throughout Tayside.

Scope further self-care and secondary prevention and consider the use of emerging information technologies such as Smart Phone Apps, internet and webcasts to support patients and staff to improve nutritional care.

Renal dietitians plan to trial the use of teleheath for nutritional support patients using the 'Florence' text messaging system. It is hoped that this approach can also be used to help individuals to manage their phosphate restriction.

For Cows' Milk Allergy (CMA):

Design an update session for health visitors in response to a follow-up survey which assessed the impact and changes in practice. Apply improvement methodologies to the referral pathway for children with CMA from primary to secondary care and make recommendations. Work with stakeholders to identify and reduce health inequalities in the management of CMA.

The planned health visitor update sessions on the CMA pathway did not progress due to a lack of staff availability; therefore, we have been unable to review implementation of the pathway. Despite this, introductory training continued to be delivered to health visiting staff on the diagnosis, management and treatment of colic, reflux, constipation and mild to moderate non IgE mediated CMA. Continuous improvement activities have been undertaken to inform further developments such as a review of specialist milk spending and group weaning education sessions for CMA.

Recommendations from this year's Report

Below are the recommendations from our topics in this year's Report. They feature in our 2017/18 work plans and progress will be updated in my next Report

Health Protection

Priority theme	Specific topics	Recommendations for 2017/18
Blood borne viruses	Hep B vaccination for exposed and at-risk babies	Establish electronic call/recall system
		Agree robust multi-disciplinary pathway for identification and follow-up of eligible patients
	Prevention for high-risk/vulnerable groups	Develop strategies to inform and reduce risks associated with 'chemsex', commercial sex work, and injecting drugs
Immunisation programmes	Scottish Vaccination Transformation Programme	Lead three year wholesale reorganisation of services in line with national programme
	IT/records systems (e.g. GP, hospital, child health etc)	Advocacy for national renewal of electronic systems so that they inter-connect
		Develop more efficient local interim solutions to multiple recording/data entry
		Pursue full access to immunisation call/recall system for Health Protection Team admin. staff
	Unscheduled/catch-up vaccinations	Clarify responsibilities of Immunisations service/GPs/others and streamline pathways
	Staff education and training	Develop regular comprehensive training and update programmes for immunisers
	Accessibility and uptake	Work with services delivering staff flu, pregnancy and other programmes to enhance awareness and accessibility
Gastrointestinal infections	E. coli	Revise protocols to ensure consistency in where, when and how exclusion is required
		Streamline financial compensation for those excluded so vulnerable individuals and families are not disadvantaged
	Multiplex Polymerase Chain Reaction (PCR) testing	Management of anticipated increase in workload from more sensitive testing
		Resolve management of asymptomatic chronic carriers in whom clearance difficult
	Lyme disease	Engage with national public information and management development work
	Campylobacter	Commonest single pathogen notified in Scotland - participate in national epidemiological study
Environment	Air pollution	Responding to national initiatives to identify and remediate high emissions areas
	Lead in water	Implementation of new quality standards including in schools and childcare facilities
Tuberculosis (TB)	National TB Framework	Develop and implement strategies for screening and detection of latent TB in new entrant and other high-risk groups
		Increase screening accessibility by extending to peripheral sites
Health Protection Team management	Resilience	Identify and train nurses from wider work-force to provide health protection nursing team resilience
	Administration capacity	Explore opportunities to re-direct staff time
		Formalise documentation in electronic systems when using staff resilience
	Out-of-Hours	Engage with national project evaluating arrangements, including mutual aid options
	Action cards (administration team)	Ensure continuous review and update
	Team development	Ongoing review and update of mandatory training requirements
		Develop team induction programme

Halting the Obesity Epidemic

We will do all that we can to make sure obesity becomes an explicit priority at strategic and delivery levels for NHS Tayside and local authorities.

We will engage with external partners to integrate support and provide sustainable preventative and treatment services based on the following outcomes:

- Access to a free-of-charge 12-week Weight Watchers© programme is extended to women of childbearing age.
- UK Baby Friendly accreditation is achieved as a minimum standard by NHS Tayside.
- There is a robust analysis of the necessary steps for healthy eating and physical activity for children, young people and families that address obesity prevention.
- Vulnerable families continue to be assisted to develop fundamental food skills and access affordable healthy food.
- NHS Tayside's Nutrition and Dietetic service supports partners in activities that prevent and control obesity.
- An improved adult weight management service tier 3 programme is implemented.
- Obesity prevention and control strategies in the workplace are developed and implemented.
- A standardised framework supporting high-quality, consistent evaluation of obesity prevention and treatment is developed.
- The principles of co-production and asset based approaches continue to be applied to the design and delivery of all obesity prevention and treatment approaches.

In addition to the above we will work with partners to identify opportunities to create leptogenic environments whereby physical activity and the consumption of healthy food and drinks are easy, affordable and widely accepted, making a healthy lifestyle the default option.

Realistic Medicine

Across NHS Tayside we have programmes in place that are embracing the challenge set by Realistic Medicine. The programmes all encourage patient-centred care and a shift in our ways of working to consider more proactive responses to the needs of our communities.

In 2017/18 we recommend an increase in the availability of these resources across Tayside to begin to shift care upstream and meet people's needs in a sustainable way e.g.

- The Equally Well programme in Dundee has been established to address some of the personal and socio-economic circumstances that impact on people's health and wellbeing that primary care have neither the time nor sometimes skills to address. Link Workers work across four general practioner (GP) practices to address these unmet needs and support people to make the necessary lifestyle changes to invest in their future health. Investing in social prescribing gives alternates to medical prescribing and when medical intervention and treatment are necessary then it can build resilience, enabling people to cope with the required burden and in turn improve disease control.

- The Enhanced Community Support model (ECS) trialled in South Angus and Perth and Kinross for the care of frail elderly patients is a good example of shifting care upstream. This model of care recognises that older people should have access to proactive care in response to escalating health and social care requirements in the community, relevant to the needs of the person and hence increase the patient's resilience and ability to cope in their own home.

- The Area Drugs and Therapeutics Collaborative hosted by Healthcare Improvement Scotland has developed materials for patients to help them to understand what the right treatment is for them as an individual. The leaflet entitled 'Medicines in Scotland: What's the right treatment for me?' is a valuable resource to begin a conversation with the patient to enable them to work with their doctor or other health care professional to understand their treatment options and how to gain the greatest benefit from treatment.

Sexual Health and Blood Borne Viruses

Delivering a comprehensive and integrated tiered approach to primary prevention.

- Appropriate hepatitis B (HBV) vaccination coverage and uptake, in particular for people who inject drugs (PWIDs)
- Sustained action to reduce teenage pregnancy and securing effective leadership and local engagement for the Scottish Government's Pregnancy, Parenthood, and Young People (PPYP) strategy
- Inclusive Relationships, Sexual Health and Parenthood Education (RSHP), underpinned by standards and performance indicators
- Improved awareness among young men who have sex with men (MSM) of the risks of human immunodeficiency virus (HIV)
- Improving availability and uptake of long acting reversible contraception (LARC)

- Strengthening partnership with Alcohol and Drug Partnerships (ADPs) and addictions services to ensure effective prevention programmes and increase access to harm reduction, injecting equipment provision (IEP) and Opiate Substituition Therapy (OST)
- Ensuring effective partnerships with Community Planning Partnerships (CPPs), in particular Integrated Children's Services
- Work with individuals, communities and the media to reduce stigma and discrimination associated with poor sexual health and blood borne viruses (BBVs).

Reducing undiagnosed population

- Reducing undiagnosed HIV and late diagnosis Implementing effective hepatitis C (HCV) case-finding and eradication strategies.

Targeted behaviour change interventions

- Design and delivery of behaviour change interventions for high-risk behaviours, including increased engagement of women who inject drugs with sexual and reproductive health.

Effective delivery of care and treatment

- Implement Pre Exposure Prophylaxis (PrEP) for prevention of HIV in 2017 as part of a comprehensive, combination approach to HIV prevention
- Support the introduction of human papilloma virus (HPV) vaccination in MSM in 2017
- Work with prison healthcare to make sure people in custody have equitable access to testing, treatment and care
- Ensure access to adequate resources for treatment to meet the aims of the HCV elimination strategy Review provision for people ageing with HIV.

Substance Use

In order to deliver public health improvements within current resource constraints there needs to be a strategic shift from treatment and care towards prevention and early intervention.

Priority areas will include:

- Reducing health inequalities
- Focusing on prevention and early intervention
- Increasing prevention interventions targeting children at risk of early initiation into substance misuse
- Involving communities to co-produce change

Angus (ADP) is leading a review and redesign of current service provision to strengthen and enhance experience of people/families with alcohol/drugs and/or mental health problems focusing on a whole family approach model. The pilot phase demonstrated successful change and as a result the whole family approach model is in the process of being embedded more widely across services in Angus.

Dundee ADP and Integration Joint Board (IJB) are in the process of developing an 'Integrated Alcohol and Drug Services - Strategic and Commissioning Plan (2017-2020)' that sets out the strategic priorities and guides the delivery of a transformational improvement programme across the city. Produced to provide clear direction for services this plan will drive forward, inform and enhance the already well-established partnership approach to achieving better outcomes for people who need alcohol and drug services.

Reducing alcohol availability

The NHS Tayside Directorate of Public Health will be working closely with the newly formed Licensing Boards to provide the information and evidence required to inform the development of overprovision policy statements over the next 18 months.

A vision for the future

Tayside will progressively be a region where healthy and responsible attitudes to alcohol and other drugs prevail. Increasingly, prevention needs to become a key focus for joined-up, evidence-informed and accessible services which are designed and delivered as an equal partnership between the public, a range of organisations and professionals. The outcomes being sought should more and more be those which are important to the individuals and communities as well as the professionals. Progress needs to be monitored carefully using quantitative and qualitative information from as many sources as possible.

Population Profile Tayside

Population

Demographics

The demography of a population is an important factor in tackling health issues. Many illnesses, conditions and health related behaviours are associated with age, gender or other demographic characteristics. An awareness of population distributions and attributes helps identify those likely to experience health inequalities.

The estimated population of Tayside on 30th June 2016 was 415,470, an increase of 430 (0.1%) from 2015. Similar in proportions to previous years, 48.6% of the population were males and 51.4% females.

Tayside's population is distributed across three local authority areas, in 2016 there were 116,520 residents (28.0% of the Tayside population) in Angus, 148,270 in Dundee (35.7%) and 150,680 in Perth and Kinross (36.3%). Chart 1 displays the age structure of the Tayside population and its three local authority areas for 2016.

The proportions in each age category across the three local authority areas are relatively similar. However, Dundee City has a higher proportion of the population who are of working age and a lower proportion of those who are pensionable in comparison to its Tayside counterparts.

Many illnesses, conditions and health related behaviours are associated with age, gender or other demographic characteristics

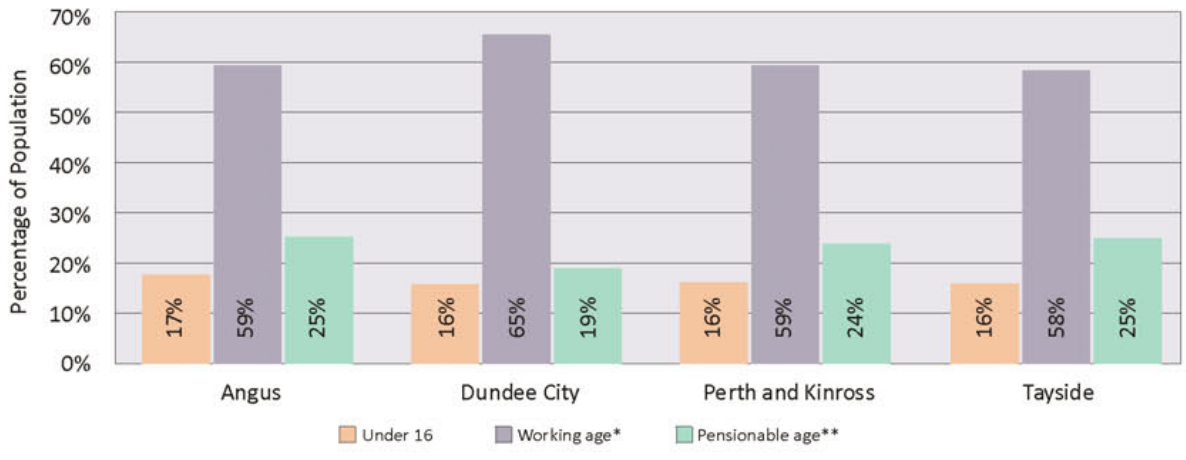
Minority Ethnic Population

The 2011 Census reported that 3.2% (13,111 individuals) of the Tayside population were of non-white ethnicity. This varied across the region with the corresponding proportions in Angus, Dundee City and Perth and Kinross being 1.3%, 6.0% and 2.1% respectively.

Life Expectancy

Life expectancy at birth is the average number of years a newborn infant can expect to live if current mortality rates continue to apply. Life expectancy at birth has increased over the last decade across Tayside residents by 2.8 years in males and 2.2 years in females[1]. Chart 2 summarises the current life expectancy estimates (2012-2015 based) for Tayside's three local authorities.

Chart 1: Age structure of the Tayside resident population - June 30, 2016



Source: National Records of Scotland (NRS) Mid Year Populations Estimates (MYPE), June 30th 2016
Notes: *Working age at 30 June 2016 was defined as men aged 16 to 64 and women aged 16 to approximately 62 years and 237 days
**Pensionable age at 30 June 2016 was 65 for men and approximately 62 years and 238 days for women

[1] 2003-2005 based life expectancy for Tayside males 75.0 years and females 79.4 years
[2] SIMD_2016 current version is based on 2011 Data Zone, direct comparisons with previous SIMDs is not possible

Chart 2: Tayside residents' life expectancy at birth by gender - 2013-2015 based

Source: National Records of Scotland (NRS) - Life Expectancy Tables

The current life expectancy across Scotland is 77.1 years for males and 81.1 years for females. Dundee City life expectancy figures are lower than both Scottish averages; these are also the lowest life expectation of the three Tayside local authority areas for both genders. In comparison, those living in Perth and Kinross are expected to live the longest of all Tayside residents (both genders).

Deprivation

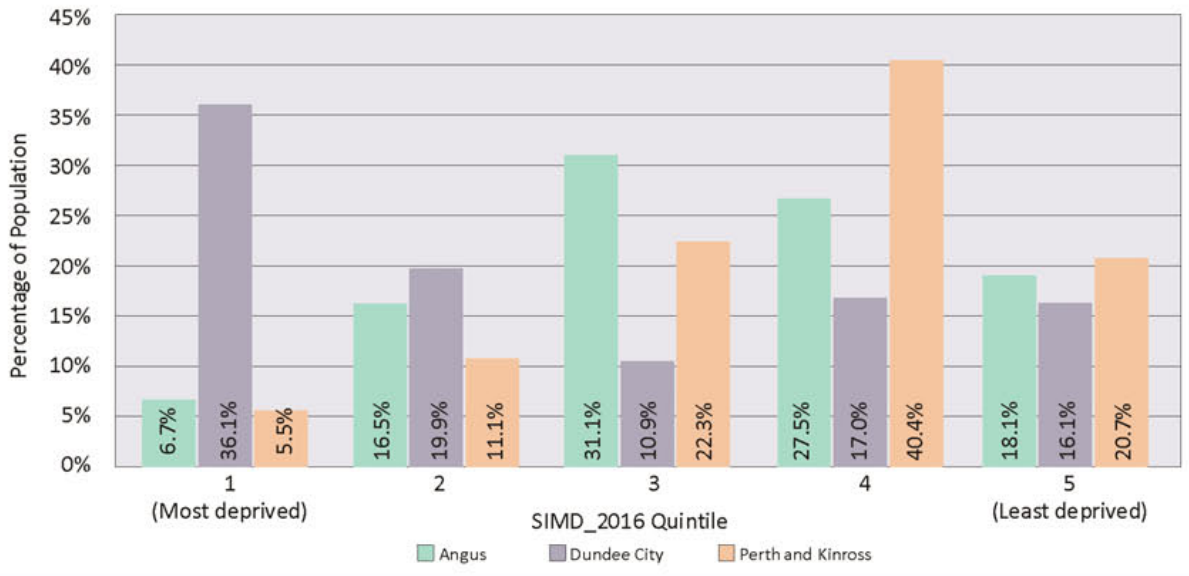
The Scottish Index of Multiple Deprivation (SIMD)[2] is an area-based measure of deprivation, identifying small area concentrations of multiple deprivation in a comparative manner. It combines the domains of income, employment, health, education, skills and training, housing, geographic access and crime, based on a ranking system from most to least deprived. These ranks can be grouped into quintiles.

In a standard population, 20% of the population would be expected to live within each quintile. Locally across Tayside there are large variations between the differing levels of deprivation. Chart 3 below displays the population proportions residing in each deprivation quintile for all three of the local authority areas.

As shown in Chart 3, in 2015 Dundee City had the greatest proportion of their residents living within the most deprived areas (SIMD Quintiles 1 and 2). In Quintile 1 (20% most deprived) 36.1% of the Dundee City population resided here, more than five times when compared to its Tayside counterparts within this quintile.

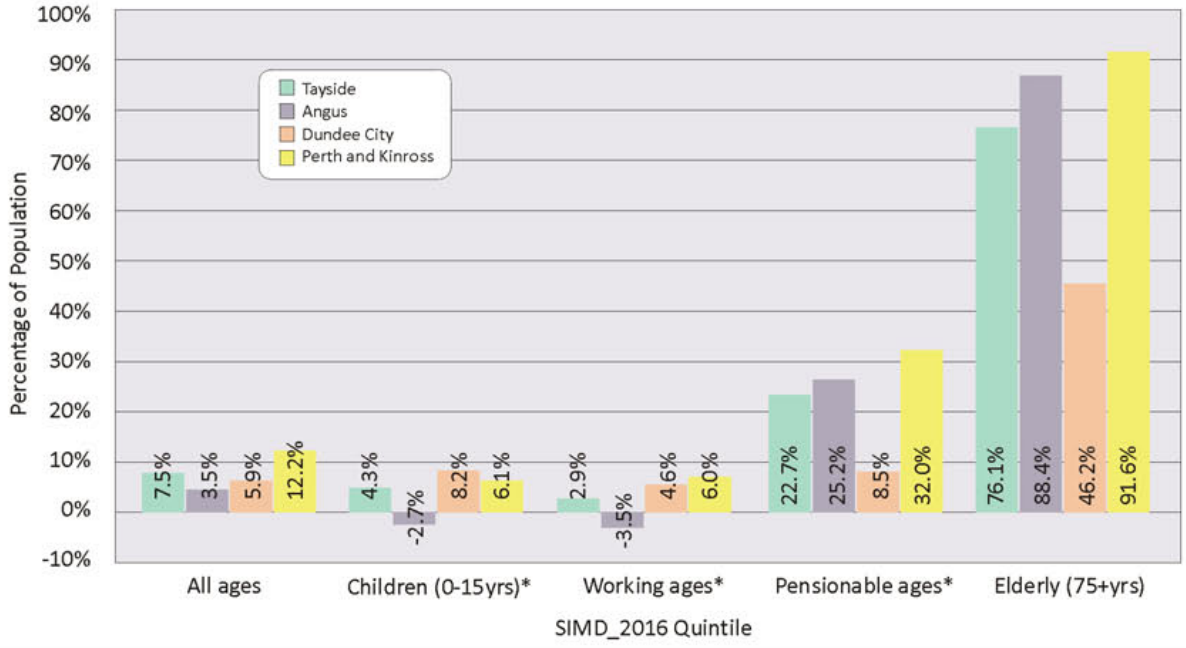
In comparison, the Perth and Kinross area recorded the highest proportion of their population residing in the least deprived areas (SIMD Quintiles 4 and 5).

Chart 3: Percentage of Tayside resident 2015 mid-year population estimate by SIMD_2016 Quintile



Source: SAPE 2015 (based on data zones 2011) via National Records of Scotland (NRS) and SIMD_2016 via Scottish Government

Chart 4: Tayside projected population changes by age group (all persons), 2014 and 2039



Notes: * Children under 16, working age and pensionable age populations based on state pension age (SPA) for a given year. Working age and pensionable age are over estimated from SPA. As set out in the 2014 Pensions Act, between 2014 and 2018, state pension age will rise from 62 to 65 for women. Then between 2019 and 2020, it will rise from 65 years to 66 years for both men and women. A further rise in state pension age to 67 will take place between 2026 and 2028. Between 2044 and 2046, state pension age will increase from 67 to 68. The UK Government plan to review state pension age every five years in line with life expectancy and other factors.
Source: National Records of Scotland (NRS) Projected Population Report - 2014 population estimate based

Population Projections

The total Tayside population is projected to increase by 7.5% (N=444,763) by 2039 (2014 population estimate based). Displayed in Chart 4 are the projected changes in the Tayside population, showing the variations in the differing age groups across the three local authority areas.

Perth and Kinross is expected to represent the largest projected population change by 2039, an increase of 12.2% (N=167,087) from the baseline estimate of 2014.[3] The other two local authority areas are also projected to increase in total population by 2039: Angus is projected to increase in population by 3.5% (N=120,799), with a 5.9% increase across Dundee City (N=156,877).

As shown in Chart 4, of those age groups encompassed within the population of Tayside, those of pensionable age, and especially those aged 75+ years, are projected to display the greatest increase in population size by 2039 from the 2014 baseline estimate.[4] Over the next 25 years, the most elderly age band, those aged 85+ years, is projected to increase by 128.7%.[5] Of Tayside's three local authority areas, both Angus and Perth and Kinross are predicted to show the greatest increases in these elderly age groups. With intervening factors over the forthcoming years that may impact on the accuracy of these estimates, population projections should be viewed with some caution. However, the potential population increase does require some consideration for any future planning of services and resources.

Births

In 2015 there were 3,977 live births in Tayside[6], a rate of 51.7 per 1,000 females aged 15-44 years. While this may simply be a natural annual fluctuation, the rate does represent a minor reduction in births from the previous year (2014=54.6) and the lowest in the last decade.

[3] Estimates (All Ages) Angus = 116,740, Dundee City = 148,130, Perth and Kinross = 148,930

[4] 75+ years Tayside Pop; 2014 = 39,028 compared with 2039 = 68,728, an increase of 29,700 persons

[5] 85+ years Tayside Pop; 2014 = 10,908 (2.6% of total Tayside Pop) compared with 2039 = 24,944 (5.6% of total Tayside Pop)

[6] Based on Tayside Health Board of Residence (based on board boundaries 01/04/14), regardless of location of birth

Across Tayside, 26.8% of births were to mothers in Angus, 39.1% were to mothers in Dundee City and 34.1% to mothers in Perth and Kinross. This resulted in live birth rates of 54.7, 47.8 and 54.4 per 1000 females in Angus, Dundee City and Perth and Kinross respectively in 2015. These rates represent a slight decline in Angus and Dundee City compared to the previous year. However, they do not represent a significant change in Perth and Kinross between 2014 and 2015.[7,8]

In more recent years the rate of live Tayside births has shown a decline

There is a slight decline in figures when comparing the live birth rates (per 1,000 females aged 15-44 years) for Tayside mothers between 2005 (rate=52.7)and 2015 (rate=51.7) As presented in Chart 5, across all localities including Scotland, there was an initial general increase in the first half of the decade, while in more recent years the rate of live Tayside births has shown a decline, reflecting similar rates to those at the start of the decade.

Taking into consideration these fluctuations over the decade, both Angus and Dundee City have recorded a slight reduction in their live birth rate between 2005 and 2015, while Perth and Kinross has changed very little over this period.[9]

Ill health

Many patterns of diseases and conditions demonstrate inequalities between genders, age groups or geographical areas.

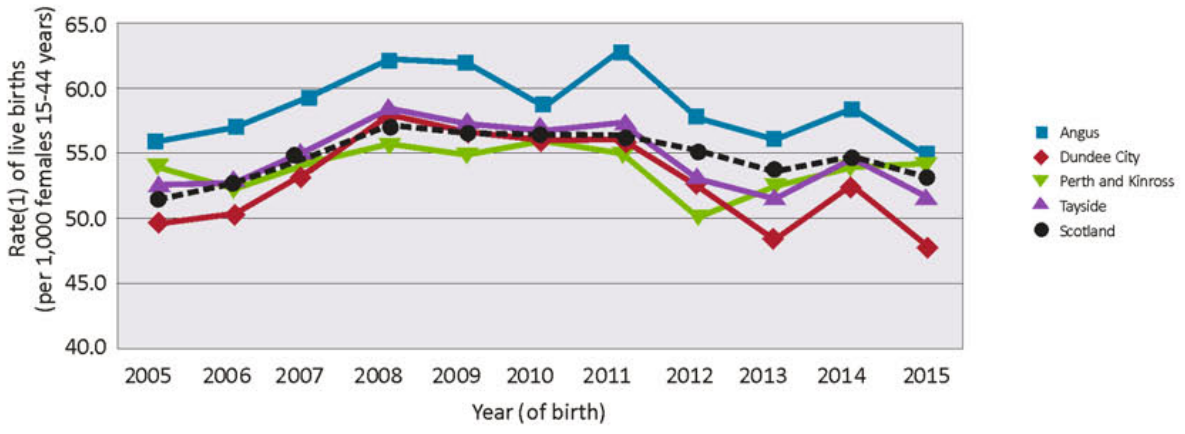
It is estimated that one in four adults (aged 16+ years) report some form of long term condition (LTC) and by the age of 65 nearly two thirds will have developed a LTC. Examples of common LTCs include diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD). Some people will need to be hospitalised at some point (either as an emergency or elective) as a result of their LTC.

Chart 6 on the following page compares the age standardised rates in 2011/12 and 2015/16 for those Tayside residents aged under 75 years who were discharged from hospital with a diagnosis of diabetes mellitus, COPD, coronary heart disease (CHD) and asthma.

The chart also shows the rate of cancer registrations for the calendar years 2011 and 2015.

Dundee City has higher rates than either Angus or Perth and Kinross in all of the conditions examined. Although CHD hospital discharge rates are the highest of the conditions considered, they have decreased over time while rates for diabetes, cancer registrations, COPD and asthma have predominantly increased.

Chart 5: Rate of live births by mothers area of residence - 2005-2015



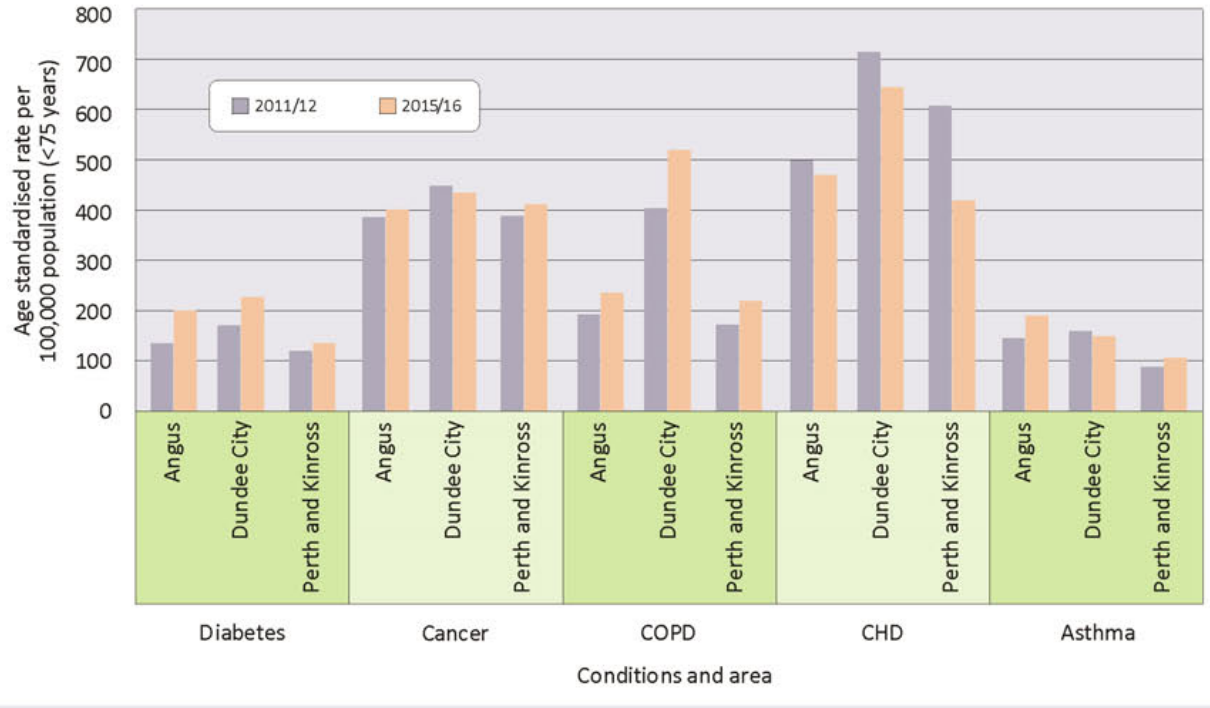
Source: National Records of Scotland (NRS) - Vital Events Birth Table 3.14
Note: 1. Rate per 1000 females aged 15-44 years (Calculated by NRS)

[7] 2014 Live Birth Rates: Angus - 58.4; Dundee - 52.6; Perth and Kinross - 54.1

[8] Perth and Kinross Live Births Rates: 54.1 (2014) and 54.4 (2015)

[9] Rates: Angus 55.9 (2005) and 54.7 (2015); Dundee 49.5 (2005) and 47.8 (2015); Perth and Kinross 54.2 (2005) and 54.4 (2015)

Chart 6: Age standardised rates for those aged under 75 years for selected conditions across Tayside 2011/12 and 2015/16 (cancer registrations compare calendar years 2011 and 2015)



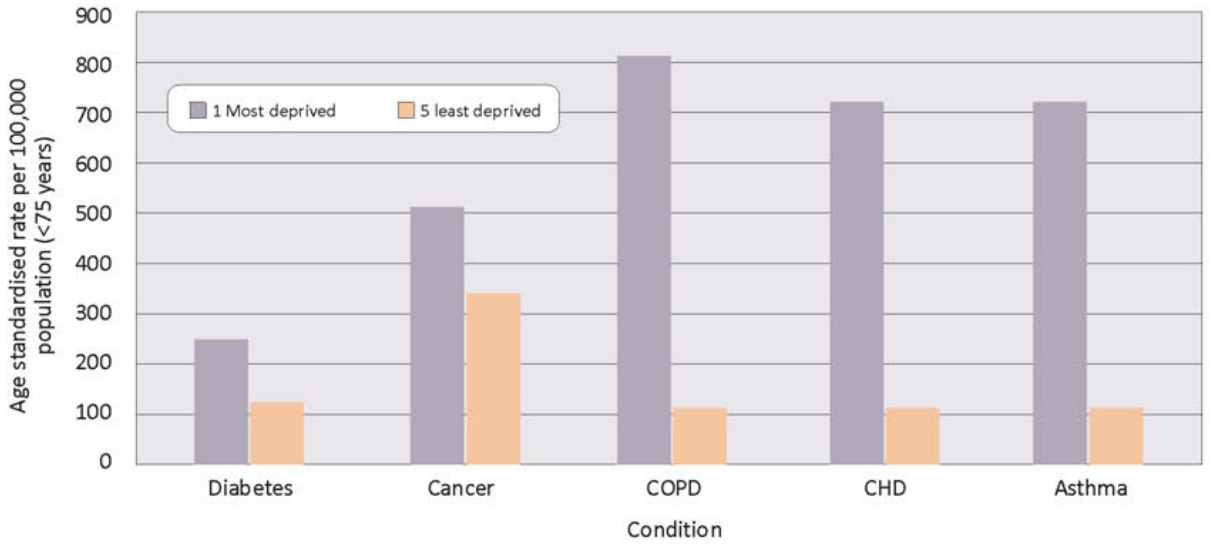
Notes: Diabetes mellitus defined by ICD10 codes E10-E14. Cancer defined by ICD10 codes C00-C96 excl C44. COPD defined by ICD10 codes J40-J44. CHD defined by ICD10 codes I20-I25. Asthma defined by ICD10 codes J45-J46. Source: SMR01, SMR06 and NRS

Chart 7 shows the clear inequality gradient that exists when the hospital discharge rates for these selected conditions for those aged under 75 are examined by deprivation. This is particularly evident for COPD where rates in the most deprived areas are eight times higher than those in the least deprived. This is likely to be associated with the historical differences in smoking rates when most and least deprived areas are compared.

Health risk behaviours

The health and wellbeing of the population is known to be influenced by a number of health risk behaviors. These include alcohol and drug misuse, poor diet and nutrition, lack of physical activity and tobacco use. Some of these topics are explored in more detail later in this year's Director of Public Health's Annual Report.

Chart 7: Comparison of age standardised rates for the most and least deprived areas in Tayside for selected conditions 2015/16 (2015 for cancer registrations)



Source: SMR01, SMR06, NRS and SG SIMD2016

Table 1: Various health risk behaviours in Tayside and Scotland		
Health risk behaviour	**Tayside**	**Scotland**
Smoking prevalence (adults aged 16+ years)	20.8%	20.2%
Estimated smoking attributable deaths (per 100,000 popn)	329.2	366
Alcohol related hospital stays (per 100,000 popn)	449.9	664.5
Deaths from alcohol conditions (per 100,000 popn)	21.9	22.1
Drug related hospital stays (per 100,000 popn)	142.0	133.6
Drug related deaths (per 100,000 popn)	16.4	13.5
Active travel to work	18.3%	15.7%
Source: ScotPHO Health and Wellbeing Profiles (Tayside)		

Table 1 summarises the prevalence or rate of selected health risk behaviours and compares Tayside with the national average for the most recent data available. While Tayside shows favourable rates compared to Scotland as a whole, there are strong links with deprivation for these indicators with Dundee City having much higher rates than the rest of Tayside.

Mental Health

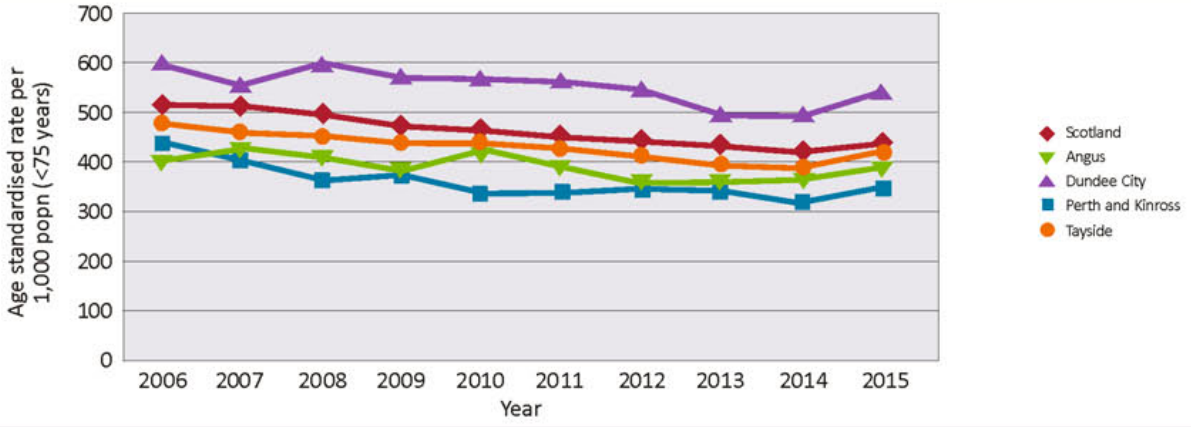
Over the last 10 years, age standardised rates of psychiatric hospitalisation have consistently been higher in Tayside than the national average. However, despite some fluctuations, the Tayside rates have decreased over time from 424.0 per 100,000 in 2002 to 342.6 per 100,000 population in 2014.

Rates of hospital discharge for those with a specific diagnosis of depression have also decreased over time. Prescribing data show that rates of prescribing of drugs for anxiety/depression/psychosis have risen over the last five years in Tayside from 16.3% of the population in 2012 to 18.3% in 2015. These prescribing rates are slightly higher than the national average (18.0%). This may mean that these conditions are being managed in the community.

With some fluctuations, the number of suicides in Tayside has reduced over time. On average between 2010 -2014, there were 51 deaths each year by intentional self-harm, an age standardised rate of 12.7 per 100,000 population; three quarters of these deaths were males.

Over the last 10 years, age standardised rates of psychiatric hospitalisation have consistently been higher in Tayside than the national average

Chart 8: Premature (<75 years) mortality in Tayside and Scotland - 2006-2015



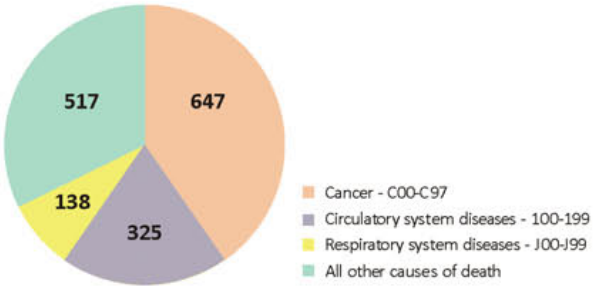
Source: National Records of Scotland (NRS)

Mortality

Death rates vary across age groups and different geographical areas. Premature mortality rates (those dying under the age of 75 years) are far higher in Dundee City than the rest of Tayside and indeed Scotland (see Chart 8). Overall, premature mortality rates have decreased since 2006 although there have been increases in the intervening years. Data from 2015 show the first increases in all areas of Tayside since 2006.

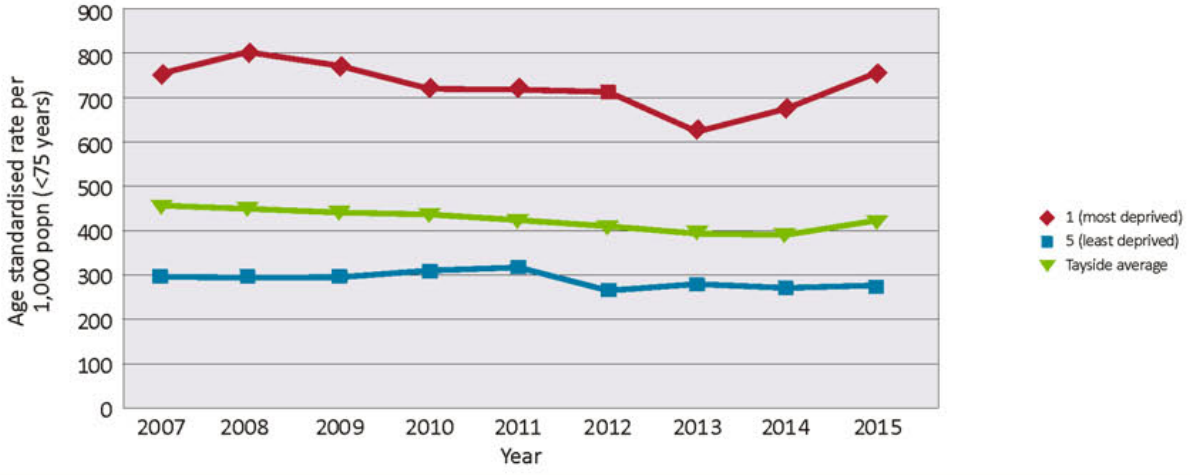
Cancer and diseases of the circulatory (includes CHD and stroke) and respiratory systems account for the majority (68.2%) of premature deaths across Scotland. Rates of these diseases have decreased over time up to 2015 with the exception of cancer which has increased to a peak in 2015. Tayside rates are lower than the Scottish average for each of these diseases, but there is large variation within Tayside with Dundee City having above average rates for each of these causes. Chart 9 shows the 1,627 premature deaths in Tayside by category of death.

Chart 9: Premature (<75 years) mortality by cause of death in Tayside - 2015



Analysis of premature death by deprivation shows a clear inequality gradient. Chart 10 compares the rate of the most and least deprived communities in Tayside with the average rate. In 2015, there was a widening of the gap between the most and least deprived quintiles due to an increase in rates in the most deprived areas being accompanied by a reduction in the least deprived rate.

Chart 10: Premature (<75 years) mortality in Tayside and Scotland - 2006-2015



Source: NRS and SG SIMD 2012 and SIMD 2016

Health Protection

The Health Protection Team's Function

The core health protection function relates to the statutory duties of NHS Boards to protect their populations from infectious diseases and environmental hazards. This is achieved through both reactive and strategic work carried out by the Health Protection Team (HPT) in preventing, monitoring, maintaining preparedness for, and responding to individual cases, outbreaks and other incidents. Additionally, the health protection function includes coordinating and providing technical expertise to immunisation programmes, and efforts to reduce the burden of infectious disease in the community.

The NHS Tayside Health Protection Team Vision

To take action and provide leadership, expert guidance and support to prevent and manage risks to the health of the public from infectious diseases and environmental hazards

There are three key elements in the delivery of the health protection function:

- Risk identification
- Risk management
- Risk communication

This basic model underpins the various activities and areas of work undertaken by the HPT daily, which in turn can be broken down into five broad themes:

- Surveillance, prevention and control of communicable diseases and environmental hazards.
- Provision of specialist advice and support to primary care, hospitals, and other relevant organisations such as care homes and nurseries, to support effective delivery locally of the core health protection purpose of prevention and control of infectious disease and environmental hazards.
- Investigation and management of a full range of health protection incidents (including single cases and outbreaks of diseases such as meningococcal meningitis, tuberculosis (TB), food poisoning, and environmental release of chemical, biological or radiological agent).
- Coordinating and contributing to planned, preventive programmes including routine and selective immunisations, emergency and resilience planning, and public information and education initiatives.
- The conduct of clinical audit, research and teaching, and contributing to and undertaking continuous professional development relating to health protection.

Topic areas within which these activities are undertaken include:

- Immunisation and vaccine preventable diseases
- Respiratory infections (including TB and pandemic influenza planning)
- Gastrointestinal and waterborne infections and zoonoses (diseases that can be transmitted from animals to humans)
- Blood borne viruses
- Infection control in non-NHS community settings
- Port health
- Environmental health
- Resilience planning

By its nature, the health protection function is subject to sporadic and often unpredictable challenges, with the potential for surges in demand inherent in the responsibility to respond to new and emergent incidents and public health threats. Thus a key priority is sustaining strategic resilience within the Directorate of Public Health to maintain the capacity necessary for effective management of outbreaks and public health incidents.

National and legislative context

The cornerstone of health protection practice is the Public Health etc. (Scotland) Act 2008,[8] which defines a comprehensive set of infectious agents, clinical illnesses and more general health risks that are notifiable and which medical professionals have a legal responsibility to inform health protection services of, with appropriate urgency.

Statutory duties and responsibilities set out in the 2008 Act include the surveillance and public health management of these notifiable diseases and organisms, and monitoring, control and management of environmental health hazards. The Act defines Competent

Persons for the delivery of functions in relation to premises (led by the local authorities) and persons (led by the NHS Board). Competent Persons have significant powers to require, or seek the Sherriff to enforce, restrictions on businesses and individuals, including closure of premises, exclusion from work or other settings, decontamination, and quarantine of individuals.

Supporting and directing Health Boards and local authorities in fulfilling their statutory and professional responsibilities are a range of national technical expert and oversight agencies, including Health Protection Scotland (HPS), Scottish Environmental Protection Agency (SEPA), water quality regulators, and resilience planning partnerships. In 2015, a Scottish Health Protection Network was established bringing together these territorial and national expert agencies in a national structure, with coordination, quality assurance and governance provided by HPS. This network liaises with UK and international counterparts in a joined up system of global disease surveillance and incident response.

In 2016/17, the HPT has participated in a new set of initiatives introduced by the Scottish Government towards establishing a new public health strategy for Scotland. This aims to achieve greater coordination of the wider public health workforce across the NHS and other sectors, and a 'Best for Scotland' approach to managing national services on a consistent, Scotland-wide basis. This has included a focus on a review of the delivery of the health protection function out-of-hours through on-call rota arrangements.

Health Protection challenges in Tayside

There are many similarities but also significant variations between local authority areas in key health protection risks and challenges, which are shaped by the physical and human geography of the Tayside area, and specific local demands and expectations.

Both Angus and Perth and Kinross are home to many rural communities, where working and residential environments are associated with exposure to farm and wild animals, soil and untreated water sources. Agricultural and rural exposure to environmental pathogens can result in a range of infectious diseases e.g., *Cryptosporidium*, *E. coli* O157, and Lyme disease, and significant potential exists for chemical and biological contamination of private water supplies.

Amongst the agricultural and other workers of Perth and Kinross and Angus there are a large number of migrant workers and travellers. The specific health needs of these groups include those associated with poor standards of accommodation, transient use of primary health care services, and imported infections. The standard of residential accommodation has been a concern, especially where caravans are used.

In contrast with the rest of Tayside, Dundee is a wholly urban area with a relatively high population density and high levels of deprivation. The city's large number of temporary residents includes students from across the UK and international locations. Infectious diseases common to other areas of the world can therefore present in temporary residents, with a good example being a small but significant number of cases of TB.

Dundee has the biggest percentage of flatted property per head of population in Scotland, which results in a wide range of environmental health problems. The city's industrial legacy means that there are many former industrial sites zoned for development. Screening for contaminated land with a view to remediation is a major environmental health function.

Amongst several large commercial gatherings and events across Tayside, Perth and Kinross hosts the largest annual music festival in Scotland, 'T in the Park', whose campsite facilities provide accommodation to an estimated 65,000 people over four days, with a concomitant risk of outbreaks of communicable disease. More generally, the thriving tourist industry of both Angus and Perth and Kinross results in many visitors to the area, who may develop infections typically associated with holiday populations e.g. norovirus.

The coastal location of Tayside carries particular significance for health protection

The coastal location of Tayside carries particular significance for health protection. Both Dundee's seaport and airport accommodate international traffic, while the harbour at Montrose, for example, is involved in ammonium sulphate storage. Port health issues are also relevant to Perth harbour.

There are a number of Control of Major Accident Hazards (COMAH) sites throughout Perth and Kinross, and Dundee has one lower tier COMAH site. A wastewater treatment works and Shell and BP Onshore Pipeline Systems are located in Angus. Like a number of other local authorities, Dundee has a range of measures in place to improve air quality, since it has targets for airborne particulate matter (PM_{10}) and nitrogen dioxide (NO_2) currently not being met in the city centre and around major arterial routes. Some Angus premises use biomass boilers which can also produce particulate matter if they have insufficient filtration.

Joint working arrangements

Like many public health services in Scotland, health protection relies on coordinated strategic efforts between various organisations. The Public Health Act of 2008 required the development of a Joint Public Health Protection Plan (JPHPP), setting out the arrangements in Health Board areas for delivery of the health protection function, and giving an overview of health protection priorities, provision and preparedness. The JPHPP for Tayside has been renewed and updated for 2016-2018, and delivery is supported through a range of well-established local professional network groups.

- **Tayside Gastrointestinal Liaison Group**
  Ensures the NHS, three local authorities, Tayside Scientific Services and other key stakeholders take a consistent approach in reporting, investigating, monitoring and controlling gastrointestinal infectious disease.

- **Joint Tayside and Fife Water Group**
  This partnership between the NHS and other statutory organisations fulfils responsibilities in protecting and informing the public on the risks associated with public and private water supplies and blue-green algae (BGA).

- **Communicable Diseases - National Pregnancy Screening Programme**
  The programme offers screening to all pregnant women for human immunodeficiency virus (HIV), rubella, syphilis and hepatitis B, with onward referral for diagnosis and treatment as required. Follow-up must be in line with NHS Quality Improvement Scotland and relevant Managed Clinical Network (MCN) standards.

- **Tayside Sexual Health and Blood Borne Virus Managed Care Network** (SH&BBV MCN)
  This multi-agency accredited MCN is charged with implementing and monitoring delivery of the Scottish Sexual Health and BBV Framework 2011-15,[2] the Hepatitis C Action Plan,[3] and the HIV Action plan.[4] Representation includes NHS Tayside, voluntary sector agencies, and local authorities.

- **Tayside Significant Infections Group**
  This multi-professional group focuses on planning and preparedness for pandemic influenza and other new and emerging disease and hazards potentially posing a high-level threat to services across NHS Tayside, allied with the regional Resilience Planning Partnership.

- **TB network groups**
  In 2016, the Scottish TB Action Plan[5] became a Framework, and the HPT engages actively with the

national network implementing and overseeing its recommendations. This includes establishing and coordinating a local TB multi-disciplinary team (MDT) with clinical and microbiology colleagues, and participation in regional case review and peer education programmes.

- **Tayside Immunisation Steering Group (TISG)**
  The TISG coordinates delivery of all UK routine and selective childhood and adult vaccination programmes. It brings together NHS pharmacy, administration, finance, community and school nursing, and children's services, along with primary care and local authority education departments. In 2016/17 the TISG structure was refreshed and renewed with a new operational subgroup and occupational seasonal influenza short-life working group, which has freed the main group to prepare for and plan implementation of the Scottish Vaccination Transformation Programme[6] announced in February 2017. This involves a shift away from general practices delivering immunisations in favour of more centrally-managed services.

In Scotland, infectious diseases and environmental hazards disproportionately affect deprived and marginalised populations

Health Protection and Inequalities

In Scotland, infectious diseases and environmental hazards disproportionately affect deprived and marginalised populations, linked to upstream determinants such as low socioeconomic status and migration, which can in turn lead to downstream risk factors such as tobacco, alcohol and drug use, poor living conditions, limited social networks, and difficulty in accessing services.

In 2016/17, a significant piece of work overseen by the HPT explored the scale of minority ethnic and migrant communities in Tayside, in order to inform planning for enhanced screening and case-finding for TB among these potentially high-risk groups in line with national TB Framework priority actions.

Over the decade between the 2001 and 2011 UK Censuses, the non-white ethnic population in Tayside increased by over 5,500, from 7,495 to 13,294 individuals. The proportion of the population of Tayside that identified as non-white increased from 1.9% to 3.2%. 'Asian' (including Scottish and British) was the largest single non-white ethnic population group (2.1%), followed by 'African' (0.4%) and then both 'Mixed/Multiple' and 'Other' (0.3%). In 2011 Dundee City recorded the highest proportion of non-white individuals in its council area (6%), accounting for 66% of Tayside's total non-white ethnic population as a whole.

Analysis was carried out of data on adult overseas nationals registering for a new National Insurance (NI) number for the purposes of work, benefits or tax credits, which provide an indication of the number of new arrivals coming to a particular area. In 2015/16, a majority of overseas nationals in Tayside were registered within Perth and Kinross, accounting for 51.9% (N=2,774) of the total. Overseas nationals in Dundee City accounted for 24.8% (N=1,352) and in Angus 24.3% (N=1,327), of the total for Tayside.

There is some variation between the three Tayside local authority areas in terms of country of origin of their NI number allocations. Romanian is the most common single nationality of non-UK nationals registered in Tayside as a whole (29.7%) and both Angus (47.9%) and Perth and Kinross (30.6%). In comparison, among Dundee's allocations, those of Romanian origin represented only 9.8%, and the largest grouping was Polish nationals, representing 19.9% of the city's allocations.

1,275 clinical and laboratory notifications were received by the HPT in the year 2016/17, an average of 3.5 per day

A separate analysis indicates that every year between 700 and 1,000 students from countries around the world with high TB incidence register with the Universities of Abertay and Dundee (combined), and it is likely that most are not included in the NI number statistics. In all, it is estimated that around 12,000 individuals come to Tayside each year who would at least fit criteria for requiring screening for latent TB infection. Many will also be at risk of a range of infectious and environmental illnesses depending on the country and area of origin.

Other sectors of the population which are potentially vulnerable and/or associated with being under-served include rural communities and people experiencing homelessness. In 2013/14, 19.1% of the Tayside population resided in 'accessible rural areas', and 5.2% were living in 'remote rural areas'. During 2014/15, Dundee City Council received 1,102 applications for assistance under Homeless Person's Legislation, compared with Angus (597 applications) and Perth and Kinross (680 applications). Over the last eight years there has been a decline in the number of applications, most pronounced in Perth and Kinross.

The exploration of vulnerable communities in Tayside will be taken forward to seek solutions to better identify and make health protection related services more accessible for them, including appropriate screening for latent TB and other infections, and routine immunisations.

Overview of core activities in 2016/17

Under the 2008 Public Health Act there is a list of diseases that registered medical practitioners have a statutory duty to notify to their public health department based on reasonable clinical suspicion, and a largely corresponding set of organisms that diagnostic laboratories also have a statutory duty to notify. The HPT uses the national HPZone electronic record system to document these notifications and coordinate responses, which include issuing information and advice to individuals, professionals and the public; putting exclusions in place; offering pre and post-exposure antibiotics and vaccinations to reduce the risk of disease and tracking trends.

HPZone data show that, in total, 1,275 clinical and laboratory notifications were received by the HPT in the year 2016/17, an average of 3.5 per day, and ranging from common infections requiring limited follow-up such as campylobacter, to severe and complex cases such as E. coli O157, Legionnaires' disease and TB. Additional to this are other reports and enquiries the team responds to, including water quality failures and potential environmental hazards, and requests for advice on vaccinations. In total these numbered 698 in 2016/17.

The notifications and enquiries figures include those which led on to the HPT declaring and managing an outbreak or other public health incident. In total there were 30 of these situations in 2016/17. Some are quite routine, including infectious respiratory and gastrointestinal outbreaks in care homes. Others are more challenging, and among the most significant were outbreaks associated with childcare settings, including one of E. coli O157 and one of meningococcal infection, and infections of pertussis (whooping cough) and TB in healthcare workers. All such incidents are subject to detailed 'lessons learned' and reporting processes.

Strategic Priorities

In recent years, the HPT has been guided in setting priorities by the Chief Medical Officer for Scotland's 2012 annual report, which specified key challenges and priorities in relation to communicable diseases, many of which remain relevant today:

- Gastrointestinal and food-borne infections - reflecting complex transnational foods chains, and zoonoses such as *Salmonella, Cryptosporidium, E. coli* O157 and Lyme disease.
- Travel and international health, and emerging and re-emerging infections - with millions of international journeys made from and to Scotland every year, the threat of gastrointestinal, viral and vector-borne infections such as chikungunya, Zika, avian influenza and MERS-CoV is significant.
- Environmental factors - estimated to account for 14% of the UK's disease burden; the main environmental concern for Tayside is air pollution, to which traffic is a major contributor.
- Resilience and emergency preparedness - highlighting the need to predict and respond to established and emerging global health threats posed by infectious diseases, environmental hazards, natural disasters and bioterrorism

Many of these threats and activity themes remain highly relevant and current in 2017, and for the years ahead. They have informed the NHS Tayside HPT's own work-planning and prioritisation programme, consisting of regular development events and management and professional knowledge update meetings, in service of realising the team's long-term strategic vision. Priority work-streams for 2017/18 been identified provisionally as summarised Table 1 on the following page.

Strategies to meet these priorities and the challenge of current and emerging health protection threats will include becoming technologically smarter, particularly in surveillance, risk communication, and applying national guidance; and increasing collaboration towards resilient, multi agency structures and national strategic plans such as the new Vaccination Transformation Programme, the Sexual Health and Blood Borne Virus Framework, national TB Framework, and VTEC/E Coli O157 Action Plan.[7]

Table 1		
Priority theme	**Specific topics**	**Recommendations for 2017/18**
Blood borne viruses	Hep B vaccination for exposed and at-risk babies	Establish electronic call/recall system
		Agree robust multi-disciplinary pathway for identification and follow-up of eligible patients
	Prevention for high-risk/vulnerable groups	Develop strategies to inform and reduce risks associated with 'chemsex', commercial sex work, and injecting drugs
Immunisation programmes	Scottish Vaccination Transformation Programme	Lead three year wholesale reorganisation of services in line with national programme
	IT/records systems (e.g. GP, hospital, child health etc)	Advocacy for national renewal of electronic systems so that they inter-connect
		Develop more efficient local interim solutions to multiple recording/data entry
		Pursue full access to immunisation call/recall system for HPT admin. staff
	Unscheduled/catch-up vaccinations	Clarify responsibilities of Immunisations service/GPs/others and streamline pathways
	Staff education and training	Develop regular comprehensive training and update programmes for immunisers
	Accessibility and uptake	Work with services delivering staff flu, pregnancy and other programmes to enhance awareness and accessibility
Gastrointestinal infections	E. coli	Revise protocols to ensure consistency in where, when and how exclusion is required
		Streamline financial compensation for those excluded so vulnerable individuals and families are not disadvantaged
	Multiplex Polymerase Chain Reaction (PCR) testing	Management of anticipated increase in workload from more sensitive testing
		Resolve management of asymptomatic chronic carriers in whom clearance difficult
	Lyme disease	Engage with national public information and management development work
	Campylobacter	Commonest single pathogen notified in Scotland - participate in national epidemiological study
Environment	Air pollution	Responding to national initiatives to identify and remediate high emissions areas
	Lead in water	Implementation of new quality standards including in schools and childcare facilities
TB	National TB Framework	Develop and implement strategies for screening and detection of latent TB in new entrant and other high-risk groups
		Increase screening accessibility by extending to peripheral sites
Health Protection Team management	Resilience	Identify and train nurses from wider work-force to provide health protection nursing team resilience
	Administration capacity	Explore opportunities to re-direct staff time
		Formalise documentation in electronic systems when using staff resilience
	Out-of-Hours	Engage with national project evaluating arrangements, including mutual aid options
	Action cards (administration team)	Ensure continuous review and update
	Team development	Ongoing review and update of mandatory training requirements
		Develop team induction programme

References

1. Public Health etc. (Scotland) Act 2008 a.s.p. 5
2.Scottish Government. The Sexual Health and Blood Borne Virus Framework 2011-15. Edinburgh: The Scottish Government; 2011
3. Scottish Government. Hepatitis C Action Plan for Scotland Phase II: May 2008 March 2011. Edinburgh: The Scottish Government; 2008
4. Scottish Government. HIV Action Plan in Scotland. Edinburgh: The Scottish Government; 2009
5. Scottish Government. A TB Action Plan for Scotland. Edinburgh: The Scottish Government; 2011
6. Scottish Government. General Practice: Contract and Context Principles of the Scottish Approach Post SLMC Conference Update. Edinburgh: The Scottish Government; 2017
7. Scottish Government. VTEC/*E. coli* O157 Action Plan for Scotland 2013 2017. Edinburgh: The Scottish Government; 2013

Halting the Obesity Epidemic

Introduction

Overweight/obesity remains a major public health issue and occurs when energy intake from food and drink consumption, including alcohol, is greater than the body's energy requirements over a prolonged period, resulting in the accumulation of excess body fat. Body Mass Index (BMI), a measurement comparing weight to height, is commonly used as a measure of overweight and obesity.

Prevalence of obesity in the UK has more than doubled in the last 25 years and it is estimated that by 2050, 60% of men, 50% of women and 25% of children will be obese.[1] In adults a BMI between 25 and 30 indicates overweight and a BMI greater than 30 indicates obesity. Obesity and overweight levels are generally higher in the most disadvantaged groups, but the socioeconomic status gradient is much clearer and steeper in women than in men. The Scottish Health Survey[2] shows that for the period 2012/15 in Tayside:

- Almost 65% of adults (68% men and 62% women) were overweight or obese compared to 69% and 61% in Scotland.
- Almost 29% of adults were in the obese category, which is slightly higher than the Scotland figure of 28%.
- Obesity is more prevalent in women (30%) than men (27%).

Poor diet and inactivity are significant issues,[2] for example:

- 69% of adults in Tayside have fewer than the recommended five portions of fruit and vegetables per day, compared to 70% in Scotland.
  - The average number of portions per day is 3.1 in Tayside and 3.2 in Scotland.
  - In Tayside 10% of men consume no fruit or vegetables per day compared to 9% of women.
  - 21% of men and 21% of women in Tayside consume five portions or more per day. This is very similar to the figures for Scotland (20% and 21%, respectively).
- 62% of adults in Tayside (63% in Scotland) meet the recommendation of at least 150 minutes of moderately intensive physical activity or 75 minutes vigorous activity per week or an equivalent combination of both.
  - There is a marked difference between men and women, with 67% of men in Tayside (68% in Scotland) meeting recommendations compared to 58% of women (58% in Scotland).

For Primary One children in Tayside during 2015/16:[3]

- 76.1% were classified as healthy weight (defined as BMI above 2nd centile and below 85th centile), a small increase on the 2014/15 figure of 75.2% and slightly less than the Scotland average of 76.8%.
- 23.1% were at risk of overweight/obesity (defined as BMI on and above 85th centile) combined.
- The risk of obesity (defined as BMI on and above 95th centile) has reduced slightly from 11% in 2014/15 to 10%.

Being obese or overweight can increase the risk of premature death and developing a range of serious diseases including, type 2 diabetes, hypertension, heart disease and some cancers. This situation is avoidable but the solution is complex.

Prevalence of obesity in the UK has more than doubled in the last 25 years and it is estimated that by 2050, 60% of men, 50% of women and 25% of children will be obese

Multi-agency partnership working is necessary to make 'sustainable changes to our living environment in order to shift from one that promotes weight gain to one that supports healthy choices and healthy weight for all'. [4]

The Scottish Government identified four preventative actions:[4]

- Control exposure to, demand for, and consumption of, excessive amounts of highly calorific foods and drinks.
- Increase opportunities for physical activity in daily lives and minimise sedentary behaviour.
- Establish lifelong habits for positive health behaviour.
- Increase the responsibility of organisations for the health and wellbeing of employees.

The Scottish Government also calls for assurance that cost effective and appropriate weight management services are provided.[4]

Getting the Best Start in Life

The diet and nutritional status of the mother before conception and during pregnancy, the feeding received in the first few months of life, the introduction of complementary feeding and, the diet and nutritional status of the growing infant all contribute to the long-term health of the population.[5, 6]

Healthy Start

Poorer households in Scotland have a worse diet than affluent households.[7] The national Healthy Start scheme provides monetary vouchers (for cows' milk, infant formula milk, fruit and vegetables) and free vitamins to those most in need. Uptake of the scheme in Tayside is around 70%, which is on a par with the rest of Scotland (Chart 1). Healthy Start vitamin supplements are important because 8% of children under five in the UK do not have enough vitamin A in their diet, families in lower income groups tend to have less vitamin C in their diet, and all pregnant and breastfeeding women and young children are at risk of vitamin D deficiency (teenagers, younger women and those from ethnic minorities are particularly at risk).[8, 9]

What are we doing to improve uptake of Healthy Start and reduce inequalities?

- Healthy Start is introduced by midwives to all pregnant women at booking, and opportunistically by multi-agency partners (e.g. housing association and voluntary sector personnel).

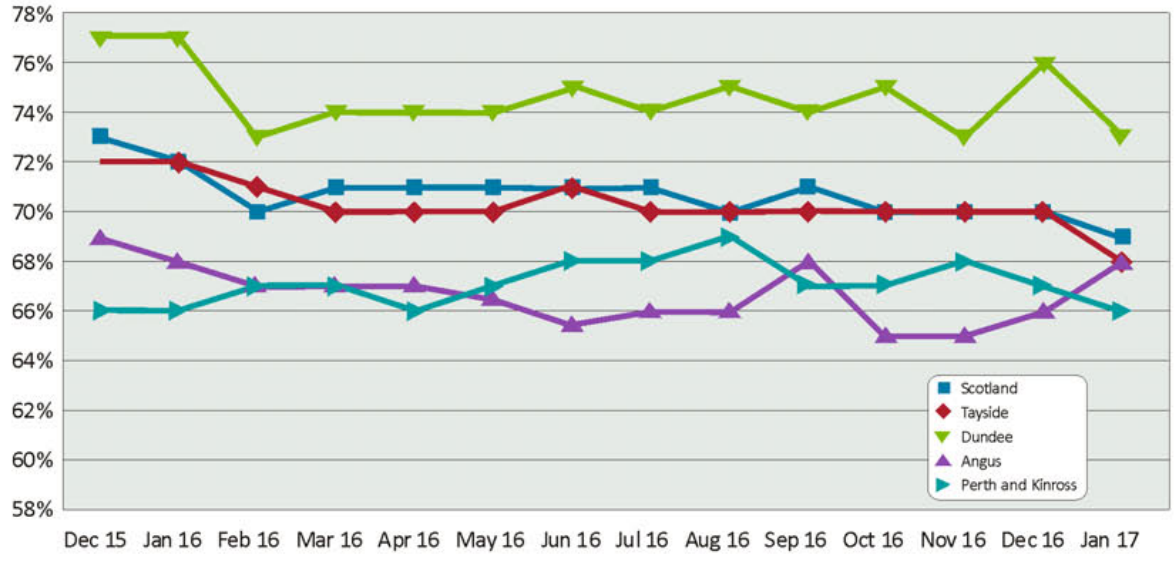
8% of children under five in the UK do not have enough vitamin A in their diet, families in lower income groups tend to have less vitamin C in their diet

- Healthy Start vitamin supplements for pregnant or lactating women and children are issued throughout Tayside. Between April 2016 and March 2017 midwives issued over 12,000 units of vitamin tablets to pregnant and breastfeeding women and health visitors issued over 6,000 units of children's vitamin drops.

Infant Feeding

Exclusive breastfeeding for the first six months of an infant's life is the ideal. Evidence shows short and long-term health benefits for both mothers and infants and several factors influence whether or not a mother continues to breastfeed. In 2015/16 Tayside's exclusive breastfeeding rate at 10 days was 38.9% compared to 35.6% in Scotland which represents a 1.7% increase since

Chart 1: Uptake of Healthy Start Vouchers by NHS Tayside, Local Authority and Scotland Average



Source: Scottish Government Healthy Start statistics, 2015-2017

Exclusive breastfeeding for the first six months of an infant's life is the ideal

2013/14 (Chart 2). At 6-8 weeks 29.2% of babies were exclusively breastfed compared to 28.2% in Scotland, which is a 3.3% increase since 2013/14 (Chart 3).

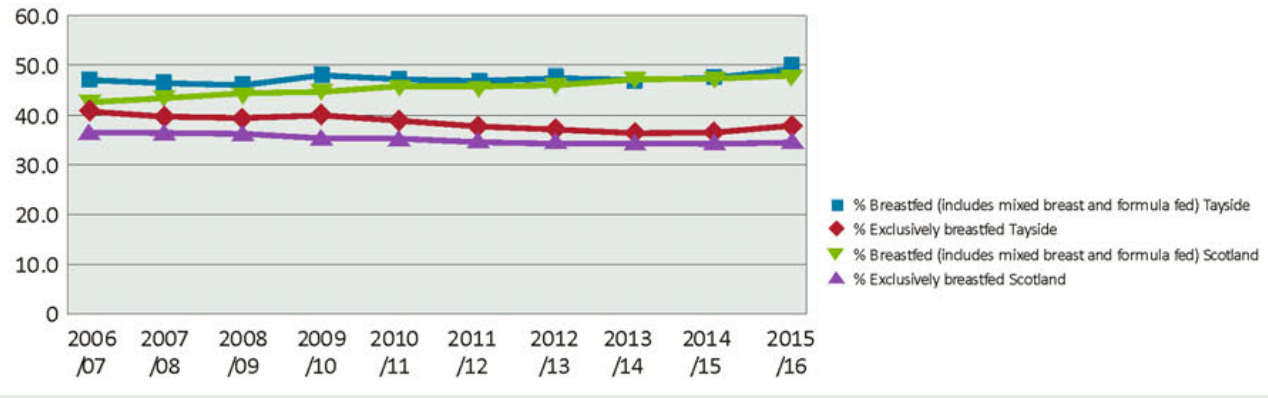
What are we doing to improve infant feeding and reduce inequalities?

- We are continuing to improve the knowledge, skills and confidence of all those working with pregnant women and new mothers by delivering separate two-day courses on breastfeeding management and maternal and infant nutrition; plus two online training programmes, each covering infant formula milk and breastfeeding challenges.
- We are working with maternity and community nursing services to maintain UNICEF UK Baby Friendly Initiative accreditation.
- We are working with neonatal services to implement the UNICEF UK Baby Friendly standards.
- We are providing additional support to mothers through breastfeeding support workers, peer support volunteers, telephone contacts and social media. We have extended the additional breastfeeding support in one area of Dundee as a test. We have increased the number of breastfeeding volunteers and are supporting a volunteer coordinator role.
- We are providing impartial information about infant formula milks to NHS Tayside staff to share with parents.
- In partnership with mothers we are continuing to increase the number of cafés and restaurants participating in the Breastfeeding Welcome scheme.

Maternal Obesity

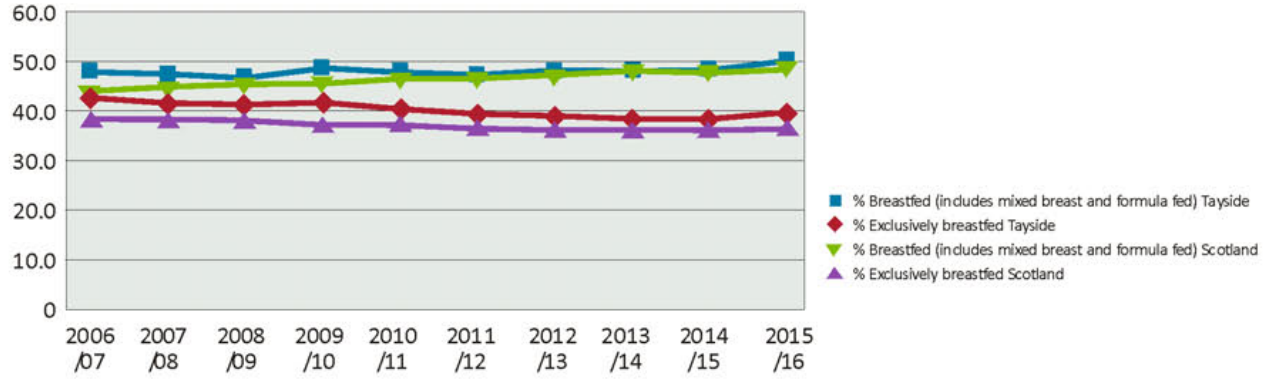
Obesity in pregnancy is currently 'the biggest challenge facing maternity services today'.[10]

Chart 2: Breastfeeding at the first health visitor visit - NHS Tayside and Scotland



Source: ISD Breastfeeding statistics, Financial year 2015-16

Chart 3: Breastfeeding at the 6-8 week health visitor review - NHS Tayside and Scotland



Source: ISD Breastfeeding statistics, Financial year 2015-16

Women with obesity are more than twice as likely to have a stillborn baby and the risk increases with increasing BMI. Babies born to mothers with obesity are less likely to be breastfed and are more likely to have congenital anomalies (especially neural tube defects) and to require admission to neonatal units. It is also more difficult to monitor the health of these babies during pregnancy and birth.

The mother's health is also at risk. They are more likely to have pregnancy related complications such as gestational diabetes, pre-eclampsia, haemorrhage following birth, thromboembolism and deliver their babies by caesarean section.

What are we doing to address maternal obesity and reduce inequalities?

Underpinned by national guidance[11] and in partnership with multi-disciplinary and multi-agency personnel and local women we have developed, delivered and evaluated:

- Written information for all pregnant women with a BMI over 30, on the risks of obesity in pregnancy and how to access available support and guidance. This is issued after discussion with the midwife.
- The optiMUM programme (an exclusive lifestyle programme for pregnant women with a BMI over 30), which is now integrated into antenatal services and offered throughout Tayside. This nationally recognised service was allocated Scottish Government funding for an independent evaluation.
- A vulnerable care pathway with specific guidance on the management of pregnant women with a BMI over 30.
- A free-of-charge 12-week Weight Watchers© programme for postnatal women with a BMI over 30 at pregnancy booking.

Complementary Feeding and Family Food Skills

People living in areas of deprivation are less likely to eat wholemeal bread and vegetables, and are more likely to drink soft drinks (not diet drinks) and eat more processed meats, whole milk and sugar.[9]

Babies born to mothers with obesity are less likely to be breastfed and are more likely to have congenital anomalies

COMMUNITY COOK IT

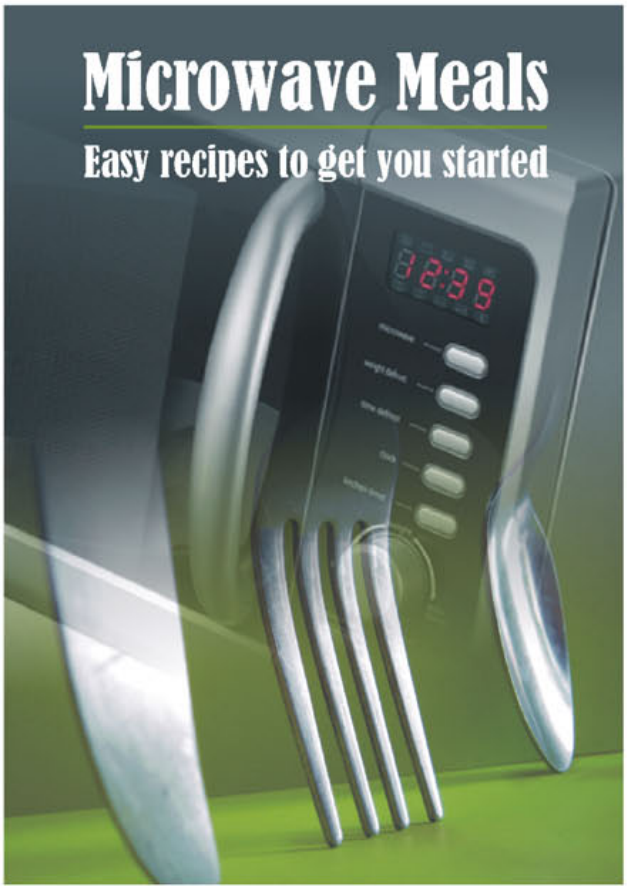
Adults in Scotland consumed an average of just over three portions of fruit and vegetables a day in 2015[2], compared to the recommended minimum of five portions. Over the past several decades a change in cooking and food preparation skills has resulted in an increased use of pre-prepared, packaged and convenience foods, which require fewer and/or different skills from what is often referred to as 'traditional cooking'. This change has also had an important impact on healthy eating.

- 77% of children receive solid food before the recommended age of six months.
- Over half of children aged 4-18 months in Scotland who had food other than milk, had eaten a commercial baby or toddler meal.[12]
- Children continue to consume too much sugar and not enough fruit and vegetables[3] especially children from areas of deprivation.[13]
- 14% of children aged 2-15 years eat at least five portions fruit and vegetables every day.[14]

What are we doing to increase food skills and reduce inequalities?

- We are working with NHS Tayside's Nutrition and Dietetic Service and the Dundee Healthy Living Initiative (DHLI) to develop and/or deliver food related training. Examples include the Royal Environmental Health Institute for Scotland's Elementary Food Hygiene and Food and Health courses, NHS Tayside's practical food skills' programme 'Community Cook It' and 'complementary feeding' training.
- We are continuing to support Dundee's local food skills' network that supports anyone delivering practical food activities.

- We are working in partnership with Dundee Leisure and Culture, and Dundee City Council to support and sustain the nutrition and play programme, 'Eat Well Play Well'.
- We are harnessing more opportunities to work with partners to partly fund and/or support them in delivering practical food activities and cooking courses within disadvantaged communities across Tayside including 'Eat Well Play Well' groups, parent lunchtime session in schools, parent and child cooking courses (DHLI), healthy lifestyle courses and practical food skills sessions (Helm Health in Dundee).
- We are developing practical nutrition resources which support partners to provide consistent and evidence-based nutrition messages such as a traffic light guide to complementary feeding and a resource for microwave meals.



Protecting Health

Child Healthy Weight

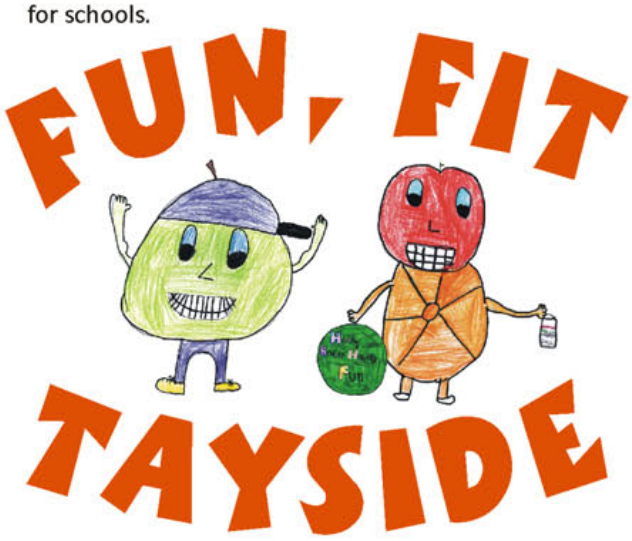
Childhood obesity persists into adulthood with the likelihood increasing markedly for obese teenagers.[15, 16] Risk factors include sedentary lifestyle, poor diet, social deprivation and parental obesity. Adults have an important role in determining the lifestyle choices of children, particularly during the earliest years of a child's development. Factors such as income, gender and a person's ethnicity increases the impact of obesity within certain population groups.[1]

In children and teenagers a wide range of health problems can be associated with excess weight including high blood pressure, diabetes, psychosocial dysfunction and the worsening of existing conditions such as asthma. Management of childhood obesity is important due to the high prevalence of overweight and obesity. In 2015/16, 23.1% of Primary One pupils were overweight or obese[3].

What are we doing to tackle childhood obesity and reduce inequalities?

The Paediatric Overweight Service Tayside (POST) continues to deliver:

- A weekly clinical service at Perth Leisure Pool, Kirkton Community Centre in Dundee and the Saltire Centre in Arbroath for children and young people aged under 16 years who are actively managing their weight.
- Community groups e.g. 'Get Going' in Dundee (delivered by partner organisation Mytime Active until July 2016).
- A co-production approach to child healthy weight called 'Learn Well'. In Dundee's east end and the North Muirton and Pitcairn areas of Perth and Kinross, 'Learn Well' is engaging with the local community around promoting healthy lifestyle, healthy weight and normalising discussions on body weight. In Dundee, community engagement events were held with over 200 people attending at Craigiebarns and Rowantree primary schools. The POST team is working in these schools, as well as, Pitcairn and North Muirton to promote the Daily Mile and delivery of 'Fun Fit Tayside' - a child healthy weight health promotion programme for schools.



Workforce

A healthy workforce is essential to help Scotland increase sustainable economic growth. Rising levels of obesity make a significant and growing contribution to levels of illness and subsequently sickness absences in the workforce. Currently 2.5 million people in Scotland are in employment (25% in public sector) and given the amount of time individuals spend at work there is a real opportunity to engage a larger proportion of the adult population in activities that prevent obesity.

Given the amount of time individuals spend at work there is a real opportunity to engage a larger proportion of the adult population in activities that prevent obesity

In addition, our current obesogenic environment (places, situations or practices) promotes excessive weight gain and/or discourages healthy lifestyle choices within the home or workplace.[17, 18]

What are we doing to improve diet and lifestyle in the workforce and reduce inequalities?

- All workplaces participating in the Healthy Working Lives (HWL) programme are required to address healthy eating and physical activity within the workplace setting as part of the criteria for the Silver Award. Thirteen NHS Tayside sites are registered for participation in the HWL programme with six of the sites having reached Silver Award level or above. A further 15 non-NHS workplaces throughout Tayside have also achieved either the Silver or Gold Award.
- The HWL team regularly promotes healthy eating information in all workplaces and this year included the Scottish Cancer Prevention Network's healthy eating assessment and healthy recipes and other healthy recipes.
- All 10 NHS Tayside dining areas serving food to staff and the public hold the national 'healthyliving award plus'. NHS Tayside has two non-NHS providers; one currently holds the award and the other has applied.
- NHS Tayside continues to include Health Promoting Health Service criteria in the specification for the combined vending contract for drinks, confectionery and snacks.[19, 20, 21]
- In the NHS setting the Healthcare Retail Standard (HRS) creates an environment where healthier choices are easier choices and gives an opportunity for retailers to encourage the nation to eat more healthily. Fifty percent of food items and a minimum of 70% of soft drinks stocked must meet agreed criteria; HRS also restricts promotions to healthier items and meal-deals.[21] Five retail premises (one NHS, two non-NHS premises and two non-NHS trolley services) comply with the HRS. Two further non-NHS retail premises are working towards achieving the HRS in 2017/18.

Effective Health Services

The number of overweight or obese adults within our population is now so high that being a healthy weight is no longer 'normal'. What can be done to treat overweight/obesity depends on how able or willing an individual is to change various lifelong behaviours relating to food and physical activity.

Adult Weight Management

Sustained modest weight loss (5-10%) has a number of health benefits:

- Improves physical, mental and social wellbeing
- Improves pre-existing obesity related co-morbidities
- Reduces future risk of obesity related co-morbidities

The Scottish Government advocates a four tiered service:

Tier 1: Population-wide health improvement work: pre-healthcare lifestyle advice; self-care including workplace support and activities; community pharmacy and commercial weight management programmes.
Tier 2: Primary Care: healthcare assessment, advice, support, intervention and monitoring which may include referral to practice or community-based services (e.g. lifestyle adviser support service, Counterweight®, Winning Weigh, community dietetic service or commercial slimming organisations) and possible drug therapy.

Tier 3: Specialist Weight Management: access to a multi-disciplinary team and more intensive assessment and support for people with severe and complex obesity.
Tier 4: Specialised bariatric surgical service: referral only after full and active engagement in tier 3.

What are we doing to improve adult weight management services and reduce inequalities?

Helping people to lose and/or maintain weight is the central aim of NHS Tayside's specialist adult weight management service.

Helping people to lose and/or maintain weight is the central aim of NHS Tayside's specialist adult weight management service

We continue to:

- Listen to patients who make it clear that being able to access the best treatment close to home is a priority.
- Review the clinical pathway in line with the recommended tiered approach.
- Support being an opt-in service, ensuring an individual's 'readiness to change' is assessed prior to treatment.
- Deliver a multi-disciplinary group programme for tier 3 covering diet, activity/inactivity and behaviour change which includes access to physiotherapy and clinical psychology, and if necessary, to other therapies such as anti-obesity medication and surgery.

We have also:

- Commenced a revamp of the tier 3 programme and designed a new programme around patients' comments and feedback.
- United child and adult weight management services in order to provide a more integrated approach.
- Started to discuss the best way to combine work with parents, children and young people to address childhood obesity.

Recommendations

During 2015/16 we reviewed Tayside's Healthy Weight Strategy (2005). A fact file was created which forms a central part of the evidence-base and includes information on demography, national and local obesity policy drivers, healthy weight related data and, local healthy weight services and activities. An assessment of the Strategy's 52 recommendations (82 elements) showed that implementation varied from 'no progress' (three elements) to 'significant' or 'sustained improvement' (37 elements). Therefore, whilst we have made some progress since 2013/14 there is still much to do.

We will do all that we can to make sure obesity becomes an explicit priority at strategic and delivery levels for NHS Tayside and local authorities.

We will engage with external partners to integrate support and provide sustainable preventative and treatment services based on the following outcomes:

- Access to a free-of-charge 12-week Weight Watchers© programme is extended to women of childbearing age.
- UK Baby Friendly accreditation is achieved as a minimum standard by NHS Tayside.
- There is a robust analysis of the necessary steps for healthy eating and physical activity for children, young people and families that address obesity prevention.
- Vulnerable families continue to be assisted to develop fundamental food skills and access affordable healthy food.
- NHS Tayside's Nutrition and Dietetic service supports partners in activities that prevent and control obesity.
- An improved adult weight management service tier 3 programme is implemented.
- Obesity prevention and control strategies in the workplace are developed and implemented.
- A standardised framework supporting high-quality, consistent evaluation of obesity prevention and treatment is developed.
- The principles of co-production and asset based approaches continue to be applied to the design and delivery of all obesity prevention and treatment approaches.

Whilst personal responsibility plays an important role in weight gain, in obesogenic environments inactivity and over consumption of energy dense foods are easy, affordable and widely accepted; making an unhealthy lifestyle the default option. Therefore, in addition to the above we will work with partners to identify opportunities to create leptogenic environments whereby physical activity and the consumption of healthy food and drinks are easy, affordable and widely accepted, making a healthy lifestyle the default option.

References

1. Foresight, 2007. Tackling Obesities: Future Choices: Summary of Key Messages. The Stationary Office: UK, 2007. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/287937/07-1184x-tackling-obesities-future-choices-report.pdf [accessed 21.04.14].
2. The Scottish Government. The Scottish Health Survey 2012-2015, results by NHS Boards. Available at: http://www.gov.scot/Publications/2016/09/2408/downloads#res505568 [accessed 08.05.17]
3. Information Services Division (ISD) Scotland. Primary 1 Body Mass Index (BMI) Statistics. School Year 2006/07 - 2015/16. Available from: http://www.isdscotland.org/Health-Topics/Child-Health/Publications/data-tables.asp?id=1807#1807 [accessed 01.05.17].
4. The Scottish Government. Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight. Edinburgh: The Scottish Government 2010. Available at: http://www.scotland.gov.uk/Resource/Doc/302783/0094795.pdf [accessed 08.05.17].
5. The Scottish Government. Improving Maternal and Infant Nutrition: A Framework for Action. Edinburgh: The Scottish Government 2011. Available at: http://www.scotland.gov.uk/Resource/Doc/337658/0110855.pdf [accessed 08.05.17].
6. NHS Health Scotland. Setting the Table. Edinburgh: NHS Health Scotland 2014. Available at: http://www.healthscotland.com/uploads/documents/21130-SettingtheTable_1.pdf [accessed 08.05.17].
7. Nelson M, Erens B, Bates B, Church S and Boshier T. Low income diet and nutrition survey. The Food Standards Agency 2007. Available at: http://tna.europarchive.org/20110116113217/http://www.food.gov.uk/multimedia/pdfs/lidnssummary.pdf [accessed 08.05.17].
8. Scientific Advisory Committee on Nutrition. The Nutritional Wellbeing of the British Population. London: TSO 2008. Available at: http://webarchive.nationalarchives.gov.uk/20081105144316/http:/www.sacn.gov.uk/pdfs/nutritional_health_of_the_population_final_oct_08.pdf [accessed 08.05.17].
9. Scientific Advisory Committee on Nutrition. Vitamin D and Health. London: 2016. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/537616/SACN_Vitamin_D_and_Health_report.pdf [accessed 01.05.17].
10. Saving Mother's Lives Reviewing maternal deaths to make motherhood safer: 2006–2008. BJOG 2011; 118: Supplement 1. Available at: http://www.oaa-anaes.ac.uk/assets/_managed/editor/File/Reports/2006-2008%20CEMD.pdf [accessed 01.05.17]
11. National Institute for Health and Care Excellence (NICE). Weight management before, during and after pregnancy. NICE public health guidance 27. London: NICE, 2010. Available at: https://www.nice.org.uk/Guidance/PH27 [accessed 08.05.17].
12. The Scottish Government. Diet and Nutrition Survey of Infants and Young Children in Scotland. Edinburgh: The Scottish Government 2011. Available at: http://www.scotland.gov.uk/Publications/2013/03/5846/downloads#res416010 [accessed 08.05.17].
13. The Food Standards Association. Survey of sugar Intake among children in Scotland. The Food Standards Association 2008. Available at: https://www.food.gov.uk/sites/default/files/multimedia/pdfs/publication/surveyofsugarscotland0308.pdf [accessed 08.05.17].
14. The Scottish Government. The Scottish Health Survey 2014: Volume 1: Main Report. Available at: http://www.gov.scot/Publications/2015/09/6648 [accessed 08.05.17]
15. Reilly JJ, Methven E, McDowell ZC, Hacking B, Alexander D, Stewart L et al. Health consequences of obesity. Archives of Disease in Childhood 2003; 88: 748-52.
16. Reilly JJ. Descriptive epidemiology and health consequences of childhood obesity. Best Practice and Research Clinical Endocrinology and Metabolism 2005; 19: 327-41.
17. Swinburn B., Eggar G and Raza F. (1999). Dissecting obesogenic environments; the development and application of a framework for identifying and prioritizing environmental interventions for obesity. Preventive Medicine, 29; 6: 563-570.
18. Foresight. Tackling Obesities: Future Choices: Obesogenic environments. The Stationary Office: UK, 2007. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295682/07-1112-obesogenic-environments-workshops.pdf [accessed 08.05.17].
19. The Scottish Government. Health Promoting Health Service: Action in Acute Care Settings CEL14(2008). Edinburgh: The Scottish Government 2008. Available at: http://www.sehd.scot.nhs.uk/mels/CEL2008_14.pdf [accessed 05.05.14].
20. The Scottish Government. Health Promoting Health Service: Action in Hospital Settings. CEL 01(2102). Edinburgh: The Scottish Government 2012. Available at: http://www.sehd.scot.nhs.uk/mels/CEL2012_01.pdf [accessed 05.05.14].
21. The Scottish Government. Health Promoting Health Service: Action in Secondary Care Settings CMO(2015)19 letter. Available at: http://www.sehd.scot.nhs.uk/cmo/CMO(2015)19.pdf [accessed 01.05.17]

Realistic Medicine

In her first Annual Report, Realistic Medicine,[1] Dr Catherine Calderwood, Chief Medical Officer, set out to engage clinicians with her vision that our health services could work to reduce unnecessary treatment, address unacceptable variation in outcomes, and deliver more appropriate, personalised care: the concept of minimally disruptive medicine.

Putting people at the centre of decision-making and building a personalised approach are key to our Chief Medical Officer's plans to change the way in which we work across all professions in NHS Scotland. Realising Realistic Medicine[2] has set out the ways in which we can change patients' experiences of our health service. Both Reports encourage clinicians to manage clinical risk and become improvers and innovators whilst addressing unwarranted variation.

Figure 1: Realistic Medicine - key message

Source: Chief Medical Officer's Annual Report Realistic Medicine

'In striving to provide relief from disability, illness and death, modern medicine may have over reached itself and is now causing hidden harm - or at best providing some care that is of lesser value'.[1]

This requires a culture shift within the NHS, where the norm is that the responsibility for health is removed from the patient and placed with the prescriber, who is expected to to follow clinical guidelines. It is increasingly recognised that clinical guidelines that are developed for single disease-states can not necessarily be extrapolated to manage those with multiple diseases, and that implementation of all applicable guidelines can drive polypharmacy.[1] [3]

> Evidence demonstrates that at least 50% of people on four or more medications often do not take them as prescribed

Polypharmacy is an increasing burden on both the patient and the NHS

We are all aware that as our populations live longer they are more likely to develop a range of long-term conditions - all of which can require multiple medications. Up to 11% of all unplanned hospital admissions are attributable to medicines-related harm. Research shows that this increases with age. In Tayside, the Acute Frailty Team found that 42% of patients with unplanned hospital admissions in the over 80 age range have medicine-related component to their admission.[4]

Potentially, inappropriate prescribing can occur where medication is prescribed in a traditional condition-specific manner, rather than as part of a holistic person-centred approach. Evidence demonstrates that at least 50% of people on four or more medications often do not take them as prescribed, and up to 6% of all admissions to hospital are caused by incorrect use of medicine.

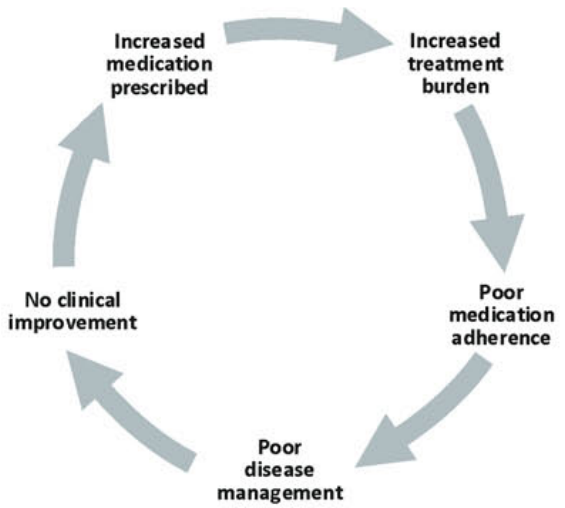
From a public health perspective I am aware of the differential uptake of treatments by members of our more disadvantaged communities and the poorer outcomes that are often experienced by them from NHS care. A significant contributor to the poorer outcomes are problems with health literacy (the ability to understand and make use of information that sustains and improves health) amongst these populations. The delivery of care from within communities holds the prospect of addressing some of the issues with health equity that are caused by the need to navigate journeys through complex secondary care pathways. These are significant challenges for our healthcare systems – not just for the added cost that we collectively bear, in a time when resources are tighter than ever, but also for how

we enable our citizens to gain as high a quality of life as possible.

The World Health Organisation (WHO), and World Bank combined data globally estimate that mismanaged polypharmacy contributes to 4% of the world total avoidable costs due to suboptimal medicine use. A total of 0.3% of global total health expenditure, or 18 billion US dollars worldwide, could be saved by managing polypharmacy correctly.

Treatment burden can be assessed using polypharmacy as an index. The more medicines you take, the greater the burden of storing, organising, scheduling doses and understanding what each medicine does. The greater the burden, the less likely you are to take your medicines as intended. This situation causes an increasing problem for the patient and creates a condition in which they are unable to comply with the medicines prescribed and so do not meet the therapeutic outcomes, leading to more medicines being added.

Figure 2: Cycle of polypharmacy, treatment burden and treatment failure



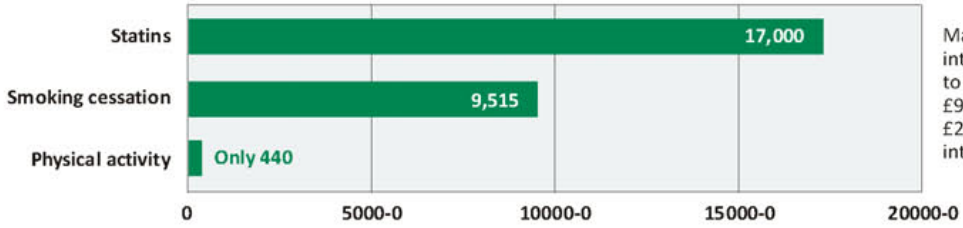
Alcohol and tobacco consumption, physical inactivity, lack of a nourishing diet and poor mental wellbeing are the most pressing causes of ill health across all groups of the population

Alcohol and tobacco consumption, physical inactivity, lack of a nourishing diet and poor mental wellbeing are the most pressing causes of ill health across all groups of the population

Alcohol and tobacco consumption, physical inactivity, lack of a nourishing diet and poor mental wellbeing are the most pressing causes of ill health across all groups of the population, but are particularly prevalent in poorer communities. Inequalities in power and in resources, including for some, the inability to afford necessities such as fuel, make it difficult for some people to live healthily or make healthy lifestyle choices. For better population health individuals need to be supported directly, but it is equally important that we improve the circumstances within which people are born, live, work and age.

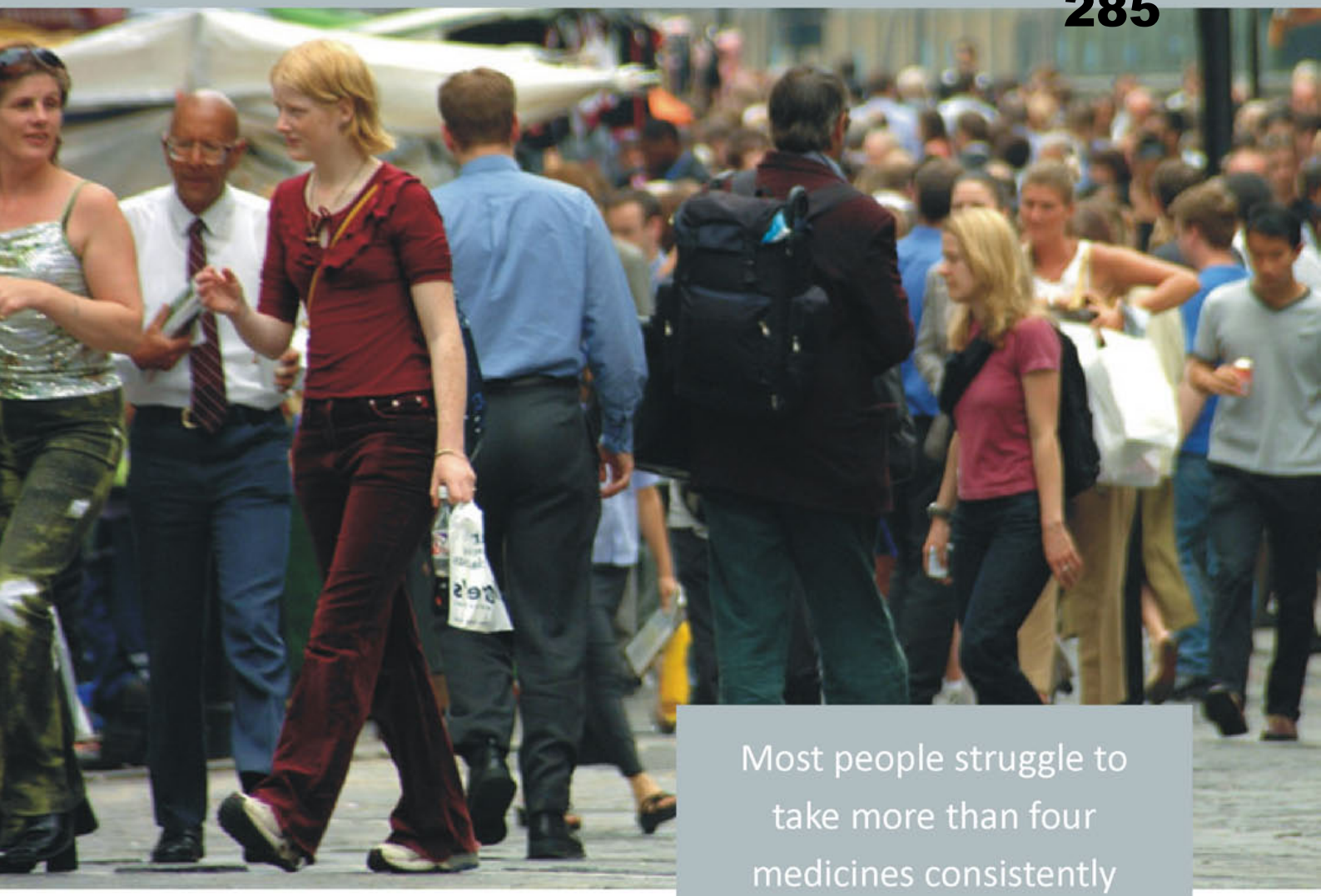
Recent controversy over the widespread prescribing of statins[5] demonstrates our over reliance on medicines to fix problems arising from lifestyle choices. Little scrutiny has taken place over the effect prescribing a statin has on a person's diet and lifestyle changes and it is argued that by prescribing a statin it discourages adoption of lifestyle changes that would have a greater impact on their overall health and wellbeing. The consequences of this over reliance can be demonstrated effectively by looking at the cost of interventions by Quality-Adjusted Life Years (QALY) of statins, smoking cessation and physical activity.

Figure 3: Cost of interventions by quality-adjusted life year (QALY)



Maximum figures cited for each intervention. Ranges were £10,000 to £17,000 for Statins, £221 to £9,515 for smoking cessation, and £20 to £440 for physical activity interventions

Note: One QALY is equivalent to one year of life at full health. Cost per QALY is a common way to compare interventions, with lower cost meaning greater effectiveness.
Source: Transform Scotland for sustainable transport.



Most people struggle to take more than four medicines consistently and as prescribed

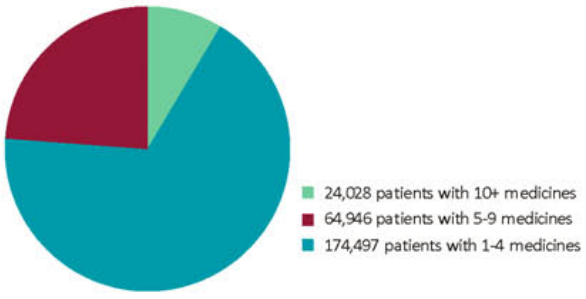
Number of medicines prescribed across Tayside

Figure 4 below demonstrates the number of medicines prescribed to patients across NHS Tayside from July to December 2016. From this it can be seen that nearly 89,000 people in Tayside have a considerable treatment burden which may in itself be having a negative impact on their health. Most people struggle to take more than four medicines consistently and as prescribed.

The Triple Aim Framework

The Triple Aim Framework is a concept developed by the Institute for Health Care Improvement. It hypothesises that to change service delivery for the better all three aims must be considered simultaneously.[6]

Figure 4: Patient count by number of distinct British National Formulary (BNF) paragraphs for NHS Tayside between July and December 2016 for patients of all ages



Source: PIS dataset for NHS Tayside July to December 2016

Figure 5: The Triple Aim Framework

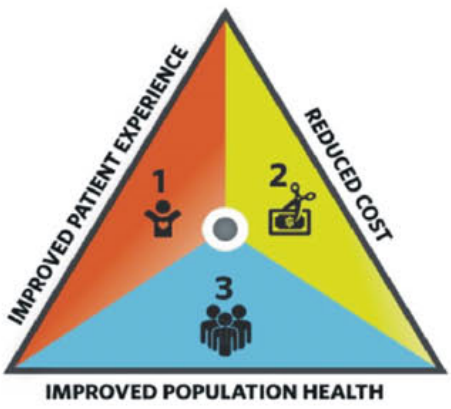


Image source: Medical University of South Carolina

By empowering people to take responsibility for their health and supporting decisionmaking we can improve the patient's experience of our healthcare system.The Triple Aim concept helps us to address the current imbalance of investment across the health service. If we can shift the balance towards preventative actions and health promotion and away from cost of treatment we can have a positive impact on our population's health.

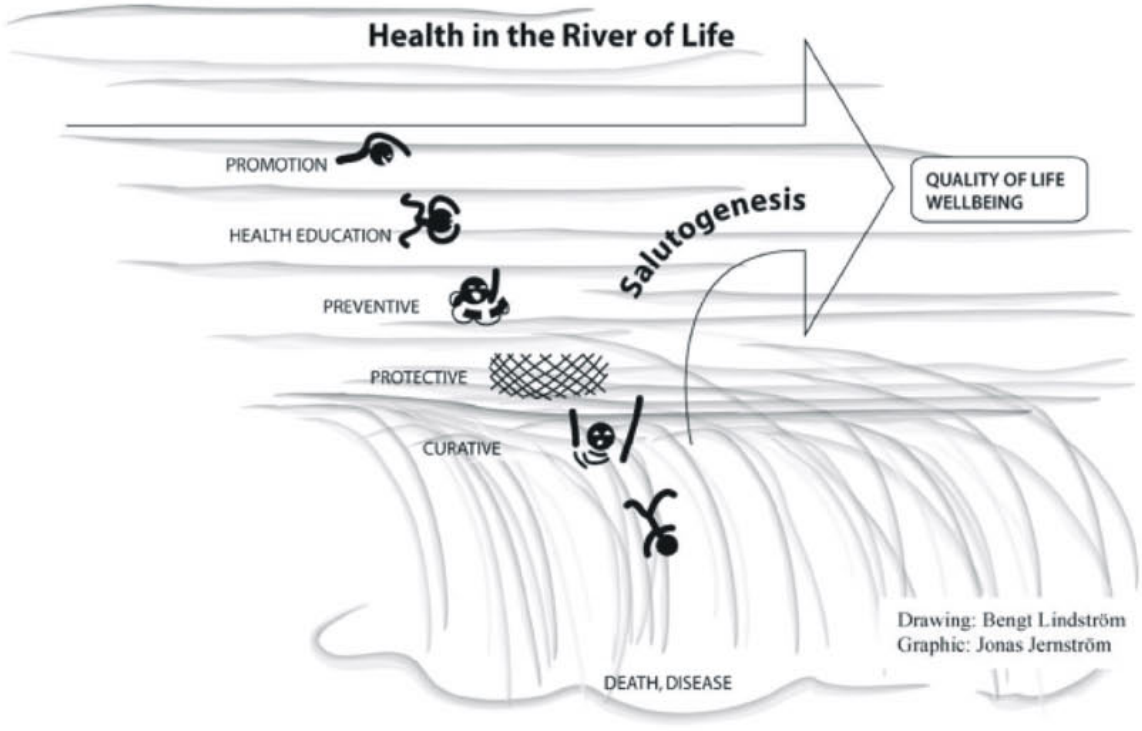
Why improving health means moving upstream

One of the ways that the difference between the usual health approach and the public health approach has been described is as a river. The following stages are described moving up the river: (i) cure or treatment of diseases; (ii) health protection/disease prevention; (iii) health education and finally on top health promotion (Figure 6). Health promotion holds a rather different perspective, relating mainly to resources or assets, for health and life not primarily risk and disease. All approaches ultimately strive to improve health, but through different perspectives. If our current approach to health services was compared to this concept we would see that there is a 'down river bias', focusing on processes where the risk exposure already may have caused damage (cure, protection, prevention and often health education).[7] The health concept in this way of thinking about health is constructed from the understanding of disease, illness and risks. However, in the health promotion approach we bring the focus upstream finding resources, initiating processes not only for health but wellbeing and quality of life. To create sustainable healthcare, our approach must be focussed upstream.

> The obligation for public services and for individuals is to ensure that we plan, design and provide high-quality services in ways which best meet people's needs in a safe environment in a sustainable way

The obligation for public services and for individuals is to ensure that we plan, design and provide high-quality services in ways which best meet people's needs in a safe environment in a sustainable way. This approach to the planning and delivery of public services is likely to be better for people, carers, families and communities, and appropriate management of medication is absolutely at the vanguard of effective delivery of better outcomes.

Figure 6: Health in the River of Life



Source: Health in the River of Life, Eriksson and Lindström 2008[7]

Figure 7: Genetic and lifestyle risks

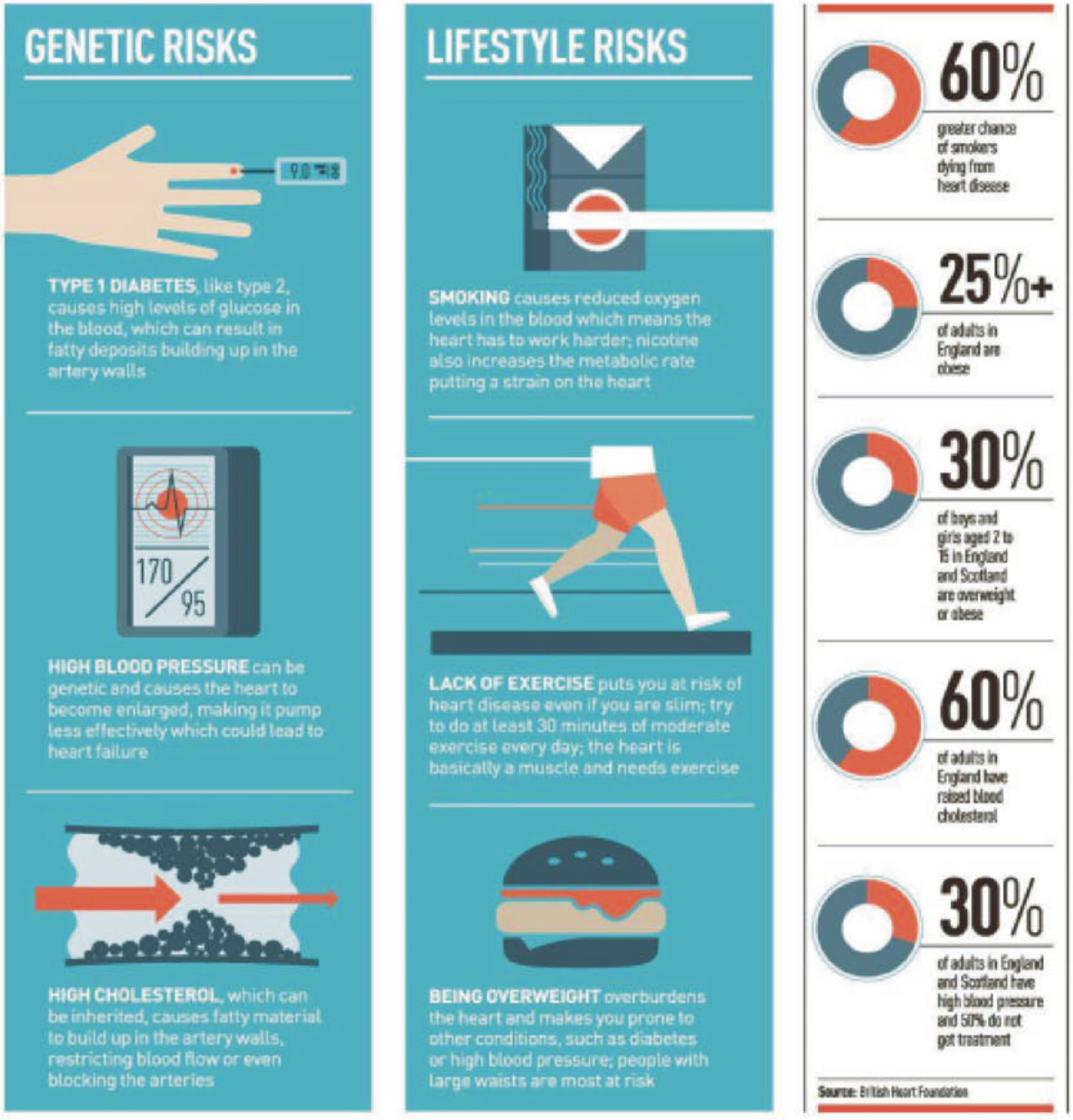


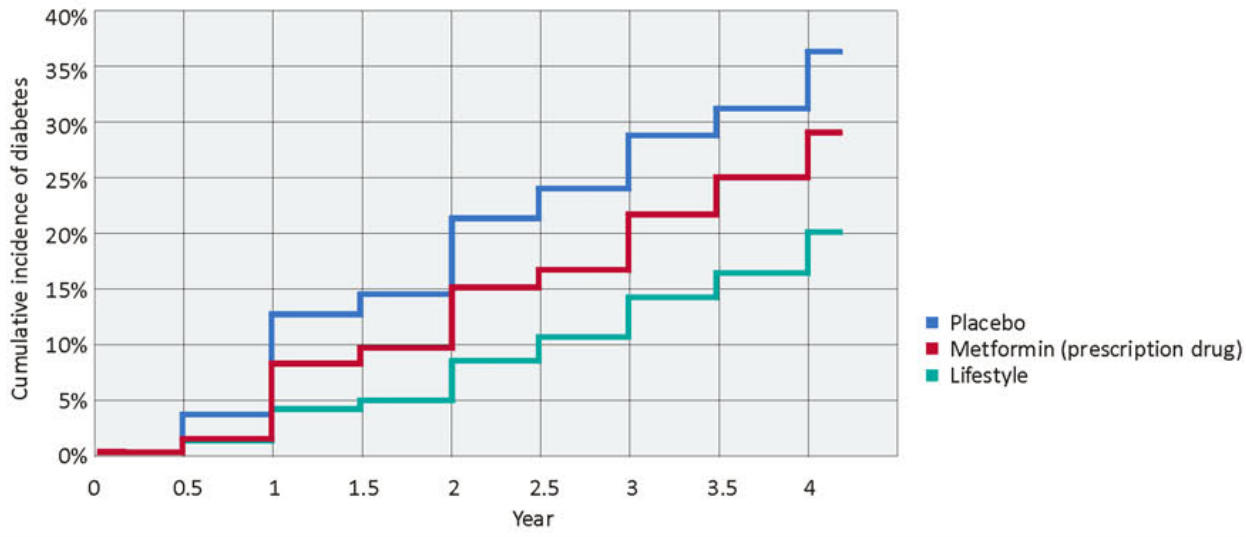
Image source: Raconteur 'Know the risks and be healthy' - 2013

As clinicians, we can only help the people with whom we consult to manage some of their risk factors (Figure 7). The people in our communities have a responsibility to take action to manage the risk factors within their own ability to control, such as lack of physical activity, being overweight and smoking. However, there are sections within our population that are not capable of taking these actions on their own. It is our responsibility as a healthcare service to provide these communities with support to enable them to do so. The benefit derived from successfully managing these lifestyle factors is likely to be greater than the benefits accrued through prescribing medication.

Lifestyle, Environment and Epidemics

Major challenges to population health have been recognised over time, e.g. John Snow's work to limit the spread of cholera; improvements in housing and nutrition and work to limit the spread of tuberculosis. Changes to lifestyle and environment have been key to tackling epidemics over the last 150 years. The challenges we face today due to obesity related diseases including heart disease, cancer and type 2 diabetes are likely to be no different. As demonstrated in Figure 8 on the following page, weight loss is the key to controlling the diabetes epidemic we now face.

Figure 8: Prevention and cure of type 2 diabetes



Source: BMJ 2002[8]

Snapshot of the health of Scotland's population in 2015

- 10,000 deaths and 128,000 hospital admissions relate to smoking
- Only 21% of the population met or exceeded five portions of fruit or vegetables daily target
- 65% of adults aged 16 years or over were overweight with 29% being obese
- Only 65% of adults aged 16 years or over met current physical activity guidelines
- There were 664.5 per 100,000 population alcohol related hospital admissions

Source: Scottish Health Survey

The concept of minimally disruptive medicine focuses on patients achieving their own goals for life and health whilst imposing the smallest possible treatment burden. The concept requires clinicians to consider the support structures patients have at home before they prescribe and it requires them to consider what treatment burden could be removed to enable the patient to achieve their goals and aspirations for life.[9] [10] [11] [12]

Prescribers are often patients too

There is evidence that doctors would choose different treatment for themselves than for their patients. For example doctors are less likely to choose a surgical option than the general population. They are also less likely to choose medication for illnesses such as depression than they would usually prescribe to their patients[13].

'..this really does involve a change of mind-set for many, including the 'gentle art of doing nothing'. We need to understand better why healthcare professionals tend to default to action and often make incorrect assumptions about what people are seeking'.[2]

From this, it has been suggested that clinicians may focus too much on achieving therapeutic objectives rather than considering inconvenience and treatment burden for the patient, however, when a clinician chooses for themselves they are aware of the daily inconvenience this may cause and how this will affect their lifestyle choices so choose the minimally disruptive option.

There is evidence that doctors would choose different treatment for themselves than for their patients

Loneliness and Health

NHS Highland's report 'Loneliness and Health' demonstrates the impact on health from loneliness and how this impacts on the wider communities' health outcomes and inequalities. The findings from this report are striking.

Having weak social relationships increases the chance of an early death to the extent that it is:
• The equivalent of smoking 15 cigarettes
• Greater than not exercising
• Twice as harmful as being obese
Source: NHS Highland 'Loneliness and Health'

80% of patients with one or more long-term condition felt lonely.[14] When this factor is combined with the challenges posed by long-term conditions and the additional treatment burden of polypharmacy, it is unsurprising that this group of people, with diminished resilience, visit the general practitioner (GP) more often and enter the prescribing cycle.

Improving resilience and addressing loneliness are important in coping with polypharmacy and allowing patients to be in control of their health.

'You should expect the doctor (or other health professional) to explore and understand what matters to you personally and what your goals are, to explain to you the possible treatments or interventions available with a realistic explanation of their potential benefits and risks for you as an individual, and to discuss the option and implications of doing nothing. You should expect to be given enough information and time to make up your mind. You should consider carefully the value to you of anything that is being proposed whether it be a treatment, consultation or diagnostic investigation and be prepared to offer challenge if you feel it appropriate'.[2]

80% of patients with one or more long-term condition felt lonely

Balancing benefits

When deciding to prescribe a medication to a patient the absolute risk reduction for commonly prescribed drugs should be used as a guide to inform patients about risk and benefits to them as individuals. The Number Needed to Treat (NNT) can be used to aid judgement as to whether prescribing a medicine is in the best interests of a patient, when considering their wishes and their pre-existing prescribed medicines.[15] NNT is the number of patients that need to be treated in order for one to benefit.

Recent figures published by National Institute for Health and Care Excellence (NICE) on some common treatments GPs prescribe demonstrate the absolute benefit of treatment in terms of their Number Needed to Treat (NNT).

Conclusion: People first, patients second

If we are to shift this balance and encourage patients to become decision makers, we will require a significant culture change within the NHS. The ideal is that the patient should be responsible for supplying their expertise of their situation and lifestyle goals. The clinician will support decisions using their expert knowledge and experience to provide the patient with all the information required to make a balanced and informed decision. This approach will change the type of work undertaken by healthcare staff and increase the capacity of the individual to make choices - supporting individuals to take responsibility to safeguard their own health as an investment in their future.

Table 1: Summary of treatment effects of commonly prescribed drugs

Intervention	Diagnosis	Outcome prevented (in one patient)	Annual NNT
Anticoagulation	Atrial fibrillation	Ischemic stroke	40
Antidepressant	Depression	Relapse of depression	4
Antihypertensive	Hypertension	Death	1,050
Aspirin	Angina	Death	192
β-blocker	Heart failure	Death	42
Oseltamivir	Influenza	Pneumonia	100
Pioglitazone	Type 2 diabetes	Major adverse cardiovascular death	145
Statin	Cardiovascular primary prevention	Cardiovascular death	1,949
Statin	Cardiovascular secondary prevention	Cardiovascular death	239

Source: Adapted from Pulse, January 2017[16]

Recommendations

Across NHS Tayside we have programmes in place that are embracing the challenge set by Realistic Medicine. The programmes all encourage patient-centred care and a shift in our ways of working to consider more proactive responses to the needs of our communities.

The Equally Well programme in Dundee has been established to address some of the personal and socio-economic circumstances that impact on people's health and wellbeing that primary care have neither the time nor sometimes skills to address. Link Workers work across four GP practices to address these unmet needs and support people to make the necessary lifestyle changes to invest in their future health. Investing in social prescribing gives alternates to medical prescribing and when medical intervention and treatment are necessary then it can build resilience, enabling people to cope with the required burden and in turn improve disease control.[17]

The Enhanced Community Support model (ECS) trialled in South Angus and Perth and Kinross for the care of frail elderly patients is a good example of shifting care upstream. This model of care recognises that older people should have access to proactive care in response to escalating health and social care requirements in the community, relevant to the needs of the person and hence increase the patient's resilience and ability to cope in their own home.

The Area Drugs and Therapeutics Collaborative hosted by Healthcare Improvement Scotland has developed materials for patients to help them to understand what the right treatment is for them as an individual. The leaflet entitled 'Medicines in Scotland: What's the right treatment for me?' is a valuable resource to begin a conversation with the patient to enable them to work with their doctor or other health care professional to understand their treatment options and how to gain the greatest benefit from treatment.[18]

In 2017/18 we recommend an increase in the availability of these resources across Tayside to begin to shift care upstream and meet people's needs in a sustainable way.

References

1. **Calderwood, Catherine.** *Chief Medical Officer's Annual Report Realistic Medicine.* s.l. : Scottish Government, 2016. ISBN: 9781785449475.
2. . *Realising Realistic Medicine Chief Medical Officer's Annual Report.* s.l. : Scottish Government, 2017.
3. *Multimorbidity: a challenge for evidence based medicine.* **D.Campbell-Scherer.** pp. 165-166, s.l. : Evidence Based Medicine, 2010.
4.**NHS Tayside Department of Pharmacy.** www.communitypharmacy.scot.nhs.uk/documents/nhs_boards/tayside/newsletters/NHS_Tayside_Newsletter_June_240616_11.pdf. [Online] [Cited: 4 May 2017.]
5. *Lessons from the controversy over statins.* **F.Godlee.** pp 1100-1101, s.l. : The Lancet, 18th March 2017, Vol. 389.
6. **Institute for Health Care Improvement.** www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx. [Online] [Cited: 18 April 2017.]
7. *A salutogenic interpretation of the Ottawa charter.* **Lindstrom, Eriksson and.** 2, s.l. : Health Promotion International, 2008, Vol. 23. pp190-199.
8. *Prevention and cure of type 2 diabetes.* **Pinkney, Jonathan.** 325, 2002. 232.
9. *Minimally disruptive medicine; a pragmatically comprehensive model for delivering care to patients with multiple chronic conditions.* **A.Leppin.** s.l. : Healthcare, 2015.
10. *We need minimally disruptive medicine.* **F.Mair.** pp2803, s.l. : BMJ, 2009.
11. *Thinking about the burden of treatment.* **F.Mair, C.May.** pp 349, s.l. : BMJ, 2014.
12. *Shared decision making- the pinnacle of patient centred care.* **M.Barry.** pp 780-781, s.l. : The New England Journal of Medicine, 2012.
13. *What would you do if you were me, doctor?: randomised trial of psychiatrists' personal v. professional perspectives on treatment recommendations.* **R.Mendel.** pp441-447, s.l. : The British Journal of Psychiatry, 2010, Vol. 197.
14.**The annual report of the director of public health.** *Loneliness and Health.* s.l. : NHS Highland, 2016.
15. **NHS Scotland.** www.polypharmacy.scot.nhs.uk/nnt/bymedicine/. [Online] [Cited: 4 May 2017.]
16. **Pulse.** www.pulsetoday.co.uk/download?ac=27466. [Online] [Cited: 25 May 2017.]
17. **NHS Tayside.** *Community Health Research & Evaluation. Evaluation of sources of support services SOS 100 cases (2011/14).* 2015.
18. **Healthcare Improvement Scotland.** www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/adtc_resources/medicines_booklet.aspx. [Online] 2017. [Cited: 25 May 2017.]

Sexual Health and Blood Borne Viruses

Introduction

Sexual health and blood borne viruses (BBVs) - human immunodeficiency virus (HIV), hepatitis B (HBV) and hepatitis C (HCV) - remain a major public health issue. The number of individuals infected with a BBV continues to grow, and whilst there has been significant reduction in teenage conception rates, they remain high in comparison to Western Europe and sexually transmitted infections (STIs) continue to rise, especially among young people.

Many people living with BBVs continue to face stigma and social exclusion

Poor sexual health and BBVs affect people from all walks of life, however they disproportionately impact on particular communities and there is a clear association with disadvantage and poverty. Many people living with BBVs continue to face stigma and social exclusion.

The impact on the health and wellbeing for individuals living with BBVs and their carers is considerable, as are the associated costs of health and social care.

The long-term consequences of HBV and HCV are significant, with up to 85% of people infected with HCV going on to develop chronic disease; putting them at high-risk of liver cirrhosis and cancer. HCV is responsible for up to three quarters of all liver cancer cases and two thirds of all liver transplants in the developed world. There is no cure for HIV or for chronic HBV, but increasingly effective treatments that can prolong life and improve the quality of life are available. Chronic HCV is curable and Scotland is committed to its elimination. A highly effective vaccine is available against HBV.

The cost of treating BBVs has risen significantly in recent years. The estimated HIV-related lifetime costs for diagnosed patients is estimated at £360,800. In Tayside, the cost of drug treatment for HIV and HCV has risen significantly in response to better case-finding and dramatic improvements in drug therapy. Treatment as Prevention (TasP) is now recognised as an important element of a combination approach to HIV prevention and is emerging as a promising intervention in combating the transmission of HCV in people who inject drugs (PWIDs). The increasing economic burden of treatment, as well as the long-term consequences for individuals, reinforces the importance of effective primary prevention.

The refreshed Scottish Government Sexual Health and Blood Borne Virus Framework 2015-2020 continues to promote an integrated approach that encompasses prevention, testing, treatment and care. The Framework has five strategic outcomes:

- Fewer newly acquired BBV and sexually transmitted infections and unintended pregnancies;
- A reduction in the health inequalities gap in sexual health and BBVs;
- People affected by BBVs lead longer, healthier lives;
- Sexual relationships are free from coercion and harm;
- A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and BBVs are positive, non-stigmatising and supportive.

In Tayside, the multi-agency Sexual Health and BBV Managed Care Network (MCN) provides strategic leadership, overseeing the planning and commissioning of effective preventative interventions as well as treatment and support. The MCN also ensures strong and cohesive partnerships across Tayside and with each of the Health and Social Care Partnerships, Alcohol and Drug Partnerships (ADPs) and the three local authorities in Tayside.

There remains a major challenge to identify individuals who may have acquired their infections decades earlier and who are not in contact with services

Prevention and Health Improvement

The MCN strives to ensure that we have a comprehensive, evidence-based approach to prevention that combines education; health promotion; behavioural interventions, early intervention; asset based approaches; as well as biomedical interventions, including testing and TasP.

The BBV Prevention Strategy developed in 2013 remains the basis for action. More recent evidence in relation HIV Pre-exposure Prophylaxis (PrEP) as well TasP for both HIV and HCV has increased the importance of these interventions. In 2016, a local Health Improvement Plan for Sexual Health and BBV in Tayside was developed and will enable the MCN to adopt a more proactive and planned approach to health improvement that will inform future investment and disinvestment strategies as well as an improved basis for collaboration with key planning partners including the ADPs and Integrated Children's Services.

The MCN commissioned TASC Scotland to undertake insight gathering with young people focussing on healthy relationships and what young people felt they needed to 'make it good'. The Tayside work is being utilised nationally to develop key messages and to support the implementation of the Scottish Government Pregnancy, Parenthood, and Young People (PPYP) strategy.

An ongoing outbreak of HIV in PWIDs in Glasgow has reinforced the need for increased awareness of HIV risk in this population, particularly those who are homeless. The importance of regular testing for BBVs, effective joint working with drug treatment services and easy access to clean injecting equipment (IEP) and Opiate Substitution Therapy (OST) are vital to ensure transmission rates in this population remain low.

Understanding and responding to the Public Health Challenge in Tayside

Under diagnosis is the major public health challenge for all three BBVs and complicated STIs. Whilst testing for HIV and HCV has increased, it is estimated that 17% of individuals infected with HIV in Scotland remain undiagnosed and half are diagnosed at a late stage of their infection. Almost half the people infected with HCV in Scotland remain undiagnosed and the majority of those chronically infected are not currently in specialist care. Significant progress has been made in diagnosing individuals with HCV in Tayside, due to the widespread introduction of dry blood spot testing.

There remains a major challenge to identify individuals who may have acquired their infections decades earlier and who are not in contact with services.

Hepatitis B (HBV)

In Tayside the number of notified cases of HBV infection has shown a rising trend in recent years. The majority of new cases are detected amongst people who were born in countries of medium or high prevalence, or whose families reside in these countries. For these individuals, infection is likely to have been acquired at birth or in childhood. The risk of chronic infection and its complications is greatly increased when infection is acquired at a young age, compared with infection acquired in adulthood. This trend, and appropriate responses, has been identified UK wide.[1]

Testing of pregnant women and completion of HBV vaccination for babies born to HBV infected mothers in Tayside is good, with 100% receiving four doses of HBV vaccine in 2015 and 100% receiving at least three doses in 2016 (final data pending).

Hepatitis C (HCV)

The prevalence of HCV amongst Scots is estimated at 0.7% of the population. In Scotland in 2015, there were 1,857 reported laboratory diagnoses of HCV infection, 11% (192) of whom reside in Tayside, 90% of these were amongst people who had been exposed to injecting drug use.[2] We have seen a decline in the number of diagnoses since 2014 however this is mirrored across Scotland.

Tayside is widely acknowledged as a world leader in innovation and delivery of HCV care and can rightly claim to be first in class

Scotland is globally recognised for its comprehensive response to HCV and in particular translating strategic aspirations into practice on the ground. Tayside is widely acknowledged as a world leader in innovation and delivery and can rightly claim to be first in class.

The integrated approach to HCV has resulted in 78% of the estimated antibody positive population being diagnosed, whilst treatment has increased from 41 patients in 2007/08 to 174 in 2016/17 with 12.7% of those treated in prison. National treatment targets have been consistently exceeded and cure rates continue to be high. Referral and attendance rates are good at 92% and 85% respectively in 2016. Comparative data from across Scotland in the recent Needle Exchange Surveillance Initiative (NESI) report (2015/16 data), reinforces this - Tayside shows the highest rate of testing in PWIDs within the last 12 months (62% v 48%), fewer people unaware or their diagnosis (24% v 36%) and the highest reported proportion of PWID in treatment (45% v 28%).[3]

Results from a BBV testing and case-finding pilot project in general practice in Dundee were positive with increased rates of referral to specialist services, particularly for patients who were lost to follow up and improved levels of self-reported knowledge and confidence by general practitioners (GPs) and practice nurses. This work was replicated in Angus practices in 2016. It is the intention to seek its inclusion as part of the Integration Joint Boards' (IJBs) commissioning plans from 2017/18 onwards.

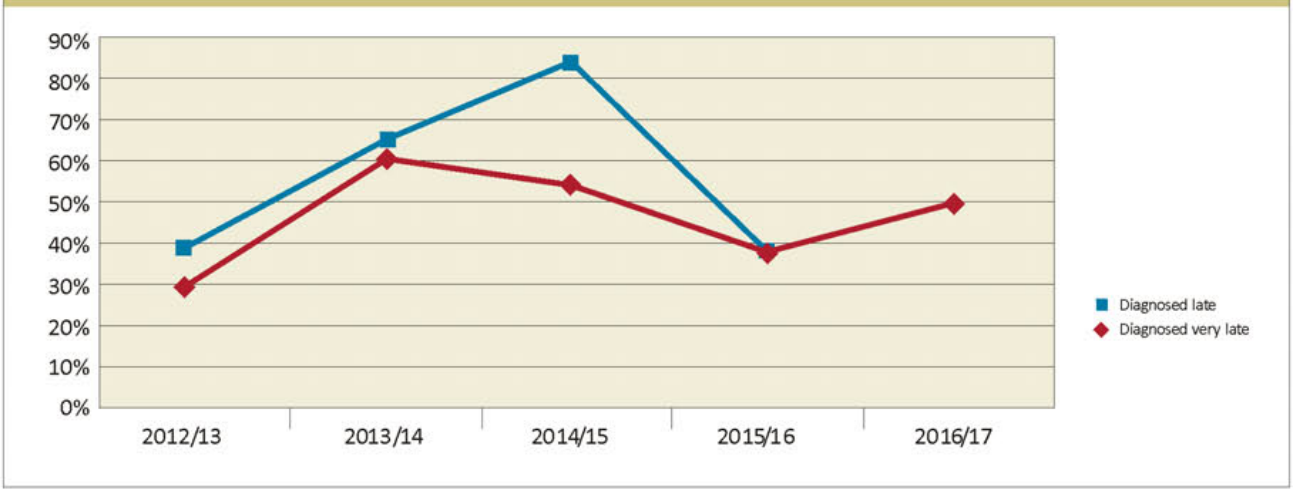
Tayside's success in tackling HCV, in particular the innovation, skill and care of the clinical team and partner organisations has resulted in it continuing to lead a number of major clinical trials. This research and audit is at the forefront of developments in practice and is a major contributor to the international body of evidence. Future research studies over the next two years will aim to eradicate HCV in Tayside by diagnosing and treating 80% of PWIDs who have HCV.

Human Immunodeficiency Virus (HIV)

More than 280 cases of HIV infection were newly identified in Scotland in 2016[4], and prevalence of HIV in the population is increasing as survival improves. Whilst not reaching the epidemic levels in the UK predicted in the 1980s, HIV infection remains a significant cause of morbidity and mortality in Scotland. We have seen a reduction in diagnoses in the last year which appears to be mirrored across the UK. This may be attributable to the introduction of TasP.

In Tayside in 2016, there were 16 new diagnoses of HIV infection.[4] Late diagnosis of HIV (Chart 1) remains an issue with 50% of our new diagnoses considered very late and at immediate risk of acquired immune deficiency syndrome (AIDS) associated morbidity and mortality. This led to the development of an HIV late diagnosis proforma, agreed with general practitioner (GP) colleagues, and a review process that will be piloted in 2017.

Chart 1: Late diagnosis of HIV in Tayside based on local data

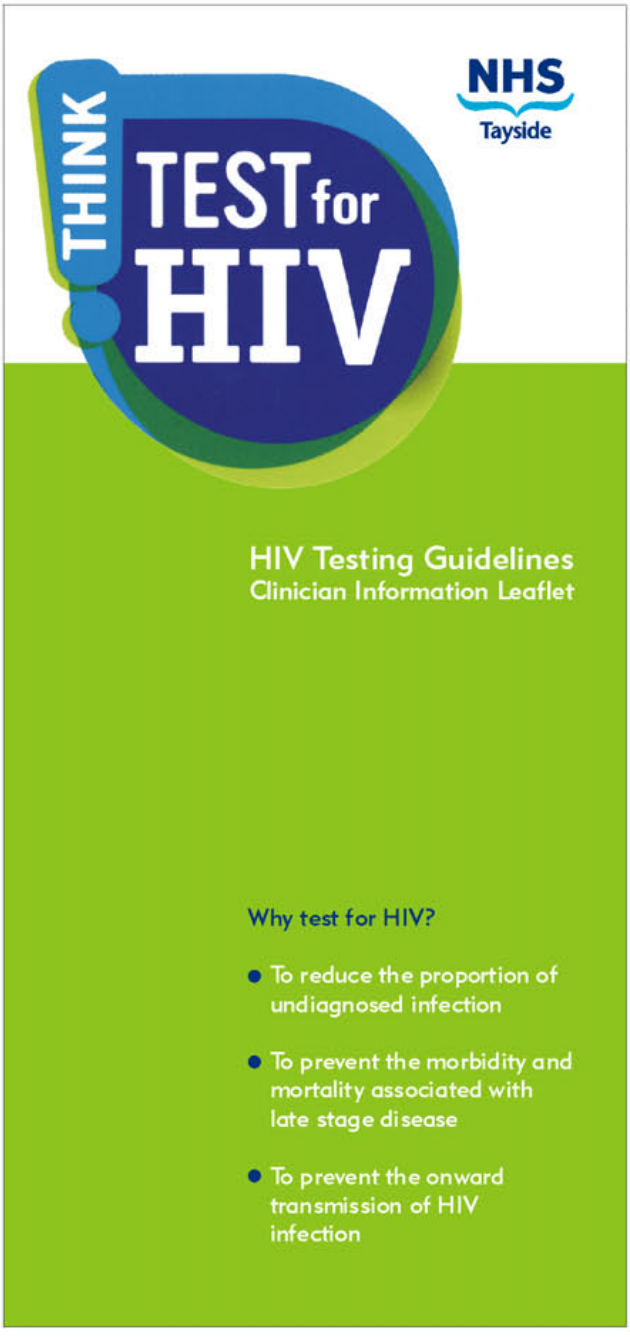


There were an estimated 392 people living with HIV in Tayside as at 31 December 2016. 88% are attending services and 97% are receiving treatment. This compares favourably with the rest of Scotland where 89% of people living with HIV are attending services and 95% are on treatment.[4]

88% are attending services and 97% are receiving treatment. This compares favourably with the rest of Scotland where 89% of people living with HIV are attending services and 95% are on treatment

Historically, Tayside has the highest proportion of people infected in Scotland with HIV whose exposure risk was injecting drug use. New infections in this population are extremely rare due to the widespread provision of harm reduction interventions and provision of IEP. We are taking steps to ensure that the recommendations from the Glasgow outbreak are acted upon and strengthen local responses in particular for vulnerable homeless populations.

There is a rising trend in young Men who have Sex with Men (MSM) acquiring HIV, with MSM accounting for the majority of new diagnoses. The remainder of new diagnoses are in the heterosexual population. These changing patterns are important because they indicate where prevention efforts are best focussed.



Men Only Tayside (MOT)

The MOT service is a unique collaboration between NHS Tayside and Terrance Higgins Trust that aims to prevent HIV and STI transmission in gay and bisexual men; improve access to services and encourage regular testing. It combines outreach health promotion, community capacity building, peer-led education with dedicated clinical services and support for men living with HIV.

The number of MSM seen by the NHS Tayside sexual health service has increased by 85% since the introduction of the MOT service in 2012. There has been a 27% increase in attendances between 2015/16 and 2016/17. HBV vaccination and HIV testing uptake were 79% and 88% respectively. 100% would recommend the service to a friend.

Reassuringly, local data for 2016/17 has shown a 50% reduction in syphilis diagnoses from 2015/16

Sexually Transmitted Infections (STIs)

The highest prevalence of STIs is in young people aged 16-24 and in MSM. Chlamydia remains the most common STI; the highest rates of diagnoses are seen in women and those aged under 25 years with NHS Tayside having the highest recorded rates in Scotland. However, the rate of genital chlamydia, even with minor annual fluctuations, has decreased over the last decade in Tayside.

Across Scotland, there has been a 28% increase in diagnoses of gonorrhoea between 2015 and 2014. In Tayside, the number of diagnosed cases increased by 39.5% from 86 in 2014 to 120 cases in 2015.[5] A proportion of the increase in diagnoses is due to more effective testing, however, Health Protection Scotland, suggest that it is also likely that the incidence of infection has also increased. Unlike genital herpes and chlamydia, the majority of gonorrhoea diagnoses are reported in males and is thought to be largely due to an increase in transmission among MSM.

Peak numbers of infectious syphilis diagnoses (N=316) were recorded in Scotland in 2015 with almost double the number of cases reported in 2014. 96% of cases recorded were male (N=302), with the majority identifying as MSM.[6] The MCN has been monitoring infectious syphilis in Tayside following an increase in diagnoses in heterosexuals in 2013/14. Reassuringly, local data for 2016/17 has shown a 50% reduction in syphilis diagnoses from 2015/16.

Teenage conception

The significant reduction in teenage conception in Tayside has been maintained and is greater than reported for Scotland and compares with the best performance in the UK. Local data to the end of June 2016 show an overall 55.1% reduction in teenage conception rates since a peak in 2007 and a 67.1% reduction over the same time period in the youngest age group (females aged 13-15 years).

Local data to the end of June 2016 show an overall 55.1% reduction in teenage conception rates since a peak in 2007 and a 67.1% reduction over the same period in the youngest age group (females aged 13-15 years)

There is a strong link between teenage pregnancy and deprivation across all age groups. This applies across Scotland but the inequality gradient is steeper in Tayside.

The reduction in teenage pregnancy is a result of sustained action by local authorities, the voluntary sector and NHS Tayside working together to implement a clear plan that combines a range of evidence-based interventions, including early intervention in early years of life, youth development, support for parents, education and information for young people as well as improved access to sexual health and contraceptive services.

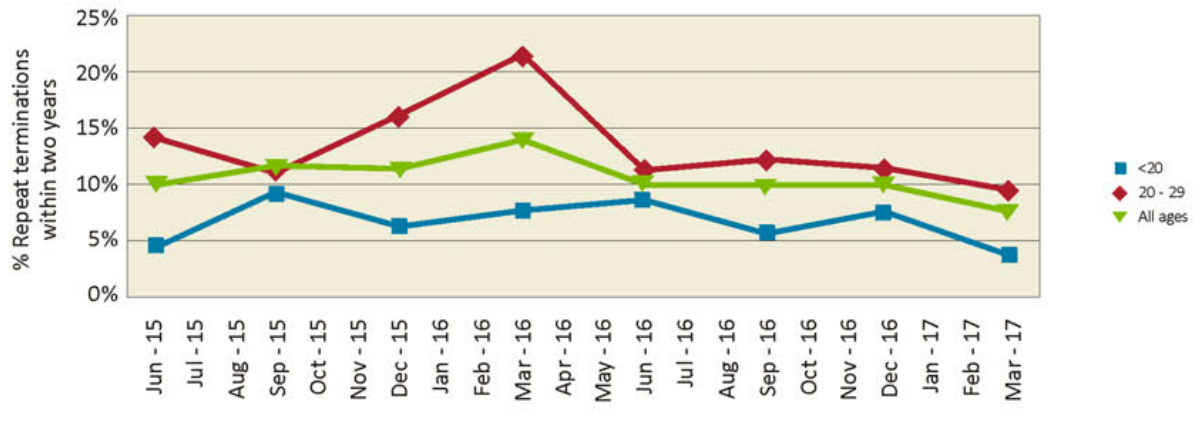
The Scottish Government published its first Pregnancy and Parenthood in Young People Strategy in 2016. It provides a renewed commitment to multi-agency action as well as a greater emphasis on healthy relationships, access to long acting reversible contraception (LARC)and support for young parents aged up to 25.

Termination of pregnancy

Tayside has the highest rates of termination of pregnancy (TOP) in Scotland (13.9 per 1000 women aged 15-44 compared to 11.6 per 1000 across Scotland in 2015). However, rates of TOP have declined overall in line with reductions seen across Scotland. Almost 60% of all terminations are in women aged 20 to 29. National data shows that Tayside remains well above the national average for repeat TOP. However, local data for rapid repeat TOP (within two years), shows a reduction to 9.5% in 2016/17 from 12% in 2015/16. It is too soon to identify if this is an ongoing downward trend (Chart 2).

The proportion of early terminations has been rising steadily in recent years, with 75.4% of all terminations performed at less than nine weeks in 2015, compared to 62.2% in 2009. There has also been a sustained increase in the use of medical methods compared to surgical terminations.

Chart 2: Rapid repeat termination in Tayside local data



What makes the difference?

The MCN has achieved transformational change in some of the most complex and challenging areas of public health. Evidence-based innovation and shared solutions fostered by mutual 'ownership' by professionals, individuals and communities deliver seamless, effective and person-centred care and tangible outcomes for individuals. Critical to its success has been the emphasis on:

- building a common vision, purpose, values and culture
- distributed leadership
- ambitious aims and robust performance management
- use of strength-based approaches to realise individual potential

These elements, coupled with the exceptional degree of cross-agency 'buy-in' have been key to reducing new transmissions, diagnosing and engaging those conventionally regarded as 'hard to reach'.

The whole systems approach to prevention, care, and treatment and the use of a programme budget to support commissioning connects the Directorate of Public Health with professionals across the system and ensures that prevention is integral to planning and delivery of person-centred care. In a very real sense, prevention is no longer just a priority for public health professionals, it is embraced by everyone.

Recommendations - challenges and priorities for the future

Delivering a comprehensive and integrated tiered approach to primary prevention.

- Appropriate HBV vaccination coverage and uptake, in particular for PWIDs
- Sustained action to reduce teenage pregnancy and securing effective leadership and local engagement for the PPYP
- Inclusive Relationships, Sexual Health and Parenthood Education (RSHP), underpinned by standards and performance indicators
- Improved awareness among young MSM of the risks of HIV
- Improving availability and uptake of LARC
- Strengthening partnership with ADPs and addictions services to ensure effective prevention programmes and increase access to harm reduction, IEP and OST
- Ensuring effective partnerships with Community Planning Partnerships (CPPs), in particular Integrated Children's Services
- Work with individuals, communities and the media to reduce stigma and discrimination associated with poor sexual health and BBV.

Reducing undiagnosed population

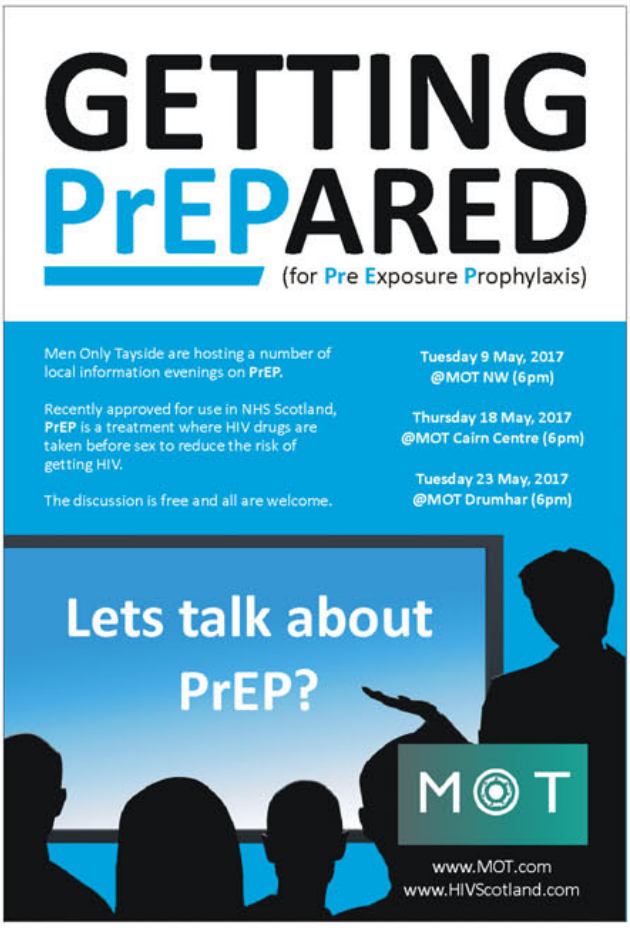
- Reducing undiagnosed HIV and late diagnosis
- Implementing effective HCV case-finding and eradication strategies.

Targeted behaviour change interventions

- Design and delivery of behaviour change interventions for high-risk behaviours, including increased engagement of women who inject drugs with sexual and reproductive health.

Effective delivery of care and treatment

- Implement PrEP for prevention of HIV in 2017 as part of a comprehensive, combination approach to HIV prevention
- Support the introduction of human papilloma virus (HPV) vaccination in MSM in 2017
- Work with prison healthcare to make sure people in custody have equitable access to testing, treatment and care
- Access to adequate resources for treatment to meet the aims of the HCV elimination strategy
- Review provision for people ageing with HIV.



References

1. Hepatitis B Foundation. Rising Curve: chronic hepatitis B infection in the UK. 2007
2. Health Protection Scotland. Surveillance of known hepatitis C antibody positive cases in Scotland: results to 31 December 2015. 2016
3. Health Protection Scotland. Needle Exchange Surveillance Initiative (NESI) 2008-09 to 2015-16. 2017
4. Health Protection Scotland. HIV infection and AIDS: Quarterly report to 31 December 2016. 2017
5. Health Protection Scotland. Chlamydia trachomatis and Neisseria gonorrhoea infection in Scotland: laboratory diagnosis 2006-2015. 2016
6. Health Protection Scotland. Syphilis in Scotland 2015: update. 2016

Substance Use

Substance Use

Introduction

Problem alcohol and drug use (collectively known as substance use/misuse) disproportionately affects people who live in areas of greater socioeconomic deprivation. Substance use adversely impacts health and wellbeing. For example, alcohol is known to be a causal factor in over 200 diseases and injury conditions. [1] Furthermore substance use in an individual can have wider effects on family, friends and the community. Substance use is therefore a major public health concern and is a significant cause and consequence of health inequity. Alcohol and Drug Partnerships (ADPs), which are embedded within the Community Planning Partnerships (CPPs) of the three Tayside local authorities, undertake a strategic role to develop good quality accessible services that promote the recovery of those affected (both directly and directly) by substance use. In terms of future government arrangements, ADPs and Integration Joint Boards (IJBs) were recently advised by the Scottish Government to establish closer working connections to develop greater strategic coherence across the improvement agenda for Health and Social Care Partnerships.

This section provides:

- An overview of substance use in Tayside currently
- An update on recent achievements and ongoing activities
- A look forward to future priorities

Alcohol

Alcohol is considered the drug that causes the greatest harm in Scotland. [2]

Consumption

A considerable proportion of adults continue to drink alcohol in excess of safe government guidelines.

The Scottish Health Survey showed that for Tayside during the period 2012-2015:[3]

- 29% of men and 15% of women drink alcohol at levels that are considered hazardous or harmful (over 14 units per week)

What is encouraging, however, is that it appears attitudes towards alcohol in young people are changing. The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) 2013 showed that in Tayside:[4]

- 40% of 13 year olds and 67% of 15 year olds report having been drunk at least once (compared to 56% and 74% respectively in 2010).
- 3% of 13 year olds and 20% of 15 year olds reported drinking alcohol in the week prior to the survey (14% and 32% respectively in 2010).

The SALSUS 2013 survey also showed that the most common sources of alcohol for under-age young people in Tayside were friends, relatives or the home either with or without permission.

Substance use is therefore a major public health concern and is a significant cause and consequence of health inequity

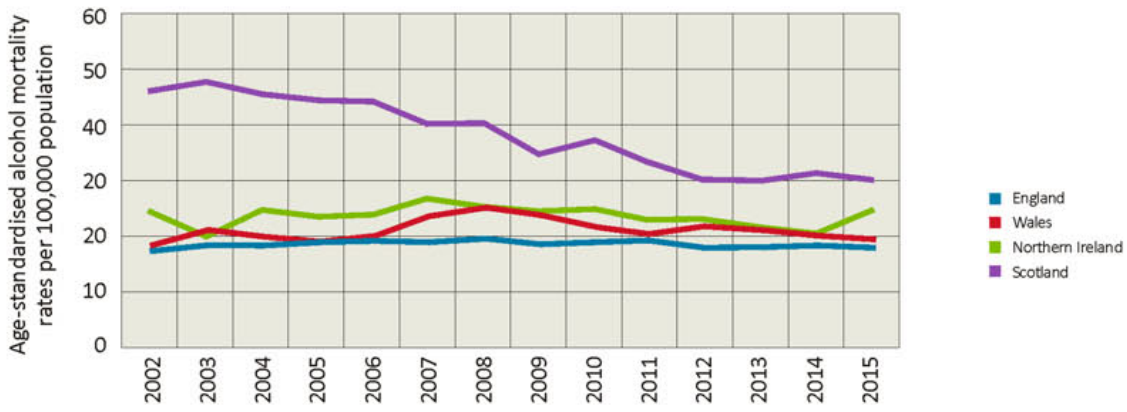
Health Harm and Inequity

Between the years of 2002 and 2012 alcohol-related mortality in Scotland decreased, however, that downward trend is now starting to stall. In addition, Scotland continues to have greater health harm as a consequence of alcohol relative to our UK neighbours (Chart 1).

Tayside has a higher rate of alcohol-related deaths (23.7 per 100,000 population in 2015) than Scotland as a whole (21.8 per 100,000 population). Local authority comparisons in 2015 showed that Dundee City is amongst the worst areas for alcohol-related death rate in Scotland (38.0 per 100,000 population).[5]

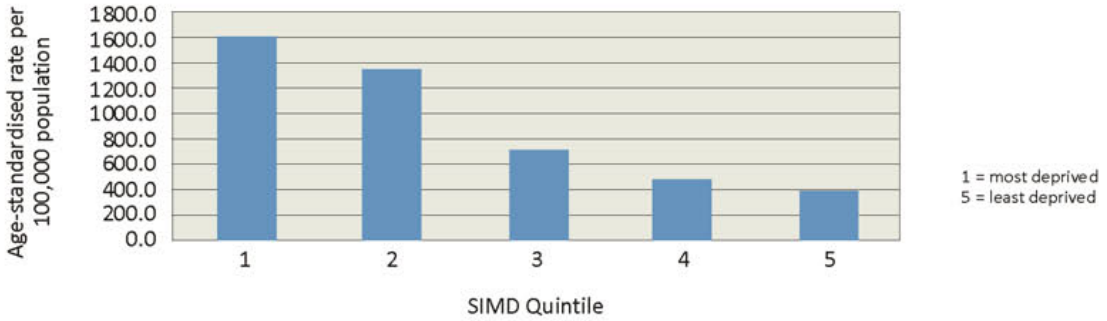
In Tayside there were 3,357 alcohol-related accident and emergency department (A&E) attendances in 2016 and 1,792 alcohol related hospital discharges in 2015/16. When considering the socioeconomic status of those attending for alcohol-related conditions a clear deprivation gradient exists (Charts 2 and 3).

Chart 1: Alcohol-related deaths in males across the UK, 2002-2011



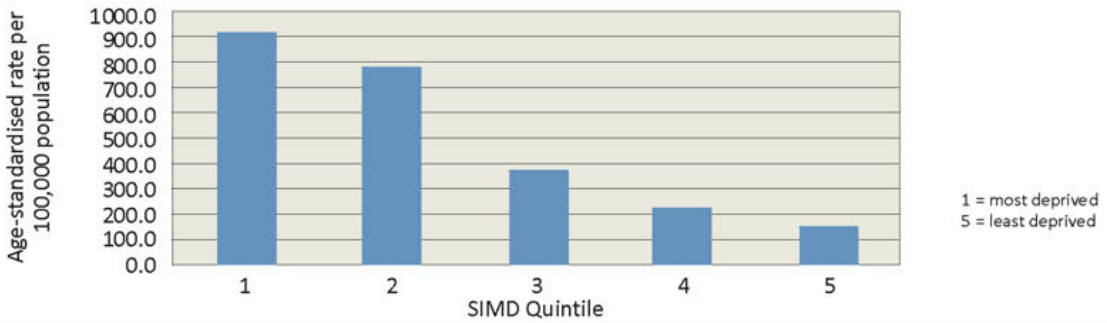
Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency (February 2017)

Chart 2: Tayside alcohol-related attendances (2015) at A&E by SIMD 2016



Source: NHS Tayside Business Unit

Chart 3: Tayside alcohol-related hospital discharges (2015/16) by SIMD (2016)



Source: SMR01 (Extracted via BOXI 10/03/2017)

One in two people in Scotland reports having experienced harm as a result of someone else's drinking

Social Harm

The Scottish Crime and Justice Survey for 2014/15 reported that in just over half of violent crimes (54%) the victim thought that the offender was under the influence of alcohol.[6]

Local analysis for Dundee in 2013/14 showed where alcohol was involved in the following incidents:

- 46% of petty assaults
- 27% of breaches of the peace
- 12% of drug offences
- 21% of sexual crimes
- 23% of culpable and reckless conduct

Of note, these percentages are likely to be an under-representation of where alcohol was involved as the data are dependent on the recording officer identifying an alcohol factor. Generally, figures for Tayside are much higher and amongst the worst in Scotland for breach of the peace and common assault offences which are commonly associated with alcohol consumption.[5]

It is estimated that one in two people in Scotland reports having experienced harm as a result of someone else's drinking.[7] One in three people in Scotland reports being exposed to having heavy drinkers in their lives and people who know heavy drinkers are more likely to report experiencing harm from others drinking in private places such as the home or private parties. People who report harm from someone else's drinking also report lower life satisfaction compared to others.

Living with a problem drinker can result in relationship problems, tensions within the household, arguments and chaotic lifestyles. This can have a direct impact on children for whom there is worry, fear and uncertainty, the potential for neglect and reduced school attendance.[7]

Availability

In 2015, 20% more alcohol was sold per adult in Scotland than in England and Wales, and almost all of this (97%) was because of higher sales in supermarkets and off-licences.[8] Almost three-quarters of alcohol currently sold in Scotland is purchased from off-sales trade.

Neighbourhoods with higher numbers of alcohol outlets have significantly higher alcohol-related death rates and alcohol-related hospitalisation rates.[9] Residents of neighbourhoods with the highest availability are more than twice as likely to die from an alcohol-related death than those with the fewest outlets.[9] Furthermore, higher densities of off-sales alcohol outlets are found in the most deprived areas of Scotland.[10]

The contribution made to alcohol-related harm from off-sales outlets is greater than that of on-sales outlets.[11] Reasons for this include: generally cheaper alcohol available to buy from off-sales outlets than on-sales; large volumes obtainable from off-sales outlets and lack of supervision of alcohol consumption when purchased from an off-sales outlet.[12]

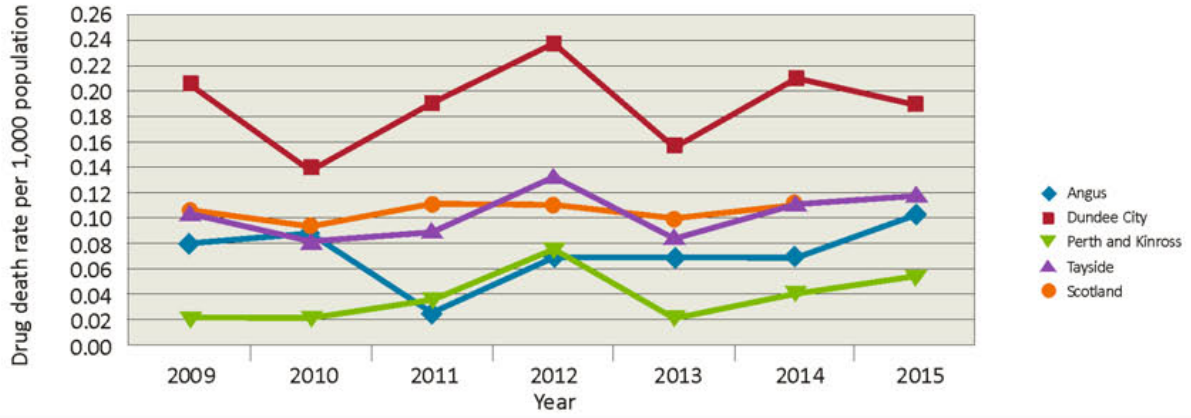
Dundee has the fourth highest alcohol outlet availability in Scotland.[9] Angus and Perth and Kinross have lower alcohol outlet availabilities than Scotland as a whole but nonetheless still have pockets of high availability.

The alcohol-related harm in a population is directly associated with alcohol consumption levels.[8] The increased availability of alcohol in the commercial and public setting results in an increased availability of alcohol in the social setting and vice versa; therefore contributing to changing the social and cultural norms that promote harmful use of alcohol.

prevalence of problem drug use in Dundee is much higher (2.8%). Similarly, although the overall rate of drug related hospital discharges was lower (137 per 100,000 population) in Tayside in 2015 compared to the rate for Scotland as a whole (143 per 100,000 population), the rate for Dundee was much higher (233 per 100,000 population).[5]

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) 2013 found that 2% of 13 year olds and 7% of 15 year olds in Tayside had used illicit drugs in the last month (1% and 9% respectively in 2010).[4]

Chart 4: Tayside drug death rate per 1,000 population by local authority area 2009-2015 (and Scotland to 2014)



Source: Drug Deaths in Tayside, Scotland 2015

Population-based policy options, such as the use of taxation to regulate the demand for alcoholic beverages, restricting alcohol availability and implementing bans on alcohol advertising, have been shown to be the most effective strategies to reduce the harmful use of alcohol.[13,14]

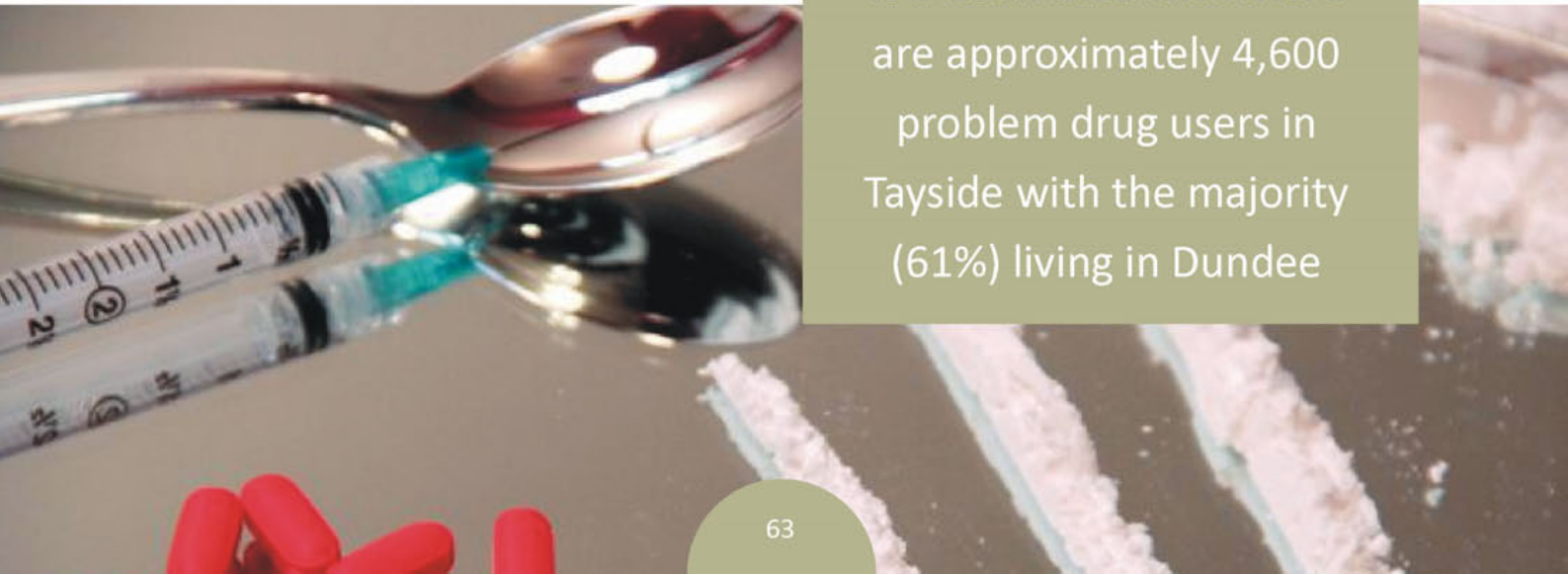
Drugs

It is estimated that there are approximately 4,600 problem drug users in Tayside with the majority (61%) living in Dundee. The prevalence of problem drug use overall in Tayside (1.7%) is comparable to the national average (1.7%). However, at a local authority level, the

In Tayside, over the period 2013-2016, there were 21.3 per 1000 maternities recording drug use compared to the Scottish rate of 13.3.[5] In 2015 the rate of child protection cases where parental drug and/or alcohol problems had been identified was 14.2 per 10,000 population aged under 18. Overall in Scotland the rate was 9.7.

The number of drug deaths in Tayside in 2015 was 48. The trends over time of drug deaths in each of the local authorities are shown in Chart 4.

It is estimated that there are approximately 4,600 problem drug users in Tayside with the majority (61%) living in Dundee



Substantial evidence links levels of availability and access to alcohol with increased consumption and harm

Activities and Achievements

Alcohol Licensing

Substantial evidence links levels of availability and access to alcohol with increased consumption and harm. Recognised strategies that are both effective and cost effective to reduce harmful use of alcohol include restricting alcohol availability. The Licensing (Scotland) Act 2005 requires Licensing Boards to promote the protection and improvement of public health in the work that they do.

The Directorate of Public Health is continuing to influence and advocate for action to reduce alcohol availability and access through involvement in the continuous development of the Overprovision Policy (Dundee) and informing the local licensing processes across Tayside.

Social attitudes to alcohol in Tayside

In 2015 the three Tayside ADPs commissioned a survey to explore local attitudes and behaviours in relation to alcohol.[15] 2078 responses were gathered. The key points arising from the survey were:

- Drinking alcohol appears to be the social norm
- People from deprived areas drink less often but consume more units when they do drink
- Males and Dundee residents reported the highest levels of consumption
- Younger people and people from deprived areas are more likely to get drunk
- There is a low awareness of Licensing Boards and uptake of opportunities to influence licensing decisions.

Alcohol Brief Interventions (ABIs)

All patients attending A&E departments and wider acute settings should be screened opportunistically for harmful or hazardous drinking, offered and given an ABI. Patients identified as dependent, and those with harmful or hazardous drinking patterns who request further help should be directed to an appropriate support service (including health, social services, local authority and voluntary sector).

In Tayside, the Scottish Government HEAT Standard was substantially exceeded in 2015/16 with 6,759 ABIs delivered against a target of 4,758.

Drug and alcohol treatment

The Scottish Government HEAT standard used to assess access to substance misuse services requires that 90% of people who needed help with their drug or alcohol problem should wait no longer than three weeks for treatment.

NHS Tayside has consistently met this standard since it was established in 2013. In the most recent quarter, from January to March 2017, 96.7% (588) clients engaged with treatment within three weeks of referral.

Preventing and Reducing Drug Deaths

Each drug death in Tayside is individually reviewed by the multi-agency Tayside Drug Deaths Review Group which then takes forward specific actions highlighted as a result of the analysis and review of drug death cases.

The most recent Report of Drug Deaths in Tayside was published in August 2016 and details the findings of the Tayside Drug Death Review Group with recommendations made to take future work forward.

There has been a year-on-year increase in the proportion of drug death victims who have suffered from problematic alcohol use

Key findings of the report and actions being undertaken to address these areas are summarised below:[16]

- **Alcohol misuse**

  There has been a year-on-year increase in the proportion of drug death victims who have suffered from problematic alcohol use. In 2015, 63% had suffered from problematic alcohol use at some point in their lives while 14 (29%) were known to be misusing alcohol at the time of their death.

  The Tayside Drug Death Group are working with alcohol services to ensure occasional drug use can be identified where possible and incorporated into the care plan of the individual.

  Information on managing a drug overdose and the provision of naloxone training will be promoted to individuals who attend alcohol services.

- **Service contact**

  67% of individuals had been in contact with specialist services in the six months prior to death but only 44% were still in touch at the time of death.

  Services will ensure that individuals with a poor history of engagement have a risk plan and support that encourages engagement, including peer support and networks.

  The use of assertive outreach models in priority cases will be explored and services will be encouraged to be trauma-focussed.

- **Raising awareness of drug overdose**

  An event is now held annually to publicise the Tayside Drug Death Report and to promote awareness of overdose and its effect on families, friends and communities.

  The multi-agency Tayside Overdose Prevention Working Group reports to the Tayside Drug Deaths Review Group and has progressed the implementation of a comprehensive action plan to tackle the many factors contributing to drug deaths. It has initiated a number of improvement activities across Tayside, taking full account of the strategic recommendations within the Tayside Drug Death report and using these to formulate improvement plans across the region.

Recovery Outcomes Tool

The Recovery Outcomes Tool was developed as a key component of the Drug and Alcohol Information System (DAISy) with the aim of providing a consistent and comparable picture of recovery for drug and alcohol service users across Scotland. Angus ADP was one of four ADPs nationally to pilot the Recovery Outcomes Tool. The evaluation of the tool was positive and determined that it could be used in relation to an individual's recovery journey to aid discussion, agree progress and identify potential gaps and support required. A Tayside Working Group has been established to roll out the project in time for the scheduled 'go live' date of April 2018.

Children affected by parental substance use

Living with a problem drinker or someone who uses substances can result in relationship problems, tensions within the household, arguments and chaotic lifestyles.

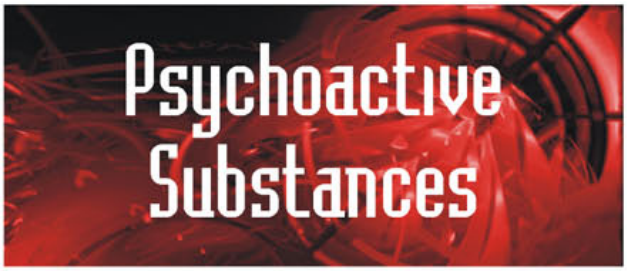
'Rory' is a learning resource for primary school aged children affected by parental drinking. It aims to help children who are affected by a problem drinking parent feel less confused or guilty about what is happening and encourage them to talk to an adult they can trust. For

children who are not affected by a problem drinking parent it aims to increase understanding, empathy and compassion to other children who may have a difficult home life.

The Rory resource was developed by Alcohol Focus Scotland and in 2016, 27 teachers were trained in the use of Rory in Angus. As a result of the training, teachers reported feeling much more confident in identifying children who may be affected by harmful parental drinking and raising the issue of parental drinking with children.

New Psychoactive Substances

The Psychoactive Substances Act 2016 came into force on 26th May 2016 and made it an offence to produce, supply, offer to supply, possess with intent to supply, import or export psychoactive substances. A psychoactive substance is any substance intended for human consumption that is capable of producing a psychoactive effect, excluding food, alcohol, tobacco, nicotine, caffeine and medical products.



New psychoactive substances continue to be a concern principally due to their unpredictability and the potential for significant adverse effects. However, their use represents a small proportion of overall drug use.

Chemsex

'Chemsex' is a term that is used to describe the use of substances, such as crystal meth and ketamine, just before or during sex. In response to recent, growing concern regarding the practice of 'chemsex' in the UK, the three Tayside ADPs in collaboration with Terrence Higgins Trust Scotland conducted a survey to gather information on drugs taken around the time of sex and associated impact in 2015.[17]

61% of 261 respondents advised that they had used alcohol directly before or during sex in the last three months with 87 reporting that use of alcohol had resulted in them having sex that they had not intended to have. 15% of 65 respondents advised that they used drugs directly before or during sex.

Future priorities

In order to deliver public health improvements within current resource constraints there needs to be a strategic shift from treatment and care towards prevention and early intervention.

Priority areas will include:

- Reducing health inequalities
- Focusing on prevention and early intervention
- Increasing prevention interventions targeting children at risk of early initiation into substance misuse
- Involving communities to co-produce change

Angus ADP is leading a review and redesign of current service provision to strengthen and enhance experience of people/families with alcohol/drugs and/or mental health problems focusing on a whole family approach model. The pilot phase demonstrated successful change and as a result the whole family approach model is in the process of being embedded more widely across services in Angus.

Dundee ADP and IJB are in the process of developing an 'Integrated Alcohol and Drug Services - Strategic and Commissioning Plan (2017-2020)' that sets out the strategic priorities and guides the delivery of a transformational improvement programme across the city. Produced to provide clear direction for services this plan will drive forward, inform and enhance the already well-established partnership approach to achieving better outcomes for people who need alcohol and drug services.

- **Reducing alcohol availability**

  The NHS Tayside Directorate of Public Health will be working closely with the newly formed Licensing Boards to provide the information and evidence required to inform the development of overprovision policy statements over the next 18 months.

A vision for the future

Tayside will progressively be a region where healthy and responsible attitudes to alcohol and other drugs prevail. Increasingly, prevention needs to become a key focus for joined-up, evidence-informed and accessible services which are designed and delivered as an equal partnership between the public, a range of organisations and professionals. The outcomes being sought should more and more be those which are important to the individuals and communities as well as the professionals. Progress needs to be monitored carefully using quantitative and qualitative information from as many sources as possible.

References

1. World Health Organization. Global status report on alcohol and health 2014. Available from: www.who.int/substance_abuse/publications/global_alcohol_report/en/ [Accessed May 2017]
2. Sharp C, Marcinkiewicz A, Rutherford L. Attitudes towards alcohol in Scotland: results from the 2013 Scottish Social Attitudes Survey. NHS Health Scotland; 2014
3. Scottish Government / National Statistics. The Scottish Health Survey 2015 Edition. Available from: www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey [Accessed May 2017]
4. Scottish Government / National Statistics. Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS): National Overview 2015. Available from: www.isdscotland.org/Health-Topics/Public-Health/SALSUS/ [Accessed May 2017]
5. The Scottish Public Health Observatory. ScotPHO Online Proflies Tool. Available from: www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool [Accessed May 2017]
6. Scottish Government / National Statistics. Scottish Crime and Justice Survey 2014/15: Main Findings. Available from: www.gov.scot/Topics/Statistics/Browse/Crime-Justice/crime-and-justice-survey/publications [Accessed May 2017]
7. Hope A, Curran J, Bell G, Platts A. Unrecognised and under-reported: the impact of alcohol on people other than the drinker in Scotland. Glasgow: Alcohol Focus Scotland; 2013.
8. Beeston C, McAdams R, Craig N, Gordon R, Graham L, MacPherson M, McAuley A, McCartney G, Robinson M, Shipton D, Van Heelsum A. Monitoring and Evaluating Scotland's Alcohol Strategy. Final Report. Edinburgh: NHS Health Scotland; 2016.
9. Richardson EA, Shortt NK, Pearce J, Mitchell R. Alcohol-related illness and deaths in Scottish neighbourhoods: is there a relationship with the number of alcohol outlets. Edinburgh: Centre for Research on Environment, Society and Health and Alcohol Focus Scotland. 2014.
10. Shortt NK, Tisch C, Pearce J, Mitchell R, Richardson EA, Hill S, Collin J. A cross-sectional analysis of the relationship between tobacco and alcohol outlet density and neighbourhood deprivation. BMC public health. 2015;15(1):1014.
11. Richardson EA, Hill SE, Mitchell R, Pearce J, Shortt NK. Is local alcohol outlet density related to alcohol-related morbidity and mortality in Scottish cities?. Health & place. 2015;33:172-80.
12. Forsyth AJ, Davidson N. Community off-sales provision and the presence of alcohol-related detritus in residential neighbourhoods. Health & place. 2010;16(2):349-58.
13. Chisholm D, Rehm J, Van Ommeren M, Monteiro M. Reducing the global burden of hazardous alcohol use: a comparative cost-effectiveness analysis. Journal of studies on alcohol. 2004;65(6):782-93.
14. Anderson P, Chisholm D, Fuhr DC. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. The Lancet. 2009;373(9682):2234-46.
15. Tayside Public Health Population Health Intelligence Team. Social Attitudes to Alcohol in Tayside. Available from: www.angus.gov.uk/downloads/file/2469/tayside_social_attitudes_to_alcohol_survey [Accessed May 2017]
16. Snowdon C. Drug Deaths in Tayside, Scotland 2015. Angus, Dundee City and Perth and Kinross Alcohol and Drug Partnerships. August 2016
17. Terrence Higgins Trust in collaboration with Tayside Alcohol and Drug Partnerships. Drugs, Alcohol and Sex in Tayside. What we now know. 2016

NHS Tayside

Director of Public Health 2016/17 Annual Report

Transformational Public Health

ITEM No …12……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19 DECEMBER 2017**

REPORT ON: **IMPROVING SCOTLAND'S HEALTH: A HEALTHIER FUTURE – ACTIONS AND AMBITIONS ON DIET, ACTIVITY AND HEALTHY WEIGHT**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB59-2017**

1.0 PURPOSE OF REPORT

To inform the Integration Joint Board of the Scottish Government's consultation on 'Improving Scotland's Health: A Healthier Future – Actions and ambitions on Diet, Activity and Healthy Weight and the proposed plan for responding to the consultation.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Recognises that the Scottish Government has firmly identified obesity as a priority for action;

2.2 Acknowledges that the Dundee Healthy Weight Partnership (DHWP) is co-ordinating a response to the consultation document on behalf of Dundee Health & Social Care Partnership;

2.3 Indicates support for the DHWP response to inform the co-creation of a joint response from Tayside;

2.4 Considers taking part in one of the national road shows.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 The Scottish Government's consultation document A Healthier Future proposes a range of fundamental actions to improve diet and weight. We have the opportunity to consider these, make comment and ultimately influence the final strategy for Scotland.

4.2 The future health of millions of children, the sustainability of our health and social care services, and the economic prosperity of Scotland all now depend on a radical upgrade in our approach to the prevention and treatment of obesity. The challenges facing health and social care require a major shift in the way we approach both individual care and public health in general. The large number of people accessing doctors and hospitals for obesity-related preventable conditions is putting severe pressure on a system that is already struggling to cope with an ageing population and tight budgets. As the ministerial introduction from Aileen Campbell aptly says 'Our diets, activity, and weights are among the biggest public health challenges we face'.

4.3 UK legislation, such as the Soft Drinks Industry Levy, has been introduced to tackle some of the issues, but there are limits to what can be achieved through central Government intervention. Action across Scotland and a more community based approach is needed in order to tackle today's major obesity challenge and inspire changes in public behaviour. We need to create a social movement around obesity prevention, shift the health and social care system towards a more prevention based model, explore how and discover new methods to encourage behavioural change and reinforce healthy lifestyle choices.

4.4 The consultation runs until 31 January 2018 and four interactive road shows are scheduled for Glasgow (Wednesday, 6 December 2017), Edinburgh (Friday, 8 December 2017), Inverness (Wednesday, 10 January 2018) and a virtual event (Thursday, 11 January 2018). These will be chaired by Dr Drew Walker and facilitated by the Scottish Public Health Network.

4.5 Tackling obesity is identified as a priority in the Programme for Government with key commitments to limit the marketing of food high in fat, sugar and salt and, provide more support for people with type 2 diabetes to lose weight. In launching the consultation, the Government announced funding of £42M over the next five years to expand these services. NHS Tayside and partners must carefully consider how to use this investment, in particular to enhance and secure our weight management service.

4.6 The consultation document draws on experience of implementing the Obesity Route Map, learning from tackling other public health challenges such as alcohol use and smoking, and a growing body of evidence on the action necessary to improve the health of the whole population. Other proposals include:

- Action on junk food advertising
- Action on food purchases for consumption outside the home
- Preventative services including information, advice and support for children and families on healthy eating
- Practical support for small and medium sized food manufacturers to reformulate and develop healthier products
- A range of opportunities for people to be more active
- Working with the public sector and a wide range of partners to support local improvement work on diet and weight

4.7 The Dundee Healthy Weight Partnership (DHWP) group was established following the decision of the Health, Social Care & Wellbeing Executive Board to include obesity prevention within the Dundee City Plan. The DHWP recently hosted an event that aimed to kick-start a movement in the City to help people to eat as well as possible and be as active as possible in order to be a healthy weight. The group is coordinating a response to the consultation on behalf of the Dundee Partnership.

5.0 POLICY IMPLICATIONS

There are no major issues in respect of Equality Impact Assessment for the creation of a consultation response.

6.0 RISK ASSESSMENT

This paper refers to the creation of a consultation response and does not constitute any risk for the IJB.

7.0 CONSULTATIONS

The Chief Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 24 November 2017

Dr Drew Walker
Director of Public Health
NHS Tayside

Joyce Thompson
Dietetic Consultant in Public Health Nutrition
NHS Tayside

Dr Laura Stewart
Nutrition & Dietetic Service Lead – Weight Management & Diabetes
NHS Tayside

IMPROVING
SCOTLAND'S
HEALTH

A Healthier Future –

Action and Ambitions on Diet, Activity and Healthy Weight

Consultation Document

Scottish Government
Riaghaltas na h-Alba
gov.scot

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

ISBN: 978-1-78851-351-7

Published by The Scottish Government, October 2017

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS226926 (10/17)

A Healthier Future –

Action and Ambitions on Diet, Activity and Healthy Weight

Consultation Document

The Scottish Government, Edinburgh 2017

Contents

Ministerial Introduction

Scotland finds itself in a position where we produce some of the finest food and drink in the world but, as a nation, our diet can often leave much to be desired. The pace of modern life means that all too many of us, all too frequently, eat food that is quick, cheap and high in calories. Indeed, some people feel they have no other choice.

Our diets, activity, and weights are among the biggest public health challenges we face, with very significant preventable impacts on our health, public services and the Scottish economy.

As a government, our ambition is to change our food culture. While this change will not be easy, it is necessary. And it will need leadership and sustained action across all sectors of our society. Government alone cannot achieve this ambition.

There are three broad areas where we intend to act:

- Transforming the food environment
- Living healthier and more active lives
- Leadership and exemplary practice

In our **Programme for Government**, we set out our ambition for Scotland to be the best place in the world to grow up, and the best place in the world to be cared for and to be healthy. That is why we have committed to a new approach which is as important as our actions on smoking and alcohol.

Scotland's obesity rates continue to be amongst the highest in the developed world. The potential costs to our health services – and to the economy – of increasing numbers of people with chronic ill-health and becoming too ill to work, are very significant.

Given the links between obesity and deprivation, and the significant and consequent health inequalities for women and children, we need to address and target the specific needs of different parts of our population, as well as achieving improvement overall.

In considering the best approach, we have drawn on our experience of implementing the **Obesity Route Map**, the learning from our actions to address alcohol use and smoking, and the broad consensus on evidenced actions that will lead to success. In particular, we have concluded that:

- a broad range of interventions is needed because the factors contributing to overweight and obesity are complex.
- consumer education and personal responsibility are important, together with physical activity, but they will not be sufficient to produce the change we want to see across Scotland as a whole and they will not be sufficient for people who are already overweight and obese.
- interventions that rely less on individual choice and more on changes to the wider environment are essential in making healthier choices easier when we eat at home, eat out or eat on the go.

In short, we want everyone in Scotland to eat as well as possible, with healthy weight and diet across the population. Improving the food environment is critical to achieving this aim.

We want to hear what people who live, work and consume food and drink in Scotland think is necessary to achieve this.

We welcome your views on action which would have the greatest impact and what we should prioritise. And we welcome your thoughts on actions we should take forward in the longer-term. As with our ground-breaking strategies on alcohol and tobacco, this is the start of a progressive plan of action, learning from our experience in Scotland and further afield.

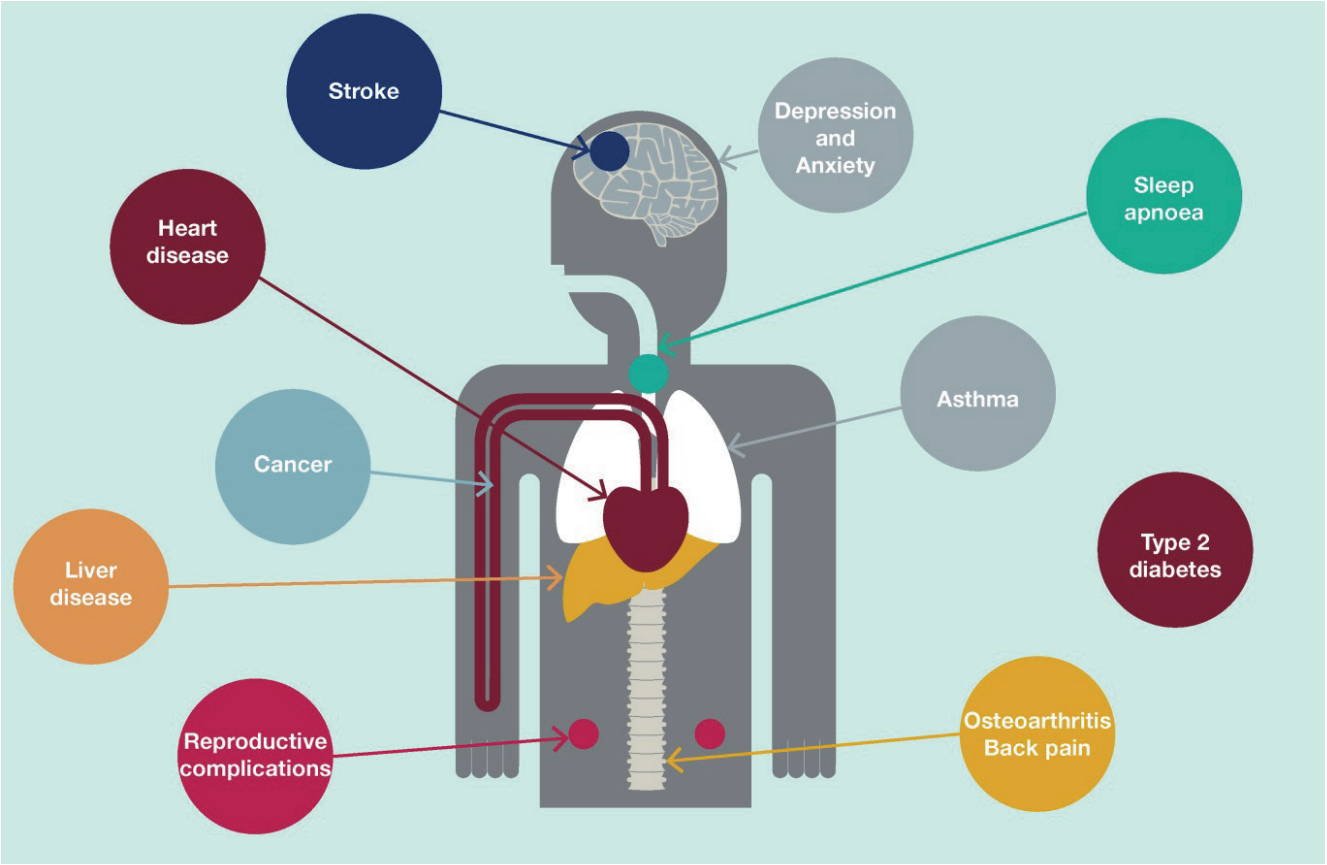
AILEEN CAMPBELL MSP
Minister for Public Health & Sport

Transforming the food environment

1.1 Many of us find it challenging to make healthy choices, particularly when food and drink high in fat, salt and sugar is cheap, widely available, and heavily promoted. As a consequence, we are consuming significantly more calories than we need, with around 20% of all calories and fat, and 50% of sugar coming from so-called 'discretionary foods'[1].

1.2 Poor diet is associated with significant harms to public health and wider socioeconomic performance. Much of that harm is driven by overconsumption leading to people becoming overweight and obese. A good diet and healthy weight significantly reduces the risks of developing type 2 diabetes, 13 types of cancer, and other diseases including cardiovascular disease and depression[2, 3].

Obesity Harms Health



Source: Public Health England

1 Discretionary foods are foods we do not need and have little or no nutritional value, such as confectionery, crisps, cakes, biscuits and sugary drinks. Food Standards Scotland 2015 The Scottish Diet: It Needs to Change - Situation Report

2 Centers for Disease Control and Prevention 2017 Vital Signs Monthly Report (October)

3 Food Standards Scotland 2016 Monitoring foods and drinks purchased into home in Scotland, using data from Kantar WorldPanel

1.3 The food and drink industry has a pivotal role to play in leading, enabling and supporting healthier purchasing. We know that marketing boosts purchasing of foods high in fat, salt and sugar, which are already over-consumed[3].

1.4 Significant work is already well established in Scotland – such as the **Healthyliving Award** and the Scottish Grocers Federation **Healthy Living Programme** which help caterers and small retailers to offer healthier choices. These voluntary schemes have informed the development of Scotland's mandatory **Healthcare Retail Standard** which sets strict criteria for hospital food and drink provision and in-store promotions.

1.5 There is growing recognition across industry of the need to support healthier diets. Some progress has been made through voluntary action – such as front of pack labelling and removal of confectionery from some checkouts. However, we want to enable industry to go further so we can deliver the scale and pace of change needed.

1.6 In 15 years, progress towards meeting the **Scottish Dietary Goals** has remained stubbornly challenging. Furthermore, action is inconsistent across the food and drink sector, leading some to call for a level playing field across retail, catering and manufacturing. There is clearly no single solution, rather a wide range of regulatory and other action is required to create a food environment that better supports healthier purchasing.

Promotions

1.7 Promotions are a key strand of marketing activity designed to encourage consumers to purchase products more quickly, more frequently and in greater quantities than in the absence of the promotion. In Scotland latest figures[4] show that 35% of all food and drink purchased was on price promotion, with food high in fat, salt and sugar more likely to be purchased on promotion than healthier alternatives (around 50% compared to around 30% respectively).

50% of the sugar we consume comes from discretionary foods

Source: Food Standard Scotland

1.8 We have engaged the food and drink industry on voluntary action to support healthier diets, most recently through our **Supporting Healthy Choices Voluntary Framework**. Despite constructive engagement with the food and drink industry, this approach has not delivered sufficient commitment to action, particularly in relation to promotions. We therefore believe that more specific targeted action is required to improve the balance of promotional activity towards healthier options.

4 Food Standards Scotland 2016 Foods and drinks purchased into the home in Scotland using data from Kantar WorldPanel

1.9 We will therefore take forward measures to restrict the promotion of food and drink high in fat, sugar and salt.

1.10 The primary aim is to reduce the public health harm associated with poor diet and the excessive consumption of food and drink high in fat, salt and sugar, including the risks of developing type 2 diabetes, 13 types of cancer and other conditions such as cardiovascular disease and depression.

1.11 In developing our approach, it is important that we clearly define both the types of foods and the types of promotions to be targeted for maximum benefit to public health. We are currently considering how we approach this.

The Scottish Government is minded to act to restrict price promotion on food and drink products which are high in fat, salt and sugar. This could include:

– multi-buy;

– X for Y;

– temporary price promotions.

1.12 Food and drink products high in fat, salt and sugar could be defined by:

– the existing nutrient profiling model[5]; or

– a specific nutrient e.g. sugar and saturated fat; or

– foods that contribute the most calories to the diet.

Question 1

Are there any other types of price promotion that should be considered in addition to those listed above?

Please explain your answer.

Question 2

How do we most efficiently and effectively define the types of food and drink that we will target with these measures?

Please explain your answer.

1.13 We are in the early stages of developing our proposals for legislative action. Your feedback will inform our approach and we will engage with stakeholders on our final proposals in early 2018.

1.14 We will also continue to engage with industry on opportunities to increase the promotion and availability of healthy food, building on work already underway – in particular the Scottish Grocers Federation **Healthy Living Programme,** which seeks to increase the range of healthier products on offer in convenience stores in low income areas. We will also work with retailers to promote uptake of the **Healthy Start Programme** and implement the industry-led **Fruit, Vegetables and Potatoes Action Plan** for increasing the consumption of Scottish produce.

5 Nutrient profiling model was developed by the Food Standards Agency and uses a scoring system which balances the contribution made by beneficial nutrients that are particularly important in children's diets with components in the food that children should eat less of. It is used by Ofcom as basis for BCAP and CAP codes for broadcast and non-broadcast media restrictions for advertising on food and drink high in fat, salt and sugar to children. The model applies equally to all food and non-alcoholic drink. Department of Health 2011 The Nutrient Profiling Model – Policy Paper

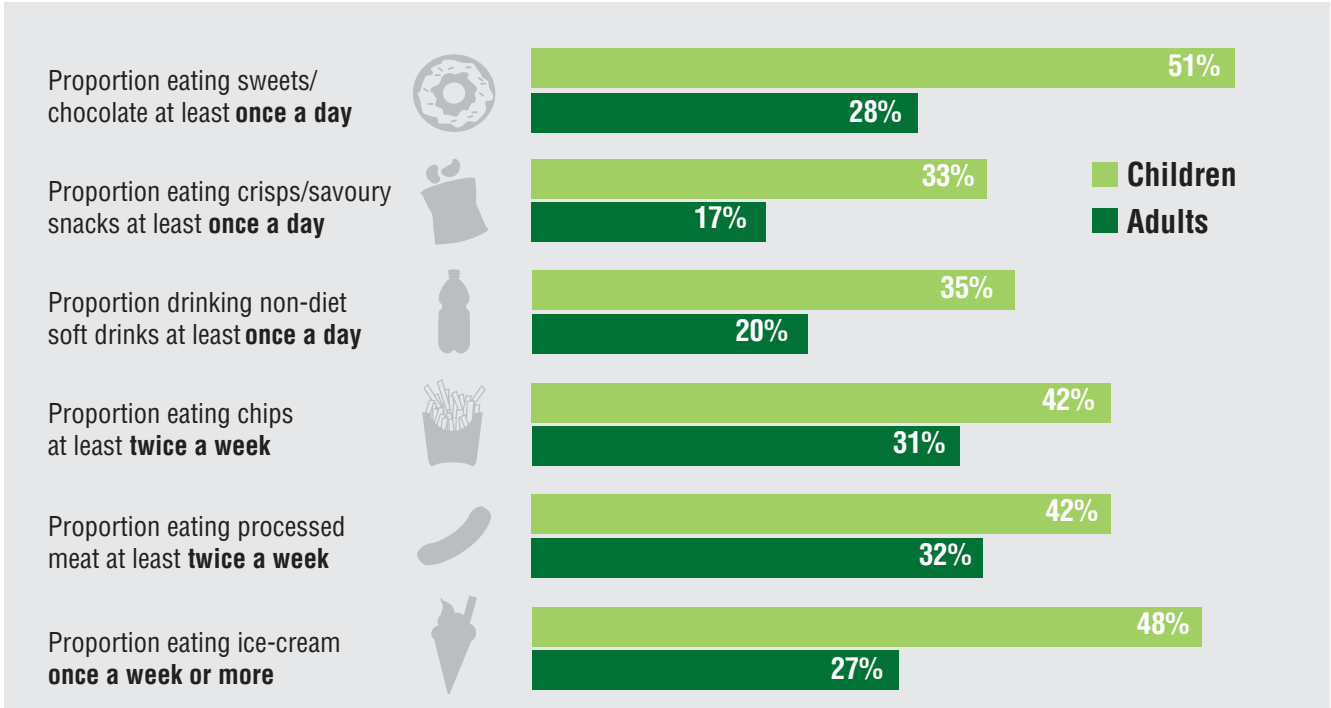
Advertising

1.15 Promotions and advertising are significant drivers of behavioural change. Promotions influence consumer decisions at the point of purchase, with complementary messaging through advertising in the wider environment. Advertisements appear in a variety of media, with out of home advertising accounting for 66% of an individual's total exposure to marketing in any day[6]. We equally recognise that advertising can also be a powerful force for positive messaging on healthy eating.

1.16 While we welcome recent ASA measures to limit junk food and drink advertising aimed at children, they do not go far enough. We believe there is scope to further strengthen current restrictions for both broadcast and non-broadcast advertising of food and drink high in fat, salt and sugar, to encourage healthier purchasing particularly in relation to children.

Scottish Health Survey 2016: Children's diets

Overall, children in Scotland tended to consume foods and drinks high in fat and/or sugar more often than adults



Source: Scottish Health Survey 2017

6 According to the Institute of Practitioners in Advertising (IPA)

1.17 A positive change in this area would be to extend current restrictions on the advertising of food and drink high in fat, salt and sugar to all programmes before the 9pm watershed. As broadcast advertising is currently reserved, we will strongly press the UK Government to ban the broadcast advertising of foods high in fat, salt and sugar before the 9pm watershed. If they will not act, we will request these powers are devolved to the Scottish Parliament.

1.18 We will monitor and review the implementation and impact, in 2018, of the Committee of Advertising Practice (CAP) code on non-broadcast advertising of products high in fat, salt and sugar. If we assess this is not sufficient, we will take any necessary steps to embed good practice. We will also continue to press the CAP to adopt the revised nutrient profile model once it is available.

1.19 We will explore the scope to, and commission research to examine, the extension of the current CAP restrictions at, or near, streets or locations commonly used by a high proportion of children (for instance, children's visitor attractions and Safer Routes to Schools). We will also explore opportunities to restrict advertising on buses, trains and transport hubs.

Question 3

To what extent do you agree with the actions we propose on non-broadcast advertising of products high in fat, salt and sugar?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly disagree

Please explain your answer.

Out of home sector

1.20 The out of home[7] sector – referring to food and drink purchased and consumed outside the home – has the potential to play a significant role in driving improvements to the Scottish diet. In 2015 alone, there were 948 million visits to out of home establishments in Scotland – up 3% on the previous year (compared to only a 1.3% increase in England)[8].

7 Out of home establishment include restaurants, takeaways, sandwich shops, bakeries and coffee shops.
8 Overview of Out of Home Market in Scotland. NPD Crest Report. 2015

1.21 Evidence suggests that, overall, the food and drink provided out of home is skewed towards less healthy options[9]. The sector is very diverse, ranging from multi-nationals and UK companies to local independent outlets – and is still growing. Food and Drink is a growth sector in Scotland and our commitment to becoming a **Good Food Nation** is part of our efforts to encourage the sector to focus on healthy, fresh and nutritious food. Some work has been done to promote healthy eating in the out of home sector, for example through the **Healthyliving Award**. But there is scope for the sector to do much more to support healthier food provision.

1.22 Working with Food Standards Scotland, NHS Health Scotland and stakeholders, we will produce Scotland's first sector specific strategy for out of home providers by summer 2018. This will include action on:

- calorie labelling
- portion size and calorie cap options
- promotions and marketing
- advice on healthier processes e.g. cooking methods and reformulation; and
- nutritional standards for public sector procurement.

1.23 The out of home strategy will be relevant for large and small businesses across the public, private and voluntary sectors. We will engage with relevant stakeholders as we develop our strategy.

Question 4

Do you think any further or different action is required for the out of home sector?

Yes ☐ No ☐ Don't know ☐

Please explain your answer.

Planning system and the food environment

1.24 We will research precedent, evidence and good practice on the relationship between the planning system and food environment, including exploring how food outlets in the vicinity of schools can be better controlled, with a view to informing the review of Scottish Planning Policy.

Labelling

1.25 Labelling, with simplified nutrition information, works alongside dietary advice, industry reformulation and other changes to the food environment to make healthier choices easier. It has an important role to play in both retail and out of home settings to help consumers make informed food and drink choices. It can also encourage food manufacturers to reformulate their food products to gain a more positive nutrient profile.

9 Food Standards Scotland (2017). Diet and Nutrition Board Paper. Proposals for setting the direction for the Scottish Diet: One year on: http://www.foodstandards.gov.scot/publications-and-research/fss-board-meeting-8-march-2016

1.26 The UK-wide voluntary **Front of Pack (FoP)** colour coded nutrition labelling scheme was introduced in 2013 following extensive consultation with businesses, consumer groups and public health professionals. It has good uptake, with around two thirds of pre-packed foods and drinks in the UK displaying a FoP label, and is popular with consumers. Around 80% of people say they look at the label when shopping and those that do tend to have a healthier shopping basket with fewer calories, less sugar, fat and salt and higher fibre content[10].

1.27 We will explore how we can strengthen the current labelling arrangements and improve the way in which we communicate important information to families. In doing so, we will consider the effectiveness and impact of other labelling approaches.

Question 5

Do you think current labelling arrangements could be strengthened?

Yes ☐ No ☐ Don't know ☐

Please explain your answer.

Reformulation and innovation

1.28 Changing consumer preferences, as well as the influence of initiatives such as the UKG's Soft Drinks Industry Levy and Public Health England's (PHE) reformulation programmes, are creating incentives for manufacturers to produce healthier food.

1.29 This, in turn, is creating important opportunities for Scottish businesses. **Ambition 2030** recognises the opportunities that come with a greater demand for healthier food in helping to grow the Scottish food and drink sector. Large food and drink businesses are more likely to have the resources needed to invest in product reformulation and innovation, such as research and development and technical capacity. For many small and medium enterprises (SME), it is more challenging. As 98% of Scottish food businesses are SMEs, we must ensure that they have the support they need to compete in this area and enhance Scotland's reputation for healthier food products.

1.30 We will invest an initial £200,000 over the next 3 years to help Scottish SMEs reformulate their products. With Food and Drink Federation Scotland and Food Standards Scotland, we will develop a wider package of support including access to practical advice, academic and technical expertise and knowledge exchange, as well as promoting other relevant initiatives such as the recently launched **Make Innovation Happen** service.

10 From a presentation at an open Westminster Food and Nutrition Forum (12 September 2017) based on recent research (not yet published) exploring consumers' understanding and use of the UK's front of pack (FoP) nutrition labelling scheme carried out by Kantar Worldpanel and commissioned by the Department of Health

Question 6

What specific support do Scottish food and drink SMEs need most to reformulate and innovate to make their products healthier?

Food and drink levies

1.31 We support the introduction of the UK Government Soft Drinks Industry Levy from April 2018. The significant levels of reformulation that companies have already undertaken in response are encouraging. Notwithstanding the important role this can have in supporting our endeavours, we are concerned at the lack of transparency of the existing soft drinks levy and the way in which it is allocated to Scotland.

1.32 To that end we will be engaging with the UK Government to seek more transparency on how the soft drinks levy is distributed.

1.33 However, the scope of the levy should be extended to include sugary milk-based drinks containing less than 95% milk, consistent with advice from Food Standards Scotland. The current threshold of 75% is much too low, allowing milk to be used as a carrier of added sugars into children's diets with some drinks exceeding more than 8g/100ml[11]. We think that threshold should also apply to dissolvable powders for milk-based drinks such as milkshakes or hot chocolate since their added sugar levels are comparable and feature in products aimed at children.

1.34 We will call for the UK Government to extend the Soft Drinks Industry Levy to include sugary milk-based drinks, including dissolvable powders, containing less than 95% milk.

11 See the Food Standards Scotland response to the Soft Drinks Industry Levy consultation.

Living Healthier and More Active Lives

2.1 As well as creating the conditions for healthier weight and diet, we want to enable personal change, allowing all of us to start, live and age well.

Health inequalities

2.2 The overarching aim of the Scottish Government is to create a fairer Scotland and reduce inequality. It is not fair that those with the poorest health outcomes are those living in poverty. The obesity strategy will seek to prioritise work with families in poverty and on low incomes to design services and approaches that meet their specific needs and are impactful. This will be aligned to existing approaches to create a fairer Scotland such as the **Child Poverty Strategy.**

2.3 The devolution of the **Healthy Start Vouchers** provides an opportunity to tailor the scheme to Scottish needs and better support families on the lowest incomes.

Developing a positive relationship with food from birth to adulthood

2.4 We want Scotland's future generations to start life with a healthy weight (both under and over); grow at a healthy rate; and have a positive attitude to, and experience of, food. Our plans for maternal and infant health, building on our achievements through the **Maternal and Infant Nutritional Framework**, are therefore integral to this strategy and the action we propose for improving diet and weight. Also important will be opportunities offered through increased professional support via the **Family Nurse Partnership** and **Universal Health Visiting Pathway** in Scotland.

2.5 Beginning, where possible, with breastfeeding, our aim is to establish good overall food behaviours, including healthy food and healthy eating patterns, as part and parcel of Scottish family life.

2.6 We want to ensure children start school with a healthy weight. This means getting better at prevention, starting with children in the early years, providing support to parents on the need for good food, good sleep and healthy weight to get them ready to learn. This means continuing to offer support to children, their parents and carers, and wider families when weight becomes an issue. We must also exploit the widest range of opportunities in children's surroundings to promote healthy living including, for example, through nursery and school meals, their learning, and play spaces.

70% of children's excess weight gain is achieved by age 5

2.7 For long-term benefit, we want to see effective support and advice maintained as children progress through school and emerge into adulthood. We want to ensure that they are equipped with the knowledge to make positive choices in life, both for themselves and as the potential parents of the future. That means information and advice for families – delivered at the right time and in the right way – about physical activity, sleep, dental health, food and cooking are vital.

2.8 In our schools, through the **Curriculum for Excellence**, every child and young person in Scotland is entitled to a broad general education which includes learning about food and health. This ensures pupils develop a full understanding of food issues in their widest sense. As well as learning how to cook, food education encompasses food choices and the influences of advertising and culture. Since 2015 we have provided free school meals to every child in Primary 1 to 3 at all publicly funded schools in Scotland. This targets our resources to the youngest school children, giving them the opportunity to benefit from a nutritious meal at a crucial stage of their education, and encourages the development of healthy eating habits which can be sustained as they grow older.

2.9 We know that conversations with parents about weight and the food children eat, can be sensitive and difficult, and we recognise how the realities of parenting can present challenges. That is why we seek to enable, empower and support parents, building on existing strengths and assets to help deliver improved outcomes.

2.10 We will improve the way in which services engage, inform and support women before first pregnancy to ensure they start their pregnancy at a healthy weight and in good physical health – and are given support to breastfeed. We will specifically target women and families who are most at risk.

2.11 To reduce the percentage of children starting primary school overweight or obese, we will use a preventative approach through the health visitor pathway and wider early years workforce to engage with families to promote healthy eating, portion control and mealtime behaviours and, where appropriate, offer referrals to family healthy living and weight interventions.

2.12 We will use social marketing, building on **Eat Better Feel Better**, to help young families and other groups – such as teenagers and young people leaving home for the first time – improve the way they shop, cook and eat.

2.13 We will develop training and resources to ensure front-line staff across a range of disciplines have the knowledge, skills and confidence to discuss weight, portion control and good mealtime behaviours to give the right advice and refer appropriately. This will be built into wider work with families.

2.14 We will complete the school food and drink regulation review with a view to moving them closer towards the **Scottish Dietary Goals**. This includes ensuring the regulations can support children – especially primary school pupils – to have access to more fruit and vegetables as part of their school day.

2.15 We will work with NHS Boards to maintain and examine expanding the child healthy weight work as a core part of preventative service provision. Together with healthy weight interventions, this will include work in schools and communities on healthy diet and physical activity, and targeted work with vulnerable children and their families.

2.16 Healthy weight, diet and nutrition already fit with our **Maternal and Infant Nutrition Framework,** but will also play a role within the forthcoming ten year **Child and Adolescent Health and Wellbeing Action Plan** which will be launched during the Year of Young People.

2.17 During 2018, the Year of Young People, we will set up collaboration with Young Scot and the Scottish Youth Parliament to better understand and respond to children and young people's perceptions and experiences of food; the role it plays in their lives; and their food behaviours.

Question 7

Do you think any further or different action is required to support a healthy weight from birth to adulthood?

Yes ☐ No ☐ Don't know ☐

Please explain your answer.

Supported weight management

2.18 As already stated, the majority of adults in Scotland are overweight (65%)[12], bringing a higher risk of developing serious diseases. In particular we are seeing a worrying increase in type 2 diabetes. That is why, in our **Programme for Government**, we have made a commitment to deliver a new approach to weight management for people with, or at risk of, this disease.

The Health Service spends around 9% of its total health expenditure treating type 2 diabetes

12 The Scottish Government: Health Survey, 2017. http://www.gov.scot/Resource/0052/00525472.pdf

Scottish Health Survey 2016: Obesity

Two thirds
(65%) of adults in Scotland were overweight, including

29%
who were obese, in 2016

These figures are largely unchanged since 2008

Source: Scottish Health Survey 2017

2.19 While we do not know the exact cause, we know that obesity and being overweight are the most significant factors that increase the risk of diabetes. The risks of developing type 2 diabetes are seven times higher for people who are obese compared to those with a healthy weight, and three times higher for people who are overweight. Latest data show that 87% of adults with type 2 aged 16-54 years are overweight[13].

2.20 The number of people in Scotland with Type 2 Diabetes is significant and growing. In 2016, over 250,000 people were diagnosed with Type 2 in Scotland, with 17,000 new cases each year. Diabetes UK estimates suggest that over 500,000 people in Scotland are at risk of developing type 2 diabetes[14].

2.21 Type 2 diabetes has a serious impact on people's lives, with real risks of cardiovascular disease, sight loss and amputation. Moreover, it puts pressure on our health services, with treatment costs accounting for around 9% of total health expenditure. It also affects productivity and, ultimately, our economy due to increased sickness absence and early retiral due to ill-health.

2.22 However, for many, type 2 diabetes can be avoided which is why – with the Scottish Diabetes Group – we are developing a prevention framework in which diet and exercise are key components. This is drawing on studies showing that significant changes in diet and exercise leading to weight loss can delay or prevent the onset of diabetes

13 Scottish Diabetes Survey Monitoring Group: Scottish Diabetes Survey 2016
http://www.diabetesinscotland.org.uk/Publications/Scottish%20Diabetes%20Survey%202016.pdf

14 Diabetes UK: State of the Nation 2015 report, The Age of Diabetes
https://diabetes-resources-production.s3-eu-west-1.amazonaws.com/diabetes-storage/migration/pdf/SOTN%2520Diabetes.pdf

and its associated morbidity. Encouragingly, evidence is also beginning to demonstrate that weight loss, along with lifestyle behaviour changes, can reduce – and in some cases halt – reliance on medications. These types of behaviour changes can even reverse the type 2 diagnosis.

2.23 To implement our **Programme for Government** commitment, we will invest £42m over five years to establish supported weight management interventions as a core part of treatment services for people with, or at risk of, type 2. We propose to target 95,000 people (30% of those diagnosed) in order to make an impact on population health.

2.24 We will measure the effectiveness of interventions through existing databases; specifically, we will track the reduction in drug prescriptions and, in the longer term, the reduction and delay of complications such as cardiovascular disease, sight loss and amputation.

Question 8

How do you think a supported weight management service should be implemented for people with, or at risk of developing, type 2 diabetes – in particular, the referral route to treatment?

Healthy living and other interventions

2.25 We also want to ensure a wide range of support is available to help people eat better, eat less, and be more active, no matter where they live in Scotland. Clearly interventions must be able to demonstrate positive outcomes.

2.26 We want to support opportunities to make more use of 'health defining' moments by bringing together healthy living interventions and services in health settings. The **ActWELL** pilot in breast screening, funded by the Scottish Government, is illustrating what can be achieved, as it supports women to make lasting changes with a focus on physical activity, diet and weight.

2.27 The added bonus is that we can expect the effectiveness of the outcomes of these interventions to increase as improvements are made to the environment.

Obese people are 7 times more likely to develop Type 2 Diabetes than those with a healthy weight

2.28 We will continue to support the delivery and development of healthy living interventions as a treatment through the NHS and the third sector, such as the innovative **Football Fans In Training**[15].

2.29 To improve the quality of services across Scotland and equality of access, we will work with the NHS and partners to develop guidance on minimum standards for programmes and sustainable weight management pathways for children and adults, taking account of the evidence on effectiveness and cost effectiveness.

2.30 As part of the action outlined above, we will look specifically at non-health referral pathways through other partners such as employment and social work services.

Question 9

Do you think any further or different action on healthy living interventions is required?

Yes ☐ No ☐ Don't know ☐

Please explain your answer.

Physical activity

2.31 Evidence[16] shows that physical activity is one of the best things we can do to improve our health, whether we are overweight or not. **The Active Scotland Outcomes Framework** sets out the Scottish Government's vision for an active nation. Physical activity is about getting people moving. Daily walking, playing in a park, going to a gym, training with a team, or aspiring to win a gold medal – it doesn't matter how people get active it just matters that we do. We want more people to be more active, more often.

2.32 The 2014 **Commonwealth Games Legacy programme** has funded a range of targeted interventions with relatively inactive groups such as the elderly, disabled people, teenage girls and those with lower socio-economic status. We are committed to Scotland becoming the first 'Daily Mile' nation, with roll out to nurseries, schools, colleges, universities and workplaces.

2.33 We are also committed to putting active travel at the heart of our transport planning. Investment will increase from £40 million to £80 million per year, from 2018-19, to make our towns and cities friendlier and safer spaces for pedestrians and cyclists. We will also appoint an Active Nation Commissioner to ensure delivery of world-class active travel infrastructure across Scotland.

15 FFiT is funded by the Government, developed in partnership by SPLTrust and Glasgow University and successfully delivered by the Community Coaches of Scotland's Professional Football teams.

16 The Lancet: http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)31070-4.pdf

2.34 As important as it is to our health, modern life – including sedentary jobs – means that, for most of us, being active is not enough. Action on diet and behaviour change, alongside physical activity, remain essential to our goal of helping everyone live healthier, longer lives.

2.35 We will use our increased investment in active travel to encourage more to walk and cycle and link this with our efforts to support weight management activity and use the existing network of clubs and volunteers that support people to become active. As well as having a positive impact on our environment and reducing congestion, this will support our ambitions to become a more Active Scotland and will play an important role in us all being healthier.

2.36 We will use the improvements to our planning system to ensure that the places and spaces we live in enable active travel and healthy choices. This will build on the work we have done with the **Place Standard**[17] to support the development of healthy, sustainable communities and ensure everyone has the opportunity to shape and influence the places in which we live.

2.37 We will give further thought to how to create active places to make it easier for everyone to be more active.

2.38 We will use existing programmes, such as **Active Schools** and the **Daily Mile**, to ensure being active continues to play an important role in maintaining a healthy weight.

Question 10

How can our work to encourage physical activity contribute most effectively to tackling obesity?

17 Place Standard: https://www.placestandard.scot/

Leadership and Exemplary Practice

3.1 There is already broad consensus that more needs to be done in Scotland to tackle obesity and the associated inequalities. The cost of obesity and poor health – human, societal and economic – are unsustainable; but with the right action they are largely preventable.

3.2 We need to create a whole nation approach that improves Scotland's weight and diet and gets us more active. This will demand strong leadership and broad commitment, as well as ambitious and progressive action right across the system. We will need to build the will and momentum, at national and local levels, to support and implement bold policies. These are vital if we are to increase the scale and pace of change, and achieve long-term gains at population level.

Public sector leadership

3.3 For the public sector, and the communities they serve, we see new opportunities emerging for effective leadership through Community Planning Partnerships and Integration Authorities. During 2019, these local arrangements will be further supported by the establishment of a new national public body with specific responsibility for the public's health. Further support will also be sourced through related joint working with other expert organisations – for example Food Standards Scotland and Obesity Action Scotland. The new national priorities for public health, due to be published in early 2018, will help to generate wide discussion and action.

Food & drink industry leadership

3.4 Equally we now need industry – including manufacturers, retailers and caterers – to show leadership and commitment. The food and drink industry is extremely important to Scotland's economy and we welcome Scotland Food & Drink's strategy for growth, **Ambition 2030**, and its commitment to health and wellbeing. In translating this into action, we would ask industry to see the re-balancing of food towards healthier options – whether people eat at home, eat out, or eat on the go – as a key measure of success. This connects with our aspiration that Scotland is a **Good Food Nation**, where people from every walk of life take pride, pleasure, and benefit from, the food they buy, serve, and eat day by day.

3.5 This, along with wider policy such as the UKG soft drinks levy and reformulation programmes, and changing consumer preference, reflects the direction of travel we want to see. Taken together, these are leading to growing demand for healthier products which, over time, will create important new market opportunities. This is a challenging agenda, particularly for Scotland's small and medium-sized enterprises, and we therefore want to work constructively with industry in developing our respective plans, and to support it effectively.

Leading by example

3.6 An important part of the leadership role is leading by example. Whether as individuals, employers, service providers or purchasers of goods and services, there are many different ways in which the public, private and voluntary sectors can do this. The Scottish Government is developing plans for promoting the health and wellbeing of its workforce, but every employer in Scotland has an interest in this as a key means of improving recruitment, retention and productivity. Moreover, evidence shows that those who have important roles in caring for people and influencing their behaviours can do this more effectively when they are fit and well.

3.7 Elsewhere in the public sector we have had some success in making it easier for people to buy and eat more healthily. Schools must now meet statutory regulations for all food and drink they provide and the **Healthyliving Award** and **Healthcare Retail Standard** have transformed catering and retail outlets across the NHS.

3.8 However, there is scope for all of us – across the public, private and voluntary sectors – to do a lot more. The challenge is making change systematic and spreading the benefits to the entire population.

3.9 We will invite and support a select number of local government and health leaders to enhance and share their improvement work on weight and diet in their areas, harnessing the widest range of public, private and voluntary sector partners. In particular we will support work to improve the local environment in our most vulnerable communities.

3.10 We will develop plans to further support the health and wellbeing of Scottish Government staff, being an exemplar and encouraging others in the private, public and voluntary sectors – particularly the NHS – to commit to action.

3.11 We will ensure that health and environmental sustainability are key considerations in public procurement of food.

3.12 We will expand the **Healthyliving Award** to publically funded catering locations which do not currently offer customers a mark of health.

3.13 We will also explore opportunities to extend relevant **Healthcare Retail Standard** criteria beyond the NHS to other retail settings operating in publicly funded locations.

3.14 We will renew our commitment to the community food initiatives that make healthy, affordable food more accessible and equip people, particularly in deprived communities, with the knowledge and skills they need to prepare healthy meals.

Question 11
What do you think about the action we propose for making obesity a priority for everyone?

Question 12
How can we build a whole nation movement?

Evidence-based improvement

3.15 Consistent with the approach taken so far, we are committed to policy and action which is grounded in the evidence. This means we will continue to:

- evaluate our actions and be prepared to change our approach using, for example, improvement methodology and 'small tests of change';
- monitor the extent of the problem and the impact of our actions through established approaches such as the **Scottish Health Survey**;
- monitor and collaborate on the most up to date evidence base through the **Scottish Food and Drink Research, Evidence and Evaluation Collaborative**[18]; and
- make the research and evidence base widely available to inform policy and practice across Scotland.

3.16 We will put in place a robust monitoring and evaluation programme to inform the development and measure the impact of new proposals.

3.17 We will host a biennial international conference to measure progress and share good practice.

Question 13
What further steps, if any, should be taken to monitor change?

Question 14
Do you have any other comments about any of the issues raised in this consultation?

18 A body consisting of policy and analytical experts from Scottish Government, Food Standards Scotland, NHS Health Scotland alongside academics with expertise in the field of food and drink research. The body's function is to improve the coherence and relevance of food and drink related research in Scotland through building collaborations between policy makers, intermediary organisations and researchers.

Annex A
Responding to this Consultation

We are inviting responses to this consultation by 31st January 2018.

Please respond to this consultation using the Scottish Government's consultation platform, Citizen Space. You view and respond to this consultation online at https://consult.scotland.gov.uk/health-and-social-care/a-healthier-future. You can save and return to your responses while the consultation is still open. Please ensure that consultation responses are submitted before the closing date of 31st January 2018.

If you are unable to respond online, please complete the Respondent Information Form (see "Handling your Response" below) to: DietPolicy@gov.scot

Handling your response

If you respond using Citizen Space (http://consult.scotland.gov.uk/), you will be directed to the Respondent Information Form. Please indicate how you wish your response to be handled and, in particular, whether you are happy for your response to published.

If you are unable to respond via Citizen Space, please complete and return the Respondent Information Form attached included in this document. If you ask for your response not to be published, we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

Where respondents have given permission for their response to be made public, and after we have checked that they contain no potentially defamatory material, responses will be made available to the public at http://consult.scotland.gov.uk. If you use Citizen Space to respond, you will receive a copy of your response via email.

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us. Responses will be published where we have been given permission to do so.

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to DietPolicy@gov.scot

Scottish Government consultation process

Consultation is an essential part of the policy-making process. It gives us the opportunity to consider your opinion and expertise on a proposed area of work.

You can find all our consultations online: http://consult.scotland.gov.uk. Each consultation details the issues under consideration, as well as a way for you to give us your views, either online, by email or by post.

Consultations may involve seeking views in a number of different ways, such as public meetings, focus groups, or other online methods such as Dialogue (https://www.ideas.gov.scot)

Responses will be analysed and used as part of the decision-making process, along with a range of other available information and evidence. We will publish a report of this analysis for every consultation. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.

Annex B
Respondent Information Form

Scottish Government
Riaghaltas na h-Alba
gov.scot

A HEALTHIER FUTURE –
ACTION AND AMBITIONS ON DIET, ACTIVITY AND HEALTHY WEIGHT
- RESPONDENT INFORMATION FORM
Please Note this form **must** be completed and returned with your response.

Are you responding as an individual or an organisation?

☐ Individual

☐ Organisation

Full name or organisation's name

If you are responding on behalf of an organisation, please tell us the type of organisation for which you are providing a response.

☐ Food and Drinks Industry Representative body

☐ Manufacturer

☐ Retailer

☐ Out of home provider (e.g. restaurant, fast food outlet, coffee shop)

☐ Public Sector Health Organisation

☐ Third Sector Health Organisation

☐ Other (please note in the text box provided)

Phone number

Address

Postcode

Email

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

- ☐ Publish response with name
- ☐ Publish response only (without name)
- ☐ Do not publish response

Information for organisations:

The option 'Publish response only (without name)' is available for individual respondents only. If this option is selected, the organisation name will still be published.

If you choose the option 'Do not publish response', your organisation name may still be listed as having responded to the consultation in, for example, the analysis report.

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

- ☐ Yes
- ☐ No

Annex C
Summary of Consultation Questions

Question 1

Are there any other types of price promotion that should be considered in addition to those listed above?

Please explain your answer.

Question 2

How do we most efficiently and effectively define the types of food and drink that we will target with these measures?

Please explain your answer.

Question 3

To what extent do you agree with the actions we propose on non-broadcast advertising of products high in fat, salt and sugar?

- ☐ Strongly agree
- ☐ Agree
- ☐ Neutral
- ☐ Disagree
- ☐ Strongly disagree

Please explain your answer.

Question 4

Do you think any further or different action is required for the out of home sector?

Yes ☐ No ☐ Don't know ☐

Please explain your answer.

Question 5

Do you think current labelling arrangements could be strengthened?

Yes ☐ No ☐ Don't know ☐

Please explain your answer.

Question 6

What specific support do Scottish food and drink SMEs need most to reformulate and innovate to make their products healthier?

Question 7

Do you think any further or different action is required to support a healthy weight from birth to adulthood?

Yes ☐ No ☐ Don't know ☐

Please explain your answer.

Question 8

How do you think a supported weight management service should be implemented for people with, or at risk of developing, Type 2 Diabetes – in particular the referral route to treatment?

Question 9

Do you think any further or different action on healthy living interventions is required?

Yes ☐ No ☐ Don't know ☐

Please explain your answer.

Question 10

How can our work to encourage physical activity contribute most effectively to tackling obesity?

Question 11

What do you think about the action we propose for making obesity a priority for everyone?

Question 12

How can we build a whole nation movement?

Question 13

What further steps, if any, should be taken to monitor change?

Question 14

Do you have any other comments about any of the issues raised in this consultation?

Annex D
Glossary

A

Active Scotland Outcome Framework

The Active Scotland Outcomes Framework describes Scotland's ambitions for sport and physical activity.

Visit the following **link** for more information.

ActWELL

Following successful pilot work, the ActWELL study (lead by the University of Dundee in conjunction with Breast Cancer Now and NHS Breast cancer screening clinics) aims to assess the benefits, costs and acceptability of a community delivered, personalised weight management programme (ActWELL) in women attending routine breast cancer screening clinics (in Aberdeen, Dundee, Edinburgh and Glasgow). Recruitment started in July 2017 and the response from women has been very high.

Visit the following **link** for more information.

Ambition 2030

An ambitious plan to drive growth in Scotland's farming, fishing, food and drink industry. **Ambition 2030** was developed by the Scotland Food & Drink Partnership, an industry-led partnership of the main organisations in the farming, fishing, food and drink sector, alongside The Scottish Government and its key agencies.

Visit the following **link** for more information.

B

BMI

See **body mass index.**

Body mass index (BMI)

Weight in kg divided by the square of height in metres. Adults (aged 16 and over) can be classified into the following BMI groups:

BMI (kg/m_2)	Description
Less than 18.5	Underweight
18.5 to less than 25	Normal
25 to less than 30	Overweight
30 to less than 40	Obese
40 and above	Morbidly obese

Although the BMI calculation method is the same, there are no fixed BMI cut-off points defining overweight and obesity in children. Instead, overweight and obesity are defined using several other methods including age and sex specific BMI cut-off points or BMI percentiles cut-offs based on reference populations. Children can be classified into the following groups:

Percentile cut-off	Description
At or below 2nd percentile	At risk of underweight
Above 2nd percentile and below 85th percentile	Healthy weight
At or above 85th percentile and below 95th percentile	At risk of overweight
At or above 95th percentile	At risk of obesity

Source: Scottish Health Survey 2017

C

Committee of Advertising Practice

The Committee of Advertising Practice (CAP) is the sister organisation of and is administered by the Advertising Standards Authority (ASA). The CAP is responsible for creating and maintaining the UK code of Non-broadcast Advertising, sales, promotion and direct marketing which regulates non-broadcast marketing communications.

Community Food Initiatives

Projects or programmes tackling locally identified barriers to a healthy diet, for example a community-run café in a low income neighbourhood or a community garden run with people who are homeless.

Visit the following **link** for more information.

Community Planning Partnership

A Community Planning Partnership (or CPP) is the name given to all those services that come together to take part in community planning. There are 32 CPPs across Scotland, one for each council area. Each CPP is responsible for developing and delivering a plan for its council area.

Visit the following **link** for more information.

D

Daily Mile

The Daily Mile – a free, simple and effective concept of jogging, walking and running for 15 minutes to improve the physical, social, emotional and mental health and wellbeing of people regardless of age, ability or personal circumstances.

Visit the following **link** for more information.

E

Eat Better, Feel Better

A Scottish Government campaign launched in 2015 which aims to encourage and support people to make healthier choices to the way they shop, cook and eat.

Visit the following **link** for more information.

F

Food Environment

The food environment comprises the foods available to people in their surroundings – and includes the nutritional quality, safety, price, convenience, labelling and marketing of these foods. This includes supermarkets, convenience stores, cafes, restaurants, takeaways, work and school canteens, and all other venues where people procure and eat food.

Source: FAO (2016) Influencing Food Environments for Healthy Diets. Food and Agriculture Organization of the United Nations, Rome.

Food Standard Scotland (FSS)

FSS was established by the Food (Scotland) Act 2015 as a non-ministerial office, part of the Scottish Administration, alongside, but separate from, the Scottish Government. FSS develops policies, provides policy advice to others, is a trusted source of advice for consumers and protects consumers through delivery of a robust regulatory and enforcement strategy.

Visit the following **link** for more information.

Front of Pack Labelling

See **traffic light labelling**.

Fruit, Vegetables & Potatoes Action Plan

A new Fruit, Vegetable & Potato Industry Leadership Group (announced June 2017) is developing the first Sector Action Plan to capitalise on market opportunities, and grow the sector whilst also trying to drive increased consumption of healthy Scottish produce. This work complements Ambition 2030 and the new group, which for the first time brings together all key representatives across the sector, will identify the specific actions needed to overcome any barriers to growth, develop new market opportunities, and address issues facing the sector, including the implications of Brexit and access to labour.

G

Good Food Nation

Good Food Nation is the next phase of Scotland's National Food and Drink Policy. It highlights the successes of Scotland's first food and drink policy, **Recipe for Success**, whilst recognising the continuing challenges within Scotland's food and drink sector. Becoming a Good Food Nation recognises the need to move towards a healthier, more resilient and sustainable food system.

Visit the following **link** for more information.

H

Healthcare Retail Standard

The **Healthcare Retail Standard** (HRS) is a set of criteria developed for retail outlets in all healthcare settings across Scotland. These criteria require the retail outlet to have at least 50% of their products from a healthier range. They also restrict what can be actively promoted in these stores.

Visit the following **link** for more information.

Health Inequalities

The unfair and unavoidable differences in people's health across social groups and between difference population groups.

Health Visitor Pathway

The pathway presents a core home visiting programme to be offered to all families by Health Visitors as a minimum standard. Along with these core home visits Health Visitors exercising the function of a Named Person on behalf of their Health Board will be required to be available and responsive to parents to promote support and safeguard the wellbeing of children by providing information, advice, support and help to access other services.

Healthy Living Programme

The Scottish Grocers' Federation (SGF) Healthy Living Programme is a Scottish Government sponsored programme whose main objectives are to increase the range, quality and affordability of fresh produce and other healthier products from across categories in convenience retail stores across Scotland.

Visit the following **link** for more information.

Healthy Start Vouchers

Healthy Start Vouchers are being devolved as part of the Welfare Foods provisions of the Scotland Act (2016). They are currently administered by Department of Health and provide low income pregnant women and children under the age of 4 with vouchers worth £3.10 per week to purchase fruit, vegetables and milk (one for pregnant women and those with a baby under the age of one; and one for each child in the family under four years old). It will be integrated with the Best Start Grant (Scottish replacement for the Sure Start Maternity Grant) following commencement.

Healthy Weight

See **Body Mass Index.**

Healthyliving Award

The Healthyliving Award is a national award for the foodservice sector in Scotland. Eating out plays an important part in people's lives and what people are increasingly looking for is good healthier food.

Visit the following **link** for more information.

M

Make Innovation Happen

Make Innovation Happen is a new and ambitious service to support food and drink businesses to innovate in Scotland.

Visit the following **link** for more information.

O

Obese

See **Body Mass Index**.

Out of home

Any food or drink purchased for immediate consumption outside the home, including takeaway or home-delivered food.

Overweight

See **Body Mass Index**.

P

Population health

Population health is an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at, and acts upon the broad range of factors and conditions that have a strong influence on our health. This broader notion of health recognizes the range of social, economic and physical environmental factors that contribute to health.

Preventing Obesity Route Map

In February 2010, the Scottish Government and COSLA launched a long-term obesity strategy entitled Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight. It is most commonly referred to as the 'Obesity Route Map'

Visit the following **link** for more information.

Promotion

Promotion is advertising a product or brand, generating sales, and creating brand loyalty.

Source: McCarthy, Jerome E. (1964). Basic Marketing. A Managerial Approach. Homewood, IL: Irwin. p. 769. **ISBN 0256025339**.

Public Health

Public health focuses on the health of populations as a whole rather than on individuals. It deals with the behavioural, social and environmental factors that influence the health of populations.

Public Health England (PHE) Reformulation Programme

PHE Reformulation Programme – A UK Government policy, launched in their Childhood Obesity Action Plan (2016) and administered by Public Health England, that sets a target for manufacturers to achieve a 20% sugar reduction by 2020 with a (5% in the first year) across the top 9 categories of food that contribute most to intakes of children up to the age of 18 years.

Visit the following **link** for more information.

S

Scottish Dietary Goals

The Goals describe, in nutritional terms, the diet that will improve and support the health of the Scottish population. They are set at the Scottish population level. They indicate the direction of travel, and assist policy development to reduce the burden of obesity and diet-related disease in Scotland. They will continue to underpin diet and health policy in Scotland and will be used for scientific monitoring purposes.

Visit the following **link** for more information.

Scottish Health Survey

The Scottish Health Survey (SHeS) provides a detailed picture of the health of the Scottish population in private households and is designed to make a major contribution to the monitoring of health in Scotland.

Visit the following **link** for more information.

Small Test of Change

Small tests of change are mini-interventions that allow healthcare teams and others to try out new ideas quickly and cost-efficiently.

Visit the following **link** for more information.

SME – Small and medium enterprise

Small-sized enterprises have fewer than 50 employees. Medium-sized enterprises have fewer than 250 employees.

Source: The Procurement Reform (Scotland) Act 2014 – section 9(3)

Soft Drinks Industry Levy

The Soft Drinks Industry Levy is a UK Government policy proposal featured in the 2016 Childhood Obesity Action Plan. The proposed levy will apply to the production and importation of soft drinks containing added sugar. The levy is due to take effect from April 2018.

Visit the following **link** for more information.

Supporting Healthy Choices Voluntary Framework

The Supporting Healthy Choices Voluntary Framework set out the Scottish Government and the then Food Standards Agency in Scotland ambition to work collaboratively with partners to improve Scotland's diet and tackle health inequalities. The framework called on industry partners to implement a range of voluntary commitments which reflect the action believed necessary to rebalance diets in Scotland.

Visit the following **link** for more information.

T

Traffic Light Labelling

Traffic light labelling is a front-of-pack nutrition labelling scheme to help consumers see, at a glance, what is in their food. The label is colour-coded red, amber and green, and highlights 'percentage reference intakes' (formerly known as guideline daily amounts), to show how much fat, saturated fat, salt, sugar and energy is in a product.

- Red colour coding means the food or drink is high in this nutrient and we should try to have these foods less often or eat them in small amounts.
- Amber means medium, and if a food contains mostly amber you can eat it most of the time.
- Green means low, and the more green lights a label displays the healthier the choice.

Visit the following **link** for more information.

ISBN: 978-1-78851-351-7

This document is also available on The Scottish Government website:
www.gov.scot

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS266926 (10/17)

ITEM No …13……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19 DECEMBER 2017**

REPORT ON: **WINTER PLANNING ARRANGEMENTS**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB58-2017**

1.0 PURPOSE OF REPORT

To inform the Integration Joint Board of the Winter Planning arrangements and Unscheduled Care Improvement Plan.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of the cover report and NHS Tayside Winter Plan 2017/18 (attached as appendices 1 and 2) which were presented to the NHS Tayside Board Meeting held on 26 October 2017;

2.2 Approves and endorses Dundee Health & Social Care Partnership's contribution to the Winter Plan;

2.3 Notes the Improvement Plans that underpin the Winter Plan;

2.4 Notes the Resilience Plans for winter preparedness.

3.0 FINANCIAL IMPLICATIONS

The financial implications for Dundee Health & Social Care Partnership of the winter plan arrangements as set out in this report will be contained within existing budgeted provision and available funding streams..

4.0 MAIN TEXT

4.1 The NHS Tayside Winter Plan 2017/18 (the Plan) describes the collaborative approach to planning for "winter" by NHS Tayside and the Health and Social Care Partnerships of Angus, Dundee and Perth & Kinross. The plan forms the local Unscheduled Care Action Plan, is aligned to the Five Year Transformation Plan and is underpinned by the Six Essential Actions for Unscheduled Care. This plan has been written taking full account of the winter planning guidance 'The National Unscheduled Care Programme: Preparing for winter 2017/18' (DL (2017) 19).

4.2 The aim of the Plan is to assure NHS Tayside Board, the Scottish Government and the population of Tayside that plans and systems are in place to support the early intervention and action at points of pressure and to minimise the potential disruption to services, people who use services and their carers.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	This is a Tayside plan. There is a risk that the plan is not achieved as described and there is an increase in the number of people delayed leading to boarding of patients and cancellation of elective operations.
Risk Category	Operational, Financial
Inherent Risk Level	15 – Extreme
Mitigating Actions (including timescales and resources)	Local planning is in place to ensure the Dundee partnership will fulfil its requirements. The impact on the system will be monitored daily. Christmas/New Year plans will be completed.
Residual Risk Level	9 - High
Planned Risk Level	6 - Moderate
Approval recommendation	Given the moderate level of planned risk it is recommended that the level of risk is accepted.

7.0 CONSULTATIONS

The Chief Finance Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

David W Lynch
Chief Officer

DATE: 24 November 2017

Diane McCulloch
Head of Service

Item Number
NHS Tayside Board
26 October 2017

Winter Planning Arrangements

1. PURPOSE OF THE REPORT

The purpose of this report is to present to NHS Tayside Board the Winter Planning arrangements and Unscheduled Care Improvement plan. This plan describes the collaborative approach to planning for "winter" by NHS Tayside and the Health and Social Care Partnerships of Angus, Dundee and Perth & Kinross. The plan forms our local Unscheduled Care Action Plan, is aligned to our Five Year Transformation Plan and is underpinned by the Six Essential Actions for Unscheduled Care. This plan has been written taking full account of the winter planning guidance 'The National Unscheduled Care Programme: Preparing for winter 2017/18' (DL (2017) 19).

The aim of the Winter Plan 2017/18 is to assure NHS Tayside Board, the Scottish Government and the population of NHS Tayside that plans and systems are in place to support the early intervention and action at points of pressure and to minimise the potential disruption to services, people who use services and their carers. The winter period described as being between 1 November 2017 and 31 March 2018. This plan also is strengthened by our NHS Board contingency and resilience planning that is already in place.

Importantly this is an integrated plan and work has been ongoing to ensure partnerships and acute services are developing cohesive plans for winter and with key partners such as the Scottish Ambulance Service (SAS). Our winter plan this year focuses on resilience, festive period arrangements in addition to the temporary arrangements put in place alongside our more sustainable improvement plan for year round service delivery. A separate plan is in place for broader aspects of unscheduled care which is overseen by an Unscheduled Care Programme Board and appointed clinical leads.

The National Unscheduled Care Programme, uses the Six Essential Actions for Improving Unscheduled Care to inform its approach. The Six Essential Actions are:

- Clinically focused and empowered hospital management
- Hospital capacity and patient flow (emergency and elective) realignment
- Patient rather than bed management
- Medical and surgical processes arranged to improve patient flow through the unscheduled care pathway
- Seven day services appropriately targeted to reduce variation in weekend and out of hours working
- Ensuring patients are optimally cared for in their own homes or a homely setting.

2. RECOMMENDATIONS

The Board is asked to:

1. Approve and endorse the winter plan for submission to Scottish Government

2. Approve the festive arrangements
3. Note the improvement plans that underpins the winter plan
4. Note the resilience plans for winter preparedness in place

3. EXECUTIVE SUMMARY

The Winter Plan 2017/18 aims to support the best use of locally available resources as demand rises and /or capacity is limited in order to sustain safe, effective and person-centred care in line with our quality ambitions. It is recognised at both a local and national level that all year planning is required for unscheduled care. The Winter Plan is the escalation plan that enhances and supports the Board Local Unscheduled Care Improvement Plan. To further support the Winter Plan there is a system wide Escalation Plan and each Health & Social Care Partnership has their own detailed local plans. The escalation plans have agreed systems and process to respond to increased demand or capacity pressures with an escalation framework for health and social care with agreed actions and triggers.

In planning for Winter 2017/18 there is recognition of a number of key challenges and a focus on how these will be addressed:

- Elective Activity - NHS Tayside has reviewed elective activity over a three week period 18 December 2017 – 8 January 2018 to support the predicted rise in unscheduled care admissions circa 7% (650 patients) over December and ring fenced capacity for elective / expedited cancer pathway and urgent surgical cases
- The interim divert in place from 21 August for all unscheduled general surgery from Perth Royal Infirmary to Ninewells Hospital to support capacity & flow at Perth Royal Infirmary will remain in place
- Capacity within acute services – an agreed whole system response to the findings from the Day of Care audits and delayed discharge plans is being agreed to ensure availability of bed for unscheduled care underpinned by a robust escalation response if required
- Staffing - staffing rotas will be in place by November 2017 this will include the management and professional support over weekends and public holidays.
- Additional services will be put in place by key support services like Pharmacy, Radiology, Facilities and Transport
- Norovirus - the NHS Board has clear policies and procedures for the management of norovirus, including providing guidance to care homes to help keep patients in those homes should they acquire norovirus
- Flu immunisation - a robust programme of immunisation to address the flu virus has been established for both NHS Tayside staff and the public. Staff are being supported to access flu immunisation in order to protect patients, minimise staff's risk of exposure and reduce potential absence from work. The most vulnerable in the population i.e. children, people with underlying health conditions and the elderly have been invited to uptake immunisation in order to promote health and minimise the risk and impact that flu on these group
- Managing in severe weather - contingency plans are in place across all agencies should this situation arise, including access to suitable vehicles

The winter plan aims to minimise the potential disruption to services and improve outcomes for those who need to access services. This includes preventing delays in patients being discharged from hospital and preventing unnecessary admissions to hospital.

This paper provides an overview of the plan and associated improvement actions. The plan builds on learning from winter 2016/17 from what worked and what did not. This plan is built jointly partnership with all Health and Social Care Partnership and NHS Tayside

4. REPORT DETAIL

The plan is a whole system health and care response to ensure the needs of our population are met over the winter period through resilience and effective planning in particular for frail elderly and those who are acutely ill. Our plan aims to provide safe and effective care for people using services by ensuring effective levels of capacity and staffing are in place to meet unexpected activity levels in communities and across our acute sector.

This plan is underpinned by full business continuity arrangements and daily management of capacity and flow through our established leadership and safety and flow huddle infrastructure.

This Winter Plan will be supported by a suite of measures across the system which will enable informed decision-making implemented through our safety huddle framework which includes escalation processes. This will be supported by weekly look back to encourage system learning and continuous improvement.

5. CONTRIBUTION TO NHS TAYSIDE'S STRATEGIC AIMS

The plan is based on the 2020 Vision for Health and Social Care describes a health and social care system which is centred on:

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

This plan supports the NHS Tayside Local Delivery Plan, Five Year Transformation Plan and the Strategic Improvement Plans of the Health and Social Care Partnerships in Perth & Kinross, Dundee and Angus. Specific to this winter plan are the following standards:

- 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
- Zero delayed discharges over two weeks and working toward discharge from hospital within 72 hours of being ready for discharge.

6. MEASURES FOR IMPROVEMENT

See full report for detailed measurement plan

7. IMPACT ASSESSMENT & INFORMING, ENGAGING & CONSULTING

There is a dedicated communication and engagement process which supports this plan. Stakeholders have been engaged in the development of this plan and include all Chief Officers of the Health and Social Care Partnerships, General Managers and clinicians. A winter planning session was held on 22 August 2017 to support development of the plan document in partnership with clinicians and managers.

The session covered key issues such as

- Resilience
- Unscheduled / Elective care
- Health & Social Care Plans
- Seasonal Flu

- Respiratory Pathway
- Management information
- Out of Hours
- Governance
- Integration of Key Partners / Services

As in previous years, the Communications Team support the organisation's preparations for winter through the local and national winter campaigns.

NHS Tayside proactively links with the '*Be Healthwise This Winter'* campaign, tailoring the national key messages for the local situation and a local audience and releasing media releases and social media messages throughout the winter period.

The *Be Healthwise This Winter'* and Ready Scotland campaigns are featured on the NHS Tayside website using the digital assets provided by the national campaigns. We will also run a norovirus campaign with many messages featuring over the winter months.

Social media is the best channel for instant updates to information and will be used extensively, along with media releases, website updates, radio updates and sharing of messages with local partners for onward distribution.

The Corporate Communications Team updates the NHS Tayside website with weather and travel information as necessary and promotes Ready Scotland on the front page of its website.

The Communications Team will continue with regular press releases reminding people where to go seek appropriate support out of hours and over the holiday period. They will have a public communications strategy to raise awareness of access arrangements over the festive period, which includes an advertising campaign in local media with GP, pharmacy and MIIU opening hours. This is supported by regular social media and website posts to share information and signpost to available services.

The communications department has a proactive approach to ward closures to norovirus outbreaks and alerts all media outlets, updates social media and NHS Tayside website to every incident as soon as alert received from Infection Control Department. Clear key messages are deployed, including details of any visiting restrictions. NHS Tayside communications also actively promotes Norovirus publicity materials and national campaign assets and shares widely through social media channels, including Facebook and Twitter and local media.

NHS Tayside communications promotes our flu vaccination campaign to all NHS Tayside staff and volunteers, as well as members of the public in at-risk groups. Posters are produced for each area with details of local staff clinic sessions on NHS Tayside sites and key messages about protecting yourself and your family, your patients and the service. Information about public vaccination clinics in surgeries and pharmacies across Tayside are advertised in the local media and on social media. National campaign digital assets are also included on NHS Tayside's website and social media.

8. PATIENT EXPERIENCE

The plan takes a whole system health and social care response to support the best use of locally available resources as demand rises and/or capacity is limited in order to sustain safe, effective and person-centred care.

9. RESOURCE IMPLICATIONS

As in previous years, Scottish Government has committed additional resource to all territorial Boards in supporting dedicated, multidisciplinary teams to improve patient flow. NHS Tayside's share of this resource is £392k.

The Health and Social Care Partnership has invested in additional capacity in the Health, Social Care and third sector workforce through Change Fund, Integrated Care Fund and latterly the Delayed Discharge funding streams to support both the unnecessary admission to hospital and prevention of discharge delay.

10. RISK ASSESSMENT

There are four key areas within NHS Tayside strategic risk profile that this plan has the potential to impact upon, these are:

- Access to elective care service over the festive period
- 4 hours emergency access target
- Delayed Discharge target
- Capacity and Flow
- Financial Performance

11. LEGAL IMPLICATION

There are no known legal implications

12. INFORMATION TECHNOLOGY IMPLICATIONS

There are no known IT implications that are not already being addressed as part of NHS Tayside E-Health Plan

13. HEALTH & SAFETY IMPLICATIONS

There are no known Health and Safety Implications

14. HEALTHCARE ASSOCIATED INFECTION (HAI)

There are no healthcare associated infection implications

15. DELEGATION LEVEL

Chief Operating Officer
Chief Officers of Health & Social Care Partnership in Angus, Dundee and Perth & Kinross

16. TIMETABLE FOR IMPLEMENTATION

November 2017-March 2018

17. REPORT SIGN OFF

Lorna Wiggin Chief Operating Officer	Lesley McLay Chief Executive

Vicky Irons Chief Officer Angus Health & Social Care Partnership	David Lynch Chief Officer Dundee Health & Social Care Partnership	Rob Packham Chief Officer Perth & Kinross Health & Social Care Partnership

18. SUPPORTING DOCUMENTS

NHS Tayside Winter Plan
'The National Unscheduled Care Programme: Preparing for winter 2017/18' (DL (2017) 19)'.

360

Appendix 2

NHS Tayside

Winter Plan 2017/18

Contents

Introduction

NHS Tayside and health and its partner organisations have taken a collaborative approach for winter planning in 2017/18 through the Tayside Unscheduled Care Board.

The winter plan has been developed as part of our local Unscheduled Care Action Plan in line with our 5 year Transformation programme, is underpinned by the Six Essential Actions taking full account of the winter planning guidance 'The National Unscheduled Care Programme: Preparing for winter 2017/18' (**DL (2017) 19**).

The winter plan focuses on early prevention and intervention with actions agreed for points of pressure in order to minimise potential disruption to services and continue to provide safe and effective care of our population. Our plan is strengthened by resilience planning and business continuity arrangements to provide assurance and aims to provide assurance to NHS Tayside Board, Scottish Government and our population for winter period November 2017 – March 2018.

In response to the needs of our frail, elderly population and patients with chronic conditions affected by winter, a whole system health and social care approach to develop an integrated plan was essential. The Tayside and Fife health and social care partnerships and the Ambulance Service (SAS) have participated in workshops to develop the plan to ensure timely access to care in the right setting. Third sector involvement is through the health and social care partnerships.

The focus on improved resilience over the festive period taking account of learning from previous winters will see some alternative arrangements in place this year combined with sustainable improvement which will underpin year round sustainability.

A separate plan is in place for broader aspects of unscheduled care which is overseen by the Unscheduled Care Programme Board and the programme team and has clear clinical leadership.

This plan will be underpinned by full business continuity arrangements and daily management of safety, capacity and flow NHS Tayside established safety and flow framework with senior clinical and management leadership and multiprofessional input to safety and flow huddle infrastructure 7 days per week.

This Winter Plan will be supported by a suite of measures across the system and the use of Safe Care which will provide decision support for the Safety and Flow Framework and escalation processes (see appendix 1). This will be supported by weekly look back to encourage system learning and continuous improvement.

Specific to this winter plan are the following standards:

- 4 hours from arrival to admission, discharge or transfer for A&E treatment (95% with stretch 98%)
- Zero delayed discharges following 72 hours of being ready for discharge

Governance & monitoring Infrastructure for 2017/18

- An Unscheduled Care Board is established chaired by the Associate Medical Director for Medicine and Head of Service, Health and Community Care Dundee Health & Social Care Partnership and will use flow measures to assess the impact of the plan.
- An Unscheduled Care Programme Team is in place including a Programme Manager, and in addition an Improvement Advisor and data analyst for each major site. These posts form part of the support teams for unscheduled care, continuous improvement and the implementation and evaluation of the winter plan.
- Resilience and Business Continuity arrangements and management plans are in place and have been tested prior to winter.
- NHS Tayside's Board Assurance framework has a corporate whole system risk related to capacity and flow. A scoring system has been developed for the key measures to enable an overall risk score to be presented. This is presented and discussed at each Board meeting.
- Senior Leadership and operational meetings with membership across acute and health and social care services. Chief Officers, Heads of Health, Community care and General Managers and Associate Nurse Directors are members of whole system committees and working group.
- Chief Officers Group in place for Perth and Kinross with established attendance and contribution from General Manager and Associate Nurse Director for Perth Royal Infirmary for specific flow and capacity issues related to Perth Royal Infirmary
- A Tayside wide severe weather plan is in place including triggers for multi-agency coordination.
- Daily staffing levels for our acute hospitals are monitored through Safe Care system as part of our rostering system and daily safety and flow huddles.
- Supporting human resource policies are in place covering severe weather, adverse conditions and service disruption.
- Communications teams disseminate information with update website informing the public and staff on planning for winter, where to go for services and public health messages

Winter planning

NHS Boards and Health and Social Care Partnerships have a responsibility to undertake effective Winter Planning to ensure that the health and social care needs of the population continue to be met in a timely and effective manner regardless of any increases in demand or additional challenges associated with the winter period.

There is clear focus on community services through enhanced community support to prevent admission where possible due to the continuing pressures on inpatient beds and challenged with workforce deficits. The available workforce has a direct bearing on NHS Tayside ability to create additional beds in times of increased pressure. These are known as "surge beds". As a result, delivery of the actions within the plan must be achieved.

The Scottish Government asks Health Boards to ensure they have plans for the following:

- Resilience (plans to keep services going when there are unexpected or major pressures, including adverse weather)
- Communications to staff and public regarding plans and know who to turn to
- Unscheduled and Elective Planning (plans to provide correct staffing levels, facilities and beds to care for both emergency patients and patients who are attending for planned operations).
- Out of Hours Services planning
- Norovirus outbreak plans

- Seasonal Flu plan
- Robust Respiratory Pathway to manage increased respiratory admissions over winter

A full evaluation of the winter plan delivery for 2015/16 compared to the Scottish Government self-assessment framework was undertaken and has informed the preparation of this winter plan.

Managing winter pressures

This will ensure that leadership, and information intelligence is available to help inform decision making and infrastructure that allows responsive management of capacity.

- Triumvirate site management is in place with Associate Site Director, Associate Nurse Director and Associate Medical Director identified for the Perth Royal Infirmary and Ninewells Hospital sites.
- Health and Social Care Partnerships are established with integrated management teams, weekly capacity and discharge meetings in place. These weekly meetings highlight and respond to challenges in delayed discharges.
- A daily huddle framework is in place with attendance from senior clinical staff and support services chaired by a senior leader. Huddles take place at 08.00, 13.30, 16.30 and 21.30 daily on weekdays to identify and respond to safety concerns and system pressures. Health and Social Care Partnership employees are participating in daily huddles. A cross site huddle in partnership with Scottish Ambulance Service is in place daily on weekdays.
- Safety Huddles, focus on proactive discharge planning including, pre noon discharges/ weekend discharges.
- Divert protocol developed for Perth Royal Infirmary and Ninewells Hospital
- Standard operating procedures and action cards in place – update and revised with escalation process. Embedded as part of the Hospital safely and flow huddle.
- *System Watch*[1] predictors are utilised to anticipate the level of emergency admission. Utilising the improved communication and leadership of the Safety Huddles*, has ensured* a focus on proactive discharge planning including, pre noon discharges, weekend discharges, utilisation of discharge lounge and criteria led discharge.
- 98% performance against the four hour standard is a top priority for NHS Tayside linked to patient safety outcomes. Where there are waits out with the four hour standard these are reviewed, lessons learned and disseminated. There is regular daily and weekly review of performance.
- A day of care audit completed in Perth Royal Infirmary & Perth & Kinross Community Hospitals September 2017 to inform changes.
- Reorganisation of acute hospital management arrangements ensures a site-specific approach and senior management presence from 8.00 to 20.00 hours, including the weekend daytime hours and with 24 hour on-call support.
- A review of support services such as portering, cleaning, pharmacy and transport will be undertaken to ensure capacity is aligned to demand, not just within hours, but also across 7 days and out of hours periods

Staffing

- Daily staffing levels are monitored through Safe Care system as part of our rostering system and daily safety & flow huddles supporting placement of staff in areas of staffing pressure and high patient acuity

[1] www.isdscotland.org/Products-and-Services/**System**-**Watch**

- SafeCare is a system which indicates if a clinical area has a safe level of staffing at the time that the data regarding patient acuity (the Shelford Scale) is entered into the HealthRoster programme
- There will be proactive recruitment of newly qualified nursing professionals in October and November to fill any current vacancies as part of ongoing recruitment campaigns.
- GP Out-of-Hours service is working to 80% GP shifts for festive period filled by October 2017.

Delivering Scheduled care

It is important that NHS Boards ensure that their focus is on unplanned admissions which can be higher in winter periods. However to ensure a whole system approach NHS Tayside has reviewed how planned care will be delivered to ensure they can both be delivered safely together at times of pressure

- NHS Tayside as part of its festive arrangements will support additional capacity for unscheduled care through a clinically prioritised approach to elective capacity from 18 December 2017 to 8 January 2018, along with expedited cancer pathway and urgent surgical cases
- An interim divert is in place effective from 21 August for all unscheduled general surgery in Perth Royal Infirmary to Ninewells Hospital to support unscheduled medicine capacity and flow at Perth Royal Infirmary
- We will continue to optimise the use of theatre capacity across all of our theatre estate but especially at Stracathro hospital where there is ring fenced elective surgery capacity
- 7 day AHP support across our orthopaedics wards at Perth Royal Infirmary and Ninewells Hospital supporting pathways of care and early discharge
- Optimisation of Theatre Admission Suite (TAS) for Surgery and Orthopaedic patients to reduce overcrowding on wards on day of admission and / or admitting day before surgery for non clinical reason.
- Cancer/Urgent Patient flow during festive period with multidisciplinary team meetings during festive period. Within Colorectal service a generic email has been set up for specialist nurses to manage any urgent queries/patients. Festive period leave planned to ensure Cancer Tracking Team, Specialist Nurses and Consultants are available to support a no delays in patient journey
- Transport arrangements to be discussed with patients at pre admission, e.g. Pre Assessment clinics/Out-Patients to ensure all journeys meet the criteria for Scottish Ambulance Service transport services.
- Ambulance workshops planned for November to inform / update and train staff regarding ambulance booking and criteria and other available transport options
- Planned Endoscopy list reduced for planned appointments to an increase in capacity for inpatient and urgent care over festive period

Delivering Unscheduled care

Surge capacity will be challenging to create due to nurse staffing availability. The focus has to be on how we use our available footprint and reduce delays to in-patient journeys by working in partnership with health and social care and a number of measures that maintain effective discharges and appropriate admission avoidance and the care of frail older people and those with chronic conditions who are at risk of hospital admission through optimum anticipatory care over the festive period. This will require close collaboration between all

teams that contribute to effective discharge and admission over this period and a shared understanding of each other's local plans.

Avoidance of Admission

- An Acute Frailty Team in Acute Medicine Unit at Ninewells Hospital and at front door at Perth Royal Infirmary. The Acute Frailty Team consist of pharmacy, Medicine for the Elderly consultant, Occupational therapy and Physiotherapy staff. The Acute Frailty Team will in-reach 1630-2030 and review all patients over age 75 to ensure continuity for patients in Acute Medicine Unit /Short Stay Medicine for 48 hours. It supports a reduction in emergency bed days use by over 75 year old people supporting improved pathways of care and preventing unnecessary admission or prolonged stays in hospital
- The Clinical Investigation Unit in Medicine will have increased capacity for semi planned admission by identifying elective pathways for certain conditions what will avoid unscheduled admission via the Acute Medical Unit e.g. DVT, liver disease, anaemia and heart failure this supports reduction in boarding in Medicine in particular ward 4 compared to previous winter and an overall reduction in emergency bed days used in Medicine.
- Dundee Enhanced Community Support rapid Assessment (DECSA) will put in place a specialist advanced nurse practitioner to ensure coordination & continuity of care working with local GPs and community nursing to deliver timely and proactive multidisciplinary response to the identification of need by promoting care planning that puts older people in control
- Enhanced Community Support is in place in all other localities supporting the achievement of personal outcomes, promoting independence, wellbeing and resilience and supporting a flexible, person-centred approach to individualised pathways.
- A professional to professional GP advice line to the Acute Medical Unit Ninewells is available Monday to Friday which supports preventing avoidable admissions and enhanced primary and secondary care communication and relationships.
- Extended Ambulatory Assessment in the Acute Medical Unit in Ninewells Hospital up to 20.00hrs weekdays and opening on a Sunday 1200- 1700 supporting reduction in avoidable admissions at weekend
- Ambulatory Care Models Being Assessed In PERTH ROYAL INFIRMARY

Maintaining effective discharges

- Discharge lounge Perth Royal Infirmary and Ninewells Hospital will support increased pre noon discharges from 31% to 40% as well as safe and effective discharge planning increased patient experience and effective working with Scottish Ambulance Service.
- Weekend discharge coordinator in place to support Ninewells Hospital and Perth Royal Infirmary – working as joint discharge hub with social care facilitating safe discharge / transfer from hospital at weekend liaison and negotiation with patients, their relatives / carers, and multi-disciplinary / multi-agency teams to identify and arrange the most appropriate support or discharge destination for each individual once they are medically, socially and functionally fit for discharge or transfer from hospital.
- Discharge hubs in Perth Royal Infirmary and Ninewells Hospital to work together to support Perth & Kinross patient's repatriation/ early supported discharge Dundee and Angus have an integrated and dedicated hospital discharge hub; jointly with social work. The Hub Group (Dundee/Angus Discharge Task and Finish Group) hold Priority Huddles weekly.
- Daily Dynamic Discharge in orthopaedic in Ninewells and commenced in surgery. Full out programme underway with Daily Dynamic Discharge champion to support roll out in medicine. This work supports a reduction in average length of stay, increase in number

of discharges and improvement in performance against emergency access target. Supports Increase in number of discharges pre-noon and less discharges late in the evening

- Work closely with Scottish Ambulance Service as a key partner at our daily huddles to manage capacity and determine changes to Scottish Ambulance Service that support more evening and weekend discharges.
- Twice daily review by a consultant in acute assessment areas ensures active care management Cardiology, Medicine for the Elderly, Respiratory and Gastroenterology teams to do both morning and evening in-reach into Acute Medical Unit morning in-reach with daily decision-making reviews and multi-disciplinary rounds focusing on facilitating discharge when patients are deemed medically and therapeutically fit
- Weekly delayed discharge review meetings Perth & Kinross, Dundee and Angus with hospital management and Health & Social Care managers.
- Weekly meeting between Medicine for the Elderly Consultants and Psychiatry of Old Age to discuss delays in discharge and capacity across the two services in Perth Royal Infirmary.
- Daily multidisciplinary Board rounds in place with further multidisciplinary team meetings planned throughout the week to agree Planned Date of Discharges.

Anticipatory Care

- Medicine for the Elderly consultants in place to support management of frail elderly patients working between acute and primary care setting /community hospitals
- Early Frailty Identification algorithm to identify COPD patients in the community who are frail and at risk of admission to hospital. This supports managing patients within their own home and prevents unnecessary admissions to hospital and providing access to a rapid response team to reduce admission to acute care.
- Focus of developing an Anticipatory Care Plan for dementia with a specific focus on Care Homes and the Advanced Dementia Practice Model ensuring Prognostic Palliative Score are recorded on e-KIS (electronic key information summary for GP's) and the paper Anticipatory Care Plan for all care home residents with a diagnosis of dementia.
- Improving outcomes of patient's with decompensating liver disease by recruiting a Specialist Hepatology Nursing Team to work with the medical and nursing staff within ward 2 Ninewells Hospital managing patients within their own home and prevent unnecessary admissions to hospital. Reducing the level of unscheduled care and reducing hospital length of stay by increasing access to short stay wards for assessment and treatment rather than the acute ward.
- Strata tool in place to link patient information systems between the community and acute services to enable community care teams to identify patient needs and anticipate future care needs

Supporting capacity and flow

- Electronic Whiteboards implemented in all acute wards and in many Community Hospital settings that support improved communication and information sharing
- Review of Pharmacy support for oncology to ensure no delays on care over the festive and winter period
- Additional Physiotherapy and Occupational therapy in the Acute Medical Unit to support extended working hours 0800- 2000 Monday to Friday and 0830 – 1630 Saturday / Sunday in Ninewells and in Perth Royal Infirmary
- Additional AHP input into Arbroath Infirmary covering seven days

- Readmissions analysis underway to understand why patient are readmitted following hospital care. This will help us better understand target some patient population to explore improvements in care pathways
- Advanced Nurse Practitioner support across the surgical floor in Ninewells, coordinating junior doctor activities for unscheduled surgical admissions.

Care in a community setting

- Health and Social Care Partnerships have developed plans to address expected levels of demand over the winter period including additional care at home staff, additional commissioned hours, temporary care home capacity and tests of change for home care in reach and service retention
- Proactively reduce non-complex (excluding Code 9) patient delays by co-ordinating available health and social care capacity
- Full review and utilisation of capacity in community hospital and step down/up beds and Intermediate care models including residential and Nursing Home Care support care in a community setting
- There has been a strong focus on Anticipatory Care Planning and identification of 'at risk' individuals through [2]SPARRA and other mechanisms are shared and proactively managed though social work-GP liaison arrangements and e-KIS. There is now a more concentrated Anticipatory Care Planning work focussed on dementia and deteriorating frail person for 2017/18
- Promote Power of Attorney through local campaigns as a means of increasing number of applications, so that adults are not waiting in hospital settings for decisions on their care upon discharge
- Additional hours to the Mental Health Outreach Service in Dundee to respond to requests for Guardianship reports.

Specifically each of the partnership has programmes of activities that further support their communities as follows:

Angus

- The 'Help to Live at Home' programme in Angus continues to develop our home care local market for private and thrid party providers of care with the aim to increase efficiency and capacity of home care provision.
- In partnership with the third sector and Social Enterprise Care in Angus work in partnership with the aim to provide increased befriending, volunteer driving and home support Home Care market in Angus incentivising private providers in harder to reach areas.
- Promote Power of Attorney through local campaigns as a means of increasing number of applications, so that adults are not waiting in hospital settings for decisions on their care upon discharge.
- Mental Health Officer recruited to address guardianship delays.
- Review In-Patient Care provision in Community Hospitals.
- Review Residential and Nursing Care Home provision.

[2] www.isdscotland.org/Health-Topics/Health-and-Social.../**SPARRA**/

Dundee

- The Resource Matching Unit is now established and along with the increase resource provision has increased capacity and efficiency of the care at home service.
- There has been the implementation of a Discharge Management Learning Framework and Learning Networks as a means of promoting and enabling consistency in practice and ensuring effective person centred communication during transition between hospital and home
- Develop an 'early indicator of deteriorating health and well-being tool', for use by front line social care staff in to reduce the instances of hospital admissions, increase the use of preventative interventions, and assist people to look after their health and well-being
- Support more people to be assessed at home or a homely setting rather than in hospital by completing and evaluating the 'Moving Assessment into the Community' project for older people in Dundee.
- In Dundee we have put in place an Integrated AHP model for enablement and rehabilitation in Dundee community; collocated enablement, social work and health OT and community physiotherapy providing single point of access to improve access, reduce duplication, share skills and support more elderly people at home
- Dundee Smart Flat and Step Down Housing Service in place to support care at home
- Social Work Occupational Therapy Service and Equipment with a single shared pathway across Health for accessing equipment and adaptations

Perth & Kinross

- Home care protocol/policy in place
- Additional home care Integrated Intermediate Care Model packages and ability to increase capacity through the use of intermediate care beds
- Joint Perth & Kinross health improvement plans in place to support more placement locally
- Review of the community provision for patients requiring Psychiatry of Old Age to enhance the available community support and support care home provides to care for residents in house rather than seeking admission
- The Discharge Hub in PRI and local community hubs will continue to support care in the community to provide care at home and also to support timely discharge. The hub is already supporting prevention of delays in hospital
- The new Home care contracts are in place and will be consolidated to support increased supply.
- Implementation of the Older Peopled Service Improvement Plan this winter with discharge to assess models planned from January 2018
- Acute frailty and acute medicine receiving pathway development and tested

Preparing for winter

This section focuses on our preparation and plans for resilience and business continuity in the event of any outbreak or norovirus or influenza or respiratory infections. The section details our plans for communication and services that are provide to support the public over the winter period (OOH) to know who to turn or and where and how to access services when GP services are closed.

Resilience

- Escalation contact details updated for Dundee, Perth and Kinross and Angus
- Resilience micro web site in place to promote to staff and include as one stop for huddle information "how staff can staff section"

- Escalation / divert document published on micro site for staff
- Rota for duty cover for festive period will also be placed on the micro site
- Escalation and trigger framework (OPEL framework) published and tested with all Heath and social care and SAS partners prior to 31 October. Action cards to be updated and published on micro site that support escalation plans.
- Multi-agency pandemic flu scenario testing completed
- Permanent 24hrs-a-day teleconferencing facility to allow staff to set up an unplanned teleconference call at any time of the day or night
- 4x4 adverse winter weather protocol in place

Effective communication

NHS Tayside will ensure there are robust communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent.

- NHS Tayside website provides all festive provision information for staff. We use the Met Office National Severe Weather Warning System to provide information on the localised impact of severe weather events. Action cards in place
- NHS Tayside proactively links with the 'Be Healthwise This Winter' campaign, tailoring the national key messages for the local situation and a local audience and releasing media releases and social media messages throughout the winter period. The 'Be Healthwise This Winter' and 'Ready Scotland' campaigns are featured on the NHST website using the digital assets provided by the national campaigns. We will also run a norovirus campaign with many messages featuring over the winter months. The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies
- Local 'Know who to turn to' campaigns, supported by local redirection policies in A&E to educate patients about the most appropriate professional to meet their needs. A&E / MIU joined up messages
- A directory of services and alternatives to admissions is published on the NHS Tayside website covering primary and community services and also third and independent sector social care provision.
- Social Media used to provide instant updates to information and will be used extensively, along with media releases, website updates, radio updates and sharing of messages with local partners for onward distribution with Plan Proactive Facebook / Twitter campaign
- Communication to all care homes with key messages regarding OOH support, festive closures etc
- The Corporate Communications Team updates the NHS Tayside website with weather and travel information as necessary and promotes Ready Scotland on the front page of its website
- Public communications strategy to raise awareness of access arrangements over the festive period and includes advertising campaign in local media with GP, pharmacy and Minor Injury Unit opening hours. Supported by regular social media and website posts to share information and signpost to available services. Cascade through locality groups and web resources e.g. community watch
- The Communications Department has a proactive approach to ward closures to norovirus outbreaks and alerts all media outlets, updates social media and NHS Tayside website to every incident as soon as alert received from Infection Control Department. Clear key messages are deployed including details of any visiting restrictions.

- The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the 'Stay at Home Campaign' message.
- Ready reckoner regarding key contact & and service levels are available for all staff to - these will be further developed and shared across the health and care system in 2016/17
- Messages to staff re professional responsibility regarding flu/norovirus and winter vomiting
- Renal staff will manage communication to patients and GP regarding dialysis in conjunction with SAS over the festive period.
- Discharge coordination through joint working Dundee & P&K discharge hubs to maximise patient flow. Messages to all staff re locality discharge pathways published onto resilience micro site including Fife discharge pathway
- Communications - Protocol for Issuing Information to Patients, Public, Staff and Visitors During Service Disruption/Cancellation
- Communications - Pandemic Influenza Preparedness and Response Communications and Engagement Plan

Out-of-Hours Preparedness

- From November – March out-of-hours will have additional Medicine for the Elderly expertise supporting GP decision making via Medicine for the elderly on call team to work with GP and Specialist Nurse.
- Paediatric trained GPs will work specific sessions to see sick children and monitor at out-of-hours centre rather than referring to the Paediatric Assessment Unit where appropriate.
- NEWS (National Early Warning Score) pathways are in place following to ensure rapid identification of deteriorating patient
- An Advanced Paramedic Practitioner will be based in the Kings Cross Primary Care Emergency Centre to consult patients
- GP triage – it is intended that addition GP triage shifts will cover the busy public holiday periods with a view to increasing the time disposition and appointing patients the following morning rather than within a four hour period, or dealing with problems over the telephone where appropriate.
- Community pharmacies can deal with minor illnesses with direct referral to out-of-hours where required
- Access to Mental Health out-of-hours Crisis Team to triage patients
- NHS24 prediction data is not available until late October but where this and out-of-hours service data differ, capacity will be planned around the greater of the two.
- Resource Availability over eight day festive public holiday period confirmed for all Primary Care Emergency Centres - Arbroath Infirmary, Kings Cross Health and Community Care Centre, Perth Royal Infirmary including GP shifts, drivers, nursing staff etc
- Annual leave applications from 22 December 2017 to 5 January 2018 will be considered on an individual basis but are unlikely to be compatible with maintaining full staff availability. Duty manager in place over the festive period
- The management team monitor activity weekly and decide on any extra capacity required.
- 10 cars will be available for use over the two festive holiday weekends to assist with the expected level of demand of home visits at peak times. (Three more than base level)
- Increase GP Triage to two GPs on 27 / 28 December 2017 and 2 / 3 January 2018

- All Practices are contacted pre festive period requesting that they keep patient special notes up to date
- Demand Management - Resources will be targeted around priorities across Tayside by the Team Leaders and dispatchers. Patients will be offered transportation to other Primary Care Emergency Centres if no alternatives can be identified
- Out-of-hours service staff will email during December a briefing newsletter to all staff outlining the arrangements for the festive period and winter period January to March including extra staffing and escalation plans and communication arrangements with NHS24 and other agencies both internal and external
- Tayside out-of-hours and NHS24 communicate regularly. Agreement around escalation process and local contingency arrangements for local centres. Agreement reached around the sharing of information between NHS 24 and out-of-hours.
- Out-of-hours escalation process is under discussion with NHS24
- Contact arrangements are in place for a clear for reporting vehicle faults and breakdowns over the Public Holiday period and emergency out-of-hours contact list is available to the management team in case of severe weather.
- An enhanced payment for GPs is offered across the festive period to support shift coverage
- A process has been developed to ensure effective and efficient use of the Scottish Ambulance Service paramedic service.
- The evening and overnight district nursing services in both Dundee and Perth are co-located with the out-of-hours service. Both formal and informal communication is improved with case discussions and working together on complex cases
- Regular meetings in place with Emergency Department to liaise with A+E Consultants regarding services and any issues which arise.
- A list of community pharmacists that will be open over the festive period in addition to rota will be published. Contractor lists are available on intranet. Additional supplies of drugs will be ordered for the festive period.
- Links are in place with Social Work departments across Tayside to identify what/when/where services will be available over the festive and winter period through the Tayside capacity planning structure
- Nursing Homes can contact the out-of-hours service using the 'Fast Track' number to whereby the nurse is providing a triage rather than a non clinical NHS24 triage to determine urgency. Designated GPs are available to call the nursing homes back regarding specific cases

Preparing for and Implementing Norovirus Outbreak Control Measures

NHS Tayside has a comprehensive plan in the event of any outbreak which is robust and tested

- Infection Prevention and Control Teams will be required to confirm they have read the revised guidance Health Protection Scotland Norovirus Outbreak Guidance. The Health Protection Team will update local guidance / resources and circulate alongside nationally-produced materials advising care homes on timely preparation, identification and management of norovirus cases and outbreaks due to be refreshed in September 2017. Health Protection Scotland usually update norovirus guidance in the autumn of each year.
- Specific communication will be in place with regards to outbreak in the community setting such as care home and residential homes with regards to reopening and closures. This will also be communicated at the daily capacity and flow huddles
- Update advice/standards to care homes/residential care setting re receiving patients post outbreak /infection
- Infection Prevention and Control Teams will be supported in the execution of a Norovirus Preparedness Plan before the season

starts. NHS Tayside Health Protection Team routinely works and communicates closely with Infection Prevention and Control Teams through established phone and email pathways, providing confidence that relevant information will promptly be shared. Risk assess each case and liaise wards

- Health Protection Scotland Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff; with all up to date national and local guidance is accessed via the Norovirus Section on the Infection Control site of Staffnet.
- Organisational awareness raised by Norovirus Vital Signs which will be issued October 2017.
- Daily hospital huddles held at Ninewells Hospital and Perth Royal Infirmary where Infection Prevention and Control Teams will be in attendance/ update daily
- Communication includes engagement via the NHS Tayside Communications Team to alert and inform relevant stakeholders e.g. patients, visitors, staff, public via local media, pop up banners, etc.
- There is direct communication with Dundee University Medical School to minimise any impact on teaching
- Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks. This is included within standard procedures.
- On receipt of national norovirus situation, information received weekly from Health Protection Scotland is distributed by Infection Control General Manager to Executive and Director generic distribution list.
- Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the Infection Prevention and Control Teams the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge. This is incorporated into ongoing communication/education throughout the year. Clinical areas referred to are included.
- Microbiologist on call 24/7. To provide adequate Infection Prevention and Control Teams cover across the whole of the festive holiday period and Infection Control Nurses rostered either onsite/on call over festive period. Microbiology offers enhanced weekend service for respiratory and norovirus testing in peak virus season
- Infection Control Team alerted to issues via hospital wide daily safety huddles where relevant to respond to rapidly changing norovirus situations, e.g. the closure of multiple wards over a couple of days.
- There is a direct line of communication and collaborative working between Infection Control & Support Services re forward planning/resource allocation of Domestic Services, Laundering Services including curtain changing staff to support additional cleaning and readiness for ward/bay re opening
- A generic Infection Control email is available to support current communication channels to optimise resources and response to the rapidly changing norovirus situation.
- Publicity materials to spread key messages around norovirus and support the ‘Stay at Home Campaign’ message will be widely distributed throughout NHST ayside.

Seasonal Flu, Staff Protection and Outbreak Resourcing

NHS staff

There is substantial evidence available which recommends staff vaccination against flu:

1. By being vaccinated, staff are less likely to transmit infection, even if asymptomatic, and can therefore reduce morbidity and/ or mortality in vulnerable patients.
2. As well as an investment in staff and patient health and wellbeing health care workers can act as positive role models for patients aged 65 and over, those with long-term health conditions and pregnant women to take up the offer too.
3. The vaccine is safe and there are sufficient supplies to vaccinate the workforce.

It is important that staff are vaccinated against seasonal flu, particularly front-line staff and those working in areas where patients might be at greater risk (paediatric, oncology, maternity, care of elderly, haematology, critical care facilities). The aim is to vaccinate 50% of front line staff as poor influenza vaccine uptake by staff and patients does lead to additional requirements for antiviral prophylaxis if outbreaks occur in wards.

Achieving uptake targets remains a challenge, including among clinical staff. Planning for programme delivery in 2016/17 will revisit options for seeking to increase uptake especially in these staff groups. We will ensure the following actions are taken:

- All of our staff has easy and convenient access to the seasonal flu vaccine. In line with recommendations in Chief Medical Officer (CMO) Letter (2014)12 clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations however we will coordinate a vaccination programme with partners including a peer vaccination programme
- As in previous years, peer vaccinators will work across multiple shift times in areas with high risk patients. Occupational Health services additionally offer drop-in appointments at major healthcare sites, and community pharmacies are funded to vaccinate any NHS Tayside employee.
- Guidance is available from OHSAS and leaflet to staff when not to stay off work
- Medical staff awareness of prophylactic antiviral treatment will be enhanced and a survey re campaign effectiveness to community / care
- Staff education to ensure appropriate personal protective equipment is worn when dealing with suspected cases of transmissible infection and that there are sufficient supplies of type IIR masks in areas. Proactive refresher session to manage outbreaks in demo rooms.

Outbreak management

The winter plan takes into account the predicted surge of flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period.

- The Health Protection Team will implement its established incident or major incident management plans and procedures as and when warranted – co-ordinated with Board-level resilience responses.
- Robust communication pathways between Infection Prevention and Control Teams and Health Protection Team are well-established, including direct phone/page numbers, continuously staffed admin/call-handling provisions, generic team email addresses, and out-of-hours arrangements.
- Access ICT equipment planned proactive engagement with clinical areas e.g. flu repellent mask / respirator / face fit test high risk areas
- Influenza H1N1/Pandemic Flu Hospital Response Plan - Emergency Clinical Management Action Cards in place
- Influenza H1N1/Pandemic Flu Hospital Response Plan & Local Resilience Partnership Pandemic Flu Response Plan in place
- Early Autumn marketing Flu campaign to >65 and condition specific including Severity of Flu messages

- Appointment of Vaccination Programme Manager and established co-ordination group
- Processes are in place for circulation of guidance from Chief Medical Officer and other relevant sources on use of antivirals to clinical professionals.
- Close liaison between Public Health Consultants in Health Protection and Pharmacy, and with Ninewells Pharmacy, will ensure timely supply of antivirals and/or vaccine for targeted administration as required.
- The Health Protection Team receives the regular flu activity updates from Health Protection Scotland, and these are monitored by a designated Consultant and Nurse specialists. The team is well-practised at using established communication pathways, both ad-hoc (e.g. email distribution lists) and routine (e.g. newsletters), to promptly forward and provide summaries of key updates and advice to clinical colleagues.

Respiratory Pathway

Respiratory conditions are recognised as a significant factor in additional winter pressures and were a particular feature of 2015/16. A specialist respiratory service is in place and will be augmented with the following:

- NHS Tayside will put in place COPD exacerbation follow up in Dundee / Angus and Perth & Kinross to support patents to stay in their own home.
- Ceiling of care pathway for COPD in test such as e.g. baseline oxygen saturation that supports proactive patient management.
- Trial with Scottish Ambulance Service paramedics to have referral rights refer to community out-of-hours teams (Tayside).
- Put in place rescue packs early steroids / antibiotics for known brittle COPD patients.
- Local guidance and information is in place to promote self-management and supported self-management and will be communicated as part of communication plan.
- The respiratory pathway links with Anticipatory Care Plans and telehealth.
- Promote range of respiratory guidelines and public information leaflets.

Festive Period Planning

The festive period planning covers the period where normal working will be affected by the public holidays over the Christmas and New Year period. For this year, this will cover a three week period – 18th December 2017 to 7th January 2018.

During this period, the aim will be to ensure that appropriate health services are available to meet the changed pattern of demand and to ensure that people have appropriate access to all services in a timely fashion. In particular, services are planned to address the expected winter surges in unscheduled activity particularly following the public holidays. The aim of the Winter Plan is also to mitigate the impact on services in January as a result of lost capacity during the festive period. This will require aligned levels of staffing across the sectors to ensure effective discharge and appropriate admissions.

Evidence from previous festive periods also demonstrates that a large number of planned operating theatre lists are stepped down for the following reasons; Surgeon, Anaesthetist and wider staff group planned leave; increase unscheduled care demand and fewer patients wishing to have surgical intervention at this time. In view of this the General Manager, Associate Medical Director and Clinical Lead for theatres reviewed the theatre schedule and provided a plan from 18 December 2017 to 8 January 2018 for Ninewells, Perth Royal Infirmary and Stracathro that supports a realignment of capacity and staffing to ensure that appropriate health services are available to meet the changed pattern of demand.

A review of the previous year's seasonal downturn shows a natural reduction of approximately 30% of theatre sessions. Over the three week period it is proposed to provide

sufficient theatre sessions to accommodate all emergency, trauma, clinically urgent, clinically prioritised routine elective and cancer surgery. It is anticipated that this planned approach will support the expected surges in unscheduled activity.

A revised theatre schedule has been prepared and agreed, following discussion with Clinical Leads. This outlines the theatre sessions which will continue to run each day over this period. The table below provides a summary of this schedule for both Ninewells and Perth sites.

Ninewells	**Sessions Planned to Run**	**Perth**	**Sessions Planned to Run**
Week commencing 18th December	84	Week commencing 18th December	23
Week commencing 25th December	45	Week commencing 25th December	12
Week commencing 1st January	45	Week commencing 1st January	12

As described above there will still be sufficient theatre sessions to accommodate emergency, trauma, clinically urgent, clinically prioritised routine elective and cancer surgery. The table below provides an estimate of the volume of this activity over the 3 week period.

	APPROXIMATE ACTIVITY WHICH WILL CONTINUE TO BE DELIVERED							
	Emergency / Urgent			**Cancers (New Patients only)**	**Elective Routine - Clinically Prioritised**			
Specialty / Site	**Nwells**	**PRI**	**Total**	**Total**	**Nwells**	**PRI**	**SXH**	**Total**
Ophthalmology	4	0	**4**	**0**	83	0	0	**83**
Orthopaedics	100	24	**124**	**0**	38	38	0	**76**
Plastic Surgery (inc Breast)	50	0	**50**	**22**	26	0	0	**26**
General Surgery	63	20	**83**	**13**	24	29	0	**53**
Urology	8	0	**8**	**7**	25	49	0	**74**
Gynaecology	9	0	**9**	**2**	15	0	0	**15**
ENT	2	0	**2**	**2**	31	0	0	**31**
OMFS	4	0	**4**	**0**	7	0	0	**7**
Neurosurgery	6	0	**6**	**0**	10	0	0	**10**
Obstetrics	77	0	**77**	**0**	20	0	0	**20**
Vascular Surgery	19	0	**19**	**0**	7	0	0	**7**

Oral Surgery	1	0	**1**	**0**	5	0	0	**5**
Total	**341**	**45**	**386**	**46**	**291**	**116**	**0**	**407**

The emergency / urgent activity is based on activity that was undertaken in the previous year and will be subject to some variation as will the clinically prioritised cases.

The benefits of taking a planned approach over the festive period are as follows:

- Access to timely care for those patients who require an unscheduled admission
- Staffing deployed across services to support changed patterns of admissions
- Co-ordination of staff leave will support maximising of theatre capacity form 8 January 2018
- Detailed work is being undertaken to confirm the reduction in Clinical Supplies spend and supplementary spend

The risks associated with this proposal are:

- Potential impact on personal TTG guarantees as outlined below:

TTG Position 2017/18										
	Jun	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
June Trajectory included in LDP	1668	2010	2421	2785	3176	3473	3834	4195	4571	4890
Actual Patients > 12 weeks	1668	1630	1780	1787						
Current Revised Forecast				1787	1822	2005	2603	3164	3581	3935

Measures

1. Business continuity plans tested with partners.
Outcome: • The board has fully tested business continuity management arrangements / plans in place to manage and mitigate against key disruptive risks including the impact of severe weather.
Local indicator(s): • progress against any actions from the testing of business continuity plans.

2. Escalation plans tested with partners.
Outcome: • Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.
Local indicator(s): • attendance profile by day of week and time of day managed against available capacity • locally identified indicators of pressure (i.e.) % occupancy of ED, utilisation of trolley/cubicle, % of patients waiting for admission over 2, 4 hours • all indicators should be locally agreed and monitored.

3. Safe & effective admission / discharge continues in the lead-up to and over the festive period and also in to January.
Outcomes: • Emergency and elective patients are safely and effectively admitted and discharged over the Christmas - New Year holiday period. • The numbers of patients receiving elective treatment reduces and the risk of boarding medical patients in surgical wards is minimised. • Patients do not have unnecessary stays in hospital; hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January.
Local indicator(s): • daily and cumulative balance of admissions / discharges over the festive period • levels of boarding medical patients in surgical wards • delayed discharge • community hospital bed occupancy • number of Social Work assessments including variances from planned levels.

4. Strategies for additional surge capacity across Health & Social Care Services
Outcome: • The risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised. The staffing plans for additional surge capacity across health and social care services is agreed in October. The planned dates for the introduction of additional acute, community and social work capacity are agreed and that capacity is operational before the expected surge period. It is essential that additional capacity is developed alongside appropriate arrangements to create a safe and person centred environment.
Local indicator(s): • planned additional capacity and planned dates of introduction • planned number of additional staffed medical beds for winter by site and the planned date of introduction of these beds; • planned number of additional intermediate beds in the community and the planned date of introduction of these beds; • levels of boarding. • planned number of extra care packages • planned number of extra home night sitting services • planned number of extra next day GP and hospital appointments

5. Whole system activity plans for winter: post-festive surge / respiratory pathway.
Outcome: • The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. Hospital models will include flows between front doors, receiving units, and downstream wards.

Local indicator(s):

- daily number of cancelled elective procedures;
- daily number of elective and emergency admissions and discharges;
- number of respiratory admissions and variation from plan.

6. Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

Outcome:

- NHS Boards have, and use, a range of analysis to effectively plan for and monitor winter capacity, activity, pressures and performance at board and site levels.

Local indicator(s) :

- Agreed and resourced analytical plans for winter analysis.

7. Workforce capacity plans & rotas for winter / festive period agreed by October.

Outcomes:

- Rotas and workforce capacity plans for all disciplines are agreed for the winter (and particularly the 4 day festive holiday) period by October to underpin safe and effective admission and discharge of emergency and elective patients. This should encompass all relevant health and social care services.
- Maintain discharges at normal levels over the two 4 day festive holiday periods

Local indicator(s):

- workforce capacity plans & rotas for winter / festive period agreed by October;
- effective local escalation of any deviation from plan and actions to address these;
- extra capacity scheduled for the 'return to work' days after the four day festive break factored into annual leave management arrangements.
- number of discharges on each of the 4 day festive holiday periods compared to number of normal daily discharges

8. Discharges at weekends & Public holidays

Outcome:

Patients are discharged at weekends and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital. Medical and Nurse Directors provide monthly report on weekend (pre-noon) discharge rate progress and performance.

Local indicator(s):

- % of discharges that are criteria led on weekend and bank holidays;
- daily number of elective and emergency admissions and discharges.

9. The risk of patients being delayed on their pathway is minimised.

Outcome:

- Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these

units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge. Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital. There is early engagement with SAS for ambulance discharge and transfer. Medical and Nurse Directors provide monthly report on ward by ward, in/out balance, daily discharge progress and performance.
Local indicator(s): • distributions of attendances / admissions; • distribution of time to assessment; • distribution of time between decision to transfer/discharge and actual time; • % of discharges before noon; • % of discharges through discharge lounge; • % of discharges that are criteria led; • levels of boarding medical patients in surgical wards.

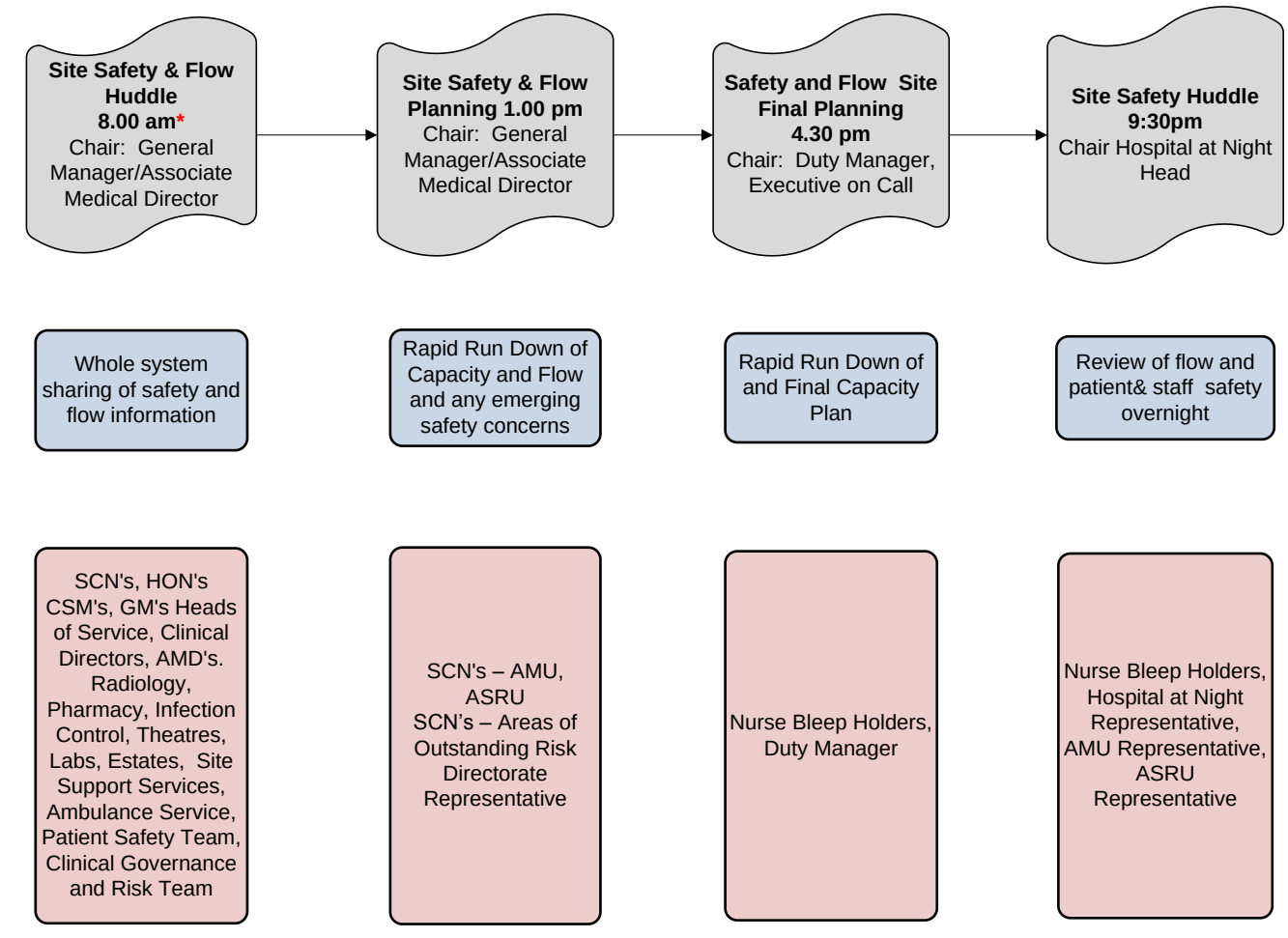
10. Communication plans
Outcome: • The public and patients are kept informed of winter pressures, their impact on services and the actions being taken.
Local indicator(s) : • daily record of communications activity; • early and wide promotion of winter plan

11. Preparing effectively for norovirus and influenza.
Outcome: The risk of norovirus and influenza outbreaks becoming widespread throughout a hospital is minimised through the effective implementation of the HPS Norovirus Outbreak Guidance (2016/17) and other national guidance which is incorporated as it is updated.
Local indicator(s): • number of wards closed to norovirus; • application of HPS norovirus guidance. • Number of wards closed due to influenza virus

12. Delivering seasonal flu vaccination to public and staff.
Outcome: • CMO uptake targets for seasonal flu vaccination for those aged 65 and above, at risk groups and front line staff are delivered in accordance with CMO Guidance.
Local indicator(s): • % uptake for those aged 65+ and ‘at risk’ groups; • % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.

Appendix 1
Safety and Flow Huddle Diagram

NHS TAYSIDE SAFETY & FLOW



* Site-wide report to be circulated following 8am huddle

ITEM No …14……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19 DECEMBER 2017**

REPORT ON: **FINANCIAL MONITORING POSITION AS AT OCTOBER 2017**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **DIJB50-2017**

1.0 PURPOSE OF REPORT

The purpose of this report is to provide the Integration Joint Board with an update of the projected financial monitoring position for delegated health and social care services for 2017/18.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of this report including the overall projected financial position for delegated services to the 2017/18 financial year end as at 31 October 2017.

2.2 Notes the position with regards to the Large Hospital Set Aside as stated at 4.3.11 and approves the proposal to not effect the planned saving in lieu of a recovery action plan.

3.0 FINANCIAL IMPLICATIONS

3.1 The financial monitoring position for Dundee Health and Social Care Partnership based on expenditure to 31 October 2017 shows a net projected overspend position of £2,528k which is a deterioration on the previously reported figures based on the September expenditure position of a £1,813k overspend. The overspend is primarily as a result of overspends in GP prescribing of £2,618k. The prescribing overspend is subject to the risk sharing arrangement outlined in the Integration Scheme whereby responsibility for meeting the shortfall in resources remains with NHS Tayside.

3.2 The current year projected overspend position is significantly less than the final outturn for delegated NHS services to Dundee IJB in 2016/17 where an overspend of £3,462k was incurred.

4.0 MAIN TEXT

4.1 Background

4.1.1 As part of the IJB's financial governance arrangements, the Integration Scheme outlines that "The Chief Finance Officer will ensure routine financial reports are available to the Chief Officer and the Integration Joint Board on a timely basis and include, as a minimum, annual budget, full year outturn projection and commentary on material variances."

4.1.2 The IJB confirmed the overall budgeted resources for delegated services at its meeting in June 2017 following receipt of confirmation of the NHS delegated budget having already accepted Dundee City Council's budget at its meeting in March 2017. Members of the IJB will recall that risks around the prescribing budget and within services hosted by Angus and Perth & Kinross IJBs were identified. This financial monitoring position reflects the status of these risks as they display within cost centre budgets.

4.1.3 The financial information presented has been provided by the finance functions of NHS Tayside and Dundee City Council as set out within the Integration Scheme.

4.2 Projected Outturn Position – Key Areas

4.2.1 The following sets out the main areas of note from the financial information contained within Appendices 1 (Summary Position) and 2 (More Detailed Position) and provides commentary on the reasons for significant variances, actions being taken to manage these and outlines the key elements of risk which may remain.

4.3 Services Delegated from NHS Tayside

4.3.1 Members will recall from the budget paper presented to the IJB in June that there were a number of significant risks and challenges highlighted within delegated budgets from NHS Tayside. This included a testing savings target across services as a reflection of the overall financial challenges facing NHS Tayside. The IJB has moved to deliver more savings on a recurring basis for 2017/18 with over £1.1m of efficiencies factored in to the staff costs budget to reflect turnover and vacancy management. NHS Tayside continues to develop its comprehensive Transformation Programme to deliver service efficiencies and improvement. A number of the workstreams within this programme have been applied to delegated services, which combined with local service delivery efficiencies, constitutes Dundee Health and Social Care Partnership's Transformation Programme. These efficiencies have been incorporated into service budgets where identifiable and the financial projections take into account the anticipated achievement of a number of these savings.

4.3.2 The financial projection for services delegated from NHS Tayside to the IJB indicates a projected overspend of around £2,524k by the end of the financial year.

4.3.3 A number of service underspends are noted within Mental Health, Continuing Care, Community Nursing and Allied Health Professionals (AHP) primarily as a result of staff vacancies. This is additional to the staff efficiency savings incorporated into the base budget for these services and therefore provides a further contribution to achieving the overall savings target.

4.3.4 Staff cost pressures exist in a number of other services such as the Medicine for the Elderly budget and Palliative Care. The Medicine for the Elderly Budget was highlighted as a financial risk given the significant overspend associated with it. Over the last year however, this overspend has been managed downwards following reshaping of the wards at Royal Victoria Hospital and subsequent efficiencies.

4.3.5 It is anticipated that with further reshaping of services and emergence of efficiencies through NHS Tayside's Transformation Programme that overall services directly managed by Dundee Health and Social Care Partnership will balance by the end of the financial year.

4.3.6 The Family Health Services prescribing budget currently projects a shortfall totalling £2,618k. This reflects an increase of £553k from that reported to the October IJB, based on the September 2017 expenditure to date (previously £2,065k projected overspend).

4.3.7 This increase is primarily due to a range of factors including the impact of price increases and demand across the prescribing budget. The forecast assumes that all other anticipated savings will be delivered. Some of these may be high risk however there is a programme of further savings being pursued not yet included in the plan.

4.3.8 A number of initiatives continue to be developed through NHS Tayside's Transformation Programme supported by the Prescribing Management Group (PMG). The PMG function as a collaborative with delegated authority from the three Tayside IJBs and NHS Tayside Board, to allocate, monitor and agree actions to make optimal use of the prescribing budget. The PMG will deliver a whole system approach to developing prescribing action plans, implementation of prescribing projects and monitoring, identification and management of financial risks within prescribing. Dundee HSCP contributes to the PMG and will continue to explore innovative ways of safely delivering services in a more cost effective manner. Members will recall that the IJB agreed to invoke the risk sharing arrangement with NHS Tayside in relation to this budget whereby the leadership of delivery of efficiency savings within this budget remains the responsibility of NHS Tayside.

4.3.9 Members of the IJB will also be aware that Angus and Perth & Kinross IJBs host delegated services on behalf of Dundee IJB and a number of services are hosted by Dundee on behalf of Angus and Perth and Kinross. These are subject to a risk sharing agreement whereby any over or underspends are reallocated across the three Tayside IJBs at the end of the financial year. The financial monitoring position of these services in their totality are reflected in each of the IJB's financial monitoring reports and for information purposes the projected net impact of these services on each IJB's budgeted bottom line figure is noted. The net impact to Dundee IJB of hosted services is a further projected overspend of £108k.

4.3.10 As outlined in Report DIJB27-2017 regarding Hosted Services Arrangements (June 2017), the financial position continues to be impacted on by the significant overspend in the Mental Health Inpatient service hosted by Perth & Kinross IJB. However, through the release of cost pressures funding and other interventions, the net share to Dundee is reduced from an initial reported figure of £500k based on the June figures to an overspend of approximately £300k. Other hosted services previously highlighted as areas of financial risk such as the Out of Hours & Forensic services hosted by Angus have also seen reductions in the projected overspend for the year through a range of interventions. These will continue to be monitored closely and reported more fully to the IJB over the course of the financial year.

4.3.11 NHS Tayside has recently indicated its intent to request the IJB to implement a recovery plan in line with the terms of the Integration Scheme for the net overspend currently projected. Given the residual overspend relates primarily to the prescribing budget which was not accepted by the IJB, discussions continue with NHS Tayside as to the IJB's position on this matter. Further information will be provided to the IJB once this position becomes clearer. However given it is unlikely that NHS Tayside will be in a position to deliver a reduction in the value of the Large Hospital Set Aside in 2017/18 as set out within Dundee IJBs Transformation Efficiency Programme it is proposed to refrain from effecting this reduction in lieu of a recovery plan for Dundee IJB.

4.4 Services Delegated from Dundee City Council

4.4.1 Due to the nature of the local government budget process, an efficiency savings plan for services delegated by Dundee City Council was in place prior to services becoming delegated to Dundee Integration Joint Board. These efficiencies are embedded within service budgets and the financial monitoring reflects performance in achieving these.

4.4.2 The financial projection for services delegated from Dundee City Council to the IJB notes a net underspend primarily within Physical Disabilities, Mental Health and Substance Misuse services. This is mainly due to the timing of the completion of developments for accommodation based care and the original recurring revenue investment programme no longer in alignment for 2017/18. Within this overall position, a number of pressure areas continue to emerge which have been primarily met through funding for demographic pressures as part of additional social care investment, particularly for Older People's services. The financial position continues to reflect the impact of responding to the challenge of reducing delayed discharges through investment in additional capacity for care at home services and care home placements.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

6.1 In preparing the Dundee City Integration Joint Board's 2017/18 revenue monitoring (to October 2017), the Chief Finance Officer considered the key strategic, operational and financial risks faced by the IJB for the 2017/18 financial year. In order to alleviate the impact these risks may have, should they occur, a number of general risk mitigation factors are utilised by the Integration Joint Board. These include the:-

- identified current integration funding set aside to meet any unforeseen expenditure
- system of perpetual detailed monthly monitoring enabling early identification of budget pressures and subsequent remedial work where required
- level of general fund balances available to meet unforeseen expenditure
- level of specific reserves (Integration and Transformation) to meet any unforeseen expenditure
- possibility of identifying further budget savings and efficiencies during the year
- specific underwriting of constituent bodies where overspends occur. The Integration Scheme outlines specific risk sharing arrangements whereby responsibility for meeting any shortfall lies with one of the constituent bodies.

6.2 The risks in 2017/18 revenue monitoring have now been assessed both in terms of the probability of whether they will occur and the severity of their impact on the Integration Joint Board should they indeed occur. These risks have been ranked as either zero, low, medium or high. Details of the risk assessment, together with other relevant information including any proposed actions taken by the Integration Joint Board to mitigate these risks, are included in Appendix 3 to this report. Given the actions identified to mitigate these risks these are deemed to be manageable.

7.0 CONSULTATIONS

The Chief Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 28 November 2017

Appendix 1

DUNDEE INTEGRATED JOINT BOARD - HEALTH & SOCIAL CARE PARTNERSHIP - FINANCE REPORT 2017/18 **AS AT Oct 2017**

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Net Budget £,000	Projected Overspend / (Underspend) £,000	Net Budget £,000	Projected Overspend / (Underspend) £,000	Net Budget £,000	Projected Overspend / (Underspend) £,000
Older Peoples Services	37,892	854	14,458	-235	52,350	619
Mental Health	4,489	-202	3,386	-60	7,875	-262
Learning Disability	22,310	288	1,224	-35	23,534	253
Physical Disabilities	6,684	-467	0	0	6,684	-467
Substance Misuse	801	-228	2,406	-175	3,207	-403
Community Nurse Services / AHP / Other Adult	421	29	11,333	-152	11,754	-123
Hosted Services	0	0	17,907	-269	17,907	-269
Other Dundee Services / Support / Mgmt	639	-269	26,142	-330	26,781	-599
Centrally Managed Budgets			-1,383	1,255	-1,383	1,255
Total Health and Community Care Services	**73,236**	**4**	**75,474**	**0**	**148,710**	**4**
Prescribing (FHS)	0	0	32,212	2,618	32,212	2,618
Other FHS Prescribing	0	0	707	-105	707	-105
General Medical Services	0	0	24,256	-111	24,256	-111
FHS - Cash Limited & Non Cash Limited	0	0	17,120	14	17,120	14
Grand Total	**73,236**	**4**	**149,769**	**2,416**	**223,005**	**2,420**
Hosted Services*			5,496	108	5,496	108
Grand Total	**73,236**	**4**	**155,265**	**2,524**	**228,501**	**2,528**

***Hosted Services - Net Impact of Risk Sharing Adjustment**

ITEM No …14……..

Appendix 2

Dundee City Integration Joint Board – Health & Social Care Partnership – Finance Report

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Psychiatry Of Old Age (POA) (In Patient)			4,594	145	4,594	145
Older Peoples Services -Community			501	(20)	501	(20)
Continuing Care			2,252	(425)	2,252	(450)
Medicine for the Elderly			3,625	250	3,625	250
Medical (POA)			634	11	634	11
Psychiatry Of Old Age (POA) - Community			1908	(240)	1,908	(240)
Intermediate Care			944	70	944	70
Older People Services	37,892	854			37,892	854
Older Peoples Services	37,892	854	14,458	(235)	52,350	619
General Adult Psychiatry			3,386	(60)	3,386	(60)
Mental Health Services	4,489	(202)			4,489	(202)
Mental Health	4,489	(202)	3,386	(60)	7,875	(262)
Learning Disability (Dundee)	22,310	288	1,224	(35)	23,534	253
Learning Disability	22,310	288	1,224	(35)	23,534	253

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Physical Disabilities	6,684	(467)			6,684	(467)
Physical Disabilities	6,684	(467)	0	0	6,684	(467)
Alcohol Problems Services			483	(35)	483	(35)
Drug Problems Services			1,923	(140)	1,923	(140)
Substance Misuse	801	(228)			801	(228)
Substance Misuse	801	(228)	2,406	(175)	3,207	(403)
A.H.P. Admin			363	(26)	363	(26)
Physiotherapy			3,265	(44)	3,265	(44)
Occupational Therapy			1,378	(48)	1,378	(48)
Nursing Services (Adult)			5,454	(30)	5,454	(30)
Community Supplies - Adult			135	10	135	10
Anticoagulation			368	(15)	368	(15)
Joint Community Loan Store			371	0	371	0
Intake/Other Adult Services	421	29			421	29
Community Nurse Services / AHP / Intake / Other Adult Services	421	29	11,333	(152)	11,754	(123)

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Palliative Care – Dundee			2,481	103	2,481	103
Palliative Care – Medical			1,008	(11)	1,008	(11)
Palliative Care – Angus			315	4	315	4
Palliative Care – Perth			1,567	100	1,567	100
Brain Injury			1,552	78	1,552	78
Dietetics (Tayside)			2,523	(113)	2,523	(113)
Sexual & Reproductive Health			1,991	90	1,991	90
Medical Advisory Service			151	(43)	151	(43)
Homeopathy			26	2	26	2
Tayside Health Arts Trust			57	0	57	0
Psychology			4,427	(466)	4,427	(466)
Eating Disorders			288	(5)	288	(5)
Psychotherapy (Tayside)			790	26	790	26
Learning Disability (Tayside AHP)			732	(35)	732	(35)
Hosted Services	0	0	17,907	(269)	17,907	(269)
Working Health Services			0	0	0	0
The Corner			394	5	394	5
Resource Transfer			8,570	0	8,570	0
Grants Voluntary Bodies Dundee			176	(20)	176	(20)
IJB Management			748	0	748	0
Partnership Funding			14,523	0	14,523	0
Carers Strategy			143	0	143	0
Public Health			473	10	473	10
Keep Well			576	(180)	425	(180)
Primary Care			540	(145)	540	(145)
Support Services/Management Costs	639	(269)			639	(269)
Other Dundee Services / Support / Mgmt	639	(269)	26,142	(330)	26,781	(599)
Centrally Managed Budgets			(1,383)	1,255	(1,383)	1,255

	Dundee City Council Delegated Services		NHST Dundee Delegated Services		Partnership Total	
	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000	Annual Budget £,000	Projected Over / (Under) £,000
Total Health and Community Care Services	**73,236**	**4**	**75,474**	**0**	**148,710**	**4**
Other Contractors						
Prescribing (FHS)			32,212	2,618	32,212	2,618
Other FHS Prescribing			707	(105)	707	(105)
General Medical Services			24,256	(111)	24,256	(111)
FHS - Cash Limited & Non Cash Limited			17,120	14	17,120	14
Grand Total H&SCP	**73,236**	**4**	**149,769**	**2,416**	**223,005**	**2,420**
Hosted Recharges Out			(10,489)	(200)	(10,489)	(200)
Hosted Recharges In			15,985	308	15,985	308
Hosted Services - Net Impact of Risk Sharing Adjustment			**5,496**	**108**	**5,496**	**108**
Large Hospital Set Aside			**21,000**	**0**	**21,000**	**0**

Appendix 3

Risk Assessment

Risks – Revenue Monitoring	Assessment*		Risk Management / Comment
	Original	**Revised**	
General Inflation – General price inflation may be greater than anticipated	(3/2)	(3/2)	Procurement strategy in place, including access to nationally tendered contracts for goods and services. In addition, fixed price contracts agreed for major commodities i.e. gas and electricity.
Savings – Failure to achieve agreed level of savings and efficiencies	(2/2)	(2/2)	General risk mitigation factors (reference section 6) in particular, regular monitoring will ensure savings targets are met.
Emerging Cost Pressures – The possibility of new cost pressures or responsibilities emerging during the course of the financial year.	(2/2)	(2/2)	General risk mitigation factors (reference section 6) in particular, regular monitoring to ensure shortfalls are identified as early as possible and corrective action can be taken as necessary.
Chargeable Income – The uncertainty that the level of chargeable income budgeted will be received.	(3/3)	(3/3)	General risk mitigation factors (reference section 6) in particular, regular monitoring by departments to ensure any shortfalls are identified as early as possible and corrective action can be taken as necessary.
Demographic Changes – This can lead to increased demand both in a client sense and in the contents of clients' packages. This is particularly relevant in cases where needs lead to expensive packages.	(3/2)	(3/2)	General risk mitigation factors (reference section 6), in particular, regular monitoring by departments to ensure any shortfalls are identified as early as possible and corrective action can be taken as necessary.
Specific Pressures – These include specific areas where overspends are expected. GP Prescribing; net impact of hosted services; and Family Health Services have indicated an overspend position for 2017/18.	(4/4)	(4/4)	These overspends are subject to the risk sharing arrangement outlined in the Integration Scheme whereby responsibility for meeting the shortfall in resources remains with NHS Tayside as noted in Dundee IJB's Budget Report agreed in June 2017

***Scoring recorded (Impact/Likelihood)**

ITEM No …15……..

REPORT TO: **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 19 DECEMBER 2017**

REPORT ON: **TRANSFORMATION PROGRAMME UPDATE REPORT**

REPORT BY: **CHIEF OFFICER**

REPORT NO: **DIJB56-2017**

1.0 PURPOSE OF REPORT

This report provides Dundee Integration Joint Board with an update of Dundee Health and Social Care Partnership's Transformation Programme.

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of this report, the progress to date of the Transformation Programme and the planned next phases of development.

3.0 FINANCIAL IMPLICATIONS

3.1 The value of the funding set against Dundee Health and Social Care Partnership's Transformation Programme is £14.943m and consists of additional Scottish Government funding provided over recent years to support the integration of health and social care services, to implement national policy in relation to social care and to support the transformation of services.

3.2 The Transformation efficiency programme for 2017/18 of £5.65m was agreed by Dundee IJB at its meeting on 27th March 2017 (Report DIJB9-2017) in order to deliver a balanced integrated budget. Actual performance against this programme is reflected within the financial monitoring position of the partnership as reported at each IJB meeting.

4.0 MAIN TEXT

4.1 Background

4.1.1 Dundee Integration Joint Board approved Report DIJB15-2016 – Planning for Additional Resources at its meeting on 4th May 2016. This report outlined the scale and range of additional funding provided by the Scottish Government to support organisational change and to meet the challenges of increasing demographic pressures within health and social care. This funding was further described as being a key element to the delivery of the Strategic and Commissioning Plan in Report DIJB39-2016 – Transformation Programme which was approved at the IJB in August 2016 through providing the opportunity for Dundee Health and Social Care Partnership to carry out significant tests of change.

4.1.2 The IJB approved a further range of investments in tests of change to support the delivery of the Strategic and Commissioning Plan at its meeting on 25th October 2016 (Report DIJB50-2016 – Transformation Programme – Additional Innovation and Development Fund Investment)

4.1.3 As part of the overall Transformation Programme a range of efficiency savings to the value of £5.65m were agreed by the IJB in order to agree a balanced integrated budget for 2017/18 at the IJB's meeting on 27th March 2017. This combined suite of investment programme,

service redesign opportunities and service efficiency savings is known as the Transformation Programme.

4.2 Updated Position - Governance

4.2.1 In order to provide a governance structure to oversee, support and ensure the delivery of the overall Transformation Programme, a Transformation Delivery Group has been established. This group brings together all the key strategic and operational leads responsible for the delivery of significant change in the health and social care system including the voluntary sector and staff side / trade union representation.

The Transformation Delivery Group works with a range of key partners to:

- embed both the ethos of and principles of personalisation into the approach taken to engage and support our citizens and carers
- deliver on the challenges ahead, including increasing the quality and experience of those who access our services
- reduce inequalities
- provide better outcomes for our people/citizens and
- deliver the business of the Health and Social Care Partnership within the resources available to the Integration Joint Board.

4.2.2 The Transformation Delivery Group will report to the Performance and Audit Committee and when required to the Integrated Strategic Planning Group and the Dundee Integration Joint Board. It will ensure that the Transformation Programme is driven by the Dundee Strategic Plan and the Dundee City Plan and ensure that programme change leads are adequately supported in their work to deliver on the transformation programme. Ultimately the Transformation Delivery Group provides an agreed layer of scrutiny and assurance to the IJB and Integrated Strategic Planning Group by monitoring the delivery of the change programmes endorsed through the Dundee Integration Joint Board. The success of the Transformation Programme will be measured against achieving the vision and strategic priorities set out in the Strategic and Commissioning Plan 2016-2021.

4.3 Transformation Investment Programme

4.3.1 A summary of the Transformation Investment Programme is set out in Appendix 1. A number of tests of change have previously been evaluated as making significant improvement to services in terms of alternative health and social care pathways with better outcomes, building service and community capacity and demonstrating an early intervention and preventative approach and have now been mainstreamed.

4.3.2 A further range of projects had previously been provided with funding until March 2018 and these will be evaluated by January 2018 to determine whether they are contributing to the strategic priorities in a positive way and if so, identifying what the sustainable funding opportunities will be to support these in future. However this will be set against an anticipated challenging financial settlement for 2018/19. A further report will be brought back to the IJB before the beginning of the 2018/19 financial year outlining these proposals.

4.3.3 Other elements of additional Scottish Government funding have been applied against the impact of national policy directives such as the implementation of the living wage for all adult social care workers, implement changes to charging for social care services (to benefit service users), preparations for the implementation of the Carers Act and to expand social care provision. In addition, an element of this funding has been applied to support the Reshaping Care for Older People strategy as agreed by the IJB at its meeting on 31 October 2017 (Report DIJB37/2017 – Proposed Model for Care for Older People). This includes a reliance on carry forward of unallocated transformation change funds from previous years to transition to the new Dundee Enhanced Community Support and Acute model of integrated care, therefore maintaining the level and purpose of these change funds as set out within the IJB's reserves is essential.

4.4 Transformation Efficiency Programme

4.4.1 As outlined in the financial monitoring report on this agenda (Item 14 : Report DIJB50 – 2017), with the exception of the prescribing budget and net effect of hosted services, Dundee Health

and Social Care Partnership's operational budget is projected to break-even by the end of this financial year. While this is primarily down to the delivery of the planned transformation efficiency savings, a number of these have not been delivered as intended due to various factors however a range of other compensatory efficiencies have been achieved during the year to mitigate the effect of this shortfall. The detail of this is described in Appendix 2.

4.4.2 This efficiency programme will continue to progress throughout 2017/18 with a further programme for 2018/19 and beyond to be developed and discussed with the IJB prior to the start of the new financial year.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	Risk that the Transformation Programme does not deliver the agreed range of service redesign investment and efficiency proposals necessary to deliver better outcomes for the citizens of Dundee within the available resources.
Risk Category	Financial
Inherent Risk Level	20 - Extreme
Mitigating Actions (including timescales and resources)	Transformation Delivery Group in place to govern, monitor and drive Transformation Programme.
Residual Risk Level	15 - Extreme
Planned Risk Level	12 - High
Approval recommendation	Given the level of inherent risk is partly mitigated by the actions being undertaken and impacted by a range of factors it is recommended that the level of risk is accepted.

7.0 CONSULTATIONS

The Chief Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

28 November 2017

ITEM No …15……..

Appendix 1

Additional Scottish Government Funding	**Fund Value 2017/18**	**Less: Commitments**	**Net Residual Funding 2017/18**	
	£'000s	**£'000s**	**£'000s**	**Comments**
Health & Social Care Integration Fund (Allocated 2016/17)				
- 1st Tranche (Partnership Funding)	3,830	-3,830	0	Funding allocated to mainstream successful tests of change and to support roll out of Dundee Enhanced Community Support & Acute Model
- 2nd Tranche (Living Wage / LA Pressures)	3,830	-3,830	0	Funding fully allocated to support the introduction of the living wage for all adult social care workers, changes to charging and to support local authority pressures in 2016/17 as set out by the Scottish Government.
Additional Social Care Investment Funding 2017/18	3,253	-3,253	0	Funding fully allocated to support the full year effect of living wage, 2017/18 living wage increase, sleepovers further changes to charging, Carers Act pre-implementation and social care investment
Integrated Care Fund*	3,100	-3,338	-238	Planned use of Carry Forward from previous years to support over commitment in future years
Delayed Discharge Fund	930	-930	0	
Total	14,943	-15,181	-238	

Additional Scottish Government Funding	**Fund Value 2017/18**			
	£'000s			
* Integrated Care Fund Investment Detail				
1. Community Capacity Building	505			
2. Early Intervention/Prevention	152			
3. Protecting People	176			
4. Carers	146			
5. Community Assessment Model	912			
6. Models of Care	722			
7. Workforce Development/Engagement	171			
8. Community Rehabilitation Models	511			
9. Independent Sector	43			
	3,338			

Appendix 2

Dundee Health & Social Care Partnership Transformation Programme

Primary IJB Strategic Plan Priority	Transformation Project Description	2017/18 Estimated Efficiency £000	2017/18 Saving Achieved	Additional Information
Managing our Resources Effectively:				
	Re-modelling of Dundee City Council's Home Care Service	250	0	Discussions progressing with staff and Trade Unions re the most appropriate model of service provision
	Integrated Management & Support Savings	135	135	
	Developing a flexible, responsive and modernised workforce	1,496	1,496	Additional unplanned, non-recurring efficiencies achieved through staff turnover to offset other delivery programme areas not being achieved
	Implement agreed Joint Equipment Store arrangements with Angus Health & Social Care Partnership	30	30	
	Review of Resource Transfer Commitments	75	75	.
	Reduce allocations for demographic growth and Strategic Planning Bridging Finance as set out in the Transformation Programme	750	750	
	Total Managing our Resources Effectively	**2,736**	**2,486**	
Changing Models of Support/Pathways of				

Primary IJB Strategic Plan Priority	Transformation Project Description	2017/18 Estimated Efficiency £000	2017/18 Saving Achieved	Additional Information
Care:				
	Remodel Housing Support to move to Amenity Housing Provision (retain very sheltered housing models of care)	90	90	
	Impact of Minor Service Redesign Programmes (Joint Equipment Store, Community Nursing, Neuro Rehabilitation Services)	34	34	
	Total Models of Support/Pathways of Care	**124**	**124**	
Other: Managing our Resources Effectively, Changing Models of Support/Pathways of Care, Early Intervention/Prevention:				
	Strategic Commissioning – Implementation of range of interventions identified by client specific strategic planning groups	1,065	1,065	
	Impact of Unscheduled Care Programme on Reducing Large Hospital Set Aside ***Less: Transitional Funding***	1,500		Saving not effected as part of Dundee IJB's response to deliver a recovery action plan as requested by NHS Tayside (as noted within Financial Monitoring Report DIJB50-2017)

Primary IJB Strategic Plan Priority	Transformation Project Description	2017/18 Estimated Efficiency £000	2017/18 Saving Achieved	Additional Information
	Net Saving	(1,000) 500	 n/a	
	Total Other	**1,565**	**1,065**	
	Total Transformation Workstreams Managed Directly by Dundee Health & Social Care Partnership	**4,425**	**3,675**	
Managing Our Resources Effectively	**Draw Down from NHS Tayside's Transformation Programme (including procurement, workforce, repatriation, service redesign, operational efficiencies**	1,140		Savings embedded in operational activity through for example staff rota management, more efficient purchasing of services. These have not been separately quantified within Dundee IJB delegated services.
	Other Non-Recurring Operational Savings	**0**	**1,890**	Range of non-recurring savings across health and social care budgets achieved to offset non-achievement of planned efficiency savings initiatives. Figure includes savings from NHS Transformation Programme draw down as noted above but not quantifiable.
	Total Dundee Transformation Programme Workstreams	**5,565**	**5,565**	

404