DATA LABEL: Public

West Lothian Integration Strategic Planning Group

Working group that sits below the Integrated Joint Board

West Lothian Civic Centre
Howden South Road
LIVINGSTON
EH54 6FF

10 November 2016

A meeting of the **West Lothian Integration Strategic Planning Group** of West Lothian Council will be held within the **Strathbrock Partnership Centre, 189(a) West Main Street, Broxburn EH52 5LH** on **Thursday 17 November 2016** at **2:00pm**.

For Chief Executive

BUSINESS

Public Session

1. Apologies for Absence

2. Order of Business, including notice of urgent business

3. Declarations of Interest - Members should declare any financial and non-financial interests they have in the items of business for consideration at the meeting, identifying the relevant agenda item and the nature of their interest.

4. Confirm Draft Minutes of Meeting of West Lothian Integration Strategic Planning Group held on Thursday 06 October 2016 (herewith).

5. Commissioning Plan for Older People - Report by Director (herewith)

6. Risk Management Report - Report by Director (herewith)

7. Locality Planning Update - Report by Director (herewith)

8. Primary Care Update - Report by Director (herewith)

9. West Lothian Winter Plan - Report by Director (herewith)

10. Workplan (herewith)

NOTE **For further information please contact Val Johnston, Tel No.01506 281604 or email val.johnston@westlothian.gov.uk**

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION STRATEGIC PLANNING GROUP held within STRATHBROCK PARTNERSHIP CENTRE, 189(A) WEST MAIN STREET, BROXBURN, EH52 5LH, on 6 OCTOBER 2016.

Present – Jim Forrest (Chair, Director, West Lothian Council), Alan Bell (Social Care Professional), Ian Buchanan (User of Social Care), Carol Bebbington (Health Professional), Jacqui Campbell (Health Professional), Jane Houston (Union Health), Mairead Hughes (Health Professional), Jane Kellock (Health Professional), Mary-Denise McKernan (Carer of Users of Health Care), Charles Swan (Social Care Professional), Robert Telfer (Commercial Provider of Social Care) and Patrick Welsh (Chief Finance Officer)

Apologies – Marion Barton, Margaret Douglas, Elaine Duncan, Pamela Main, James McCallum, Carol Mitchell and Alistair Shaw

1. MINUTE

The Group confirmed the Minute of its meeting held on 11 August 2016 as being a correct record. The Minute was thereafter signed by the Chair.

Matters Arising

Page 41, item 6 – Participation and Engagement Strategy

The Panel was advised that the draft Participation and Engagement Strategy consultation process was still underway. It was proposed to submit the draft to the January 2017 meeting of the Integration Joint Board for approval.

2. ADULTS' MENTAL HEALTH COMISSIONING PLAN

A report had been circulated by the Director in respect of the Strategic Commissioning Plan for Adults' Mental Health.

The report advised that at the meeting of 24 March 2016 the Integration Joint Board (IJB) approved its strategic plan which included details of how high level outcomes were to be achieved through a process of strategic commissioning. The Strategic Plan also included a commitment to develop a series of care group based commissioning plans.

The West Lothian Strategic Commissioning Plan for Adults' Mental Health set out strategic ambitions, priorities and next steps required to deliver integrated health and social care support and services for adults with mental health problems, their families and carers in West Lothian for the next three years. Attached to the report at Appendix 1, was the draft of the Plan. The Group was invited to comment on the commissioning plan for Adults' Mental Health before it was presented to the IJB on 18 October 2016 for approval.

During the course of the discussion the Senior Manager, Community Care Support & Services, suggested that some amendments be made to the

Plan prior to it being submitted to the IJB for approval to include more detailed information relating to the programme of changes and delivery of service.

In response to a question relating to the gap in specialist service provision for people aged 65+, it was suggested that this issue related more to the redesign programme and the role of specialist teams rather than the commissioning plan.

The following amendments were recommended to be made to the Plan:

Page 1 – Councillor Toner was no longer the Chair of the Integration Joint Board. To be amended to Councillor Danny Logue to reflect the change; and

P14 – Hosted Health Services – Provider should be NHS Lothian on behalf of West Lothian – not West Lothian IJB.

The Group agreed that the Plan be updated to reflect the recommended amendments and circulated to members of the SPG for consideration prior to it being submitted to the IJB for approval.

Decision

- To note the contents of the commissioning plan for Adults' Mental Health;

- To note that the plan would be presented to the IJB on 18 October 2016 for approval subject to the amendments outlined above.

3. LEARNING DISABILITY COMMISSIONING PLAN

A report had been circulated by the Director in respect of the strategic commissioning plan for adults with a learning disability.

The report recalled that at the meeting on of 24 March 2016 the Integration Joint Board (IJB) approved its strategic plan which included details of how high level outcomes were to be achieved through a process of strategic commissioning. The Strategic Plan also included a commitment to develop a series of care group based commissioning plans.

The West Lothian Strategic Commissioning Plans for Adults with a Learning Disability set out the strategic ambitions, priorities and next steps required for delivering integrated health and social care support and services for people with a learning disability and autism, their families and carers in West Lothian for the next three years. Attached to the report at Appendix 1 was the draft Learning Disability Commissioning Plan.

The Group was advised that this particular commissioning plan was complex to produce. It was proposed to develop a Lothian-wide resource for people from West Lothian with very complex care needs. Providers of

local support services available for people with challenging behaviour would also be reviewed with cost comparisons carried out between local resources and out of area resources. It was also important to ensure that respite and short break opportunities were available to meet the needs of service users, families and carers.

During the course of the discussion a number of risks were highlighted, details of which were outlined in the report. The following amendments to the Plan were also recommended:

- Page 1, Councillor Toner was no longer the Chair of West Lothian Integration Joint Board. To be amended to Councillor Danny Logue to reflect the change; and

- Page 7, point 14, referred to West Lothian CHCP. This should read "West Lothian needs to continue….."

The Group was asked for comments on the details of the strategic commissioning plan for adults with a learning disability. A report on the strategic commissioning plan for adults with a learning disability would be presented to the IJB meeting on 18 October 2016 for approval.

Decision

1) To note the contents of the commissioning plan for adults with a learning disability;

2) To note that the plan would be presented to the IJB on 18 October 2016 for approval, subject to the amendments outlined above.

4. PERFORMANCE REPORT

The Group considered a report (copies of which had been circulated) by the Director providing details of the current performance report on the indicators supporting the National Health and Wellbeing Outcomes. The Group also considered details contained within the Balanced Scorecard (copies of which were tabled).

The report explained that each Integration Authority would be required to publish an annual performance report to set out how the national health and wellbeing outcomes were being improved based on a core suite of indicators and measures. The core suite of indicators, based on both administrative data and survey feedback, were developed to support integration of health and social care and designed to allow comparison between areas and to assess improvement over time.

The current West Lothian performance was summarised in Appendix 1 to the report. It was noted that this information was provisional at this time as some of the datasets were still being developed. As outlined in the Strategic Plan the framework for strategic measurement and management system would be based on a balanced scorecard approach. The scorecard would measure organisational performance across four balanced perspectives:

- Financial & Business;
- Customer – experiences and outcomes;
- Internal Processes; and
- Learning and Growth.

Consideration was also required in relation to the additional local measures which would form the basis of the scorecard. Improved data sharing across health and social care would play a key role in the integration agenda.

The Group then considered the Balanced Scorecard. During the course of the discussion the Group was invited to comment or to email Carol Bebbington directly once they had considered the Balanced Scorecard in more detail. The Head of Social Policy recommended that the "Services are safe" outcome in the Balance Scorecard should include adult protection data.

The Group agreed that the performance report was useful in reporting progress and identifying areas for improvement. Further analysis of the survey results was in progress to provide a better understanding of the issues. While the provisional data demonstrated that West Lothian was on par or better than the Scottish average there were known challenges with regards to unscheduled care and reducing delayed discharge for which there was focussed improvement work in progress.

The Group was asked to:

1. Note the contents of the report and discuss the usefulness of the Summary Performance National Health and Wellbeing Indicators to report progress and identify areas for improvement; and

2. Discuss the data requirements to support local performance and to provide a broader picture and context for West Lothian which would support the development of the Annual Report.

Decision

1. Noted the contents of the report and Balanced Scorecard;

2. Noted the recommendation to include adult protection data within the "Services are safe" outcome in the Balanced Scorecard; and

3. Agreed that comments relating to the Balanced Scorecard be forwarded to Carol Bebbington.

5. WORKPLAN

A workplan had been circulated which provided details of the work of the Strategic Planning Group over the coming months.

The following changes to the workplan were recommended:

- Lothian Hospital Plan Update – to be considered on 19.01.17;
- Risk Register Review – Lead Officer to be Carol Bebbington;
- Primary Care Update to be included for consideration at the meeting on 17.11.16 – Lead Officer Carol Bebbington;
- West Lothian Winter Plan – to be included for consideration at the meeting on 17.11.16 – Lead Officer Carol Bebbington;
- January 2017 meeting to include the following items:

– Technology Enhanced Programme Update (TEC) – Lead Officer Alan Bell;

– Health Improvement Health Intelligence (HIHI) Update – Lead Officer Carol Bebbington;

– West Lothian Frailty Programme Update – Provisionally to January meeting – to be confirmed.

Decision

To note the content of the workplan and the changes outlined above.

6. FINAL COMMENTS

In conclusion, Jacquie Campbell advised the Group that she had been appointed as Interim Chief Officer based at Waverley Gate. Aris Tyrothoulakis has been appointed as Hospital Director based at St John's Hospital and would attend future meetings of the SPG.

Decision

- To note the update from Ms Campbell; and
- To note that COINS be updated to reflect this change.

WEST LOTHIAN STRATEGIC PLANNING GROUP

Date: 17 Nov 2016
Agenda Item: 5

OLDER PEOPLE COMMISSIONING PLAN

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To seek comments from the Strategic Planning Group for the strategic commissioning plan for Older People as presented in Appendix 1.

B RECOMMENDATION

To invite comments on the details of the strategic commissioning plan for Older People (Appendix 1). A report on the strategic commissioning plan for Older People will be presented to the IJB meeting on 29 November 2016 for approval.

C TERMS OF REPORT

Background
At the meeting of 24 March 2016 the Integration Joint Board (IJB) approved its strategic plan which includes details of how high level outcomes are to be achieved through a process of strategic commissioning. The Strategic Plan also includes a commitment to develop a series of care group based commissioning plans.

The strategic commissioning approach seeks to deploy available resources with maximum effectiveness on priority outcomes as informed by the detailed Needs Assessment.

A short life Working Group was established to develop the three year commissioning plan for Older People. A draft plan has now been prepared for the approval of the IJB (Appendix 1).

Structure of the plan
All care group commissioning plans follow a similar structure.

- Section 1 gives an overview, setting out vision, values, aims and outcomes, and the approach taken.
- Section 2 details the main recommendations arising from the Needs Assessment, locating these against existing strategies and policies and confirming whether they are to be addressed by specific commissioning intentions.

- Section 3 details the specific commissioning commitments, informed by the Needs Assessment, and provides information on the planned spend to meet these commitments.
- Section 4 is titled Next Steps and details a number of strategic change proposals.

Section 4 – Next Steps

This would not normally be expected to form a significant part of a commission plan. However, it is considered necessary for the current stage of the development of the IJB. It has already been noted that the IJB budget is not yet developed to the level appropriate to commissioning plans. This in turn limits the extent to which commissioning commitments can be detailed. In addition, organisational arrangements within the scope of the IJB are undergoing considerable change and this is likely to have an impact on commissioning commitments.

The programmes of change are:

Dementia
- Confirm model of dementia post diagnostic support
- Produce Up to date Dementia Training plan

Carers
- Review support needs of carers of those with dementia
- Review and identify core baseline training requirements for carers of older people and develop an associated core training / reference pack.
- Review overall provision and make recommendations based on Carers Bill.

Information
- Undertake an option appraisal re potential for the creation of a central information HUB for Older Peoples Services.

Community Capacity Building
- Support service providers to incorporate wherever possible a community capacity building approach to the way in which they deliver services.

Telecare
- Expand potential use of telecare to support older people and carers of older people.

Home / Community Support
- Continue ongoing review care at home contracts and associated performance.
- Review the function / role of day care provision reflecting on the impact of SDS and reported reduction in demand for placements.
- Identify potential development opportunities

Service Integration
- Joined up care pathways
- Geriatric Assessment and Frailty Pathway

End of Life Care
- Review to be undertaken of specialist service agreements.
- Monitor uptake of palliative care by those with a non- malignant condition.
- Non-home based palliative care to be part of Homely Setting project in Frail Elderly Programme

Support Health and Care in the Community

- Review REACT hospital at home and rehabilitation pathway to prevent admission and facilitate early supported discharge.
- Develop REACT model as part of Frailty Hub project in Frail Elderly Programme

D CONSULTATION

- Strategic Planning Group

E REFERENCES/BACKGROUND

- West Lothian Integration Joint Board meeting - 05 April 2016

F APPENDICES

1. Older People's Commissioning Plan

G SUMMARY OF IMPLICATIONS

Equality/Health	In developing its Strategic Plan, the IJB took account of the requirements for mainstreaming equality by aligning its strategic outcomes with the equality outcomes. The plan was subject to an integrated equalities impact assessment and this commissioning plan is covered by that assessment.
National Health and Wellbeing Outcomes	The commissioning plan addresses the relevant National Health and Well-Being Outcomes in accordance with the IJB Strategic Plan.
Strategic Plan Outcomes	The commissioning plan is aligned to relevant Strategic Plan outcomes and will incorporate detailed performance indicators.
Single Outcome Agreement	The Strategic Plan outcomes are aligned to the Single Outcome Agreement outcomes related to health and social care.
Impact on other Lothian IJBs	None.
Resource/finance	The implementation of commissioning plans will require to take account of available resources.
Policy/Legal	Public Bodies (Joint Working) (Scotland) Act 2014 and statutory regulations and guidance.
Risk	Main risk: IJB005, Inadequate Funding

H CONTACT

Contact Person:
Alan Bell, Senior Manager Community Care Support & Services
mailto:Alan.bell@westlothian.gov.uk

Tel 01506 281937

17 November 2016

Appendix 1 **Older People Strategic Commissioning Plan - schedule**

		2016 Week Ending																				
	Activity	April	May	June	01-Jul	08-Jul	15-Jul	22-Jul	29-Jul	05-Aug	12-Aug	19-Aug	26-Aug	02-Sep	09-Sep	16-Sep	23-Sep	30-Sep	07-Oct	14-Oct	21-Oct	Comment
	Analyse																					
1	Needs assessment undertaken																					Ongoing
2	Terms of ref approved for Commissioning Group	23-Apr																				Completed
3	Outline Commissioning Plan template agreed		6th May																			Completed
4	Commissioning Group membership agreed		13-May																			Completed
5	Invitations issued to proposed members		25-May																			
7	Preparation of planning material																					Commenced
8	Initial planning docs circulated to group			21-Jun																		
9	Meeting of Commissioning Group			21-Jun																		
	Plan																					
10	Agree scope of Commissioning Plan			21-Jun																		
11	Identify current resources available			21-Jun																		
12	Prioritise Needs Assessment recommendations			21-Jun																		
13	Discuss action plan and activities			21-Jun																		
14	Prepare action plan and agree activities																					
15	Prepare draft plan for review																					
16	Meeting of Commissioning Group			21-Jun			15-Jul			03-Aug				30-Aug								
17	Investment/Disinvestment plans agreed													30-Aug								
	Review																					
18	Review and update draft plan																					
19	Equality Impact Assessment																					
20	Meeting of Commissioning Group			21-Jun			15-Jul			03-Aug				30-Aug								
22	Amendments to draft plan																					
23	Submit draft plan to IJB Strategic Planning Group																22-Sep					
24	IJB Strategic Planning Group Meeting																		6th Oct			
	Do																					
25	Submit plan for IJB for agenda																		06-Oct			
26	IJB Meeting																				18-Oct	

WEST LOTHIAN STRATEGIC PLANNING GROUP

Date: 17 Nov 2016
Agenda Item: 6

RISK MANAGEMENT REPORT

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To advise the Strategic Planning Group on the approach being taken to the management of risk and to advise the Group of the risks identified

B RECOMMENDATION

. *The Strategic Planning Group is asked to*

1. . To note progress on risk management as set out in this report

2. To consider the risks identified, and the control measures in place to mitigate their impact.

C TERMS OF REPORT

Risk may be defined as the effect of uncertainty on the ability of an organisation to achieve its objectives.

The objective of risk management is to ensure that risks are properly identified, assessed and managed. Risks may fall into a number of different categories, for example environmental (e.g. severe weather), financial (e.g. funding arrangements) or social (e.g. changes in demographics).

The Integration Scheme between West Lothian Council and NHS Lothian requires the IJB to operate a risk management strategy. The risk management strategy will comprise relevant policies and procedures for the management of risk. These are currently in the process of being developed.

The Integration Scheme also requires that the IJB maintains a risk register and that the Director produces and agrees a list of the risks to be reported and monitored. A risk register has been set up using West Lothian Council's Covalent system, and the risks to be reported and monitored are attached as

appendix 1.

The risks were identified by the IJB Senior Management Team during a risk management session facilitated by West Lothian Council's risk manager.

All of the risks have been scored for likelihood (i.e. an estimate of how likely they are to happen) and impact (i.e. an estimate of the harm arising should they occur) using a five by five risk matrix. These two ratings are multiplied together to provide a risk score. As will be apparent, the scores range between 1 and 25. The higher the score, the higher the assessed risk and therefore the greater potential impact on IJB objectives.

It is important to note that the risks identified represent high level, or strategic, risks to the IJB's objectives. Operational risks are separately recorded in the risk registers of both West Lothian Council and NHS Lothian.

In relation to appendix 1

- The original risk score represents the uncontrolled risk, that is to say the potential impact if controls are absent or fail;
- The traffic light icon represents the risk ranking based on the score (i.e. high, medium high, medium or low);
- The risk matrices represent the risk score (a combination of likelihood and impact).
- The current risk score represents the current risk, i.e. assuming that current controls are in place and effective;
- The assigned to column identifies the officer assigned to manage the risk;
- The internal controls are those processes in place to reduce the risk from original risk score to current risk score.

D CONSULTATION

HSCP Senior Management Team.

E REFERENCES/BACKGROUND

F APPENDICES

1. West Lothian Integration Joint Board's Risks

G SUMMARY OF IMPLICATIONS

Equality/Health	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, equality impact assessment has not been conducted.

National Health and Wellbeing Outcomes	Effective risk management is a pre-requisite for effective performance All National Health and Well Being Outcomes
Strategic Plan Outcomes	Effective risk management is a pre-requisite for effective performance All Strategic Plan Outcomes
Single Outcome Agreement	Effective risk management is a pre-requisite for effective performance We live longer healthier lives and have reduced health inequalities Older people are able to live independently in the community with an improved quality of life
Impact on other Lothian IJBs	Shared Risks
Resource/finance	Within available resources
Policy/Legal	None
Risk	This report sets out progress in relation to management of the IJB's risks

H CONTACT

Contact Person:
Carol Bebbington, Senior Manager Primary Care & Business Support
mailto:carol.bebbington@nhslothian.scot.nhs.uk

Tel 01506 281017

10th November 2016

West Lothian Integration Joint Board Risks

Generated on: 10 November 2016 11:33
Report Layout: Original and current risks with internal controls

Risk Code and Title	Description	Original Risk Score	Traffic Light Icon	Current Likelihood	Current Impact	Current Risk Score	Traffic Light Icon	Assigned To	Internal Controls
IJB005 Inadequate Funding	Funding is inadequate to meet strategic objectives, or is inadequately apportioned.	25		3	4	12		Jim Forrest	S95 Officer Due diligence by S95 Officer Approval of resource allocations by IJB Board Monitoring / reporting of progress / outturn Scrutiny by Audit Committee Financial Regulations / rules for overspends
IJB008 Workforce Management	Performance inhibited by: funding pressures; IJB resource allocation; inability to recruit and retain key professional staff.	12		4	3	12		Jim Forrest	Current NHS and WLC workforce management arrangements. Reporting to, and monitoring by, IJB SMT and Board.
IJB002 Ineffective Strategic Plan	Ineffective strategic plan leads to key objectives not being achieved.	20		2	5	10		Jim Forrest	National outcomes. Local outcomes. Clear vision as to what is required Strategic Plan based on national and local policy Review of plan by IJB SMT Approval of plan by IJB Board

Risk Code and Title	Description	Original Risk Score	Traffic Light Icon	Current Likelihood	Current Impact	Current Risk Score	Traffic Light Icon	Assigned To	Internal Controls
IJB001 Governance Failure	Lack of leadership and / or ineffective governance leading to failure to meet key objectives, financial overspends or reputational damage.	15		2	5	10		Jim Forrest	Director / S95 Officer Standing Orders / Scheme of Administration Audit Committee / scrutiny Code of Conduct Policies and Procedures – financial, governance, risk Procedures for assessing disputes re resource allocations Governance / legal advice
IJB009 Demographic Changes	Current service models unable to meet future service demands, e.g. in relation to ageing population.	20		3	3	9		Jim Forrest	Strategic Plan Programme / service redesign Management of customer expectation
IJB004 Failure of Clinical and Care Governance	Harm to service users.	25		2	4	8		Jim Forrest	Existing clinical and care governance arrangements within NHS and Social Policy. Effective performance reporting to IJB SMT and Board. Care and governance group to be formed.
IJB006 Failure of Health and Safety Arrangements.	Harm to employees / volunteers	25		2	4	8		Jim Forrest	Existing health and safety arrangements on council and health sides Effective performance reporting to IJB SMT and Board

Risk Code and Title	Description	Original Risk Score	Traffic Light Icon	Current Likelihood	Current Impact	Current Risk Score	Traffic Light Icon	Assigned To	Internal Controls
IJB003 Inadequate Performance Management	Inadequate performance management leads to key performance measures not met.	12		2	3	6		Jim Forrest	Agreed outcomes / performance measures Robust performance management within WLC / NHS Regular monitoring by IJB SMT Regular reporting of performance to IJB
IJB007 Community Planning Failure	Inability to work effectively with partners leading to poorer outcomes.	9		1	3	3		Jim Forrest	Participation in Community Planning arrangements. Strategic Plan.

West Lothian Integration Joint Board

Date:17 Nov 2016
Agenda Item:7

STRATEGIC PLANNING GROUP

LOCALITY PLANNING UPDATE

REPORT BY DIRECTOR

A PURPOSE OF REPORT

The purpose of this report is to provide the Strategic Planning Group (SPG) with an update on locality planning in West Lothian since April 2016 when the SPG approved terms of reference for the east and west locality planning groups and agreed to deliver a development event for group members.

B RECOMMENDATION

It is recommended that members of the SPG:

1. Note the terms of the report; and
2. Note that the Director will provide a further update to the group at its meeting on 20 April 2017.

C TERMS OF REPORT

C.1 Background

The Public Bodies (Joint Working) (Scotland) Act 2014 requires that the Integration Joint Board (IJB) strategic plan divides the IJB area into at least two localities and requires the IJB to develop measures for delivery of services to those different localities.

The IJB approved the Strategic Plan 2016-2026 on 31 March 2016. The plan duly identified two West Lothian localities: east and west.

The main communities in the east locality are Broxburn, East Calder, Linlithgow, Livingston and Winchburgh. The main communities in the west locality are Armadale, Bathgate, Blackburn, Fauldhouse, West Calder and Whitburn.

The Strategic Plan notes that the way health and social care services are delivered locally can have a significant impact on how the main health and well-being challenges for communities are addressed.

C.2 Locality Groups

At its meeting on 7 April 2016, the SPG approved terms of reference for locality groups which will guide the development of locality plans. The terms of reference are attached as appendix 1 to this report. It was further agreed that the groups would comprise representatives of the following groups:

- health and social care professionals involved in the care of people who use services;
- the housing sector;
- the third and independent sectors;
- carers and patient representatives; and
- people managing services.

Officers subsequently established membership of the groups based on the SPG's guidance. Details of locality group membership are included in appendix 1.

The SPG also agreed to hold a development event for members of the locality groups to provide background on the work required of the groups and to develop initial work plan priorities for 2016/17.

C.3 Localities Development Day

The development event was held on 10 June 2016 at Howden Park Centre.

The programme was introduced by the Director. The morning session comprised an introduction to integration and localities, an update on commissioning plans, a presentation on links to regeneration plans and concluded with reflections from the Heads of Service.

The afternoon session involved east and west workshop sessions, each led by a public health consultant. This part of the day focused on providing more details of locality issues and assets and an initial discussion on priorities in each area.

The event was well attended with most group members able to take part.

The notes from the workshops are attached as appendix 2, for information.

C.4 Locality Plan Development Group Meetings

The groups will meet every two months. Both groups have met twice so far, on 28/29 September and 9/10 November.

The agenda for the first meetings included a reminder of the terms of reference and membership, a review of the locality developmental day summaries, an update on commissioning plans and regeneration plans, an update on GP cluster groups (east only, due to leave commitments), consideration of information required and an initial discussion on engagement.

The agenda for the second meetings included a presentation on the implications of the development plan on service provision in health and social care and consideration of a possible structure for presenting locality plans and an outline work plan.

The proposed format and outline work plan are attached as appendices 3 and 4, for information. These may be amended following consideration by the

groups in November.

C.5 Scottish Government – Guidance

The Scottish Government has issued guidance on locality planning. This is attached as appendix 5.

C.6 Future Updates

It is proposed to provide updates to the SPG at approximately six monthly intervals with the next report due on 20 April 2017.

D CONSULTATION

Good progress has been made since the SPG last considered a report on locality planning in April 2016 and work will continue under the guidance of the locality plan development groups and through engagement with the community with a view to preparing draft plans for consideration by the SPG in spring 2017.

E REFERENCES/BACKGROUND

Public Bodies (Joint Working) (Scotland) Act 2014 and related statutory instruments and guidance.

West Lothian IJB Strategic Plan 2016-2026.

Localities Guidance, The Scottish Government, July 2015.

F APPENDICES

1. Terms of reference and east and west locality plan development groups
2. Notes from the locality planning development day
3. Proposed format of locality plans
4. Proposed outline work plan for locality plan preparation
5. Scottish Government 'Localities Guidance', July 2015

G SUMMARY OF IMPLICATIONS

Equality/Health	The draft locality plans will be subject to an integrated impact assessment.
National Health and Wellbeing Outcomes	The locality plans will make a positive contribution to strategic plan outcomes.
Strategic Plan Outcomes	Positive contribution to strategic plan outcomes.
Single Outcome Agreement	Finalised locality plans will support the single outcome agreement.
Impact on other Lothian IJBs	The IJBs will share best practice on the delivery of locality planning.

Resource/Finance	Locality plans will be prepared within existing resources.
Policy/Legal	Public Bodies (Joint Working) (Scotland) Act 2016 and associated regulations and guidance.
Risk	None.

H CONTACT

Steve Field
Head of Service, West Lothian Council
01506 282386
steve.field@westlothian.gov.uk

17 November 2016

East Locality Group

Terms of Reference and Membership

A. Remit of Locality Group

The West Lothian Integration Joint Board (IJB) has established two localities within West Lothian in accordance with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

The localities have been built up from 2011 datazones to support data capture for planning purposes and aligned as best fit to General Practice (GP) populations and multi-member wards to support development of integrated models around GP Practice clusters as well as localities. The geographies of the localities are laid out in section G.

The East Locality Group is to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the IJB Strategic Commissioning Plan and to influence how resources are utilised in their area.

The purpose of the East Locality Group is to:

- Support the principles that underpin collaborative working to ensure a strong vision for service delivery.
- Support GPs to play a central role in providing and coordinating care to local communities and by working more closely with others – including wider primary care team, secondary care, social care colleagues and third sector providers - to help improve outcomes for local people.
- Support a proactive approach to capacity building in communities and better integrated working between primary and secondary care.
- Provide a consultative function to the Integration Joint Board when a decision is to be made that is likely to significantly affect service provision in a locality.

The East Locality Group will develop a locality plan which will take account of community plans and local regeneration plans within the localities. It is anticipated that the locality plan will build on the insights, experiences and resources in localities to support improvements in local networks, enable development of robust and productive professional relationships and improve health and wellbeing outcomes.

The locality plan will include

- A list of all services under the management of the IJB of which the locality is a part
- A note of the priorities for each locality under each of the service headings
- Planned expenditure for each service heading, using the locality budget as

determined taking account of population need and any factors relating to provision of services in the area.

The locality plan will be consistent with appropriate commitments within the following related high level strategies: West Lothian IJB Strategic Plan, care group Commissioning Plans, West Lothian Health and Social Care Partnership (HSCP) Engagement Framework, West Lothian Single Outcome Agreement, NHS Lothian Local Delivery Plan, NHS Lothian Clinical Strategy, West Lothian Housing Strategy, and West Lothian Council Corporate Plan.

B. Frequency

The group will meet quarterly.

C1. Lead Officer

The group will be chaired by Jane Kellock.

C2. Contact

The Lead Officer will be supported by support officer/s from within West Lothian HSCP.

D. Reporting

The group will report to the West Lothian Integration Strategic Planning Group in accordance with the IJB Strategic Plan.

E1. Membership Profile

Participants are chosen in line with the Health and Social Care Localities Guidance, July 2015 to provide the relevant knowledge and expertise to fulfil the remit of the group.

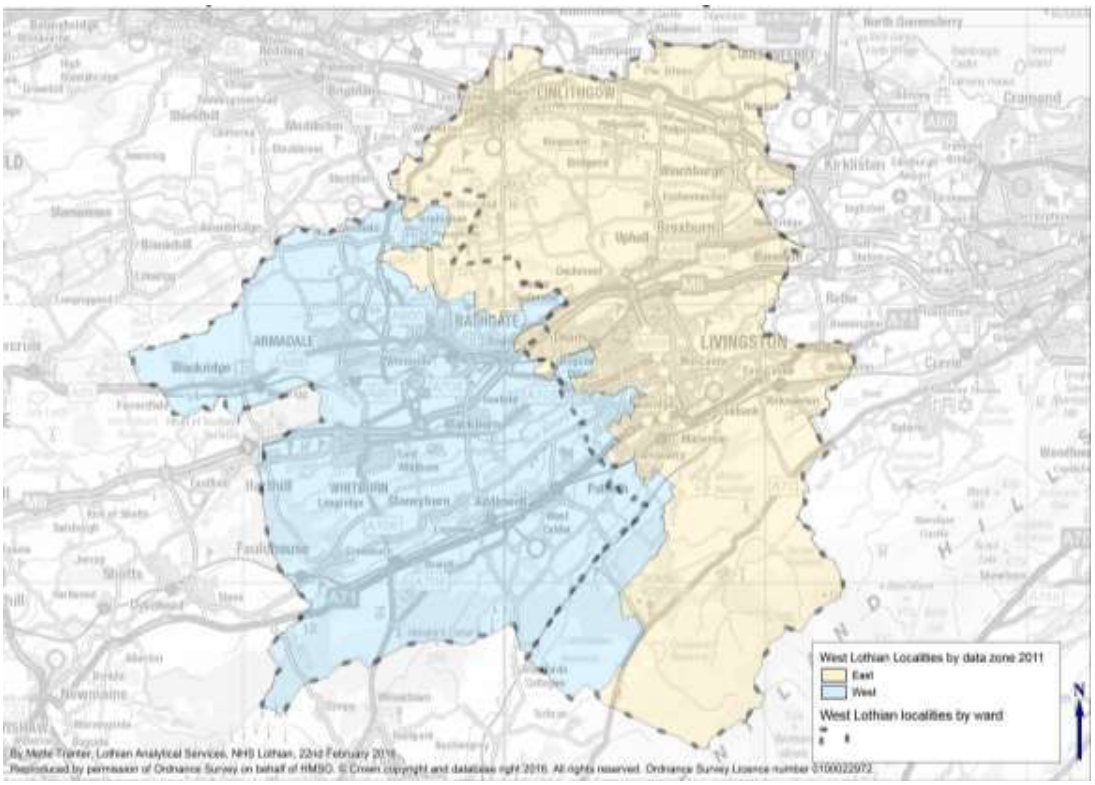
E2. Membership

Member	Role
Jane Kellock	Lead Officer
Dr Iain McLeod	GP representative
Colin Small	Health Care representative
Helen Smart	Health Care representative
Alistair Shaw	Housing representative
Dawn Woodward	Housing representative
Pamela Main	Social Care representative
Rachel Mackay	Social Care representative
Bridget Paterson	Third sector provider representative
Robert Telfer	Independent sector representative
Ian Buchanan	Service user representative
Mary-Denise McKernan	Carer representative
Susan Gordon	CPP
Douglas Grierson	Regeneration Team

F. Review

The terms of reference will be reviewed on an annual basis.

G. Locality areas



West Locality Group

Terms of Reference and Membership

A. Remit of Locality Group

The West Lothian Integration Joint Board (IJB) has established two localities within West Lothian in accordance with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

The localities have been built up from 2011 datazones to support data capture for planning purposes and aligned as best fit to General Practice (GP) populations and multi-member wards to support development of integrated models around GP Practice clusters as well as localities. The geographies of the localities are laid out in section G.

The West Locality Group is to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the IJB Strategic Commissioning Plan and to influence how resources are utilised in their area.

The purpose of the West Locality Group is to:

- Support the principles that underpin collaborative working to ensure a strong vision for service delivery.
- Support GPs to play a central role in providing and coordinating care to local communities and by working more closely with others – including wider primary care team, secondary care, social care colleagues and third sector providers - to help improve outcomes for local people.
- Support a proactive approach to capacity building in communities and better integrated working between primary and secondary care.
- Provide a consultative function to the Integration Joint Board when a decision is to be made that is likely to significantly affect service provision in a locality.

The West Locality Group will develop a locality plan which will take account of community plans and local regeneration plans within the localities. It is anticipated that the locality plan will build on the insights, experiences and resources in localities to support improvements in local networks, enable development of robust and productive professional relationships and improve health and wellbeing outcomes.

The locality plan will include

- A list of all services under the management of the IJB of which the locality is a part
- A note of the priorities for each locality under each of the service headings
- Planned expenditure for each service heading, using the locality budget as determined taking account of population need and any factors relating to provision of services in the area.

The locality plan will be consistent with appropriate commitments within the following related high level strategies: West Lothian IJB Strategic Plan, care group Commissioning Plans, West Lothian Health and Social Care Partnership (HSCP) Engagement Framework, West Lothian Single Outcome Agreement, NHS Lothian Local Delivery Plan, NHS Lothian Clinical Strategy, West Lothian Housing Strategy, and West Lothian Council Corporate Plan.

B. Frequency

The group will meet quarterly.

C1. Lead Officer

The group will be chaired by Marion Barton.

C2. Contact

The Lead Officer will be supported by support officer/s from within West Lothian HSCP.

D. Reporting

The group will report to the West Lothian Integration Strategic Planning Group in accordance with the IJB Strategic Plan.

E1. Membership Profile

Participants are chosen in line with the Health and Social Care Localities Guidance, July 2015 to provide the relevant knowledge and expertise to fulfil the remit of the group.

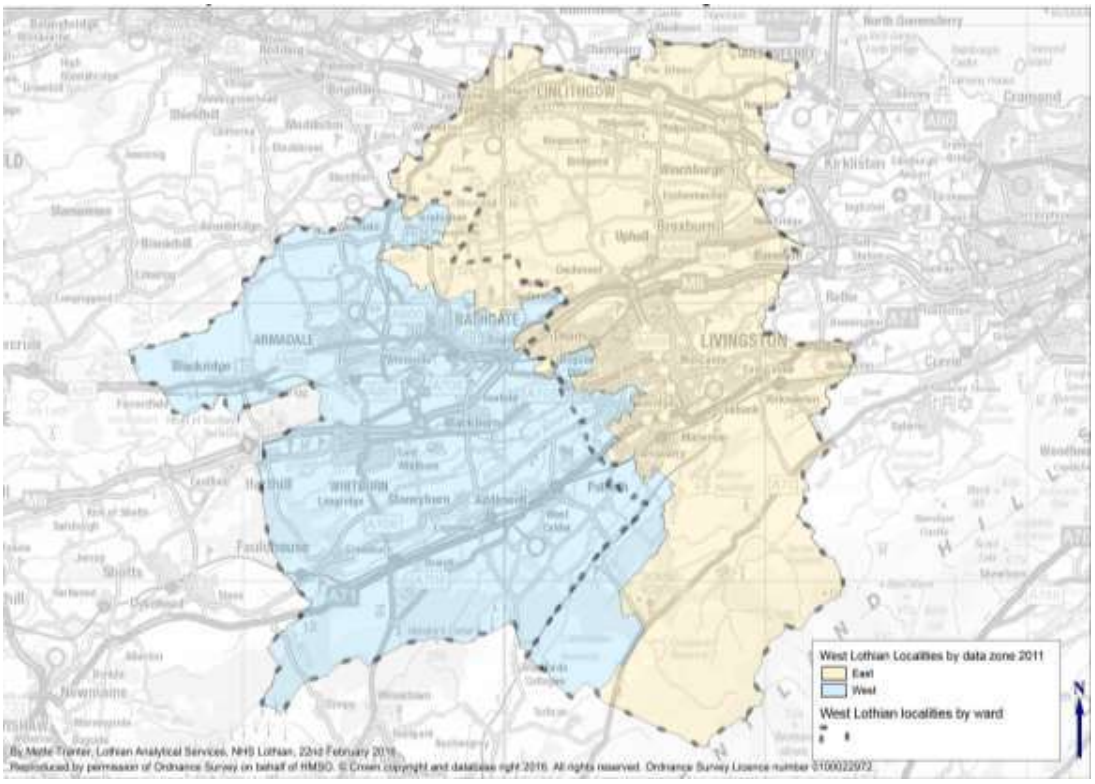
E2. Membership

Member	Role
Marion Barton	Lead Officer
Dr Steven Haig	GP representative
Linda Yule	Health Care representative
Margaret Douglas	Health Care representative
Carol Bebbington	Health Care representative
Margaret Williamson	Health Care representative
Stephen McCulloch	Housing representative
Alan Bell	Social Care representative
Karen McGhee	Third sector provider representative
Marcia Stewart	Independent sector representative
Ian Brown	Service user representative
Gill Burns	Carer representative
Joanna Anderson	CPP
Laura Wilson	Regeneration Team

F. Review

The terms of reference will be reviewed on an annual basis.

G. Locality areas



West Lothian Localities Planning day
Friday 10th June 2016
Notes from workshop sessions

Chair:	Jane Kellock	Head of Social Policy
Facilitator:	Aisha Chaudhary	NHS Lothian Health Promotion
Localities Group Members:	Ian Buchanan	Craigshill Community Council
	Douglas Grierson	WLC Regeneration
	Mary-Denise McKernon	Carers of West Lothian
	Colin Small	NHSL
	Dawn Woodward	Trust HA

East Locality of West Lothian:
Linlithgow
Broxburn
Uphall
Winchburgh
Livingston
East Calder

Regeneration area plans include:
Ladywell, Dedridge, Knightsridge
Craigshill
Bridgend

Session 1
What works well in East West Lothian

- ✓ x4 Neighbourhood networks in Livingston; enables further engagement with local communities
- ✓ Engaging carers through community facilities for example coffee mornings set up providing further engagement with health services and information i.e. Marie Curie and benefits advice services
- ✓ Place specific engagement with specific populations groups, for example young people through football activities
- ✓ Local knowledge shared through partnerships to identify services and create links
- ✓ Networking effective and non complex
- ✓ Health & Social Care Partnership structures are in existence and operating
- ✓ Use of social media through Facebook for community engagement, enquiries, sharing information and distributing needs assessment survey
- ✓ Community newsletter
- ✓ Buildings: partnership centres which are accessible
- ✓ New house builds
- ✓ Hospital facility
- ✓ Strong Health & Social Care Service

Top 3 successes in East West Lothian include:
1. Partnership working
2. Use of community assets
3. Places of interest

Key Challenges to build on:
- ✓ Demand on GP service
  - Complex cases
  - Need to develop expertise to manage such cases

Mindful of:
Community asset mapping due in Aug

New SIMD data out approx autumn

- Time constraint to deal with cases effectively
- Availability of appointments

✓ Workforce shortage
- Consider the role of the GP service
- Alternative services options with wider role ie community pharmacy

✓ Similar position with Health & Social Care services
- Requirement to purchase specialist services to meet the need of growing demand
- Supply/demand

✓ Engage and communicate with public on access to public services and what would best work

✓ Raise public awareness and educate how they should be making best use of existing services and access alternative services where possible

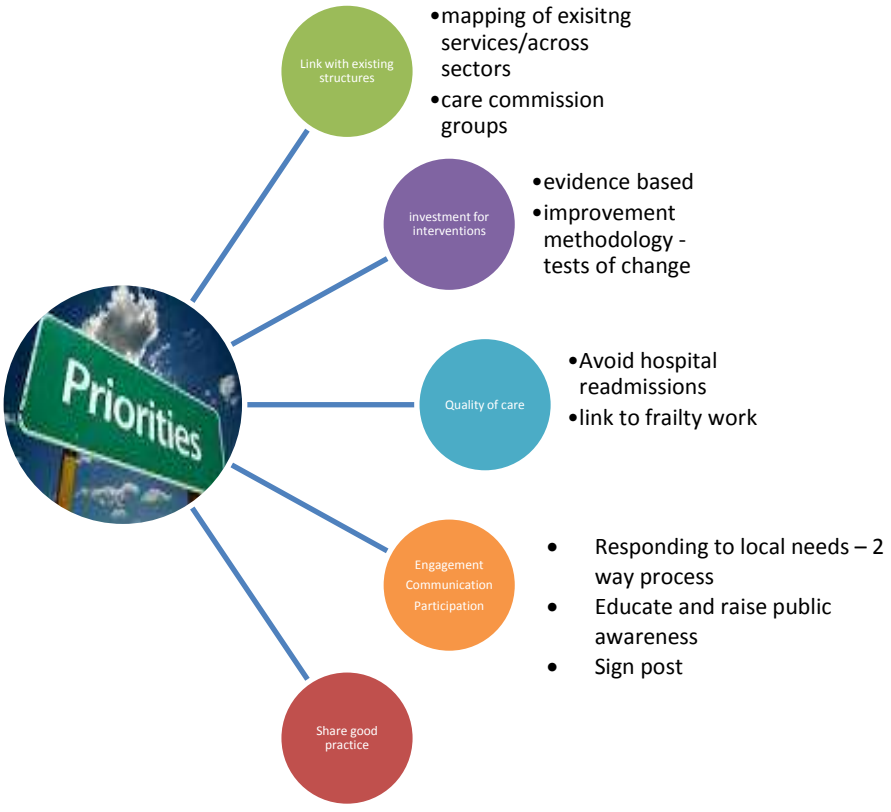
✓ Improve how existing services operate to deliver better service and route i.e. NHS 24 triage patients to out of hours service – improvements

✓ Manage expectations of population and supply, particular to local areas

✓ Health inequalities are prevalent across regions/areas not just in areas of deprivation. Consider interventions that are evidence based, which work. Consider improvement methodology approach to existing interventions.

✓ Impact of housing benefit cap on most vulnerable households

Session 2
Priorities / Scope of the Localities Group



Some additional comments which came out through the discussion:

✓ Better understanding of breadth of services and areas which require support

✓ Support for GP practice – look at particular hot spots in the system to facilitate best use of resources and better value for investment

✓ Support people better to make use of and access community based services

WEST LOTHIAN IJB - WEST LOCALITY

Notes from West Locality Group discussion on Localities Development Day 10th June 2016.

The group discussion was in two parts:

1. The characteristics of the locality, both strengths and challenges
2. Priority issues to be worked on to develop a Locality Plan

The key discussion points that were captured on the flip charts are noted below.

1. Characteristics of the locality

Ex mining communities

- Heritage
- Health legacy

Rurality

- Several distinct communities, rural and remote, could lead to isolation
- Rural nature can also affect access and increase inequalities – eg if cant access employment
- Smaller communities can feel they get fewer resources than Livingston

Demographic change

- Growing population – 2/3 existing WL population; 1/3 incomers
- Aging population
- Rising numbers of people with long term conditions

Impact on needs and demands for services

- Demographic change leads to increased demand and pressure on services
- [Q - Do incomers differ in their use of services?]
- Sense of mismatch of need and demand – some with high levels of need make little use of services and vice versa
- Increasing need for both formal and informal care – families may be less able to care because carers themselves are older; or may be working; families are smaller; 'sandwich carers' caring for more than one person so under pressure; but may also have more generations able to provide care – need to support young carers

Sense of community

- Strong community identity and spirit
- Poor image from outsiders but community spirit among residents
- But potential lowering of this sense of identity as new people move in, people in new developments may not integrate
- Stoical in relation to health, often low use of services
- Perception that people more open to change than previously

Economic issues

- Most industry is service and distribution, and public sector employment
- Lot of commuting – dormitory towns, may affect sense of community
- Unemployment, underemployment, low wages
- So high need for access to financial advice and support

Housing

- Old housing stock and newer developments
- New housing can bring developer contributions for schools but not health facilities – though also pressures on some schools. Schools noted as an important focus for community.
- Increased housing implies loss of greenspace
- High level of churn – people may aspire to move out - can lead to concentrations of disadvantage as people with highest needs move into properties that are vacated

Transport

- Transport challenging in rural areas
- [Q - What proportion of population, and which groups, are dependent on public transport?]
- Increased connections over last 20 years
- Increased traffic – due to rising population and increased car ownership – potential air quality issues

Infrastructure

- Good community infrastructure – Community Development Trusts, Pastors etc
- Also good leisure and other facilities
- Perception of decline of town centres, lot of fast food and charity shops
- But also overall increase in shops, restaurants, services, facilities, sports participation

High perception of crime although low crime rates – noted new Police Community Teams

2. Priorities to work on for Locality Plan

Make use of information, data and intelligence

- Use needs assessment to identify gaps
- Also identify good practice that could spread

Access issues

- Look at why people attend A&E
- GP access and DNAs – will be looked at by cluster group
- Access to other services
- Consider developing links into services for people with highest needs who do not attend for support

Support to maintain people at home

- Includes support for families and unpaid carers
- Consider resilience, support, information and access needs

Develop community capacity

- Use of community led evaluation – make sure this includes people with the highest needs

Develop third sector capacity

- Role of VSG

Develop/support GP practices

- Recognised as central to people's experience of health and social care
- Capacity in GP
- Partnership with third sector eg support groups, buddies etc
- Breakdown barriers to other services

- Make better use of Partnership centres and multi-agency teams – eg share information across, signpost to other services
- Share best practice

Margaret Douglas
10 June 2016

Locality Plan Template

1. Foreword
   - Informal welcome to the plan from the IJB chair and director

2. Legislative and policy context
   - Public Bodies (Joint Working) (Scotland) Act 2014
   - West Lothian IJB Integration Scheme
   - West Lothian IJB Strategic Plan
   - Scottish Government Localities Guidance (especially s6.4 and s9.0)
   - West Lothian Single Outcome Agreement/Community Planning

3. Locality planning in West Lothian
   - Description of east and west localities
   - Outline of the representation and role of locality plan development groups

4. Demographics
   - Profile of the specific locality population to include information on issues identified at the development day
   - Links to regeneration plans

5. Financial resource alignment
   - How social policy and health budgets are spent in the locality
   - How locality plans relate to commissioning plans

6. Services
   - Identification of services under the management of the IJB
   - Identification of other assets eg third sector resources

7. Participation and engagement
   - Input from the Health Experience Survey (http://www.hace15.quality-health.co.uk/)
   - Feedback from services, groups and individuals

8. What is working well
   - Areas where service provision is anticipated to meet demand
   - Any tweaks required

9. Needs and priorities
   - Areas where service require development or improvement is required
   - Proposed outcomes
   - Measures of success

10. Action plan
    - three year LP; one year action plan
    - actions; budget; target dates; milestones; responsible officer

Work Plan

- November: complete profiling, review of assets

- December: prepare consultative draft

- January: carry out engagement

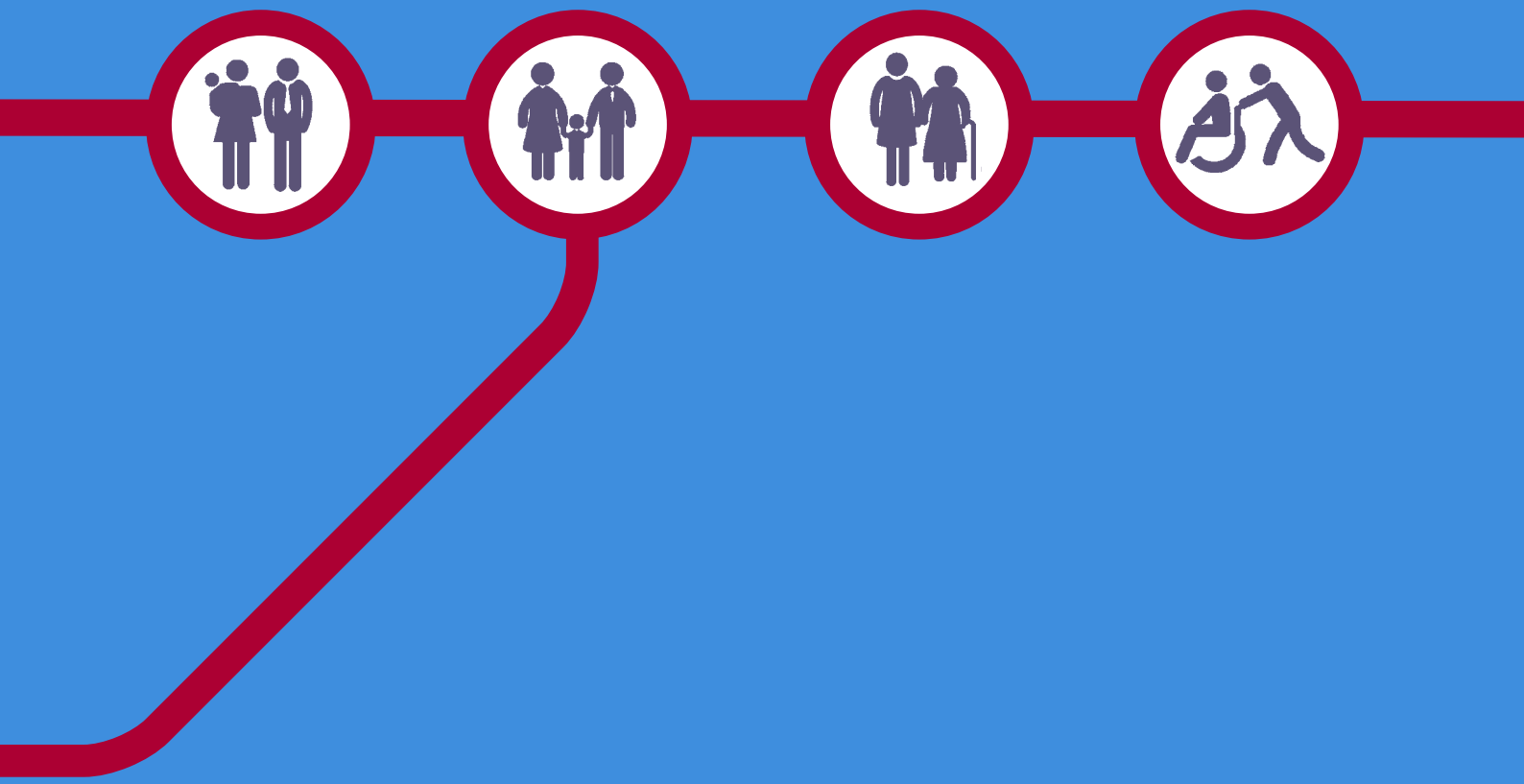
- February: finalise plan

- March: SPG consideration

The Scottish Government
Riaghaltas na h-Alba

Localities Guidance

Guidance on what localities are for, the principles upon which they should be established, and the ethos under which they should operate



Public Bodies (Joint Working) (Scotland) Act 2014

Health and Social Care Integration

1 WHAT IS THIS GUIDANCE ABOUT?

1.1. The Public Bodies (Joint Working) (Scotland) Act 2014[1] (the Act) puts in place the legislative framework to integrate health and social care services in Scotland. Section 29(3)(a) of the Act requires each Integration Authority to establish at least two localities within its area.

1.2. A criticism of Community Health Partnerships was the lack of opportunity for communities and professionals – including GPs, acute clinicians, social workers, nurses, Allied Health Professionals, pharmacists and others – to take an active role in, and provide leadership for, local planning of service provision. Localities provide one route, under integration, to improve upon this, and to ensure strong community, clinical and professional leadership of strategic commissioning of services[2].

1.3. This guidance reinforces the importance of localities. Achieving the aspirations we share for health and social care integration will rely upon partners across the health and social care landscape, and their stakeholders, focussing, together, on their joint responsibility to improve outcomes for people. Every locality will involve a range of people from different backgrounds, who are accustomed to different working styles and arrangements. When different people come together with a shared responsibility in this way it can of course take some time to find the best way to work together. This guidance should be used to support the establishment of localities, particularly during the period of transition to new ways of working under integration.

> ' . . . effective services must be designed with and for people and communities – not delivered 'top down' for administrative convenience'
>
> **The Christie Commission Report**
> Commission on the future delivery of public services, June 2011

2 HOW IS THIS GUIDANCE SET OUT?

2.1 This guidance covers the following topics:

- Who should read this guidance?
- What other guidance is relevant?
- What is this guidance for?
- What are localities?
- What are the legal requirements on Integration Authorities relating to localities?
    - In the Act
    - In Regulations
- Who should be involved in localities?
- How should localities work in practice?

[1] http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf
[2] http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans

- What is the relationship between localities and community planning?
- Partners participating in localities:
    - General Practice
    - Primary Care
    - Secondary Care
    - Housing
    - Social Work and Social Care
    - Third, voluntary and independent sector
    - Communities
- Summary

3 WHO SHOULD READ THIS GUIDANCE?

3.1 This guidance is for everyone who is involved in integration in local health and social care systems. In particular, it is of interest to:

- the members of Integration Authorities, upon which the legislation places responsibilities in terms of establishing, supporting and understanding activity in localities;
- people working in Health Boards and Local Authorities, who will need to support and help implement the requirements on Integration Authorities to establish, support and understand activity in localities;
- clinicians and other professionals, for whom localities provide a real opportunity to contribute directly to the shape of local service provision;
- people working in multi-disciplinary teams;
- members of strategic planning groups;
- people working in the third and independent sectors who provide a range of social care services for people within localities; and
- people in local communities, who can get involved in localities in order to support and influence the design and delivery of health and social care services.

4 WHAT OTHER GUIDANCE IS RELEVANT?

4.1 This guidance should be read alongside the Scottish Government's guidance on clinical and care governance[3] under integration, guidance on managing integrated budgets[4], and guidance on strategic commissioning[5] for integration.

5 WHAT IS THIS GUIDANCE FOR?

5.1 This guidance sets out what localities are for, the principles upon which they should be established, and the ethos under which they should operate. It describes what it should be like for different people and professions to take part in locality arrangements, and it covers some of the practicalities that Integration

[3] http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/working_Groups/CCGG/ClinCareGovFwork
[4] http://www.scotland.gov.uk/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance
[5] http://www.gov.scot/Resource/0046/00466819.pdf

Authorities should take into account when establishing and supporting localities.

5.2 The guidance has been written with input from a range of partners, reflecting the people and professionals who need to take part in localities.

5.3 This guidance does not repeat the arguments already made about why localities are important, or why Scotland is integrating health and social care. Both of these principles are taken as read. It builds upon, but does not repeat, All Hands On Deck[6], the think-piece previously published by the Scottish Government on the importance of localities, to which this guidance is complementary.

5.4 Section 53 of the Act states that Local Authorities, Health Boards and Integration Authorities must pay regard to any guidance, such as this, issued by Scottish Ministers in relation to the Act.

6 WHAT ARE LOCALITIES?

6.1 A locality is defined in the Act as a smaller area within the borders of an Integration Authority. The purpose of creating localities is not to draw lines on a map. Their purpose is to provide an organisational mechanism for local leadership of service planning, to be fed upwards into the Integration Authority's strategic commissioning plan – localities must have real influence on how resources are spent in their area.

6.2 Each Integration Authority is required to define and agree the area of each of its localities in consultation with local professionals and communities. Locality areas should relate to natural communities and take account of clusters of GP practices, which may in turn need to be realigned to fit with other services. The size of localities will vary, but will need to feel "right" to people living and working in the area: large enough to offer sufficient scope for service improvement, but small enough to feel local and "real".

6.3 In this guidance, when we refer to localities, we are referring to the group of people in these areas who must play an active role in service planning for the local population, in order to improve outcomes.

6.4 Localities must:

a) Support the principles that underpin collaborative working to ensure a strong vision for service delivery is achieved. Robust communication and engagement methods will be required to assure the effectiveness of locality arrangements.

b) Support GPs to play a central role in providing and co-ordinating care to local communities, and, by working more closely with a range of others – including the wider primary care team, secondary care and social care

[6] http://www.jitscotland.org.uk/wp-content/uploads/2014/10/All-Hands-on-Deck-2013.pdf

colleagues, and third sector providers – to help improve outcomes for local people.

c) Support a proactive approach to capacity building in communities, by forging the connections necessary for participation, and help to foster better integrated working between primary and secondary care.

7 WHAT ARE THE LEGAL REQUIREMENTS ON INTEGRATION AUTHORITIES RELATING TO LOCALITIES?

In the Act – Role in Strategic Planning

7.1 The Public Bodies (Joint Working) (Scotland) Act 2014 places a number of requirements on Integration Authorities that relate to the role of localities in strategic planning, as follows:

a) Within the strategic commissioning plan, each Integration Authority (lead agency or Integration Joint Board) must include information on the following two points:

i. How it will divide its area into two or more localities, i.e., what the boundaries of each locality are; and

ii. How it will carry out its functions in relation to each such locality: this information must be set out separately for each locality, and cannot just be a generic statement that assumes that all localities will work in the same way as one another. (Section 29)

b) When setting up and running its strategic planning group, the Integration Authority must include a person to represent the interests of each locality. One person can represent more than one locality, where that is agreed locally to be appropriate. (Section 32)

c) Where an Integration Authority is taking a decision that is likely to significantly affect service provision in a locality, it must take such action as it thinks fit to involve and consult appropriate representatives of that locality in the decision, and must also pay reasonable expenses and allowances to enable those representatives to give their view. (Section 41)

In Regulations: Annual Performance Reporting

7.2 The (Public Bodies) (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014[7] contain further detail, setting out the matters relating to localities on which the Integration Authority must report annually. These Regulations establish with further clarity the Integration Authority's responsibilities in relation to the influence that localities must have, and must be shown to have had, on the strategic commissioning plan and service delivery.

[7] http://www.legislation.gov.uk/ssi/2014/326/contents/made

7.3 The Integration Authority's annual performance report must include an assessment of performance in planning and carrying out functions in localities, as follows:

a) a description of the arrangements made in relation to consulting and involving localities;

b) an assessment of how these arrangements have contributed to the provision of services and support in each locality;

c) the proportion of the Integration Authority's total budget that was spent on each locality; and

d) in relation to the information described at c), above, a comparison between the reporting year and the five preceding reporting years (or, where there have been fewer than five preceding reporting years, all preceding reporting years).

8 WHO SHOULD BE INVOLVED IN LOCALITIES?

8.1 To ensure the quality of localities' input to strategic planning, they must function with the direct involvement and leadership of:

- health and social care professionals who are involved in the care of people who use services.
- representatives of the housing sector.
- representatives of the third and independent sectors.
- carers' and patients' representatives.
- people managing services in the area of the Integration Authority.

9 HOW SHOULD LOCALITIES WORK IN PRACTICE?

9.1 Locality arrangements must be fair, accountable, practical and proportionate. Integration Authorities, and the strategic commissioning plans they produce, must be more than the sum of the parts of locality plans. Strategic and locality level planning must work together to create the best possible working arrangements and to enable them to take account of local, and often deep rooted, issues, such as inequalities and poverty.

9.2 Localities exist to help ensure that the benefits of better integration improve health and wellbeing outcomes by providing a forum for professionals, communities and individuals to inform service redesign and improvement.

9.3 The views and priorities of localities must be taken into account in the development of the strategic commissioning plan produced by the Integration Authority. This means that localities should plan for how the Integration Authority's resources are to be spent on their local population, and the strategic commissioning plan should consolidate plans agreed in localities. For some

services or care groups, it will make sense for more than one locality to work together to plan what is needed.

9.4 The starting point for the budget for locality plans will be the Integration Authority's resources that are currently used by the locality population. This historic share should be set alongside a "fair" share target, based on locality populations weighted to take account of population need and any factors relating to provision of service in the area. Local systems can obtain information on the resource use and fair share benchmarks for their localities using data available from NHS NSS[8].

9.5 Localities must be well organised, and with sufficient structure to co-ordinate their input to strategic planning. The principle of moving away from top-down planning will only work if each locality is organised and supported to make an effective contribution. Each locality must therefore have a locality lead, who may be a GP from one of the practice clusters in the locality.

9.6 Each locality plan should include:

- A list of all the services under the management of the Integration Authority of which the locality is a part;
- A note of priorities for each locality under each of the service headings; and
- Planned expenditure under each service heading, using the locality budget described above.

10 WHAT IS THE RELATIONSHIP BETWEEN LOCALITIES AND COMMUNITY PLANNING?

10.1 Each Integration Authority will have two or more localities, which will contribute to its strategic commissioning plan. The Integration Authority will be a statutory community planning partner and therefore subject to duties placed on Community Planning Partnerships and partners by Part 2 of the Community Empowerment (Scotland) Bill.

10.2 Some locality arrangements already exist under community planning; it will be important that localities for integration build upon and take account of such arrangements, and create effective relationships between CPPs and Integration Authorities that health achieve the national health and wellbeing outcomes.

11 PARTICIPATING IN LOCALITIES

11.1 Different participants in localities will bring different skills and insights to the process. Working across and with one another is critical to the success of integration. People and communities will be enabled to flourish only where all parts of the system work collaboratively to empower local decision making and active citizenship. This section sets out some principles for the kind of experience that different participants should have.

[8] http://www.isdscotland.org/Products-and-Services/Health-and-Social-Care-Integration/

11.2 **General Practice**. The GMS contract makes provision for every GP practice to nominate an integration liaison, which provides a starting point for GP engagement in integration.

11.3 GP involvement in localities will to some extent vary from place to place. The key principle is that GPs must be meaningfully and thoroughly represented, engaged and directly involved in localities. In some places, this could mean that the locality group includes a named GP, or other practice member, from every GP practice. In other places, it could mean that the locality group includes a GP, or other practice member, from each of its GP clusters. The role for these representatives, whether GPs themselves or other practice members, will be to meet with the locality lead on a regular basis, to provide a clinical community of leadership.

11.4 Agreement on GP membership of localities should be reached by the Integration Authority and the Local Medical Committee. Additionally, the contribution of local Area Clinical Forum and Professional Advisory Committees will be critical to the development of localities, and to ensuring that each representative group has the opportunity to contribute appropriately.

11.5 **Primary Care**. Each profession in the wider primary care team should have the opportunity to participate in the development of the locality plan and local decision making that affects their profession, either via membership of the locality or via a clear mechanism that enables them to feed into and be made aware of the decision making process.

11.6 **Secondary Care**. It will be important to take account of the views of people working in secondary care. Again, arrangements in this respect will vary from place to place; local Managed Clinical Network and Community Hospital arrangements will provide a starting point for secondary care engagement in localities. Clinicians and representatives from unscheduled care and geriatric medicine specialists, in particular, should be involved.

11.7 **Housing**. Localities should also take account of input from people who have responsibility for housing, given the focus within integration on supporting people, as far as possible, to stay in their own homes and building healthy, resilient communities.

11.8 **Social Work and Social Care**. Social workers, and people working in social care more generally, play an important role in helping people to maintain their independence; their input will be critical to effective locality arrangements.

11.9 **Communities**. People living locally must have a meaningful role in localities. Existing Public Participation Forums and local patient participation groups can play a valuable role as communities of interest, as can existing planning and consultative groups such as Community Councils or Local Area Networks.

11.10 Integration is intended specifically to improve care for people with complex support requirements. Many will be older people. Disabled people will also form a key constituency, for whom localities – and integration more widely –

bring the opportunity to influence service design to make a really positive difference to their lives. It is often challenging for older people and disabled people to be heard, much less to engage meaningfully in co-production[9]. It will be important that localities are set up with accessibility and creativity in mind, particularly for people who are socially isolated. Integration Authorities should consider innovative approaches to engaging people, including identifying how third sector organisations may be better placed to facilitate the involvement of people for whom participation may present challenges.

11.11 The contribution of public health and health promotion is vitally important to support the evidence base of what each locality areas challenges are and to assist in making the biggest impact on inequalities.

12 SUMMARY

12.1 Localities can play a very powerful role in making integration a success across Scotland. By using this guidance to build upon the insights, experience and resources in localities, Partnerships can improve local networks, develop robust, productive professional relationships, and improve outcomes.

[9] http://www.ilis.co.uk/get-active/publications/co-production-toolkit

This publication is available at **www.scotland.gov.uk**

Any enquiries regarding this publication should be sent to us at
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WEST LOTHIAN STRATEGIC PLANNING GROUP

Date: 17 Nov 2016
Agenda Item: 8

PRIMARY CARE REPORT

REPORT BY DIRECTOR

A PURPOSE OF REPORT

The purpose of this report is to provide an overview of the current challenges being experienced in Primary Care and the actions being taken to support and sustain service provision.

B RECOMMENDATION

. *The Strategic Planning Group is asked to*

1. *Note the contents of the report*
2. *Note the current challenges facing Primary Care*
3. *Support the management team in their actions*
4. *Contribute to the proposed Primary Care Development event in February 2017*

C TERMS OF REPORT

GP Practices are facing a number of challenges which are affecting service delivery and capacity to meet demand. This paper outlines the current issues and the impact on West Lothian Practices and provides overview of the measures taken to support General Practice provision.

Changing Practice Populations

GPs are facing rising patient demand from an ageing population with multiple complex health conditions who are supported to live in community settings. Care of frail elderly patients in community settings takes up a very significant and expanding proportion of GP time. As the number of frail older people living with complex medical needs continues to increase this places additional demands on GP practices.

In addition population growth in the core development areas of Armadale, East

Calder, Whitburn, Bathgate and Winchburgh is having significant impact on General Practices and their capacity to manage the demand and increase in list size associated with population growth.

Workload
There is good evidence nationally of substantial increases in practice consultation rates, average consultation duration and total clinical workload3. Between 1998 and 2012 GP consultations increased by 24%.

The average member of the public sees a GP six times a year; this is twice the number compared to a decade ago.

Recruitment
There are significant challenges in recruitment and retention to GP posts across the country for partner, salaried, locum, and out of hours positions.

West Lothian has 22 practices and current level of GP vacancies is equivalent to10 WTE. These vacancies are spread over several GP Practices.

Workforce
Increasingly practices are staffed by GPs working part time. This is driven in part by the increasing number of female GPs, who on return from maternity leave often reduce their hours of work. In addition 40% of female GPs leave GP employment before age 40.

The majority of GP trainees (65%) are now female. The average age of the GP workforce has increased from 43 to 47 and 60% of GPs intend to retire early.

Morale
In the SGPC national survey:
54% of GPs felt their current workload was unmanageable or unsustainable
54% felt there had been an inappropriate and unrecorded transfer of work
71% felt their workload had a negative impact on their quality of life
43% felt they had insufficient time with patients
54 % reported their morale being low or very low.

Work life balance for GPs was worse than for doctors in training and hospital consultants, with GPs reporting working outside their regular hours very often

OOH Primary Medical Services
Out of Hours (OOH) primary medical services in Lothian are delivered by Lothian Unscheduled Care Service (LUCS) over evenings, overnight, weekends and public holidays. Demand on the service has increased by 18% since its establishment in 2005/06.

For West Lothian the service is based in St John's Hospital in OPD 2 and is delivered by a multidisciplinary team including salaried GPs and ad hoc (independent contractor) GPs. The current ratio of ad hoc to salaried GPs is around 70:30. There are significant difficulties in recruitment and retention of ad hoc and salaried GPs by LUCS. Although previous shortages were limited to specific periods such as Christmas and summer holidays, there are increasingly regular occasions when bases have to run on less than a full complement of

staff, offer a reduced service or even close for short periods.

Anecdotally there appears to be an overspill of work from day time GP practice presenting to the OOH service. This may be a reflection of the difficulty that patients may have in accessing daytime general practice.
A national review of OOH primary care recommends establishment of a network of Urgent Care Resource Hubs and Urgent Care Centres. Planning is underway on how this will be delivered in Lothian.

General Practice Education and Training
Approximately 40% of graduates from Scottish medical schools move to work in England after graduation. The fill rate for trainee posts has dropped significantly over recent years and in a number of specialties, including general practice, there are substantial shortages. This year for the first time around 20% of GP training places in the south-east region are unfilled.

Immigration policy changes have also caused a decline in the number of international medical graduates from outside the European Union working in the NHS. Surveys suggest that difficulty in recruitment is likely to continue and the planned increased GP training places are unlikely to be filled. Even if all training places are filled, pressures will continue in the short to medium term.

Staff shortages are also experienced in those nursing positions that work in or with GP practices.

Community Nursing
District Nursing and Health Visiting play a key role in delivery of primary care services, but there are also significant challenges in recruitment and retention for these staff groups.

For health visitors, district nurses and practice nurses around 50% of the workforce are 50 years of age or older. This is older than the age profile for nursing in the acute sector.

Practice Nursing
Practice nurses roles include chronic disease management, travel advice, contraception and non-medical prescribing. The proportion of consultations handled by nurses or other general practice staff has increased from 25% in 1995/96 to 38% in 2008/09. Further expansion could be explored.

Over recent years, primary care Advanced Nurse Practitioner (ANP) posts have been established, with these practitioners managing a similar acute caseload to GPs in both daytime and out of hours general practice. An educational programme is being delivered locally. Fourteen places were funded in 2015/16, and eleven are funded for 16/17.

A national survey of practice nurses conducted in 2015 reported that one in three (33.4%) practice nurses were due to retire by 2020.

Changes to the GMS Contract
The Scottish Government and the BMA in Scotland have over recent years agreed on an increasingly Scottish version of the national GMS contract. In

2016/17, the Quality and Outcomes Framework (QOF) was retired in Scotland and replaced by a Transitional Quality Arrangement (TQA) pending agreement of a new Scottish GMS contract from 2017/18 onwards.
These changes are intended to cut bureaucracy for practices to allow a shift towards quality improvement based around small clusters of GP practices working together to review data and plan improvements.

The coming GP contract is expected to strengthen and reinforce the role of GPs as expert generalists and senior clinical decision makers in the community. Primary care utilisation of a wider workforce and encouragement for all disciplines to work to the upper limit of their practice should allow GPs to focus on complex care and undifferentiated presentation.

Practice Numbers
Of the 123 GP practices in Lothian, over 95% operate as independent contractors; only six are directly managed by HSCPs under Section 2c of the contract. All of the 22 GP Practices in West Lothian operate as independent contractors.
In West Lothian 6 practices are receiving some degree of support from the HSCP such as help with managing the list size, financial support, help with recruitment and staffing, premises support and business support to maintain service provision.
As a reflection of the pressure on list sizes 40 practices in Lothian now have some degree of restriction on new registrations two of whom are in West Lothian. No practice in Lothian has formally closed their list.

Expansion of GP Training Places NES has advertised 100 additional three year GPST programmes through the upcoming recruitment round, starting in February 2017.

GP training schemes in Lothian have been redesigned to improve attractiveness to potential applicants by moving to a system in which all Lothian trainees rotate through Edinburgh for some of their hospital placements.

NES Scotland Returner and NES Enhanced Induction Programmes
These schemes are for doctors who have previously worked in UK general practice (but have not practiced for 2-5 years) and who intend to return to work in Scotland and for doctors who have trained in general practice (usually abroad) and who are included on the GMC GP Register but have never worked in UK general practice. There is also a local induction scheme run by Lothian.

Doctors undergoing the NES Scotland Returner and the NES Enhanced Induction programmes receive a bursary.

Scottish Government GP Recruitment and Retention Fund Over £2 million of funding has been allocated to recruitment and retention projects across the country, as part of the Government's Primary Care Investment Fund.

In Lothian two proposals were supported:
- WISEDOCS - a locum pool of recently retired GPs, supported to return to work for a period of time doing locum sessions in local practices, and
- A Clinical Development Fellow scheme combining work in a daytime

contractor GP practice with either Out of Hours work or A&E work, and participation in the NHS Lothian Quality Academy.

LEGUP (List Expansion Grant Uplift Scheme)
This scheme provides a short term financial incentive for practices to take on more patients. The expectation is that once practices have been supported to expand, the increased list size will generate the increased income needed to maintain service provision.

The HSCP have distributed this funding across 6 practices in the last two years

Integrated Care Pharmacists
The introduction of Clinical Pharmacists (Integrated Care Pharmacists) working in GP practices is a widespread development that appears to help in addressing capacity and workload issues in General Practice. Clinical Pharmacists, who may have non medical prescriber training, are able to take on a wide range of clinical work at practice level including: medication reviews, polypharmacy reviews, medicines reconciliation and review of repeat prescribing.

Scottish Government funding has allowed recruitment of around eight Band 8A clinical pharmacists deployed initially within practices at greatest need of support.

Skill Mix
Research suggests that 27% of GP appointments were potentially avoidable – including patients who could have been seen by another member of practice staff.
A range of practitioners could help to support GP workload by helping with clinical management in a range of areas:

- Physiotherapy – for musculoskeletal problems
- Optometry – for acute eye problems
- Community Pharmacy – for minor illness and medication queries
- Advanced Nurse Practitioners – for all acute presentations
- Practice Nursing –skill development to include non medical prescribing
- Healthcare assistants – not widely used in GP practice
- Dentists – for dental and oral health problems

These practitioners already provide services in primary care and these services need to be actively promoted so the public use them as the first point of contact for appropriate problems.

West Lothian practices are keen to explore how signposting can ensure patients are directed to right resource first time to improve access and promoted best use of resources. Posters have been developed and information is being promoted through range of media. In addition we are exploring staff training options for practice staff to enhance their skills in signposting patients.

IT and eHealth
GP practice clinical IT systems are provided and maintained by NHS Lothian eHealth. Most practices in Lothian use VISION, a smaller number of practices

use EMIS. There is widespread agreement that IT provision to GP practices is outdated. Most GP practices have ageing PCs with outdated and poorly compatible software. GP systems are very slow and are prone to crashing. These limitations are extremely frustrating and operationally inefficient as they impact on GP consulting time. The opportunity cost of time spent waiting for systems to load and rebooting PCs in the consultation is immense, not to mention the cumulative effect of these frustrations on morale.
GP systems also have no connectivity with those used in the acute sector, the out of hours service, community nursing and the acute sector.
Lothian could embrace the use of technology in patient care, for example:

- Use of email and text messages to communicate with patients
- On line appointment booking and prescription request management
- Email surgery consultations
- Web based patient enquiries eg Ask My GP
- Use of mobile devices eg for home visits and care home work
- Wi-Fi networks for decision support and internet access.

Although there may be operational and information governance concerns around many of these initiatives, they are not insurmountable and are supported by professional bodies such as RCGP Scotland (ref 2022)

Premises
Premises are critical to the development of Primary Care and models of care to support patients in the community. These need to be of sufficient standard and meet the clinical accommodation requirements.

Over the past two years the HSCP have undertaken refurbishment and created additional clinical capacity in Stoneyburn, Carmondean, Linlithgow and Whitburn (with further works planned over next 2 years) Health Centres and work is currently in progress on substantial programme of refurbishment at Dedridge Health Centre.

Work has commenced on the new Blackburn Partnership Centre which will be completed in 2017 and we are progressing work to develop new premises in East Calder and Armadale.

The GP in Murieston has completed and moved into new premises at the beginning of July.

Risk Register
The sustainability of Primary Care remains a high risk on the HSCP Risk Register and a very high risk on the NHS Lothian Risk Register.

To inform our plan and priorities for support each practice has been assessed on risk rating scale and the findings shared with the practices. This has enabled the management team to initiate early dialogue with the most vulnerable practices and to offer various packages of support.

Primary Care Summit
A Summit meeting was held in Musselburgh in September to identify actions that

can be taken to resolve some of the issues
This identified that work is needed to:

- Transfer resource from secondary care to primary care to support development and facilitate more care in the community
- Develop financial and other support for contractor practices and ensure an appropriate governance framework
- Promote skill mix to utilise pharmacy, physiotherapy, mental health nursing, advanced nurse practitioners etc in general practice, especially in contractor practices
- Better manage demand on GPs by signposting patients to alternative sources of help and by reducing inappropriate workload
- Encourage use of technology in provision of patient care – e.g. telephone consultations, demand triage, email and web based services
- Expand the Primary Health Care Team with appropriate range of skills and competencies to enhance capacity and manage demand appropriately.
- Develop a professional standard marketing and recruitment strategy to include contractor practice vacancies
- Find an appropriate balance between autonomy and innovation within HSCP areas.

It is proposed that West Lothian hold a Primary Care Summit in February 2017. It is intended that this will be on a protected learning time session to enable wide stakeholder engagement and will focus on the key issues identified and current West Lothian position in order to inform our Primary Care work plan and support sustainability in General Practice

D CONSULTATION

Primary Care Summit 2016

Primary Care & Community Forum

E REFERENCES/BACKGROUND

F APPENDICES

G SUMMARY OF IMPLICATIONS

Equality/Health	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, equality impact assessment has not been conducted.
National Health and Wellbeing Outcomes	All National Health and Well Being Outcomes

Strategic Plan Outcomes	Primary Care is critical to all Strategic Plan Outcomes
Single Outcome Agreement	We live longer healthier lives and have reduced health inequalities Older people are able to live independently in the community with an improved quality of life
Impact on other Lothian IJBs	Mutual Aid, Management of Risk
Resource/finance	Within available resources
Policy/Legal	None
Risk	High Risk on HSCP Risk Register

H CONTACT

Contact Person:
Carol Bebbington, Senior Manager Primary Care & Business Support
mailto:carol.bebbington@nhslothian.scot.nhs.uk

Tel 01506 281017

10th November 2016

West Lothian Strategic Planning Group

Date:17 Nov 2016
Agenda Item:9

WEST LOTHIAN WINTER PLAN

REPORT BY DIRECTOR

A PURPOSE OF REPORT

The purpose of this report is to inform the Strategic Planning Group of the Winter Plan developed for 2016/17 and to outline the activities underway to prepare for the winter period when it is recognised that demand for services is likely to be at its highest level.

B RECOMMENDATION

The Strategic Planning Group is asked to

1. *Note the contents of the report*
2. *Note the progress made in developing the Winter Plan, which will ensure key services are maintained for critical patients and customers, and the organisation's reputation is protected*
3. *Support the activities and management responsibilities to ensure winter preparedness and effective response to adverse situations*

C TERMS OF REPORT

West Lothian HSCP and St John's Hospital are required to plan for the winter period when it is recognised that demand for services is likely to be at its highest level. This plan for 2016/17 builds on previous Winter Plans for West Lothian and the local actions already in place to support prevention of admission and early discharge.

The Winter Plan aims to provide safe and effective care for people using services and should ensure effective levels of capacity and funding are in place to meet expected activity levels to support service delivery across the wider system of health and social care.

The plan takes into account the Scottish Government guidance (DL (2016) 18) with a continuing focus on integration, improving delayed discharge, the six essential actions to improving unscheduled care performance and planning for the additional pressures and business continuity challenges that are faced in winter.

6 Essential Actions to Improving Unscheduled Care Performance

1. Clinically focussed and empowered management
2. Capacity and patient flow alignment
3. Patient rather than bed management- operational performance
4. Medical and surgical processes arranged to pull patients from emergency department
5. 7 day services
6. Ensuring patients are cared for in their own homes

The outcomes of winter planning are to ensure: -

- The provision of high quality, responsive services are maintained through periods of pressure;
- The impact of pressures on the levels of service, national targets and finance are effectively managed;
- That a process is in place to meet the reporting requirements of the Scottish Government.
- That comprehensive plans are in place covering the requirements of the Scottish Government Health Department outlined in their Winter Planning communications;
- Assurance for the Director of West Lothian HSCP, the Site Director St John's Hospital and the Chief Operating Officer NHS Lothian that effective Winter Plans exist.

The HSCP and St John's Hospital management teams have established a Winter Planning Group to monitor and evaluate the winter planning process and to take any actions necessary in implementation of the plan.

The winter plan needs to be viewed within the context of the range of interventions already in place within West Lothian to prevent admissions and support early discharge, with additional processes agreed to respond to emerging needs as a result of winter pressures

The delivery of the Winter Plan requires additional resources to support implementation, particularly in relation to increased capacity within St John's Hospital, REACT, Community Nursing and AHP teams and recruitment processes are in progress.

The HSCP and St John's Hospital will be represented at the major winter planning meetings in NHS Lothian and West Lothian Council

D CONSULTATION

St John's Hospital and the HSCP management teams have contributed to the preparation of the Winter Plan

E REFERENCES/BACKGROUND

Preparing for Winter 2016/17, DL (2016) 18

F APPENDICES

West Lothian Winter Plan 2016/17

G SUMMARY OF IMPLICATIONS

Equality/Health	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, equality impact assessment has not been conducted.
National Health and Wellbeing Outcomes	All National Health and Wellbeing Outcomes
Strategic Plan Outcomes	Underpins all Strategic Plan Outcomes
Single Outcome Agreement	We live longer healthier lives and have reduced health inequalities Older people are able to live independently in the community with an improved quality of life
Impact on other Lothian IJBs	Mutual Aid
Resource/finance	Additional Winter Plan funding (£795K) has been received to support implementation of the Winter Plan.
Policy/Legal	None
Risk	Failure to recruit the required staff will impact on the delivery of the Winter Plan

H CONTACT

Contact Person:
Carol Bebbington, Senior Manager Primary Care & Business Support
mailto:carol.bebbington@nhslothian.scot.nhs.uk
Tel 01506 281017

9th November 2016

St Johns Hospital & West Lothian HSCP

Winter Plan 2016/17

1. Business continuity plans tested with partners			
Outcome: The board has business continuity management arrangements in place to manage and mitigate all key disruptive risks including the impact of severe weather.		**Indicators:** • progress against any actions from the testing of business continuity plans.	
Action	**Owner**	**Status**	**Complete**
1. **All Business continuity plan to be reviewed and tested**	HSCP &Site Director/ General Manager/ SMT	• Regular testing in situ with Resilience Officers • NHSL Policies in situ as appropriate • Ongoing review	Complete but ongoing.
2. **Severe weather plans to be put in place** and managed via local resilience site meetings.	Site /HSCP Management team	• Ongoing review • Robust plans in situ	Complete but ongoing.

3. **Norovirus outbreak plans to be refreshed** and circulated via the same meeting.	Infection Control	• Regular testing in situ • Ongoing review	Complete but ongoing.
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.		**Indicators:** • attendance profile by day of week and time of day managed against available capacity; • % occupancy of ED • utilisation of trolley/cubicle • % patients waiting for admission over 4,8,12 hours	

Action	Owner	Status	Complete
1. Escalation policy in situ and embedded into operational management of the SJH site.	Site management team/Site & Capacity team	• Daily use of Escalation policy • Ongoing review as and when required	Ongoing
2. SJH Front door **ED and MAU to evidence robust escalation** processes including: a. Volume attending in the hour (escalation thresholds > than RIE 20 / STJ 10 / WGH 10 / RHSC 10) b. Escalation of first assessment waits at 90 minutes and above c. Escalation of any patient waiting at 3 hours with no management plan d. Escalation of high resuscitation activity	Associate Nurse Director/ Clinical Nurse Manager	• In situ • Ongoing review of exit block, BLACK escalation	Ongoing
3. **All site flow teams, Senior Charge Nurses, CMT members to have clear understanding of roles in response to escalation**. - .Daily UCC & Flow Debrief will continue to raise issues and themes to be addressed in relation to capacity and flow and this should be documented and circulated to core site CMT members and form the basis of any informal report to the Chief Officer	Associate Nurse Director/ Clinical Nurse Manager	• In situ	Ongoing

for Acute or to Scottish Government.			

3. Safe & effective admission/discharge continues in the lead-up and over festive period and also in to January

Outcome: Emergency and elective patients are safely and effectively admitted and discharged over the Christmas – New Year holiday period. Over this period the numbers of patients receiving elective treatment reduces. NHS Boards should minimise the risk of boarding medical patients in surgical wards. This will help ensure that patients do not have unnecessary stays in hospital; and hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January	Indicators: • Daily/ cumulative admissions/discharges over the festive period • levels of boarding • delayed discharges • bed occupancy • number of SW assessments including variances from planned levels

Action	Owner	Status	Complete
1. All flow activity at SJH will be monitored on a daily basis via the morning Safety Huddle chaired by the Site Director or nominated representative, and at the 1pm and 4 pm Planning Meetings. 2. Focused attention will be given from the weekend start 16th, 17th and 18th December to ensure daily discharge quotas are met. This will continue throughout the winter months with much more focus on discharges. 3. The REACH nurse and Elderly care team will look to manage the frail elderly patients and provide support for the discharge hub on reducing the number of delayed patients awaiting POC/NH - Reasons for admission will be closely monitored to ensure those patients that can remain in NH remain so and admission avoidance is prioritised. 4.Daily dynamic Discharge to be rolled out: Ward 8 Ward 9	Site Director/AND/ CSM Megan Reid/CNM's/ CN's	• Safety Huddles established at SJH • Daily debrief • October date planned to commence.	Partial

5. From 16th December onwards, focused attention will need to be given to: - New package of care allocation; - Restart package of care; - Community support teams including 'Hospital to Home' and 'Hospital at Home'. It is important that, REACT operate and pull out hospital discharges on Friday 16th December and, 22nd, 23rd and 24th December as well as H&SCP teams prioritising POC starts. - REACT looking to increase AHP and ANP service over Winter period **to work a 7 day week.** - Increased ROTAS service - Increase OT/PT for medical wards - Home Care Liaison model - Additional Respiratory Nurse input	Social Work Team REACT Discharge Hub HSCP	• Concern regarding POC position in W/L and how it will cope over winter.	Progressing
6**. Delayed Discharge activity will be monitored and reported on a daily basis from each site Control Rooms** including additions to the list and removals based on average POC number and wait. Equipment store within HSCP to prioritise for discharges and palliative care needs.	Discharge Hub/CMT	• HSCP SMT integral here to work with SJH site team • AHP/ CNM to closely monitor efficiency of community store and escalate delays affecting discharging.	Ongoing
7**.All patients to be monitored on an internal social work standard**: 24 hours to allocation of social work and 72 hours to assessment 8.**Enhanced weekend Pharmacy Service** extended week	Helen Dunn/ Discharge Hub	• DC Hub monitor with SW lead.	

day and weekend working to support discharges. • Early discharge planning and IDL preparation is paramount. • Extend working day 7 days per week • Extend to 7pm Mon-Fri • Extend to 4pm Sat/Sun to support patient discharge and flow. • Audit efficiency of this extending working as part of lessons learned for next year winter planning. • Dedicated porter for pharmacy to enhance patient flow and discharges. Part of winter funding. 9. **Additional medical staffing** to cover flexible capacity and/or medical boarders. 10. **Plan for additional winter beds** on the SJH site to support increased medical demand 11.**Elective activity** for H&N surgical services to agree scheduled programme and agree flexible beds for medical patients, being mindful of keeping boarding to a minimum. 12.**Use of DOSA** as the norm, prioritising urgent and cancer cases only. 13. **Work with Infection control** colleagues to review 'clean' beds in the H&N wards to allow flexible use of beds to support flow. 14.**Rapid response team** (domestic services) to be in situ.	John Heggie CD CSM CSM CMT Infection Control. Facilities.	• All Progressing as part of SJH winter plan • All progressing as part of SJH winter plan	

4. Strategies for additional surge capacity across Health and 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	Indicators: • 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;

arrangements to create a safe and person centred environment		• 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	
Action	**Owner**	**Status**	**Complete**
1. Open surge capacity in Ward 15 up to 18 beds. 2. **Additional nursing and medical staff** to be recruited. 3. **Work with HSCP** re: robust plan for reducing number of delays on the SJH site and provision for POC availability. 4. Refer to GP action plan around increased provision of appointments.	CSM/CNM/ CD HSCP	• Winter bids submitted • Recruitment of staff is a priority. • Joint SHH/HSCP Winter Plan and Integrated Winter Plan Meetings	Partial
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. The hospital models will include flows between front doors, receiving units, and downstream wards.		Indicators: • Daily number of cancelled elective procedures • Daily number of elective and emergency admissions and discharges • Number of respiratory admissions and variation from plan	
Action	**Owner**	**Status**	**Complete**
1. **The January 'in patient' elective programme to be reviewed weeks 4th and 11th January and only urgent cases and cancer cases** to be progressed as required for the H&N specialities. The day case programme to continue as usual and indeed increased as appropriate. 2. **All flow activity to be managed in an 'anticipatory' way 24/48 hours in advance across all adult sites, downstream sites**. Those flow markers that indicate a sluggish system should be highlighted via the daily safety and planning meetings including: • inadequate discharges to match admissions	CSM/GM Site Director CMT/Site & Capacity	• Progressing plan. • Day case to be the norm. • In situ • Reviewed daily at Safety Huddle and frequently throughout the day thereafter as necessary.	Partial

• increased boarding activity across the site • medical boarding into the surgical specialities • increase in delayed discharges • norovirus outbreaks **<u>Respiratory</u>** 1.**Respiratory team to manage 5/7 activity and outreach for the site.** The team also to act as an interface with Primary Care and Hospital at Home teams. 2.**Speciality doctor** to operate hot clinic with nursing support. 3.**The Respiratory Nurse Specialist Service** at St John's will support SJH site and work with CHCP on admission avoidance 4. **COPD** care bundle supporting patient group. 5. **REACT team** together with REACH nurse and MOE team be a key link to support immediate and early discharge support over these weekends in January. .	CD CD/CNM CNM REACH/MOE /REACT	• Daily debrief to review previous day's performance with action planning. • Infection control integral at these meetings • Ongoing challenges to Consultant recruitment- ability to deliver a respiratory winter plan remain high risk.	

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	Indicators: • Agreed and resourced analytical plans for winter analysis

Action	Owner	Status	Complete
1. New analytical support to aid winter planning through Basic Building Blocks analysis. 2. **Agree standard UCC** dashboards across Lothian to aid effective analysis 3.**Submit** required reporting to SG around UCC performance	HIU Angela Tuohy CSM	• External review of BBB and LOS analysis being prepared ahead of winter • Analyst identified.	**In progress**

over winter			

7. Workforce capacity plans & rotas for winter / festive period/ agreed by end of October

Outcome:	Indicators:
• 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	• 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

Action	Owner	Status	Complete
1. **Recruit to Additional medical** staff for both ED and Medicine. (1 Consultant in ED and Med, 1 Spec Doc in ED and Med) 2. **Medical consultant rotas for all specialities to be reviewed to ensure adequate festive period cover**, including the 4 day breaks, weekends and the time in between when senior reviews are critical to expedite discharge.	CD	• Await funding confirmation. Likely to be locum. • Rotas being collated. • Double up on weekend working from Nov 15 ongoing to enhance patient safety and ensure discharges over the weekend.	Partial
3. **Respiratory Medicine** – link into Lothian wide Respiratory cover plan. 4. Use of Respiratory Nurse specialists to enhance support	Kim Dickson CSM RIE CNM/Resp team	• RIE/WGH being asked for support for Respiratory service	Partial
5. Senior Charge Nurse Cover for the festive weekends and January month should be reviewed to ensure adequate 7/7 rota cover at band 6 and 7 level and should include night duty or extended days where appropriate.	Clinical Nurse Managers	• Festive rotas being finalised with Band 6 or 7 cover over weekends. Mon- Fri CNM cover in situ with senior management.	Partial

6. **Hogmanay Plan to be delivered** which includes additional junior medical and nursing staff rostered within the ED from 31st Jan – 4th Jan inc. • Need to see LUCS winter plan – **Sian Tucker** • Enhanced nursing staffing for January – March if supported via winter (x 4 additional Band 5 and x 2 Band 2)	CSM/CNM/ CD	• Increased ED nursing and medical staff on duty each shift from 31st Dec through until 4th Jan inc. • 31st Dec – x 1 extra Late shift, x 1 extra ND (medical) extra nurse on DD and ND. • 1st-4th Jan inc – x 1 extra Day shift, x 1 extra Back shift (medical), x 1 extra Staff Nurse DD and ND	Partial

8. Discharges at weekend and bank holiday			
Outcome: Patients are discharged at weekend 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.		Indicators: • % of discharges that are criteria led on weekend and bank holidays • daily number of elective and emergency admissions and discharges.	
Action	**Owner**	**Status**	**Complete**
1. **All adult sites and the children's hospital to have adequate support services in place at the weekend and at the festive period** (notably the second week of festive period) to ensure effective numbers of discharges are delivered this includes:			In progress.
a. **Transport hub to support any additional transport carriers as required**.	Joan Donnelly	• Link to OP CMT winter plan.	
b. **Therapy support at front door areas over the festive period (**notably the public holidays on the second week) and increased support at the weekends to the roaming teams especially January.	AHP leads	• Already part of winter plan – recruitment to posts vital.	
c. **Consider weekend 'hospital' social work support** to ensure timely assessments for patients admitted on Friday. Any additional support for the PH on the second week to be seriously considered.	HSCP	• To be considered.	
d. **Discharge Hub** to operate over 7 days.		• To be discussed with HSCP team	
e. Discharge lounge to operate over 7 days**.**	CSM/CNM	• Require a robust presence from SW colleagues over the 2 week festive period	

f. Discharge lounge to review operational policy and stretch patient criteria. 2. **Weekly review** of weekend discharging with the MDT with planned actions. 3. **Weekend senior nurse –** provide overview of weekend position for Monday debrief. 4. **Facilities** support for rapid turnover of single rooms/beds.	AMD/CSM CNM Facilities	• Increased staffing as per winter plan. • Part of UCC debrief on a Monday morning. • As per winter plan.	

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.

Indicators:
- 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

Action	Owner	Status	Complete
1. **Daily flow activity continues to be monitored** on SJH site and reported to Chief Officer via Control Room. The markers here includes: - admission and discharges - by noon discharges - boarding levels	Site Director	• Focus remains here • Daily debrief of performance indicators and actions taken to improve	In progress
2. **Downstream Hospitals have admission and discharge quotas** agreed and monitored in the same way as adult acute. - St Michael's and Tippethill.	Site Director/ Delayed Discharge lead.	• Increased focus will be on this. • High risk and concerns given current status.	To be agreed.
3. **SJH site** need to be able to access Edinburgh downstream facilities due to number of Edinburgh	Site Directors/	• Focus remains here	Ongoing

delays.	Discharge Hub	• Daily debrief of performance indicators and actions taken to improve	
4. **Weekend discharge** should also be a focus in the downstream hospital and focus must be on: - Package of care restarts at the weekend - New package of care restarts at the weekends - Families 'gapping' POC until start on Monday	D/C Hub	• Agreed action plan with HSCP	To be agreed.
5. **All boarding processes** from wards to reflect identification of those patients who have an estimated date of discharge within 24 hr. 6. **Nurse Practitioners** key to management of boarding patients.	CNMs/ Medical Staff	• Nurse practitioners in wards 9, 21 and 25 are identifying borders early in the day. • Criteria Led Discharge is priority • Ensure boarding documentation is completed for all patients to ensure junior doctors in boarding wards are informed and be able to discharge safely.	Progressing

10. Communication Plans

Outcome: The public and patients are kept informed of winter pressures, their impact on services, and the actions being taken.	**Indicators:** • daily record of communications activity • early and wide promotion of winter plan		
Action	**Owner**	**Status**	**Complete**
1. **Daily inter site communications** will be enhanced to ensure focused discussion on site activity, pressures and resilience planning for acute and downstream sites.	Angela Tuohy	• In situ	Complete and ongoing
2. The **9.30am teleconference is the key communication** point and this will be chaired by the Lead for Flow and Capacity and a core member of site CMTs will be in attendance.	Angela Tuohy	• X 3 daily teleconferences	Complete and ongoing
3. **Link in with Communications** team re: plan for communicating with the public regarding winter	Communications	• Await guidance	Progressing.
4. **Review current patient/relative** discharge documentation to ensure discharge planning is proactive from the onset of admission	Discharge Hub/CNM's/ Megan Reid	• CNM's progressing.	Progressing.

11. Preparing effectively for norovirus			
Outcome: The risk of Norovirus outbreaks becoming widespread throughout a hospital is minimised through the effective implementation of the HPS Norovirus Outbreak Guidance (2016 / 17).		**Indicators:** • number of wards closed to Norovirus • application of HPS Norovirus guidance.	
Action	**Owner**	**Status**	**Complete**
1. **Infection Control and Surveillance should be raised at every site Safety Huddle** by the nominated IC Nurse for the day and any concerns on any issues of IC including Norovirus should be raised at this time with appropriate and specific actions agreed.	Site Director/AND	• In situ	Complete and ongoing
2. **Where outbreaks are noted**, specific consideration will be given to these areas and a review by the Associate Nurse Director for the site to ensure local plans and approach are robust and in place. This includes HPS Guidance.	AND/IC team leads	• In situ	Complete and ongoing
3. **External communications from the site to other sites** in the system will be robust and via the Control Room. This will ensure any high risk patient transfers across the system are noted and precautions taken for any emergency admissions to any site via this route.	Angela Tuohy	• In situ	Complete and ongoing
4. **Introduction and monitoring of the HPS Norovirus Outbreak Guidance (2016/2017)**	Infection Control	•	

5. **Uniform Policy will be emphasised at every site safety huddle and a critical friend approach will be taken** as usual for all uniformed and non uniformed staff.	AND/CNM	• Ongoing surveillance	Complete and ongoing
6. **Hand Hygiene will be emphasised at every opportunity**.	All clinical team	• Ongoing surveillance • Audits ongoing • Staff sickness to be robustly managed esp if any sign of Norovirus with 48hr clear policy	Complete and ongoing
12. Delivering seasonal flu vaccination to staff and public			
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		**Indicators:** • % 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	.
Action	**Owner**	**Status**	**Complete**
1. **All sites will have a flu programme in place by October** and will be lead by the Associate Nurse Director. This will be supported by a Healthy Working Lives Initiative to ensure staff remain in good health during the winter period. 2. **Vaccination of Risk Groups by General Practice**	AND HSCP	• Plan in situ • Ward clinics to function again this year. • Primary Care delivering immunisation programme	Progressing.

WORKPLAN FOR WEST LOTHIAN STRATEGIC PLANNING GROUP 2016-17

Date of SPG meeting	Title of Report	Lead Officer	Action
17 November 2016			
	Commissioning Plan for Older People	Alan Bell	
	Risk Register Review	Carol Bebbington	
	Locality Group Update	Jane Kellock/Marion Barton	
	Primary Care Update	Carol Bebbington	
	West Lothian Winter Plan	Carol Bebbington	
19 January 2017			
	Lothian's Hospital Plan Update	Colin Briggs/Jacqui Campbell	
	Technology Enhanced Programme Update (TEC)	Alan Bell	
	Health Improvement Health Intelligence (HIHI) Update	Carol Bebbington	
Provisional	West Lothian Frailty Programme Update	Carol Bebbington	
	NHS Lothian Oral Health Strategy	Robert Naysmith	Work on the Oral Health Strategy is being led by the South East and Tayside (SEAT) Dental Public Health Network. RN will advise if paper will be available for this meeting.
	Health Improvement Activity	Dr Margaret Douglas	Report & presentation
2 March 2017			
	Strategic Plan Annual Review		
	Annual review of performance		