DATA LABEL: Public

Health and Care Policy Development and Scrutiny Panel

West Lothian Civic Centre
Howden South Road
LIVINGSTON
EH54 6FF

2 February 2017

A meeting of the **Health and Care Policy Development and Scrutiny Panel** of West Lothian Council will be held within the **Council Chambers, West Lothian Civic Centre** on **Thursday 9 February 2017** at **2:00pm**.

For Chief Executive

BUSINESS

Public Session

1. Apologies for Absence

2. 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.

3. Order of Business, including notice of urgent business

4. Confirm Draft Minutes of Meeting of Health and Care Policy Development and Scrutiny Panel held on Thursday 08 December 2016 (herewith).

5. NHS Lothian Health Board Minute - Report by Depute Chief Executive (herewith)

6. West Lothian IJB Minute - Report by Depute Chief Executive (herewith)

7. Oral Health Improvement within West Lothian - Report by Head of Oral Health Improvement, West Lothian (herewith)

8. Family Nurse Partnership - Report by Depute Chief Executive (herewith)

9. Childhood Immunisation Uptake - Report by Depute Chief Executive

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(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 HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL of WEST LOTHIAN COUNCIL held within COUNCIL CHAMBERS, WEST LOTHIAN CIVIC CENTRE, on 8 DECEMBER 2016.

Present – Councillors Anne McMillan (Chair), John McGinty, Janet Campbell, Mary Dickson, George Paul and Frank Toner

In attendance – Mary Benson, Senior People's Forum Representative

Apologies – Bridget Meisak, Voluntary Sector Gateway West Lothian

1. DECLARATIONS OF INTEREST

No declarations of interest were made.

2. MINUTE

The Panel confirmed the Minute of its meeting held on 20 October 2016. The Minute was thereafter signed by the Chair.

3. NHS LOTHIAN HEALTH BOARD MINUTE

A report had been circulated by the Depute Chief Executive to which was attached the Minute of the NHS Lothian Board meeting held on 3 August 2016.

Decision

To note the contents of the report and Minute.

4. WEST LOTHIAN INTEGRATION JOINT BOARD MINUTES

A report had been circulated by the Depute Chief Executive to which was attached the Minutes of West Lothian Integration Joint Board meetings held on 23 August and 18 October 2016.

Decision

To note the contents of the report and Minutes.

5. CHIEF SOCIAL WORK OFFICER'S ANNUAL REPORT 2015-2016

The Panel considered a report (copies of which had been circulated) by the Head of Social Policy providing an overview of the statutory work undertaken during the period 2015-2016. The Chief Social Work Officer's Report 2015/2016 was attached at appendix 1 to the report.

The Chief Social Work Officer's Report 2015/2016, attached as an appendix to the report, provided an overview of the role and

responsibilities of the Chief Social Work Officer and outlined the governance arrangements that were in place in West Lothian. The report highlighted the council's statutory duties, the decisions that were delegated to the Chief Social Work Officer and provided a summary of service performance. The role of the Chief Social Work Officer was to provide professional governance, leadership and accountability for the delivery of social work and social care services, whether these be provided by the local authority or purchased from the voluntary or private sectors. In addition, there were a small number of duties and decisions that related primarily to the curtailment of individual freedom and the protection of both individuals and the public, which must be made either by the Chief Social Work Officer or by a professionally qualified social worker to whom responsibility had been appropriately delegated.

The Senior Manager, Community Care Support and Services, advised that the delivery of social work services was challenging and in light of the current economic situation the importance of delivering vital services to the most vulnerable and marginalised in the community would test the council's capacity, creativity and commitment over the forthcoming year.

The Senior Manager then responded to questions from Panel members, confirming that it was essential to continue to develop and improve services while constantly seeking to become more efficient. Constrained public spending was a high challenge for social policy services as well as increases in demand for services due to an increasing population and increased complexity of needs. West Lothian Social Policy was well placed to address these challenges and would continue to contribute significantly to the delivery of positive outcomes for the people of West Lothian.

It was recommended that the Panel note the contents of the Chief Social Work Officer's annual report for 2015-2016 which was submitted to the Scottish Government's Chief Social Work Advisor.

Decision

To note the contents of the report.

6. WINTER PLAN 2016/17

The Panel considered a report (copies of which had been circulated) by the Director providing details of the winter plan developed for 2016/17 outlining the activities underway to prepare for the winter period when it was recognised that demand for services was likely to be at its highest level.

The Senior Manager, Primary Care & Business Support, advised Panel members that an integrated plan between West Lothian HSCP and St John's Hospital was in place for the winter period to provide safe and effective care for people using services. The plan focused on integration, improving delayed discharge, improving unscheduled care performance and planning for the additional pressures and business continuity

challenges that were faced in winter. The HSCP and St John's Hospital were represented at the major winter planning meetings in NHS Lothian and West Lothian Council.

The delivery of the Winter Plan required additional resources to support implementation, particularly in relation to the higher levels of demand on services, increased capacity within St John's Hospital, REACT, Community Nursing and AHP teams.

In response to a question from Panel members in relation to resource issues and bed availability at St John's Hospital, the Senior Manager advised that a recruitment process was underway to provide additional nursing and medical staff to support proposals to implement increased capacity within St John's Hospital. Alternative models of care were also being considered, i.e. 'Hospital at Home' service. Panel members were advised that the recruitment process commenced in September 2016, however, difficulties had been experienced in recruiting hospital nursing staff. It was reported that there was an increase in Community Nursing Staff, OT staff and Physiotherapists. Members were also advised that a review was being carried out to assess the best model for weekend discharging.

It was recommended that the Panel note the contents of the report and the progress made in developing the Winter Plan, which would ensure key services were maintained for critical patients and customers, and the organisation's reputation was protected.

Decision

To note the contents of the report.

7. OLDER PEOPLE'S COMMISSIONING PLAN

The Panel considered a report (copies of which had been circulated) by the Head of Social Policy providing details of the development of the Strategic Commissioning Plan for Older People. The Older People's Commissioning Plan 2016/17 – 2018/19 was attached as an appendix to the report.

The Senior Manager, Community Care Support and Services, advised Panel members that at its meeting held on 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. A short life working group was established to develop the three year commissioning plan. The draft plan was subject to stakeholder consultation including the IJB Strategic Planning Group. At the time of writing the report the final draft of the Strategic Commissioning Plan for Older People had not been considered by the (IJB). This was submitted to the meeting of the IJB on 29 November 2016 and subsequently approved.

During the course of the discussion the Senior People's Forum (SPF)

representative highlighted that the SPF did not have representation on the IJB. She stated that other authorities in Scotland had invited a SPF representative to participate in meetings. She asked if consideration could be given for a representative from the SPF to be invited to participate in meetings of the West Lothian Integration Joint Board to allow senior people's views to be shared. The Senior Manager undertook to forward the SPF representative's comments to the Director.

It was recommended that the Panel notes the Strategic Commissioning Plan for Older People.

Decision

1. To note the contents of the report; and

2. To note that the Senior Manager undertook to forward the Senior People's Forum representative's request for a representative of the SPF to be invited to participate in WL IJB meetings to the Director.

8. LEARNING DISABILITY COMMISSIONING PLAN

The Panel considered a report (copies of which had been circulated) by the Head of Social Policy providing an update on the development of the Strategic Commissioning Plan for Adults with a Learning Disability. The Learning Disability Commissioning Plan 2016/17 – 2018/19 was attached as an appendix to the report.

The report explained that the Integration Joint Board (IJB) approved its strategic plan at its meeting held on 24 March 2016, 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.

A short life working group was established to develop the three year commissioning plan. The draft plan was subject to stakeholder consultation including the IJB Strategic Planning Group. The Senior Manager, Community Care Support and Services, advised Panel members that West Lothian has a faster than average population growth, an aging population and growing numbers of people living longer with disabilities, long term conditions and complex needs. Health and Social Care services were required to ensure that resources were targeted to achieve the greatest impact on those most in need.

The final draft of the Strategic Commissioning Plan for Adults with a Learning Disability was approved by the IJB at its meeting on 18 October 2016. The IJB would receive regular progress reports and there would be an annual review of the plan.

It was recommended that the Panel notes the Strategic Commissioning Plan for Adults with a Learning Disability as approved by the Integration Joint Board meeting on 18 October 2016.

Decision

To note the contents of the report.

9. OCCUPATIONAL THERAPY INFORMATION DAY

The Panel considered a report (copies of which had been circulated) by the Head of Social Policy providing details of the outcomes following a public information event to promote occupational therapy (OT) services to members of the public held during National OT Week.

The Senior Manager, Community Care Support and Services, introduced the Group Manager for OT and Housing with Care to the Panel. Members were advised that West Lothian has a well-established partnership approach to joint working with benefits in efficiency and sharing good practice. The joint OT teams planned an open day to promote the service to members of the public, raising awareness in the community of the benefits, support and advice that was available. An update was then given on the OT Information Day held at Howden Park Centre, Livingston, on 8 November 2016, which was positively supported by those in attendance. Although the event did not attract a large amount of people, those that did attend benefited by obtaining information on other resources and increasing their knowledge of OT. Staff from Health and Social Care also gained information regarding their colleagues and services supporting their practice.

In response to questions from Panel members in relation to advertising home aids and adaptations on the CHCP web site to promote the service to members of the public, the Senior Manager advised that the CHCP web site was being reviewed to improve the look and content of the web site in general. The Group Manager also confirmed that OT staff liaise regularly with Operational Services staff to ensure medical and OT equipment were recycled rather than being disposed of in bulky uplifts.

It was recommended that the Panel notes that the OT Information Day event on Tuesday 8 November 2016 was positively support by attendees.

Decision

To note the contents of the report.

10. WORKPLAN

The Panel noted the contents of the workplan which would form the basis of the Panel's work over the coming months.

Decision

To note the contents of the workplan.

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West Lothian Council

HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL

NHS LOTHIAN BOARD

REPORT BY DEPUTE CHIEF EXECUTIVE

A. PURPOSE OF REPORT

To update members on the business and activities of Lothian NHS Board.

B. RECOMMENDATION

To note the terms of the minutes of Lothian NHS Board dated 5th October 2016 in the Appendices to this report.

C. SUMMARY OF IMPLICATIONS

I	**Council Values**	Focusing on our customers' needs Being honest, open and accountable Working in partnership.
II	**Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)**	Council requires the activities of certain outside bodies to be reported to elected members on a regular basis, as part of its Code of Corporate Governance.
III	**Implications for Scheme of Delegations to Officers**	None.
IV	**Impact on performance and performance Indicators**	Working in partnership.
V	**Relevance to Single Outcome Agreement**	We live longer, healthier lives.
VI	**Resources - (Financial, Staffing and Property)**	None.
VII	**Consideration at PDSP**	Regularly reported to Health & Care PDSP for noting.
VIII	**Other consultations**	None required.

D. TERMS OF REPORT

On 29 June 2010 the Council Executive decided that the activities of certain outside bodies should be reported within the council to ensure all elected members are aware of the business of those bodies and to help to ensure their activities are more effectively scrutinised.

In accordance with that decision the business of Lothian NHS Board was to be reported to this meeting by the production of its minutes. The relevant documents are produced in the Appendix to this report.

E. CONCLUSION

This report ensures that members are kept appraised of the activities of Lothian NHS Board as part of the council's Code of Corporate Governance.

F. BACKGROUND REFERENCES

West Lothian Council Code of Corporate Governance.

Council Executive, 29 June 2010

Appendices/Attachments: 1

Appendix 1 Minutes of the meeting of Lothian NHS Board held on 5th October 2016

Contact Person:	Jim Forrest, Depute Chief Executive
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CMT Member:	Jim Forrest, Depute Chief Executive
Date:	9th February2017

DRAFT **1.1**

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 5 October 2016 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Mrs Kay Blair; Councillor H Cartmill; Councillor D Grant; Councillor R Henderson; Mr M Hill; Ms C Hirst; Mr P Johnston; Councillor C Johnstone; Mr A Joyce; Ms F Ireland; Mrs A Mitchell; Mr P Murray; Mr J Oates; Mr G Walker; Mrs L Williams and Dr R Williams.

Executive and Corporate Directors: Mr J Crombie (Acting Chief Executive); Mrs J Butler (Interim Director of Human Resources & Organisational Development); Dr D Farquharson (Medical Director); Mrs S Goldsmith (Director of Finance); Professor A K McCallum (Director of Public Health & Health Policy); Professor A McMahon (Executive Director, Nursing, Midwifery & AHPS - Executive Lead REAS & Prison Healthcare) and Dr S Watson (Chief Quality Officer).

In Attendance: Mr R McCulloch-Graham (Chief Officer Health & Social Care Partnership for Edinburgh for item 36); Ms E McHugh (Joint Director Midlothian Health & Social Care Partnership for item 36); Mr D A Small (Joint Director East Lothian Health & Social Care Partnership for item 36) Dr C Whitworth (Consultant in Renal Medicine (for item 38))and Mr D Weir (Corporate Services Manager).

Apologies for absence were received from Mr T Davison, Mrs J McDowell and Professor M Whyte.

Mr Robert Wilson

The Chairman reminded the Board that this was the first public meeting since the death of former Board member Mr Robert Wilson. The Board recorded its sadness at the death of Mr Wilson and recorded its appreciation for all the sterling work that he had done on behalf of the Board. The Board recorded its sympathy to Mr Wilson's family.

Welcome and Introduction

The Chairman welcomed members of the public and press to the Board meeting. He also welcomed Ms K Preston, Non Executive Board Member, Health Improvement Scotland as an observer to the meeting.

The Board also welcomed Mrs Janis Butler, Interim Director of Human Resources and Organisational Development who was attending her first formal Board Meeting in her new role replacing Mr Boyter. Ms F Ireland was also attending her first formal Board Meeting replacing Ms Meiklejohn as Chair of the Area Clinical Forum.

The Chair advised that Joint Directors Mr David Small, Mr Rob McCulloch-Graham and Ms Eibhlin McHugh Joint Directors / Chief Officers of 3 of the Partnerships would be attending to discuss agenda item 2.5 (Primary Care Update).

He also advised that Dr C Whitworth would attend the last part of the meeting for the discussion on agenda item 2.7 (Support and Development of Realistic Medicine in Lothian). Dr Whitworth had clinical commitments in the morning and the paper had been placed last on the agenda to accommodate her work pattern.

Declaration of Financial and Non-Financial Interest

The Chairman reminded members they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. There were no declarations of interest.

31. Items for Approval

31.1 The Chairman reminded members that the agenda for the current meeting had been circulated previously to allow Board members to scrutinise the papers and advise whether any items should move from the approval to the discussion section of the agenda. No such requests had been made.

31.2 The Chairman sought and received the approval of the Board to accept and agree the following recommendations contained in the previously circulated "For Approval" papers without further discussion.

31.3 Minutes of the Previous Board Meeting held on 3 August 2016 – Approved.

31.4 Running Action Note – Approved.

31.5 Research and Development Strategy 2016-2020: Clinical Research Driving Efficient, Innovative and Effective Healthcare – The Board approved NHS Lothian's Research and Development (R&D) Strategy for 2016-2020.

31.6 Committee Memberships – The Board confirmed Professor Moira Whyte as an ex-officio member of the Finance & Resources Committee and confirmed that Professor Whyte and Ms Ireland would be ex-officio members of the Strategic Planning Committee. The Board appointed Cllr H Cartmill as a member of the Healthcare Governance Committee and also appointed Ms F Ireland as a member of the Acute Hospitals Committee.

31.7 Review of Board's Standing Orders – The Board reviewed the proposed changes and approved the revised standing orders.

31.8 'Stick Your Labels' Campaign – The Board recognised the adverse effects on health of poverty and the stigma associated with poverty and signed up to the 'Stick your Labels' campaign and the 3 pledges noted in the paper. The Board also supported the actions in the report to meet the 3 pledges and recommended that the Integration Joint Boards also consider endorsing the campaign.

31.9 Acute Hospitals Committee – Minutes of 6 September 2016 – Endorsed.

31.10 Audit & Risk Committee – Minutes of 5 September 2016 – Endorsed.

31.11 Healthcare Governance Committee – Minutes of 26 July 2016 – Endorsed.

31.12 Strategic Planning Committee – Minutes of 11 August 2016 – Endorsed.

31.13 Staff Governance Committee – Minutes of 27 July 2016 – Endorsed.

31.14 East Lothian Integration Joint Board – Minutes of 30 June 2016 – Endorsed.

31.15 Edinburgh Integration Joint Board – Minutes of 15 July & 19 August 2016 – Endorsed.

31.16 Midlothian Integration Joint Board – Minutes of 16 June 2016 – Endorsed.

31.17 West Lothian Integration Joint Board – Minutes of 31 May 2016 – Endorsed.

Items for Discussion

32. Financial Position to 31 August 2016

32.1 The Board were advised that the Quarter 1 financial position had been discussed at the Finance & Resources Committee based on the month 4 position. The month 5 financial position was showing a slight improvement with an in-month underspend of £1m after factoring in corporate flexibility and NRAC (National Resource Allocation Committee) benefit received from the Scottish Government.

32.2 In terms of the current financial position the key drivers were GP prescribing; junior doctors and 2015/16 unachieved efficiency savings. The Board acknowledged a positive improvement in nursing costs particularly in respect of agency spend.

32.3 At the Finance & Resources Committee the main discussion had been around the quarter 1 review. A detailed consideration of the forecast of breakeven at the year end had been undertaken as well as the details of discussions being held between a number of Health Boards and the Scottish Government around the challenging financial position. At national level there was now more focus on joint working to identify potential financial savings and also to share intelligence.

32.4 The quarter 1 financial review was suggesting that the Board could be provided with reasonable assurance that financial breakeven could be achieved in 2016/17 although there would remain a reliance on non recurrent resources. It was for this reason that the Director of Finance was keen to focus attention beyond 2016/17 with a view to moving to a sustainable recurrent financial position.

32.5 The Finance & Resources Committee had expressed concern about how financial breakeven would be achieved given the level of necessary savings in the financial plan. The Board were advised that the following 3 factors provided the necessary degree of assurance – a changed approach to the local reinvestment plans and funding – improved operational performance and finally the availability of additional NRAC and reserves which had been factored into the financial position.

32.6 The Finance & Resources Committee debate had discussed the risks of achieving financial breakeven with particular focus on the detrimental impact on outpatient performance. It had been agreed that the concerns around the consequential impact

on the delivery of service performance targets should be escalated to the Board and the Acute Hospitals Committee for discussion. This request featured as one of the recommendations contained within the circulated Board paper.

32.7 It was noted that in parallel to the Finance & Resources Committee debate that Mr Crombie as Chief Operating Officer and Acting Chief Executive along with the Director of Finance had held separate discussions with the Scottish Government around inpatient and treatment time guarantees (TTG) and what could be done to improve the position. The discussions had concluded that the position came down to the availability of finance and physical capacity within the system. With the exception of minor local capacity it had been concluded that the only viable option was to start to reuse the independent sector with it being recognised that there would be financial consequences of adopting this approach. The Scottish Government had identified 2 funding sources to support this change in direction. It was noted that even with the additional funding of £6m that this only delivered 9000 outpatients and still left 11000 at the end of March 2017 who would be in excess of their TTG. The shift in emphasis therefore still represented a significant residual risk to the Board.

32.8 The Board were advised that work was underway around the 2017/18 financial position to address the significant underlying recurrent gap which was not sustainable. In the previous financial year the position had been further complicated with the introduction of the Integration Joint Boards and the time taken to agree budgets. It would be important to try and move to a position of aligning the budget setting process with the 4 Lothian Local Authorities. Part of the consideration of the 2017/18 position would be to look at primary care fragility. The Board noted that a primary care summit event had been held on 29 September and had identified the need to use some of the NRAC benefit to invest in primary care pressures. Discussions were ongoing with the Scottish Government about how best to support primary care. It was noted that given the fact that the National Spending Review would not conclude until later in the year that there was a need to invest immediately in primary care.

32.9 The Chairman suggested that the main issue for the Board to consider was in terms of the concerns raised by the Finance and Resources Committee in respect of service delivery impacts.

32.10 The suggestion was made that the achievement of targets depended on different factors of which finance was only one. In response to a question the Chairman advised that he had attended the launch of the Independent Review of Targets in Scotland's NHS to be chaired by Professor Sir Harry Burns. The Chairman described the objectives and process for the review advising that this would include consultation opportunities. It was agreed that the Acting Chief Executive would invite Professor Sir Harry to a meeting of senior colleagues to discuss the review process and how best NHS Lothian could play into this.

32.11 The Board were advised that savings in the current year would be factored into forecasts of delivery and validated by finance. Where areas of uncertainty had been identified discussions would be held between finance and managers to identify non recurrent solutions. The Board noted that it was for reasons like these that focus on the future financial position was so important as it was necessary to address the gap between revenue expenditure and revenue income.

32.12 The Acting Chief Executive provided a detailed update on progress being made with the theatre improvement plan process which would include some cultural training and

data drive information. He was optimistic that benefits would be evidenced moving forward.

32.13 The question was posed about whether the extra use of the private sector was realistic and pragmatic and to what timeline this work would be delivered. The Board were advised of the National Procurement Contract which would ensure value for money. It was noted that the first part of the exercise would be to identify what capacity was available at what cost. The timeframe continued to be work in progress. It was confirmed that appropriate safeguards would be put in place through the Acute Medical and Nurse Directors to ensure a safe and efficient patient experience.

32.14 The issue was raised about whether work had been undertaken to drill down and find out whether there was any correlation with the ongoing quality work and whether formal engagement was underway to maximise opportunities. The Board were advised that there was evidence emerging that there were downstream improvements in the quality of care provided which would in the longer term lead to financial benefit. A recent presentation around the re-provided Royal Hospital for Sick Children had evidenced this movement. It was noted that although the process was not entirely embedded that this work would be taken forward by the Chief Quality Officer.

32.15 The Board were advised that the Clinical Change Cabinet model was being used to engage with people on a site and campus basis. At these sessions clinicians presented their ideas to Executive and Corporate Directors and took them back to their workplaces for progressing endorsed by the support of the Clinical Change Cohort model. It was felt there was evidence that this sent a powerful message about engagement. Work was underway to link quality work with patients with it being expected that this would take a short time to develop.

32.16 In terms of expenditure assurance was sought that appropriate levels of scrutiny had been applied to areas like property, equipment and administration. The Board noted that significant work had been undertaken in facilities where savings had been made. Work also continued around the rationalisation of the estate although it was felt that further work might be needed around transport.

32.17 It was agreed in terms of next steps following the Board debate around recommendation 4 in the paper that the following activities would be carried out: -

- A meeting would be sought with Professor Sir Harry Burns as previously discussed by the Board.
- The Risk Management Committee and the Audit & Risk Committee would look at the issues with a view to providing more granularity to address the various points raised.
- The Healthcare Governance Committee would also take account of the issues raised within the context of the new risk assurance function for Board Committees. Dr Williams confirmed this would be appropriate commenting that the Committee had escalated a number of issues in the past to the Board.

32.18 It was agreed that there would also be benefit in the Finance and Resources Committee, Healthcare Governance Committee and the Acute Hospitals Committee triangulating to progress matters further. The Chairman commented on the essential performance and risk management linkages which he felt were pivotal. It would be important therefore for the 3 committees to coalesce to work out these dynamics.

32.19 The Board agreed the recommendations contained in the circulated paper.

33. Quality and Performance Improvement

33.1 The Board were advised that diagnostic, inpatient and TTG performance had been discussed with the Scottish Government in terms of how best to move to a balanced position for the rest of the year. The 4 hour access target performance was positive and above the Scottish average.

33.2 The Board were advised that the delayed discharge position was unprecedented across all 4 of the partnerships. The lack of care at home provision had been signposted by all partnerships as an issue that needed to improve moving into the winter period as current levels were not sustainable.

33.3 Child & Adolescent Mental Health Service (CAMHS) performance had deteriorated slightly with psychological therapy performance having shown slight improvement. It was noted that delayed discharges, CAMHS and psychological therapy performance would all be considered at a Healthcare Governance and Acute Sector Workshop to be held later in the year. It was noted that Board Committees were also using the assurance process to obtain evidence against performance.

33.4 The question was raised about whether respective action plans were costed prior to being agreed. The Board were advised that a parallel process was in place around outpatients, TTG and access targets with there being a need to look at using finance to improve respective positions as well as consideration being given to quality links. It was reported that CAMHS and psychological therapy action plans were costed and therefore affordable.

33.5 The Board were advised that the position moving forward was to create services that were self sustaining. It was important to remember that not all issues that need to be addressed were from an acute perspective. It was noted that if a successful self sustaining quality programme was managed internally then more appropriate performance focus could be introduced. It was agreed that such an approach would be transformational and would need initial investment although once sustained it should reduce cost.

33.6 Surprise was expressed about the national removal of the primary care 48 hour access indicators from the Quality Outcomes Framework (QOF) given the poor position which was worsening. The Board were advised that in the past targets had moved to reflect changing circumstances. The Acting Chief Executive commented however that the previous week's primary care summit had been testament that NHS Lothian was committed to primary care and that this level of commitment transcended finances and agreement had been reached that there was a need for a more intrinsic view of how to practice primary care. The enthusiasm generated by the primary care practices at the summit meeting had been welcomed and the Board now needed to consider how to provide additional investment in discussion with the Scottish Government. The Board were advised that primary care would be a critical area to make progress in during the following year. The Board would remain focussed on primary care performance even in the absence of the national monitoring target. It was agreed that there was still some way to go to translate aspirations into tangible benefits.

33.7 The Healthcare Governance Committee agenda had changed focus and now used the quality and performance report and the risk register as well as seeking information from Executive Directors who if necessary would attend the Committee. If necessary the issue would be escalated to the Board to provide performance assurance. At the next

meeting there would be a specific focus on patient care and outcomes where the Committee would be looking for detailed action plans and timescales.

33.8 The point was made in respect of delayed discharges and the winter plan that there was a need for more assurance given the current issues about the limited availability of people to deliver packages of care. There was a need to understand better what contingency plans were being put in place. The Board were advised that a number of workstreams were underway with close working between the acute sector and IJBs to address and come forward with responses when capacity was under duress. This collegiate approach assured a wider understanding of the components and limitations of individual plans.

33.9 In terms of the above consideration was being given to demand and capacity with initial work to be concluded by the end of October 2016. There would be a need to identify capacity that could reasonably expect to be delivered. If capacity was not being delivered then there would be a need to consider how best to respond to this position. It was noted that all 4 partnerships were working on the delayed discharge and ergo the winter position.

33.10 In terms of winter planning a planning group had been established looking at proposals with £2.6m having been deployed to allow appropriate preparation for winter. The First Minister had announced an additional £1m for this area and this would be utilised appropriately to ensure additional capacity supported by contingency arrangements. It was noted that the winter planning process was a data based intelligence one with a clearer understanding being available within the next 2 – 4 weeks.

33.11 The Board were updated on work being undertaken by the Chief Quality Officer in stroke and accident and emergency. The work had been taken forward through workforce engagement. This process had heard a lot of detail about what the statistics meant and whether in fact the correct things were being measured. The intention was to bring together a range of stakeholders. All of this work was being conducted within the quality framework and also linked to patient safety. The Healthcare Governance Committee remained concerned about the position in respect of stroke performance and had asked the Clinical Lead to provide a paper for consideration by the Committee.

33.12 It was noted that the Healthcare Governance Committee focus was helpful. In terms of issues like delayed discharges it was noted that each Council had a process of scrutiny in place. It was felt there was a need to think about how best to join up governance arrangements between respective organisations. The Board noted that it was hoped that the Healthcare Governance and Acute Hospitals Committee Workshop would bring more focus about how to link with IJBs and partnership to provide appropriate assurance.

33.13 The Chairman suggested that the recommendations in the current Board paper were not adequate and needed to address issues where the answer was not yet known. This point would be addressed in future iterations of the paper.

34. Healthcare Associated Infection

34.1 The Board were advised that the Vale of Leven Report recommended that the Board should receive a paper on Healthcare Associated Infection (HAI) providing high level data and performance outcomes.

34.2 The Board were advised in respect of Staphylococcus Aureus Bacteraemia that since May 2015 the incidence had generally fallen. However there had been a significant spike of 19 cases in August. The breakdown of the 19 cases was provided to the Board. It was noted that it would be important to be vigilant around this and any potential similar issues given recent positive performance in this area.

34.3 Positive progress was being made with Clostridium Difficile performance particularly in the over 65 year age group despite an outbreak at St John's Hospital in the summer. The benefits of the revised model of antimicrobial prescribing continued and had been discussed at previous Board meetings.

34.4 It was noted from the paper that St John's Hospital had received an unannounced Healthcare Environment Inspectorate visit on 10-11 August 2016 with the report due to be published on 18 October 2016.

34.5 The Board agreed the recommendations contained in the circulated report.

35. NHS Lothian's Corporate Risk Register

35.1 The Board noted that quite appropriately most of the issues contained in the risk register had either been discussed separately or would subsequently be discussed at the meeting.

35.2 It was reported that the Board paper was work in progress in respect of the roles of the Board Governance Committees. The Board agreed that paragraph 3.2.4 which stated 'the Board is to ask for assurance through its Governance Committees that adequate improvement plans are in place to attend to the corporate risks and in most instances are set out in the quality and performance paper presented to the Board and relevant governance committees (see table 1 below)' should be included as a recommendation in the main Board paper.

35.3 Reference was made to the bottom two bullet points in table 2 of page 4 of the paper with the question being raised about whether there was an issue that interpretation of data when within tolerance levels. The point was made different tolerance levels were in play and in some instances this reflected a cumulative position.

35.4 The Board were advised that a reference to the fact that 90% of staff would recommend NHS Lothian as a good place / very good place to work by December 2015 with a tolerance level of 93 – 95% linked to the Annual Staff Survey which would not be occurring in the current year. The reference should therefore be removed from the paper. National discussions were being held about whether the staff survey would continue given the introduction of iMatter. The Chairman commented there was a need for a measure in this area and that it should be preferably be iMatter based.

35.5 The Board agreed the recommendations contained in the circulated paper subject to the inclusion of para 3.2.4 as part of the main Board paper recommendations.

36. Primary Care Update

36.1 The Chairman welcomed Mr McCulloch-Graham, Ms McHugh and Mr Small to the meeting. Mr Small explained to the Board the differences between the original version of the Board paper and the revised version.

36.2 The Board were advised that in Lothian there were 42 practices with restricted lists as well as a number who had not yet reached that point although they had suggested and signalled difficulties through a combination of issues including population growth, demographic changes and difficulties around recruitment and retention.

36.3 The position in Edinburgh and Midlothian was that 50% of practices were restricted with the position in Edinburgh worsening. It was noted however that there were no Lothian practices with a closed patient list. In the event that a patient was experiencing difficulty in obtaining registration with a Lothian General Practitioner there was an assignment process in place where a practice would be identified for the patient. The recruitment and retention difficulties were also being felt by the Lothian Unscheduled Care Service.

36.4 The Board were advised of the significant steps being undertaken to address primary care priorities. It was noted that following on from a previous Board Development Session that all of the phase 1 recommendations identified had been implemented partly assisted by Scottish Government funding. The additional investment had supported the provision of more phlebotomists, advanced nurse practitioners and practice based pharmacists all of which were intended to reduce workload on GPs leaving them to deal with things that only a GP could deal with.

36.5 In addition to the above additional support was being provided through 'leg up' funding, the primary care transformation fund, premises and the review of Health Visitors.

36.6 The Board noted that all of the above efforts had not resolved the pressures being experienced in general practice. A primary care summit had been held on 29 September 2016 which had been positively received. A key output from this event had been the agreement that each Integration Joint Board would have local discussions over the next few months. The outcome of these discussions would be fed back into a future summit event which would be used to influence the Integration Joint Board and the NHS Lothian strategic plans and to also assist in the prioritisation of additional investment. It would be important through this ongoing process to demonstrate that NHS Lothian was a good place to work.

36.7 The summit event had concluded that the immediate issues to be addressed were around increasing the pace of implementing skill mix in primary care through the deployment of advanced nurse practitioners and phlebotomists; addressing previously identified issues and progressing the need for new ways of addressing workforce issues.

36.8 The Board were advised that the situation varied even within partnerships. In East Lothian the position was affected by levels of deprivation and significant housing developments which were moving some practices to crisis point. Practices were being engaged in attempting to find solutions. In East Lothian the system was about to go out to tender for a new practice in Newtongrange and this would help to alleviate some current pressures. A lower level mental health issues pilot was also being undertaken in Newbattle and it was anticipated that by addressing this and some other longer term conditions that this would relieve pressure on GP practices. The point was made that public engagement around how to use services differently would be important. Work was already underway with lead partners to obtain and encourage localised responses.

36.9 The point was made that there was a danger of focussing on a small number of practices rather than addressing the broader issues. A key issue was felt to be the need to consider how to make GP practice more attractive to medical students. There

was also felt to be a risk in terms of the amount of effort made around practices in crisis and the possible detrimental effect this had on other practices. The Board were advised in terms of making GP practices more attractive that work had been undertaken to address some of the previous issues of concern like building dilapidation; the selling of existing premises often by the sole remaining partner ('last man standing') and the need to show that investment was being made in primary care and other professions to free up GP time to do only what they could do. It was also felt that the improvements made in the new GMS contract would be beneficial.

36.10 The Board were reminded that 'Our Health Our Care' made clear statements about the role of primary care. It was felt the demise of the 48 hour access target was an issue. The suggestion was made that the Board needed a future looking strategy which clearly laid out ambitions and timelines around primary care investment and development. This should cover a 10-20 year timeframe and address issues around recruitment and premises etc. It had been encouraging at the Primary Care Summit Event that GPs had not perceived the service as being in crisis. The Chairman concurred with the need for a longer view strategic approach and felt that the basis of this would emerge from the primary care summit process.

36.11 The point was made in terms of the predominant use of the 'face to face' model of care that consideration should be given to the opportunities afforded by the use of IT and that this should be addressed in any future Board paper. An example was provided of phone based access and a vision online approach where appointments and prescriptions could be ordered and this was being rolled out. It was noted that issues around IT was an area of general concern within primary care. A national procurement process was underway to scope what a replacement system would look like.

36.12 The suggestion was made that primary care needed the same degree of level of focus and attention as had been applied to the paediatric service. The Acting Chief Executive commented that at the Primary Care Summit this issue has been addressed and he had advised that an Executive Board Director would focus on primary care. The composite views of IJBs would also be important to supplement the Executive level of focus in primary care for the next year. This increased focus would be reflected in discussion at future Board meetings.

36.13 The need for a longer term primary care strategy was broadly welcomed given the potential for reputational risk around access to GP practice lists. The point was made that if solutions were agreed at local level then there was a need to give serious consideration about how to engage with the local population through vehicles like community groups and patient groups to obtain their views and ensure these were reflected in the strategy. There was a clear need to work with the public to manage GP demand whilst recognising that in some instances other staff could respond to patient issues rather than the GP.

36.14 The point was made that any engagement process needed to produce tangible outcomes with it being noted that the GP Sub-committee had produced a useful paper around skill mix. The point was made however that in the past NHS Lothian and partners had not been good at up-scaling proposals. There was also a need to consider what to do about the situation where a practice was reduced to 'a last man standing' position with a partner who often owned the premises and was looking to disengage from the service. It was suggested that more medical graduates might be attracted to GP practice if they did not have to worry about the business aspects of being an independent contractor e.g. premises etc. The Board were advised that the system had moved to the second phase of recruiting more pharmacists and advanced nurse

practitioners. In terms of advanced nurse practitioners the Scottish Government had created 200 training places through National Education Scotland. The Health Visitor position was also improving with the Nurse Director chairing a group looking at skill mix and other issues. In terms of issues around the 'last man standing' in a practice it was noted that the Health Board was the place of last resort to take on issues like leases.

36.15 It was suggested that the move to locality working should help with skill mix and that in Edinburgh locality teams were being appointed to. There was also an issue about how good business support was provided to primary care through the transformational process rather than waiting until a crisis position had been reached.

36.16 It was recognised that despite the difficulties that the GP service provided in Scotland was a world class one which provided responsive solutions to issues that emerged through the public health out of hours rota. Moving forward it was suggested there would be significant benefit in working with the most vulnerable populations to develop appropriate models of care. The point was raised that compared to other parts of the UK that Scotland did not tender for primary care services with appointments being made from competent professionals. In addition there was a cadre of expert professional people who worked in the third sector who could deliver services to people whose diagnosis was not the top priority.

36.17 The Chairman reminded the Board that the paper had been put forward as a comment document. He felt the Primary Care Summit Event had been useful and full of positivity.

36.18 The suggestion was made that the paper before the Board was a seminal one in terms of a key risk area for the Board. Discussions had been held with GPs in East Lothian with simple but important issues emerging like the fact that not all GPs understood demand and whether GP practices would be expected to know what to do about that. In those instances expertise and support should be offered to GP practices. Whilst it was recognised that there was a need to concentrate on overcoming staffing issues there were a number of issues that could be addressed quickly at an affordable cost to ease the transformational process.

36.19 The Board noted that the summit event outcomes had identified short term process improvement issues as well as the need for fundamental redesign.

36.20 The question was raised about whether enough was being done with Scottish housing providers to address some of the reported issues around the condition of GP practice buildings given that they had experience in managing and maintaining property. It was agreed this was an issue that needed to be considered at Integration Joint Board level. The Board were advised that the Area Clinical Forum would welcome ongoing engagement following the primary care summit. It was noted in terms of housing development growth that there was currently insufficient engagement with developers about the approach to impacts on local GPs etc and this dialogue needed to be enhanced as this was currently a fundamental weakness in the process. It was noted that the local development plan for the City of Edinburgh Council for the first time ever picked up on these issues although a formula for the 'ask' from developers was still missing. It was suggested that this would be a key focus for the NHS and IJBs moving forward.

36.21 The Primary Care Summit had reported on experiences in NHS Forth Valley where solutions had been quickly applied and where these had been unsuccessful this had been accepted and lessons learned. The importance of creating the correct conditions

at local level to test initiatives and learn from them would be important as would be the ability to change direction. It was suggested that this approach needed to be an explicit part of the forward direction. It was noted that in the corporate world this approach was embedded with there being an acceptance that mistakes would often happen before progress was evidenced. There was a need to give staff permission to try out different approaches even if this went wrong. The embedding of a self sustainable approach was supported.

36.22 The Chairman thanked IJB colleagues for sharing their thoughts with the Board and advised that the position paper had provided a degree of confidence about the forward direction albeit this would be the start of a wider higher level of focus around the development of primary care. In terms of the need for longer term transformational change the granting of permission to test initiatives at local level demonstrated quality improvement in real time. The Area Clinical Forum was also accepted as being a useful focal point.

36.23 In terms of the development of a plan for the Board to engage with IJBs and others it was reported that the newly appointed Medical Director who would replace Dr Farquharson when he retired had agreed to lead the forward programme as the Executive Director Lead. A Star Chamber Group would be established to support short term improvements and a testing model would be central to this work.

36.24 It was agreed there would be a need to provide a position paper to the next Board meeting recognising that a key output of the primary care summit had been that each IJB over the next few months would come up with local plans and this would inform any future final strategic plan.

36.25 The Board agreed that primary care should remain a standing item on the Board agenda and that assurance on progress should be reported through the Healthcare Governance Committee. The Strategic Planning Committee would also have a role in adopting a holistic approach in support of the Healthcare Governance Committee.

37. Person Centred Culture

37.1 The Board noted that in the previous few months the focus of attention had been on where the system was in respect of managing complaints, addressing feedback and learning arising from complaints. The focus had shifted following a meeting with the Scottish Public Services Ombudsman (SPSO) and his team on 17 August 2016 with the Chairman along with senior managers in NHS Lothian where it had been agreed to implement a focussed programme of work.

37.2 In response to this meeting the Nurse Director had responded to the SPSO detailing a list of actions that would be taken forward during the coming months. This work would incorporate the recommendations from the external report that had been undertaken by Dr Dorothy Armstrong at the beginning of 2015. NHS Lothian was in the progress of completing an SPSO self assessment framework which was being progressed through the Chief Nurses Group. At a future meeting the Board would receive a final composite action plan to replace the current draft version.

37.3 The Nurse Director and the Head of Patient Experience had met with Chief Nurses to understand local level issues. As part of this process an exercise was underway to look at the way in which complaints were responded to as well as issues around how response letters were compiled. Updates on progress in this area would be made to

both the Board and the Healthcare Governance Committee. In recognition of the importance of this issue a small working group had been established chaired by Ms Hirst, Non Executive Board Member. This group had agreed to be the complaints champion in order to understand the actions needed to address concerns and recommendations and how to take these forward. Future work would need to address cultural issues as there was a need to move from a position of viewing complaints as a negative issue and move to viewing them in a more positive light. Consideration was being given on how to support teams through the transition.

37.4 The Board noted that the inpatient survey publication had been timely as it reinforced a lot of known messages. It was important to recognise that more than 90% of respondents had stated that they had received good care. There was however a need to reflect on those patients who did not feel the same. A key issue had been that a lot of people had not been able to distinguish who had been in charge and how to make a complaint. Noise had also featured as an issue of patient concern.

37.5 The Board were advised that work was underway to build on the survey results and other issues with additional information being available from the 'tell us 10 things' (TTT) process. In respect of the TTT process consideration was being given to using volunteers to distribute and take back in questionnaires. An electronic solution through the use of an app board was being considered for the Royal Hospital for Sick Children. There was a recognition that there was need to make it easier for people to provide feedback. A good response rate of 43% had been received from the inpatient survey.

37.6 An update was provided on the increasing demands being experienced by the complaints team. The majority of telephone complaints related to waiting times issues and it was felt there was need to let patients and GPs know what the current position was in order to reduce the number of complaints received into the system.

37.7 Ms Hirst commented that complaints had been an issue for some time and that there was no quick fix with improvement taking some time because of the complexity of the issues. There were a number of immediate issues that needed to be addressed. The importance of recognising positive performance was stressed with there being a need to recognise and learn from aspects that were working well. In terms of communication there was also a need to consider those complained about. There was a need to do subtle but significant changes to the way in which complaints were handled. It would not be possible in the short term to transform SPSO complaints as there was a significant backlog. There was a need to understand why NHS Lothian did not uphold complaints and the SPSO office did. It was felt that the complaints upheld rate was the best measure and that this should be focussed upon to see why NHS Lothian was not upholding as many complaints as the SPSO.

37.8 An observation was made that prison complaint numbers appeared to be disproportionate to the prison population. It was felt there was a need to drill down into the numbers to understand why these numbers were so high. It was reported that there was some context about complaints from prisons that could not be discussed in public. Dr Dorothy Armstrong had visited both of the Lothian prisons. The Nurse Director would also be meeting with prisoners to see if there was a way of moving towards an improvement in the prison complaint process.

37.9 The point was made that it would be useful if the Internal Audit department could bring focus to complaints as part of the improvement process. The Nurse Director commented that he would arrange for this to be included in the work programme for the Internal Audit department in the forthcoming year.

37.10 Reference was made to the previous 'power of apology' training that had been undertaken with it being understood that current problems would not be resolved overnight. It was felt to be important however for the Board to have sight of the sequence of actions and anticipated delivery timescales. The Board noted that the final action plan would address this issue and come to the Board in December 2016. The indicators suggested that NHS Lothian's complaints performance was improving and it was important therefore for the discussion to recognise this context. Team and site specific work was being undertaken as the whole organisational approach needed to link to the quality agenda.

37.11 The Board noted that the Healthcare Governance Committee maintained a focus on complaints performance. It was noted that it would be useful for this Committee and the Board to learn about changes made as a result of the proposals discussed as the current Board meeting. The Board were advised that this would form part of the learning process and there would be a need to provide evidence assurance that this was the case. Ms Hirst commented there was a high level of data contained in the Board report and this needed to be narrowed down to what the Board and the Healthcare Governance Committee really needed to know about. Work was underway to distil down the information in order to provide data in order to demonstrate change.

37.12 The Board welcomed the spotlight on complaints with it being recognised that responding to a complaint about yourself was difficult and inappropriate. It was reported that investigatory work could be undertaken by human resources staff with expertise in this area. This approach would also be beneficial if a complaint needed to progress to consideration by a professional regulatory body.

37.13 The Board agreed the recommendations contained in the circulated paper.

38. Support and Development of 'Realistic Medicine' in Lothian

38.1 The Chairman welcomed Dr Caroline Whitworth to the meeting.

38.2 The Board noted that discussion around realistic medicine should be considered within a 200 year historical context reflecting back to a time when the harmful effects of medicine was recognised. The Chief Medical Officer report reflected this position. There had been significant shifts and outcomes in respect of improvements and cures as medicine moved into a more scientific arena with the availability of guidance based healthcare and the production of guidance and recommendations.

38.3 The Board advised that there was a strong feeling internationally that healthcare professionals needed to embrace a technological approach with there being a need for patients and families to decide whether there was a different more holistic approach in future. It was noted that medical treatment did not always work out and that people needed to be part of the decision making process.

38.4 The move to realistic medicine would represent a big and challenging cultural change. This CMOs report synthesised a lot of international thinking around realistic medicine which required complex issues to be looked at with patients.

38.5 It was noted in order to deliver high quality modern health care that there was a need to look at all of the available options and to open dialogue with patients about what mattered to them and then give them time and space to reach a considered decision.

To make this happen would require a cultural shift from Board members and others to achieve these aspirations whilst recognising that at the moment the exact outcomes were not known. The process moving forward was about transformational change through the cultural quality change process.

38.6 The importance of nurturing realistic medicine in Lothian that was already happening would be important through consultation and discussion with others through the adoption of the following broad principles: -

- Better shared decision making should be the norm
- Leadership should be provided to support people delivering realistic medicine recognising the influence of national issues around education and the need to reflect this in the examination curriculum structures
- To obtain a feel for the challenges that realistic medicine meant in practice and report this to meetings like the Board and the Healthcare Governance Committee.

38.7 A key challenge moving forward would be to allow clinicians to practice realistic medicine and learn from mistakes in a supportive leadership environment. This position would need to be discussed with the Scottish Government and other Health Boards. The way forward would be to think about visible leadership to create permission for people to carry out small tests of change. A key aspect would be around patient centred care and shared decision making. It was noted that realistic medicine was already being practiced in primary care and some other areas in the acute sector.

38.8 The Acting Chief Executive commented that this was a seminal paper and was an example of something that challenged the heart of existing procedures. The steps that were evolving would require a Board leadership and engagement process with clinicians. The proposals had been discussed and fully endorsed by Executive and Corporate Directors.

38.9 The Board's role would involve providing a safety net for clinicians and to support them through very difficult decisions and this was discussed and recognised.

38.10 The point was made that the Board paper referred to patients and needed to be expanded to include relatives and carers as part of the process of working with the full family unit. It was noted that often patients were clear about what they wanted and this led to difficult discussions with the family about expectations.

38.11 The question was raised about whether what was being proposed was outside NHS Lothian's ability to influence and how this would be reflected in discussions around the training of future medical practitioners. In response a suggestion was made that NHS Lothian was probably not that far ahead of other Boards who would also be discussing this issue and it would be important to fully utilise the levers that were available to pull.

38.12 The Board were reminded that one of the core principles of realistic medicine was around patient centred care and this would need to be a key part of the strategy. Reference was made to a recent stroke event where the focus had been on compassionate care and patient centeredness. There was a view that this was the correct time for the Board to show leadership around realistic medicine.

38.13 A point was raised that while momentum was growing that there was still a lack of understanding around the impact on the patient and their families. It was agreed that communication would be fundamental and there would be a need to properly and clearly articulate the benefits of this process if it were to be successful. The suggestion

was made that the Board and its Non Executive members had a formal role in raising awareness around the process. Assurance would be obtained through proper testing of difficult approaches before wider implementation.

38.14 The testing model was broadly supported with it being noted that a risk was that clinicians would feel vulnerable if using treatment plans that were different from the standard. It was noted that the discussions being held would be about the most important life decisions and that there was a need to look at legislative advocacy arrangements as part of the testing process. The vulnerability of clinicians was recognised as being important with reference being made to a National Institute of Clinical Excellence paper which was an English based guidance document which addressed a summary of helpful approaches. It was noted that the vulnerability of clinicians was one of the key reasons for seeking the support of the Board and the Executive.

38.15 It was suggested that the key challenge for the Board would be the first time that something went wrong. It was noted that with any roll out of a programme it should be possible to obtain a quick impact and the question was posed about where these impacts might occur in the near future and how the process would systematically build up from patient feedback in this area.

38.16 The Board noted that the CMO's report had provided the 'big bang' impact and that realistic medicine had been happening for a number of years in primary care and areas like renal medicine albeit it had not been tagged as such.

38.17 A key consideration would be to provide recognition to the process that would allow clinicians to make the cultural move. It would be important that patient feedback included recognition of the patient experience. The point was made that it would be important to provide project management support to manage the required transformational change. It would be important to build wherever possible on existing work and patient feedback rather than create a new process.

38.18 The point was made that whilst the proposal was exciting that it would inevitably lead to a lot of focus and there would be a significant task to balance the proposal in respect of transformational change with philosophy and behaviour. The power relationship would be with patients and families who would have explicit expectations of the process. A significant workstream would be to support healthcare professionals and measure the benefits to patients. The missing part of the proposal to date was how to empower patients and families to ask difficult questions.

38.19 A suggestion was made that whilst the direction of travel was appropriate that the tag-line of realistic medicine needed to be considered to make it more appropriate with the use of phrases like dignity, compassion and supporting patient care as these were more positive when moving to debate in potentially more hostile discussion environments. The point was made that the CMO report had been positively received by virtually all recipients. It was suggested that realistic medicine could be delivered as part of the key values of NHS Lothian.

38.20 It was suggested there was a need to gather data systematically about patient choices as part of the transformation process as this would change the way the organisation invested in services. It was reported that the intention would be about the systematic collection of evidence to understand the decisions that people made and to identify any trends such as people not attending for treatment because of reasons like travel distances which would reinforce existing inequality issues.

38.21 The primary care cost implications were discussed with it being noted that implementation would have financial consequences in the short and medium term because of the time needed to discuss issues with patients.

38.22 The Chairman commented that the discussion at the Board meeting had been significant and fundamental. Acceptance of the proposals would give clinicians a licence to adopt the philosophy and features of realistic medicine. The Chair stressed that the Board was being asked to support and provide commitment as the accountable body and it would be important to stand behind this commitment and to provide support to clinicians where necessary if things went wrong that were not related to competency.

38.23 The Board endorsed the paper and the discussion held at the meeting.

39. Any Other Competent Business

39.1 Strategic Planning Board Workshop – Board members were advised that a workshop session would be held on 13 October to which all Board members were invited to attend.

39.2 Integrated Impact Assessment - Dr Williams commented that the Healthcare Governance Committee had raised concerns about the process for and the number of impact assessments being undertaken. The Acting Chief Executive advised that he would take this issue away and bring back a recommendation for the next Board meeting.

40. Date and Time of Next Meeting

40.1 The next meeting of Lothian NHS Board would be held at 9:30am on Wednesday. 7 December 2016 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

41. Invoking of Standing Order 4.8

41.1 The Chairman sought permission to invoke Standing Order 4.8 to allow a meeting of Lothian NHS Board to be held in private. The Board agreed to invoke Standing Order 4.8.

Return to first page

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West Lothian Council

HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL

WEST LOTHIAN INTEGRATION JOINT BOARD

REPORT BY DEPUTE CHIEF EXECUTIVE

A. PURPOSE OF REPORT

To update members on the business and activities of West Lothian Integration Joint Board.

B. RECOMMENDATION

To note the terms of the minutes of West Lothian Integration Joint Board dated 29th November in the Appendix to this report.

C. SUMMARY OF IMPLICATIONS

I	**Council Values**	Focusing on our customers' needs Being honest, open and accountable Working in partnership.
II	**Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)**	Council requires the activities of certain outside bodies to be reported to elected members on a regular basis, as part of its Code of Corporate Governance.
III	**Implications for Scheme of Delegations to Officers**	None.
IV	**Impact on performance and performance Indicators**	Working in partnership.
V	**Relevance to Single Outcome Agreement**	We live longer, healthier lives.
VI	**Resources - (Financial, Staffing and Property)**	None.
VII	**Consideration at PDSP**	Reported to Health & Care PDSP for noting.
VIII	**Other consultations**	None required.

D. TERMS OF REPORT

On 29 June 2010 the Council Executive decided that the activities of certain outside bodies should be reported within the council to ensure all elected members are aware of the business of those bodies and to help to ensure their activities are more effectively scrutinised.

In accordance with that decision the business of West Lothian Integration Joint Board was to be reported to this meeting by the production of its minutes. The relevant documents are produced in the Appendix to this report.

E. CONCLUSION

This report ensures that members are kept appraised of the activities of West Lothian Integration Joint Board as part of the council's Code of Corporate Governance.

F. BACKGROUND REFERENCES

West Lothian Council Code of Corporate Governance.

Council Executive, 29 June 2010

Appendices/Attachments:	Minutes of the meetings of West Lothian Integration Joint Board held on 29th November 2016
Contact Person:	Jim Forrest, Depute Chief Executive 01506 281977 Jim.Forrest@westlothian.gov.uk
CMT Member:	Jim Forrest, Depute Chief Executive
Date:	9th February 2017

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 29 NOVEMBER 2016.

Present
Voting Members – Danny Logue (Chair) Susan Goldsmith, Alex Joyce, Alison McCallum (substitute for Martin Hill), John McGinty, Anne McMillan, Frank Toner, Lynsay Williams.

Non-Voting Members – Ian Buchanan (Stakeholder Representative),Elaine Duncan (Professional Advisor), Jane Houston (Staff Representative), Mairead Hughes (Professional Advisor), Jane Kellock (Chief Social Work Officer), Mary-Denise McKernan (Stakeholder Representative), Martin Murray (Staff Representative), Patrick Welsh (Chief Finance Officer).

Apologies – Martin Hill (Vice-Chair), Jim Forrest (Director) and Marion Barton (Head of Health Services).

In Attendance – Carol Bebbington (Senior Manager Primary Care and Business Support), Alan Bell (Senior Manager, Communities and Information, WLC), James Millar (Standards Officer)

1. DECLARATIONS OF INTEREST

Danny Logue declared a non-financial interest as an employee of NHS Lothian.

Alison McCallum declared a non-financial interest as Director of Public Health and Health Policy, NHS Lothian.

2. MINUTE OF MEETING OF WEST LOTHIAN INTEGRATION JOINT BOARD HELD ON TUESDAY 18 OCTOBER 2016

The West Lothian Integration Joint Board approved the minute of its meeting held on 18 October 2016.

3. MINUTE OF MEETING OF WEST LOTHIAN INTEGRATION STRATEGIC PLANNING GROUP HELD ON 30 JUNE 2016

The West Lothian Integration Joint Board noted the minute of meeting of the Strategic Planning Group held on 30 June 2016.

4. MINUTE OF MEETING OF WEST LOTHIAN INTEGRATION STRATEGIC PLANNING GROUP HELD ON 11 AUGUST 2016

The West Lothian Integration Joint Board noted the minute of meeting of the Strategic Planning Group held on 11 August 2016.

5. AUDIT, RISK AND GOVERNANCE COMMITTEE - MEMBERSHIP

The Board considered a report (copies of which had been circulated) by the Standards Officer concerning changes to the appointment of the Chair and members of the Audit Risk and Governance Committee.

The Standards Officer recalled that the Board had established its Audit, Risk and Governance Committee on 5 April 2016. It had agreed its remit and membership and had appointed its members at the same time.

The report went on to inform the Board of changes made to the health board's appointed members to the Board, and changes arising from the appointment of Danny Logue as Chair of the Board.

The Board was invited to:-

1. Note that Martin Hill had replaced Julie McDowell as the Chair of the Audit, Risk and Governance Committee.

2. Note that due to his appointment as Chair of the Board, Danny Logue could no longer be a member of the Committee.

3. Appoint a replacement for Danny Logue on the Committee, drawn from the voting members appointed by the Council.

Decision

To note the terms of the report; and

To appoint John McGinty as a replacement for Danny Logue on the Audit, Risk and Governance Committee.

6. ALCOHOL AND DRUGS PARTNERSHIP SERVICES AND FUNDING

The Board considered a report (copies of which had been circulated) by the Director advising of the £350k reduction in direct grant funding for Alcohol and Drugs Partnerships in 2016/17 and the proposed actions to bring commissioned service expenditure in line with available financial resources.

The current ADP Commissioning Plan 2015-2018 was attached as Appendix 1 to the report. It had been developed with the collaboration and support of all the partners. In line with the standard approach for strategic commissioning in the IJB, the plan was informed by an independent needs assessment.

The Board was informed that the Scottish Government draft budget published in December 2015 included a reduction in the combined drug and alcohol funding from £69.2 million in the current financial year to £53.8 million in 2016-17.

The Cabinet Secretary for Health wrote to Health Board Chief Executives in early January 2016 stating her expectation that existing services, resources

and outcomes would be maintained at 2015/16 levels and that increased Board baseline budgets were expected to go towards meeting the funding shortfall.

The Scottish Government had subsequently confirmed ADP funding allocations to NHS Boards for 2016-16 in a letter of 4 July, a copy of which was attached as Appendix 2. The result of that was that the ADP funding allocation for Lothian had reduced from £11.470 million to £8.887 million (23% reduction).

For West Lothian, the total budget reduction for commissioned services would be £350,000 in 2017/18.

The report explained that a series of stakeholder consultation events had been arranged to review the ADP commissioning plan with the objective of bringing investment in line with available resources from 1 April 2017. The process included engagement with service users.

The stakeholder consultations had focused on trying to establish a consensus around the mix of provision consistent with the strategic needs assessment and the revised budget. There had been a general agreement to the following changes in commissioned services:-

Therapeutic Support Service
Assertive Outreach and Criminal Justice Services
Services for Children and Young People Affected by Parental Substance Misuse
Recovery Service – Public Social Partnership
In-house provision

It was recommended that the Board:-

- Note the reduction of £350k from 2015/16 in the Scottish Government's direct grant funding to Alcohol and Drugs Partnerships in 2016/17.

- Note the consultation with stakeholders on the possible measures to achieve the budget reduction within the context of the current commissioning plan.

- Agree the following specific measures from 1 April 2017 in respect of commissioned services:-

    1. Renegotiate the current Therapeutic Support Service contract for a further year with a reduced budget saving of £11,533 on current expenditure

    2. Tender for the procurement of a service providing early intervention support for vulnerable adults using an assertive outreach model and treatment and recovery support for those involved in the criminal justice system, with a saving of £51,095 on current expenditure.

    3. Tender for the procurement of a service to focus on support for children and young people affected by parental substance misuse using a whole family holistic service model. It was proposed that the

service operated alongside in-house staff providing additional key working support to young people who were experiencing a wide range of problematic behaviours. The new service specification would be developed following a period of collaboration with stakeholders and service users with a saving of £42,865 on current expenditure.

4. Continue with the Recovery Service PSP but with a reduced budget, saving £42,426 on current expenditure.

5. Reduction of £102,081 on current budgets for in-house addictions services.

There followed a discussion concerning the potential impact of the proposed actions to bring commissioned service expenditure in line with available financial resources. It was acknowledged that the impact would be known at a later stage, but that work could start now to gather information with a view to writing to the Cabinet Secretary for Health and Sport. It was suggested that, by writing to the Cabinet Secretary, the IJB could seek clarity regarding her expectation that existing services, resources and outcomes could be maintained at 2015-16 levels. At the same time, the IJB would highlight concern for the risks associated with service users.

Decision

1. To note the terms of the report.

2. To agree the recommendations set out in Section B of the report; and

3. To agree to write to the Cabinet Secretary for Health and Sport, Shona Robison MSP seeking clarity regarding her expectation that existing services, resources and outcomes be maintained at 2015-16 levels, given that the Scottish Government funding allocation for 2016-17 had reduced by 23%.

7. OLDER PEOPLE COMMISSIONING PLAN

The Board considered a report (copies of which had been circulated) by the Director seeking approval for the strategic commissioning plan for Older People as presented in Appendix 1 to the report.

The Board was informed that a short life Working Group had been established to develop the three year commissioning plan for Older People

All care group commissioning plans followed a similar structure as follows:-

Section 1 gave an overview, setting out vision, values, aims and outcomes, and the approach taken.

Section 2 detailed the main recommendations arising from the Needs Assessment, locating these against existing strategies and policies and confirming whether they were to be addressed by specific commissioning intentions.

Section 3 detailed the specific commissioning commitments informed by the Needs Assessment, and provided information on the planned spend to meet these commitments.

Section 4 was titled Next Steps and detailed a number of strategic change proposals. The programmes of change were listed in the report.

The Board was invited to approve the strategic commissioning plan for Older People as presented in Appendix 1 to the report.

Decision

To approve the strategic commissioning plan for Older People as presented in Appendix 1 to the report.

8. FINANCIAL REPORT - UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on the financial performance in respect of the IJB's 2016/17 delegated resources based on the mid year monitoring position undertaken by NHS Lothian and West Lothian Council.

A table within the report showed the outturn forecast position, which was based on the 2016/17 monitoring exercise undertaken by NHS Lothian and West Lothian Council. Appendix 1 provided further detail on the forecast position shown. As shown in the table, an overspend of £2.428 million was forecast on the payment to the IJB and an overspend of £916,000 was forecast against the notional share of acute set aside resources attributed to West Lothian. This represented an increased overspend of £604,000 on NHS Lothian delegated functions compared to the position previously reported to the Board on 18 October 2016. A summary of key risks and service pressures had been identified and these were noted in the narrative against the relevant components of the delegated budget.

As part of the 2016/17 payment to the IJB from the council and NHS Lothian there were £3.895 million of budget savings identified. The monitoring undertaken estimated that £3.733 million of the target was achievable.

In addition, the share of acute set aside budget included a share of acute savings totalling £298,000 of which £199,000 was estimated to be achievable.

While in overall terms satisfactory progress was being made on the delivery of 2016/17 savings, it was vital that savings were fully achieved on a recurring basis.

The report provided a summarised budget position for 2016/17. An overspend of £3.344 million was projected, of which £2.428 million related to the NHS Lothian payment functions and £916,000 related to share of acute set aside.

It was recommended that the IJB:-

1. Note the forecast outturn for 2016/17 in respect of IJB delegated functions taking account of saving assumptions.

2. Note the action being undertaken by partner bodies in partnership with the IJB in respect of managing within available 2016/17 budget resources.

3. Note the position on 2017/18 budget planning.

Decision

To note the terms of the report.

9. PRIMARY CARE REPORT

The Board considered a report (copies of which had been circulated) by the Director providing an overview of the current challenges being experienced in Primary Care and the actions being taken to support and sustain service provision.

The paper outlined the current issues impacting on West Lothian practices and provided overview of the measures taken to support General Practice provision.

It was noted that were significant challenges in recruitment and retention to GP posts across the country for partner, salaried, locum, and out of hours' positions. Over £2 million of funding had been allocated to recruitment and retention projects across the country, as part of the Government's Primary Care Investment Fund.

The report then went on to provide commentary in relation to the following issues:-

- Scottish Government GP Recruitment and Retention Fund
- General Practice Education and Training
- NES Scotland Returner and NES Enhanced Induction Programmes
- Workforce
- Morale
- OOH Primary Medical Services
- Community Nursing
- Practice Nursing
- Changes to the GM Contract
- Practice Numbers
- List Expansion Grant Uplift Scheme
- Integrated Care Pharmacists
- DSkill Mix
- IT and eHealth
- Premises
- Risk Register
- Primary Care Summit

In relation to Primary Care Summit, it was proposed that West Lothian hold a local primary care summit to build on the emerging themes from the pan Lothian event and to look in more detail at the current issues affecting primary care in West Lothian. The main aims would be to identify local priorities and specific actions to support sustainability in general practice and to agree how these would be developed and delivered locally and to identify those priorities which would require wider engagement with NHS Lothian and the Scottish Government and how these would be taken forward. It was intended that the summit would be held on 22 February 2017 to enable the primary healthcare teams to fully participate.

The IJB was asked to:

- Note the contents of the report.
- Note the current challenges facing Primary Care.
- Support the management teams in their actions.
- Support the proposed Primary Care Summit event in February 2017.

Decision

1. To note the terms of the report.
2. To agree to support the management teams in their actions and to support the proposed Primary Care Summit event in February 2017.

10. RISK MANAGEMENT

The Board considered a report (copies of which had been circulated) by the Director providing an update on progress in relation to risk management.

The Board was informed that the Integration Scheme required that the IJB maintain a risk register and that the Director produced and agreed a list of the risks to be reported and monitored. As reported in May, a risk register had been set up using West Lothian Council's Covalent system, and the risks to be reported and monitored were listed in Appendix 1 to the report.

All of the risks had been scored for likelihood and impact. In report provided an explanation in relation to Appendix 1.

In terms of impact on objectives, the IJB risk had been mapped to the nine national health and wellbeing outcomes. Appendix 2 to the report outlined the results of that exercise.

The risks had been identified by the IJB Senior Management Team during a risk management session facilitated by West Lothian Council's risk manager. The methodology used was attached Appendix 3 to the Report.

The Panel was asked to:

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

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

Decision

To note the terms of the report.

11. CHIEF SOCIAL WORK OFFICER REPORT

The Board considered a report (copies of which had been circulated) by the Head of Social Policy attaching a copy of the Chief Social Work Officer's annual report for 2015-16.

The Chief Social Work Officer Report provided an overview of the role and responsibilities of the Chief Social Work Officer and outlined the governance arrangements that were in place in West Lothian. The report highlighted Council's statutory duties, the decisions that were delegated to the Chief Social Work Officer and gave a summary of service performance.

The Chief Social Work Officer concluded that the delivery of social work services was challenging and in light of the current economic situation the importance of delivering vital services to the most vulnerable and marginalised in our community would test our capacity, creativity and commitment over the forthcoming year. It was essential to continue to develop and improve services while constantly seeking to become more efficient. Social Policy was well placed to address these challenges and would continue to contribute significantly to the delivery of positive outcomes for the people of West Lothian.

The Board was asked to:-

1. note the contents of the Chief Social Work Officer's annual report for 2015-2016 and

2. note the submission of the report to the Scottish Government Chief Social Work Advisor.

Decision

1. To note the terms of the report.

2. To note that the Chief Social Work Officer's annual report would be submitted to the Scottish Government Chief Social Work Advisor.

12. PERFORMANCE REPORT

The Board considered a report (copies of which had been circulated) by the Director setting out the requirements for the Annual Performance Report and updating the Board on the current performance against the indicators

supporting the National Health and Wellbeing Outcomes.

The Board was informed that under the 2014 Public Bodies (Joint Working) (Scotland) Act, the IJB was required to publish an annual performance report setting out an assessment of performance in planning and carrying out the integration functions for which they were responsible. The 2014 Act obliged the IJB to publish their Performance Report covering the performance over the reporting year no later than four months after the end of the reporting year. Reporting years began on 1 April annually and therefore the Performance Report covering be period April 2016 to March 2017 was required to be published no later than end of July 2017.

It was noted that purpose of the performance report was to provide an overview of performance in planning and carrying out integrated functions and was produced for the benefit of the IJB and their communities.

Appendix 1 to the report set out the current West Lothian performance against the core integration indicators. Appendix 2 provided a time series for integration indicators and Appendix 3 provided benchmarking performance against other partnerships in Scotland.

Whilst the provisional data demonstrated that West Lothian was on par or better than Scottish average there were known challenges with regards to unscheduled care and reducing delayed discharge for which there was focussed improvement work in progress. Further analysis of the Health and Social Care Experience results was in progress to provide a better understanding of the issues and where interventions should be targeted to improve on these outcomes in particular in relation to the experience of care in general Practice, impact of services and support on improving or maintaining quality of life and support for carers to continue in their caring role.

It was proposed that officers commence preparation on the draft Annual Performance Report in order to build as full and accurate an assessment of how health and social care was being delivered for people and communities in West Lothian.

The Board was asked to:-

1. Note the contents of the report.

2. Note the requirements for the Annual Performance Report and agree the plan to development it.

3. Note the current performance report against the National Health and Wellbeing Outcomes.

Decision

To note the terms of the report.

13. HEALTH AND CARE GOVERNANCE

The Board considered a report (copies of which had been circulated) by the Director outlining arrangements being put in place to meet Health and Care Governance requirements as outlined in the Integration Scheme.

The report advised that the Audit, Risk and Governance Committee had considered a report in September 2016 providing an update on progress with implementation of the Integration Scheme since its approval in June 2015 and providing information on the steps proposed to complete outstanding actions. It noted that additional work was required to establish a Health and Care Governance Group in accordance with the Integration Scheme Regulations 2014.

The report contained a proposal for the Health and Care Governance Group to be chaired by a Board Member of the IJB and take membership from the Health Board, the Council and others, including

- Members of Senior Management Team
- Chief Social Work Officer
- Clinical Director
- Chief Nurse
- Allied Health Professional Lead
- Public Health Consultant
- Associate Medical Director Acute Services
- Associate Nurse Director Acute Services
- Service user and carer representative
- Third sector and independent sector representatives

Appendix 1 to the report was the proposed Terms of Reference for the Group.

The role of the Health and care Governance Group would be to consider matters relating to strategic plan development, clinical and care governance, risk management, service user feedback and complaints, care standards, education, learning, continuous improvement and inspection activity. The Group would provide advice to the Strategic Planning Group and Locality Planning Groups within the partnership and would consider the potential health and care governance impact of any service redesign or development proposals prior to their approval by the IJB.

The Integration Joint Board was asked to:-

1. Note the contents of the report.

2. Note the IJB responsibility for governance and assurance and discuss the proposed arrangements for Health and Care Governance

3. Consider the draft Terms of Reference for the Health and Care Governance Group and agree the membership.

Decision

1. To note the terms of the report.

2. To agree the proposed Terms of Reference for the Health and Care Governance Group as set out in Appendix 1 to the report.

3. To agree that Anne McMillan be appointed as Chair of the Group.

14. WORKPLAN

A copy of the Workplan had been circulated for information.

Decision

To note the Workplan.

West Lothian Council

HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL

ORAL HEALTH IMPROVEMENT WITHIN WEST LOTHIAN

REPORT BY, HEAD OF ORAL HEALTH IMPROVEMENT, NHS LOTHIAN

A. PURPOSE OF REPORT

To advise on progress in Oral Health Improvement within West Lothian HSCP This paper focuses, in particular, on children's oral health within West Lothian.

B. RECOMMENDATION

The purpose of this paper is for noting purposes.

C. SUMMARY OF IMPLICATIONS

I	**Council Values**	• Focusing on our customers need's • Being honest, open and accountable • Providing equality of opportunities • Making best use of our resources • Working in partnership • Developing employees
II	**Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)**	None
III	**Implications for Scheme of Delegations to Officers**	None
IV	**Impact on performance and performance Indicators**	
V	**Relevance to Single Outcome Agreement**	
VI	**Resources - (Financial, Staffing and Property)**	Scottish Government funded via the NHS Scottish Dental Action Plan.
VII	**Consideration at PDSP**	None
VIII	**Other consultations**	NHS Lothian

D. TERMS OF REPORT

This paper informs the board on progress within oral health improvement within West Lothian. This paper focuses on children's oral health within West Lothian.

Background

While oral health in Scotland had shown a gradual improvement since the 1960's, data from the Scottish Health Boards Epidemiology Programme during the 1980's and 90's showed that this had begun to plateau. In 2002 and 2003 the then Scottish Executive launched two consultation documents "*Towards Better Oral Health In Children"* and "*Modernising NHS Dental Services in Scotland".* Following these consultations the Scottish Executive responded with their "*Action Plan for improving oral health and Modernising NHS Dental Services."* published in March 2005. In 2012 a National Oral Health Improvement Strategy for priority groups was published which provided recommendations for frail older people, those with special care needs and people experiencing homelessness.

Children's Oral Health in West Lothian

Detailed epidemiological data for P1 pupils is collected as part of the National Dental Inspection Programme (www.ndip.scottishdental.org) which replaced the Scottish Health Boards Epidemiology Programme in 2004. These surveys demonstrate that the proportion of P1 children who have no obvious dental disease met the 2010 national target of 60%. `However the status of children in West Lothian is the worst of the 4 HSCP's in NHSL and 3-3.5 percentage point decline between 2014 and 2016 in these data is concerning.. A new target has been released of 75% of P1 children having no obvious dental disease by 2022.

The figure overleaf gives these data over the last 30 years and illustrates the effect of the interventions that are in place to date. However, there is no evidence of improvement across NHSL over the last 6 years.

2016 detailed results (http://ndip.scottshdental.org/wp-content/uploads/2016/10/2016-10-25-NDIP-Report.pdf page 45, table A3.7

2016 Primary One results

HSCP name	% no obvious decay experience
East Lothian	72.4
Edinburgh	73.1
Midlothian	68.8
West Lothian	**63.7**

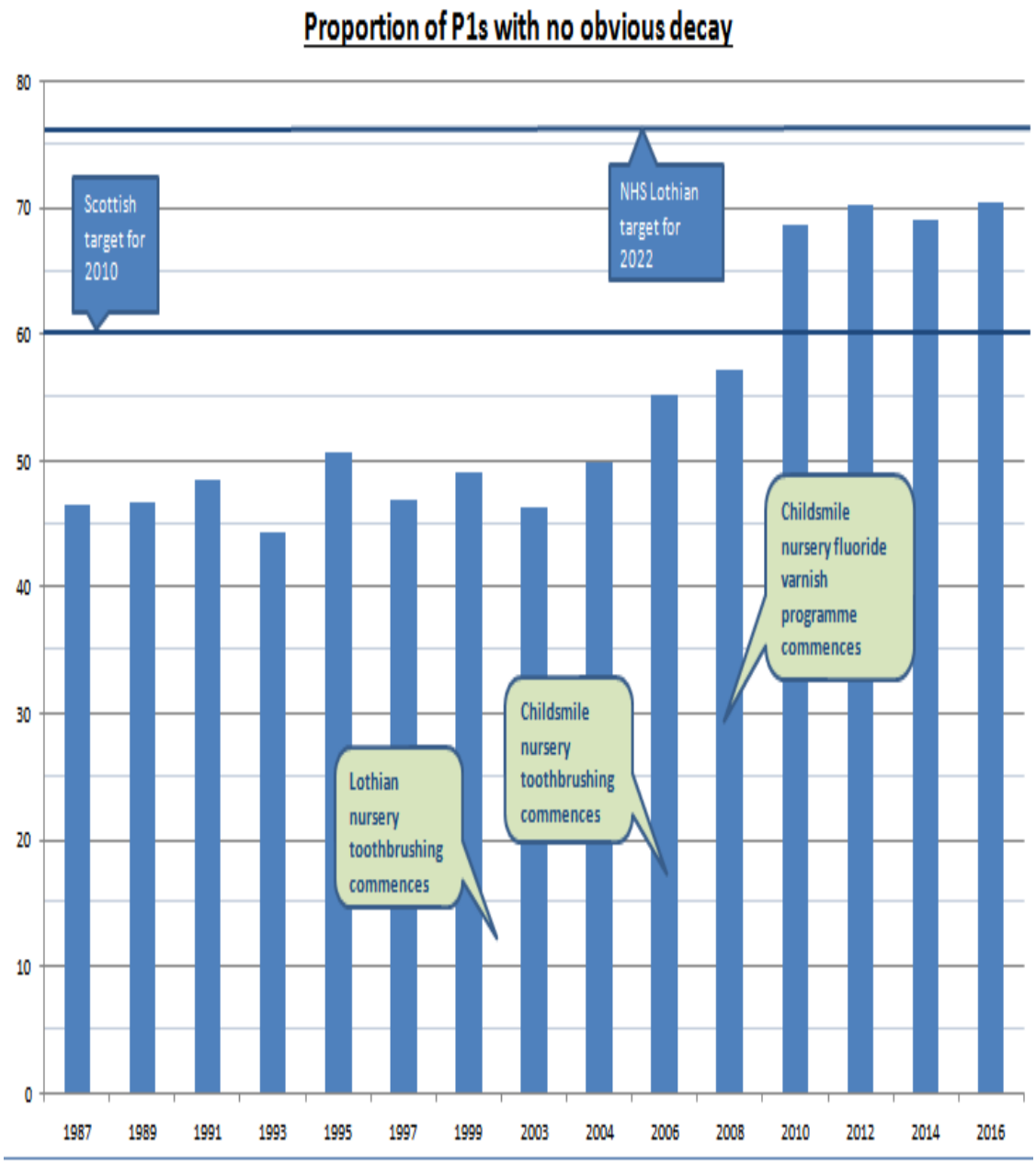
2014 Primary One results

HSCP	% no obvious decay experience
East Lothian	72.5
Edinburgh	68.6
Midlothian	68.5
West Lothian	**67.3**

2012 Primary One results

HSCP	% no obvious decay experience
East Lothian	73.2
Edinburgh	73.6
Midlothian	65.0
West Lothian	**65.7**

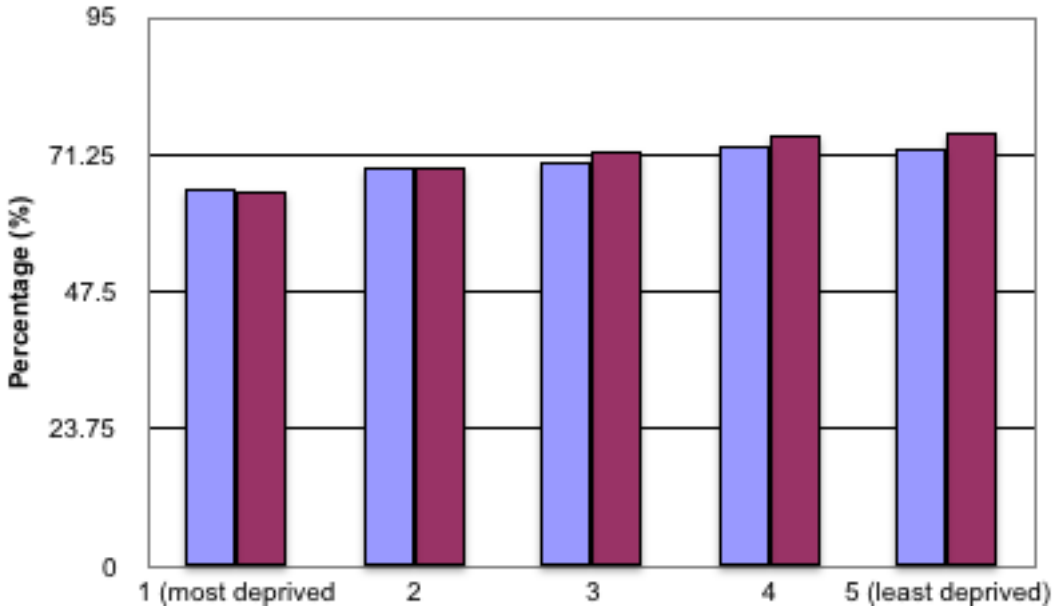
NHS Lothian Wide



Snapshot of % Children Registered with a General Dental Practice within West Lothian, Source ISD, MIDA data extracted April 2016

WEST LOTHIAN	% 0-2 years of age	% 3-5 years of age	% 6-12 years of age
March 2014	43.2	84.4	97.2
March 2015	43.5	84.1	99.6
March 2016	41.5	83.7	102.0

Dental registration is now life-long, so registration per se is not a measure of engagement with Oral Care Services. A better measure of engagement with oral health services is the participation rate, with participation defines as a patients attendance at an NHS dental practice for examination or treatment in the two years prior to the time point of interest.



These data will still overestimate the proportion who seek regular care as they include individuals seeking emergency care only. Admission to hospital for tooth extractions under general anaesthetic remains the most common reason for a child under 12 to be admitted to hospital in the Lothians.

Current Oral Health Improvement measures in place for children within West Lothian.

Childsmile National Programme

Childsmile is national programme designed to improve the oral health of children in Scotland and reduce inequalities both in health and access to dental services.

It is funded by the Scottish Government and has four main components

- Childsmile Core
- Childsmile Practice
- Childsmile Nursery
- Childsmile School

How did Childsmile start?

Childsmile developed largely from two demonstration programmes during 2006-2008 laid out in the Action Plan for Modernising Dental Services in Scotland (Scottish Executive 2005)

www.child-smile.org

Childsmile Core

All nurseries, state and private, are offered the opportunity to have a nationally supported toothbrushing programme. This allows all children the opportunity to toothbrush on a daily basis. Training, education and materials are provided for nursery staff by NHS Dental Health Support Workers (DHSW). Following implementation of the programme, monthly support is given to the nursery by a designated NHS Lothian DHSW.

All west Lothian nurseries currently participate in the toothbrushing programme.

All children within West Lothian receive a government funded toothbrushing pack six times by the time the age of 5. These packs are distributed by NHS Lothian on behalf of the Scottish Government.

Childsmile Practice

- Facilitate Childsmile training and offer on-going support to all General Dental Practices with West Lothian
- Work with Health Visitors so that children are encouraged to register their child at a dental practice after birth. The child health early years pathway requires every child to be assessed for dental referral, where appropriate, during the health visitors 6-8 week assessments & 27-30 month assessments.
- Provide home visits to vulnerable families where appropriate providing support, advice and sign posting where necessary.
- Facilitate the attendance of parents with their children at dental practices where this is problematic.

Childsmile Nursery

3 and 4 year old children in pre-school nurseries from the lowest quintile Scottish Index of Multiple Deprivation (SIMD) are offered two fluoride varnish (FV) applications per year, applied in the actual nursery setting. This is dependent on the parent consenting and the child being at nursery on the day of application.

Currently there are 3 separate fluoride varnishing teams working throughout West Lothian. Teams consist of specially qualified dental nurses and support workers.

Childsmile School

As children from the targeted nurseries in the Childsmile Nursery programme move onto Primary Schools, they continue to be offered two fluoride varnish applications per year. The intention of the programme is that Childsmile Nursery and School will offer children two FV applications on entry into ante pre-school nursery through to Primary 4, in communities from the lowest quintile of SIMD profile.

Special Care Provision

Plans are underway to introduce toothbrushing and fluoride varnish applications to Special Schools within West Lothian, similar to main stream schools, where current funding allows.

Caring for Smiles (National Elderly Programme)

Caring for Smiles is Scotland's national oral health promotion, training and support programme, which aims to improve the oral health of older people, particularly those living in care homes. NHS Lothian Caring for Smiles dental teams are delivering on-going training sessions in all care homes across West Lothian. This includes local support with Oral Health Risk Assessments and Oral Care Plans for residents.

Care home staff are invited to participate in the SCQF recognised accredited foundation and intermediate award in Oral Care via the Caring for Smiles programme. This is supported and delivered by NHS Lothian dental staff. 20 carers in West Lothian were recently successful in obtaining this qualification

A strategic partnership approach to working closely with Care at Home providers in West Lothian will be developed within NHS Lothian Oral Health Service.

Mouth Matters (National Prison Oral Health Improvement Programme)

Following the transfer of health care services from the Scottish Prison Service (SPS) to NHS Scotland in November 2011, oral health was one of the 11 key areas for health improvement efforts outlined in the first joint health improvement framework, *Better Health, Better Lives for Prisoners.*

Responding to the complex oral health needs of prisoners and young offenders can present a considerable challenge.

Within HMP Addiewell oral health care is part of the weekly induction process for new prisoners. Oral health care is also being carried out with families of prisoners, including young children. On release from HMP Addiewell prisoners are supported with information about obtaining registration with a General Dental Practitioner.

Oral Health training sessions are now being delivered to prison staff and other health care providers within HMP Addiewell

E. CONCLUSION

Towards the end of 2016 the Scottish Government undertook a consultation ”Scotland’s Oral Health Plan. A Scottish Government Consultation Exercise on the Future of Oral Health Services. (September 2016)”.

Responses to the consultation are being analysed and a new Oral Health Plan is expected later in 2017. This will determine the focus of future NHS Dental Services, including Oral Health Improvement.

F. BACKGROUND REFERENCES

Appendices/Attachments:	None
Contact Person :	Fiona Rodger Head of Oral Health Improvement Fiona.rodger@nhslothian.scot.nhs.uk 0131 470 5598
CMT Member:	Jim Forrest, Depute Chief Executive
Date of Meeting	9th February 2016

West Lothian Council

HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL

FAMILY NURSE PARTNERSHIP

REPORT BY DEPUTE CHIEF EXECUTIVE, HEALTH AND SOCIAL CARE PARTNERSHIP

A. PURPOSE OF REPORT

The purpose of this report is to inform the Health and care Policy Development and Scrutiny Panel of the implementation and progress of The Family Nurse Partnership (FNP) in West Lothian.

B. RECOMMENDATION

It is recommended that the Health and care Policy Development and Scrutiny Panel:

1. Note the contents of the report
2. Note the progress made in implementing the FNP Programme in West Lothian.

C. SUMMARY OF IMPLICATIONS

I	**Council Values**	• Focusing on our customers' needs • Being honest, open and accountable • Providing equality of opportunities • Making best use of our resources • Working in partnership • Developing employees
II	**Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)**	None.
III	**Implications for Scheme of Delegations to Officers**	None.
V	**Relevance to Single Outcome Agreement**	
VI	**Resources - (Financial, Staffing and Property)**	Managed within existing resources.
VII	**Consideration at PDSP**	None.
VIII	**Other consultations**	FNP have committed to regular meetings and consultations with all stakeholders including Health, Social Care and 3rd Sector partners.

D TERMS OF REPORT

Background
In 2012/2013 there were 180,000 children living in relative poverty in Scotland. Poverty causes social exclusion, poor outcomes for families and has high costs to society. However, there is strong evidence to suggest that intervening early can help make a difference. (Scottish Government, Jan 2015 and Brain Dorman, June 2008).

Some of the most exciting scientific discoveries in the last few years have come from neuroscience. Nowhere is this more important than in understanding how early relationships and experiences shape the infant brain and set the pattern for our psychological and cognitive development and subsequent adult health. Inadequate physical and emotional care of infants and a poor parent/infant relationship affects how neural pathways and chemical responses become 'hardwired' and make it much more difficult for some children to thrive and lead healthy and happy lives.

This knowledge is radically changing how we view early childhood and has brought pregnancy and infancy to the forefront of preventive health care and early intervention. There is now an imperative for intervening in pregnancy and the first years with programmes of sufficient intensity that work for the most vulnerable families.

Family Nurse Partnership
Family Nurse Partnership (FNP) supports a multiagency early intervention approach to help break the intergenerational cycles of poverty, deprivation and poor outcomes in people's lives. This is a long term strategy that enables change in families to impact on the well-being for the children.

FNP embeds the principles of Getting It Right for Every Child (GIRFEC) with a focus on improving outcomes for children, young people and their families.

FNP is an evidenced based preventative early intervention programme. Specially trained family nurses deliver an intensive, structured home visiting service. It is offered, on a voluntary basis, to first time mothers under the age of 20years from early pregnancy until the child is 2 years old. It aims to improve pregnancy outcomes, child health and development and the mother's economic self-sufficiency.

FNP uses a strength based approach, resulting in a strong therapeutic relationship between the client and the nurse. Family Nurses aim to connect with people's intrinsic motivation to do the best for their children by using effective methods to support change in people's lives and in their behaviours.

Family Nurse Partnership – Lothian
NHS Lothian established FNP programme delivery in January 2010 as the first 'test site' in Scotland. The service commenced with a team of 6 family nurses and 1 Supervisor who enrolled clients living within the Edinburgh Community Health Partnership (CHP) area.

Through a process of planned service expansion the first team were able to deliver the programme as part of 'small-scale permanence' and began recruiting a second cohort of clients in September 2012. To support a concurrent service delivery model a second and third team were appointed and commenced client recruitment of a third and fourth cohort of clients from August 2013 and August 2014 respectively. With the appointment of the additional teams NHS Lothian has been able to offer a concurrent service delivery model to clients living across Edinburgh CHP from September 2012. The service has expanded to include enrolment of clients from West Lothian Community Care Health Partnership (CCHP) from March 2013, from Midlothian CHP since April 2014 and from East Lothian CHP since April 2016. Since August 2015 we have also been working in partnership with our colleagues in the Scottish Borders

testing a hybrid model of service delivery allowing eligible clients in that area to be offered the FNP Programme. Within our newer service delivery areas we have worked hard to replicate our effectively evaluated service implementation model used with our first cohort of clients from the Edinburgh City phase of programme introduction (Scottish Government, Oct 2013)

The client demographics and characteristics as we progress the service have seen little change. The client average age at enrolment is between 17.5-17.9 years. The caseloads across teams have approx 92.3% of clients who speak English as their first language. The remaining 7% are predominantly clients who have moved to Scotland from Eastern European countries and speak Polish or Romanian.

The vulnerability/intensity of the clients is similar across all areas of NHS Lothian and remains consistently high. This is measured in relation to several factors including age, mental health problems, child protection, child poverty and deprivation. Overall 81% of our clients recruited come from the 2 most deprived quintiles as measured by Scottish Index of Multiple Deprivation (SIMD) indicators (2012).

Family Nurse Partnership – West Lothian
Progress March 2013 to Jan 2017
Client retention
Eligible clients are identified using the Maternity TRAK system. The total number of clients enrolled = 401. 11 clients remain in the engagement phase. There is a current programme acceptance rate of 81.6% (the target being ≥75%).

Programme quality and fidelity
Presently 248 clients have completed the pregnancy phase; 10 clients have left the programme during pregnancy phase. 168 clients have now completed the infancy phase; 25 have left the programme in infancy. 103 clients have now completed the toddler phase; 6 clients have left the programme in the toddler phase; giving a total attrition rate of = 14.3%; the target is 40% or less.

E. CONCLUSION

FNP has successfully integrated into the West Lothian area. There has been successful engagement and retention of clients; supporting them through pregnancy and birth of their children, and moving them on to specialist services and employment, training and education advice, as appropriate.

F. BACKGROUND REFERENCES

Brain Dorman, June 2008 http://www.scotland.gov.uk/Topics/Statistics/Browse/Social-Welfare/IncomePoverty/BDPres
iSD Scotland NHS National Services, Jan 2015 http://www.isdscotland.org/Products-and-Services/GPD-Support/Deprivation/SIMD/
Scottish Government, Jan 2015
http://www.scotland.gov.uk/Topics/Statistics/Browse/Social-Welfare/IncomePoverty
Scottish Government Oct 2013 http://www.scotland.gov.uk/familynursepartnership

Appendices: None

Contact Person: Pamela Murray
FNP Supervisor
Pamela.murray@nhslothian.scot.nhs.uk
01316594735 or 07540675042

Date of meeting: 9th February 2017

West Lothian Council

HEALTH AND CARE POLICY DEVELOPMENT AND SCRUTINY PANEL

CHILDHOOD IMMUNISATION UPTAKE

REPORT BY DEPUTE CHIEF EXECUTIVE, HEALTH AND SOCIAL CARE PARTNERSHIP

A. PURPOSE OF REPORT

To advise of the childhood immunisation uptake quarterly report December 2016.

B. RECOMMENDATION

To note childhood immunisation uptake in West Lothian not only is continually higher than other areas in Lothian but also higher that the Scottish average.

C. SUMMARY OF IMPLICATIONS

I	**Council Values**	• Focusing on our customers' needs • Being honest, open and accountable • Providing equality of opportunities • Making best use of our resources • Working in partnership • Developing employees
II	**Policy and Legal (including Strategic Environmental Assessment, Equality Issues, Health or Risk Assessment)**	None.
III	**Implications for Scheme of Delegations to Officers**	None.
V	**Relevance to Single Outcome Agreement**	The childhood immunisation uptake will impact positively on health and wellbeing indicators within the Single Outcome Agreement.
VI	**Resources - (Financial, Staffing and Property)**	Managed within existing Health Visiting resources.
VII	**Consideration at PDSP**	None.
VIII	**Other consultations**	NHS Lothian.

D. TERMS OF REPORT

The uptake of childhood immunisations within West Lothian HSCP has been continually higher than other areas in Lothian but also higher than Scottish average. This effect has been more striking in this quarter and is seen at all stages – at 12 months, 24 months and preschool booster by age 6 – achieving well over 95% at each of these stages (indeed 99% of one antigen). In comparison to the rest of Lothian, uptake for primary immunisations at 12 months continues to fall and, at 96.2%, is nearly 1% below the Scottish average and the lowest uptake for over 5 years

This drop in the rest of Lothian is thought to be mainly due to the addition of the men B programme from September 2015 with longer appointment times needed. Recent changes to the men B programme should see a return to more normal appointment schedules.

Uptake of both doses of MMR and of final DTP/polio by 6 years of age across Lothian as a whole is above 95% and above Scottish average. Challenges remain in Edinburgh with uptake of second MMR at 92.4%. The recent outbreak of measles in Edinburgh shows how important it is to keep MMR uptake well above 95%.

Within West Lothian, the Community Child Health Department administers the scheduling and appointments for the immunisation programme which are delivered by the Health Visiting teams attached to General Practice. Health Visitors attribute the success of the childhood immunisation uptake to the following factors.

- Health Visitors educate, advise and explain to parents the importance of attending appointments, promoting in detail the Immunisation Programme at 1st home visit and contacts thereafter.
- Immunisation booklet given to parents pre 6-8 week check at a home visit by the Health Visitor which gives parents the opportunity to ask any questions in relation to immunisations.
- Good professional trusting relationship.
- The Public Health Staff Nurses, as part of the Health Visiting teams, deliver the immunisation programmes, along with developmental reviews giving parents continuity.
- Health Visiting teams are flexible to accommodate parents (e.g. can often offer appointment times and dates out-with clinics).
- The Health Visiting teams follow up Did Not Attend appointments and actively look to immunise non attendees.
- Immunisation clinics are held in local and familiar places for parents.
- Extra immunisation clinics are planned when Health Visiting teams become aware of an increasing Queue print from Community Child Health.

E. CONCLUSION

West Lothian wish to retain their high levels of uptake for childhood immunisations and will continue to work with the Health Visiting teams and NHS Lothian to manage the immunisation programmes within local communities. Monitoring uptake across Lothian and against Scotland will support early identification of challenges that would impact on our ability to keep our children safe. It is with the continued hard work and

commitment by the Health Visiting teams that West Lothian can take pride in achieving such excellent rates of uptake.

Childhood immunisation data for the most recent quarter ending September 2016 were published on the ISD website on 13 December.
http://www.isdscotland.org/Health-Topics/Child-Health/

F. BACKGROUND REFERENCES

Appendices:	Appendix 1 : Childhood Immunisation Uptake Quarterly Report, from 1st July to 30th September 2016 Appendix 2 :Routine Childhood Immunisation Programme
Contact Person:	Mairead Hughes Chief Nurse, West Lothian Health and Social Care Partnership 01506 281003 Mairead.Hughes@nhslothian.scot.nhs.uk
Date of meeting:	9th February 2017

Childhood Immunisation Uptake Quarterly Report, from 1st July to 30th September 2016

Childhood immunisation uptake at 12 months of age:

Figure 1. Primary and booster immunisation uptake rates by 12 months of age, by quarter, NHS Lothian, March 2011 to September 2016

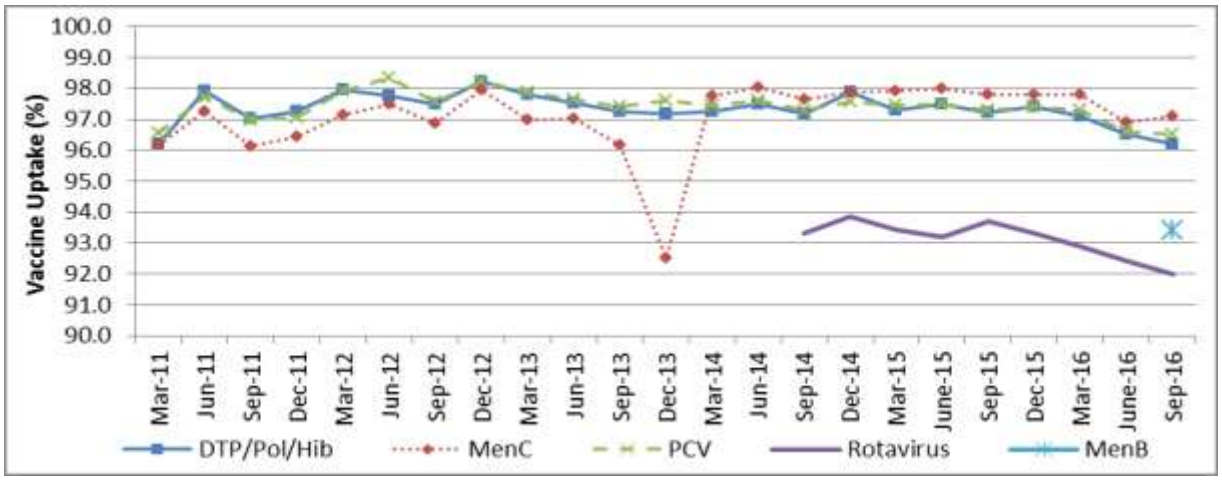
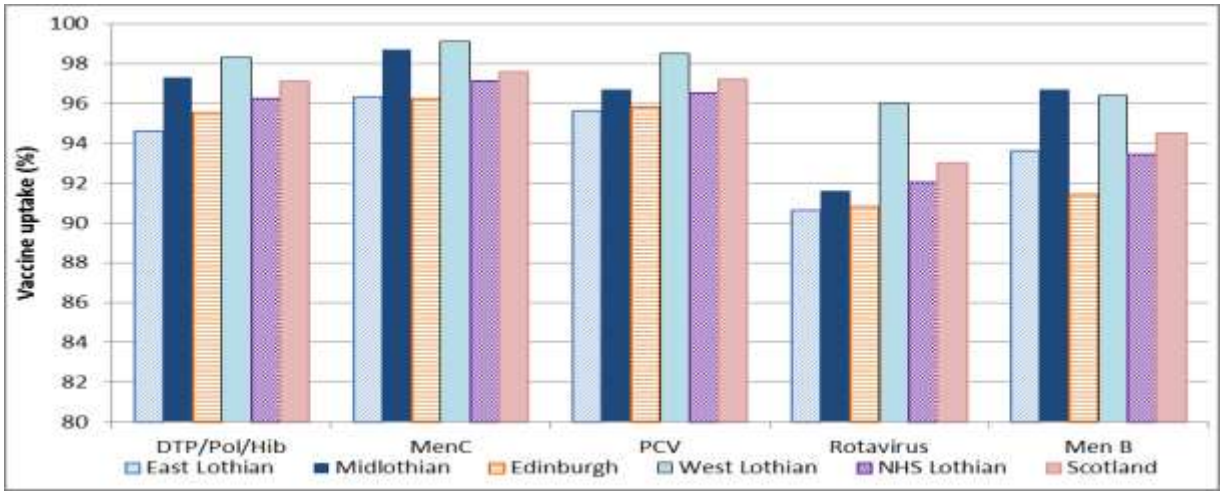


Table 1. Immunisation uptakes by 12 months of age across Health and Social Care Partnerships

		Primary course				
Primary immunisation uptake rates by 12 months of age	Number in Cohort	DTP/Pol/Hib	MenC	PCV	Rotavirus	Men B
East Lothian	297	94.6	96.3	95.6	90.6	93.6
Midlothian	299	97.3	98.7	96.7	91.6	96.7
Edinburgh	1300	95.5	96.2	95.8	90.8	91.4
West Lothian	529	98.3	99.1	98.5	96	96.4
NHS Lothian	2425	96.2	97.1	96.5	92	93.4
Scotland	14719	97.1	97.6	97.2	93	94.5

Figure 2. Primary and booster immunisation uptake by 12 months of age, NHS Lothian, July to September 2016



Childhood immunisation uptake at 24 months of age:

Figure 3. Primary and booster immunisation uptake rates by 24 months of age, by quarter, NHS Lothian, March 2011 to September 2016

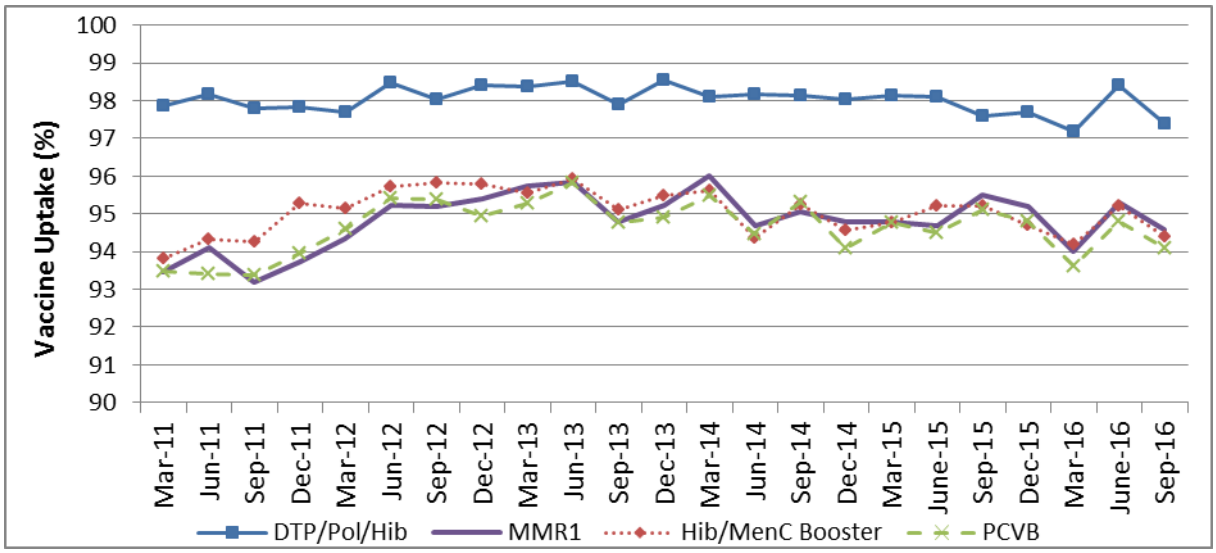
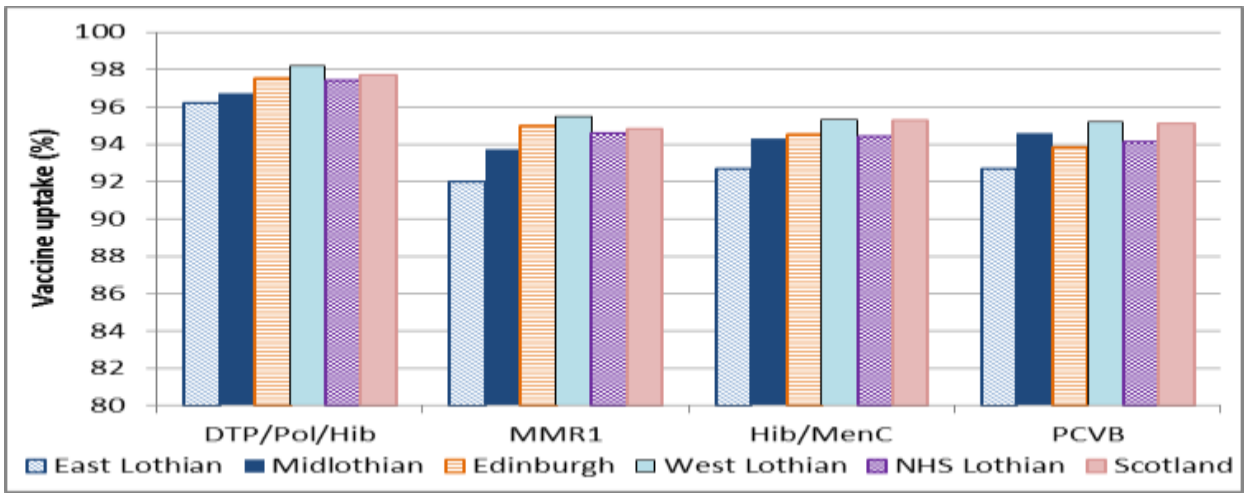


Table 2. Immunisation uptakes by 24 months of age across Health and Social Care Partnerships

		Primary course		Booster course	
Primary immunisation uptake rates by 12 months of age	Number in Cohort	DTP/Pol/Hib	MMR1	Hib/MenC	PCVB
East Lothian	288	96.2	92	92.7	92.7
Midlothian	331	96.7	93.7	94.3	94.6
Edinburgh	1428	97.5	95	94.5	93.8
West Lothian	601	98.2	95.5	95.3	95.2
NHS Lothian	2648	97.4	94.6	94.4	94.1
Scotland	15346	97.7	94.8	95.3	95.1

Figure 4. Primary and booster immunisation uptake by 24 months of age, NHS Lothian, July to September 2016



Childhood immunisation at 5 years old:

Figure 4. Primary and booster immunisation uptake rates by 5 years of age, by quarter, NHS Lothian, March 2011 to September 2016

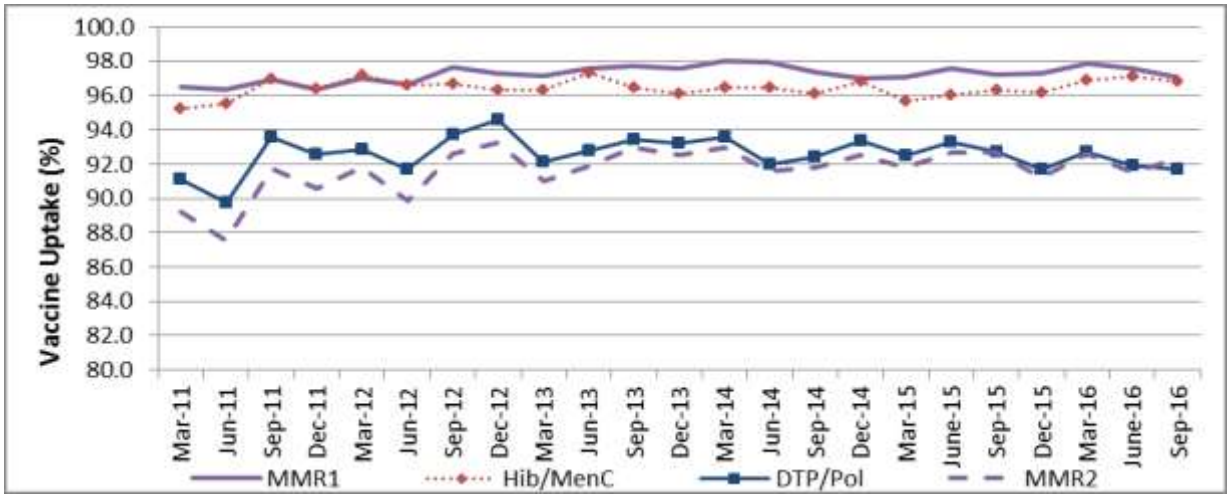
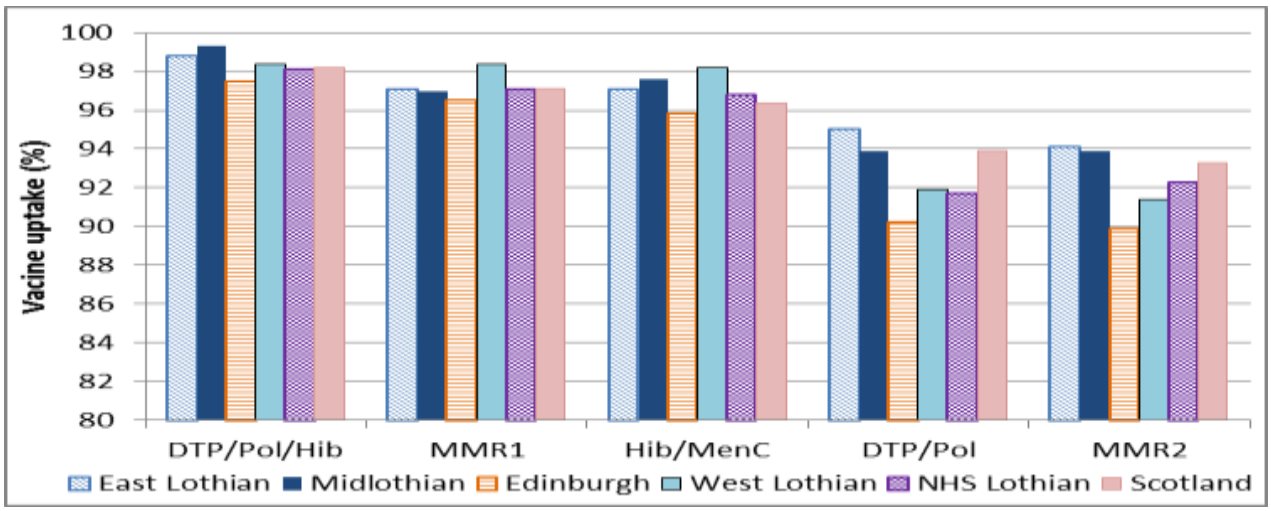


Table 3. Immunisation uptakes by 5 years of age across Health and Social Care Partnerships

		Primary course		Booster course		
Primary immunisation uptake rates by 5 years of age	Number in Cohort	DTP/Pol/Hib	MMR1	Hib/MenC	DTP/Pol	MMR2
East Lothian	339	98.8	97.1	97.1	95	94.1
Midlothian	297	99.3	97	97.6	93.9	93.9
Edinburgh	1292	97.5	96.5	95.8	90.2	89.9
West Lothian	607	98.4	98.4	98.2	91.9	91.4
NHS Lothian	2535	98.1	97.1	96.8	91.7	92.3
Scotland	15390	98.2	97.1	96.4	93.9	93.3

Figure 5. Primary and booster immunisation uptake by 5 years of age, NHS Lothian, July to September 2016



Childhood immunisations at 6 years old:

Figure 6. Booster immunisation uptake rates by 6 years of age, by quarter, NHS Lothian, March 2011 to September 2016

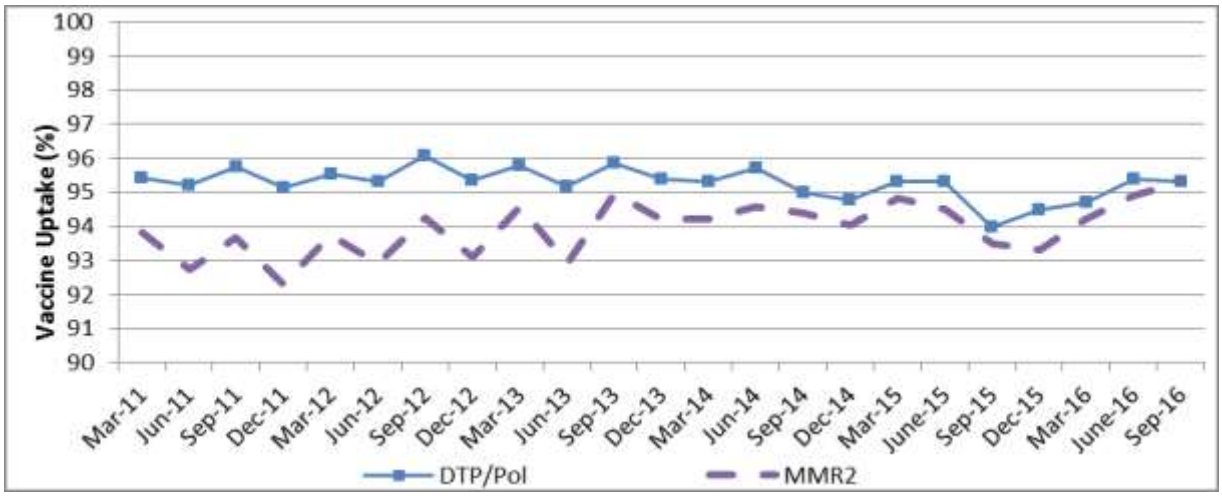
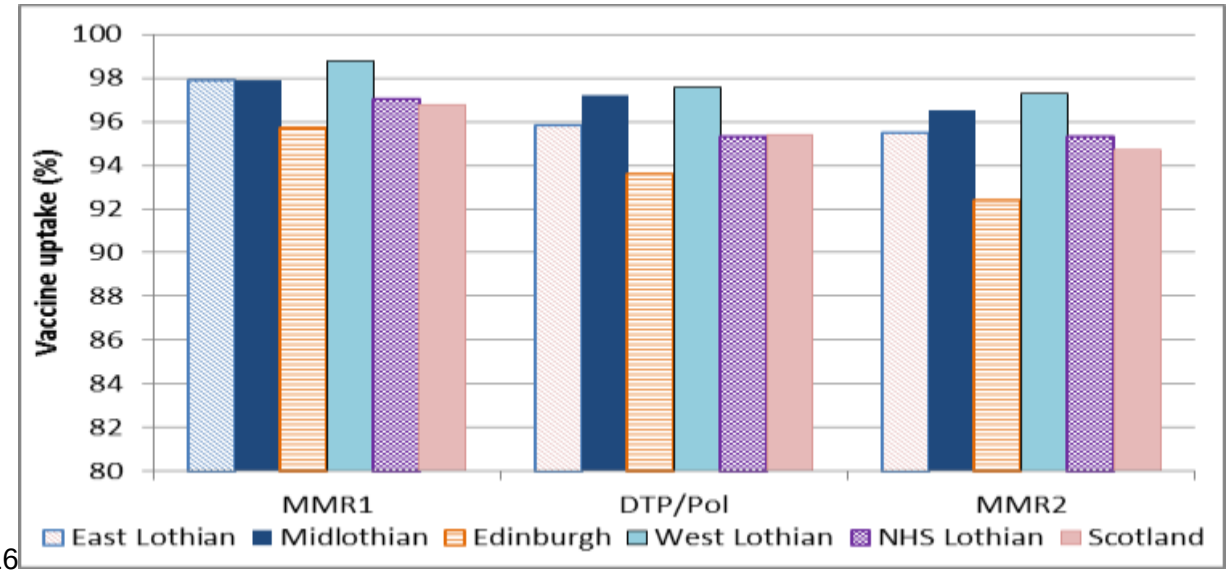


Table 4. Immunisation uptakes by 6 years of age across Health and Social Care Partnerships

		Booster course		
Primary immunisation uptake rates by 5 years of age	Number in Cohort	**MMR1**	**DTP/Pol**	**MMR2**
East Lothian	334	97.9	95.8	95.5
Midlothian	289	97.9	97.2	96.5
Edinburgh	1266	95.7	93.6	92.4
West Lothian	590	98.8	97.6	97.3
NHS Lothian	2479	97	95.3	95.3
Scotland	15262	96.8	95.4	94.7

Figure 7. Booster immunisation uptake by 6 years of age, NHS Lothian, July to September 2016



Men B Catch up programme:

Table 5. MenB Vaccine Uptake Rates by 12 months of age for the catch-up cohorts born May - June 2015

NHS Board of residence	Children born in May 2015			Children born in June 2015				
	Number in cohort	MenB		Number in cohort	MenB Dose1		MenB Dose2	
		No.	%		No.	%	No.	%
NHS Ayrshire and Arran	268	218	81.3	331	310	93.7	254	76.7
NHS Borders	83	74	89.2	83	81	97.6	71	85.5
NHS Dumfries & Galloway	124	112	90.3	115	111	96.5	104	90.4
NHS Fife	301	254	84.4	347	315	90.8	248	71.5
NHS Forth Valley	264	218	82.6	241	224	92.9	177	73.4
NHS Grampian	524	394	75.2	534	460	86.1	330	61.8
NHS Greater Glasgow & Clyde	1,092	919	84.2	1,071	984	91.9	738	68.9
NHS Highland	239	214	89.5	224	197	87.9	137	61.2
NHS Lanarkshire	563	535	95.0	588	567	96.4	487	82.8
NHS Lothian	**779**	**674**	**86.5**	**810**	**767**	**94.7**	**613**	**75.7**
NHS Orkney	16	14	87.5	24	23	95.8	21	87.5
NHS Shetland	19	17	89.5	17	14	82.4	14	82.4
NHS Tayside	318	280	88.1	387	372	96.1	330	85.3
NHS Western Isles	17	14	82.4	23	21	91.3	16	69.6
NHS Board unknown	2	..	..	..	..	..		
Scotland	**4,609**	**3,938**	**85.4**	**4,795**	**4,446**	**92.7**	**3,540**	**73.8**

Appendix 2

Routine Childhood Immunisation Programme

Each immunisation is given as a single injection into the muscle of the thigh or upper arm, except rotavirus, which is given by mouth (orally) and flu, which is given as a nasal spray.

When to immunise	Deseases protected against	Vaccine Given	Site*
2 months old	Diptheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenza type b (Hib)	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
	Rotavirus	Rotarix	By mouth (orally)
	Meningococcal group B (MenB)	MenB (Bexsero)	Left thigh
3 months old	Diptheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Rotavirus	Rotarix	By mouth (orally)
4 months old	Diptheria, tetanus, pertussis, polio and Hib	DTaP/IPV/Hib (Pediacel or Infanrix IPV Hib)	Thigh
	Pneumococcal disease	PCV (Prevenar 13)	Thigh
	Meningococcal group B (MenB)	MenB (Bexsero)	Left Thigh
Between 12 and 13 months old – within a month of the first birthday	Hib and meningococcal group C	Hib/MenC (Menitorix)	Upper arm/thigh
	Pneumococcal disease	PCV (Prevenar 13)	Upper arm/thigh
	Measles, mumps and rubella (German Measles	MMR (Priorix or MMR VaxPRO)	Upper arm/thigh
	Meningococcal group B (MenB)	MenB (Bexsero)	Upper arm/left thigh
2 to 11 years – annually	Influenza (flu)	Fluenz Tetra (flu nasal spray – if nasal spray unsuitable, use inactivated flu vaccine)	Nasal spray (both nostrils), injection if nasal spray contra-indicated
3 years 4 months old or soon after	Diptheria, tetanus, pertussis, and polio	dTaP/IPV (Repevax or DTaP/IPV (Infanrix-IPV)	Upper arm
	Measles, mumps and rubella	MMR (Priorix or MMR VaxPRO) (check first dose has been given)	Upper arm
Girls aged 11 to 13 years old	Cervical cancer caused by human papillomavirus (HPV) types 16 and 18	Gardasil	Upper Arm
Around 14 years old	Tetanus, diphtheria and polio	Td/IPV (Revaxis), and check MMR status	Upper arm
	Meningococcal groups ACWY	MenACWY (Nimenrix or Menveo)	Upper arm

- Where two or more injections are required at once, these should ideally be given in different limbs. Where this is not possible, injections in the same limb should be given 2.5 cm apart.

Non routine immunisations for at-risk babies

At birth, 1 month old, two months old and 12 months old	Hepatitis B	Hep B	Thigh
At birth	Tuberculosis	BCG	Upper arm (intradermal)
6 months old to 2 years – annually	Influenza (flu)	Inactivated flu vaccine	Upper arm

HEALTH & CARE POLICY DEVELOPMENT AND SCRUTINY PANEL WORKPLAN – FEBRUARY 2017

	ISSUE	LEAD OFFICER	PDSP DATE
1	Ready for Excellence	Lesley Aitken	14/4/17
2	Project Search update	Pamela Main	14/4/17
	Reporting Activities of Outside Bodies –		
3	Minutes of Lothian NHS Board	Jim Forrest	Standing item
4	Minutes of West Lothian Integration Joint Board	Jim Forrest	Standing Item