DATA LABEL: Public

West Lothian Integration Joint Board

West Lothian Civic Centre
Howden South Road
LIVINGSTON
EH54 6FF

8 March 2017

A meeting of West Lothian Integration Joint Board will be held within the **Strathbrock Partnership Centre, 189 (a) West Main Street, Broxburn EH52 5LH** on **Tue 14 March 2017** at **2:00pm**.

BUSINESS

Public Session

1. Apologies for Absence

2. Order of Business, including notice of urgent business

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

4. Minutes -

   (a) Confirm Draft Minute of Meeting of West Lothian Integration Joint Board held on Tuesday 31 January 2017 (herewith)

   (b) Correspondence Arising From Previous Decisions (herewith)

   (c) Note Minute of Meeting of West Lothian Integration Strategic Planning Group held on Thursday 17 November 2016 (herewith)

5. Financial Assurance of 2017/18 Budget Contributions - Report by Chief Finance Officer (herewith)

6. Strategic Plan Annual Review, Health and Social Care Delivery Plan and Directions - Report by Director (herewith)

7. Primary Care Premises Report - Report by Director (herewith)

8. Membership Review - Report by Director (herewith)

9. Risk Management Policy and Strategy - Report by Director (herewith)

10. West Lothian Technology Enabled Care Programme (WL TEC) - Report by Director (herewith)

11. Calls for Views on Destitution and Asylum in Scotland - Report by Director (herewith)

12. National Health and Social Care Workforce Planning - Report by Director (herewith)

13. Consultation - Organ and Tissue Donation and Transplantation - Report by Director (herewith)

14. Workplan (herewith)

15. Proposed Meeting Dates 2017/18 (herewith)

NOTE **For further information contact Anne Higgins, Tel: 01506 281601 or email: anne.higgins@westlothian.gov.uk**

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 31 JANUARY 2017.

Present –

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

Non-Voting Members – Ian Buchanan (Stakeholder Representative), Jim Forrest (Director), Jane Houston (Staff Representative), Jane Kellock (Chief Social Work Officer), Mary-Denise McKernan (Stakeholder Representative), Martin Murray (Staff Representative), Patrick Welsh (Chief Finance Officer).

Apologies – Anne McMillan, Elaine Duncan, Mairead Hughes and Marion Barton

In Attendance – Alan Bell (Senior Manager, Communities and Information, WLC), James Millar (Standards Officer), Steve Field (Head of Service, WLC).

1. DECLARATIONS OF INTEREST

There were no declarations of interest made.

2. MINUTES

(a) The West Lothian Integration Joint Board approved the minute of its meeting held on 29 November 2016.

(b) The West Lothian Integration Joint Board noted the correspondence arising from its previous meeting.

The Board further noted that, to date, there had been no response to the letter concerning Alcohol and Drug Partnership Funding.

The Board agreed to re-send the letter to the Cabinet Minister and to provide a copy to the Chair of NHS Lothian.

(c) The West Lothian Integration Joint Board noted the minute of the meeting of the Strategic Planning Group held on 6 October 2016.

(d) The West Lothian Integration Joint Board noted the minute of meeting of the Audit Risk and Governance Committee held on 23 September 2016.

3. IJB FINANCE UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on the budget forecast position for 2016/17 and an update in relation to the 2017/18 Scottish Draft Budget, including an initial assessment of the implications for health and social care services.

The Chief Finance Officer informed the Board that, as previously reported, it was anticipated by NHS Lothian and West Lothian Council that a break even position would be achieved for 2016/17. There remained a degree of uncertainty around a number of aspects of the 2017/18 budget but an initial estimate of high level implications for both partner bodies and health and social care functions was set out in the report. This would be subject to further work over the coming weeks and months.

The report provided a table showing the most recent 2016/17 monitoring exercise undertaken by NHS Lothian and West Lothian Council.

Appendix 1 to the report provided further detail on the forecast position. An overspend of £2.095 million was forecast on the payment to the IJB and an overspend of £913,000 was forecast against the notional share of acute set aside resources attributed to West Lothian. A breakeven position was forecast for Adult Social Care services.

The Chief Finance Officer went on to explain that the updated position represented an improved outturn position of £336,000 on NHS Lothian delegated functions compared to the position previously reported to the Board on 29 November 2016. The previously highlighted key pressure areas were largely unchanged, and the improved position was largely due to reduced spend forecast in prescribing, although this area remained the most significant IJB budget pressure. Taking account of the overall breakeven position anticipated by NHS Lothian, the overspend on IJB functions would be managed and a breakeven position would effectively be achieved for 2016/17.

In relation to the draft Scottish Budget 2017/18, it was reported that Scotland's total proposed spending plans, as set out in the Draft Budget 2017/18, amounted to £38,048 million, an increase of £923.8 million compared to the 2016/17 Scottish budget. In terms of IJB delegated services, the relevant portfolio movements were shown in a table within the report. The two Scottish Government portfolios which included funding for NHS Boards and Local Government were Health and Sport (Health) and Communities, Social Security and Equalities (Local Government). These made up £22,995 million (60.4%) of the £38,048 million total 2017/18 Draft Budget. Taking account of the movement in SG funding across both portfolios, there was a cash reduction compared to 2016/17 funding levels of over £40 million.

The report went on to examine the position in relation to:- Initial NHS Lothian 2017./19 Funding Position, Initial West Lothian Council 2017/18 Funding Position, Health and Social Care Fund, Scottish Government

Priorities for IJBs – Draft Budget 2017/18.

The Chief Finance Officer reported that it was clear from the draft 2017/18 Scottish Budget that the 2017/18 budget process would be extremely challenging for NHS Boards, Local Authorities and Integration Authorities. Compared to the very significant growth in West Lothian expenditure demands evident in 2016/17 across areas such as elderly care at home (20%), elderly care homes (11%), learning disability care (24%) ad prescribing (6%), the overall cash reduction highlighted in Section C.3 of the report in Scottish Government revenue funding for portfolios including health and social care funding was clearly of concern.

At this stage there remained a number of uncertainties including confirmation still required on funding streams and work was currently progressing with NHS Lothian and the council to prepare a 2017/18 budget position for IJB delegated functions.

In terms of future year budgets, it was clear from Treasury public spending plans in place that future year funding would continue to be very constrained. Taken in conjunction with increasing demands within health and social care, it was considered important going forward that medium term financial strategy and planning was developed during 2017. Discussions were taking place with the council's Head of Finance and Property Services and the NHS Lothian Director of Finance to consider this for 2018/19 onward.

It was recommended that the IJB:-

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

2. Note the provisional impact assumed on NHS Lothian and West Lothian Council funding taking account of the 2017/18 Scottish Draft Budget.

3. Note the 2017/18 Health and Social care funding included in the 2017/18 settlement and the breakdown of the funding.

4. Note the Scottish Government letter to Lothian IJBs in respect of expectations around the 2017/18 budget settlement.

5. Note that a report on the financial assurance of IJB 2017/18 budget contributions from NHS Lothian and West Lothian Council, along with proposed Directions, would be presented to the Board on 14 March 2017.

Decision

To note the terms of the report and the recommendations by the Chief Finance Officer.

4. PARTICIPATION AND ENGAGEMENT STRATEGY CONSULTATIVE

DRAFT

The Board considered a report (copies of which had been circulated) by the Director informing the Board of the comments received on the consultative draft of the Participation and Engagement Strategy and recommending responses to comment received, including changes to the strategy.

The Director recalled that, at its meeting on 11 August 2016, the IJB Strategic Planning Group had noted the terms of a draft strategy and action plan for 2016/17 that had been prepared by officers. The group agreed to put these out to consultation prior to approval by the IJB.

The report advised that consultation took place over a 26 day period extending from 16 September to 12 October. The consultation was based on a Survey Monkey questionnaire and the questions and responses were attached as Appendix 1 to the report.

The Board was informed that the number of respondents via Survey Monkey was 15. 85% of responses were from individuals and 15% were from organisations. Three email responses were also received from organisations.

Question 1 asked if the respondents agreed or disagreed with the 17 core commitments in the strategy. There was a high level of endorsement for the proposed commitments with all receiving 80% - 100% strongly agree/agree responses except PES12 (development of the website) which received 79% in the category strongly agree/agree.

Question 2 asked consultees to explain if they disagreed with any of the proposed commitments and why that was the case.

Question 3 invited additional comments on the proposed commitments.

Question 4 invited suggestions for any additional actions to be added to the action plan.

Question 5 invited any additional comments not covered by previous answers.

Responses received to questions 2-5 and the three sets of comments received by email were summarised in Appendix 2 to the report along with a recommended response.

The Board noted that the majority of comments received were positive or asked for clarification on various points. A small number had suggested revisions to the strategy, and these suggestions were summarised in the report.

A finalised strategy document showing the recommended changes was attached as Appendix 3 to the report. A finalised action plan showing recommended changes was attached as Appendix 4 to the report. Appendix 5 to the report was an integrated impact assessment of the

strategy.

The Integration Joint Board was asked to:-

1. note the comments received on the consultative draft;

2. agree the proposed responses to the comments received;

3. agree the resulting changes to the strategy and action plan for 2016/17;

4. approve the revised strategy as IJB policy; and

5. endorse the action plan for 2016/17.

Questions raised by IJB members were then dealt with by the Head of Service. In particular, the Board was informed of the development of a Plain English version and an easy-read version of the strategy.

Decision

1. To note the terms of the report.

2. To agree the proposed responses to the comments received and to agree the resulting changes to the strategy and action plan for 2016/17.

3. To approve the revised strategy as IJB policy.

4. To endorse the action plan for 2016/17

5. ADULT SUPPORT AND PROTECTION BIENNIAL REPORT

The Board considered a report (copies of which had been circulated) by the Head of Social Policy informing members about the submission of the West Lothian Public Protection Committee's 2014-2016 Adult Support and Protection Biennial report to the Scottish Government on 31 October 2016.

The Head of Social Policy informed the Board that the West Lothian Public Protection Committee's 2014-2016 Adult Support and Protection Biennial report addressed the two years of activity and of action on adult protection; confirming that the local Adult Support and Protection multi-agency practice arrangements were operating well.

The report outlined the strong practice links that had been developed by the Public Protection Committee with those agencies providing a service to members of the public. The Public Protection Committee's commitment to developing both Intra-agency and multi-agency practice enabled it to continually strive to achieve the right support and protection for adults at risk within a public protection focus. The approach ensured it continued to routinely audit practice examples, its performance indicators and engaged with service users and carers to enable it to respond flexibly to

opportunities whilst strategically planning for the future.

The Board was asked to note the submission of the report for information.

Decision

To note the terms of the report.

6. CONSULTATION RESPONSE TO NEW NATIONAL HEALTH AND SOCIAL CARE STANDARDS

The Board considered a report (copies of which had been circulated) by the Head of Social Policy attaching a proposed response to the public consultation in relation to the proposed new National Health and Social Care Standards.

The Head of Social Policy informed the Board that a public consultation exercise had taken place on proposed new standards with all responses requiring to be submitted no later than 22 January 2017. The Board noted, however, that it had been agreed by Scottish Government because of the timescales involved, West Lothian IJB could submit their response after the close of the consultation period. Thus enabling their views to be taken into consideration however they would not be included in the final report produced following the closure of the consultation period.

The Scottish Government consultation was seeking comments as to whether anything was missing or required to be added to the standards. The consensus of opinion expressed by all at the consultation meeting was the standards were felt to be comprehensive overall with a few benefiting from some additional text predominantly to clarify meaning or context. No significant omissions were identified which was deemed to be reassuring by those participating in the consultation exercise.

The Head of Social Policy concluded that the new proposed standards should enable services to deliver and demonstrate how those who used health and social care services were able to receive a personalised service of their choice throughout their care journey in order to best improve their quality of life.

The Board was asked to approve the proposed response from the IJB, a copy of which was attached as Appendix 1 to the report.

Decision

To approve the proposed response as recommended by the Head of Social Policy.

7. SCOTTISH GOVERNMENT HEALTH AND SOCIAL CARE DELIVERY PLAN

The Board considered a report (copies of which had been circulated) by the Director advising the Board of the recently published Scottish

Government's Health and Social Care Delivery Plan.

The Board was informed that, in December, the Scottish Government had published its Health and Social Care Delivery Plan outlining the plan for delivering the Scottish Government's Vision for improving health and social care.

The Plan set out the government's programme to further enhance health and social care services so that the people of Scotland could live longer, healthier lives at home or in a homely setting and that Scotland had a health and social care system that:

- was integrated
- focused on prevention, anticipation and supported self-management
- would make day-case treatment the norm, where hospital treatment was required and could not be provided in a community setting
- focused on care being provided to the highest standards of quality and safety, whatever the setting, with the person at the centre of all decisions.
- ensured people got back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

The plan addressed challenges which were recognised in the Audit Scotland report, NHS in Scotland 2016.

Finally, the Board was informed that the IJB Strategic Plan was due to be reviewed in March 2017. It would be appropriate to take account of the Health and Social care Delivery Plan within the review.

The Board was asked to note the Scottish Government's Health and Social Care Delivery Plan and to agree to take account of the plan within the annual review of the IJB Strategic Plan.

Questions raised by Board members were then dealt with by the Director and by the Senior Manager Community Care Support and Services.

Decision

To note the Scottish Government's Health and Social Care Delivery Plan and to agree to take account of the plan within the annual review of the IJB Strategic Plan.

8. SCHEME OF DELEGATION FOR IJB OFFICERS

The Board considered a report (copies of which had been circulated) by the Standards Officer seeking approval of a list of powers and

responsibilities to be delegated by the Board to its officers, as part of the Board's governance arrangements.

Currently, the Board only had one member of staff – the Chief Officer, known locally as the Director. It had other officers who were not members of its staff but who carried out duties for it (for example, the Chief Finance Officer, the Standards Officer). It also received support from officers and employees of the council and the heath board. They were not employed by the Board and they were managed by the Director in his complementary roles in the management structures of those two organisations.

The Standards Officer informed the Board that one part of the Board's decision-making structures which still required to be approved was a document setting out the scope and rules for decisions being taken by officers on behalf of the Board. That document would be known as the Scheme of Delegation to Officers.

Each of the posts covered by the Scheme had its own role description used by the Board's Appointments Committee and the Board itself when the posts were first filled. It was not the Scheme's purpose to replace those or duplicate them or repeat them. The Scheme was part of a governance framework for efficient, effective and accountable decision-making amongst the Board, its committees and its officers. It was noted that the Scheme was not designed to be an exhaustive list of things that officers could do on behalf of the Board. It recorded the most significant and standing delegations of powers and responsibility to officers. There was no need for it to record temporary or one-off instructions or delegations to officers. Those were recorded in minutes of Board and committee meetings. As a general rule, it was suggested that delegations which would last for more than six months would be included.

The proposed Scheme was attached as Appendix 1 to the report.

The Board was invited to:-

1. approve the Scheme of Delegations in the appendix

2. delegate to the Standards Officer the powers to make administrative changes to the Scheme as required from time to time, and to amend and re-publish the Scheme as and when required by further delegations authorised by the Board.

3. agree that the Scheme should be comprehensively reviewed every three years.

4. note that the approved Scheme would be published alongside the Board's Standing Orders and committee and working group remits to provide an open and transparent set of decision-making rule ad procedures.

Decision

1. To approve the Scheme of Delegations as recommended by the

Standards Officer.

2. To delegate to the Standards Officer the powers to make administrative changes to the Scheme as required from time to time, and to amend and re-publish the Scheme as and when required by further delegations authorised by the Board.

3. To agree that the Scheme should be comprehensively reviewed every three years.

4. To note that the approved Scheme would be published alongside the Board's Standing Orders and committee and working group remits to provide an open and transparent set of decision-making rules and procedures.

9. ETHICAL STANDARDS IN PUBLIC LIFE

The Board considered a report (copies of which had been circulated) by the Standards Officer informing the Board of duties arising under statute and guidance in relation to the ethical standards in public life regime, and inviting the Board to agree a process to ensure compliance by the Board and its members and officers.

The Standards Officer advised that the Integration Joint Board was a devolved public bodies (public body) for the purposes of the Ethical Standards in Public Life etc (Scotland) Act 2000 (the Act). The regime was built around a code of conduct.

The duties which applied to the IJB itself as a corporate body were as follows:-

- To adopt a Code of Conduct and have it approved by the Scottish Ministers
- To promote the observance by members of high standards of conduct in accordance with statutory guidance
- To assist them to observe the code in accordance with statutory guidance
- To set up a register of members' interests, and then to maintain it and make it available for public inspection, again in accordance with statutory guidance
- To appoint a Standards Officer to ensure that it met its statutory duties

The report went on to list the statutory duties relating to Board members.

It was noted that the Board and its members and officers had already made significant progress towards meeting their statutory duties. However, there were some statutory duties which still had to be met.

Those were the more general duties about promoting high standards of conduct and observance of the code in accordance with guidance. Steps had to be taken by the Boards, its members and officers to meet those promotion and observance duties, and these were examined in the report.

The steps which were proposed to ensure compliance with the statutory duties were:-

- Immediately on their appointment, the Standards Officer to provide a form for registration of interests with explanatory information and the opportunity for a meeting with the Standards Officer to explain.

- Once the entries in the form were clarified and finalised, the Standards Officer to make it publicly available as part of the Board's overall register of members' interests.

- The register and the code to be published on the internet with an explanation about the legal requirements.

- The Standards Officer to send bi-annual reminders to members to check the accuracy of their register and notify any changes within one month of them happening.

- The Standards Officer to record any notified changes and amend the register accordingly.

- The Standards Officer to inform members of any significant developments in an appropriate way, for example, by email, depending on how significant and complex they were.

- The Standard Officer to provide (at least) an annual briefing and training session each autumn for members, outwith Board meetings, on the ethical standards regime for the preceding financial year and about their duties and compliance.

- The Standards Officer to submit an annual report to the Board at its last meeting of the calendar year about the ethical standards regime.

- The current process to continue whereby there is a standing item on the agenda for Board meetings to remind members to consider their position in relation to declarations of interest and withdrawal from meetings.

- The Code and these compliance procedures to be formally reviewed by the Audit Risk and Governance Committee every three years from the date of establishment of the Board (September 2015).

- The committee's recommendations to be reported to the Board for noting and approval.

The Standards Officer recommended that members of the IJB:-

1. Note the statutory duties incumbent on the Board and its members and officers in relation to ethical standards in public life.

2. Note that the audit Risk and Governance Committee had considered the proposals in the report at its meeting on 6 January 2017 and recommended that they be adopted by the Board.

3. Agree the proposals in paragraph 5.1 of the report.

Decision

1. To note the terms of the report and;

2. To agree the proposals in paragraph 5.1 of the report.

10. WORKPLAN

A copy of the Workplan had been circulated for information.

Decision

To note the Workplan.

To note the intention to bring a paper to the March IJB meeting concerning Lothian Hospitals Strategic Plan.

Public Engagement Unit

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Councillor Danny Logue
Chair, West Lothan Integration Joint Board
West Lothian Civic Centre
Howden South Road
LIVINGSTON
West Lothian
EH54 6FF

Your ref: DL/KR
Our ref: 2017/0006105
16 February 2017

Dear Councillor Logue

Thank you for your letter to Shona Robison regarding Alcohol & Drug Paretnership Funding received on 16 February 2017.

Your letter has been passed to the relevant office for response or appropriate action. The Scottish Government aims to respond to you within 20 working days. Where this is not possible, we will endeavour to keep you updated on the progress of your response.

Yours sincerely

K McArthur

Kevin McArthur
Public Engagement Unit

Minister for Public Health and Sport
Aileen Campbell MSP

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Scottish Government
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RECEIVED 15 FEB 2017

Councillor Danny Logue
West Lothian Integration Joint Board
West Lothian Civic Centre
Howden South Road
LIVINGSTON
West Lothian
EH54 6FF

Your ref: DL/KR
Our ref: 2017/0001019
9 February 2017

Dear Councillor Danny,

Thank you for your letter of 16 December 2016 to Shona Robison MSP, Cabinet Secretary for Health, Wellbeing and Sport, regarding Alcohol and Drug Partnership (ADP) funding for West Lothian Integration Joint Board (IJB). I am replying as the issues raised in your letter fall within my portfolio.

I note the concerns you raise regarding the provision of services provided by Alcohol and Drug Partnerships (ADPs). The allocation of the 2016/17 ADP Funding has to be seen in the overall budget context, which took place against the backdrop of the toughest public expenditure conditions we faced.

I would like to assure you that we remain fully committed to supporting those with an addiction. As such, supporting the work and delivery of services by ADPs remains a priority. The draft Scottish Government budget for 2017/18 provides for the allocation of £53.8 million to support Alcohol and Drug services. This sits alongside funds provided from other NHS sources, statutory partners and the third sector, which collectively makes up the resources package for this important work.

The Scottish Government actively supports effective local decision-making and has put in place an infrastructure to achieve that. We are continuing to support delivery of Alcohol and Drug outcomes through our National Support Team and investment in National Commissioned Organisations.

Their focus on achieving best value and the best outcomes for their clients is of critical importance.

Hope this is helpful,

AILEEN CAMPBELL

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION STRATEGIC PLANNING GROUP of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189(A) WEST MAIN STREET, BROXBURN EH52 5LH, on 17 NOVEMBER 2016.

Present – Jane Kellock (Chair, West Lothian Council), Alan Bell (Social Care Professional), Carol Bebbington (Health Professional), Steve Field (WLC), Clare Gorman (Health Professional), Dianne Haley (Health Professional), Jane Houston (Union Heath), Mairead Hughes (Health Professional), Mary-Denise McKernan (Carer of Users of Health Care), Martin Murray (Union WLC), Charles Swan (Social Care Professional) and Patrick Welsh (Chief Finance Officer)

Apologies – Colin Briggs, Ian Buchanan, Dr Margaret Douglas, Elaine Duncan, Jim Forrest and Robert Telfer

1. MINUTE

The Group confirmed the Minute of its meeting held on 6 October 2016. The Minute was thereafter signed by the Chair.

2. COMMISSIONING PLAN FOR OLDER PEOPLE - REPORT BY DIRECTOR

A report had been circulated by the Director in respect of the strategic commissioning plan for older people.

The report recalled that at the meeting 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. The Strategic Plan also included a commitment to develop a series of care group based commissioning plans.

A short-life working group had been established to develop the three year commissioning plan for Older People. A draft plan had now been prepared for the approval of the IJB. As with all commissioning plans it followed a specific structure which was as follows :-

- Section 1 – Provided an overview
- Section 2 – Detailed the main recommendations
- Section 3 – Detailed the specific commissioning commitments; and
- Section 4 – The next steps

The report then explained that Section 4 would not normally form a significant part of a commissioning plan however it was felt that this was necessary at this stage because the IJB budget was not yet developed to the level appropriate to commissioning plans. This in turn limited the extent which commissioning commitments could be detailed. In addition, organisational arrangements within the scope of the IJB were undergoing

considerable change and this was likely to have an impact on commissioning commitments.

The programme of change covered areas such as Dementia, Carers, Telecare, Community Support, End of Life Care, Community Capacity Building, Care in the Community and Service Integration and the report provided a narrative on these areas. It was further noted that the some elements of the plan were complex and would be difficult to implement.

In relation to the effect, of the plan, on carers and particularly on the back of the Carers (Scotland) Act 2016 coming into being, it was agreed that a separate discussion would be undertaken with Mary-Denise McKernan on this very subject.

Complimentary to the plan was details of the Frail Elderly Programme which was targeting and identifying a particular group to design a whole system model of care that would improve outcomes, individual experience and deliver value for money. There were four projects within Phase 1 and each project would be developing recommendations for change and gathering data to support the recommendations made. The projects were as follows :-

- St John's Hospital In-Patient Re-Design – to design a more streamlined pathway for frail elderly patients who were admitted into hospital with an in-patient stay through to discharge;

- Family Hub and Templar Rapid Access Clinic – to provide patients, families and GP's with one point of contact to refer frail elderly patients, before they reached an acute stage, for appropriate assessment and care;

- Intermediate Care Review – would explore the contribution that intermediate care provision could make to whole system review and redesign, including community hospital provision; and

- Older People's Mental Health Project - would focus on key initiatives to improve the dementia care pathway and enhance community provision around the OPACT service, the Memory Assessment and Treatment Service.

It was anticipated that a programme of change would be in place by the start of 2017 with some elements being implemented by the start of the new financial year.

There was a general discussion about the current position with care for the elderly, noting that demand across West Lothian for elderly care services was on the increase particularly with an ever aging population. Requests for nursing home places was also on the rise and concerns with contractual arrangements with both private and public providers of care home place were just a number of issues impacting on service delivery today and into the future.

The Group were being asked to comment on the commissioning plan which had not been circulated so it was agreed that this would be

circulated after the meeting and that any feedback was to be submitted direct to Alan Bell by 4.00pm on Monday 21 November 2016.

Decision

1) Noted the contents of the report;

2) Agreed that the plan itself would be circulated to all SPG members and that any feedback was to be submitted to Alan Bell by 4.00pm on Monday 21 November 2016;

3) Agreed that a separate discussion would be undertaken with Mary-Denise McKernan with regards to the impact on carers;

4) Noted the work of the Elderly Frail Programme;

5) Noted the concerns around service provision at some care homes; and

6) Noted the concerns with regards to the rise in demand for nursing home care places; and

7) Noted the many challenges ahead due to an aging population and that efforts continued amongst partners to address needs in both the present day and into the future.

3. RISK MANAGEMENT REPORT

A report had been circulated by the Director advising of the approach being taken to the management of risk and to advise of the risks identified.

The group were advised that the Integration Scheme between West Lothian Council and NHS Lothian required the IJB to operate a risk management strategy. The risk management strategy would comprise of relevant policies and procedures for the management of risk. The Integration Scheme also required the IJB to maintain a risk register. A risk register had therefore been devised by using West Lothian Council's covalent system and the risks to be reported and monitored were attached as Appendix 1 to the report.

The risks detailed had been identified by the IJB Senior Management Team during a risk management session facilitated by West Lothian Council's Risk Manager.

All of the risks had been scored for likelihood and impact using a five by five risk matrix. The scores ranged from 1 to 25, with the higher the score, the higher the assessed risk and therefore the greater potential impact on IJB objectives.

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

Lothian.

In relation to Appendix 1 the following was to be noted :-

- The original risk score represented the uncontrolled risk, that was to say the potential impact if controls were absent or failed;
- The traffic light icon represented the risk ranking based on the score;
- The risk matrices represented the risk score;
- The current risk score represented the current risk
- The "assigned to" column were those processes in place to reduce the risk from original risk score to current risk score.

A discussion was undertaken on the risks identified and it was agreed, that in light of the earlier discussion on the Older Peoples Commissioning Plan, to include an additional risk to be known as "Failure of Provider".

It was also agreed to amend the wording of risk IJB0002 to "Failure of Deployment of Strategic Plan"

And finally it was agreed to include the scoring matrix to understand better the scoring and grading mechanism.

Decision

1) Noted the contents of the report;
2) Agreed to include an additional risk, to be known as "Failure of Provider";
3) Agreed to amend risk IJB0002 to "Failure of Deployment of Strategic Plan"; and
4) Agreed to include details of the matrix used for scoring.

4. LOCALITY PLANNING UPDATE

A report had been circulated by the Director providing an update on locality planning in West Lothian since April 2016 when the SPG approved the terms of reference for the east and west locality groups and to also seek approval to deliver a development event for group members.

At its meeting on 7 April 2016 the SPG approved the terms of reference for locality groups which would guide the development of locality plans. The terms of reference were attached to the report at Appendix 1. Officers subsequently established membership of the groups based on the SPG's guidance. The SPG also agreed to hold a development event for members of the locality groups to provide background on the work required of the groups.

An event was held on 10 June 2016 and the report provided a brief summary of the programme for the day. The event was well attended and a note from the day was attached to the report at Appendix 2.

The groups would meet every two months with both groups having met twice so far. The agenda for the first meeting included a reminder of the terms of reference and membership, a review of locality developmental day summaries, an update on commissioning plans and regeneration plans. The agenda for the second meeting included a presentation on the implications of the development plan on service provision in health and social care and consideration of a possible structure for presenting locality plans and an outline work plan.

The proposed format and outline work plans were attached to the report as Appendices 3 and 4.

It was proposed that updates would be provided to the SPG every six months with the next report due on 20 April 2017.

It was recommended that members of the SPG :-

1) Note the terms of the report; and

2) Note that the Director would provide a further update to the group at its meeting on 20 April 2017.

Decision

1) Noted the contents of the report

2) Agreed that the Minutes of past Locality Group meetings would be forwarded to Union Representatives and thereafter a further briefing could be provided if necessary; and

3) Agreed to include Union Representatives on the distribution list for papers for both groups.

5. PRIMARY CARE UPDATE

A report 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 group were advised that GP practices were facing a number of challenges which were affecting service delivery and capacity to meet demand. The report then provided a summary of the main issues that were facing GP practices and covered matters such as :-

- Changing practice populations

- Workload

- Workforce
- OOH Primary Medical Services
- Community Nursing
- Practice Nursing
- Changes to GMS contracts
- Expansion of GP training places
- NES Scotland Returner and NES Enhanced Induction Programmes
- List Expansion Grant Uplift Scheme (LEGUP)
- Integrated Care Pharmacies
- Skill mix
- IT and eHealth
- Premises
- Risk register

The report also provided a summary of a Primary Care Summit that was held in Musselburgh in September 2016 which identified actions that could be taken to resolve some of the issues and included :-

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

- ❖ Find an appropriate balance between autonomy and innovation within HSCP areas.

It was also being proposed that West Lothian would hold a Primary Care Summit in February 2017 which would be a protracted learning time session to enable wide stakeholder engagement and focus on the key issues identified.

The Strategic Planning Group was asked to :-

1) Note the contents of the report;

2) Note the current challenges facing Primary Care;

3) Support the management team in their actions; and

4) Contribute to the proposed Primary Care Development event in February 2017.

Decision

1) Noted the contents of the report

2) Agreed that the report be forwarded to the next scheduled meeting of the IJB; and

3) Agreed that the IJB would be asked to make representation through the appropriate channels with regards to developer contributions towards medical facilities.

6. WEST LOTHIAN WINTER PLAN

A report had been circulated by the Director advising of the Winter Plan developed for 2016-17 and to outline the activities underway to prepare for the winter period when it is recognised that demand for services was likely to be at its highest level.

The group were advised that West Lothian HSCP and St John's Hospital were required to plan for the winter period. The plan attached to the report at Appendix 1 built on previous Winter Plans for West Lothian and provided details of the local actions already in place to support prevention of admission and early discharge.

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

The outcome of winter planning was to ensure :-

- The provision of high quality, responsive services were maintained through periods of pressure;

- The impact of pressure on levels of service, national targets and finance were effectively managed;

- That a process was in place to meet the reporting requirements of the Scottish Government;

- That comprehensive plans were in place covering the requirements of the Scottish Government Health Department outlined in their Winter Planning communications; and

- Assurance for the Director of West Lothian HSCP, the Site Director St John's Hospital and the Chief Operating Officer NHS Lothian that effective Winter Plans existed.

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

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

It was recommended that the Strategic Planning Group :-

1) Note the contents of the report;

2) Note the progress made in developing the Winter Plan, which would ensure key services were maintained for critical patients and customers and the organisations reputation was protected; and

3) Support the activities and management responsibilities to ensure winter preparedness and effective response to adverse situations.

Decision

1) Noted the contents of the report;

2) Agreed that future versions of the plan were to include a legend to assist with abbreviations; and

3) Agreed that any further suggestions to the format and layout of the plan were to be forwarded to Carol Bebbington

7. WORKPLAN

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

Decision

To note the contents of the workplan

West Lothian Integration Joint Board

Date: 14 March 2017

Agenda Item: **5**

FINANCIAL ASSURANCE OF 2017/18 IJB BUDGET CONTRIBUTIONS

REPORT BY CHIEF FINANCE OFFICER

A PURPOSE OF REPORT

The purpose of this report is to set out the outcome of the financial assurance process on the contributions that West Lothian Council and NHS Lothian have identified to be delegated to the IJB for 2017/18.

B RECOMMENDATIONS

It is recommended the IJB:

1. Notes the financial assurance work undertaken to date;
2. Agrees the allocation of additional 2017/18 Health and Social Care Fund resources, taking account of Scottish Government requirements;
3. Agrees that council and NHS Lothian 2017/18 budget contributions are allocated back to Partners, via Directions, to operationally deliver and financially manage IJB delegated functions from 1 April 2017;
4. Agrees that the Directions attached in Appendix 3 to this report are issued to West Lothian Council and NHS Lothian respectively;
5. Agrees that, in accordance with Scottish Government requirements, Audit Scotland and CIPFA Best Practice, the IJB will request that Partners work in conjunction with the Director and Chief Finance Officer to prepare a medium term financial strategy for IJB delegated functions;
6. Agrees the updated IJB Annual Financial Statement attached in Appendix 4.

C TERMS OF REPORT

C.1 Background

A key aspect in the ability of the IJB to deliver its Strategic Plan and improve health and social care outcomes is the level and adequacy of resources available. This report considers the level of 2017/18 resources delegated to the IJB by West Lothian Council and NHS Lothian.

As previously reported to the IJB, this process will also consider assumptions, risks and budget saving plans incorporated within the 2017/18 resources set out for IJB delegated functions.

C.2 Purpose and Approach to Financial Assurance

As noted in the Scottish Government guidance and approved IJB Financial Regulations, the purpose of undertaking financial assurance is to allow the IJB to understand the assumptions and risks associated with the annual resources allocated by West Lothian Council and NHS Lothian. The council and NHS Lothian are, in accordance with legislation, responsible for agreeing the functions delegated to the IJB and setting their respective budgets including the level of payments and set aside resources to the IJB.

The matters to be taken into account as part of this assurance process are:

- Assessment of prior year expenditure on IJB functions
- Information on assumptions regarding estimated budget to be delegated to the IJB for 2017/18 and comparison against previous year spend and anticipated 2017/18 demands
- Information on key budget risks associated with functions that will be delegated to the IJB
- Information on the value of approved budget savings for 2017/18 that relate to IJB functions
- Details of any non-recurring funding included in the budget resources delegated to the IJB

The above approach will form the basis of reviewing the 2017/18 resources identified in this report by West Lothian Council and NHS Lothian. In addition, the approved West Lothian IJB Integration Scheme will also inform the approach taken on financial assurance.

C.3 West Lothian Council Resources

West Lothian Council approved its 2017/18 budget on 20 February 2017, including the 2017/18 level of resources associated with functions delegated to the IJB of £69.396 million. This took account of additional Scottish Government Health and Social Care funding to IJBs of £107 million specifically for social care. For West Lothian, the share of this funding has been confirmed as £3.060 million.

C.3.1 Health and Social Care Fund

The 2017/18 Scottish Budget included an additional £100 million to be transferred from NHS Boards to Integration Authorities in order to protect investment in social care. This £100 million has been allocated to support the continued delivery of the Living Wage, sleepovers and help ensure sustainability in the care sector. A further £7 million is being provided directly to Integration Authorities towards disregarding the value of war pensions from social care financial assessments, and for pre-implementation work in respect of the new carers legislation. A breakdown of the additional £107 million is shown below.

- **£50 million –** To provide for the full year effect of the 2016/17 Living Wage implemented from 1 September 2016
- **£20 million –** To provide for an increase in the Living Wage hourly rate to £8.45 for all social care staff supporting adults in care homes and care at home / housing support settings including adult day care workers and personal assistants
- **£10 million –** To meet the financial impact of delivering the living wage for sleepover care provision (this will be reviewed in year to consider its adequacy with a commitment to discuss and agree how any shortfall should be addressed)

- **£20 million –** To ensure the commitments made in relation to the Living Wage can be sustained going forward (takes account of limited provider contributions in 2016/17 and assuming no provider contribution to increased Living Wage staff costs in 2017/18)
- **£5 million –** To provide for the lost income to councils resulting from the removal of war veteran pensions from social care financial assessment calculations
- **£2 million –** Relates to additional funding to prepare for the implementation of the Carers' Bill

As noted, West Lothian IJB's share of this additional funding has been confirmed at £3.060 million and this will be fully used to meet the above costs. It should be noted that this £107 million is additional to the £250 million included in the 2016/17 Scottish Budget and the full £357 million has been baselined as recurring funding from 2017/18 and has been allocated to the IJB. West Lothian IJB's total share of this national funding is £10.190 million which is taken account of in the council's budget planning and contribution given it relates to council provided services.

To reflect the additional support provided through the Fund, the Scottish Government gave local authorities flexibility to adjust their allocations to Integration Authorities in 2017/18 up to their share of £80 million below the level of budget provided in 2016/17 (as adjusted for any one-off items of expenditure which should not feature in the 2016/17 baseline). Taking account of social care demands, West Lothian Council has not used this flexibility, which would have allowed it to reduce its contribution by £2.29 million.

C.3.2 Financial Assurance

The table below shows the 2017/18 budget, compared to the equivalent 2016/17 and 2015/16 budgets in respect of council functions delegated to the IJB.

West Lothian Council – Resources Associated with Delegated IJB Functions			
	2015/16 Budget £'000	2016/17 Budget £'000	2017/18 Budget £'000
WLC Delegated Functions	61,643	66,156	69,396
Growth in Resources		4,513	3,240

Appendix 1 shows further details on the split of the above resources against the various adult social care functions/services in each year.

2016/17 Budget Position

A breakeven position is forecast against the 2016/17 budget. However there continues to be a number of pressure areas throughout the service due to increasing demands for social care services.

Increased numbers of older people in residential care are causing a pressure of £298,000. This reflects an increasing frail elderly population and West Lothian's growth in the over 75 age group being the highest in Scotland. Adult care for clients with learning and physical disabilities is also experiencing substantial cost pressures of £789,000 combined due to increased client numbers and, in particular, an increasing number of high cost complex care clients. The pressures noted are being offset against savings elsewhere in the budget including staffing underspends which are largely due to the early delivery of 2017/18 budget savings.

2017/18 Budget

The 2017/18 budget resources total £69.396 million. This level of resource provides for the estimated additional costs associated with staff pay awards, apprenticeship levy costs, demographic and demand led pressures and contractual inflation, including the estimated costs of continuing to meet the Living Wage commitment.

The 2017/18 budget also reflects savings of £1.408 million which will require to be delivered to manage within the resources of £69.396 million delegated to the IJB. While comprehensive budget planning has been undertaken to realistically assess the additional cost demands to be budgeted for in 2017/18, and savings required as a result, there are a number of key risks and uncertainties that will require to be closely monitored during 2017/18.

Key Risks and Uncertainties

- Increasing demands and inflationary pressures in social care capacity. West Lothian has the fastest growing elderly population in Scotland and while the budget resources assume additional net growth £3.536 million to meet growth in direct care demands, there is a risk that demand will outstrip the assumptions and resources available. Particular risk areas include learning disability care and elderly care at home and care home spend
- Increasing demand to shift the balance of care from a hospital setting to a community / social care setting and reduce delayed discharges. As well as elderly clients this also particularly relates to high cost adult complex care clients
- The continuation of the Living Wage for all independent and third sector providers as well as wider inflationary demands. The 2017/18 increase to the Living Wage will require significant discussion and negotiation with a range of care providers. In addition, there are particular risks around the National Care Home Contract which has not yet been settled with care providers.
- Delivery of 2017/18 Savings. Substantial saving totalling £1.408 million will be required to be achieved. Ongoing monitoring of progress towards delivery will be required on a regular basis.

C.4 NHS Lothian Resources

The 2017/18 financial plan assumptions in this report take account of total funding confirmed by the Scottish Government and the overall NHS Lothian budget figures that will be reflected in the report to NHS Lothian Finance and Resources Committee on the 15 March 2017. The budget funding assumptions contained in this report will also be reflected in the Local Delivery Plan submitted to the Scottish Government at the end of March 2017. After taking account of cost pressures, additional funding, financial recovery plans and in year flexibility, there is currently a remaining gap across NHS Lothian of £35 million. This represents 2.2% of the total recurring NHS budget.

It is important to note that NHS Lothian financial planning is undertaken at Business Unit level, rather than IJB level, and the focus of NHS Lothian is to balance its budget at Business Unit level in the first place, which will then feed through to IJBs. NHS Lothian will continuing working with its Business Unit management teams and IJBs with the objective of balancing the remaining £35 million gap and achieving an overall breakeven position for 2017/18.

Two key factors around this will be the close management of expenditure during the year and scope for further funding during 2017/18.

C.4.1 Financial Assurance

The 2017/18 budget associated with NHS delegated functions for West Lothian is £145.065 million. This represents an increase in budget resources compared to last year's agreed contribution of £4.480 million. This is over and above the £10.190 million of NHS funding transferred to the council in respect of the Health and Social Care Fund referred to earlier in the report. At this stage, based on initial spend forecasts and saving assumptions, there is a gap forecast of £2.2 million for 2017/18 against the budget resources. West Lothian's share of the 2017/18 gap is equivalent to 1.5% of the budget contribution, compared to the NHS Lothian overall gap of 2.2% This is summarised in the table below.

NHS 2017/18 Contribution to IJB			
	2016/17	2017/18	2017/18
	Funding £'000	Funding £'000	Initial Gap £'000
Core West Lothian Health Services	92,069	94,953	1,542
Share of Pan Lothian Hosted Services	17,578	18,264	49
Payment to IJB - Total	**109,647**	**113,217**	**1,591**
Notional Share of Acute Set Aside	30,938	31,848	629
Total	**140,585**	**145,065**	**2,200**
*Budget Increase in 2017/18		**4,480**	
2017/18 Initial Budget Gap			**1.5%**

Appendix 2 shows further details on the split of the above resources across the NHS Lothian contribution.

2016/17 Budget Position

The latest 2016/17 monitoring position in respect of IJB delegated functions is that pressures of £1.928 million in the payment to the IJB will be managed through an overall breakeven position across NHS Lothian. As previously, reported the main pressure areas relate to prescribing and mental health areas. Prescribing continues to be a pressure across Lothian and overall spend growth to date this year has been 5%, made up of 2% on volumes and 3% on prices. Staffing costs are the other key pressure area, driven by high medical agency costs resulting from difficulties in filling vacancies, particularly so in Mental Health.

In addition, there is a forecast pressure of £809,000 in the set aside element of the West Lothian budget which is also being managed as part of the overall breakeven position across NHS Lothian.

2017/18 Budget

The 2017/18 budget contribution from NHS Lothian is £145.065 million. As noted this reflects additional funding of £4.480 million and means that NHS Lothian have complied with the Scottish Government requirement to maintain their contribution at least at the 2016/17 cash level. Saving plans totalling £2.550 million for 2017/18 are taken account of in arriving at the budget contribution of £145.065 million.

The budget contribution reflects additional budget to fully meet additional pay costs as well as significant additional resources to meet prescribing pressures. For 2017/18, NHS Lothian have invested an additional £8.5 million into primary care prescribing budgets, of which West Lothian's share is £3.2 million. This represents a 38% share of the additional funding compared to West Lothian's normal NRAC share of 21% and takes account of the prescribing pressure forecast for West Lothian in 2016/17.

Based on the methodology agreed by NHS Lothian for allocating resources, it is considered that the revised contribution represents a fair share of resources to the IJB, albeit there currently remains a gap to be addressed. A number of potential options and opportunities to manage the remaining pressures in the West Lothian IJB contribution. These include a further £2 million identified across Lothian for efficient prescribing in 2017/18 and, subject to agreement on the basis of allocation, West Lothian will receive further funding from this source as a means of managing prescribing pressures in 2017/18.

Further 2017/18 funding of £128 million for NHS Boards is still to be allocated by the Scottish Government. Scope for this to meet existing pressures is still to be determined but this will assist in increasing resources available for NHS Lothian and IJBs for investment in priority areas such as primary care. In addition, close management and monitoring of expenditure through NHS Lothian and IJBs working in partnership will be important in meeting the objective to breakeven for 2017/18.

Key Risks and Uncertainties

The following specific risks will require to be closely monitored during 2017/18.

- Prescribing. As set out above, significant additional resources of £3.2 million have been provided to help meet West Lothian prescribing pressures. However, even allowing for this, prescribing will remain a key risk as prices and growth in volumes continue to indicate likely pressures in this area.
- Mental Health. Cost pressures in West Lothian mental health services continue to be a major risk. Discussions are ongoing regarding funding availability. Difficulties in filling vacant posts and the resulting high medical agency costs have contributed to increased costs
- Delayed Discharge. Pressures in this area continue to be a budget risk and will require continued joint working to reduce bed days lost
- Delivery of savings required to ensure spend is managed within available 2017/18 resources. This will require to be closely monitored during the year

C.5 Financial Assurance – Key Points

As noted the purpose of the financial assurance process is to set out the assumptions and risks associated with the contributions provided by NHS Lothian and the council. The council and NHS Lothian are, in accordance with legislation, responsible for agreeing the functions delegated to the IJB and setting their respective budgets including the level of payments and set aside resources to the IJB.

The IJB is then responsible for allocating the resources it has been provided back to partners to operationally deliver services. For governance on responsibility for delegated functions, this will be through Directions issued to the council and NHS Lothian who remain operationally responsible for delivering services within the resources available. The Directions to both bodies are appended to this report and further information on the approach to Directions and associated service delivery are set out in a separate report to the Board.

As noted in the approved West Lothian Integration Scheme in respect of financial assurance, 'if any such (financial assurance) review indicates that the projected expenditure is likely to exceed the initial payments to the Board, then the relevant party will be notified. The relevant party, will be required to take action to ensure that services can be delivered within the available budget.' Such action will be in partnership with the IJB taking account of the various joint forums established in relation to delivery and management of delegated functions.

Based on the financial assurance undertaken to date, the NHS Lothian budget and resulting IJB contribution is showing a gap compared to forecast spend. This will require to be closely monitored during the year and through partnership working the objective will be to achieve a breakeven position for 2017/18.

Similarly, the council, whilst approving a balanced budget position, will also be responsible for managing within the resources available. Taking account of the budget resources identified in this report the table below shows the indicative level of 2017/18 resources associated with IJB functions.

West Lothian IJB – 2017/18 Delegated Resources	
	£'000
Adult Social Care	69,396
Core Health Services	94,953
Share of Hosted Services	18,264
IJB Payment	**186,213**
Acute Set Aside	31,848
Total IJB Resources	**214,461**

In addition, financial assurance will be ongoing during the year as part of regular financial reporting on the 2017/18 resources associated with IJB functions. As noted in this report, there are a number of risks across health and social care that will require to be closely managed.

C.6 Future Financial Strategy

The IJB has a statutory responsibility for delegated health and social care functions in relation to the strategic planning of future health and social care delivery. The IJB's strategic plan and strategic commissioning plans should help inform decisions around prioritisation of resources, new models of service delivery and disinvestment decisions, all of which will be necessary in the medium term financial planning process.

Strategic planning of future service delivery and financial planning are intrinsically linked. An informed approach to future service delivery over the medium term must take account of assumptions around available resources over the same period and ultimately resource availability will be a key determinant of shaping future service delivery. As part of the 2016/17 Scottish Budget there is a requirement for NHS Boards to undertake three year financial planning. In addition, the council have approved a priority based approach to medium term financial planning as part of the 2017/18 budget approved on the 20 February 2017.

Taking account of this and the challenge of a continuation of constrained financial resources, it is recommended that the Board requests partners to work with the IJB Director and Chief Finance Officer on preparation of a financial plan for IJB delegated functions over a minimum three year period. It is further proposed that this will be reflected in Directions issued to Partners and a further update on the proposed approach to the IJB's medium term financial strategy will be brought to the Board on 27 June 2017.

C.7 Annual Financial Statement

Section 39 of the Public Sector (Joint Working) (Scotland) Act 2014 requires that each Integration Authority must prepare an Annual Financial Statement on the resources delegated to the IJB. Scottish Government guidance states that the Annual Financial Statement should include each and all of the remaining years of the published strategic commissioning plans.

The IJB strategic commissioning plans covered the period 2016/17 to 2018/19 and accordingly the Annual Financial Statement attached in Appendix 4 reflects the 2017/18 budget contributions contained in this report along with indicative contributions for 2018/19. As the 2018/19 budget planning is still to be commenced, the value of the 2017/18 contributions are also reflected as the indicative 2018/19 resources.

D CONSULTATION

Relevant officers in NHS Lothian and West Lothian Council.

E REFERENCES/BACKGROUND

Public Bodies (Joint Working) (Scotland) Act 2014

Local Government (Scotland) Act 1973

F APPENDICES

Appendix 1 – West Lothian Council Delegated Resources

Appendix 2 – NHS Lothian Delegated Resources

Appendix 3 – Directions to NHS Lothian and West Lothian Council

Appendix 4 – WL IJB Annual Financial Statement

G SUMMARY OF IMPLICATIONS

Equality/Health	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, equality impact assessment has not been conducted. The relevance assessment can be viewed via the background references to this report.
National Health and Wellbeing Outcomes	The 2017/18 budget resources delegated to the IJB will be used to support the delivery of outcomes.
Strategic Plan Outcomes	The 2017/18 budget resources delegated to the IJB will be used to support the delivery of the Strategic Plan.
Single Outcome Agreement	The 2017/18 budget resources delegated to the IJB will be used to support the delivery of the Single Outcome Agreement.
Impact on other Lothian IJBs	None.

Resource/Finance	The indicative 2017/18 budget resources relevant to functions that will be delegated to the IJB from 1 April 2017 have been estimated at over £214 million.
Policy/Legal	None.
Risk	There are a number of risks associated with health and social care budgets, which will require to be closely managed.

H CONTACT

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14 March 2017

Appendix 1

SOCIAL CARE SERVICES DELEGATED TO WEST LOTHIAN IJB

2015/16 Budget (£'000)		2016/17 Budget (£'000)	2017/18 Budget (£'000)
12,317	Learning Disabilities	14,341	16,496
5,873	Physical Disabilities	5,860	6,095
2,928	Mental Health	3,082	2,786
25,066	Older People Assess & Care	28,360	29,667
6,868	Care Homes & HWC	7,366	7,353
5,933	Contracts & Commissioning Support	4,647	5,071
2,658	Other Social Care Services	2,500	1,928
61,643	**Total Adult Social Care Services**	**66,156**	**69,396**
	Annual Increase in Resources	**4,513**	**3,240**

NHS DELEGATED FUNCTIONS AND INDICATIVE RESOURCES

	2016/17	2017/18
Core Health Services	**£'000**	**£'000**
Community Hospitals	3,114	3,059
Mental Health	11,484	12,213
District Nursing	2,869	2,932
Community AHPS	3,326	3,396
GMS	22,975	21,782
Prescribing	33,525	36,767
Resource Transfer	6,885	6,782
Other Core	7,891	8,022
Total Core Health Services	**92,069**	**94,953**
Hosted Health Services		
Sexual Health	924	1,016
Hosted AHP Services	2,218	2,275
Hosted Rehabilitation Medicine	1,110	959
Learning Disabilities	3,779	3,241
Mental Health	681	425
Substance Misuse	1,074	1,166
Oral Health Services	2,061	2,140
Hosted Psychology Service	1,088	1,276
Hosted GMS	1,838	1,928
Public Health	271	287
Lothian Unscheduled Care Service	1,935	1,979
UNPAC	0	1,389
Strategic Programmes	930	495
Other Hosted Services	-331	-312
Total Hosted Health Services	**17,578**	**18,264**
TOTAL INDICATIVE NHS PAYMENT TO IJB	**109,647**	**113,217**
Acute Set Aside Services		
A & E (outpatients)	4,104	4,239
Cardiology	5,856	6,251
Diabetes	462	465
Endocrinology	407	136
Gastroenterology	1,872	1,570
General Medicine	7,758	8,559
Geriatric Medicine	5,570	5,539
Infectious Disease	3,187	2,969
Rehabilitation Medicine	732	752
Respiratory Medicine	177	180
Therapies/Management	813	1,188
TOTAL SET ASIDE	**30,938**	**31,848**
OVERALL TOTAL	**140,585**	**145,065**
2017/18 INCREASE IN RESOURCES		**4,480**

Appendix 3

West Lothian Integration Joint Board – Directions to NHS Lothian

1	Implementation date	1st April 2017
2	Reference number	WLIJB/WLC/D01-2017
3	Integration Joint Board (IJB) authorisation date	14th March 2017
4	Direction to	NHS Lothian Health Board
5	Purpose and strategic intent	In accordance with the IJB Strategic Plan, to provide effective services to all service users and carers within West Lothian Council area, promoting the highest standards of practice in accordance with statutory obligations, policies and procedures. To provide services to all service users and carers within the geographical boundaries of West Lothian which promote health, wellbeing and quality of life. To provide services to all service users and carers within the geographical boundaries of West Lothian which: – Maximise independent living – Provide specific interventions according to the needs of the service user – Provide an ongoing service that is regularly reviewed and modified according to need – Provide a clear care pathway – Contribute to preventing unnecessary hospital admission – Support timely hospital discharge – Prevent unnecessary admission to residential or institutional care

		– Are personalised and self-directed, putting control in the hands of the service user and their carers
6	Does this direction supersede or amend or cancel a previous Direction?	This Direction supersedes the 2016/17 Direction to NHS Lothian for core community health services.
7	Type of function	Integrated function
8	Function(s) concerned	All services planned and delivered by West Lothian IJB which are delivered within the geographical boundaries of the West Lothian Health and Social Care Partnership as they relate to primary and community health services and defined as health care services as required by the Public Bodies (Joint Working) (Scotland) Act 2014. This includes additional functions exercisable in relation to health services as they relate to provision for people under the age of 18 as defined in West Lothian Integration Joint Board's Integration Scheme. – District nursing – Allied Health Professional services: physiotherapy, occupational therapy – Mental health services – General Medical Services – General Dental Services – General Ophthalmic Services – General Pharmaceutical Services – Primary Care Prescribing – Inpatient services provided at St Michael's Hospital, Tippethill Hospital, Maple Villa – Community Learning Disability services

		– Community Palliative Care services – Continence services provided outwith a hospital – Kidney dialysis services provided outwith a hospital – Services provided by health professionals that aim to promote public health The Chief Officer in West Lothian will be the lead operational director for these services.
9.	Required Actions / Directions	West Lothian IJB directs NHS Lothian Health Board to provide health services as outlined in Section 8, and ancillary support as required for effective functioning of those services for the population of West Lothian. Over the course of the financial year 2017-2018, West Lothian IJB directs NHS Lothian Health Board to work with the IJB Chief Officer and officers supporting the IJB to progress and implement the care group commissioning plans below: Older People – Adults with Learning Disabilities – Adults with Physical Disabilities – Adults with Mental Health problems – Adults with Alcohol and Drug problems These commissioning plans provide details of: – Specific needs of the relevant client group based on a detailed needs assessment, including stakeholder engagement – Specific outcomes to be addressed consistent with the IJB Strategic Plan – How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.) – How specific needs of localities will be addressed Transformational change and further integration of Health and social care service

		delivery will be key to achieving IJB outcomes. This will require a joined up approach to strategic and financial planning to prioritise financial resources while maximising performance against strategic outcomes **West Lothian Health and Social Care Delivery Plan** The West Lothian Health and Social Care Delivery Plan sets out key operational and transformational changes progressing and proposed to meet national health and social outcomes. West Lothian IJB directs NHS Lothian to work in partnership with West Lothian IJB to deliver the West Lothian Health and Social Care Plan, which sets out the IJB's vision on transforming service delivery to meet national health and social care outcomes at a West Lothian level. **Medium Term Financial Strategy** An informed approach to future service delivery over the medium term is critical and must take account of assumptions around available resources. West Lothian IJB directs NHS Lothian to work with the West Lothian IJB Chief Officer and Chief Finance Officer to develop a financial strategy over a minimum three year period from 2018/19. A robust approach to both aspects above, which take account of the Strategic Plan and Strategic Commissioning Plan priorities will be essential in meeting future health and social care needs for the population of West Lothian

Appendix 3

10.	Budget 2017/2018	Budget 2017/18 (£'000) Community AHPs 3,396 Community Hospitals 3,059 District Nursing 2,932 GMS 21,782 Mental Health 12,213 Other 8,022 Prescribing 36,767 Resource transfer 6,782 Total 94,953
11.	Principles	As a fundamental principle, any material changes to 2017/18 budget or expenditure plans for delegated functions should be subject to full discussion and agreement by West Lothian IJB. West Lothian IJB expects that the principles of Best Value (to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost, maintaining regard to economy, efficiency, effectiveness) are adhered to in carrying out this direction.
12.	Aligned National Health and Wellbeing Outcomes	To support the following national outcome measures: 1. People are able to look after and improve their own health and wellbeing and live in good health for longer 2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community 3. People who use health and social care services have positive experiences of those services, and have their dignity respected

		4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services 5. Health and social care services contribute to reducing health inequalities 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being 7. People using health and social care services are safe from harm 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide 9. Resources are used effectively and efficiently in the provision of health and social care services
14.	Aligned priorities, strategies, outcomes	This direction relates to and will be monitored against the detailed performance framework aligned with West Lothian IJB's Strategic Plan and Health and Social Care Delivery Plan.
15.	Compliance and performance monitoring	1. In order to ensure West Lothian IJB fulfils its key strategic planning and scrutiny functions, and further develops and coordinates the implementation of its Strategic Plan, monitoring our own and our partners' performance is imperative. The primary responsibility for performance management in respect of delivery of the integration outcomes will rest with the IJB and NHS Lothian Health Board will provide performance information so that the IJB can develop a comprehensive performance management system. 2. In addition to the specific commitments set out in West Lothian IJB's Integration Scheme and the obligations regarding provision of information under the Act, NHS Lothian Health Board will provide the IJB with any information which the IJB may require from time to time to support its responsibilities regarding strategic planning, performance management reporting, and public accountability. 3. Details of how compliance and performance will be measured and reported on

		(performance indicators, delivery outcomes, targets etc.) is provided in the appropriate care group commissioning plan. 4. The IJB , through its officers, will meet on a regular basis with senior NHSL officers to discuss cost, quality and performance matters linked to the Strategic Plan and local Health and Social Care Delivery Plan. This will be incorporated into regular updates to the IJB on the IJBs performance against key strategic outcomes. 5. The IJB directs NHS Lothian Health Board, through its officers, to provide an annual report in the final quarter of financial year 2017-18 on how it: – assesses the quality of services it provides on behalf of the IJB – ensures the regular evaluation of those services as part of an integrated cycle of service improvement 6. The IJB directs NHS Lothian Health Board, through its officers, to provide financial analysis, budgetary control and monitoring reports as and when requested by the IJB. The reports will set out the financial position and outturn forecast against the payments by the IJB to NHS Lothian Health Board in respect of the carrying out of integration functions. These reports will present the actual and forecast positions of expenditure compared to Operational Budgets for delegated functions and highlight any financial risks and areas where further action is required to manage budget pressures.
16.	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	N/A

Appendix 3

1	Implementation date	1st April 2017
2	Reference number	WLIJB/WLC/D04-2017
3	Integration Joint Board (IJB) authorisation date	14 March 2017
4	Direction to	NHS Lothian Health Board
5	Purpose and strategic intent	In accordance with the IJB Strategic Plan, to provide effective services to all service users and carers within West Lothian Council area, promoting the highest standards of practice in accordance with statutory obligations, policies and procedures. To provide services to all service users and carers within the geographical boundaries of West Lothian which promote health, wellbeing and quality of life. To provide services to all service users and carers within the geographical boundaries of West Lothian which: – Maximise independent living – Provide specific interventions according to the needs of the service user – Provide an ongoing service that is regularly reviewed and modified according to need – Provide a clear care pathway – Contribute to preventing unnecessary hospital admission – Support timely hospital discharge – Prevent unnecessary admission to residential or institutional care – Are personalised and self-directed, putting control in the hands of the service user and their carers

6	Does this direction supersede or amend or cancel a previous Direction?	This Direction supersedes the 2016/17 Direction to NHS Lothian for hosted services.
7	Type of function	Integrated (hosted)
8	Function(s) concerned	A range of delegated functions defined as health care services as required by the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 and including additional functions as they relate to provision for people under the age of 18 as defined in West Lothian Integration Joint Board's Integration Scheme, require them to be provided as part of a single Lothian-wide service, commonly referred to as "hosted services". These services will be managed at a pan-Lothian level by one of the Chief Officers of the Lothian IJBs in their role as a Joint Director of NHS Lothian (the IJB area in brackets confirms the Chief Officer who will manage this service) The services are: – Dietetics (Midlothian) – Art Therapy (Midlothian) – Lothian Unscheduled Care Service (East Lothian) – Integrated Sexual and Reproductive Health service (Edinburgh) – Clinical Psychology Services (West Lothian) – Continence Services (Edinburgh) – Public Dental Service (including Edinburgh Dental Institute (West Lothian) – Podiatry (West Lothian) – Orthoptics (West Lothian) – Independent Practitioners (East Lothian via the Primary Care Contracting

		Organisation) – SMART Centre (Edinburgh) – Royal Edinburgh and Associated Services (Director of Mental Health accountable to the Chief Officer of Edinburgh and the NHS Lothian's Chief Executive) – Substance Misuse (Ritson Inpatient Unit, LEAP and Harm Reduction (Director of Mental Health accountable to the Chief Officer of Edinburgh and NHS Lothian's Chief Executive)
9.	Required Actions / Directions	West Lothian IJB directs NHS Lothian Health Board to provide health services as outlined in Section 8, and ancillary support as required for effective functioning of those services for the population of West Lothian. Over the course of the financial year 2017-2018, West Lothian IJB directs NHS Lothian Health Board to work with the IJB Chief Officer and officers supporting the IJB to progress and implement the care group commissioning plans below : – Older People – Adults with Learning Disabilities – Adults with Physical Disabilities – Adults with Mental Health problems – Adults with Alcohol and Drug problems These commissioning plans provide details of: – Specific needs of the relevant client group based on a detailed needs assessment, including stakeholder engagement – Specific outcomes to be addressed consistent with the IJB Strategic Plan – How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.) – How specific needs of localities will be addressed

		Transformational change and further integration of health and social care service delivery will be key to achieving IJB Outcomes. This will require a joined up approach to strategic and financial planning to prioritise financial resources while maximising performance against strategic outcomes. **<u>West Lothian Health and Social Care Delivery Plan</u>** The West Lothian Health and Social Care Delivery Plan sets out the key operational and transformational changes progressing and proposed to meet national health and social care outcomes. West Lothian IJB directs NHS Lothian to work in partnership with West Lothian IJB to deliver the West Lothian Health and Social Care Plan, which sets out the IJB's vision on transforming service delivery to meet national health and social care outcomes at a West Lothian level. **<u>Medium Term Financial Strategy</u>** An informed approach to future service delivery over the medium term is crucial and must take account of assumptions around available resources. West Lothian IJB directs NHS Lothian to work with the West Lothian IJB Chief Officer and Chief Finance Officer to develop a financial strategy over a minimum three year period from 2018/19. A robust approach to integrated strategic and financial planning, which takes account of the Strategic Plan and Strategic Commissioning Plan priorities will be essential in meeting future health and social care needs for the population of West Lothian.
10.	2017/18 Resources	<u>2017/18 Payment to IJB</u> — <u>(£'000)</u> Sexual Health — 1,016 Hosted AHP Services — 2,275 Hosted Rehabilitation Medicine — 959 Learning Disabilities — 3,241

		Mental Health	425
		Substance Misuse	1,166
		Oral Health Services	2,140
		Hosted Psychology Service	1,276
		Hosted GMS	1,928
		Public Health	287
		Lothian Unscheduled Care Service	1,979
		UNPAC	1,389
		Strategic Programmes	495
		Other Hosted Services	-312
		Total Hosted Health Services	18,264
11.	Principles	As a fundamental principle, any material changes to 2017/18 budget or expenditure plans for delegated functions should be subject to full discussion and agreement by West Lothian IJB. West Lothian IJB expects that the principles of Best Value (to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost, maintaining regard to economy, efficiency, effectiveness) are adhered to in carrying out this direction.	
12.	Aligned National Health and Wellbeing Outcomes	To support the following national outcome measures: 1. People are able to look after and improve their own health and wellbeing and live in good health for longer 2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	

		3. People who use health and social care services have positive experiences of those services, and have their dignity respected 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services 5. Health and social care services contribute to reducing health inequalities 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being 7. People using health and social care services are safe from harm 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide 9. Resources are used effectively and efficiently in the provision of health and social care services
14.	Aligned priorities, strategies, outcomes	This direction relates to and will be monitored against the detailed performance framework within West Lothian IJB's Strategic Plan and Health and Social Care Delivery Plan.
15.	Compliance and performance monitoring	1. In order to ensure West Lothian IJB fulfils its key strategic planning and scrutiny functions, and further develops and coordinates the implementation of its Strategic Plan, monitoring our own and our partners' performance is imperative. The primary responsibility for performance management in respect of delivery of integration outcomes will rest with the IJB and NHS Lothian Health Board will provide performance information so that the IJB can develop a comprehensive performance management system. 2. In addition to the specific commitments set out in West Lothian IJB's Integration Scheme and the obligations regarding provision of information under the Act, NHS Lothian Health Board will provide the IJB with any information which the IJB may require from time to time to support its responsibilities regarding strategic planning, performance management,

		and public accountability. 3. Details of how compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.) will be provided in the appropriate care group commissioning plan. 4. The IJB, through its supporting officers, will meet on a regular basis with senior NHSL officers to discuss cost, quality and performance matters linked to the Strategic Plan and local Health and Social care delivery Plan. This will be incorporated into regular updates to the IJB on performance against key strategic outcomes. 5. The IJB directs NHS Lothian Health Board, through its officers, to provide an annual report in the final quarter of financial year 2017-18 on how it: – assesses the quality of services it provides on behalf of the IJB – ensures the regular evaluation of those services as part of an integrated cycle of service improvement 6. The IJB directs NHS Lothian Health Board, through its officers, to provide financial analysis, budgetary control and monitoring reports as and when requested by the IJB. The reports will set out the financial position and outturn forecast against the payments by the IJB to NHS Lothian Health Board in respect of the carrying out of integration functions. These reports will present the actual and forecast positions of expenditure compared to Operational Budgets for delegated functions and highlight any financial risks and areas where further action is required to manage budget pressures.
16.	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	NHS Lothian Health Board carries out functions across four local authority areas. Some of the functions that will be delegated to the Lothian IJBs are currently provided as part of a single Lothian-wide service, commonly referred to as “hosted services” and identified in Section 8 of this Direction. As such there is not currently a separately managed budget for those services by local authority area. NHS Lothian Health Board has identified a budget for “hosted services” integrated functions based on an apportionment of the relevant NHS Lothian budgets.

Appendix 3

1	Implementation date	1st April 2017
2	Reference number	WLIJB/WLC/D03-2017
3	Integration Joint Board (IJB) authorisation date	14 March 2016
4	Direction to	NHS Lothian Health Board
5	Purpose and strategic intent	In accordance with the IJB Strategic Plan, to provide effective services to all service users and carers within West Lothian Council area, promoting the highest standards of practice in accordance with statutory obligations, policies and procedures. To provide services to all service users and carers within the geographical boundaries of West Lothian which promote health, wellbeing and quality of life. To provide services to all service users and carers within the geographical boundaries of West Lothian which: – Maximise independent living – Provide specific interventions according to the needs of the service user – Provide an ongoing service that is regularly reviewed and modified according to need – Provide a clear care pathway – Contribute to preventing unnecessary hospital admission – Support timely hospital discharge – Prevent unnecessary admission to residential or institutional care

		– Are personalised and self-directed, putting control in the hands of the service user and their carers
6	Does this direction supersede or amend or cancel a previous Direction?	This Direction supersedes the 2016/17 Direction to NHS Lothian for set aside health services.
7	Type of function	Set aside
8	Function(s) concerned	All adult acute hospital health services planned by West Lothian IJB and defined as hospital services as required by the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Act 2014 and as defined in West Lothian Integration Joint Board's Integration Scheme. 1. Accident and Emergency services provided in a hospital 2. Inpatient hospital services relating to the following branches of medicine: – General medicine – Geriatric medicine – Rehabilitation medicine – Respiratory medicine – Psychiatry of learning disability 3. Palliative care services provided in a hospital 4. Services provided in a hospital in relation to an addiction or dependence on any substance 5. Mental health services provided in a hospital except secure forensic mental health services Services provided on the three acute hospital sites within NHS Lothian (Royal Infirmary of Edinburgh, Western General Hospital and St. John's Hospital) will be operationally managed by the relevant site director.

9.	Required Actions / Directions	West Lothian IJB directs NHS Lothian Health Board to provide health services as outlined in Section 8, and ancillary support as required for effective functioning of those services for the population of West Lothian. Over the course of the financial year 2017-2018, West Lothian IJB directs NHS Lothian Health Board to work with the IJB Chief Officer and officers supporting the IJB to progress and implement the care group commissioning plans below: – Older People – Adults with Learning Disabilities – Adults with Physical Disabilities – Adults with Mental Health problems – Adults with Alcohol and Drug problems These commissioning plans provide details of: – Specific needs of the relevant client group based on a detailed needs assessment, including stakeholder engagement – Specific outcomes to be addressed consistent with the IJB Strategic Plan – How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.) Transformational change and further integration of health and social care service delivery will be key to achieving IJB outcomes. This will require a joined up approach to strategic and financial planning to prioritise financial resources while maximising performance against strategic outcomes. **West Lothian Health and Social Care Delivery Plan** The West Lothian Health and Social Care Delivery Plan sets out the key operational and transformational changes progressing and proposed to meet national health and social care outcomes. West Lothian IJB directs NHS Lothian to work in partnership with West Lothian IJB to deliver the West Lothian Health and Social Care Plan, which sets out the IJB's vision on transforming service delivery to meet national health and social care outcomes at a West Lothian level.

		Medium Term Financial Strategy An informed approach to future service delivery over the medium term is crucial and must take account of assumptions around available resources. West Lothian IJB directs NHS Lothian to work with the West Lothian IJB Chief Officer and Chief Finance Officer to develop a financial strategy over a minimum three year period from 2018/19. A robust approach to integrated strategic and financial planning, which takes account of the Strategic Plan and Strategic Commissioning Plan priorities will be essential in meeting future health and social care needs for the population of West Lothian.
10.	2017/18 Resources	2017/18 IJB Set Aside — (£'000) A & E (outpatients) — 4,239 Cardiology — 6,251 Diabetes — 465 Endocrinology — 136 Gastroenterology — 1,570 General Medicine — 8,559 Geriatric Medicine — 5,539 Infectious Disease — 2,969 Rehabilitation Medicine — 752 Respiratory Medicine — 180 Therapies/Management — 1,188 Total Set Aside — 31,848

Appendix 3

11.	Principles	As a fundamental principle, any material changes to 2017/18 budget or expenditure plans for delegated functions should be subject to full discussion and agreement by West Lothian IJB. West Lothian IJB expects that the principles of Best Value (to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost, maintaining regard to economy, efficiency, effectiveness) are adhered to in carrying out this direction.
12.	Aligned National Health and Wellbeing Outcomes	To support the following national outcome measures: 1. People are able to look after and improve their own health and wellbeing and live in good health for longer 2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community 3. People who use health and social care services have positive experiences of those services, and have their dignity respected 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services 5. Health and social care services contribute to reducing health inequalities 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being 7. People using health and social care services are safe from harm 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide 9. Resources are used effectively and efficiently in the provision of health and social care services
14.	Aligned priorities, strategies, outcomes	This direction relates to and will be monitored against the detailed performance framework within West Lothian IJB's Strategic Plan and Health and Social Care Delivery Plan.

15.	Compliance and performance monitoring	1. In order to ensure West Lothian IJB fulfils its key strategic planning and scrutiny functions, and further develops and coordinates the implementation of its Strategic Plan, monitoring our own and our partners' performance is imperative. The primary responsibility for performance management in respect of delivery of integration outcomes will rest with the IJB and NHS Lothian Health Board will provide performance information so that the IJB can develop a comprehensive performance management system. 2. In addition to the specific commitments set out in West Lothian IJB's Integration Scheme and the obligations regarding provision of information under the Act, NHS Lothian Health Board will provide the IJB with any information which the IJB may require from time to time to support its responsibilities regarding strategic planning, performance management, and public accountability. 3. Details of how compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.) will be provided in the appropriate care group commissioning plan. 4. The IJB, through its supporting officers, will meet on a regular basis with senior NHSL officers to discuss cost, quality and performance matters linked to the Strategic Plan and local Health and Social Care Delivery Plan. This will be incorporated into regular updates to the IJB on performance against key strategic outcomes. 5. The IJB directs NHS Lothian Health Board, through its officers, to provide an annual report in the final quarter of financial year 2017-18 on how it: – assesses the quality of services it provides on behalf of the IJB – ensures the regular evaluation of those services as part of an integrated cycle of service improvement 6. The IJB directs NHS Lothian Health Board, through its officers, to provide financial analysis, budgetary control and monitoring reports as and when requested by the IJB. The reports will set out the financial position and outturn forecast against the payments by the IJB to NHS Lothian Health Board in respect of the carrying out of integration functions. These reports will present the actual and forecast positions of expenditure compared to Operational Budgets for delegated functions and highlight any financial risks and areas where further action is required to manage

		budget pressures.
16.	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	NHS Lothian Health Board carries out functions across four local authority areas. The set aside hospital functions that will be delegated to the Lothian IJBs are currently provided as a Lothian-wide service. As such there is not currently a separately managed budget for those services by local authority area. NHS Lothian Health Board has identified a budget for set aside functions based on an apportionment of the relevant NHS Lothian budgets.

Appendix 3

West Lothian Integration Joint Board – Direction to West Lothian Council

1	Implementation date	1st April 2017
2	Reference number	WLIJB/WLC/D02-2017
3	Integration Joint Board (IJB) authorisation date	14th March 2017
4	Direction to	West Lothian Council
5	Purpose and strategic intent	In accordance with the IJB Strategic Plan, to provide effective services to all service users and carers within West Lothian Council area, promoting the highest standards of practice in accordance with statutory obligations, policies and procedures. To provide services to all service users and carers within the geographical boundaries of West Lothian which promote health, wellbeing and quality of life. To provide services to all service users and carers within the geographical boundaries of West Lothian which: – Maximise independent living – Provide specific interventions according to the needs of the service user – Provide an ongoing service that is regularly reviewed and modified according to need – Provide a clear care pathway – Contribute to preventing unnecessary hospital admission – Support timely hospital discharge – Prevent unnecessary admission to residential or institutional care

		– Are personalised and self-directed, putting control in the hands of the service user and their carers
6	Does this direction supersede or amend or cancel a previous Direction?	This Direction supersedes the 2016/17 Direction issued to West Lothian Council for adult social care services.
7	Type of function	Integrated function
8	Function(s) concerned	All services planned and delivered by West Lothian IJB which are delivered within the geographical boundaries of the West Lothian Health and Social Care Partnership as they relate to adult social care services and defined by the Public Bodies (Joint Working) (Scotland) Act 2014. This includes additional functions West Lothian Council has chosen to delegate to the IJB as defined in West Lothian Integration Joint Board's Integration Scheme. All Adult social care services: – Learning Disabilities – Physical Disabilities – Mental Health – Older People Assessment & Care – Care Homes & Housing With Care – Contracts & Commissioning Support – Other Adult social care services The IJB Director will be the lead operational director for these services which are to be delivered through the Director's Joint Management Team and in cooperation and partnership with NHS Lothian.

9.	Required Actions / Directions	West Lothian IJB directs West Lothian Council to provide adult social care services for the population of West Lothian as set out in the West Lothian Integration Scheme. Over the course of the financial year 2017-2018, West Lothian IJB directs West Lothian Council to work with the IJB Chief Officer and officers supporting the IJB to progress and implement the care group commissioning plans below: – Older People – Adults with Learning Disabilities – Adults with Physical Disabilities – Adults with Mental Health problems – Adults with Alcohol and Drug problems These commissioning plans provide details of: – Specific needs of the relevant client group based on a detailed needs assessment, including stakeholder engagement – Specific outcomes to be addressed consistent with the IJB Strategic Plan – How compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.) – How specific needs of localities will be addressed Transformational change and further integration of health and social care service delivery will be key to achieving IJB outcomes. This will require a joined up approach to strategic and financial planning to prioritise financial resources while maximising performance against strategic outcomes. **West Lothian Health and Social Care Delivery Plan** The West Lothian Health and Social Care Delivery Plan sets out the key operational and transformational changes progressing and proposed to meet national health and social care outcomes. West Lothian IJB directs West Lothian Council to work in partnership with West Lothian IJB to deliver the West Lothian Health and Social Care Plan, which sets out the IJB's vision on transforming service delivery to meet national health and social care outcomes at a West Lothian level.

		Medium Term Financial Strategy An informed approach to future service delivery over the medium term is crucial and must take account of assumptions around available resources. West Lothian IJB directs West Lothian Council to work with the West Lothian IJB Chief Officer and Chief Finance Officer to develop a financial strategy over a minimum three year period from 2018/19. A robust approach to integrated strategic and financial planning, which takes account of the Strategic Plan and Strategic Commissioning Plan priorities will be essential in meeting future health and social care needs for the population of West Lothian.
10.	2017/18 Resources	2017/18 Payment to IJB — (£'000) Learning Disabilities — 16,496 Physical Disabilities — 6,095 Mental Health — 2,786 Older People Assess & Care — 29,667 Care Homes & HWC — 7,353 Contracts & Commissioning Support — 5,071 Other Social Care Services — 1,928 Total Adult Social Care Services — 69,396
11.	Principles	As a fundamental principle, any material changes to 2017/18 budget or expenditure plans for delegated functions should be subject to full discussion and agreement by West Lothian IJB.

		West Lothian IJB expects that the principles of Best Value (to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost, maintaining regard to economy, efficiency, effectiveness) are adhered to in carrying out this direction.
12.	Aligned National Health and Wellbeing Outcomes	To support the following national outcome measures: 1. People are able to look after and improve their own health and wellbeing and live in good health for longer 2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community 3. People who use health and social care services have positive experiences of those services, and have their dignity respected 4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services 5. Health and social care services contribute to reducing health inequalities 6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being 7. People using health and social care services are safe from harm 8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide 9. Resources are used effectively and efficiently in the provision of health and social care services

14.	Aligned priorities, strategies, outcomes	This direction relates to and will be monitored against the detailed performance framework within West Lothian IJB's Strategic Plan and Health and Social Care Delivery Plan.
15.	Compliance and performance monitoring	1. In order to ensure West Lothian IJB fulfils its key strategic planning and scrutiny functions, and further develops and coordinates the implementation of its Strategic Plan, monitoring our own and our partners' performance is imperative. The primary responsibility for performance management in respect of delivery of integration outcomes will rest with the IJB and West Lothian Council will provide performance information so that the IJB can develop a comprehensive performance management system. 2. In addition to the specific commitments set out in West Lothian IJB's Integration Scheme and the obligations regarding provision of information under the Act, West Lothian Council will provide the IJB with any information which the IJB may require from time to time to support its responsibilities regarding strategic planning, performance management, and public accountability. 3. Details of how compliance and performance will be measured and reported on (performance indicators, delivery outcomes, targets etc.) will be provided in the appropriate care group commissioning plan in accordance with the detailed performance framework within West Lothian IJB's Strategic Plan. 4. The IJB, through management supporting the IJB, will meet on a regular basis to discuss social care cost, quality and performance matters linked to the Strategic Plan and local Health and Social Care Delivery Plan. This will be incorporated into regular updates to the IJB on performance against key strategic outcomes. 5. The IJB directs West Lothian Council, through its officers supporting the IJB, to provide an annual report in the final quarter of financial year 2017-18 on how it: – assesses the quality of services it provides on behalf of the IJB – ensures the regular evaluation of those services as part of an integrated cycle of service improvement 6. The IJB directs West Lothian Council, through its officers supporting the IJB, to provide

		financial analysis, budgetary control and monitoring reports as and when requested by the IJB. The reports will set out the financial position and outturn forecast against the payments by the IJB to West Lothian Council in respect of the carrying out of integration functions. These reports will present the actual and forecast positions of expenditure compared to Operational Budgets for delegated functions and highlight any financial risks and areas where further action is required to manage budget pressures.
16.	Relevance to or impact on other Lothian IJBs and/or other adjoining IJBs	N/A

WEST LOTHIAN INTEGRATION JOINT BOARD

ANNUAL FINANCIAL STATEMENT

Section 39 of the Public Sector (Joint Working) (Scotland) Act 2014 requires that each Integration Authority must publish an Annual Financial Statement on the resources that it plans to spend in implementing its Strategic Plan and Strategic Commissioning Plans.

The Scottish Government guidance notes that the Annual Financial Statement should be updated before the end of each financial year and should cover all of the remaining years of the published Strategic Commissioning Plans. West Lothian IJB Strategic Commissioning Plans cover the period 2016/17 to 2018/19 and accordingly, the updated Annual Financial Statement below covers 2017/18 and 2018/19. No financial settlement has been provided to NHS Lothian or the council for 2018/19 and, given this, 2018/19 budgets are not available Financial planning for 2018/19 will be progressing over the coming months as part of a medium term approach to financial planning.. Taking account of this and uncertainty over future grant funding, indicative 2018/19 resources are shown at the same level 2017/18 resources for the purposes of the Annual Financial Statement.

The Annual Financial Statement is split into four areas:

- Adult Social Care Services
- Core West Lothian Health Services
- Hosted Health Services
- Set Aside Hospital Acute Services

Adult Social Care Services

The council's approved 2017/18 contribution to the IJB is shown below along with indicative resources for 2018/19, equal to the level of 2017/18 budget resources

NHS Delegated Services

The NHS Lothian contribution for 2017/18 is also shown below along with indicative resources for 2018/19, equal to the level of 2017/18 budget resources.

As part of anticipated ongoing public sector funding constraints, both West Lothian Council and NHS Lothian will face significant financial challenges over 2017/18 and 2018/19. Health and social care demands are continuing to increase and taken in conjunction with constrained funding, it will be important that available resources are prioritised to meet the care needs of the West Lothian population

West Lothian Integration Joint Board – Annual Financial Statement			
	2017/18	**2018/19**	**Total Two Year**
	Budget	**Indicative Budget**	**Indicative Budget**
Adult Social Care Services	**£'000**	**£'000**	**£'000**
Learning Disabilities	16,496	16,496	32,992
Physical Disabilities	6,095	6,095	12,190
Mental Health	2,786	2,786	5,572
Older People Assessment and Care	29,667	29,667	59,334
Care Homes and Housing with Care	7,353	7,353	14,706
Contracts and Commissioning Support	5,071	5,071	10,142
Other Social Care Services	1,928	1,928	3,856
Adult Social care Services - Total	**69,396**	**69,396**	**138,792**
Core West Lothian Health Services			
Community Hospitals	3,059	3,059	6,118
Mental Health	12,213	12,213	24,426
District Nursing	2,932	2,932	5,864
Community AHPs	3,396	3,396	6,792
General Medical Services	21,782	21,782	43,564
Prescribing	36.767	36.767	73,534
Resource Transfer	6,782	6,782	13,564
Other Core	8,022	8,022	16,044
Core West Lothian Health Services - Total	**94,953**	**94,953**	**189,906**

	2017/18 Budget	2018/19 Indicative Budget	Total Two Year Indicative Budget
Hosted Health Services	**£'000**	**£'000**	**£'000**
Sexual Health	1,016	1,016	2,032
Hosted AHP Services	2,275	2,275	4,550
Hosted Rehabilitation Services	959	959	1,918
Learning Disabilities	3,241	3,241	6,482
Mental Health	425	425	850
Substance Misuse	1,166	1,166	2,332
Oral Health Services	2,140	2,140	4,280
Psychology Services	1,276	1,276	2,552
Hosted General Medical Services	1,928	1,928	3,856
Public Health	287	287	574
Lothian Unscheduled Care	1,979	1,979	3,958
UNPACS	1,389	1,389	2,778
Other Hosted Services	183	183	366
Hosted Health Services - Total	**18,264**	**18,264**	**36,528**
Acute Set Aside Services			
Accident and Emergency (Outpatients)	4,239	4,239	8,478
Cardiology	6,251	6,251	12,502
Diabetes	465	465	930
Endocrinology	136	136	272
Gastroenterology	1,570	1,570	3,140
General Medicine	8,559	8,559	17,118
Geriatric Medicine	5,539	5,539	11,078
Infectious Disease	2,969	2,969	5,938
Rehabilitation Medicine	752	752	1,504
Respiratory Medicine	180	180	360
Therapies / Management	1,188	1,188	2,376
Acute Set Aside - Total	**31,848**	**31,848**	**63,696**
TOTAL	**214,461**	**214,461**	**428,922**

WEST LOTHIAN INTEGRATION JOINT BOARD

Date: 14 March 2017
Agenda Item: **6**

STRATEGIC PLAN ANNUAL REVIEW, HEALTH AND SOCIAL CARE DELIVERY PLAN & DIRECTIONS

REPORT BY DIRECTOR

A PURPOSE OF REPORT

The purpose of this report is to outline the Draft First Annual Review of the IJB Strategic Plan 2016-26, the draft Health and Social Care Delivery Plan and the proposed approach to Directions for 2017/18

B RECOMMENDATION

. *The Integration Joint Board is recommended to*

1. *Receive the report;*
2. *Discuss the contents of the report;*
3. *Approve the Draft First Annual Review of the Strategic Plan, the Draft Health and Social Care Delivery Plan and the approach to Directions for 2017/18*
4. *Agree an IJB development session to be held in June 2017 which will focus on the Health and Social Care Delivery Plan and transformational change required to support this.*

C TERMS OF REPORT

BACKGROUND

The Public Bodies (Joint Working) (Scotland) Act 2014 placed a duty on the IJB to develop a Strategic Plan for the integrated functions and budgets under its control.

The Strategic Plan is the document setting out the arrangements for carrying out the integration functions and how these are intended to contribute to the achievement of the relevant national health and wellbeing outcomes for the partnership.

The Strategic Plan 2016-26 was developed during the course of 2015/16 with engagement of stakeholders through the Strategic Planning Group. The Strategic Plan 2016-26 was approved by the IJB at its meeting on 31st March 2016.

This report refers to the Draft First Annual Review of the Strategic Plan 2016-26, covering the 2016/17 period (Appendix 1)

DELEGATED FUNCTIONS
NHS Lothian and West Lothian Council delegate functions and make payments to the Integration Joint Board (IJB) in respect of those functions.

The IJB has the responsibility for the planning and resourcing of the delegated functions as set out in the Integration Scheme to enable it to deliver on local strategic outcomes and gives directions to the council and health board as to how they must deliver services in pursuit of the Strategic Plan and allocates payments to them to permit them to do that.

Similarly, managerial arrangements for the operational delivery of integrated services and accountability to the IJB through the Chief Officer are set out in the Integration Scheme.

These arrangements also include a shared planning responsibility for appropriate NHS Lothian resources designated as 'set aside' amounts regarding large hospital functions of a primarily unscheduled care nature.

STRATEGIC PLAN
The strategic plan is the output of activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

The Strategic Plan takes account of the integration delivery principles and the national health and wellbeing outcomes. The Act also includes provision for review of the Strategic Plan periodically within the lifetime of the plan and in consultation with the Strategic Planning Group. The review of the Strategic Plan should include the effectiveness of the plan in delivering integrated functions and whether a replacement plan is required.

FIRST ANNUAL REVIEW
The Strategic Plan has been reviewed on the basis of consistency with the policy, economic and social context and ongoing accordance with values, resources, appropriateness, feasibility and desirability.

The vision and values set out in the Strategic Plan remain relevant and have a good fit with NHS Lothian and West Lothian Council, encapsulating the purpose of the partnership. It is noted that the values require continuous reinforcement and promotion to support their practical demonstration.

The priorities and programmes outlined in the Strategic Plan are considered to be consistent with the refreshed needs assessment. Taking these priorities into delivery within localities (including emerging arrangements for Primary Care Clusters) is a developmental requirement and is aligned with ensuring explicit connection with the Community Planning Partnership regeneration plans.

Further opportunities for taking forward the Strategic Plan relate to the potential offered by multi-disciplinary and cross-sector working at a locality level together with wider engagement and participation at the locality level. In addition, there are opportunities to benefit from new technology, streamlining processes and sharing resources.

The first Annual Review of the Strategic Plan 2016-26 preserves stability in the plan and does not require a replacement plan. The first Annual Review confirms progress and reiterates and reinforces the direction set by the 2016-26 plan. The review up-dates and refreshes the policy drivers for the plan.

RESOURCING THE STRATEGIC PLAN
Under Scottish Government guidance, developed by the Integrated Resource Advisory Group (IRAG), the Strategic Plan should incorporate a medium term financial plan for the

resources within its scope.
The IJB in leading on the preparation of the Strategic Plan should set out the total resources included in each year of the plan. This is to be undertaken to ensure that there is appropriate resourcing and devolution of responsibility to deliver in line with the outcomes and priorities set out in the plan.

In keeping with the guidance cited above, NHS Lothian and West Lothian Council are expected to provide indicative three year allocations to the IJB which should be in line with the Strategic Plan. This rolling indicative allocation is subject to annual approval through the respective budget setting processes.

The final, detailed allocation to the IJB will be contingent on the budget setting process of the parent bodies and the indicative partnership budget is at this stage high-level and based on a number of financial planning assumptions. A revised detailed integrated budget will be presented to the IJB following the conclusion of this process. It should be emphasised that significant variance in the financial allocations from the parent bodies will impact on the ability of the IJB to commission services that deliver the Strategic Plan and require further review.

The IJB must be assured that the Strategic Plan and the resources available are, within the strategic context of NHS Lothian and West Lothian Council and consistent with the aims to:

- Improve the quality and consistency of services for patients, carers, service users and their families;
- Provide seamless, integrated, quality health and social care services in order to care for people in their homes, or a homely setting, where it is safe to do so; and
- Ensure resources are used effectively and efficiently to deliver services that meet the needs of the increasing number of people with long term conditions and often complex needs, many of whom are older.

HEALTH AND SOCIAL CARE DELIVERY PLAN
Commitment to providing a delivery framework for key programmes of work underpinning the 2020 Vision for health and social care was set out by the First Minister in October 2016. This followed on from the publication of the Audit Scotland report 'Changing Models of Health and Social Care' (10th March 2016).

The Health and Social Care Delivery Plan (published on 19th December 2016) addresses this central finding of the Audit Scotland report. The Delivery Plan reinforces the 2020 Vision of a Scotland with high quality integrated services, focused on prevention, early intervention and supported self-management. Where hospital care is required, day-based treatment should be the norm and people should be supported to remain or return home as soon as they are ready to do so.

The Delivery Plan shifts focus toward the 'triple aim' of *better quality* of care, *better health* through improved wellbeing and addressing inequalities over the life course, and *better value* through the sustainable and efficient use of available resources.

The aim of the Delivery Plan and the targeted programmes of work detailed within are to drive forward the pace of change in health and social care and to give strategic coherence to previously separate areas of policy, thereby bringing the focus required for transformational change.

The Delivery Plan clearly states that achieving sustainability in health and social care requires transformation and making best use of the totality of resources while continuing to meet current and emerging demand and cost pressures.

Appendix 2 sets out the draft West Lothian Health and Social Care Delivery Plan which takes account of the Strategic Plan review and the Scottish Government's Health and Social Care Delivery Plan.

It is intended to hold an IJB development session in June 2017 which will focus on the Health and Social Care Delivery Plan and transformational change required to support this.

APPROACH TO DIRECTIONS

Directions to partner bodies are required to meet statutory requirements and ensure there is accountability in terms of clearly setting out the functions / services and associated resources that will be delegated to Partners to operationally deliver health and care services to the West Lothian population.

In addition, operational and transformational change to service delivery will be set out in the West Lothian Health and Social Care Delivery Plan. This will set out the intentions for current year and future year delivery of health and social care services and the proposed means of achieving progress against overall health and social care delivery outcomes.

For governance it is important that there is clarity on the IJB delegated functions and services that NHSL and WLC are responsible for operationally carrying out on behalf of the IJB along with the associated resources, and that there is a means of formally recording this arrangement between the IJBs and Partners. Clarity on the governance arrangements and roles around the planning and delivery of delegated functions is a statutory requirement terms of directions as set out in 2014 Act below.

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Public Bodies (Joint Working) (Scotland) Act 2014 Section 26 – Where an integration authority is an integration joint board, it must give a direction to a constituent authority to carry out each function delegated to the integration authority.

A direction under section 26 must:

- *Must set out the amount which has been set aside by the Health Board for the use of the body who is to carry out the function*
- *Must, in any other case, set out, or set out a method of determining payments that are to be made by the integration authority to the body who is to carry out the function*
- *Must specify how such an amount or, as the case me be, such a payment is to be used*

IJB plans, informed through discussion with NHS and WLC service managers, in respect of operational service delivery performance and transformational change programmes will be set out in the West Lothian Health and Social Care Delivery Plan. This Plan will be issued to Partners in conjunction with the 2017/18 IJB Directions which note the requirement for all Partners to work together to implement the Delivery Plan. The Delivery Plan will form the basis of monitoring progress and performance in meeting operational and strategic objectives/outcomes.

The high level Directions for 2017/18 will be included within the IJB Financial Report to the Board. Regular review of performance against the West Lothian Health and Social Care Delivery Plan will be undertaken with Partner bodies and reported to the Board as part of the quarterly performance updates.

D CONSULTATION

Strategic Planning Group 2nd March 2017

E REFERENCES/BACKGROUND

- Public Bodies (Joint Working) (Scotland) Act 2014, and related statutory instruments and guidance
- Scottish Government Guidance and Advice - National Health and Wellbeing Outcomes: A framework for improving the planning and delivery of integrated health and social care services (February 2015)
- West Lothian IJB Strategic Plan 2016-2026
- Audit Scotland Report: Changing Models of Health and Social Care (10th March 2016)
- Health and Social Care Delivery Plan (19th December 2016)

F APPENDICES

1 Draft First Annual Review of the Strategic Plan 2016-26

2 Draft West Lothian Health and Social Care Delivery Plan

G SUMMARY OF IMPLICATIONS

Equality/Health	The report has been assessed as having little or no relevance with regard to equality or the Public-Sector Equality Duty. As a result, equality impact assessment has not been conducted.
National Health and Wellbeing Outcomes	All National Health and Well Being Outcomes
Strategic Plan Outcomes	All Strategic Plan Outcomes
Single Outcome Agreement	We live longer healthier lives and have reduced health inequalities Older people are able to live independently in the community with an improved quality of life
Impact on other Lothian IJBs	Co dependencies in relation to some NHS provisions.
Resource/finance	The Strategic Plan First Annual Review report is presented in line with Scottish Government published Strategic Planning, Commissioning and Finance Guidance. The report has implications for the IJB in relation to both finance and quality in relation to the need for the IJB to be assured that the indicative partnership budget is sufficient to deliver the outcomes and priorities set out in the Strategic Plan.

Policy/Legal	The Strategic Plan First Annual Review report is presented in accordance with legal requirement on the IJB to review the Strategic Plan on a periodic and regular basis, to involve the Strategic Planning Group in this review and to decide whether a replacement plan is required. The report also refreshes the Strategic Plan taking account of policy and legal change over the last year which has a direct bearing on the operation of the Partnership.
Risk	No new risk implications arise from this report. Strategic and financial risks for have already been identified and noted in the Risk Register.

H CONTACT

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24/02/2017

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West Lothian Integration Joint Board

Strategic Plan 2016-26

First Annual Review 2016-17

Foreword

We are pleased to introduce this first Annual Review of our Strategic Plan 2016-26 which set out the strategic vision and direction to deliver positive outcomes for the people of West Lothian.

This first Annual Review sees much stability in our Strategic Plan.

Our Vision remains: ***to increase wellbeing and reduce health inequalities across all communities in West Lothian***

The core partnership values set out in our plan remain stable and appropriate.

There have been important legislative and policy changes in the last year and this Annual Review reflects the key changes. These reinforce the priorities set out in our Strategic Plan and also require us to continue on our improvement journey.

Our refreshed needs assessment shows that inequalities continue to be a challenge for our residents, our communities and for us as a partnership. Everyone should have the highest level of wellbeing possible but significant differences in physical and emotional wellbeing exist within our communities. These significant inequalities were highlighted in our Strategic Plan 2016-26. Tackling inequalities must continue to motivate our action and we remain strongly committed to preventative outcome based approaches and to working together to prevent, mitigate and undo the factors that cause poverty and inequality.

The challenges we face cannot be underestimated. The constrained financial context in particular is something that all partners must face. Quality, safety and efficiency must be carefully balanced. We must also ensure sufficient investment in prevention.

Our Partnership is only as good as the people working in it and we would like to thank everyone involved for their dedication, compassion and creativity. Without this we would not have made the progress that we have over the last year.

Through 'thinking differently' about how we provide and commission care and support services we can create opportunities for redesigning how care and support is delivered and do this more efficiently together and in ways that fit more closely with our residents wishes.

By looking at the totality of resources we have and planning together for how we make best use of these we can continue to deliver continued progress over the coming year.

Danny Logue
Chair of Integration Joint Board

Jim Forrest
Chief Officer

1 Review of 2016-17

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 required new arrangements to be put in place for the delivery of integrated health and social care functions. As part of the integration process West Lothian Integration Joint Board (IJB) developed a Strategic Plan detailing how it will plan and deliver services to meet the adult care needs in local communities.

1.2 The Strategic Plan is required to include arrangements for the area of West Lothian to be divided into at least two localities, to be determined by the IJB, and for the Plan to include measures for strategic aspects of services to be delivered to those different localities.

1.3 West Lothian IJB Strategic Plan describes the strategic vision and direction for West Lothian IJB from 2016-2026 and builds on the real progress already made as a result of strong and effective joint working between West Lothian Council, NHS Lothian and partners.

1.4 The Strategic Plan 2016-26 was approved by the Integration Joint Board in March 2016.

1.5 This first Annual Review of our Strategic Plan 2016-26 seeks to ensure that the vision, outcomes and priorities are aligned with available resources and investments. The Strategic Plan also relates to how the range and quality of services required to deliver on the plan can be sustained within the allocated budget.

2.0 Vision Values & Outcomes

2.1 The IJB's vision is "**to increase wellbeing and reduce health inequalities across all communities in West Lothian"**

2.2 The values of the Health and Social Care Partnership align with those of both West Lothian Council and NHS Lothian. The values also encompass key features of the purpose of integration. The values of the Partnership are illustrated below.

2.3 In order to tackle the challenge of reducing the health inequalities gap in West Lothian, the IJB is strongly committed to the development of a preventative

outcomes-based approach, with an emphasis on effective early interventions to tackle social inequalities and improve wellbeing in communities.
To this end the strategy focuses on prevention, early intervention and collaborative working to ensure services are planned, co-ordinated and evaluated on the delivery of outcomes and resources are targeted to achieve the greatest impact on those most in need

2.4 The high-level outcomes set out in plan support delivery of the nine National Health and Wellbeing Outcomes; the health and well-being outcomes within the Single Outcome Agreement; and personalisation- enabling people to identify their own needs and make choices about how and when they are supported

2.5 The Strategic Plan 2016-26 identifies the need to transform how we work in order to deliver the positive outcomes linked to the vision of the Partnership and to manage the increasing demand within constrained resources.

3.0 Needs Analysis

3.1 The needs assessment underpinning our priority-setting for the Strategic Plan 2016-26 was completed on 2015/16 which identified major key issues:

- Ageing population
- Growing numbers of people live with disabilities, long term conditions, multiple conditions and complex needs
- Health inequalities

This has been extended to support a more thorough understanding of the needs of specific client groups which has informed our thematic Strategic Commissioning Plans for Older People, Learning Disability, Physical Disability, Mental Health and Alcohol and Drugs.

In addition, we have started to develop more detailed Locality Profiles which will be used to support Locality Planning.

3.2 West Lothian has many assets across its urban and rural communities and a rich history and culture. Marked inequalities remain between communities; this is reflected most starkly in differences of life expectancy between areas even a few miles apart with poor health and wellbeing outcomes strongly linked to deprivation. There is a direct association between inequality and heart disease, cancer and respiratory conditions and lifestyle choices such as diet, physical activity and smoking. Tackling inequality by taking action to prevent, mitigate and undo its causes remains a strategic priority.

4.0 Localities

4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 required the IJB to establish at least two localities within its area. The two localities selected for best fit with GP practices, datazones and multi-member ward areas are
• East (Linlithgow, Broxburn, Uphall, Winchburgh, Livingston and East Calder)
• West (Armadale, Blackridge, Blackburn, Bathgate, Whitburn, Fauldhouse and Breich Valley)

4.2 A Locality Development Event was held in 2016 to set the context and establish the East and West Locality Groups. The Groups are meeting regularly and taking forward the development of locality planning arrangements and are represented in all strategic commissioning processes and decision making. In support of the locality planning Locality Profiles are being developed and will link to the CPP regeneration

plans to ensure an integrated approach to planning and development.

5.0 Partnership Services

5.1 The scope of the plan includes all adult social care services, primary care and community health services, some adult acute services and some NHS Lothian Hosted services. These are fully detailed in our Strategic Plan 2016-26 and in the Integration Scheme.

5.2 Effective partnership working should result in good quality care and support for people and their carers and includes developing inclusive, mutually beneficial relationships that improve the quality and experience of care. This includes the relationships between individuals, their carers and service providers. It is also about relationships within and between organisations and services involved in planning and delivering health and social care in the statutory, independent and voluntary sectors.

5.3 The partnership also has a responsibility, with our local hospital services at St John's Hospital for planning services that are mostly used in an unscheduled way to ensure that we work across the health and care system to deliver the best, most effective, care and support. Service areas associated with unplanned use are included in the 'set aside' budget.

'Set aside' budget relates to strategic planning rather than day-to-day management. Key areas within the 'set aside' budget are: accident and emergency; inpatient services for general medicine, geriatric medicine, rehabilitation, cardiology and respiratory medicine. NHS Lothian are developing a Hospital Plan and the IJB will provide strategic direction to ensure these services are planned to meet the needs of the West Lothian Population.

6.0 Strategic Commissioning

6.1 The Strategy commits the IJB, working with partners, to
• Commission services which focus on prevention and early intervention and which enable people to live independently in their own homes where they chose to do so
• Empower people to live independently through applying the principles of personalisation in the way in which we commission services
• Undertake appropriate consultation and involvement with service users and their carers to achieve their agreed outcomes when commissioning services
• Engage positively with providers of health and social care services in the public, voluntary and private sector
• Adhere to relevant procurement legislation and guidance and ensure that services are commissioned in a way that is fair, transparent and open
• Ensure that quality, equality and best value principles are embedded through our commissioning processes.

6.2 Throughout 2016/17 we have undertaken comprehensive needs assessments for:

- Older People
- Mental Health
- Adults with Physical Disability
- Adults with Learning Disability

These needs assessments have in turn informed the development of thematic commissioning plans for these client groups which have been approved by the board.

6.3 In keeping with Scottish Government guidance, we will develop a Market Facilitation Plan in 2017 which will ensure there is diverse, appropriate and affordable provision available to meet needs and deliver effective outcomes both now and in the future based on a good understanding of need and demand. This will involve a collaborative

approach between the commissioning and procurement functions in health and social care, as well as those involved in housing, planning and community development and recognises the role that health and social care and support partners have in actively contributing towards economic growth in the West Lothian area, whilst creating employment opportunities for West Lothian residents.

7.0 Strategic Priorities

7.1 This First Annual Review of the Strategic Plan 2016-26 reaffirms the strategic priorities and programmes and considers these to be consistent with the refreshed needs assessments.

- Tackling Inequalities
- Prevention and early intervention
- Integration and coordinated care
- Managing our resources effectively

7.2 Achieving a sustainable health and care system for West Lothian requires transformational change over time to improve health and well-being outcomes and support transition to future models of care. This is being supported through managed change programmes such as the frailty programme, redesign of mental health services and developments in primary care.

8.0 Performance

8.1 Baseline performance has been mapped against the National Health and Wellbeing Outcome core suite of measures. Key operational scorecards have been put in place and are reported to the SPG and IJB.

Alongside this planning and performance leads have been working together to put in place performance reporting systems and operational management information.

9.0 Partnership Resources

9.1 The Partnership operates within a challenging financial context. This impacts on the mutual dependency of arrangements with West Lothian Council and NHS Lothian. Financial challenges across our parent bodies have significant implications for the IJB and the wider health and care economy.

Our Strategic Plan takes into account the current planned efficiency assumptions. Efficiency requirements are for a minimum of 3% year-on-year and reflect national expectations for the NHS in Scotland. This sits beside targeted funding of national priorities.

10.0 Governance

10.1 A range of appropriate governance arrangements have been put in place, including Clinical and Professional leadership; Audit and Risk Management; Performance Framework and Health and Care Governance

10.2 Further assurance is provided through the responsibility of the Chief Social Work Officer to report directly to the Council and the responsibility of the Health Leads to report directly to the Medical Director and the Nurse Director who in turn report to the NHS Board on professional matters.

Throughout the period the safe and effective delivery of services has continued;

10.3 Organisational development work has been taken forward to support integrated

working within multi-disciplinary teams and a workforce development plan has been drafted.

10.4 Community engagement has been progressed with development of a Participation and Engagement Plan which sets out the range of opportunities and methods for influencing strategic planning and service improvement.

11.0 Planning into the future

11.1 In refreshing our delivery plan we will take account of the requirements within the Health and Social Care Delivery Plan which focuses on

- Health and social care integration
- Building capacity in primary and community care
- The Six Essential Actions
- The National Clinical Strategy and 'Realistic Medicine'
- Public health improvement;
- Cross-cutting action on workforce planning, engagement and market facilitation

.

Appendix 2

West Lothian Health & Social Care Delivery Plan DRAFT

Our vision is…

To increase wellbeing and reduce health inequalities across all communities in West Lothian

We serve…

Population of West Lothian circa 180,000.

We are succeeding when…

- 5% Reduction in unplanned hospital admissions by 2019 against 2016 baseline
- Maintain unscheduled bed days (Acute Specialties) at average of 7769 per month
- Maintain the 4 hour 95% standard within A&E
- There are no people waiting more than two weeks for discharge from when they are ready (Standard Delays)
- Reduce standard Delayed Discharge Bed days by 10% compared to 2016 mean
- Improve End of Life Care & reduce proportion of time spent in large hospital setting in last 6 months of life to 10.5%
- Maintain 92% of People 75+ in the Community

The journey we need to take…

In 2016/17 we spent approx. £200.2m on current service model

- Episodic Care Model -focus on hospital services for specialist and acute care
- Duplication of assessments; complex care pathways
- Technology playing a limited role
- Limited OOH options contributing to unnecessary admissions e.g. 5 day service model in REACT & AHP
- NHS Lothian & WLC leading prioritisation and resource allocation
- Self management support in some services
- Carers have some support in their caring role

This needs to change because..

Demand on unscheduled hospital care is not sustainable; 5 day service models limit capacity to shift balance of care; Workforce supply is affecting ability to deliver care; Need to focus on prevention, early intervention and community based solutions

Our transformational journey

Priority changes

- Whole system Frailty Programme
- Whole system actions to reduce delayed discharges
- Support wider use of ACP
- Review Palliative Care provision
- Redesign Mental Health Services
- Embed Case Management
- Improve access and capacity of Primary Care
- Support locality development & community capacity
- Implement Care Home and Care at Home Contracts
- Technology Enabled Care Programme
- Implement new GMS contract
- Review referral pathways
- Integrate principles of *Realistic Medicine*
- Determine public health priorities and refresh health improvement plan

Long-term enablers

- Hospital Plan to support reconfiguration of beds and space utilisation
- IT systems to support clinical requirements
- Health and Social Care Workforce Development Plan
- Locality Plans
- Commissioning Plans
- Market Facilitation Plan
- Primary Care Development Plan
- Participation and Engagement Plan
- Culture & Values
- Partnership & team working
- Increased investment in Primary Care (move toward 11% of frontline NHS Budget)

Critical stakeholders: *Population in West Lothian, GP Practices, St Johns Hospital (A&E, Medical Directorate) Staff, NHS Lothian, West Lothian Council*

In 2019 we will spend *£200.8m on the following service model*

- More specialist acute care in community
- Integrated Health &Social Care model making best use of resources
- Increase availability of 24/7 working to support care delivery at home or in homely settings
- Work with partners and communities to co-design solutions & allocate resources
- Increase self management using personal outcomes approach
- Increase anticipatory and preventative approaches
- Further develop carer support and value contribution in caring role
- More effective use of technology

This is beneficial because…

Enhancing the availability of & access to services in the community will shift the balance of care: underpin prevention of admission, early supported discharge & provide support for planned & continuous care

West Lothian Health and Social Care Delivery Plan

HSCDP Programme Theme	National Actions/ Targets	Local Actions	Objectives	Performance measure	Timescale
1. Health and Social Care Integration					

1.1 Reducing inappropriate use of hospital services	• In **2017** ensure HSCPs act as 'key levers' in shifting the balance of care by making full use of powers to shift investment into community provision, reducing inappropriate hospital use and redesigning service provision across hospital and community settings.
	• In **2017**, agree plan for raising 'delayed discharge' performance to the top quartile as a step toward eliminating delayed discharges, reducing unscheduled hospital care and shifting resources into primary and community care.
	• By **2018**, reduce unscheduled bed-days in hospital care by up to 10 percent through reduced 'delayed discharge', admission prevention and reducing length of stay.
	• By **2021**, everyone who needs palliative care will get hospice, palliative or end of life care, supported by a 'Key Information Summary' for all, personalised plans and a doubling of palliative and end of life provision in the community.
		• Fully Implement Whole System Frailty Programme
		• Contribute to development of Lothian Hospital Plan
		• Implement actions across whole system to reduce Delayed Discharges
		• Identify where investment can be shifted to community setting through redesign programmes
		• Support wider use Anticipatory Care Planning
		• Review Palliative Care provision and develop plan to increase capacity
		• Establish Clinical Care Home Lead and work with practices to improve systems, processes and reviews
		• Implement Commissioning Plans
		  • Older People
		  • Mental Health
		  • Physical Disability
		  • Learning Disability
			To maintain unplanned admission rate, exploring further opportunities to prevent inappropriate admission and to look for improvements from 2018.
			
			To maintain unscheduled bed-days in hospital care by reducing delayed discharges, avoidable admissions and inappropriately long stays in hospital.
			
			Maximise proportion of people discharged from hospital within 3 days and achieve no delays beyond 14 days for standard delayed discharges
			
			Improve End of Life Care and reduce the proportion of time spent in large hospital in last 6 months of life to 10.5%
				Maintain Unscheduled Admissions at average of 1628 per month (all ages)
				
				Maintain Unscheduled Bed Days (acute specialties) at average of 7769 per month
				
				Reduce standard delayed discharge bed days by 10% compared to 2016 average
				
				The percentage of the last six months of life spent in large hospital to be no more than 10.5%
					2017/18
					
					2017/18
					
					2017/18
					
					2018/19

1.2 Shifting resources to the community	• By **2021**, HSCPs increase spending on primary care services to 11 percent of the frontline NHS budget.	• Develop and implement Primary Care Development Plan	Increase spending on primary care services to 11 percent of the frontline	Baseline spend	2020/21

			NHS budget		
1.3 Supporting the capacity of community care	• In 2017, take forward a programme of work to deliver change in the adult social care sector, together with COSLA and other partners including reform of the National Care Home Contract, social care workforce issues and new models of care and support in home care.	• Strengthen level of direct involvement in networks • Implement National Care Home Contract when agreed • Develop new models of care and support in the community	Implement Care Home Contract Increase capacity of care at home provision	Maintain 92% of people >75 to remain in their own home Maintain 7.2 % of people >75 to be supported in care home	2017/18
2. National Clinical Strategy					
2.1 Building up capacity in primary and community care	In **2017**, invest in recruitment and expansion of primary care workforce ANPs, practice access to advanced pharmacy, and paramedics. By **2018**, increased health visitor numbers with a continued focus on early intervention through the Universal Health Visiting Pathway. By **2020**, implementation of recommendations of Improving Practice Sustainability Working Group, the GP Premises Working Group and the GP Cluster Advisory Group – enhancing sustainability and links to HSCPs.	• Develop Workforce plan to deliver primary and community care • Develop agreement with SAS to support Primary Care • Work with Pharmacy to appoint advanced skilled pharmacists • Implementation of Universal Pathway • Support GP Cluster development	Increase capacity and capability in the primary care and community workforce Review care pathways to streamline access and service provision	Workforce profile HV activity to demonstrate 11 home visits and 3 reviews by 2020 Evaluate impact of changes in D&E pilot	2017/18
2.2 Supporting new models of care	In **2017**, negotiate new General Medical Services contract as basis for MDTs and clear GP leadership In **2017**, test and evaluate new models of primary care and share learning. In **2017**, launch Oral Health Plan. By **2018**, roll-out the Family Nurse Partnership programme.	• Implement New GMS Contract • Test models for change in Primary Care (D&E Pilot) • Develop Oral Health Plan for Lothian • Roll Out FNP programme	Increase capacity and capability in the primary care and community workforce Improve Oral Health provision with focus on prevention, early intervention & improvement	Evaluate impact of changes in D&E pilot TBC	2017/18
2.3 Reducing unscheduled care	In **2017** roll out of the Unscheduled Care Six Essential Actions. In **2017** complete a survey of admission and referral avoidance opportunities to inform model for	• Inpatient redesign through Frailty programme • Roll out Discharge to Assess model	To maintain unplanned admission rate, exploring further opportunities to prevent inappropriate admission and to look for	Maintain Unscheduled Admissions at average of 1628 per month (all ages)	2017/18

	reducing unscheduled care through integrated working.	• Maximise Weekend Discharge • Support Case management approaches	improvements from 2018. To maintain unscheduled bed-days in hospital care by reducing delayed discharges, avoidable admissions and inappropriately long stays in hospital. Maximise proportion of people discharged from hospital within 3 days and achieve no delays beyond 14 days for standard delayed discharges	Maintain Unscheduled Bed Days (acute specialties) at average of 7769 per month Reduce standard delayed discharge bed days by 10% compared to 2016 average	2017/18 2017/18
2.5 Improving outpatients	By **2020**, reduction in unnecessary attendances and referrals to outpatient services through the Modern Outpatient Programme. Reducing the number of hospital-delivered outpatient appointments by 400,000, reversing the rise in new appointments.	• Review Referral Pathways • Implement Technology Enabled Care Programme	Establish baseline for referral rates and set improvement targets Evaluate impact of technology enhanced care programme	Reduce unnecessary attendances and referrals for outpatient services	2017/18
2.7 Reducing the unnecessary cost of medical action	By **2018**, integrating principles of realistic medicine into the core of learning and professional practice. By **2019**, put in place a Single National Formulary to tackle health inequalities and reduce variation in medicine use and cost (including overall cost).	• Increase awareness and discussion on 'realistic medicine' principles at corporate level and professional lead level	Demonstrate change in prescribing practices Establish baseline for referral rates and set improvement targets	Reduce prescribing costs Reduce unnecessary hospital referrals/ admissions	2017/18
3. Public health improvement					
3.1 Supporting national priorities	• In **2017**, develop consensus on national public health priorities, with SOLACE and COSLA, to direct public health improvement work locally, regionally and nationally. • By **2019**, develop a single, national health improvement body to strengthen leadership.	• Work with Public Health/HIAHI to determine public health priorities	Establish priorities for action Establish inequalities indicators in conjunction with public health and CPP and determine baseline	Baseline Inequalities Indicators	2017/18

	By **2020**, set up local joint public health partnerships between local authorities, NHS Scotland and others to delivery national public health priorities.				
3.2 Supporting key public health issues	In **2017**, ongoing delivery of targets in 'Creating a Tobacco Free Scotland' (reducing smoking rates to less than 5 percent by 2034, implement legislation on second-hand smoke, hospital grounds. In **2017**, refresh the Alcohol Framework including minimum unit pricing. In **2017**, consult on a new diet and obesity strategy. In **2017**, introduce Active and Independent Living Improvement Programme regarding living well, physical activity, self-management and living independently. By **2021**, deliver Maternal and Infant Nutrition Framework focusing on improving early diet choices and health improvement in the earliest years	• Work with Public Health/HIAHI to determine public health activities in support of reducing harmful lifestyle behaviours and deliver positive outcomes • Promote Alcohol Brief Interventions within primary and community care • Review ADP Commissioning Plan	Establish improvement targets for • Smoking Prevalence • Obesity prevalence • Alcohol related admissions • Breastfeeding rates	Smoking Prevalence Obesity prevalence Alcohol related admissions Breastfeeding rates	2017/18
3.3 Supporting mental health	By **2018**, improve access to mental health support, e.g., computerised CBT By **2019**, evaluation of effective and sustainable models primary care mental health and roll out. By **2020**, improve access to mental health services including Child and Adolescent Mental Health	• Redesign all adult mental health services • Implement Mental Health Commissioning Plan • Develop collaborative across all sectors to support access	Improve access and delivery of mental health services to ensure effective and sustainable delivery	TBC	2017/18
3.4 Supporting a More Active Scotland	In **2017**, produce new delivery plan to support the Active Scotland Outcomes Framework and the Vision for a More Active Scotland. By **2019**, embed National Physical Activity Pathway in clinical settings	• Promote physical activity interventions to enhance well being and support health improvement in long term conditions	TBC	TBC	2018/19
4. Cross-cutting actions	National Health and Social Care Workforce Plan	Develop integrated health and social care workforce development plan	Ensure staff have the skills competencies and training to support new	Workforce structure, capacity plans	2017/8

			ways of working		
	Engagement	Implement participation and engagement plan	Ensure active engagement and participation in the development of new models of care and service redesign		2017/18
	Locality Planning	Locality profiles Develop locality plans	Ensure localities/ communities influence strategic planning and that developments are suited to local needs	Locality Plans	2017/18
	Market Facilitation	Develop Market Facilitation Plan	Ensure there is diverse, appropriate & affordable provision available to meet needs and deliver effective outcomes based on a good understanding of need and demand	Market Facilitation Plan	2017/18

WEST LOTHIAN INTEGRATION JOINT BOARD

Date: 14 March 2017

Agenda Item: **7**

PRIMARY CARE PREMISES REPORT

REPORT BY DIRECTOR

A PURPOSE OF REPORT

The purpose of this report is to set out the Primary Care premises priorities for West Lothian and to recommend actions to adjust the existing Infrastructure to support the needs of the steadily growing West Lothian population.

B RECOMMENDATION

. *The Integration Joint Board is asked to*

1. *Note the contents of the report*
2. Note the progress made in developing new premises and refurbishing existing premises to increase physical capacity for primary care and community service provision.
3. Approve the Primary Care premises priorities for West Lothian and actions required to match Primary Care infrastructure to population growth including:
    a. Development of new Health Centre premises in East Calder
    b. Development of an additional GP practice in new building in Armadale
    c. Refurbishment of Whitburn Health Centre
    d. Progress the established development of Blackburn Partnership Centre to implementation in September 2017.
4. Recognise that premises, GMS income and associated funding streams are only part of the community service capacity which needs to be developed. This work needs to come together with the workforce planning for all associated disciplines.

C TERMS OF REPORT

POPULATION AND HOUSING

The total number of households in West Lothian is projected to change from 75,035 in 2014 to 87,436 in 2039, which is an increase of 17 per cent. In Scotland as a whole, the projected number of households is set to increase by 14 per cent over the same 25 year period.

Over the same period the population of West Lothian is planned and expected to grow by approximately 15,323 which is equivalent to 2.8 average sized GP practices

	2014	**2019**	**2024**	**2029**	**2034**	**2039**
Total number of households	75,035	78,406	81,250	83,714	85,777	87,436
Population projections	177,200	181,188	184,974	188,169	190,657	192,523
Table 1: Source National Records of Scotland Demographic Factsheet (January 2017)						

West Lothian Council is at an advanced stage in replacing the West Lothian Local Plan with a new Local Development Plan (LDP). Preparation of LDPs is a statutory requirement under the Planning (Scotland) Act 2006 and Development Planning Regulations 2008 and Scottish Government, through Scottish Planning Policy 2014, promotes a plan-led system to assist in the delivery of development that contributes towards economic growth.

The council has published their Proposed Plan which sets out the council's settled view as to where most new development should take place (and where it shouldn't). It gives an indication as to when development is anticipated to be delivered, informs decisions on investment in infrastructure e.g. schools and roads, and sets out the policies that will be used to inform decisions on planning applications. It will be reviewed every five years to ensure an up to date plan is in place to guide future development in the area. The LDP covers the ten year period from 2014 to 2024 but it also sets out a longer term planning strategy for West Lothian.

A key component of the spatial strategy is the need to allocate land for housing development. In order to provide adequate land to meet future housing needs, and having regard to housing projections and the Scottish Government's policy of providing a generous supply of land for housing, the key housing objectives for the LDP are to

- Direct growth to places where it will support sustainable development goals, community regeneration;
- Ensure that necessary social and physical infrastructure accompanies growth;
- Allow for a range of house types and sizes across all sectors;
- Achieve and maintain a minimum of 5 years effective housing land supply in each of the sectors identified in the current housing needs and demand assessment;
- Have regard to significantly increased demand for rented housing; and
- Deliver affordable housing, particularly in the areas of highest demand.

The scale of housing development proposed in the LDP is set by the approved South East Scotland Strategic Development Plan and its associated Supplementary Guidance for Housing (SG). The housing land requirement for West Lothian is identified as providing for a minimum of 18,010 houses over the period 2009 to 2024.

This is well above the NRS projections outlined in table 1 and if completed would lead to potential population growth by 2024 of 39,081 – equivalent to 7 new GP practices

NHS CAPITAL PLANNING

The development, procurement and implementation of capital and revenue funded projects across NHS Lothian are managed through the Capital Planning and Projects Team. The team are responsible for the development of business cases for the programme of major new acute and primary care facilities, management of the Board's capital equipment replacement programme and the on-site management of strategic projects following appointment of designers and contractors.

The Lothian Capital Investment Group (LCIG) is chaired by the Director of Finance and made up of representatives from across the Board. LCIG considers bids for capital projects and their recommendations are either approved under delegated authority or recommended for consideration by the Board's Finance & Performance Review (F&R) Committee.

Infrastructure projects are required to comply with the terms of the Scottish Capital Investment Manual (SCIM). This applies to both capital schemes and schemes using third party developer funding or other ways of providing premises for independent contractors.

Depending on the value of the scheme, the stages – each of which need to submit to governance - are:

- Strategic Assessment
- Initial Agreement
- Standard Business Case (within delegated limits, i.e. <£5m) or
- Outline Business Case then Full Business Case if > £5m.

Schemes greater than £5m require Scottish Government approval at each stage, in addition to that of NHS Lothian and the Integrated Joint Board. The time to get through this can be considerable and pragmatic and helpful decisions will be required at times to avoid the consequences of delays which may threaten service provision.

For smaller projects under £250K applications can be made through the Capital Funding Pipeline and West Lothian has benefitted from this funding source in refurbishment schemes for some of our older Health Centre premises.

PRIMARY CARE INFRASTRUCTURE

To date Primary Care Infrastructure development has been driven by a response to the poor state of existing premises, the capacity of individual practices to raise awareness of their particular issues and the opportunities created by sites becoming available. The linkage of premises development to population growth was previously largely opportunistic and not always adequate.

Population growth in the core development areas together with difficulty in recruiting GPs to replace those retiring/ leaving is having significant impact on General Practices and their capacity to manage the demand. In addition to adjusting premises infrastructure we are supporting development of new roles and partnership working to manage capacity issues and support provision of primary care.

Whilst it is noted that the Local Development Plan requires developers to make contribution to the infrastructure to support population growth this is currently used to develop schools and roads etc and does not extend to health care provision

The Scottish Government review of Primary Care Premises is due to report and it is anticipated that this may give a strengthened role in premises provision and management to the NHS/IJBs.

Independent contractors' views on their practice size, the suitability of their buildings and their location may vary from other assessments and there is no mechanism to oblige an independent practice to move or grow.

In 2014 we assessed all of the West Lothian Primary Care premises against the following criteria to determine priorities for development.

- Physical Condition of existing premises
- Functional Suitability of existing premises
- DDA / Statutory Compliance
- Control of Infection Compliance
- Deprivation
- Practice Population Growth
- Potential Future Practice Population Growth
- Joint Development Opportunity
- Site Development Opportunity

From this the former CHCP agreed a list of priorities and actions. The Primary Care Premises Plan (appendix 1) has been refreshed to update progress against these.

PRIORITY DEVELOPMENTS

Blackburn Partnership Centre build is in progress and due to complete in September 2017.

The Calderwood development is impacting on capacity within East Calder Health Centre. The GP practice have indicated willingness to grow to accommodate the population growth however the existing premises are too small and not fit for purpose. LCIG provided resources to support preparation of plans and discussions are being progressed with West Lothian Council to identify development options preferably adjacent to the new partnership centre which is being built next to the existing Health Centre. Initial Agreement is being progressed for approval.

The Southdale development in Armadale is having a major impact on the existing GP practice who have recently placed restrictions on their list with corresponding impact now on neighbouring practices. LCIG provided resources to support preparation of plans and discussions are being progressed with the developer at Southdale regarding site availability and procurement. Initial Agreement is being progressed for approval.

Winchburgh core development is being progressed and population growth is having impact on existing Primary Care provision. The health centre is small and landlocked with little development potential. The LDP has a site set aside within the plan for health and social care development. The practice has recently merged with Kirkliston to form new GP practice. There is also significant housing development in Kirkliston and the premises there are modern with room for expansion. Discussions are being progressed with the practice to determine future requirements.

The Heartland Development in Whitburn is in progress and the GP practice is now seeing growth in their population. The Health Centre has potential for refurbishment and we have engaged architects to draw up plans to reconfigure the internal space which will enable creation of 6 additional consulting rooms and 2 interview rooms. The cost of this development will be in the region of £150- 200K and application will be made to the Capital Pipeline to resource this. There are also site issues in relation to traffic management and plans have been approved to create additional parking and turning for liveried vehicles to rear of building to manage the health and safety risks on site.

Summary
Population growth due to new housing has been estimated; these figures will be locality sensitive and will be adjusted and refined annually. Accordingly, the premises plan is only recommending capital investment where there is a known substantial population increase and/or the urgent requirement to renew existing premises.

The provision of Primary Care infrastructure is moving from an opportunistic approach to deliberate planning in parallel with West Lothian's Local Development Plan. Although the LDP offers a very helpful guide to expansion, it does not account for the cumulative development of small schemes nor associated timescales. This means we have to be able to respond to a more complex picture than that indicated by the plan alone and be mindful of the impact of population growth and subsequent demand on GP practices who may in turn require a range of additional support to maintain service provision.

Whilst we await the report from the Scottish Government review of Primary Care Premises it is anticipated that this may strengthen the role of the NHS/IJBs in primary care premises provision and management.

D CONSULTATION

NHS Lothian Capital Planning Team

Primary Care and Community Forum

E REFERENCES/BACKGROUND

Scottish Capital Investment Manual

F APPENDICES

1. Primary Care Premises Plan

G SUMMARY OF IMPLICATIONS

Equality/Health	Rapid Impact Assessment has been undertaken which highlighted the risks associated with any new population being unable to access a GP list or appointments are thought to be greater for areas of widespread economic deprivation. The consequences of substantial numbers of the population by-passing Primary Care Services would be increased pressure on Acute and other direct access health and social care service
National Health and Wellbeing Outcomes	All National Health and Well Being Outcomes
Strategic Plan Outcomes	Underpins all Strategic Plan Outcomes
Single Outcome Agreement	We live longer healthier lives and have reduced health inequalities Older people are able to live independently in the community with an improved quality of life
Impact on other Lothian IJBs	Co dependencies on NHS Lothian Capital Planning and Projects Team and competing priorities for investment
Resource/finance	NHS Lothian Capital Resources
Policy/Legal	Compliance with the terms of the Scottish Capital Investment Manual
Risk	Impact on access for patients to primary care services and additional pressure on whole system

H CONTACT

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6th March 2017

Appendix 1: Primary Care Premises Plan (Revised January 2017)			
Location	Priority	Plan	Comments
Armadale & Armadale Clinic	1	Re-provision with increased capacity	HubCo drafted plan Negotiation with Southdale developer re site availability and procurement Progressing Initial Agreement for approval
East Calder	2	Re-provision with increased capacity	HubCo drafted plan Negotiation with West Lothian Council re site availability Progressing Initial Agreement for approval
Blackburn	3	Re-provision with increased capacity	New Build in progress due to open September 2017
Linlithgow	4	Expansion or re-provision	Refurbishment completed to increase clinical capacity and improve space utilisation 2016
Winchburgh	5	Re-provision with increased capacity	Discussion with Practice re requirements following merger with Kirkliston
Carmondean	6	Refurbishment to increase clinical capacity and space utilisation	Refurbishment completed 2016
Dedridge	7	Refurbishment to increase clinical capacity and space utilisation and meet DDA/HAI standards	Refurbishment completed 2016
Whitburn	8	Refurbishment to increase clinical capacity, improve space utilisation and meet DDA/HAI standards	Architect Plans developed Application for Capital Pipeline 2017/18
Murieston	9	Re-provision with increased capacity	GP developed new premises: Opened 2016
Craigshill	10	Refurbishment to increase clinical capacity, improve space utilisation and meet DDA/HAI standards	Draft plans 2017/18
Boghall	11	Determine future use of building	Exploring options for future use
Bathgate	12	Maintenance in accordance with Lease	Modern Facility (2001)
Howden	13	Refurbishment to increase clinical capacity, improve space utilisation and meet DDA/HAI standards	Completed refurbishment 2014
Kirkliston	14	Maintenance in accordance with Lease	Modern Facility (2003) Discussion with Practice re requirements following merger with Winchburgh
Blackridge	15	Maintenance as required	Refurbishment to increase clinical capacity and space utilisation and meet DDA/HAI standards completed 2004
Stoneyburn	16	Maintenance as required	Refurbishment to meet DDA/HAI standards completed 2015
Fauldhouse	17	Maintenance in accordance with Lease	Modern Facility (2013)
Strathbrock	18	Maintenance in accordance with Lease	Modern Facility (2002)
West Calder	19	Maintenance in accordance with Lease	Modern Facility (2013)

West Lothian Integration Joint Board

Date: 14 March 2017
Agenda Item: **8**

MEMBERSHIP REVIEW

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To review membership of the Board, the Strategic Planning Group (SPG) and the Audit Risk & Governance Committee.

B RECOMMENDATION

1. To note the current membership of the Board, the SPG and the committee (Appendix 1)

2. To note the statutory guidance in relation to the role of the third sector interface (West Lothian Voluntary Sector Gateway) in the integration of health and social care

3. To agree to one representative of the West Lothian Voluntary Sector Gateway, to be chosen by it, becoming a non-voting member of the Board

4. To agree to one representative of the West Lothian Voluntary Sector Gateway, to be chosen by it, becoming a member of the SPG

5. To otherwise note that there are places in the membership of the SPG to be filled and to consider how to do so

6. To agree in principle, despite the statutory barrier to committee membership for non-Board members, that wider participation and involvement at the Audit Risk & Governance Committee is desirable

7. To instruct officers to explore ways in which that might be achieved and to report back to the Board accordingly

8. To consider if there are other changes that should be explored in relation to membership of the Board, the SPG and the Board's committees

C TERMS OF REPORT

1 Background

1.1 Membership of the Board, the SPG and committees set up by the Board is controlled by statutory rules. Appendix 1 shows current appointments and the relevant categories of membership for each.

1.2 The Board and the SPG had previously asked for their membership to be brought back for review at a future Board meeting. The Audit Risk & Governance Committee has asked officers to consider what steps could be taken to widen participation at that committee.

1.3 There are some categories of membership for the SPG which are not yet represented there.

2 The Gateway

2.1 The West Lothian Voluntary Sector Gateway (the Gateway) is the third sector interface for West Lothian recognised by the Scottish Government. It has a key role in representing sectoral interests, facilitating communication with the sector and influencing policy and planning that affects voluntary organisations. Formal involvement would strengthen the work of the board and the SPG.

2.2 At the time when the Board was established in 2015, it was agreed that West Lothian Leisure would represent the third sector on the Board. Given its key role in preventing West Lothian people from developing health and social care issues, this is a positive relationship and there is no suggestion that this should change.

2.3 However, following officer level discussions with the Gateway, it is proposed that representation of the third sector is strengthened by inviting the Gateway to provide a non-voting member to sit on the Board and also to provide an additional member of the Strategic Planning Group (SPG).

2.4 There is statutory guidance in place which sets out the expected role of the third sector interface in the integration of health and social care and their involvement in these two bodies would be in accord with that guidance.

2.5 It should be noted that the Gateway already has a representative on the Board's East Locality Plan Development Group. The sector is represented by the Chief Executive of the Citizen's Advice Bureau on the West Locality Plan Development Group.

2.6 The Board has the statutory power to appoint such additional non-voting members to the Board and the SPG as it sees fit. Any additional member of the Board would have to comply with rules about disqualification from membership and the Board's Code of Conduct.

3 Audit Risk & Governance Committee

3.1 Membership of committees of the Board is restricted by law to Board members. The Audit Risk & Governance Committee has recommended that participation of non-Board members at that committee be facilitated in some other way.

3.2 The recommendation was based on the principle that scrutiny by the committee of the Board's activities should be as thorough and rigorous as possible and that this could be assisted by drawing on the expertise and experience of those who do not sit as Board members, either voting or non-voting. It is recognised in general terms that independence and objectivity are valuable elements in the scrutiny arrangements for any public body. The council for example has appointed a non-councillor member to its Audit & Governance Committee.

3.3 Although non-Board members cannot be appointed as full members of a Board committee, participation could be achieved by some other means, for example by their appointment as advisers or associate members. They would not be able to move motions or amendments or to vote but could be given access to papers in the same way as committee members. The Code of Conduct would not apply directly to them but if appointed their appointment could be made conditional on them agreeing to abide by the requirements of the Code in relation to general conduct and dealing with conflicts of interest at committee meetings.

D CONSULTATION

Audit Risk & Governance Committee

E REFERENCES/BACKGROUND

Public Bodies (Joint Working) (Scotland) Act 2014 and related statutory regulations

The Role of the Third Sector Interfaces, Scottish Government, 2015 - http://www.gov.scot/Publications/2015/04/2089

F APPENDICES

1. Membership rules and current membership

G SUMMARY OF IMPLICATIONS

Equality/Health	The proposed widening of participation and membership in the work of the IJB has the potential to strengthen equality and health outcomes
National Health and Wellbeing Outcomes	The recommendation is consistent with national mental health and wellbeing outcomes
Strategic Plan Outcomes	The recommendations are consistent with the Integration Scheme and the Strategic Plan
Single Outcome Agreement	The Gateway is a key community planning partner; the recommendation is consistent with the SOA
Impact on other Lothian IJBs	None

Resource/Finance	None
Policy/Legal	Public Bodies (Joint Working) (Scotland) Act 2014 and related statutory requirements and guidance
Risk	None

H CONTACT

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James Millar, Standards Officer, james.millar@westlothian.gov.uk, 01506 281613

14 March 2017

APPENDIX 1

BOARD MEMBERSHIP

Voting members	
Four members appointed by health board	Susan Goldsmith, Martin Hill, Alex Joyce, Lynsay Williams
Four members appointed by council	Danny Logue, John McGinty, Anne McMillan, Frank Toner
Non-voting members	
Director (Chief Officer) (appointed by IJB)	Jim Forrest
Chief Social Work Officer (appointed to post by council)	Jane Kellock
Finance Officer (Section 95 Officer) (appointed by IJB)	Patrick Welsh
GP Representative (appointed by health board)	Elaine Duncan
Secondary Medical Care Practitioner (appointed by health board)	James McCallum
Nurse Representative (appointed by health board)	Mairead Hughes
Third sector (appointed by IJB)	Robin Strang
Service user (appointed by IJB)	Ian Buchanan
Carer (appointed by IJB)	Mary-Denise McKernan
Staff (appointed by IJB)	Jane Houston (or Martin Murray)
Such other members as IJB sees fit	Martin Murray (or Jane Houston) (staff)

STRATEGIC PLANNING GROUP MEMBERSHIP

Health professionals (and from health board)	Carol Bebbington, Elaine Duncan, Steven Haigh, Mairead Hughes, Jim Forrest
Social care professionals (and from council)	Alan Bell, Jane Kellock, Charles Swan
Users of health care	Vacant
Carers of users of health care	Vacant

Commercial providers of health care	Vacant
Non-commercial providers of health care	Jacquie Campbell, James McCallum
Users of social care	Ian Buchanan
Carers of users of social care	Mary-Denise McKernan
Commercial providers of social care	Robert Telfer
Non-commercial providers of social care	Pamela Main
Non-commercial providers of social housing	Alistair Shaw
Third sector bodies carrying out activities related to health care or social care	Robin Strang
Representative from each locality	Vacant
Public Health, NHS Lothian (and Public Dental Service)	Margaret Douglas (Robert Naysmith)
Staff	Jane Houston, Martin Murray

SPG Statutory membership requirements

1. At least one person nominated by the Health Board
2. At least one person nominated by the local authority
3. One person in respect of designated groups, being:-

- health professionals (operating in West Lothian)
- users of health care (residing in West Lothian)
- carers of users of health care (caring for someone residing in West Lothian)
- commercial providers of health care (operating in West Lothian)
- non-commercial providers of health care (operating in West Lothian)
- social care professionals (operating in West Lothian)
- users of social care (residing in West Lothian)
- carers of users of social care (caring for someone residing in West Lothian)
- commercial providers of social care (operating in West Lothian)
- non-commercial providers of social care (operating in West Lothian)
- non-commercial providers of social housing (operating in West Lothian)

- third sector bodies (operating in West Lothian and carrying out activities related to health care or social care, includes representative groups, interest groups, social enterprises and community organisations

4. One person to represent the interests of each locality set out in the plan
5. Such other persons as the integration authority considers appropriate

AUDIT RISK & GOVERNANCE COMMITTEE

Two voting health board appointed IJB members	Martin Hill, Lynsay Williams
Two voting council appointed IJB members	John McGinty, Anne McMillan
Two non-voting IJB members	Jane Houston, Martin Murray

West Lothian Integration Joint Board

Date:14 March 2017
Agenda Item: **9**

RISK MANAGEMENT POLICY AND STRATEGY

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To advise the Integration Joint Board (IJB) of the Risk Management Policy and Risk Management Strategy.

B RECOMMENDATION

1. To approve the Risk Management Policy.

2. To approve the Risk Management Strategy.

C TERMS OF REPORT

A risk management policy is an essential element of an effective system for managing risks. The proposed IJB Risk Management Policy is attached as an appendix.

The Policy defines risk as being the effect of uncertainty on the ability of an organisation to achieve its objectives. The IJB's stated policy is to effectively mitigate risks to the achievement of its objectives by implementing robust risk management strategies, policies and procedures.

The Risk Management Strategy sets out how the IJB will implement the Risk Management Policy and is also attached as an appendix. The Strategy includes provision for the approval of policy, strategy and procedures, and for the review of the risk register by the IJB and the Audit, Risk and Governance Committee at regular intervals. Responsibilities in relation to risk management are set out in the appendix to the Strategy.

D CONSULTATION

IJB Senior Management Team.

E REFERENCES/BACKGROUND

None.

F APPENDICES

1. Risk Management Policy

2. Risk Management Strategy

G SUMMARY OF IMPLICATIONS

Equality/Health	The report has been assessed as having little or no relevance with regard to equality or the Public Sector Equality Duty. As a result, an equality impact assessment has not been conducted.
National health and Well-Being Outcomes	Effective risk management is a pre-requisite for effective performance.
Strategic Plan outcomes	Effective risk management is a pre-requisite for effective performance.
Single Outcome Agreement	Effective risk management is a pre-requisite for effective performance.
Impact on other Lothian IJBs	None.
Resource/finance	None.
Policy/Legal	The report asks for approval of the IJB risk management policy and strategy.
Risk	A risk management policy and strategy are essential elements of an effective system for managing risks.

H CONTACT

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14 March 2017

WEST LOTHIAN INTEGRATION JOINT BOARD

RISK MANAGEMENT POLICY

1. Risk can be defined as the effect of uncertainty on an organisation's objectives. West Lothian Integration Joint Board defines risk as those threats, opportunities or unexpected events that may affect its ability to achieve its corporate objectives.

2 The Integration Joint Board recognises that effective risk management is a key component of its governance processes. The Integration Joint Board's policy is to effectively mitigate risks to the achievement of its objectives by implementing robust risk management strategies, policies and procedures, which enable managers to effectively identify, assess, and mitigate risk.

3 The Integration Joint Board's risk register sets out the high level risks to its objectives and identifies the officers responsible for managing these risks. The risk register includes key controls and risk actions designed to mitigate these risks. Assigned officers ensure that the risk register is kept up to date for risks, key controls and risk actions.

4 Risk appetite may be defined as the amount of risk that an organisation is willing to accept, in the pursuit of its strategic objectives. The Integration Joint Board shall approve a risk appetite statement which sets out the IJB's attitude to risk.

5 The Integration Joint Board's operational risks are managed on its behalf by West Lothian Council and NHS Lothian. The Integration Joint Board monitors risk management arrangements within West Lothian Council and NHS Lothian and satisfies itself that effective risk management arrangements are in place within these organisations.

6 In relation to the management of residual risk, i.e. after key controls have been implemented, West Lothian Council and NHS Lothian are expected to ensure that where appropriate, effective insurance arrangements are in place.

14 March 2017

WEST LOTHIAN INTEGRATION JOINT BOARD

RISK MANAGEMENT STRATEGY

14 March 2017

1. INTRODUCTION

1.1 The West Lothian Integration Joint Board has approved a risk management policy which sets out its approach to the management of risk.

1.2 This strategy sets out how the Integration Joint Board implements the risk management policy objectives.

2 RESOURCES AND RESPONSIBILITIES

2.1 The Integration Joint Board, through its Director, shall ensure that sufficient resources are deployed to effectively identify, manage and mitigate risks to its objectives.

2.2 Responsibilities in relation to risk management are set out in this strategy and are summarised in the appendix.

3 POLICIES, STRATEGIES AND PROCEDURES

3.1 The Integration Joint Board approves the risk management policy and strategy. The Integration Joint Board shall be invited to review and approve the risk management policy and strategy at least once every four years.

3.2 The operation of the risk management policy and strategy shall be reviewed periodically for effectiveness by the Audit, Risk and Governance Committee.

3.3 Standard procedures for assessing and managing risks shall be developed by the Integration Joint Board's Risk Manager which shall be authorised by the Integration Joint Board Senior Management Team.

3.4 The risk management procedures shall provide for material risks to the Integration Joint Board's objectives to be correctly identified, consistently assessed and effectively managed.

4 RISK APPETITE

4.1 The Integration Joint Board shall approve a risk appetite statement which sets out its attitude to risk and which shall be used to inform its decision making.

4.2 The operation of the risk appetite statement shall be reviewed periodically for effectiveness by the Audit, Risk and Governance Committee.

5. RISK MANAGEMENT

5.1 The Integration Joint Board shall maintain a risk register which documents material risks to the achievement of its objectives. The risk register shall contain sufficient detail to determine:

- the nature of the risk, including the harm that may arise should the risk crystallise;

- the risk owner, and also the person with day to day responsibility for managing the risk, if different;
- the inherent risk score, which is an estimate of the risk before applying control measures;
- the current risk score, which is an estimate of the risk with current controls in place;
- the target risk score, which takes cognisance of the approved risk appetite statement and may be the same or lower than the current risk;
- details of the control measures currently in place to mitigate the risk;
- where appropriate, actions which are planned or in progress to reduce the current risk further.

5.2 It is the responsibility of the Director to ensure that the risk register is kept up to date and is an effective tool for the management of risk.

5.3 The Senior Management Team shall review the risk register every two months to determine whether any changes need to be made to the risks, their scores, control measures or risk actions. In reviewing the risks, the Senior Management Team shall have regard to the IJB strategic plan, and matters such as financial planning, complaints, health and safety, emergency planning, and business resilience.

6 REVIEW OF THE RISK REGISTER

6.1 The Integration Joint Board shall review the risk register annually and may review the risk register more frequently if it considers necessary. The Integration Joint Board may specify the format of the reports and the information it wishes to review.

6.2 The Audit, Risk and Governance Committee shall review the risk register at least twice per annum and may review the risk register more frequently if it considers necessary. The Audit Risk and Governance Committee may specify the format of the reports and the information it wishes to review.

7 INTERNAL AND EXTERNAL AUDIT

7.1 The Integration Joint Board has appointed an Internal Auditor who prepares a risk based internal audit plan. The risk based internal audit plan is approved by the Audit, Risk and Governance Committee.

7.2 All internal and external audit reports shall be submitted to the Audit, Risk and Governance Committee for its consideration.

7.3 Internal and external audit recommendations shall be entered into the risk register as risk actions in accordance with procedures authorised by the Senior Management Team. Progress in implementing such risk actions shall be reported to the Senior Management Team. Progress shall also be reported to the Audit, Risk and Governance Committee annually, or more frequently should the Committee require.

7.4 Protocols shall be developed for the sharing of relevant internal audit reports between the NHS Lothian internal audit service and the four Lothian IJB's.

8 ANNUAL REPORT

8.1 The internal auditor shall submit an annual report which includes an opinion on the Integration Joint Board's framework of governance, risk management and control. This shall be considered by the Audit, Risk and Governance Committee.

9 TRAINING

9.1 In order to ensure that risks to the Integration Joint Board's objectives are effectively managed, all participants must understand their role in relation to the management of risks. The Senior Management Team will regularly review risk management training and development needs and source any training required.

APPENDIX

RESPONSIBILITIES IN RELATION TO INTEGRATION JOINT BOARD RISK MANAGEMENT

West Lothian Integration Joint Board

- approves the risk management policy, the risk management strategy, and the risk appetite statement;
- reviews the risks included in the risk register.

West Lothian Integration Joint Board Audit, Risk and Governance Committee

- reviews the risk management policy, the risk management strategy and the risk appetite statement;
- reviews the risks included in the risk register and considers progress in mitigating risks;
- approves the annual risk based internal audit plan;
- considers reports from the internal auditor on the audit of key risks;
- considers reports from the external auditor in relation to their external audit work;
- considers the internal auditor's and external auditor's annual reports.

Director

- ensures that sufficient resources are deployed to effectively identify, manage and mitigate risks to the IJB's objectives;

Senior Management Team

- approves risk management procedures;
- identifies and assesses risks to the Integration Joint Board's objectives and ensures that these are effectively managed;
- takes decisions in accordance with the approved risk appetite;
- monitors progress in managing risks, including the effectiveness of internal controls and progress in relation to risk actions;
- satisfies itself that appropriate and effective insurance arrangements are in place.

Internal Auditor

- prepares a risk based annual internal audit plan and conducts risk based audits.
- prepares an annual report providing an opinion on the IJB's framework of governance, risk management and control.

Risk Manager

- provides advice and support on risk management and business continuity matters;
- prepares risk management policies, procedures and strategies.

Managers

- effectively manage risks assigned to them.

West Lothian Council

NHS Lothian

Date: 14/03/2017
Agenda Item: **10**

Integration Joint Board

TECHNOLOGY ENABLED CARE (TEC) PROGRAMME – PROGRESS REPORT

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To provide a six-monthly progress report on the West Lothian Technology Enabled Care (TEC) Programme.

B RECOMMENDATION

To note the progress on the West Lothian Technology Enabled Care (TEC) Programme and the contribution this programme is making to the IJB Strategic Plan.

C TERMS OF REPORT

West Lothian has been awarded funding by Scottish Government to participate in the 2 year national programme, to build on our original investment in telecare technology and accelerate commitment in line with emerging national and local priorities and technological developments. The TEC programme is firmly located within the overall strategic objectives of the IJB as detailed in its Strategic Plan and associated Commissioning Plans

Work is progressing on all deliverables, with most projects currently at the implementation phase. A summary of achievements to date are as follows:

1. Expansion of home health monitoring

- A full time Support Worker's post, dedicated to the introduction of Florence is currently being advertised.
- The Florence implementation plan has been agreed with the TEC Sponsors.
- The following protocols for the introduction of the use of Florence are with the Provider for approval:
  1. Use of Flo for Vitamin B12 injections
  2. Use of Flo for Hypertension (48hour check)
  3. Use of Flo to support the issue of community equipment
- Woundsense machines have been cleared by Medical Equipment Management and are currently being tested by community nurses at 2 GP surgeries.

2. Expanding the range and extent of Telecare

- Strategic Outline Business Cases have been approved by the WL TEC Board for the following:
  - **Diversifying the use of technology – Activity Monitoring Trial:** Four different types of activity monitoring equipment are currently being tested to identify and evaluate the benefits of each and where best applicable. 68 have benefitted from the use of the equipment to date.
  - **AICO Interface to Telecare:**
  - Housing & Building Services are undertaking a programme of repairs in council houses using the supplier AICO. We are testing the AICO system and how this can be linked to our alarm receiving centre (Careline) by the use of equipment called "universal sensors" and connected to our telecare equipment. Two homes are now fully operational with another 8 planned for this initial phase.
  - **Introduction of wearable Technology to monitor emotional state in Maple Villa**
  - NHS Lothian's Information Governance and Security Manager has given approval for project. Functionality has been increased in the room sensors following ideas from staff. Watches and sensors are running on-site ready to be implemented when staff and patients are ready. The project is expected to go live with two people signed up within the next month.
  - **GPS Devices**

    2 types of GPS devices are currently being tested by 7service users.
- A member of staff now dedicated to promoting the use of Activity Monitoring.
- A series of TEC Roadshows will start on 1st March – for staff initially. Plans are being developed to extend this.

3. Expanding the use of video-conferencing

- Currently exploring the potential for the introduction of "attendanywhere" , a web-based platform that helps health care providers offer video call access to their services as part of their 'business as usual', day-to-day operations.
- Instead of travelling to their appointment, patients or service users enter the clinic's online waiting area from a web browser or app on their computer, smartphone, or tablet. The health service is notified when they arrive, and a provider joins the consultation when ready.

D CONSULTATION

Strategic Planning Group

E REFERENCES/BACKGROUND

National Technology Enabled Care programme

https://sctt.org.uk/programmes/

F APPENDICES

G SUMMARY OF IMPLICATIONS

Equality/Health	Projects initiated under the WLTEC Programme will be subject to an equality impact assessment
National Health and Wellbeing Outcomes	The WL TEC Programme will support the relevant National Health & Wellbeing Outcomes in accordance with the IJB Strategic Plan.
Strategic Plan Outcomes	The WL TEC Programme is aligned to relevant Strategic Plan Outcomes and will incorporate detailed performance indicators.
Single Outcome Agreement	The WL TEC Programme outcomes are aligned to the Single Outcome Agreement outcomes related to health and social care.
Impact on other Lothian IJBs	None
Resource/finance	All resource requirements contained within the TEC funding from Scottish Government.
Policy/Legal	"A National Telehealth and Telecare Delivery Plan for Scotland 2016: Driving Improvement, Integration and Innovation".
Risk	Identified separately for each project. No issues for IJB level risks.

H CONTACT

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Telephone 01506 218937

14 March 2017

West Lothian Council

NHS Lothian

Date: 14/03/2017
Agenda Item: **11**

Integration Joint Board

CALL FOR VIEWS ON DESTITUTION AND ASYLUM IN SCOTLAND

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To provide a response to the Equalities and Human Rights Committee in respect of their call for views on destitution and asylum in Scotland.

B RECOMMENDATION

To approve the response to the Equalities and Human Rights Committee in respect of their call for views on destitution and asylum in Scotland.

C TERMS OF REPORT

The Scottish Parliament's Equalities and Human Rights Committee is intending to examine the issue of destitution and asylum in Scotland.

The Committee's focus is about how public services mitigate the impact of destitution on asylum seekers. The British Red Cross estimates1 over 700 people presented as destitute in Glasgow in 2015. When asylum seekers have no means of support they often rely on friends, charities or sleep rough. People who are destitute are also more vulnerable to abuse and exploitation.

The Committee has identified three questions that they would like input on:

1. As a public service provider, what support are you able to provide to asylum seekers and what are the main barriers to providing support.

2. We'd also like to hear about how a person's need for support is assessed and what would make this assessment process easier, please make reference to any policies and procedures within your organisation.

3. If your area does not have experience of asylum seekers, it would be helpful to know what policies, guidance or procedures are in place or being developed to address support for asylum seekers.

The following response is suggested on behalf of the IJB.

1. This is a very broad question which is probably easiest answered by noting that each case is dealt with on an individual basis and support tailored dependent upon circumstances. For example, if an asylum seeker is

   - A child traveling alone or with their family/guardian they will be supported as a child in need in accordance with the Social Work Scotland Act/Children Scotland Act; this includes provision of housing and an appropriate level of funding to support them whilst their claim for asylum is being processed. Children and their families are offered access to any other supports/referrals they may require for example, psychological support; health referrals; support to access specialist asylum support such as transport costs. The provision of funding to support such families comes within Social Work Scotland Act Section 22 funding. It is our understanding there is no additional funding provided by government.
   - A vulnerable adult – Adult Protection legislation would be considered and appropriate support offered
   - A lone adult – this is perhaps where there is a limited role for social work and would depend how they came into contact with social work, for example, picked up by police. In such circumstances it is likely that a referral would be made for assessment if appropriate and then onward referral to other agencies such as the council's Advice Shop.
   - In all the above circumstances consideration would be given to whether a person had been trafficked and then support provided as required.

2. West Lothian Council has a *"No Recourse to Public Funds Procedure"* see Appendix 1.
3. We are not aware of any additional work being progressed at this stage. The *"No Recourse to Public Funds Procedure"* remains the primary guidance in West Lothian.

D CONSULTATION

West Lothian Council Housing Building and Construction Services

E REFERENCES/BACKGROUND

None

F APPENDICES

No Recourse to Public Funds Procedure

G SUMMARY OF IMPLICATIONS

Equality/Health	None
National Health and Wellbeing Outcomes	None
Strategic Plan Outcomes	None
Single Outcome Agreement	Consistent with the Equalities Outcomes measures within the Single Outcome Agreement 2013

Impact on other Lothian IJBs	None
Resource/finance	None
Policy/Legal	None
Risk	None

H CONTACT

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14 March 2017

West Lothian Council

Social Policy

No Recourse to Public Funds (NRPF)

Guidance and Procedure

Management Information		
Lead Officer	**Name:**	**Susan McKenzie**
	Designation:	**Group Manager**
	Tel:	**01506 281347**
Lead Service Area	**Children and Families**	
Date Agreed	**7/9/2016**	
Last Review Date	**N/A**	
Next Review Date	**7/9/2017**	
Agreed by	**Head of Social Policy**	
Has an Equality Impact Assessment been completed for this procedure	**No – whilst the council have control over how the procedural aspect of this document is implemented, policy and practice is legislated for within various sections of the relevant Acts.**	

Final Version: 7 September 2016

Contents

Purpose

To ensure, through the operation of the Social Policy No Recourse to Public Funds Panel, the fair and consistent provision of services, including financial assistance, to families with children subject to immigration control, who have "no recourse to public funds" (NRPF). The NRFP Panel[1] will oversee all NRPF cases referred to it and be the decision making body, authorising recommendations made in assessment(s). In summary the panel's remit is:

- To review at regular intervals financial assistance provided to families;
- To agree on longer term financial support and accommodation requirements;
- To reduce/withdraw financial support;
- To offer support, advice and make decisions on each case; and
- To provide a quality assurance role for the NRPF process.

Guidance from both NRPF Network and COSLA has been heavily drawn upon in the production of this Guidance and Procedure. The complexity of this area of work is acknowledged and there is recognition that there may be requirements to refer to additional guidance and/or seek consultation and legal advice on a case by case basis. Guidance, relevant template documents and useful contacts are appended.

Scope

This procedure applies to Team Managers and Social Workers in Child Care and Protection Teams (CC&P), Social Care Emergency Team (SCET) and other Social Policy Services as deemed appropriate.

The child of a family not entitled to public funds may be a child in need, as defined below, and where a child is in need, the Local Authority has a duty to provide assistance in terms of Section 22 of the Children (Scotland) Act 1995. Pregnant women, whether or not they have other children, will fall within the scope of this procedure. Adults with no dependent children are not the responsibility of Children and Families and will be signposted to the appropriate service area.

Work carried out in relation to NRPF and subsequent support offered to families is considered out with the scope of the Social Care (Self-directed Support)(Scotland) Act 2013.

Note: All families who fall within the scope of this policy and procedure must be referred to the No Recourse to Public Funds Panel within 28 days from the point of referral.

Definitions

Child – For the purposes of this procedure a child is defined as a child or young person under the age of 18 years.

[1] Full terms of Reference for the NRPF Panel are available on the Intranet.

Child in Need – any child unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development; any child whose health or development is likely to be significantly impaired; any disabled child; any child adversely affected by the disability of any other person in his/her family.

No recourse to public funds (NRFP) – No recourse to public funds is an immigration control which is imposed on a person subject to immigration control and means they have no entitlement to benefits or council housing.

A person is subject to immigration control in the following circumstances:-

1. They requires leave to remain and do not have it;
2. They have leave to enter or remain with a condition of NRPF;
3. They have leave to enter/remain subject to a maintenance undertaking which is an undertaking by another person to be responsible for that person's maintenance and accommodation

There is a means by which a family that are supported by local authorities can apply to have this condition lifted, but this only applies to those with current leave (see last two links in associated documents on page 11).

Groups of migrants who have NRPF include:

- asylum seekers;
- refused asylum seekers; and
- visa over-stayers.

In addition to the above sub-groups, consideration is given here to those people that have entered the UK without valid leave.

Public funds – The term "public funds" is an exhaustive[2] list:

- attendance allowance, severe disablement allowance, carer's allowance and disability living allowance;
- personal independence payment
- income support;
- council tax benefit;
- a social fund payment;
- child benefit;
- income based jobseeker's allowance;
- income related allowance (employment and support allowance);
- state pension credit;
- council housing.

EEA – European Economic Area. For list of Countries refer to UK Visa and Immigration.

[2] The following are not considered 'public funds' and therefore NRPF status does not affect access: Health care provided by NHS (see also http://www.sehd.scot.nhs.uk/mels/CEL2010_09.pdf), education, free school meals, social services support. Legal aid is also not a 'public fund', although other restrictions may apply here.

Destitution – not having adequate accommodation or cannot meet essential living needs.

Good practice

The following are recognised as good practice indicators when dealing with NRPF cases:

- All families presenting with a request for support receive a humane and customer-focused response;
- Consistent responses are provided to requests for support/services;
- An identified lead person deals with individual cases;
- Support with translation is provided where required (see section on interpretation and translation service);
- The assessment process is explained and potential outcomes identified at the outset (including the possibility of a return to country of origin);
- Where there is no duty to provide support the reasons must be set out in writing and reasonable time given to the family to allow them the opportunity to seek legal advice;
- Where there is no duty, effective signposting and support is still required;
- Workers should suggest individuals seek independent immigration advice and should not provide any advice themselves ;
- Assessments are child-focused and based on needs and potential risk; and
- Parents/carers views should be reflected in any assessments.

Interpretation and translation service

Interpreters should be used to ensure information has been understood. The use of family members as interpreters has a negative impact on the quality of interpretation and should therefore be avoided. Where required, assessments undertaken and any letters issued should be translated into the first language of the family with NRPF. If a translation service is required this can be procured via PECOS from The Big Word Translation Service. This cost will be met from the central Children and Families budget.

Summary of key steps

There are two fundamental steps in assessing whether there is a duty to support a family with NRPF:

1. Conducting an eligibility test; and
2. Carrying out assessment(s) of need
3. Conduct a Human Rights Assessment.

Eligibility

Establishing eligibility (Appendix 9) requires:

a) Establishing territorially responsibility for West Lothian - the test is whether a person is "ordinarily resident" in the area. Where someone has been transferred for health treatment, responsibility remains with the sending authority or the authority where they were resident prior to any treatment;

b) Establishing destitution – the family needs to demonstrate that they have no other means of support available and this includes establishing if they are homeless or cannot meet essential living needs, and exploring whether support could be provided by family, friends, the voluntary or community sectors, savings, a sponsor, selling anything of value, their eligibility for welfare benefits or any realistic ability to self-support through having the right to work;

c) Establishing immigration status (Social workers can liaise with the UK Immigration Enforcement via the Local Immigration Team) – a parent's/carer's immigration status determines whether there are any restrictions to support (i.e. if they are not in the asylum process) or in cases where there is Home Office support. Temporary support may be offered in such circumstances and a discharge letter issued with notice of termination of support; and

d) Establishing if a person is ineligible for the support under section 22 of the Children (Scotland) Act 1995. A person is ineligible for support under this section if they are:

    1. Persons with refugee status in another EEA country and their dependants;
    2. EEA[3] nationals and their dependents;
    3. Failed asylum seekers not complying with removal directions and their dependants; and
    4. Persons unlawfully in the UK.

Although parent(s)/carer(s) listed above are ineligible for social work support, restrictions are not applicable to children. The Children (Scotland) Act 1995 promotes the upbringing of children by their family. It is therefore good practice to support children and their parent(s)/carer(s) together in finding a resolution to the issues that have rendered the family destitute and to only consider taking children into care where there are explicit child protection concerns.

Where a parent(s)/carer(s) are ineligible, consideration needs to be given as to whether it would breach their human rights or Community Treaty rights if support was refused (see assessment of need section). You should also bear in mind that while an assessment is being conducted, support can be provided to the family in the interim.

[3]EEA nationals do not have NRPF as they are not defined as 'persons subject to immigration control' and thus have entitlement to welfare benefits. However in order to access public funds, EEA nationals must have 'right to reside' and satisfy the 'habitual residence test'. Where EEA nationals do not meet these requirements, an assessment of eligibility for accommodation and financial support under s.22 of the Children Scotland Act is the appropriate course of action.

Note: Staff have a duty to inform the Home Office of anyone who is unlawfully in the UK or who is a failed asylum seeker.

Assessment(s) of need

An assessment of need may be required irrespective of a lack of presenting needs. Being destitute with NRPF is reason enough to intervene. All children are covered by the Children (Scotland) Act 1995 regardless of immigration status and a Children in Need Assessment – S.22 is required to be completed in these instances.

In cases where a child(ren)'s parent/carer is ineligible, a Human Rights Assessment (Appendices 1 & 2) should be undertaken in conjunction with the Children in Need Assessment.. The Human Rights Assessment will establish whether support can be provided to the parent despite their being ineligible to receive the support. This process will determine any obligation to provide support and the nature/extent of that support. The Local Immigration Team (Appendix 8) should be notified when the Human Rights Assessment concludes and what actions are planned.

Actions

Referral process:

- All referrals for NRPF will be routed through the appropriate CC&P Team, where they will be screened by a Team Manager or the Duty Team Manager;
- Following discussion with the relevant Team Manager, a Social Worker will make initial contact with a family via home visit or by appointment;
- Should there be Child Protection issues identified (including child trafficking[4]/exploitation concerns) then the referral will be handled in line with existing Child Protection procedures. There is additional guidance in relation to Human Trafficking.
- Regardless of whether or not the child is placed on the Child Protection Register, or becomes Looked After and Accommodated, the allocated CC&P Team Social Worker will carry out Children In Need Assessment

Eligibility checks:

The allocated Social Worker should check that the person referred or presenting:

- is an adult with no recourse to public funds. This is usually stamped in their passport or visa[5] (if they have one), or can be deduced from their immigration status;
- has a current immigration application submitted to the Home Office - keep a record of the Home Office reference number issued;
- is a non-UK/EU/EEA national;
- does not have refugee status, or a partner with refugee status, in another country;

[4] If female trafficking is apparent or suspected then Trafficking Awareness Raising Alliance (TARA) should be contacted for advice/support (Appendix 8).

- has a need for care and attention which is not caused solely by destitution i.e. they have children in their care;
- has proof of child's identity and relationship to the adult;
- has information about how to register the child with a medical practice, with a school/nursery and that they have accessible information about support agencies; and/or
- is on a temporary visa and fleeing domestic violence with a child or children.

Assessment process:

- The Team Manager should notify the NRPF Panel of any assessment(s) being undertaken in respect of NRPF and indicate the date of likely completion in order that a meeting can be scheduled;
- The allocated Social Worker should complete a Children in Need Assessment and Human Rights Assessment where applicable;
- Assessment(s) must be submitted to the NRPF Panel at least three working days before the scheduled meeting (meetings and reviews scheduled as required).
- Assessment(s) must address the child's needs for housing, finance, education, health, and outline how these needs are to be met.
- Evidence of identity and the child's relationship to the parent(s)/carer, supported by documentation wherever possible, must be presented to the Social Worker.
- The child must be seen during the course of the assessment, and his/her views recorded where appropriate.

Note: Provided all necessary checks and information is submitted, the Social Worker may not be required to attend the NRPF Panel. However the Chairperson may invite the Social Worker and/or their Team Manager to talk to their reports. Written confirmation of decisions will be provided by the NRPF Panel within three working days of meeting.

Financial support:

- All interim funding for NRPF cases come from the Children and Families Section 22 budget and will be authorised in accordance with the Social Policy Children and Families Council Section Payment Procedure.
- All longer term funding for families with NRPF will be authorised and reviewed by the NRPF Panel.
- Financial support, where no other options are available, will be on the basis of Asylum support rates. In addition, all costs associated with utility bills will be paid and discretionary one-off payments may also be authorised for essential items that are not otherwise available e.g. pushchair or pram. The Advice Shop may assist with benefits checks.
- Once authorised, payments will be made by the appropriate Area Practice Team as per the existing procedure.
- Parents/carers must sign a declaration form relating to any savings and/or employment (Appendix 3).

- The NRPF Panel must review all cases at a minimum of 3 monthly intervals. This can be undertaken electronically if there has been little change to the situation.

Accommodation

Whenever possible, and appropriate, families with NRPF should be encouraged to find accommodation with families, friends, or the voluntary/charity sector. Where no application to apply for or extend leave has been submitted then the adult carer should strongly be advised to seek legal advice. Any advice would be from the housing options team within Housing, Construction and Customer Services.

Where families who are presenting for support already have accommodation, the suitability and likelihood of existing arrangements being continued or terminated needs to be established quickly. West Lothian Council Housing, Construction and Customer Services promote a planned and preventative approach to meeting identified housing needs and through timely referrals to the NRPF Panel will endeavour to avoid the need for crisis intervention where possible.

Where a NRPF family presents as homeless, the Housing Needs Service from Housing, Customer and Building Services will carry out an assessment making an appropriate decision in keeping with legislation and guidance and will provide temporary accommodation on a short term basis to meet immediate needs. A Journal Entry will be raised by Financial Services to ensure the appropriate transfer of funds from Social Policy to cover costs. Meeting immediate housing needs must be authorised by the Group Manager and Senior Manager (Young People and Public Protection). Thereafter arrangements will be subject to authorisation and review from the NRPF Panel.

The NRPF Panel will consider any longer term accommodation needs of the family and whether this is best served by emergency accommodation, a temporary tenancy, special let or sourcing a private let from an accredited landlord in conjunction with the Private Sector Leasing Team.

Private landlords are required to invoice the CC&P Team each calendar month. Rent will be paid monthly, at the agreed level, under Section 22 of the Children (Scotland) Act 1995, using the PECOS requisitioning system.

- Where agreed, the NRPF Panel will advise Revenues and Benefits that Council Tax payments will be met by Social Policy and reimbursement will be made by internal ledger at the end of the financial year.

Families from EEA that fail the Habitual Residency Test

- Persons who hold EEA passports are entitled to travel within the EU. However, if they are ‘economic migrants’ seeking employment, they are not entitled to Housing Benefit until they have been resident for three months and

demonstrate they are working, in education, or in training. During this time they must be financially self–reliant and/or be supported by family or friends.

- Any families who either self-refer or are referred by other agencies to Children and Families staff must be directed to the respective Area Practice Team.
- In exceptional circumstances assistance may be given in the form of travel tickets from West Lothian to London, advising the family to contact their Embassy directly (see section on travel assistance, page 10).
- In the event of an intractable situation or where there are immediate child care concerns, Housing Services may provide emergency accommodation while an assessment/plan is executed.

Interim support

Families granted Indefinite Leave to Remain in the United Kingdom no longer have NRPF and are entitled to work and/or access mainstream benefits. Families refused Leave to Remain may be eligible for some support to help them leave the country. In both cases, these families need to be re-referred to the NRPF Panel where the decision will be taken to formally withdraw support.

Support during any transition period will be factored into the decision making process to ensure families do not fall between systems and that they are not without support (Appendices 4 and 5). Signposting to the Advice Shop, Citizen's Advice Bureau and Housing Services are appropriate courses of action for those granted Leave to Remain.

Travel assistance

Staff have the power to assist and arrange travel enabling a person to return to their country of origin. In situations where return is a viable option, consideration should be given as to whether offering travel assistance discharges its duties under the Human Rights Act 1998. This would be a recommendation/decision made as part of a Human Rights Assessment and authorised by the NRPF Panel. Even when parents refuse offers of return travel, duties towards any children remain. In such cases effective collaborative working with the Local Immigration Team, Home Office and other local authority areas (where appropriate) is required.

Staff can offer to arrange travel for EEA nationals and those recognised as refugees in another EEA state. This does not allow for any cash payment to be made directly to persons travelling. Where there are children involved accommodation should be arranged pending the family's return.

If staff are approached by asylum seekers, failed asylum seekers or people who are unlawfully in the UK looking to return to their country of origin these should be referred to the Choices Assisted Voluntary Return Programme (Appendix 8). Alternatively, Embassies may also be able to purchase travel tickets for their nationals.

Responsibilities

The Group Manager for Child Care and Protection has overall responsibility for the maintenance of this procedure.

The procedure should be reviewed annually. It should be updated on an ongoing basis subject to any relevant information coming from the NRPF Network (Scotland).

Policy base

Children (Scotland) Act 1995
Immigration and Asylum Act 1999
Nationality, Immigration and Asylum Act 2002
The Human Rights Act 1998
Housing Scotland Act 2001
Code of Guidance on Homelessness
Edinburgh and Lothian's Child Protection Procedures 2012
Social Policy Children and Families Procedure: Children (Scotland) Act 1995 Section 17, 22, 29 30 Requests for Funding and Financial Assistance

Associated documents

Establishing Migrants' Access to Benefits and Local Authority Services in Scotland, A Guide for Local Authorities, Dr Sarah Kyambi, March 2012, COSLA Strategic Migration Partnership.

Practice Guidance for Local Authorities Assessing and Supporting Children and Families and Former Looked-after Children who have No Recourse to Public Funds (NRPF) for Support from Local Authorities under the Children Act 1989, NRPF Network, December 2011

Human Rights: Human Lives, A Guide to the Human Rights Act for Public Authorities, Equality and Human Rights Commission, May 2014

Home Office **Immigration Directorate Instruction**
Family Migration: Appendix FM Section 1.0b Family Life (as a Partner or Parent) and Private Life: 10-Year Routes.

Request for a change of conditions of leave granted on the basis of family or private life

Record keeping

Record Title	Location	Responsible Officer	Minimum Retention Period
Case notes	Swift	Allocated Social Worker	5 years
Assessment(s) of Need and Risk	San Server	Information Team Manager	5 years

Appendix 1: Human Rights Assessment Guidance

When completing a Child in Need Assessment with a family who are identifying themselves as having No Recourse to Public Funds **and** where their parents and carers are excluded from support provided under Sections 22, 29 or 30 of the Children (Scotland) Act 1995you will need to consider the following points in for the purposes of a Human Rights Assessment (appendix 1).

Family Composition

Completing a genogram (family/support network diagram) is preferable but make sure you include dates of birth, other names and aliases under which individuals in the family are known. Please ensure that name spellings are correct.

Confirmation of Identity

Request to see any birth certificates, nationality documents (passports) or letters from the Home Office in relation to any application the adult(s)/family have made. Take a note of the Home Office Reference number if it is present on an official letter.

Background/Chronology

- Identify whether the adult(s)/family have been supported by social care previously and if so, which area of the UK/World this has been.
- How long has the family/each applicant been in the UK?
- What is their current immigration or asylum status, what is the date of any decision or appeal and what applications remain outstanding (if known)?
- Is there any reason why the family cannot return to their country of origin (please set out in full)?

Housing/Employment and Income

- What is the adult(s)/family's current financial situation?
- What accommodation are they living in and is this remaining available in the short-term/long-term?
- What previous accommodation has the applicant/family had? How was that lost?
- How has the adult(s)/family supported themselves until now? – Charity donations/local religious/community groups/friends and family members/ employment (legal or illegal) – if working then you need to identify which employer this is with and the details of their income and whether they pay tax and national insurance.

Family and Environmental Factors

- Are there any other people or organisations that have provided or could provide any support?
- What other family or relatives do the family have in this country? What contact does the family have with them?

Returning to their Country of Origin

Establish whether or not it is possible for adult(s)/family to return home to their country of origin. What reasons are they presenting for not returning home (choice/ wish to wait until the application is responded to by the Home Office/fear of returning to country of origin/cannot afford travel costs)?

If returning to their country of origin then does the family have:

- Appropriate finance for travel costs?
- Passports/travel documents.
- What help would the family need?
- What difficulties, whether in terms of employment, schooling, medical provision or otherwise, would be caused were the family to return to their identified country of origin?

Other Considered Information

- Are there any other factor(s) which have an impact on the adult(s)/family's current situation?

- Is the adult fleeing from domestic violence?

Section 2a

Only complete this section for **individual EEA nationals** who have applied for financial or social work support from the council.

Section 2b

Only complete this section for other people subject to immigration control including those identified as having **no recourse to public funds (NRPF)** and who are not EEA nationals, **failed asylum seekers** (18+/former LAC), **over-stayers in the UK** (visa has expired).

Assessment and Recommendations

You need to consider whether there would be a breach of Article 3 or Article 8 of the UN Convention on Human Rights (1951):

- Article 3: if support were refused or withdrawn would the individual/family be subject to treatment amounting to torture or to inhuman or degrading treatment or punishment.

- Article 8: If the family or individual returned to county of origin, would the right to respect for private and family life be compromised?

In the case of failed asylum seekers, should individual/family be applying for support under section 4 of the Immigration and Asylum Act 1999 or do they have other means of support?

In the case of clients from the EU, would returning to their country of origin interfere with their exercise of EU Convention rights?

Guidance for Completing the Human Rights Assessment/Analysis Pending Immigration/Asylum Decision

The adult(s)/family will need to have a current application with the Home Office in relation to their status of leave to remain in the UK. This may be with regards to pending visa applications (over-stayers) or in relation to a pending asylum claim. If the family do not have a current application for leave to remain with the Home Office then there would not be pending a decision and their previous status would remain. Therefore, they should be returning to their country of origin and making arrangements to do this. Social Policy Children and Families may need to assist with transportation costs to the airport/travel arrangements and the Home Office can be contacted to confirm travel arrangements. Social Policy Children and Families would not be usually offering support for a family that is not awaiting a pending decision from the Home Office unless there are child protection concerns.

Legal Advice

Social Workers **should not** offer legal advice to adult(s)/families. However, you should encourage the adult(s)/family to access legal advice via an immigration solicitor. If the Human Rights Assessment is being completed as a result of a decision being reached by the Home Office and notified to the adult(s)/family and this is the **first** application decision then Social Policy can fund 1 hour of legal advice for the applicant – this is considered good practice as opposed to a duty.

Immigration/Asylum Status Issued

If the adult(s)/family have been granted leave to remain in the UK which will entitle them to have recourse to public funds then by Social Policy Children and Families removing their financial support the family would not be considered as destitute as they can make an active benefit claim. The outcome of the Human Rights Assessment should reflect this by identifying that there will be a ***four week*** notice period of withdrawal of financial support for the family following the decision of the NRPF Panel. During this notice period then the adult(s)/family should be signposted to the Advice Shop where they should be supported in completing an appropriate benefit claim.

Immigration/Asylum Status Refused

The person(s) has received notification from the Home Office that their application for leave to remain in the UK has been refused. This will mean that the family remain with no recourse to public funds whilst in the UK and are no longer pending a decision by the Home Office. A local authority has the power to provide the flights home for the family. . As a result of this leave status refusal, financial support by

West Lothian Council services may no longer be appropriate. There may be circumstances where the family are appealing the decision or the family state that the cannot return to their home country. Four weeks notice should be issued to the family for withdrawal of current financial support arrangements in accordance with the Social Policy No Recourse to Public Funds Guidance and Procedure.

Appendix 2:

WEST LOTHIAN COUNCIL CHILDREN AND FAMILIES HUMAN RIGHTS ASSESSMENT FORM

Introduction

This form is designed for use in relation to requests/requirements for a Children in Need Assessment – S22 from service users who are subject to immigration control and have no recourse to public funds under s.115 Immigration and Asylum Act 1999 **and** who fall within the restricted categories in Schedule 3 of the Nationality, Immigration and Asylum Act 2002.

Specifically, this form has regard to the following Articles of the European Convention on Human Rights:

- Article 3, prohibition of torture or inhuman or degrading treatment or punishment; and
- Article 8, right to respect for private and family life.

Article 3 is an absolute right. There are 5 components to Article 3: inhuman treatment, degrading treatment; inhuman punishment, degrading punishment; torture. There are two key issues in relation to Article 3: (i) whether the facts of a service user's claim fit into one of the 5 components of article 3 and (ii) the need to show a minimum level of severity for Article 3 to be engaged. More detailed guidance is available online here.

Article 8 grants a right to respect for private and family life, home and correspondence. The right to respect for private life can include medical issues and education. Article 8 is a qualified right. Public authorities are prohibited from interfering with the Article 8 right except where the grounds for interference are in accordance with law, they pursue a legitimate aim and they are necessary and proportionate. The following are legitimate aims: the interests of national security, public safety or the economic well-being of the country, the prevention of disorder or crime, the protection of health or morals, or the protection of the rights and freedoms of others. Detailed guidance is available online here.

This form is designed to supplement, not replace, the Children in Need Assessment – S22. The most recent Children in Need Assessment – S22 should be appended to this Human Rights assessment. For information about the context, process and reasons for conducting a Human Rights Assessment see Practice Guidance for Local Authorities (pages 20 – 27).

Section 1: Key Information

Family Composition: Include date of birth, other names and aliases under which individuals are known.

Confirmation of Identity: Is there a certificate, nationality document etc?

Background / Chronology: Provide a brief history of background and any social service support. In completing this section the following questions should be used as a checklist:

1. How long has the family/each applicant been in the country?
2. What is their immigration or asylum status? What is the date of any decision or appeal and what applications remain outstanding?
3. What are the medical, educational, social or other needs of each family member (include details of the GP and any person or organisation consulted or being consulted)?
4. What is the financial situation? What accommodation is available? What previous accommodation has the applicant/family had? How was that lost?
5. How has the applicant/family supported itself until now?
6. Are there any other people or organisations who have provided or could provide any support?
7. Is there any reason why the family cannot return to their country of origin (please set out in full)?
8. What other family or relatives do the family have in this country? What contact does the family have with them?
9. What difficulties, whether in terms of employment, schooling, medical provision or otherwise, would be caused were the family to return home?
10. Is there any other factor or factors which ought to be borne in mind?

Section 2: Immigration Status

2a. EU Nationals[6]: **Complete this section for individual EU nationals who have applied for financial or social work support from the Council. For other people subject to immigration control with no recourse to public funds, including failed asylum seekers, complete section 2b.**

Purpose of Assessment: Please record and explain to the individual/ family the purpose of this assessment.

[6] Austria; Belgium; Bulgaria; Cyprus; the Czech Republic; Denmark; Estonia; Finland; France; Germany; Greece; Hungary; Ireland; Italy; Latvia; Lithuania; Luxembourg; Malta; the Netherlands; Portugal; Romania; Slovakia; Slovenia; Spain; Sweden; UK.

Assessment of current situation: Is the individual/family destitute? Have they any other available means of support? Are children attending school?

Assessment of ability to work: Is the individual or anyone in the household able to work? Are there health needs that affect the service user's ability to work? Please record/obtain relevant medical proof where appropriate.

Other Means of Support: Does the individual think that they might be able to become self-supporting in the near future? Are they having support from friends, family, religious communities, charities etc? If yes, please obtain details.

Travel needs: Establish whether or not it is possible for client to return home to their country of origin. Have they the means (finance, passport, travel documents)? If not, what help would the family need?

EU Convention rights: Is the client working or have they been working recently and a) are now seeking work or b) are temporarily unable to work due to illness? Is the client self-employed? Is the client studying?

2b Failed Asylum Seekers/Over-stayers: **Complete this section for failed asylum seekers who have been issued with removal directions or who did not claim asylum at port of entry (e.g. at an airport), and other people subject to immigration control who have no recourse to public funds.**

Purpose of Assessment: Please record and explain to the individual/ family the purpose of this assessment.

Assessment of current situation: Does the family originate from a " Safe State" as defined by the Home Office?[7] Is the individual/family destitute? Has the family any other available means of support? Are children attending school?

[7] Albania; Bolivia; Bosnia Herzegovina; Brazil; Ecuador; India; Jamaica; Kosovo; Macedonia; Mauritius; Moldova; Mongolia; Montenegro; Peru; Serbia; South Africa; South Korea Ukraine; Ghana (men only); Gambia (men only); Kenya (men only); Liberia (men only); Malawi (men only); Mali (men only); Nigeria (men only); Sierra Leone (men only).

Assessment of Health Needs: If the individual or anyone in the household was legally able to work, could they do so? Please record/obtain relevant medical proof where appropriate.

Other Means of Support: Does the individual think that they might be able to become self-supporting in the near future? Are they having support from friends, family, religious communities, charities etc? If yes please, obtain details.

Travel needs: Establish whether or not it is possible for client to return home to their country of origin. Have they the means (finance, passport, travel documents)? If not, what help would the family need?

Section 3: Assessment and Recommendations

Human Rights: Consider whether there would be a breach of Article 3 or Article 8:

Article 3: If support were refused or withdrawn would the individual/family be subject to treatment amounting to torture or to inhuman or degrading treatment or punishment?

Article 8: If the family or individual returned to county of origin, would the right to respect for private and family life be compromised?

In the case of failed asylum seekers, should the individual/family be applying for support under section 4 of the Immigration and Asylum Act 1999 or do they have other means of support?

In the case of clients from the EU, would returning to their country of origin interfere with their exercise of EU Convention rights?

Recommendation: Assessing officer should make recommendation as to the future of this case based on their assessment. Is there any other support to be considered? Provide a reasoned conclusion.

Confirmation of recommendation/decision: Team manager should make a decision as to why this person should/should not receive continued support.

Name of Service User	Signature	Date
Name of Assessment Officer	**Signature**	**Date**
Name of Team Manager	**Signature**	**Date**

Appendix 3: NRPF Declaration of Destitution

Note: Where it is apparent there is a language barrier, this form must be translated into the first language of the person presenting. Translation support should also be used to take into account any potential literacy issues and to ensure that the parent/carer fully understands the declaration they are making and the ramifications of making any false declaration.

Child's name:	
Child's Swift ID:	

Children and Families

I am getting emergency support today from the West Lothian Council, under Section 22 of the Children (Scotland) Act, because of my immigration and financial situation, and because I am destitute.

I agree to be completely open with social services about my situation and any changes to:

1) My financial support (e.g. family, friends, faith groups, Child Support Agency);
2) My salary, if have the legal right to work;
3) If I start getting benefits; and/or
4) If my immigration situation changes.

Date	Type and amount of support (e.g. cash/vouchers)	Parent's name	Parent's signature

Appendix 4: Notification of support withdrawal - leave status granted

Date:

Private and Confidential
Name
Address

Dear

Re: Withdrawal of Financial Support from West Lothian Council Children and Families – Leave Status Granted

I write following the completion of a Human Rights Assessment. West Lothian Council Social Policy Children and Families have assessed that you will not be identified as destitute, , if financial support from the Local Authority is withdrawn.

This outcome has been reached as it has been confirmed that you have been issued leave status by the Home Office and therefore have recourse to public funds whilst residing in the United Kingdom.

Therefore, we are issuing a four week notification from <DATE OF NRPF PANEL DECISION> that we shall be withdrawing all financial support to you and your family in relation to previously being identified as having No Recourse to Public Funds, with all payments ceasing by <DATE OF WITHDRAWAL>.

The Local Immigration Team for West Lothian has been informed of this decision.

Yours sincerely

Team Manager
Child care and Protection Team
Social Policy
West Lothian Council

Appendix 5: Notification of support withdrawal - leave status refused

Date:

Private and Confidential
Name
Address

Dear

Re: Withdrawal of Financial Support from West Lothian Council Children and Families – Leave Status Refused

I write following the completion of a Human Rights Assessment. West Lothian Council Social Policy Children and Families have assessed that you will not be identified as destitute, if financial support from the Local Authority is withdrawn.

This outcome has been reached as you have been refused leave status by the Home Office, you currently have no further pending decisions from the Home Office in relation to your leave status, and you are able to access support via <the Home Office/Family & Friends> or are able to return to your country of origin.

Therefore, we are issuing a for week notification from <DATE OF NRPF PANEL DECISION> that we shall be withdrawing all financial support to you and your family in relation to previously being identified as having No Recourse to Public Funds, with all payments ceasing by <DATE OF WITHDRAWAL>.

If during this notification period, you wish to discuss support with returning to your identified country of origin then please contact <SOCIAL WORKER> on <TELEPHONE NUMBER>.

The Local Immigration Team for West Lothian has been informed of this decision.

Yours sincerely

Team Manager
Child Care and Protection Team
Social Policy
West Lothian Council

Appendix 6: Notification of support accepted - pending leave status

Date:

Private and Confidential
Name
Address

Dear

Re: Request for Support from West Lothian Council Children and Families Services Accepted

I write to you following the completion of a Human Rights Assessment, and evidence of a pending decision regarding an application to the Home Office for leave status. West Lothian Council Social Policy Children and Families have assessed that you will be identified as destitute, under the guidance of the European Convention on Human Rights, if financial support from the Local Authority is not provided.

Therefore, we will be offering you support (including financial assistance) as of <DATE OF SUPPORT DECISION> as part of an ongoing support plan under the guidance of the Children (Scotland) Act 1995.

The support offered (including financial arrangements) will be reviewed regularly and amended in accordance with any change of your current circumstances or decisions issued by the Home Office in relation to your pending application. You will be notified of any changes by your allocated Social Worker.

If during this period you wish to discuss support with returning to your identified country of origin then please contact <SOCIAL WORKER> on <TELEPHONE NUMBER>.

The Local Immigration Team for West Lothian has been informed of this decision.

Yours sincerely

Team Manager
Child Care and Protection Team
Social Policy
West Lothian Council

Appendix 7: Notification of support refused - pending leave status

Date:

Private and Confidential
Name
Address

Dear

Re: Request for Support from West Lothian Council Children and Families Services Refused

I write to you following the completion of a Human Rights Assessment and the request for evidence of a pending decision regarding an application to the Home Office for leave status.

West Lothian Council Social Policy Children and Families have assessed that you will not be identified as destitute, if financial support from the Local Authority is not provided.

Therefore, we will not be offering you support (including financial assistance) at this present time. If you experience a change in your current circumstances or believe that any children in your care are at significant risk of harm then you should present at your nearest social work office.

The Local Immigration Team for West Lothian has been informed of this decision.

Yours sincerely

Team Manager
Child Care and Protection Team
Social Policy
West Lothian Council

Appendix 8: Useful contacts

Useful contacts referred to within this policy and procedure:

Local Immigration Team
United Kingdom Border Agency Local Immigration Team for West Lothian
Leader: Simon Myszker
Tel: 0131 335 4860
Email: Simon.myszker@homeoffice.gsi.gov.uk
Email (emails picked up daily): edidoi@homeoffice.gsi.gov.uk

Refugee Action
Choices Assisted Voluntary Return Programme
Email: choice@refugee-action.org.uk
Tel: 0800 800 0007

Trafficking Awareness Raising Alliance (TARA)
Email: corporatevaw@drs.glasgow.gov.uk
Web: www.communitysafetyglasgow.org
Tel: 0141 276 7724

Other useful contacts:

AIRE Centre (Advice on Individual Rights in Europe)

Children and Families Across Borders

City of Edinburgh Council
Sean Bell
Children's Practice Team Manager
South West Edinburgh
sean.bell@edinburgh.gcsx.gov.uk

Janet Wiseman
Local Partnership Manager
Interventions and Sanctions Directorate
Immigration Enforcement
Festival Court 3, 200 Brand Street, Glasgow G51 1DH
Tel: 0141 555 6054
Janet.Wiseman@homeoffice.gsi.gov.uk

No Recourse to Public Funds Network is a network of local authorities and partner organisations focusing on the statutory duties to migrants with care needs who have no recourse to public funds.

Rights of Women (Immigration and asylum law)

West Lothian Council

NHS Lothian

Integration Joint Board

Date: 14 March 2017
Agenda Item: **12**

NATIONAL HEALTH AND SOCIAL CARE WORKFORCE PLANNING

REPORT BY DIRECTOR

A PURPOSE OF REPORT

This report provides the IJB response to the Scottish Government's discussion paper in relation to workforce planning.

B RECOMMENDATION

It is recommended that the IJB approves the draft response in appendix 1 for submission to the Scottish Government by the deadline of 28 March 2017.

C TERMS OF REPORT

The need for a National Health and Social Care Workforce Plan was recognised in the Programme for Government. This national Plan is concerned with upwards of 360,000 people nationally who deliver health & social care services that support people across Scotland enabling them to live longer lives in better health.

IJBs are required to complete integrated workforce development plans and they are tasked with managing integrated budgets to deliver or commission integrated health & community care services. This requires a planned approach to the workforce which provides these services.

The discussion paper proposes that a national framework should be developed to assist IJBs in their workforce planning which would ensure a consistent approach is taken across the different areas of the partnerships. The suggestion is to adopt a 6 stage model already used in Health which broadly correlates with other related industry workforce planning tools (SSSC's 8 stage model and Third Sector's 4 stage model).

The discussion paper highlights the need to address priority workforce planning areas including recruitment and retention.

The draft response is provided as appendix 1, which contains the following key points:

- that a national workforce development framework should be developed that also allows for local variances
- that IJBs will and should be responsible for local workforce planning and contributing to both regional and national workforce plans
- that further consultation regarding the representation of the group who will design the framework
- recognises the need for workforce planning in key areas as per the attached response
- that all Organisational Development and Learning and Development resources across the IJB work collectively to plan and deliver on workforce plans

D CONSULTATION

This response has been developed through the Organisational Development Board with membership from the management team and NHS Lothian and West Lothian Council organisational development and human resource teams.

E REFERENCES/BACKGROUND

IJB Organisational Development Workforce Plan

National Health and Social Care Workforce Planning: discussion document

F APPENDICES

National Health and Social Care Workforce Planning: discussion document response

G SUMMARY OF IMPLICATIONS

Equality/Health	The report has been assessed as relevant to equality and the Public Sector Equality Duty. An equality impact assessment has been conducted. The assessment can be viewed via the background references to this report.
National Health and Wellbeing Outcomes	People who work in health and social care service are competent and confident and appropriately skilled to undertake the work they do and are supported to continuously improve the information, support, care and treatment they provide. Resources are used effectively and efficiently in the provision of health and social care services
Strategic Plan Outcomes	Underpins all Strategic Plan outcomes

Single Outcome Agreement	That we have a skilled and competent health & social care workforce to support: – People to live longer healthier lives and have reduced health inequalities – Older people to live independently in the community with an improved quality of life
Impact on other Lothian IJBs	Closer collaborative working to jointly delivery of some elements of training and development
Resource/finance	Within available resources
Policy/Legal	None
Risk	None

H CONTACT

Isobel Meek
Social Policy Learning & Quality Assurance Manager
01506 283910
Isobel.meek@westlothian.gov.uk

14 March 2017

APPENDIX 1

Q1. Are these roles the right ones, or do you have an alternative model? What steps will be needed to ensure these proposals are fully effective?

Nationally
We welcome the proposal to deliver a co-ordinated plan at a national level from which regional and local planning can be progressed to ensure that there are sufficient resources and capacity to deliver future services. Recognition of the workforce planning that will be required to support service change will create numerous challenges for community based care, delivered through appropriate locally determined, multi-disciplinary teams.

In order to strengthen workforce planning nationally, as identified, this requires a much wider representation from IJBs and social care representatives than that currently undertaken by the Government. Without a clear statement of the existing groups, it is not possible to agree that they remain fit for purpose, therefore we would ask that a list of these groups be published. We would also expect that consultation takes place in relation to the recruitment and remit of any new groupings.

It seems a sensible approach that once established and agreed, these groups would take forward the National Workforce Plan and that they would encourage the sharing of information around best practice. Again a national approach to developing policy, strategy, guidance and identifying national priorities would sit well at this level.

We would refer the government to the recent review of social work education in relation to the planning for student intakes (numbers) and student practical placement learning which is less structured and considered than students in health settings and which will possibly require a national solution. There is also a need to nationally address recruitment of social care workers to ensure sufficient capacity to deliver future services and continued working with the Government to address this issue alongside staff retention, pay and reward would also be welcomed. We would suggest that another national priority should be in the area of continued delivery of our statutory Mental Health Officer services which nationally, is an ageing workforce.

Regionally
Whilst regional planning will still be required in some sectors, this needs to take account of the differing needs of IJB localities to ensure that all three levels of planning will work to deliver expected outcomes within identified timescales. It is anticipated that this will present some challenges.

Locally
We agree that whilst not employers themselves, IJBs should produce workforce and organisational development plans as they will play a key role in shaping workforce intelligence forecasting and workforce demand for their localities which they will be addressing through strategic commissioning and service procurement.

Q2. How can organisational and individual collaborative working be improved, and barriers removed, so that workforce planning can be effectively co-ordinated to ensure people get the care they need where and when they need it?

With national workforce planning addressing any main priority area in terms of recruitment and retention of staff, local working across IJBs could address the areas of broader workforce planning through the identification of staffing profiles across the Partnerships. From this needs analysis can be undertaken and shortfalls planned for in advance. A collective approach could then be taken for workforce planning and the

appropriate linkages with local further educational and higher educational establishments to address local needs. There is also a role for organisational and learning & development colleagues across IJBs to work more collaboratively in addressing and skills and knowledge gaps.

Q3. How should workforce data be best collated and used to undertake workforce planning in an integrated context based on current approaches of a nationally–led NHS system and locally-led system?

Effective workforce planning requires intelligent and insightful data. Currently, workforce data collection varies across the different parts of the health & social care sector. There needs to be some analysis of the data that we gather to ensure that it is meaningful and fit for purpose and that it assists us to identify and remove any barriers to collaborative working. It would seem a collaborative approach between the SSSC's Workforce Data collection Team and the ISD is required. The data also needs to be accurate and up to date. This recognised need for improvement in data collection is particularly essential for the social services sector as currently, workforce data collected by the SSSC is at least one year out of date!

Q4a. How might employers and other relevant interests in the Health and Social Care sector work, jointly and individually, to identify and tackle recruitment and retention issues, ensuring priority gaps are identified and addressed:

As the SSSC registration for the social services workforce is a qualification based registration, this needs to be addressed in strategic planning. In these challenging financial times there must still be provision for organisations to take on new employees who will then require access to vocational qualifications for registration. This needs to be part of the strategic planning at national, regional and local levels. We should also monitor any impact the living wage may have on the movement of workers seeking better pay and reward. Is it palatable to look at setting national pay and reward agreements?

Q4b). Are there any process or structural changes that would support collaborative working on recruitment?

Across IJBs the different partners will have different terms and conditions which could create difficulties in the short, medium and long term. Is there an appetite/resources to address these differences and if so, what would we aim to achieve?

Q5. Based on what is said above, would it be helpful at national level to have an overarching process (or principles, or framework) for workforce planning across the Health and Social Care sectors?

We welcome the proposal to deliver a co-ordinated plan at a national level from which regional and local planning can be progressed to ensure that there are the resources and capacity to deliver future services. Recognition of the required 'shift' and the workforce planning that will be required to support this change will create numerous challenges for community based care, delivered through appropriate locally determined, multi-disciplinary teams.

The identification of the many layered and different approaches taken to workforce planning across the health & social care sector ranging from the 6 steps model in Health, the 8 stage guidance as outlined by the Scottish Social Services Council (SSSC) and the 4 stage process used within the third sector is helpful to establish the need for a consistent approach. We would in the main agree that the development of a national framework seems sensible but would concur that there needs to be an agreed

acceptance that the framework will allow for some variance between employers to meet their own needs given the difference in size and shape of the organisations across the sector.

We would also suggest that as with the SSSC 8 stage model, the new framework should also encompass not only implementation and monitoring of the workforce plan but, also the evaluation of the plan's aims, objective and outcomes.

Q6a). How can a more coordinated and collaborative approach be taken to assessing student intake requirements across all relevant professions, and what other issues should be addressed to remove barriers to successful workforce planning?

It is difficult in these challenging times to reliably and confidently plan for future service delivery however growing demographics and the continuing increase in service users' expectations of services, a coherent plan needs to be in place. IJB strategic plans should help to inform workforce intelligence and demands which is key in planning to meet the often persistent vacancies in some professions and areas of predicted growth. We also need to develop mechanisms/improve mechanisms that mean future workforce needs are aligned with training processes. Could any current links be strengthened/or created to ensure that there is a better connection between employers and further and higher educational establishments in planning numbers/intakes?

Q6b). What other issues should be addressed to remove barriers to successful workforce planning in both health and social care?

As previously stated, there needs to be a clear correlation between local, regional and national plans to address our future workforce needs.

National Health and Social Care Workforce Planning: Discussion Document

Healthier Scotland
Scottish Government

February 2017

CONTENTS

NATIONAL HEALTH AND SOCIAL CARE WORKFORCE PLANNING NATIONAL DISCUSSION DOCUMENT

Ministerial foreword

Our population is living longer and that's very good news for all of us. However, our longer lives bring with them a need for care that recognises multiple health and social care needs but allows us to remain connected to our communities throughout our lives and, as much as possible, to carry on living at home or in a homely setting.

This Government is taking a number of fundamental steps to implement transformational change in Scotland that will help us to deliver the care we will need in the future. The key components of change in health and social care are:

- the National Clinical Strategy;
- health and social care integration;
- public health improvement; and
- NHS governance reform.

The Delivery Plan for Health and Social Care which I launched in December set out the framework and actions needed to ensure that our health and social care services are fit to meet the challenges of our changing society. The four components set out above are neither exclusive to health, nor are they exhaustive – for example, Self-Directed support is an important aspect of social care - but taken together, they have the potential to bring about the transformation that is essential for the long-term sustainability of our services and the continuing improvement of the nation's health and wellbeing.

Making sure that we have the right people, in the right place at the right time to deliver better outcomes in future, and particularly to ensure that we can care for individuals and families appropriately in a community setting rather than in hospital, means changes in key areas, including how we make decisions about our health and social care workforce.

In future, workforce planning needs to recognise the interdependence of several key workforce sectors – the NHS, local government, the independent and third sectors and the newly created Integration Joint Boards (IJBs). This requires staff from all backgrounds and in all professions, to work more closely with each other across boundaries, often in teams and to the top of their professional roles.

We have sound workforce planning methodologies, with good principles applying to the services which health and social care staff currently provide. But they vary considerably in how they describe roles, responsibilities and educational frameworks, and are too weighted towards the single systems in which staff have traditionally operated. We now need a more mature approach, so we can use these

methodologies more flexibly, intelligently and predictively as tools to help us design jobs and roles which make sense in an integrated context, and which make the most of the world class skills our staff possess. Doing so will help ensure that these skills are combined collectively to deliver the improved services Scotland's people need. And it will reinforce confidence in the stability and sustainability of services – whether provided in hospitals or care homes – in these uncertain times.

I want all health and social care staff to feel engaged and supported to continuously improve the care and treatment they provide. The health and social care services we need can only be delivered with the full engagement and contribution of a valued and skilled workforce. At the heart of our transformation agenda is a broader, more integrated, more highly skilled, supported, and engaged workforce. That means getting our planning right in order to support individuals with the right experience and skills to deliver a service that is person-centred, and allows individuals working in any sector to feel they are making a difference.

I also want to pay tribute to those of our health and social care staff who have chosen to work in Scotland from across the EU. These committed and dedicated people continue to make a huge contribution to our nation's health and care, and we are in no doubt that free movement of labour throughout the 31 countries of the European Economic Area has helped ensure we have the skilled workforce we need. We greatly value our non-UK EU citizens and their wider contribution to our society and will do all we can to see that their rights, and their place in our nation, are protected.

This discussion document acknowledges the complexity of the system we work within but also the overriding need to collaborate in order to achieve the outcomes we need from our services in future. It sets out the background of what we have done to date to improve workforce planning, outlines some of the workforce challenges, and aims to start a conversation to support our mutual aims to transform health and social care services. It is the start of a process of improving workforce planning across health and social care and sets out the case for new thinking about how to plan the workforce.

This is a further step in the continuous process to ensure we have an effective workforce planning system in place. This will aid the hard working and dedicated staff who every day ensure Scotland has one of the best health and social care systems in the world. It builds on work already undertaken to identify the improvements required, and sets out some key early challenges that we believe can be tackled to ensure a more effective system.

I look forward to working with you to realise our ambition of a health and social care workforce fully fit for Scotland's future.

SHONA ROBISON
Cabinet Secretary for Health and Sport

1 - WHAT IS THIS ABOUT AND WHY ARE WE DOING IT?

Introduction

1. The need for a National Health and Social Care Workforce Plan was recognised in the Programme for Government which set out a commitment –

"*To ensure we have the right staff for our health and care services now and in the future we will shortly publish a new draft National Workforce Plan. This will outline a range of workforce planning improvements required to deliver enhanced primary and secondary care in Scotland, including work on bringing together a range of professionals into GP surgeries.*"

2. In its widest sense, the Plan will be about upwards of 360,000 people who deliver health and social care services which support people across Scotland, enabling them to live longer lives in better health, and empowered to deal with challenges circumstances which arise. It is the largest public service in Scotland, encompassing people working in a wide range of settings – from people's homes to hospital theatres - and with a wide range of skills and expertise – from interpersonal skills to dealing with highly technical equipment. There are many new approaches being developed to meeting the challenges facing services – demographic change, rising demand and expectation, financial constraints – but the fundamental contribution to transforming services will be made by this workforce.

3. Recognising the scope of this workforce, it is important to reflect on the reasons why development of the Plan can only be done collaboratively:

- This workforce is highly valued by the Scottish Government, by the employing organisations and, most importantly, by the people who use services and by the wider public. It is right, therefore, that shared effort is focussed on developing this workforce and in planning for the workforce which is needed now and into the future.
- This workforce is diverse in many ways including skills, employers, work context, governance and levers for change. Approaches to workforce planning and development will need to reflect, and be responsive to, this diversity.

The Plan's purpose will be to deliver a workforce which is deployed in the right places, in the right numbers, doing the right things.

4. The forthcoming and future workforce Plans will need to ensure the needs of different employers are addressed, that the different roles and responsibilities which relevant employers have are fully understood, and that their views are reflected in agreed actions. This requires careful consideration of the individual and joint roles within health and social care workforce planning. If this is not clearly understood, then achieving an improved workforce planning process with clear and identifiable impacts will be difficult if not impossible, given the recent addition of 31 new Integration Joint Boards engaged in planning, alongside existing NHS Boards, local authorities and community planning partnerships (CPPs).

5. The Scottish Government will publish, in Spring 2017, a National Health and Social Care Workforce Plan that takes forward its commitment to a sustainable

workforce to support the *Health and Social Care Delivery Plan*[1] published in December 2016. This Workforce Plan will help decide how to close the gap between what we have and what we will need, in order to deliver high-quality, safe, effective and person-centred integrated services to those who need them. It will help to align workforce planning more effectively to identify capacity challenges at an earlier stage and deal with them effectively; and improve workforce planning practice, making clearer what should be planned at national, regional and local levels and how this links to planning at a social care employer level.

6. Any discussion about a health and social care workforce Plan must reflect recent developments in health and social care integration and existing approaches in each sector. This document therefore aims to cover the workforce engaged in providing all health and social care services in Scotland, including adult social care, children's social care services, mental health and primary care. While the NHS and local authorities are major employers, third and independent sector organisations are, collectively, major providers in these areas, and their input to this document is welcomed.

7. Employers and providers find themselves in different places on workforce planning. Workforce capacity challenges are complex and distinctive: they can be difficult to overcome, and solutions may work for some areas and parts of the health and social care sector, but not for others.

8. It should be emphasised that this discussion document is not about "one size fitting all". Scottish Ministers have committed to strengthening NHS Scotland workforce planning to develop its regional capacity; but it is also the right time to consider how workforce requirements are assessed and planned in a coordinated way across the range of organisations involved in providing care and support, to ensure people's healthcare and social care needs are met.

9. Input is welcomed from across all areas of delivery, including the independent contractor sector – General Practitioners, General Dental Services, Pharmacy and General Ophthalmic Services – to the development of the Plan. As part of the wider NHS, these independent contractors employ the vast majority of health staff that fall outside our normal approach to workforce planning. They are significant employers, and their views on the issues and questions raised in this document are actively sought.

10. All workers require training - but for many healthcare professionals, training is often long, complex and subject to regulation at UK level. While social care professional regulation is a devolved matter, training for social workers, and those then progressing to be mental health officer or child protection specialists, is similarly long and complex. This cannot be ignored in bringing about improvements to workforce planning, in whatever part of health and social care. Organisations and individuals involved in regulating, training and developing our workforce are invited to contribute their views on the questions posed by this document.

[1] http://www.gov.scot/Publications/2016/12/4275

11. Our aspiration is that the Plan becomes more inclusive over time. As we move to the first iteration of the Plan, we want to start from a realistic position which recognises that different providers face complex and distinct challenges, and these differences need to be understood and reflected in any agreed approach.

12. For those reasons, the Plan will be part of a developing approach. It will be the first in a regular series aimed at improving the workforce planning system and practice, as well as developing more effective and informed intelligence.

13. We know that the many professional staff groups across health and social care face challenges which are very specific in nature. Reference to these has been deliberately kept to a minimum in this document. Its focus lies on consulting organisations and individuals on workforce planning in a more strategic context about how to achieve workable solutions across different sectors. It will, though, be necessary to consider profession-specific issues in more detail as we move towards a published Plan in Spring 2017.

14. Further information on the context, timescale and approach to this work has been set out at Appendix 2 to the Health and Social Care Delivery Plan[2].

Why is a national workforce Plan needed?

15. Health and social care in Scotland is shifting away from hospital and residential care towards community based services supporting people to live in their own homes where possible. The demographic challenges are well known, and in common with similar economies, Scotland's population is ageing – and this will contribute towards an increase in the complexity of health and care needs in the longer term. While the methods we use to plan a workforce have taken us so far, these challenges require us to look again at what we have, make adjustments and develop new models.

16. For NHS Scotland, the past 10 years have seen an expansion in numbers of staff working in NHS Scotland, and overall staff levels in the NHS are now at their highest level ever. This is also true for the workforce in social care services. We now need to go beyond numbers in responding to changing demography, social attitudes and career aspirations, changing demands on staff time and skills, and systemic change in how and where care is delivered.

17. This is true for all providers of health and social care services in Scotland. Combining reliable and useable intelligence will help determine not only whether the numbers of staff we have are sufficient, but whether they are the right balance; working where they need to be, when they need to be there; and applying their professional knowledge and skills to best effect in providing safe and high quality health and social care and support - regardless of which organisation employs them.This will allow us to take a person-centred approach to our workforce strategy, to ensure people using care are at the heart of decisions about the workforce.

[2] http://www.gov.scot/Publications/2016/12/4275

18. The challenges are many and complex.

- An ageing population living longer, but with increasing presentations of mental health problems, obesity, dementia, diabetes and other long term conditions.
- Significant developments in the social care service sectors will require national and local workforce planning and need to be reflected in further discussion, including the expansion of early learning and childcare.
- Rising standards and expectations about the quality of care from people who experience care, and from the Scottish Government – and the consequent need to ensure the future workforce can support the delivery of increasingly complex and high-quality care.
- Recruitment and retention presents all employers with challenges for different professions and in different geographical areas across Scotland, and in some cases, in areas of multiple deprivation.
- A changing workforce age profile, coupled with recent pension changes, mean that in future staff will retire later, with the workforce average age increasing. A significant proportion of staff are due to retire in the coming years, while many of those currently working retain protected entitlements around retirement. These all have implications for workforce planning.
- Planning for a more sustainable workforce will require a more sensitive understanding of supply and demand, and of risk-based intelligence to inform recruitment decisions and education requirements.
- Treatment and care must achieve a better “fit” with the needs of the population covered and with the geography of that population, or risk over-provision in some areas and under-provision in others.
- Gaps in some parts of the workforce and increasing demand, in conjunction with requirements to meet performance targets, also create additional pressures on the service that workforce plans will need to consider.
- Working patterns are changing: if trained professionals are increasingly working less than full time, then more need to be trained to achieve the same contribution to people’s healthcare needs and outcomes.
- Integration will require responsive and appropriate workforce planning, while respecting governance structures and responsibilities in place within different sectors.
- The role and prevalence of carers and unpaid staff and volunteers in meeting people’s needs, particularly in social care.
- Workforce planning for the primary care sector needs to be improved. In primary care the development of multi-disciplinary teams in and out of hours will need to be promoted; and to do that, better data and planning will be required, and innovation in recruitment and retention by both the NHS and independent contractors supported and encouraged.
- National data needs to build in more intelligence about the shape of the future workforce, as well as more focussed intelligence on our current staff.
- We need to fill gaps within our workforce, as far as possible from within employed staff resources, rather than from expensive agencies.
- The processes involved in workforce planning need to be less labour-intensive and less based on historical roles and models;

- The long timescales required to produce many healthcare professionals – eg a minimum of 10 years for a GP;
- Financial challenges across the wider public sector;
- Professional and cultural issues;
- The need to embed the principles of safer recruitment into workforce planning and growth.
- Communication issues between boundaries and sectors, which frustrate the development of regional working;

19. It is therefore the right time to invest our efforts in a co-ordinated Plan at a national level. We envisage that work around national and regional workforce plans will compliment and improve services across the health and social care sectors. This would help to ensure that health, social care and support provided by staff is directed to the most appropriate setting, and ensure the resources and capacity required to deliver services is recognised and planned for. The aim is to accurately identify the gaps in supply and actions required to close them so that the vision for health and social care can be delivered. That vision, set out in the Health and Social Care Delivery Plan and in the National Clinical Strategy, is for community based care, delivered through appropriate locally determined multi-disciplinary teams, with regional specialist centres focussed on more complex needs, to bring about direct and positive effects on people's health and wellbeing.

20. Achieving a "shift" in the balance of care therefore means that some services currently delivered within large institutions are likely in future to be delivered in a variety of smaller community settings. If workforce planning is fully to support that shift, the changes envisaged will require a proactive workforce, able to respond quickly and effectively where people most want services - within their homes and communities.

21. The most effective use of the workforce means working to the top of clinical skill set – whatever the professional field; and ensuring patients get access to the *right health professional* at the *right time*, whether an AHP, a nurse or a doctor. "Triage" and evidence-based models of care delivery, which make best use of the talents of the whole team, help to free up the most expert of staff for high level and complex work that only they can undertake. Making the most of AHP expertise has helped manage demand and reduce waiting time for consultant appointments, for example in Musculoskeletal pathways being developed in Orthopaedics, or through a more sustainable, digitally enabled, regional model for image reporting involving both consultant Radiologists and AHP Radiographers.

22. We expect the Plan published in 2017 to be:

i. <u>a strategic document</u>, setting out the workforce vision for health and social care services, the priorities to be taken forward, the assessment of current resources to deliver the vision, actions to close the gap between what we have and what we need, and clarity on the distinct roles each party will take on to ensure we have a coherent whole system approach.

ii. <u>at a national level</u>, drilling down appropriately to regional/local levels;

iii. active and useable. It will make coherent workforce planning links between national and regional activity and offer frameworks for practical workforce planning in both the NHS and providers of social care services.

23. The Plan will also be influenced by:

- public service reform and integration of health and social care, allowing space for NHS Boards, Local Authorities and IJBs to plan for the workforce for the health and social care system that Scotland needs, now and in future;
- the need to recognise the challenges in bringing together a workforce plan for a social service sector made up of approximately 2,600 separate employers from the public, private and voluntary sectors, alongside an NHS which is effectively a single organisation with 22 employers working with numerous independent contractors in primary care.
- The need to take account of the Public Health workforce, emerging roles in health protection and health improvement, and development of those roles via NHS Health Scotland and NHS Education for Scotland (NES).
- Within NHS Scotland, the progressing plans for elective centres; recommendations on workforce planning from Audit Scotland; the NHS Scotland Workforce 2020 Vision, *Everyone Matters*; within social care, the Scottish Government's *Vision and Strategy for Social Services*; and within primary care, the workforce recommendations from *Pulling Together*, the report of the independent review of primary care Out of Hours Services; and
- approaches and methodologies in use which support development of services delivered by multi-disciplinary teams – for example, the Workforce Planning Guide by the Scottish Social Services Council, the NHS Scotland 6 Step Model, and local authority tools and guidance. Integrating elements from these methodologies in a proportionate and sensible way, and setting them out in clear and understandable guidance, will help to define workforce needs for the future.

24. The issues on which the Plan will need to focus will require careful consideration to ensure the health and social care workforce has all the support it needs.

2 – WHAT WORKFORCE PLANNING IS CURRENTLY DONE?

1. Workforce planning is a complex activity taking place at different levels, over different timescales, with the involvement of a multiplicity of stakeholders. It may be useful to provide a general understanding of what people view as workforce planning. Audit Scotland[3] has provided a helpful definition (though it does not directly address the fundamental changes taking place to health and social care).

> Workforce planning is the process that organisations use to make sure they have the right people with the right skills in the right place at the right time. To manage their workforces effectively, organisations need to have up-to-date information on:
>
> - the numbers of people they employ to carry out different tasks
> - what skills the workforce has and where there are gaps
> - what skills and staff will be needed to deliver future services and priorities.
>
> They must then plan and manage their workforces, and make any necessary changes, to meet their organisational objectives.

Within the health and social care sector, the importance of having people with the right values is embedded in national approaches to safer recruitment.

2. In brief, workforce plans currently apply across health and social care as follows:

- IJBs, though not employers themselves, have to produce workforce development/organisational development plans; and must also produce strategic commissioning plans which identify local needs and show how these will be met;
- Local Authorities and other social care services employers operate various approaches to workforce planning for their workforce – as recognised in a 2016 research project supported by the Social Work Services Strategic Forum[4];
- NHS Boards are required to produce and submit annual workforce plans and there is also a requirement on them to ensure the full range of services are provided, including working with independent contractors in primary care;
- Third and independent sector employers are likely to do local workforce planning to enable adequate staffing resources, but scale and scope of this varies from employer to employer. Much of this provision is commissioned by the IJB or Local Authority.

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[3] http://www.audit-scotland.gov.uk/docs/central/2013/nr_131128_public_sector_workforce.pdf

[4] "*Recruitment and Retention in the Social Service Workforce in Scotland*" – Shona Mulholland, Jo Fawcett and Sue Granville (Why Research) http://www.gov.scot/Resource/0051/00512889.pdf - see wider context at http://www.gov.scot/Topics/People/social-services-workforce/SWSSF

3. Several organisations also provide support for, and input to, workforce planning in Scotland:

- IJBs are required to complete integrated workforce development plans.
- IJBs are tasked with managing integrated budgets to deliver or commission integrated health and community care services. This requires a planned approach to the workforce which provides these services.
- The Scottish Social Services Council (SSSC), working with the Care Inspectorate, collects and publishes a range of workforce related data intended to assist social services providers in planning their workforces.
- Local Authorities and other providers of social care services use a range of means to ensure that they have in place the workforce capacity to deliver those services.
- For NHS Scotland, Scottish Government sets the policy direction, guides and monitors. *Everyone Matters: 2020 Workforce Vision* launched in June 2013 makes a commitment to strengthening workforce planning to ensure that we have people with the right skills, in the right numbers, in the right jobs.
- Scottish Government leads and manages, through the Scottish Shape of Training Transition Group, detailed medical specialty supply and demand profiles.
- The Scottish Government's Nursing and Midwifery Workload and Workforce Planning Programme provides a validated framework and suite of tools enabling NHS Boards to make sustainable, evidence-based decisions on nursing and midwifery workforce requirements - mandated in Local Delivery Plans (LDPs) since 2013. Scottish Ministers have committed to enshrine safe staffing in law, placing the tools on a statutory footing in future.
- Workforce planning is a statutory requirement for all NHS Boards: each NHS Board must plan its workforce according to local needs and circumstances.
- NHS Boards are required to complete and submit Local Delivery Plans (LDPs) and must demonstrate the actions they are taking to ensure workforce planning takes place.
- NES holds core data on the numbers and progression status through training of key sectors of the healthcare workforce, particularly nurses and midwives, doctors and dentists. This data is critical to understanding the short, medium and long term supply pipelines for these workforce groups into NHS Scotland. NES provides a comprehensive report every 2 years on workforce planning in dentistry and have built up a valuable data base over the years.

4. While many of these working arrangements are close, they do not always work strategically and in some cases compete directly with each other to recruit the right staff. Each of the major organisations maintains distinct objectives with regard to workforce planning, and there is no fully integrated workforce planning system that addresses challenges collaboratively. There are opportunities to examine how a "whole system" approach to workforce planning can look at challenges and resources across health and social care and address these effectively. This will help the shift from hospitals towards communities, taking into account that some parts of the health and social care workforce are highly mobile, both within the UK and internationally.

5. For NHS Scotland, workforce planning is a statutory requirement established in 2005. The current guidance contained in CEL 32 (2011) was issued on 19 December 2011[5]. This revised guidance was developed to include an internationally recognised "Six Step Methodology to Integrated Workforce Planning" for use by the NHS workforce planning community across Scotland. It also established that this methodology could be used for other areas of planning, most notably financial and service planning. In essence, the six steps are:

Step 1 – Defining the plan
Step 2 – Service Change - what you want to do?
Step 3 – Defining the Required Workforce – what you need to achieve this?
Step 4 – Workforce Capability – what do you have at present?
Step 5 – Action Plan – what needs to happen to deliver the change required?
Step 6 – Implementation and Monitoring

There are strong similarities in approach between this methodology, the 8-stage guidelines set out by the Scottish Social Services Council, and a 4-stage process used within the third sector.

6. The need to improve and harmonise current NHS Scotland workforce planning practice is specific. It involves ensuring NHS Boards use the existing workforce planning methodology more consistently, and requiring them to do this in a regional context. And it will involve looking at how workforce planning for doctors, dentists, nurses and midwives is carried out nationally and how it might operate more effectively at regional and local levels than is currently the case. Though workforce planning arrangements differ for Allied Health Professionals, Healthcare Scientists and other key groups of NHS staff, those groups will also play an important part in addressing this need.

7. At the same time, there are also opportunities to examine how a "whole system" approach to workforce planning can look at challenges and resources across health and social care and address these effectively. This will only succeed if there is agreement about how a joint approach to workforce planning might work. That might imply a "framework" approach allowing for some variation between employers. It is encouraging that there is some similarity between methodologies referred to above, though there is further scope for common ground to be reached on roles and their definitions – where for example the term "Healthcare Assistant", and the associated education and training requirements for that role - is perceived differently within health and social care systems.

8. Making the most of these opportunities (within NHSS, as a priority; and across wider health and social care, in the longer term) will help achieve the best results possible from:

- Public Sector reform to enable NHS Boards, Local Authorities and IJBs to collaboratively deliver the health and care services that Scotland now needs;
- Programme for Government commitments on health and social care;
- The need to achieve integrated services delivered by multi-disciplinary teams.

[5] http://www.sehd.scot.nhs.uk/mels/CEL2011_32.pdf

- National Clinical Strategy objectives, including those on Cancer, Primary Care and developing plans for Elective Centres;
- The forthcoming (early 2017) Mental Health Strategy, which will deliver the Scottish Government's commitment to achieve parity of mental and physical health. This will require more emphasis on shaping the workforce via IJBs because the majority of health contacts with the population will fall outside acute settings.

National workforce planning

9. Workforce planning at a national level is currently carried out to support Scottish Ministers' decisions on the NHS Scotland workforce. The Scottish Government co-ordinates action and funding to:

- control student intake numbers to medicine, dentistry and nursing, and in the medical and dental supply chain beyond undergraduate education;
- support Scottish Ministers on NHS workforce planning policy;
- monitor and report on trends in the workforce arising from the publication of official statistics on workforce numbers and workforce projections;
- enhance workforce planning in NHS Scotland through improved data quality, better workforce intelligence, and application of a consistent methodology to assess and mitigate workforce risk;
- advance NHS Scotland workforce issues in a service context.

10. In NHS Scotland, student intake planning for the "controlled" professions – Doctors, Nursing, and Dentists – is carried out by separate groups convened for those purposes. These groups model and forecast numbers of students required in future training intakes which best meet the needs of future services, assessing demand and reflecting professional judgement and statistical analysis. Those needs must also take into account the conditions under which public funds are allocated by the Scottish Government for training, enabling educational institutions to provide training to the required level from within allocated resources. The main groups are:

a) **Medical** – Undergraduate medical numbers are set annually under the principles of "controlled" student numbers by Scottish Government on the advice of the Medical Undergraduate Group. The Shape of Training Transitions Group takes decisions on postgraduate medical training intakes with input from NHS Education for Scotland (NES) about medical supply and demand, and professional judgement input from Royal Colleges, BMA Scotland and others.
b) **Dental** - The Dental Student Intake Reference Group takes account of NES and other projections in deciding how many trainees are needed in future. This group communicates its recommendations to Ministers for approval. The Scottish Funding Council (SFC) is then responsible for allocating places across Scotland's Dental Schools, within available Scottish Government (SG) funding.
c) **Nursing and Midwifery** - The Student Nursing and Midwifery Intake Group triangulates statistical input from NES and ISD with SG analysis and professional judgement from the main representative bodies. This group

makes recommendations to Ministers about numbers of funded student places across the main categories of nursing and midwifery. SFC is then responsible for allocating the places across HEIs from within SG funding.

11. For social care services, the national Scottish Government role involves:

- providing resources to ensure the supply of degree-qualified social workers in Scotland.
- funding the Scottish Social Services Council (SSSC) to undertake the role of provider of Official Statistics on the social services workforce in order to provide workforce intelligence, monitor and report on trends in the workforce
- requiring the SSSC to set the qualifications required by certain categories of workers across the workforce and assess the quality of the qualifications.

12. Also at national level, SSSC works on a range of issues affecting the social care workforce, including demand for social workers, Mental Health Officer (MHO) provision and on data, qualifications and registration.

Regional Workforce Planning

13. Currently, regional workforce planning within NHS Scotland varies. Differing regional structures vary in how they respond to cross-board capacity problems as they affect particular services and professions. As a strategic priority for "scheduled care" provided in hospitals, the Health and Social Care Delivery Plan sets out arrangements for strengthening regional planning for services, with NHS Boards working together through three regional groups. That Scottish Ministers have committed to strengthen regional workforce planning is therefore a logical step. While regional workforce planning to date has enabled positive outcomes to be reached involving co-ordination of staff resource between Boards, a fully developed regional workforce planning capability across the NHS in Scotland – able to operate proactively and co-operatively across its territorial boundaries – now needs to be realised.

14. A National Workforce Planning Forum, with membership drawn from the principal workforce planners from all 22 NHS Boards – has sought to reduce variability in regional workforce planning practice, to encourage the use of cross-boundary solutions by sharing data and to bring more consistency to workforce planning across Scotland. The Forum has had to work with a diverse agenda in complex and difficult territory where workforce data is often variable and where Boards have different, and sometime conflicting, priorities. Consequently it has not always been able to access the input and intelligence it needs around changes in service models and associated capacity constraints. As such, the Forum has had limited capacity to wield sufficient influence at national, or even regional level.

15. There is limited regional planning for social service services, and indeed limited demand. There may be an opportunity to look at how a regional approach to workforce planning might be evolved in light of IJB roles and responsibilities.

Local workforce planning

16. Local workforce planning takes place in a variety of levels and within a variety of contexts – at NHS Board level, within Local Authority areas and IJB boundaries. Different challenges affect each of these systems.

17. For individual NHS Boards, it is essential to make accurate predictions over a number of future years to plan services properly. Boards estimate their future staff requirements in their workforce plans and workforce demand projections. In doing so, Boards need to ensure that these plans are driven by - and reflect – the design of their services in order to maintain quality of care and ensure efficiency. They must take into account factors such as changing models of care and where people live, advances in medicine and new technologies and drug treatments. As the majority of the future workforce will be drawn from the current workforce, Boards also need to take account of factors influencing the development of the existing workforce in order to meet future need.

18. This is an exacting process, and NHS Boards can experience difficulty in predicting accurate numerical projections of the number of staff needed, particularly in the medium to long term. Boards' ability to project anticipated staffing needs can be subject to shorter-term financial challenges: funding for workforce initiatives may be too short term in nature; there may be restrictions in how funds can be utilised, or difficulties in prioritising spend; funding may not be easily identifiable and difficult to plan for and monitor; or funding may not be targeted carefully enough to bring about intended change.

19. There is scope to reduce the level of detail NHS Boards are required to provide in workforce plans and projections, and for Scottish Government and NHS Boards to work more closely together to forecast more effectively – for example by using medical profiles to support local workforce planning. Closer and clearer working relationships should also help in wider considerations on how local workforce planning can be aggregated most effectively at regional level.

20. In the Scottish social care services sectors, it is understood that most, if not all, employer organisations take decisions at local level (that is, at employer or establishment level) about workforce planning and collect data on:

- Services provided/used and current staff numbers and costs
- Current vacancies
- Current training activity

Most organisations use this data for budget setting, day to day management and planning for short term needs, with a recent study indicating that some do use data for longer-term workforce planning. Local Authorities do workforce planning for their own workforce, but there is, as yet, no clear picture of the extent to which employers in the independent and third sectors use formal workforce planning tools - though resources such as the SSSC Workforce Planning Guide[6] are generally available.

[6] http://learningzone.workforcesolutions.sssc.uk.com/course/view.php?id=25

21. Though IJBs are not employers themselves, they are accountable for planning staffing needs for the services delegated to them by local authorities and NHS Boards. They play a key role in shaping workforce demand and in supporting 'intelligent forecasting'. A legislative requirement operates on IJBs to produce a workforce development plan and an organisational development plan. How IJBs choose to action this is left to local decision-making. As they have only been fully up and running since April 2016, workforce planning is currently a live issue.

22. Some of the complexities of integration, and the scale in which it is taking place, extend to workforce planning. The social services sector comprises a wide range of areas and service types and employs over 200,000 social services staff across approximately 2,600 third, independent and public sector employers[7]. [8] These service providers run just over 8,000 separate registered care services. Differing governance structures and responsibilities are in place across different sectors, although Local Authorities remain responsible for procuring social care services. Recognising these challenges, and the variety of methodologies in place will be important to ensuring workforce planning has full relevance in an integrated context.

23. Given the market arrangements prevalent in social care, there are strong interconnections between strategic commissioning and service procurement, workforce planning and pay, recruitment and retention and a range of other factors. One question is how beneficial a systematic approach to workforce planning can be for parts of the social care system. Independent and third sector social care service providers may be commissioned, primarily by Local Authorities or IJBs, to deliver a service for a fixed period of time (eg 3 years) before the contract is put out for tender again. Any uncertainty regarding renewal of contract can therefore make proactive workforce development and planning difficult. In the longer term, these providers will need strategic commissioning plans to be clear about what kind of care and support will be commissioned in the future, so that they can plan and develop their workforce appropriately in order to respond.

24. As a large number of social care service employers have a workforce of fewer than 30 people, and some are sole employees, there are also questions about the kind of workforce planning input that might reasonably be expected of those employers; and what kind of planning the commissioning bodies should be involved in. There are already examples of effective working between independent employers and local authorities around workforce training and development, but agreeing clearer and wider arrangements which can bring about more systematic approaches to workforce planning should help reduce some of the uncertainty experienced by providers.

25. The Plan will need to address these challenges and opportunities, which will require further discussion with IJBs, Local Authorities, independent and third sector interests.

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[7] http://data.sssc.uk.com/data-publications/22-workforce-data-report/128-scottish-social-service-sector-report-on-2015-workforce-data

[8] The 200,000 figure relates to the whole of the social service sector, including children's services. Adult social work and adult social care services account for c.145,000 people in the social service workforce.

3 – AREAS FOR IMPROVEMENT

1. There are a number of practical issues to consider in improving workforce planning, to give an accurate assessment of the work needing to be undertaken now and over the next 5, 10 and 15 years.

Updated Guidance/Structural Framework

2. Each NHS Board is currently required to produce an annual workforce plan, and IJBs are required to ensure they have developed one. These plans often acknowledge the changes required to deliver national strategies, but are either unable to articulate this fully, or choose not to address this – for example, in the absence of financial certainty. This works against effective long-term workforce planning (more than five years) and workforce plans tend only to outline fairly superficial responses to problems with recruitment and retention or succession planning.

3. This is not an issue for NHS Boards alone; it also involves Scottish Government. One way Scottish Government might address this is by setting out requirements within a clearer context for NHS Boards, using a more structured framework. In developing new guidance and setting out a framework for NHS Boards, the SG could take the opportunity to develop guidance which would be of wider use to IJBs and local authorities as well. This might offer more explicit guidance about the need to address particular constraints. Other areas where Scottish Government might work with NHS Boards and IJBs to improve the methodology of workforce planning are:

- Refining the processes around workforce plans, projections and LDPs.
- Seek ways to use the 6-step methodology more consistently and insightfully, so that NHS Boards and IJBs can predict workforce supply and demand trends with greater accuracy and sensitivity, and align these with service needs and priorities.
- Provide structured opportunities to look at recruitment – eg improved targeting and advertising – influencing NHS Boards' approach to locum and private sector use.

Workforce Data

4. One area that must improve if workforce planning is to be more effective is the quality and availability of data across all sectors. We need confidence in this to:

- take forward policies in pursuit of better health and social care
- improve outcomes for the people of Scotland
- ensure we have enough people with the right skills, doing the right thing in the right place at the right time.

5. Health and social care services are pressed on many fronts and need confidence that they are collecting, collating and using the right information, proportionately and intelligently, to plan for and deliver the services they provide. An important part of the Plan will therefore involve reviewing data requirements -

assessing how to streamline them and improving workforce data collection. This will focus on:

- reducing data "demand" where appropriate by focussing on what is needed;
- harnessing available insight, research and analysis to enable workforce planning to relate much more closely to delivery of successful clinical and patient outcomes as people experience them; and
- identifying and filling gaps where necessary.

6. There are some practical opportunities to refine the collection and use of data. These might include:

- examining how official statistics produced on a quarterly basis might cross-refer more helpfully with known management information held from day to day by NHS Boards.
- further work to compare, understand and analyse data respectively held for the NHS Scotland workforce (by ISD Scotland)[9] and for the social care services workforce (by SSSC)[10];
- reducing the demands of the currently quarterly statistical reporting cycle to free up analytical capacity within ISD Scotland and within NHS Boards themselves.
- Streamlining the projections process which will mean NHS Boards report only essential elements – and cut out unnecessary effort.
- Committing further time and resource to researching and analysing need and demand, and combining that information intelligently to factor in age, geography, training demands, career attractiveness and other factors.
- Committing resource to assessing gaps and identifying options for filling them, particularly in the area of primary care.

7. Improving workforce planning will require a better understanding of the numbers and contribution of non-UK EU citizens to NHS and social services in Scotland. While it is estimated that non-UK citizens account for approximately 5% of the total NHS workforce in Scotland, and around 6.8% of Scotland's doctors, the sensitivity of this data on the NHS Scotland workforce is being improved; and to achieve a better understanding of this within social care, COSLA, the Coalition of Care and Support Providers Scotland (CCPS) and Scottish Care are working at national level with the Office of the Chief Social Work Adviser. More refined data covering all health and social care sectors should help to inform workforce planning developments and will contribute significantly to our understanding of the challenges outlined in this document. Better information on the vital contribution made by EU citizens will also play an important part in designing and implementing effective recruitment strategies in future.

[9] http://www.isdscotland.org/Health-Topics/Workforce/

[10] The most recent report (with data from December 2015) was published in August 2016 and is available at http://data.sssc.uk.com/data-publications/22-workforce-data-report/128-scottish-social-service-sector-report-on-2015-workforce-data

Co-ordinating student intakes across professions

8. Each national group dealing with the control of student intakes deals with its own set of complex issues and takes advice combining statistical analysis with professional judgement. While improvements are being made to these processes, this is an area where, rather than continue to plan student intakes in professional silos, there is scope to make better connections across the professions, in line with the clinical priorities envisaged by the National Clinical Strategy. More detailed discussion will also be needed with further and higher education institutions and others about aligning these priorities with the education sector's capacity to meet ongoing need for trained staff across health and social care.

9. For the longer term, a more strategic approach is needed to encourage younger people to make positive choices about careers in health and social care. More work on career opportunities, labour markets and how these influence recruitment and retention will help to build evidence to support further action.

Strengthening demand dimensions in workforce planning

10. Current workforce planning models are largely predicated on supply factors. The 6 step methodology does makes provision for demand-led factors but how Boards interpret and observe the guidance needs to be considered carefully. Assumptions which are currently factored into workforce plans tend to be supply-based and service-related ones relating to perceived difficulties in securing sufficient capacity. It is critical that we understand planned future models of care and likely demand and articulate this as part of more intelligent, evidence-based workforce planning. We need to develop our understanding of demand factors and their effects on recruiting and retaining staff across all service areas.

11. In the longer term, the Plan will need to develop a series of actions, perhaps set within a framework of tools accessible by different employers, allowing them to use these to build sufficient numbers of appropriately trained and qualified staff. This will involve exploring how to develop better intelligence through workforce analysis – being clear how a range of demand factors impact on supply. This will be covered in more detail in the Plan.

Strengthening Workforce Planning Networks

12. While structural changes will not solve workforce planning issues on their own, there are opportunities to examine how we might improve and extend workforce planning structures to include social care and other sectoral interests, regionally and nationally rather than locally. Broadly, a workforce planning network might be configured as follows:

- **Nationally** – the establishment of a National Workforce Planning Group, to be taken forward in partnership between Scottish Government and key health and social care stakeholders, to ensure there is clarity of responsibility, governance and expectation. Dialogue to facilitate and establish this would include membership from the wider medical and non-medical professions. This group will also involve IJBs, primary care and social care representatives. It will require a

work programme that is solutions-driven with an active and dynamic agenda that prioritises workforce planning challenges and links them clearly to national clinical and other strategic priorities. Its work programme would recognise the need to bring in a range of contributions from providers within a timescale appropriate to them.

- **Regionally** – Regional workforce planning already takes place in the NHS, but is variable in scope. A more inclusive and mandated regional approach across Scotland might allow solutions to be identified, designed and delivered across boundaries. Regional workforce planning would need to be backed by clear governance, and the ability to reach balanced conclusions taking full account of differences in employment markets and economic drivers within regions.
- **Locally** – with guidance from Scottish Government, NES, Scottish Social Services Council, the Care Inspectorate, Social Work Scotland and other key organisations, and input from trade unions, there are opportunities for NHS Boards, Local Authorities and IJBs to work together constructively using a framework approach to share workforce planning data, solutions and good practice – building on what works best in differing situations and locations.

13. The process for all three levels of planning will need to fit together and have clear timescales and expected outputs.

4 - WHO NOW NEEDS TO DO WHAT?

1. The matters raised for shared discussion in this document will need close involvement and careful consideration from individuals and organisations. This Discussion Document is the first step, rather than an end point.

2. The Plan in Spring 2017 will identify potential solutions to the challenges we face. To help inform its contents, your views are invited on the following questions:

GOVERNANCE

We need to improve the current system so that each layer takes responsibility for actions that are appropriate to it. We propose to put in place governance arrangements which will help stakeholders set the direction of the workforce plan; to check and advise on progress; and to resolve contentious issues. The following table sets out broad proposals for workforce planning roles at national, regional and local levels.

Question 1. Are these roles the right ones, or do you have an alternative model? What steps will be needed to ensure these proposals are fully effective?

Strategic Level	**Workforce Planning role/activity: (these are suggestions for consideration. The Plan in Spring will set out more definitive proposals based on feedback to this discussion document.)**
National - these actions are done in partnership with relevant stakeholders from across the health and social care sectors. Where possible existing groups will be used, perhaps revitalised with a new action orientated remit. Where required, new groupings will be formed to undertake specific tasks (for example, a new monitoring and scrutiny body may be required to inject challenge into the workforce planning system).	The role we propose for this level is the following: • preparation and publication of the National Workforce Plan, which will set the vision and principles • collating and sharing evidence of best practice • developing and agreeing policy/strategy/guidance • identifying national priorities, including professions and geographical areas where national action is required • coordinating ongoing monitoring and scrutiny • agreeing remedial action required at a national level.

Regional – The current system does allow for regional planning, but feedback we have received is that the system needs to improve so that required actions are taken forward in a coordinated and effective way that has definite impact. We need to consider how best to create a regional planning structure for the health and social care sector that is effective and has appropriate authority for decisions to be implemented once agreed. This may ask organisations such as NHS Boards, Local Authorities and IJBs to work together to determine workforce requirements across health and social care, rather than decisions being taken independently of each other.	The role we propose for this level is: • identification of regional priorities • agreeing and implementing actions to ensure health and social care needs are met as effectively as possible across geographical regions and priority professions (for instance ensuring that remote rural areas are served effectively, and that resources within fragile professions are deployed to most effective use) • regular monitoring to ensure delivery is effective.
Local – This level of the health and social care sector is where most of the day to day operational decision-making will take place, and there are a wide range of organisations working independently of each other to ensure health and social care needs are met. If a more effective national and regional planning process is put in place it could significantly reduce the burden on those planning front line delivery by ensuring they only need to tackle the issue which they can have best impact on. This does not mean a one size fits all approach as at the local level we will see a range of ideas and approaches being implemented that are appropriate to that area,. This needs to be encouraged and catered for so that informed, relevant, effective and prompt decision making can continue.	The individual organisational roles for this area may vary in terms of the detail but broadly fit within the following criteria: • IJB local workforce planning in partnership with Local Authorities and NHS Boards, setting out workforce requirements across the agreed responsibilities that each IJB has. • Any health and social care needs for local areas that remain the responsibility of Local Authorities , working with the third and independent sectors. • NHS Board Planning for local secondary and primary care sector, ensuring local needs are met effectively.

WORKFORCE PLANNING ROLES

“Silo” approaches to workforce planning can prevent effective delivery of integrated services, following systems rather than persons.

<u>Question 2.</u> How can organisational and individual collaborative working be improved, and barriers removed, so that workforce planning can be effectively co-ordinated to ensure people get the care they need where and when they need it:

- Nationally?
- Regionally?
- Locally?

WORKFORCE DATA

Intelligent and insightful data is crucial to workforce planning, but data capture and analysis varies in scope and quality both within the NHS and between NHS and wider care systems. In order to improve our understanding of the challenges the health and social care sectors face, we need to ensure we have the most accurate and relevant data possible, and that this data is used effectively to undertake workforce planning across and between organisations.

Question 3. How should workforce data be best collated and used to undertake workforce planning in an integrated context based on current approaches of a nationally-led NHS system and a locally-led care system?

RECRUITING AND RETAINING STAFF

Employers are often in competition with each other to recruit staff from the same market, and for a variety of reasons can find posts difficult to fill – causing pressure on services and people who need and use them. A more collaborative approach to recruitment at a regional, and in some cases national level may help us to address recruitment pressures more effectively and efficiently.

Question 4a). How might employers and other relevant interests in the Health and Social Care sector work, jointly and individually, to identify and tackle recruitment and retention issues, ensuring priority gaps are identified and addressed:

- Nationally?
- Regionally?
- Locally?

Question 4b). Are there any process or structural changes that would support collaborative working on recruitment?

CLEAR AND CONSISTENT GUIDANCE

There is considerable variation in workforce planning practice across the Health and Social Care sector. National guidance for the NHS has helped put in place a standard system, but this needs to be refreshed and its implementation improved. This guidance sets out an approach that is recognised internationally as the most effective way to undertake workforce planning. In essence it asks those planning workforce requirements to answer the following questions:

- What is to be delivered?
- What do you have to deliver it?

- What do you need to deliver it?
- If there is a gap, how will you close it?

Woven through this is regular monitoring and evaluation to ensure approaches taken are having an effective impact.

Public and private sector organisations utilise this approach all over the world, and Health Boards have used it to progress workforce planning in the NHS. We believe it would be appropriate to use the same approach for other organisations within the health and Social Care sector where that is required, taking care to ensure its use is appropriate to each. This is not about rolling out an NHS approach for others to use, this is rolling out an internationally recognised process that allows an organisation to efficiently map out their workforce requirements as best they can using the data to hand. It may not require every organisation to undertake the process, as long as those planning have accurate and relevant data which would allow them to assess workforce requirements in the short, medium and longer term.

<u>Question 5.</u> Based on what is said above, would it be helpful at national level to have an overarching process (or principles, or framework) for workforce planning across the Health and Social Care sectors?

STUDENT INTAKES

Labour markets for doctors, dentists, nurses and midwives are complex and subject to uncertain future supply factors. Absolute certainty that estimates will be correct is not possible given the range of factors in play, and overly precise approaches provide little flexibility. Successful workforce planning relies on the creation of a surplus supply of an appropriately skilled and deployed workforce, meaning we need to strike the correct balance between ensuring a sufficient supply whilst at the same time doing our best to provide those coming out of training with an opportunity of employment. Vacancies in some professions remain persistent and capacity pressures continue for some clinical and nursing specialties. Student intake planning for “controlled” professions – doctors, nurses and midwives and dentists – is carried out by separate planning groups, each committed to ensuring all qualified professionals secure employment. Decisions on intakes are informed by statistical analysis and professional judgement, but also influenced by this commitment and on available funds. There is scope for the training process to align more effectively with workforce planning objectives, predicting supply needs against a more comprehensive set of demand factors, and making better connections across professions.

<u>Question 6a).</u> How can a more coordinated and collaborative approach be taken to assessing student intake requirements across all relevant professions, and what other issues should be addressed to remove barriers to successful workforce planning?

<u>Question 6b).</u> What other issues should be addressed to remove barriers to successful workforce planning in both health and social care?

Responding to this Consultation

We are inviting responses to this consultation by 28 March 2017.

Please respond to this consultation using the Scottish Government's consultation platform, Citizen Space. You view and respond to this consultation online at https://consult.scotland.gov.uk/health-workforce/national-health-and-social-care-workforce-plan. You can save and return to your responses while the consultation is still open. **Please ensure that consultation responses are submitted before the closing date of 28 March 2017.**

If you are unable to respond online, please complete the Respondent Information Form (see "Handling your Response" below) to: Rona Watters, Directorate for Health Workforce and Strategic Change: Health Workforce Policy, Area GR, St Andrew's House, Regent Road, Edinburgh, EH1 3DG.

Handling your response

If you respond using Citizen Space (http://consult.scotland.gov.uk/), you will be directed to the Respondent Information Form. Please indicate how you wish your response to be handled and, in particular, whether you are happy for your response to published.

If you are unable to respond via Citizen Space, please complete and return the Respondent Information Form attached included in this document. If you ask for your response not to be published, we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

Where respondents have given permission for their response to be made public, and after we have checked that they contain no potentially defamatory material, responses will be made available to the public at http://consult.scotland.gov.uk. If you use Citizen Space to respond, you will receive a copy of your response via email.

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us. Responses will be published where we have been given permission to do so.

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to Rona Watters, Directorate for Health Workforce and Strategic Change: Health Workforce Policy, Area GR, St Andrew's House, Regent Road, Edinburgh, EH1 3DG.

Scottish Government consultation process

Consultation is an essential part of the policy-making process. It gives us the opportunity to consider your opinion and expertise on a proposed area of work.

You can find all our consultations online: http://consult.scotland.gov.uk. Each consultation details the issues under consideration, as well as a way for you to give us your views, either online, by email or by post.

Consultations may involve seeking views in a number of different ways, such as public meetings, focus groups, or other online methods such as Dialogue (https://www.ideas.gov.scot)

Responses will be analysed and used as part of the decision making process, along with a range of other available information and evidence. We will publish a report of this analysis for every consultation. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.

Scottish Government
Riaghaltas na h-Alba
gov.scot

RESPONDENT INFORMATION FORM

Please Note this form **must** be completed and returned with your response.

Are you responding as an individual or an organisation?

☐ Individual

☐ Organisation

Full name or organisation's name

Phone number

Address

Postcode

Email

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

☐ Publish response with name

☐ Publish response only (without name)

☐ Do not publish response

Information for organisations:

The option 'Publish response only (without name) is available for individual respondents only If this option is selected, the organisation name will still be published.

If you choose the option 'Do not publish response', your organisation name may still be listed as having responded to the consultation in, for example, the analysis report.

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

☐ Yes

☐ No

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

Any enquiries regarding this publication should be sent to us at
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West Lothian Council

NHS Lothian

Date: 14/03/2017
Agenda Item: **13**

Integration Joint Board

ORGAN AND TISSUE DONATION AND TRANSPLANTATION CONSULTATION

REPORT BY DIRECTOR

A PURPOSE OF REPORT

To provide a response to the Scottish Government in respect of their consultation on organ and tissue donation and transplantation.

B RECOMMENDATION

To approve the response to the Scottish Government in respect of their consultation on organ and tissue donation and transplantation.

C TERMS OF REPORT

The Scottish Government is committed to increasing numbers of organ and tissue donors to help reduce the numbers of people in Scotland waiting for transplants or dying waiting. *The Donation and Transplantation Plan for Scotland, 2013-2020* is already delivering meaningful improvements, however, the Scottish Government now wants to consider two ways to potentially increase numbers of deceased organ and tissue donors:

1. seeking to increase numbers of referrals

2. seeking to increase the number of times when donation is "authorised" to proceed

In particular, the Scottish Government has agreed to consider the introduction of an opt-out system of donation if this can be developed in a way which will do no harm to trust in the NHS or to the safety of transplantation.

A "soft" opt-out system was introduced in Wales in December 2015 and there have been mixed indications so far about the impact this legislative change has had. It is not yet clear if the new system is likely to lead to an overall increase in consent rates and donors.

The Scottish Government is consulting on a range of matters related to these two key approaches to increasing numbers of deceased organ and tissue donors – see Appendix 1. A draft response on behalf of the IJB is provided in Appendix 2. The IJB is invited to approve the submission of this response to the Scottish Government.

D CONSULTATION

None

E REFERENCES/BACKGROUND

A Donation and Transplantation Plan For Scotland 2013-2020

F APPENDICES

1. Organ and Tissue Donation and Transplantation - a consultation on increasing numbers of successful donations

2. Response to Consultation on Organ and Tissue Donation and Transplantation

G SUMMARY OF IMPLICATIONS

Equality/Health	None
National Health and Wellbeing Outcomes	None
Strategic Plan Outcomes	None
Single Outcome Agreement	Consistent with the Equalities Outcomes measures within the Single Outcome Agreement 2013
Impact on other Lothian IJBs	None
Resource/finance	None
Policy/Legal	None
Risk	None

H CONTACT

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14 March 2017

Organ and Tissue Donation and Transplantation

A consultation on increasing numbers of successful donations

December 2016

Scottish Government
Riaghaltas na h-Alba
gov.scot

Contents

Foreword

Organ and tissue donation and transplantation is an incredible development in modern healthcare. It is genuinely life-changing and one of the greatest gifts a person can give. Organ and tissue donation saves and improves lives. It allows people to lead full and happy lives, return to work, and contribute to society.

While the NHS in Scotland, with the amazing help of donors and their families, has already achieved a huge amount in increasing numbers of organ and tissue donors, we need to continue doing more in order to help reduce the numbers of people in Scotland waiting for transplants or dying waiting.

Much work is already in progress to help with this – we are already delivering meaningful improvements as a result of our *Donation and Transplantation Plan for Scotland, 2013-2020*. However, this consultation looks at two ways we could potentially increase numbers of deceased organ and tissue donors – by seeking to increase numbers of referrals and by seeking to increase the number of times when donation is 'authorised' to proceed. In particular, the Scottish Government has agreed to consider the introduction of an opt out system of donation if this can be developed in a way which will do no harm to trust in the NHS or to the safety of transplantation. We will also be monitoring the progress in Wales carefully to learn lessons from their experience of introducing a new opt out system.

Our presumption is in favour of taking an opt out system forward as part of a long-term process of culture change to encourage people to support donation. However, I am keen to hear your views on these proposals and others in this consultation so I would encourage you to respond to the questions we raise. Whatever the outcome of this consultation, rest assured the Scottish Government will continue to work both within Scotland and with our partners across the UK to increase organ and tissue donation and to allow more people to benefit from life-saving or life-changing transplants.

Aileen Campbell
Minister for Public Health and Sport

Introduction

Organ and tissue transplantation can save and significantly improve lives, but at present there are insufficient donors to meet the number of organs needed by people on the transplant waiting list, as well as the need for tissue transplants. This consultation seeks views on ways in which we can increase the number of organ and tissue donors and transplants in Scotland. We have already made good progress in increasing organ donation and transplantation in Scotland over recent years, with an 83% increase in the number of people who donated organs after their death in Scotland between 2007-08 and 2015-16. In 2015-16 there were **183 organ donors in Scotland** (99 who had died and 84 living donors) and 415 people from Scotland received transplants. However, despite these successes, there were still 542 people on the active transplant waiting list in Scotland, waiting for an organ.

Background – What is organ and tissue donation?

Over the past few decades, surgical advances have allowed hospitals to remove organs from one person – a donor – and then transplant each of the organs into a person who needs a new organ. Donors who donate their organs after they die can **potentially save the lives of up to nine people**[1].

Only a small proportion of people (less than 1%[2]) die in circumstances where it is possible for them to be an organ donor. At the moment, it is only possible to donate if you die in a hospital – normally in a Critical Care area (for example an intensive care unit) - and, even then, there may be a number of reasons why organ donation is not possible, such as medical reasons (if some or all of the organs are not functioning well) or for legal reasons (where there is an investigation into the cause of death and the Procurator Fiscal may not be able to allow some or all organs to be donated).

Therefore, this makes it very important that, where a person has died or has an unsurvivable brain injury, and where they could be a potential donor, they are identified as such and the procedures necessary to enable possible donation are initiated.

In Scotland, donors who have just died (known as deceased donors), can donate:

- Kidneys
- Liver
- Heart

[1] While most donate fewer organs, it is possible for one patient to potentially save or transform the lives of up to 9 people: 2 kidneys, heart, 2 lungs, pancreas, small bowel and 1 liver, which can in some cases be split in two and transplanted into 2 people (this does not include lives saved or transformed by tissue donation)

[2] *Taking Organ Transplantation to 2020 – A UK Strategy* notes that over half a million people die each year in the UK, but fewer than 5000 people each year die in circumstances or from conditions where they could become donors.

- Lungs
- Pancreas (including for islet cells)
- Small bowel (or multi visceral organs where a patient needs a transplant of several organs – this can include for example the stomach or spleen as well as the small bowel)

In addition to organs, donors can also donate **tissue**. This includes: eyes, tendons, heart valves, bone and skin. Such tissue can be used in anything from severe eye disease to reconstructive surgery and skin grafts. Donated tissue can significantly improve the lives of others – and in some cases, such as heart valves, saves lives. Unlike organs, which in most cases need to be transplanted within a few hours of the donor's death, it may be possible to donate tissue up to 48 hours after a person has died. Therefore, even if a person cannot be an organ donor, they may still be able to donate tissue. In this consultation, where we refer to measures to improve organ donation from people who have died, this would normally also include increasing tissue donation.

Over half of all donated organs in Scotland come from people who have died (deceased donors), but it is also possible for living people to donate some organs. Most living organ donors donate one of their two kidneys as it is possible to live healthily with just one kidney. It is also possible for a living donor to donate a part of their liver or occasionally their lung, but this happens less often. Some living people also donate some of their bone, for example if they have a hip replacement operation. The Scottish Government and NHS Scotland are working on a project to encourage an increase in the numbers of living kidney donors, but this consultation paper focuses on ways of increasing donation from deceased donors.

How does organ and tissue donation currently work in Scotland?

While Scotland has its own legislation governing organ and tissue donation and transplantation – currently the Human Tissue (Scotland) Act 2006 - organ donation and the allocation of organs to transplant recipients is managed across the UK by NHS Blood and Transplant (NHSBT). Organs need to be carefully matched to a recipient, taking into account things like the blood group, age, weight and the tissue type of the donor and potential recipient. This is important to give the best possible chance for a transplant to be successful. If an organ is not a good match with the recipient, there is a significant risk that it won't function effectively.

NHSBT is responsible for managing the UK's national transplant waiting list and for matching and allocating organs on a UK-wide basis. While this means that some organs from donors in Scotland may go to people in other parts of the UK (and occasionally elsewhere in Europe), it also means that people in Scotland may receive an organ from elsewhere in the UK or the rest of Europe.

If someone is dying or dies in circumstances where they could be an organ donor,

for example in an intensive care unit or occasionally an emergency medicine department, a Specialist Nurse for Organ Donation (SNOD) will check to see if the patient has authorised donation themselves. People can formally authorise donation by joining the NHS Organ Donor Register, or can make someone close to them aware of their donation wishes. At this point, a sensitive discussion with the patient's family will start to take place with regard to donation.

If donation is to proceed, the clinical team caring for the patient will work with the SNOD, who will ensure all the necessary clinical checks are made. This will include checking that there are suitable recipients for each organ that can be donated. Throughout this process, the comfort and needs of the donor patient remain paramount and the main focus of the clinical staff in the critical care unit will be on caring for their patient. SNODs also work hard to support the donor's family during this difficult time and to answer any questions the family has.

The organs are then retrieved by a completely different team of specialist surgeons who are not otherwise involved in the care of the patient. Organs are always removed with the greatest care and respect. They are then stored in fluid and usually kept cool to help preserve them and transported to whichever hospital or hospitals will carry out the transplant(s). As soon as possible, a separate team of surgeons will then transplant each organ into the patient who is going to receive it.

While donated organs can normally be retrieved at most acute hospitals, there are three transplant units in Scotland, which each have specialist facilities dedicated to the transplantation of organs into recipient patients:

- The Royal Infirmary of Edinburgh (liver, kidney, pancreas and islet cell transplants)
- The Queen Elizabeth University Hospital, Glasgow (kidney transplants)
- The Golden Jubilee National Hospital, Clydebank (heart transplants)

Most Scottish patients have their transplant undertaken in one of the three Scottish transplant units. However, a small number of Scottish patients receive their transplant in other parts of the UK. These usually relate to rarer transplants where it is in the best interest of patients to receive transplants in specialist centres. These treatments are fully paid for by NHS Scotland.

Meanwhile, most tissue donation in Scotland is managed by the Scottish National Blood Transfusion Service (SNBTS), although NHSBT manages donation of eyes across the UK. SNBTS has its own Tissue Donor Co-ordinators (TDCs), specialist nurses who work closely with NHSBT SNODs to coordinate donations in cases where both organs and tissue may be donated.

Progress made so far

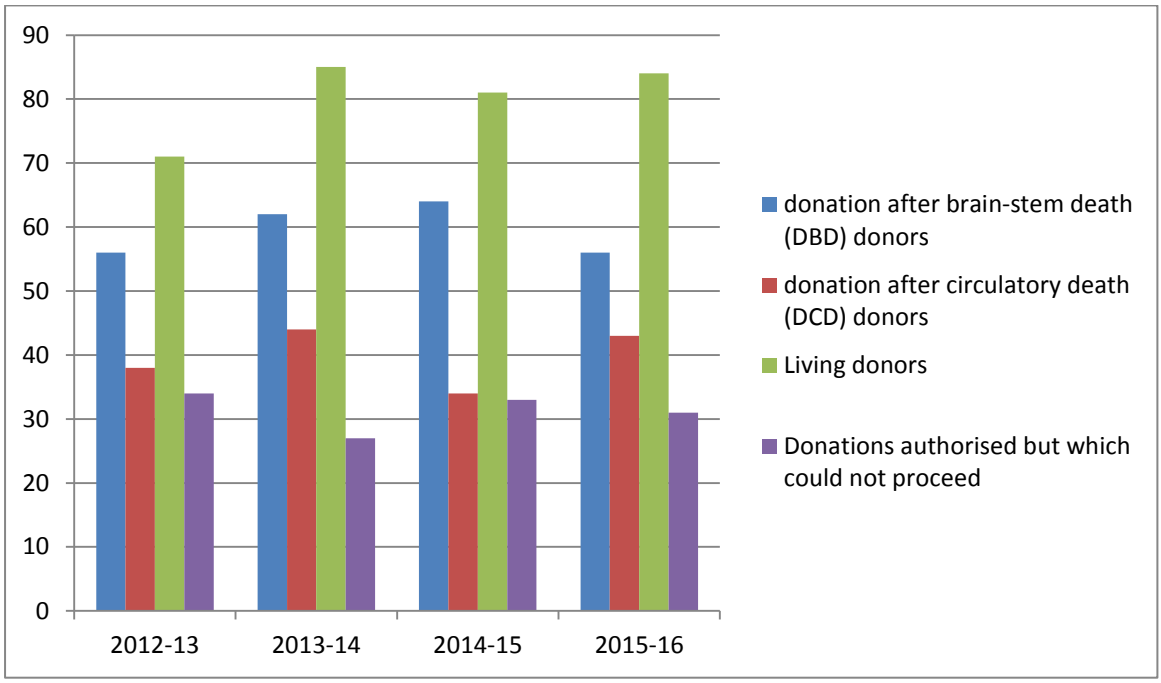
Considerable progress started being made after the publication of the UK Organ Donation Taskforce's report in 2008. In 2007-08 there were only 54 deceased donors in Scotland and 209 transplants from deceased donors. In particular, the development and training of dedicated SNODs to approach families, along with other improvements to the hospital infrastructure available to support donation, started to increase deceased donations. In 2013, the Scottish Government published *A Donation and Transplantation Plan for Scotland 2013-2020*. This set out 21 recommendations to increase donation and transplantation, building on the earlier Taskforce report.

Significant progress has already been made through implementing these recommendations, such as:

- successful and ongoing awareness-raising campaigns, which have encouraged more people to sign up to the NHS Organ Donor Register (ODR) – the proportion of the Scottish population who have joined the ODR increased from 29% in 2007/08 to 43% by October 2016;
- a project with Kidney Research UK which trains volunteers from black, Asian and minority ethnic (BAME) backgrounds to become peer educators to increase awareness of kidney disease and promote organ donation within BAME communities. This is important because families from BAME communities are much less likely to authorise organ donation, but statistically are more likely to need an organ transplant because of increased incidence of diabetes, heart disease and kidney disease;
- a schools educational resource pack has been provided to all secondary schools in Scotland. It has been recognised internationally as an important resource in increasing awareness about organ and tissue donation among young people;
- a new dedicated regional manager for Scotland is in post. Her role focuses on managing the SNODs in Scotland and taking forward key initiatives to help increase donation (previously the postholder covered both Scotland and the Northern region of England).

However, while **Figure 1** shows that numbers of organ donors has been gradually increasing overall over recent years, there is still more that can be done. Increasing the number of donors further remains a challenge, particularly given that fewer than 1% of people die in circumstances where they can donate.

Figure 1 – numbers of organ donors and non-proceeding donors in Scotland by financial year[3]



The Scottish Government, the Scottish Donation and Transplant Group and the dedicated Regional Manager for Scotland are taking forward a number of new initiatives, including:

- a project to raise awareness of and increase kidney donations from living donors in Scotland;
- considering piloting a model of designated requesters in two or more hospitals, which is based on an approach used in Australia where only clinicians and SNODs who have had specialist training approach families for authorisation of donation, to see if this helps increase authorisation rates further (currently any SNOD or clinician can approach a family about authorising organ donation);
- updating the existing agreement between the Scottish Donation and Transplant Group and the Crown Office and Procurator Fiscal Service (COPFS) which seeks to minimise the number of occasions when Procurators Fiscal are unable to allow donation to proceed due to needing a full post mortem examination of the potential donor's body;
- the Scottish Government will be working with clinicians, SNODs and NHSBT to explore opportunities for children or very young babies to donate their organs. This is a very sensitive subject, but we know that parents can draw some comfort from the fact that some good has come out of the tragic death of their baby or child;
- in 2015-16, 19 families refused to authorise donation because they felt the process was going to take too long. NHSBT is therefore working to try to shorten

[3] Source – NHS Blood and Transplant (NHSBT)

donation processes generally and also to see if donation processes can potentially be undertaken in a different order to allow for quicker, limited donations (of only kidneys and possibly also the liver) in cases where families would otherwise refuse authorisation due to concerns about the length of time the process will take. This trial might help increase donations in at least some extra cases in future.

Summary of areas considered in the consultation paper

This consultation is split into two sections. They cover different parts of the organ donation process, but are closely linked: the hospital identifying and referring potential donors and then the donation being authorised by the family. Delivering real increases in the number of donors and transplants will require progress in both of these areas.

The **first chapter** seeks views on alternative ways of potentially increasing the proportion of cases where organ and/or tissue donation is authorised. This looks at the pros and cons of an opt out system allowing authorisation to be deemed in certain circumstances, with safeguards – that is where, for most people, unless they have opted out of organ or tissue donation or their family know they did not want to donate their organs or tissue, donation can be deemed to be authorised. Such a system could potentially help tackle the problem of people 'not getting around' to making their wishes known.

Other potential options, such as a reciprocity system (where in cases of equal medical need, a person who had joined the ODR would get priority over someone who had not), were considered carefully, but have not been included in this consultation because they were not considered practical and raised significant ethical concerns. The option of a 'mandated choice' system – where everyone would be legally required to make clear whether or not they wished to be a donor – was also considered, but not included as it raised significant issues about how people could be forced to make such a decision, as well as significant practical issues in establishing and enforcing a system to collect everyone's views.

The **second chapter** looks at whether we should encourage hospital clinicians to refer to a SNOD patients who are expected to die in an intensive care unit or emergency department in circumstances which would potentially enable them to be an organ donor. This would also include referring most patients dying elsewhere in a hospital to a TDC, to consider further whether they could be a donor. Such an approach could help tackle the problem of people who have expressed a wish that they want to be a donor not being referred to a SNOD or TDC at the point of death. While in some of these cases it may not be possible for the person to be a donor for medical reasons, this would help ensure that, where needed, a case was considered by a transplant surgeon – in many cases, the person may at least be able to donate some organs or tissue.

Chapter 1 – Increasing Authorisation for Organ and Tissue Donation

Introduction

This chapter explores whether an 'opt out' system would increase the number of cases where donation is authorised – either through the explicit permission of the donor who has died, through the support of the family, or where authorisation can be deemed to be in place. Under Scottish legislation (the Human Tissue (Scotland) Act 2006), organs and tissue can only be donated from someone who has died if either the person themselves 'authorised' donation before they died – for example by joining the NHS Organ Donor Register (ODR) or by carrying a donor card – or if their nearest relative authorises the donation on their behalf.

The legislation does permit organs or tissue to be donated without needing the family's permission, if the person who has died has already authorised it. However, in practice, the support of the family is key to providing background information on the potential donor to enable the transplant surgeons to decide whether their organs or tissue are likely to be safe for transplantation. Therefore, currently donation would not proceed if the family were not content to authorise donation. Families are much more likely to authorise donation if their loved one was known to have wanted to be a donor. This is known as an 'opt in' system.

While authorisation is only one of several steps in enabling donation (and ultimately transplantation) to go ahead, it is important as each year a significant proportion of families refuse authorisation for their loved one's organs to be donated – in 2015-16 in 43% of cases in Scotland where family members were approached about donation authorisation was not given or the family overrode the authorisation the person had previously given themselves. That is despite surveys suggesting the great majority of Scottish people support organ donation[4], even if many of them do not get around to joining the ODR.

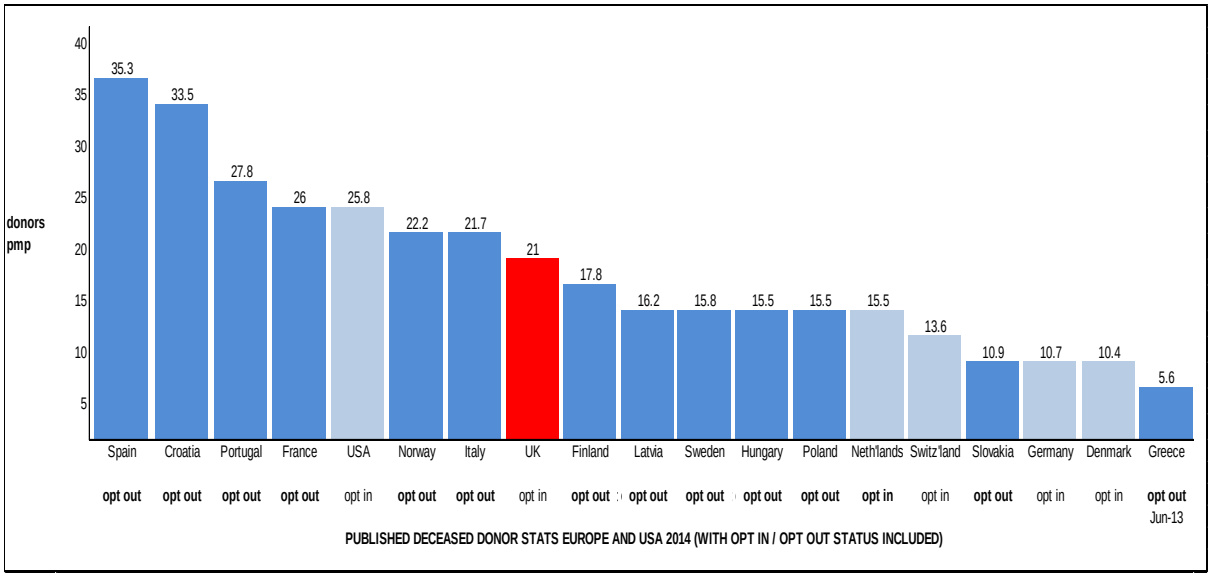
There are a number of different models of consent/authorisation used in different countries throughout the world. Most countries either use an opt in system, like the current Scottish system (where explicit authorisation or consent is needed), or an opt out system (where donation can usually take place unless someone has explicitly stated that they don't want to be a donor) and there can be a range of variations within these systems.

The chart below shows that numbers of organ donors per million people in the population varies dramatically across different European countries, although it is not always the case that those countries with opt out systems have higher donation

[4] For example, in a survey of 1032 people in Scotland in August 2016 carried out by TNS, 70% of people agreed that '*we should all register to be organ donors*'

rates. This is because donation rates are affected by a wide range of factors – authorisation (or consent) for donation is just one of them.

Figure 2 – Deceased organ donors per million population in key countries – September 2014[5]



The current opt in system

Keeping the current system remains an option. As noted in the introduction, there are a number of other initiatives being taken forward through the Scottish Donation and Transplant Group (SDTG) to help increase donation rates, which do not need changes to the current legislation.

The current opt in system has the advantage of avoiding donation proceeding in cases where the family thinks the potential donor may have objected, but the donor never explicitly raised any concerns, or potentially in cases where it would cause distress to the family. Also, the current system – along with the SDTG's initiatives – has been shown to be effective at increasing numbers of donors and transplants, and is well understood by NHS staff and families. One survey this year also suggested that it may be more popular amongst the Great British public than an opt out system[6]. While our current system is an opt in system, people in Scotland can also already choose to actively make clear they do not wish to be a donor by registering to 'opt out' via the Organ Donation Scotland website.

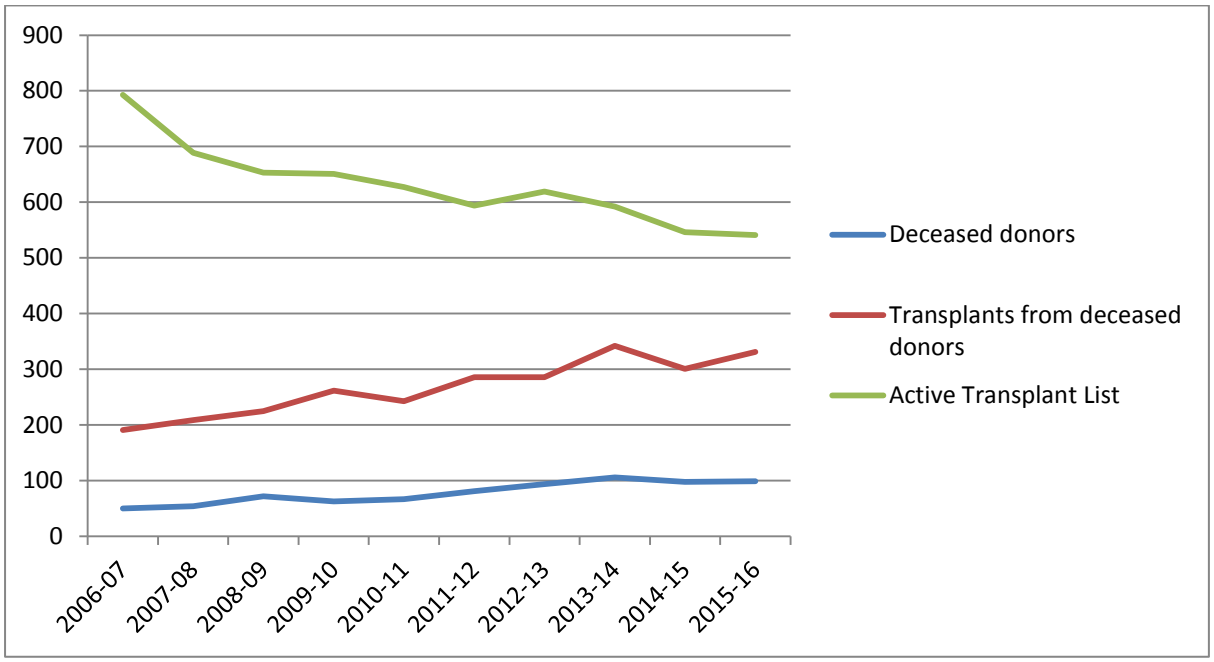
[5] See Council of Europe Transplant Newsletter September 2015: https://www.edqm.eu/sites/default/files/newsletter_transplant_2015.pdf

[6] See https://www.ipsos-mori.com/researchpublications/researcharchive/3728/Wishes-of-organ-donors-should-take-priority-over-wishes-of-their-families-public-says.aspx - a survey of 1001 adults in Great Britain (but this does not provide a breakdown of responses provided by those in Scotland). 49-50% favoured the current opt in model, while 37-42% favoured an opt out/deemed consent model.

A soft opt out system

There has already been significant debate about whether or not there should be an opt out system of organ donation in Scotland. International evidence as to whether or not an opt out system in itself makes any significant difference to numbers of organ (or tissue) donors is unclear and subject to debate.

Figure 3 – changes in number of deceased organ donors in Scotland, transplants and those on the waiting list over time[7]



Rates of organ donation can be higher in countries with opt out systems, although it is often unclear whether it is the opt out system itself or other factors (such as developments in donation and transplant resourcing, prioritisation in hospitals or awareness raising amongst the public) which have helped increase donation rates. For example, Spain currently has the highest organ donation rates in the world (approx. 35 donors per million population) and is often quoted as an example of an opt out system working well. However, Spain only observed a significant increase in donation numbers after improvements to their infrastructure, and many years after the legal basis for opt out had been introduced. It is also worth noting that, due to differing donation procedures, a significant proportion of donors' organs in Spain are not transplanted[8]. In addition, as shown in Figure 2, Scotland and the rest of the UK already have higher donation rates per million population than some of the countries operating opt out systems.

[7] Source – NHS Blood and Transplant (NHSBT)

[8] For example, in 2014, an average of 24% of donated kidneys in Spain were not used for transplant because no transplant centre would accept them. This is compared to only 10% in the UK because in the UK no organs are removed from a donor unless they have already been accepted by a transplant hospital as being suitable for one of their patients.

A ‘soft’ opt out system was introduced in Wales in December 2015 and there have been mixed indications so far about the impact this legislative change has had. It is not yet clear if the new system is likely to lead to an overall increase in consent rates and donors. Data from NHSBT shows there were 25 deceased donors in Wales from April to September 2016, compared to 60 in 2014-15 and 64 in 2015-16. It is however too early to draw meaningful conclusions from the first short period of operation.

While the evidence from other countries is often inconclusive, given the increasing levels of public interest in developing an opt out system, the Scottish Government would consider the introduction of an opt out model if such a step would be supported by the general public and by stakeholders, and if it can be introduced in a way that will do no harm – either to the public perception of organ donation and trust in the NHS, or to the operation of processes required to take donation forward.

The existing UK NHS Organ Donor Register (ODR) allows anyone in Scotland to either opt in or to register their wish not to donate (often referred to as ‘opting out’), by confirming if they do or don’t want to be an organ or tissue donor when they die (people can also opt in on a qualified basis if they are willing to donate certain organs or tissue, but not others). A change to an opt out system of donation could legally permit donation to proceed where authorisation can be ‘deemed’ on the basis that a person has not opted out by recording that wish on the ODR, or by otherwise noting in writing that they did not wish to donate their organs and/or tissue.

However, there would be likely to be significant concerns that such a rigid opt out system – sometimes called a ‘hard’ opt out system - might lead to people becoming donors even if they would not have wanted to. It may be they had not got round to opting out or were not able to understand that they needed to opt out.

Therefore, it is likely that a ‘soft’ form of opt out system would be more acceptable, one that provides additional safeguards to ensure donation does not proceed in cases where the family knew that their loved one did not want to be a donor. These safeguards would have to be structured in a way that was not overly complex and did not cause delays to the organ donation process. An overly complex or time-consuming process will lead to donations being unable to proceed. Too many administrative obstacles would also mean that there would be little or no difference in practice from the current Scottish opt in system.

Question 1 – what do you think of the principle of a soft opt out system for Scotland?

Question 2 - are there any changes you would make to the current ‘opt in’ authorisation system, other than moving to opt out?

Question 3 – where someone has joined the Organ Donor Register (ODR) or indicated in another way that they wish to donate, what do you think should happen if the potential donor's family opposes the donation?

How soft opt out could work in Scotland

A workable soft opt out system would be expected to involve the following three 'steps'[9]:

1. high profile **awareness-raising campaigns**, for at least twelve months before introduction of the new system and on a regular basis after implementation. This would be designed to ensure as many people as possible think about organ and tissue donation, discuss it with their families and either opt in or, if they don't want to be a donor, opt out. It would be important to ensure these campaigns take account of the needs of people who either speak little or no English and people with disabilities or learning difficulties who may need extra support to understand the new system and/or to opt out if they want to. Efforts would also need to be made to allow people who may be harder to reach to opt out if they want to, including prisoners and others who may not have access to the internet. Education and training for a range of healthcare professionals and other professional groups involved would also be required during this time.

2. **deemed authorisation** - in the event of death of someone in hospital in circumstances where their organs or tissue could potentially be donated (and they were not in any of the 'excepted' categories under step three below), a Specialist Nurse for Organ Donation (SNOD) or a Tissue Donor Co-ordinator or person who takes authorisation for eye donation (TDC) would undertake the following checks to help them reach decisions:

    - if the person had registered as opting out, no donation could proceed (unless the family provided evidence that the person had confirmed in writing more recently that they had changed their mind);
    - if the person had registered as opting in, the family would be informed and SNODs/TDCs would start the process of examining the feasibility of donation (unless again the family provided evidence that the person had confirmed verbally or in writing more recently that they had changed their mind);
    - if the person had not registered any decision on the ODR, a SNOD/TDCs would approach the person's family to discuss the fact that the person was not on the ODR and therefore, in the absence of other information, would

[9] Note – this is just a summary of steps and steps 2 and 3 would be considered at the same time. Authorisation procedures would not be taken forward in cases where there were already known medical reasons why the person could not be a donor. These procedures would also not be taken forward if the Procurator Fiscal refuses to consent to any donation – NHS staff must inform the Procurator Fiscal under certain circumstances, such as if the death was suspicious.

be deemed to have authorised donation. The family or friends would be asked if their relative/friend had expressed any objections to organ donation. If the person was not known to have expressed any objections then the assumption would be that donation could proceed; **this would count as** '**deemed authorisation**';

- however, there could potentially still be scope for donation not to proceed if it was clear that proceeding would cause distress to the family (and lead to them potentially refusing to provide the important background information which is needed in most cases to decide if it is safe to proceed with donation and subsequent transplant). In Wales, families can still refuse to allow donation to proceed even where the legislation would allow donation to proceed on the basis of deemed consent and this has happened already;
- in the relatively rare cases where the person did not have any family or close friends – or at least none who were contactable within the necessary timeframe – then, if they did not come under any of the explicit authorisation categories below, donation could be considered to be authorised unless the person had opted out. However, in these cases, NHS staff would still need to consider whether or not they had sufficient information on the patient and his or her medical history to be sure the organs or tissue would be safe to transplant. In some cases, they may still be able to proceed where sufficient information is available from medical records.

Question 4 – if there was a soft opt out system, what do you think of the proposed checks above?

Question 4(a) - if you think these are not sufficient, what other checks would be needed (apart from those set out under step 3 below)?

Question 5 – in any opt out system, what do you think should happen if a deemed authorisation donation was likely to distress the potential donor's family?

3. In cases where someone dies and checks made by SNODs or TDCs suggest that they may fall into any of the following categories, donation (of either organs or tissue or both) could only be authorised with **explicit authorisation**, either from the person themselves or from their family:
   - someone who, over a period of time before their death, did not have capacity to take a decision on donation (see further details below on who this would cover);
   - a child under a certain age – we would still view it as appropriate for children of 12 years old or over to be able to self-authorise their own donation if they wish, but it may not be appropriate for someone's authorisation to be 'deemed' unless they are at least 16 years old;

- anyone who had not been resident in Scotland for at least 12 months before their death. It is proposed that this would be a relatively straightforward assessment of whether or not their 'main' home had been in Scotland for 12 months or more, but they would not necessarily need to live there all the time – for example, students or members of the armed forces would count as resident if they were generally in Scotland over 50% of the year even if they stayed somewhere else during their holidays or had periods working abroad during that time.

We are acutely aware of the importance of ensuring any opt out system takes account of the rights of people who are unable to make their own decisions. In hospital immediately before their death, almost all potential donors would be considered 'incapable' of making their own decisions, but these separate explicit authorisation provisions would only be expected to apply where the person suffered from incapacity over a period of time before their death due to a mental disorder or physical disability – with the result that they cannot be considered to have been capable of taking a decision on organ donation for some time before their death. This would probably mean it is likely they could not have made their own decisions for more than a year before their death. However, it might also be appropriate for the system to allow the flexibility to require explicit authorisation as appropriate in certain cases where a person's lack of capacity was over a shorter period. This would recognise that they may not have had sufficient ability or understanding to make their views on organ donation known. We are therefore keen to hear your views on when a person should be classed as not having capacity to make their own decisions under this provision (see question 7 below).

If a potential donor falls into any of the three 'excepted' categories above:

- Similar procedures would apply to the current ones in that donation would normally only be authorised in these circumstances where a family member provides authorisation on the person's behalf. The Human Tissue (Scotland) Act 2006 already defines who would be classed as the person's nearest relative (if there is no family member, the decision can be made by a friend of long-standing);
- However, if the adult or child had opted out of donation then their view would be respected. If they had opted in, then that should be sufficient to authorise a donation if they were 12 years old or over (particularly for anyone who had been living in Scotland for less than twelve months or if the person had opted in at a time when they did have the capacity to make that decision). However, there would still be scope for donation not to proceed if it was clear that proceeding would cause distress to the family or if the family and/or medical records made sufficiently clear that the person did not have the capacity to understand what they were doing at the point they opted in and the family did not agree to authorise donation;

- In cases where the person was not known to have expressed a view either way, the nearest relative would be asked to decide whether or not to authorise donation. As happens under the current system, they should base their decision on what they think their relative would have wanted in cases where it is possible to know this. In cases where it is not possible to know what the person might have wanted, their nearest relative would need to make their own decision;
- In the case of children, it would be the child's parent(s) or another person with parental responsibilities and rights who would decide. For looked-after children, a local authority currently cannot authorise donation if no parent is available, although there may be a case for reconsidering this restriction – for example, in England and Wales where a person in a local authority has parental responsibility for a child in care then the local authority staff member can give consent to donation.

The potential approach set out above would involve SNODs, TDCs and/or clinicians (or in some cases eye donation specialists if only eye donation is being considered) needing to make a judgement about a potential donor's situation in order to decide whether or not they fall into one of the categories where explicit authorisation is required. They would normally be the ones deciding whether or not explicit authorisation would be required, although they would consult their senior managers in NHSBT or SNBTS if they were unsure in a particular case. Given the limited timescales available to seek authorisation for donation, it might not always be possible, for example, to be sure if a person had been resident in Scotland for more than twelve months or if they had sufficient capacity to make their own decisions about donation before coming to hospital. Therefore, we would propose that detailed guidance and training should be provided for SNODs, TDCs and other healthcare workers before the implementation of any opt out system. We would also propose that, where there is some doubt about whether or not a person falls into one of the 'excepted' categories, explicit authorisation should always be sought from the person's nearest relative.

Question 6 – if there was a soft opt out system, what do you think about the categories of people set out above for whom explicit authorisation would still be needed from the person themselves or family member?

Question 6(a) – if these are not sufficient, why do you think this?

Question 7 – in what circumstances do you think an adult should be viewed as not having the capacity to make their own decisions about donation and therefore should not be subject to any deemed authorisation provisions?

Question 8 – under what age do you think children should only be donors with explicit authorisation?

Question 9 – for children who are in care, what are your views on allowing a local authority which has parental responsibilities and rights for the child to authorise donation for the child if no parent is available?

Donations of less common types of organs or tissue under an opt out system

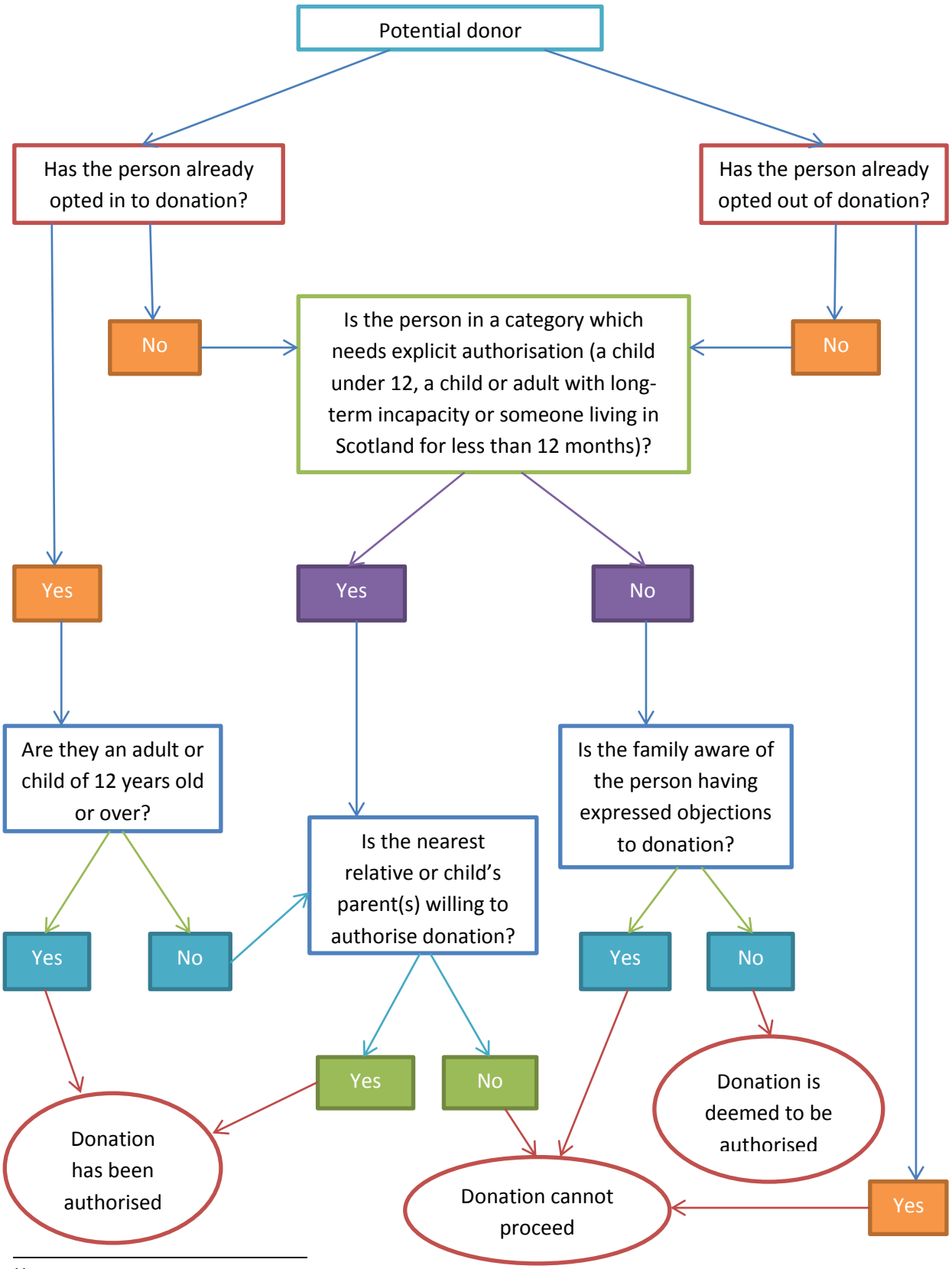
While this model of deemed authorisation could cover the more common types of organ and tissue donation, it may still be appropriate to only allow for more rare and novel types of tissue or organs to be donated with explicit authorisation from either the donor themselves or their family. For example, it is now possible for limbs to be transplanted; it is also possible to undertake facial tissue transplants, although this is not currently carried out in the UK. In the Welsh opt out legislation, there is a list of these rarer types of organs or tissue – referred to as 'excluded material' – where express consent is still required for it to be donated[10]. A similar provision could be considered in any future Scottish legislation to specify the types of organs and tissue where deemed authorisation either could or could not be used.

In addition, we would propose that any deemed authorisation approach would only apply to donation where this is for transplantation. It would not apply to donation for research purposes as this could still only happen with explicit authorisation from the donor or their family. While donation for research remains very important and there is significant demand for such organs, we do not feel this is sufficient to allow organs to be removed on the basis of deemed authorisation only.

Question 10 – in any opt out system, what provisions do you think should apply to the less common types of organs and tissue?

[10] See the Human Transplantation (Excluded Relevant Material)(Wales) Regulations 2015 at http://www.legislation.gov.uk/wsi/2015/1775/pdfs/wsi_20151775_mi.pdf

Figure 4 - Flowchart of authorisation pathways for potential organ and tissue donors[11]



[11] Note – this flowchart is based around donations of 'standard' organs and tissue for transplantation – it does not cover either donations for research or the proposals around rarer types of donation – in both cases explicit authorisation from either the donor or their family would be needed.

Benefits and disadvantages of this soft opt out model

This process would have potential benefits in a number of cases by permitting organs to be donated in cases where a person is in favour of donation, but has not got around to signing up to the Organ Donor Register. It may also in some cases make things easier for relatives by taking away much of the pressure in making what can be a very difficult decision, but still giving them the chance to object if they know that their relative did not want to be a donor. If there is sufficient ongoing awareness-raising through a range of media to ensure that people who do not want to donate have sufficient opportunity to easily opt out, then it may be acceptable to authorise donation on the basis that the person has chosen not to opt out.

Table 1 below sets out the reasons given why families refused authorisation for organ donation in 2015-16. In 28 cases, the family said their relative had previously expressed a wish not to donate. The table also shows that in all the other cases, the donations could potentially have been 'deemed' to be authorised, assuming they did not fall into an excepted category where explicit authorisation was needed. However, it is likely that a majority of others would also not ultimately proceed because either a) explicit authorisation would be needed, b) because the family might override the deemed authorisation or c) due to medical reasons.

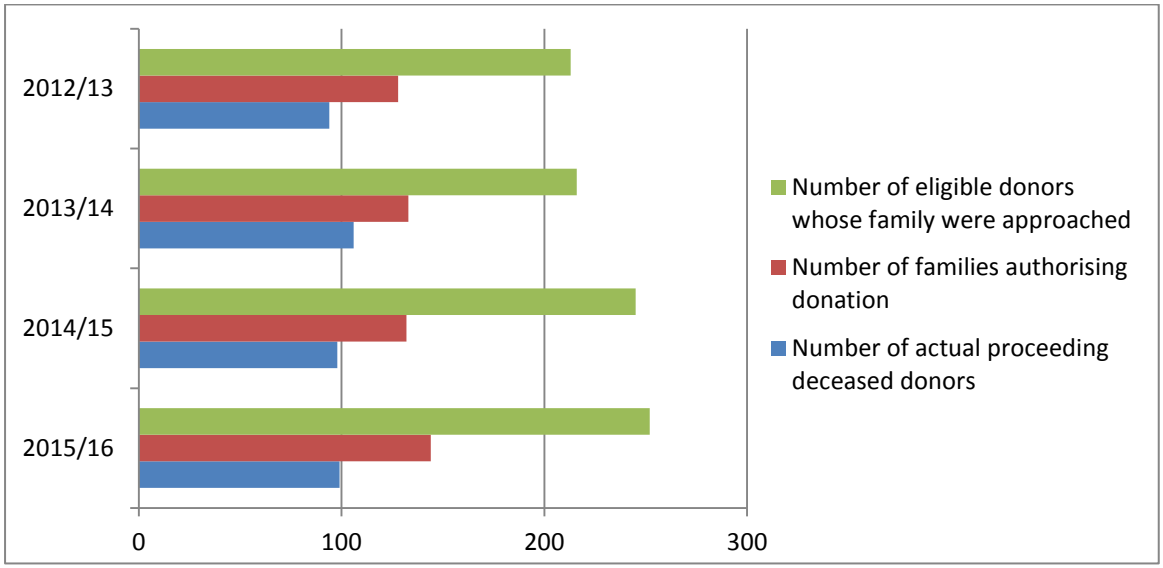
Table 1 – Reasons given why families did not provide authorisation – 2015-16

Reason	No of DBD donors	No of DCD donors
Patient previously expressed a wish not to donate	7	21
Family were not sure whether the patient would have agreed to donation	<5	13
Family did not believe in donation	<5	<5
Family felt it was against their religious/cultural beliefs	<5	-
Family was divided over the decision	-	<5
Family felt the patient had suffered enough	<5	7
Family did not want surgery to the body	<5	5
Family had difficulty understanding/accepting neurological testing	<5	<5
Family felt the length of time for donation process was too long	<5	16
Family concerned that organs may not be transplanted	-	<5
Strong refusal - probing not appropriate	<5	5
Other	<5	11
Total refusals	**23**	**85**

Source – NHS Blood and Transplant (NHSBT) – covers approaches in Scottish hospitals
Note – where fewer than 5 families refused for a particular reason, this has been marked <5 in order to help protect their identities
DBD donors are ones who have been diagnosed as brain dead, while DCD donors are ones who will be certified as dead after their heart stops beating and they have stopped breathing.

However, clearly such a deemed authorisation approach could carry risks. Deemed authorisation would be a legal authorisation. Nonetheless, it is still likely to be difficult to assume it is accepted that someone authorises their donation just because they have not opted out. The model above however aims to provide sufficient safeguards for the groups of people who are less likely either to be able to sufficiently understand the meaning or implications of opting in or out or may be unaware of the legislation due to not having been in Scotland for very long.

Figure 5 – numbers of families approached compared to those giving authorisation and actual donor numbers



Source - NHSBT – Note that families are only approached where initial checks based on the information the Critical Care unit has suggest the person's organs are likely to be suitable for donation

Figure 5 above suggests that an opt out system has the potential to increase authorisation rates, which in turn could increase the number of people who actually go on to donate organs. However, it is impossible to judge to what extent authorisation or actual donations would increase as more people are likely to opt out of donation (under the current system, only 1146 people in Scotland had so far opted out at the end of September 2016) and some would still need explicit (rather than 'deemed') authorisation. Based on the Welsh experience, it is likely that a number of families would also still refuse to support the donation and clinicians would feel unable to proceed.

Regardless of the amount of awareness-raising, there are still likely to be a significant number of people not in any of the listed categories needing explicit authorisation who would neither opt in or out – this is often likely to be either because they don't want to think about death or don't think it will happen to them for a long time or just because they don't get round to it. In Wales, the level of awareness of their new opt out legislation is high as a result of their awareness-

raising campaign. As a result, they have made clear to people that anyone who neither opts in or out of donation is still making an **active choice** to allow their organs to be donated. As at 31 March 2016, 165,129 people in Wales had opted out of donating their organs (just over 5% of the population), while 1,113,090 had opted in.

Surveys suggest the great majority of people do support donation (70% of people in an August 2016 survey[12]). It could also be argued that if people have been given sufficient information, it is their responsibility to explicitly opt out if they don't want to be a donor, but there is still a possibility a model based on 'deemed' authorisation leads to people becoming donors when they actually would not have wanted to donate. This could risk being viewed by some as the state taking people's organs, rather than people actively choosing to give them. Any such perception could lead to a loss of trust in the NHS and the system more widely, which might actually lead to an increase in numbers of people choosing to opt out. It could also lead to conflict with families, which would be likely to put SNODs, TDCs and doctors in a very uncomfortable position and make it difficult for them to gather sufficient information from the family about the patient's lifestyle to be reassured the organs or tissue will be safe to transplant. In such cases, NHS staff would often decide not to proceed with donation even if the legislation permitted it.

As suggested above, a model which allows for authorisation if someone has not opted out, but still recognises and allows for donation not to proceed if it is likely to cause severe distress or conflict with the family should help increase authorisations to some extent, but avoid the opt out system being too rigid.

Pre-death tests for potential donors

There also needs to be consideration for potential Donation after Circulatory Death (DCD) donors[13] to determine whether or not 'deemed authorisation' of donation should allow certain actions to be taken before death to help facilitate donation, such as blood tests, X-rays, urine tests or planning the timing of withdrawing the patient's life-sustaining treatment. If these were not allowed or were only permitted with explicit authorisation from the patient or their nearest relative then this is likely to prevent successful organ donation proceeding, even if the authorisation for donation could be deemed. Given time constraints in the organ donation process, it is vital that a number of tests have been carried out before treatment is withdrawn from a DCD patient to ensure that the organs are likely to be safe to transplant and are a good match for a transplant recipient. Organs need to be removed from the patient very soon after their death and be transplanted into a recipient within a few hours or

[12] Survey of 1032 people by TNS on behalf of the Scottish Government as part of the Organ Donation 2016 campaign evaluation – 70% agreed with the statement "*as organ donation saves lives, we should all register to be organ donors*"

[13] Note – this issue does not apply in the same way for donors who donate after being diagnosed as brain-stem dead (DBD donors). While tests also need to be carried out on DBD donors, they are only done after it is confirmed that the donor is dead.

a transplant will not be successful. DCD donation normally also requires NHS staff to plan the timing of withdrawing the patient's treatment (in discussion and agreement with the patient's family) in order to allow for the necessary tests and other checks to be carried out, for the recipients of each of the organs to be identified and for the team of retrieval surgeons to arrive at the donating hospital.

Currently, up until the point of death, for adults, the legislation governing support provided to and any tests carried out on patients, such as potential donors who are unconscious and therefore unable to express their own decisions at the time, is the Adults with Incapacity (Scotland) Act 2000. At the moment, a number of tests are carried out prior to death, although this currently only happens where either the donor themselves has previously made clear that they wish to be a donor or where the donor's family has authorised the donation on their behalf. In all cases, the SNODs or other medical professionals ensure the donor's family is aware of and comfortable with any tests being carried out. However, we are in the process of considering whether, in the future, people joining the ODR need to have more detailed information and a greater awareness about what tests might potentially be needed if they were to become a donor.

Currently in Scotland, a number of tests are already being carried out as part of the routine care of the type of patients who might go on to become DCD donors. All patients in an Intensive Care Unit already have an existing line placed in their artery which allows blood samples to be taken without needing further injections. Similarly all patients in Intensive Care will have had a urinary catheter inserted as part of their care so this also allows for urine samples to be taken in a non-invasive way. However, in a number of cases, additional tests will be needed, depending on which organs are being considered for donation, on the patient's medical circumstances and on, for example, any countries the potential donor had visited recently. Normally, this would not include tests which would be considered invasive. Tests such as bronchoscopies have very occasionally been carried out – and on the rare occasion this happens, the test is done with the support of relatives who have authorised the donation and in a way that minimises the possibility of the patient experiencing any discomfort. We would propose that, in future, bronchoscopies should not be carried out, unless it was clear that the donor themselves had indicated in advance that they were willing to consent to that sort of test.

Question 11 – which tests do you think medical staff should be able to carry out on a donor before they withdraw life-sustaining treatment to check if their organs or tissue are safe to transplant, both where a patient's authorisation for donation is 'deemed', as well as where the donation is explicitly authorised:

- **a) Blood tests?** - for tissue typing to find a good recipient match, to detect any infections, such as HIV or Hepatitis, or for testing the patient's blood gases to check how well the lungs function;
- **b) Urine tests?** - to check if the patient has any infections;

- **c) X rays?** - to check for any undiagnosed medical problems;
- **d) Tests on a sample of chest secretions?** - taken via a tube to test how well the lungs function. Chest secretions are often removed from patients in Intensive Care as part of their treatment to help make them more comfortable so would be removed anyway as part of their care – this would therefore involve testing samples of the secretions that have been removed;
- **e) Tests on the heart such as an ECG** (electrocardiogram) or **ECHO** (echocardiogram)[14]**?** – these tests check if the heart is functioning well.

Question 12 – if you answered no to some or all options in question 11, are there any circumstances when particular tests could be permitted?

Question 13 – where it is agreed a patient's condition is unsurvivable and it will not cause any discomfort to them, what do you think about medical staff being allowed to provide any forms of medication to a donor before their death in order to improve the chances of their organs being successfully transplanted, such as providing antibiotics to treat an infection or increasing the dose of a drug the patient has already been given[15]?

Authorised representatives (also known as proxies)

In England and Wales, it is possible for people to nominate one or two representatives to make decisions about donation for them when they die. This is not an option at present in Scotland. In reality, very few people have nominated a representative (only 57 people in England and Wales had done so as at 31 March 2016) and including representatives in the chain of decision-making could make donation processes more complex and lengthy. Firstly, this is because it may be difficult to contact the representative(s), particularly if they have changed their contact details. Secondly, it is normally vital to keep the family involved as, unless they have been estranged from the donor for many years, they may have important information on the potential donor's history and lifestyle that will help doctors and SNODs or TDCs to decide if the person's organs or tissue are likely to be safe for transplanting. In addition, if a person is capable of nominating a representative, there are very few cases where they would not be capable of also deciding whether or not they wish to donate, so it is unlikely that a representative would be needed.

[14] Currently in Scotland these tests are not required for DCD patients as hearts are only donated by patients diagnosed as brain-stem dead. However, DCD heart donation has been trialled in some hospitals in England and might potentially be extended to include some Scottish donors in future.
[15] For example, a patient may be given a drug such as Noradrenaline to improve their blood pressure – maintaining or increasing the dose of this after the decision has been taken to withdraw life sustaining treatment will help improve the blood flow to the organs. If antibiotics are used to treat an infection which the donor has, that will help mitigate any impact of the infection on the organ transplant recipient(s)

It has been suggested that looked-after children are one category of people who might benefit from being able to nominate a representative, although again if the child is able to make the decision to nominate a representative they are probably sufficiently mature to opt in or opt out (if they are 12 years old or over then they could be a donor under the current system without needing permission of a parent or other person with parental responsibility if they are signed up to the ODR). Local authorities are not currently permitted to authorise donation for children in their care (see the section on an opt out system).

In addition, people who are estranged from their families or who know their family have very different views about donation from their own may also not want family members to make decisions for them, but again if they are able to nominate a representative, they should also be able to make their own advance decisions about donation in almost all cases. In cases where no partners or family members are available, the legislation already permits a friend of long-standing to authorise organ or tissue donation.

Therefore, on balance, we do not think that authorised representatives would be necessary. The evidence from England and Wales suggests they are very rarely appointed and have not been used. The Scottish Parliament has already considered this point when it debated the Human Tissue (Scotland) Act 2006, but it decided, at that time, that appointed representatives were unnecessary. Given that including them in the process would create potential delays and conflicts with families, we propose not to include them, but would be grateful for views on this.

Question 14 – what do you think about allowing people to appoint one or more authorised representatives to make decisions for them?

Question 14(a) – if you think this should be allowed, in what circumstances do you think an authorised representative would be useful?

Question 15 – do you have any other comments which you think should be taken into account in relation to any Scottish opt out system?

Chapter 2 – Increasing Numbers of People considered as Potential Organ and Tissue Donors

Introduction

It is already accepted that, as part of good end-of-life care, everybody should have the option to be a donor, particularly if they have expressed a wish to do so. This is both for the wider public good by helping deliver much-needed transplants, but also as it can, in time, help grieving families to know that something positive has come from the tragic loss of their loved one.

The number of referrals to the Special Nurses for Organ Donation (SNODs) has increased by 85% since 2011/12, despite a decline in numbers of people dying in circumstances where they could be organ donors. Therefore progress is already being made in identifying potential opportunities for donation. However, there are still some potential donors who are missed each year because the clinical teams caring for the patient do not consider donation and do not contact a SNOD or Tissue Donor Co-ordinator (TDC), mainly for patients who die after circulatory death.

Figure 6 – proportion of total cases which met existing referral criteria that were referred to Specialist Nurses for Organ Donation – 2015-16

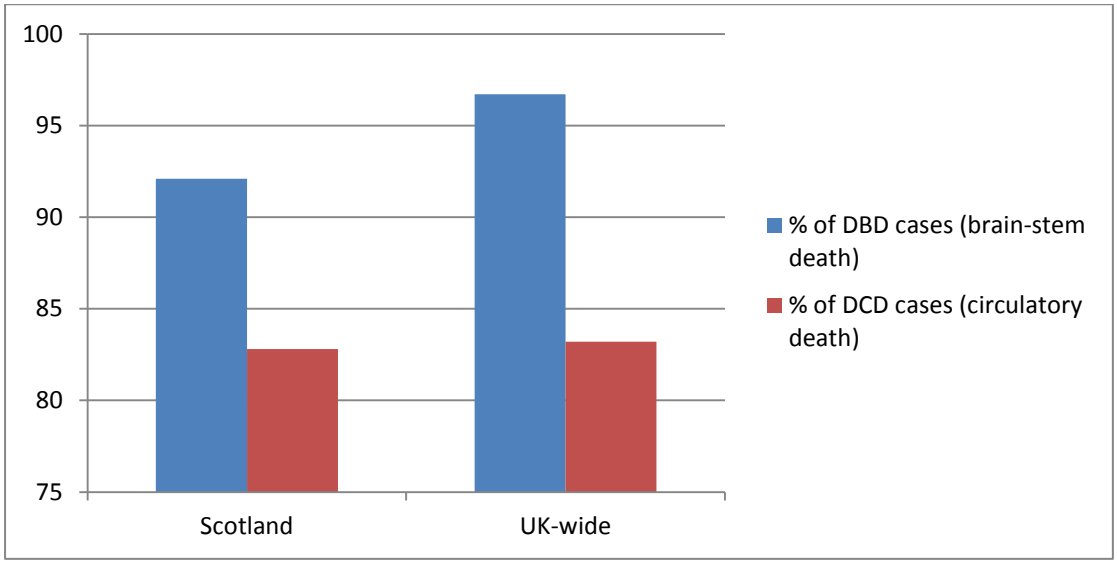


Figure 6 above shows that 17% of potential DCD patients in Scotland were not referred to the SNODs in 2015-16 – some of those patients were on the Organ Donor Register (ODR). While Scotland's performance is not significantly lower than the UK average, there is still scope for improvement as around 20 referrals of potential donors are being missed each year. Meanwhile, for tissue donation, while there are fairly good referral rates from some hospital units, many patients who could be tissue donors are not referred by the relevant hospital departments.

In some cases, this lack of referral was due to an oversight by clinical staff who had not thought about donation – for tissue donation this seems to be common due to

lack of awareness of the possibility of tissue donation, as well as, for example, staff in areas such as Emergency Departments feeling they are too busy to refer a patient. Further, in some cases, even though the patient met the current criteria for referral for donation, clinicians seem to have assumed the patient would not be a suitable donor. This is either because of health issues which may make the patient's organs/tissue unsuitable for transplantation or because the clinicians thought that the length of time between withdrawing treatment and the patient's death would be likely to mean the patient's organs would not be viable for transplantation. Organ or tissue donation should be considered in every case where the patient does not have any 'absolute' contraindication to donation i.e. where they definitely could not donate any of their organs[16] or tissue - for example if the patient was over a certain age (currently organs cannot be donated from those who are 85 years old or over, although it may be possible to donate corneas from patients who are older) or has certain 'live' cancers. For most patients, it may often be possible for at least some organs or tissue to be donated.

Hospital doctors may sometimes have concerns that the patient's health problems might be such as to make a particular patient unsuitable to be an organ/tissue donor. However, clinicians who are not dealing with organ/tissue transplantation on a daily basis are not necessarily experts in determining whether there are any contraindications to organ or tissue donation. It is the staff who deal with organ and tissue donation and transplantation on a daily basis who are the experts in this field and the ones who can best advise whether or not organs and/or tissue from a particular patient would be suitable for transplantation. Therefore, it is always best for the patient's case to be referred to the SNODs or TDCs early on to investigate if donation is possible, even if the doctor caring for the patient thinks it is unlikely. In some cases, the patient will indeed not be suitable for donation and he/she will be quickly ruled out after a telephone conversation with the SNOD or TDC; in other cases however, the patient may be able to successfully donate.

A limited system has been implemented in Scotland where the relevant Regional Clinical Lead for Organ Donation will require an NHS Board's donation committee (which is there to help support donation in their area) to investigate and provide an explanation, especially if a person who was pronounced brain-stem dead in an intensive care unit and was on the ODR was not referred to a SNOD.

Proposals to reduce numbers of missed referrals

If all patients in critical care areas were referred either at the point a doctor decides to carry out brain-stem death testing (for potential donation after brain-stem death (DBD) cases) or at the point the doctor documents the decision to withdraw treatment (for potential donation after circulatory death (DCD) cases) this would be likely to **increase the number of organ donation referrals in Scotland by around 20-30 each year**. We would consider whether the guidance should provide specific

[16] See the NHSBT policy note at http://www.odt.nhs.uk/pdf/contraindications_to_organ_donation.pdf

clinical triggers which should lead to an organ donation referral[17]. While not all of these patients would become actual donors, a proportion of them should do. For tissue donation, doctors should also refer patients who die outwith Critical Care Units as tissue donation can still take place up to 48 hours after the patient has died (or up to 24 hours in the case of eye donation)[18].

Therefore, greater encouragement should be given to all hospital doctors to **refer any patient for consideration as an organ and/or tissue donor if they are expected to die in a critical care area and are under the age of 85,** with other parts of hospitals also encouraged to refer those who have recently died for consideration as a potential tissue donor. Greater awareness raising of organ and tissue donation and the role of SNODs and TDCs among staff working across hospitals could be helpful in making staff who have never or rarely been involved in donation more aware of the advice and support that SNODs or TDCs can provide. While some staff working in Intensive Care Units will be very familiar with organ donation, others in Emergency Departments may be much less familiar with it. Similarly, staff in other hospital departments are not always aware of the potential for tissue donation.

When a patient is referred to the donation service, the local SNOD or TDC will discuss the patient's key health issues with the clinician by telephone to decide if any absolute contraindications to donation apply and to check whether the patient had either opted in or opted out on the ODR. If there are any health concerns which might prevent a particular organ/tissue being donated, the SNOD or TDC would speak to transplantation medical staff to get their view on whether or not the organ(s) or tissue could be transplanted.

To help encourage further increases in referrals, the Chief Medical Officer (CMO) could for example issue guidance to hospitals to encourage them to refer all patients who meet the criteria above – either as a potential organ or tissue donor. As SNODs and TDCs work closely together, staff would only need to refer a patient to one or other, not both. In cases where this did not happen and the patient was on the ODR, there may be a case in some circumstances for the Regional Clinical Lead for Organ Donation asking the relevant hospital to investigate the circumstances. That would help those hospitals to learn lessons for the future and address any issues identified locally, such as around lack of awareness of organ and tissue donation or misunderstandings about what constitutes a contraindication to donation.

The CMO's guidance could also re-emphasise the importance of all hospital staff doing what they can to facilitate donation, stress that SNODs and TDCs are there to

[17] For example there are some existing guidance documents which set out suggested clinical triggers for considering donation, such as the National Institute for Health and Care Excellence (NICE) guidance for England on improving donor identification https://www.nice.org.uk/guidance/cg135/chapter/1-recommendations

[18] Note – outside the central belt of Scotland, currently heart valves and corneas are the only tissue that can be donated. Within the central belt, tendons and skin can also be donated.

support hospital staff, and encourage clinicians to always involve SNODs or TDCs in approaches made to families about donation. On average in 2015-16, SNODs were involved by doctors in only 69% of approaches to families in Scotland, although involvement rates improved during the second half of the year (across the UK they were involved in 83% of cases). Authorisation rates are significantly higher where a SNOD is involved in the approach discussions with the family.

The proposed CMO guidance has advantages in that it can be implemented relatively quickly and encourages all potential donors to be fully considered, even if it is later agreed that the person would not be a suitable donor for medical or other reasons. Some clinicians may have concerns that it could put additional work pressure on them and other NHS staff and lead to difficult discussions with families. However, given that these proposals would only be expected to lead to around 20 to 30 extra cases each year across Scotland where families would be approached about organ donation, it is unlikely to place individual departments under significant extra pressure. There would also be a likelihood of some extra approaches to families about donating tissue only (where the patient has been ruled out as a potential organ donor), but these would all be carried out by the TDCs. It is worth noting that, for example, the North West region of England already has a 'required referral' policy for hospitals – evidence from the operation of this policy could be considered in developing any new CMO guidance.

Strengthened guidance on referrals should help generate greater awareness and lead to more referrals to the donation service. It would reduce the risk of referrals being missed due to an oversight and some of these patients could reasonably be expected to become donors. It would also promote consistency in practice across NHS Boards and promote equity in the approach taken across Scotland. For those patients who are on the ODR, referral helps to ensure that attempts are made to see if their wish to be a donor can be taken forward. Where the person cannot be an organ donor for medical reasons, the referral may still help enable them to be a tissue donor instead.

Question 16 – what do you think about providing CMO guidance to encourage clinicians to refer almost all dying or recently deceased patients – particularly those who are under 85 years old - for consideration as a potential organ or tissue donor?

Question 17 – what do you think about making it a procedural requirement for clinicians to involve a specialist nurse for organ donation, tissue donor co-ordinator or another individual with appropriate training in approaches to families about donation, wherever that is feasible?

Equalities Impact Assessment

If there are proposed changes to legislation as a result of the findings of this consultation, the Scottish Government will be carrying out a number of Impact Assessments, including an Equalities Impact Assessment. We are required to carry out an Equalities Impact Assessment in order to ensure compliance with our duties under the Equality Act 2010 and associated regulations. The Equalities Impact Assessment aims to ensure that any new Scottish Government policies or legislation help promote opportunities where possible for a range of equalities groups and at the very least avoid any discrimination or other unfair treatment of any particular groups of individuals, based on, for example, their gender, race, religion or disability.

We do not feel that the proposals in this consultation would be likely in most cases to impact on individuals in any equalities group differently from others, although there are some specific provisions for children and adults who do not have the capacity to understand or make their own decisions about organ or tissue donation – likely to be those with serious disabilities – to help protect their interests. There may also be some implications for some people from minority ethnic groups if they do not have a good understanding of English, as well as those with visual or hearing impairments, in ensuring that they are sufficiently aware of any changes that may be adopted in relation to a deemed authorisation system.

We would be grateful for your views on any equalities impacts to ensure that they can be fully considered as part of the Impact Assessment.

Question 18 – do you think there are particular impacts or implications for any equalities groups from any of the proposals in this consultation, either positive or negative? If yes, please provide details.

In the question above, equalities groups should be taken to mean any different impacts the proposals might have on any particular groups of people based on their:

age
being pregnant or on maternity leave
disability
gender reassignment
race
religion or belief
sex, or
sexual orientation

Please note, we will also be carrying out a Children's Rights and Wellbeing Impact Assessment, which will take account of responses to a number of the earlier questions in this consultation, where those relate to children (either directly or indirectly).

How to respond and what happens next

Responding to this Consultation

We are inviting responses to this consultation by **14 March 2017**.

If you only wish to answer some of the questions, feel free to do so. If you wish to make additional comments that relate to organ and tissue donation and transplantation, but are not directly relevant to any of the questions, please add in your comments at the end of your response.

Please respond to this consultation using the Scottish Government's consultation platform, Citizen Space. You can view and respond to this consultation online at https://consult.scotland.gov.uk/health-protection/organ-and-tissue-donation-and-transplantation

You can save and return to your responses while the consultation is still open. Please ensure that consultation responses are submitted before the closing date of **14 March 2017**.

If you are unable to respond online, please complete the Respondent Information Form (see "Handling your Response" below) to:

email: Organ_donation_scotland@gov.scot

or write to us at:

Organ and Tissue Donation consultation
Scottish Government
Health Protection Division
St Andrew's House
Regent Road
Edinburgh EH1 3DG

Handling your response

If you respond using Citizen Space (http://consult.scotland.gov.uk/), you will be directed to the Respondent Information Form. Please indicate how you wish your response to be handled and, in particular, whether you are happy for your response to published.

If you are unable to respond via Citizen Space, please complete and return the Respondent Information Form attached included in this document. If you ask for your response not to be published, we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

Where respondents have given permission for their response to be made public, and after we have checked that they contain no potentially defamatory material, responses will be made available to the public at http://consult.scotland.gov.uk. If you use Citizen Space to respond, you will receive a copy of your response via email.

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us. Responses will be published where we have been given permission to do so.

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to sharon.grant@gov.scot.

Scottish Government consultation process

Consultation is an essential part of the policy-making process. It gives us the opportunity to consider your opinion and expertise on a proposed area of work.

You can find all our consultations online: http://consult.scotland.gov.uk. Each consultation details the issues under consideration, as well as a way for you to give us your views, either online, by email or by post.

Consultations may involve seeking views in a number of different ways, such as public meetings, focus groups, or other online methods such as Dialogue (https://www.ideas.gov.scot).

Responses will be analysed and used as part of the decision making process, along with a range of other available information and evidence. We will publish a report of this analysis for every consultation. Depending on the nature of the consultation exercise, the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.

If you have any questions about responding to the consultation, please email organ_donation_scotland@gov.scot or call us on 0131 244 9228. You can also use these contact details if you would like to request a copy of this consultation in a different format.

Consultation on Organ and Tissue Donation and Transplantation

RESPONDENT INFORMATION FORM

Please Note this form **must** be completed and returned with your response.

Are you responding as an individual or an organisation?

☐ Individual

☐ Organisation

Full name or organisation's name

Phone number

Address

Postcode

Email

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

☐ Publish response with name

☐ Publish response only (anonymous) – Individuals only

☐ Do not publish response

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

☐ Yes

☐ No

List of Questions

Question 1 – what do you think of the principle of a soft opt out system for Scotland?

- I support the principle of a soft opt out system in Scotland ☐

- I do not support the principle of a soft opt out system ☐

Question 2 – are there any changes you would make to the current 'opt in' authorisation system, other than moving to opt out?

Question 3 – where someone has joined the Organ Donor Register (ODR) or indicated in another way that they wish to donate, what do you think should happen if the potential donor's family opposes the donation?

- medical staff should still proceed with the donation ☐

- medical staff should not proceed with the donation ☐

Question 4 – if there was a soft opt out system, what do you think of the proposed checks set out in step 2 (on pages 14 to 15)?

- these are sufficient to decide if a donation can be deemed to be authorised ☐

- these are not sufficient to decide if a donation can be deemed to be authorised ☐

- don't know ☐

Question 4(a) - if you think these are not sufficient, what other checks would be needed (apart from those covered in questions 6 to 8 below)?

Question 5 – in any opt out system, what do you think should happen if a deemed authorisation donation was likely to distress the potential donor's family?

- the donation should still proceed ☐

- the donation should not proceed ☐

- don't know ☐

Question 6 – if there was a soft opt out system, what do you think about the categories of people set out under step 3 (pages 15 to 17) for whom explicit authorisation would still be needed from the person themselves or family member?

- the categories above are sufficient ☐

- the categories above are not sufficient ☐

- don't know ☐

Question 6(a) – if these are not sufficient, why do you think this?

Question 7 – in what circumstances do you think an adult should be viewed as not having the capacity to make their own decisions about donation and therefore should not be subject to any deemed authorisation provisions?

Question 8 – under what age do you think children should only be donors with explicit authorisation?

- under 12 ☐

- under 16 ☐

- under 18 ☐

- other (please specify) ☐

Question 9 – for children who are in care, what are your views on allowing a local authority which has parental responsibilities and rights for a child to authorise donation for the child if no parent is available?

- they should be allowed to authorise donation of a child's organs or tissue in those circumstances ☐

- they should not be allowed to authorise donation of a child's organs or tissue ☐

- don't know ☐

Question 10 – in any opt out system, what provisions do you think should apply to the less common types of organs and tissue?

- deemed authorisation provisions should only apply to the more common organs and tissue (kidneys, liver, pancreas, heart/heart valves, lungs, small bowel and stomach, tendons, skin, corneas, bone) ☐

- deemed authorisation provisions should apply to all organs and tissue ☐

Question 11 – which tests do you think medical staff should be able to carry out on a donor before they withdraw life-sustaining treatment to check if their organs or tissue are safe to transplant, both where a patient's authorisation for donation is 'deemed', as well as where the donation is explicitly authorised:

- **a) Blood tests?** - for tissue typing to find a good recipient match, to detect any infections, such as HIV or Hepatitis, or for testing the patient's blood gases to check how well the lungs function;
  - yes ☐
  - no ☐
  - don't know ☐
- **b) Urine tests?** - to check if the patient has any infections;
  - yes ☐
  - no ☐
  - don't know ☐
- **c) X rays?** - to check for any undiagnosed medical problems;
  - yes ☐
  - no ☐
  - don't know ☐
- **d) Tests on a sample of chest secretions?** - taken via a tube to test how well the lungs function. Chest secretions are often removed from patients in Intensive Care as part of their treatment to help make them more comfortable so would be removed anyway as part of their care – this would therefore involve testing samples of the secretions that have been removed;
  - yes ☐
  - no ☐
  - don't know ☐
- **e) Tests on the heart such as an ECG** (electrocardiogram) or **ECHO** (echocardiogram)[19]**?** – these tests check if the heart is functioning well.
  - yes ☐
  - no ☐
  - don't know ☐

Question 12 – if you answered no to some or all options in question 11, are there any circumstances when particular tests could be permitted?

- if the person had previously made clear they wished to be a donor ☐

- if the donor's family provided consent on the donor's behalf ☐

- such tests should never be permitted before death ☐

[19] Currently in Scotland these tests are not required for DCD patients as hearts are only donated by patients diagnosed as brain-stem dead. However, DCD heart donation has been trialled in some hospitals in England and might potentially be extended to include some Scottish donors in future.

Question 13 – where it is agreed a patient's condition is unsurvivable and it will not cause any discomfort to them, what do you think about medical staff being allowed to provide any forms of medication to a donor before their death in order to improve the chances of their organs being successfully transplanted, such as providing antibiotics to treat an infection or increasing the dose of a drug the patient has already been given[20]?

- they should be able to provide such forms of treatment ☐

- they should be able to provide such treatment, but only where the donor's family provides consent ☐

- they should not be able to provide any such treatment just to help the donation ☐

Question 14 – what do you think about allowing people to appoint one or more authorised representatives to make decisions for them?

- this should be allowed ☐

- this is not necessary ☐

- don't know ☐

Question 14(a) – if you think this should be allowed, in what circumstances do you think an authorised representative would be useful?

Question 15 – do you have any other comments which you think should be taken into account in relation to any Scottish opt out system?

Question 16 – what do you think about providing Chief Medical Officer (CMO) guidance to encourage clinicians to refer almost all dying or recently deceased patients for consideration as a potential organ or tissue donor?

- CMO guidance should be provided to encourage more referrals ☐

- CMO guidance should not be provided ☐

- other (please specify) ☐

[20] For example, a patient may be given a drug such as Noradrenaline to improve their blood pressure – maintaining or increasing the dose of this after the decision has been taken to withdraw life sustaining treatment will help improve the blood flow to the organs. If antibiotics are used to treat an infection which the donor has, that will help mitigate any impact of the infection on the organ transplant recipient(s)

Question 17 – what do you think about making it a procedural requirement for clinicians to involve a specialist nurse for organ donation, tissue donor co-ordinator or another individual with appropriate training in approaches to families about donation, wherever that is feasible?

- this should be a requirement ☐

- this should not be a requirement ☐

- don't know ☐

Question 18 – do you think there are particular impacts or implications for any equalities groups from any of the proposals in this consultation, either positive or negative? If yes, please provide details.

Glossary of terms and acronyms used in this consultation

Authorisation – under the Human Tissue (Scotland) Act 2006, organ or tissue donation can proceed where it has been 'authorised', either by the donor themselves or their nearest relative. Authorisation can be given in writing (such as by joining the ODR) or by telephone. This is similar to 'consent', which is required in England, Wales and Northern Ireland. However, in the case of consent, the donor or their nearest relative has to have been given certain detailed information before they can consent; for authorisation, information is available if people want it, but they do not have to show they have seen the information before they can authorise donation.

DBD – Donation after Brain-stem Death (or Brain Death) – this is where donation takes place after two doctors have confirmed that the person is dead using neurological criteria to show that the person no longer has any brain-stem function, (where the patient is on life support and has completely and irreversibly lost the capacity for consciousness and the ability to breathe independently). The patient will usually have suffered either some form of severe head trauma, for example in a car accident, or have had a severe stroke.

DCD – Donation after Circulatory Death – this is where donation takes place after doctors have confirmed that the person is dead using cardio-respiratory criteria (where their heart has stopped beating and they have stopped breathing for a period of five minutes). The person will have suffered some form of critical illness and death happens after it is agreed that their life-sustaining treatment should be withdrawn because they cannot recover or breathe without life support.

CLOD – Clinical Lead for Organ Donation – each Scottish hospital where donation can take place has a doctor who leads on championing organ donation in their hospital and making their colleagues aware of developments in procedures or opportunities associated with donation. There are also two Regional CLODs who oversee the work of the CLODs in their area.

HTA – Human Tissue Authority – this is the organisation which regulates organ donation and transplantation across the UK. It carries out certain checks to ensure, for example, that no living donors are being paid to donate a kidney or any other organ.

NHSBT – National Health Service Blood and Transplant – a UK NHS body which coordinates preparations for organ donation and manages operations to remove organs from donors. It also oversees the allocation of organs to transplant recipients. Its staff work with NHS staff in Scottish hospitals to ensure the donation process works as smoothly as possible. The Scottish Government provides funding to NHSBT to cover its costs for delivering its service in Scotland. NHSBT also provides blood and tissue services, but these do not operate in Scotland, although they do manage Scottish eye donations (see SNBTS below for the Scottish equivalent).

ODR – the National Health Service Organ Donor Register – this is the UK-wide register of people who have confirmed that they agree that some or all of their organs or tissue can be donated after their death. People can either join the register online or by filling in a paper form. People can now also use the ODR to confirm if they do NOT wish to donate any of their organs, known as 'opting out'. If someone has just died or is about to die, SNODs or TDCs (defined below) can access the register to check if that person had either signed up to the register or opted out of donation.

Opt in system – an opt in system of organ donation is one where donation can only proceed if there is explicit authorisation or consent for donation, either from the donor themselves or in some cases from their family. Scotland currently has an opt in system of donation.

SDTG - Scottish Donation and Transplant Group – this Group brings together a range of stakeholders with different interests and/or expertise to provide advice to Ministers on donation and transplantation. The Group aims to help increase donation and transplantation, particularly by implementing the recommendations in the Scottish Government's *A Donation and Transplantation Plan for Scotland 2013-2020*.

Soft opt out – this is a system of organ and tissue donation, also known as a deemed consent (or authorisation) system. A soft opt out system starts from the assumption that most adults can be a donor when they die unless they have stated that they do not wish to donate, but it normally allows for the family's views to be taken into account in some way.

SNBTS – Scottish National Blood Transfusion Service – SNBTS is part of NHS Scotland and is the Scottish body which collects blood in Scotland and delivers it to Scottish hospitals so it is available, for example, where someone needs a blood transfusion. It also manages Scottish tissue donations and services, such as donations of skin, heart valves and tendons.

SNOD – Specialist Nurse for Organ Donation (or Special Nurse – Organ Donation) – these nurses are employed by NHSBT and work in hospitals to support donor families and, where donation is likely to proceed, they help make arrangements to ensure the donation can take place and that the organs have been allocated to transplant recipients by NHSBT.

TDC - Tissue Donor Co-ordinator - these nurses are employed by SNBTS and work in hospitals to raise awareness and provide teaching about tissue donation. Where donation is likely to proceed, they help make arrangements to ensure the donation can take place.

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

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Consultation on Organ and Tissue Donation and Transplantation

RESPONDENT INFORMATION FORM

Please Note this form **must** be completed and returned with your response.

Are you responding as an individual or an organisation?

☐ Individual

☒ Organisation

Full name or organisation's name

West Lothian Integration Joint Board

Phone number	01506 281937

Address

West Lothian Civic Centre Howden South Road Livingston, West Lothian

Postcode	EH54 6FF
Email	Alan.bell@westlothian.gov.uk

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

☒ Publish response with name

☐ Publish response only (anonymous) – Individuals only

☐ Do not publish response

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

☒ Yes

☐ No

List of Questions

Question 1 – what do you think of the principle of a soft opt out system for Scotland?

- I support the principle of a soft opt out system in Scotland ☒

- I do not support the principle of a soft opt out system ☐

Question 2 – are there any changes you would make to the current 'opt in' authorisation system, other than moving to opt out?

Question 3 – where someone has joined the Organ Donor Register (ODR) or indicated in another way that they wish to donate, what do you think should happen if the potential donor's family opposes the donation?

- medical staff should still proceed with the donation ☐

- medical staff should not proceed with the donation ☒

Question 4 – if there was a soft opt out system, what do you think of the proposed checks set out in step 2 (on pages 14 to 15)?

- these are sufficient to decide if a donation can be deemed to be authorised ☒

- these are not sufficient to decide if a donation can be deemed to be authorised ☐

- don't know ☐

Question 4(a) - if you think these are not sufficient, what other checks would be needed (apart from those covered in questions 6 to 8 below)?

Question 5 – in any opt out system, what do you think should happen if a deemed authorisation donation was likely to distress the potential donor's family?

- the donation should still proceed ☐

- the donation should not proceed ☐

- don't know ☒

Question 6 – if there was a soft opt out system, what do you think about the categories of people set out under step 3 (pages 15 to 17) for whom explicit authorisation would still be needed from the person themselves or family member?

- the categories above are sufficient ☒

- the categories above are not sufficient ☐

- don't know ☐

Question 6(a) – if these are not sufficient, why do you think this?

Question 7 – in what circumstances do you think an adult should be viewed as not having the capacity to make their own decisions about donation and therefore should not be subject to any deemed authorisation provisions?

Question 8 – under what age do you think children should only be donors with explicit authorisation?

- under 12 ☒

- under 16 ☐

- under 18 ☐

- other (please specify) ☐

Question 9 – for children who are in care, what are your views on allowing a local authority which has parental responsibilities and rights for a child to authorise donation for the child if no parent is available?

- they should be allowed to authorise donation of a child's organs or tissue in those circumstances ☐

- they should not be allowed to authorise donation of a child's organs or tissue ☐

- don't know ☒

Question 10 – in any opt out system, what provisions do you think should apply to the less common types of organs and tissue?

- deemed authorisation provisions should only apply to the more common organs and tissue (kidneys, liver, pancreas, heart/heart valves, lungs, small bowel and stomach, tendons, skin, corneas, bone) ☐

- deemed authorisation provisions should apply to all organs and tissue ☒

Question 11 – which tests do you think medical staff should be able to carry out on a donor before they withdraw life-sustaining treatment to check if their organs or tissue are safe to transplant, both where a patient's authorisation for donation is 'deemed', as well as where the donation is explicitly authorised:

- **a) Blood tests?** - for tissue typing to find a good recipient match, to detect any infections, such as HIV or Hepatitis, or for testing the patient's blood gases to check how well the lungs function;
  - yes ☐
  - no ☐
  - don't know ☒
- **b) Urine tests?** - to check if the patient has any infections;
  - yes ☐
  - no ☐
  - don't know ☒
- **c) X rays?** - to check for any undiagnosed medical problems;
  - yes ☐
  - no ☐
  - don't know ☒
- **d) Tests on a sample of chest secretions?** - taken via a tube to test how well the lungs function. Chest secretions are often removed from patients in Intensive Care as part of their treatment to help make them more comfortable so would be removed anyway as part of their care – this would therefore involve testing samples of the secretions that have been removed;
  - yes ☐
  - no ☐
  - don't know ☒
- **e) Tests on the heart such as an ECG** (electrocardiogram) or **ECHO** (echocardiogram)[19][1]**?** – these tests check if the heart is functioning well.
  - yes ☐
  - no ☐
  - don't know ☒

Question 12 – if you answered no to some or all options in question 11, are there any circumstances when particular tests could be permitted?

- if the person had previously made clear they wished to be a donor ☐

- if the donor's family provided consent on the donor's behalf ☐

- such tests should never be permitted before death ☐

[1] Currently in Scotland these tests are not required for DCD patients as hearts are only donated by patients diagnosed as brain-stem dead. However, DCD heart donation has been trialled in some hospitals in England and might potentially be extended to include some Scottish donors in future.

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Meeting Date: 14 March 2017
Item No: 14

Action Note Ref	Workplan Item	Matter Arising and Decision Taken	Lead Officer	IJB Meeting Date
		MARCH		
A/N 16 Feb 2016 Item 005		**Membership of SPG** - Board agreed that the membership of the SPG be reviewed after 6 months of operation and that a paper be brought to the Board at the appropriate time.	James Millar	14 March 2017
	Workplan Item	Strategic Plan Annual Review/Annual Review of Performance		14 March 2017
	Workplan Item	Lothian Hospitals Strategic Plan		14 March 2017
		New Premises (Primary Care, Partnership Centre)	Carol Bebbington	14 March 2017
A/N 31 Jan 2017		Financial Assurance of 2017/18 Budget Contributions from NHS Lothian and WL	Patrick Welsh	14 March 2017
		Proposed Meeting Dates 2017/18		14 March 2017
A/N 23 Aug 2016		Six Monthly Progress Report on WL TEC Programme	Alan Bell	14 March 2017
		Risk Management Policy and Strategy	Kenneth Ribbons	14 March 2017
		Consultation on Destitution and Asylum in Scotland	Jane Kellock	14 March 2017
		APRIL		
	Workplan Item	NMC Revalidation (Validation of Nursing)	Mairead Hughes	20 April 2017
		JUNE		
		Arrangement to liaise/co-operate with other Lothian IJBs		14 March 2017
	Workplan Item	Provision of Support Services	Jim Forrest	14 March 2017
		FUTURE UNSPECIFIED MEETING		
	Workplan Item	Community Planning Partnership/IJB Relationship		27 June 2017
	Workplan Item	SW Audit	Jane Kellock	27 June 2017
		REPORTS DUE ON A CYCLICAL BASIS		
	To be Presented	Audit of Annual Accounts	Patrick Welsh	By 30 September
	To be Reviewed Annually	Standing Orders	James Millar	
A/N 29 Nov 2016	To be Reviewed Annually	Review of Performance		
	To be Reviewed Annually	Risk Register	Kenneth Ribbons	
A/N 31 Jan 2017	To be Reviewed Every 3 Years	Delegation of Powers to Officers	James Millar	
	To be Presented Annually	Chief Social Work Officer's Annual Report	Jane Kellock	Around Nov/Dec each year

Date:14 March 2017
Agenda Item: **15**

West Lothian Integration Joint Board
Proposed Meeting Dates 2017/18

AGENDA AND REPORTS ISSUED	**BOARD MEETING At 2.00 pm**
Wednesday 20 September 2017	**Tues 26 September 2017**
Wednesday 25 October	**Tues 31 October 2017**
Wednesday 29 November	**Tues 5 December 2017**
Wednesday 17 January 2018	**Tues 23 January 2018**
Wednesday 7 March 2018	**Tues 13 March 2018**
Wednesday 25 April 2018	**Tues 1 May 2018**
Wednesday 20 June 2018	**Tues 26 June 2018**

Meetings will be held in Meeting Rooms 2 & 3 at Strathbrock Partnership Centre unless otherwise advised.