NHS Lothian

Health Inequalities Strategy

December 2014

NHS LOTHIAN HEALTH INEQUALITIES STRATEGY

CONTENTS

INTRODUCTION

> *Of all the challenges facing Scotland, the gaping health inequalities and high mortality rates are clearly our greatest.*
>
> *Health Scotland Overview for Ministerial Taskforce on Health Inequalities Nov 2012*

Health inequalities are *'systematic, unfair differences in the health of the population that occur across social classes or population groups'.*

In Scotland there are significant inequalities in health between people who are socially and economically well off, and those who are socially disadvantaged. In Lothian this means for example that people living in the most affluent communities in Lothian can expect to live twenty one years longer than people living in the most deprived communities. People living in the most deprived communities also have poorer physical and mental health throughout their lives.

Health inequalities do not just affect the most deprived communities and individuals. For almost every health indicator there is a clear gradient showing progressively poorer health with decreasing affluence and influence. Nor are health inequalities only related to socio-economic position. People who are disadvantaged by race, disability, gender and other factors also have poorer health.

This strategy sets out how NHS Lothian intends to respond to these inequalities and achieve greater equity in health for the Lothian population. It recognises that health inequalities reflect much broader societal forces that the NHS cannot address on its own. However, NHS services play an important role in mitigating the effects of these wider social inequalities on health, and NHS organisations can also work with partners to try to address the underlying influences.

Much of the work to achieve health equity forms part of community planning arrangements in the four Lothian local authorities. This strategy focuses more specifically on the role that NHS Lothian can play through its own services.

This document contains:

- A profile of the most vulnerable populations in Lothian who have the poorest health
- A summary of the policy context and literature on the causes of health inequalities and types of interventions most likely to be effective
- An outline of current actions that NHS Lothian is taking to reduce health inequalities
- A description of the overall approach to health inequalities
- An action plan for 2014-17
- How the plan will be monitored and reviewed

FUTURE PRIORITY ACTIONS

The following table summarises the areas of action that NHS organisations can take to mitigate and reduce health inequalities. It shows the priority actions that NHS Lothian will take over the next three years.

Types of action	Priority actions 2014-2017
Procurement Policies that support employment and income for populations with fewer economic levers	Develop use of community benefit clauses in contract specifications and procurement strategies
NHS as Employer Actions relating to employment policies that support vulnerable people to gain employment or ensure fair terms and conditions for all staff Actions to support staff to support the most vulnerable patients	Increase support and training for NHS Lothian staff on financial and IT literacy Continue to pay all staff at least the living wage Increase recruitment opportunities for young people and vulnerable groups through socially responsible recruitment programme Staff training to enable them to respond to social & economic circumstances affecting patients health. This should include cultural competence. Train staff in health literacy tools & techniques to Improve patient safety, communication, self management & understanding and inform about available resources
Planning and delivery of Clinical services Actions to target universal services to the most vulnerable people in Lothian Actions to investigate and amend service provision to ensure appropriate for all groups – RIA, equity audit, deliver in other settings etc Services that are universal but most needed by people in specific populations Provision of support to access and use universal services Services that are only needed by particular population groups	Develop, learn from and build on initiatives that seek to increase capacity in primary care to mitigate health inequalities and identify ways to sustain these if successful Develop routine use of 'work outcomes' in patient recovery plans Identify patients at risk of financial insecurity and enable access to appropriate services Increase number of practices with welfare advice and income maximisation services Ensure evidence based vocational rehabilitation services available to support those with health conditions to return to/retain employment Use findings from Early Years Collaborative and implement identified best practice across NHS Lothian.

Prioritisation of early years provision	Implement Learning Disability Health Inequalities Plan to ensure NHS services can meet needs of people with learning disability Ensure Health & Social Care Partnership Strategic Needs Assessments explicitly assess significant inequalities in each area and identify opportunities to mitigate health inequalities Ensure patient pathways in the Strategic Plan identify vulnerable groups and ways to improve their ability to access effective care Continue routine use of impact assessment of new policies and plans
Partnership Services in above categories that are delivered in partnership with others, or that we fund but are delivered by others NHS as advocate for wider actions by partners	Ensure public health/health promotion input to community planning partnerships including economic partnerships Work with local authority and voluntary sector partners to develop impact assessments that identify the impacts of their policies on health inequalities Advocate for routine payment of at least the living wage
Monitoring and evaluation	Develop measures of determinants of health inequalities and use these in monitoring the impacts of this and other strategies Review priority actions in 3 years

POPULATION PROFILE

In 2012, 843,733 people lived in Lothian, 15.9% of the total Scottish population. Some groups of the population are more likely to experience poor health than others. The table below gives some demographic information showing the diversity of the population. It identifies some of the populations that differentially experience poor health, with some key issues to consider in providing healthcare[1].

Population	Key issues for NHS Lothian
Men and Women	Male life expectancy is 77 years, significantly lower than female life expectancy at 81.4 years. Men experience higher rates of most diseases eg lung and colorectal cancer, CHD and stroke. Young men more likely to commit suicide or be involved in accidents or violence. Women are more likely to suffer ill health particularly mental ill health, suggesting that women spend more years in poor health. Women are higher risk of domestic violence.
Older people	Approximately 7% of the Lothian population, around 60,000 people, is aged over 75 years. Women substantially outnumber men in older age groups. The population as a whole is ageing as people are living longer. However the average age in more deprived communities tends to be lower because life expectancy is lower. The risk of morbidity and mortality rises with age – but this rise occurs 10-15 years earlier in the most deprived populations. Isolation and poverty compound the health problems associated with old age.
Children and young people	Children and young people under 16 years make up approximately 17% of Lothian's population. Socio-economic health inequalities are evident from a very young age, indeed from before birth. Early years experiences including poverty have a very significant impact on children's lives and health into adulthood. Looked After children have particularly poor outcomes.
Lesbian, Gay and Bisexual people	In 2010 the Integrated Household Survey reported that 1.4% of respondents indentified as gay or lesbian and 0.55% as bisexual. Between 5% and 12% of people are estimated to have had a same sex experience or contact. Experience of homophobic abuse and violence is associated with high rates of mental illness and self-harming behaviour. Men who have sex with men are at risk of blood borne viruses.

[1] Further information on these key issues is available in the Rapid Impact Assessment guidance at http://www.nhslothian.scot.nhs.uk/YourRights/EqualityDiversity/ImpactAssessment/Pages/default.aspx

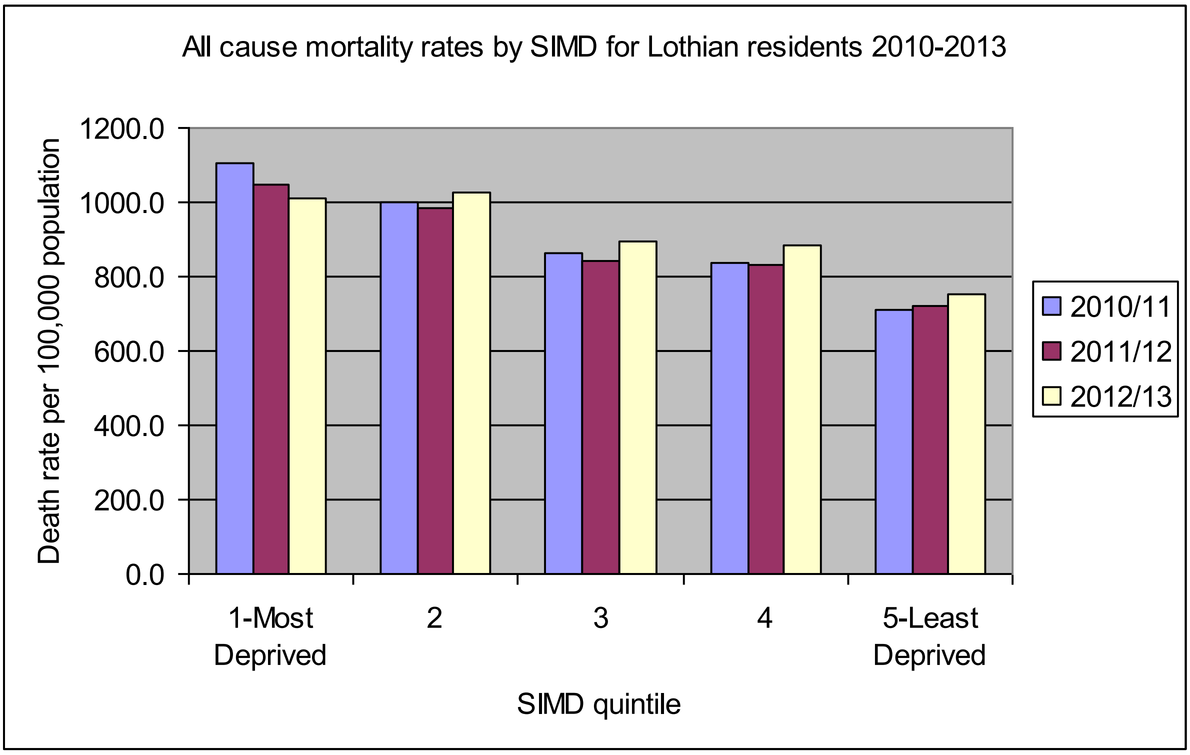
Population	Key issues for NHS Lothian
Transgender people	Transgender people frequently experience discrimination, abuse and violence and are at increased risk of substance use and self harm.
People with physical disability	2011 census data suggest that 8% of Lothian residents' day to day activities are limited a lot and 9% of residents' activities are limited a little. These rates are higher among older people. People with a disability may find it more difficult to access services via public transport or walking, to retain employment, and may experience harassment.
People with learning disability and/or Autism	About 2% of the population has a learning disability but only a quarter to a fifth of these are identified to health and social care services. Based on national estimates, approximately 1700 people (children and adults) in Lothian are identified as having learning disabilities. People with learning disabilities have higher than population average rates of morbidity and mortality from all diseases with notably higher rates of death from respiratory disease, cardiovascular disease and some of the rarer forms of cancer such as gall bladder, stomach and gullet. Prevention and health promotion is not always effective with people with learning disabilities. Autism affects 1 in 100 people, so there are approximately 8,500 people in Lothian with autism. Autism causes difficulty with both verbal and non-verbal communication; difficulty with social interactions; and restrictive, reciprocal and stereotypical routines of behaviour.
People with mental health problems	Around 14% of the adult population has a mental health condition. This proportion is higher in women than men. Mental ill-health is often hidden – with stigma attached to accessing services. The risk of many physical conditions is also increased in people with mental health problems. Similarly, many people with multi-morbidity have poor mental health – among people from most deprived communities this is more common. People with protected characteristics related to race, disability, sexual orientation can experience discrimination and harassment which impacts negatively on mental health.
Minority ethnic people	Most Lothian residents (94.3%) identify as White (European (including 17,350 Polish people), British or Scottish); this is slightly lower than the Scotland average. There are 31,000 (3.7%) Asian Scottish people in Lothian; in Edinburgh 5.5% of the population identify as Asian. No other area in Lothian has a rate above the Scotland average of 2.7%. South Asians experience higher rates of diabetes and heart disease. Black Africans have a high rate of HIV diagnosis and are at higher risk of hypertension and glaucoma.

Population	Key issues for NHS Lothian
	Gypsy Travellers experience high morbidity and have lower life expectancy. Many people from minority ethnic communities experience difficulties accessing services related to language or cultural barriers, or lack of familiarity with services.
People with different religions or beliefs	43% of the Lothian population identified as no religion, 47% Christian, 2% Muslim in the 2011 census.
People living in poverty	11% of the Lothian population is classified as income deprived by SIMD 2012 Average pay is lower in West Lothian than the Scottish average. Pay for Midlothian residents and people who work in East Lothian is also low. Research suggest that between £350 and £550 per working adult is being lost in Lothian households as a result of welfare reform. Most of these financial losses will affect people already on low incomes, notably people with disabilities and lone parents with children. Poverty often clusters in certain geographical neighbourhoods, but most people who are income deprived do not live in the most deprived neighbourhoods. This is particularly the case for some minority ethnic groups. Poverty is a strong risk factor for poor health and lower life expectancy. For almost every health indicator there is a clear gradient showing better health with increasing affluence. Poverty compounds the impact of social inequalities, and often co-exists with other disadvantages.
Homeless people	Homeless people suffer substantially poorer physical and mental health than the rest of the population. Health starts to deteriorate within two weeks of homelessness and there is a high risk of substance misuse.
People involved in the criminal justice system	Prisoners are predominantly young, male, white and from disadvantaged backgrounds. Three quarters (73%) of prisoners have an Alcohol Use Disorder, with 36% possibly alcohol dependent. When studied. 73% tested positive for illegal drugs on admission to prison and 17% tested positive on liberation. 76% of prisoners smoke. 1 in 5 are estimated to be Hepatitis C positive. The NHS is now responsible for Prison Health.
People with low literacy/numeracy	Educational inequalities have a significant and independent impact on health. 27% of Scottish adults face occasional challenges and constrained opportunities due to literacy difficulties, but will generally cope with their day-to-day lives. 4% have problems that affect their ability to cope with day-to-day life.

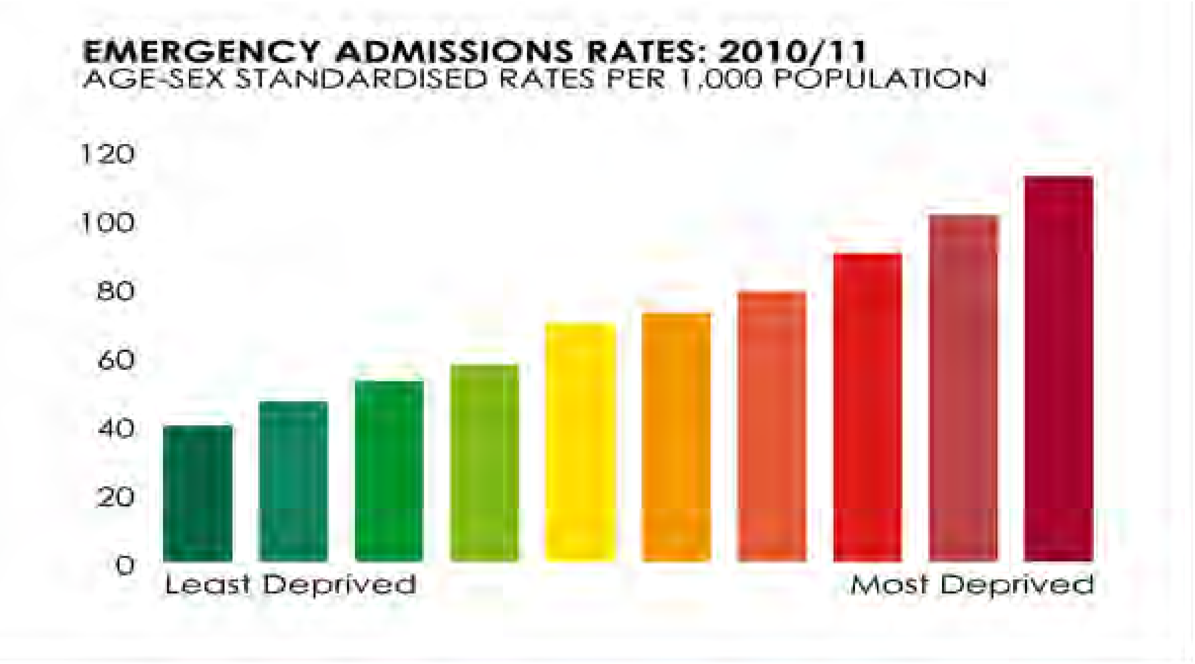
Population	Key issues for NHS Lothian
	Health literacy is the ability to obtain, read, understand and use healthcare information. People with poor health literacy have poorer outcomes but simple tools, eg Teachback, can mitigate this.
Carers	9% of Lothian adults provide unpaid care. 5% provide between 1 and 19 hours per week, 2% provide more than 50 hours. Unpaid carers are disproportionately women and older. Being a carer can lead to isolation, loss of income and harm to the carer's own health. Children can also be carers, with adverse impacts on their own education, health and wellbeing.
NHS Lothian Staff	NHS Lothian is a large employer and directly employs over 23,000 people. 78% of the workforce is female, 5% is from a non-white ethnic group, 34% is aged over 50 years. Many will be carers, or have a long term condition or disability.

The inequalities gradient in Lothian

The graph below shows the gradient in health outcomes by deprivation, measured by the Scottish Index of Multiple Deprivation (SIMD). For almost any measure of health there is a gradient showing poorer outcomes with increasing deprivation. This has a significant human cost in suffering, mortality and morbidity.



There is also a financial cost, as increasing morbidity due to deprivation results in higher need for health care, with higher rates of outpatient attendances, hospital admissions and use of primary care services. The graph below shows the gradient in emergency hospital admissions.


EMERGENCY ADMISSIONS RATES: 2010/11
AGE-SEX STANDARDISED RATES PER 1,000 POPULATION
120
100
80
60
40
20
0
Least Deprived
Most Deprived

POLICY CONTEXT, CAUSES AND INTERVENTIONS

Policy context

> *Social injustice is killing people on a grand scale.*
>
> *WHO. Closing the Gap in a Generation. Global Commission on the Social Determinants of Health, 2008*

Health inequalities are recognised as a priority locally, nationally and internationally. The Scottish Government produced Equally Well, the report of the ministerial review of health inequalities, in 2008. This recognised the need for cross sectoral work to reduce health inequalities. It contained 78 recommendations across a range of policy areas including actions relating to the early years, improving physical environments, tackling poverty, addressing specific harms to health and support for vulnerable groups. Equally Well was reviewed in 2010 and again in 2012/13, with support from NHS Health Scotland which led a policy review to identify the areas to focus on.

In 2008 the World Health Organisation published the report on the Global Commission on the Social Determinants of Health, led by Sir Michael Marmot. This contained three overarching priority recommendations: improve daily living conditions; tackle the inequitable distribution of power, money and resources; measure and understand the problem and assess the impact of action. Michael Marmot has subsequently led a European review of health inequalities and a review for the English Department of Health that resulted in the Fair Society Healthy Lives report. This contained six strategic objectives:

- Give every child the best start in life
- Enable all children, young people and adults to maximize their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and developing sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

Although these reports have been produced in different contexts for different audiences, they all recognise that health inequalities reflect wider social inequalities, and cannot be tackled by the health sector alone.

Understanding the causes of health inequalities

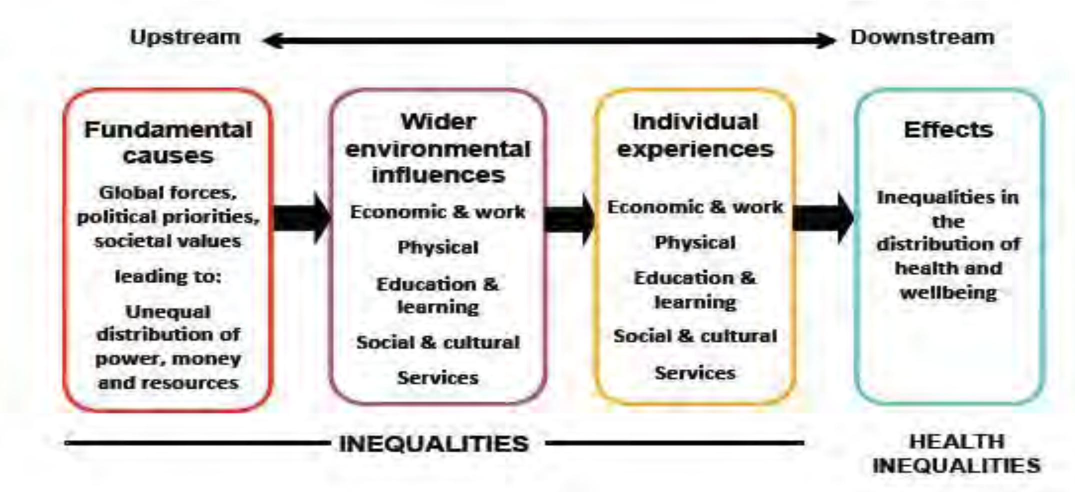
Put simply, the higher one's social position, the better one's health is likely to be…These serious health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, 'bad', unhealthy behaviour, or difficulties in access to medical care, important as those factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society.'

Michael Marmot. Fair Society Healthy Lives, 2010

The existence and width of health inequalities cannot be attributed to a single clinical or behavioural risk factor. They are the result of social circumstances and reflect the underlying distribution of power and resources in the population.

It is now accepted that the underlying roots of health inequalities relate to the unfair distribution of power, money and resources. The social and political forces that maintain this unfair distribution are termed the '**fundamental causes**' of health inequalities. These fundamental causes affect the distribution of **wider environmental influences** such as the availability of jobs, good quality housing, education and learning opportunities, access to services, social status. This results in differences in **individual experiences** of, for example, discrimination, prejudice, low income, poor opportunities. This is illustrated in the model below.

Figure: Fundamental Causes of Health Inequalities



Source: NHS Health Scotland Policy Review for the Ministerial Task Force (2013)

These differences in individual experiences affect people's health in three main ways:

- **Differential exposure** to environmental, cultural, socio-economic and educational influences that impact on health.

- The psychosocial consequences of **differences in social status**. There is now strong evidence that 'status anxiety' leads to psychological and physiological changes that affect health.

- Accumulation of these effects over the **lifecourse**. The inequalities in health that are observed now will reflect not only current status but also differences in experiences at earlier stages in life. This is why interventions targeting families and the early years are so important.

What should we do about health inequalities?

> *Tackling health inequalities is a matter of social justice. It's unacceptable in 21st century Scotland that some people can expect to die earlier than others, simply due to an accident of birth or circumstances.*
>
> *Scottish Government. Equally Well, 2008*

The description of the causes of health inequalities suggests that no single approach is sufficient to reduce health inequalities - concerted efforts are required across many partners at local and national levels.

There are three types of action that are needed:

- Actions that **mitigate** the health and social consequences of social inequalities. People who are socially disadvantaged have higher health needs and the level and intensity of service provision should reflect that. These actions target the effects - shown on the far right of Figure 1.

- Actions that help individuals and communities **resist** the effects of inequality on health and wellbeing. These include targeted health improvement activities, community development activities that increase social capital in deprived areas, improvements to the physical environment in deprived areas. These are predominantly addressing individual experiences and environmental influences as shown in Figure 1.

- Actions that **undo** the underlying structural inequalities in power and resources. These are the most challenging to implement. They include provision of high quality universal services such as education, housing, employment and improved environments particularly in the most deprived areas. But ultimately undoing structural inequalities requires fundamental socio-economic and political measures. These may include economic policies that support social mobility and prevent high wage differentials; income maximisation services; reducing the democratic deficit across the social spectrum; increasing the number of people on the electoral roll. Key policy areas for action to reduce social and health inequalities are *employment, income and education*.

Structural, population approaches – v- individual approaches

Evidence from the scientific literature suggests that interventions that are *most likely to* be effective in reducing health inequalities are structural changes to the environment, legislation and regulatory controls, fiscal policies, reducing price barriers, income support, accessibility of public services, prioritising disadvantaged groups, and intensive support for vulnerable population groups.

Interventions *least likely* to reduce health inequalities include mass media campaigns, written materials, campaigns reliant on people opting in; messages designed for the whole population, or approaches that involve significant cost or other barriers.

Health improvement – v - health inequalities

It is important to distinguish between health improvement activities and actions to reduce health inequalities, as they are often confused. Health improvement includes policies, actions and interventions designed to improve health and prevent ill health. They target people who are currently well, rather than healthcare interventions for people who are, or perceive that they are, unwell. Health improvement activities are usually delivered to groups or whole populations rather than individuals. Health improvement activities do not necessarily reduce health inequalities unless specifically targeting disadvantaged groups. They may actually increase inequalities if affluent people are better able to act on them.

Actions to tackle health inequalities may include targeted delivery of healthcare to mitigate health inequalities; targeting of health improvement activities; and actions that seek to address the fundamental causes discussed above.

Targeting of interventions

A common approach to tackling health inequalities is to target support and interventions to the geographical areas identified as being deprived, most commonly the most deprived 15% areas measured by the Scottish Index of Multiple Deprivation (SIMD). There are several reasons why this approach cannot reduce health inequalities on its own:

- Many disadvantaged people do not live in these deprived areas – only about half of people who are income deprived live in the 15% most deprived areas by SIMD. So if an intervention is provided only to people living in targeted areas, other equally needy people will miss out.
- As noted earlier, health inequalities do not only affect the most disadvantaged groups of people but occur across the socio-economic gradient. Even if these targeted interventions could raise the level of health of the people in the targeted areas to that of people in the most affluent areas, there would still be a gradient in the rest of the population.
- Similarly, this approach is only concerned with socio-economic inequalities (using geography as a crude proxy) and misses inequalities relating to other characteristics such as race or disability.
- Actions that only target the most deprived communities implicitly situate the problem with those communities rather than with the fundamental causes and are unlikely to tackle these fundamental causes.
- Explicit targeting may actually exacerbate harm by labelling and stigmatising those communities.

Despite these caveats, targeting is appropriate for many situations. Clearly, interventions seeking to improve health and mitigate health inequalities should be provided in proportion to the level of ill health. And poor physical and social environments in some communities leads to poorer health in the people who live there. So it often makes sense to target environmental interventions geographically – examples would include improvements to greenspace or interventions to increase social capital, especially linking social capital that supports people to link with others in other groups and communities. But for the reasons above, it is important that individually focused interventions are provided universally, but with greater quantity of service, and strong locality working, in the areas where the need is greatest. The Fair Society Healthy Lives report called this ‘proportionate universalism’.

The role of healthcare organisations

Although all the major policy documents identify that health inequalities requires a multi-sectoral response, some recent reports have considered the specific role of health organisations. The most obvious role is to mitigate and prevent health inequalities by providing healthcare and health improvement interventions in proportion to need.

High quality, universal healthcare that is available to everyone with no or minimal cost barriers is in itself important to mitigate and reduce health inequalities. But within the universal service there are often other barriers that prevent some disadvantaged groups of people from receiving care. These include physical, social, environmental and practical barriers such as mismatch between service design and patient need, cultural differences between patients and staff, low expectations, poor experience, transport costs and lack of capacity where the need is highest. These all contribute to what is termed the ‘inverse care law’ – that quantity and quality of care may be poorest for those with the highest needs.

The ‘Deep End’ group of general practices serving populations living in deprived areas has identified the increased workload for these practices and advocates that practices in deprived areas should have a package of additional support to meet the health needs of their populations. The package includes additional GP time; attached specialist workers; link workers to improve joint working with other services including the third sector.

A Canadian report identified the following priorities to ensure health services meet the needs of a culturally and linguistically diverse population:

- Develop health equity targets and plans in consultation with communities and community members.
- Improve health literacy.
- Increase equitable access to prevention and curative services for underserved populations.
- Develop inter-sectoral collaborative and knowledge exchange mechanisms.
- Increase the capacity of the health system to serve the needs of the diverse population.

The Institute for Health Equity identifies the following areas of work that NHS organisations can do to help reduce health inequalities:

- Workforce education and training – to build awareness of health inequalities and skills to work with all communities.
- Working with individuals and communities – build relationships of trust and respect, take a social history and use to tailor support to individuals' needs, refer to services that address root causes.
- NHS organisations – ensure NHS provides good work for its staff, use purchasing power to support local community, culture of equality and fairness.
- Work in partnership
- Advocacy

This has been summarised further in a NHS Health Scotland document as follows:

- The quality of services the NHS plans and provides
- What the NHS does in partnership
- The NHS as an employer and procurer
- The advocacy role of the NHS

These reflect the mitigate/prevent/undo framework outlined above.

CURRENT ACTION IN NHS LOTHIAN

Reducing health inequalities requires effective partnership working across a range of organisations.

Audit Scotland, Health inequalities in Scotland, 2012.

NHS Lothian has recognised health inequalities as a priority for many years. In 2006 the NHS Board approved a Strategic Framework that outlined its role to take forward three strands of work:

1. Work to ensure that mainstream services are accessible by and appropriate for all groups within the population. This includes use of impact assessment to ensure new services are planned to be equitable, and equity audits of service areas to identify and address inequalities in access or outcomes.
2. Work to provide additional support to ensure that specific disadvantaged groups can access NHS services. This includes provision of targeted services or advocacy that helps people access services.
3. Partnership work with other organizations to help address the determinants of health inequalities. NHS Lothian action with partners to address underlying causes of health inequality includes targeting of health improvement activities; provision of welfare advice in health settings; partnership with employability services and providing intensive support to vulnerable families.

Strands 1 and 2 are ways in which NHS Lothian can target its work to **mitigate** health inequalities, whereas strand 3 contributes to help **prevent** and **undo** inequalities. Since the strategic framework was approved, it has been used to structure health inequalities work. As a framework rather than a strategy, there was no overall action plan or separate monitoring framework but NHS Lothian has implemented a series of interventions to meet the needs of particular vulnerable populations. In addition, Rapid Impact Assessment is now used routinely to ensure new plans consider differential impacts.
The Board also has an Equality Outcomes Action Plan that details work to improve outcomes for people with protected characteristics as defined in the Equality Act. The group developing of this strategy undertook some scoping of the range of work that NHS Lothian is currently doing to mitigate, prevent, and undo health inequalities. This is summarised in the table below.

Current NHS Lothian actions to address health inequalities

Action on health inequalities	Mainstream Services	Specialist Services	NHS as employer	Procurement and capital planning	Wider Partnerships	Outcomes
Mitigate the severity of the health and social consequences of social inequalities	High quality universal primary care Amendments to mainstream services to ensure they are appropriate for all groups – eg communication support/transport/ location of service/ reminders etc Use of RIA, equity audit etc to assess whether services are equitable, with changes accordingly Higher provision of mainstream community services in communities with higher needs Prioritisation of the universal services	Services that are specifically for disadvantaged populations such as Keep Well; Access Practice; MEHIS; Willow; advocacy support etc	Staff training and support to ensure staff understand impact of deprivation and respond appropriately	New NHS buildings meet the standards set out in the Healthy Built Environment strategy.	Social care/ voluntary sector provision that is targeted according to need Delivery of services that mitigate poverty and disadvantage in partnership with other agencies eg drugs/alcohol services Case management approaches are often most effective for people who need multiple services	Reduced mortality and morbidity in identified disadvantaged groups

	that most benefit disadvantaged groups eg drugs/alcohol services					
Prevent the effects of inequality on health and wellbeing.	Prioritisation of services for early years Prioritisation of health promotion, preventive, community and primary care services – these all are needed most by the most disadvantaged	Health improvement initiatives that are targeted specifically to disadvantaged groups	HR policies that minimise job strain and increase job control	Implementation of actions in Sustainable Development Action Plan – to minimise future inequalities arising from climate change	Input to SOA indicators CPP Health improvement partnerships – programmes targeting vulnerable communities Public health support/ HIA work for activities that enhance public space/ physical environments – these most benefit the most vulnerable eg work on policies such as 20mph zones Support for community development activities	Reduced gap in health determinants OR improved health determinants in disadvantaged groups

Undo the underlying structural inequalities in power and resources		Services within health settings that address poverty and inequality eg: Benefits and money advice Health literacy support	HR policies that reduce social gradients Targeted recruitment/support to access employment for people furthest from labour market Equal opportunities policies	Procurement policies that provide community benefit – particularly employment of groups that are furthest from the labour market	NHS as advocate: Input to SOA indicators Support for universal services/ policy that reduces gaps - especially related to education, employment, income max etc	Reduced gap across population in resources/power/status

MAKING A DIFFERENCE

Intellectual opposition to social injustice is only the beginning of understanding

Graham Watt, British Journal of General Practice, 2011

Health inequalities is a ‘wicked issue’ that needs concerted action and changes across many different organisations at different levels. Reducing the underlying inequalities in income, wealth and power needs actions to focus on income, employment and education. The NHS may have a more limited role in ‘undoing’ the underlying social inequalities but has an important role to mitigate the health consequences. Within the NHS, the overall approach to mitigate and tackle health inequalities should include:

- Using the potential of the NHS as a large employer and through procurement to provide employment, education and training opportunities with fair terms of employment for all staff.
- Ensuring services are available and accessible to all, and are delivered proportionate to need, to reverse the ‘inverse care law’. This means increasing provision of geographically based primary and community services in the areas with highest needs.
- Increasing the priority given to primary and community services relative to secondary and tertiary services, as the most disadvantaged groups benefit most from these.
- Increasing the priority given to early years and preventative interventions relative to interventions in later life, as the most disadvantaged groups benefit most from these.
- Ensuring the social issues that impact on patients’ health and ability to use healthcare are viewed as legitimate issues for health professionals to consider, are systematically recognised, patient management reflects these needs and patients are referred or signposted to appropriate support.
- Investing in partnerships with voluntary sector and other organisations that are better placed to address social issues that affect patients’ health.
- Working with partners to raise awareness of underlying causes and to advocate for policies and interventions that reduce inequalities in income, wealth and power.

Fully implementing these may be challenging and requires a long term commitment throughout NHS Lothian. This cannot be delivered by one service alone, or by a few projects or initiatives. The action plan below presents the detailed actions that are planned for the three years 2014-17, with some key measures of progress. In addition to these specific actions, NHS Lothian will continue to prioritise the areas noted above and recognise the responsibility of all parts of the organisation to support these in order to tackle health inequalities.

NHS LOTHIAN HEALTH INEQUALITIES STRATEGY ACTION PLAN 2014-17

Procurement			
Project	**Lead**	**Milestones**	**Measure**
Develop use of community benefit clauses in contract specifications and procurement strategies	Community Benefits Group	Community benefits tracking report – November 2014 Agreed increase in targeted community benefits in project specifications – as new projects specified, review November 2015 Realisation of agreed benefits – according to projects' timescales	Numbers of training opportunities Numbers of apprenticeships Spend in Supported Businesses

NHS Lothian as employer			
Project	**Lead**	**Milestones**	**Measure**
Increase support and training for NHS Lothian staff on financial and IT literacy	Health Promotion/ Learning and Development	Review uptake of training currently in place - Expand and/or redesign current training	Number of people accessing training/support Self reported confidence with financial/IT literacy
Continue to pay all staff at least the living wage	HR	Currently in place Continue to monitor	Number of staff below living wage
Increase recruitment opportunities for young people and vulnerable groups through socially responsible recruitment programme	Socially Responsible Recruitment Group	Programmes identified for the following groups: School leavers Vulnerable young people, including those with a disability Graduates with a disability People with learning disabilities People with autism People who have been long term unemployed Women returning to work, education or training	Numbers of people from identified vulnerable groups offered placements/ training Numbers of people recruited from identified vulnerable groups Number who sustain employment >6mths

Clinical services			
Project	**Lead**	**Milestones**	**Measure**
Staff training to enable them to respond to social & economic circumstances affecting patients' health. This should include cultural competence.	Health Promotion/ Learning and Development	Small group to be established Training needs assessment – May 2015 Training developed for different staff groups – December 2015 Delivery of training - from January 2016	Numbers and proportions of different staff groups who receive training Evaluation of training
Train staff in health literacy tools & techniques to Improve patient safety, communication, self management & understanding and inform about available resources	Person Centred Education Group	Delivery of training - ongoing Targeted increase in staff training Piloting of health literacy tools	Number of staff trained Patient feedback
Develop, learn from and build on initiatives that seek to increase capacity in primary care to mitigate health inequalities and identify ways to sustain these if successful	Edinburgh Community Health Partnership/ Health and Social Care Partnerships	Evaluation of results of current initiatives and identification of successful ways of working – coordinated by Scottish Government, expected results March 2016 Business case to sustain key initiatives – timescale depending on evaluation findings Integration into partnership initiatives such as Total Place - ongoing	Demonstrated benefits from primary care initiatives Identified recommendations/models of care
Develop routine use of 'work outcomes' in patient recovery plans	Health Works Strategy Group	Pilot routine use of work questions, with appropriate use in patient management, in 2 settings – Sep 15 Use of 'work outcome' approach in other settings - from Jan 2016	Case note audit - Proportion of notes meeting standard for work questions Patient feedback – proportion of patients reporting work questions asked and reflected in management.

Identify patients at risk of financial insecurity and enable access to appropriate services	NHS Lothian Welfare and Employability Advice Group	Prepare information for staff and patients on sources of advice and support – completed October 2014 Pilot use of screening questions in 2 settings - Sep 2015 Increased use of screening questions, with associated training and support – March 2015	Number of settings routinely asking about financial insecurity Number of patients signposted to appropriate services
Increase number of NHS settings with access to and links with welfare advice and income maximisation services	NHS Lothian Welfare and Employability Advice Group	Brief prepared scoping current welfare advice services – Jan 2015 Plan to increase access to welfare services – developed by March 2015, implemented from April 2015	Number of NHS settings with access to and links with welfare advice service
Ensure evidence based vocational rehabilitation services available to support those with health conditions to return to/retain employment	Health Works Strategy Group	Business case for service prepared, will include agreement on future service and links with DWP service - March 2015 Rollout of service model across Lothian – March 2017	Number of patients seen by WHS Proportion of employed patients who retain employment at 3 and 6 months Proportion of previously out of work patients who gain employment, which is retained at 6 months
Use findings from Early Years Collaborative and implement identified best practice across NHS Lothian.	Early Years Collaborative Workstream groups	Use improvement methodology to increase documentation of Healthy Start eligibility and increase proportion of eligible women and children who receive vouchers. – March 2016 Increase access to other information and advice for vulnerable families through partnership with other agencies.	Proportion of pregnant women with documentation of Healthy Start eligibility and recorded as being eligible for Healthy Start at booking Proportion of eligible women and children receiving vouchers Proportion of eligible women receiving Healthy Start vouchers by 16 week antenatal appointment

Implement Learning Disability Health Inequalities Plan to ensure NHS services can meet needs of people with learning disability	Learning Disability Health Inequality Group	Implementation the Learning Disability LDP guidance. Mainstream learning from test site work, developing social prescribing for people who may have a learning disability Evaluate and use findings from LD Health Inequality enquiry events held in 2014. Ensure all public facing health information is delivered in accessible formats.	Number of people accessing social prescribing Relevant measures to be developed to reflect findings from enquiry events Number of information resources available in accessible formats
Ensure Health & Social Care Partnership Strategic Needs Assessments explicitly assess significant inequalities in each area and identify opportunities to mitigate health inequalities	Public health/ Health and Social Care Partnerships	Strategic needs assessments completed including identification of inequalities, vulnerable groups, and relevant actions – April 2015 Ensure needs assessments and commissioning plans prioritise prevention, early intervention, primary and community services and address inequalities across the lifecourse.	Explicit demonstration of inequalities issues within each needs assessment
Ensure patient pathways in the Strategic Plan identify vulnerable groups and ways to improve their ability to access effective care	Public health/ leads for each pathway	Impact assessment or inequalities report completed for each pathway Recommendations included in pathway work	Explicit demonstration of inequalities issues within each pathway
Continue routine use of impact assessment of new policies and plans	Equality Impact Assessment Steering Group	Complete pilot of Combined Impact Assessment – April 2015 Identify impact assessment leads in each area to facilitate CIAs – April 2015 Audit of implementation of actions from impact assessments – ongoing	Number of impact assessments Proportion of actions implemented in agreed timescales

IMPLEMENTATION AND MONITORING

The action plan above identifies a group or service to lead each of the actions. Some of these are existing groups but others have been established specifically to implement the actions in this strategy. These groups are responsible to deliver the actions and report back to the Strategy Group.

The Strategy Group will meet quarterly to review progress against these actions and identify and seek to address any problems or issues that arise in their implementation. The group will report to the NHS Lothian Strategic Planning Group.

As well as reviewing progress with the short term actions, the Strategy Group will also continue to raise awareness of health inequalities, influence other strategies and plans, and develop other areas of action to reduce health inequalities.

The group will review this strategy in three years.

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APPENDIX 2

Improving the Health and Wellbeing of Lothian's Children and Young People

NHS Lothian strategy for children and young people 2014 – 2020

Contents

1. Introduction

NHS Lothian believes that every child should have the best start in life and grow up being healthy, confident and resilient.

This strategy sets out a clear vision, principles and approach for how NHS Lothian will work with children and young people, their families, the public, the third sector and the 4 local authorities across Lothian to improve the physical and emotional health and wellbeing of children and young people across Lothian.

Based on an understanding of our child population and what we know from children and young people accessing services, this strategy builds on the commitments NHS Lothian has already made in the 4 Integrated Children's Services Plans for East Lothian, Edinburgh, Midlothian and West Lothian. It also builds on our existing assets, especially:

- Our services – that are life-saving, safe, evidence-based, efficient and fast to respond when we know children and young people need help
- Our partners – including children, young people, their families, the public, third sector and the 4 local authorities across Lothian, all who have a wealth of knowledge, skills and expertise
- Our staff – who are highly motivated, passionate, knowledgeable and experienced
- Our values – such as respecting our diverse child and young population, their background, culture, environment, abilities and needs.

Getting it Right For Every Child (GIRFEC), the national policy which underpins this strategy and the new Children and Young People (Scotland) Act which incorporates the principles of the United Nations Convention on the Rights of the Child (UNCRC), has evidenced that to improve the life chances and wellbeing of all children and young people in Scotland, we must focus on keeping children Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible and Included (also known as the wellbeing indicators). We know we cannot do this alone and therefore rely on our strong working relationships with partners, children and parents to ensure children's needs and rights are met.

We shall continue to respond to health needs when they are presented. We must also have a trained, effective workforce that has the capacity to respond to the current needs of children and young people and be ready for emerging needs.

If we are to seriously improve the longer term health needs of not only children, but our future adult population, then we must get better at focusing on prevention and early interventions. That means we start with reducing inequalities during pregnancy and continue to reduce inequalities throughout the life course. The Early Years Change Fund, introduced by the Scottish Government in 2013, is one mechanism for helping us consider how we shift the balance of emphasis, mindset and physical resource towards prevention activities.

2. What children and young people have told us

Outcome this section covers:

Children, young people and their families will be involved in decisions that affect their health and wellbeing

In developing this strategy, we commissioned the Children's Parliament to produce a consultation toolkit with associated training. Staff across the NHS and within local authorities and the third sector helped us gather the views of children and young people from across Lothian about what was important to them about the health services they use and need. We received comments from over 300 children and young people between the age of 3 and 25 in the form of photos, cartoons and completed questionnaires. The main themes identified in the responses are as outlined below:

2.1 How we engage children and young people in their care and treatment

The strongest message that came from those we consulted was the importance of how we involve children and young people. This was in relation to individual care and in relation to improving services. Many children and young people had positive experiences of how healthcare staff involved them and spoke to them about what was happening. Some however felt that staff spoke to their parents or carers rather than them directly and they didn't like that.

One child said: "I think you should have children's surveys too. My mum does surveys when she's at the doctors but I have never been asked to do one."

Another young person said: "Good services ask us what we think is good."

Suggestions to help improve how we involve children and young people included:

"Speak to us, not at us or our carers."

"Do not make decisions without us."

"Could probably answer some of the questions about ourselves better than mum or dad. You could ask us first then if we don't know ask mum or dad."

"Children and young people should be involved in deciding what should be checked when evaluating services and how they could be improved."

"NHS should be thinking of ways of supporting individual young people not see them as one group."

2.2 Recognising how children and young people feel

Many children and young people commented on their feelings about speaking to healthcare staff or going into hospital. Because they did not know what to expect, they felt nervous or scared. For some, they commented on waiting long times to be seen and commented on the environment. There were many comments from children and young people about staff being nice and how that helped them feel better, e.g. "I was worried and they were nice" and, "Nurses are nice people. They look after everybody and know all about special medicines to make you feel better."

Suggestions for how we could make improvements included:

"By looking at me, listening and helping. So that I know what happens."

"All doctors and nurses should remember to tell us what is going to happen to us."

"When I go to hospital I feel a bit worried and they could do things that are kind or comforting to make me not feel bad."

"Tell me in a nice way that you will be ok."

"They could have more good books to read when you have to wait."

"Having clocks that I can read, like the ones with just the numbers and not the hands, then I would know what time it is."

Related to the above were comments made by specific groups of young people:

"For marginalised groups like asylum seekers / refugees or specific things in relation to legislation or relevant health provision, the level of awareness and understanding is completely different with each service."

"As soon as you come out as LGB or T to a staff member, any issues you may be struggling with in relation to mental health are attributed to your sexual orientation and / or gender identity."

The issue of feeling labelled also came from other children, including Looked After Children and young people with a mental health problem. One young person suggested that there would be value in educating teachers on depression so that they could have been supported earlier.

2.3 Access to health Information and health services

One comment from a young person summed up the views of others - "If you don't know something then how can you be expected to make good choices and be healthy?"

Some suggestions made by children and young people included:

"You need to know stuff so that you know what to do and where to go in case something bad happens."

"Health drop ins should be open more, more places open in school holidays."

"Some services should be focused on to stop illness in the future, things such as dental care / mental health before problems start."

2.4 What we will do next

What was clear from what children and young people told us is that there is a great deal of good work to build on. Many told us that they like the services they use and they like the people that provide their care. There is, however, more that we can do to ensure that we consistently include them in decisions about their healthcare; respect them for who and what they are and acknowledge how they feel.

To fully acknowledge the contribution children and young people have made, we will share what children and young people have told us, through the creation of an interactive display, including the artwork and present it to Children's Services teams within NHS Lothian. Children's Services Quality Improvement Teams can then consider the specific issues for their service. We will also present the report to the Children's Partnerships across Lothian so that we can share the learning with our partner agencies.

Feedback from those staff that undertook the consultation exercise with children and young people was that it was a beneficial exercise and that they enjoyed it (both the children and the staff). To demonstrate our ongoing commitment to engaging children and young people, we will seek to undertake an annual consultation activity with children and young people and continue feeding back what they tell us to staff across NHS Lothian. This will be in addition to the large number of small consultation exercises that take place with children and young people through our services already.


3. Scope of "Improving the Health and Wellbeing of Lothian's Children and Young People"

The scope of this NHS Lothian strategy is far reaching. It has the potential to affect not only services for children and young people but all adult services that work with parents or carers. This strategy therefore aims to create a child-centred ethos within NHS Lothian alongside identifying the specific services it will provide for children and young people.

This strategy will not duplicate or rewrite existing Lothian strategies, frameworks and plans that are already in existence. It will support the delivery of the NHS Lothian Strategic Clinical Framework which prioritises prevention and reducing inequalities – the foundation of this strategy. It compliments the Refreshed Maternity Framework, A Sense of Belonging: A Joint Strategy for Improving the Mental health and Wellbeing of Lothian's population, the 2011 – 2016 Lothian Sexual Health Strategy and the NHS Lothian Strategic Plan – Our Health, Our Care, Our Future. Improving the Health and Wellbeing of Lothian's Children and Young People brings together the key components of these strategies to help articulate NHS Lothian's overall strategic approach to improving children and young people's health.

This strategy will focus on achieving the following outcomes, aligned with the Rights of the United Nations Convention on the Rights of the Child (UNCRC):

- Every child and young person will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity (Article 24 UNCRC)
- Disabled children and young people will have their additional needs met (Article 23 UNCRC)
- Children, young people and their families will be involved in decisions that affect their health and wellbeing (Article 12 UNCRC)
- NHS Lothian staff will have an increased understanding of the needs of the younger population and will use this understanding to inform the planning and delivery of services (Article 3 UNCRC)
- To improve health and resilience in those more vulnerable to poor health NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions (Article 24 UNCRC)
- The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children's services, and the development of services at St John's Hospital (Articles 24 & 42 UNCRC)

- NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population of children and young people (Article 42 UNCRC)
- Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy (Articles 43 -54 UNCRC)

Improving the Health and Wellbeing of Lothian's Children and Young People will focus on NHS Lothian's contribution to achieving these outcomes and will seek continued support from our partners to make progress towards outcomes that cannot be solely achieved by NHS Lothian.

We think that the best way to explain our strategy is through a 'life stages' approach, in line with NHS universal service provision. We can therefore describe this as:

Early Years	School age	Young people in transition
Maternity (Conception to 1 month)	5 – 11 years (primary)	16 – 25 years, for young people that require specific services, e.g. young people with a disability and young people leaving residential care
1 month – 4 years (pre-school)	12 – 18 years (secondary)	

Explaining our strategy in this way enables us to articulate the different approaches and interventions that children may need growing up to become healthy, confident and resilient adults.

As this approach ensures that the needs of children and young people are considered from conception through to adulthood, this strategy recommends that any new strategies or frameworks being developed by NHS Lothian take into account the life stages identified above. This will also ensure that issues relating to transition from children's to adult services will be considered.

4. Understanding the health needs of children and young people in Lothian

Outcome this section covers:
NHS Lothian staff will have an increased understanding of the needs of the younger population and will use this understanding to inform the planning and delivery of services

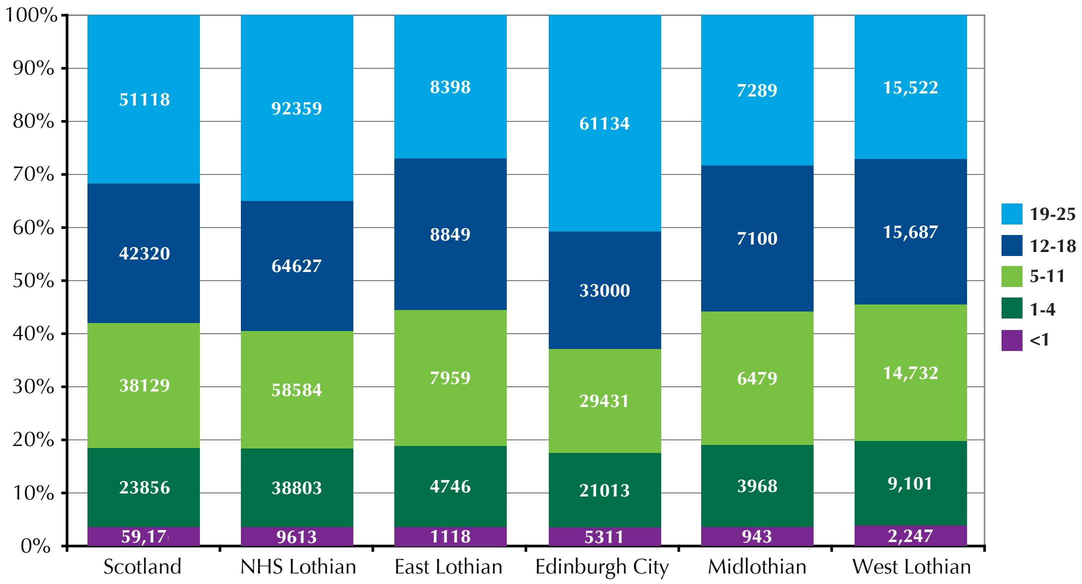
Information available locally and nationally has been used to build up a profile of the health and wellbeing of children and young people in Lothian. This section provides an overall picture/snapshot whilst appendix 1 provides links to national data sources used for this section which, in some but not all cases contain information at Local Authority level.

4.1 Current and Future Profile of Children and Young People in Lothian

Current Population

Chart 1 shows the most recent numbers of children and young people in Lothian compared to Scotland. There are a total of 265,833 under 25s in Lothian, just over 30% of the total population for Lothian. Edinburgh City has the fewest proportion of young people aged 18 and under (59%) compared to 73% in East Lothian and West Lothian. The figure for Lothian as a whole is 65 per cent, slightly less than the Scotland figure (68%).

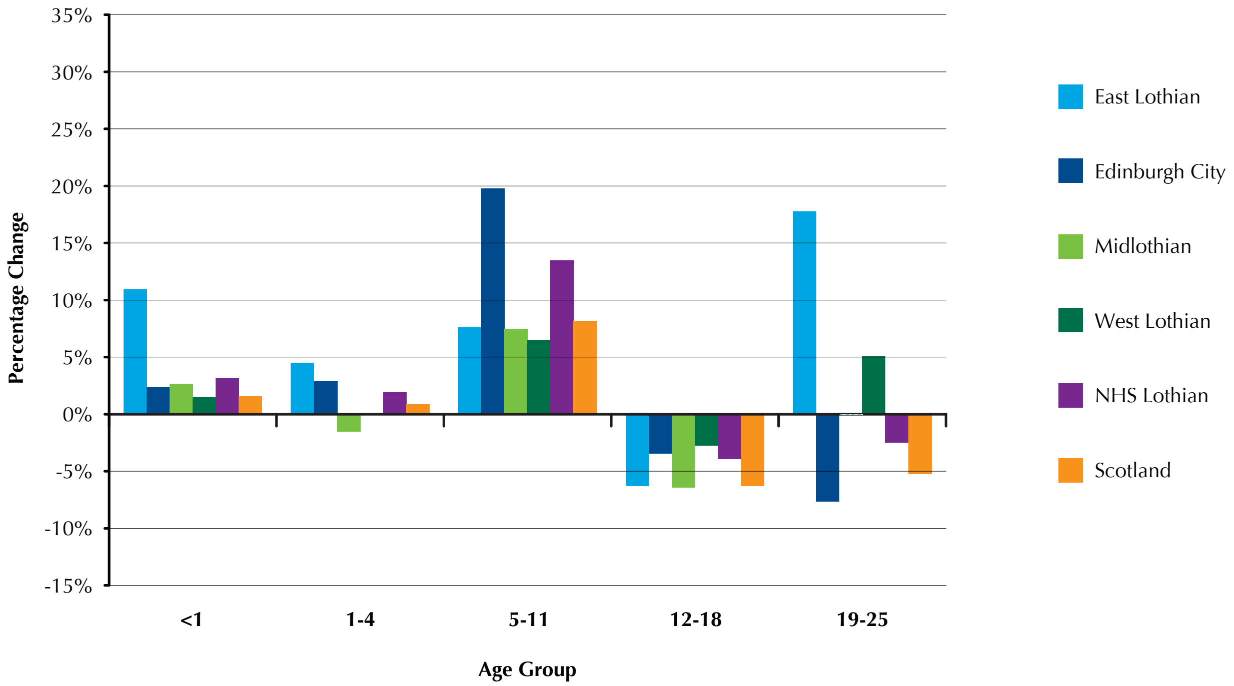
Chart 1 Population Estimates by Age Group



Projected Populations for 2017 and 2022

Chart 2 shows that by 2017 the population of Lothian children in the age group 5 -11 will increase by 13% to 67,606. This is greater than the percentage increase in Scotland for the same age group (8%). The largest increase will be in City of Edinburgh (20%).

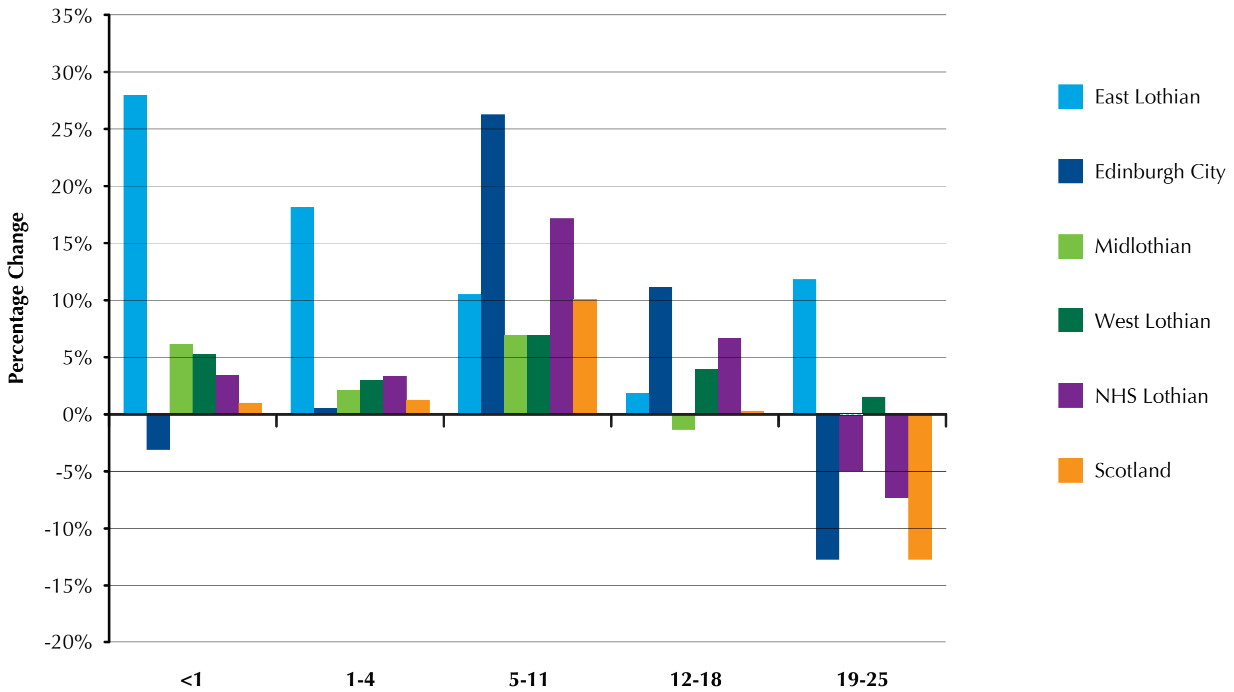
Chart 2: 5 Year Population Projections



The 10 year population projections paint a slightly different picture in Lothian, particularly in the 12 – 18 age group. In contrast to the 5 year projection all Local Authorities (apart from Midlothian) and Lothian as a whole will see an increase in numbers. The largest increase will be in City of Edinburgh (11%). For Lothian as a whole the largest projected increase will be in the 5 -11 age group, an increase of 17%.

While the NRS projections for Lothian show a slight increase to 2030, the figures recorded by maternity services in Lothian show a levelling off and perhaps evidence of a slight decline.

Chart 3: 10 Year Population Projection



4.2 Information About the Health and Wellbeing of Children and Young People in Lothian

Key Points

- The percentage of babies with a healthy birth weight in Lothian was 90.1 in year ending March 2011, above the Scottish Average (89.9%). This percentage has remained relatively stable over the last 5 years. In Scotland as a whole, rates of healthy birth weight are lower in the most deprived areas, however the figures are less marked in Lothian according to latest figures. Birth weight that is not within normal ranges has a strong association with poor health outcomes in infancy, childhood and across the whole life course, including long term conditions such as diabetes and coronary heart disease.
- In Lothian the most common age for starting a family in the most affluent areas is 30-34, the equivalent figure is 20-24 in the area of highest deprivation.
- The teenage pregnancy rate (16 and under) in Lothian has fallen over recent years and is similar to the Scottish Average (5.6 per 1000 in NHS Lothian, 5.7, Scotland average).

- In Lothian in 2012 the overall percentage of women who reported smoking at the time of their first antenatal booking was 17.7% which is less than the Scottish average of 19.3%. It should be noted that there is known to be considerable under-reporting of smoking by pregnant women.
- Over 45% of pregnant women in Lothian are overweight or obese at time of booking. Maternal weight outwith the normal boundaries is associated with complications in pregnancy for both the mother and child, including an increased likelihood of stillbirth and neonatal death. Data from Lothian in 2011/12 confirms this increased risk with pregnant women who are obese approximately twice as likely to suffer a stillbirth or neonatal death.
- The prevalence of overall and exclusive breastfeeding at the 6-8 week review has remained static across both Scotland (36.5% and 26.2% respectively in 2012) and Lothian (48.7% and 34.6% respectively in 2012) over the last 5 years. There are a number of personal, social and cultural issues that are strongly associated with the likelihood of breastfeeding including maternal age, deprivation and smoking status. Scotland-wide figures show that mothers in the least deprived areas are nearly 3 times as likely to exclusively breastfeed at 6-8 weeks compared with mothers in the most deprived areas. Within Lothian figures range from City of Edinburgh which has the highest rates (58.6% overall & 41.4 exclusive) to West Lothian which has the lowest rates (33.3% overall & 23.4% exclusive).
- There are currently around 560 children aged 15 and under on the child protection register in Lothian.
- There were 2,289 looked after and accommodated children/young people (including kinship care) in Lothian in 2012.
- There are currently 58 children in Lothian who have been identified as having exceptional healthcare needs (CEN). The best estimate of the overall prevalence of CEN currently available is around 30 per 100,000 in Scotland. The figure for Lothian is very similar to the Scottish Average (34).
- NHS Lothian currently has 1,395 children with a learning disability present at last assessment on the Support Needs System (SNS).
- Around 1 in 5 births in Lothian is to a mother born outside the UK.
- NHS Lothian had 0.8% new vision concerns at 27-30 month review between April and September 2013, and 1% new hearing concerns during the same time period.
- Official UK statistics estimate 1 in 10 children between the ages of 1 and 15 has a mental health disorder. Many mental health problems start early in life. Half of those with lifetime mental health problems first experience symptoms by the age of 14.

- In the quarter ending September 2013, 1,014 referrals were made to the Child and Adolescent Mental Health Services. The referral rate per 1,000 people under 18 for Lothian was 6.8, slightly higher than the figure for Scotland (5.3).
- In Scotland the target of the national immunisation programme is for 95% of children to complete courses of the following childhood immunisations by 24 months of age: Diptheria, Pertussis, Tetanus, Polio and Hib. An additional national target of 95% uptake of 1 dose of the Measles, Mumps and Rubella (MMR) vaccine by 5 years of age (with a supplementary measure at 24 months) was introduced in 2006 to focus efforts on reducing the number of susceptible children entering primary school. Latest data published shows that in Lothian 94.8% of children are immunised against MMR, slightly lower than the Scottish Average. 97.9% of babies were immunised against Diptheria, Pertussis, Tetanus, Polio and Hib. The figure for Scotland is 98.2%.
- The levels of Primary 1 children who are classed as being overweight or obese using epidemiological categorisation is very similar to the Scottish average: 21.7% in Lothian compared to 21.9%. Data for 2011/12 show that Scotland wide the prevalence of unhealthy weight amongst children in Primary 1 increases with deprivation.
- Latest dental inspection figures found that 76.9% of P7 children and 69.8% of P1 children in Lothian have no obvious decay experience. These are slightly higher than the Scottish figures (72.8% & 66.3% respectively). Scotland wide figures show that there are clear inequalities in terms of dental disease looking at deprivation categories. Although all categories have shown an improvement since 2009, there is still a large difference in levels of P7 children with no obvious decay experience in the most deprived group (60.7%) and the least deprived group (81.5%).
- The age groups with the highest rates per population attending Accident and Emergency are for those aged 4 and under. In the year ending March 2013 29,394 children aged 4 and under attended Accident and Emergency. 17% were admitted as inpatients.
- There were 41,546 Accident & Emergency attendances in the year ending December 2013 at the Royal Hospital for Sick Children; 14% were admitted as inpatients.
- The latest SALSUS figures for substance use show, overall, that 72% of 15 year-old pupils report not using any substances regularly or recently; 5% of pupils are using all 3 (cigarettes, alcohol and drugs) and 8% are using 2 types. Alcohol is the most commonly used substance on a regular basis; 21% vs 13% regular smokers (usually 1 or more cigarettes per week) and 12% using drugs in the last month.
- The number of domestic abuse incidents recorded by the police in Lothian is around 5,300 incidents per year, of which 45% of incidents were witnessed by children and young people. This figure is considered to be an underestimate and evidence shows that witnessing and/or experiencing domestic abuse represents a serious mental, physical and psychological risk to our young people.

5. Policy Context

The Scottish Government's ambition is that Scotland should be the best place in the world for children and young people to grow up. There are a number of national policies and local strategies that we link with to help achieve this ambition and ensure that children and young people who live in Lothian will have the best possible start in life and achieve the best outcomes.

The Refreshed Maternity Framework (2011) has been designed to address all care from conception, throughout pregnancy and during the postnatal phase. This document clearly outlines the strategic direction for maternity services in Scotland and NHS Lothian is delivering on this Framework.

Similarly, the Neonatal Care in Scotland: A Quality Framework (2013), outlines the approach required to deliver high quality care for neonates and their families across Scotland. The South East of Scotland and Tayside (SEAT) Managed Clinical Network for Neonatal Services, of which NHS Lothian is a key member, has an approved work plan that drives local delivery of this Framework.

Recognising the plethora of national policy related to children and young people, the Scottish Government published a summary of Scottish Government policy, titled Supporting Young People's Health & Wellbeing in March 2013. This document brings together key policies from across a range of Scottish Government Directorates and helpfully provides a broad overview of the national context in which NHS Lothian operates.

This document also outlines the key themes of the Children and Young People (Scotland) Act, which was passed by the Scottish Parliament in February 2014. This legislation combines proposals to improve the delivery of children's rights and services for children and young people. It is wide-ranging in its focus, building on the foundations of Getting it Right for Every Child (GIRFEC) and has implications for NHS Lothian, particularly with the responsibilities outlined for the Named Person. We will therefore be working with our partner organisations to:

- Embed children's rights in the design and delivery of local policies and services (as outlined within the UNCRC)
- Improve the way our services support children and families by ensuring every child and young person has a single point of contact through the role of the Named Person
- Ensure better permanence planning for Looked After Children by extending support to young people leaving care for longer, i.e. up to the age of 25

6. Our vision and principles

NHS Lothian's vision is that every child should have the best start in life and grow up being healthy, confident and resilient.

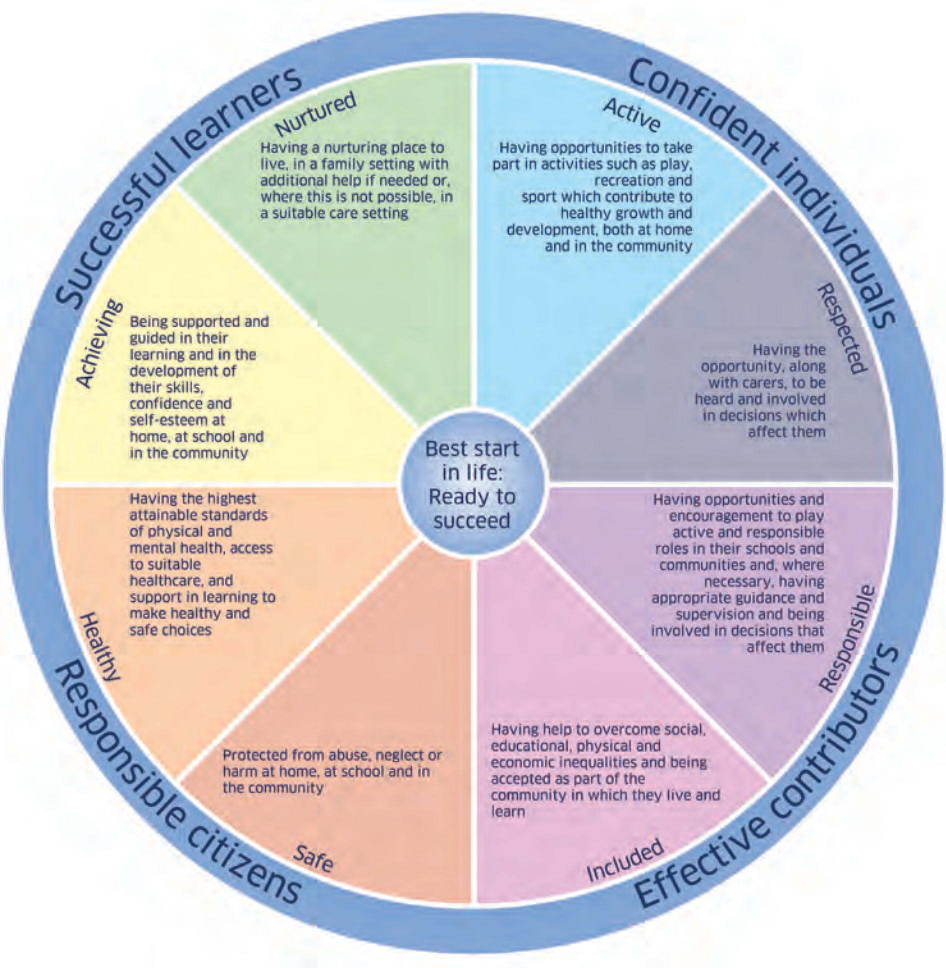
This vision will only be achieved by building on the capacities and assets of our staff working jointly with local people living and working in our communities. Achieving this vision requires collective action to:

- Focus on our relationships with children, young people and their families and our partner organisations.
- Enable local people to be part of the solution to the challenges we face
- Focus on our strengths
- Indentify ways that we make best use of our skills, knowledge and resources

The diagram below, developed by an organisation called Brighter Future Together, outlines the many assets that can be found within local communities and helps us articulate who our partners are that we will be working with to achieve our vision.

6.1 Principles of Getting It Right For Every Child (GIRFEC)

NHS Lothian has worked to ensure that the national principles and indicators of Getting it Right for Every Child (GIRFEC) are at the heart of all services working directly with children, young people, their families and carers. The following diagram, often described as the Wellbeing Wheel, demonstrates what NHS Lothian is committed to making a reality. We know that we cannot do this alone, which is why we are working with all our partners to implement it.



The Wellbeing Wheel is used courtesy of the Scottish Government

7. Meeting the health needs of children and young people in Lothian

Outcomes this section covers:

- NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health or resilience in those more vulnerable to poor health
- Every child and young person will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity
- Children and young people with disabilities will have their additional needs met
- Children, young people and their families will be involved in decisions that affect their health and wellbeing.

From the time that a woman finds out she is pregnant, through to birth, NHS Lothian has a maternity service across Lothian that supports the family to ensure that the child comes into the world as healthy as possible. Where extra support is required, we have a flagship neonatal unit and targeted initiatives such as PrePare (for pregnant women with a drug or alcohol problem) and Family Nurse Partnership (for teenage mothers) that are held in high regard.

When a child is born through to age 5, the first point of contact for support is through the Health Visiting Service with responsibility transferring to the School Nurse from the time a child starts school. Throughout this time, GPs will also play a key role when a parent identifies a health care need for their child. There are specialist services for those children that have additional support needs or are more vulnerable.

Addressing the needs of vulnerable children can only be achieved where services work together. The recent inspections of children's services in Edinburgh, Midlothian and East Lothian evidenced that NHS Lothian has strengths in protecting children and keeping them safe, however, we know that we can always do better. Where we have to focus more of our energies is in relation to increased prevention activities, helping prevent situations where children are at risk and, where they are in difficult situations, have the resilience to manage them. This agenda will therefore continue to remain a priority for NHS Lothian and our 4 local authority and voluntary sector partners within the 4 Integrated Children's Services Plans.

7.1 Transforming our services - Putting children's services at the centre of our plans

For a long time, and in common with much of the rest of the UK, we have planned the way we deliver health services separately in different parts of our system (primary care, acute care, NHS, local councils). We have also tended to plan around buildings, or around individual services. Our Health, Our Care, Our Future, the NHS Lothian Strategic Plan 2014 – 2024 proposes a radical shift away from this 'traditional' approach to a patient-centred, whole-system approach, focusing much more explicitly on the needs of people who use NHS Lothian's services.

This plan is predicated on the need for radical redesign to deliver sustainable improvements in health and care services in Lothian. A central tenet of service redesign is to focus on the patients' journey and experience, to help identify where service improvements are necessary and to involve a wide range of service users and providers in analysing and redesigning patient pathways.

Using intelligence and evidence, we have identified a child that represents children using our services. The child is 6 years old and is called Sophie. She has a range of health, social care and education needs, but is not a child with very significant health problems. We plan to use Sophie in order to get staff, children and young people, parents and carers to think about how well our services meet Sophie's needs. We also want to find out what the barriers are to meeting her needs and how we could improve support to Sophie and her family to help improve her health.

This is being conducted through a designed and managed process of engagement during 2014 and will inform significant parts of the final plan.

To bring all this work together, a plan will be developed to support implementation of this strategy. It will include a suite of performance measures that will demonstrate NHS Lothian's progress towards achieving our vision.

8. Addressing health inequalities

Outcome this section covers:
NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health or resilience in those more vulnerable to poor health.

Michael Marmot's review of health inequalities (2010) provides the most comprehensive summary of the impact of health inequalities and approaches to reducing health inequalities.

Marmot notes that:

- People from different socioeconomic groups experience avoidable differences in health, wellbeing and length of life and that this is unfair and unacceptable
- These differences are strongly influenced by inequalities in experiences of daily life that are typically mediated through differences in education, occupation, income, gender, ethnicity and race
- These differences are also influenced by an over arching socio-political and cultural and social context.

Health inequalities can be observed in the distribution of many diseases and risk factors. Health inequalities have become more pronounced in the UK over the past 30 years. The difference in life expectancy at birth by socioeconomic status provides a stark and incontestable reminder of this fact. The differences by income are even further accentuated for disability-free life expectancy. Similar gradients are observed for maternal smoking, breastfeeding, childhood obesity, childhood accidents and many other key risk factors and conditions.

Marmot's report also summarises the current evidence and recommendations for tackling health inequalities in the United Kingdom. These recommendations, the culmination of decades of research, are consistent with earlier reports on health inequalities. However, what sets the Marmot report apart is the particular focus on maternal and child health (the early years), early intervention and parenting (see appendix 2 for a more detailed list of key messages).

The Marmot report also notes that "focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage" referring to this as "proportionate universalism". This has clear relevance to discussion on universalism and targeting. The approach of offering a comprehensive programme of child health reviews and interventions (e.g. vaccination) for all children in Lothian is an example of a universal approach.

To address and reduce health inequalities requires 3 types of action:

- Actions to **mitigate** the health and social consequences of social inequalities
- Actions to help individuals and communities **resist** the effects of inequality on health and wellbeing
- Actions to **undo** the underlying inequalities in power and resources. Key areas are *employment, income and education*.

8.1 Current NHS Lothian approach

NHS Lothian has adopted a 'whole system approach' that recognises 3 strands to the role of health services in addressing health inequalities. The 3 strands of work are:

- Ensuring mainstream services are accessible to and appropriate for all groups in the population – using tools like impact assessment and equity audit
- Providing additional support and targeted services for disadvantaged groups whose needs cannot be fully met by mainstream services – for example the Homelessness and Health Team, Family Nurse Partnerships, Looked After Children's Nurses and Throughcare and Aftercare Nurses
- Working with partners to address underlying causes of health inequalities.

These approaches will be integral to the delivery of this Children and Young People's Strategy.

9. Working in Partnership and Community Planning

Outcomes this section covers:
NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health and resilience in those more vulnerable to poor health.

Partnership working is a "must do" for children and young people's services for a range of practical and financial reasons:

- Taking a holistic approach to improving children and young people's health and reducing health inequalities is complex, with a range of different agencies involved (including health care, children and families services, voluntary sector and youth services)
- Many children and young people are vulnerable or have limited ability to negotiate complex bureaucracies. They therefore need services that are well integrated at the point of contact, are easy to negotiate and are focused on their needs
- Partnership working can help minimise bureaucracy and duplication as well as maximise integration for service users and staff
- Resources are scarce, but the task is broad. It therefore makes sense for us to work together, strategically and operationally, to make best use of the knowledge, experience and skills we have that will make sure we achieve our collective vision for children and young people.

Effective partnership working is essential for children, young people and their families, who can often experience fragmented services, a lack of continuity and conflicting information in situations where local agencies fail to collaborate effectively.

There are strong examples of good partnership working between NHS Lothian and our community planning partners, as evidenced in the recent inspections of Children's Services in Edinburgh, Midlothian and East Lothian, for example:

- A clear strategy for integrating children's services, including strong involvement of the voluntary sector
- Meaningful involvement of children and young people to shape policies and services
- Strong partnership working and promotion of team working across services.

For partnership working to happen effectively across services, it should be demonstrated through leadership. NHS Lothian is actively engaged strategically and operationally within each of the 4 Community Planning Partnerships (CPPs) which demonstrate that leadership across Lothian. Each CPP has a focus on early years outlined in its Single Outcome Agreement, with a children and young people's sub group and Children's Integrated Services Plan driving delivery and partnership working.

All partners in the 4 CPPs in Lothian have signed up to the high level outcome, 'Every child has the best start in life and is ready to succeed'. Details of how this outcome will be achieved are outlined in each of the local plans and take into account the needs of all children, while recognising the specific needs pertaining to local communities in that CPP area. This includes the crucial role that parents play in giving children the best start in life and the additional support some parents need with bringing up their children.

Ensuring that children and young people are protected from emotional and physical harm is a priority for NHS Lothian and our local authority partners. The commitment, approach and actions to be taken are clearly outlined in the Interagency Child Protection Procedures for Edinburgh and the Lothians. Our commitment to keeping children safe can be demonstrated through a range of prevention activities that take place and through specialist services including a consultant delivered 24/7 service for medical examinations of children where concerns about physical abuse or neglect have been raised. Keeping children safe from harm is also an integral component of the 4 Integrated Children's Services Plans that NHS Lothian helped develop and is currently helping to implement.

NHS Lothian is also committed to driving the work of the Early Years Collaborative and is heavily involved in testing new approaches across the 3 work streams (conception to 1 year, 1 year to 3 years and 3 years to 5 years), using the Plan, Do, Study, Act methodology. With a principle of 'think big, start small, scale fast', early years staff have been encouraged to move quickly, using the 'tests of change' model of improvement, record the tests they are making and measure the progress that is being made. NHS Lothian staff will continue to work with our community planning partners through the Early Years Collaborative to encourage a culture that supports innovation and using data to drive improvement.

There is also an opportunity to improve shared learning and good practice across Lothian. To this end, it is proposed that a new Lothian Children and Young People's Programme Board be formed with representation from NHS Lothian, the 4 local authorities, General Practice and the third sector to share good practice. Further details of the remit of this group are discussed in section 11.

10. Reprovision of the Royal Hospital for Sick Children

Outcome this section covers:
The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children and young people's services and the development of services at St John's Hospital

We are committed to maintaining Edinburgh's reputation as a world-class facility for healthcare and research. Our work to re-provide services from the Royal Hospital for Sick Children (RHSC), Child and Adolescent Mental Health Service (CAMHS) and the Department of Clinical Neurosciences on the Little France site will help us to provide children and their families with facilities and services that ensure they receive the highest possible standards of care and provide a safe, spacious, light and comforting environment which promotes recovery and meets the needs of children, young people and their carers.

The benefits of having children's, maternity and adult services on the same site are well documented. This new building will bring the pieces of the jigsaw together to create a new centre of excellence at Little France. Having paediatric care, specialist neonatal care, adult neurosciences and children's and adult emergency departments all on 1 site will ensure that teams can share experience and expertise for the benefit of children and their families as well as adult patients.

The existing RHSC provides a comprehensive range of dedicated children's services, caring for over 100,000 children, up to the age of 13, and to age 18 in certain cases, from across Lothian and beyond. Services include accident and emergency, acute medical and surgical care, specialist surgical and medical care, haematology and oncology, neurosciences, day care, and critical care. The busy outpatients department cares for more than 34,000 patients a year. A number of regional and national services are hosted by RHSC, including the Paediatric Intensive Care Unit and the national Scoliosis service.

The hospital has been based at its current site in the centre of Edinburgh for almost 120 years. A 3 floor extension was added in 1995 and the vacated wards created a new Paediatric Intensive Care unit. Based on current projections, the emergency department for children and young people will expect to see around 50,000 attendances a year by 2016. The hospital is also expected to admit 9,500 inpatients, treat 8,000 day cases and see 64,000 outpatients under 18 years of age.

Plans for this project have been developed over a number of years. Specific factors driving the need for change in children's and young people's services and clinical neurosciences are:

- The age and limitations of the current premises
- The need to deliver sustainable specialist services whilst meeting the challenge of relatively small numbers of patients and small numbers of clinical experts
- The national policy for Paediatric Intensive Care Units in Scotland, which have been commissioned under NHS National Services since 2007, sited in 2 hospitals for children and young people
- The need to provide care for young people up to 16 years of age, and up to 18 in some cases, in age appropriate facilities.

Clinical benefits of integrating the services into 1 building, supporting the Board's and national strategic ambitions include:

- The ability to deliver paediatric and adult neurosurgery in the same theatre suite, maximising the utilisation of specialist equipment (e.g. intra-operative MRI) and expert staff, with direct internal access to age-appropriate critical care wards
- Mental health services on the same site as acute hospital services for children and young people, supporting their physical and psychological care
- Joint-working and economies of scale in high-cost specialist clinical areas such as theatres and radiology
- The opportunity to improve emergency access to services by incorporating a helipad on the roof of the new build.

The Reprovision of the new facility brings about opportunities for redesign of services and work has already started in this area with a focus on patient pathways and models of care.

Extensive public consultation has taken place in the development of the proposals for this project utilising existing stakeholder groups and in addition, specific stakeholder groups have been set up to ensure that patients and partner organisations have an understanding and input into the project.

The project will co-locate services currently provided at the existing Royal Hospital for Sick Children based in Sciennes, Edinburgh and CAMHS based at the Royal Edinburgh Hospital, Morningside with the adult clinical neuroscience services currently provided out of the Western General Hospital on Crewe Road South, Edinburgh, on the existing RIE site adjacent to the RIE Hospital at Little France.

Linked to the RHSC reprovision, we will also continue to look for opportunities to develop specialist outpatient services and more day surgery/ programmed investigation services at St John's Hospital, to meet the needs of the population in West Lothian by providing these services more locally, wherever possible.

11. Workforce Planning: Ensuring that we have a workforce that is fit to meet the demands of a growing population of children and young people

Outcomes this section covers:

NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population.

The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children's services and the development of services at St John's Hospital.

11.1 Workforce Planning: An Overview

NHS Lothian is committed to working closely with staff, the NHS Lothian Partnership Forum and the population in aligning workforce capacity to meet the needs of children, young people and their families for today and tomorrow, across all NHS services.

In taking forward workforce planning across those services working with children and young people, NHS Lothian endorses the nationally sponsored 6 step workforce planning methodology.

Workforce planning should be developed on an integrated basis that makes clear connections with service planning and financial planning. Such plans should also be able to respond to emerging issues and developments.

11.2 Workforce Planning: Child and Maternal Health Services

NHS Lothian's greatest asset is undoubtedly its workforce, operating across a wide range of settings in the delivery of a vast array of services, many of which are provided on a 24 hour/ 7 days a week basis. NHS Lothian is therefore committed to ensuring that its workforce has the right skills and is in the right place to provide the high quality, safe, effective, person-centred care that children, young people and their families deserve.

The development of this strategy is therefore crucial to supporting the formulation of robust child and maternal health workforce plans that deliver for the short, medium and long term.

There are a number of significant challenges within child and maternal health services in Lothian. This section sets out some of the key issues that need to be addressed. It also highlights where a robust and integrated workforce planning approach can ensure that we are able to provide a workforce that is fit for a leading 21st century public sector health provider.

These challenges, and NHS Lothian's collective responses, will form part of a wider Child and Maternal Health Implementation Plan, an element of which will reflect the ongoing workforce planning activity across a range of specific service areas. This Action Plan, addressing issues outlined below, will be driven by a Workforce Planning subgroup of the Lothian Children and Young People's Programme Board.

11.3 Key Issues

Implications of the Children & Young People (Scotland) Act for Midwives and Health Visitors

NHS Lothian welcomes the Scottish Government's move towards prevention and early intervention through the Named Person, as set out in the Children and Young People (Scotland) Act. For NHS Lothian, this means that we have increased duties to promote wellbeing of children and be the first point of contact for providing support and responding to concerns.

The Scottish Government has estimated the additional resource implications of introducing the named person to routine Midwifery and Health Visiting Services and that this equates to over £16 million for Scotland.

Based on the number of live births (9,794) and numbers of 0-5 year old children (48,980 - 2011 census), NHS Lothian estimates that this will place additional demand for workforce resource, particularly across Maternity and Health Visiting services.

The Scottish Government is also currently leading a national review of the Health Visiting Service and will report during 2014, in response to the national shortage of trained Health Visitors.

While it is recognised that changes as a result of the Act and the national review are not likely to come into effect until 2016, there are 2 main challenges facing NHS Lothian, namely:

- Funding any additional capacity recognised within the Act; and
- The feasibility of being able to develop and/or recruit to midwifery and health visiting roles in order to make a step change within our current workforce.

Such changes will require innovative planning across a range of key stakeholders in order to meet the requirements of the Act. This may involve elements of service re-design, options for new ways of working as well as a review of skill mix across teams. As a matter of priority, we have also committed to fund an additional 10 nurses to undertake Health Visitor training for 2014/15 with a view to reviewing training needs in response to the national review. This will be a priority action during the first year of the strategy.


11.4 Maternity Services

The opening of the Lothian Birth Centre has been an unprecedented success within NHS Lothian, with over 1,500 midwife-led births during 2012-13. However, this move of low risk births out of the main labour ward has highlighted more clearly the increasingly high percentage of complex cases going through the labour ward. There has also been a corresponding increase in length of stay within the postnatal wards, despite an increase of 10 postnatal beds within the SCRH with the opening of the birth centre. This in turn impacts on patients moving through services, leading to capacity and staffing pressures at SCRH and an increasing number of times that patients are diverted to St John's Hospital at short notice.

The service has already developed an internal improvement plan and has recently implemented the National Maternity Patient Safety Programme, which aims to reduce avoidable harm by 30% (including post partum haemorrhage), reduce stillbirth by 15%, address safety culture within the organisation and improve women's satisfaction with care by 2015. There is centrally funded midwifery time in Simpsons and St John's to lead the programme of work that will achieve these aims.

Maternity services have also worked closely with the National Gender Based Violence Programme to ensure midwives receive training and support on the introduction of routine enquiry of domestic abuse to pregnant women. Responses and interventions following disclosure are recorded centrally and community midwives are identifying an approximate disclosure rate of 8-10%. Close working relationships with Police, Child Protection Advisers, Health Visitors and specialist voluntary sector services has resulted in improving the health, safety and wellbeing for those families where domestic abuse is an ongoing concern. We will continue to build on this work as a matter of priority.

Taking all this into account, there is a recognition that both workforce (medical and midwifery) and capacity needs to be reviewed now with some urgency, in order to ensure we have a safe and sustainable maternity service for women and babies. The Chief Midwife will lead this work with recommendations being identified within the first year of the strategy.

11.5 Hospital Paediatric Workforce Pressures:

We currently face significant challenges with regards to the number of Paediatric and Neonatal Consultants. Gaps in middle grade registrar rotas caused by maternity leave, less than full time training and out of programme training currently affect all paediatric and neonatal rotas in Lothian (as well as Borders and Fife). This includes the neonatal intensive care unit at the Royal Infirmary Edinburgh (RIE), the paediatric intensive care unit at the Royal Hospital for Sick Children (RHSC), general and speciality paediatric rotas at RHSC and the paediatric and neonatal service at St John's. From August 2013 there have not been middle grade trainees allocated to the paediatric and neonatal unit at St John's or Borders for out of hours work.

11.6 Paediatric Workforce Planning: Short, Medium and Long Term

Workforce solutions to the issues across Paediatric services in Lothian will need to be planned for the short, medium and long term. A range of measures have been implemented to build current capacity within Paediatric and Neonatology services across NHS Lothian.

In terms of planning over the medium term, NHS Lothian has reviewed the outcomes of the commissioned independent Tailored Workforce Support Team (TWST) Report, which was set up by the Scottish Government Health and Social Care Directorates, in conjunction with NHS Lothian, to look at the future sustainability of the service. A range of alternative models and workforce options to maintain the service in the medium to long term have been highlighted and are currently being considered in full.

Looking to the longer term it will be important that any workforce planning activity reflects the Scottish Government's 20:20 vision as well as NHS Lothian's Strategic Clinical Framework, and is in accordance with NHS Lothian's Vision and Values.

In taking forward this work it will be important to work closely with other NHS Boards given that NHS Lothian provides a number of services across the region.

11.7 Community Child Health

The Community Child Health service is a consultant-led service delivering secondary and tertiary paediatric services to the children of Lothian. Acknowledged priorities are children and young people with a disability – encompassing both physical disabilities and learning difficulties – and vulnerable children - including Looked After Children and those requiring protection from harm. Specialist child protection services are delivered by Community Child Health, including interagency referral discussions with partner agencies (Police and Social Work) and medical examinations of children where concerns about neglect, physical or sexual abuse have been raised.

Currently the service is facing significant workforce pressures due to an ageing medical workforce and the associated loss of key personnel, knowledge and skills following retirement and limited responses to recruitment attempts. This is recognised as a national challenge and requires effective workforce planning, working with key stakeholders to ensure that these crucial services remain sustainable over the longer term.

11.8 Child and Adolescent Mental Health

Improving access to specialist services for children and young people with mental health services is a priority for NHS Lothian. The Scottish Government also requires the NHS in Scotland to measure the time children and young people wait for treatment, including for Child and Adolescent Mental Health Services (CAMHS). The Scottish Government has set a target for the NHS in Scotland to deliver a waiting time target from a child's referral to treatment for specialist CAMH services to be 18 weeks from December 2014. Work completed to date to agree a tolerance level for CAMH service waiting times has determined that the CAMH services target should be delivered for at least 90% of children.

The single Lothian-wide CAMHS provides a tiered model of care to support and treat children and young people, (and their families and networks of support) aged from 0 to 18 years old, with mental health problems and mental illness. Tier 4 provision includes a 12 Bedded inpatient unit serving the population of South East Scotland, an intensive home treatment team and 4 intensive treatment day services.

Tier 3 provision comprises 15 community / outpatient teams which fall within the remit of the access target. 9 of these teams are geographically defined:

- North Edinburgh: General and ADHD
- South Edinburgh: General and ADHD
- West Lothian: General and ADHD
- Midlothian: General and ADHD
- East Lothian: General including ADHD.

The remaining 4 teams provide specialist CAMHS to specific populations:

- Children and young people who have experienced sexual trauma and also children presenting with sexualised behaviour problems - the Meadows team
- Children and young people with learning disabilities
- Children and young people with mental health problems and physical health conditions – PPALs Team
- Edinburgh Connect – a team serving looked after and accommodated children in Edinburgh.

In April 2011 the upper age range for all referrals to the service was extended to 18 years in line with the requirement of the Mental Health (Scotland) Act and with national policy guidance for specialist CAMHS. No additional resource was allocated to the service to manage the extension of service provision.

The referral rate for Lothian CAMHS continues to increase year on year, inclusive of an increase across the whole spectrum of mental health conditions. For example, children and young people with serious eating disorders including anorexia nervosa have significantly increased in the time period. In comparison with other Scottish Health Boards, NHS Lothian has one of the highest referral rates and rate of accepted referrals.

The expected prevalence of mental health problems in the child population is 10%[1] so although the Lothian referral rate is 0.6%, which is higher than the Scottish mean, this would indicate that in comparison with other Scottish Boards the thresholds are appropriate.

The service also works indirectly to support the work of those working in education, primary care and the third sector to improve outcomes for children who do not meet the threshold for referral to specialist CAMHS. If evidence-based intervention is offered early in a child's life and early in the problem cycle then that minimises the impact of the mental health problem on the child's ordinary development and life. There is evidence that early intervention also leads to reduced health spend across the life cycle.

There has been a concerted effort to improve waiting list management by CAMHS services. The Quest funded A12 team have been working with the clinical services on a number of service improvement strands including:

- Cleansing of data to ensure accurate wait times information
- Introduction of standard operating procedures for ensuring data quality and improved data completeness
- Agreement of standard operating procedures to ensure consistent and efficient management of services' waiting lists.
- Development of a monthly CAMHS waiting times dashboard
- Planned implementation of the Remind+ telephone and text reminder system to reduce non-attendance.

In addition, The Choice and Partnership Approach Model (CAPA) which is designed to improve services' capacity and patient flow will be implemented across Lothian services.

[1] 10% prevalence – not all children and young people will be referred to specialist CAMHS. Part of a specialist CAMH service is to build capacity within with Universal Services to enhance their ability to work with children and young people with mental health problems

With the Demand and Capacity activities and further planned improvements planned, the CAMHS Executive Management Team have identified the resource required to sustain current performance and ensure that the target of 90% of children and young people requiring CAMHS are seen within 18 weeks by December 2014. This is currently being considered as part of NHS Lothian's Financial Plan prioritisation process.

Led by the Strategic Programme Manager for Mental Health and Wellbeing, the CAMHS Executive are working to ensure that there is an increased locality focus to tier 3 provision.

A CAMHS hub model is being developed which will ensure that there is greater alignment and closer working with key third sector partners within localities. This will offer increased opportunities for co-working, liaison and consultation in line with Getting It Right For Every Child (GIRFEC) principles. This will also take account of the planned re-provisioning of the Sick Children's Hospital.

11.9 General Practice

In 2013, A Vision for General Practice in the Future NHS was published by the Royal College of General Practitioners. This outlines the changing landscape in which an understanding of high-quality health care is changing. It recognises the move towards a 21st century system of integrated care, where clinicians work closely together in flexible teams, formed around the needs of the patient and not driven by professional convenience or historic location. It is therefore crucial that GPs are involved in the development of plans for the integration of children's services.

Furthermore, the report states that GPs in 2022 will need expert generalist clinical skills, particularly in the context of managing children with complex medical conditions and that, "They will be able to respond to both urgent and routine needs, providing first-contact services to the majority of children…..". It is therefore important that GPs generally have opportunities to maintain their knowledge and skills.

NHS Lothian's Strategic Plan 2014 - 2024 outlines the need to review GP numbers and workforce support in light of the population and demographic changes. In addition, to support GP training in the management of children and young people, GPs are encouraged to access programmes such as the Lothian Fellowship Programme for paediatrics and the National Education for Scotland Paediatric Scholarships, which are particularly aimed at GPs with a Special Interest or wanting to take a lead in the practice.

11.10 Integration of Children's Services

The Christie Commission report outlined the importance of integrating services to reduce the complexity and fragmentation of public sector services and have a stronger focus on improving outcomes for people. The integration of adult health and social care services, the creation of the shadow Health and Social Care Partnerships and anticipated future dissolution of the Community Health Partnerships (CH(C)Ps) in April 2015 has a consequential effect for Health Visiting and School Nursing services that are currently managed within CH(C)Ps across Lothian.

There are many opportunities brought by the integration of children's services, building on the principles of GIRFEC and for improving the outcomes of children and their families. As we work through the practicalities of what this means for staff and the services we offer, NHS Lothian makes a firm commitment to working with staff to:

- Fully involve them in decisions that affect them
- Identify the opportunities integration brings
- Ensure that any identified risks are mitigated
- Ensure that patient safety and quality of care will be sustained or enhanced and that there is no inequity across Lothian
- Explore more opportunities for interagency training and development that results in improved joint working and in improved outcomes for the children and families staff work with.

12. Finance

Children and young people are crucial to the future wellbeing and prosperity of Scotland. Healthier adults in the future will reduce the demand placed on NHS services.

The Scottish Government in its report "The Financial Impact of Early Years Interventions in Scotland" has indicated that investing in early years services produces the potential for savings in the short, medium and long term.

Discussions within NHS Lothian during 2012 resulted in a proportion of the additional monies that are received from the Scottish Government to reflect population changes being utilised to support Early Years. Further discussions are required locally and with the Scottish Government to identify resources that are required to implement the requirements of the Children and Young People (Scotland) Act from 2014.

The financial baseline for this strategy will be 2012-13, recognising that the development of this strategy and NHS Lothian's commitment to early years has begun a shift in resource, in line with the Early Years Change Fund.

Table 1: NHS spend on healthcare services for children and young people (0-17 years) 2012/13.

Spend on Under 18s	Edinburgh	East Lothian	Midlothian	West Lothian	Lothian Wide	Non-Lothian and other	Total
Inpatients	£12,564,899	£3,128,096	£2,318,175	£7,009,273	£0	£15,949,753	£40,970,197
Day Cases	£2,680,065	£643,881	£467,809	£1,342,948	£0	£1,892,494	£7,027,197
Outpatients	£8,808,712	£1,997,269	£1,838,613	£3,621,171	£0	£1,235,196	£17,500,961
Community	£9,571,093	£2,182,610	£1,866,719	£4,002,711	£13,797,364	£203,576	£31,624,074
Payments to Third Sector Organisations					£603,000		
Totals	£33,624,770	£7,951,857	£6,491,316	£15,976,103	£14,400,364	£19,281,019	£97,725,429

Table 2: NHS Additional spend on healthcare services for children and young people 2013/14

Spend on Under 18s	Edinburgh	East Lothian	Midlothian	West Lothian	Lothian Wide	Total
Increase in population - Health Visitors	£135,500	£34,000	£34,000	£67,750		£271,250
Implement 27-30 month review – Health Visitors	£162,000	£40,500	40,500	£81,000		£324,000
Implement 27-30 month review – Speech & Language Therapy	£22,000	£5,500	£5,500	£11,000		£44,000
Increase in population – school nurses	£42,000	£11,500	£11,500	£21,000		£86,000
Enteral Feeding for Children					£86,000	£86,000
Implement CEL 16 – review all looked after children					£595,907	£595,907
Totals	£361,500	£91,500	£91,500	£180,570	£681,907	£1,407,157

13 . Governance and performance improvement arrangements for overseeing implementation of this strategy

Outcome this section covers:
Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy

The implementation of this strategy will require improvements to the current process of measuring how children and young people's healthcare services are performing. The production of good quality data and information will be necessary in order to ensure that we know that every child has the best start in life and is growing up healthy, confident and resilient.

While we are good at collating data, we need to ensure that we are collating the right data that evidences whether we are achieving positive outcomes or not. We will therefore review the data we collate and ensure that it helps:

- Practitioners understand more about the children they work with, either individually or at population level
- Contribute to demonstrating progress towards the outcomes of this strategy and the Integrated Children's Services Plans agreed with partners.

To oversee implementation of this Strategy, the 'NHS Lothian Children and Young People's Strategy and Modernisation Group' has been replaced by the Lothian Children and Young People's Health and Wellbeing Programme Board.

The remit of this group will be to:

- Drive forward and oversee the implementation of this strategy, monitoring progress against identified indicators and outcomes
- Identify and progress areas of work where there is a greater chance of improving children and young people's outcomes by working across Lothian
- Share learning across partners and geographical areas in order to improve the quality of service provision at a local and regional level
- Clarify the contributions to be made by each agency towards the identified Lothian wide outcomes
- Support the integration of children and young people's services where appropriate in order to improve the pathways of care for children and young people.

Appendix 1

1. http://www.gro-scotland.gov.uk/statistics/theme/population/index.html
2. http://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/2013-08-27/2013-08-27-Births-Report.pdf?39985293150
3. http://www.isdscotland.org/Health-Topics/Sexual-Health/Publications/2013-06-25/2013-06-25-TeenPreg-Report.pdf?26044863463
4. http://www.isdscotland.org/Health-Topics/Child-Health/Publications/2013-10-29/2013-10-29-Breastfeeding-Report.pdf?6295412779
5. https://isdscotland.scot.nhs.uk/Health-Topics/Waiting-Times/Publications/2014-02-25/2014-02-25-CAMHS-Report.pdf?48232668639
6. http://www.isdscotland.org/Health-Topics/Child-Health/Publications/data-tables.asp?id=1194#1194
7. https://isdscotland.scot.nhs.uk/Health-Topics/Child-Health/Publications/2014-02-25/2014-02-25-P1-BMI-Statistics-Publication-2012-13-Report.pdf?84937685729
8. http://www.isdscotland.org/Health-Topics/Dental-Care/Publications/2013-10-29/2013-10-29-NDIP-Report.pdf?42231386900
9. http://www.isdscotland.org/Health-Topics/Public-Health/SALSUS/

Appendix 2

Key messages from Fair Society, Healthy Lives Marmot Review
http://www.marmotreview.org/

1. Is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.
2. There is a social gradient in health – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
3. Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.
4. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.
5. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
6. Economic growth is not the most important measure of our country's success. The fair distribution of health, wellbeing and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.
7. Reducing health inequalities will require action on 6 policy objectives:
   - Give every child the best start in life
   - Enable all children young people and adults to maximise their capabilities and have control over their lives
   - Create fair employment and good work for all
   - Ensure healthy standard of living for all
   - Create and develop healthy and sustainable places and communities
   - Strengthen the role and impact of ill health prevention.
8. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.
9. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

From: The Marmot Review (2010). Fair Society, Healthy Lives. www.themarmotreview.org (accessed 1 June 2)

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Healthcare Governance Committee
25 November 2014

Medical Director

PATIENT SAFETY PROGRAMME ANNUAL REPORT

1 Purpose of the Report

1.1 This report is to provide assurance on the progress being made by Scottish Patient Safety Programme (SPSP) in Lothian.

1.2 To update the Board on progress within and across all the patient safety programmes, Acute Adult, Primary Care, Mental Health, Paediatrics, Neonatology and Maternal Health.

1.3 Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

The Healthcare Governance Committee is asked to:

2.1 Review the range of workstreams under the patient safety programme and the breadth and depth of programme coverage across NHS Lothian required to deliver the Reducing Mortality and Preventing Harm improvement plan and achieve the Scotland-wide 20% reduction in the Hospital Standardised Mortality Rate by December 2015.

2.2 Note that the indicators for measuring harm have changed to include the 10 essentials and 9 point of care priorities for patient safety and development of the Scottish Patient Safety Indicator

2.3 Note that in July 2014, following a consultation exercise, the final drafts of the Board leadership and infrastructure driver diagrams were sent by Health improvement Scotland (HIS) to boards (see Appx 1). The aim of the driver diagrams is for Boards to provide leadership and strategic support to improve safety and quality and a sustainable infrastructure at all levels of the organisation to support the improvement of safety and quality outcomes in the Board

2.4 Note that HIS undertook a supportive visit to NHS Lothian in August 2014. Draft feedback has been received and summarised in this paper but the finalised report is still to be provided. This external review of the SPSP is to provide support and not scrutiny; however it should give the board some assurance with regard to the progress of the programme.

2.5 Note that the challenges to achieving the aims of the programme are, leadership, time to undertake improvement training and initiatives, staffing levels particularly in the winter and competing demands and activities

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Discussion of Key Issues

3 ACUTE ADULT PROGRAM

CEL 19 (2013)

CEL 19 set out for all NHS Boards in Scotland the 10 patient safety essentials (see appendix 1) which should be implemented everywhere and the 9 point of care priorities which all boards should be able to demonstrate that they are testing and implementing using quality improvement methodologies.

3.1.1 Patient Safety Essentials

All clinical areas are submitting relevant data and the data is collated and fed back to wards, clinical and senior management teams through QIDS and collated data is reported on a monthly basis to HIS. HIS in turn carry out quarterly reviews of the Safety Program and associated data with each board. Assessments in January and July 2014 demonstrated that NHS Lothian was one of 5 Boards reporting data and is on target for all the measures. The next review is due to take place in early December 2014.

The CEL also sets out an expectation that boards would put in place arrangements to ensure that staff are supported to deliver these measures reliably and consistently to all patients who could benefit. To this end, the clinical effectiveness teams have been meeting with all Senior Charge Nurses and Clinical Nurse Managers with the aim of reviewing and validating the data and data collection processes, assessing understanding of the data and use of the compliance reports and improving the use, quality and reliability of the data. Dr Nikki Maran is carrying out similar meetings with Clinical Directors to do the same.

To date 67% (75) wards and 73% (43) of the theatres have had a CEL 19 gap assessment of the 10 essentials. 37 wards, 16 theatres and 44 non inpatient areas are still to be reviewed.

The overwhelming benefit of the ward meetings is the opportunity for the Senior Charge Nurses to rethink and refresh the way safety and measurement is viewed and understood by the staff. The Senior Charge Nurses are very willing to try new ways of working. HIS and the safety team have been impressed with the level of competence the Senior Charge Nurses have around data.

The reviews have highlighted additional training needs with regard to the use of QIDS, the Quality Improvement Data System used to collect and report wards data and the Ward Scorecard. A substantial resource has gone into the development of the ward scorecard with the Scheduled Care Senior Management Team to bring together and report information on quality, activity, finance and staffing from ward to Board and it enables quality to be seen in the context of performance and finance.

CEL 19 encourages Boards to step down frequency of measurement when compliance is reliable and in order to reduce the data burden. NHS Lothian has developed a process for step down which increases frequency of measurement if the assurance mechanisms identify a reduction in process compliance or outcome. As there has to date been no national guidance on how to measure reliability once wards are allowed to step down, this NHS Lothian approach has been shared by HIS with other boards as good practice.

Within NHS Lothian, compliance figures are generated from a random sample of 5 ward audits per relevant measure per week and this random sample of 20 measures is entered into the QIDS database at the end of each month. Reliability is defined as >95% compliance per month over a period of 9 months thereby allowing 5% variation on 3 data points over that time. It should be noted that other boards are not applying the same criteria for reliability as NHS Lothian. This inconsistency has been discussed with HIS who are only asking for a board level compliance and consider the most important data to be the level of spread which we report monthly.

Although monthly compliance overall is good there is a significant challenge to achieving the high reliability of >95% compliance over a period of 9 consecutive months on every appropriate measure for every ward. Table 1 shows that 4/10 essentials do not meet the overall reliability criteria.

Table 1: Overall Board Compliance with Essentials

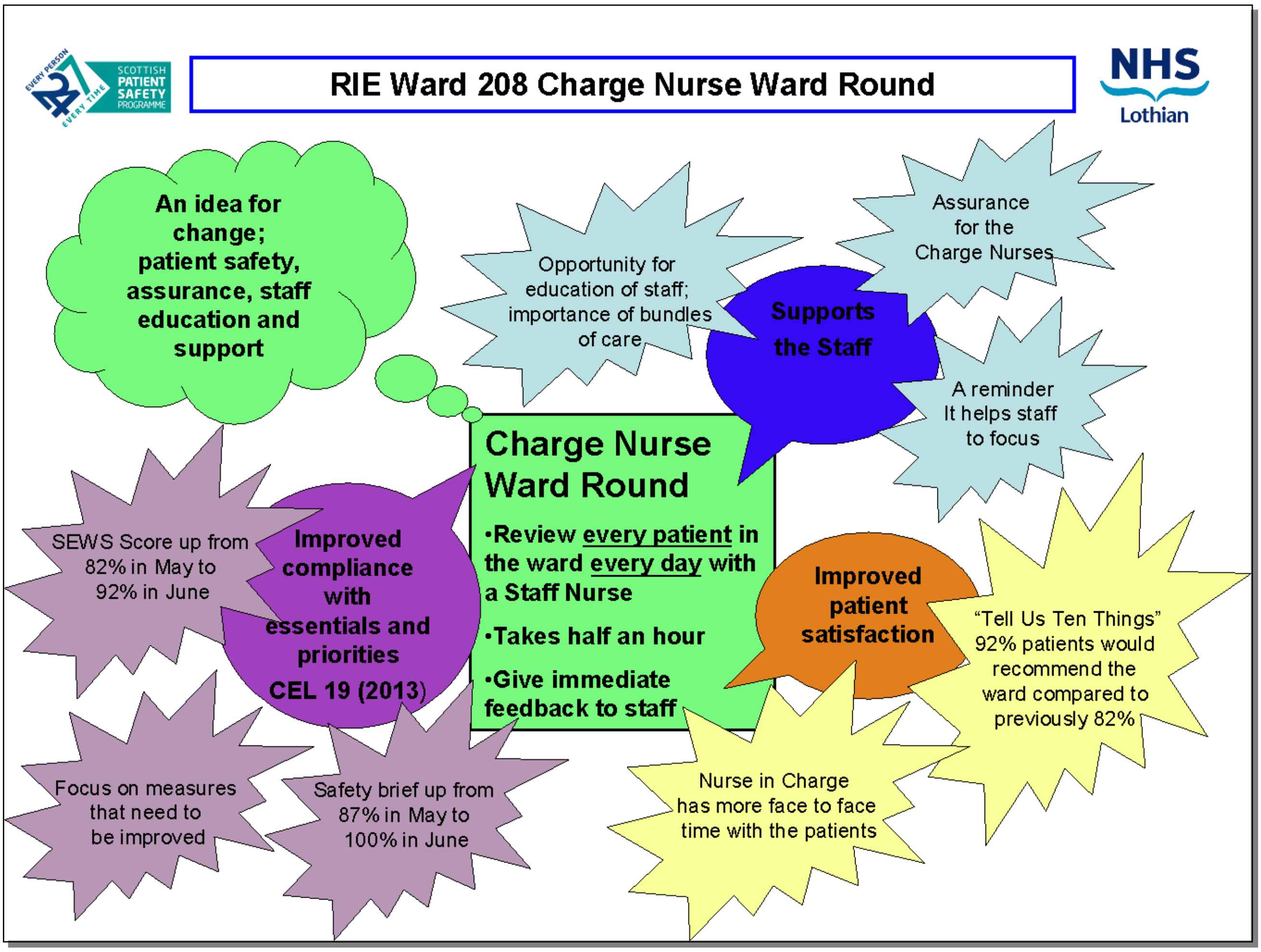
	Essential	**Meets reliability criteria**
1	Hand Hygiene	Yes
2	CVC maintenance bundle	No
3	CVC insertion	Yes
4	Daily Goals in ICU	Yes
5	PVC maintenance bundle	No
6	Ward safety briefings	Yes
7	Compliance with SEWS	No
8	VAP bundle	No
9	Surgical safety briefing	Yes
10	Safety walkrounds	Yes

As part of the assessment reviews, best practice with regard to improving data quality, validation and assurance is being identified and shared and it is already beginning to show improved performance in some of the wards. Examples of this are:

- The Senior Charge Nurses are encouraged to review compliance with all the relevant measures in real time for individual patients. Senior Charge Nurse Billie Flynn has introduced a charge nurse ward round which means that every day the nurse in charge reviews every patient with the nurse delivering their care. The ward round takes 40 minutes and the feedback from patients and staff has been very positive and has improved compliance with safety and quality measures (see Figure 1). Some Senior Charge Nurses build reviews into ward rounds, engaging the medical staff in the process, and daily feedback on performance is part of safety briefings.

- A patient focussed audit tool which combines all the measures into one is being tested at the Western General Hospital and has been welcomed by the Senior Charge Nurses because it refocuses on the patient, making it more meaningful and efficient. The introduction of the TRAK paper-light system is a challenge as some of the processes that have been developed to improve reliability such as, screening tools, assessments, stickers and checklists are not currently available on TRAK and staff are reluctant to duplicate or to work on both paper and electronic records. The measurement of compliance is also more difficult. This will be discussed with the TRAK development team.

Figure 1: RIE Ward 208 Charge Nurse Ward Round



3.1.2 Point of Care Priorities

The 9 point of care priorities are all being tested and have varying degrees of implementation and spread across NHS Lothian. These are:

Deteriorating Patients
Sepsis
Falls
VTE
CAUTI
Pressure Ulcers
Heart Failure
Surgical Site infections
Safer Use of Medicines

3.1.3 Scottish Patient Safety Indicator

Consultation across NHS Scotland took place to determine the best approach to the measurement of harm in acute healthcare and this led to the development of the Scottish Patient Safety Indicator (SPSI) with an aim of reducing the occurrence of 4 specified harms:

- Cardiac Arrest
- Catheter Associated Urinary Tract Infections (CAUTI)

- Falls with Harm
- Pressure Ulcers (Grade 2–4)

Due to difficulties with measurement of CAUTI, this is being excluded from the indicator by HIS at present. The aim is that 95% of people in acute adult healthcare are free from the other **three harms.**

NHS Lothian has achieved the 95% harm free care at board level as measured by the indicator. Initially despite the CAUTI outcome measured by Lothian being the number of positive urine cultures, which was a large number and overestimate, the harm free percentage was 97%. Since removing CAUTI as one of the indicators the harm free indicator is above 99%. (See Table 2).

Table 2: SPSI for Acute Adult Inpatient Areas (RIE, WGH, SJH and Liberton)

Month	CA	Falls	PU	Unique Harm Combined	Number of Patients who had >1 Harm	Harmfree	Discharges	Harmfree Care %
Nov-13	15	16	4	35		9204	9239	99.6
Dec-13	19	8	9	36		9330	9366	99.6
Jan-14	21	20	8	49		9498	9547	99.5
Feb-14	15	11	9	35		8999	9034	99.6
Mar-14	15	20	8	42	1(CA+FALLS)	9729	9771	99.6
Apr-14	17	23	10	49	1(FALLS+PU)	9497	9546	99.5
May-14	9	15	11	35		10390	10425	99.7
Jun-14	15	7	11	33		9891	9924	99.7
Jul-14	11	16	4	31		9965	9996	99.7

The SPSI requirement is to work towards implementing this concept from a patient perspective at ward level rather than a high level Board measure. Although this work has not started on the wards as yet, it fits well with the intention to measure all care delivered to individual patients using the patient focussed audit.

A pilot of Executive WalkRounds in Primary Care commenced in November 2013, and is due for completion next month, with a full evaluation scheduled for early 2015. Dr Richard Williams is the lead GP on all pilot visits accompanied by a non-executive. Actions will be followed up 6 months after the WalkRound.

In addition to the 6 Executive WalkRounds in the last 12 months, the maternity service are testing a system of local leadership WalkRounds on both sites. The aim is to improve care and to identify what matters to both staff and service users.

Clinical areas are chosen in a variety of ways, they can volunteer and the majority do, and there is currently a waiting list. Executives can also request to visit certain areas. As part of the programme all areas are to be visited so areas who have not had a WalkRound are entered into the programme and we are on the second round of the acute inpatient areas, mental health, paediatrics, and maternity. Dr Nikki Maran has been raising awareness of the walkrounds with medical staff and engagement and participation of medical staff has improved.

Table 3: Key WalkRound Themes

Theme	Frequency	%
Environment	48	31
other	33	21
staffing	27	17
Flow/activity	16	10
Pt focus	16	10
IT	13	8
Boarding	3	2

One of the measures of success is the number of completed actions. Over the last year, 72% of actions agreed have been completed i.e. 124/173.

3.1.4 Executive Leadership WalkRounds

The aim of the SPSP Executive Safety WalkRounds is to connect senior management with frontline staff in a formalised and recorded discussion about patient safety in order to strengthen communication, enhance safety culture and speed up organisational delivery of corporate and strategic actions for safer systems. It enables senior leaders to see and hear first hand issues faced by frontline staff on a daily basis which standard reports cannot achieve. There is also the opportunity to identify and celebrate good practice.

The Non-Executives joined the WalkRound programme in 2013 and have been committed and enthusiastic participants who are well prepared in advance of the WalkRounds, engage well with staff and patients, encouraging openness and they have been confident leads when executives have not been available to lead the WalkRounds

Table 4: Number of WalkRounds

RIE incl Lauriston	20
WGH	14
SJH	16
RHSC	4
Liberton	1
Roodlands	1
Royal Edin Hospital	6
Total	62
Cancelled	3

3.1.5 The Management of the Deteriorating Patient

Background

The effective management of deteriorating patients is a priority in CEL 19 and is considered pivotal to the reduction in cardiac arrest rates and to HSMR. NHS Lothian has chosen to implement the bundle approach used successfully in NHS Salford. This involves use of 8 interventions

-Reliable observations -Goals of care
-Escalation -DNACPR

-Patient safety at a glance board	-Sepsis 6
-Structured ward round	-Allocation of roles

The initial emphasis in Lothian was early identification of deteriorating patients through the use of the Standardised Early Warning Score Chart (SEWS) and standardisation of escalation and response to clinical deterioration.
Between January 2013 and January 2014 using the Salford change package, 37 wards, received deteriorating patient training by the Clinical Education Team and 11 surgical wards at the RIE and 8 on the WGH site, started to put in place the changes.

The training and improvement work was well received, however, challenges remain particularly around the following:-

- The use of electronic capture for SEWS observations & frequency of observations
- Unreliable escalation processes including problems with availability of middle grade medical staff, harmonisation of bleeps and escalation of boarded patients
- Availability of staff for training and education and medical engagement
- Capturing data to show change at a local level

3.1.6 Testing Breakthrough Series Collaboratives

NHS Lothian Clinical Governance team agreed to test a Breakthrough Series collaborative (BSC) approach, similar to that used in NHS Salford to further develop and implement the deteriorating patient bundle. One-day collaborative sessions took place in May and November 2014. The initial focus has been on the front door areas and downstream wards. Acknowledging the differences in microsystems at the RIE and WGH, initially the BTS were site based, multi-disciplinary, and shared existing good practice. As St. John's had made considerable progress with the Salford Bundle Implementation already, the focus there has been to test a SEPSIS collaborative and sustain improvements in reduction of cardiac arrests.

These collaborative sessions have been well attended by members of the multidisciplinary team, education (including QMU, Napier), site management and Hospital At Night staff. The content of the agenda for the day included the Deteriorating Patient Change Package, Human Factors and Quality Improvement methodology. Teams were encouraged and supported to develop work plans most suited to their clinical areas and identify their first tests of change with members of the Clinical Effectiveness team. Following the Collaborative the clinical teams were supported with ward based improvement, coaching, mentoring, regular workshops and the opportunity to discuss challenges and success as in figure 2 below.

The second sepsis learning session was run as a cross-site collaborative. All clinical areas on each site were invited to the second collaborative sessions at WGH and RIE (including Liberton) in November and in April 2015 there will be a large cross site collaborative bringing all the work streams and sites together to share their improvements.

Figure 2: Oscar Berg – Collaboration Pyramid

3.1.7 Progress with implementation of the Salford Bundle

There are 8 interventions which when carried out reliably can have a positive outcome for deteriorating patients:

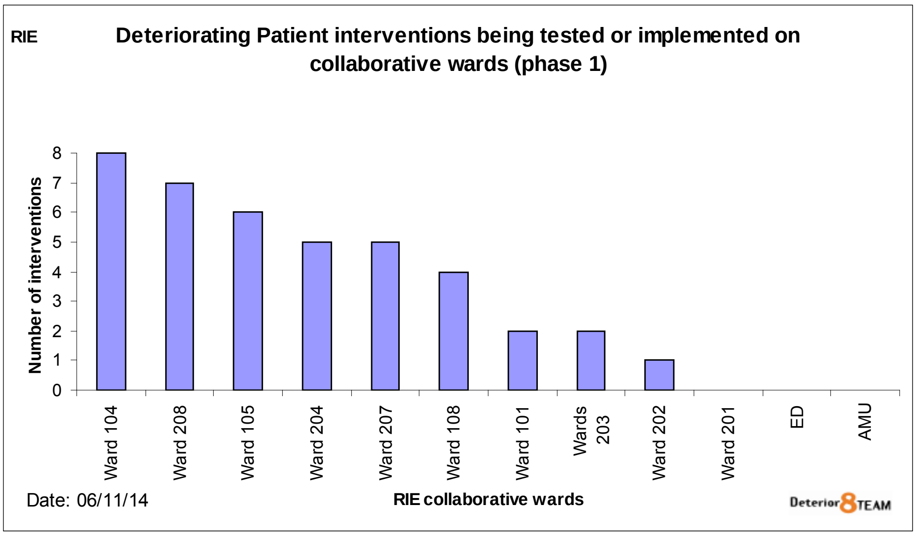
-Reliable observations	-Goals of care
-Escalation	-DNACPR
-Patient safety at a glance board	-Sepsis 6
-Structured ward round	-Allocation of roles

The charts below show how many of these interventions are currently being tested or implemented in the wards in the first 'tranche' of the Deteriorating Patient collaboratives on the WGH and RIE sites. Because St Johns was the initial pilot site within NHS Lothian for the Deteriorating Patient work stream, the St John's data includes all acute adult wards.

These charts do not reflect the full amount of work being carried out in relation to the Deteriorating Patient work stream as a number of wards out with the collaboratives are also implementing these changes. The CGST are supporting many of the 8 interventions in both collaborative and non collaborative wards through awareness and Quality Improvement training before testing can begin.

The RIE wards that have made most progress are wards 104, 205, and 108. Wards 201, 202, 203 have had disruptions due to reorganisation and a lack of continuity in both leadership and staffing.

Chart 1: RIE Collaborative Wards



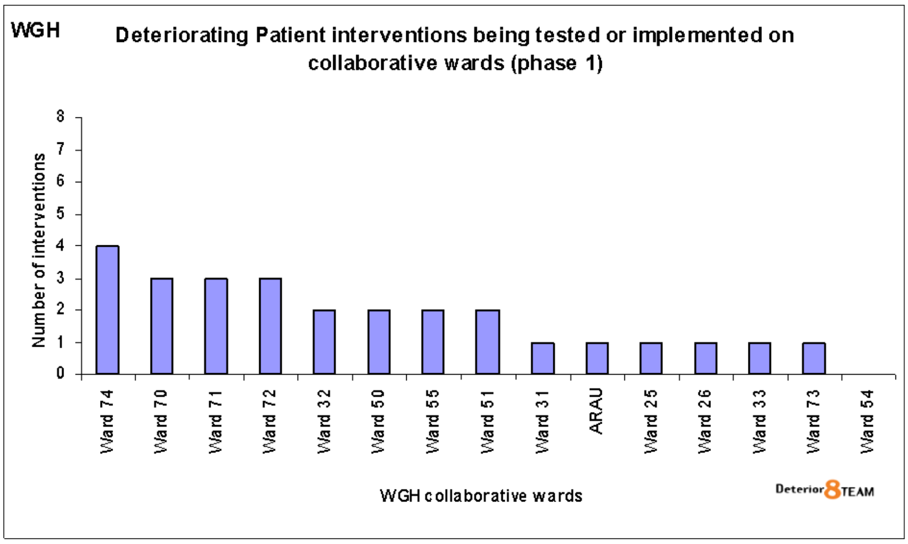
All in the WGH wards state that staff are performing manual observations on all patients with either a raised SEWS or those with whom they have a concern. Assurance audits on two wards confirm this.

Escalation plans are more difficult, there is evidence of systems in place but feedback from nursing staff is that the process is very complicated due to the complexity of teams on wards and the wide spread use of mobile phones by medical staff. Nikki Maran and the Clinical lead fellows will increase medical engagement within to overcome these barriers to escalation.

Many wards have patient safety at a glance boards in place, the wards in the Royal Victoria Building have multidisciplinary involvement at huddles but other areas do not. We are about to test a new board in ARAU.

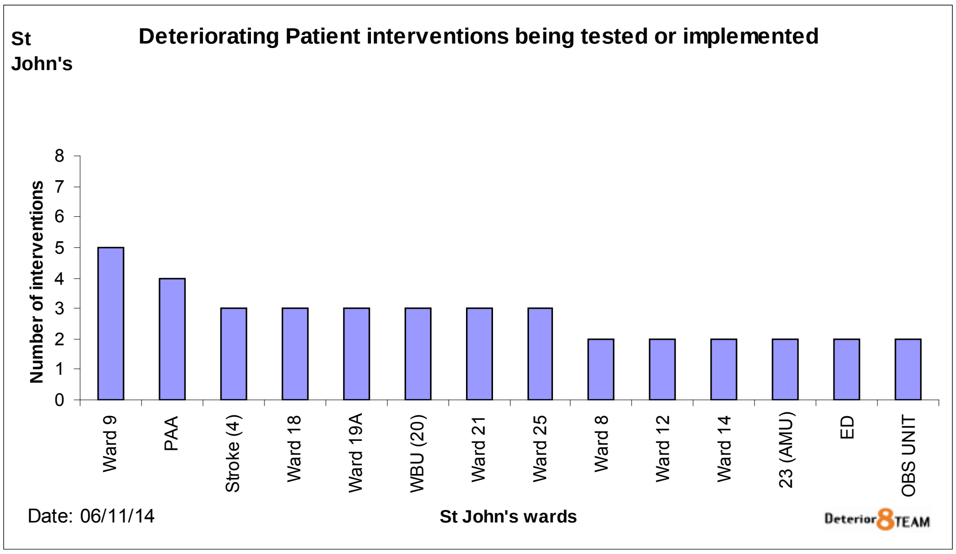
The structured ward rounds including ceilings of care and nurse led DNACPR are being implemented well in areas such as Regional Infectious Diseases Unit, however, the issue of paper light is affecting these processes since they rely on the use of stickers.

Chart 2: WGH Collaborative Wards



The spread of the deteriorating patient work stream is underway in SJH and offers pockets of excellence whereby several of the DP elements are in place. There is, however, a significant amount of work to be done yet to gain assurance that these elements are routine within all clinical areas.

Chart 3: SJH Collaborative Wards



Three other significant pieces of work which support deteriorating patient workstream are currently ongoing in NHS Lothian. The findings from each of these pieces of work have been fed into the collaborative learning sessions.

3.1.8 Cardiac Arrest Reviews

In order to better understand which of a number of variables would make most impact on cardiac arrest calls, it was agreed that a retrospective case note review be carried out of patients in whom cardiac arrest calls had been made over a 5 month period on one site (RIE) This was led by Dr N Maran & Mrs M Mathers (Resuscitation Officer RIE) and follows on from a similar snapshot audit of cardiac arrest calls carried out in March 2013.

There are approximately 32 cardiac arrest calls made each month on the RIE site, approximately half of which are medical emergency calls. Of the true cardiac arrest calls, many of these calls are made to specialist areas such as CCU, cath labs and other critical care areas. Of these, a high proportion are VF arrests and survival rates are high, however these are not included in national reporting figures and therefore were not included in this case note review. Of the 45 cardiac arrests occurring out with these areas between October 2013 and February 2014, 30 case notes were reviewed according to set criteria, including accuracy and timing of SEWS scoring, documented escalation prior to arrest call, seniority and timing of last medical staff review and presence & timing of anticipatory care plans or DNACPR order. Each admission was also assessed for predefined triggers and adverse events using an adaptation of the IHI global trigger tool.

The key findings of the case note reviews are:

4 cardiac calls were made in patients with DNACPR orders in place.

- In 12 patients, resuscitation was considered to have been futile in light of patient co-morbidities. In all of these patients, earlier decision making and discussion with patients and families around appropriateness of CPR would have been appropriate.
- In 12 patients, clinical observations prior to the cardiac arrest were either inaccurate, incomplete or infrequent for level of SEWS recorded.
- In 8 cases, there was evidence of lack of appropriate escalation of care or response to escalation at medical level prior to cardiac arrest call.
- Senior review of patients was more likely to achieve appropriate planning however documentation of senior review was poor and time from last consultant review of the patient was variable.

Actions which would address the findings of the case note reviews are all included in the deteriorating patient change package including improved reliability of SEWS scoring, robust escalation plans and improved use of anticipatory planning.

Cardiac arrest rates for each ward are now fed back as part of the ward scorecard. We have worked with clinical areas with higher cardiac arrest rates to carry out case note reviews within a multidisciplinary team and have developed improvement plans based on the deteriorating patient change package to address appropriate issues on the basis of findings

It was agreed by CMG that learning from such case note reviews should be shared across the organisation to inform change but should also be locally owned. Summaries of cardiac arrest calls from the preceding week will be shared at the hospital safety brief on the RIE site every Friday morning. This will allow early identification of patients in whom full review should be undertaken by the local team. Case note review by parent teams using an agreed proforma including data described should be carried out in all cases of cardiac arrest call. All such patients should be presented and discussed at local morbidity & mortality meetings with appropriate learning and actions agreed, documented and followed up at appropriate CMT.

All cardiac arrests will be centrally reviewed on a monthly basis on RIE site. Other acute sites are currently working on similar plans.

Significant learning from cardiac arrest review should be shared on annual basis at interdisciplinary meeting Learning from Adverse Clinical Events in Lothian meeting (previously ‘divisional M&M’).

Failure to achieve reduction in cardiac arrest call rate makes it unlikely that Lothian will achieve 20% reduction in HSMR required.

3.1.9 Structured Ward Rounds

The Royal College of Surgeons of Edinburgh (RCSEd) was successful in obtaining a Health Foundation SHINE grant to undertake Quality improvement work on developing and implementing a surgical ward round checklist from June 2014 – May 2015. This work is being led in RIE by Mr Simon Paterson-Brown and supported by Dr N Maran supervising a whole time surgical fellow and part time psychologist. The outcome of this project is likely to contribute significantly to developing the evidence base required for the structured wardround within the deteriorating patient workstream.

3.2 Rapid Response Teams

The Scottish Government and Healthcare Improvement Scotland are advocates of Rapid Response Teams. There is emerging improvement evidence of the positive impact a Rapid Response Team can have and this has been demonstrated within Lothian using the Paediatric Emergency Team in both outcomes (reduction in mortality) and impact on length of stay in Intensive Treatment Unit.

Given lack of clarity regarding an ideal team structure and benefits of rapid response teams in acute adult care, it makes it difficult to make a firm recommendation on where and how to deploy them across NHS Lothian acute sites.

As a means of seeking further clarity on both impact and type of response, it was recommended that on the RIE site we gain a greater understanding of the barriers to escalation, the level of activity and type of activity this team/or individual may be asked to respond to, and to test improvement interventions. Identification of funding has enabled recruitment of an Advanced Nurse Practitioner (ANP), Gordon Mills, for 12 months, working as part of the Deteriorating Patient Collaborative. Follow up of patients who are identified as having experienced deterioration on general wards in RIE has identified the following themes

- The majority of the patients reviewed deteriorated between the hours of 9pm-8am.
- SEWS scoring and charting was generally well done in 85% of cases.
- There is poor documentation of the time of escalation, escalation to medical review, treatment escalation plans and medical re-review.
- Generally poor documentation around SIRS and the implementation of Sepsis 6.

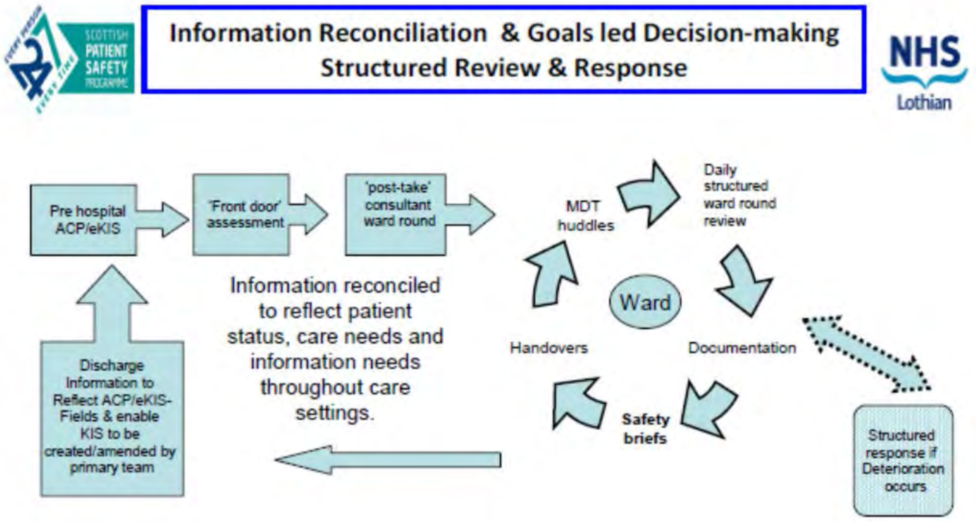
The next steps are to:

- test the use of stickers to improve documentation of escalation and response.
- review in more detail if the patients who deteriorated overnight could have been identified and treatment plans made earlier in the patient journey.
- review and feedback individual ward data from this scoping project, medical emergency data, cardiac arrest data, critical care admission data.
- test a model to improve reliable, timely escalation and response to deteriorating patients in one clinical area to inform future clinical practice and make recommendations about a model of rapid response.

3.2.1 Anticipatory Care Planning (ACP)

Work is progressing within pilot areas in NHS Lothian to develop prototype concepts and processes to enable structured response and review for patients with limited reversibility and risk of further deterioration (Fig 3). Changes being tested include structured ward round templates, ACP summary tools and discharge letter formats to facilitate information reconciliation and goals of care communication with patients/families and throughout care settings.

Figure 3: Information Reconciliation and Goals Led Decision Making Structured Review and Response



The current exploration of how to best support professionals to be *Conversation ready* suggests a 'skill set' beyond the traditional focus on communication skills and current competency frameworks. Shared learning with colleagues within the national *Conversation ready* project has been helpful as they also are beginning to look at this in more depth. The importance of alignment with the new Health Promoting Palliative Care Programme is recognised in supporting the patients, public and staff to be *Conversation ready*.

Dr Nikki Maran, the Associate Medical Director for Patient Safety is chairing a working group involving many teams including acute medicine, medicine of the elderly, vascular, respiratory, oncology, primary and palliative care/SPICT and Lothian leads for the Key Information Summary (KIS) and Person Centred care and Patient & Public Involvement in order to reduce duplication, maximise sharing and learning and ensure alignment.

3.2.3 Sepsis

The Sepsis workstream was initially launched within the SPSP as a national collaborative with the VTE workstream and a clinical lead (Dr Ross Paterson, Consultant in Critical Care and SPSP Fellow) and pilot wards identified. Testing and improvement work progressed in these areas along with pockets of improvement work in other areas.

As the deteriorating patient work stream gained momentum, based on the improvement shown at St John's, its inclusion as a national SPSP priority and sepsis being identified in local cardiac arrest reviews as a contributory factor in deteriorations, it became clear that the Sepsis work stream should be integrated with the deteriorating patient work stream. Following a 'standalone' sepsis collaborative for St John's, all acute adult sites were invited to the 2nd sepsis collaborative on 31st October it is now integrated into the deteriorating patient collaborative programme.

SJH has engaged several wards in the drive to introduce Sepsis 6. Since May 2013, delivery of Sepsis 6 bundle has been collated on 269 patients. Of these, 43% have successfully received treatment within 1 hour. The elements of the Sepsis 6 bundle which are consistently highlighted as requiring improvement are delivery of antibiotics within 1 hour and the taking of blood lactate levels.

There are 7 wards now undertaking measurement of Sepsis 6 and roll out of Sepsis care within the hour. These wards are Stroke Unit, Rehabilitation, Primary Assessment (PAA), ENT, Burns, Plastics (all Head and Neck Directorate) and the Emergency Department.

The majority of effort in the last 6 months has been concentrated within the ED, where the majority of Sepsis patients present. The staff in this department have fully engaged in education, awareness sessions delivered by SPSP, PDSA Improvement and data collection training. Data provided demonstrates an improvement in the delivery of Sepsis 6 from 38% in May to 57% by October. This is a slow but steady improvement and a Sepsis Champion has been appointed by the SCN to take forward further plans to improve compliance.

Head and Neck Services have been conversant with the concept of Sepsis 6 for over a year and are the most consistent and self sufficient with data collection. Delivery of Sepsis 6 is now fully embedded within the three participating wards and the Senior nursing staff within all 3 wards are extremely proactive regarding this topic. PAA, whilst a weekday unit only, has good medical engagement in delivery of Sepsis 6 and are the most consistently performing unit in all aspects of Sepsis 6 within SJH.

Future plans to spread Sepsis 6 are principally within the Acute Medical Receiving Unit which also incorporates a 6 bed High Dependency / Coronary Care Unit.

At the WGH Ward 23 is re-launching awareness of the sepsis 6 and has a sepsis box in place. RVB Urology continues to provide data although there has been a gap due to staff changed. DCN, ARAU and MOE are also taking forward Sepsis 6 implementation.

In the RIE, maternity triage, wards 207, 208, 107, 202, 108 and Surgical Observation Unit are testing Sepsis 6.

The main measures associated with prompt recognition and treatment of sepsis are:

- % of patients with elevated early warning score (SEWS) who had documented Systemic Inflammatory Response Syndrome (SIRS) score (Chart 4).
- % of patients with Sepsis Six performed within 1 hour of time zero (Chart 5).
- % of patients whose antibiotic choice was compliant with policy. This is not currently being measured explicitly in relation to Sepsis but NHS Lothian does use a more generic measure for antibiotic prophylaxis.

There has been an inability to gather outcome data around sepsis both nationally and locally, with discussion around using positive blood cultures and sepsis as reason for critical care admission as proxy measures.

Chart 4: Sepsis – Documented SIRS Score

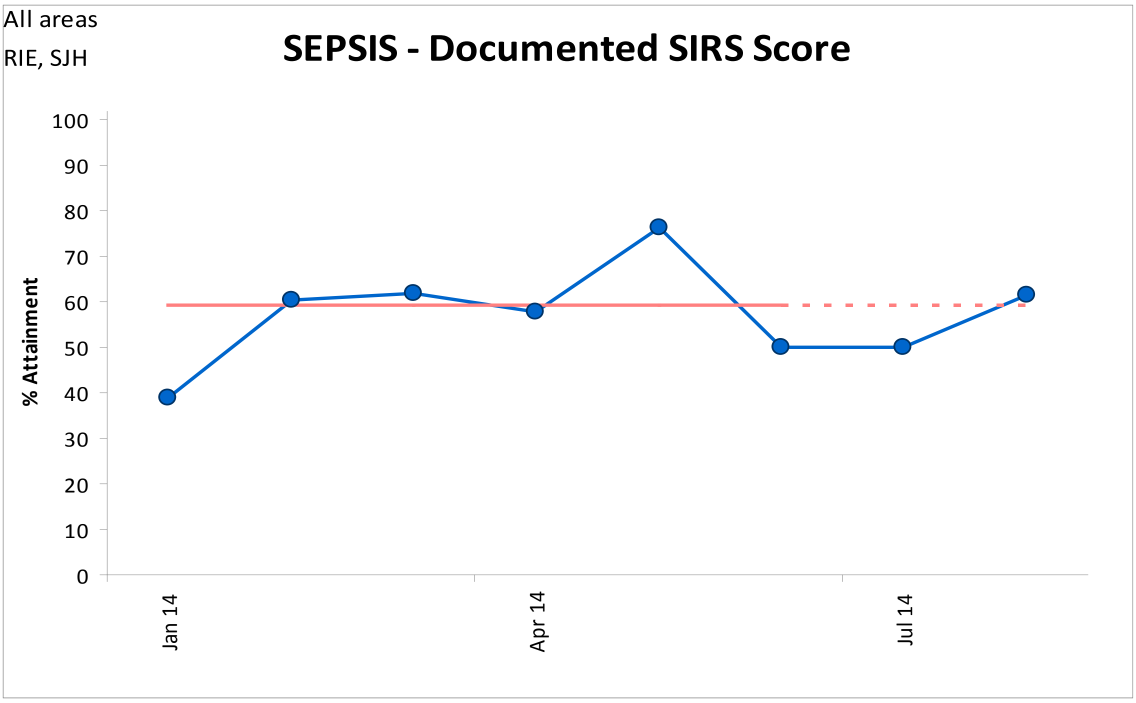
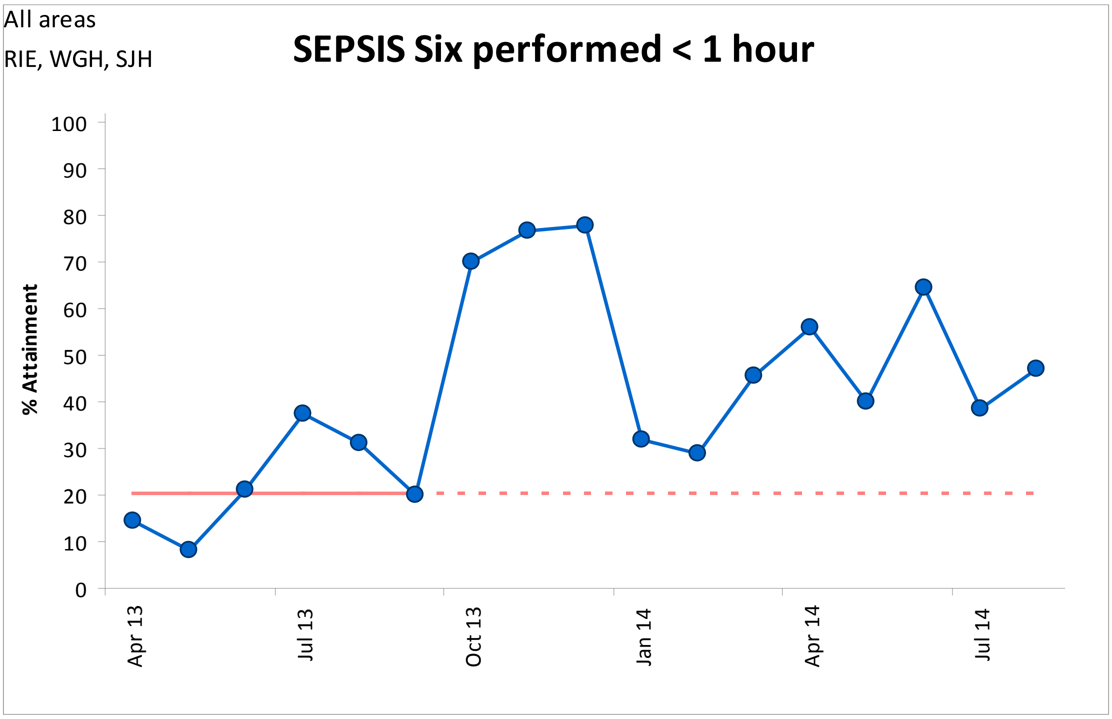


Chart 5: Sepsis Six Performed <1 hour



3.2.4 Heart Failure

Health Improvement Scotland have recognised that Boards have to prioritise their safety work and although Heart failure and Venous Thomboembolism (VTE) are priorities identified in CEL 19, NHS Lothian have informed HIS that it is not currently prioritising these workstreams while we focus is on the other CEL 19 priorities, in particular the deteriorating patient workstream. Clinical teams, however continue to strive towards improvement in these workstreams.

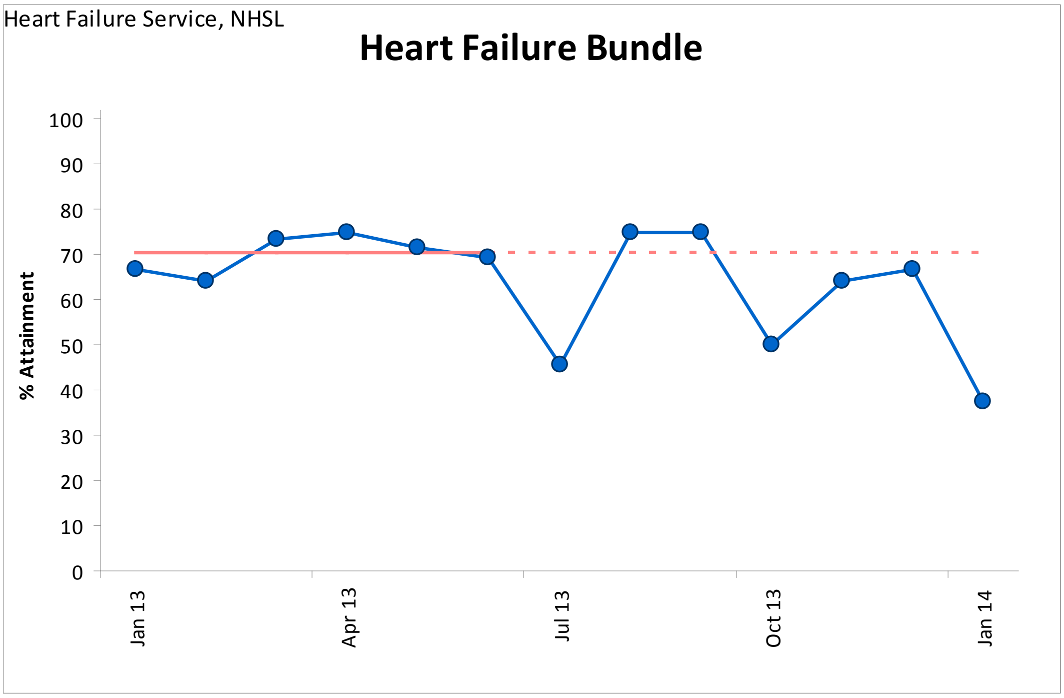
The aim of the Heart failure bundle is to deliver reliable, evidence-based care for patients with heart failure (HF) secondary to left ventricular Septum Defect (LVSD). The bundle elements consist of the requirement to have:

- an expert review during admission
- evidence based drugs prescribed during in-patient stay
- referral to specialist Heart Failure Nurse service before or at time of discharge

This has been a challenging work stream that has been piloted at RIE over the last 3 years with little progress despite great efforts by the Cardiac Rehabilitation Nurse Specialists and input from a medical consultant in WGH. This is largely due to the time and difficulties of reliably capturing the compliance data. Current efforts are attempting to capture the data using a template for discharge which is being developed on TRAK. This should guide medical staff to record the information required in the bundle which could then be reviewed more easily. If this is successful, compliance and spread to other services would be easier.

The cardiology directorate will imminently advertise a new post for a cardiology consultant to lead heart failure services and the remit of the post will include this improvement work. Support will be given by Dr Catherine Labinjoh, a Cardiology Consultant cardiologist who works part time in Lothian, and who has led improvements in heart failure services in NHS Forth Valley so that we can learn from their best practice.

Chart 6: Compliance With Heart Failure Bundle



3.2.5 Venous Thromboembolism (VTE)

VTE has been a safety work stream since the inception of the programme and teams have been working to improve compliance however the criteria and measurement requirements changed in 2013 in line with the updated SIGN guidelines. The measures are:

- Percent of patients who had a documented VTE risk assessment for **patient and admission related risks and contraindication** within 24 hours of admission.

- Percent of patients who had the correct pharmacological/mechanical thromboprophylaxis administered.
- Percent of patients with documented reassessment of VTE risk as per local policy (< 72 hours).
- Percent of patients informed of risks and benefits of VTE prophylaxis.

Compliance with the administration of the correct prophylaxis is generally good (Chart 8) however the documentation of the risk assessment, reassessment and informing patients is more variable. Currently 6/97 wards are reporting on this measure.

Chart 7: VTE – Risk Assessment

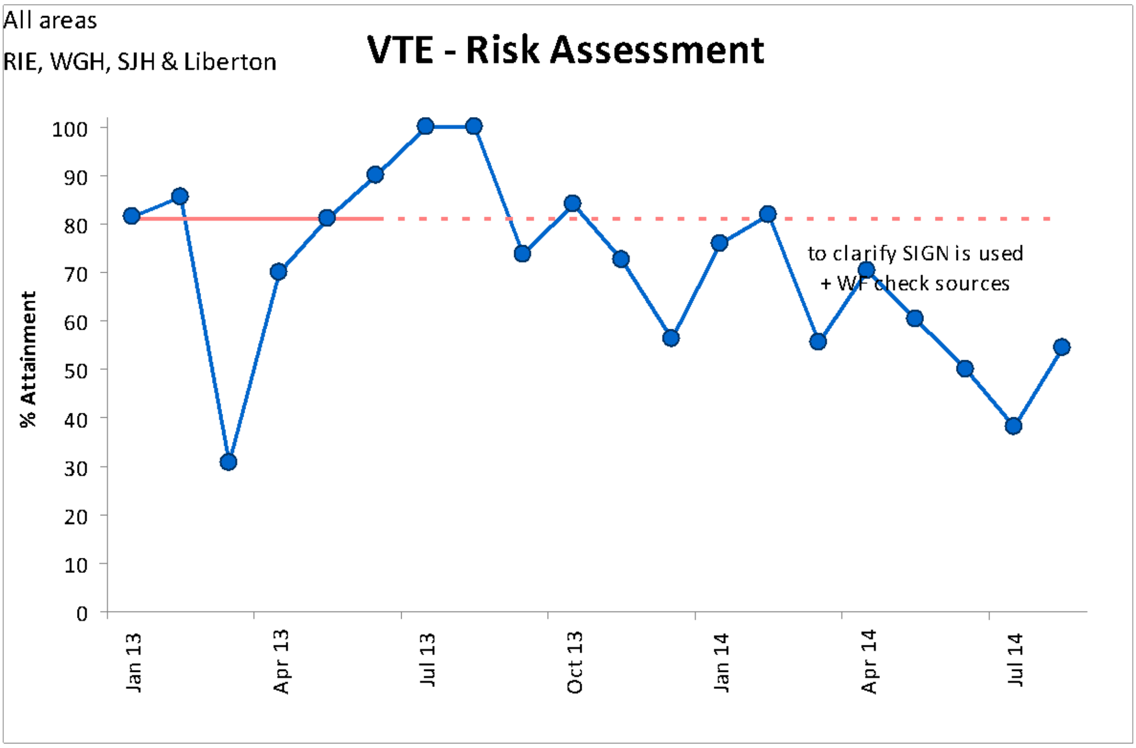


Chart 8: VTE – Correct Prophylaxis Administered

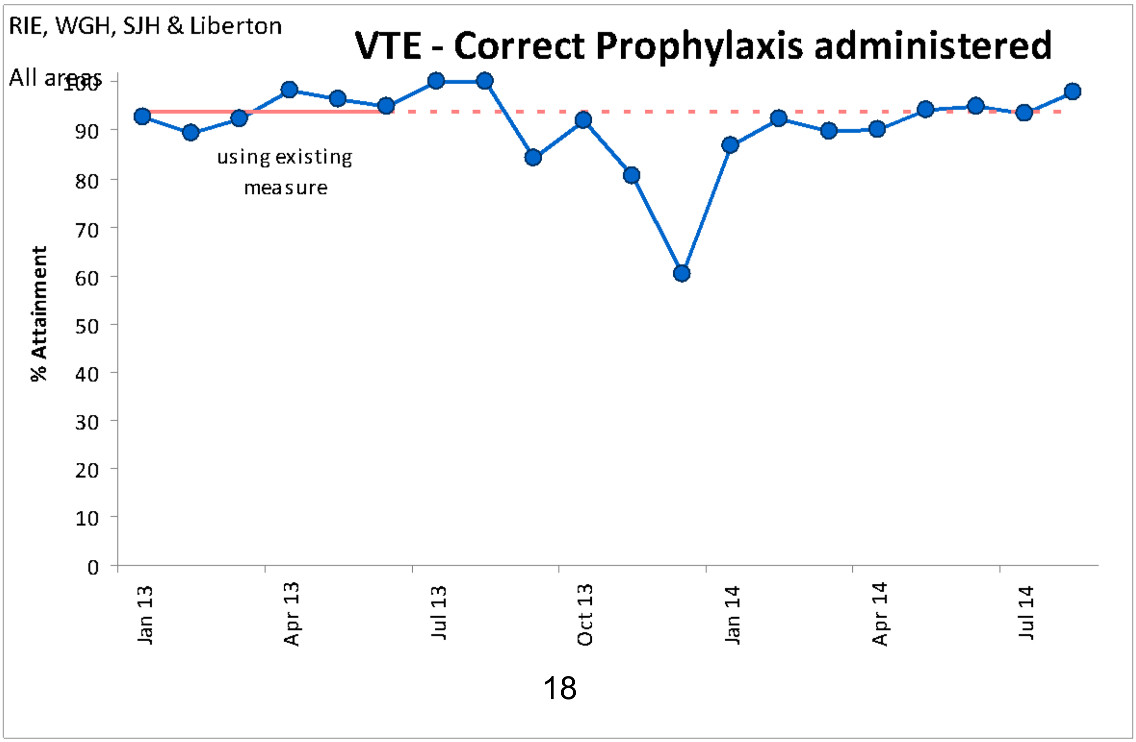


Chart 9: VTE – Reassessment of Risk

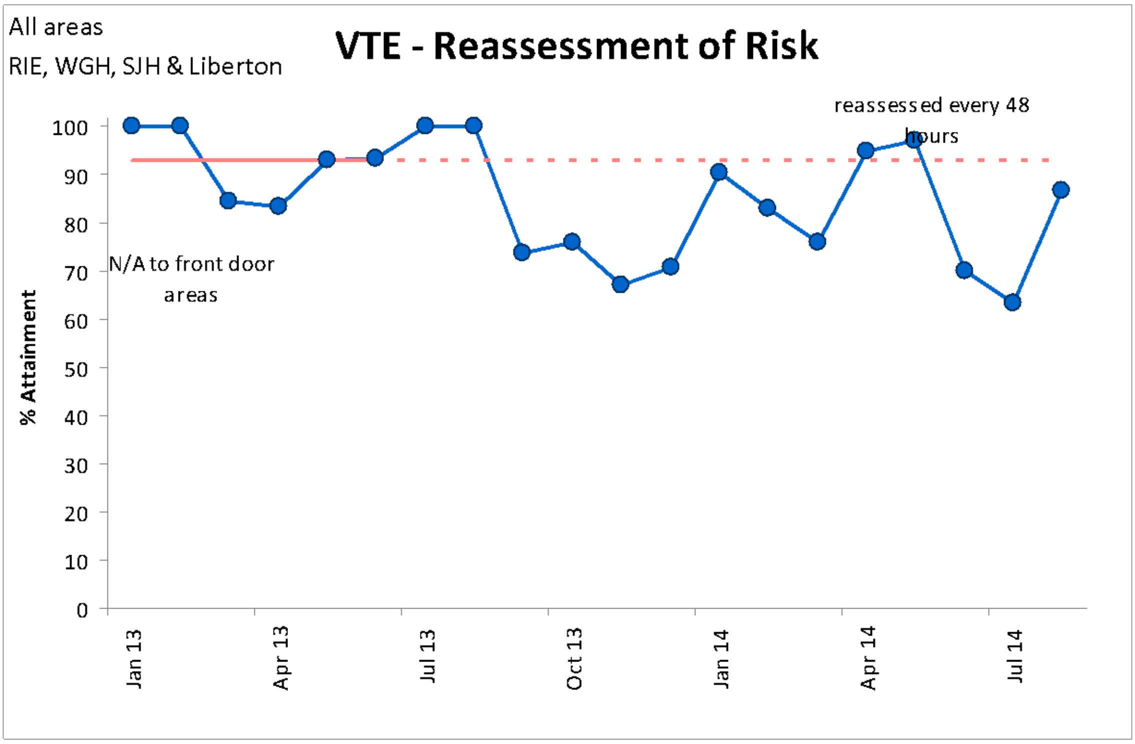
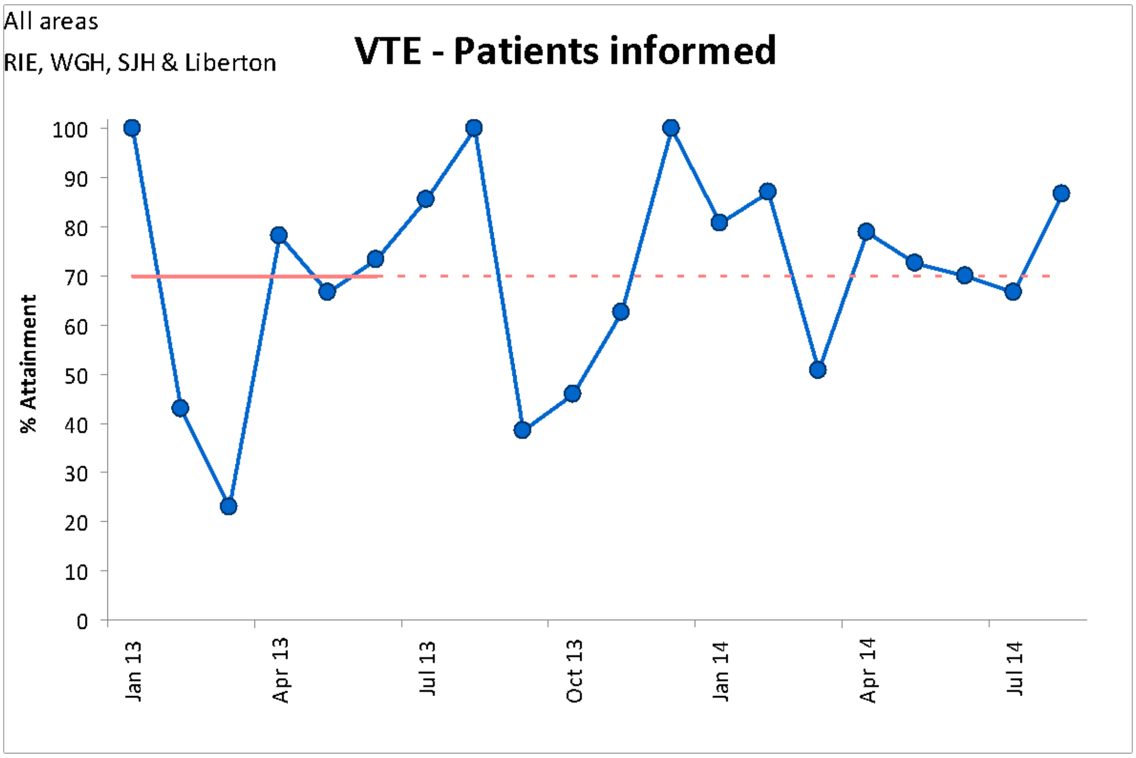


Chart 10: VTE – Patients Informed



Next Steps.
To try to improve the process clinical staff have included the VTE review in a ward round checklist as a prompt. As the main prescribers, junior doctors in a number of specialities at RIE measure compliance with VTE monthly in order to improve reliability. Some teams are using locally developed stickers and in their own personal time have been sticking them onto the prescription charts; however this is not a sustainable process. The new national prescription chart has the requirements built into it however the chart is still in the testing phase and it is unlikely to be in place for

the next year. Support will be sought from the Drug and Therapeutics Committee to make changes to the existing chart as an interim measure to support this work.

3.2.6 Falls Prevention Programme

Patient falls with harm continues to be one of the main incidents reported across NHS Lothian. In response to staff feedback and examining the evidence around falls reduction, Care Rounding has been rolled out after testing across the UHD, starting with areas with highest incidence of falls. Rollout is still taking place across community sites.

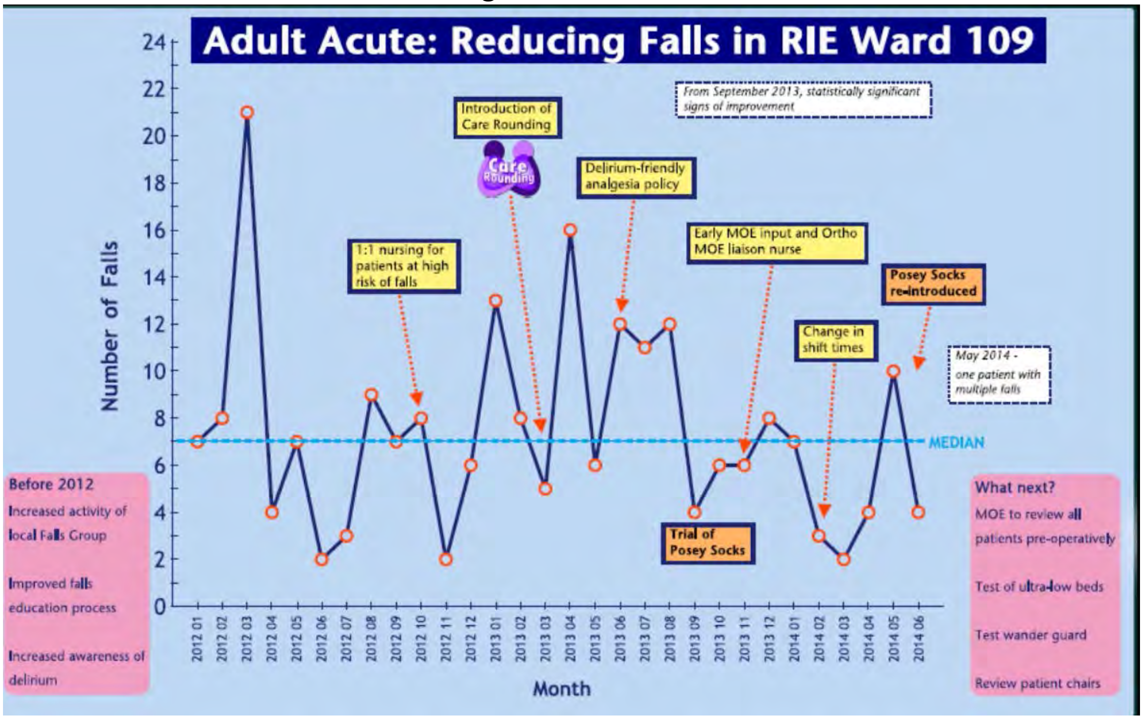
The SPSP aim of the falls prevention work is that:

- sustained improvements are demonstrated in process measure(s) in 50% of applicable wards on each of the RIE, WGH and SJH sites by December 2015
- and an improvement demonstrated in the outcome measures on each of the 3 sites by December 2015.

The Delivering Better Care Hub and the Falls Coordinators are leading on this work using a mini-collaborative model to establish, learn from and share the best practice starting with pilot sites on each of the 3 acute hospital sites.

Best practice is being led by the orthopaedic wards who have reduced falls rate by 50% over the last 6 months. They introduced a number of changes based on their review of falls such as changing the nursing shift pattern to an earlier start as the majority of patients were falling in the morning. Night sedation was changed to omit opioids which tend to cause confusion in elderly patients. Posy socks were introduced to reduce the potential for slipping. Other medicine of the elderly wards have introduced night lights to help patients see better at night, beds that lower to floor level and hot milky drinks at bed time and seen a reduction in falls. The local learning has been shared locally and nationally with other teams.

Chart 11: Acute Adult: Reducing Falls in RIE Ward 109



3.2.7 Pressure Ulcer Improvement Work

Work between the Tissue Viability Nurses and Clinical Governance has highlighted through the use of run charts that there is a continued increase in reporting of pressure ulcers which is good and in line with other boards in Scotland. Areas are improving reporting rather than the situation getting worse i.e. we now think areas who did not report before are now doing so and therefore this would suggest that previous data was not robust, we continue to work on this.

Monthly run charts on the ward scorecard show information for all sites, and number rate and days between reporting in line with the new measure commenced April 2014. Wards continue to report Grade 2 and above on Datix. Senior Charge Nurses undertake local investigations for PU to ascertain further learning / prevent further damage.

Test sites have been identified using the new SPSP methodology, sites being identified based on pareto charts that demonstrate areas where most improvement was required. The aim is to show 50% sustained improvement in the test sites. Test sites are Ward 8 SJH, Ward 70 WGH, Ward 109 RIE and Ward 7 Liberton.

Each test site will be supported by the Delivering Better Care Hub using a mini collaborative and integrating it with falls improvement, hydration and nutrition. A variety of initiatives are being tested but core to all areas will be care rounding, care planning, improved risk assessment and strengthening link nurses.

Next Steps
SPSP want Lothian and Grampian and Glasgow to look at all acquired PU's for Dec to see how many were unavoidable vs avoidable, using the Glasgow template. Recent evidence is showing that number that are avoidable is much less than 95% and could be as low as 60%.They hope to get SPSP and Scottish Government to revise what they are looking at in relation to PU we could have prevented. Is likely to be an intense piece of work for December. NHS Lothian has also asked other boards if they would share their nationally reported pressure ulcer data so that we can compare to see whether we have similar rates or whether we are under reporting.

3.2.8 Catheter Associated Urinary Tract Infection (CAUTI)

Improvement in CAUTI could potentially impact on many work streams in the programme. As part of the SPSI work it was identified that patients who have CAUTI often also fall so improvements in CAUTI may contribute to a reduction in falls. It will also support the work being done on improving appropriate antibiotic prescribing, reducing sepsis and cardiac arrest.

Change in measurement
Since 2008 compliance with the CAUTI maintenance bundle has been measured. The changes made in 2013 included:

1. an additional measure to the maintenance bundle,
2. the introduction of a CAUTI insertion bundle
3. and ward based outcome measures meeting the following criteria:

- urinary catheter in situ or removed within previous 48 hours
- and diagnosis of CAUTI documented in the medical notes
- and an antibiotic has been prescribed on the medication chart to treat a CAUTI

The challenge has been to ask wards to record daily the number of catheters on the ward at midnight and record it on the safety cross to determine the number of catheter days (denominator) and to identify patients with CAUTI.

The process to identify patients who may be diagnosed with CAUTI being tested is:

- Patients with catheters will be highlighted on the Patient Status At a Glance board in the doctors room
- Doctors will notify staff when they have diagnosed CAUTI and prescribed an antibiotic for it
- At the MDT huddle/safety brief any new CAUTIs will be identified
- CAUTI will be recorded on the safety cross (numerator)

Pilot Wards
Three wards at RIE are currently testing this approach. Two wards are currently testing the insertion and maintenance bundles

At the WGH Ward 33 (DCN) are testing the safety cross with urology to follow. The progress of the maintenance bundle is being held up by the need to change the documentation to comply with the audit tool from HPS and that the wards are going paper light and the audit tool is not available on Trak

At SJH CAUTI has been introduced to 3 wards and a fourth is identified. All wards are collecting data on number of catheter days and a plan to engage medical staff in the audit / data collection is currently underway. Ward 12 has also been identified as a ward which can test the Catheter Passport as they frequently have a caseload of patients who are discharged with in dwelling catheters.

3.2.9 Surgical Site Infection

The surgical site infection requirement consists of a ward and a theatre bundle. The bundles are being tested in maternity for patients who have a caesarean section as this was previously much improvement work has already been done in this service

The Ward Bundle Includes:

- Ensure that a clinical risk assessment for Methicillin resistant Staphylococcus aureus (MRSA) has taken place (maternity has national exemption for this)
- Hair is not removed if possible. Razors were not used if hair was removed
- Patient has showered (or bathed/washed if unable to shower) on day of or day before surgery using soap
- The wound dressing remains intact for 48 hrs post operatively unless clinically indicated
- Aseptic technique is used if there is excessive leakage and need for dressing change

Maternity triage and Assessment do the preoperative assessment preparation for women having caesarean sections and include information about showering on the day, not removing hair and guidance on the wound dressing.
The process for the measurement of this new bundle is being tested in ward 119

The Theatre Bundle Consists of

- The appropriate prophylactic antibiotic is administered within 60 minutes before the operation (blade to skin)
- 2% chlorhexidine gluconate in 70% isopropyl alcohol solution – if patient sensitive use povidine-iodine solution
- The patient's body temperature is maintained ≥ 36° in the peri-operative period (exclude cardiac patients)
- Known diabetic patients' glucose level kept at < 11mmols/l throughout the operation

These measures are in place in theatres but the measurement of bundle compliance is new and a process for collecting the data is being tested. Outcome at day 10 is being measured and linking this with the patients who are re-admitted with sepsis will be tested

The recommendation for 2% chlorhexidine gluconate in 70% isopropyl alcohol solution to be used as a surgical skin preparation in theatres is based on evidence that indicates it is more effective than povidone iodine which is currently in use. In September 2013, following an increase in SSI rates both at REI and SJH, 2% chlorhexidine in alcohol was introduced as skin preparation prior to caesarean section procedures. The introduction of the new preparation seemed to have made a significant impact on the SSI numbers on both sites according to control chart rules.

2% chlorhexidine gluconate in 70% isopropyl alcohol is not used in other theatres and has been raised at the Infection Control Committee who have written to the Formulary Committee for it to be reviewed as there are cost implications were it to be implemented across NHS Lothian. Recognising the current financial implications and resulting limitation on availability, Health Protection Scotland say it will be appropriate for teams working to reduce SSI to focus improvement activity on other elements and document CHG 2% as not available in the interim while they work with national procurement to mitigate this.

3.3 Safer Use of Medicines

Although included in patient safety priorities, Medicines reconciliation has also become the focus on the CMO(2013)18 letter of September 2013:Safer use of medicines.

This sets out the requirements for boards to improve medicines safety through medicine reconciliation (Medrec) by the end of 2015. Accurate timely medicines reconciliation on admission to, and discharge from, hospital is an integral part of clinical care but is complex and time consuming to complete. As Medicines reconciliation affects all patients who take medications of any sort, it is a measure which affects all of the safety programs.

The Medicines Reconciliation goals are:

- 95% compliance with medicines reconciliation within 24 hours of admission
- 95% of patients have an accurate in-patient prescription chart within 24 hours of admission
- 95% compliance with medicines reconciliation on discharge
- 95% of patients have an accurate medicines list on the Interim Discharge Letter (IDL)

As a priority 'front door' area, the Acute Admission Unit at the Royal Infirmary are the pilot site for Med rec on Admission and have been able to demonstrate a sustained improvement in this measure in Chart 12.

Chart 12: Medication Reconciliation Performed on Admission - CAA

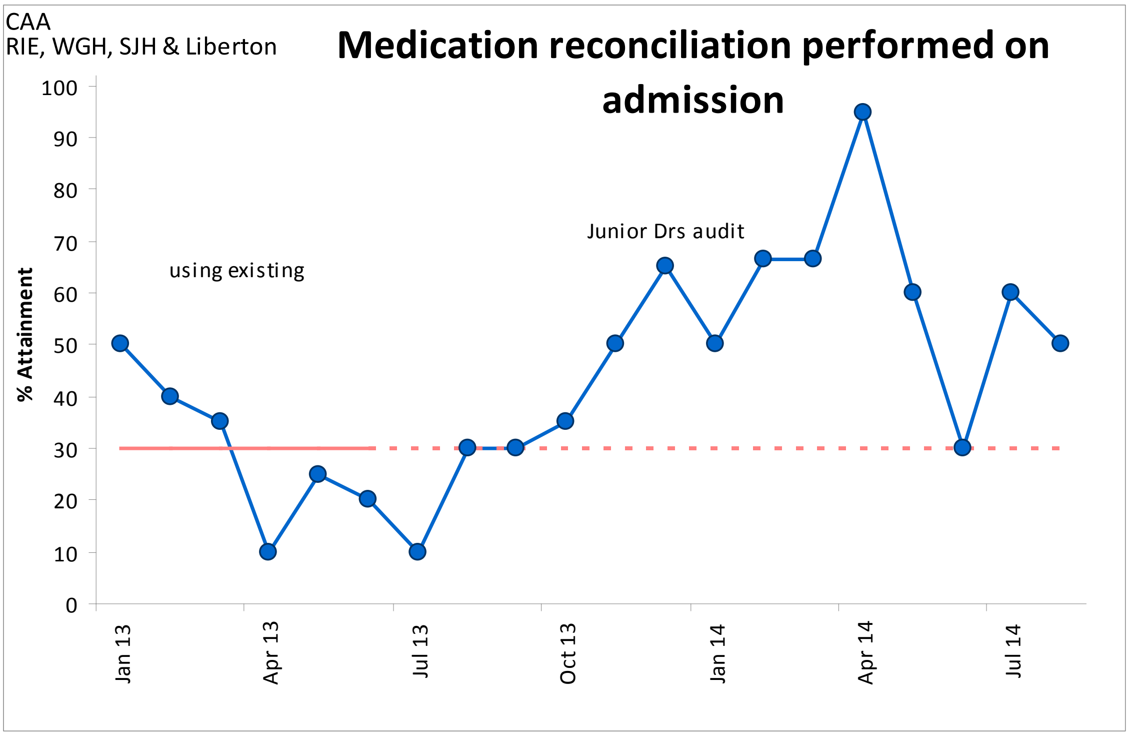
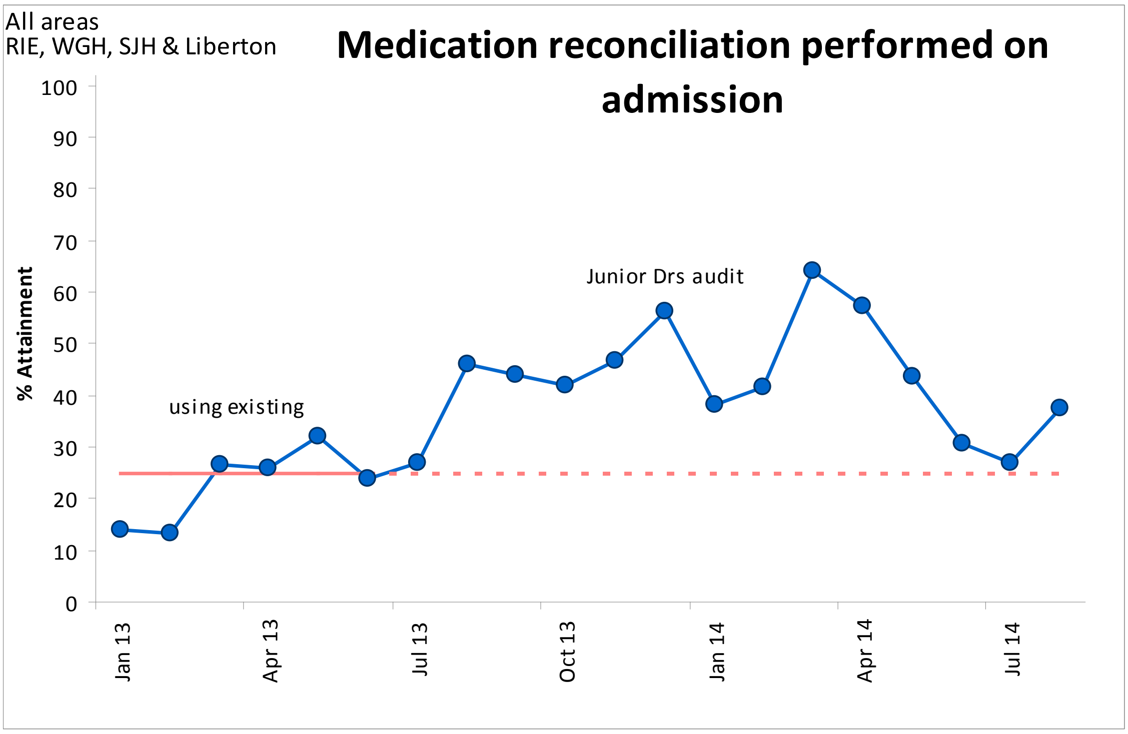


Chart 13: Medication Reconciliation Performed on Admission – All Areas



The overall Board measure in Chart 13 consisting of the RIE, WGH, SJH who report on med rec on admission have shown sustained improvement over the last year but have not achieved the 95% compliance goals.

Chart 14 shows the attainment and spread of this measure which is currently 8/51 wards and at its height at the beginning of 2013, 24/51 wards were reporting however this has not been sustained. Chart 15 shows that ward 25 at St John's hospital is in the early stages of med rec on discharge.

Chart 14: Attainment and Spread on Admission

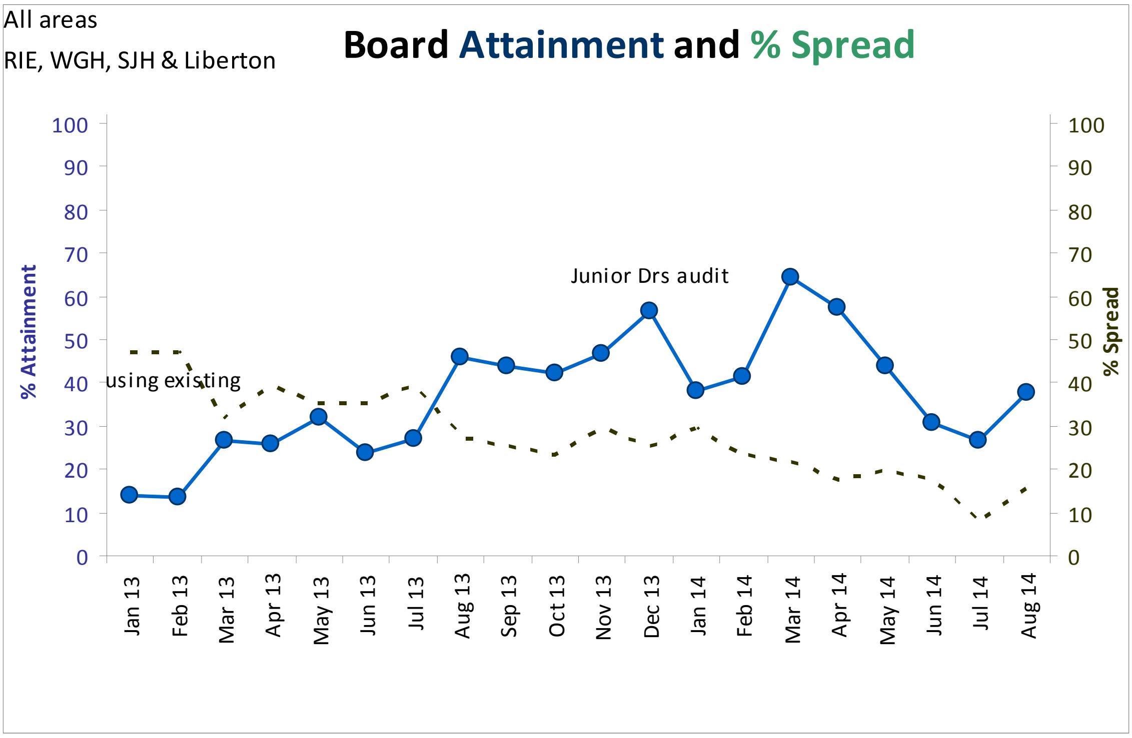


Chart 15: Medication Reconciliation Performed on Discharge

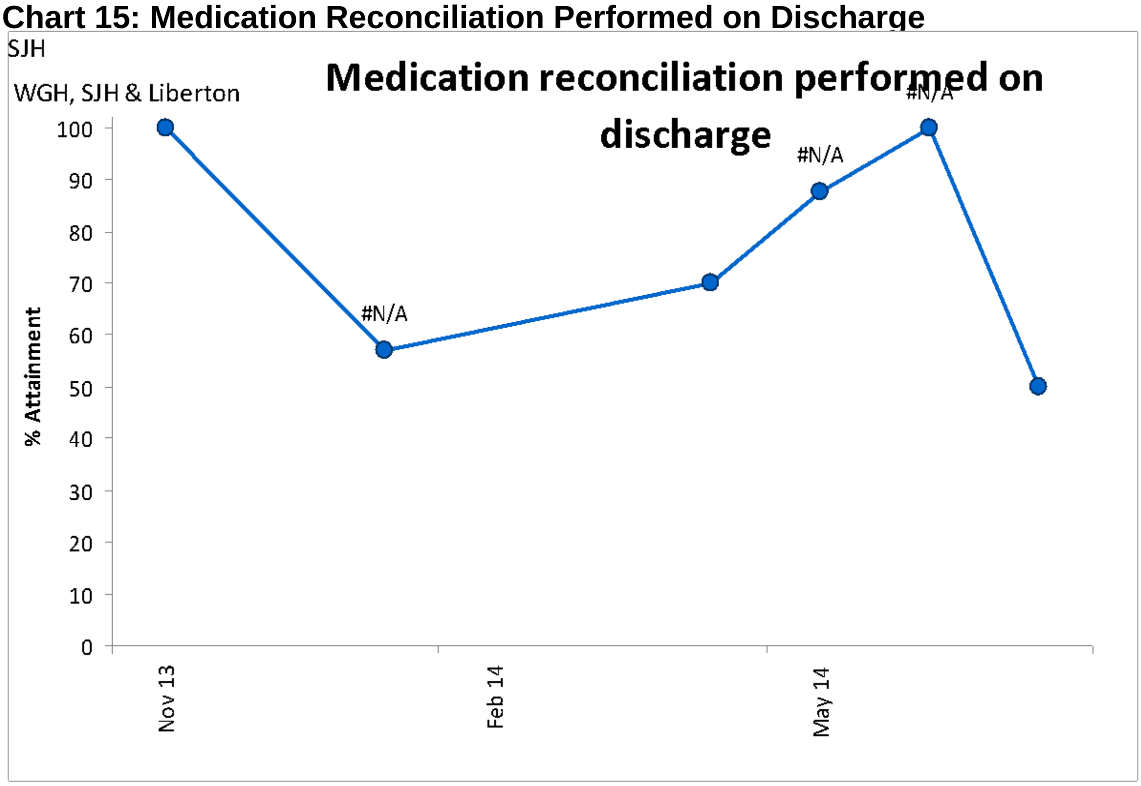
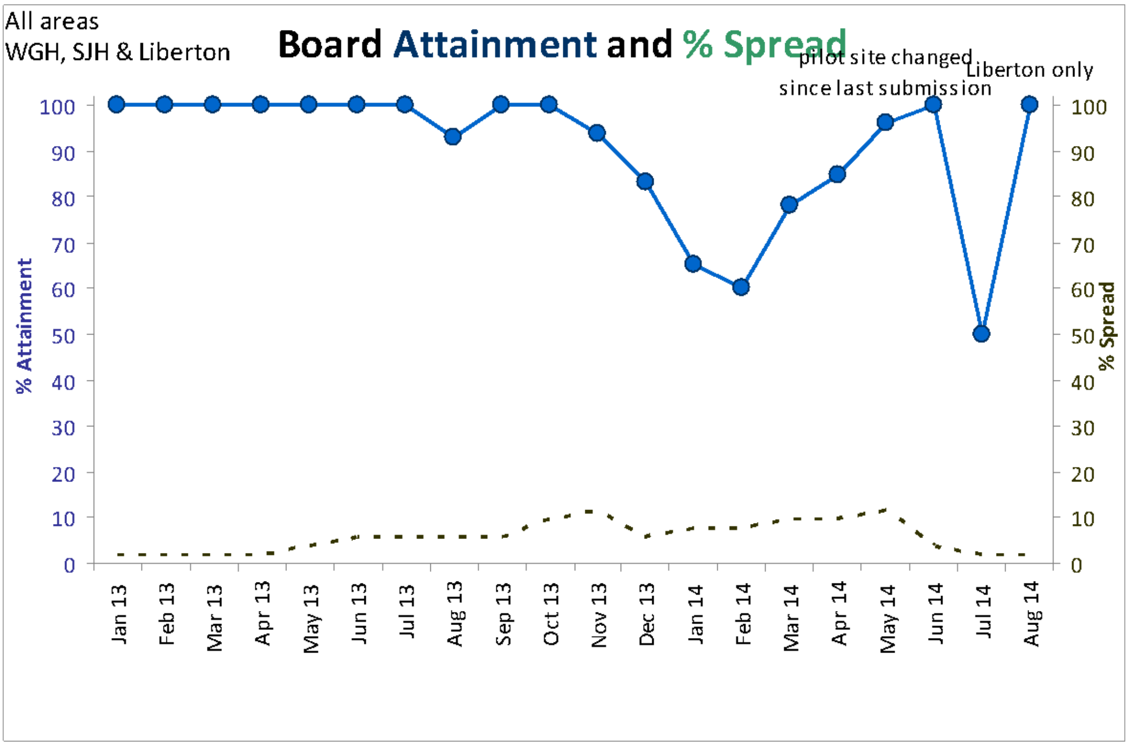


Chart 16 shows 6/51 wards reporting in November 2013 however this was not sustained and 1 of 51 wards is currently reporting on this measure.

Chart 16: Board Attainment and % Spread



Med rec is a challenge not only for NHS Lothian but for all boards. A multidisciplinary short life working group chaired by Dr Nikki Maran, Associate Medical Director for Safety has been set up and a community pharmacist is currently working with clinical leads to undertake the mapping of the med rec processes as part of the gap analysis out of which the action plan will be developed.

Table 5 sets out the CMO 18 guidance & NHS Lothian's current position in relation to the guidance

Table 5:

Guidance	Current position
Involve patients in this work	In place in Primary Care
Establish multi-professional leads for medicines reconciliation	In place
Medical clinical champions in individual specialties.	In place in front door & renal
Local mechanisms to co-ordinate quality improvement work which report to the local Area Drugs and Therapeutics Committee.	Quality improvement Teams with reporting through QIDS not reported to D&T but to service & management monthly
Undertake a gap analysis and develop local action plans which set out how compliance with the guidance in this letter in relation to medicines reconciliation will be achieved.	Mapping to inform gap analysis is under way
Ensuring that medicines reconciliation is integrated with other key strategic policies i.e. HEAT, OPAH, flow, HSMR	Not in place yet
Development and implementation of a ratified policy clearly outlining the medicines reconciliation process including roles and responsibilities	Previous work on this is being updated as part of mapping & gap analysis
Ensuring medicines reconciliation is a core part of training for all doctors, pharmacists, nurses and pharmacy technicians	In place for doctors, pharmacists & technicians not for nursing as yet
Adopting the medicines reconciliation e-learning module as mandatory training for all doctors, pharmacists, nurses and pharmacy technicians	Module available but uptake is not yet monitored, work in progress
Implementing medicines reconciliation in acute receiving units as a priority area, where it should be tested, embedded and spread to other clinical areas.	In place at front door on 3 acute sites but not reliable yet. Has spread to other areas
Include medicines reconciliation prompts and charting in standardised paper and electronic in-patient prescribing systems.	Not in place, awaiting new national prescription chart
Develop and implement electronic enablers to safer medicines reconciliation in collaboration with e-health	Electronic Care Summary and electronic medrec form available on TRAK

4 The Maternity Care Quality Improvement Collaborative (MCQIC)

4.1 The Maternity Care work stream, along with Paediatrics and Neonates, came together on 8th March 2013 to form the Maternity Care Quality Improvement Collaborative (MCQIC). The overall aim is to improve outcomes and reduce inequalities in outcomes in maternity settings in Scotland.

The aim of the programme is by 2015 to:

- Reduce avoidable harm in women and babies by 30%
- Increase the percentage of women satisfied with their experience of maternity care to greater than 95%

National Funding was provided for Maternity Champions to be appointed in every board for a period of 2 years. Their role is to work with national and existing local improvement colleagues to:

- Build capacity and capability in improvement science locally
- Facilitate the introduction of care bundles and initiatives
- Support data collection and dissemination

Dr Corinne Love, Consultant Lead has also been appointed as the national Maternity Clinical Lead for Obstetrics. Karen Nattan (SJH) and Caroline Pound (RIE) each have a .5wte role as maternity champions to lead the safety and improvement work over the next two years in NHS Lothian. Whilst maternity care has the advantage of having funded champions in place, it carries the risk of a having a person dependant system and robust planning will reduce this risk. Three Learning Sessions to support this work and increase capability have taken place over the last 12 months.

4.1.1 Leadership & Culture

There is regular and consistent data submission on the reporting template (toolkit) from both RIE and SJH sites. The national reporting template is used for clinical governance reporting too. Project plans are being developed and this is a structured approach to ensure staff ownership and programme delivery.

Weekly multidisciplinary adverse event case note reviews are ongoing and some staff have had incident training and human factors training.

The maternity unit at RIE tested the culture tool and have developed and action plan to address the issues raised. This activity is ongoing and yields valuable information to improve safety and quality processes in the service.

4.1.2 Women Centred Care

It was evident that there are a number of surveys and audits undertaken to focus on patient care and satisfaction. The anaesthetic audit facilitates follow up of any anaesthetic complications including post operative pain. The postnatal satisfaction survey undertaken on the post natal wards in St John’s has been in place since November 2013 with a keen understanding of the merit of moving this survey to when the woman is at home which will involve the community (primary care links) midwives also.

4.1.3 Teamwork, Communication & Collaboration

The service has implemented a daily cross site capacity huddle, safety huddle and safety brief to identify issues and plan the day in relation to workload or any concerns.

Safe, Effective Reliable Care

CTG interpretation and the escalation tool were shown as user friendly process for staff to deliver reliable care. A purple fresh eyes and buddy review sticker is a helpful prompt for independent CTG review. There is clear use of improvement methodology evidenced by driver diagrams, PDSA, annotated run charts outlining the improvement process.

4.1.4 Neonatal Unit Patient Safety Overview

Patient safety and quality improvement are not new to the neonatal unit (NNU) in Edinburgh. The safety programme is building on a long-standing foundation of quality improvement work and evidence based guidelines. In 2010 the NNU joined the Vermont Oxford Neonatal network which enables them to tap into a valuable source of quality improvement experience and to benchmark outcome data against similar neonatal units worldwide.

The Newborn Care Collaborative
Towards the end of 2013, with the realisation that there were many people within the neonatal unit working on improvement projects, and with the ever growing number of requirements to submit data to multiple places, the Newborn Care Collaborative (NCC) was set up. The NCC is comprised of the Quality Improvement Team, patient safety team, audit group, guideline group, pharmacy group, risk management group and, most importantly every member of the neonatal team and the parents. This enables the NNU to co-ordinate work more efficiently and avoids duplication of effort. It also means that the whole unit has a single, clear vision: which is “getting it right for every baby and family every time”. Increasing numbers of staff are involved in quality improvement and patient safety projects. There are currently over 24 working groups and many other individuals are involved in data collection, audits and other improvement work.

The neonatal unit at St Johns as a smaller unit is at the start of its improvement journey. In March of this year the St John’s Neonatal Unit Governance Group was set up to put in place structures to enable patient safety, risk management, managed clinical network and guideline activity to be developed more effectively. In addition, St John’s SCBU is an integral part of the Newborn Care Collaborative and is represented at the NCC meetings.

Key Objectives
Dr Claire L Smith, Consultant Neonatologist leads on safety and three key areas are being worked on to report to SPSP:

1. Reducing admissions with hypothermiato NNU. This aim has lead to some promising multidisciplinary and cross-site working.

2. Reducing the risk of developing necrotising enterocolitis/increasing likelihood of natural feeding at discharge. There is extensive work ongoing to improve gut health and nutrition which includes parent information in the form of posters, leaflets, DVDs and a breast-feeding app, support for early lactation, use of donor

breast milk in selected babies, revised infant feeding charts and potential future recruitment of an infant feeding advisor to the NNU. There is a trend towards increased rates of mother's milk on discharge.

3. Increasing effective communication within and across teams. We have incorporated a raft of measures to improve communication within and between teams including safety briefs, safety scorecards, SBAR handovers and a monthly run chart of data displayed to staff and families. The NNU have also incorporated means of measuring senior attendance at the cot side and senior communication with parents within 24 hours of admission – the rates of both have increased and are now consistently high.
   These three areas represent a fraction of our QI activity and we are working towards reporting on more measures.

Parental Involvement

Increasing parental involvement is a key aim of the NCC and in addition to the measures described above, we have enlisted parent members to the NCC and have parent feedback questionnaires available through the Babylink website, which also provides parents access to baby diaries and reports that they can share with family/friends as they choose. They have introduced a "you said we did" box into the parent lounge area and review and respond to comments regularly – comments and responses are posted in the parent lounge too. The NNU are continuing to work on increasing parent information leaflets and have started using "Our journey together" charts for parents of preterm babies to help them chart their progress towards going home.

Over the past few years they have had a successful drive to reduce infection rates and continue to work on strategies to reduce this further where possible.

Within the next few weeks they plan to introduce a NEWS (newborn early warning score) chart to help identify at the earliest opportunity, babies who are receiving routine care who may be deteriorating.

They are currently collating the results of the first neonatal unit safety culture questionnaire which it will inform potential improvements to the safety culture.

There are many more examples of QI work ongoing in the neonatal unit as they continually strive to improve the care they provide to babies and families. The NNU aims to be responsive to latest best practice evidence and to incorporate this into routine care.

4.1.5 Paediatric Care

In the Paediatric Programme (SPSPP) a Scottish Avoidable Harm Tool has been developed and is replacing the Institute for Healthcare Improvement (IHI) Paediatric Trigger Tool (PTT). The aim is to collect data on any of the areas of preventable harm based on indicators developed by clinicians with support from HIS. However, the PTT is currently still being used in NHS Lothian as the local clinical team find it helpful for improvement.

The Paediatric Serious Harm Index is being tested in Paediatrics and consists of the following measures:

- Serious Safety Events (SSE)

- Ventilator Associated Pneumonia *–For Edinburgh and Glasgow Only*
- Catheter Associated Blood Stream Infections
- Unpredicted admissions to ITU
- Medicine Errors

The introduction of Paediatric Early Warning Score (PEWS) has seen a reduction in numbers in unplanned admissions to intensive care.

The paediatric programme has been in place within NHS Lothian since 2010 and is clearly established in a number of clinical areas. The paediatric team are supported by the local QI support team and have also further benefitted from the introduction of a Patient Safety Coordinator role to support learning from adverse events. This role will allow the team to use local data to identify area for improvement. The local team indicated that learning from adverse events occurs with information shared via several routes including the quality management team, corporate management team and the chief nurse meetings. This in turn prompted the culture survey to staff.

In the clinical areas it is clear that teams have been able to integrate various improvement initiatives including Releasing Time to Care, Leading Better Care with SPSP activity. Safety briefs and SBAR communications are embedded activities in some clinical areas and just the way things are done.

5. Scottish Patient Safety Programme for Mental Health

5.1 The Scottish Patient Safety Programme for Mental Health (SPSP-MH) started in 2012 with a focus on reducing the harm experienced by individuals in receipt of care from mental health services. This is a new venture, and as there is no evidence set and outcome measures, the focus has been on developing initiatives that contribute to increased patient (and staff) safety.

5.1.1 Medicines Reconciliation

This is being undertaken and documented in all wards. Compliance is measured regularly (for 4 parameters on 10 patients per month) and is improving but is not yet fully reliable, especially out of hours. To improve the process in induction Junior Doctors are being asked to print out the Emergency Care Summary from GP's and file it in the notes so that the information is readily accessible.

5.1.2 Error Free Prescribing

This is being encouraged as prescription charts need to be accurate, legible and up -to -date. It needs to be audited regularly with feedback about what needs to be improved, to ensure that the information is clear and so prevent mistakes being made. IPCU is achieving 70% compliance regularly but there is still room for improvement. Most omissions are for minor physical health treatments, such as a skin cream which can be detrimental to the patient's mental health and wellbeing.

5.1.3 As Required Medication

Medication stickers are being used to record when a patient receives As required (PRN) medication either orally (yellow) or by intramuscular means (red) and prompts recording of the drug details, the observations thereafter and a note of whether or not the medication has achieved the aim. Analysis of these is important in the decision to try an alternative medication. These were initially developed in IPCU and are now being used throughout Scotland as a national template.

5.1.4 Physical Health

Physical healthstickers (green) have been introduced to help prompt nurses to asses, convey and document the reason for calling a duty doctor regarding deteriorating physical health issues. The stickers use SBAR to format the information and require basic physical observations to be done in advance of the call. Mental Health courses no longer contain training to carry out full physical health checks so guidance on how to use the stickers and specific SEWS training have raised staff awareness.

5.1.5 Safety Briefs

These are a documented method of communicating appropriate information concisely at handover. They have proved valuable, especially for AHPs visiting and for staff who cannot be there at the time of handover. The forms and process are still evolving to meet the needs of the various parts of the service.

5.1.6 Safety Climate Surveys

These will be carried out on a regular basis to capture the views of staff and patients. A recent staff survey emphasised how well mental health teams work together and support each other, but also highlighted the problems that drug and alcohol issues (including legal highs) bring to the everyday life on the wards.

With the closer integration of community and inpatient mental health services, community staff are also keen to be included in SPSP. The programme has initially had a focus on acute adult inpatient services but a combined integrated care pathway (ICP) is being developed to ensure that risk assessments are shared and the patient has a more seamless transition between services.

6. Patient Safety in Primary Care (SIPC)

Healthcare Improvement Scotland's Patient Safety in Primary Care rollout programme goal states*: 'All NHS territorial boards and 95% of primary care clinical teams will be developing their safety culture and achieving reliability in 3 high-risk areas by 2016'.*

2014 has seen the launch of the third enhanced service in NHS Lothian, Outpatient Communications, which aims to build on the previous enhanced services and focuses on closing the gap across the Primary Care/Secondary Care interface. The focus is on communications from secondary to primary care following a patient's attendance at an outpatient appointment (described as ensuring 'GP practices have safe and reliable systems for handling written and electronic communication received from external sources'). Practices need to map out their current procedures, discuss with patients their experiences, and measure care using a new care bundle.

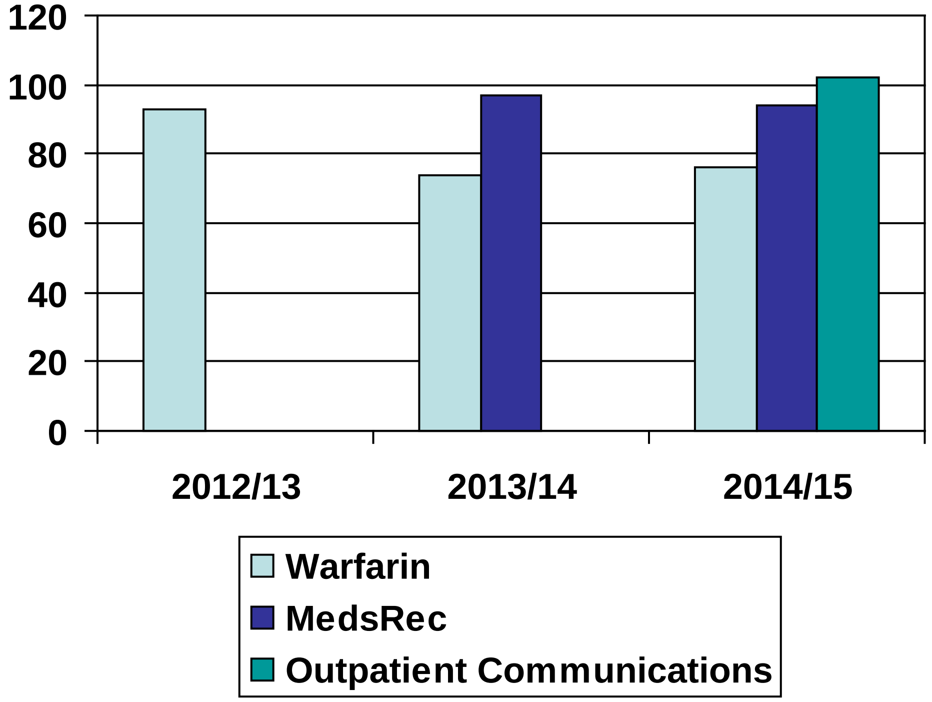
Over 200 members of practice staff attended a half-day learning session to further disseminate the methodologies encouraged by the first two enhanced services. Practices are required to submit evidence of monthly bundle data, patient involvement work and a list of all improvement changes made to practice during the enhanced service.

In order to continue to embed the work of the first two enhanced services around Warfarin and Medicines Reconciliation, there are two smaller enhanced services which require practices to continue to collect and submit data on care bundles.

Practices are continuing to carry out structured case note reviews, using the Trigger Tool, and inviting all staff to complete the annual safety climate survey.

GP practices have continued to engage with the Scottish Patient Safety Programme, and we have seen a year-on-year increase in the sign-up to each enhanced service. Chart 17 shows the overall improvement over time in the workstreams.

Chart 17: GP Practice Enhanced Service Sign Up



7. Human Factors

7.1 The work in using a Human Factors approach which focuses on the non-technical aspects of healthcare which regularly contribute to adverse events is of particular relevance to claims. This entails providing Board-wide events to provide staff with the knowledge of human factors to make their own daily work environment and activities safer. This has included team based training and the use of human factors in adverse event training and analysis of adverse events. The particular focus for 2013/14 has been introducing HIF training and Patient Safety improvement plans in theatres in Lothian following a number of adverse events in this area, some of which are relating to types of litigation claims.

7.1.1 Human Factors Conference (23rd August 2013)

As part of building safety capacity, the SPSP Clinical Lead organised a conference for clinical teams in August 2013 which focused on using human factors to enhance patient safety culture and deliver reliable high quality care. The aims of the day were to:

- Provide an opportunity for teams working on patient safety improvement to explore what can be achieved by integrating human factors into their work.
- Build on previous learning sessions both locally and nationally for patient safety and continue to build a community of learning to develop mechanisms for linking human factors education into new and existing programmes such as incident investigation and service redesign.

7.1.2 Human Factors Theatre Team Training

A series of incidents in NHS Lothian's theatres within an 18 month period (February 2012 - August 2013) was a cause of concern for the board. It became clear from the investigation reports that many of these could have been avoided if recommended systems and processes had been followed and that problems were less to do with the technical / professional skills of theatre staff but rather with their non-technical skills such as teamwork and communication.

Similar findings in the past in other safety critical industries have lead to the recognition that Human Factors plays an important role in the way that individuals and teams function when at work and have used the science behind this to develop interventions to improve safety.

The importance of teamwork has been highlighted by many patient safety reports in the last 20 years including the 'Bristol Enquiry', the Institute of Medicine report, to Err is Human, and NCEPOD and CMACE (maternal mortality) reports, yet to date few teamwork interventions have been developed to address this need.

Objectives at Outset

It was agreed that theatre teams on all sites should attend a multi professional team training session. Where possible, staff would attend the sessions with other members of their theatre team including, theatre nurses, medical staff, clinical support workers, porters and recovery staff. The sessions were designed to address basic understanding of Human Error and human performance limitation and introduce key concepts of Human Factors science particularly focussed on tools which have been demonstrated to improve communication and teamwork tailored for the perioperative environment. The training session was based on an evidence-based intervention which has been used in healthcare institutions across the USA, Team STEPPS® and this adaptation has been recognised by the Royal College of Surgeons of Edinburgh and the Royal College of Anaesthetists for CPD approval.

The educational objectives of the training were to equip individuals to:

- Understand the limitations of human cognition and why individuals make mistakes.
- Recognise key times of risk including the effects of stress & fatigue.
- Explore rationale for use of team events such as briefing, debriefing and use of checklists in building resilience and maintaining safety.
- Introduce tools to enhance communication and team performance across professional boundaries and hierarchy.
- Agree approaches to developing high reliability teams in the clinical workplace.

Recognition of the importance of further support in the workplace from both experts and clinical champions was given from the outset. The aim of this support would be to:

- Enable teams to identify and implement process improvements.
- Strengthen safety culture amongst theatre teams throughout NHS Lothian.

Measurable Outcomes
The course was initially produced by Dr N Maran and Mr Craig McIhenny and was developed and delivered by a multi professional faculty based at the Scottish Centre for Simulation and Clinical Human Factors but representing 4 other health boards from across Scotland. Although the course was piloted in NHS Lothian, it is likely that this model will be rolled out to other health boards over the coming years.

Outcome Measures
Never event incidents
Datix reports
Changes to checklists
Equipment issues
Theatre efficiency measures
Theatre safety climate

Process Measures
Process audit compliance; PSP/QIDS
Compliance with and evolution of checklists
Compliance and quality of pre-list briefing
Compliance and issues highlighted from debriefing
Qualitative & quantitative measures of communication & teamwork

Outcomes to Date
Since May 2013 there has been one near miss that could have resulted in a Significant Adverse Event, this is currently being investigated.

Numbers who have been involved
Between January and May 2014, 25 sessions were run in 4 venues across NHS Lothian and 850 staff attended. There are approximately 1000 staff within theatres, anaesthetics and surgery and Dr Maran is working with the CMT to agree a way forward in ensuring training is undertaken by all.

What Next
This team training was an initial introduction to give theatre staff a greater awareness of the effects of human factors on their daily work.

Further introductory session will be offered to staff that were not able to attend on previous invitation and new members of staff. However, in all successful interventions such as those described in research, this type of training requires to be supported in clinical areas. This will be done in NHS Lothian through identification of local Human Factors Advocates and the support of a HF expert. Funding has been secured to employ a human Factors and quality improvement expert for a 12 month period from late October 2014to support staff in clinical areas with this ongoing work. A measurement plan has been outlines as above to evaluate the initiative. Funding has also been secured from NES to undertake safety climate survey as part of the intervention evaluation.

8. Building Capacity and Capability

8.1 The Patient Safety Programme continues to increase the number of additional work streams and changes in the measurement framework. In order to deliver the depth and coverage of these new and existing work streams, increasing infrastructure is required in terms of capacity and capability building of service teams, reporting and frontline support to test, implement and embed reliable safety practices using quality improvement methodology.

Non-recurring resource for one year was secured through SPSP/LBC to provide additional clinical leadership and improvement infrastructure and develop a community of practice to help enable and equip a wider range of staff to participate in improvement work and in doing so influence the culture of the organisation. The focus is on capacity and capability-building for frontline teams to support timely delivery of the safety programme. A project manager and additional improvement leads, along with three SPSP Fellow medical improvement leads and data support have been appointed focusing on Deteriorating Patients, SEPSIS and Catheter Associated Urinary tract Infection (CAUTI). The additional resource has been used to:

1. Map existing educational resources for all grades and professions
2. Develop local quality improvement resources
3. Test different delivery methods for QI for different groups and levels i.e.
    - QIT leads
    - QIT teams
    - Wards, Community Teams, Primary Care
    - Individuals i.e. Clinical Leads
    - AHP’s, Advance Nurse Practitioners
    - Undergraduates
    - Foundation doctors to Clinical Directors
    - Hospital Sites and across sites

The following delivery methods have been used, tested and developed:

- Local Breakthrough Series Collaboratives (BTS)
- Master classes/ improvement clinics
- Dedicated quality improvement capacity to support front line times
- Coaching for improvement
- Fellows and Improvement Advisor support
- Building an understanding of the human factors which contribute or cause harm
- Ward based simulation

Measures of Success are:

- Clinical engagement
- Staff QI confidence and competence
- Spread of QI activity

Challenges to Success are:

- Leadership
- Time to undertake improvement training and initiatives
- Staffing levels particularly in the winter
- Competing demands and activities
- Medical engagement

8.1.1 Clinical Development Fellows (CDF)

In August 2014, 18 new clinical development fellows (junior doctors 3-4 years post-qualification) were appointed to NHS Lothian. Each of the CDFs has been appointed to training-approved clinical posts but also has protected time within their job to carry out quality improvement projects under the supervision of senior Basic QI methodology teaching has been delivered by Drs Patterson and Maran along with other members of the clinical effectiveness team and project supervision is being provided by many of the previous SPSP fellows across NHS Lothian. Areas of QI work include anticipatory planning, end of life care and medicines reconciliation.

8.1.2 South East Scotland School of Anaesthesia Quality Improvement and Research (SQuaRes) Trainee Network

This newly established network aims to develop the quality improvement and research expertise of all anaesthetic trainees in South East Scotland. The network is trainee led but QI teaching and support across the region is being provided by Dr N Maran & Dr Ross Paterson (Quality improvement lead for Sepsis) and Dr David Love (SPSP fellow NHS Borders). A region-wide audit of post-anaesthetic quality measures is being carried out in December 2014 and thereafter, all trainees in South East Scotland will undertake improvement projects which will be aligned to organisational priorities.

Both of these initiatives will develop considerable capacity and capability for quality improvement amongst junior medical staff within NHS Lothian.

8.1.3 The Breakthrough Series Collaborative Model (BTS) used in the deteriorating patient workstream provides a framework to optimise the likelihood of success for improvement teams. It is a proven intervention in which wards and departments can learn from each other and from recognised experts around a focused set of objectives

Critical success factors include leadership support; patients at the helm; a clear aim; focus on measurement; an agreed timeframe and clinical engagement. Teams commit to working together over a fixed period and attend a number of learning sessions between which there are ‘action periods’ where teams test changes. Learning sessions provide instruction in the theory and practice of improvement and feedback to senior leaders, focusing the organisation’s learning.

Each team reports on their methods and results, lessons learned and provide social support and encouragement for making further changes. During the intervening action periods participating teams have direct access to specialist improvement advisors and one another with regular dialogue with the support team, frequent written updates and supportive ward visits.

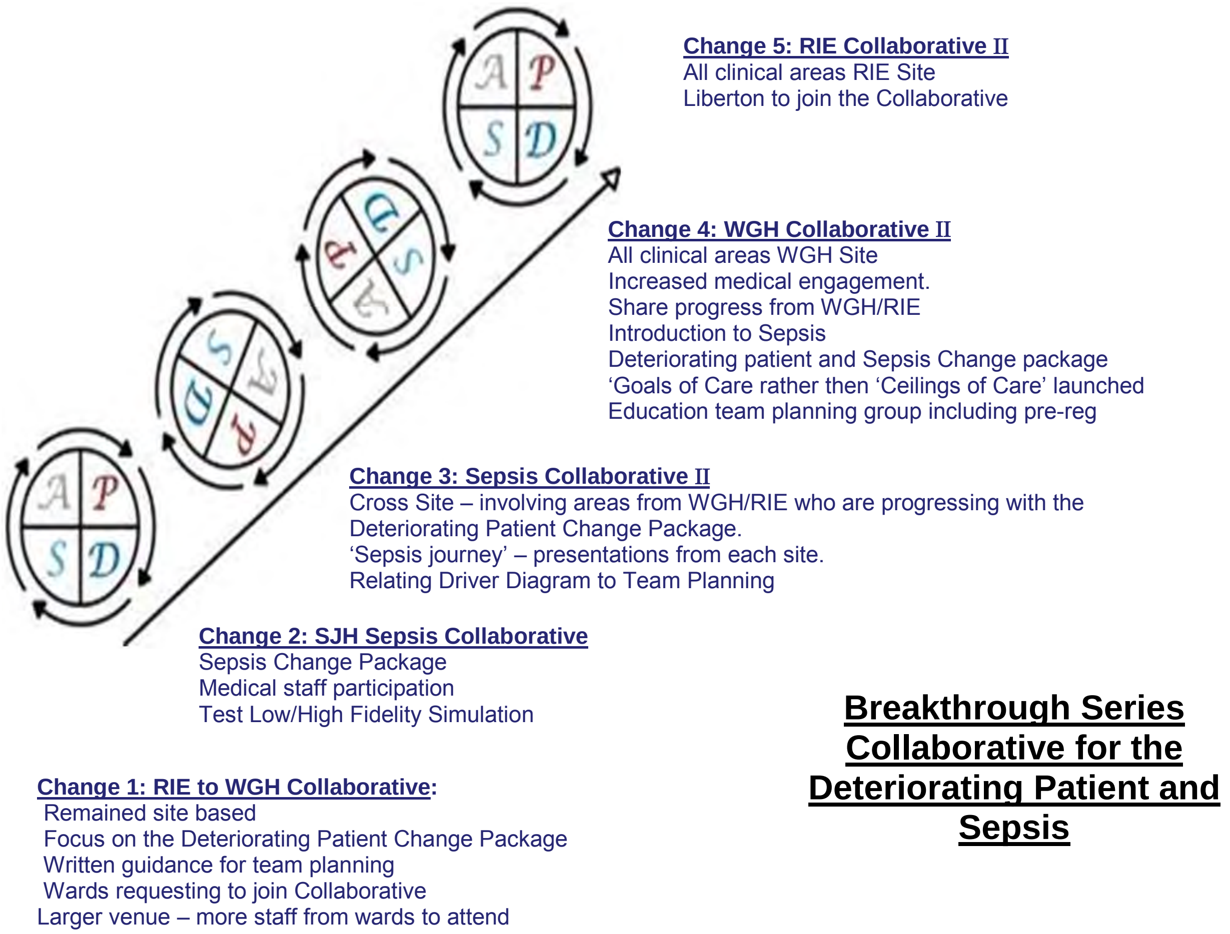
Outcomes

By December 2014 300 staff will have attended the 6 Breakthrough Series Collaboratives for deteriorating patients and sepsis, 2 on each site. The master classes that were held between the first and second collaborative were less well attended with a total of 44 staff over 7 sessions. The most successful model for delivering QI training and support is using existing ward or service meetings and delivering short sessions.

In the WGH the Medicine of the Elderly Team have set up a 'mini collaborative' to take forward improvements between collaborative which helped to sustain momentum and enthusiasm and resulted in greater capacity and capability and the implementation of many improvements. The opportunity for staff to learn about best practice from their peers at the collaborative was very well received. The

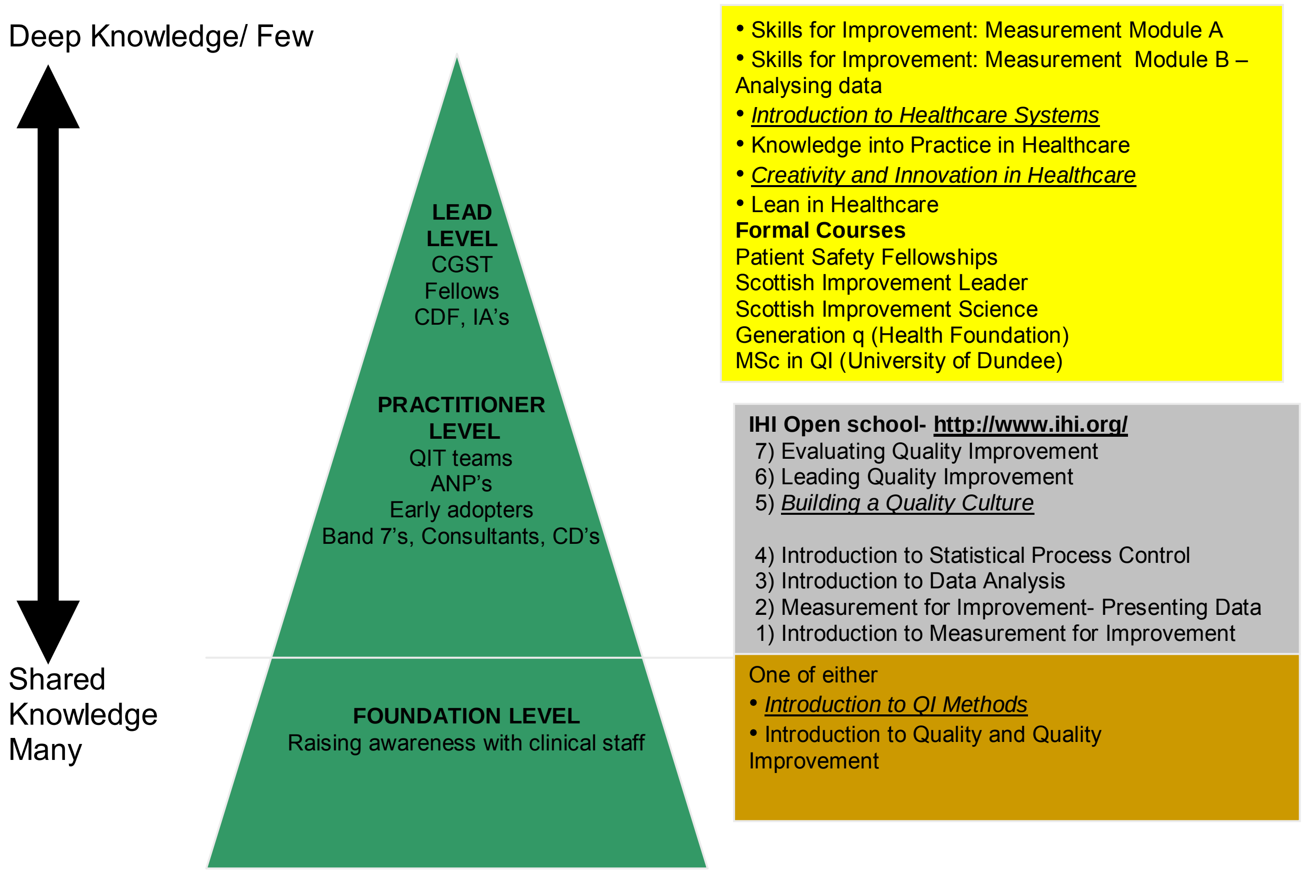
Figure 4 below shows the PDSA cycles undertaken and the changes made to the collaboratives as a result of the learning.

Figure 4: PDSA Cycles



8.1.4 NHS Lothian are using the National Education Scotland (NES) Quality Improvement Curriculum Framework which is based on a 3 level workforce model to map QI resources and gaps and to develop a capability plan. The QI Curriculum is being tested with AHPs, led by the AHP Director.

Figure 5: Building Capacity and Capability in Quality Improvement



Having been unsuccessful in obtaining any places in cohort 6 of the SPSP fellowship in 2013, two applicants were successful in the 2014 cohort, a Consultant Physician from RIE Acute Medical Unit and an AHP from West Lothian. NHS Lothian currently have ten SPSP Fellows (2 have left) and seven IHI trained Improvement Advisors (IAs) (2 have left). Appendix 3 lists the NHS Lothian IA's and Fellows and their contribution to the Board. This demonstrates that we are now recognising and utilising this valuable resource well within the board.

9. HIS Patient Safety Programme Supportive Visit August 2014

9.1 The visit was a pilot to test the process for including the entire safety programme i.e. acute adult, maternity, neonatal, paediatric, mental health and primary care, in one visit instead of having several separate visits over the year.

The aim of the visit was to review the successes, challenges and next steps for each of the safety programmes against their aims and measures and to have an overview of the Lothian safety journey and the level of integration between the programmes as well as providing support where required. It was an improvement and not an inspection approach. A generally positive draft report was provided for comment but the final report has not been issued yet.

Organisational priority and infrastructure

In terms of organisational priority and infrastructure HIS commented that a strong sense of focus on safety was seen and heard at the RIE hospital daily site huddle with both reflective and proactive approaches to the management of patient flow, high risk patients (boarders), a range of harms, adverse events and staffing. A film of the huddle has been shared with other boards at the national flow conference and the Safety Learning Session as best practice and many boards have attended and adopted this model.

This sense of focus was again highlighted for HIS through the open and honest discussions had with a range of teams where improvements were identified and actions taken, an example being the safety culture survey completed by the staff within the Royal Hospital for Sick Children after a series of incidents

HIS said the Quality Improvement Teams provide support across a range of the programmes. SPSP Fellows and Improvement Advisors are well utilised and support a number of areas of improvement. NHS Lothian has invested in its QI capacity including specific support for the patient safety programme; however some of these are supported with non-recurrent funding and sustainability was highlighted as a concern during the visit.

Leadership
Strong clinical and operational leadership with a focus on patient safety was visible throughout the 3 days with this very clearly experienced as outlined above within the hospital huddles which are well attended by all staff groups including excellent representation from senior leaders producing tangible benefits throughout the whole site. An opportunity for NHS Lothian is to further explore how to widen the impact of the site huddle, for example involving GPs linking into the huddle through the discussions covering the discharge.

A range of leadership WalkRounds were described, both at an executive and modified local level, in settings such as mental health, primary care and maternity. HIS said it may be opportune to complete jointly, WalkRounds across programmes for example maternity and primary care in view these are being tested within community settings.

Climate surveys are being undertaken across programmes, allowing the gathering of qualitative feedback not easily captured elsewhere. HIS said it was not evident how the learning across these is being shared or themes are identified however consideration should be given to reviewing the themes from the executive and local level WalkRounds and linking them to the results from recent culture surveys undertaken.

Data for improvement
HIS reflected that data was evident from patient bedside to board level and mechanism for assurance and continued improvement in a number of settings were evident both in terms of the data displayed and the process described by staff. They thought it clear that CEL19 has had a significant impact on the high standard of self assurance and the validity of data. The visiting team saw evidence of staff using data for improvement, with areas of priority identified at ward level, for example, ‘topic of the month’ was displayed in many wards. This emphasised the engagement and ownership of data by front line staff. In most cases data was presented within the clinical area however the team supporting the primary care programme were using other means such as the intranet, news letters and a range of different forms of media to keep participating teams engaged.

Improvement capability
HIS said it was evident, particularly within the acute adult settings visited, that the front line teams understood quality improvement methodology and were applying this to particular issues or concerns within their clinical setting. The acute adult and primary care programmes have been well supported throughout their development and the capacity and capability which has grown through this could be utilised across the newer programmes to support them in their improvement journey.

During the opening morning session, teams from across the board presented their work. Consideration of regular opportunities to share across programmes and sites would be encouraged. The delivery of local collaboratives which are already in existence in Lothian would be ideal vehicles to bring a broader perspective and learning. Medicines reconciliation and handover were common themes throughout the 4 programmes and a whole site view of these may help to address them within a NHS Lothian context.

10. Key Risks
Failure to spread and sustain good patient safety practice from pilot areas.

11. Risk Register
Failure to sustain and spread safety initiatives to meet the safety programme goals for harm reduction.

12. Impact on Inequality, Including Health Inequalities
The work set out by this paper, which incorporates existing data and the development and monitoring of new indicators, will have a positive impact on inequality.

This paper combines elements of the NHS Lothian Quality Improvement Strategy and so does not in itself require an impact assessment. The constituent elements of the Quality Improvement Strategy have been subjected to impact assessment as they have been developed, including the HEAT programmes (assessed in March & April 2010) and the Scottish Patient Safety Programme (assessed in May 2009).

The findings of the Equality Diversity Impact Assessment in SPSP are that particular note must be made of the harm to patients with disabilities as part of the measurement of harm. The changes to the assessment documentation encourage systematic and standardised screening for all risks including screening of cognitive impairment.

13. Involving People
Not applicable.

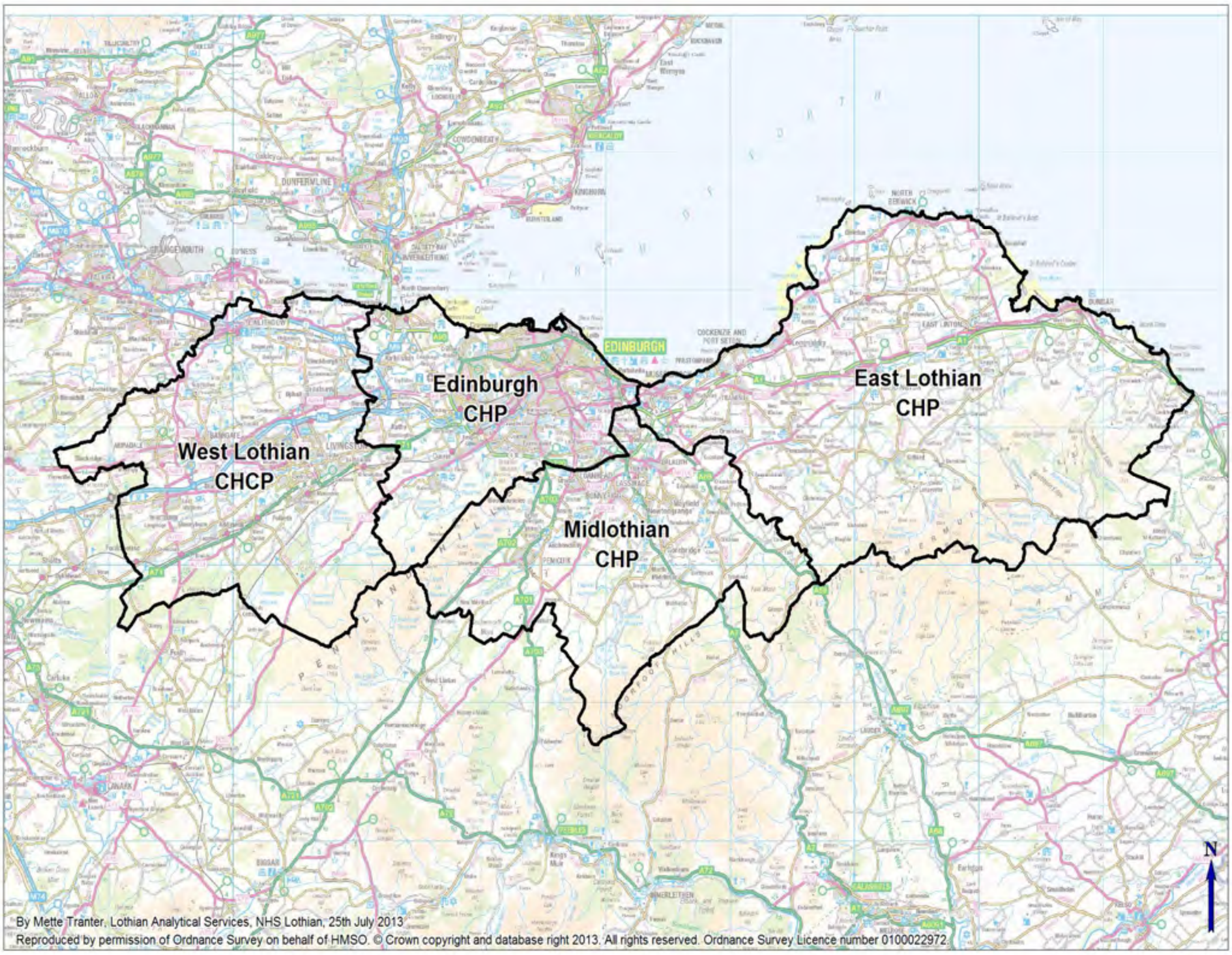
14. Resource Implications
The resource implications are the time it takes clinicians to collaborate, collect data and make the appropriate improvements. The resources to develop and spread and sustain the safety programme in new areas such as Women & Children’s Services, Mental Health, General Practice and Community Services, and deliver the mortality and harm reduction plan.

Annette Henderson
Patient Safety Programme Manager
10 November 2014

List of Appendices

Appendix 1: CEL 19 Patient Safety Essentials
Appendix 2: Leadership and Infrastructure Driver Diagrams
Appendix 3: List of SPSP Fellows and Improvement Advisors & their roles

NHS Lothian
Prescribing Action Plan
2014/16



November 2014

Prescribing Action Plan 2014/16

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Appendices

The Prescribing Action Plan has undergone a Rapid Impact Assessment carried out by members of the Primary Care Pharmacy Team and a Health Inequalities Manager in November 2014.

Acknowledgements

We would like to thank NHS Lothian for supporting the work of the CH(C)P Prescribing Forum. The group wishes to acknowledge the work of the Primary Care Pharmacy Team in the writing of this plan.

The group would like to thank the Medicines Management Team and members of the Prescribing Budget Setting Group for sharing their annual reports.

The group additionally wishes to acknowledge the work of the Lothian Joint Formulary Pharmacist, Formulary Committee and Lothian Joint Formulary Working Groups in the development of the Lothian Joint Formulary.

The group wishes to acknowledge contributions made by Mark Hunter, Head of Primary Care Contractor Office Finance and Zena Trendell, Prescribing Accountant Analyst in the generation of financial data.

Members of CH(C)P Prescribing Forum

See Appendix 1: Terms of Reference for Community Health (and Care) Partnership Prescribing Forum for membership details.

1. EXECUTIVE SUMMARY

During the financial years 2014/15 and 2015/16, individual Community Health (and Care) Partnerships (CH(C)Ps) will continue to be accountable for their General Practice and Nursing locality prescribing budgets. Governance arrangements are being developed in anticipation of the Scottish Government's Act to integrate health and social care services. This will lead to the formation of Health and Social Care Partnerships following the dissolution of the CH(C)Ps and may have financial implications in terms of fiscal accountability for the prescribing budget in the future.

In developing this plan, the CH(C)P Prescribing Forum has focused on prescribing actions that support NHS Lothian's strategic intent. NHS Lothian's draft strategic plan for 2014-2024 "Our Health, Our Care, Our Future" outlines a range of propositions which will allow us to:

- improve the quality of care
- improve the health of the population
- provide better value and financial sustainability.

The NHS Lothian Prescribing Action Plan formalises actions for 2014/16, which will determine clear strategies to support high quality, cost-effective, evidence-based prescribing. To further promote whole system working across NHS Lothian, a corporate CH(C)P Prescribing Action Plan has been developed using a joint framework. Individual CH(C)Ps will continue to produce local delivery plans that reflect and address local variations and pressures.

This plan has been developed by the NHS Lothian Primary Care Pharmacy Team and progressed through the CH(C)P Prescribing Forum as the management group with collective responsibility for primary care prescribing. The key strands within this Prescribing Action Plan are as follows.

Delivery of financial stewardship for the total primary care prescribing budget

The plan provides an outline of the budget-setting process to both CH(C)P and individual GP practice level and includes a description of the key workstreams of the locality Primary Care Pharmacy Teams and Lead General Practitioners, supporting high quality, cost-effective prescribing while contributing to the delivery of the requisite Local Re-investment Programme financial target of £4.303m. The plan additionally provides detail on the range of performance monitoring and benchmarking reports generated by NHS Lothian Medicines Management Team and the primary care Data Analyst.

Implementation strategies to support the roll out of the plan include the availability of Prescribing Management Payments and contractual practice prescribing review visits under General Medical Services Quality and Outcomes Framework Medicines Management domain indicators; MM001(S) and MM002(S) by the locality Primary Care Pharmacist as Board Prescribing Adviser. Regular feedback will be given to practices on performance relative to budget, Prescribing Indicator attainment and Lothian Joint Formulary adherence via local GP practice representative meetings and on an individual practice basis as required.

The NHS Lothian Prescribing Action Plan addresses the key areas which will contribute to enhanced financial management and delivery of clinical effectiveness.

The Therapeutics Branch of the Scottish Government Pharmacy and Medicines Division

The Scottish Government established an Efficiency and Productivity Framework for the NHS that included key areas to address within prescribing. This work was originally progressed through the Quality, Efficiency and Support Team (QuEST) to March 2015. Key workstreams are now within the remit of the Chief Pharmaceutical Officer, driven by the Therapeutics Branch of the Pharmacy and Medicines Division in the Directorate for Finance, eHealth and Pharmaceuticals. NHS Lothian Pharmacy Services post holders provide two members to the Therapeutics Branch; Clinical Lead and Lead Pharmacist (Systems).

The Scottish Prescribing Advisers Association

NHS Lothian has significant Primary Care Pharmacy Team representation on both the **Scottish Prescribing Advisers Association** Executive and Information Technology subgroup. This facilitates inter-Board pollination of ideas and the sharing of best practice and successful initiatives to optimise performance and efficiency.

Audit Scotland's "Prescribing in general practice in Scotland" (Jan 2013) – next steps

The Audit Scotland report "Prescribing in general practice in Scotland" (Jan 2013) was widely heralded as an excellent news story for general practice and particularly NHS Lothian, where comparison of spend per weighted head of population by NHS board demonstrates expenditure well below the Scottish average. NHS Lothian's outstanding position was further highlighted particularly in light of the fact that it is the only low cost board with low levels of prescribing support in terms of whole-time equivalent staff per 100,000 population.

Following publication of the report, NHS health boards were provided with a self-assessment checklist available at:
http://www.audit-scotland.gov.uk/docs/health/2013/nr_130124_gp_prescribing_ch.pdf.
Page 5 of the checklist requests assessment of the following position:

> "***We have examined our level of prescribing support staff in relation to the level of prescribing and spending in our area. We have considered whether to prepare a business case for making additional prescribing support available as part of an invest-to-save initiative."***

The Primary Care Pharmacy Team has reviewed its current position and believes that there is an urgent requirement to increase the existing capacity of the team by 3.0 WTE Prescribing Support Pharmacy Technicians (see section 4.3.3).

Work continues within the Primary Care Pharmacy Team and Medicines Management Team to optimise Lothian Joint Formulary adherence, Prescribing Indicator and National Therapeutic Indicator attainment and reduce unnecessary waste through initiatives such as non-clinical medication review training for practice staff and review of repeat prescribing processes.

NHS Lothian Local Re-investment Programme (LRP) 2014/15

NHS Lothian is required to release £4.303m of prescribing efficiencies through the rollout of a number of key initiatives. LRP project workstreams have been developed and include polypharmacy review, prescribing in asthma, training and support for general practice administrative staff in non-clinical medication review and the review of unlicensed pharmaceutical specials. A protocol has been produced in partnership with Pharmacy Services (including Quality Assurance) and in consultation with Lothian Chemist Contractors Committee, which supports community pharmacists to procure unlicensed medicines in line with national best practice guidance and NHS Lothian approved policies and procedures. In addition, pharmacy, medical and nursing colleagues will be required to work collaboratively to promote the best use of wound management products in line with the Lothian Joint Formulary.

General Medical Services (GMS)

Within the updated Scottish GMS contract, practices are required to meet with the Board Prescribing Adviser (Primary Care Pharmacist in NHS Lothian) at least annually and agree three prescribing actions. This constitutes indicator MM001(S). The prescribing actions offered to practices are taken from a basket of markers and include a range of projects that cover quality, safety (including initiatives within the Scottish Patient Safety Programme – Primary Care) and cost-effectiveness. Practices may also agree additional actions with their Prescribing Advisor if required. The practice must also undertake an audit of an area of prescribing that is a clinical issue that has been agreed with the Prescribing Adviser.

Evidence of change for the three prescribing actions should be provided and the clinical audit should be submitted to the Board in order to achieve full QOF point allocation under indicator MM002(S).

The current Scottish Quality and Outcomes Framework (QOF) guidance for the GMS contract 2014/15 states:

Table 1: QOF Medicines Management (MM) Domain

Indicator	**Points**
MM001(S). The practice meets with the NHS Board prescribing adviser at least annually and agrees 3 actions related to prescribing	4
MM002(S). The practice meets with the NHS Board prescribing adviser, has agreed 3 actions related to prescribing and subsequently provided evidence of change. The practice should also undertake an audit of an area of prescribing that is a clinical issue that has been agreed with the NHS Board prescribing adviser.	9
MM003(S). A medication review is recorded in the notes in the preceding 15 months for all patients being prescribed 4 or more repeat medicines. Standard 80 per cent	10

General Practice Intervention Project 2014

The General Practice Intervention Project 2014 will be rolled out across all GP practices from Quarter 1 (Apr–Jun 2013). As in previous years, this project focuses on agreed areas of prescribing, e.g. substitution of premium priced products from an approved list of interventions and support Lothian Joint Formulary adherence. Prescribing Management Payments will be available to all participating practices to reimburse them for clinical and administrative time.

Repeat Prescribing Systems and the Scottish Therapeutic Utility

Practice administrative staff continue to have access to NHS Lothian initiatives such as non-clinical medication review training sessions on InPS Vision repeat prescribing systems. This training is run by the Primary Care Pharmacy Team in partnership with eHealth colleagues. Comparable training has also been developed for EMIS practices and can be delivered in house on a one-to-one or group basis. Practice staff are further supported to implement the learning within their own practice through mentorship by the Prescribing Support Pharmacy Team.

Having developed the original Lean in Lothian Repeat Prescribing Application for Gpass, NHS Lothian has been the main beta-test site for the rebuild of the Scottish Therapeutics Utility (STU) as commissioned by the Scottish Government's Therapeutics Branch. STU is a valuable practice-based tool that provides practices with a suite of reports on repeat prescribing. It has a high degree of flexibility to meet the needs of clinical and non-clinical practice staff and primary care prescribing support teams to undertake a range of medicines management functions. Within the InPS Vision version, it is possible to open an individual patient's clinical record from a number of the reports in order to correct obvious errors, such as item duplication, or to stimulate a level one, two or three medication review. Targeting repeat medication reviews to patients with identifiable issues should aid resource management, increase efficiency, and support improved patient safety.

NHS Lothian Prescribing Indicator (PI) attainment

During 2013/14, Lothian practices collectively saw an increase in PI attainment from 80% in March 2013 (baseline info) to 88% in March 2014.The major proportion of Prescribing Management Payments for 2014/15 will again be awarded using a formula that takes account of improvements or maintenance of individual practice PI attainment. This is subject to gateway conditions (see section 2.4). Details of the revised 2014/15 NHS Lothian PIs are contained in Appendix 2.

Lothian Joint Formulary Adherence

The Lothian Joint Formulary (LJF) enables best use of NHS resources by supporting safe, effective and economic prescribing in line with the clinical governance agenda. All practices are encouraged to increase LJF adherence and this is an area where practices have traditionally performed well even in the absence of a complete electronic formulary within prescribing IT systems. The NHS Lothian Medicines Management Team (MMT) continues in its efforts to roll-out eLJF-CLINICAL for InPS Vision and this now includes a child formulary.

The revised LJF adherence measures introduced during 2013/14 will continue to be monitored during 2014/15

The LJF adherence measures are as follows:

- **Gliptins** – sitagliptin as a percentage of all gliptins
- **Statins** – simvastatin and atorvastatin as a percentage of all statins
- **Dressings** – LJF antimicrobial dressings as a percentage of all antimicrobial dressings

See Appendix 3 for more details.

Scottish Patient Safety Programme in Primary Care

The Primary Care Pharmacists have worked in collaboration with Clinical Governance to launch the Scottish Patient Safety Programme (SPSP) DMARD Care Bundle. The DMARD Care Bundle was presented by the Primary Care Pharmacy Team at the SPSP learning day in June 2013, which was attended by representatives from all GP practices engaged in SPSP methodology. An intranet page was set up with a summary of the care bundle and links to the relevant tools and resources and is available at http://intranet.lothian.scot.nhs.uk/NHSLothian/Healthcare/A-Z/SPSPinPC/DMARDS/Pages/DMARDsCareBundle.aspx

As this care bundle is not included in the enhanced service, the Primary Care Pharmacists have offered this piece of work to practices as a MM001(S) prescribing action.

Invest to Save Programme Initiatives

As previously mentioned, Audit Scotland asked boards as part of their self-assessment to consider business cases for making additional prescribing support available as part of an invest to save initiative.

NHS Lothian's Invest to Save Programme has supported the following additional prescribing support resource in pursuance of the work programme outlined in this Prescribing Action Plan:

- **1 x FTE Band 5 Prescribing Support Technician- eLJF-CLINICAL**

  This resource continues to support the development, quality assurance and roll out of the newly authored electronic formulary eLJF-CLINICAL. The post-holder additionally provides education and training to staff within general practices that migrated from GPASS to InPS Vision and EMIS in 2011/12. The evaluation of this post is ongoing. See section 4.3.2

- **0.5 FTE Band 5 Prescribing Support Nurse**

  Primary Care Pharmacy work collaboratively with the Clinical Nurse Manager to provide strategic direction and operational support to a nurse who is trained to access prescribing data and provide education and training to non-medical prescribers on the updated wound management formulary. This post is currently under evaluation.

- **3.0 FTE Band 5 Prescribing Support Technicians**

These technician posts are currently under recruitment with post-holders expected to be in place by December 2014 / January 2015 until March 2016. Successful recruitment will augment capacity and optimise the skill mix within the existing Prescribing Support Pharmacy Team on a pan-Lothian basis. Key result areas for this team include:

- Prescribing support, including the development and analysis of PRISMS reports and implementation of Lothian Joint Formulary
- Review of repeat prescribing systems
- Clinical governance, including development of prescribing audits, standard operating procedures and protocols
- Medicines management information such as Lothian Joint Formulary adherence feedback and support
- Education and training, e.g. non-clinical medication review

- Review of prescribing for identified patient groups, such as care home residents and those receiving medication in a multi-compartment compliance aid.

Further information on this project is included in section 4.3.3

The following were previously successful Invest to Save posts but are now being funded on a non-recurring basis through top-slice of the Primary Care Prescribing Budget:

- **3 x FTE Band 7 Integrated Care Pharmacists (Polypharmacy)**
  To undertake polypharmacy medication reviews in conjunction with General Practitioners, to record pharmaceutical interventions and promote the national polypharmacy guidance.
  Following the success of the initial project, which was showcased nationally through the original Scottish Government QUEST programme to March 2013, the CH(C)P General Managers have funded the project and posts for a further 12 months through a top slicing of the primary care prescribing budget.
  For further information, refer to section 4.2.1 and 4.2.5.

- **1 x FTE Band 5 Prescribing Support Technician –“Specials”**
  This technician post supports the unlicensed “specials” medicine workstream as outlined in section 4.2.3. The original aims and objectives of the post have been overtaken by the publication of changed Drug Tariff arrangements in Scotland as outlined in PCA (P) 2013 4 – Pharmaceutical Services Reimbursement of Special Preparations and Imported Unlicensed Medicines. The resource has therefore become necessary for the Board to meet its contractual obligations and for further areas of efficiency to be explored.

  In 2014/15, the General Managers took the decision to finance this post for a further 12 months in recognition of the good work being delivered. The post is funded by top slicing the primary care prescribing budget.

Community Pharmacy

The membership of the NHS Lothian CH(C)P Prescribing Forum recognises the important contribution of Community Pharmacy contractors in the delivery of safe, quality and cost-effective pharmaceutical care to the people of Lothian. The ongoing support of NHS Lothian's community pharmacy teams is essential to the successful delivery of the Prescribing Action Plan. Community Pharmacy has been consulted during the development of the key themes within this year's plan and will continue to be updated as the plan is implemented.

Public Partnership Fora

The valuable benefits of joint working between locality Public Partnership Forums and the Primary Care Pharmacy Team was previously achieved through the Efficient Use of Medicines Forum in NHS Lothian. This Forum was disbanded in 2014 as CH(C)Ps undergo a restructure and Health and Social care partnerships are formed.
The collaborative working previously achieved through the Efficient Use of Medicines Forum will be continued as new working groups are established as the reorganisation process develops.

Non-medical prescribing

The CH(C)P Prescribing Forum will continue to develop a suite of prescribing reports that monitor the quality and cost-effectiveness of prescribing by non-medical prescribers. The growth in the number of suitably trained non-medical prescribers highlights the ongoing need for supported governance arrangements. Additionally, NHS Lothian funds and facilitates the annual Non-medical Prescribing Conference.

2. INTRODUCTION AND CONTEXT

2.1 Background

NHS Lothian has a practice population in excess of 905,000. There are 126 GP Practices and 182 Community Pharmacy Contractors.

Table 2: Population, GP Practices & Community Pharmacies by CH(C)P (April 2014)

CH(C)P	Edinburgh	East Lothian	Midlothian	West Lothian	Lothian
Population	525,755	104,356	88,992	186,490	905,593
	58.1%	11.5%	9.8%	20.6%	100.0%
General Practices	74	16	12	24	126
	58.7%	12.7%	9.5%	19.1%	100.0%
Community Pharmacies	107	23	20	32	182
	58.8%	12.6%	11.0%	17.6%	100.0%

2.2 Aim of the plan

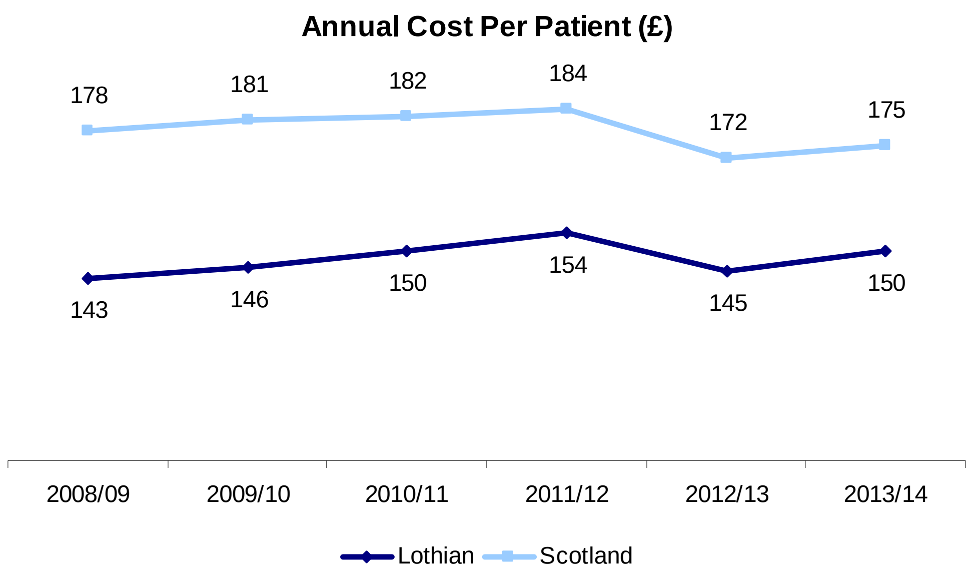
The aim of this document is to formalise an action plan for the period from April 2014 to March 2016, which will determine clear strategies to support high quality, evidence-based and cost-effective prescribing for GP practices and the nursing locality budget in Lothian. The prescribing budget will be monitored on a monthly basis approximately three months in arrears and stakeholders will receive feedback on all relevant measures. This will help ensure the highest standards of financial stewardship and the most efficient use of prescribing resources while attempting to reduce avoidable variation. The plan builds on much of the work already well established across NHS Lothian.

2.3 Prescribing budget devolution

General Practice prescribing (including non-medical prescribers) costs the NHS in Scotland over £970 million per year and represents around 11 per cent of annual NHS expenditure. Health Boards have highlighted the budgetary risks associated with General Practice prescribing pressures and they expect the volume of prescribing to increase by approximately 2.5% during 2014/15.

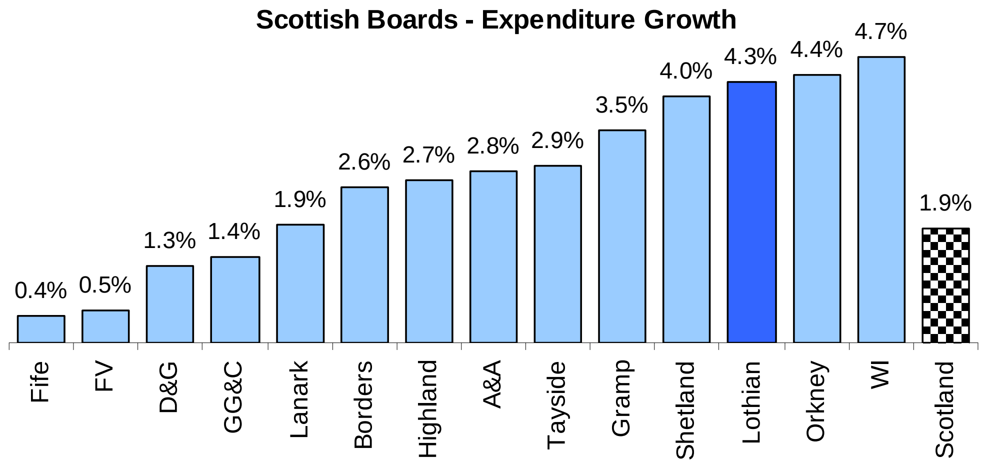
NHS Lothian has the lowest prescribing cost per patient per annum in Scotland (£150) when comparing data on the total list size. If prescribing costs in NHS Lothian were at similar levels to the Scottish average (i.e. £175 per patient per annum) this would have resulted in additional costs during 2013/14 of £22m.

Chart 1: Comparison of NHS Lothian Cost per Patient Figures to the Scottish Average



For many years now Lothian practices have successfully completed prescribing projects and initiatives to improve the quality and cost-effectiveness of prescribing. For the year 2013/14, Lothian practices showed an expenditure reduction of £3.6m for LRP/efficiency projects. Overall expenditure increased by 4.3% (£5.4m) relating to cost pressures for Drug Tariff price amendments, short supply of medicines and Special Preparation fixed tariff prices. Volume/item growth was 2.5% for Lothian compared to 1.9% in Scotland. Lothian in particular starts from a very low baseline and is one of only three areas in Scotland in which there has been continued and sustained population growth in recent years. There is also increasing evidence of a shift in the balance of care from acute services to more community-based services.

Chart 2: Comparison of Scottish Health Boards' Expenditure Change (2012/13 v 2013/14)



As stated in the Scheme of Establishment: "CHPs will have overall responsibility of the management of the Prescribing Budget with individual practice budgets also being identified." Once the overall NHS Lothian resource available in 2014/15 was determined, the individual CH(C)P prescribing budgets and subsequently individual practice budgets were agreed.

2.3.1 CH(C)P Prescribing Budgets for 2014/15

The overall prescribing budget allocation for 2014/15 is £131.1m following the application of LRP/efficiencies totalling £4.303m. The Medicines Management Team (MMT) full year forecast as detailed in the "Report on Prescribing Pressures in Primary Care - Looking Forward to 2014/15" is expecting expenditure of £137.5m for the year prior to any efficiency.

Table 3: Summary of Prescribing Budget 2014/15

	£000's
13/14 Budget	131,200
14/15 Uplift	4,500
Sub-total	*135,700*
Planned LRP Projects	-2,500
Sub-total	*133,200*
Additional LRP	-1,803
14/15 Allocated Budget	**131,397**

Four possible budget distribution options were presented to the CH(C)P General Managers for consideration. The methodology for the chosen model is based on 2013/14 year-end budgetary shares adjusted for individual CH(C)P predicted LRP/efficiencies.

Further adjustments take place annually at the start of the financial year and these include £1.5m of contingency funding and £0.8m for flu vaccinations (£2.3m in total) to be distributed to CH(C)P's on a quarterly basis. This will cover the quarterly patient list size movements and Shared Care Agreement (SCA) adjustments.

Table 4: Budget Allocation by CH(C)P for the Financial Year of 2014/15

Area	**Initial 13/14 Budgets £000's**	**Final 13/14 Budget £000's**	**Adj for Contingency Fund £000's**	**Restated 13/14 Budget £000's**	**14/15 Uplift £000's**	**14/15 LRP £000's**	**Topslice £000's**	**Initial 14/15 Budget £000's**
EDIN	66,586	67,776	-1,197	66,579	2,336	-2,263	-153	66,499
EL	17,322	17,472	-308	17,163	607	-571	-39	17,160
ML	14,533	14,706	-260	14,447	514	-490	-34	14,437
WL	29,584	30,315	-535	29,780	1,039	-979	-68	29,772
MAS	615	671		671	4			675
LUCS	260	260		260				260
Contingency	2,300	0	2,300	2,300				2,300
Total	**131,200**	**131,200**	**0**	**131,200**	**4,500**	**-4,303**	**-294**	**131,103**

2.3.2 Practice Prescribing Budgets for 2014/15

Individual practice budgets have been set using a two part model:

- Shared Care Agreement (SCA) drugs have been funded in full and will be adjusted accordingly each quarter throughout the year along with list size movements.
- The remaining budget is derived from the weighted budgetary model as developed by the Prescribing Budget Setting Group (PBSG).

The PBSG is a sub-group of the General Practice Prescribing Committee (GPPC) and is commissioned by the CH(C)P Prescribing Forum.

2.4 Prescribing Management Payments (PMPs)

NHS Lothian recognises that the targeted use of Prescribing Management Payments is an excellent way to engage GP practices in prescribing projects and reward them for the achievement and/or maintenance of high Prescribing Indicator (PI) attainment and as a result payments will continue to be awarded in 2014/15. CH(C)P General Managers have approved the allocation of discretionary funding in recognition and appreciation of the excellent achievements made by the majority of NHS Lothian practices over many years.

As in 2013/14, this year's Prescribing Management Payments will be divided into Phase 1 and Phase 2 payments. Phase 2 will be paid to reward practices for PI attainment based on performance to December 2014 to allow payment within the current financial year.

2.4.1 Phase 1 – General Practice Intervention Project (GPIP 2014)

Phase 1 payments will be calculated following participation in GPIP 2014 (see section 4.1.1).

Practices must complete GPIP 2014 in order to qualify for Phase 2 payments and as such **GPIP 2014 will act as a gateway to PI attainment payments**.

2.4.2 Phase 2 - NHS Lothian Prescribing Indicators Attainment

Phase 2 payments will only be available to practices that participate in GPIP 2014.

For 2014/15 it is agreed that practices will again be rewarded to maximise PI attainment. Payments will be based on PI performance to December 2014 to allow payment within the current financial year; the value of which will be determined once the total spend on GPIP 2014 is known.

The Phase 2 PMP allocation by locality will be divided up between eligible practices based on percentage PI attainment and practice list size using the calculation in figure 1 below.

Figure 1

[x p per patient] x percentage attainment of 12 Prescribing Indicators

based on data to December 2014 from Medicines Management Team

to ensure payment within the current financial year.

e.g. Practice A with 8,000 patients attains10 out of 12 PIs (83.3%) will receive

£0.0x x 8,000 x 0.833 = £6,664x

If the practice achieved all 12 PIs (100%) the payment would then be £8,000x

$$\textit{where } x = \frac{\text{(£CH(C)P allocation – spend on GPIP 2014) x 12 (total no PIs available)}}{\text{Total list size in CH(C)P x total no PIs attained at December 2014.}}$$

3. NATIONAL INITIATIVES

3.1 Formulary decisions on new medicines

CMO (2012)1, *Guidance to further strengthen the safe and effective use of new medicines across the NHS in Scotland*, was issued in February 2012 and provided further detail on NHS Boards' requirements to manage the introduction of new medicines that have been accepted by the Scottish Medicines Consortium (SMC). The main aspects of the CMO letter that relate to Formulary Committee (FC) are that NHS Boards are expected to reach a decision on SMC accepted medicines within 90 days of the issue of SMC advice to the NHS Board and are expected to publish on their website the formulary decision within 14 days of the decision being reached.

This 90-day timescale means that clinical teams need to make timely applications to FC. The achievement of this standard is being continually monitored, but more can be done to make applications within the timescale.

The CMO letter provides standard wording for the FC decisions:

- Included on the NHS Board formulary for the indication in question
- Included pending protocol
- Not included on the NHS Board formulary because the NHS Board decision is that the medicine does not represent sufficient added benefit to other comparator medicines to treat the condition in question
- Not included on the NHS Board formulary because clinicians do not support the formulary inclusion
- Not included on the NHS Board formulary because clinicians have not responded to an invitation to apply for formulary inclusion for this medicine
- Not included pending protocol.

This standard wording is used for all FC decisions. 'NHS Board Formulary' is replaced with LJF 1st or 2nd choice or Prescribing Note, or Additional List. A statement is included where the drug is Specialist Use Only. Where the medicine is 'not included' a subsequent submission will be accepted at any time.

All FC decisions are posted on the LJF website (Formulary Committee minutes and web tables of new drug decisions.)

3.2 New medicines "not recommended" by the Scottish Medicines Consortium

The Scottish Government circular CEL 17 (2010) provided good practice guidance to provide a framework within which NHS Boards should operate when dealing with requests for medicines, which have been appraised within their licensed indication by the SMC but have not been recommended for use within NHSScotland.

The NHS Lothian Medicines Utilisation Review Group (MURG) reviews the prescribing of medicines across primary and secondary care. In order to support and advise GPs, the group produced a summary of Scottish Medicines Consortium (SMC) 'not recommended' medicines in response to feedback on GP prescribing.

The Scottish Government has advised that a new Peer Approved Clinical System (PACS) will be introduced. The aim of a PACS is to increase patient access to new medicines through greater clinical involvement in decision-making about individual cases and increased consideration of patient outcomes.

3.3 The Scottish Government Pharmacy and Medicines Division Therapeutics Branch

The National Therapeutic Indicators were first published in March 2012, following consultation with the Scottish Prescribing Advisors Association (SPAA) Executive, to support Boards in identifying areas of prescribing variation. The third set of National Therapeutic Indicators (NTIs) was published in May 2014 and is detailed in appendix 4. Their aim is to support and improve the quality, safety and cost-effectiveness of primary care prescribing by comparison between all Scottish general practices. The list of NTIs is compiled from a combination of established indicators, indicators used in other countries and those highlighted by national priorities. Consensus on the final list is achieved between the Scottish Government Therapeutics Branch and representatives from a range of NHS Board Prescribing Support and Medicines Management Teams. The NTIs continue to highlight the quality of primary care prescribing in Scotland and provide an opportunity to reflect on clinical practice based on robust quality outcomes data, validated by NHS Information Services Division. The use of the NTIs in 2014/15 is optional, but encouraged as good practice.

Due, in part, to the success of the **Polypharmacy** pilot project during 2012/13 within NHS Lothian, Scottish Government toolkits and models of practice for review of polypharmacy have been made available to Boards across Scotland. The requirement for a polypharmacy review also becoming embedded in the Quality Outcomes Framework under Quality and Productivity domain, indicators QP006(S) and QP007(S).

A revised Polypharmacy Service Level Agreement for 2014/15 has been developed to support the clinical review of patients resident in care homes and additional high risk patients as identified by the practice. The Scottish Patient At Risk of Re-admission and Admission (SPARRA) list has helped practices to prioritise the following at risk groups:

- Patients on medications associated with a high risk of adverse drug reactions
- Care home residents (where the practice is not the lead).

Other workstreams included in the plan for the Therapeutics Branch to March 2016 include the following:

- Development and roll out of the Scottish Therapeutics Utility
- Repeat prescribing systems and reducing avoidable waste
- Review of medicines management within the Scottish GMS contract
- The Diabetes Prescribing Strategy and the Respiratory Prescribing Strategy
- Gluten–free foods
- Wound management
- Oral nutritional supplements

3.4 Scottish Prescribing Advisers Association

The strengthening of the Scottish Prescribing Advisors network is deemed essential to the successful delivery of a more consistent national approach to prescribing efficiency and productivity. Through the Scottish Prescribing Advisors Association Executive, corporate prescribing actions plans are shared to ensure optimal prescribing workstreams nationally and avoid duplication of effort. Boards are encouraged to share prescribing projects and protocols, including resources and outcomes. An annual national conference is held in October where further examples of best practice and innovative workstreams can be showcased to the ultimate benefit of all Boards.

In 2014/15 the Scottish Prescribing Advisors Association will develop and roll out a secure web-based resource that will facilitate the sharing of health board prescribing action plans and prescribing project tools, e.g. practice protocols and audits. NHS Lothian is central to the development of this resource and will be a test site for early adoption. The Primary Care Pharmacy Team remains mindful of the requisite governance arrangements when using such a medium for communication and will ensure all relevant committees and groups have approved the content shared with our colleagues locally and nationally.

4. NHS LOTHIAN LOCAL RE-INVESTMENT PROGRAMME – PRIMARY CARE PRESCRIBING INITIATIVES

Primary Care prescribing has been given the target of £4.303m for LRP/efficiencies. Achieving this target will be a challenge for the CH(C)P General Managers and it has been noted that this is a considerable risk. Plans formulated before the financial year total £2.5m and are on schedule to deliver (these are detailed on Table 4). The off-patent drug calculations have been discussed with the Medicines Management Team (MMT) and templates were submitted for the Prescribing Actions Plans (PAP).

Table 5: Breakdown of 2014/15 Local Re-investment Programme Plans

Project	**Risk level**	**Planned target/ estimated benefit £000's**
13/14 Full year effect	Low	500
GPIP		500
PSP team activities		200
Dietetics		50
Pain management		50
Respiratory		50
Sub-total		***1,350***
Polypharmacy	Medium	150
Antimicrobials		50
Special preparations		50
Sub-total		***250***
Diabetic needles	High	50
Non-clinical medication reviews		100
Sub-total		***150***
Off-patent medicines		750
Total		**2,500**

Table 6: Additional Local Re-investment Programmes for 2014/15

	£000's	**Risk level**
Planned projects (Revised targets / additional sum)	450	Medium/High
Phase II schemes	600	Medium/High
Phase III / additional schemes	750	High
Total	**1,800**	

Table 7: Breakdown of LRP Prescribing Programme 2014/15 by CH(C)P

CH(C)P	**Edinburgh £000's**	**East Lothian £000's**	**Midlothian £000's**	**West Lothian £000's**	**Lothian £000's**
Planned projects	923	231	207	389	1,750
Off-patent benefit	403	97	78	172	750
Sub-total	*1,326*	*328*	*285*	*561*	*2,500*
Additional plans	938	243	205	417	1,803
Total	**2,263**	**571**	**490**	**979**	**4,303**

The National Generic Drug Tariff for 2014/15 has been in place since 1 April 2013 as part of a two year agreement (PCA2013(P)21) and continues to have set tariff prices that are 2.55% lower than in 2012/13. However, there are exceptions to this in that where community pharmacies are unable to procure medicines within the tariff reimbursement price an adjustment will be made. Furthermore, tariff amendments will be made for those considerably out of step with the English tariff prices. For 2014/15, Pharmacy Services Division (PSD) has provided reassurance that the impact of these price changes will be cost-neutral across Scotland.

4.1 Low risk

4.1.1 General Practice Intervention Project (GPIP 2014)

As previously mentioned under section 2.4.1, discretionary funding has been agreed to support a prescribing intervention project where practices are asked to identify specific, targeted interventions from patients' medication records that result in more cost-effective prescribing. Practices that participated in the intervention project in 2013 are thanked for their contribution, which produced an in-year financial efficiency of £639.5K. GPIP 2014 will again be critical to the successful delivery of the Prescribing LRP Programme 2014/15. Practices are reminded that, as in previous years, participation in the project remains the gateway to Prescribing Management Payments.

To maximise in-year budgetary benefit, GPIP 2014 will be launched in Quarter 1 (April 2014 – June 2014). Practices will receive a project pack that will include full details of the approved interventions along with a service protocol, sample patient letter and payment claim forms. Electronic copies will be emailed to all Practice Managers. Practices with InPS Vision will also receive a range of IT system searches to facilitate identification of patients within the project.

As in previous years, reimbursement of administrative costs will be available to participating practices. The payment for participation has been increased this year in recognition of the increased cost of administering GPIP at practice level. Interventions that require more significant clinical input and monitoring will be paid at £15 per intervention, while those that require minimal clinical input, e.g. omeprazole 20mg tablets to capsules, will be reimbursed at £7.50.

4.1.2 Prescribing Support Pharmacy Team

The pan-Lothian Prescribing Support Pharmacy Team is now fully embedded within Primary Care Pharmacy Team across all CH(C)Ps. The Prescribing Support Pharmacists (PSPs) and Prescribing Support Technicians (PSTs) work under the direction of the locality Primary Care Pharmacist(s) and closely with practice teams to implement agreed prescribing reviews as indicated by NHS Lothian Efficiency and Productivity Programme 2014/15. Under the direction of the locality Primary Care Pharmacists, team members engage in additional workstreams in partnership with Medicines Management Team, CH(C)P General Managers and NHS Lothian Finance department to identify outlying practices and prioritise prescribing development projects to achieve agreed measures. Furthermore, the PSPs and PSTs work closely with other health and social care colleagues within NHS Lothian to support successful delivery of key strategies, policies and programmes.

A key role for the PSP Team within the extended Primary Care Pharmacy team is the development and production of a range of clinical prescribing protocols which formalise the activities undertaken when team members work in general practice. The resulting protocols are formally peer reviewed by the team and authorised for a predefined time period by the Primary Care and Community Pharmacy Co-ordinator. Details of the current menu of Prescribing Support Pharmacy Team protocols are available in appendix 5. Further to this, a number of complementary GMS MM001(s) resource packs have been developed to support agreed prescribing actions.

4.1.3 Dietetics

The Primary Care Pharmacy and Dietetic Services multi-professional working group continues to meet approximately bi-monthly to progress joint working in this therapeutic area. The group facilitates promotion of the Lothian Joint Formulary and monitors and reviews prescribing trends to identify and correct avoidable variation within and across the four CH(C)Ps.

Promotion of Complan Shake® as formulary 1st choice oral nutritional supplement (ONS) remains a high priority with an agreed target of approximately 25% of primary care patients anticipated to be suitable for this product. Work also includes supported discharge from hospital and follow-up review of patients on Complan Shake® in the community and specialist reviews of ONS use in care homes. Dietetic services continue to provide educational support to the polypharmacists, Integrated Care Pharmacists, Prescribing Support Pharmacists and technicians and specialist review of team protocols and GMS MM001/2 packs.

In line with the new NHS Lothian specialist Weight Management Service, prescribing guidance for orlistat has been reviewed. Orlistat should now only be prescribed to patients as part of a comprehensive weight management programme with orlistat sitting in tier 3.

The group actively reviews and discusses the progress being made through the pilot community pharmacy Gluten-Free Food Service with accompanying analysis of prescribing data and associated costs.

Work is also progressing as part of an extended work plan to review primary care prescribing guidance for infant nutritional formulae and thickeners.

4.1.4 Pain management

Work continues in Lothian GP practices to review the use of fentanyl and buprenorphine patches, raising awareness of the appropriate use of these products in an attempt to moderate the growth in their use. This review work is offered as GMS MM001 prescribing action, supported by written project protocols. Similarly, a protocol is available to practices in support of an MM001 prescribing action to review patients prescribed lidocaine plasters. The protocol highlights the importance of regular review of product efficacy, with discontinuation if appropriate. Previous work has shown that discontinuation is possible in a large proportion of patients.

Practices are encouraged to use cost-effective plain paracetamol preparations, rather than more costly alternative formulations. This is currently a Lothian Prescribing indicator, hence is monitored regularly and communicated with all practices.

Following publication of SIGN 136: Management of Chronic Pain: SIGN 136: Management of Chronic Pain development of further work is underway to support improved and cost-effective prescribing for chronic pain in association with the recently established NHS Lothian Chronic Pain Special Interest Group.

Various elements are planned including:

- Update of Lothian Joint Formulary sections on analgesics
- NES educational event for community pharmacists to raise awareness of current guidance and best practice in the management of chronic pain
- GP Protected Learning Time (PLT) sessions on the management of chronic pain that will highlight key points from SIGN 136 and give guidance on rational prescribing in chronic pain, including the importance of accurate assessment of pain and a rational approach to pain management; stressing the importance of dose titration to effective dosage review of efficacy with discontinuation of agents that are not effective and systematic recording of analgesic history, efficacy and adverse effects.
- Pilot work is planned during 2014-15 that will inform development of MM001 and MM002 projects for 2015-16. Practices will be strongly encouraged to undertake these projects, the PLT sessions having taken place by this time. It is proposed that patients prioritised for review will include those with chronic pain prescribed potent opiates and those prescribed multiple analgesics.

4.1.5 Respiratory

Asthma

The purpose of this workstream is to ensure people in Lothian with asthma are reviewed annually and maintained on the most appropriate, safe and effective medication. A template is recommended to ensure patients receive a consistent, structured annual review which has been shown to improve clinical outcomes of people with asthma. The template was developed through the Respiratory Managed Clinical Network and is recommended for use when reviewing all patients with asthma in Lothian.

A prescribing audit is being encouraged, with the objective of reviewing adults and children (over 5 years) with a diagnosis of chronic asthma who are on Step 3 or 4 of the SIGN/British Thoracic Society guidelines. The audit encourages the practitioner to step down well controlled patients to the lowest effective dose of inhaled corticosteroids, thus minimising the risk of adverse effects. The audit will also include a review of the devices prescribed and assess for appropriateness in terms of the licensed dose and age of patient. Further to this, patients will have their inhaler technique assessed to ensure maximal benefit is obtained from their medication. These initiatives are in line with the recommendations of the National Therapeutic Indicator No. 3, High Strength Inhaled Corticosteroids.

Chronic Obstructive Pulmonary Disease (COPD)

The purpose of this workstream is to ensure people in Lothian with COPD are prescribed an inhaled corticosteroid at the dose recommended in the summary of product characteristics in an appropriate device. Work is being undertaken to support practices in improving their knowledge and understanding of prescribing guidelines in relation to inhaled corticosteroids in COPD, thus ensuring inhaler technique is assessed and that patients are reviewed regularly.

Community Pharmacy Respiratory Enhanced Service

The purpose of this workstream is to increase patient's awareness of the new "Living it Up" web-based service and COPD digital postcards by engaging community pharmacists to promote this service. In addition, 10 pharmacies are being offered the chance to participate in a pilot project to support improving the care of COPD patients by offering inhaler technique training and concordance reviews to this patient group in their pharmacies.

Protected Learning Events

The purpose of this workstream is to ensure that a consistent message regarding diagnosis and treatment of respiratory conditions is presented across Lothian. The Respiratory Managed Clinical Network (MCN) is running education events in each CH(C)P during protected learning time sessions. This will ensure all practices in Lothian have the opportunity to update their knowledge on diagnosis and treatment of respiratory conditions in line with current recommendations and the Lothian Joint Formulary.

4.2 Medium Risk

4.2.1 Polypharmacy Service Level Agreement

CEL 36 (2012) *Appropriate Prescribing for Patients and Polypharmacy Guidance for Review of Quality, Safe and Effective Use of Long-Term Medication*, was published by the Scottish Government in November 2012. Boards were asked to consider this piece of work within their local Prescribing Action Plans.

NHS Lothian supported the pilot project, jointly funded by Scottish Government, in 2012/13. The project utilised a team of up to three WTE specialist clinical pharmacists and recruited 54 GP practices under a Service Level Agreement (SLA). Targeting patients, predominantly in care homes, aged over 75 years and on medicines from 10 or more British National Formulary (BNF) categories, resulted in just over 2,600 patients having a joint GP/Pharmacist polypharmacy review undertaken.

In November 2012, NHS Lothian welcomed the publication of National Polypharmacy Guidance available at www.sehd.scot.nhs.uk/mels/CEL2012_36.pdf

A revised Service Level Agreement was offered to practices in 2013/14 reviewing the cohort of patients within each practice as directed by the national Polypharmacy Guidance, i.e. those who were aged over 75 years, who received medicines from 10 or more BNF categories in the previous 12 months and had a SPARRA risk score of 40 – 60%. SPARRA is the Scottish Patients At Risk of Readmission and Admission and is a risk prediction tool that scores the patients' likelihood of hospital admission in the next 12 months. Patients with SPARRA scores > 60% receive more targeted intervention from other services and this may include medication review by an Integrated Care Pharmacist. Over 2,700 medication reviews were undertaken in the 86 practices which took part.

The 14/15 SLA is a combination of the previous two years, involving both care home patients and those targeted by the national guidance. Ninety-two practices have signed up to the service, encompassing medication reviews for over 4,800 patients. Practices will again receive a payment for participating in the joint polypharmacy review between the pharmacist and the GP. This review complements the requirements under the new Scottish General Medical Services QOF contract indicators QS004-6(s) for 2014/15.

The Scottish GMS Contract (sGMS) uses risk prediction tools such as SPARRA to support practices to identify their patients most likely to benefit from an Anticipatory Care Plan (ACP). The sGMS contract states that a polypharmacy review should form part of the ACP and so the 2014/15 SLA complements this contractual requirement.

The NHS Lothian polypharmacy review model requires practices to undertake a 1:1 clinical discussion between the clinical pharmacist and the GP and the completion of an intervention spreadsheet necessary for detailed project analysis. Both of these elements are outwith the QOF.

The aim of this initiative is to optimise patient care. The polypharmacy reviews undertaken in both 2012/13 and 2013/14 resulted, on average, in one medicine per patient being stopped. Many of these medicines are categorised as "high risk" and are known to put frail patients at potentially higher risk of hospital admission. Stopping these medicines resulted in opportunistic cost efficiency on a recurring basis (£112 and £64 per patient per annum for 12/13 and 13/14 projects respectively).

Prescription for Excellence – developing clinical capacity via 'Teach and Treat'

Prescription for Excellence, published jointly by the Scottish Government and NHSScotland in September 2013, is a visionary document that outlines the development of NHS pharmaceutical care in Scotland over the next 10 years through integrated partnerships and innovation.

The main objective of the plan is that all patients, regardless of their age and care setting, will receive high quality pharmaceutical care using the clinical skills of the pharmacist to their full potential. One key objective to deliver this aim is that, by 2023, all pharmacists providing NHS pharmaceutical care will require to be NHS accredited clinical pharmacist independent prescribers, working in partnership with the medical profession in the management of long term conditions. Medical practitioners will continue to have overall responsibility for diagnosis.

In order to support the aim of expanding the number of pharmacist independent prescribers, National Education Scotland (NES) are funding the establishment of a 'Teach and Treat' Polypharmacy review clinic in 2014/15. An experienced, qualified independent prescriber will run a case-holding polypharmacy review clinic in a GP practice, building their confidence and expertise in undertaking in-depth medication review, independent prescribing, consultation skills and clinical skills. In addition, they will enhance their competence in teaching and supervision by supporting the development of other independent pharmacist prescribers working in the clinic. The independent prescriber trainer will work in partnership with NES to standardise training, supervision and evaluating outcomes.

4.2.2 Antimicrobial stewardship

National data show that NHS Lothian uses a higher proportion of antibiotics with high association to C.difficile acquisition (the "4C" antibiotics); 12.8% of overall total compared with 8.9% for Scotland for 2012/13. Co-amoxiclav prescribing remains particularly high for this period; 10.21 items/100,000/day as compared with 7.07 for Scotland.

This position has been widely publicised to prescribers and the NHS Lothian Antimicrobial Management Team (AMT) delivered Practice Learning Time (PLT) sessions across all localities during 2012/13 to raise awareness of the local issues of antimicrobial resistance and clostridium difficile management.

The national primary care quality prescribing indicators included an indicator to measure total antibiotic use for the first time. These require NHS Boards to either achieve a target level or to show a specified shift towards the target. 76.8% of Lothian's practices met the target or demonstrated the requisite shift (January to March 2014 data; 58.4% met the target, 18.4% achieved the shift towards the target). In Scotland overall, 57.5% of practices achieved the target or demonstrated the specified shift towards target.

Improvements to antimicrobial stewardship will continue with reviews and audits, in combination with signposting to appropriate educational resources.

4.2.3 Unlicensed Pharmaceutical Medicines (Specials)

The Primary Care Pharmacy Team has continued analysing the prescribing data available from Information Services Division (ISD), to interrogate the use of unlicensed medicines within primary care. The NHS Lothian guidance for community pharmacists for the procurement of unlicensed medicines, first circulated in February 2013, has been updated twice since then to reflect price changes and status of a number of products. The Primary Care Pharmacy Team will continue to support the work required to implement the procurement authorisation process which has resulted from the government directive.

A payment reclaim process was implemented in July 2014. NHS Lothian is liaising with colleagues at Practitioner Services Division (PSD) and has processes in place to match submitted invoice claims against the pre-authorisations database. Pharmacy contractors risk non-payment for all non Part 7S claims, unless they had been authorised on the database or were within the expected claim value as specified on the NHS Lothian unlicensed product guide. NHS Lothian may seek to reclaim monies which have been paid otherwise than in accordance with the terms of the Scottish Drug Tariff.

Work remains ongoing to review the clinical appropriateness of unlicensed medicines within primary care. GP Practices will again be offered this as an agreed action as part of the GMS contract for 2014/15 under MM001(s).

Specific work streams will be taken forward by the team concentrating on dermatology products and omeprazole suspension reviews.

NHS Lothian currently prescribes 44% of drug tariff omeprazole suspension products dispensed throughout Scotland. This costs NHS Lothian on average £40,000 a month.

The primary care team will continue to undertake individual practice-based omeprazole reviews, as well as supporting a prescribing programme for GPs to switch patients to alternative licensed products where the GP considers this clinically appropriate.

4.2.4 Scriptswitch® Pilot (Edinburgh CHP only)

ScriptSwitch® is a prescribing support tool. Funding has been allocated to support a comprehensive 12 month pilot of the use of ScriptSwitch® software in Edinburgh CHP. See section 6.2.2 for further details.

4.2.5 Integrated Care Pharmacists

Work is undertaken by Integrated Care Pharmacists across all the CH(C)Ps within NHS Lothian. See sections 6.1 West Lothian Community Health and Care Partnership, 6.2 Edinburgh Community Health Partnership and 6.3 East and Midlothian Health & Social Care Partnerships for further detail.

4.2.6 Smoking Cessation

Work continues to support the rational use of therapy to aid smoking cessation in Lothian. This has recently included involvement in revising Lothian Joint Formulary section 4.10.2 Nicotine Dependence, and developing standard operating procedures for use by the Stop Smoking Service.

Reports are produced periodically for the co-ordinator of the service to monitor prescribing patterns.

4.3 High Risk

4.3.1 Non-Clinical Medication Review (NCMR) Training

In 2012/13, the Primary Care Pharmacy team ran a structured programme of two half-day training courses for InPS Vision GP practices, in conjunction with GMS Facilitators on the eHealth team.

NCMR training was continued in 2013/14 through a programme of practice-based one-to-one training sessions. The Primary Care Pharmacy Team continued to undertake follow-up visits to practices once initial training had been completed to support the implementation of appropriate non-clinical medication review processes.

A training pack to support NCMR for the EMIS clinical system has been produced and offered to interested practices throughout 2014/15. To date, nine practices have undertaken the EMIS training.

The structured NCMR training programme will be re-introduced in 2014/15, with one-to-one training being offered to practices where staff cannot be released for training courses.

The aim of this work is to ensure that Repeat Prescribing records are as accurate as possible, maximise the efficiency of the level 2 and 3 medication reviews carried out by clinicians, help improve the repeat prescribing systems within practices, and support the continuing focus on the efficient use of medicines and reduce waste. By documenting non-clinical medication review interventions on the practice systems, data can be gathered centrally by the PCP Team, with an aim of producing a report summarising both the quantitative and qualitative outcomes from this large volume of work.

4.3.2 eLJF-CLINICAL Technician

This resource supports the development and maintenance of the newly authored eLJF-CLINICAL and will provide education and training to practices that migrated from GPASS to InPS VISION and EMIS in 2011/12. The evaluation of this post is ongoing.

4.3.3 Prescribing Support Pharmacy Technicians

Prescribing Support Pharmacy Technicians (PSPTs) contribute to the provision of NHS Lothian medicines management initiatives, working in partnership with other health and social care professionals, e.g. staff within general practices and care homes to deliver safe, effective, person-centred pharmaceutical care and reduce avoidable waste.

Key result areas from the PSPT job description include:

- Prescribing support, including the development and analysis of PRISMS reports and implementation of Lothian Joint Formulary
- Review of repeat prescribing systems
- Clinical governance, including development of prescribing audits, standard operating procedures and protocols
- Medicines management information, such as Lothian Joint Formulary adherence feedback and support
- Education and training, for example Non-clinical Medication Review.

By building additional technician capacity, the existing Primary Care Pharmacy Teams across all CH(C)Ps will be augmented to ensure a responsive resource that can be targeted at priority areas within prescribing. This will optimise in-year delivery of LRP while ensuring flexibility to adapt to the changing environment that is primary care prescribing.

By increasing the Band 5 Prescribing Support Pharmacy Technician resource, the existing Band 7 Prescribing Support Pharmacists, as specialist clinical pharmacists, will be released to perform an increasing number of complex clinical patient reviews. Both pharmacist and technician roles will thus be working to the top of their skill set and professional competencies. Previous experiences within the team of joint working between pharmacists and technicians, e.g. care home reviews, has evidenced additional synergy. By optimising the outputs of the team from these complementary but distinctly different roles, the following benefits are anticipated:

- Improved clinical outcomes
- Improved patient safety
- Reduced avoidable medicines waste
- Containment of expenditure growth through improved repeat prescribing processes
- Improved quality of repeat medication review (both clinical and non-clinical) in general practice
- Increased engagement between practices, community pharmacies and the Primary Care Pharmacy Team
- Increased engagement with a range of other stakeholders, e.g. social care colleagues and private sector care homes
- More robust capture of prescribing intervention outcomes including LRP.

Additional scoping will be undertaken to investigate the opportunities for integrated working across the primary/secondary interface, e.g. domiciliary medication concordance reconciliation visits to patients post-discharge from hospital.

4.3.4 Progesterone only contraceptives

The Lothian Joint Formulary (LJF) has been updated to include prescribing the progestogen-only contraceptives (POCs) by generic name in line with the Area Drug and Therapeutics (ADTC) policy on branded generics.
See section 5.7 Generic Prescribing for full details.

The Primary Care Pharmacy Team will implement support materials to facilitate a change in prescribing behaviour and promote formulary compliance. The Lothian Joint Formulary has been amended to include generic drug names and eLJF-CLINICAL updated accordingly. In addition, the Scriptswitch® pilot in Edinburgh CHP will further support this change.

The project is high risk as in-year delivery is difficult to attain. These medicines are often prescribed in high volume, e.g. up to 12 months supply at any time, so any patient switch may not result in a change in supply until 12 months later. The POCs often sit within a patient's acute record rather than repeats, so identifying patients to switch is particularly difficult.

4.3.5 Emollients

The use of Lothian Joint Formulary (LJF) recommended drugs and cost-effective prescribing of emollient products is promoted through a range of initiatives in primary care. Practitioners are encouraged to use LJF 1st choice products wherever possible, as clinically indicated.

The General Practice Intervention Projects run across all localities includes targeted interventions to consider switching patients from non–preferred emollient preparations to more cost-effective LJF products.

A protocol for review of emollient products for use by the Prescribing Support Pharmacy Team in GP practices supports these recommendations.

The emollients detailed in the Minor Ailment Scheme Formulary, accessed by Community Pharmacy reflect LJF formulary choice emollients.

4.3.6 Diabetic needles

In association with representatives from the NHS Lothian Diabetes Managed Clinical Network, the use of more cost-effective needles for the administration of insulin in the community setting will be supported at individual patient review.

4.3.7 “Other” LRP initiatives

An additional £100k has been allocated to “other” LRP initiatives through locally co-ordinated Prescribing Development Schemes. An example of the bespoke work undertaken through this scheme includes a Brown Bag Review, which encourages patients to attend for a holistic medication review. The aim is to identify and discuss concordance and pharmaceutical care issues to improve patient safety and reduce avoidable waste.

5. OTHER NHS LOTHIAN QUALITY AND COST-EFFECTIVE PRESCRIBING INITIATIVES

5.1 NHS Lothian Prescribing Indicators (PIs) 2014/15

The NHS Lothian Prescribing Indicators (PIs) for 2014/15 have been agreed by the General Practice Prescribing Committee (GPPC). Full details of each of the PIs are included in the "General Practice Prescribing Committee Annual Report for Prescribing Budget Setting Recommendations in 2014/15" and a summary is available in Appendix 2.

The main points to note are:

- Eight of the PIs remain unchanged (total antibiotics, fluoroquinolones, cephalosporins, effervescent paracetamol formulations, esomeprazole, rosuvastatin, Fostair® and ezetimibe)
- No new PIs have been added
- Modification of the amlodipine, and co amoxiclav targets
- The introduction of an optional 5% reduction target against practice baseline at Q3 2013/14 (Dec 13) for Proton Pump Inhibitors
- The measure for generic prescribing has been updated, oral contraceptives excluded and the target set at the Audit Scotland recommended optimum of 80%.

All GP practices are encouraged to maximise PI attainment. Practices receive detailed feedback on PI performance throughout the financial year as the quarterly reports become available from NHS Lothian Medicines Management Team. This remains a high priority area as PI attainment is widely acknowledged as a key marker for an individual practice's cost-effective, quality prescribing. Previously the Prescribing Budget Setting Group (PBSG) has found that high PI attainment is associated with lower prescribing spend.

Focus on PIs will be supported by discussion at GP representatives meetings, information circulated from the Medicines Management Team and the Lothian Prescribing Bulletin, which is distributed to all prescribers in primary care within NHS Lothian. As previously mentioned, the NHS Lothian PIs mirror a significant number of measures within the National Therapeutic Indicators 2014/15 - http://www.ljf.scot.nhs.uk/PrescribingBulletins/Prescribing%20Bulletins/National%20Therapeutic%20Indicators%202014-15.pdf

5.2 Lothian Joint Formulary Adherence

The updated Lothian Joint Formulary (LJF) adherence measures introduced in 2013 were reported during 2013/14. The three new measures are designed to support current areas of interest across primary and secondary care (see Appendix 3 for updated measures). The new measures were developed in discussion with the Medicines Utilisation Review Group (MURG) who will also be monitoring these. Practices where adherence is below the Lothian average will be encouraged to review their prescribing in that specific therapeutic area.

InPS Vision is the IT prescribing system of choice in NHS Lothian. InPS Vision practices are encouraged to prescribe using eLJF-CLINICAL where possible. It is recognised that individual practices may require additional support to ensure optimum use of eLJF-CLINICAL as it evolves. Every opportunity will be taken to promote the LJF, including the updated website www.ljf.scot.nhs.uk as it contains a plethora of prescribing resources. Practice Managers will be instrumental in taking this workstream forward and will be informed of all training for both clinical and non-clinical staff as dates become available.

5.3 Support to Non-medical Prescribers

Nurses and Allied Healthcare Professionals

NHS Lothian currently has 348 community nurse prescribers and 155 independent or supplementary prescribers in Primary Care. The governance surrounding nurse and allied health professional prescribing has been improved by ensuring the use of one unique cipher code per prescriber. This has reduced the room for error where prescribing is apportioned to the wrong budget code.

Monitoring of prescribing using Prisms is recommended for all v100, v150 and v300 prescribers and the PCPs have been key is providing this data. The annual Non-medical and Allied Healthcare Professional (NMAHP) conference is another opportunity to promote the Lothian Joint Formulary as best practice and emphasise that all personal core formularies should be based on the LJF.

In January 2013, Health Improvement Scotland issued a report on the quantity and quality of published evidence looking at both cost and clinical effectiveness for silver dressings. As a result of this study and following discussion with a local nursing group which included the acute services, NHS Lothian took the decision that silver products could not be prescribed without consultation with tissue viability experts and they were removed from the formulary. To support this measure and optimise LJF adherence, an invest to save post for 0.5 wte band 6 nurse has been in place since January 2014. Working alongside the NMAHP prescribing lead and PCPs, there has been a targeted approach to the following: increasing awareness and providing education on local antimicrobial guidelines and the Lothian Joint Formulary and use of eLJF-CLINICAL. Antimicrobial adherence and stock order (GP10 A) reviews have also been undertaken. These workstrands are all aimed at supporting safe, cost-effective prescribing of wound management products.

An important aspect of this initiative has been to ensure that the nurses are supported and understand the aims and objectives of the wider prescribing agenda. To help achieve this, articles have been published in the Lothian Prescribing Bulletin and circulars relating to wound care have been distributed to all nurses in Lothian. Educational events have been held on a pan-Lothian level, at the annual NMAHP conference and practice nurse competency updates. This support has also been provided locally through protected learning time events, locality meetings and at individual practice level. Good practice has been highlighted, including the principles that underpin this, with a view to replicating good practice across Lothian.

Pharmacists

The provision of Scottish Government funding in 2014/15 allows NHS Lothian to continue to support 14 Community Pharmacist Independent /Supplementary Prescribers in the running of 19 clinics. These clinics span a range of clinical specialities including Chronic Obstructive Pulmonary Disease, asthma, diabetes (including cardiovascular risk), hypertension and warfarin. Prescribing is on a GP10P form.

5.4 Analysis of high value reports

Monthly reports are prepared by the Primary Care Pharmacy Team data analyst to identify individual prescription items with a value in excess of £500. Work is ongoing in partnership between the Primary Care Pharmacy Team and Medicines Management Team to formalise a process for routine review and action where prescribing issues are identified in this area. Examples of potential issues may include reallocation of funds where payment errors have been identified between community pharmacy endorsement and prescription quantities, GP prescribing of drugs classified as “Specialist Use Only” by LJF and identification of expensive special formulations of drugs which may be appropriate for contingency fund application. The details of these reports will be shared with the relevant practices to ensure that any potential errors in endorsing and subsequent cost implications are dealt with.

5.5 Scottish Drug Tariff Issues

Practices will be encouraged to undertake specific reviews to maximise savings that emerge due to changes in the drug tariff. Practices have historically been made aware of significant price differences as drug patents expire. This may also include a review of premium priced formulations of specific drugs, including analgesics. To this end, any clinically appropriate but financially beneficial changes from branded to generic products have been included as an option within GPIP 2014/15.

In late 2013/14 and continuing into 2014/15, there are a considerable number of supply and manufacturing problems, which have led to medicines shortages and temporarily increased prices for some commonly prescribed items. This is largely outwith the control of the CHPs, but can have a significant effect on the budget position. This will require vigilance during the current financial year.

5.6 Wound management

Targeted work is continuing with nursing colleagues, including the Clinical Nurse Managers, Community Nurse Team Leaders and the Tissue Viability Nurses. The Prescribing Support Nurse for wound management has been a key member of the Primary Care Pharmacy Team in supporting prescribing initiatives.

A number of reports highlighting particular areas of prescribing have been developed, thus improving prescribing feedback (see section 5.3). These reports are available to all nurse prescribers on request.

Various articles pertinent to wound management have been published in the Lothian Prescribing Bulletin, most recently an article on adhesive tapes in May 2014. A number of initiatives are in development to improve the quality and cost-effectiveness of prescribing of wound management products, including targeted work on stock order (GP10A) ordering, prescribing of foam dressing products and antimicrobial adherence reviews. The pilot work started previously, including the use of the care home dressing request form will continue.

Silver dressings have been removed from the LJF. Strategies have been developed and educational sessions put in place to ensure appropriate use of antimicrobial dressings and increase awareness of local antimicrobial guidelines and eLJF-CLINICAL.

Work will continue with NHS Lothian Procurement to establish an ordering system that will allow nurses to order first dressings through Professional Electronic Commerce On-line System (PECOS).

The work strands detailed will be reviewed throughout 2014/15.

5.7 Generic prescribing

As previously mentioned, the Audit Scotland report *Prescribing in general practice in Scotland*, states that an estimated annual saving of £2 million could be achieved by increasing the use of a further 10 generic drugs across Scotland. GP practices in Lothian have a high generic prescribing rate, with 122 out of 124 eligible practices attaining the PI target of ≥ 80% Attainment ranges from 78% to 90%.

A previous efficiency and productivity workstream promoted prescribing of Cerelle® as the cost-effective brand recommended in LJF section 7.3.2 Progestogen–only contraceptives. The LJF has been updated to include prescribing the progestogen-only contraceptives by generic name in line with the ADTC policy on branded generics. ADTC Branded Generic Policy Statement April 14 . Some generic medicines have been given a brand name by the manufacturer for marketing reasons; these products are referred to as 'branded generics.' ADTC do not endorse the prescribing of branded generics as they may be associated with related financial and clinical risks due to potential product switching and there may be reduced prescriber and patient confidence with subsequent detrimental clinical outcomes. The exception to this is combined oral contraceptives, which are recommended to be prescribed by brand name. Progesterone-only contraceptives will now be recommended for prescribing by generic name with the price set within the Scottish Drug Tariff.

To ensure savings from generics are maximised, practices receive analysis of their generic savings report at least annually during their GMS prescribing visit. This supports the identification of proprietary products that are being prescribed that can be changed to a more cost-effective generic product where clinically appropriate. Due to the fluidity of the Scottish Drug Tariff and the patent expiry of a number of branded products, practices are reminded to review patients regularly and make changes accordingly. Although it is never anticipated to be 100%, appropriate generic prescribing allows the use of lower-cost medicines with no detriment to patient care. Prescribing by brand should be reserved for those items with a narrow therapeutic index where the use of generic products could compromise clinical effectiveness.

6. COMMUNITY HEALTH (AND CARE) PARTNERSHIP-SPECIFIC PRESCRIBING INITIATIVES

6.1 West Lothian Community Health and Care Partnership

West Lothian Community Health and Care Partnership (CHCP) benefits from a multi-professional locality Medicines Management Team, with membership consisting of the Clinical Director, Clinical Lead GP and prescribing support GPs, along with representatives of the Primary Care Pharmacy team, community pharmacy, nursing management and NHS Lothian PCCO Finance Department. The team meets approximately bi-monthly to discuss all matters relating to medicines management, including individual practices' performance against allocated prescribing budgets and associated measures such as PI attainment and LJF adherence. The minutes of the Medicines Management Team are shared with the local Primary Care and Community Forum (GP reps meeting) and the West Lothian CHCP Interface Group where primary/secondary care issues are progressed. Through West Lothian CHCP Medicines Management Team, agreement has been sought to progress a number of additional workstreams in line with local priorities and pressures.

6.1.1 Mainstreaming the positive outcomes of the General Practice Medicines Management Project 2013/14

West Lothian CHCP committed funding to support an innovative medicines management project in 2013/14. 20 of the 24 GP practices in West Lothian participated. In order to share learning and disseminate the positive outcomes of this project, targeted interventions are being offered to relevant practices on an individual basis. Examples include further support and training for practice admin staff new to non-clinical medication review and intensive review of the data within the Scottish Therapeutics Utility.

For the four practices that did not participate in the project, there is the extended offer of prescribing support resource to develop registers of patients in receipt of multi-compartment compliance aids, with a requirement that prescriptions are reviewed and standardised to a 28 day prescribing interval. Evidence from the initial project suggests that this is the optimal prescribing interval to reduce avoidable waste and provide a regular and consistent medicines reconciliation point for Community Pharmacy colleagues.

In recognition of the importance of sharing relevant quality and efficiency workstreams with the broader Primary Care Pharmacy team, a range of protocols and GMS MM001/2 packs have been developed to include priority patient groups, such as care home residents and those registered for the Chronic Medication Service. In addition, a range of resources have been shared with the team, for example, a revised Repeat Prescribing Process Review.

Central to the 2013/14 project was the adoption of a Balanced Scorecard (BSC) approach as a performance measurement tool for both the participating GP practice teams and the WL CHCP Primary Care Pharmacy team. Evaluation of the design and implementation of the BSC was undertaken as an academic research project for a Masters in Business Administration. Resulting recommendations will be made to senior managers on completion of the study.

6.1.2 Wound management

The Primary Care Pharmacy Team are working with nursing colleagues on several work-strands to promote adherence to Lothian Joint Formulary (LJF) advice for wound products and support cost efficient use of products.

A number of GP practices have chosen to implement use of the Care Home Dressing Prescription Request Form for wound products as a contractual prescribing action under MM001/MM002.The request form details LJF first choice wound products (excluding antimicrobials). Care Homes are required to use the form when requesting wound products. The pharmacy team have requested that practices keep copies of requests from care homes for non-formulary wound products, which the team will review.

A suite of prescribing reports have been produced and shared with the local nursing management team, to be cascaded to individual prescribers. These reports detail all wound products prescribed on an individual prescriber basis and those issued through stock order requests (by GP practice).

Work has been ongoing on a pan-Lothian basis to develop bespoke prescribing reports for foam products, detailing foams prescribed and adherence to LJF guidance. These are available for individual nurse prescribers, CH(C)Ps and NHS Lothian.

In West Lothian the foam reports are being produced for a cohort of nurse prescribers as a pilot in the first instance.

The NHS Lothian Prescribing Support Technician for eLJF-CLINICAL has supported the use of this prescribing tool with nursing colleagues in the locality.

6.1.3 Omacor Review

In July 2014 The Lothian Joint Formulary Committee agreed to reclassify Omacor® to **not included** on the LJF as an additional treatment for secondary prevention of myocardial infarction (MI), as the medicine does not represent sufficient added benefit to other comparator medicines to treat the condition in question. This decision is in line with the National Institute for Health and Care Excellence (NICE) updated **Clinical Guideline (CG) 172 MI-secondary prevention: secondary prevention in primary care and secondary care for patients following a myocardial infarction** (November 2013) Myocardial infarction – secondary prevention: full guideline (a partial update of NICE CG 48) recommending "**not** to offer or advise people to use omega-3 fatty acid capsules or omega -3 fatty acid supplemented foods to prevent another MI".

Cardiologists across Lothian fully supported the review of patients in primary care currently prescribed Omacor® as an additional treatment for secondary prevention of myocardial infarction with the view to stopping treatment with immediate effect and no new patients are to be initiated on Omacor® by secondary care cardiology teams.

The Clinical Director of West Lothian CHCP has written to all GP practices in West Lothian to request that they identify all relevant patients and discontinue this product in line with the updated guidance.

Implementation of this recommendation has the potential to release significant prescribing budget efficiencies and will continue to promote quality, cost-effective and evidence-based prescribing.

6.1.4 Integrated Care Pharmacist for Long Term Conditions

In West Lothian the Integrated Care Pharmacist is involved with the REACT, Hospital at Home service, reviewing patients referred. Referrals into the service are accepted from a variety of sources, including health and social care Allied Healthcare Professionals (AHP's), Templar Day Hospital, Emergency Department and Observation ward staff, secondary care pharmacists working within St John's Hospital, staff working with the community falls team, community AHPs and support staff within WLCHCP.

Work is also being undertaken with West Lothian GP practices to review patients in housing with care to assess how they manage their medication. Clinical pharmacy reviews and assessment of high risk patients is being carried out with a range of GP practices.

In addition, work is being undertaken in partnership with the polypharmacy pharmacist to offer patients and carers clinic appointments and/or domiciliary visits with a pharmacist to discuss their medication. This service is agreed as a revised model of the standard polypharmacy SLA and comparative evaluation is ongoing.

6.2 Edinburgh Community Health Partnership

Edinburgh Community Health Partnership (CHP) is the largest CHP in Scotland and is a part of the Edinburgh Health and Social Care Partnership. The CHP is divided into five groupings based on the previous Local Health Care Co-operative (LHCC) structure; North West, North East, South West, South East and South Central. Budgetary accountability for prescribing, under the remit of the Assistant General Manager, is supported by GP Prescribing Lead, the Primary Care and Community Pharmacy Co-ordinator, Primary Care Pharmacists, Primary Care Pharmacy Team and NHS Lothian Finance team.

6.2.1 GP Prescribing Development Scheme

The Edinburgh CHP discretionary Prescribing Management Payment fund for 2014/15 is set at £190k. A proportion of this will be used to pay for practice involvement in GPIP 2014, NHS Lothian Prescribing Indicator achievement and the prescribing development scheme.

CHP engagement with GP practices is seen as paramount to maintaining quality, cost-effective prescribing across Edinburgh CHP. It is therefore proposed that a proportion of the Edinburgh CHP Prescribing Management Payment fund is offered to GP practices in order to support innovative prescribing projects through a local Prescribing Development Scheme. Practices will be invited to submit proposals to an Edinburgh CHP prescribing group for approval and funding will then be provided to support the selected projects. Proposals that examine health inequalities, waste reduction, reducing risk of avoidable admission and effective use of resources were particularly welcomed for 14/15. Although final reports are awaited, examples of such work include:

- Pilot of iCOPD tool for review of COPD patients in GP practice
- Review of prescribing for depression
- Heart failure due to LVSD Management beyond QOF
- Review of benzodiazepine prescribing
- Review of gabapentinoid prescribing.

Practices allocated funding will be expected to submit a written report on project completion.

6.2.2 ScriptSwitch® Pilot

ScriptSwitch® is a prescribing support tool. Funding has been allocated to support a comprehensive 12 month pilot of the use of ScriptSwitch® software in Edinburgh CHP. This software is in use in a number of other NHS Boards in Scotland and the pilot aims to establish whether the reported net savings are achievable in the lowest cost per patient mainland NHS Board.

The practices selected to participate reflect the different geographic, demographic and socio-economic profiles within the CHP. In association with finance colleagues, clear outcomes, both quantitative and qualitative, will be reported.

6.2.3 Integrated Care Pharmacist

The Integrated Care Pharmacist (Change fund) works in partnership with the City of Edinburgh Council to conduct medication reviews and act as a point of contact for advice and referral for all those patients who currently receive a package of care.

The pharmacist is a key member of COMPASS, which is now operating in the NW and SE of the city, with roll-out city-wide in the future.

The pharmacist reviews all patients presented at COMPASS and referrals into the service are also accepted from IMPACT nurses, Homecare and Reablement, Intermediate care services, ECAT, TEAM 65, Social Work and GP's.

Recent work has seen the review of care home patients with the Pharmacist, GP and consultant geriatrician.

6.3 East and Midlothian Health and Social Care Partnerships

East Lothian and Midlothian Health and Social Care are two separate entities previously supported by one management structure (East and Midlothian Community Health Partnerships) but, with the advent of Health and Social Care Partnerships (H+SCPs), they have moved towards two separate management structures. They will become entirely separate on 1/4/15 when the new H+SCPs come into being. Budgetary accountability for prescribing is under the remit of the two Heads of Health and is supported by the Joint Directors, Clinical Directors, Primary Care Pharmacist, Prescribing Support Pharmacy Team and NHS Lothian Finance Team. The Midlothian Clinical director currently has a lead role in prescribing management across the two areas.

6.3.1 Midlothian and East Lothian Prescribing Intervention Project (MEPIP)

As previously mentioned under section 2.4.1, discretionary funding has been agreed to support a prescribing intervention project. As in previous years, reimbursement of administrative costs will be available to participating practices. Payment is made to practices based on the clinical input required.

6.3.2 Training session on eLJF-CLINICAL

A training session will be delivered to all VISION practices across East and Midlothian. The focus of the session will be to highlight the functionally of eJF-CLINICAL to ensure all prescribers are familiar with the eLJF. By increasing the use of eLJF-CLINICAL, adherence to the formulary should improve.

6.3.3 Educational Session for Trainee General Practitioners

A training session will be held for all doctors new to Primary Care. The session will contain information on national, NHS Lothian and local CHP initiatives to manage prescribing. The session provides information on Prescribing Indicators, Lothian Joint Formulary and other measures that are in place to help ensure that prescribing is of good quality and is cost-effective.

6.3.4 Newsletter

A local newsletter is produced to highlight to all prescribers within East and Midlothian prescribing issues pertaining to the two CHPs. The newsletter is produced 10 times per year and provides additional local information on prescribing for East and Midlothian clinicians. The newsletter is well received within all practices.

6.3.5 Integrated Care Pharmacist

In Midlothian, the Integrated Care Pharmacist works with the Rapid Response Team. This involves conducting medication reviews for both the intermediate care and assessment beds that are available to the team. Medication reviews are also carried out on patients who have fallen and the pharmacist liaises with the Falls Co-ordinator in Midlothian. Referrals are also taken from Social Work, carers, GPs and occupational therapists to do reviews in patients' own homes. When possible, some Polypharmacy reviews have been undertaken within Practices. Specific pieces of work are being undertaken looking at medication prompts, and the development of a medicines administration policy with Midlothian Council.

7. COMMUNITY PHARMACY INITIATIVES

Community Pharmacy

Community Pharmacy teams are contracted to deliver the four core elements of NHS Pharmaceutical Care Services; the Public Health Service, the Minor Ailment Service, the Acute Medication Service and the Chronic Medication Service. To support Community Pharmacy in adhering to local prescribing policies and guidelines, initiatives have included the development of bespoke sections of the Lothian Joint Formulary for minor ailments and smoking cessation and Patient Group Directions to support access to urgent repeat medicines including in "out of hours" situations. The NHS Lothian Community Pharmacy Champions have been central to this and they continue to work closely with the Primary Care Pharmacy team to optimise a whole system approach to pharmaceutical care.

In relation to this year's Prescribing Action Plan, a summary letter has been distributed to chemist contractors across all CH(C)Ps in Lothian to ensure that they are informed and engaged with prescribing initiatives including GPIP 2014/15. In addition, all Prescribing Support Pharmacy Team protocols contain a statement on the importance of effective communication with local Community Pharmacies about any practice-based reviews being undertaken. The aim is to provide seamless pharmaceutical care to patients and their carers.

7.1 Chronic Medication Service (CMS)

The Chronic Medication Service is part of the revised Community Pharmacy contract. It formalises the contribution of community pharmacists to the management of patients with long term conditions by improving the patients' understanding of their medicines.

It has two main elements:

1. **Pharmaceutical care**
   Eligible patients are invited to register for the service by the community pharmacist. Once a patient is registered, the community pharmacist creates a Pharmaceutical Care Record, carries out a patient assessment and records any associated pharmaceutical care actions which result.

   Patients with complex pharmaceutical care issues may benefit most from the establishment of a structured pharmaceutical care plan.

   Messages identifying registered patients and the pharmacy with whom they are registered flow into the GP clinical system

2. **Serial prescriptions**
   GPs are now able to generate serial prescriptions for registered patients they deem clinically stable and whose medicines are unlikely to change over the duration of the prescription. The serial prescription is currently for either 24 or 48 weeks duration and is dispensed by the community pharmacy at intervals defined by the prescriber.

   When a serial prescription is in place messages detailing the dates of medicine collection flow into the GP clinical system and at the end of the prescription an end of treatment summary is sent from the pharmacy to request a further prescription and impart any non-urgent information considered useful.

The Pharmaceutical Care Record (PCR) supports the documentation of identified care issues and includes support tools for New Medicines and High Risk Medicines, as well as sections covering gluten-free foods and stop smoking services. Additional tools may be added to the PCR in future to further support community pharmacists in delivering the Scottish Patient Safety Programme in Primary Care.

All practitioners involved in CMS have received training in the generation of serial prescriptions.

The CMS Steering Group provides operational and strategic support for the service. The Community Pharmacy Champions support pharmacy contractors to deliver the service across NHS Lothian.

7.2 Gluten-free food service

In November 2013 the Scottish Government announced the introduction of the Gluten-free food (GFF) Pharmaceutical Service as a one year pilot running from 1st April 2014 to 31st March 2015. Full details are available at: PCA (P) (2013) 29.

Both adult and paediatric patients with a confirmed diagnosis of either **Coeliac Disease** or **Dermatitis Herpetiformis** will benefit from this scheme. Patients eligible for the new service will be identified by their GP.

The GFF Service allows patients to self-manage their gluten-free prescriptions with the assistance of community pharmacy. Community pharmacies can only supply items approved by the Lothian Joint Formulary. Patients who require additional items that are not listed within formulary as a result of specific dietary requirements are not eligible for the service and prescribing will remain with the GP.

Patient registration for the service is required and this is achieved through completion of the Patient Registration Form by the GP. The patient's GP must agree the number of units the patient is entitled to each month based on age and sex and sign the form to allow the patient to register for this service.

Newly diagnosed patients will be reviewed by specialist dietetic services in line with the NHS Lothian care pathway for diagnosis and initial treatment of coeliac disease.

Full details of the service and the products which can be supplied are available at. http://www.nhslothian.scot.nhs.uk/Services/A-Z/GlutenFreeFoodService/Pages/default.aspx (available through NHS Lothian intranet only).

7.3 Minor Ailment Service Formulary Adherence

Minor Ailment Service Formulary for Community Pharmacy

Prescribing costs of the Minor Ailment Service (MAS) element of the community pharmacy contract will continue to be attributed to the primary care prescribing budget in 2014/15. Support and feedback via data analysis will be provided to this growing group of prescribers. Provision and analysis of this data aims to improve LJF Minor Ailment Formulary awareness and adherence. As in previous years, the Primary Care Pharmacy Team will work closely with the NHS Lothian Community Pharmacy Champion group to ensure a whole system approach is adopted.

Pilot work was undertaken by the Primary Care Pharmacy Team to produce a range of bespoke MAS formulary compliance reports for community pharmacy contractors in a number of therapeutic areas, including emollients, headlice treatments, coughs and colds, laxatives and antacids.

These reports were shared with the Pharmacy Champions group for comment in the first instance. The reports were positively received by the Champions group and considered useful.

Discussion as to how to streamline the production of these reports and the most appropriate method of sharing the reports with community pharmacy contractors is ongoing.

7.4 Respiratory Enhanced Service/Service Level Agreement

A Community Pharmacy-based Respiratory Enhanced Service has been established in 2014. The purpose of this workstream is to increase patients' awareness of the new "Living it Up" web-based service and COPD digital postcards by engaging community pharmacists in promoting this service.

See section 4.1.5 for further details

CORE REFERENCES

Websites

Community Pharmacy Scotland
http://www.communitypharmacyscotland.org.uk/

Information Services Division
http://www.isdscotland.org/

Lothian Joint Formulary
http://www.ljf.scot.nhs.uk/

Medicines and Healthcare Products Regulatory Agency (MHRA)
http://www.mhra.gov.uk/

NHS Scotland: Diabetes Prescribing Strategy 2014 to 2016
http://www.sehd.scot.nhs.uk/cmo/CMO(2014)14-Diabetes%20Prescribing%20Strategy%20June%202014.pdf

NHS Scotland: Putting Scotland's health on the web
http://www.show.scot.nhs.uk/

NHS Scotland: Respiratory Prescribing Strategy 2014 to 2016
http://www.sehd.scot.nhs.uk/cmo/CMO(2014)14-Respiratory%20Prescribing%20Strategy%20June%202014.pdf

Scottish Antimicrobial Prescribing Group
http://www.scottishmedicines.org.uk/SAPG/Scottish_Antimicrobial_Prescribing_Group__SAPG_

Scottish Drug Tariff
http://www.isdscotland.org/Health-Topics/Prescribing-and-Medicines/Scottish-Drug-Tariff/

Scottish Intercollegiate Guidelines Network
http://sign.ac.uk/

Scottish Medicines Consortium
http://www.scottishmedicines.org.uk/

Scottish Patient Safety Programme: Primary Care
http://www.healthcareimprovementscotland.org/our_work/patient_safety/spsp/patient_safety_in_primary_care.aspx

The Scottish Government: Health and Social Care
http://www.scotland.gov.uk/Topics/Health

The Scottish Government: Quality, Efficiency and Support Team (QuEST)
http://www.scotland.gov.uk/Topics/Health/Quality-Improvement-Performance/Supporting-Improvement

NHS Lothian Documents

General Practice Prescribing Committee Annual Report for Prescribing Budget Setting Recommendations in 2014/15 (February 2014)

Medicines Management Team Report on Prescribing Pressures in Primary Care - Looking Forward to 2014/15 (January 2014)

NHS Lothian draft strategic plan 2014- 2024 Our Health, Our Care, Our Future
http://intranet.lothian.scot.nhs.uk/nhslothian/corporate/a-z/ourhealthourcareourfuture

NHS Lothian Policy and procedures for the use of unlicensed medicines
http://intranet.lothian.scot.nhs.uk/NHSLothian/NHSLothian/BoardCommittees/AreaDrugTherapeutics/MedicinesGovernancePoliciesADTCPolicyStatements/Documents/NHS%20Lothian%20Policy%20and%20Procedures%20for%20the%20Use%20of%20Unlicensed%20Medicines%20June%202014.pdf

Other Resource Documents

Healthcare Associated Infection Task Force: The Scottish Management of Antimicrobial Resistance Action Plan (ScotMARAP 2) (2014-18), available at:
http://www.scottishmedicines.org.uk/SAPG/News/ScotMARAP2_final.pdf
[accessed 3 November 2014]

NHS Education for Scotland Scottish Reduction in Antimicrobial (ScRAP) Programme, available at:
Scottish Reduction in Antimicrobial Prescribing (ScRAP) Programme - Antibiotics - Infectious diseases - Resources by topic - Educational Resources - About NES Pharmacy - Pharmacy - By discipline - Education and training - NES
[accessed 3 November 2014]

Polypharmacy Guidance, NHS Scotland and the Scottish Government (October 2012), available at:
http://www.central.knowledge.scot.nhs.uk/upload/Polypharmacy%20full%20guidance%20v2.pdf
[accessed 3 November 2014]

Prescribing in general practice in Scotland, Audit Scotland (January 2013), available at:
http://www.audit-scotland.gov.uk/docs/health/2013/nr_130124_gp_prescribing.pdf [accessed 3 November 2014]

Prescription for Excellence: A Vision and Action Plan for the right pharmaceutical care through integrated partnerships and innovation (September 2013), available at:
http://www.scotland.gov.uk/Resource/0043/00434053.pdf [accessed 3 November 2014]

Royal Pharmaceutical Society: Guidance on Improved Patient Outcomes – the better use of multi-compartment compliance aids (July 2013), available at:
http://www.rpharms.com/support-pdfs/rps-mca-july-2013.pdf [accessed 3 November 2014]

Royal Pharmaceutical Society: Improving Pharmaceutical Care in Care Homes (March 2012), available at:
http://www.rpharms.com/promoting-pharmacy-pdfs/rpscarehomereportfinalmarch2012.pdf [accessed 3 November 2014]

The British Medical Association and the Scottish Government: Scottish Quality and Outcomes Framework 2013/2014: Guidance for NHS Boards and GP practices (May 2013)

Appendix 1: Terms of Reference for Community Health (and Care) Partnership Prescribing Forum

Purpose

The CH(C)P Prescribing Forum will allocate, monitor and agree actions to make optimal use of the primary care prescribing budget within the efficiency and productivity framework and the NHS Lothian financial plan.

The forum exists to facilitate a corporate approach to developing prescribing action plans, implementation of prescribing projects and monitoring, identification and management of financial risks within primary care prescribing.

Remit

- To consider, inform and input to the NHS Lothian Report on Prescribing Pressures in Primary Care. To identify, consider and target areas of prescribing pressure within Prescribing Action Plans.
- To consider, discuss and agree the recommendations of the Prescribing Budget Setting Group (PBSG) report.
- To discuss and agree the prescribing budget allocations by CH(C)P.
  (Agreement will be reached by Heads of Health / General Managers in closed session, and not by membership vote.)
- To consider corporate prescribing actions which support safe, effective and economic use of medicines.
- To develop detailed efficiency and productivity prescribing plans with associated financial targets, report on the progress of these initiatives, identify risks associated with prescribing plans and consider impact on CH(C)P and corporate LRP.
- To develop Prescribing Action Plans by CH(C)P.
- To discuss, develop and agree systems to influence prescribing decisions including agreement of, review and monitoring of prescribing incentive schemes.
- To create a forum for multidisciplinary team members including although not limited to nursing, dietetics, specialist nursing to contribute to, seek advice/engagement from and participation in prescribing efficiency and productivity work streams.
- To discuss, agree and apply methodology to the division of primary care prescribing LRP targets amongst individual CH(C)Ps

Operating and reporting arrangements

The group reports through Heads of Health / General Managers to the appropriate CH(C)P Performance Committees.

Minutes and Reports will also be sent to:

Medical Director (Executive Lead for Prescribing and Chair Prescribing Efficiency Group PEG)
Director of Pharmacy (Operational Lead for Prescribing)
General Practice Prescribing Committee (GPPC)
Clinical Directors CH(C)Ps
LUHD Prescribing Forum

Membership

Heads of Health / General Managers/Ass. General Managers of CH(C)Ps *(Chair)*
Representative(s) of Finance Business Partners – CH(C)Ps *(Vice Chair)*
Head of Finance – Primary Care Contracts Office
Prescribing Accountant Analyst – Primary Care Contracts Office
CH(C)P Prescribing Lead GPs
Associate Director of Pharmacy – Contracted Community Pharmacy Services and CHP Development
Primary Care and Community Pharmacy Co-ordinator
Clinical Nurse Manager
CH(C)P Primary Care Pharmacists
Lead Pharmacist – Medicines Management Team
GP Medicines Management Advisor

Members may be co-opted as required.
The chair will be a Head of Health /General Manager, with the Finance Business Partner (vice chair) taking the chair in the event of decision making processes pertaining to budget allocation.

Frequency of meetings

Meetings will be held monthly, usually the second Thursday of each calendar month to tie in with reporting schedules. Papers should be submitted by the preceding Thursday except finance papers which may not be available until day of meeting.

Quorum

Business shall not be transacted at a meeting of the forum unless at least 5 members are present and there is representation for each CH(C)P and at least one of each representing general management, finance, primary care pharmacy and a GP lead.

Agreed by the CHCP Prescribing Forum
October 2014

Appendix 2: NHS Lothian Prescribing Indicators 2014/15

1. GENERIC PRESCRIBING (REVISED MEASURE AND TARGET)
Generic prescribing rate (excluding oral contraceptives) ≥ 80% per quarter

Formulary Compliance	Quality	Cost-Effective
✓		✓

2. TOTAL ANTIBIOTICS
Items per 1000 patients per day ≤ 2 per annum

Formulary Compliance	Quality	Cost-Effective
	✓	✓

3. CO-AMOXICLAV (REVISED TARGET)
Items per 1000 patients per day ≤ 0.10 per annum

Formulary Compliance	Quality	Cost-Effective
✓	✓	

4. FLUOROQUINOLONES
Items per 1000 patients per day ≤ 0.08 per annum

Formulary Compliance	Quality	Cost-Effective
✓	✓	

5. CEPHALOSPORINS
Items per 1000 patients per day ≤ 0.10 per annum

Formulary Compliance	Quality	Cost-Effective
✓	✓	

6. EFFERVESCENT/SOLUBLE PARACETAMOL AND PARACETAMOL COMBINATIONS
Total number of items of paracetamol and paracetamol combinations prescribed as effervescent/soluble as a percentage of all paracetamol combination tablets and capsules ≤ 5% per quarter

Formulary Compliance	Quality	Cost-Effective
✓	✓	✓

7. ESOMEPRAZOLE
Total number of esomeprazole scripts ≤ 4% of esomeprazole and LJF recommended PPIs per quarter

Formulary Compliance	Quality	Cost-Effective
✓		✓

8. EZETIMIBE
Ezetimibe DDDs (including the combination ezetimibe & simvastatin) ≤ 3.25% as a percentage of all lipid lowering drugs per quarter

Formulary Compliance	Quality	Cost-Effective
✓		✓

Appendix 2: NHS Lothian Prescribing Indicators 2014/15 (continued)

9. PROTON PUMP INHIBITORS (PPIs) (ADDITIONAL TARGET)
PPIs DDDs per 1000 patients per day ≤ 105 per quarter **OR** 5% reduction target against practice baseline at Q3 2013/14

Formulary Compliance	Quality	Cost-Effective
✓	✓	✓

10. AMLODIPINE (REVISED TARGET)
Total number of items of amlodipine ≥ 70% of all prescriptions for dihydropyridine calcium channel blockers per quarter

Formulary Compliance	Quality	Cost-Effective
✓	✓	✓

11. FOSTAIR®
Total quantity of Fostair® inhalers ≥ 15% of total quantity of inhalers of Seretide MDI 125 and 250; Symbicort100/6 and 200/6 per quarter

Formulary Compliance	Quality	Cost-Effective
✓	✓	✓

12. ROSUVASTATIN
Rosuvastatin DDDs ≤ 5% as a percentage of all statins per quarter

Formulary Compliance	Quality	Cost-Effective
✓	✓	✓

Prescribing Budget Setting Group Annual Report for Prescribing Budget Setting in 2014 - 2015 and Lothian Prescribing Bulletin Supplement to issue 66, March 2014 LPB Issue 66,PIs, March 2014,

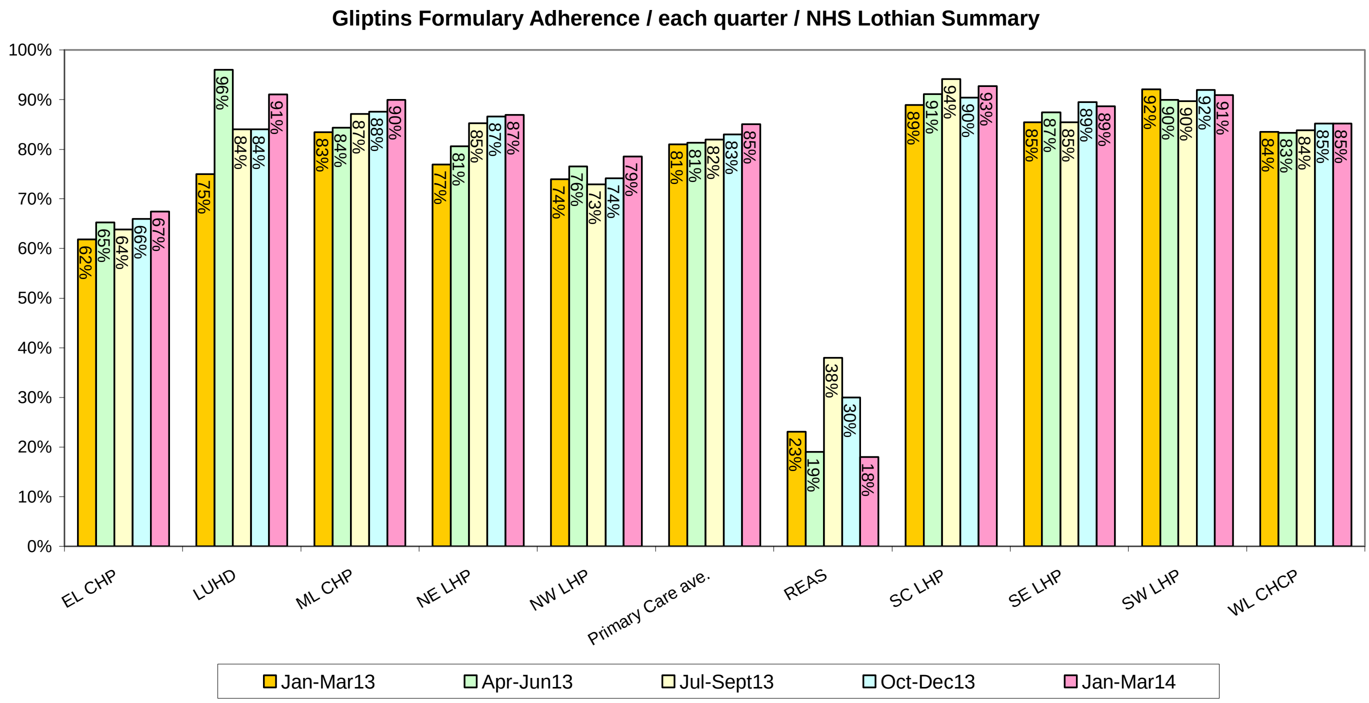
Appendix 3: Lothian Joint Formulary Adherence Measures

The Lothian Joint Formulary:

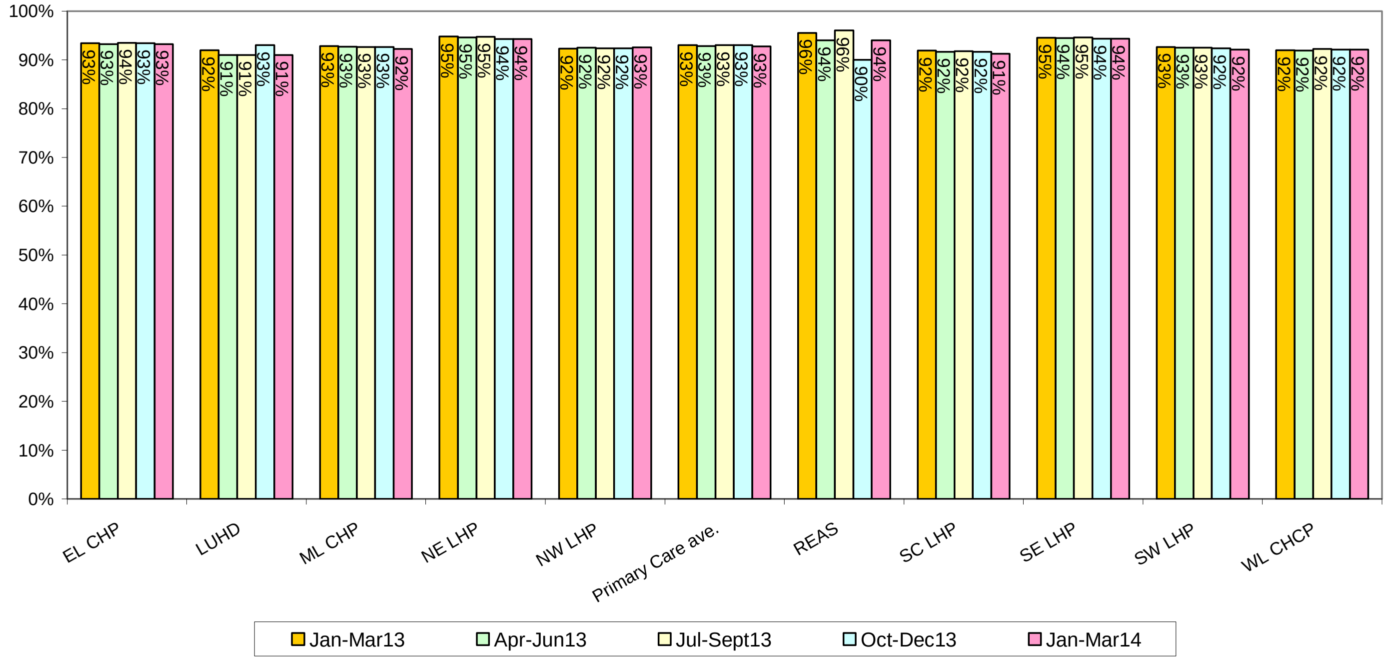
- Provides guidance on first and second choice drugs for a wide range of conditions
- Is a constantly evolving and dynamic document
- Contains prescribing notes with key messages on best practice
- Encourages seamless care
- Facilitates the integration of the latest evidence-based medicine into clinical practice.

Table 8: Lothian Joint Formulary Adherence Measures 2014/15

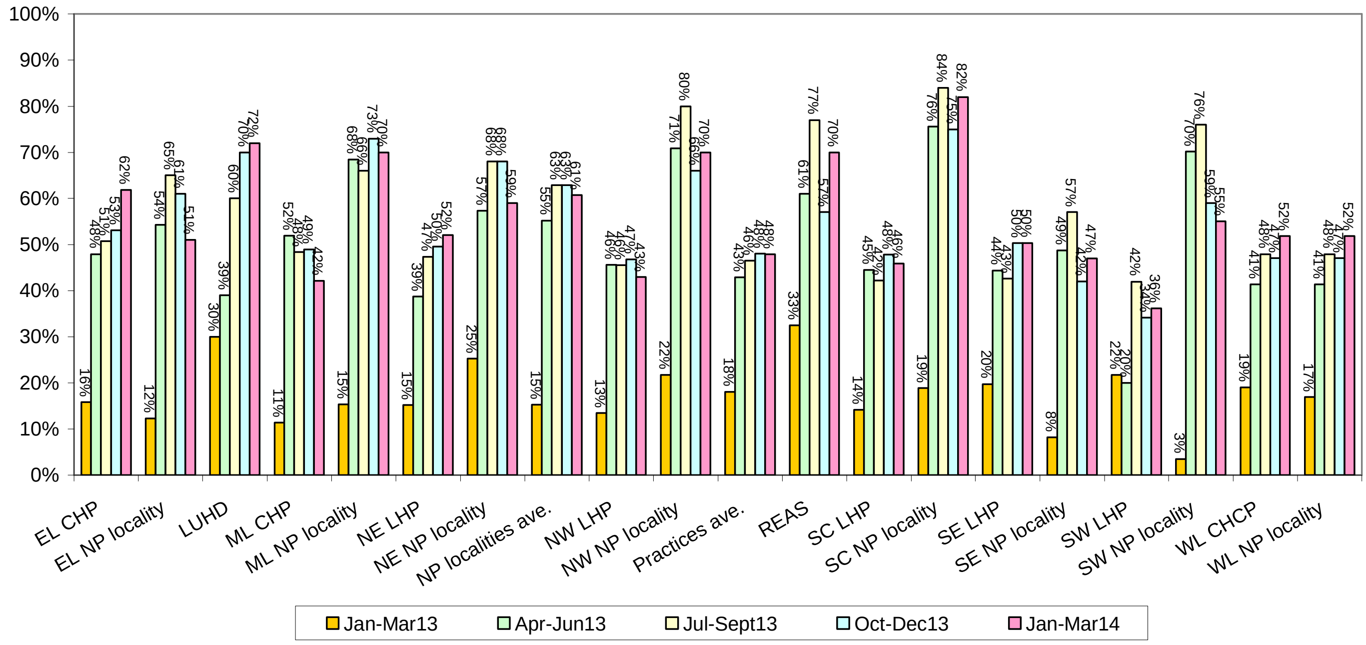
LJF Section/Group	**Measure of LJF adherence (%) = Formulary items as a percentage of all items in the relevant LJF section**
Gliptins	Sitagliptin as a percentage of all gliptins
Statins	Simvastatin and atorvastatin as a percentage of all statins
Dressings	LJF antimicrobial dressings as a percentage of all antimicrobial dressings



Statins Formulary Adherence / each quarter / NHS Lothian Summary



Antimicrobial Dressings Formulary Adherence / each quarter / NHS Lothian Summary (including each Locality Nurse Prescribing)



For further information and details, please refer to Lothian Joint Formulary at www.ljf.scot.nhs.uk.

Appendix 4: The National Therapeutic Indicators 2014/15

The National Therapeutic Indicators 2014-15 in order of BNF chapter are as follows:

1. **PROTON PUMP INHIBITORS:** DDDs per 1,000 patients per day *

NHS Lothian PI	Intervention Project	Prescribing Support	Other
✓			

2a. **HIGH STRENGTH CORTICOSTEROID INHALERS:** High Strength Corticosteroid Inhalers (including Fostair®) as a percentage of all corticosteroid inhalers (items)

NHS Lothian PI	Intervention Project	Prescribing Support	Other

2b. **HIGH STRENGTH CORTICOSTEROID INHALERS:** High Strength Corticosteroid Inhalers (excluding Fostair®) as a percentage of all corticosteroid inhalers (items)

NHS Lothian PI	Intervention Project	Prescribing Support	Other
			✓ MM001/2

3. **HYPNOTICS AND ANXIOLYTICS**: Hypnotics and anxiolytics DDD per 1,000 patients per day *

NHS Lothian PI	Intervention Project	Prescribing Support	Other
			✓ Polypharmacy

4a. **OPIOID ANALGESICS:** Strong opioids DDDs per 1,000 patients per day*

NHS Lothian PI	Intervention Project	Prescribing Support	Other
		✓	

4b. **OPIOID ANALGESICS:** Step 2 Opioids other than strong opioids DDDs per 1,000 patients per day*

NHS Lothian PI	Intervention Project	Prescribing Support	Other
	✓	✓	

5a. **TOTAL ANTIBIOTIC:** Total antibiotic script items per 1,000 patients per day

NHS Lothian PI	Intervention Project	Prescribing Support	Other
✓		✓	✓ MM001/2

5b. **4C ANTIBIOTICS**: 4C antibiotics script items per 1,000 patients per 100 days

NHS Lothian PI	Intervention Project	Prescribing Support	Other
✓		✓	✓ MM001/2

7. **ANTIDIABETIC DRUGS:** metformin as a percentage of all anti-diabetic drugs (DDDs)

NHS Lothian PI	Intervention Project	Prescribing Support	Other
			✓ MCN

7a. **NSAIDs INCLUDING COX-2 INHIBITORS:** DDDs per 1,000 patients per day*

NHS Lothian PI	Intervention Project	Prescribing Support	Other
			✓ Polypharmacy

7b. **NSAIDs INCLUDING COX-2 INHIBITORS:** Ibuprofen and naproxen as a percentage of all NSAIDs (DDDs)

NHS Lothian PI	Intervention Project	Prescribing Support	Other
			✓ Polypharmacy

8. **ANTIMICROBIAL WOUND PRODUCTS**: Antimicrobial wound products as percentage of total wound products (items)

NHS Lothian PI	Intervention Project	Prescribing Support	Other
		✓	✓ Invest to Save/LJF Adherence Measures/ MM001/2

** These measures will also be made available using the population figures that have been weighted to account for prescribing need and are available within the PRISMS database.*

LPB Issue 67, May 2014

Appendix 5: Prescribing Support Pharmacy Team Protocols and GMS MM001(S) Packs

Approved Protocols

BNF Chapter 1 – Gastro-intestinal system
Esomeprazole Review

BNF Chapter 2 – Carviovascular system
Clopidogrel for secondary prevention in ischaemic stroke
Review of Concomitant Clopidogrel and Omeprazole or Esomeprazole
Review of Ezetimibe Prescribing
Review of Nifedipine to Amlodipine
Rosuvastatin – Review to support NHS Lothian Prescribing Indicators
Simvastatin Oral Suspension Review

BNF Chapter 3 – Respiratory system
Review of steroid nasal sprays to support LJF Adherence

BNF Chapter 4 – Central nervous system
A Review of Buprenorphine Patches
A Review of Fentanyl Patches
A Review of Lidocaine 5%Medicated Plaster
Review of paracetamol-containing analgesic formulation
Pregabalin Dose Optimisation and Adjustment Review
Tramadol Dose Optimisation and Adjustment Review

BNF Chapter 7 – Obstetrics, gynaecology, and urinary tract disorders
Anticholinergics Review

BNF Chapter 13 – Skin
LJF Adherence Review of Emollient Products

Other
Brand to Generic Review
General Practice Intervention Project Cost-effective Reviews
Non-clinical Review of Ordering Process in Care Home
Unlicensed Meds Review

Appendix 5: Prescribing Support Pharmacy Team Protocols and GMS MM001(S) Packs (continued)

In addition, the following are available as GMS MM001(s) packs.

Approved packs

BNF Chapter 3 – Respiratory system
Adrenaline Auto Injector Review
Asthma Bluebay
Easihaler

BNF Chapter 4 – Central nervous system
Review of Buprenorphine Patches
Review of Fentanyl Patches
Review of Lidocaine Patches

BNF Chapter 5 – Infections
Antibiotic Review

BNF Chapter 6 – Endocrine System
Diabetes – Diabetes Bundle Care Review

BNF Chapter 9 – Nutrition and Blood
Calcium and Vit D Supplementation
Oral Nutritional Supplements – Complan Shake® Review

BNF Chapter 10 – Musculoskeletal & Joint Diseases
DMARD Care Bundle
Gout

BNF Chapter 13 – Skin
Dovobet Review
LJF Emollient Review

Other
Repeat Prescribing Process Review
Scottish Therapeutics Utility (STU)
Specials

Appendix 6: Primary Care Pharmacy Team Work Remit

The remit of the Primary Care Pharmacy Team (including the pan-Lothian Prescribing Support Pharmacy Team) is extensive. Much of the work undertaken is designed to maximise prescribing cost-efficiency while supporting safe, quality, effective and evidence-based use of medicines. This involves supporting the implementation of and adherence to the Lothian Joint Formulary. Liaison with secondary care colleagues is required to discuss and resolve interface issues.

Primary Care Pharmacists (PCPs) are the health board Prescribing Advisors with contractual obligations under the GMS QOF Medicines Management Domain outlined in table 8 below.

Table 9

QOF Medicines Management Domain Indicator	QOF Points
MM001(S) The practice meets with the NHS Board prescribing adviser at least annually and agrees three actions related to prescribing.	**4**
MM002(S) The practice meets with the NHS Board prescribing adviser, has agreed 3 actions related to prescribing and subsequently provided evidence of change. The practice should also undertake an audit of an area of prescribing that is a clinical issue that has been agreed with the NHS Board prescribing adviser.	**9**

The PCP's role is to lead, develop and promote the evidence-based clinical and cost-effective use of medicines across the CHP through partnership working to improve the quality of prescribing; to contribute to strategic and operational planning, particularly with regard to prescribing, across CH(C)Ps and NHS Lothian to ensure the delivery of high quality pharmaceutical care to patients.

The PCPs manage and co-ordinate the work of a team of Prescribing Support Pharmacists (PSPs) and Prescribing Support Technicians (PSTs). The PSP/T's are involved in analysing prescribing information and deliver on the implementation of practice-based prescribing initiatives, to influence changes in prescribing and to facilitate the safe, effective and economic use of medicines across the CHP.

Primary Care Pharmacists are available to provide pharmaceutical advice and medicines information to all healthcare professionals in NHS Lothian but also to members of the senior management teams within the CH(C)Ps and at corporate level as required. The team analyses prescribing data against agreed measures and benchmarks to identify existing and emerging outliers. This ensures the timely offer of additional prescribing support to individual practices with the aim of correcting their position where possible. The PCPs are required to remain up-to-date with clinical and organisational developments. The team is led by the Primary Care and Community Pharmacy Co-ordinator with the exception of East and Midlothian CHPs where the co-ordinator works closely with the PCP in a professional support capacity.

The following is the short description of the current work programmes the PCP team are involved in to support practices, non-medical prescribers and other health and social care partners as required.

Ongoing corporate commitments

- Develop and implement the NHS Lothian Prescribing Action Plan
- Professional secretary and administrative support to CH(C)P Prescribing Forum
- Professional secretary and administrative support to General Practice Prescribing Committee
- Prescribing Indicator Special Interest Group (development of new PIs and review of existing PIs for PBSG)
- Representation on Lothian Joint Formulary Working Groups
- Representation on Managed Clinical Networks
- Lothian Joint Formulary Implementation Group
- Lothian Prescribing Bulletin editorial team
- Representation at CH(C)P Quality Improvement Teams
- Local Reinvestment Programme working groups, e.g. unlicensed pharmaceuticals
- Non-clinical medication review training and support for practice staff
- PCPs as Board Prescribing Advisers have contractual requirements under the QOF Medicines Management domain
- Membership of national groups e.g. Scottish Prescribing Advisors Association (SPAA) Executive, SPAA IM&T subgroup and Scottish Antimicrobial Prescribing Group (SAPG)
- Representation on the Lothian Area Pharmaceutical Committee.

Monthly, bi-monthly or quarterly

- Locality PCP(s) with NHS Lothian Primary Care Contractors Organisation Finance Department to investigate actual and potential budgetary out-lying practices and discuss and agree corrective action as appropriate
- PCP provides analysis and feedback to practices on prescribing budget position, PI attainment and LJF adherence as reports are released
- Investigation of items appearing on high value drug report with practice/prescriber concerned as necessary
- Attend Interface Group (WL CHCP only) and Clinical Pharmacy Group to facilitate single system discussions on medicines management issues
- Meet with other healthcare professionals within project groups to drive forward LRP initiatives, e.g. dietetics services, nursing and wound management.

As required

- Liaise with a range of Health and Social Care colleagues within and across CH(C)Ps and other Boards, including:
    - Controlled Drugs Governance Team
    - Antimicrobial Management Team
    - Medicines Management Team
    - Community Pharmacy Champions and Pharmacy Locality Group Co-ordinator
    - Substance Misuse and Harm Reduction Team
    - Smoking Cessation Co-ordinator
    - Clinical Nurse Managers
    - CH(C)P Senior Management Team
    - Clinical Governance Support Team.
- Provide SPA Level 2 or other relevant PRISMS prescribing data for individual GP appraisal
- Liaise with NHS Lothian Medicines Information department in the initiation and implementation of a pan-Lothian database for Medicines Information enquiries (MI Databank)

Appendix 7a: NHS Lothian - Top 50 drugs by Gross Ingredient Cost

Table 10

	Approved Name	September 2011 to August 2012	September 2012 to August 2013	Difference	%age change
1	SALMETEROL WITH FLUTICASONE PROPIONATE	£7,115,912	£7,133,209	£17,296	0.2%
2	DUMMY	£3,750,638	£3,483,048	-£267,591	-7.7%
3	TIOTROPIUM	£3,030,678	£3,300,727	£270,050	8.2%
4	BLOOD GLUCOSE TESTING STRIPS	£2,566,927	£2,816,376	£249,449	8.9%
5	PREGABALIN	£1,858,755	£2,569,969	£711,214	27.7%
6	WOUND MANAGEMENT DRESSINGS	£2,491,375	£2,514,837	£23,462	0.9%
7	SOLIFENACIN	£1,630,797	£1,977,108	£346,311	17.5%
8	EMOLLIENTS	£1,642,387	£1,881,765	£239,378	12.7%
9	ENTERAL NUTRITION	£1,620,649	£1,776,936	£156,288	8.8%
10	CO-CODAMOL	£1,696,599	£1,757,480	£60,881	3.5%
11	NICOTINE	£1,561,186	£1,672,085	£110,899	6.6%
12	BUDESONIDE WITH FORMOTEROL FUMARATE	£1,589,302	£1,593,672	£4,370	0.3%
13	OMEPRAZOLE	£1,359,679	£1,496,909	£137,229	9.2%
14	PARACETAMOL	£1,130,689	£1,429,649	£298,960	20.9%
15	INSULIN GLARGINE	£1,300,178	£1,305,626	£5,448	0.4%
16	MESALAZINE	£1,213,266	£1,305,528	£92,262	7.1%
17	FOODS FOR SPECIAL DIETS	£1,305,204	£1,279,391	-£25,813	-2.0%
18	LEVOTHYROXINE SODIUM	£950,725	£1,248,757	£298,032	23.9%
19	OXYCODONE	£1,000,744	£1,174,738	£173,994	14.8%
20	BECLOMETASONE DIPROPIONATE	£1,181,211	£1,149,285	-£31,926	-2.8%
21	SALBUTAMOL	£1,080,978	£1,051,674	-£29,304	-2.8%
22	TACROLIMUS	£975,489	£1,035,467	£59,979	5.8%
23	INSULIN ASPART	£854,097	£919,018	£64,921	7.1%
24	TEMAZEPAM	£160,630	£894,211	£733,581	82.0%
25	DALTEPARIN SODIUM	£710,027	£884,602	£174,575	19.7%
26	MONTELUKAST	£973,923	£874,301	-£99,622	-11.4%
27	VENLAFAXINE	£782,246	£859,218	£76,971	9.0%
28	TRAZODONE HYDROCHLORIDE	£421,962	£849,238	£427,275	50.3%
29	FENTANYL	£785,093	£840,901	£55,807	6.6%
30	SIMVASTATIN	£874,642	£838,612	-£36,030	-4.3%
31	CANDESARTAN CILEXETIL	£1,663,331	£834,175	-£829,155	-99.4%
32	METFORMIN HYDROCHLORIDE	£797,458	£824,320	£26,861	3.3%
33	SILDENAFIL	£738,603	£816,725	£78,122	9.6%
34	ROSUVASTATIN	£727,294	£800,582	£73,288	9.2%
35	GABAPENTIN	£882,752	£798,005	-£84,747	-10.6%
36	PHENYTOIN	£177,785	£746,011	£568,226	76.2%
37	HYPODERMIC EQUIPMENT	£671,338	£737,286	£65,948	8.9%
38	MACROGOLS	£708,694	£728,326	£19,632	2.7%
39	LIRAGLUTIDE	£679,637	£723,515	£43,878	6.1%
40	HYDROCORTISONE	£693,746	£721,604	£27,858	3.9%
41	DULOXETINE	£548,068	£718,371	£170,303	23.7%
42	ILEOSTOMY BAGS	£620,486	£704,224	£83,738	11.9%
43	BIPHASIC INSULIN ASPART	£854,097	£702,606	-£151,492	-21.6%
44	METHADONE HYDROCHLORIDE	£803,803	£696,204	-£107,599	-15.5%
45	TRIPTORELIN	£618,300	£688,324	£70,024	10.2%
46	SITAGLIPTIN	£547,392	£667,660	£120,268	18.0%
47	SERTRALINE	£406,805	£657,212	£250,406	38.1%
48	COLOSTOMY BAGS	£648,126	£652,120	£3,994	0.6%
49	DICLOFENAC	£622,975	£649,207	£26,232	4.0%
50	ATORVASTATIN	£4,448,748	£628,484	-£3,820,263	-607.9%
		£65,475,430	**£66,409,298**	**£933,868**	**1.4%**

Appendix 7b: NHS Lothian - Top 50 drugs by Items (prescriptions)

Table 11

	Approved Name	September 2011 to August 2012	September 2012 to August 2013	Difference	%age change
1	OMEPRAZOLE	355,512	370,257	14,745	4.0%
2	SIMVASTATIN	365,721	357,628	-8,093	-2.3%
3	CO-CODAMOL	331,998	331,554	-444	-0.1%
4	PARACETAMOL	299,227	310,601	11,374	3.7%
5	ASPIRIN	324,169	303,066	-21,103	-7.0%
6	EMOLLIENTS	265,890	289,051	23,161	8.0%
7	SALBUTAMOL	276,364	280,107	3,743	1.3%
8	LEVOTHYROXINE SODIUM	250,980	270,915	19,935	7.4%
9	LISINOPRIL	256,649	265,450	8,801	3.3%
10	BENDROFLUMETHIAZIDE	260,705	243,448	-17,257	-7.1%
11	AMLODIPINE	169,321	182,973	13,652	7.5%
12	AMITRIPTYLINE	148,290	153,268	4,978	3.2%
13	AMOXICILLIN	163,832	151,124	-12,708	-8.4%
14	ATORVASTATIN	124,973	150,591	25,618	17.0%
15	LANSOPRAZOLE	137,904	149,306	11,402	7.6%
16	BISOPROLOL FUMARATE	124,681	135,917	11,236	8.3%
17	ATENOLOL	144,912	134,809	-10,103	-7.5%
18	IBUPROFEN	124,406	126,302	1,896	1.5%
19	DICLOFENAC	128,207	126,188	-2,019	-1.6%
20	METFORMIN HYDROCHLORIDE	118,197	125,511	7,314	5.8%
21	CITALOPRAM	124,863	124,707	-156	-0.1%
22	BECLOMETASONE DIPROPIONATE	119,868	123,548	3,680	3.0%
23	FLUOXETINE	112,938	117,858	4,920	4.2%
24	TRAMADOL HYDROCHLORIDE	108,204	116,676	8,472	7.3%
25	DIAZEPAM	112,256	112,032	-224	-0.2%
26	SALMETEROL WITH FLUTICASONE PROPIONATE	112,244	111,988	-256	-0.2%
27	FUROSEMIDE	109,935	110,202	267	0.2%
28	CETIRIZINE	96,291	105,433	9,142	8.7%
29	WARFARIN SODIUM	91,591	99,294	7,703	7.8%
30	CALCIUM WITH VITAMIN D	94,378	97,689	3,311	3.4%
31	RAMIPRIL	88,206	91,427	3,221	3.5%
32	PREDNISOLONE	86,591	90,499	3,908	4.3%
33	FOLICACID	84,498	82,558	-1,940	-2.3%
34	BLOOD GLUCOSE TESTING STRIPS	79,057	81,843	2,786	3.4%
35	CANDESARTAN CILEXETIL	71,527	78,007	6,480	8.3%
36	NICOTINE	67,878	73,869	5,991	8.1%
37	MACROGOLS	67,926	72,278	4,352	6.0%
38	MIRTAZAPINE	65,508	72,041	6,533	9.1%
39	HYPODERMIC EQUIPMENT	65,577	69,693	4,116	5.9%
40	FLUCLOXACILLIN	67,852	67,297	-555	-0.8%
41	GABAPENTIN	56,062	67,018	10,956	16.3%
42	ALENDRONIC ACID	64,347	65,973	1,626	2.5%
43	DIHYDROCODEINE TARTRATE	67,819	65,938	-1,881	-2.9%
44	CLOPIDOGREL	43,603	65,011	21,408	32.9%
45	TRIMETHOPRIM	62,815	64,673	1,858	2.9%
46	COMPOUND ALGINIC ACID PREPARATIONS	64,072	62,118	-1,954	-3.1%
47	CLOTRIMAZOLE	61,157	60,860	-297	-0.5%
48	CLARITHROMYCIN	64,113	60,233	-3,880	-6.4%
49	BETAMETHASONE	57,299	59,150	1,851	3.1%
50	WOUND MANAGEMENT DRESSINGS	56,943	58,568	1,625	2.8%
		6,797,356	**6,986,547**	**189,191**	**2.7%**

Appendix 8: Glossary of Acronyms

ACP	Anticipatory Care Plan
ADTC	Area Drug & Therapeutics Committee
AHP	Allied Healthcare Professional
AMT	Antimicrobial Management Team
BSC	Balanced Scorecard
CH(C)P	Community Health (and Care) Partnerships (collective term)
CHCP	Community Health and Care Partnership
CHP	Community Health Partnership
COPD	Chronic Obstructive Pulmonary Disease
COMPASS	COMPrehensive ASSessment
CMS	Chronic Medication Service
DDD	Defined Daily Dose
ECAT	Elderly Care Assessment Team
FC	Formulary Committee
GMS	General Medical Services (GP Contract)
GPIP	General Practice Intervention Project
GPPC	General Practice Prescribing Committee
H+SCP	Health and Social Care Partnership
IMPACT	IMProved Anticipatory Care and Treatment
ISD	Information Services Division
LHCC	Local Health Care Co-operative
LJF	Lothian Joint Formulary
LPB	Lothian Prescribing Bulletin
LRP	Local Re-investment Project
LVSD	Left Ventricular Systolic Dysfunction
MAS	Minor Ailment Service
MCN	Managed Clinical Network
MEPIP	Mid & East Lothian Prescribing Intervention Plan
MM001(S)	Medicines management indicator 1 in QOF
MM002(S)	Medicines management indicator 2 in QOF
MM003(S)	Medicines management indicator 3 in QOF
MMT	Medicines Management Team
MURG	Medicines Utilisation Review Group
NES	National Education Scotland
NMAHP	Non-Medical and Allied Healthcare Professional
NTI	National Therapeutic Indicator
ONS	Oral Nutritional Supplements
PACS	Peer Approved Clinical System
PBSG	Prescribing Budget Setting Group
PCCO	Primary Care Contractor Office
PCP	Primary Care Pharmacist
PECOS	Professional Electronic Commerce On-line System
PI	Prescribing Indicator
PIS	Prescribing Information System
PLT	Protected Learning Time
PMP	Prescribing Management Payments
PRISMS	Prescribing Information System for Scotland

PSD	Pharmacy Services Division
PSP	Prescribing Support Pharmacist
PST	Prescribing Support Technician
QuEST	Quality and Efficiency Support Team
REACT	Rapid Elderly + Assessment Care Team
SAPG	Scottish Antimicrobial Prescribing Group
SPARRA	Scottish Patient At Risk of Re-admission and Admission
STU	Scottish Therapeutics Utility
QOF	Quality Outcomes Framework
SCA	Shared Care Agreement
SIGN	Scottish Intercollegiate Guidelines Network
SMC	Scottish Medicines Consortium
SPSP	Scottish Patient Safety Programme

NHS LOTHIAN

DRAFT FINANCIAL LDP

Revenue Outturn Statement

Line no	2014-15 Total		2015-16 Rec £000s	2015-16 Non-Rec £000s	2015-16 TOTAL	2016-17 Rec £000s	2016-17 Non-Rec £000s	2016-17 TOTAL	2017-18 Rec £000s	2017-18 Non-Rec £000s	2017-18 TOTAL	2018-19 Rec £000s	2018-19 Non-Rec £000s	2018-19 TOTAL	2019-20 Rec £000s	2019-20 Non-Rec £000s	2019-20 TOTAL
		Total Expenditure															
1.01	851,549	Clinical Service - Pay	858,551	22,695	**881,246**	876,357	27,343	**903,701**	889,108	40,657	**929,765**	899,336	20,026	**919,361**	909,524	20,080	**929,605**
1.02	864,591	Clinical Service - Non-Pay	871,597	23,123	**894,720**	889,611	27,787	**917,398**	902,573	41,307	**943,880**	913,016	20,362	**933,378**	923,424	20,418	**943,842**
1.03	17,055	Non-Clinical Service - Pay	17,059	560	**17,619**	17,331	580	**17,911**	17,607	851	**18,458**	17,888	440	**18,329**	18,175	441	**18,616**
1.04	21,706	Non-Clinical Service - Non-Pay	21,712	713	**22,425**	22,057	739	**22,796**	22,409	1,082	**23,492**	22,767	560	**23,328**	23,132	562	**23,694**
1.05	0	Outgoing funds - Health & Social Care Integration			**0**			**0**			**0**			**0**			**0**
1.06	1,754,901	**Total Gross Expenditure**	1,768,920	47,091	**1,816,011**	1,805,356	56,450	**1,861,806**	1,831,697	83,897	**1,915,594**	1,853,007	41,389	**1,894,396**	1,874,255	41,501	**1,915,756**
		Less															
1.07	273,483	Operating Income	273,637	8,985	**282,622**	277,991	9,309	**287,300**	282,425	13,643	**296,068**	286,938	7,063	**294,001**	291,534	7,079	**298,613**
1.08	83	Incoming funds - Health & Social Care Integration			**0**			**0**			**0**			**0**			**0**
1.09	273,566	**Total Gross Income**	273,637	8,985	**282,622**	277,991	9,309	**287,300**	282,425	13,643	**296,068**	286,938	7,063	**294,001**	291,534	7,079	**298,613**
1.10	**1,481,335**	**Total Expenditure**	**1,495,282**	**38,106**	**1,533,388**	**1,527,365**	**47,141**	**1,574,506**	**1,549,273**	**70,254**	**1,619,527**	**1,566,069**	**34,326**	**1,600,395**	**1,582,721**	**34,422**	**1,617,143**
1.11	**63,514**	**Total Non-Core RRL Expenditure** (line 7.12)	**n/a**	**54,371**	**54,371**	**n/a**	**57,581**	**57,581**	**n/a**	**81,951**	**81,951**	**n/a**	**48,131**	**48,131**	**n/a**	**48,221**	**48,221**
1.12	**82,467**	**FHS Non Discretionary Net Expenditure**	**84,116**		**84,116**	**85,799**		**85,799**	**87,515**		**87,515**	**89,265**		**89,265**	**91,050**		**91,050**
		Core RRL Expenditure															
1.13	1,335,354	Core Revenue Resource Outturn	1,411,166	(16,265)	**1,394,901**	1,441,566	(10,440)	**1,431,126**	1,461,758	(11,697)	**1,450,061**	1,476,804	(13,805)	**1,462,999**	1,491,671	(13,799)	**1,477,872**
1.14	1,328,234	Core Revenue Resource Limit (RRL) (line 1.24)	1,397,605	(5,718)	**1,391,887**	1,419,500	(7,176)	**1,412,324**	1,441,789	(8,076)	**1,433,713**	1,464,479	(9,887)	**1,454,592**	1,487,578	(9,887)	**1,477,691**
1.15	**(7,120)**	**Saving / (Excess) against Core RRL**	**(13,561)**	**10,547**	**(3,014)**	**(22,066)**	**3,264**	**(18,802)**	**(19,969)**	**3,621**	**(16,348)**	**(12,325)**	**3,918**	**(8,407)**	**(4,093)**	**3,912**	**(181)**

Recurring and Non-Recurring Core Revenue Resource Limit Projection

Line no	2014-15 Total £000s		2015-16 Rec £000s	2015-16 Non-Rec £000s	2015-16 TOTAL	2016-17 Rec £000s	2016-17 Non-Rec £000s	2016-17 TOTAL	2017-18 Rec £000s	2017-18 Non-Rec £000s	2017-18 TOTAL	2018-19 Rec £000s	2018-19 Non-Rec £000s	2018-19 TOTAL	2019-20 Rec £000s	2019-20 Non-Rec £000s	2019-20 TOTAL
1.16	1,355,570	Baseline allocation	1,219,425	n/a	**1,219,425**	1,272,448	n/a	**1,272,448**	1,294,737	n/a	**1,294,737**	1,317,427	n/a	**1,317,427**	1,340,526	n/a	**1,340,526**
1.17		Anticipated allocations - recurring (line 5.57)	31,128	n/a	**31,128**	0	n/a	**0**	0	n/a	**0**	0	n/a	**0**	0	n/a	**0**
1.18	1,355,570	*Updated baseline*	1,250,553	n/a	**1,250,553**	1,272,448	n/a	**1,272,448**	1,294,737	n/a	**1,294,737**	1,317,427	n/a	**1,317,427**	1,340,526	n/a	**1,340,526**
1.19	324	Carry forward	n/a	0	**0**	n/a		**0**	n/a		**0**	n/a		**0**	n/a		**0**
1.20	(37,830)	Transfer of depreciation / amortisation (line 7.02)	n/a	(32,830)	**(32,830)**	n/a	(32,830)	**(32,830)**	n/a	(32,830)	**(32,830)**	n/a	(32,830)	**(32,830)**	n/a	(32,830)	**(32,830)**
1.21	0	Revenue transferred to capital	n/a		**0**	n/a		**0**	n/a		**0**	n/a		**0**	n/a		**0**
1.22	10,170	Anticipated allocations - earmarked / non-rec (line 5.57)	147,052	27,112	**174,164**	147,052	25,654	**172,706**	147,052	24,754	**171,806**	147,052	22,943	**169,995**	147,052	22,943	**169,995**
1.23	**(27,336)**	**Sub-total**	147,052	(5,718)	**141,334**	147,052	(7,176)	**139,876**	147,052	(8,076)	**138,976**	147,052	(9,887)	**137,165**	147,052	(9,887)	**137,165**
1.24	**1,328,234**	**Core Revenue Resource Limit (RRL)**	**1,397,605**	**(5,718)**	**1,391,887**	**1,419,500**	**(7,176)**	**1,412,324**	**1,441,789**	**(8,076)**	**1,433,713**	**1,464,479**	**(9,887)**	**1,454,592**	**1,487,578**	**(9,887)**	**1,477,691**

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NHS LOTHIAN

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Efficiency Savings

2015-16

Line no	Saving Scheme Details		Rec £000s	Non-Rec £000s	Total £000s	Risk rating: Unidentified %	High %	Med %	Low %
	Efficiency & Productivity Workstreams					%	%	%	%
2.01	Service productivity		1,213		**1,213**	n/a	29%	63%	8%
2.02	Drugs and prescribing		6,394	50	**6,444**	n/a	78%	17%	5%
2.03	Procurement		2,946	925	**3,871**	n/a	52%	28%	20%
2.04	Workforce		10,977	548	**11,525**	n/a	44%	31%	25%
2.05	Shared services	HR			**0**	n/a			100%
2.06		Facilities			**0**	n/a			100%
2.07		Other shared services			**0**	n/a			100%
2.08	Support services (non-clinical)		2,284	1,000	**3,284**	n/a	11%	61%	28%
2.09	Estates and facilities		1,513	0	**1,513**	n/a	21%	79%	0%
2.10	Unidentified savings			2,150	**2,150**	100%	n/a	n/a	n/a
2.11	**Total In-Year Efficiency Savings**		**25,327**	**4,673**	**30,000**	**2,150**	**13,141**	**9,715**	**4,994**
2.12	Cash-releasing Savings		25,327	4,673	30,000				
2.13	Productivity Savings (non-cash)				0				
2.14	**Total In-Year Efficiency Savings** (must match line 2.11)		**25,327**	**4,673**	**30,000**				

2016-17

Line no	Saving Scheme Details		Rec £000s	Non-Rec £000s	Total £000s	Risk rating: Unidentified %	High %	Med %	Low %
	Efficiency & Productivity Workstreams					%	%	%	%
2.01	Service productivity				**0**	n/a			100%
2.02	Drugs and prescribing				**0**	n/a			100%
2.03	Procurement				**0**	n/a			100%
2.04	Workforce				**0**	n/a			100%
2.05	Shared services	HR			**0**	n/a			100%
2.06		Facilities			**0**	n/a			100%
2.07		Other shared services			**0**	n/a			100%
2.08	Support services (non-clinical)				**0**	n/a			100%
2.09	Estates and facilities				**0**	n/a			100%
2.10	Unidentified savings		30,000		**30,000**	100%	n/a	n/a	n/a
2.11	**Total In-Year Efficiency Savings**		**30,000**	**0**	**30,000**	**30,000**	**0**	**0**	**0**
2.12	Cash-releasing Savings		30,000		30,000				
2.13	Productivity Savings (non-cash)				0				
2.14	**Total In-Year Efficiency Savings** (must match line 2.11)		**30,000**	**0**	**30,000**				

2017-18

Line no	Saving Scheme Details		Rec £000s	Non-Rec £000s	Total £000s	Risk rating: Unidentified %	High %	Med %	Low %
	Efficiency & Productivity Workstreams					%	%	%	%
2.01	Service productivity				**0**	n/a			100%
2.02	Drugs and prescribing				**0**	n/a			100%
2.03	Procurement				**0**	n/a			100%
2.04	Workforce				**0**	n/a			100%
2.05	Shared services	HR			**0**	n/a			100%
2.06		Facilities			**0**	n/a			100%
2.07		Other shared services			**0**	n/a			100%
2.08	Support services (non-clinical)				**0**	n/a			100%
2.09	Estates and facilities				**0**	n/a			100%
2.10	Unidentified savings		30,000		**30,000**	100%	n/a	n/a	n/a
2.11	**Total In-Year Efficiency Savings**		**30,000**	**0**	**30,000**	**30,000**	**0**	**0**	**0**
2.12	Cash-releasing Savings		30,000		30,000				
2.13	Productivity Savings (non-cash)				0				
2.14	**Total In-Year Efficiency Savings** (must match line 2.11)		**30,000**	**0**	**30,000**				

Efficiency Savings

2018-19

Line no	Saving Scheme Details		Rec £000s	Non-Rec £000s	Total £000s	Risk rating: Unidentified %	High %	Med %	Low %
	Efficiency & Productivity Workstreams					%	%	%	%
2.15	Service productivity				**0**	n/a			100%
2.16	Drugs and prescribing				**0**	n/a			100%
2.17	Procurement				**0**	n/a			100%
2.18	Workforce				**0**	n/a			100%
2.19	Shared services	HR			**0**	n/a			100%
2.20		Facilities			**0**	n/a			100%
2.21		Other shared services			**0**	n/a			100%
2.22	Support services (non-clinical)				**0**	n/a			100%
2.23	Estates and facilities				**0**	n/a			100%
2.24	Unidentified savings		30,000		**30,000**	100%	n/a	n/a	n/a
2.25	**Total In-Year Efficiency Savings**		**30,000**	**0**	**30,000**	**30,000**	**0**	**0**	**0**
2.26	Cash-releasing Savings		30,000		30,000				
2.27	Productivity Savings (non-cash)				0				
2.28	**Total In-Year Efficiency Savings** (must match line 2.25)		**30,000**	**0**	**30,000**				

2019-20

Line no	Saving Scheme Details		Rec £000s	Non-Rec £000s	Total £000s	Risk rating: Unidentified %	High %	Med %	Low %
	Efficiency & Productivity Workstreams					%	%	%	%
2.15	Service productivity				**0**	n/a			100%
2.16	Drugs and prescribing				**0**	n/a			100%
2.17	Procurement				**0**	n/a			100%
2.18	Workforce				**0**	n/a			100%
2.19	Shared services	HR			**0**	n/a			100%
2.20		Facilities			**0**	n/a			100%
2.21		Other shared services			**0**	n/a			100%
2.22	Support services (non-clinical)				**0**	n/a			100%
2.23	Estates and facilities				**0**	n/a			100%
2.24	Unidentified savings		30,000		**30,000**	100%	n/a	n/a	n/a
2.25	**Total In-Year Efficiency Savings**		**30,000**	**0**	**30,000**	**30,000**	**0**	**0**	**0**
2.26	Cash-releasing Savings		30,000		30,000				
2.27	Productivity Savings (non-cash)				0				
2.28	**Total In-Year Efficiency Savings** (must match line 2.25)		**30,000**	**0**	**30,000**				

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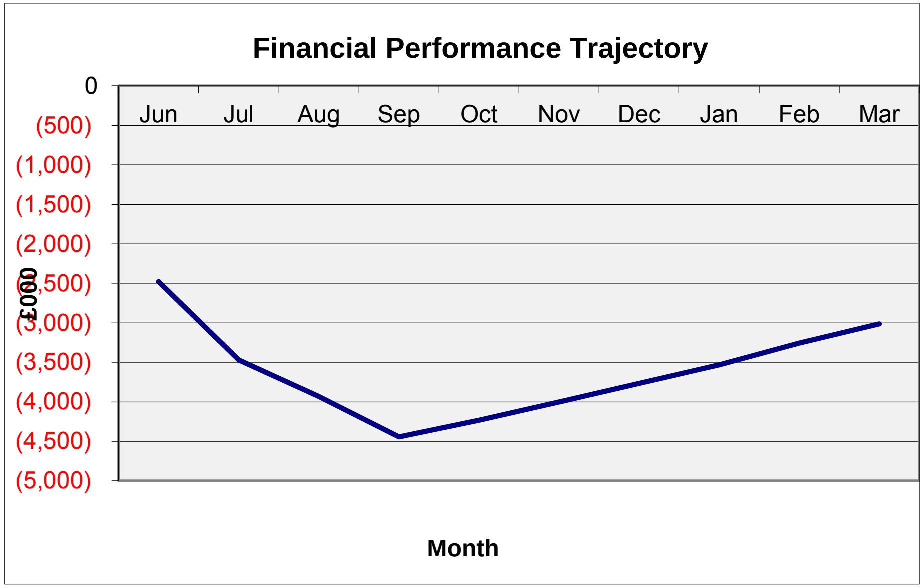
DRAFT FINANCIAL LDP

Financial Trajectories

	Revenue Outturn Saving / (Excess) against Core RRL as at the end of:	£000s
3.01	Jun	(2,480)
3.02	Jul	(3,472)
3.03	Aug	(3,933)
3.04	Sep	(4,443)
3.05	Oct	(4,234)
3.06	Nov	(4,002)
3.07	Dec	(3,768)
3.08	Jan	(3,533)
3.09	Feb	(3,254)
3.10	Mar	(3,014)

Efficiency Savings Cumulative efficiency savings as at the end of:	Total Savings £000s
Jun	4,960
Jul	6,804
Aug	8,843
Sep	10,931
Oct	13,250
Nov	15,589
Dec	17,940
Jan	20,726
Feb	23,517
Mar	30,000



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Financial Planning Assumptions

Line no	2014-15	Assumptions - uplift (%)		2015-16	2016-17	2017-18	2018-19	2019-20
4.01	2.69%	Resources	Base uplift	1.80%	1.80%	1.80%	1.80%	1.80%
4.02	1.54%		NRAC	0.59%	0.00%	0.00%	0.00%	0.00%
4.03	0.00%		Other	0.00%	0.00%	0.00%	0.00%	0.00%
4.04	1.00%	Pay	Base uplift	1.00%	1.00%	1.00%	1.00%	1.00%
4.05	0.00%		Incremental drift	0.00%	0.00%	0.00%	0.00%	0.00%
4.06	0.00%		Other	1.40%	2.20%	0.00%	0.00%	0.00%
4.07	2.10%	**Prices**		2.50%	2.50%	2.50%	2.50%	2.50%
4.08	1.00%	**GP prescribing**	Price	2.30%	1.00%	1.00%	1.00%	1.00%
4.09	2.50%		Volume	3.40%	2.50%	2.50%	2.50%	2.50%
4.10	6.49%	**Hospital drugs**	Price	5.50%	1.00%	1.00%	1.00%	1.00%
4.11	0.00%		Volume	8.50%	6.00%	6.00%	6.00%	6.00%
4.12	0.00%	**Family health services**	General Dental Services - independent contractors	0.00%	0.00%	0.00%	0.00%	0.00%
4.13			General Dental Services - salaried services	0.00%	0.00%	0.00%	0.00%	0.00%
4.14	0.00%		General Ophthalmic Services	0.00%	0.00%	0.00%	0.00%	0.00%
4.15	0.00%		Pharmaceutical contractors' remuneration	0.00%	0.00%	0.00%	0.00%	0.00%

Risk Assessment

	Key Assumptions / Risks	Risk rating (please select from drop-down)	Impact / £
4.16	Local Reinvestment Programme	High Risk	Delivery of recurring savings do not match the level anticipated
4.17	Scheduled Care	High Risk	Risk that additional investment will not deliver required volume
4.18	Unscheduled Care	High Risk	Continued management of financial exposure on capacity pressures
4.19	Delayed Discharge	High Risk	Need to ensure the required reductions achieved within budget
4.20	Parental & Adoption Leave	High Risk	This will be implemented in 15/16; no provision has been made
4.21	Rates Rebates and Property Sales	Medium Risk	Level of sales and rebates are less than anticipated
4.22	Prescribing	High Risk	Increase is greater than FP provision; short supply inflates prices
4.23	Hep C Drugs	High Risk	Useage of the new range of Hep C Drugs is greater than projection
4.24	PTC - Two Tier Agreement full implementation; transitional points correction application	Medium Risk	Once quantified costs are higher than provision
4.25	SGHD Allocations	High Risk	Availability of SGHD funded programmes & initiatives
4.26	Capital Programme	High Risk	Revenue consequences are a significant pressure
4.27	Equal Pay	High Risk	Discussions are ongoing with CLO, but no provision has been made
4.28	Bed Reductions	High Risk	RP plans include closure of 114 beds, faster discharge will be require
4.29	Social Care Investment	High Risk	Resdesigning of services requires prioritisation of social care budget
4.30			
4.31			
4.32			

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Revenue Resource Limit - Anticipated Allocations

Line no	Anticipated Allocations	Directorate	SG Contact Name	2015-16 Recurring £000s	2015-16 Earmarked £000s	2015-16 Non-Rec £000s	2015-16 TOTAL	2016-17 Recurring £000s	2016-17 Earmarked £000s	2016-17 Non-Rec £000s	2016-17 TOTAL	2017-18 Recurring £000s	2017-18 Earmarked £000s	2017-18 Non-Rec £000s	2017-18 TOTAL	2018-19 Recurring £000s	2018-19 Earmarked £000s	2018-19 Non-Rec £000s	2018-19 TOTAL	2019-20 Recurring £000s	2019-20 Earmarked £000s	2019-20 Non-Rec £000s	2019-20 TOTAL
5.01	Brokerage Repayments	Health Finance, eHealth & Pharmaceuticals	Robert Peterson				0				0				0				0				0
5.02	eHealth Bundle	Health Finance, eHealth & Pharmaceuticals	Lesly Donovan		9,741		9,741		9,741		9,741		9,741		9,741		9,741		9,741		9,741		9,741
5.03	Effective Prevention Bundle	The Quality Unit	Andy Bruce		7,100		7,100		7,100		7,100		7,100		7,100		7,100		7,100		7,100		7,100
5.04	Dental Services Bundle	Health & Social Care Integration	Tom Ferris		2,030		2,030		2,030		2,030		2,030		2,030		2,030		2,030		2,030		2,030
5.05	Mental Health Bundle	Health & Social Care Integration	Geoff Huggins		1,151	711	1,862		1,151	711	1,862		1,151	711	1,862		1,151		1,151		1,151		1,151
5.06	HAI Bundle	CNO, Patients, Public & Health Professions	Andrew Wilkinson		958		958		958		958		958		958		958		958		958		958
5.07	Nursing Bundle	CNO, Patients, Public & Health Professions	Susan Malcolm			203	203			203	203			203	203			203	203			203	203
5.08	PMS Bundle	Health & Social Care Integration	Marlene Walker		4,123		4,123		4,123		4,123		4,123		4,123		4,123		4,123		4,123		4,123
5.09	Maternity Services and Maternal and Infant Nutrition Bundle	Children & Families	Lynne Nicol		589		589		589		589		589		589		589		589		589		589
5.10	Alcohol Funding	CMO, Public Health & Sport			5,838		5,838		5,838		5,838		5,838		5,838		5,838		5,838		5,838		5,838
5.11	Drug Treatment Funding	CMO, Public Health & Sport			5,679		5,679		5,679		5,679		5,679		5,679		5,679		5,679		5,679		5,679
5.12	Equally Well Test Sites	CMO, Public Health & Sport					0				0				0				0				0
5.13	Keep Well / Well North	CMO, Public Health & Sport			800		800		800		800		800		800		800		800		800		800
5.14	Research Support and UKCRC Budget	CMO, Public Health & Sport				10,135	10,135			10,135	10,135			10,135	10,135			10,135	10,135			10,135	10,135
5.15	AAA Screening	CMO, Public Health & Sport				141	141			141	141			141	141			141	141			141	141
5.16	Glasgow Centre for Population Health	CMO, Public Health & Sport					0				0				0				0				0
5.17	Organ Donation Taskforce (NSS)	CMO, Public Health & Sport					0				0				0				0				0
5.18	SNBTS vCJD (NSS)	CMO, Public Health & Sport					0				0				0				0				0
5.19	CYP Specialist Services National Delivery Plan (NDP)	Children & Families	Fiona McKinley				0				0				0				0				0
5.20	Unscheduled Care	Health Workforce & Performance	Suresh Gajjar			1,120	1,120			1,120	1,120			1,120	1,120			1,120	1,120			1,120	1,120
5.21	Immunisation programme	CMO, Public Health & Sport	Janet Sneddon			1,923	1,923			1,923	1,923			1,923	1,923			1,923	1,923			1,923	1,923
5.22	IVF Waiting Times Implementation	Children & Families	Lynne Nicol				0				0				0				0				0
5.23	Early Years - Family Nurse Partnership	Children & Families	Carolyn Wilson			1,832	1,832			1,832	1,832			1,832	1,832			1,832	1,832			1,832	1,832
5.24	Positron Emission Tomography (PET) SCAN	The Quality Unit	Rachael Dunk		1,069		1,069		1,069		1,069		1,069		1,069		1,069		1,069		1,069		1,069
5.25	NHS GG&C Emergency Medical Retrieval Services (EMRS)	The Quality Unit	Liz Porterfield				0				0				0				0				0
5.26	NHS Carer Information Strategies	Health & Social Care Integration			732		732		732		732		732		732		732		732		732		732
5.27	Primary Medical Services	Health & Social Care Integration			105,340		105,340		105,340		105,340		105,340		105,340		105,340		105,340		105,340		105,340
5.28	Scottish Dental Access Initiative (SDAI)	Health & Social Care Integration					0				0				0				0				0
5.29	NES - Optometry CET & DOCET	Health & Social Care Integration					0				0				0				0				0
5.30	NES - Aberdeen Dental School	Health & Social Care Integration					0				0				0				0				0
5.31	NES - Workforce Psychology Development	Health & Social Care Integration					0				0				0				0				0
5.32	Emergency & Access Delivery Team (EADT)	Health & Social Care Integration					0				0				0				0				0
5.33	Combat Stress - National Support Services	Health & Social Care Integration					0				0				0				0				0
5.34	Salaried General Dental Services	Health & Social Care Integration	Tom Ferris		6,412		6,412		6,412		6,412		6,412		6,412		6,412		6,412		6,412		6,412
5.35	Distant Islands Allowance	Health Finance, eHealth & Pharmaceuticals					0				0				0				0				0
5.36	Highland and Islands Travel Scheme	Health Finance, eHealth & Pharmaceuticals					0				0				0				0				0
5.37	Island Boards - Partnership Working	Health Finance, eHealth & Pharmaceuticals					0				0				0				0				0
5.38	Golden Jubilee activity	Health Finance, eHealth & Pharmaceuticals			(3,049)		(3,049)		(3,049)		(3,049)		(3,049)		(3,049)		(3,049)		(3,049)		(3,049)		(3,049)
5.39	Stracathro Regional Treatment Centre	Health Workforce & Performance	Suresh Gajjar				0				0				0				0				0
5.40	18 Weeks allocations	Health Workforce & Performance	Suresh Gajjar				0				0				0				0				0
5.41	Distinction Awards for NHS Consultants	Health Workforce & Performance	Dave McLeod		4,352		4,352		4,352		4,352		4,352		4,352		4,352		4,352		4,352		4,352
5.42	Waiting Times - AST allocation	Health Workforce & Performance	Suresh Gajjar	5,000		932	5,932			932	932			932	932			932	932			932	932
5.43	Early Detection of Cancer	Health Workforce & Performance	Dr David Linden			43	43			43	43			43	43			43	43			43	43
5.44	QUEST Local Quality & Efficiency Support	Health Workforce & Performance	Calum Wallace				0				0				0				0				0
5.45	Modernising Medical Careers (NES)	Health Workforce & Performance	Dave McLeod				0				0				0				0				0
5.46	Calman 100 Implementation (NES)	Health Workforce & Performance	Dave McLeod				0				0				0				0				0
5.47	Leadership Programme (NES)	Health Workforce & Performance	John Cowie				0				0				0				0				0
5.48	National Implementation of eEES - GG&C	Health Workforce & Performance	Dave McLeod				0				0				0				0				0
5.49	Police Custody Transfer	Health Finance, eHealth & Pharmaceuticals	Julie McKinney		1,144		1,144		1,144		1,144		1,144		1,144		1,144		1,144		1,144		1,144
5.50	Patients Rights Act - Delivery Support	Health Workforce & Performance	Suresh Gajjar				0				0				0				0				0
5.51	Reshaping the Medical Workforce	Health Workforce & Performance	Johann MacDougall				0				0				0				0				0
5.52	NDC Top Sliced Contributions	Health Finance, eHealth & Pharmaceuticals	Alan Morrison		(1,697)		(1,697)		(1,697)		(1,697)		(1,697)		(1,697)		(1,697)		(1,697)		(1,697)		(1,697)
5.53	NSD Risk Share	Health Finance, eHealth & Pharmaceuticals	Alan Morrison		(5,039)		(5,039)		(5,039)		(5,039)		(5,039)		(5,039)		(5,039)		(5,039)		(5,039)		(5,039)
5.54	Enzyme replacement / orphan drugs	Health Finance, eHealth & Pharmaceuticals	Alan Morrison				0				0				0				0				0
5.55	Assumed parity uplift to funding (NRAC)	Health Finance, eHealth & Pharmaceuticals	Alan Morrison				0				0				0				0				0
5.56	Further anticipated allocations (copied from line 6.50)			26,128	(221)	10,072	35,979	0	(221)	8,614	8,393	0	(221)	7,714	7,493	0	(221)	6,614	6,393	0	(221)	6,614	6,393
5.57	**Total Anticipated Allocations**			31,128	147,052	27,112	205,292	0	147,052	25,654	172,706	0	147,052	24,754	171,806	0	147,052	22,943	169,995	0	147,052	22,943	169,995

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Revenue Resource Limit - Further Anticipated Allocations

Line no	Further Anticipated Allocations	Directorate (please select from drop-down)	SG Contact Name	2015-16 Recurring £000s	2015-16 Earmarked £000s	2015-16 Non-Rec £000s	2015-16 TOTAL	2016-17 Recurring £000s	2016-17 Earmarked £000s	2016-17 Non-Rec £000s	2016-17 TOTAL	2017-18 Recurring £000s	2017-18 Earmarked £000s	2017-18 Non-Rec £000s	2017-18 TOTAL	2018-19 Recurring £000s	2018-19 Earmarked £000s	2018-19 Non-Rec £000s	2018-19 TOTAL	2019-20 Recurring £000s	2019-20 Earmarked £000s	2019-20 Non-Rec £000s	2019-20 TOTAL
	Please list further anticpated allocations not included in the list on Form 5																						
6.01	Commmunity Pharmacists Champions		Shelagh Scott		37		37		37		37		37		37		37		37		37		37
6.02	PMS change Manager		Gary Johnston			85	85			85	85			85	85			85	85			85	85
6.03	Pre-registration Training		Shelagh Scott		(377)		(377)		(377)		(377)		(377)		(377)		(377)		(377)		(377)		(377)
6.04	)elayed Discharge - interim 2 to support winter preparedness		Tracy Slater			712	712				0				0				0				0
6.05	Dementia Funding for commitment 11		Susan Campbell			5	5				0				0				0				0
6.06	Scotstar		Barbara Crowe			(627)	(627)			(627)	(627)			(627)	(627)			(627)	(627)			(627)	(627)
6.07	Maternity Care Quality Improvement		Susan Campbell			38	38			38	38			38	38			38	38			38	38
6.08	AST Primary care Initiative		Roy Garscadden		100		100		100		100		100		100		100		100		100		100
6.09	Health & Welfare Reform Development Fund		Daniel Kelly			38	38				0				0				0				0
6.10	Scotland A Research Ethics Committee		Graeme Campbell			50	50			50	50			50	50			50	50			50	50
6.11	HNC year 1 funding		Janet McVea			266	266			266	266			266	266			266	266			266	266
6.12	HNC Continuing Students		Janet McVea			308	308			308	308			308	308			308	308			308	308
6.13	Eyecare Integration Programme		Claire McKenna			11	11				0				0				0				0
6.14	Cancer Modernisation - Surgical Oncology		David Linden			22	22			22	22			22	22			22	22			22	22
6.15	Cancer Modernisation - Acute Oncology		David Linden			72	72			72	72			72	72			72	72			72	72
6.16	Patinent Advice and Support Service (PASS)		Sandra Falconer		(75)		(75)		(75)		(75)		(75)		(75)		(75)		(75)		(75)		(75)
6.17	ealth Visitors to support GIRFEC & the Early Years Agenda		John Froggatt		288		288		288		288		288		288		288		288		288		288
6.18	Augumentative & Altenrative Communication		Sandra Falconer			150	150			150	150			150	150			150	150			150	150
6.19	Health Inequalities		Pauline Macdonald			128	128			128	128			128	128			128	128			128	128
6.20	ISB funding		Gary Johnston			181	181			181	181			181	181			181	181			181	181
6.21	Designation of all Adult Stem Cell Transplants		Alan Morrison		(458)		(458)		(458)		(458)		(458)		(458)		(458)		(458)		(458)		(458)
6.22	LUCAP - delayed discharge		Tracy Slater			1,050	1,050			1,050	1,050			1,050	1,050			1,050	1,050			1,050	1,050
6.23	Edinburgh Headroom Project		Claire McKenna			280	280			280	280			280	280			280	280			280	280
6.24	Capital to Revenue Transfer					5,700	5,700			5,000	5,000			4,100	4,100			3,000	3,000			3,000	3,000
6.25	IVF Heat Target		Sarah Corcoran			986	986			986	986			986	986			986	986			986	986
6.26	Mid Year PIDS - HAI Delivery plan		Allison Wood			12	12			12	12			12	12			12	12			12	12
6.27	Advocacy Provision		Sandra Falconer		72		72		72		72		72		72		72		72		72		72
6.28	AHP NDP Project Leads		Susan Campbell			17	17			17	17			17	17			17	17			17	17
6.29	Person Centred & Healthcare Portfolio		Joanna Swanson			44	44			44	44			44	44			44	44			44	44
6.30	AHP Consultant in Dementia		Ewen Cameron			69	69			69	69			69	69			69	69			69	69
6.31	Scottish Abortion Care Providers Network		Rebekah Carton			8	8			8	8			8	8			8	8			8	8
6.32	naged Diagnostic Networks-MDICN,SCBMDN,SMVN & SPAN		Paul Currie			(62)	(62)			(62)	(62)			(62)	(62)			(62)	(62)			(62)	(62)
6.33	Cancer Modernisation - CEPAS		David Linden			83	83			83	83			83	83			83	83			83	83
6.34	Cancer Modernisation - CMF Project Support		David Linden			10	10			10	10			10	10			10	10			10	10
6.35	SDS policy secondment		Calum Drummond			30	30			30	30			30	30			30	30			30	30
6.36	Cardiac Rehabilitation Lead		Cheryl McNulty			4	4				0				0				0				0
6.37	Dementia Improvement Support - 8 Pillars Model test Site		Ewen Cameron			50	50			50	50			50	50			50	50			50	50
6.38	/omen Personality Disorder Edinburgh & cornton Vale Prison		Ewen Cameron			66	66			66	66			66	66			66	66			66	66
6.39	Diabetes Lead Clinician		Chris Booth			46	46			46	46			46	46			46	46			46	46
6.40	Community Care Benchmarking		Karl Zaczek			35	35			35	35			35	35			35	35			35	35
6.41	Secondment costs - MC		Steve Hanlon			17	17			17	17			17	17			17	17			17	17
6.42	CHKS 1516					(57)	(57)				0				0				0				0
6.43	Petscan FDG Radiology Drugs				192		192		192		192		192		192		192		192		192		192
6.44	Delayed Discharge - share			4,272			4,272				0				0				0				0
6.45	Employability Funding Project Search 1516					45	45				0				0				0				0
6.46	Veterans 1st Point					200	200			200	200			200	200			200	200			200	200
6.47	Integration Fund			4,493			4,493				0				0				0				0
6.48	Additional Drugs			4,863			4,863				0				0				0				0
6.49	PPRS			12,500			12,500				0				0				0				0
6.50	**Total Further Anticipated Allocations** (copied to line 5.56)			**26,128**	**(221)**	**10,072**	**35,979**	**0**	**(221)**	**8,614**	**8,393**	**0**	**(221)**	**7,714**	**7,493**	**0**	**(221)**	**6,614**	**6,393**	**0**	**(221)**	**6,614**	**6,393**

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Non-Core RRL Expenditure

Line no	2014-15 Total £000s		2015-16 Total Non-Rec £000s	2016-17 Total Non-Rec £000s	2017-18 Total Non-Rec £000s	2018-19 Total Non-Rec £000s	2019-20 Total Non-Rec £000s
		Non-Core RRL Expenditure					
7.01	18,843	Capital Grants (line 8.102)	16,580	19,500	43,870	10,050	10,140
7.02	37,830	Depreciation / Amortisation	32,830	32,830	32,830	32,830	32,830
		ODEL - IFRS PFI Expenditure					
7.03	1,357	PFI/PPP/Hub - Depreciation	1,357	1,357	1,357	1,357	1,357
7.04		PFI/PPP/Hub - Impairment					
7.05		PFI/PPP/Hub - Notional Costs					
7.06	1,357	**Total IFRS PFI Expenditure**	1,357	1,357	1,357	1,357	1,357
		Anually Managed Expenditure					
7.07	3,590	AME - Impairments	1,010	1,300	1,300	1,300	1,300
7.08	1,300	AME - Provisions	2,000	2,000	2,000	2,000	2,000
7.09	594	AME - Donated Assets Depreciation	594	594	594	594	594
7.10		AME - Movement in Pension Valuation					
7.11	5,484	**Total AME Expenditure**	3,604	3,894	3,894	3,894	3,894
7.12	**63,514**	**Total Non-Core RRL Expenditure** (copied to line 1.11)	**54,371**	**57,581**	**81,951**	**48,131**	**48,221**

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Infrastructure Investment Programme

Line No	2014-15 £000s		2015-16 £000s	2016-17 £000s	2017-18 £000s	2018-19 £000s	2019-20 £000s
		Capital Expenditure					
		Property					
8.001	5,184	Statutory compliance and backlog maintenance property expenditure	6,500	4,000	4,000	4,000	4,000
8.002	285	Radiotherapy equipment construction works	0	0	0	0	0
8.003	0	Enabling works for stand alone NPD projects	0	0	0	0	0
8.004	3,396	Enabling works for hub initiative projects	0	0	0	0	0
8.005	669	Trenant Extention & Ratho GP Reprovision	0	0	0	0	0
8.006	400	Astley Ainslie & Liberton Improvements	0	0	0	0	0
8.007	497	Bundle Sub Debt Investment	0	0	0	0	0
8.008			0	0	0	0	0
8.009	2,360	REH (Sub Debt Invest, Master Planning, Phase 1-2 & other)	1,063	12,094	13,712	2,441	528
8.010	3,645	WGH (Front door, Asceptic Pharmacy Modernisation & others)	5,440	2,008	6,000	6,500	0
8.011	3,562	SJH (MRI Scanner, SCBU, Dental Decontamination)	3,187	1,000	0	0	0
8.012	3,450	Capital to revenue transfer	5,700	5,000	4,100	3,000	3,000
8.013		Royal Victoria Hospital Integrated Care Facility	5,000	20,000	5,000	0	0
8.014		Edinburgh Cancer Centre and Enabling	500	4,000	5,000	15,000	15,000
8.015		Lauriston (Reprovision of Eye Pavillion Services & EDI)	300	10,500	8,000	0	0
8.016		Theatre Capacity SJH	100	10,000	10,000	2,900	0
8.017		Partnership Centre (Firhill, Blackburn, North West)	58	1,828	0	0	0
8.018		East Lothian Community Campus	863	2,500	6,050	0	0
8.019	(2,146)	Over commitment to be managed	(15,135)	(68,330)	(22,168)	829	(16,671)
8.020			0	0	0	0	0
8.021	3,127	Other	7,377	6,980	807	4,510	15,120
8.022	**24,429**	**Total Property Expenditure**	**20,954**	**11,579**	**40,501**	**39,180**	**20,977**
		Equipment					
		Medical Equipment					
8.023		Equipping costs of revenue financed projects	0	0	0	0	0
8.024	568	Imaging (CT / Ultrasound / MRI / Gamma Cameras)	1,154	1,624	1,109	1,127	1,127
8.025		Other X ray (Angio / Dental / Fluoroscopy / General X Ray)	0	0	0	0	0
8.026	2,182	Radiotherapy	2,599	866	2,545	1,801	0
8.027		PET Replacement Programme	0	0	0	0	0
8.028		IV systems (Syringe and Volumetric Pumps)	0	0	0	0	0
8.029	4,606	Other medical equipment eg defibrilators, dialysis machines, endoscopes	9,340	13,147	8,975	9,120	9,120
8.030	*7,356*	*Sub-total - Medical Equipment*	*13,093*	*15,637*	*12,629*	*12,048*	*10,247*
		Vehicles					
8.031		Emergency vehicles					
8.032		Patient Transport Service (PTS)					
8.033		Support services vehicles					
8.034		Other vehicles					
8.035	*0*	*Sub-total - Vehicles*	*0*	*0*	*0*	*0*	*0*
		Other Equipment					
8.036		Plant and machinery					
8.037		Other					
8.038	*0*	*Sub-total - Other Equipment*	*0*	*0*	*0*	*0*	*0*
8.039	**7,356**	**Total Equipment Expenditure**	**13,093**	**15,637**	**12,629**	**12,048**	**10,247**
		IM&T Projects					
8.040	2,000	e-Health projects	2,000	2,000	2,000	2,000	2,000
8.041	85	National Pacs Refresh 2007-17					
8.042							
8.043							
8.044							
8.045							
8.046							
8.047							
8.048							
8.049							
8.050							
8.051							
8.052		Other					
8.053	**2,085**	**Total IM&T Expenditure**	**2,000**	**2,000**	**2,000**	**2,000**	**2,000**
		Other Capital Expenditure					
8.054		Intangible assets					
8.055		Other					
8.056	**0**	**Total Other Expenditure**	**0**	**0**	**0**	**0**	**0**
8.057	**33,870**	**Total Gross Direct Capital Expenditure**	**36,047**	**29,216**	**55,130**	**53,228**	**33,224**
		Capital Receipts					
8.058		Other capital grants received					
8.059	(1,000)	Asset sale proceeds (net book value) (from line 8.111)	(3,151)	(1,986)	(26,551)	(30,441)	(12,238)
8.060		Other					
8.061	**(1,000)**	**Total Capital Receipts**	**(3,151)**	**(1,986)**	**(26,551)**	**(30,441)**	**(12,238)**
8.062	**32,870**	**Total Net Direct Capital Expenditure (line 8.057 plus line 8.061)**	**32,896**	**27,230**	**28,579**	**22,787**	**20,986**
		Indirect Capital Expenditure					
8.063	18,843	Capital Grants (line 8.102)	16,580	19,500	43,870	10,050	10,140
8.064							
8.065							
8.066							
8.067	**18,843**	**Total Indirect Capital Expenditure**	**16,580**	**19,500**	**43,870**	**10,050**	**10,140**
8.068	**51,713**	**Total Net Capital Expenditure (line 8.062 plus line 8.067)**	**49,476**	**46,730**	**72,449**	**32,837**	**31,126**
		Capital Resource Limit (CRL)					
8.069	23,992	SGHSCD formula allocation	25,988	25,988	25,988	25,988	25,988
8.070		Asset sale proceeds reapplied (net book value)					
8.071	19,322	Project specific funding	6,522	6,576	37,663	5,048	0
8.072	2,467	Radiotherapy funding	2,599	866	2,545	1,801	5,138
8.073	3,454	Hub/ NPD enabling funding	6,977	13,300	6,253	0	0
8.074	2,478	Other centrally provided capital funding	7,390	0	0	0	0
8.075	0	Revenue to capital transfers (line 1.21)	0	0	0	0	0
8.076	**51,713**	**Total Capital Resource Limit**	**49,476**	**46,730**	**72,449**	**32,837**	**31,126**
8.077	**0**	**Saving / (Excess) against CRL**	**0**	**(0)**	**0**	**(0)**	**(0)**

Revenue Finance - NPD / hub Asset Additions

	2014-15 £000s	Revenue Finance - NPD / hub Asset Additions	2015-16 £000s	2016-17 £000s	2017-18 £000s	2018-19 £000s	2019-20 £000s
8.078	17,815	AUC Recognition	99,555	93,954	7,188		
8.079							
8.080							
8.081							
8.082							
8.083							
8.084							
8.085	**17,815**	**Total Revenue Finance - NPD / hub Asset Additions**	**99,555**	**93,954**	**7,188**	**0**	**0**

External Funding Commitments

	2014-15 £000s	Payments	2015-16 £000s	2016-17 £000s	2017-18 £000s	2018-19 £000s	2019-20 £000s
8.086		Existing PPP unitary charges					
8.087		Proposed PPP unitary charges					
8.088		Proposed hub initiative unitary payments					
8.089		Finance leases					
8.090		Operating leases					
8.091	**0**	**Total**	**0**	**0**	**0**	**0**	**0**

Memorandum

	2014-15 £000s	Capital Grants	2015-16 £000s	2016-17 £000s	2017-18 £000s	2018-19 £000s	2019-20 £000s
8.092	4,702	Consort Life Cycle Costs	4,790	4,870	4,960	5,050	5,140
8.093	13,567	RHSC/DCN Reprovision	6,840	7,130	32,910	0	0
8.094	150	Endoscopy Decontamination Unit RIE	1,150	0	0	0	0
8.095	212	Additional Assessment Beds RIE	800	2,500	500	0	0
8.096	0	Additional Beds Wards 120/220 RIE					
8.097	460	LEPP RIE					
8.098	500	Gp Premises Modernisation	3,000	5,000	5,000	5,000	5,000
8.099	5	Rie Increase Renal Capacity					
8.100	(753)	Capital Grants < £50k	0	0	500	0	0
8.101							
8.102	**18,843**	**Total** (copied to lines 7.01 and 8.063)	**16,580**	**19,500**	**43,870**	**10,050**	**10,140**

	2014-15 £000s	Source of capital receipts (please enter all figures as negative)	2015-16 £000s	2016-17 £000s	2017-18 £000s	2018-19 £000s	2019-20 £000s
8.103	(1,000)	14/15 Disposals					
8.104		15/16 (Est Gen Hosp, Polbeth Clinic, Springwell House)	(3,151)				
8.105		16/17 (Mornigside Drive, Craiglea, Edenhall Hosp, Hopetoun Unit,Corstorphine Hospital)		(1,986)			
8.106		17/18 (Bangour V, AAH, Herdmanflat,Belhaven,Marchhall Nursing Home & other)			(26,551)		
8.107		18/19 (RHSC, AAH,Bangour V)				(30,441)	
8.108		19/20 (Bangour Village)					(12,238)
8.109							
8.110							
8.111	**(1,000)**	**Total** (copy to line 8.059)	**(3,151)**	**(1,986)**	**(26,551)**	**(30,441)**	**(12,238)**

	2014-15 £000s	Donated assets	2015-16 £000s	2016-17 £000s	2017-18 £000s	2018-19 £000s	2019-20 £000s
8.112	(523)	Donated assets additions - income					
8.113	523	Donated assets additions - expenditure					

	2014-15 £000s	Property	2015-16 £000s	2016-17 £000s	2017-18 £000s	2018-19 £000s	2019-20 £000s
8.114	0	PFI reversionary interest for projects signed prior to 1 April 2009					

NHS Lothian #
Risk Schedule - 2015/16

Key Assumptions / Risks	Risk rating	Impact
Local Reinvestment Programme	High	Delivery of recurring savings to the value required to meet the known gap between anticipated income and planned activities.
Scheduled Care	High	There requires to be continued management of the financial exposure on elective capacity pressures. The risk that additional investment in capacity will not deliver the required volume and to meet the DFP Strategy.
Unscheduled Care	High	Continued management of the financial exposure on unscheduled care capacity pressures
Delayed Discharge	High	Need to manage the volume of delayed discharges and the cost of new initiatives to deliver the required reductions will not succeed
Parental and Adoption Leave	High	The implementation of paid parental leave until the child is 14 years has been modelled with various scenarios; the initial take up will be high. An implementation dateof April 2014 has been agreed. No additional funding has been assumed in the Financial Plan.
Rates Rebates and Property Sales	Medium / High	The ongoing rateable value appeal of the GMS properties could generate substantial backdated rebates. At present £5m has been assumed as part of the non recurring support available for 2015/16.
Prescribing	Medium	A sustained level of short supply has been included in the financial plan along with growth and price increases, however there is the potential for increases to be greater than projected.
Changes to the IPTR process	High	It has been assumed that these costs will be offset by national savings in the drug tariff along with any further costs incurred in year.
Hep C Drugs	High	The useage of the new range of Hep C Drugs is greater than the costed projection.
Changes to pay terms & conditions, specifically the review of the implementation of transitional points under Agenda for Change and the ongoing discussions with Consort on the full implication of the Two Tier Agreement	Medium	Neither of these issues can at the moment be fully quantified. The financial consequence has not be included in the financial pland and will need to be monitored as the year progresses.
SGHD Allocations	High	Availability of SGHD funding for previously seperately funded programmes and initiatives.
Capital Programme	High	NHSiL has an ambitious capital programme which requires significant resources in addition to those available to deliver. The revenue consequences of the programme are a significant pressure to the organisation
Equal Pay	High	Discussions are continuing with CLO and Audit Scotland woth regards to the treatment of this potential financial exposure.
Bed Reductions	Very High	The LRP programme anticipates a total reduction of 114 beds across Unscheduled Care Services. This will require sufficient capacity being available across other services to accommodate faster discharge
Social Care Investment	Very High	The overall plan around LRP and redesign will require additional investment into a variety of care streams from Social Care Services. At this stage there is a material risk that this investment is not prioritised in the budget for Social Care, resulting in a care deficit leading to increased delayed discharges in the hospital setting.