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1. NHS Ayrshire and Arran’s Population – Use of Services

1.1 Changing Use of Health and Care Services

This briefing focuses on NHS Ayrshire and Arran, but many of the challenges experienced by the NHS Board, and highlighted in this document, are common across the Health and Social Care system as a whole in Scotland, the wider UK and Europe.

Across Europe our environment is changing and health systems are facing significant challenges of aging populations, the rise in chronic diseases and ongoing constraints on public finances. We are living in a world where almost 40 percent of Europeans will be over the age of 60 by 2050, and where populations are shrinking. Furthermore we are witnessing:

- 80% of over 65 have at least one chronic disease (National Council on Aging);
- 50% have two or more chronic diseases (Centre for Chronic Disease and Control);
- 1 in 6 in the EU have a mild to serious disability (Papworth Trust); and
- Chronic disease accounts for 77% of total disease in Europe (European Chronic Disease Alliance).

It costs three times more to look after a 75 year old and five times more to look after an 80 year old than a 30 year old. Currently, chronic disease consumes 80% of the health care budget across Europe.

Existing systems are designed to deliver acute care, and whilst these systems need to re-orientate to meet a changing landscape, they still need to continue to deliver acute care to meet extant demand. This is proving to be a universal challenge.

Re-orientation requires a balance of resource allocation across the whole health and care system. Acute service provision cannot bear the burden of care as other parts of the system are reconfigured; and transformation can only happen when there is a foundation of operational and financial stability.

Within the Scottish health and social care system the predicament is similar, but in its favour:

“Scotland’s smaller size as a country supports a more personalised, less formal approach than in England. The Scottish NHS has also benefited from a continuous focus on quality improvement over many years. It uses a consistent, coherent method where better ways of working are tested on a small scale, quickly changed, and then rolled out. Unlike in the rest of the UK, this is overseen by a single organisation that both monitors the quality of care and also helps staff to improve it.” Nuffield Foundation July 2017.

However, the challenges are real, significant and in need of urgent collective action. It is within this context that the detail within this briefing should be considered.

1.2 Ayrshire’s Population

The population within NHS Ayrshire and Arran is older than average and overall, is decreasing with the greatest population increases expected in the older age groups. By 2020:

- over 23% of the population will be over 65 years of age, compared to 19.6% across Scotland;
- the number of people aged 75 or over is projected to increase by 33% by 2024, compared to an increase of 29% projected for Scotland;
- the population is projected to further decrease by 1.3% by 2024, compared to a projected 3.1% increase in the Scottish population; and
- the working age population of Ayrshire and Arran (who consume less of our resources) is projected to decrease by 2.1% by 2024, compared to a projected increase of 3.4% for Scotland.
The local birth rate has been gradually decreasing over the last five years, and has been lower than the Scottish average for the last decade. In 2016, the birth rate was 9.4 per 1000, compared to a rate of 10.1 per 1000 for Scotland.

Accessibility issues exist for several “remote and rural” communities within NHS Ayrshire and Arran area, which covers an area of 3,369 square kilometres and includes two islands. This dynamic also makes it difficult to attract and retain staff in some parts of the region.

Lifestyle factors are strongly linked to chronic disease, disability and deaths. These are more prevalent in more deprived areas, increasing inequality.

Smoking – 22.7% of adults smoke compared to 20.2% for Scotland, with significantly more smoking attributable admissions and smoking in pregnancy compared to the national average.

Alcohol and drugs – There are significantly higher rates of alcohol and drug-related hospital stays in Ayrshire compared to Scotland.

Diet – 11.2% of Primary 1 children are obese, significantly higher than the Scotland level of 9.9%.

Physical inactivity – There are significantly lower rates of active travel to work in Ayrshire and Arran than the national average.

Mental health – There are significantly lower levels of wellbeing than Scotland as a whole, and higher levels of potential psychiatric illness. Analysis of primary care data showed that there have been upward trends over the last decade within Ayrshire and Arran in the numbers of people recorded with dementia, new diagnosis of depression, and severe and enduring mental illness.

1.3 Health Outcomes

Increased proportion of lives spent in poor health - People are living longer but the length of time that they spend in good health is not increasing. More years spent living in poor health creates additional demand for health and social care services. Men spend an average of 14.2 years and women spend an average of 17.8 years in poor health, which is longer than the Scottish average of 13.5 years for men and 15.6 years for women.

Disease prevalence and main causes of death – Cancer is the main overall cause of death with 1,257 deaths in total in 2016; 1,247 people died of circulatory diseases in 2016, and 647 died of respiratory diseases.

Premature mortality describes deaths under the age of 75 years in the population and it is considered to be a useful indicator of overall health. Figure 1.1 below shows that overall mortality rates and premature mortality rates are consistently higher than Scotland for all the main causes of death.
Significant ongoing health inequalities in life expectancy are evident between the most and least deprived communities. These affect the quality and quantity of many people’s lives and result in earlier onset of long term conditions, higher levels of premature death and higher use of health and social care services.

- There is an 8.9 year difference in life expectancy between men living in the most and least deprived areas.
- Women living in the least deprived areas have a life expectancy of 81.3 compared to 76.1 for women living in the most deprived areas.
- Average life expectancy for both men and women in Ayrshire and Arran is below the national average.

**Health service usage** – there is significantly higher number of hospitalisations for a range of diseases compared to the Scottish average, including coronary heart disease, chronic obstructive pulmonary disorder and asthma. Ayrshire and Arran residents have a significantly higher rate of emergency hospitalisation and patients over 65 years with multiple emergency hospitalisations, compared to the Scottish average. This has the effect of increasing pressure on health and care services. We have undertaken work to explore the underlying reasons for these variances in emergency admissions and have detailed our analysis below.

### 1.4 Understanding Demand

Whilst population health will drive need for services, national benchmark tools would suggest that against key measures, operational performance is somewhat out of kilter with the rest of Scotland and not explained by routine analysis. Local analysis, supported by ISD colleagues, highlights that a greater understanding of the impact of both the age and deprivation profile of Ayrshire residents is required to fully appreciate how Ayrshire and Arran’s population characteristics impact on need for services.

Admission rates vary substantially across Scotland ranging from 8,446 to 13,792 per 100,000 population (2014-15 data)\(^1\). Rates are highest in NHS Ayrshire and Arran at 131% of the Scottish average. Several other

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\(^1\) Data from ISD website, “Annual inpatient and day case activity – NHS Board of Residence” October 2016 release. Using Board of Treatment data gives similar rankings and trends, though for NHS A&A admissions by Board of Treatment run at 96% of Board of Residence – i.e. a small net outflow of patients to other Boards.
Boards have notably high levels, specifically Borders, Greater Glasgow and Clyde, and Lanarkshire, but none to the same extent as Ayrshire and Arran.

When comparing bed day rates by NHS Board, Ayrshire and Arran’s excess is reduced to 120% of the Scottish average. High admission rates (131%) are partly mitigated by the shorter than average length of stay (LOS). Ayrshire and Arran’s LOS is the third lowest in Scotland at 93% of the Scottish average.

Ayrshire and Arran has the fourth highest population of older adults (≥65 years) in Scotland, and the fourth lowest population of younger adults (18-45 years). The three Boards (Dumfries & Galloway, Borders and Highland) with older populations and fewer young adults all have significantly higher life expectancy at birth and at age 65, suggesting healthier populations. Ayrshire and Arran is unique amongst these four boards in having high levels of deprivation.

The table below shows the calculated excess of admissions and bed days in Ayrshire and Arran compared to the Scottish average (as a % of the Scottish average in brackets). The data are then adjusted for age, deprivation, and then age and deprivation combined.

<table>
<thead>
<tr>
<th></th>
<th>Excess Admissions</th>
<th>Excess Bed Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unadjusted population</td>
<td>11,972 (31%)</td>
<td>55,660 (20%)</td>
</tr>
<tr>
<td>Age-standardised</td>
<td>9,578 (25%)</td>
<td>26,743 (9%)</td>
</tr>
<tr>
<td>Deprivation-standardised</td>
<td>9,179 (24%)</td>
<td>41,693 (12%)</td>
</tr>
<tr>
<td>Age and deprivation</td>
<td>6,894 (18%)</td>
<td>7,244 (2%)</td>
</tr>
</tbody>
</table>

A large part of the excess in admissions and most of the excess bed days in Ayrshire and Arran compared to the Scottish average are explicable by the age and deprivation structure of the population.

After adjusting for age and deprivation, there remains a reduced excess in admissions compared to the Scottish average. With the mitigation of shorter length of stay, the excess in bed days compared to the Scottish average is reduced to a negligible level. The residual excess after adjustment lies predominantly amongst more deprived younger adults (19-45 years), which may be in part explained by net outward migration of healthier, less-deprived young adults for education and work opportunities, and the least deprived older adults (≥75 years) which may be explained by limited family networks and the impact on social care of net inward migration of people retiring to Ayrshire.

Whilst this analysis requires further development, it does show that a greater percentage of variation to the Scottish average can be explained. It legitimises the high levels of admission to our unscheduled care services in Ayrshire in that Ayrshire’s population is indeed different. This suggests that the particular characteristics associated with Ayrshire and Arran’s ageing population and significant levels of deprivation appropriately drive a greater level of use of service than might be expected.

This high level of demand for services doesn’t come without challenges which can be seen in our operational performance data and associated impacts on financial performance.
2. NHS Ayrshire and Arran’s Progress in delivering our Local Delivery Plan (LDP)

2.1 NHS Ayrshire and Arran’s Annual Review 2016-17

NHS Ayrshire and Arran’s Annual Review of 2016-17 was conducted by Shona Robison MSP, Cabinet Secretary for Health and Sport, on Friday 20 October 2017. The Review, held in public, described and discussed both the challenges and areas of success experienced in the delivery of our LDP during 2016-17. During the review the Chairman of the NHS Board recognised and acknowledged the hard work and commitment of teams across health and social care in Ayrshire and Arran who work tirelessly to deliver the highest quality of care to the people who use our services.

As part of the Annual Review process a Chairman’s Self-Assessment is prepared which sets out progress made throughout the year. This is made available to members of the public ahead of the meeting through the NHS Ayrshire and Arran website. The Self Assessment for 2016-17 can be accessed via the link: http://www.nhsaaa.net/media/2962/selfassessment2017.pdf. Letter from the Cabinet Secretary for Health and Sport is appended.

2.2 NHS Ayrshire and Arran – Progress against LDP 2017-18

NHS Ayrshire and Arran submitted its LDP for 2017-18, in line with the guidance, in March 2017. The paper was presented to the NHS Board.

Link to the finance component here: http://www.nhsaaa.net/media/2214/20170327bmp17a.pdf
Link to the LDP process paper here: http://www.nhsaaa.net/media/2215/20170327bmp17b.pdf

Link to the LDP paper that went to the Board for approval here: http://www.nhsaaa.net/media/2260/20170626bmp07.pdf

An update on performance against the LDP is provided below and the midyear position paper that will be presented to the Performance Governance Committee at its meeting on the 4 December is appended.

2.2.1 Unscheduled & Urgent Care

The population health challenges in Ayrshire translate into high levels of patients attending our Emergency Departments and a high proportion who are subsequently admitted to hospital. Patients who come to hospital for urgent assessment or care do not only go through our Emergency Departments though. Since opening our Combined Assessment Units (CAUs) on both our main hospital sites we have observed an expected reduction of patients attending the Emergency Departments, with more now being assessed and cared for within this alternative setting as is demonstrated in Figure 2.1 below.
Prior to our Combined Assessment Units opening, our two main hospital sites would normally have had an average of 320 patients attending for emergency assessment and care. Following the opening of the Combined Assessment Units on both main hospital sites on average there are 295 patients attending the Emergency Departments each day. Around 100 patients are admitted to our two CAUs per day, although about a third of these are transferred from the Emergency Departments. The remaining two thirds are mainly GP referrals with a small proportion being other types of referrals. High levels of patients attending and being admitted to our hospitals results in us operating well above 90% capacity throughout the year. This continues to be a challenge, particularly during times of increased seasonal demand for unscheduled and urgent assessment and care.

We do however ensure that patients have appropriate shorter lengths of stay where possible, although, as a result of our older population characteristics we have challenges with patients being delayed in hospital whilst awaiting their care to be transferred to a more appropriate setting. Figure 2.2 demonstrates that the number of patients who are delayed in hospital for more than two weeks beyond their discharge date, and the associated numbers of Occupied Bed Days are high within Ayrshire and Arran. This is due to challenges in social care provision. NHS Ayrshire and Arran works closely with the Integrated Joint Boards and Local Councils to address this matter.
2.2.2 Planned Care

Figure 2.3 illustrates the numbers of people who are treated within the 12 week Inpatient and Daycase Treatment Time Guarantee, and highlights that the waiting list size has remained relatively stable over the past year.

The number of patients waiting over 12 weeks for an Inpatient or Daycase appointment is shown in figure 2.3 below. This highlights that the overall number of patients waiting beyond the 12 week period is not continuing to rise.
The waiting times target of a maximum of 12 weeks for Outpatient appointments also continues to be challenging, as Figure 2.4 below illustrates. However, as with Inpatient and Day case waiting times we are managing the overall waiting list size, ensuring that the numbers of patients waiting more than 12 weeks is not increasing.

We realise that we are not unique in this regard, with other NHS Boards facing the same challenges and whilst we recognise this we continue to work to ensure that we prioritise those most urgent cases and keep waiting times beyond the 12 week period as short as possible both for Inpatient and for Outpatient appointments.
In fact, we can demonstrate in figure 2.5 below that throughout the past year we have continued to perform well against the 31 day and 62 day Cancer targets for referral and treatment of these patients who require our urgent care. Whilst this is critically important we also know that by detecting cancer at an earlier stage, we will give every patient the best chance of a positive outcome. Through the Detect Cancer Early programme we are ensuring that over a quarter of patients being diagnosed with breast, lung and colorectal cancers are diagnosed at the earliest stage, exceeding the challenge set within the LDP targets. There is more to be done in this important area and we aim to continue to improve on this already good performance in this area.

*Figure 2.5: ‘31 Day All Cancer Treatment’ and ‘62 Day Suspicion of Cancer Referral’ Performance – NHS Ayrshire and Arran*

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2.2.3 Quality

Hospital Standardised Mortality Ratio

Despite the high demand for services, our high occupancy rates and our challenges in transferring care we continue to ensure patients experience high quality and safe care. As Figure 2.6 shows we have consistently kept Hospital Standardised Mortality rates below 1.0 at both our main hospital sites. This means that the number of deaths within 30 days of admission for a hospital is fewer than predicted.
Healthcare Acquired Infections

In addition we do well in ensuring our HAI rates are as low as possible. There is room for improvement but our target for Clostridium Difficile is being met where this had proved challenging in the past. Our rates of MRSA and MSSA are not as low as we had planned but this is a challenge faced across Scotland, and we are currently the best performing mainland Board in Scotland. Figure 2.7 below highlights the extent to which performance has improved in Ayrshire and Arran with the two LDP Standards.

Scottish Patient Safety Programme (SPSP)

SPSP is a unique national initiative led by Healthcare Improvement Scotland that aims to improve the safety and reliability of healthcare and reduce harm for patients in Scotland.

SPSP focuses on the following areas:
- Acute Adult;
- Maternity & Children's Quality Improvement Collaborative (MCQIC);
- Mental Health; and
- Primary Care.

Within the Acute Adult programme the Safety Essentials approach has been fully embedded and is consistently measured. This has resulted in sustained improvement in the numbers of falls, cardiac arrest and pressure ulcers. SPSP work through the Maternity and Children’s Quality Improvement Collaborative has led to reductions in the stillbirth rate within maternity services and a sustained reduction in serious safety events within paediatric services.

The SPSP programme for Mental Health has led to a sustained reduction in control and restraint situations in acute admission wards, and through work to improve communication at points of transition has improved the quality of experience for both staff and patients. In Primary Care the SPSP programme has also led to improvements in safety systems and processes and in medicines reconciliation.
3. Ayrshire’s Integration Joint Boards (IJBs) - Performance and Progress

In addition to the Annual Review meeting, the Scottish Government issued guidance in March 2016 stipulating the requirement for Integration Authorities to publish performance reports from 2016-17 onward. The guidance requires the performance reports to be published within four months of the end of the performance reporting period and to consider accessible versions, and public dissemination. The Performance Reports for 2016-17 for each of the three Ayrshire partnership areas were presented to the NHS Ayrshire and Arran Board on 9 October 2017. These can be accessed via the following links:

East Ayrshire Health and Social Care Partnership – Annual Performance Report 2016-17
http://www.nhsaaa.net/media/2920/20171009bmp14.pdf

North Ayrshire Health and Social Care Partnership – Annual Performance Report 2016-17
http://www.nhsaaa.net/media/2921/20171009bmp15.pdf

South Ayrshire Health and Social Care Partnership – Annual Performance Report 2016-17
http://www.nhsaaa.net/media/2922/20171009bmp16.pdf

The Ministerial Strategic Group for Health and Community Care (MSG) agreed proposals to consider quarterly updates on key indicators across health and social care to allow tracking of progress of performance across the Health and Social Care system. The following measures were proposed and analysis of performance at Health and Social Partnership level is now possible.

(1) unplanned admissions;
(2) occupied bed days for unscheduled care;
(3) Emergency Department performance;
(4) delayed discharges;
(5) end of life care; and
(6) the balance of spend across institutional and community services.

The data have been disaggregated to Health and Social Care Partnership and are shown below for the period 2016-17. Figure 2.8 below shows the Emergency Admission rate per 1,000 population for 2016-17 and highlights the high rates of Emergency Admissions in all three Ayrshire and Arran Health and Social Care Partnerships, all well above the Scottish average.

Figure 2.8: Emergency Admissions Rate per 1,000 population: H&SCP 2016-17
Whilst this can be explained to a certain extent due to the population health profile within Ayrshire and Arran, this benchmarking data highlights the extent to which this impacts on admissions and subsequently explains the reasons for the high occupancy rates within our hospitals.

Furthermore, as Figure 2.9 below illustrates the bed day rate associated with these high levels of admissions also fall well above the Scottish average for the three Ayrshire and Arran Health and Social Care Partnerships. It is clear whilst the three Ayrshire Partnerships have high rates of Emergency Admissions the bed day rate for South Ayrshire is much higher than for North Ayrshire, or indeed for East Ayrshire.

**Figure 2.9: Unscheduled bed day rate (Acute) per 1,000 population: H&SCP 2016-17**

![Bar chart showing the acute emergency bed day rate per 1,000 population for different Scottish regions, with South Ayrshire having the highest rate, followed by North Ayrshire and East Ayrshire.](chart.png)

As Figure 2.10 below highlights the high occupancy is also impacted on due to the high bed day rates for those patients who have had their discharge from hospital delayed. The benchmarking data highlight that during 2016-17 this was a particular issue for South Ayrshire Health and Social Care Partnership residents. During the same period the bed day rate for Delayed Discharges for North Ayrshire residents was below the Scotland average, and for East Ayrshire residents the bed day rate was better than the upper quartile performance for all of Scotland’s Health and Social Care Partnerships. This highlights an inequity in the discharge approaches for patients within Ayrshire and Arran dependent on their place of residence. Data for 2017-18 so far would suggest a worsening picture within North Ayrshire Health and Social Care Partnership performance against this measure as well as in total numbers of patients being delayed in hospital beyond their ‘medically fit for discharge date’.
Despite the demands on the system performance against the 4 hour maximum waiting times target has generally improved over the past few years across all the Health and Social Care Partnership areas as is illustrated in Figure 2.11 below.

**Figure 2.10 Delayed Discharges bed day rate per 1,000 (All reasons): H&SCP 2016-17**

The percentage of the last six months of a person’s life spent in a community setting is another key measure of how the Health and Social Care system is working to ensure patients receive the care they need in a homely setting wherever possible. Data for this measure have been captured and are now provided to Health and Social Care Partnerships. There is very little variation within the data however and meaningful interpretation is difficult at this stage. It is worth noting that all three Ayrshire Health and Social Care Partnership areas are performing around average levels. Within Ayrshire and Arran for the period 2016/17 the proportions were 88.2% of people in East Ayrshire, 87.3% in North Ayrshire and 85.0% in South Ayrshire spending the last six months of their life in a community setting.

**Figure 2.11: Percentage of Patients waiting less than 4 hours in Emergency Departments: H&SCP 2016-17**
Furthermore, data on the balance of care and the percentage of the population in community or institutional settings are also provided to Health and Social Care Partnerships. The data provided rely on a number of datasets being brought together, namely, SMR01 (Inpatient and Daycase episodes), SMR04 (Mental Health Inpatient and Day cases), Care Home Census returns, and Social Care Census returns. Due to this, the data provided are currently for 2015/16. As with the previous measure Ayrshire Health and Social Care Partnership data show average performance. More up to date data would be required in order to ascertain if there are any disparities over a more recent timeframe.
4. Financial Performance

4.1 Rising Pressures over the Last 3 Financial Years

The financial plan accompanying the last two Local Delivery Plans projected NHS Ayrshire and Arran having a £13.2 million deficit in 2016-2017 and in 2017-2018. In each of these years, the majority of the funding uplift to the Board (two thirds in 2016-2017 and almost three quarters in 2017-2018) was earmarked for social care.

The 2016-2017 efficiency savings required to balance cost pressures were £38.2 million (equating to 5.75%). The Board agreed a cash releasing efficiency savings target of £25 million for 2016-2017 and tasked the Board’s senior management team to bring forward other efficiencies that would take the Board to a breakeven in 2016/17. The Board also agreed to take forward a transformational change improvement programme to identify savings to address the £13.2 million recurring deficit, and to address the medium term sustainability of services.

In 2016-2017, the Board was able to break even through delivering about £21 million of recurring cash releasing efficiency savings and the balance through non-recurring measures. In both 2016-2017 and 2017-2018, the initially targeted cash releasing efficiency savings of £25 million which is around 3.5% of the revenue resource limit. In 2016-2017 some efficiency savings were achieved non-recurringly which left more to deliver in 2017-2018 and many clinical services are finding these very difficult to deliver in the face of increasing demand.

Staffing and drugs costs account for about three quarters of spend against the Board revenue resource limit. Staffing costs (including agency) rose by 10.7% between 2013-14 and 2016-17, with 2% of the increase in 2016/17 being due to a national insurance contribution increase as a result of the move to a state single pension. Medicines costs rose by about 23% between 2012-13 and 2016-17 mainly in hospital and new drugs costs.

4.2 The Current Financial Challenge

The financial pressures in the system fall into 3 main areas:

- Medical & Nursing workforce
- Unscheduled Care
- Medicines

Medical workforce challenges have seen spend on agency doctors double over the last three years from £4.5 million in 2014-15 to £9.5 million in 2016-17. This is as a result of increasing medical vacancies and, as the cost of an agency doctor averages over twice the budget for the vacant post, a £5 million cost pressure arises. The use of locum doctors is a risk based decision and is always informed by the need to keep services safe for the citizens across Ayrshire. Redesigning services and using different skills is one way that we have sought to mitigate these issues. However, the availability of medical staff is unlikely to improve significantly in the medium term therefore changes to the skill mix requirement of roles, or service redesign will be required to mitigate where possible.

Nurse agency spend doubled from £1.5 million in 2015-16 to £3m in 2016-17. Additional nursing staff have been recruited in response to the nursing workforce tools and this has resulted in agency spend reducing in 2017-18.

The combination of unscheduled care demand and delays in transferring patients to home or a social care setting manifests in the use of an additional 100 beds across the acute hospitals.

In relation to medicines, volume expressed as number of items prescribed remains within the expected range however financial challenge is driven by increasing cost per item. The expected cost per item on a
primary care prescription was expected to be £10.16 in 2017/18 however the average cost per item for the year to date is £10.53.

The month 7 year to date position shows a year to date overspend of £16.6m, which is projected to rise to £20.0m by the year end.

4.3 Ongoing Work to Minimise the Financial Deficit

4.3.1 Cash Releasing Efficiency Savings

Significant progress on increasing deliverable and implemented CRES during this year has been made, improving our in-year position, primarily through increasing identified CRES. Focus on in year efficiency opportunities has increased low risk CRES in the last quarter by £1.9m to a total of £15.4m of the £24.8m target total. The remaining schemes are considered as being at higher risk for delivery.

4.3.2 Best Value

Best Value programmes incorporating the Best Value Initiatives set out by the Scottish Government have been investigated fully and we have progressed opportunity areas seeking to deliver savings where possible, minimise waste, reduce variation, standardise approaches and improve patient experience. Although not all of the opportunities have resulted in financial savings, there are a few additional areas that are expected to generate productivity savings for 17/18.

Actions arising from the national Procurement strategy are also incorporated into our local plans and we have been rigorous in our approach to ensuring best value in respect of our procurement practices. A number of further potential procurement opportunities have been identified which are being explored:

- **Mileage** - Reduction in mileage travelled through increased use of teleconferencing facilities.
- **Fleet** - Review of lease car provision.
- **Patient Transport** - Enforcing eligibility criteria to reduce annual spend on taxis, with integrated helpdesk increasing the use of voluntary drivers.
- **Property Maintenance** - Reviewing property maintenance agreements.
- **Print & Stationery** - Reduction of desktop printers to aid cultural shift towards digital alternatives.

4.3.3 Estates Master Planning

A key component of our plan for future delivery of services is focussed on the necessary infrastructure at all points of service delivery, whether in the community or secondary care setting. Our Estates Master Plan links our existing infrastructure with the future model of service delivery, to optimise and rationalise existing infrastructure alongside a plan for new capital developments.

Demolition or disposal of unused premises where buildings have become surplus to clinical or other needs is part of this plan. This enables us to rationalise the estate with the consolidation of core properties and disposal of surplus assets by way of demolition or sale. This will increase estate performance and release capital and revenue savings back into facilities. In year savings of £150,000 are projected.

Energy Spend to Save Schemes for implementation Board wide, to reduce energy consumption and costs are being pursued. For example, Carbon Reduction Programme funding has been allocated from Scottish Government for 2017/18 for University Hospital Ayr, to install new biomass Combined Heat and Power (CHP) units to generate domestic hot water and electricity from renewable sources, and a 1MW biomass boiler to provide renewable heat to the site. This will give a revenue benefit in 2018-19.
4.3.4 Effective Prescribing

NHS Ayrshire and Arran has a well established and effective approach to improving the effective prescribing of medicines in primary care. This work has resulted in the cost per prescribed item in primary care being below the national average. This is underpinned by a proactive approach to formulary management with good compliance with the current range of medicines within the formulary.

Recognising that we have a high volume of items prescribed per patient and this has a significant impact on the overall cost per patient for prescribed medicines in primary care, we are tackling the volume of medicines prescribed, through testing an approach in respiratory, analgesics and antidepressant prescribing.

As a result of increasing costs of medicines in secondary and specialist services, an increased focus on the effective use of medicines in secondary care is being progressed. We are reviewing medicine supply arrangements to ensure patients receive the medicines they need via the appropriate supplier (secondary care, primary care or homecare). Mechanisms for supply of medicines to inpatients, outpatients and patients being discharged from secondary care is being updated to streamline processes and ensure NHS Ayrshire and Arran receives value for money. There will be a specific review of supplies to inpatients to minimise waste, as currently medicines are supplied for inpatient use and may be supplied again at discharge. Returned medicines are also not always recycled into stock therefore waste can occur. A reduction in spend on medicines for inpatients can be achieved by: use of patients’ own medicines which will be rolled out across acute services; part pack dispensing will be introduced in order to minimise waste incurred when medicines are returned from inpatient areas; and scoping of one stop dispensing.
5. Creating a Sustainable Health and Care System

It is recognised that a sustainable future for NHS Ayrshire and Arran is dependent upon addressing both the current and projected financial and operational challenges. Work has been ongoing to understand the scale of these challenges and to continue developing and implementing sustainable change programmes to address these. Over the last 18 months the following Strategic Service change Programmes (SSCPs) have been developed:

- Unscheduled Care;
- Primary Care - Ambitious for Ayrshire;
- Older People & People with Complex Needs;
- Mental Health;
- Planned Care – Improving Access;and
- Digital – Technology Enabled Care.

Further detail on these programmes of change can be found in our Transformational Change Improvement Plan and associated Delivery Plan which was approved by the NHS Board at its meeting in June 2017 and endorsed by the three Ayrshire IJBs at their meetings in June 2017. A link to the paper is here: [http://www.nhsaaa.net/media/2260/20170626bmp07.pdf](http://www.nhsaaa.net/media/2260/20170626bmp07.pdf)

Whilst there will be broader service and operational changes across the system, four areas of focus have been prioritised:

- Prevention;
- Primary Care, Community Care and Social Services;
- Digital; and
- Improving Delivery of Hospital Care.

**Prevention**

All of our programmes have prevention and self care as a component and it is a fundamental element of the integrated model of health and social care.

We recognise that minimal investment in prevention not only elicits a significant return in terms of the health of the population, it also reduces the number of people seeking access to services. However, there are significant challenges in making this shift to prevention both in terms of the need to increase investment in the prevention agenda but also to make the necessary cultural shifts in the population’s thinking about self care, and the use of health and care services.

We are adopting a more focused approach to improving population health, preventing avoidable illness and thereby reducing demand for health and social care services. Wider public services across Ayrshire and Arran will work with the health and care system to maximise prevention and early detection and to reduce the gap between the most and least deprived communities. Individuals will be supported to take action in terms of their own health behaviours, and health and care staff will adopt inequalities sensitive practice and policies in order to improve health and reduce inequalities. We also intend to implement a range of high impact targeted interventions to support people, and are investing in prevention and targeted interventions for high risk groups e.g. people with diabetes.

**Primary Care, Community Care and Social Services**

National strategy acknowledges the need to focus on primary, community and social care to meet future health and care need. In anticipation, we have undertaken the preparatory work to introduce a Multi Disciplinary Team (MDT) approach. We acknowledge that MDT working is complex. The scale of change required across professions provides a unique opportunity to progress a longer term strategy of transformational change to deliver the vision from Primary Care; improve the patient experience; and, positively impact on the local levels of unscheduled care.
**Digital**

We recognise that digital technology needs to underpin our future model of care to ensure that there is effective and timeous communication across services to support the delivery of the right care at the right time, and that the benefits of telehealthcare are utilised to provide care and support out with a hospital setting.

We firmly believe that improving our existing systems and exploiting the appropriate use of digital technology, where appropriate, will also support our drive to be as efficient and effective as possible.

**Improving the Delivery of Hospital Care**

There are ongoing social care challenges addressing demand for care at home and reablement services and accessing residential and nursing home care. The need for additional capacity in care at home and reablement services is critical, as without robust services in place, people present to hospital and once admitted, discharge becomes difficult. This results in pressure on our acute hospitals. Through the development of our Health and Care model we expect pressure in the acute environment to be alleviated, allowing us to focus on further improving the quality of hospital care for the sickest people of Ayrshire who need to be seen and treated in an acute environment.

Whilst we anticipate that these areas of focus alongside our SSCPs will bring benefit to service users and improve outcomes, it is clear that there is more to do to create sustainable modern health and care services. Improved rigour, pace and ambition is required to be able to meet the scale of the challenge, as well as longer term system change as reflected in our integrated model of health and social care.

It is recognised that continuing to make current systems and processes work faster and harder will not deliver the required step change in performance and financial stability. Therefore, we have undertaken significant work to develop the future Ayrshire and Arran Integrated Health and Care System model. Its focus is on prevention, anticipation and supported self management at home or in a homely setting. It draws on support from neighbourhood organisations and local communities. This network of health and social care services will operate on a shared care and inclusive basis. The model takes a whole system pathway approach to improve patient care and aims to reduce delay, duplication, fragmentation and, as well as being more efficient and providing best value, it will also deliver a shift in the balance of care.

It is acknowledged that a detailed business case will need to be developed to allow the new model to be implemented. We would propose that work on a business case follows the development of Regional Health and Care Delivery Plans due in March 2018 when the outcomes from this regional approach will inform our health and care model locally.
6. Performance Reporting & Governance

NHS Ayrshire and Arran has a robust and transparent governance system in place to ensure the NHS Board has access to and receives appropriate assurance in relation to the organisation’s performance in key areas of operation and finance. Links to recent NHS Board reports are provided below.

6.1 Unscheduled Care

The Corporate Management Team and NHS Board regularly consider and review the performance of the whole system around unscheduled care through a regular report which concentrates on three thematic areas. These are:

- Reducing emergency admissions by providing accessible community alternatives;
- Reducing occupancy and length of stay by improving systems and processes within the Acute Hospital; and
- Reducing delays in discharge by providing appropriate community capacity

The most recent report to the NHS Board can be accessed via the link:
http://www.nhsaaa.net/media/2944/20171009bmp11.pdf

In order to meet this challenge as a Health and Social Care system NHS Ayrshire and Arran is working closely with the three Health and Social Care Partnerships, and is implementing a Strategic Service Change Programme for Unscheduled Care which includes a range of actions and improvement measures. We will take our Winter Plan to our NHS Board at its meeting in December to seek their approval on how we configure our Health and Social Care services over the Winter Period to ensure patients experience good quality and timely care. The Plan will be available as part of the NHS Board Papers following its meeting on the 11 December.

6.2 Planned Care & Waiting Times

Our performance around planned care and waiting times is presented regularly to our Corporate Management Team and our NHS Board in the form of a Planned Care Performance paper. The most up to date version of this paper to the NHS Board can be accessed via the link:
http://www.nhsaaa.net/media/2918/20171009bmp12.pdf

6.3 Healthcare Acquired Infection

To continue to deliver high quality services, especially in the face of high demand, is challenging but we continue to improve in relation to limiting the numbers of hospital associate infections such as MRSA and Clostridium Difficile. We regularly scrutinise our performance in this area at our Infection Control Committee, at our Corporate Management Team meetings, at our Healthcare Governance Committee and through regular HAI reports to our NHS Board. The most current NHS Board paper can be found here:
http://www.nhsaaa.net/media/2937/20171009bmp04.pdf

6.4 Scottish Patient Safety Programmes

The NHS Board also receives regular reports on each of the Scottish Patients Safety Programmes:

Acute Adult SPSP: 10 Essentials of Safety
http://www.nhsaaa.net/media/2182/20170130bmp06.pdf

Scottish Patient Safety Programme in Primary Care Report
http://www.nhsaaa.net/media/2231/20170522bmp05.pdf

Scottish Patient Safety Programme – Mental Health
http://www.nhsaaa.net/media/2812/20170821bmp06.pdf
6.5 Patient Experience

The Healthcare Governance Committee and the NHS Board also consider patient experience and measures of how well we respond to Complaints and how we deal with other forms of feedback. The Patient Experience Annual Report 2016/17 was presented to the NHS Board at its meeting in August 2017. Link here: [http://www.nhsaaa.net/media/2811/20170821bmp05.pdf](http://www.nhsaaa.net/media/2811/20170821bmp05.pdf)

6.6 Financial Monitoring

Scrutiny of all resource plans (revenue and capital) and the associated financial monitoring is considered by the Corporate Management Team, the Performance Governance Committee, and the Board. At the Board meeting on 27 March 2017, the Board approved the financial plan for 2017-18. [http://www.nhsaaa.net/media/2214/20170327bmp17a.pdf](http://www.nhsaaa.net/media/2214/20170327bmp17a.pdf)

The Corporate Management Team and the NHS Board are provided with monthly Financial Management Reports and the Performance Governance Committee regularly seeks assurance at its meetings. The latest Financial Management Report to the NHS Board is provided via the link: [http://www.nhsaaa.net/media/2919/20171009bmp13.pdf](http://www.nhsaaa.net/media/2919/20171009bmp13.pdf)
Dr Martin Cheyne
Chair
NHS Ayrshire & Arran
Eglinton House
Ailsa Hospital
Dalmellington Road
Ayr
KA6 6AB

21 November 2017

Dear Martin,

NHS AYRSHERE & ARRAN: 2016/17 ANNUAL REVIEW

1. This letter summarises the main points discussed and actions arising from the Annual Review and associated meetings in Kilmarnock on 20 October. I would like to record my thanks to everyone who was involved in the preparations for the Review, and also to those who attended the various meetings. I found it a very informative day and hope everyone who participated also found it worthwhile.

Meeting with the Area Clinical Forum

2. I had a constructive discussion with the Area Clinical Forum. It was clear that the Forum continues to make a meaningful contribution to the Board’s work, and that the group has effective links to the senior management team. It was reassuring to hear that the Forum felt it had been fully involved in the Board’s determined focus on contributing to effective clinical governance and patient safety. In addition, the Forum has played a key role in terms of the development of the Board’s transformational change programme. I was also pleased to hear of the Forum’s support for the Health & Social Care Delivery Plan and the Chief Medical Officer’s commitment to Realistic Medicine. I am in no doubt that continued, meaningful engagement of local clinicians will be essential in taking forward both the critical health and social care integration agenda and other local service redesign programmes.

3. I had very interesting discussions with the representatives from the various professional committees and undertook to consider some of the points raised; for instance: the need for effective succession/workforce planning; the desire for more flexibility in the local use of resources allocated by the Government; the need for the consistent regulation of professions to underpin patient safety; the need for a consistent approach to the implementation of the Apprenticeship Levy across the UK; the need to more effectively involve the Third Sector in helping to bridge the gap that is sometimes evident between acute and primary/community care; and the need to promote learning from genuinely innovative service redesign schemes, not least in areas of greatest local pressure such as unscheduled care. I was grateful to the Forum members for taking time out of their busy schedules to share their views with me.
Meeting With the Area Partnership Forum

4. In the days preceding the Annual Review, Unison had written to the Chief Executive to confirm that their representatives were withdrawing from local partnership working, and would not be represented at the Review’s Partnership Forum meeting. Clearly, it is important for all Boards to have effective staff-side representation and partnership working arrangements in place. I believe that ongoing dialogue between parties is the best way to resolve any differences in order that local partnership arrangements can return to the preferred model of industrial relations, based on principles of mutual trust and confidence.

5. To this end, I know that Shirley Rogers, Director of Health Workforce and Strategic Change at the Scottish Government, has offered to facilitate a joint discussion with local partners as a means to making progress. I hope all partners will agree to participate constructively in such discussions and that full, local partnership working is restored as quickly as possible.

6. Whilst Unison were not present at the Area Partnership Forum meeting, as with all Ministerial Annual Reviews this year, the union had helped to organise a demonstration outside the hospital at the start of the day, on behalf of the ‘Scrap the (pay) Cap’ campaign. I stopped to speak to the campaigners on my way into the Review. I confirmed that, as announced by the First Minister on 5 September a part of our Programme for Government, it is our intention to lift the public sector pay cap for the NHS and other public sector workers; to take effect in 2018.

7. The remaining members of the Area Partnership Forum sought to reassure me that local relationships remain strong; that this is fundamental to a number of developments and improvements that have been delivered locally over the last year; and that the Forum continues to engage effectively with the Board, not least on: workforce planning and the local people strategy; the critical health and social care integration agenda; the work undertaken to scope and develop the shape of future clinical services through the transformational change programme, including the identification of staff champions; the iMatter staff experience continuous improvement model; and the considerable work undertaken to develop the local response to the health, safety and wellbeing agenda.

Patients’ Meeting

8. I would like to extend my sincere thanks to all the patients who took the time to come and meet with me. I very much value the opportunity to meet with patients and firmly believe that listening and responding to their feedback is a vital part of the process of improving health services.

9. I greatly appreciated the openness and willingness of the patients present to share their experiences and noted the specific issues raised including: the importance of well organised and timely rehabilitation which is crucial to recovery; of NHS staff listening to and respecting the views of patients and carers and to promote and support self-management, where appropriate; the need to ensure that communications with patients take place in a way which is appropriate to their needs; the need to ensure that patients were aware of their rights in relation to the review and management of their medical records; whilst improvements in technology were welcomed, there is a need to ensure that the systems employed are compatible and effective to avoid any delays; and how general NHS services should be set up to recognise, support and refer where there may be mental health issues.
10. I was pleased to hear during the Chair's presentation you reiterate the Board's clear focus on patient safety, effective governance and performance management; and on the delivery of significant improvements in local health outcomes, alongside the provision of high quality, safe and sustainable healthcare services.

11. You referenced that, during 2016, NHS Ayrshire & Arran's maternity services were subject to three reviews: two of which were commissioned by the Board in response to concerns around your perinatal mortality rates for 2013-14; I commissioned the third in December 2016, asking Healthcare Improvement Scotland (HIS) to undertake an independent review of the management of adverse events within Ayrshire Maternity Unit at University Hospital Crosshouse, in response to concerns raised by families about the management of adverse events in the unit.

12. I want to put on record my thanks to the 16 local families who were involved in contributing to the HIS review and, once again, extend my heartfelt condolences and sympathy to them. The Board has rightly apologised for the shortcomings identified by the 3 reviews and you detailed the significant work that has already been taken locally, and that is underway, to ensure that the Board fully addresses the reports' recommendations.

13. I note that: the Board’s actions include plans to appoint a Risk and Quality Improvement Team for maternity services, comprising senior maternity staff to support the changes required in the improvement plans; and that the Board has invested £1 million in midwifery staffing since 2014; as well as appointing an additional consultant obstetrician and clinical risk midwife. I welcome this response from NHS Ayrshire and Arran, and have been clear that I expect the improvement plans to be implemented and evidence of the improvements published. HIS will monitor progress against the implementation of the recommendations.

14. A detailed account of the specific progress the Board has made in a number of other areas is available to members of the public in the self-assessment paper which the Board prepared for the Annual Review. This has been posted on the NHS Ayrshire & Arran website. We then took a number of questions from members of the public. I am grateful to you and the Board team for your efforts in this respect, and to the audience members for their attendance, enthusiasm and considered questions.

Annual Review – Private Session

Health Improvement

15. NHS Ayrshire & Arran is to be commended for exceeding its target in delivering alcohol brief interventions. A brief intervention is a short motivational interview, in which the costs of drinking and benefits of cutting down are discussed, along with information about health risks. These have been proven to be effective in reducing alcohol consumption in harmful and hazardous drinkers. 4,805 alcohol brief interventions were carried out locally in 2016/17, exceeding the Board's target of 4,275.

16. The Board is also to be commended for its excellent, sustained performance against the drug and alcohol waiting times standard which specifies that 90% of people who need help will wait no longer than 3 weeks for treatment that supports their recovery. NHS Ayrshire & Arran achieved 96.3% against this standard over 2016/17.
17. I also want to put on record our thanks for the Board exceeding the local smoking cessation standard (2015/16). Final performance data for this was published in October 2016 and showed that NHS Ayrshire & Arran achieved 106.4% against the annual target. The Board is to be commended for having a well-developed tobacco prevention programme in place.

**Patient Safety and Infection Control**

18. Rigorous clinical governance and robust risk management are fundamental activities for any NHS Board, whilst the quality of care and patient safety are of paramount concern. I know that there has been a lot of time and effort invested locally in effectively tackling infection control; this is reflected in the Board delivering an 85% reduction in cases of clostridium difficile infection in those over 65 since 2007 and an 85% reduction in rates of MRSA over the same timeframe. Also, with Hospital Standardised Mortality Ratios (HSMR), the Board recorded a fall of 15.7% for University Hospital Ayr and 10.9% for University Hospital Crosshouse between the quarter ending March 2014 and the quarter ending March 2017. That said, the Board narrowly missed the March 2017 target for MRSA/MSSA, though I know you remain committed to making further progress.

19. The Healthcare Environment Inspectorate (HEI) was set up by the former Cabinet Secretary for Health and Wellbeing with a remit to undertake a rigorous programme of inspection in acute hospitals. During 2016/17, the HEI carried out inspections at Arran War Memorial Hospital and at University Hospital Ayr. The Board has given me the assurance that all the requirements and recommendations identified as a result of the other inspections, and those undertaken to consider the care of older people in local hospitals, have been properly addressed.

**Improving Access – Waiting Times Performance**

20. 2016/17 has been another difficult year for NHS Ayrshire & Arran as the Board faced challenges in delivering against the Treatment Time Guarantee, outpatients, the 8 key diagnostic tests and 18 weeks Referral to Treatment standards. You pointed out that the Board faces continuing difficulties in recruiting to a number of predominantly medical specialties which is compounded by a lack of suitable locums and the rising costs associated with using said locums, even when they are available. There are similarly pressures impacting the delivery of the 8 key diagnostic tests, with local access to CT scanning a key issue. The Board assured me that you will continue to work closely with the Government’s Access Team to support recovery and realise sustainable delivery against these key performance standards, for the benefit of local people.

21. A number of Health Boards across Scotland have struggled to meet and maintain the 4-hour A&E waiting target over the last year. The position in NHS Ayrshire & Arran has generally continued to improve over the last year whilst the number of attendances has continued to grow, with an average monthly attendance of 9,538 during 2016/17. Average performance for the year to August 2017 was 94.7%, which is the strongest performance in the equivalent period in any year since 2012. Both main acute sites have benefited from the opening of new Combined Assessment Units alongside the A&E Departments. The national unscheduled care team will continue to work closely with the Board to support implementation of the six Essential Actions across both sites; to monitor progress and to offer on-going assistance and support. The Board assured me that sustainable improvement remains a key priority. Establishing consistent performance and robust contingencies in advance of winter will be crucial.
22. The Board is to be commended for its sustained achievement against the 31-day cancer access standard with a performance of 98.8% in the second quarter of 2017. However, you have assured me that the Board is committed to improving local performance against the 62-day standard with NHS Ayrshire & Arran recording a performance of 88.5% in the same quarter, and having not met the national standard in 2016/17. The Government’s Cancer Delivery Team will continue to work with NHS Ayrshire & Arran to enable a return to above 95% performance against the 62-day standard. We will continue to keep this and other areas of access performance under close review.

**Health and Social Care Integration**

23. There are three Integration Joint Boards within the boundaries of NHS Ayrshire & Arran: East Ayrshire, North Ayrshire and South Ayrshire. All three have been fully functional since 1 April 2015, a year before the vast majority of Partnerships. All three have integrated adult and children’s health and social care for their area.

24. There clearly remains very strong collaborative working between the three Chief Officers, Councils and the NHS Board, with several services led by a ‘lead Partnership’, where one Partnership manages and provides professional leadership for an Ayrshire wide service, e.g. East Ayrshire leads on primary care, North Ayrshire on mental health and learning disabilities, and South Ayrshire on Allied Health Professionals. Pan-Ayrshire work is overseen by the Strategic Alliance, which reports to the NHS Board Chief Executive and the three Council Chief Executives, who meet regularly. Consistency of approach by the pan-Ayrshire work streams is assured by a Strategic Planning & Operation Group, which comprises the three Chief Officers, Acute Director and Director for Transformation and Sustainability.

25. East Ayrshire has maintained a good record on delayed discharge throughout the year. However, performance in North and South Ayrshire has been more challenging, with increased demand for homecare and budget constraints impacting on delays. Whilst acknowledging the general pressures on certain services and social care budgets, I have been assured that there has already been good progress in developing intermediate care services that provide alternatives to acute hospital admission and step-down care, where appropriate, following discharge. Such developments will be key in terms of appropriately planning for winter and future pressures, as Partnerships focus on ensuring, wherever possible, that people with community care needs are discharged within 72 hours of being assessed as ready for discharge.

**Finance**

26. It is vital that NHS Boards achieve both financial stability and best value for the considerable taxpayer investment made in the NHS. I am therefore pleased to note that NHS Ayrshire & Arran met its financial targets for 2016/17. As with all NHS Boards, the Scottish Government expects the Board to take all reasonable steps to live within its means and make best use of available resources as part of a balanced approach to performance. I am aware of financial challenges in 2017/18 and risk to delivering finance balance. It is therefore vital that appropriate action is being taken to identify and deliver savings, using a risk-based approach and considering the wider impact on clinical care and performance. To this end, I understand the Board is refining the local approach, including the plans for transformational change, in light of the recent PricewaterhouseCoopers review.
27. Given the significant financial and performance challenges facing NHS Ayrshire & Arran, it is clearly critical that the Board’s non-Executives are able to adequately discharge their duties, and are provided with the appropriate quality of information in order to hold the Executive team to account. I was assured that Board members received detailed information and data so felt fully informed and able to effectively scrutinise local performance and carry out their key governance role.

Conclusion

28. I thank the Board and its staff for their efforts in 2016/17: it is clear that NHS Ayrshire & Arran is making progress in taking forward a challenging agenda on a number of fronts, including improving access, maintaining tight financial control and developing local services. The Board has very good relationships with its planning partners, and is fully aware that effectively building on such relationships will be crucial in continuing to progress the local health and social care integration agenda.

29. Whilst I am happy to acknowledge the many positive aspects of performance in NHS Ayrshire & Arran, I know you are not complacent and recognise that there remains much to do. I am confident that the Board understands the need to maintain the quality of frontline services whilst demonstrating best value for taxpayers’ investment. We will continue to keep progress under close review and I have included a list of the main performance action points in the attached annex.

Best wishes,

SHONA ROBISON
MAIN ACTION POINTS

The Board must:

- Keep the Health & Social Care Directorates informed of progress with its significant local health improvement activity

- Continue to review, update and maintain robust arrangements for controlling Healthcare Associated Infection

- Continue to deliver on its key responsibilities in terms of clinical governance, risk management, quality of care and patient safety, including implementing the recommendations of the 3 maternity reviews (HIS will keep under review)

- Keep the Health & Social Care Directorates informed on progress towards achieving all access targets, including ensuring that performance against the outpatient and inpatient/day case standards at the end of March 2018 is no worse than as at the end of March 2017

- Continue to work with planning partners on the critical health and social integration agenda, including addressing the delayed discharge challenge

- Continue to work towards achieving financial in-year and recurring financial balance, and keep the Health and Social Care Directorates informed of progress in implementing the local efficiency savings programme

- Keep the Health & Social Care Directorates informed of progress with the transformation change plans, in line with the national policy
Performance Governance Committee

Monday 4 December 2017

LDP Standards Reporting 2017/18 – Mid Year Report

Authors: Paul Dunlop, Planning and Performance Officer
          Helen Strainger, Performance Manager

Sponsoring Director: Kirstin Dickson, Director for Transformation and Sustainability

Date: 23 November 2017

Recommendation

The Committee is asked to:

- Note progress at the mid-year point against the 2017/18 LDP Standards as laid out within the Local Delivery Plan element of the Transformational Change Improvement Plan.

Summary

NHS Ayrshire and Arran is monitored by the Scottish Government Health and Social Care Directorate (SGHSCD) against a number of national standards. Collectively, these are presented as the ‘LDP Standards’.

Key Messages:

It is acknowledged that it is challenging to maintain or meet the LDP 2017/18 Standards. Performance Governance Committee will require to be sighted on the areas of underperformance and support performance improvement activity in delivering the standards as described within the LDP 2017/18.
<table>
<thead>
<tr>
<th>Glossary of Terms</th>
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<tbody>
<tr>
<td>ABIs</td>
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1. **Situation**

1.1 A refreshed approach to performance scrutiny and assurance via the Pentana Performance Management System (formerly Covalent) was agreed at Performance Governance Committee (PGC) on 14 November 2016. A key component of support to this work is through the provision and use of data and information to aid performance discussion and challenge within meetings.

1.2 In addition to the discussion which takes place at each PGC on the Local Delivery Plan (LDP) Standards through the interactive Pentana Performance Portal, the PGC also receives a performance report twice a year to show the mid-year and end of year position against the LDP Standards.

1.3 This paper constitutes the mid-year report on performance against the LDP Standards 2017/18. The end of year position will be reported to PGC on 27 August 2018.

2. **Background**

2.1 In November 2016, the Committee was asked to endorse the new approach to performance assurance and to engage in further discussions on the development of a Performance Governance specific Portal. Since this time the Committee has considered the LDP Standards within the Performance Portal created for this purpose.

3. **Assessment**

3.1 This is the first of the mid-year reports on the LDP Standards following approval of a refreshed approach to performance assurance. This report is supplementary to the Pentana Performance Portal and reflects both National published data as well as locally gathered and reported data.

3.2 NHS Ayrshire and Arran monitors a number of key LDP standards, as shown within the `LDP Summary Scorecard` shown in Appendix 1.

3.3 The status of each Standard is shown using a RAG (Red, Amber, Green) status. The tolerance level used within this coding allows for a certain level of underperformance (normally 5%) within which the status would be flagged as Amber level performance. This means that some improvement is required to achieve the target or standard level of performance, noted as ‘Green’. For those indicators noted as ‘Red’ this means that the Standard is not being met and is beyond acceptable limits, requiring improvement.

3.4 The position as at the end of November 2017, against the suite of twenty-four 2017/18 LDP standards, is that there were nine indicators with a status of ‘Green’, two indicators with a status of ‘Amber’ and twelve indicators with a status of ‘Red’.

3.5 Contextual information on progress throughout the year with regard to each of the LDP Standards is provided at Appendix 2 to this paper.
4. Recommendation

4.1 PGC members are asked to note performance against LDP standards for 2017/18. They are also asked to acknowledge progress made to date and challenges faced in delivering the 2017/18 LDP Standards.
<table>
<thead>
<tr>
<th>Code</th>
<th>Measure</th>
<th>Status</th>
<th>Current Value</th>
<th>Current Target</th>
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<tbody>
<tr>
<td>LDP.1</td>
<td>Detect Cancer Early</td>
<td>🟢</td>
<td>26.13%</td>
<td>20%</td>
<td>December 2016</td>
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<tr>
<td>LDP.2</td>
<td>31-Day Cancer: All Cancer Treatment (31 days)</td>
<td>🟢</td>
<td>97.25%</td>
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<td>LDP.3</td>
<td>62-Day Cancer: Suspicion-of-Cancer Referrals (62 days)</td>
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<td>83.17%</td>
<td>95%</td>
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<td>LDP.4</td>
<td>Dementia Post Diagnostic Support</td>
<td>n/a</td>
<td>n/a</td>
<td>100%</td>
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<td>LDP.5</td>
<td>12wks TTG (IP/DC)</td>
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<td>81.4%</td>
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<td>LDP.6</td>
<td>18 weeks Referral To Treatment - Performance</td>
<td>⚫</td>
<td>74.33%</td>
<td>90%</td>
<td>September 2017</td>
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<tr>
<td>LDP.7</td>
<td>New Outpatients: Maximum 12 weeks from Referral (95%)</td>
<td>⚫</td>
<td>79.66%</td>
<td>95%</td>
<td>October 2017</td>
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<tr>
<td>LDP.8</td>
<td>Early Access to Antenatal Services</td>
<td>🟢</td>
<td>87.88%</td>
<td>80%</td>
<td>December 2016</td>
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<td>LDP.9</td>
<td>IVF Treatment Waiting Times</td>
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<td>100%</td>
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<td>LDP.10</td>
<td>Faster Access to CAMHS - 18 wks</td>
<td>🟢</td>
<td>96.3%</td>
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<td>LDP.11</td>
<td>Faster Access to Psychological Therapies - 18 wks</td>
<td>⬤</td>
<td>87.44%</td>
<td>90%</td>
<td>September 2017</td>
</tr>
<tr>
<td>LDP.12a</td>
<td>Clostridium Difficle Infections Rate (Rolling Annual Rate)</td>
<td>🟢</td>
<td>0.32</td>
<td>0.32</td>
<td>Q2 2017/18</td>
</tr>
<tr>
<td>LDP.12b</td>
<td>Clostridium Difficle Infections Number (cumulative)</td>
<td>⚫</td>
<td>64</td>
<td>60</td>
<td>September 2017</td>
</tr>
<tr>
<td>LDP.13a</td>
<td>MRSA/MSSA Bacterium Rate (Rolling Annual Rate)</td>
<td>⚫</td>
<td>0.26</td>
<td>0.24</td>
<td>Q2 2017/18</td>
</tr>
<tr>
<td>LDP.13b</td>
<td>MRSA/MSSA Bacterium Number (cumulative)</td>
<td>⚫</td>
<td>56</td>
<td>42</td>
<td>September 2017</td>
</tr>
<tr>
<td>LDP.14</td>
<td>Drug and Alcohol Treatment: Referral to Treatment</td>
<td>🟢</td>
<td>96.6%</td>
<td>90%</td>
<td>September 2017</td>
</tr>
<tr>
<td>LDP.15</td>
<td>Alcohol Brief Interventions</td>
<td>🟢</td>
<td>4,019</td>
<td>1,967</td>
<td>Q2 2017/18</td>
</tr>
<tr>
<td>LDP.16</td>
<td>Smoking Cessation (SIMD)</td>
<td>⚫</td>
<td>99</td>
<td>171</td>
<td>June 2017</td>
</tr>
<tr>
<td>LDP.17</td>
<td>48 Hour Access – GP Practice Team</td>
<td>🟢</td>
<td>90.7%</td>
<td>90%</td>
<td>2015/16</td>
</tr>
<tr>
<td>LDP.18</td>
<td>Advance Booking – GP</td>
<td>⚫</td>
<td>75.9%</td>
<td>90%</td>
<td>2015/16</td>
</tr>
<tr>
<td>LDP.19</td>
<td>Sickness Absence</td>
<td>⚫</td>
<td>5%</td>
<td>4%</td>
<td>September 2017</td>
</tr>
<tr>
<td>LDP.20</td>
<td>A&amp;E Waits to be a Maximum of 4 hours</td>
<td>⬤</td>
<td>92.47%</td>
<td>95.00%</td>
<td>October 2017</td>
</tr>
<tr>
<td>LDP.21</td>
<td>Financial Performance</td>
<td>⚫</td>
<td>-£13,789,000</td>
<td>-£7,500,000</td>
<td>September 2017</td>
</tr>
<tr>
<td>LDP.22</td>
<td>Cash Efficiencies</td>
<td>⚫</td>
<td>£6,957,000</td>
<td>£8,000,000</td>
<td>September 2017</td>
</tr>
</tbody>
</table>
Appendix 2

Assessment of LDP Indicators

Performance over the first half of 2017/18 for each of the LDP Standards is described within the narrative below.

Cancer

LDP.1: Detect Cancer Early - The target is that of all those diagnosed with breast, colorectal and lung cancer, 20% are to be diagnosed while in the first stage of the disease.
LDP.2: 31-Day Cancer: All Cancer Treatment (31 days) - The National Standard is that 95% of all patients diagnosed with cancer will begin treatment within 31 days of decision-to-treat.
LDP.3: 62-Day Cancer: Suspicion-of-Cancer Referrals (62 days) - National Standard is that 95% of all patients referred urgently with a suspicion of cancer will begin treatment within 62 days of receipt of referral.

Throughout the past six months performance has been good against the 31 day and 62 day Cancer targets for referral and treatment of these patients who require our urgent care. Whilst this is critically important we also know that by detecting cancer at an earlier stage, we will give every patient the best chance of a positive outcome. Through the Detect Cancer Early programme we are ensuring that over a quarter of patients being diagnosed with breast, lung and colorectal cancers are diagnosed at the earliest stage, exceeding the challenge set within the LDP targets.

It should be noted that close scrutiny of the Cancer Targets takes place and analysis has shown that there is no consistent trend across the cancer specialties. Any falls below target tend to be as a result of specific issues with individual patient journeys. However, public health campaigns in areas including lung cancer have meant that the services are receiving a significant increase in referrals and this may impact on the performance against the Cancer Waiting Times targets.

Planned Care

LDP.5: Treatment Time Guarantee (Maximum 12 Weeks wait to Inpatient or Daycase appointment) - The National Standard is 100% of inpatient and daycase patients to be seen within the 12 weeks Treatment Time Guarantee (TTG).

High demand and capacity shortfalls experienced in our health and social care system impact on waiting times for planned care and performance against the 12 week Inpatient and Daycase Treatment Time Guarantee is not to the standard we would like. We are confident that we are managing the waiting lists as best we can given the resources we have and as a result the overall numbers of patients waiting over 12 weeks for their appointment is not growing.

Some of the initial backlog was created in Orthopaedics and was due to cancellation of elective surgery during the winter of 2014/15 due to significant unscheduled care demand, with similar but lesser issues in subsequent winters. Staffing issues within Oral & Maxillofacial Surgery have added to an increased number of patients waiting over 12 weeks for their planned surgery over recent months.
LDP.7: Maximum 12 Weeks wait to Outpatient appointment - The National Standard is that there are zero Outpatient waits over the 12 week guarantee.

The waiting times target of a maximum of 12 weeks for Outpatient appointments also continues to be challenging. However, as with Inpatient and Day case waiting times, services are managing the overall waiting list size, ensuring that the numbers of patients waiting more than 12 weeks is not increasing.

Demand, particularly ‘urgent’ and ‘urgent, cancer is suspected’ referrals, has been one of the major contributing factors in increasing numbers of referrals for a number of specialties, resulting in capacity shortfalls. Recruitment problems remain a major issue, with short term arrangements in place while permanent recruitment continues.

LDP.6: 18 week Referral to Treatment - The National Standard is 90% of combined admitted and non-admitted patient pathways to be treated within 18 weeks of referral.

18 week RTT performance remains below target, with performance linked to the issues with stage of treatment performance and recruitment difficulties. The lowest performing specialties are Respiratory, Rheumatology, Pain Service, Oral and Maxillofacial Surgery.

LDP.8: Early Access to Antenatal Services - The target is to have at least 80% of pregnant women in each Scottish Index of Multiple Deprivation (SIMD) quintile booked for antenatal care by the 12th week of gestation.

The number of pregnant women achieving early access to antenatal services in NHS Ayrshire and Arran continues to be above the 80% target. The number who booked for antenatal care by the 12th week of gestation was 87.9% at December 2016.

LDP.9: IVF Treatment Waiting Times - By 31 March 2015, eligible patients will commence IVF treatment within 12 months.

The number of eligible patients commencing IVF treatment within 12 months continues to meet the target of 100%.

Unscheduled Care

LDP.20: A&E Waiting times to be a Maximum of 4 hours - The National Standard is that 95% of patients will wait less than 4 hours from arrival to admission, discharge or transfer for Accident and Emergency (A&E) treatment.

Waiting time compliance for the four-hour ED target was consistently above the 95% target between April and July 2017. Performance has fallen below the target at August 2017 and continues to be below target at October 2017 with 92.47% of ED attendances across NHS Ayrshire & Arran being treated, admitted, or discharged, within 4 hours of presentation. The achievement of the 4 hour target is based on a number of factors, and is influenced by the level of acuity of patients. It is worth noting that Flow 1 patients (i.e. Minor Injury patients) are seen well within the four hour target and do not result in admission to hospital.
Mental Health

LDP.14: Drug and Alcohol Treatment: Referral to Treatment - The National Standard is that 90% of clients will wait no longer than 3 weeks from date of referral received, to appropriate drug or alcohol treatment that supports their recovery.

The number of clients waiting no longer than 3 weeks from date referral received to appropriate drug or alcohol treatment that supports their recovery continues to be well above the 90% target throughout the year so far, with 96.6% recorded at September 2017.

LDP.15: Alcohol Brief Interventions - The target is to maintain the same total level of target delivery of Alcohol Brief Interventions (ABIs) as under the HEAT H4 target for 2011/12, 2012/13 and 2013/14 and to have increased to 4,275.

The number of Alcohol Brief Interventions (ABIs) to be delivered, by March 2018 is 4257, which was the same level of target recorded at March 2017. The Service continues to comfortably exceed the trajectories set to meet this target, delivering 4019 ABIs by September 2017.

LDP.10: Faster Access to CAMHS - 18 wks - To deliver faster access to specialist Child and Adolescent Mental Health Services (CAMHS) by achieving 90% of patients starting their treatment within 18 weeks of referral, based on adjusted completed waits.

Delivery against the 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) has consistently been above the 90% target since January 2017 with a position of 96.3% recorded at September 2017.

LDP.11: Faster Access to Psychological Therapies - 18 wks - To deliver faster access to Psychological Therapies by achieving 90% of patients seen within 18 weeks, based on adjusted waits.

Psychological Therapies 18 week performance although below the 90% target, continues to show an improved position with 87.44% recorded at September 2017, which is within 5% of the target. Psychological therapies are delivered by a number of professions across mental health and physical health services, which leads to complexities and challenges in delivering this target. The target is being met in some services and a significant amount of work continues towards achieving this. The review of Psychology service and associated restructure is expected to support improvement towards delivery of the target.

LDP.4: Dementia Post Diagnostic Support - By 2015/16, NHS Boards will deliver expected percentage rates of dementia diagnosis and all people newly diagnosed with dementia will have a minimum of a year’s worth of post-diagnostic support

Published post diagnostic support data only approximate the achievement of Boards in delivery of this LDP Standard. Therefore data are not sufficiently robust enough to be provided within this report. The Service has confirmed that all patients diagnosed with dementia are currently offered the one year post diagnostic support. Work continues in each Health and Social Care Partnership to establish robust reporting mechanisms for this measure.
Smoking Cessation

**LDP.16: Smoking Cessation** - The requirement is to achieve 681 successful quits, after 12 weeks, for people residing in the 40% most deprived datazones in the NHS Board (i.e. two most deprived local quintiles) over one year, ending March 2018.

Data at June 2017 shows performance below the expected trajectory, with 99 clients having successfully refrained from smoking for a period of 12 weeks against a trajectory of 171. As these data relate to all successful quits made throughout the month of June 2017, reporting is therefore subject to a time lag delay of 3 months.

An information campaign has been implemented to increase awareness of the service which is expected to result in a rise in people having still successfully refrained from smoking after 12 weeks however, it is unlikely that the end of year target will be met.

Primary Care

**LDP.17: 48 Hour Access GP Practice Team** – Target relates to achievement of over 90% for 48 hour Access or advance booking.

**LDP.18: Advance Booking GP** – The National Standard is that at least 90% of patients respond that they were able to obtain a consultation with a GP or appropriate healthcare professional within 2 working days of initial contact

Performance against the 90% target of patients responding that they were able to obtain a consultation with a GP or appropriate healthcare professional within 2 working days of initial contact continues to be met. The performance against this target will be reviewed again when the Health & Care Experience Survey (successor to the GP and Local NHS Services Patient Experience Survey) is repeated during November 2017. It should be noted that the Quality and Outcomes Framework (QOF) points allocated to performance against these targets in previous years have been allocated to new QOF measures aimed at reducing emergency admissions; demand; and prescribing costs. There is a risk, therefore, that there are no levers available to the Board to incentivise Practices towards meeting these targets, unless there is a major breakdown of service resulting in patients not being able to access services to meet identified need - which would constitute a breach of contract.

It should be noted that because the Advance Booking GP LDP measure is linked to the 48 hour access measure, achievement against this target means that overall achievement has been reached, even though the Advanced Booking measure itself is below target.

HAI

**LDP.12a: Clostridium Difficile Infections Rate (Rolling Annual Rate)** - All NHS Boards are required to achieve a rate of no more than 0.32 cases per 1,000 occupied bed days for CDIs in the 15 and over age group by the year ending 31 March 2016 (this approximates to no more than 10 cases per month).

**LDP.13a: MRSA/MSSA Bacterium Rate (Rolling Annual Rate)** - The Standard required is to achieve 0.24 or less cases per 1,000 acute occupied bed days by year ending March 2016. This equates to no more than 84 Staphylococcus Aureus Bacteraemia (SABs) by the activity year-end (7 per month).
The rate (rolling annual rate) of *Clostridium Difficile* infections remains below the maximum of 0.32 cases per 1000 total occupied bed days in patients aged 15 years and over. The Infection Prevention and Control Team continue to audit each case of CDI and ensure infection control precautions are being properly implemented to minimise the risk of onward transmission. The Board is on course to achieve the target by year end March 2018.

The National Standard for MRSA/MSSA Bacterium is to achieve a rate 0.24 or fewer cases per 1,000 acute occupied bed days. This approximates to no more than 84 *Staphylococcus Aureus* Bacteraemia (SABs) by the activity year-end (Maximum 7 per month). Current performance continues to exceed the target set. In order to achieve further reductions the focus continues to be on reducing peripheral vascular catheter (PVC) related SABs. These include spreading of the use of the DRIFT (diagnosis, resuscitation, IV medication, fluids, transfusion) mnemonic to aid PVC insertion and removal decision making and the introduction of PVC insertion packs and introduction of an insertion sticker. These are currently being developed and will be reported and scrutinised via the Prevention and Control of Infection Committee.

**Sickness Absence**

**LDP.19: Sickness Absence** - The National Standard is to achieve a sickness absence rate of 4% or less by March 2018. Locally it was agreed to revise the milestones towards the overall achievement of 4%, with an interim local target of 4.5% by 31 March 2017, moving to the National Standard of 4% by 31 March 2018.

Performance within NHS Ayrshire and Arran continues to exceed the target with a position of 5% recorded in September 2017.

The following observations have been identified and routine measures to remedy the situation are continuing:

- Line managers are fulfilling their role and responsibility as described in the Board policy, and are actively/proactively supporting staff through any period of absence, including referral/notification to the Occupational Health Service;
- Monthly Occupational Health Case Management Reviews are undertaken by the Promoting Attendance Lead and Lead Nurse for Occupational Health, which allows monitoring of appropriate referrals as well as a focus on particular areas of interest. Outcomes are shared with the service for follow up;
- A monthly summary report of staff on long term sickness absence is shared with the relevant manager to ensure appropriate action is taken;
- Monthly training sessions are scheduled throughout the year; and
- Promoting Attendance and Wellbeing training continues to be a focus of the Line Managers’ Development Programme.

**Finance**

**LDP.21: Financial Performance** - The target is to achieve a break even position by year ending 31 March 2018.

**LDP.22: Cash Efficiencies** - The target is to achieve cash efficiencies of £20,000,000 by 31 March 2018.
The revenue plan approved by the Board was for a £13.2 million deficit. This is now projected to be over £20 million due to the projected overspends against budget of over £7 million due to:

- additional unscheduled care beds that have been opened to manage increased demand and challenges with delayed discharges due to social care capacity;
- cost reductions not able to be identified and achieved.
### Monitoring Form

<table>
<thead>
<tr>
<th><strong>Policy/Strategy Implications</strong></th>
<th>The Local Delivery Plan and associated LDP Standards are NHS Ayrshire and Arran’s delivery contract with Scottish Government. These focus on the priorities for the NHS in Scotland and support delivery of the Scottish Government’s national performance framework and therefore have implications throughout the organisation.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workforce Implications</strong></td>
<td>There are no workforce implications arising directly from the LDP Standards Mid-Year report.</td>
</tr>
<tr>
<td><strong>Financial Implications</strong></td>
<td>There are no financial implications arising directly from the LDP Standards Mid-Year report.</td>
</tr>
<tr>
<td><strong>Consultation (including Professional Committees)</strong></td>
<td>Staff within the Directorate of Transformation and Sustainability regularly update the approach to, and appearance of regular reports based on feedback from a number of sources.</td>
</tr>
<tr>
<td><strong>Risk Assessment</strong></td>
<td>There is significant risk to the organisation in failing to scrutinise and challenge performance against the LDP standards and in failing to monitor progress and achieve targets set at the highest management and governance levels of the organisation.</td>
</tr>
<tr>
<td><strong>Best Value</strong></td>
<td>All the Best Value themes are addressed as part of the Local Delivery Plan and the associated LDP Standards.</td>
</tr>
<tr>
<td>- Vision and leadership</td>
<td>This paper presents some data that is not yet validated or is provisional in nature. To mitigate this, appendices have been clearly marked ‘for management information only’.</td>
</tr>
<tr>
<td>- Effective partnerships</td>
<td></td>
</tr>
<tr>
<td>- Governance and accountability</td>
<td></td>
</tr>
<tr>
<td>- Use of resources</td>
<td></td>
</tr>
<tr>
<td>- Performance management</td>
<td></td>
</tr>
<tr>
<td><strong>Compliance with Corporate Objectives</strong></td>
<td>The LDP Standards are key measures of success in the delivery of the Corporate Objectives.</td>
</tr>
<tr>
<td><strong>Single Outcome Agreement (SOA)</strong></td>
<td>Partnership working to achieve performance improvements is critical to the delivery of the LDP Standards.</td>
</tr>
<tr>
<td><strong>Impact Assessment</strong></td>
<td>This LDP Standards Mid-Year report does not require impact assessment as it is a routine report.</td>
</tr>
</tbody>
</table>