Scottish Health Council Committee meeting

Thu 17 February 2022, 10:00 - 12:30

MS Teams

Agenda

10:00 - 10:30
30 min

1. Opening Business

1.1. Welcome, introduction and apologies

10.00-10.05 *Chair*

1.2. Draft minutes of Meeting (11/11/2021)

10.05-10.10 *Chair*

Paper

Item 1.2 20211111 SHCC Minutes Draft 0.1 RJ TMG.pdf (11 pages)

1.3. Review of Action Point Register

10.10-10.15 *Chair*

Paper

Item 1.3 20220204 - Item 1.3 20220217 SHCC Action Point Register - TMG.pdf (2 pages)

1.4. Business Planning Schedule

10.15-10.20 *Director*

Paper

Item 1.4 20220217 2021-22 SHCC Business Planning Schedule.pdf (1 pages)

1.5. Proposed Business Planning Schedule 2022/23

10.20-10.25 *Director*

Paper

Item 1.5 20220217 Proposed SHCC Business Planning Schedule- 2022-2023.pdf (1 pages)

1.6. Directors Update (including Ways of Working and office accommodation)

10.25-10.30 *Director*

Verbal update

10:30 - 10:50
20 min

2. Setting the Direction

2.1. Quality Framework for Community Engagement- update

10.30-10.40 *Head of Engagement Programmes*

Verbal update

2.2. Engaging People in the work of HIS- update

10.40-10.50 *Head of Engagement & Equalities Policy*

Verbal update

10:50 - 12:05
75 min

3. Committee Governance

3.1. Scottish Health Council Committee Annual Report 2021/22 and Terms of Reference

10.50-11.00 *Chair*

Paper

- Item 3.1 20220217 - SHC Committee Draft Annual Report V01 JD TMG SD.pdf (5 pages)
- Item 3.1 20220217 SHC Committee Terms of Reference.pdf (3 pages)

3.2. Risk Register

11.00-11.05 *Director*

Paper

- Item 3.2 20220217 SHCC Risk Register Cover paper.pdf (3 pages)
- Item 3.2 Appendix 1 20220217 Risk Register- SHC Committee.pdf (1 pages)

3.2.1. Comfort Break

11.05-11.10

3.3. Rethinking Meaningful Engagement

11.10-11.25 *Director/Chair*

Paper

- Item 3.3 20220217 - SHCC paper - Rethinking Meaningful Engagement (002) SD.pdf (3 pages)
- Item 3.3 Appendix 1 20220112 - SHCC SBAR- Rethinking meaningful engagement.pdf (5 pages)

3.4. Service Change Briefing- for information

11.25-11.35 *Engagement Programmes Manager*

Paper

- Item 3.4 20220217 - Item 3.4 - Service Change Briefing v0.2 (003).pdf (9 pages)

3.5. Remobilisation and Operational Plan Progress Report- for information

11.35-11.45 *Head of Engagement Programmes*

Paper

- Item 3.5 20220217 - Remobilisation and Operational Plan CED - Progress update Q3 v0.1.pdf (19 pages)

3.6. Equality Mainstreaming Report- update

11.45-12.00 *Head of Engagement and Equalities Policy*

Paper

- Item 3.6 20220204 - SHCC paper - Equality mainstreaming update - v01.pdf (6 pages)
- Item 3.6 Appendix 1 20220204 - HIS - Inclusive language guide (November 2021).pdf (26 pages)

3.7. Governance for Engagement Sub-Committee meeting Minutes 20/01/2022

12.00-12.05 *Head of Engagement and Equalities Policy*

Paper

- Item 3.7 20220217- GFE SC draft meeting notes Jan 22.pdf (13 pages)

12:05 - 12:20
15 min

4. Reserved Business

4.1. Service Change Sub-Committee meeting minutes(27/01/2022) including NHS Ayrshire & Arran Chemotherapy (SACT) service paper and amendments to Identifying Major Service Change Guidance

12.05-12.20 *Head of Engagement Programmes*

Papers

Item 4.1 20220217 - SHC Committee - HIS-CE Service Change Sub-Committee Meeting - 27 January 2022 v0.3 (002) (002).pdf (6 pages)
Item 4.1 20220217 - Item 4.1 - Review of NHS Ayrshire Arran Chemotherapy Services v0.2.pdf (44 pages)
Item 4.1 20220217 -SHC Committee Identifying Major Service Change v0.2.pdf (7 pages)

12:20 - 12:25
5 min

5. Additional Items of Governance

5.1. Key Points

12.20-12.25 *Chair*

12:25 - 12:30
5 min

6. Closing Business

6.1. AOB

12.25-12.30 *All*

6.2. Meeting Close

12.30

12:30 - 12:30
0 min

7. Date of next meeting

19 May 2022 Venue TBC

SHCC Draft MINUTES – V0.1

Meeting of the Scottish Health Council Committee

Date: 11 November 2021
Time: 10:00am-12:30pm
Venue: MS Teams

Present
Suzanne Dawson, Chair (SD)
Christine Lester, Non-executive Director (CL)
Elizabeth Cuthbertson, Member (EC)
Dave Bertin, Member (DB)
Emma Cooper, Member (EmC)
Simon Bradstreet, Member (SB)
Jamie Mallan, Member (JM)

In Attendance
Ruth Jays, Director of Community Engagement (RJ)
Jane Davies, Head of Engagement Programmes (JD)
Victoria Edmond, Senior Communications Officer (VC)
Tony McGowan, Head of Engagement and Equalities Policy (TMG)
Janice Malone(JaM) (item 2.2)
Derek Blues (DBl) (item 3.3)

Apologies
John Glennie, Vice Chair (JG)
Alison Cox (AC)

Committee Support
Susan Ferguson, PA to Director of Community Engagement & Chair of SHC

Declaration of interests
No Declaration(s) of interests were recorded

1.	**OPENING BUSINESS**	**ACTION**
1.1	**Chair's Welcome, Introductions and Apologies**	
	The Chair (SD) welcomed everyone to the meeting via MS Teams and provided the following update to the Scottish Health Council Committee. (the Committee) 1. A two minutes silence would be observed at the meeting to mark Armistice Day 2. She thanked the Committee for the feedback regarding meetings, and confirmed hybrid meetings was the preferred option. She also noted that her preference for the development day in June would be face to face.	

	3. Both the Director of Community Engagement (HIS-CED) and SD will lead a discussion on service change to the Board of Healthcare Improvement Scotland (HIS). 4. A successful information session to enable a better understanding of the work of HIS-CED took place with Scottish Government, along with the Director of Communication from NHS Lanarkshire, who offered reflections on working with HIS-CED during the Monklands Replacement Project 5. Extended thanks on behalf of the Committee to everyone who had been involved in the work on the National Care Service Consultation. Apologies were noted as above.	
1.2	**Draft Minutes of Meeting**	
	After a correction was made to the draft minutes, the Committee meeting held on 09 September 2021, were approved as an accurate record of the meeting.	
	Matters arising	
	There were no matters arising.	
1.3	**Review of Action Point Register**	
	SD presented the action point register to the Committee. Action points: 2.3 TMG to contact JM to discuss further human rights approaches along with Rosie Tyler-Greig, Equality and Diversity Officer - meeting now arranged. 3.3 JD to arrange to meet with SB/EC to take forward PMF- meeting postponed due to sick leave – new date will be arranged. The Committee noted the content of the action point register and agreed all other actions were complete.	
1.4	**Business Planning Schedule**	
	SD presented the Business Planning Schedule to the Committee. The Committee noted the Business Planning Schedule.	
1.5	**Director's Update (including Ways of Working)**	
	The Director of HIS-CE (RJ) provided a verbal update to the Committee and highlighted the following points: 1. Planning with People delay- Scottish Government have informed us they will be	

	writing to Board Chairs and Chief Executives this week to confirm a pause of the review of the draft *Planning with People* guidance, in recognition of pressures on the service. The letter will remind Boards of engagement responsibilities. HIS-CED have worked closely with Scottish Government in respect of this. *2.* Ways of Working- A series of events have been held this week throughout HIS for colleagues in preparation for the *test of change* period to ways of working which begins in January 2022. Managers will be holding discussions with colleagues regarding their working preferences through November. *3.* HIS-CED's management team are holding their first hybrid meeting with in November. 4. Accommodation-work is in progress to ensure that staff in HIS-CED have the same opportunities for fixed, home or hybrid working as colleagues within HIS. An options paper is being developed to consider future accommodation requirements for the directorate. *5.* Staffing-most vacancies are now filled within the Directorate. The Committee thanked RJ for the verbal update and raised the following points: 1. Can a copy of the *National Care Consultation* be shared with the Committee? 2. Will the letter from Scottish Government for the pause of *Planning with People* guidance be sent to IJBs and partners? 3. Service Change role-how close are we to recruiting for the Principal Service Change Advisor role? In response to the points raised: 1. RJ confirmed that a copy would be sent to the Committee. 2. Assured the Committee that IJBs and Partners would receive the letter for the pausing of *Planning with People* guidance. 3. Informed the Committee she should be able to provide an update to the Committee by end of November on the recruitment for this role. **Action:** Copy of National Care Consultation to be sent to all Committee members.	**RJ**
2.	**SETTING THE DIRECTION**	
2.1	**Quality Framework for Community Engagement**	
	The Head of Engagement programmes (JD) provided a verbal update to the Committee and highlighted the following points:	

	1. The draft Quality Framework was launched in September with two documents being published, *Self- assessment framework and supporting guidance*, which was jointly badged with the Care Inspectorate and sent to Health Boards, IJBs and Local Authorities. The other, *Quality Framework* including our approach to providing improvement support, badged HIS only and sent to NHS Boards and IJBs. 2. Feedback from Health Boards and IJBs so far has been really positive, with a few seeking clarity on some points, such as engagement in equality impact assessments, the process and governance. 3. As developing the *Quality Framework* was in line with *Planning with People,* which has now been paused*,* the publication of this may not be finalised until next summer. However, the work with Scottish Government, health boards and IJBs continues around this and the Committee will be updated. 4. Work is still progressing with seeking testing sites to work with us around the process. Assurance was provided to the Committee that HIS-CED had worked closely with the Care Inspectorate to ensure that the documents produced reflected the needs of both organisations and the Care Inspectorate's decision to only publish the self-assessment framework and associated guidance reflects their current resourcing constraints. The Committee thanked JD for the verbal update. **Actions**: SF to resend copy of Draft Quality Framework papers/Letters to the Committee.	**SF**
2.2	**Volunteering in NHS Scotland national Programme- progress report**	
	The Volunteering Programme Manager provided an update to the Committee on the work they have been involved in over the last year with two of the biggest successes noted below. 1. **Remobilisation of volunteering guidance and risk assessment framework** was very well received and used by NHS boards and supported their decision-making in bringing volunteers back. 2. Involvement in the liaison group which oversees the **National Volunteer Co-ordination Hub**. Delivered by British Red Cross on behalf of Scottish Government.	

	The plans for the future of volunteering were also shared with the Committee: 1. To facilitate shift from operational support into a strategic position. We would like to widen our reach to volunteering across all health settings 2. The development of a range of Once for Scotland approaches to education and training (partnering with NES) for volunteers and volunteer management staff, volunteer recruitment, volunteering practice. 3. Improvements in the diversity and inclusivity of volunteering across NHSScotland. 4. Development and implementation of a quality framework for continuous improvement of the quality of volunteering practice. 5. More collaboration between NHSScotland volunteering and the wider volunteering sector, and arrangements for better collaboration and partnership working with volunteers themselves. 6. Develop the evidence base around health-based volunteering and assess its impact. We are investigating a partnership with the charity Helpforce to utilise their Insight & Impact Service. 7. Raise the profile of volunteering in health to support a shift in attitudes towards volunteering and contribute to a culture shift where the impact that volunteering makes is better understood and more importantly adequately resourced. The following points were raised by the Committee: 1. Is there any specific work in Primary Care? 2. Is there an opportunity to look at workforce planning within NHS Volunteering? 3. Good to see some leverage on work in communities but how do we improve this? In response to the points raised JM advised the Committee : 1. That work in primary care is on the agenda for the future. 2. Conversations are currently ongoing with Scottish Government with regard to workforce planning. In response to point three, it was agreed that this would be discussed at the Committee's development day or picked up at the next meeting. The Committee thanked the Volunteering Programme Manager for the update and supported the direction of travel described in the update.	
2.3	**Citizens Panel-progress report**	

	JD provided an update on the Citizens' Panel activity in the last year within HIS-CE and highlighted the following points: 1. Citizens' Panel 7- *Health and social care experience during the COVID-19 pandemic and priorities for health and social care in the future* had now concluded. And work is now in progress with Citizens' Panel 8 with the report due in January 2022.The topics the Citizens' Panel are being asked their views on are : a) Redesign of Urgent Care b) Mobilisation of Dentistry services c) Mobilisation of planned (elective) care d) The Patient Safety Commissioner. 2. The ninth Citizens' Panel survey is due to go out in January 2022. 3. Agreed a set of objectives with Scottish Government formalising key processes and outputs for the *Citizens' Panel*. 4. Advised that in order to continue the Citizens' Panel into the next financial year, discussions are planned with Scottish Government around budget and if agreed, there would be a revised procurement exercise to secure a new research contractor as current contract ends in March 2022. The Committee found the update helpful and discussion took place around details of procurement timeline, funding and the frequency of the panels. In response to the discussion, JD advised that once agreed by Scottish Government, funding would be in place for the next three years. Procurement will take approximately three months, January to March 2022 and be in place for April. She highlighted that in relation to the frequency of panels, there is a capacity challenge due to the length of time these take, however going forward the social researchers are keen to use the Panel in different ways. The Committee thanked JD for providing the update **Action: RJ to provide details of funding**	**RJ**
2.4	**Engaging People in the work of HIS-update**	
	TMG provided an update to the Committee and highlighted the following: **Equality and other impact assessments**	

	At the Committee's last meeting, a draft unified assessment template for equality and other impact assessments was shared which received positive feedback. The aim of the new template and related resources is to increase accessibility and coherence for colleagues and ensure HIS meets its duties as a public body described above. The Committee was asked to approve the new template. **Increasing the diversity of people involved in our work through volunteering** A short life working group continues to progress development of the approach previously outlined to the Committee, to secure reliable ongoing access to diverse public perspectives on our work. The working group has developed a draft public experience volunteer role outline and plan to undertake volunteer recruitment in one health board area (Lothian) over the next few months with a view to asking recruited volunteers to give us their feedback on specific questions we have about work we do. After discussion on some of the wording in parts of the template, it was agreed that TMG and JM would explore at their scheduled meeting. **Action**-TMG to pick up conversation with JM around some of the context of the template.	**TMG**
3.	**Committee Governance**	
3.1	**Risk Register**	
	As both agenda items 3.1 and 3.2 were related, SD proposed to combine both. The Committee were in agreement.	
3.2	**Risk Management Deep Dive - Service Change**	
	At its meeting on 9 September 2021, the Committee members agreed that the two existing risks should be consolidated into a new risk. A deep dive on this new, consolidated risk was proposed, to ensure appropriate risk controls, mitigations and actions are in place. 1. The Committee discussed the need to ensure that the risk wording captures the need for engagement to be meaningful, and the serious risks to the SHCC, Boards and the public if this risk is not appropriately managed. 2. The Committee considered whether the mitigations and controls in place are adequate. 3. The Committee agreed that this is to be revisited following the Board Development Day, where the	

	challenges around service change will be considered. Thereafter the HIS-CE director will discuss with the Director of Finance, Planning and Governance (AM) to ensure the wording and risk weighting are correct so it can then be considered for inclusion on the HIS Strategic Risk Register in recognition of the level of risk. **Action:** RJ to set up meeting with AM to ensure wording and risk weighting are correct.	**RJ**
3.3	**Service Change Briefing including Action Plan**	
	The Engagement Programme Manager (DBl) provided an update to the Committee highlighting some of the current activity within service change : 1. NHS Lanarkshire-Monklands/Elective Orthopaedic Surgery-advised HIS-CED are still awaiting feedback on the proposal which is due to be taken to NHS Lanarkshire's November Board meeting. 2. NHS Grampian-Review of Maternity services model at Dr Gray's (DGH), Elgin- advised we are still awaiting feedback on the 'Best Start North' review. 3. NHS Ayrshire and Arran-Review of Chemotherapy Services, NHS Ayrshire and Arran wrote to Healthcare Improvement Scotland – Community Engagement on 17 September, providing an update on operational changes that were made to Systemic Anti-Cancer Therapy (SACT) services in response to the COVID pandemic. Their Interim Chief Executive, Hazel Borland, put forward the view that these changes "were introduced on a temporary basis and are now being considered as a longer term or permanent model for service delivery" (as per HIS-CE guidance, July 2020). RJ responded to the letter on 4 October and still awaiting response. 4. A request was made to the Committee for their agreement to allow RJ to further respond to the interim Chief Executive of NHS Ayrshire and Arran requesting a date for response. 5. Online workshops – The team have been following up on contacts with colleagues in NHS Boards and Health and Social Care Partnerships (HSCPs) about further 'taster' sessions and individual workshops. The three individual workshops have taken place with NHS Tayside, and an overview was presented to the Health & Social Care Scotland communications group and NHS Grampian Engagement group. Dates have been agreed with Angus HSCP for the Duties and Principles workshop. Dates are being agreed with a number of other NHS Boards and	

	HSCPs. The Committee thanked DBI for the update and supported a response being sent to the interim Chief Executive of NHS Ayrshire and Arran before end of the calendar year.	
3.4	**Remobilisation and Operational Plan Progress Report- Quarter 2**	
	JD provided the Committee with an update on the Directorate's progress with the work outlined in the Operational and Remobilisation Plan and carried out during Q2 of 2021/22 and highlighted some of the following : 1. As remobilisation and recovery continues across health and care this has meant a considerable amount of work for all of our engagement offices to support and ensure that people and communities continue to have their voices heard. 2. Redesign of Urgent Care Gathering Views: Engagement activities were undertaken across Scotland in 11 of our Engagement offices. The purpose was to ascertain the potential enablers and challenges in accessing the newly redesigned urgent care service for those across the protected characteristics and those affected by some socio-economic factors such as homelessness, poverty, unpaid carers, people living with & affected by addictions, people living in remote and rural areas. The report was published in September 2021. 3. Unified EQIA approach: The Public Involvement team are putting the finishing touches to a new unified equality impact assessment template that will serve to help make the process easier to follow, with clear steps and supportive links to resource materials. 4. Webinars: A webinar was delivered during Q2: - Community Engagement in Primary Care – This webinar looked at different ways of engaging people in the work of primary care. The Committee were assured by the update provided.	
3.5	**Operational Plan 2021/22-Performance Measurement Framework**	
	JD provided a verbal update to the Committee highlighting the following: 1. At its September meeting, the Committee considered a paper outlining a proposed approach for developing a new Performance Measurement Framework, and endorsed proposals to significantly streamline the 50+ objectives listed in the current Operational Plan to a much smaller list of around 10. The shorter	

	list will provide a standard terminology against which all the work of the directorate – from the activities of individuals and teams to whole work programmes – can be monitored, measured and reported. It will enable us to demonstrate our outcomes and impacts more easily, and to report on work programmes and activities across multiple years. 2. Meetings with Elizabeth Cuthbertson (EC) and Simon Bradstreet (SB) have been postponed due to sickness and this will be picked up as an action from the meeting. The input from the Committee members with expertise in this area will be most welcome. 3. The Operational Plan Delivery Group, which is tasked with developing the detail of the Framework, met recently to consider the new objectives. The Group is currently considering the outcome indicators, targets, data sources which will support each objective – working with teams across the directorate and our stakeholders to ensure that they capture the breadth of our work and are pitched at an appropriate level of detail. This will also enable us to use the LEAP framework for planning. The Committee thanked JD for the verbal update. **Action** - JD to re-arrange meeting with SB and EC	**JD**
3.6	**Corporate Parenting Action Plan**	
	TMG provided the committee with an update on the Corporate Parenting Action Plan, highlighting the following points: 1. The report is published every three years and the next iteration is due April 2023. 2. Due to the ongoing restrictions of Covid certain actions have not progressed over the last year, however thanks to the work of the Graeme Morrison,(GM) the previous Public Involvement Advisor, (PIA) work to align our action plan with the relevant articles contained within the United Nations Convention on the Rights of the Child (UNCRC) and also key fundamentals and priorities from within The Promise to better demonstrate how our work contributes to upholding children's rights and promoting their wellbeing. 3. A Children and Young People Key Delivery Area Network within HIS has now been established. This network brings together colleagues from across the organisation who have responsibility for delivering work that has a full or partial focus on children and young people.	

	Thanks was expressed to both GM and Chris Third the new PIA for all the work involved past and present. The committee noted the content of the Corporate Parenting Action Plan.	
3.7	**Governance for Engagement Sub-Committee minutes**	
	TMG presented the Governance for Engagement Sub-Committee minutes from the meeting held on 19 August 2021. The Committee noted the sub-committee meeting minutes	
4.	**RESERVED BUSINESS**	
4.1	**Service Change Sub-Committee meeting minutes**	
	JD presented the Service Change Sub-Committee meeting minutes from the meeting held on 28 October 2021 The Committee noted the sub-committee meeting minutes.	
5.	**ADDITIONAL ITEMS of GOVERNANCE**	
5.1	**Key Points**	
	After discussion, the Committee agreed the following three key points to be reported to the Board: 1. Risk Deep Dive discussion 2. Volunteering 3. Prioritisation	
6.	**CLOSING BUSINESS**	
6.1	**AOB**	
	A suggestion was put forward for the committee to have informal catch ups prior to or between meetings. SD and RJ to discuss options prior to next Committee meeting.	
7.	**DATE of NEXT MEETING**	
	The next Scottish Health Council Committee meeting will be held on 17 February 2022 10am-12.30pm via MS Teams.	
	Name of person presiding: Signature of person presiding: Date:	

ACTION POINT REGISTER

Meeting: **Scottish Health Council Committee**
Date: **11 November 2021**

Minute ref	Heading	Action point	Timeline	Lead officer	Status
Committee meeting 27/05/2021 3.5	Operational Plan 2021/22	Easy-read version of the Operational Plan to be produced for sharing with multiple audiences.	11/11//2021	JD / TMG / VE	On-going – internally sourced easy-read capacity and capability currently being developed
Committee meeting 09/09/2021 2.3	Engaging People in the work of HIS	TMG to contact JM to discuss further human rights approaches along with Rosie Tyler-Grieg, Equality and Diversity Officer.	11/11/2021	TMG	Completed
Committee meeting 09/09/2021 3.3	Operational Plan 2021/22 i) Progress Report for Q1 ii) Performance Measurement Framework	JD to arrange to meet with SB/EC to take forward PMF discussions.	11/11/2021	JD	Completed– meeting dates now agreed

Committee meeting 11/11/2021 1.5	Director's Update (including Ways of Working)	Copy of National Care Consultation to be sent to all Committee members.	11/11/2021	RJ	Completed
Committee meeting 11/11/2021 2.1	Quality Framework for Community Engagement	SF to resend copy of Draft Quality Framework papers/Letters to the Committee.	11/11/2021	SF	Completed
Committee meeting 11/11/2021 2.3	Citizens Panel-progress report	RJ to provide details of funding around the revised procurement exercise	17/02/2022	RJ	Completed
Committee meeting 11/11/2021 2.4	Engaging People in the work of HIS-update	TMG to pick up conversation with JM around some of the context of the EQIA template	17/02/2022	TMG	Completed.

Scottish Health Council Committee
Business Planning Schedule

Committee Business	Lead officer	2021-2022 27/05/2021	09/09/2021	11/11/2021	17/02/2022
Strategic Business					
Quality Framework for Community Engagement	Head of Engagement and Equality Policy				
Volunteering in NHS Scotland	Programme Manager Volunteering				
Citizens Panel	Head of Engagement and Equality Policy				
Engaging People in the work of HIS	Head of Engagement and Equality Policy				
Committee Governance					
Draft Annual Report 2020/21	Chair				
Draft Annual Report 2021/22 & Committee Terms of Reference	Chair				
Proposed Business Planning Schedule 2022/23	Director				
Risk Register	Director				
Remobilisation & Operational Plan Progress Report	Director				
Service Change Briefing	Service Change Manager				
Engagement Programme Update	Head of Engagement programmes				
Corporate Parenting Action Plan	Public Involvement Advisor				
Rethinking Meaningful Engagement	Director/Equality and Diversity Advisor				
Equality Mainstreaming Report-update	Director/Equality and Diversity Advisor				
Community Engagement Directorate Updates					
Additional Items of Governance					
Governance for engagement sub-committee meeting notes	Head of Engagement & Equalities Policy				
Service Change sub-committee meeting notes	Engagement Programmes Manager				
Closing Business					
3 Key Points	Chair				
AOB					

Scottish Health Council Committee
Business Planning Schedule

Committee Business	Lead officer	2022-2023 19/05/2022	15/09/2022	17/11/2022	02/03/2023
Strategic Business					
Quality Framework for Community Engagement	Head of Engagement and Equality Policy				
Volunteering in NHS Scotland	Programme Manager Volunteering				
Citizens Panel	Head of Engagement and Equality Policy				
Engaging People in the work of HIS	Head of Engagement and Equality Policy				
Committee Governance					
Draft Annual Report 2022/23 & Committee Terms of Reference	Chair				
Proposed Business Planning Schedule 2023/24	Director				
Risk Register	Director				
Remobilisation & Operational Plan Progress Report	Director				
Service Change Briefing	Service Change Manager				
Engagement Programme Update	Head of Engagement programmes				
Corporate Parenting Action Plan	Public Involvement Advisor				
Equality Mainstreaming Report-update	Director/Equality and Diversity Advisor				
Additional Items of Governance					
Governance for engagement sub-committee meeting notes	Head of Engagement & Equalities Policy				
Service Change sub-committee meeting notes	Engagement Programmes Manager				
Closing Business					
3 Key Points	Chair				
AOB					

GOVERNANCE COMMITTEE ANNUAL REPORT 2021/22

Scottish Health Council Committee Annual Report (Draft)

Committee Chair	**Suzanne Dawson**
Lead Director	**Ruth Jays**

Introduction

In order to assist the Healthcare Improvement Scotland (HIS) Board in conducting a regular review of the effectiveness of the organisation's systems of internal control, it is good practice for Governance Committees to submit an annual report to the Board. The Annual Report describes the outcomes from the Committee during the year and provides assurance to the Board that the Committee has met its remit during the year.

This report is therefore submitted on behalf of the Scottish Health Council (SHC) Committee for the year 1 April 2021 to 31 March 2022.

Purpose of the Committee (from Code of Corporate Governance)

The purpose of the Scottish Health Council Committee is to:

Be responsible for oversight of the governance and assurance of the statutory duties of the Scottish Health Council as set out in the National Health Service (Scotland) Act 1978 as amended by the Public Service Reform (Scotland) Act 2010:

- ensuring, supporting and monitoring NHS Boards compliance with the duty to involve the public
- ensuring, supporting and monitoring the NHS Boards compliance with the duty of Equal Opportunities (in relation to the provision of services and public involvement)

The Committee will assure the Board that HIS is meeting its duties in respect of: (i) patient focus and public involvement[1] (ii) equalities (excluding staff governance) (iii) User Focus and (iv) Corporate Parenting.

Detailed terms of reference are contained within the Code of Corporate Governance. The Committee should review its terms of reference annually as part of considering its annual report.

Has the Committee reviewed its terms of reference?
Yes/No

Remit of Committee (from Code of Corporate Governance)

Remit (list each part of remit)	**How did the Committee meet its remit during 2020/21 (with examples)**
Approval of *Healthcare Improvement Scotland – Community Engagement* strategic objectives, priorities and workplan for recommendation for inclusion in the HIS strategy, corporate and operational delivery plans and to	The Committee approved the HIS – Community Engagement (HIS-CE) directorate's operational plan for 2020/21 in May 2021. This detailed the directorate's contributions to the delivery of the 2020/21 HIS operational plan. An update against delivery of the plan was provided to the committee in September.

[1] The term 'community engagement' may be used to signify the duties of patient and public involvement.

ensure convergence between these plans.	In response to the COVID pandemic the Committee considered how the Directorate was adjusting and adapting its priorities and workplan to support the organisation's remobilisation plans at each of the subsequent committee meetings. The Committee also held discussions at its development day in June 2021 on how the Directorate can better support our health and social care stakeholders around ensuring meaningful engagement in service change. The key themes discussed by the Committee are informing the Directorate's ongoing planning and reporting to the Committee.
Detailed scrutiny of performance against the workplan and delivery of outcomes	The Committee reviewed progress with the work outlined in the Directorate's operational and remobilisation plans at each meeting. The Committee also received an update on how the Directorate was responding to the COVID pandemic at each meeting.
The establishment of terms of reference, membership, and reporting arrangements for any sub committees acting on behalf of the Committee	The Committee has two sub-committees: Service Change and Governance for Engagement. The Committee received Service Change sub-committee's minutes and action points at each meeting. The Governance for Engagement sub-committee completed a full cycle of meetings with each directorate in 2021/22. The Committee received sub-committee's minutes and action points. Following the completion of the full cycle, the format, structure and learning from the process are being reviewed with any amendments proposed sent to the Committee for consideration and approval and any action points shared with HIS directors.
Approval of systems and processes by which the organisation makes assessments of performance in relation to patient focus and public involvement in health services	The Committee's Service Change sub-committee considered and made recommendations on service change issues throughout the year. In addition to receiving the sub-committee's minutes and action points, the Committee also received an update on current service change considerations at each Committee meeting. The Committee also considered and provided feedback on draft revised national guidance on community engagement for health and care services in November 2021 and received updates throughout the year on the progress of the directorate's joint work with the Care Inspectorate to develop a quality framework for community engagement.

	At its development day in June, the Committee explored the challenges associated with service change in the context of national, regional and local planning, considering the challenges and risks. The outputs from this session have informed subsequent cross-organisational discussions, including a Board masterclass, as well as informing feedback on the new national guidance for community engagement – *Planning with People*, considerations around the Quality Framework for Community Engagement and the development of a Service Change Action Plan. The Committee also received updates about the development of a performance measurement framework to enable us to demonstrate the impact of our activities against the Operational Plan.
Hold to account all HIS Directorates for performance in relation to Patient and Public Involvement, the Duty of User Focus, Corporate Parenting and Equalities Duties in the delivery of HIS functions, excluding Equalities Duties relating to workforce which fall within the remit of the Staff Governance Committee.	Specific areas reviewed by the Scottish Health Council committee during the year included: • HIS Corporate Parenting Action Plan • HIS Equality Mainstreaming Report • Volunteering and public partner roles in HIS • Citizens' Panel The Committee also informed work on refreshing the EQIA process for the organisation to ensure a consistent approach. Committee members have also been involved in the development of the HIS strategy, providing advice on stakeholder engagement. This has consisted of individual interviews with committee members to discuss what their priorities are for strategy development and stakeholder engagement. The HIS Chair and Chief Executive attended the committee in September to engage with members on the strategy and seek their feedback on its development.

Reporting arrangements
The following appendices provide a summary of the work of the Committee during 2021/22: Appendix 1 – Attendance schedule Appendix 2 – Business planning schedule Appendix 3 – Key areas of business arising from each meeting and reported to the Board

Risks (summary of risk landscape during the year)

During 2021/22 the Scottish Health Council Committee reviewed at each of its meetings

- all strategic risks/all strategic risks within the remit of the Committee
- all high and very high operational plan risks / all high and very high operational plan risks within the remit of the Committee

The following key risk was considered in more detail by the Committee:

> There is an operational and reputational risk to Healthcare Improvement Scotland's role in supporting public involvement in both regional planning and changes made in response to COVID-19 due to limited engagement. It remains unclear to what extent plans will be influenced by public involvement resulting in challenge to Healthcare Improvement Scotland's statutory role in public involvement

Following discussions, this risk has now been updated to take account more accurately of the current context and has been added to the strategic risk register.

The new risk is as follows:

> There is a risk that system pressures, together with regional/national planning and COVID remobilisation and recovery reduces the priority given to meaningful public involvement and engagement in service change resulting in failure of Boards to meet their statutory responsibilities with the subsequent operational and reputational risk to HIS.

The Committee will continue to highlight areas of risk to the Board, requesting external written evidence where this is necessary.

Conclusion: (include what worked well/not well/what are the future actions)

Did the Scottish Health Council Committee meet its remit for the year 1 April 2021 to 31 March 2022?

Yes
Commentary:
Despite the challenges that COVID-19 has continued to present during 2021/22, the Committee has successfully embedded new ways of working to ensure that it continues to meet its remit and provide governance and assurance of the statutory duties carried out by HIS-CE.

The embedding of the Governance for Engagement sub-committee has enabled assurance on the performance of all HIS directorates in engaging people in the delivery of our work. In addition, the work of the service-change sub-committee has enabled Committee members to oversee the Community Engagement Directorate's assurance of engagement activities for high profile service change programmes.

What are the future actions?
Commentary:
The committee will consider further action to ensure meaningful engagement in service change as the NHS remobilises and recovers from the pandemic, ensure a widespread awareness of our role, remit and functions by our key stakeholders and consider the implications of future hybrid working on the work of the committee. Work on the Quality Framework for Engagement – paused due to the impact of the pandemic – will restart. A number of challenges are likely to be raised with the

committee during the reporting year around major service change, and large-scale national projects such as National Treatment Centres. The Committee will consider what advice and support is required to be provided to boards and partnerships around these. The current SHC vice chair comes to the end of their term as a HIS Board member during this coming reporting year. This leaves a committee member and vice chair vacancy to be filled. Once appointed a priority will be to ensure that the new member is supported to provide continuity of expertise and scrutiny.
Sign-off Details
Committee Chair, signature, date:
Lead Director, signature, date:

Terms of Reference: Scottish Health Council Committee

1.0 Purpose

The Scottish Heath Council operates as *Healthcare Improvement Scotland – Community Engagement*.

The Committee shall be responsible for oversight of the governance and assurance of the statutory duties of the Scottish Health Council as set out in the National Health Service (Scotland) Act 1978 as amended by the Public Service Reform (Scotland) Act 2010:

- ensuring, supporting and monitoring NHS Boards compliance with the duty to involve the public
- ensuring, supporting and monitoring the NHS Boards compliance with the duty of Equal Opportunities (in relation to the provision of services and public involvement)

The Committee will assure the Board that HIS is meeting its duties in respect of: (i) patient focus and public involvement[1] (ii) equalities (excluding staff governance) (iii) User Focus and (iv) Corporate Parenting.

2.0 Remit

The duties of the Scottish Health Council Committee are:

- approval of *Healthcare Improvement Scotland – Community Engagement* strategic objectives, priorities and workplan for recommendation for inclusion in the HIS strategy, corporate and operational delivery plans and to ensure convergence between these plans
- detailed scrutiny of performance against the workplan and delivery of outcomes
- the establishment of terms of reference, membership, and reporting arrangements for any sub committees acting on behalf of the Committee
- approval of systems and processes by which the organisation makes assessments of performance in relation to patient focus and public involvement in health services
- hold to account all HIS Directorates for performance in relation to Patient and Public Involvement, the Duty of User Focus, Corporate Parenting and Equalities Duties in the delivery of HIS functions, excluding Equalities Duties relating to workforce which fall within the remit of the Staff Governance Committee.

[1] The term 'community engagement' may be used to signify the duties of patient and public involvement.

The Committee will manage any associated risks assigned to it[2]. The Committee will review its own effectiveness and report the results of the review to the Board and Accountable Officer through submission of an annual report.

3.0 Membership

The Chair of the Committee shall be the Chair of the Scottish Health Council as appointed by Scottish Ministers. There shall be up to eight other members of the Committee, two of whom shall be members of, and appointed by, the HIS Board on the recommendation of the Chair of the Scottish Health Council, and up to six who shall be members of the public appointed by the Chair of the Scottish Health Council. Committee members can serve a maximum of two four-year terms. The Director of Community Engagement is expected to attend meetings.

The Healthcare Improvement Scotland Chair cannot be a member of the Committee but has the right to attend.

The Chair of the Scottish Health Council shall be a member of the Quality and Performance Committee.

A Vice-Chair will be appointed by the Chair, who will deputise for the Chair in their absence.

4.0 Quorum

Meetings of the Committee shall be quorate when at least 50% of members are present, including at least one HIS non-executive Board member.

For the purposes of determining whether a meeting is quorate, members attending by either video or teleconference link will be determined to be present.

5.0 Meetings

The Committee will meet a minimum of four times a year. Meetings will be held at a place and time as determined by the Committee.

6.0 Information requirements

For each meeting the Scottish Health Council Committee will be provided with:

- Business Planning Schedule
- Operational Plan
- Risk register

[2] The Healthcare Improvement Scotland Risk Management Strategy describes how each risk raised on the corporate risk management system is assigned to the appropriate governance committee, dependent on its description and the context of the risk

As and when appropriate the Committee will also be provided with:

- Equality mainstreaming reports
- Corporate Parenting progress reports

Healthcare Improvement Scotland

Meeting:	**Scottish Health Council Committee**
Meeting date:	**17 February**
Title:	**Risk Register**
Agenda item:	**3.2**
Responsible Executive/Non-Executive:	**Ruth Jays, Director of Community Engagement**
Report Author:	**Ruth Jays**

1 Purpose

This is presented to the Committee for:

- Discussion

This report relates to:

- Annual Operational Plan delivery
- HIS Strategic Direction

This aligns to the following HIS priorities(s):

- Integration of health and social care
- Safe, reliable and sustainable care

2 Report summary

2.1 Situation

At each meeting the Scottish Health Council Committee is provided with a copy of the operational risks relating to the Committee's remit.

2.2 Background

The Community Engagement Directorate's risk register is detailed in Appendix 1.

Since the last Committee meeting, following discussions at the HIS Board Development day on November 17 2022 and the Audit and Risk Committee on November 24 2022, a new risk, (Risk 1163) has been added. This replaces risk 1120, taking account of the current context and capturing the risk associated with engagement in service change proposals during the pandemic. This risk has also been added to the HIS Strategic Risk Register.

There are no other changes to the risk register.

All risks continue to be reviewed in light of the COVID-19 pandemic. A risk relating to the impact of the pandemic for Healthcare Improvement Scotland is on the organisation's Strategic Risk Register.

2.3 Assessment

2.3.1 Quality/ Care

N/A

2.3.2 Workforce

Relevant workforce implications for each risk have been identified.

2.3.3 Financial

Relevant resource implications for each risk have been identified.

2.3.4 Risk Assessment/Management

Risk register attached in appendix 1.

2.3.5 Equality and Diversity, including health inequalities

The Community Engagement Directorate has a specific role in supporting equality and diversity within Healthcare Improvement Scotland which is reflected in the Directorate's risks.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

The directorate's risks have been informed by our ongoing engagement with a range of stakeholders.

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

The Committee is asked to discuss the Community Engagement Directorate's risk register.

3 List of appendices

The following appendices are included with this report:

- Appendix No1 Risk Register

Healthcare Improvement Scotland

Active Risks - Committee Report

Category	Project/Strategy	Risk No	Risk Director	Risk Description	Risk Appetite	Last Updated	Current Control	Current Mitigation	Current Update	Current Risk Level	Jan -
Operational	Community Engagement directorate wide risk	1077	Ruth Jays	There is an operational risk to HIS – Community Engagement as a result of the limited launch of the directorate undertaken in April 2020 necessitated by the on-going pandemic, resulting in a lack of widespread stakeholder recognition and understanding of our new branding, and the full range of expertise, support and services offered.	Open	01/02/2022	• Defined directorate communications approach to refocus on stakeholder recognition and understanding. • Design, delivery, on-going management and evaluation via Directorate	The directorate has operated as HIS – Community Engagement since April 2020, and has a core narrative and well-developed website to support its branding and communication efforts. Some of the website content is legacy material from the Scottish Health Council - these are being reviewed and where necessary being brought up-to-date. These are supported by a communications operational groups comprised of colleagues from all levels within the directorate. The original launch ideas pre-dating the onset of the pandemic are being revisited by the group to determine their appropriateness as part of the communications refocus work. The directorate's senior team has been taking opportunities to present to and share with external stakeholders about our role and remit (including opportunities with the Scottish Government, NHS Boards and integration authorities.	A further refocus on the branding piece with stakeholders is necessary given the limitations of the launch arrangements in April 2020. Distribution of new signage across the engagement office network estate has not been possible due to the on-going pandemic. A review of our accommodation requirements is on-going and will report during the first quarter of 2022. Due to the service continuing to be focused on the pandemic, the communications operational group is progressing the refocus work during 2022 with regular reporting as set out within the Controls section. Taking opportunities to participate in external stakeholder events to speak about our directorate's role and remit, and how we can add value to their work.	Medium - 8 Impact - 4 Likelihood - 2	Medium - 8
Reputational / Credibility	Service Change	1163	Ruth Jays	There is a risk that system pressures together with regional/national planning and COVID remobilisation and recovery reduces the priority given to meaningful public involvement and engagement in service change resulting in failure of Boards to meet their statutory responsibilities with the subsequent operational and reputational risk to HIS.	Open	01/02/2022	"Planning with People", Scottish Government and COSLA Community Engagement Guidance', Identifying options	The Scottish Health Council Committee Service Change Sub-Committee continues to provide governance over the issue and last met on 28 October 2021. This subject was the focus of a paper presented to the Scottish Health Council Committee on 9 September where recommendations were accepted. The issue was also the subject of a Board Development Day on 17 November and further actions will be developed in the light of these discussions. Ongoing discussions with boards and partnerships to emphasise need for engagement and support available via HIS-CED.	The current serious and sustained pressures in the health and social care system are having an impact on boards' ability to meaningfully engage around service change. There are also a range of service changes which were brought in on a temporary basis at the start of the pandemic and have now been in place for 18 months. We are reviewing on an ongoing basis the support we provide for boards and what more we can do to ensure relevant guidance is applied and the risks around failure to meaningfully engage are taken account of.	High - 16 Impact - 4 Likelihood - 4	High - 16

Healthcare Improvement Scotland

Meeting:	**Scottish Health Council Committee**
Meeting date:	**17 February 2022**
Title:	**Rethinking Meaningful Engagement**
Agenda item:	**3.3**
Responsible Executive/Non-Executive:	**Ruth Jays, Director of Community Engagement**
Report Author:	**Ruth Jays, Director of Community Engagement**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to:

- Annual Operational Plan delivery
- Government policy/directive
- Legal requirement
- HIS policy
- HIS Strategic Direction

This aligns to the following HIS priorities(s):

- Access to care
- Integration of health and social care
- Safe, reliable and sustainable care

2 Report summary

2.1 Situation

Since the onset of the pandemic, the range of service change being taken forward by boards and partnerships has increased rapidly, but in many cases this has not been matched by meaningful engagement. This has potentially serious implications for delivery of services to patients, legal risks for boards and risks for Healthcare Improvement Scotland – Community Engagement (HIS-CE) in discharging our statutory duties effectively. The committee is asked to:

- consider the attached paper, which sets out a way forward to support and ensure meaningful engagement and manage the risks set out above,
- approve the proposed course of action and
- suggest any further activity.

The attached paper complements activity set out in the Service Change Action Plan, which the committee has previously approved.

2.2 Background

The pace of changes brought in during the pandemic has meant that boards have not been able to carry out engagement at the level we would expect. In addition, the pandemic negatively impacted our relaunch as HIS-CE in April 2020, meaning there is a lack of awareness about our role, remit and the support we can provide.

In addition to the service changes already underway or planned, a number of capital projects are coming on stream in the next 3-5 years, and the first of a network of national treatment centres set to open at the end of 2022. Therefore, it is imperative that we ensure boards and partnerships are clear about our engagement expectations and the support we can provide them.

2.3 Assessment

The attached paper sets out a range of actions to raise awareness of our role and to support boards to take forward meaningful engagement, while recognising the continued pressure on boards.

Scottish Government has been clear in its expectations around the need for meaningful engagement and in particular its expectations around service changes brought in on a temporary basis during the pandemic which boards seek to put on a permanent footing.

Our Scottish Government sponsors are aware of our proposed activity and are supportive. The paper sets out a range of actions to provide support to boards and partnerships, which will help spread and promote a greater degree of meaningful engagement. The actions are grouped into four areas – communications, leadership, governance and resources.

Key to the success of the approach are building relationships, effectively communicating our role and achieving more widespread awareness of our remit. External activity will start from March 2022, or whenever the pandemic situation allows. Internal-to-HIS activity will be progressed immediately where possible, dependent on the impact of COVID-19 on resourcing.

2.3.1 Quality/ Care

Failure to engage meaningfully with communities on service change has the potential to negatively impact on quality of care.

2.3.2 Workforce

Potential impact on staff within boards and partnerships who may cite a lack of capacity to take forward meaningful engagement.

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

The risk around service change, communications and meaningful engagement are captured on the Committee's risk register and HIS's Strategic Risk register. Taking forward the actions set out in the paper will provide mitigation against these risks.

2.3.5 Equality and Diversity, including health inequalities

Boards and Partnerships are expected to complete impact assessments for each service change they propose.
Ensuring meaningful engagement and discharging our statutory role around assuring service changes supports HIS-CE in meeting the Public Sector Equality Duty, the Fairer Scotland Duty and the Board's Equalities Outcomes.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

- Discussion with Scottish Government Person-Centred and Participation Unit, December 2020.

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

- **Discussion**. Committee is asked to discuss the planned activity set out in the attached paper and approve the way forward.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, SBAR on Rethinking Meaningful Engagement and the role of HIS-Community Engagement

Healthcare Improvement Scotland | Community Engagement

Rethinking meaningful engagement and the role of HIS – Community Engagement

Appendix 1

Situation

Since the onset of the pandemic in March 2020, the health and social care system in Scotland has undergone more rapid and significant change than at any point since the inception of the NHS to ensure it continues to provide safe and efficient services and maintain capacity. This is likely to continue for some time to come, as the service continues to address the challenges of the pandemic, and begins to return to a more steady state once COVID becomes endemic.

There has never been a more important time to ensure meaningful engagement with service users and the public. The pandemic has thrown into sharp focus the importance of ensuring services are designed and delivered in a person-centred way. However, there has equally never been a more challenging time to ensure meaningful engagement. The current and sustained pressure on the NHS and social care, and the likelihood of this continuing for some time to come as well as the restrictions on face-to-face meetings and engagement necessitated by the pandemic, and the rapid pace of changes to services means that boards and partnerships are finding it challenging to ensure meaningful and proportionate engagement in service changes.

Background

The then Cabinet Secretary for Health and Sport wrote to NHS Board Chairs in June 2020 to set out engagement expectations during the pandemic. She clarified that the statutory duty to involve people remained as important as ever and her expectation that NHS Boards should follow national guidance[1] to assist them to comply with their duties under Section 2B of the National Health Service (Scotland) Act 1978. She encouraged NHS Boards to contact HIS-Community Engagement (HIS-CE) to seek advice, support and assurance in meeting their statutory duties. Many changes which were introduced on a temporary basis have now been in place for nearly two years. It is likely that Boards will seek to make many of these permanent in the period ahead, therefore it is essential that we provide clarity about our expectations.

[1] https://www.gov.scot/publications/planning-people/pages/2/

NHS SCOTLAND

Following this letter from the Cabinet Secretary for Health and Sport, HIS-CE published guidance for NHS Boards to enable them to make decisions about changes they had made during the pandemic and how they could move forward with meaningful engagement. This guidance was updated in November 2021[2].

There are risks around this for Healthcare Improvement Scotland and HIS-CE if Boards and Partnerships do not get this right. Therefore it is imperative that we provide advice and support to NHS Boards and Health and Social Care Partnerships to ensure that engagement is meaningful, proportionate and takes account of the COVID and system pressures context. Failure to do so could result in poorer public services, questions around the validity of our role and potential legal challenge for health boards.

At times we canface resistance and challenges to the need for meaningful engagement from within health and social care partners for a range of reasons, including: misunderstanding about what meaningful engagement is and why it is necessary; lack of support for the principles of co-design; anxiety about what public expectations are and whether these can be delivered; lack of resource/capacity; extreme pressure on the system; and concern that meaningful engagement is too difficult.

Many changes to services have been in place for nearly two years now with little or no public engagement, or indeed challenge from the public. This may lead some stakeholders to question whether meaningful engagement is necessary and a lack of appreciation of the risks of not doing so.

While the impact of the pandemic on the NHS and social care cannot be overstated, challenges around ensuring meaningful engagement have existed prior to 2020, and it is the role of HIS-CE to help support Boards and Partnerships to ensure that appropriate and proportionate engagement takes place despite the impact of the pandemic.

Assessment

HIS-CE recognises the current challenges and pressures on Boards, but is working with Boards and Partnerships to ensure they:

- continue to develop and embed their understanding of the need for engagement regarding changes made as a result of the pandemic
- recognise the risks of not meaningfully and proportionately engaging with the public around service change and redesign and how they can mitigate against these
- understand and access the advice and support HIS – CE provides, as well as the statutory responsibilities we have around assurance of engagement activities related to service change.

We have not been able to meet our aims of communicating our role or achieving widespread awareness of our remit as effectively as we would have liked due to the impact of the pandemic and the timing of our relaunch (April 2020).

Fundamental to achieving both these aims is ensuring our continued good relationships with health and social care services as well as our partners in the third and voluntary sectors and beyond.

[2] https://www.hisengage.scot/service-change/service-change-during-covid-19/

Ongoing engagement and effective relationships with each of our partners is key to ensuring that service users and the public are involved in decisions about health and care services for the future. This is an issue not just for service change, but more widely, as it is in discussions about engagement and redesign that the need for a service change may emerge and the processes to follow will become apparent.

Good relationships with boards will result in the early identification of any proposed or planned service changes and enable HIS-CE to provide the advice, support and assurance that health and care services require.

Significant challenges are emerging around national and regional planning decisions such as National Treatment Centres, regionalisation of services or National Trauma Centres. These are policy-level decisions that have been made in previous years that NHS Boards are now trying to implement. HIS-CE and the Scottish Health Council Committee need to make our position clear on these national and regional planning decisions and communicate this across the health and care system to ensure consistent broad advice around engagement is provided with further tailored advice and support on a case-by-case basis depending on the issue at hand.

Recommendation

We recommend a range of actions to provide support to boards and partnerships, which will help spread and promote a greater degree of meaningful engagement.

Key to this is building relationships, effectively communicating our role and achieving more widespread awareness of our remit. External activity will start from March 2022, or whenever the pandemic situation allows. Internal-to-HIS activity will be progressed from January 2022 where possible, dependent on the impact of COVID-19 on resourcing.

It should be recognised that we cannot entirely remove the risk of meaningful engagement not taking place in all cases. Our role is to offer and provide advice and support to boards and partnerships – we cannot compel them, nor can we carry out engagement on their behalf. However, the actions set out below will minimise this risk as far as possible. These proposed actions are as follows:

<u>Communications</u>

- A review of our communications and digital offering is required. This should include updating our website to ensure it is current, accurate and user-friendly, and ensuring that the main HIS website appropriately signposts to the HIS-CE web pages. Further discussions with the new Head of Communications are required to achieve this aim, which is linked to proposals to revamp HIS' digital presence overall. We will also review our digital offering, to ensure that all our tools, supportive material and guidance are available digitally. This is necessary to widen and improve our reach, and also take account of the current restrictions on face-to-face meeting and engagement, which are likely to continue for some time.
- We will continue to ensure that alternatives to digital are made available to ensure equity of access.
- Continue to develop and share case studies of good practice.

Leadership

- At appropriate times and subject to system pressures, a core presentation developed and delivered by the SHCC Chair and HIS-CE on the role of the directorate will be offered to every board and partnership; Scottish Government; Board Chairs; Board Chief Executives; Directors of Planning; and DMTs within HIS.
- Seeking a strong, consistent and unambiguous statement from SG about the central importance of meaningful engagement.
- Strengthen relationships with relevant Scottish Government teams, specifically the Performance Management Team to ensure appropriate flow of information about proposed service changes, including in relation to capital infrastructure.
- Improve intelligence sharing within HIS building on the new system developed by HIS-CE and consider which further mechanisms are appropriate to achieve this.
- Specific work with NXD Board members so they fully understand their statutory obligations, the risks of not involving the public and the benefits of meaningful engagement

Governance

- Strengthen the Governance for Engagement Sub-Committee process based on learning from process in the first year of scrutiny, and through alignment with the Quality Framework for Community Engagement.
- Clarify the role of regional and national planning structures and governance arrangements in supporting service changes, and more specifically the HIS-CE interface with these and expectations around meaningful public engagement to inform decision-making.
- Seek legal advice around local authority delegated services from Central Legal Office, and in particular where such services have been combined with delegated NHS services (eg care of the elderly beds in community hospital settings).

Resources

- Review our resources available to Boards and Partnerships to ensure they are easily accessible and as user-friendly as possible both in digital and more traditional formats.
- Review our processes around participation and engagement to ensure they are fit for purpose in a post-pandemic world, taking full advantage of the learning from our *Engaging Differently* work programme which has identified good engagement practice from across sectors during the pandemic.
- Work in collaboration with NHS Education for Scotland and health and social care services to create and update training resources on Turas to explain and promote the role of HIS-CE, meaningful engagement and service change responsibilities.

Ruth Jays

Director
HIS – Community Engagement Directorate
January 2022

Healthcare Improvement Scotland

Meeting:	**Scottish Health Council Committee**
Meeting date:	**17 February 2022**
Title:	**Service Change Briefing**
Agenda Item:	**3.4**
Responsible Executive:	**Ruth Jays, Director**
Report Authors:	**Derek Blues - Engagement Programmes Manager Emma Ashman, Carmen Morrison, Louise Wheeler - Service Change Advisors**

1 Purpose

To provide the Committee with an update on service change activity within *Healthcare Improvement Scotland – Community Engagement* (HIS-CE).

This is presented for:
- Awareness and noting

This report relates to:
- Annual Operational Plan delivery

This aligns to the following HIS priorities(s):
- Access to care
- Integration of health and social care
- Safe, reliable and sustainable care

2 Report summary

This report provides an update on specific guidance issues, general service change and practice development.

3 National Guidance

3.1 The *Planning with People* guidance will now be reviewed later in 2022 by the Scottish Government and COSLA to take account of current operational pressures. The Scottish Government has issued a letter to NHS Board Chief Executives and Integration Authority Chief Officers about the delay. HIS-CE has shared the letter with NHS boards engagement leads.

3.2 Five colleagues from NHS Boards and Health and Social Care Partnerships are interested in joining the Short Life Working Group to develop the aims, vision and practicalities for a network/community of practice. The team has organised a first meeting for the 15 February and will share information about the development of the network/community of practice as a small test of change before widening the scope to the wider directorate.

4. Current activity

This provides an overview of the active, more significant changes that the team has been involved in, with further detail on wider changes provided in **appendix one.**

4.1 NHS Lanarkshire – Monklands/Elective Orthopaedic Surgery:

NHS Lanarkshire considered the proposals and outcome from their engagement activity at a board meeting on 20 December 2021, where the preferred option for the siting of Elective Orthopaedic Surgery (phase 2 redesign) at the new University Hospital Monklands was approved. The Board paper included two letters from HIS – Community Engagement (11.10.21 and 01.12.21) and an action supported by the Board is to "Agree that further work will take place as proposals are developed to meet the recommendations outlined by HIS - Community Engagement".

4.1.1 NHS Grampian – Review of Maternity services model at Dr Gray's (DGH), Elgin:

No further update.

The independent review was published on 3 December 2021 and has made some medium and long term recommendations for reinstating services at Dr Gray's. The Cabinet Secretary for Health visited Moray on 20 December to discuss the recommendations with the board, staff and local stakeholders before developing an implementation plan.

We met with NHS Grampian on 6 December who said they were awaiting direction from the Scottish Government before developing any communication and engagement plans but they had spoken with Moray Maternity Voices, who are mentioned in the report, to discuss working together.

A number of clinicians have released an open letter to the Cabinet Secretary highlighting their concerns with the findings of the review.

4.1.2 NHS Ayrshire and Arran – Vascular services and Trauma & Orthopaedics:

No further update on Vascular services.

Following the Director's letter dated 16 August 2021 regarding engagement on changes to Vascular and Orthopaedic inpatient services, *Healthcare*

Improvement Scotland – Community Engagement's service change team has received no further update. We are aware that NHS Ayrshire and Arran is experiencing significant operational pressures in response to COVID-19 and a surge in need. The Engagement Programmes Manager has communicated with NHS Ayrshire and Arran to discuss next steps at an appropriate time.

On 1 September, NHS Ayrshire and Arran issued a press statement on its website, which stated: "By changing how services are configured and by concentrating major trauma and trauma cases in the Major Trauma Centres and Trauma Units, this will ensure equity of access to those specialist services for trauma patients. This change will enable Boards to develop elective centres of excellence within their local emergency hospitals.

"Supported by investment from Scottish Government, a National Treatment Centre for inpatient elective care will be created at University Hospital Ayr. This welcome investment is part of the Scottish Government's National Elective Centre Programme". (https://www.nhsaaa.net/news/latest-news/trauma-and-orthopaedics/).

4.2 NHS Ayrshire and Arran – Review of Chemotherapy Services

Healthcare Improvement Scotland – Community Engagement received a communication from NHS Ayrshire and Arran on 10th December 2021, which includes a draft engagement plan and updated EQIA. The Director of *HIS – Community Engagement* wrote to NHS Ayrshire and Arran on 23 December to summarise engagement advice previously given and outline next steps.

A separate paper (item 4.1) has been included for the Committee for discussion at the February meeting.

4.3 NHS Highland- North Skye inpatient and community bed redesign

The review started in 2019 in response to Sir Lewis Ritchie's recommendations for inpatient and Out-of-Hours Care. Three community events took place at the beginning of this year before the option appraisal process was paused in March due to COVID-19. The process has restarted with the second workshop on 16 December via Zoom to involve community representatives in the review of criteria and development of options. The case for change will be reviewed to take account of recent changes at Portree Hospital and Home Farm Care Home.

The local north Skye Community Trust will support the sharing of information with the wider community between the sessions. At the Option Appraisal meeting held on 20 January 2021 there was a proposal to hold an additional session to allow more time to consider development of the options. There was agreement in principle but this has to be confirmed.

The steering group have developed a draft 'vision' paper for sharing with the community for update and information. This paper will be the starting point for

the Option Appraisal Steering Group to agree a shared vision and understanding for future Option Appraisal meetings.

NHS Highland have re-started the option development sessions with a 'Vision for Skye' meeting held in November. It is hoped that the 'Vision for Skye' meetings will be a means to agree a way forward which is mutually acceptable by NHSH and all stakeholders.
At a meeting on 11 January 2022 there was agreement that the focus of the service development should be to develop a health and care campus. Future meetings will initially consider service requirements and then consider possible site/sites. No further meeting dates have been agreed at this time.

4.4 NHS Highland – Lochaber – Belford Hospital

A case-for-change meeting was held w/c 9 August with a range of stakeholders in attendance. This will inform options on service delivery. An option appraisal session will follow. Service Change Advisor and Engagement Officerhave been invited to attend the Lochaber Redesign Project meetings.Buchan Associates are facilitating meetings with staff and public in September. NHS Highland intends to share communications with the community and service users from late September.

A 'risk and benefits' meeting with staff and stakeholders took place on 22 October and a Stakeholder group meeting took place on 30 October. Option appraisal workshops were held in November 2021.

Stakeholder meetings are held monthly and are well attended. Information is shared and opportunities are given for questions to be asked.

A stakeholder meeting was held in December 2021 where NHS Highland advised that the option appraisal will now be conducted prior to the Outline Business Case (OBC)– this will extend the initial Agreement phase as the first part of the OBC will now be done during the Initial agreement process. NHSH and HIS-CE met on January 20 to discuss OA plans and engagement and communication plans.

4.5 NHS Highland – Royal Northern Infirmary – ward redevelopment

Ward 2 in RNI was not in use during the COVID pandemic. Services were delivered in a home setting where possible.

This ward provided a Community Hospital service for people who needed more intensive medical input than could be provided at home or those who have been treated in Raigmore but who still require some form of medical support before returning to their own home.

Engagement has taken place with people who have used the service over the period of change. NHSH have recommended that the service continue to be provided in the community and therefore not re open Ward 2. NHS Highland will continue to engage with service users and potential service users to

monitor views and feedback about the service delivery. HIS-CE provided advice at a meeting on 12 August 2021. A patient information leaflet has been drafted and HIS-CE comment supplied.

4.6 Highland – Argyll and Bute HSCP Housing and Care Home Review

Engagement in respect of Oban's Eadar Glinn Care Home Review has been resumed after delay due to COVID 19. A&B HSCP have had two meetings with HIS-CE and regular meetings have been agreed to support the development of the project. Engagement is being carried out within the community to revise and review the previously developed options with a view to hold an Option Appraisal process.

A&B HSCP have made progress with community representation recruitment to their communications group (as detailed in the Communications and engagement plan). Dunoon Community council have expressed dissatisfaction with the partnership's engagement process to HIS-CE. We continue to work with A&B HSCP to ensure meaningful engagement with people and communities throughout this review.

4.7 NHS Tayside- Mental Health and Learning Disability Services:

No further update.

We have followed up with the project lead about the implementation of changes to inpatient beds at Carseview and were advised we would be informed of progress. We note that an independent group has been set up to provide oversight and assurance of NHS Tayside's mental health services. It will work with the Tayside Executive Partnership on the implementation of recommendations made by David Strang. The new group will be chaired by Fiona Lees, a former chief executive of East Ayrshire Council, and will report on a quarterly basis to the minister.

Due to system pressures, NHS Tayside have postponed the next meeting of the communication & engagement group and are reviewing the next steps with the implementation of the Mental Health & Wellbeing strategy.

A Short Life Working Group to scope out a potential People's Panel for Mental Health Services in Tayside, which the Engagement Officer is attending, and are asking members of the group to extend an invitation to their networks to ensure involvement of people with lived experience.

4.10 NHS Western Isles – Neurological Service

An initial meeting has been held with NHSWI who approached HIS-CE to discuss potential changes to the structure of their Neurological Service. The current service is based on 3 specialist nurse posts dealing with three separate work streams. NHSWI proposes to provide an overarching service

delivery team to cover all types of neurological conditions. Some engagement work has been done with patient groups – two meetings with Neuro Hebrides support group. Other engagement work has been planned but a communication and engagement plan is yet to be developed.
An additional short meeting to discuss previous neurological engagement work and action plan developed by NHSWI and SHC in 2018 took place on 10 DecFurther meetings will take place between HIS-CE and NHSWI.

4.11 NHS Western Isles – Mental Health Strategy

NHSWI approached HIS-CE to discuss the development of a Mental Health Strategy.An initial meeting took place on December 13 with members of the NHS WI Mental Health Strategic Group. Previous engagement and consultation has taken place over a number of years to redesign Mental Health Services. There is currently no Mental Health Strategy for the Board. Feedback from historic and recent engagement has led to the development of 7 overarching commitments to inform a new strategy. A stakeholder workshop to discuss and shape the 7 commitments took place on December 15 2021. It is envisaged that further engagement on the 7 commitments will take place with a view to having the strategy developed by March 2022 with consultation on the strategy thereafter.

4.12 NHS Forth Valley

HIS-CE met with Kris Robertson, Operations Manager, NHSFV to discuss the intention to establish an Osteoporosis Service. Currently patients travel to the Golden Jubilee for services.The introduction of a service locally will reduce travel for patients. HIS-CE have been asked to attend the project team meeting in early January for continued advice and support.
Due to system pressures, NHS Forth Valley advised by email that they would contact HIS-CE at a later stage in the process. and withdrew the invitation to attend the project meeting on 10 January 2022.

5. Developing Practice

5.1 **Online workshops** – The team has been following up contacts with colleagues in NHS Boards and Health and Social Care Partnerships (HSCPs) about further ‘taster’ sessions and individual workshops.

The team has drafted an overview of the workshops and the *Planning with People* guidance for non-Executive board members. There is increasing ask for the workshops to be delivered to senior staff and executives in NHS boards and Integration Authorities.

An infographic which highlights involvement in and feedback from the sessions has been developed and is included at Appendix two.

5.2 **Animation** - The next animation on transport and access is currently being developed and has been shared with our Public Partners for feedback. The

team is considering new formats and topics to support engagement in service change/redesign.

5.3 **Resources**- To continue to help NHS boards, integration authorities and local councils effectively engage with people and communities in the planning and development of health and care services, resources have been updated to reflect current context and new Scottish Government guidance. The identifying 'major' health service change guidance has been reviewed and has been shared with sub-committee.

The team is currently considering other resources which need updated to reflect new guidance and the changing landscape of engagement.

5.4 **COVID-19** The updated paper- Engagement *and participation in service change and redesign in response to the COVID pandemic-* has been uploaded to the website and shared with colleagues in NHS Boards and Integration Authorities as part of our regular meetings.

5.5 The action plan for regional and national service change/redesign was shared with the sub-committee. The team is currently developing case studies of different approaches taken to regional planning.

6. Recommendation

The Committee is asked to note the content of this paper.

7. List of appendices

The following appendices are included with this report:

Appendix one: Service Change Wider Update, January 2022
Appendix two: Workshop infographic

Appendix one

Service Change Wider Update, January 2022

NHS Board	
National Waiting Times Centre	*Scottish Adult Congenital Cardiology Service* *Expansion Phase 2 Orthopaedics*
NHS Ayrshire and Arran	*Caring for Ayrshire*
NHS Borders	*Coldingham Medical Practice*
NHS Fife	*Review of In-patient Mental Health services*
NHS Grampian	*National Treatment Centre, Clinical Strategy, Mental Health Inpatient beds reliance pathfinder*
NHS Greater Glasgow and Clyde	*Institute for Neurological Sciences*
NHS Highland	*Review of inpatient and Community beds North Skye, Primary Care provision in Inverness, Belford replacement*
NHS Shetland	*Gilbert Bain Hospital replacement and Clinical Strategy*
Scottish Ambulance Service	*Strategy Development Framework 2021-2030*
Integration Authority	
Aberdeenshire Health and Social Care Partnership	*Insch and Aboyne community Strategic Needs Assessment*
Angus Health and Social Care Partnership	*Review of Specialist Dementia discharge pathway and Stroke Inpatient beds. Care of the Elderly inpatient beds.*
Argyll and Bute Health & Social Care Partnership	*Dementia Review*
Glasgow City Health and Social Care Partnership	*Mental Health services*
North Ayrshire Health and Social Care Partnership	*Arran Integrated Island Services*
Dumfries & Galloway Health and Social Care Partnership	*Strategic Review* *Dementia Review*
Edinburgh City Health and Social Care Partnership	*Bed Based Review*
East Lothian Health and Social Care Partnership	*East Lothian bed review*
Forth Valley – Falkirk and Clackmannanshire HSCP	*Review of Community Hospital and Primary Care services*
Moray Health and Social Care Partnership	*Business case process for replacement of Keith Health Centre and Turner Hospital. Burghead and Hopeman- Branch Surgery Review.*

Appendix two

Workshop infographic

Healthcare Improvement Scotland

Meeting:	**Scottish Health Council Committee**
Meeting date:	**17 February 2022**
Title:	**Remobilisation and Operational Plan 21-22: Progress Update Q3**
Agenda item:	**3.5**
Responsible Executive:	**Ruth Jays, Director of Community Engagement**
Report Authors:	**Jane Davies, Head of Engagement Programmes**

1 Purpose

This is presented to the Committee for:

- Discussion

This report relates to:

- Annual Operational Plan delivery

This aligns to the following HIS priorities(s):

- Mental health services
- Access to care
- Integration of health and social care
- Safe, reliable and sustainable care

2 Report summary

2.1 Situation

This paper provides the Committee with an update on the Directorate's progress with our work outlined in the Operational and Remobilisation Plans for 2021/2022 and carried out during Quarter 3 of 2021/22. The Committee is asked to discuss the contents of the paper.

2.2 Background

Since mid-March 2020 we have been facing the challenges of the global pandemic and the associated. Our staff have been working at home since then and, for the most part, have adapted well to this position. Our main priority remains the health and wellbeing of our staff alongside the ability to continue to deliver our work programmes.

In the third quarter of 2021/22 we have continued to support the remobilisation and recovery of health and care services at a pace that is consistent with the continued pressures in the system. We have been responsive to requests from NHS boards and Health and Social Care Partnerships particularly in relation to development of new engagement strategies and plans and service change issues that were put on hold earlier in the pandemic.

We have also begun to support the Healthcare Improvement Scotland (HIS) key delivery areas to ensure we can embed engagement and equalities across the organisation.

2.3 Assessment

The pandemic has presented both challenges and opportunities for staff and the directorate as a whole. The challenges remain in relation to balancing caring responsibilities, home-schooling and work priorities whilst still focusing on health and wellbeing of staff and delivering business objectives. There have been considerable opportunities for learning from and collaborating with other colleagues across the organisation and health and social care more generally, and for career progression opportunities due to the location-neutral nature of our work during the period of the pandemic

During Quarter 3 of 2021/22 our staff have continued to learn and grow in terms of their improvement knowledge and skills, participating in Cohort 3 of the Foundation Improvement Skills course and embedding their learning from the Care Experience Improvement Methodology training they undertook earlier in the year.

We continue to deliver a broad range of high quality programmes of work and our staff are to be commended on their commitment and dedication to their work as well as their enthusiasm and willingness to respond to whatever is asked of them.

We are continuing to deliver the work outlined within our Operational Plan 2021/22 whilst still responding to significant requests from across the organisation and Scottish Government to undertake national engagement exercises to support remobilisation and recovery of NHSScotland.

During Quarter 3 we have undertaken Citizens' Panel 8 and the results of this will be published in Q4 of 21/22.

2.3.1 Quality/ Care

All of our work will enable health and social care services to improve the quality of care they provide to the people of Scotland with a particular focus on ensuring that the voices and lived experience of people and communities are at the heart of decisions in relation to their own care and development and delivery of services.

We have begun to embed improvement methodologies within our own work to ensure we can improve our engagement activities and ensure improvement is at the heart of our directorate approach moving forward.

2.3.2 Workforce

We will continue to follow the most up-to-date policies and guidance to ensure the health, safety and wellbeing of our staff, particularly given the current home working policy, which will continue until for the foreseeable future.

We have been working with colleagues across the directorate to consider their ways of working for the future ensuring we understand their preferences.

2.3.3 Financial

The resource implications for the directorate's work programmes have been reflected in the 2021/22 budget.

Additional funding has been sought from Scottish Government to undertake two Citizens' Panels in 2021/22.

2.3.4 Risk Assessment/Management

Strategic and operational risks associated with our work programmes and workforce are recorded and reviewed on a regular basis by our Directorate Management Team.

An additional risk has been added to the HIS risk register in relation to the impact of the Covid-19 pandemic.

2.3.5 Equality and Diversity, including health inequalities

The directorate has a specific role in supporting equality and diversity within HIS and will continue to do this as part of our response to Covid-19. We have undertaken a number of equality impact assessments in relation to projects being delivered during the pandemic and are able to demonstrate the impact of these through our work.

2.3.6 Other impacts

N/A

2.3.7 Communication, involvement, engagement and consultation

During the pandemic we have consulted and engaged with a range of stakeholders in relation to the range of work we have been involved in. This has included patients, carers, families, community groups, third sector organisations, NHS Boards, integration authorities and Scottish Government. This has enabled us to deliver on a number of projects and see direct impacts for individuals, communities and staff.

2.3.8 Route to the Meeting

N/A

2.4 Recommendation

The Committee are asked to discuss the content of the Community Engagement directorate's Remobilisation and Operational Plan 21-22: Progress Update Q3

3 List of appendices

The following appendix is included with this report:

- Appendix 1 – Remobilisation and Operational Plan 21-22: Progress Update Q3

Scottish Health Council Committee

Remobilisation and Operational Plan 21-22
Progress Update Quarter 3 2021/22

Background

During 20-21 Healthcare Improvement Scotland took the decision to adapt our normal ways of working to provide support to NHS Boards, Integration Authorities and Scottish Government to enable them to respond to the challenges of the global pandemic. This has meant that some of the activities of the Community Engagement Directorate outlined in our 20-21 Operational Plan have been scaled back, refocused or paused in order to ensure we had the capacity to meet other demands.

However, we have been able to get back to more 'business as usual' working to provide strategic and operational advice and support to colleagues across health and social care in Scotland in relation to their engagement and involvement activities as well as equalities and human rights approaches. We have also been working closely with partners in the third sector to engage with people and communities in relation to their experiences during the pandemic.

Achievements

Outlined in the tables below are an update of the work the directorate has undertaken from October – December 2021. The pandemic has provided opportunities for our staff to work in different ways as well as enabling greater collaboration with colleagues in other directorates across the organisation and with other partners. We will continue to build on this as we progress our work programmes.

Directorate Team Work Programmes

Volunteering in NHSScotland Team During the global pandemic our Volunteering in NHS programme has had to rapidly respond to requests for support from NHS Boards in relation to volunteering. Our existing Volunteering programme was refocused whilst we responded to these significant requests.		
What we will do	**Outcomes and Impact**	**Progress Update**
• Advise and support NHS Board volunteer managers and Strategic Leads regarding the management of volunteers during the COVID-19 pandemic. • Provide guidance to NHS Boards on the stepping down of volunteering. • Provide guidance to NHS Boards on risk management, role design, fast-tracked volunteer recruitment, conviction and health screening, volunteer retention, Emergency Volunteering Leave, volunteer wellbeing and maintaining the integrity of volunteering. • In association with NHS Education for Scotland, continue to monitor and adapt training materials and induction guidance on TURAS Learn for volunteers and managers of volunteers within NHS Boards. • Engage and advise Scottish Government on the application of the Scotland Cares Campaign. • Advising Scottish Government and Westminster on the implementation of Emergency Volunteering Leave and its activation. Work with NHS Boards to consider how they will evaluate volunteering programmes and opportunities that have emerged during the pandemic to demonstrate the impact to health and care	• NHS Boards offer person-centred opportunities to volunteer in health and social care taking account of Covid-19 challenges and restrictions • NHS Boards are better able to manage their volunteering programmes • NHS Boards are better able to manage their volunteering programmes safely and in accordance with all relevant policy and legislation especially during the covid-19 pandemic • Volunteer management staff gain access to practice and development opportunities • Board and staff gain better awareness of the impact of volunteering and consider new volunteering opportunities that present themselves during the pandemic • Scottish Government gain confidence that the National volunteering outcome framework is being used and NHS boards follow policy Demonstrate that volunteering is embedded in our thematic work programmes	***Online application form*** – The System Security Policy is still waiting to be reviewed by IT at NHS Golden Jubilee. This is significantly delayed by 8 months. We are continuing to work with them to have this resolved as soon as possible. ***Future direction of the programme***: There is an opportunity now to look forward and consider how the programme can provide improved governance and leadership to volunteering practice across NHSScotland. Proposal paper developed and refined through stakeholder engagement with strategic leads for volunteering and volunteer managers across Scotland has been submitted to HIS CE Directorate Management Team and to the National Group for Volunteering for consideration. ***Volunteer Management Network:*** The network have a rolling programme of peer support network sessions and practice development sessions, each session is attended by around 20-25 volunteer managers. 4 sessions were delivered in Q3. In addition, 63 instances of individual support were provided to Volunteer Managers across Scotland. ***Developing an Evaluation Framework for Volunteering in NHSScotland:*** Discussions are underway with Helpforce and the National Group for Volunteering around using their Insight & Impact Service to evaluate and assess the impact of volunteering in NHSScotland. A pilot has been agreed to run from December 2021 - February 2022, allowing NHS boards to have conversations about their evaluation needs, and plan evaluation activities. ***Education & Training:*** The new National NHS Volunteer Induction is in development and will be available for NHS boards to utilise in Q4 via the Turas platform hosted by NHS Education for Scotland.

Service Change Team		
What we will do	**Outcomes and Impact**	**Progress Update**
• Provide advice in line with guidance, evidence and best practice on engagement in changes to health and care services particularly those services which have had to be rapidly reconfigured and provided in new and different ways in response to the pandemic. • Support NHS Boards and Integration authorities to understand our role in relation to advice, support and assurance especially during the pandemic. • Work with NHS Boards and Integration Authorities to understand the extent of service changes that have been made during the pandemic and whether these are viewed as short term measures, or longer term configurations. This will enable us to • Develop effective approaches to sharing good practice on engagement in service change across statutory bodies • Provide quality assurance assessments of engagement and consultation in major service change and ensure an open approach to share findings • Ensure that service changes in the areas of our thematic work programmes are in line with national policy and guidance and informed by best practice.	• NHS Boards and Integration authorities will engage meaningfully with people and communities in relation to service changes made throughout the pandemic to ensure that their views are fully heard and considered in relation to sustainability of those changes. • NHS Boards and Integration Authority staff increase awareness on engagement practices to support their role • Scottish Government gain assurance that engagement practice is in line with guidance including that we provided to NHS Boards and Integration Authorities during the pandemic in the context of ongoing remobilisation, recovery and renewal planning. • People and communities receive opportunities for involvement to support meaningful engagement • Demonstrable improvements in service change activity across our four thematic work programmes	***Guidance 'Planning with People'*:** Healthcare Improvement Scotland – Community Engagement met with Scottish Government to discuss next steps and the development of the 12 months testing phase. As part of our engagement with SG, the team provided significant input to the work SG had undertaken to map the approach to major service change. ***National and Regional Planning:*** A regional/national action plan has been developed (which is included in the service change paper for the committee). ***Service change workshops*** *W*orkshops for NHS boards and Health and Social care partnerships continued in Q3 covering the following areas; • Duties and principles • Planning effective engagement • Involving people in option appraisal. To date there have been a total of 19 workshops with 179 individuals participating, detail below;  Further workshops will be informed by participant feedback and will continue in Q4 including refresher sessions for CE directorate staff

		Headline service changes ***NHS Grampian – Review of Maternity services model at Dr Gray's, Elgin:*** The report of findings of the external review was published in Q3. A copy of the report can be found here. The outcome is the recommendation that, in the short-term, Model 4 Community Maternity Unit* linked mainly to Raigmore ("Moray Networked Model") is the most appropriate model to be established promptly in order to provide a safe, high-quality maternity service to women residing in Moray. ***NHS Ayrshire & Arran – Chemotherapy services*** There have been a number of communications with NHS Ayrshire & Arran about the long standing planned changes to the provision of chemotherapy services across the board area. A paper has been developed for consideration by the committee at the 17 February 2022 meeting.

Community Engagement Programmes		
What we will do	**Outcomes and Impact**	**Progress Update**
• Support the response to the pandemic through delivery of projects such as Person-centred virtual visiting and Gathering Views exercises. • Ensure that people are fully involved in decisions about health and care services by: ➢ enabling local communities to be involved in the planning and development of services and to support them in influencing how these services are managed and delivered ➢ supporting NHS Boards and Integration Authorities to continually improve the way they engage with their communities ➢ enhancing care experience through provision of support and training to staff to engage with patients and families ➢ enhancing care experience through the provision of training and support to individuals and communities to enable them to engage with NHS Boards and Integration Authorities ➢ informing national policy through gathering views on relevant services from patients, service users, carers and communities ➢ providing input to the development and implementation of our thematic work programmes and ensuring involvement and engagement in the 4 areas identified	• The views and experiences of people and communities inform new service developments and service changes made by NHS Boards and Integration Authorities in response to the pandemic. • Patients are able to keep in touch with their loved ones during the pandemic whilst in-person visiting is severely restricted. • Carers and families are supported to keep in touch with their loved ones whilst they are in hospital through the provision of devices and training. • Scottish Government, NHS Boards and Integration Authorities can demonstrate improvements in their public engagement activities across NHSScotland • People and communities are enabled and supported to engage with their general practices and other primary care providers • General Practices and other primary care staff are able to demonstrate new and innovative ways of engaging with patients. • Improved care experience for service users and their families delivered by staff who are confident and trained in engagement and involvement.	***Remobilisation and Recovery across NHS Boards and Health and Social Care Partnerships*:** As remobilisation and recovery continues across the health and care system, at the pace of boards and partnerships, due to the continued pressures. All areas are beginning to look at new engagement plans and strategies to ensure that people and communities are involved in co-designing and developing services. This has meant a considerable amount of work for all of our engagement offices to support this recovery effort and ensure that people and communities continue to have their voices heard. ***Person-centred Virtual Visiting:*** The Virtual Visiting Gathering Views exercise planned for July 2021 continues to be paused, and will be reviewed during 2022. Almost all of the virtual visiting devices have now been distributed to the boards, with only one board left to respond. This will be completed before the end of Q4. ***Voices Scotland Going Digital*** – The training pack to deliver Voices Scotland training virtually has been further refined and tested internally. Following feedback and comments the pack will now be updated and launched in Q1 of 22/23. ***Redesign of Urgent Care***: Following the publication of the Gathering Views exercise on the redesign of urgent care, the report was cited in the publication of the second national staging report from Scottish Government. Our work has informed how they take forward an external evaluation of the programme and also the next steps for this redesign project. ***Tayside Mental Health and Substance Use Pathfinder Project Engagement***: Since April 2021, the Tayside Engagement Officers have been working with colleagues from ihub and other stakeholders to support engagement in the wider Tayside Substance Use Pathfinder project led by the ihub. This has seen the development of engagement plans and communication materials for use to support the project. The long term aim for the programme is that people with a dual diagnosis of mental health and substance use have better health outcomes; joined up services; equitable access; person centred services and there is a reduction in the rate of harm for people. As part of the engagement plans, virtual engagement with service users and mental health staff from different teams based in Dundee were carried out from July – Sept 2021. The aim of the interviews being to gather lived experience from service users and to better understand the service user journey from the perspective of staff who provide the support and to find out their experiences of providing care and support. Once the virtual engagement had taken place and information gathered, the engagement officers were asked if they could participate in gathering views face to face from people with lived experience of mental health and substance use.

		During December, face to face interviews were carried out with 21 people in total. All conversations were recorded by audio which were then transcribed and reported. The findings from the combined interviews were: • A lack of access to mental health support • A link between substance use and mental health • A lack of consistency in staff - having to re-tell stories • Challenges coming off methadone • A lack of support for family members • A lack of communication between services • Invaluable support from third sector • Inspiring and supportive staff and volunteers A powerful quote from one of the interviews was: ***"At 16 when I was at the doctors saying I'm on opiates, if they had addressed that properly, understanding why, what was going on at home instead of just putting me on Methadone, I've been on for years, I could have been a productive member of society instead of just wasting my whole life being an addict. I'm not blaming, I took this drug but the solution wasn't right."*** The next steps for the engagement group are to establish a lived experience co-design group. The group will recruit people with lived experience and support members to participate fully.

The Public Involvement Unit		
What we will do	**Outcomes and Impact**	**Progress Update**
• Support staff and external stakeholders to undertake Equality Impact Assessments early in the development of work streams throughout the pandemic. • Co-ordinate and manage our public partner volunteers in the context of COVID-19 to ensure continued involvement in the work of HIS. • Deliver advice and support for involving people and communities across HIS, including support for involvement planning; advice on involvement tools and approaches; identifying and facilitating links with third sector organisations; direct support for involvement; and facilitating the production of service user, carer and public information. • Deliver advice and support across HIS to meet our legal duties in relation to equality, diversity and human rights, including support for equality impact assessments embedding a human rights based approach to our work; and designing and delivering a programme of training. • Co-ordinate, manage and develop public partner volunteers and their roles across our work. • Support cross organisational groups including the Equality & Diversity Working Group and Children & Young People Working Group. • Share and acquire public involvement knowledge and learning through collaboration at national level • Ensure that our key delivery areas inform the development and implementation of involvement and engagement activity across all HIS directorates	• Service developments and changes undertaken during the pandemic are informed by evidence from our impact assessments and any negative impacts can be mitigated against. • People and communities gain knowledge and understanding of HIS and have the ability to influence our work. • Our public partner volunteers gain supported volunteering opportunities with access to learning and development in their roles. • Third sector organisations representing the interests of various groups, gain opportunities to be involved in improving care and outcomes for people. • Our staff gain support for considering equality impacts and for planning and designing inclusive involvement in their work. • Our Board and Committees gain evidence based assurance that our work promotes equality, is informed by inclusive involvement and complies with our legal duties. • Relevant national bodies/networks gain learning and knowledge of best practice on how to involve people	***Children and Young People*:** the first meeting of the children and young people's key delivery area network was held on 2 November to bring together colleagues who are leading work that has a full or partial focus on children and young people. The network will aim to maximise HIS's collective positive impact on children and young people's rights, experiences and outcomes by sharing learning, experience, contacts and resources across work programmes. This network will report into the Children and Young People's Working Group which met in December. ***Workplace Transgender Equality Guidance*:** guidance to support transgender employees, colleagues and managers has been co-produced within the organisation. This will support HIS to be an inclusive employer that promotes equality and values diversity, now and into the future. The Executive Team has agreed that HIS will align with this guidance while undertaking work to formalise it as local policy ***LGBT+ staff network***: the LGBT+ staff network came out at the November staff huddles. Colleagues who signed up for the pride pledge have been invited to join the Pride Network on Teams as allies. ***Public Partner volunteers***: a public partner vacancy on the Quality and Performance Committee has been filled (2 public partner members) following review and revision of the public partner role description. 1 new public partner has been recruited and inducted to the HIS pool (current total 17 public partners). Public partners' vacancies with SAPG and SMC have been externally advertised and are being recruited to. ***Equality & Diversity Training***: an online training session for 15 staff was delivered and positively evaluated in November. ***Translation and interpretation***: a programme of work started in November with the appointment of fixed term project officer to develop advice on how HIS can better support engagement with a diversity of communities (interest and place). This will include reviewing materials and resources which support engaging people approaches, leading the development and testing of new resources which will improve accessibility and inclusion in community engagement approaches, building effective working relationships with voluntary organisations, user, carer and community networks throughout Scotland to understand best practice approaches to engagement with a diversity of communities.

The Participation Network		
What we will do	**Outcomes and Impact**	**Progress Update**
• Develop tools and guidance for health and care services on how to engage with people differently and safely, to ensure that all voices can be heard during the pandemic. • During the remobilisation, recovery and redesign phases of the pandemic we will continue to share research and learning around best practice in involving people and communities in health and care, with a particular focus on further developing the Engaging Differently resource. • Undertake commissioned research through the Citizen's Panel as part of remobilisation, recovery and redesign engagement activities.	• Services are able to mitigate against the inequalities that have emerged during the pandemic and provide appropriate services that respond to these inequalities. • Services are informed by the lived experience of people who have accessed them during the pandemic. • An increased number of people and communities feel supported to engage to inform health and social care service improvements • HIS staff feel increasingly confident to deliver effective evidence based engagement methods adapting new ways of engaging and involving people and communities in response to the pandemic and restrictions that have been imposed. • HIS Board and SHC Committee have confidence in the use of research evidence to shape internal priorities and policy • Approaches followed by Scottish Government always have a source of up to date evidence based practice • Professional Bodies/Researchers/Royal Colleges/Third Sector will use evidence informed methods to engage with people • NHS boards and Integration Authorities will develop skills to use the tools to engage effectively with people and communities	***Webinars****:* In November 2021 the Participation Network Team ran a series of 5 webinars with the objective to share learning on research, policy and practice of participation and engagement projects. We circulated a call for abstracts to our networks to ask if people were willing to share any of their work. We received 13 abstracts and after discussing them with the project leads we decided to run with 10 presentations over 5 webinars, 1 in each week of November. The webinars covered 10 presentations around the themes of: • Engaging in mental health services • Engaging adults with learning disabilities • Involving people with dementia • Creative Methods for engagement, and • Digital engagement in health & social care. There were around 390 attendees over the 5 webinars and included people from NHS Boards, HSCP's, local authorities, third Sector, Higher Education, Scottish Govt. as well as HIS staff. We conducted a short evaluation after each of the webinars and received 40 responses. The feedback was overwhelmingly positive and a summary is included below. • How would you rate this webinar – 100% said Excellent/Good • Did you have any problems while attending this webinar – 92% had no problems • It increased my knowledge about the topic – 98% Strongly agreed/agreed • It gave me practical tools or resources I can use in my work – 85% Strongly agreed/agreed • It put me in touch with useful contacts – 82% Strongly agreed/agreed ***Citizens' Panel*****:** Citizens' Panel survey 8 was conducted during Sept-Nov and preliminary results were reported in December. Panel members were asked their views on four topics: • Redesign of Urgent Care • Mobilisation of Dentistry services • Mobilisation of planned (elective) care, and • The Patient Safety Commissioner

		The Survey received responses from 599 panel members across Scotland, a 63% response rate of the full panel. The report will be published on HIS-CE website in Q4. During Quarter 3, Citizens' Panel survey 9 was being developed. The topics for this survey are, views on: • Public engagement • Inclusive COVID vaccination, and • COVID Vaccination Certification We worked with policy leads at Scottish Government to develop the question set. This survey will be sent out in Q4 and report in Q1 of 2022/23.

The What Matters to You? Programme		
What we will do	**Outcomes and Impact**	**Progress Update**
• Continue to build on the excellent WMTY work that transpired during the pandemic and share good practice in person-centred care. • Co-ordinate, manage, develop content and promote website and social media channels • Co-ordinate, manage, develop content of and promote resources • Collaborate nationally and internationally, sharing knowledge and experience • Produce and promote annual report • Embed What Matters to You? through our thematic work programme and ensure that it informs the development and implementation of our activities	• Patients, carers, families, people and communities continue to experience good person-centred care throughout the pandemic. • Health and social care staff (primarily) have access to accurate and up to date information and case studies • H&SC staff have access to materials to support them to begin/improve caring conversations • We have access to the most up to date knowledge and experience to inform our approaches • Scottish Government and stakeholders are informed of the impact of our work	Due to the retirement of one of our staff members, there has been a delay with the publication of the WMTY report. A new staff member is now in place and will endeavour to have the report published as soon as practicable. Planning is underway for WMTY 2022.

Supporting implementation of HIS Key Delivery Areas		
What we will do	**Outcomes and Impact**	**Progress Update**
Continue to support the remobilisation, recovery and renewal efforts of health and social care by: • Working with HIS colleagues across directorates to ensure that work across the key delivery areas is informed by lived experience and consideration of equalities and human rights • Support the development of driver diagrams and impact assessments to underpin each key delivery area • Building up a body of knowledge and evidence that supports our approach and enables us to support improvements in involvement and engagement as well as equalities and human rights approaches • Ensuring that this approach is embedded in all our activities and our work is informed by the best evidence and practice.	• The work across all of HIS key delivery areas will be informed by the lived experience of people and an equalities and human rights approach minimising any negative impacts and ensuring that equalities considerations underpin delivery of these areas. • NHS Boards and Integration Authorities will be able to better engage and involve people and communities across the key delivery areas. • There will be increased involvement of those with lived experience to enable redesign and delivery of services that better meet the needs of their users • Staff across HIS, NHS boards and Integration Authorities will have increased confidence, knowledge and skills in equalities and human rights approaches and involving and engaging people and communities • We are able to demonstrate how the key delivery areas are informed by lived experience and equalities and human rights through our reporting.	As part of our remobilisation plan and strategic discussions across the directorate we have now considered how we support the organisation's key delivery areas which are: • Safety • Older People • Mental Health • Unscheduled/urgent care • Access – including cancer services • Children and young people All of the key delivery areas are being led by an Executive Director and each area has now established a cross-organisational working group. We are reviewing our membership of these groups. We are developing our approach to supporting the key delivery areas by understanding and outlining what our offer is to these areas in terms of equalities, engagement and human rights. All of the areas present various opportunities for the directorate and we have to ensure that we enable directorates to undertake their own EQIAs and engagement activities to support each of the areas. This work will grow as each of the individual delivery areas scopes out their work programme.

Quality Framework for community engagement		
What we will do	**Outcomes and Impact**	**Progress Update**
• Continue to support the stakeholder group to inform the development of the approach and also the development of the self-evaluation tool • Engage with key stakeholders as well as Healthcare Improvement Scotland colleagues and staff across our own directorate, to test out the approach and self-evaluation tool • Undertake testing of approach and tool with identified NHS Boards and Health and Social Care Partnership sites • Provide report on test sites and amend approach and tool based on findings Ensure the Quality of Care approach informs our thematic work programmes and can be embedded in the activities we undertake	• NHS Boards and Integration Authorities able to demonstrate that they meet the current guidelines on engagement and involvement • NHS Boards and Integration Authorities can consistently improve their engagement and involvement activities ensuring it meets best practice and standards • The directorate can demonstrate that our engagement and involvement meets best practice and standards	***Quality Framework for Community Engagement***: The draft materials for the Quality Framework were published in September 2021 seeking comments and nominations for participation in a testing phase. The purpose of the framework is to • what 'good engagement' looks like and how this can be evaluated and demonstrated. • Support internal governance by carrying out routine self-evaluation and reflection on quality across an organisation. • Identify areas for improvement and actions within the organisation to improve practice. • Support and assure engagement activity within organisations as well as identify and share good practice that others can learn from. A series of self-evaluation statements have been developed from current policy and guidance to form a self-evaluation tool for organisations to understand how they deliver their engagement activity based on three domains of: 1. Undertaking Ongoing Community Engagement 2. Community Engagement on Service Planning and Design 3. Governance, Organisational Culture and Leadership. Comments on the draft materials were received and considered resulting in minor amendments to the content. In December 2021, members of the service change team met with 2 prospective partners for the planned testing phase. Further meetings are planned for early 2022 with testing planned to commence in March 2022. The materials will be finalised following the testing phase and aligned with the revisions to Planning with People for release around September 2022.

Engaging people in the work of Healthcare Improvement Scotland		
What we will do	**Outcomes and Impact**	**Progress Update**
Governance arrangements for public engagement within Healthcare Improvement Scotland • Supporting the Governance for Engagement Sub-committee who will consider evidence provided by directorates in relation to their engagement activities • Continue development of the governance proforma for HIS to ensure alignment with the Quality Framework for Community Engagement Building capacity and capability for public engagement within Healthcare Improvement Scotland including workstreams that cross our key delivery areas • Roll-out of engagement development programmes for key job roles • Roll-out of mandatory induction, training and other learning support for engagement Volunteering and Public Partner roles within Healthcare Improvement Scotland • Implement recommendations from the evaluation of volunteering roles within the organisation to enable us to demonstrate the impact and priorities for volunteering • Development of an organisational volunteering strategy aligned to organisational priorities Healthcare Improvement Scotland Public Involvement Unit • Following review of roles, roll-out of any changes to job roles within the Public Involvement Unit • Establish organisational objectives within Turas process relating to engagement	• The Scottish Health Council Committee gains robust assurance on the performance of all HIS directorates in relation to engaging people • Robust assurance gained on performance of all Healthcare Improvement Scotland directorates in relation to engaging people with demonstrable positive impacts • Clear evidence that appropriate and effective engagement of people is considered and built into project planning, delivery, evaluation and reporting with demonstrable impact • Key roles across the organisation have clearly identified objectives recorded within Turas system and individuals are able to demonstrate the impact engagement activity has had on their work programme • Improved knowledge and consistency of approach to public engagement across the organisation • Improved diversity of volunteering roles and volunteers and their management within the organisation	***Unified EQIA approach***: led by our Public Involvement Unit, a new impact assessment template and supportive resources have been finalised to increase accessibility and coherence for colleagues, offer additional guidance and links, and highlight responsibilities in relation to children and young people, care experienced children and young people, island communities and human rights. Complementary to this, a new equalities checklist resource is being created by the ihub's Evidence and Evaluation for Improvement Team to support the use of grey literature containing relevant equalities information. ***People's Experience Volunteer network***: a working group from across the Community Engagement directorate are leading work to develop a new People's Experience volunteer role to attract a diverse group of people to support the work of HIS by providing a public perspective on health and care in their local areas. Initially volunteer recruitment will be undertaken by Fife Engagement Office to test and develop the approach in the NHS Fife area.

Developing a learning system		
What we will do	**Outcomes and Impact**	**Progress Update**
• Collaborate with colleagues across HIS and health and social care to develop a learning system for community engagement that takes account of experiences during the covid-19 pandemic and builds on the innovation across HIS and beyond • Develop a system that is tested within our own directorate in the first instance • Support a model of peer learning and development that enables staff to seek out opportunities for personal development	• Demonstrable improvements in engagement and involvement activities undertaken by staff across HIS and health and social care staff supporting their continuous personal and professional development and learning	Our work on developing our learning system for engagement continues to be paused as staff respond to calls for support in other areas of learning. We will be working in collaboration with HIS colleagues to review what learning systems look like and what the outcomes of a Learning System should be. We will build our Learning System for Engagement based on findings of the HIS Learning System during the pandemic and other learning systems that we have been involved with. This will also be informed by our activities from the Quality Framework for Engagement. This work will recommence in Q4 of 2021 and will be led by our Participation Network.

Developing our people		
What we will do	**Outcomes and Impact**	**Progress Update**
• Undertake a skills mapping of our workforce to ensure that we have the baseline information necessary from which to build on • Develop a skills framework that maps across to job descriptions for all of our staff ensuring that we understand what skills are necessary for each role • Work in partnership with colleagues across Healthcare Improvement Scotland to ensure common roles have the same development opportunities and there is consistency of approach • Ensure that every member of staff has a personal development and wellbeing review and career conversation with their line manager including exploring opportunities for staff development such as shadowing, coaching, mentoring etc. • Build capacity and capability for quality improvement across the directorate at the relevant levels through attendance at courses such as HIS Foundations in Improvement Skills (HIS FIS), Scottish Improvement Leader (ScIL), Scottish Coaching and Leadership for Improvement Programme (SCLIP) etc. and deliver an improvement project in line with their current activities	• We have an understanding of the skills available across the directorate and the ability to map these to specific roles • A skilled, confident workforce that is able to deliver improvements in their work • We are able to demonstrate improvements in our engagement with staff across the directorate • An improvement in our iMatters and Culture Survey responses and scores • Staff trained in improvement methodologies and able to implement these in their work • Staff have the opportunity for career advancement and development within their role • Development of a Healthcare Improvement Scotland wide career pathway for Administrators and Engagement Officer staff	There continues to be a focus on staff health and wellbeing ensuring that our staff have the appropriate resources and support to enable them to continue working from home. This includes check-ins with staff, 1-1 meetings with managers, informal coffee catch-ups and encouraging attendance at the meditation and wellbeing sessions provided by HIS. ***HIS Campus:*** a learning needs analysis has been undertaken across HIS and 3 priority areas were identified for CED in Q3. These are: • Values Based Reflective Practice • Coaching & Leadership skills • Competency based interview skills These will be progressed in line with the new HIS Campus working group. ***Foundation Improvement Skills training (previously Scottish Improvement Foundation Skills):*** Cohort 3 of the training was delivered in Q3 and 10 staff from CED completed the course. A total of 44 CED staff have now completed FIS and another course is planned to start in Q4. This is making a significant difference to staff in terms of their confidence in delivering improvements within their own work. Several improvement projects have emerged from staff undertaking the training including improving their formal meetings, engaging with stakeholders around gathering feedback and diary management to support protected time between MSTeams meetings.

Healthcare Improvement Scotland

Meeting:	Scottish Health Council Committee
Meeting date:	17 February 2022
Title:	Equality Mainstreaming Action Plan
Agenda item:	3.6
Responsible Executive/Non-Executive:	Ruth Jays, Director of Community Engagement
Report Author:	Tony McGowan, Head of Engagement & Equalities Policy / Rosie Tyler-Greig, Equality and Diversity Advisor

1 Purpose

To share with the Committee progress on delivery of Healthcare Improvement Scotland's Equality Outcomes covering 2021 - 2025. Delivery of our published outcomes is facilitated by our Equality Mainstreaming Action Plan, which is overseen by Healthcare Improvement Scotland's Equality and Diversity Working Group. This paper highlights areas of current or recent progress that relate in particular to equality outcome one and four:

- Staff Equality Networks
- Staff resources and policy updates
- Approach to accessibility in public involvement

The Committee is asked to:

- Note progress in relation to Healthcare Improvement Scotland's equality outcomes 2021-2025.

This report relates to:

- Legal requirements
- HIS policy
- HIS Strategic Direction

This aligns to the following HIS priorities(s):

- Mental health services

- Access to care
- Integration of health and social care
- Safe, reliable and sustainable care

2 Report

2.1 Staff Equality Networks

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 (as amended) requires us to publish new equality outcomes every four years and report on progress every two years. In April 2021, we published four new equality outcomes.

Equality Outcome 1 is that '*a greater diversity of people are attracted and retained to work or volunteer with us and through sharing their relevant lived experience actively shape and strengthen HIS activities*'.

To contribute to this, we established three staff equality networks supporting colleagues from minority ethnic backgrounds, colleagues with LGBT+ identities and colleagues who are disabled or have a long-term health condition. Each network has actively engaged staff, established a presence in the organisation, has an Executive Team sponsor and is progressing work as detailed below

The **Race and Ethnicity Network** was launched in March 2021, with a Teams channel and a Source page. Five committee meetings (for staff with minority ethnic backgrounds only) took place throughout 2021. The committee identified key focus areas for 2022, including: increasing committee membership, improving awareness of the network and diversity, recruitment and progression, and introducing a system to monitor the incidence of racism within HIS. A 2022 meeting schedule is planned both for the committee and for the wider network. This will ensure the network continues to provide a space for peer support and the identification of issues by staff with minority ethnic backgrounds; and also to make progress in the identified areas. There are currently 8 committee members and 59 general members.

The **Pride Network** was launched in November 2021 and has a page on Source. Weekly informal sessions for LGBT+ staff have been run successfully since November, with a more formal bi-monthly meeting schedule starting on 9th February and including input on LGBT History Month from LGBT Youth Scotland. It has a steering group of 10 and 41 general members. The network has linked to and promoted the NHS Scotland Pride Badge Initiative, helping collect almost 100 pledges of support and ally-ship for the LGBT+ community from HIS employees.

The **Disability Network** was established in December 2021 following staff consultation sessions. A cohort of fourteen colleagues are engaged in a peer support space and are due to formalise a Terms of Reference and carry out wider communications about the network during March.

All three staff equality networks are now represented as part of the Equality and Diversity Working Group. This will help ensure cross-fertilisation of topics and wider organisational support around issues and activities.

The committee is asked to note progress in this area and consider whether any members wish to join one or more network or offer their support.

Key points to highlight:

- The disability network is the last to be established. Members will meet in March to formally agree a name for the network and shape its Terms of Reference.

- The Pride Badge Initiative remains open. The Pride Network and Race and Ethnicity Network together welcome support from Committee members who wish to be recognised as allies to the LGBT+ and minority ethnic communities.

- The Pride Network and the Race and Ethnicity Network will host a series of meetings and events throughout the year. Committee members are welcome to join or get in touch for more information.

2.2 **Staff resources and policy updates**

As part of Equality Outcome 1, we also committed to ensuring our policies and practice are cognisant of diversity within the workforce and in the population accessing health and social care services.

With the support of the Equality and Diversity Working Group, a HIS Inclusive Language Guide has been created and published on Source (see Appendix). The guide details current best practice language in relation to each of the protected characteristic groups, as well as around socio-economic deprivation, homelessness and substance dependence. This is already supporting colleagues to be confident and consistent in their use appropriate, respectful and person-centred language within HIS publications.

A local Transgender Workplace Equality Policy is due to be circulated for staff consultation following consideration by the Partnership Forum Policy sub-group. The policy has been developed by a short-life working group and aligns our earlier guidance with the suite of policies relevant to Healthcare Improvement Scotland.

The Committee is asked to note the development of policy and practice which supports HIS employees in respect of equality and diversity.

Key point to highlight:

- Language and understanding around equality, diversity and health inequality is continually evolving. Healthcare Improvement Scotland is committed to understanding and promoting best practice in relation to the diversity of communities our work engages and serves.

2.3 **Approach to accessibility in public involvement**

Equality Outcome 4 is that '*disabled people better inform and influence the development, design and delivery of Healthcare Improvement Scotland's work*'
To contribute to this, we committed to collecting and promoting learning about accessibility best practice which can support staff, volunteers and those engaging externally with Healthcare Improvement Scotland's activities.

A project within Healthcare Improvement Scotland - Community Engagement (HIS-CE) is running between November 2021 and September 2022. The project is establishing and promoting best practice approaches that will support directorate staff to engage with diverse communities, including:

- People with learning disabilities
- People with low literacy
- People whose first language is not English
- Deaf users of British Sign Language

The project is making use of staff and stakeholder engagement to scope resource requirements and develop comprehensive guidance which will include signposts to appropriate suppliers of interpretation and translation services. It is anticipated this resource will add value across Healthcare Improvement Scotland.

A suite of external facing resources to guide engagement with specific communities of interest is also being developed to support inclusive community engagement across the health and social care sector.

The Committee is asked to note on-going commitment within HIS-CE to champion inclusive engagement approaches.

Key point to highlight:

- There is an established need within HIS-CE to build specific capacity in relation to understanding and delivering accessible materials and events and to be readily able to accommodate diverse needs including different languages and Easy Read formats. Work is now underway to support this.

2.4 **Assessment**

2.4.1 **Quality / Care**

Embracing, understanding and mainstreaming equality across our organisation is key to achieving our commitment to tackling health inequalities and supporting the highest standards of health and social care in Scotland. All aspects of the equality mainstreaming action plan outlined in this paper seek to advance this ambition.

2.4.2 **Workforce**

Supporting, growing and valuing a diverse workforce is fundamental to our success. We are committed to not only bringing about improvements in the diversity of people working at all levels within our organisation, but in the way we can learn from their experience and value their contributions. We want to support our workforce in its understanding and enthusiasm for equality and diversity, enabling all employees, volunteers, board and committee members to reflect this in their work.

2.4.3 **Financial**

Any financial impact is reported as part of ongoing financial management and reporting arrangements. It is anticipated the work around accessibility will indicate small on-going costs in relation to staff training and improved ability to identify where commissioning interpretation and translation services will increase accessibility and lead to better and more inclusive engagement.

2.4.4 **Risk Assessment / Management**

Strategic and operational risks associated with our work programmes and workforce are recorded and reviewed on a regular basis.

2.4.5 **Equality and Diversity, including health inequalities**

This work is a part of our commitment to promoting equality and diversity and tackling health inequalities.

Healthcare Improvement Scotland's Equality and Diversity Working Group will monitor the progress of the equality mainstreaming action plan on an on-going basis.

2.4.6 **Communication, involvement, engagement and consultation**

Substantive internal engagement has informed the approaches of our new staff equality networks. Moreover, each network provides a clear mechanism for engaging staff to raise awareness, progress relevant work and identify areas for internal improvement. Engagement with our community engagement staff and other relevant colleagues across the organisation has informed our

approach to developing new resources around accessibility. Engagement with third sector stakeholders and experts is also currently underway.

2.4.7 **Route to the Meeting**

The Committee has received update reports previously in relation to the Engaging People work programme. These came from the process of renewing our Equality Outcomes for the period 2021-2025, as the aim is to mainstream our equality priorities across the work of the directorate and wider organisation.

3 Recommendations

The Committee is asked to:

- Note and discuss the report; and
- Endorse the next steps and timeframes provided.

Appendix

HIS Inclusive Language Guide (November 2021)

Healthcare Improvement Scotland

Inclusive Language Guide

Supporting best practice in Healthcare Improvement Scotland Communications

November 2021

NHS SCOTLAND

www.healthcareimprovementscotland.org

Contents

1. Introduction

The words we choose when we write and speak are powerful. Careless use of language can cause offence and imply that we are making assumptions about people. Inclusive language is respectful and helps us to value people for who they are. We should be aware of the language we use and the impact it has. It is about more than just knowing a list of acceptable words. This guide aims to give you confidence in using inclusive language when communicating and create a more inclusive environment for everyone. The guide will:

• support your conversations, whether they are spoken or written

• provide a standard way to express concepts, spell words and format phrases

• ensure consistent use of language in Healthcare Improvement Scotland publications and communications

• encourage productive conversations about inclusivity

• increase confidence across the organisation in how to talk about a range of equality related topics

It is important to remember when using this guide that there is not always one correct term to use - there is usually more than one way of saying something. If you have concerns about language that others are using, you can:

1. Speak to your line manager to try and resolve any issues

2. Contact our Equality and Diversity Advisor Rosie Tyler-Greig at rosie.tyler-greig@nhs.scot or 07929025815

3. Contact HR on his.hrunit@nhs.scot

4. Contact a Staff Side representative.

5. Use Healthcare Improvement Scotland's Whistleblowing Policy.

Document review

This guide has been created in collaboration with Healthcare Improvement Scotland's Equality and Diversity Working Group and staff equality networks. It will be reviewed and updated every 6 months, or more often if required. If you have any queries, comments or suggestions, please contact his.contactpublicinvolvement@nhs.scot

What to do if you use the wrong language

This document is a guide, not a policy, and everyone makes mistakes. Recognise and own your mistake. Apologise and correct yourself if you use the wrong language. Move on from your mistake and seek out further training or guidance if needed.

2. How to speak about protected characteristics

2.1 Age

General Principles

- Avoid referring to someone's age, unless it is relevant to what you are writing about
- Be accurate about who you are referring to. For example, 'people over 70' is different from 'people aged 70 and over'

Terms

We use	Meaning	We don't use
Babies	People aged 1 year and under.	
Children	People aged 12 years and under.	**Kids**
Young people	People aged between 12 and 17 years and, in some cases, up to the age of 26.	**Teenagers / Teens**
Adults	Anyone over the age of 18 years.	
Older people	People over the age of 65.	**Old people** **The aged**

2.2 Disability

General Principles

- 'Disabled people' is the term advocated by and used within the UK Disabled People's Movement. The term is associated with the Social Model of Disability which says disability arises because society is not designed to accommodate people who have impairments. The term 'people with disabilities' has been rejected because it sits within the 'medical model', which says people are disabled by their impairment or difference which should be 'fixed' by medical interventions.

- When speaking about **specific** disabilities you should put the person first. This avoids defining people in relation to their disability and prevents dehumanising labels being attached to entire groups of people. For example, use 'people with cancer' instead of 'cancer patients'.

- Not all people who are protected by the Equality Act under 'disability' would describe themselves as disabled. Avoid descriptors that assume Deaf people, autistic people and people with long-term conditions are disabled.

Terms – Disability in general

We use	Meaning	Context	We don't use
Disabled (person / people)	A person or people who have impairment/s or differences which are not fully accommodated in society and who experience barriers in their daily lives.	When referring to people who are disabled per the Equality Act 2010 definition or who have self-identified as disabled during an involvement or engagement activity.	**People / person with a disability** - this has been rejected by the UK Disabled People's Movement in the UK in favour of 'disabled people'. **The disabled** – this term is dehumanising as it identifies a group in terms of their (possibly very diverse) impairments or differences. **Handicapped** – this is generally regarded as offensive given the historical association with defectiveness, incapacity, dependency and inability to succeed

			in a competitive environment. **Physically / mentally challenged** – these terms are limited and have not been accepted by UK disabled people's groups.
Non-disabled person / people	Not disabled	When describing differences between disabled people and non-disabled people.	**Able bodied** – this implies that disabled people are not active individuals with control over their own lives, so 'non-disabled' is preferable.
Unpaid carer/s	Unpaid carers provide care and support to family members, friends or neighbours. The people they care for may be affected by disability, physical or mental ill-health, frailty or substance misuse.	When describing someone who supports a disabled person, older person or someone affected by physical or mental ill-health, frailty or substance misuse with aspects of their daily living, and where doing so is not their formal paid job.	**Carer** – without appropriate qualification, the term may be confused with members of the social care workforce.

Terms - Deafness and hearing impairment

We use	Meaning	Context	We don't use
Deaf person / people **Deaf users of British Sign Language**	Those born with no hearing may use 'Deaf' with a capital D. Many Deaf people whose first language is British Sign language (BSL) consider	When speaking about people who use British Sign Language or who are part of the Deaf Community. Although protected by the Equality Act, many BSL users	**deaf** or **deafened** - specific terms related to hearing loss.

	themselves part of 'the Deaf community'.	consider their identity primarily as part of a minority language group.	
People who are deafened, or **People who have an acquired profound hearing loss (APHL)**	People who were born able to hear but become severely deaf after learning to speak.	When talking specifically about this group.	Any of the other described terms.
People who are hard of hearing	People with mild to moderate hearing loss, who find hearing aids helpful.	When talking specifically about this group.	Any of the other described terms.
Deafblind people / person	People with a dual sensory impairment who may have some hearing loss and some sight loss. A person can be born with deafblindness or experience dual sensory impairment to varying degrees later in life.	When talking specifically about this group.	Any of the other described terms.

Terms - Learning disability

We use	Meaning	Context	We don't use
Person / people with a Learning Disability	Someone who experiences difficulties learning new things in any area of life. A learning disability may affect the way someone	When speaking specifically about people with a learning disability.	**Special needs** – we all have different, specific needs, and designating the needs of disabled people as 'special' may be seen as patronising.

	understands information and how they communicate. They can have difficulty understanding new or complex information, learning new skills or coping independently.		

Terms - Autism

We use	Meaning	Context	We don't use
Autistic people or **People on the autism spectrum,** or **X is autistic**	Anyone with Autism Spectrum Disorder (ASD) - a lifelong developmental condition which affects (in very different ways) how people communicate and interact with the world.	When specifically talking about people or groups who have Autism Spectrum Disorder.	**People with autism** – autism is not an illness, but a form of neuro-divergence. Being autistic does not mean that someone has an illness or disease. **High-/low-functioning** – functioning labels are hierarchical and inaccurate as function can be transient depending on context. **Asperger's** – this is no longer used as a diagnosis and has negative historical associations.

2.3 Gender Reassignment

General Principles

- Use ‘transgender’ or ‘trans’ as an umbrella term to describe people whose current gender identity differs from the sex they were registered with at birth. Some, but not all, trans people want to transition socially or medically or both.
- A trans woman is someone who was registered male at birth and now identifies as a woman. A trans man is someone who was registered female at birth and now identifies as a man. Although we make these differentiations, we should simply use ‘woman’ or ‘man’ and leave out the word trans, unless it is relevant.
- If you don’t know someone’s gender or you are speaking hypothetically, use the pronouns they/their/theirs.
- Use gender neutral terminology where possible. For example, say ‘Chair’ or ‘Chairperson’ instead of ‘Chairman’.

Terms

We use	Meaning	Context	We don’t use
Gender identity	What an individual experiences as their innate sense of themselves as a man, a woman or as having a non-binary gender.	Only when referring explicitly to how people understand their gender.	**Gender expression** – people may express their gender through their name, pronouns, clothing, behaviour, voice, and/or body characteristics. Gender identity is unseen and self-declared, although people will typically try to align their gender identity with their gender expression.
Trans / transgender person /people	Anyone whose gender identity differs from the sex they were registered at birth. This includes, but is not limited to, trans	When referring to a person or people who share the protected characteristic of	**Transsexual** - this is considered outdated and can be used to draw unhelpful distinctions

	men, trans women and non-binary people.	Gender Reassignment.	between trans people. **A transgender** – defining a person by their gender reassignment is inappropriate. **Transgendered -** as above. This moves the term away from being an adjective and makes it a defining noun. **Born a man/woman** –inappropriate and disrespectful. **Cross-dresser -** while some people may identify with this, it is entirely distinct to being trans.
Person with a transgender history	Someone who identifies as a man or woman but was assigned a different sex at birth. This is increasingly used by people to acknowledge a 'trans past'.	In most cases we can describe general services, services for men and services for women. You should avoid specifying 'trans women' and 'trans men' unless a transgender history is of specific relevance. For example, "Some trans men and non-binary people also require access to breast and cervical	As above

		screening programmes".	
Transitioning	The steps a trans person may take to live in the gender with which they identify.	When describing the steps available / being taken for someone to confirm their gender.	**Sex change** - Transitioning does not always include physical changes. It can include things suc things such as telling friends and family, dressing differently, and changing official documents **Pre-op / post-op-** Not all trans people want to, or can afford to, transition medically, so avoid overemphasising surgery when discussing the process of transition.
Gender confirmation surgery, or **Gender confirmation treatment**	Each trans person's transition will involve different things. This could include surgeries, hormone treatment and therapeutic interventions.	When specifically talking about these elements of a person's transition.	As above
Cis / Cisgender	Someone whose gender identity is the same as the sex they were assigned at birth. Cisgender has its origin in the Latin-derived prefix cis-, meaning 'on this side	When specifically comparing the needs of trans people with the needs of people who are not trans and writing for an LGBT+ audience, where this term is best understood.	

	of', which is the opposite of trans-, meaning 'across from' or 'on the other side of'.	For example, "In this case, the needs of transgender people will differ from the needs of cisgender people."	

2.4 Pregnancy and Maternity

General Principles

- It is important to acknowledge that this characteristic predominantly protects women, while opening up our language to be inclusive of people with different gender identities who also experience pregnancy and maternity, such as trans men and non-binary people.

Terms

We use	Meaning	Context	We don't use
Women and birthing people	People who are pregnant or who recently gave birth.	When referring to people who share the protected characteristic of pregnancy and maternity. When naming the beneficiaries of work which affects prenatal, perinatal and post-natal care.	**Mum/s or mother/s** - unless referencing a specific person or group.
Parent/s	The parent(s), including primary parent, of (a) child/ren.	When referring to a potentially diverse group who share the protected characteristic of pregnancy and maternity, and we cannot be sure that	As above.

		everyone in the group we are speaking about identifies as a woman or mum/mother.	
Birthing parent / parent who gave birth **Women who gave birth** **Breast-feeding parent /breast-feeding woman**	Person or people who gave birth.	When we cannot be specific about their gender identity/ies, we are speaking about a diverse group or we know they do not identify as women. When it is possible and / or important to be specific. As above, use judgement as to the referent person or group.	As above.

2.5 Race

General Principles

- Understand the difference between race, ethnicity and nationality: race describes physical traits and focuses on colour, whereas ethnicity refers to cultural identification and nationality is a legal identification of a person in international law
- Only refer to race and ethnicity when it is relevant to the content
- Remember that everyone has race, colour, ethnicity and nationality and everyone's identity goes beyond these factors
- Avoid generalising ethnic groups, as there is significant diversity between all ethnic groups. Be specific to the extent this is possible

- Do not overuse or misuse terms. For example, using 'minority ethnic group' when only referring to Black blood or organ donors
- Order ethnic groups alphabetically in lists, with Other, and occasionally Unknown, as the final category. Our unconscious bias can lead us to begin lists with the dominant group.

Terms

We use	Meaning	Context	We don't use
Minority ethnic (groups / people / employees / communities)	People / groups / employees / communities who share an ethnicity which is not the majority ethnicity in Scotland. This includes minority white groups such as gypsy travellers. Aim to specify groups where you can. For example, "We are particularly under-represented in relation to Black African and Black Caribbean employees".	When describing people or a group in relation to the protected characteristic of 'race'. Where a group /people do not identify as White Scottish / British / Irish.	**Ethnic minority/ies** - In recent years the term 'minority ethnic' has come to be preferred to 'ethnic minority' because it stresses that everyone belongs to an ethnic group. It places the emphasis on the *minority* rather than the ethnicity. Ethnicity is not in itself a disadvantage. **Non-white** –this defines groups in relation to the white majority. **BME** or **BAME** (Black, Asian and Minority Ethnic) – these terms are widely used but are used inconsistently. **Coloured** - 'people of colour' is often accepted as a way of defining visible minorities, however.
People with a mixed ethnic background	People with mixed ethnic heritage.	When referring specifically to people or groups with mixed ethnic heritage.	**Mixed race**

Visible minority	All ethnic minorities excluding all white groups.	When referring to minoritised groups that are non-white.	As above

2.6 Religion or belief

General Principles

- A person's identity goes beyond religion, but everyone has beliefs and values about the world they experience
- Only refer to someone's faith or religion if it's relevant to the content
- People may identify as having a particular faith but may not actively practise their religion or use a place of worship to express their faith so it's important not to make assumptions with the language that we use
- Take into account the customs and practices associated with particular beliefs but avoid stereotyping or making assumptions.
- When creating content for the general public, use 'place of worship' and 'faith leader'. When creating content for a particular religion, use the appropriate place of worship and faith leader such as 'temple' and 'Priest' for the Hindu faith.
- Try to avoid words and phrases that have links with faith and religion, such as 'Christian name'. In this example, we would say 'full name' to reduce confusion and acknowledges that people have different beliefs

Terms

There are no specific terms to offer in this section, but we do provide some guiding principles for when you are communicating about religion or religious groups.

- Use a capital letter when describing particular religions (e.g. Hinduism, Christianity), a person who practices a religion (e.g. Jew, Muslim), a religious title (e.g. Iman, Rabbi) , a religious text (e.g Torah, Quran), religious holidays (e.g. Christmas, Eid) and individual places of worship (e.g. St Pauls and St George's Church in Edinburgh).
- Use a lower case letter for the general word 'religion' and for other general terms such as 'the local mosque', 'faith', 'fatwa', 'haram', 'kosher'.

2.7 Sex and Gender

General Principles

- Use gender-neutral language where possible. For example, use chair or chairperson instead of chairman, and when referring to groups of people, use 'Hello everybody' instead of 'Hello guys'.
- Refer to people and groups as they refer to themselves – e.g. using female (she/her), male (he/him) or non-binary (they/them) pronouns. If in doubt, ask about the terms people use.
- Consider whether you mean 'sex' or 'gender' and use the most appropriate term.

Terms

We use	Meaning	Context	We don't use
Sex	Whether someone is female, intersex or male. There are different aspects to a person's sex: **Biological** - determined by a person's anatomy, which is produced by a combination of their chromosomal, hormonal, genital and gonadal characteristics, and their interactions. **Legal** - typically their sex registered at birth, although for a trans person with a Gender Recognition Certificate their legal sex is their acquired sex. **Self-defined** - a person's innate sense	When referring to the target groups for sex- specific treatment or pathways. When describing sex-specific risk factors that could lead to mistakes in medical interventions or pathways. When referencing data gathered or measures taken specifically to ensure equality of access or outcome for people who share a sex.	**Gender** – related, but focussed on social identity.

	of whether they are female or male		
Gender	Gender refers to our internal sense of who we are and how we see and describe ourselves in relation to norms, roles and relationships founded in social mores, laws, processes and policies that are based on labels of masculinity and femininity. Someone may see themselves as a man, a woman or as having a non-binary gender.	When discussing social identity instead of sex. When attempting to capture or illustrate differences between the experiences of men, women and non-binary people. When conducting equality monitoring for public or staff involvement activities.	**Sex** – related, but more linked to a person's anatomy.

2.8 Sexual Orientation

General Principles

- People of different generations may use different language to define their sexual orientation or gender identity. For example, queer is a term reclaimed by the LGBT+ community; however, some people may see this as a slur
- Do not use phrases that imply sexual orientation is a lifestyle choice
- 'LGBT+' should refer to a community and not an individual. For example, 'the LGBT+ community' and not 'a person who is LGBT+' or 'an LGBT+ woman'. Be specific about that person's identity

Terms

We use	Meaning	Context	We don't use
People / groups with a minority sexual orientation	A group protected under the 'sexual orientation' characteristic of the Equality Act. This can include, lesbians, gay people, bi/bisexual	When describing people or groups who do not identify as heterosexual.	**LGBT+ -** a broader category which includes transgender people, who are protected under a separate characteristic of the Equality Act (gender

	people, asexual people etc.		reassignment) and may have distinct needs. **Queer (unless self-identified) -** while re-claimed by the community, some people may regard this as a slur.
Ace spectrum / Aro spectrum	Umbrella terms used to describe the wide group of people who experience a lack of, varying, or occasional experiences of romantic and/or sexual attraction, including a lack of attraction.	When specifically referring to this group.	**Non-sexual –** A lack of sexual activity should be assumed.
Bi or **Bisexual**	An umbrella term used to describe a romantic and/or sexual orientation towards more than one gender.	When specifically referring to this group.	
Gay	Refers to a man who has a romantic and/or sexual orientation towards men. Also a generic term for lesbian and gay sexuality - some women define themselves as gay rather than lesbian. Some non-binary people may also identify with this term.	When specifically referring to this group.	**Homosexual**

Lesbian	Refers to a woman who has a romantic and/or sexual orientation towards women. Some non-binary people may also identify with this term.	When specifically referring to this group.	
Men who have sex with men (MSM)	An umbrella term that refers to men who have sex with men but who may not identify as being gay or bisexual. This term is often used in healthcare settings to identify the right treatment or information for an individual.	When specifically referring to this group.	**Gay** – it is important that we respect the terms people use for themselves. **Bisexual** – as above **Homosexual** – as above
Women who have sex with women (WSW)	As above, an umbrella term that refers to women who have sex with women but who may not identify as being gay, lesbian or bisexual.	When specifically referring to this group.	**Lesbian** As above

3. How to speak about other characteristics

3.1 Care experience

Terms

We use	Meaning	Context	We don't use

Care experienced person / people	Anyone who has been or is currently in care or from a looked after background at any stage of their life, no matter how short.	When discussing engagement with or the specific healthcare needs of care experienced people. When talking about Healthcare Improvement Scotland's Corporate Parenting Duty.	**LAAC (Looked After and Accommodated)** - The acronym can be used by professionals but there are cases where it is not properly explained to the young person. It sounds like the word 'lack' and can reinforce negative self-perceptions (e.g. the young person believes they are lacking something).

3.2 Poverty

General Principles

- Use 'people first' language – that is, language that references the person first and before specific challenges they experience.
- Avoid language that makes value judgements or assumptions, e.g. calling someone vulnerable or needy.

Terms

We use	Meaning	Context	We don't use
People experiencing poverty	Anyone who lacks the financial resources and essentials for a minimum standard of living.	When referring to people or groups who are recognised or identify themselves as experiencing socio-economic deprivation.	**Poor** **Needy** **Vulnerable**
People with lived experience of poverty	Anyone who has, at some point in their lives, lacked the financial resources for a minimum standard of living.	When referring to people or groups who are recognised or who identify themselves as having experienced socio-	As above

		economic deprivation.	
Socio-economic deprivation	Disadvantage in terms of access and control over economic, material or social resources and opportunities.	When describing our work in relation to the principles of the Fairer Scotland Duty.	As above

3.3 Homelessness

General Principles

- Use 'people first' language – that is, language that references the person first and before specific challenges they experience.
- Avoid language that makes value judgements or assumptions, e.g. calling someone vulnerable or needy.

Terms

We use	Meaning	Context	We don't use
Person / People experiencing homelessness	Anyone who does not have a home where they and their household can live together, or who has no right to stay where they are, or for whom it is not reasonable to stay in their home, or who lives in a motorhome or houseboat they cannot park/moor, or lives in overcrowded accommodation that is detrimental to their health and wellbeing,	Talking about a person or groups who are believed to be homeless.	**The homeless** **Homeless people** **Any derogatory term**

	or who cannot access their home.		

3.4 Substance Dependence

General Principles

- Use 'people first' language – that is, language that references the person first and before specific challenges or disorders they experience.
- Avoid language that makes value judgements or assumptions, e.g. calling someone vulnerable or needy, or saying they are 'misusing' or 'abusing' a substance.
- Be as specific as possible. The Scottish Drugs Forum offers a really comprehensive guide to language in this area. We have highlighted key aspects below, and please consult the SDF if you need further information or advice.

Terms

We use	Meaning	Context	We don't use
Person / people with a substance problem **Person / people with a substance dependency,** or	Anyone experiencing an addiction. Substance use disorder occurs when the use of alcohol or drugs impairs your health or how you function in your daily life.	When speaking specifically about this group	**Addict** **Alcoholic** **Any informal or derogatory terms / slurs**
Person / people with problem drug / alcohol use	A person or group using drugs or alcohol in a problematic way (specify which, or use 'substance' instead).	When speaking specifically about a group.	As above
Substance, or **All substances**	Psychoactive substance/s.	When speaking about psychoactive substances.	**Drink** **Other casual terms**

Substances including alcohol	Psychoactive substance/s, including alcohol (which is also a psychoactive substance)	When referring to polysubstance use (using more than one psychoactive substance) where alcohol is involved.	An audience may regard alcohol use as normal or a 'given' or not significant. In some discussions of drug related deaths the role of alcohol in polysubstance drug overdose sometimes needs to be made clear.

4. Sources that informed this document

- Data collection and publication guidance Sex Gender Identity Trans Status (www.gov.scot)
- DEEP-Guide-Language.pdf (dementiavoices.org.uk)
- Our statement on sex and gender reassignment: legal protections and language | Equality and Human Rights Commission (equalityhumanrights.com)
- Four Pillars of Deafness - deafscotland – the lead organisation for deaf issues in Scotland
- NHS Blood and Transplant (September 2021) *Inclusive Language Guide*
- Moving-Beyond-People-First-Language.pdf (sdf.org.uk)
- The Social Model of Disability - Inclusion Scotland
- Words Matter - Terms to Use and Avoid When Talking About Addiction | National Institute on Drug Abuse (NIDA)
- Substance Misuse (nhslothian.scot)
- List of LGBTQ+ terms (stonewall.org.uk)
- Healthcare Improvement Scotland (November 2021) *Workplace Transgender Equality Guidance*

5. Is something missing?

We are committed to continuously improving our approach to and representation of equality issues. If there is terminology you use as part of your work and you think it should be reflected in this guide and is currently missing or differently framed, please let our Public Involvement Team know on his.contactpublicinvolvement@nhs.scot

November 2021

You can read and download this document from our website.
We are happy to consider requests for other languages or formats.
Please contact our Equality and Diversity Advisor on 0141 225 6999
or email his.contactpublicinvolvement@nhs.scot

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DRAFT meeting Notes – V0.1

Meeting of the Governance for Engagement sub-committee

Date: 20 January 2022
Time: 10.00am - 12:00pm
Venue: MS Teams

Present
Suzanne Dawson, Chair (SD)
Simon Bradstreet, Member (SB)
Emma Cooper, Member (EmC)
Elizabeth Cuthbertson, Member (EC)
Jamie Mallan, Member (JM)

In Attendance
Ruth Jays, Director of Community Engagement (RJ)
Jane Davies, Head of Engagement Programmes (JD)
Tony McGowan, Head of Engagement and Equalities Policy (TMG)
Ann Gow, Director of NMAHP (Nursing and Midwifery and Allied Health Professionals) and Deputy Chief Executive HIS (AG)
Ruth Thompson, Associate Director Nursing and Midwifery (RT)
Simon Watson, Medical Director (SW)
Susan Ferguson, PA to Director and Chair [Note taker] (SF)

Apologies
No apologies were received

Declaration of interests
No Declaration(s) of interests were recorded

1.	**OPENING BUSINESS**	**ACTION**
1.1	**Chair's Welcome and Apologies**	
	The Chair (SD) welcomed everyone to the meeting and thanked all sub-committee members who had attended the pre-meeting on Tuesday 18 January 2022. No apologies were received for meeting. It was however noted that EC would miss the Medical Directorate presentation and discussion and that TMG would share points she had raised in an earlier communication.	
1.2	**Draft Meeting Notes and Action Points**	
	Previous meeting notes were agreed as an accurate record. As after today's meeting every directorate will have attended the sub-committee, and the cycle of meetings was now at the point of review the sub-committee were asked if they agreed to the current three action points on the register being combined into one action. They were also advised that the revised wording of the combined action would be shared with the sub-committee.	

	The sub-committee raised a point about the final report which would be produced on the meeting cycle, asking if learning for both sub-committee members and directorates would be included. TMG confirmed that this was the case. The sub-committee agreed to the combination of the three action points in the Action point register. **Action- TMG, JD, to prepare wording of combined action points to be shared with Committee members**	**TMG/JD**
1.3	**Business Planning Schedule**	
	SD noted that the 2021/22 Business Planning Schedule had now concluded and preparation needed to start for 2022/23. Quality Framework and Directorate linkage is to be considered in preparation of the new schedule. After discussion on the proposed format for the first meeting and subsequent meetings it was agreed that a pre-meeting would be scheduled within the same week as sub-committee meeting to discuss the proformas submitted. **Action-TMG and SF to prepare 2022/23 Business Planning Schedule**	**TMG/SF**
2.0	**STRATEGIC BUSINESS**	
2.1	**Governance for Engagement Directorate Proforma Review - NMAHP Directorate**	
	SD and TMG welcomed AG and RT to the meeting and invited them to talk through their presentation. **(Appendix 1)** Prior to presenting, RT provided some background on NMAHP. She advised that this was a relatively new directorate which initially consisted predominately of nurses and midwives but now has over 40 multi professional colleagues. It was also noted that the directorate engages with NMAHP colleagues across Healthcare Improvement Scotland (HIS) as well as external stakeholders. The following highlights from the presentation were as follows: **What we do** • NMAHP has four key programmes of work, consisting of NMAHP, Healthcare Staffing Programme (HSP), Excellence in Care (EIC) and the Internal Improvement oversight Board (IIOB). HSP and EIC are more aligned and will be coming together with a relaunch • The directorate now has corporate responsibility for complaints within HIS **Successes** • NMAHP forum has been better attended during COVID due to virtual meetings • Ability to access stakeholder specialist advice through the various forums • Use of public partners and/or subject matter experts in all our work • Increased engagement with multi-disciplinary stakeholders for HSP **Challenges** • More focus on engagement with patients and the public needed • Need to introduce important governance such as Equality Impact Assessments	

	(EQIA) and Project Initiation as standard across the directorate • Ensuring we use plain English and communicate in a way that is understandable to all. **Engaging effectively** • Work with IIOB short life working group • Review of corporate complaints, considering how the directorate engages with the complainants, to avoid further trauma for them. SD thanked AG and RT for their presentation and opened up to the sub-committee for questions The sub-committee's questions/points were themed around the following : 1. Use of acronyms - It is important to mention what the acronym stands for to ensure everyone understands what is being discussed, as people will lose interest and be less engaged. 2. Importance of seeing patients and public as stakeholders - if patients and public aren't seen as key stakeholders within NMAHP, how does it work? 3. Clarity on what the next steps are for NMAHP based on the actions identified 4. Use of the refreshed EQIA which is currently being worked on would be a starting point for the existing work and could help shape the next part of the journey for the directorate. 5. New staff could be used as an opportunity to start on the right foot in terms of embedding EQIA and other processes to embed an engagement approach 6. Involvement of Public Partners could add value to the work of the directorate and the engagement results that stem from it. In response to the points raised by the sub-committee, AG and RT provided the following feedback: 1. Agreed that the use of acronyms was a problem with the directorate and within the whole of HIS and the NHS more generally. Noted that involvement with the Vale of Leven families in EIC had been really helpful in highlighting the use of acronyms. 2. Advised the work the directorate does is channelled through the Health Boards who have their own public involvement officers. Highlighted that support from the HIS-CE would be required for this. 3. Advised that the directorate are keen to routinely embed EQIAs across programmes. They are also looking at public engagement within HSP, as having the right people in the right place at the right time which is of interest to the public. 4. On Public Partner involvement, they advised that they are looking for support on how best to market the work of the directorate so people are comfortable in joining as public partners	
2.2	**Governance for Engagement Directorate Proforma Review – Medical**	
	SD and TMG introduced and welcomed SW to the Governance for Engagement sub-committee meeting and invited him to talk through the presentation. **(Appendix 2)** TMG wanted to note the fantastic engagement and enthusiasm that he experienced working with Kirsty Kilgour in preparation for this meeting and asked SW to pass this on to Kirsty. SW noted that due to leave he would be delivering the presentation himself and if unable	

	to answer specific questions he would be happy to pass on to the relevant person post meeting. He also advised that there were two additional slides added to the presentation. One of these was the General Medical Council Code of Conduct for doctors, with emphasis being made on the importance of communication, partnership, teamwork and trust. SW provided an overview of the work and responsibilities of the Medical Directorate and highlighted that public engagement is more established within the more mature Medicines and Pharmacy team and less developed in the Medicine team. The highlights from the presentation were as follows : **Good practice** • Buvidal Learning System in prison pharmacy • National Review panel • Scot QR (rheumatoid arthritis) • Medicine safety (IPSOS mori) • Cancer medicines • Professional and clinical fora **Improvement areas** • Knowledge and learning • Governance • Integration across the governance functions, need to be aligned and share intelligence • Planned engagement, need to think about emergency or situations that require pace. • Better understanding of how to engage with the public The sub-committee focused their comments and feedback on the three suggested discussion points in the presentation : 1. Highlighted that the preparation for pro forma and presentation had been excellent. 2. Considering the differences between pharmacy and the other half of the directorate, what lessons can be learned from their approach? 3. Making the technical accessible, the directorate need to be clear about what questions they want answered by the public. 4. How does the directorate build on the learnings from the pharmacy team's work with prisons? What made it successful? Highlighted there could be an opportunity to investigate the factors and the impacts that made this work, and suggested an After Action Review. 5. Engagement approaches for difficult to reach clinical communities - possible matrix of approaches to be accessed by staff? 6. What are the engagement plans for this between January and March? In response to the points raised by the sub-committee SW provided the following feedback: 1. Sharing the learning from Medicines and Pharmacy can't be just transactional. There are many established forums where we should share the learning. Important to plan time in the diary to develop this. Also attending this committee meeting has been a springboard for the directorate and this will be the focus from January to March. 2. Recognising language is a specific action under the banner of patient safety.	

	Greater consideration needs to be given to what we refer to. There are ground breaking medicines that have unpronounceable names. It's important that people shouldn't feel less good about themselves because they can't pronounce the name of medicines and technologies. Vocabulary matters and there should be a greater focus on this. 3. For hard to reach groups, the academic sector is a huge influence and there is a need to engage with this. We may be able to learn from what the academic sector is doing in relation to public involvement. The directorate needs help to consider how engagement with patients and the public plays into the process. Further points were discussed around the importance of trying to influence the language used and inclusion of involving the public in technical areas. The sub-committee thanked SW for the feedback and also for attending this session.	
2.3	**Feedback, reflections and actions for directorates**	
	SD opened discussion for reflections and thoughts which were: 1. Both directorates have similar challenges as are removed from public. 2. Both directorates underestimate their ability to influence 3. Lot on information, considering timescales how does the sub-committee reflect this. 4. Will there be an action plan for the organisation based on key points, feedback, themes and learning from each directorate? **Next step/Actions** 1. TMG to continue work on the completed sessions and feed back to the sub-committee at a mop-up session to be arranged. 2. SF to check availability of sub-committee and arrange mop-up session.	**TMG** **SF**
3.0	**General Updates**	
3.1	**Quality Framework for Community Engagement**	
	As the meeting overran, JD posted the below update on the MS Teams chat. Quality Framework update - working with 4 Boards/HSCPs to test the framework. It won't be completed until Summer 2022 due to the pausing of Planning with People by SG. We will be working to look at alignment with the framework for HIS as an organisation and learning from this first year around Governance for Engagement.	
4.0	**AOB**	
	No other business was discussed, and SD closed the meeting thanking everyone for their contribution.	
5.0	**Date of next meeting** To be confirmed	

APPENDIX 1

NMAHP slide deck.

Healthcare Improvement Scotland

NMAHP Governance for Engagement Presentation

20 January 2022

Supporting better quality health and social care for everyone in Scotland

NHS SCOTLAND

About Us

NMAHP Vision:
We support Nurses, Midwives, AHPs and their teams to work together to improve the delivery of safe, effective and person-centred care, for every person every time

NMAHP Values:
- We are collaborative, curious and compassionate
- We ensure that people are central to all that we do
- We are open, honest and seek help when required
- We are resilient and reliable
- We play to our strengths
- We are confident to provide feedback, challenge and take time to celebrate success

What We Do

Notable Successes and Challenges

Successes

- Building engagement and buy-in with the NMAHP community within HIS to support the development of our internal NMAHP work
- Well established engagement from NHS Territorial Boards, ensuring there that teams are well aware of the priorities and support requirements of our stakeholders
- Use of public partners and/or subject matter experts in all our work
- Increased engagement with multi-disciplinary stakeholders for HSP

Challenges

- We need more focus on engagement with patients and the public
- Need to introduce important governance such as EQIA and Project Initiation as standard across the directorate
- Ensuring we use plain English and communicate in a way that is understandable to all.

Planning for Fairness

- EQIA Assessments are completed for some work although this is not done as routine. Plan to discuss EQIA at future DMT meeting to ensure this is done across the directorate
- We respond to any correspondence from those with a protected identity appropriately
- Further work is needed to ensure that we are doing all we can to create a positive impact for those affected by our work
- Support is needed to understand how we can do this better in our directorate

Engaging Effectively

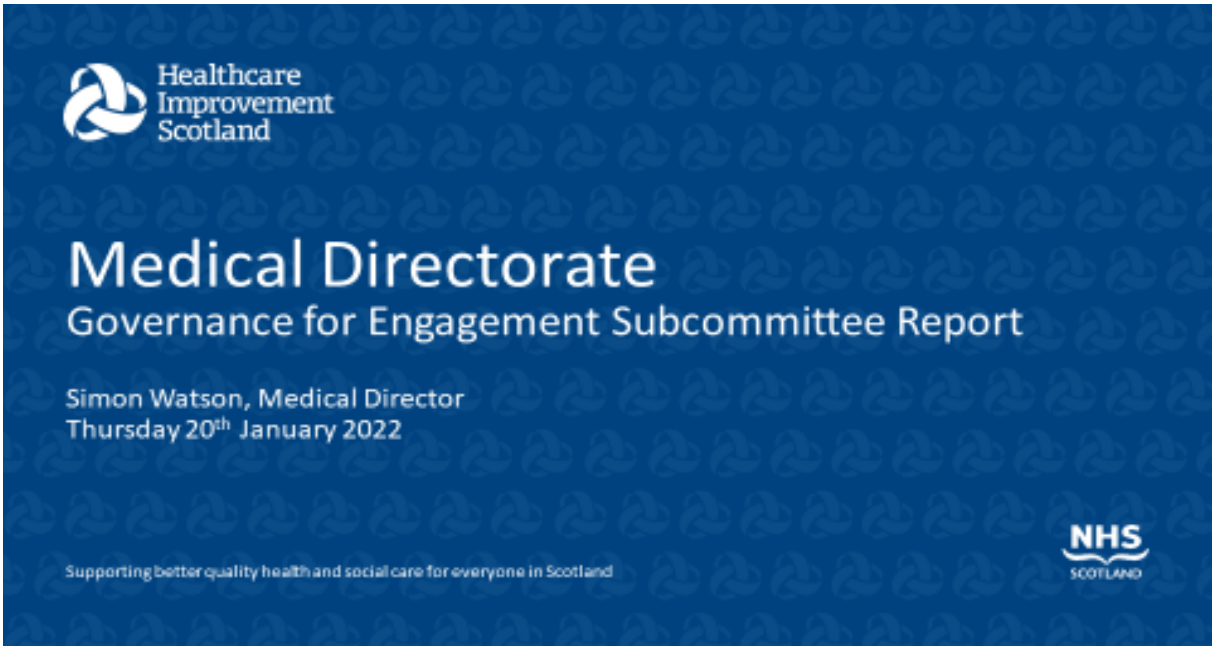
- Our main stakeholders are Nurses and Midwives and Allied Health Professionals who we ensure are involved in all of our work
- All NMAHP professional & regulatory processes & policies are developed by SLWG's including appropriate NMAHP members, presented at NMAHP forum before presenting to partnership Forums
- EIC and HSP teams have well established networks of NMAHP staff across Scotland.

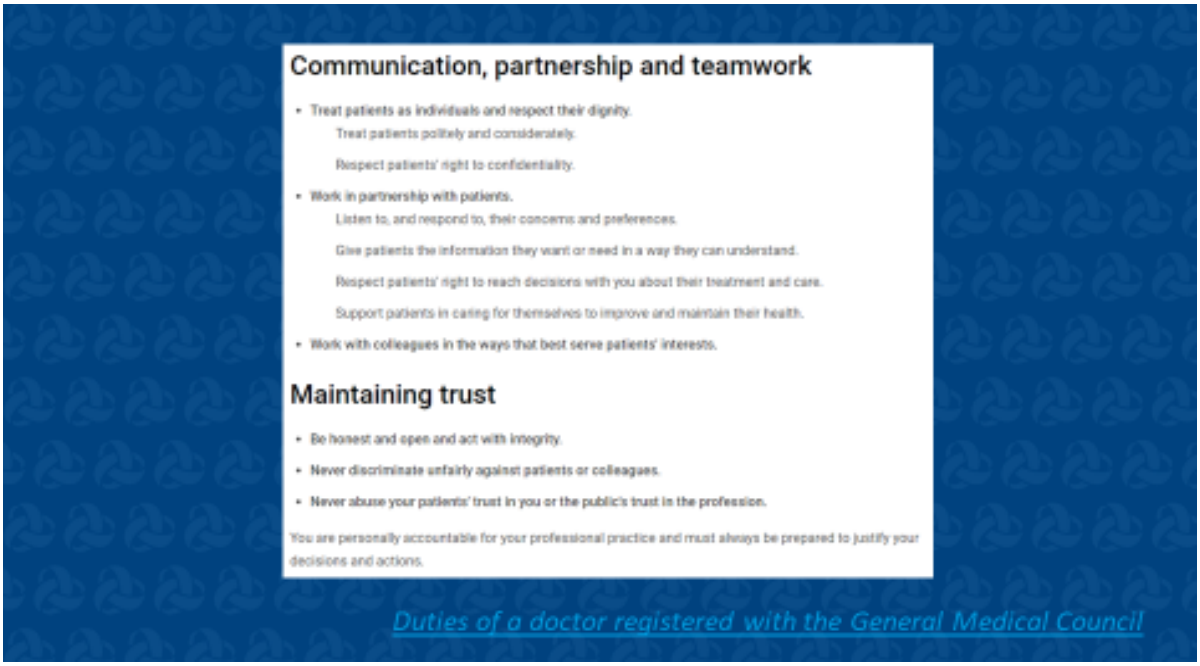
Reporting Transparently

- Following workshops and events we develop reports sharing what we have learned and describing what we are going to do next.
- We evidence our work via feedback for EIC and HSP to the national team and programme board which includes public partners
- No standard mechanism to publish engagement results

APPENDIX 2

Medical Directorate slide pack





Directorate Overview

- Organisation-wide responsibility for ensuring a coherent approach to medical, pharmacy and wider clinical leadership in HIS, including clinical and care governance (CCG) of our work.
- Providing professional leadership and being the Responsible Officer for doctors and pharmacists employed by HIS.
- Leadership of the Safety Key Delivery Area and Sharing Intelligence for Health and Care Group.
- Delivery of bespoke programmes of work commissioned by Scottish Government, with outcomes supporting patients, settings or medicines in a high-risk category.
  - Cancer Medicines, Prison Pharmacy, Controlled Drugs and the Area Drugs and Therapeutics Committee (ADTC).

Good practice:

- **The Buvidal Learning System (Prison Pharmacy)** – involved people who had previously been prisoners to give their views and experience of using opiate substitution therapies.
- **National Review Panel** – public partner was pivotal in shaping both the policy and methodology. Public partner is a full member of the review panel and its decision making.
- **ScotQR** – has a partnership arrangement with National Rheumatoid Arthritis Scotland (NRAS) to shape the deliver of real time remote monitoring of RA disease.

Good practice:

- **Medicine safety** – iPSOS Mori Poll with 1000 members of public to determine attitudes and behaviours in relation to medicine safety to inform behavioural interventions.
- **Cancer medicines** – work uses two public partners to review programme content.
- **Professional and clinical fora** – e.g. Clinical and Care Staff Forum, Pharmacy Forum, and Medical Forum. Supports professional development, shared learning and the opportunity to influence HIS and wider system.

Areas for improvement

- **Knowledge and learning:** a need for the Directorate to continue to gain a better understanding re: the application of engagement and equalities best practice to our work.
- **Governance:** a need to create more robust procedures to ensure we take a consistent approach to applying engagement and equalities standards, and that we address all of our work - not just projects that follow a typical project life-cycle.
- **Integration:** a need to continue the work of better understanding the integrations with CCG, Governance for Engagement, Staff Governance and other corporate governance functions. Work to progress this has been programmed for January – March 2022.

Discussion

- How do we take a step back to calibrate the clinical focus of our work and consider where the general public fits in?
- How do we overcome that the "internal" or "highly technical" nature of some of our work can make good engagement more challenging?
- How do we make sure we're tapping into any best practice and learning from CE's approach with the public, for application to our engagement with clinical communities across Scotland?

DRAFT MEETING MINUTES – V 0.2

Meeting of the Scottish Health Council Service Change Sub-committee

Date: 27 January 2022
Time: 10.00 - 12.00
Venue: MS Teams

Present
Suzanne Dawson, Chair
Dave Bertin, Member
Alison Cox, Member
John Glennie, Member
Christine Lester, Member

In Attendance
Derek Blues, Engagement Programme Manager- Service Change
Jane Davies, Head of Engagement Programmes
Tony McGowan, Head of Engagement and Equalities Policy
Louise Wheeler, Service Change Advisor

Service Change Sub-committee support
Carmen Morrison, Service Change Advisor

Apologies
Elizabeth Cuthbertson, Member
Ruth Jays, Director of Community Engagement
Emma Ashman, Service Change Advisor

ITEM	NOTES	ACTION
1	**WELCOME & APOLOGIES FOR ABSENCE**	
1.1	**Welcome** The Chair of the Scottish Health Council welcomed everyone to the meeting.	
1.2	**Apologies for Absence** Apologies received from Elizabeth Cuthbertson, Ruth Jays and Emma Ashman **Minutes of Previous Meeting of 26 August 2021 and matters arising** The accuracy of the note of the meeting on 26 August 2021 was approved with one suggested amendment at 2.2. Agree new wording and clear with John and Suzanne. **Actions Log** Action 1 – Updates on National and Regional Action Plan is to become a standing item on the agenda	**Head of Engagement Programmes/Engagement Programmes Manager**

	All other actions from meeting of 28 October are completed and to be removed.	
2	**STRATEGIC BUSINESS**	
	Standing Items	
2.1	**Update on Quality Framework for Engagement** Derek Blues provided a verbal update on recent activities both internally with the delivery group and externally. The recent progress has been encouraging given the current emergency footing. Feedback had been received from NHS Boards and Partnerships and this is being considered in the further development of the Framework. There have been three confirmed Expressions of Interest from NHS Boards and Partnerships to be involved in the self-assessment testing phase. These are: NHS Ayrshire and Arran, East Renfrewshire Health and Social Care Partnership, NHS Greater Glasgow and Clyde. Meetings have already taken place with two of the three areas and the third will take place next week. Members asked what other scrutiny or public bodies HIS-CE are working with on the Quality Framework and if the Improvement Service had been involved. Derek advised that the Care Inspectorate had been involved from the early stages. The improvement service have also been involved as part of the Advisory Group established by the directorate to develop the framework. Members expressed the view that the three test sites appeared to be clustered in the one geographic area and questioned whether three test sites would be adequate. HIS-CE agreed to reach out to those other sites who had expressed an interest initially. Chair thanked Derek for the update and noted that going forward the Quality Framework will assist Service Change and Governance for Engagement. She also conveyed thanks to the internal delivery group from the sub-committee.	**Engagement Programmes Manager**
	Service Change updates	
2.2	**NHS Ayrshire and Arran: West of Scotland Systemic Anti-Cancer Therapy (SACT) model** Jane Davies shared some background in advance of the discussion; • Changes to chemotherapy services within NHSA&A have been ongoing since 2014. • In May 2020 the Sub-committee gave their view that the change was considered major. • Former Director of HIS-CED Lynsey Cleland sent a letter to NHSA&A outlining the decision. NHSA&A implemented changes to its chemotherapy service in response to the COVID pandemic. These included moving tier 3 SACT services to the Kyle unit, University Hospital Ayr. These have now been in place for nearly 2 years.	

	The sub-committee is being asked to consider if the previous view given in May 2020 remains that this is a major service change. The recommendation from the sub-committee today will go to the full SHC committee on 17 February 2022 for a final decision. An SBAR had been provided to the members by Louise Wheeler. This outlined engagement to date and additional information that had been provided by NHS Ayrshire & Arran. Louise highlighted the following areas: • NHSA&A has responded to some points from our letter of 20 May e.g 70% of respondents raised issues related to transport and travel – NHSA&A highlighted use of NHS Near Me and virtual visiting in mitigation. • EQIA has been updated – this includes the number of patients who will be impacted by changes to services (this information was not available to sub-committee members in their deliberations in May 2020) • NHSA&A has addressed additional points (accommodation and environment) as a result of feedback from patient surveys. • Interim Chief Executive of NHSA&A referenced HIS-CE COVID-19 guidance on requirement for engagement as the changes have been in place for nearly 2 years. The Sub-Committee members were asked to consider; • How NHSA&A had taken into account/acted on the letter(s) from HIS-CE? • Has NHSA&A responded adequately to questions raised by HIS-CE in Sep 2021? • Have points raised by the Sub-Committee in Oct 2021 been addressed? Members asked if NHSA&A is asking the Sub-Committee to revise their decision of May 2020 and if there is precedent for this? Jane advised that NHSA&A is awaiting the Sub-Committee decision before taking their updated Communication and Engagement Plan to the NHSA&A board meeting in March 2022. Louise noted that COVID meant that changes had to be put in place quickly and that some of the changes put in place were part of the original plan. She noted that NHS A&A has not explicitly asked HIS-CE to change its view but rather shared an engagement plan for comment, which does not reflect the view previously given. Members shared their views that the Sub-Committee had given its view and should not reconsider. There was discussion about what additional requirements we could ask of NHS A&A given what they have done and taking account of the emergency footing. It was agreed that the public had not been properly consulted and that this could be an additional ask. There was recognition of the work that has been done with patients currently using the service and those with lived experience. It was further recognised about the work undertaken to mitigate some of the impacts identified in the EQIA although there may be an opportunity to for the Board to Board to consider further mitigations in order to develop realistic solutions. The Chair summed up discussion by posing two questions for members:	

	• What would HIS-CE hope to achieve from further engagement/consultation - what value would the public gain? • Does the public have an opportunity to influence? It was agreed that the added value is that the public can help to solve some of the issues and the detail of how to make the service work. The public have not had an opportunity to influence any of the decisions made to date or input to the development of the service and any public consultation should be clear about what people can influence as part of the consultation and also outline the mitigating factors they have put in place to prevent further inequalities or negative impacts. The Chair concluded that the Sub-Committee should provide clear articulation of its decision and develop a paper with detailed information and recommendations for the SHC Committee to consider at its business meeting in February. Members sought clarify on whether other Boards are implementing the West of Scotland Cancer Network Chemotherapy service changes. Louise advised that NHS Greater Glasgow & Clyde is reviewing their Systemic Anti-Cancer Therapy service, however HIS-CE has not been asked to provide support or advice. She noted the members' point that the impact of (WOSCAN) change is different for each board and therefore there may be different levels of impact on different board areas. Members suggested that moving forward with planning without taking advice/support from HIS-CE is not advisable, but implementing without that support is a risk and proposed HIS-CE should be proactive and request updates from relevant board areas.	**Head of Engagement Programmes, Engagement Programmes Manager, Service Change Advisor** **Engagement Programme Manager, Service Change Advisors**
2.3	**<u>General update on Service Change Activity</u>** Derek spoke to the paper acknowledging the contribution by Service Change Advisors in its development and drew out key activities including the establishment of a short-life-working-group to develop the Practitioners Network. He advised that an open letter raising concerns about the review of Dr Gray's Hospital in Moray has been published. Derek was asked to share the letter and the report with members. Derek advised that the interviews for the Principal Service Change Advisor role will be held on Friday 28 January 2022.	**Engagement Programme Manager**
2.4	**Update on position on national and regional service change** It was agreed that the National and Regional Action Plan was to become a standing agenda item with regular updates to demonstrate progress. Jane noted that National Treatment Centres (NTC) are all at different stages of development and that the Chief Executive of HIS has been approached by NHSA&A with regard to the NTC in that area. Jane advised that HIS-CE are in discussion with Scottish Government policy leads around engagement requirements. HIS-CE will develop guidance on minimum core standards for	

	engagement for NTCs which will include expectation for engagement including EQIA and other impact assessments. HIS-CE will work with each NHS Board on an individual case-by-case basis as each NTC is at different stages of development. It is expected that NTC communication and engagement plans will be shared with HIS-CE. Members enquired whether NTCs would automatically be considered major change. Jane advised most NTCs would be providing additional capacity to existing services or re-provisioning services on existing sites. These regional changes are not automatically MSC and need considered on a case by case basis. Louise informed members that the service change team is developing case studies on three regional changes – considering expectations around engagement, conducting a SWOT analysis to help inform consideration of minimum requirements for engagement on regional service change. The Chair noted the value of having this as a standing agenda item.	**Head of Engagement Programmes**
2.5	**Identifying Major Service Change (MSC) guidance (paper)** Louise informed the Sub-Committee that the MSC guidance had been updated to reflect the language of Planning with People guidance and recent changes to policy and practice. The revised guidance has been shared with four NHS Boards for feedback and comments received have been incorporated. Louise advised that a request for an 'appeals' process has previously been made by an NHS board. Members were asked to: i) approve the changes made to the guidance, ii) consider the development of an appeals process. The Chair thanked Louise for the paper and the SBAR presented to the members for information and consideration. Members felt that an appeals process was not appropriate, could be time consuming and may extend timelines for deliberations and decisions. It would also require establishment of another group/process which could be counter-productive. A member suggested that it might be useful to share the Sub-Committee recommendations with the NHS board in advance of these being submitted to the full SHC Committee. Members noted that the guidance indicates that the Cabinet Secretary would be arbitrator if the NHS Board and HIS-CE do not have consensus on the impact of change. It was also suggested that Appendix 1 paragraph 5 of the guidance should reference 'delegated care services'. Jane highlighted that HIS-CE role with IJBs covers delegated health services and not services delegated by Local Authorities. HIS-CE is currently seeking advice from Central Legal Office on this issue and the outcome will be shared with the Sub-Committee in due course.	

	With this amendment made, the members approved the new updated guidance. The Chair felt that it may be helpful for sub-committee members to meet with NHS Board officers regarding the change proposal and she would take this forward with the HIS-CE Senior Management Team. The Chair thanked members for their comments and discussion. It was agreed that this paper would be taken to the SHC Committee at its February meeting.	**Chair** **Head of Engagement Programmes/ Service Change Advisor**
2.6	**External workshops – engagement in service change** The content for the three workshops is: • Duties and principles for involvement in service change • Planning effective engagement in service change, and • Involving people in option appraisal. An infographic which highlights numbers of sessions and attendees along with other points of information and feedback from the workshops was shared with members for information. Sub-committee members welcomed the clarity of the infographic and thanked Carmen and those involved in producing it. During February and March the Service Change Team is offering a total of nine workshop sessions to all HIS-CE staff on; • Duties and principles for involvement on service change • Planning with People Guidance • Service Change Quality Assurance The Chair conveyed thanks from the Sub-Committee to the service change team for their work in this area.	
3	**Any other business** The Chair brought the meeting to a close at 12pm.	
	Date of next meeting – 31 March 2022 – 12noon via MS Teams	

Healthcare Improvement Scotland

Meeting:	**Scottish Health Council Committee**
Meeting date:	**17 February 2022**
Title:	**Review of NHS Ayrshire & Arran Chemotherapy (SACT) Services**
Agenda item:	**4.1 – Reserved Business**
Responsible Executive:	**Ruth Jays, Director**
Report Authors:	**Jane Davies, Head of Engagement Programmes, Louise Wheeler, Service Change Advisor**

1 Purpose

This is presented to the Committee for:

- Discussion and decision

This report relates to:

- Service Change activity and major service change recommendation

This aligns to the following HIS priorities(s):

- Access to care
- Safe, reliable and sustainable care

2 Report summary

This paper provides the Committee with an update on the Review of Chemotherapy (SACT) Services within NHS Ayrshire & Arran. This review has been discussed at several Service Change Sub-Committee meetings. The Service Change Sub-committee recommends to the SHC Committee that the review should be considered major service change in line with national guidance. The Committee are asked to approve this recommendation and agree next steps.

3 Background

In March 2020, having completed a two month public engagement exercise on its review of Chemotherapy services, NHS Ayrshire and Arran submitted a major service change template to *Healthcare Improvement Scotland – Community Engagement* (HIS-CE). This template is used to inform HIS-CE's view on the impact of a proposed change, i.e. whether it meets the threshold of major service change.

After full and detailed discussion at meetings in March and April 2020, the Service Change Sub Committee confirmed its view that the proposed changes to Chemotherapy services (inpatient, day and outpatient treatments) met the threshold for major service change. A letter reflecting this view and outlining proposed next steps was sent to NHS Ayrshire and Arran in May 2020 (appendix 1).

In September 2021, the Interim Chief Executive of NHS Ayrshire and Arran wrote to HIS-CE to advise that in response to the COVID pandemic a number of changes had been made to the chemotherapy service and that the Board planned to make these interim changes permanent (appendix 2). The letter indicated that they planned to follow the approach outlined in the HIS-CE COVID guidance (July 2020) for "Changes that were introduced on a temporary basis and are now being considered as a longer term or permanent model for service delivery*".*

The Director of HIS-CE responded to NHS Ayrshire and Arran referencing the view previously given in May 2020 on the impact of change and requesting additional information, for example to clarify how the interim changes put in place in response to the COVID pandemic differed from those previously proposed in early 2020. This development was discussed by the Service Change Sub Committee in October 2021.

NHS Ayrshire and Arran submitted the additional information requested on 10 December 2021. In her letter (appendix 3), the Interim Chief Executive states:
"As outlined in my previous correspondence, recent service changes have had to be made due to the COVID-19 pandemic response which go beyond the realms of what was discussed previously and have already been implemented".

"Following the Chemotherapy Service Review in 2019, associated engagement and EQIA activity, it was recommended that our Tier 2 ward should be located at Crosshouse. It was also indicated in the recommendations that development of further Tier 3 delivery sites should be considered and the relocation of Station 15 to Kyle Unit is the first of these sites. Therefore, this does not differ from the proposal we developed previously and engaged with people on in early 2020".

HIS-CE responded on 23 December (appendix 4) setting out our internal governance process for considering the view previously given in light of the additional information provided and our previous advice in terms of engagement and consultation.

Following an SBAR provided to the Service Change Sub Committee meeting on 28 January 2022 (appendix 5), sub-committee members discussed this change within the current context and information provided, with main points being:

- HIS-CE gave its view in May 2020 and is concerned about NHS Ayrshire and Arran's lack of progress in terms of engagement in taking our recommendations forward (revisiting the view given by HIS-CE more than a year later). Some sub-committee members expressed concern that meaningful engagement may not be seen by NHS Boards as a priority as services begin to remobilise.
- There may be a perception that by allowing a time lapse of approximately two years and moving to implementation (in response to COVID pandemic), the view of HIS-CE can be changed in terms of its expectations for engagement, for example do we change a decision or definition based on the passing of time? It was felt important to demonstrate consistency in the decision reached i.e. the decision of the meeting May 2020 still stands.
- recognition of the work that NHS Ayrshire and Arran has done to date, for example, undertaking an EQIA (appendix 6), the public engagement exercise (Jan-Mar 2020) and the value of engaging with people with lived experience (October 2020, May/Jun and Oct/Nov 2021) (appendix 7), but important to also share information and engage with the public and communities – these are patients of the future. The public may offer solutions to challenges or provide valuable insight to the detail of the model.
- There is potential this could be used as a precedent for other changes, with temporary measures put in place in response to the pandemic becoming more permanent in the longer term.
- Within regional planning, the impact of change in each Board may be different and so expectations regarding engagement may vary to reflect this, for example there are different requirements for change in Greater Glasgow and Clyde and Shetland – we need to consider individual board circumstances. Each NHS Board has duties to ensure engagement with their communities in the development, delivery of services and in decision-making.
- HIS-CE can provide our view and advice on whether a service change meets the threshold for 'major' to the Board, however, if the Board does not agree with our view on the status of change, the Cabinet Secretary can be asked to provide a decision.

Having considered these points, the Service Change Sub Committee concluded that the decision offered in May 2020 stands and the interim model put in place for chemotherapy services in NHS Ayrshire and Arran should be subject to public consultation in line with guidance on major service change.
In recognition of the work that NHS Ayrshire & Arran have already undertaken to date the Service Change Sub Committee would advise that the consultation process should:

- Seek wider feedback and contribution from the public, to support better decision-making and identify areas for improvement in the current model
- The scope of public consultation and opportunities for people to influence the proposals should be clearly articulated, for example identifying areas that the public may not be able to influence but be clear about where they may offer solutions or views on how the service works
- Consider whether proposed measures to mitigate against adverse impacts are sufficient and if other options may be further explored
- ensure that actions are undertaken to reduce any adverse impacts and these are carefully explained to the public

- Support and maintain the relationship between the NHS board and its communities.
- Take into account the work that's already been done, e.g. public information and engagement (Jan-Mar 2020), patient surveys (autumn 2020–2021).

4 Risk Assessment/Management

Strategic and operational risks associated with our work programmes and workforce are recorded and reviewed on a regular basis by our Directorate Management Team.

There is a risk that we do not reach a consensus with NHS Ayrshire & Arran on the decision that this review represents major service change. In this situation the Cabinet Secretary for Health and Sport, as the final arbitrator, will be asked to make the decision.

5 Equality and Diversity

The directorate has a specific role in supporting equality and diversity within Healthcare Improvement Scotland. We have provided advice and support to NHS Ayrshire and Arran in undertaking their EQIA and how to mitigate against any unintended negative impacts that may arise from this.

6 Route to the Meeting

This review has been considered by the Service Change sub-committee at its meeting on 28 January 2022.

7 Recommendation

The Committee are asked to:

1) discuss the content of the Review of Chemotherapy (SACT) Service in NHS Ayrshire and Arran
2) approve the recommendation by the Service Change Sub Committee that this remains major service change
3) Agree next steps

8 List of appendices

The following appendices are included with this report:

- Appendix 1 – Letter from HIS-CE Director to NHS Ayrshire & Arran Interim Chief Executive dated 12 May 2020
- Appendix 2 – Letter from NHS Ayrshire & Arran Interim Chief Executive to HIS-CE Director dated 17 September 2021

- Appendix 3 – Letter from NHS Ayrshire & Arran Interim Chief Executive to HIS-CE Director dated 10 December 2021
- Appendix 4 – Letter from HIS-CE Director to NHS Ayrshire & Arran Interim Chief Executive dated 23 December 2021
- Appendix 5 – SBAR to Service Change sub-committee at meeting on 27 January 2022
- Appendix 6 – NHS Ayrshire & Arran Equality Impact Assessment
- Appendix 7 – NHS Ayrshire & Arran Engagement Plan 2021

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Healthcare Improvement Scotland | Community Engagement

Date: 12/05/2020
Professor Hazel Borland
Nurse Director Interim Deputy Chief Executive
NHS Ayrshire and Arran,
Eglinton House,
Ailsa Hospital
Dalmellington Road, Ayr
KA6 6AB

Dear Hazel

NHS Ayrshire & Arran – Chemotherapy Services Review

Thank you for submitting information on proposed changes to chemotherapy services in NHS Ayrshire & Arran. *Healthcare Improvement Scotland – Community Engagement* recognises that this proposal has been developed from the emerging West of Scotland Cancer Network tiered model. It is our understanding that proposed changes to regional or national services should follow the principles set out in the Scottish Government's guidance, CEL4 (2010)[1].

As part of the regional model, Tier 1 services will be provided at the Beatson Cancer Centre in Glasgow, with NHS Ayrshire & Arran's proposed change including the provision of:

- The Tier 2 cancer unit at University Hospital Crosshouse (also serving as an outreach facility for its local catchment area)
- Tier 3 outreach facility provided at University Hospital Ayr
- Eight inpatient chemotherapy beds transferred from University Hospital Ayr and consolidated at University Hospital Crosshouse
- Some specialist services and treatments may be repatriated from the Tier 1 regional cancer centre (in Glasgow) to NHS Ayrshire & Arran.

This proposal would mean that all patients currently attending University Hospital Ayr would go to University Hospital Crosshouse for their initial assessment and first chemotherapy treatment. Following the initial assessment and treatment, it is anticipated that around 75% of treatments would continue to be delivered from University Hospital Ayr for those patients that would currently access their care there.

View on status of proposal

Based on the information you have shared with us, we have considered whether this proposed change would likely meet the general threshold for 'major service change'.

We feel the proposal meets the threshold for major service change on the basis that:

- Patients who are already vulnerable due to their illness may have to travel further for the initial assessment and first treatment, with a proportion also requiring to do this for further treatment appointments.
- It is unclear from the information available how many people currently attend University Hospital Ayr for their first consultant assessment appointment and first treatment.

[1] *1 https://www.sehd.scot.nhs.uk/mels/CEL2010_04.pdf*

- There has been significant public and political interest to the proposed changes with two online petitions (attracting over 13,900 signatories) – The Ayrshire Post, 'Save Station 15 at Ayr Hospital'[2] and a local councillor petition 'Save Station 15 – Retention of services in Station 15 Ayr Hospital'[3]
- Proposed change will support the implementation of the emerging West of Scotland tiered model.

We are aware that engagement with some service users and carers took place early in the process. However, it is unclear to Healthcare Improvement Scotland – Community Engagement how information on this emerging regional model has been made publicly available and what further opportunities people and communities have had to provide their views on it.

In our considerations, we note that NHS Ayrshire & Arran refers to existing operational challenges and potential benefits of the proposal, which include enhanced safety, sustainability of the service and access for patients.

Next steps

We believe that the engagement activities undertaken to date, the increased level of public awareness and the feedback received from patients and the public will be valuable in moving forward to consultation. The public consultation should meet the requirements as set out in CEL 4 (2010) guidance.

The engagement undertaken by NHS Ayrshire & Arran from January to March 2020 included focus groups, public information, discussions with patients and carers in clinical settings, local media coverage and an engagement survey. In particular, the Community Engagement Directorate highlights the significant number of people who were made aware of the proposal through the range of approaches used by NHS Ayrshire & Arran.

In addition, the engagement survey achieved a good return of 671 responses from geographic areas across NHS Ayrshire & Arran with 69% of respondents being members of the public or patients. The feedback from this exercise has enabled you to identify a number of themes that people felt required further consideration, including:

- Additional travel times for some patients and parking challenges
- Poor public transport links, rurality and increased cost of travel
- Consolidation of inpatient beds for chemotherapy and symptom management/end of life care
- Relationships with clinical and nursing staff and continuity of care

The consultation offers an opportunity to further understand the concerns and issues that people have raised so far and what considerations could be taken to respond to these points. With transport and access identified by approximately 70% of the 671 respondents, a focus of the engagement during this consultation should be targeted to understand what the concerns are from the geographic areas; what potential mitigating steps are possible; and, how these could potentially be delivered in any future model.

We are aware that some people did not appear to fully understand the proposals when made public, with perceptions that Station 15 at University Hospital Ayr may close. The consultation materials will offer an opportunity to further articulate the reasons for change and describe the proposed model. We are aware that some materials were produced in the latter parts of the recent engagement to support these. It will be important to use this type of material and build on it.

In proceeding to public consultation, NHS Ayrshire & Arran should clearly articulate which aspects of the Chemotherapy Services Review proposal people can influence through their involvement and where there are constraints that may limit choice, ensure the reasons for this are shared. For example, if the West of Scotland regional model places constraints on how chemotherapy services may be delivered within NHS Ayrshire &

[2] https://www.change.org/p/jeane-freeman-msp-ayrshire-post-save-station-15-at-ayr-hospital (29.04.20

3 https://www.change.org/p/nhs-ayrshire-and-arran-retention-of-services-in-station-15-ayr-hospital (29.04.20)

Arran, this should be clearly explained. However, the Board should be informed of, and give genuine consideration, to any alternative suggestions that are put forward as a result of the consultation.

The priority and focus of both the public and the NHS is currently in responding to the COVID-19 pandemic and we recommend careful consideration be given to the most appropriate time to take this consultation forward. We would welcome the opportunity to discuss the practicalities of this with you.

If the proposal changes I would ask that you contact us at the earliest opportunity as it may be necessary to review this position.

Whilst the points raised represent the view of Healthcare Improvement Scotland – Community Engagement, the decision on whether a change to services should be designated as 'major' rests with the Scottish Government.

Please contact me if you wish to clarify any of the above points.

Yours sincerely

Lynsey Cleland

Director of Community Engagement, Healthcare Improvement Scotland

Lynsey.cleland@nhs.net

Appendix 2

Chief Executive and Chair's Office
Eglinton House
Ailsa Hospital
Dalmellington Road
AYR
KA6 6AB

Private and confidential	Date	17th September 2021
Ruth Jays	Your Ref	
Director, Healthcare Improvement Scotland – Community Engagement	Our Ref	HB/mw
	Enquiries to	Margaret Weir
By email only:	Extension	13648
ruth.jays@nhs.scot	Direct line	01292 513648
	E-mail	aa-uhb.ceo@aapct.scot.nhs.uk

Dear Ruth,

I am writing with regard to the implementation of the West of Scotland Systemic Anti-Cancer Therapy (SACT) model in Ayrshire & Arran. This letter provides an update on our position and describes the changes that have been made to service provision over the 18 months due to the Covid-19 pandemic, to ensure patient safety and maintain service delivery over that time. We also outline our engagement work to date and key next steps.

The COVID-19 pandemic required us to rapidly reconfigure services and provide care in new and different ways. During the initial pandemic response it was necessary to adapt very quickly and develop a pathway of care for managing patients with COVID-19 alongside maintaining a level of service for other patients. One service area that we had to review and make interim changes to was our chemotherapy service. The Lead Cancer Team were asked to review chemotherapy delivery to consider whether there were any alternative options that would ensure a high quality, risk stratified and safe service. Following this review a series of relocations were implemented to better protect this group of patients. As a result, Tier 3 low risk day case chemotherapy services relocated from Station 15 University Hospital Ayr (UHA) to Kyle Ward at Ailsa campus Ayr. Complex inpatient activity and non-intensive inpatient chemotherapy was transferred from Station 15 UHA to Ward 3A University Hospital Crosshouse (UHC).

Although the Chemotherapy Service Review for future service delivery had been undertaken in 2019, the relocation of Chemotherapy Services over the past 18 months has happened as a direct result of COVID-19 and as such can be categorised as: "Changes that were introduced on a temporary basis and are now being considered as a longer term or permanent model for service delivery".

These changes had to be implemented very quickly for patient safety and consequently there was limited opportunity to undertake our normal levels of informing and engagement in relation to these changes. Although these interim changes have been brought about through necessity, we recognise the importance of hearing how these changes have affected both staff and patients and we are keen to learn from their experiences as we move towards a more permanent solution. We therefore undertook a planned period of engagement to seek feedback and experience from patients and staff.

To support the relocation of tier 3 low risk chemotherapy services to Kyle Ward at Ailsa Hospital and in line with Healthcare Improvement Scotland - Community Engagement guidance, a period of engagement was implemented to capture feedback and experiences of patients and staff during the initial six week relocation

phase in October 2020. This enabled us to not only better understand any issues and consider how these may be mitigated but also highlighted any benefits to help inform future service planning. Questionnaires were developed for use within Kyle Ward to capture patient and staff views and experience.

The feedback from patients was overwhelmingly positive, with 98% rating their overall experience at the low risk chemotherapy / supportive care unit as very good (2% did not answer) and 100% rating the treatment area as very good. Key themes that emerged reflected ease of access, an increased feeling of safety being separate from the acute hospital and a seamless flow of care provided by friendly and professional staff.

"Everything to do with the new unit is very positive and supportive. The whole environment is, compared to even station 15, exceptional and should remain such. Safety is total.'
"Nice to be away from main hospital as it's more of a homely environment"
"Kyle Ward is far superior to station 11 in all respects"
"The team is caring and reassuring. They are obviously settled in the new environment and enjoying it which passes on to the patient"

The feedback from staff was also very positive and mirrored the patient feedback, which was most encouraging and reassuring. Key themes that emerged included having more space, better staff morale, safer environment out with main hospital and improved patient experience.
"A great and successful response to a difficult and challenging situation caused by these uncertain and unsafe COVID times"
"This change has provided the chemo day unit with a better space to work in"
"I feel that the staff morale has increased working in Kyle"

As we began to remobilise services and reinstate our business as usual, it was agreed to carry out a further period of engagement around tier 3 low risk chemotherapy services delivery in Kyle Ward to reflect current status. This engagement phase took place from 17th May 2021 until the end of June 2021. Questionnaires were prepared based on the previous questions used in 2020 to ensure consistency and enable us to compare and contrast to the previous engagement during 2020. The patient feedback mirrors that of the previous engagement, with 100% of patients rating their overall experience as very good and the same key themes coming through around better parking, safety aspect being located away from main hospital and excellent staff care. This is highlighted in the attached engagement summary.
Following the Chemotherapy Service Review in 2019, the recommendation had been that the tier 2 (high risk day case and inpatient chemotherapy) site should be situated at University Hospital Crosshouse. However, any further development in the implementation of this model was paused in March 2020 due to the pandemic. We therefore took the opportunity to seek some initial feedback from patients, service users and staff on the temporary move of Tier 2 services to University Hospital Crosshouse to enable us to consider how this can be used to inform current practice and future service design. This encompassed Wards 3A, which is a SACT delivery area, and 5E which provides Tier 2 and Tier 3 day case. A summary of this engagement is attached.

We are now in a position to consider making these temporary service changes, brought about by the pandemic, our permanent model for service delivery. The proposal therefore would be that the delivery of SACT should move forward on the basis of all Tier 2 activity being based in UHC and continue to deliver Tier 3 from Kyle Ward at Ailsa Hospital, Ayr. As such, and in line with current national guidance, we will carry out a further period of informing and engagement to ensure that these service change proposals are informed by patients, service users, carers, third sector groups and staff.

We understand that this should be applied in a proportionate and realistic way, recognising that temporary models may not always reflect the previous 'status quo' for the service and therefore there is a 'new starting position'.

To support, plan and implement this crucial period of informing and engagement we have established a small steering group. In line with current guidance our engagement strategy will enable us to understand the impact on those people who currently use the services and how any adverse impacts might be mitigated

moving forward. We will begin by providing feedback to those who have already participated and inform them on the impact and influence this has had. We will inform on progress to date and set out our proposals for future service delivery in a clear and transparent way, so that those providing their feedback and experiences are fully informed and understanding of our position. We will ensure that our engagement approaches are inclusive and utilise a range of methods. As a minimum this will include patient feedback questionnaires for those currently using services, staff engagement sessions and questionnaires and targeted engagement with community and voluntary services and supports.

An informing and engagement plan is being produced which will set out a clear timeline for all activity throughout September and October 2021. Key to this engagement will be collaboration with our staff. We are currently working with our service teams to better understand the skills and capacity for staff to undertake meaningful and inclusive engagement. This will ensure that our staff can be supported and empowered to confidently and effectively engage with patients and their carers and families.

The success of the temporary relocation of Tier 3 services to Kyle Ward has been multifactorial:

- Tier 3 on a non-acute site has not been done before in Scotland - we have created a spacious multidisciplinary environment providing Tier 3 Chemotherapy, including outpatient clinics supporting effective team working and providing a streamlined pathway for patients.
- Focussed use of medical resource and increased flexibility.
- Non SACT supporting treatment in Rapid Assessment.
- This development provides new opportunities:
    - Platform to include Ayrshire Cancer Support (Ayrshire's leading cancer charity) and engage them in care.
    - Give scope for non-medical prescribing clinics to develop which would provide a one stop shop for patients
- Engagement to date has enabled the collection of valuable service user experience and evidence that supports the case for change

Engagement throughout the period of temporary change has enabled the collection of valuable service user and staff experience, particularly in relation to Tier 3 services. Moving through this next phase of engagement we will collect valuable evidence to support a case for change for Tier 2 and inform delivery of our future Chemotherapy Services and ensure the decision making process is well informed by those who use and deliver the services.

We trust that this provides you with an overview of the engagement exercises to date and our planned approach for upcoming engagement to support and inform the proposals for the new model of service delivery. Following the completion of this upcoming engagement we intend use our engagement feedback to inform a decision paper to our November NHS Board meeting (29th November) to seek approval to make these changes permanent.

In the context described above confirming that the relocation of Chemotherapy Services over the past 18 months has happened as a direct result of COVID-19 and as such can be categorised as: "Changes that were introduced on a temporary basis and are now being considered as a longer term or permanent model for service delivery"; we would very much welcome any further guidance you may have to inform and enhance our future engagement.

Yours sincerely

Hazel Borland

Professor Hazel Borland
Interim Chief Executive

Enc. Engagement Summary

Chief Executive and Chair's Office
Eglinton House
Ailsa Hospital
Dalmellington Road
AYR
KA6 6AB

Private and confidential	Date	10th December 2021
Ruth Jays	Your Ref	
Director, Healthcare Improvement Scotland – Community Engagement	Our Ref	HB/mw
	Enquiries to	Margaret Weir
By email only:	Extension	13648
ruth.jays@nhs.scot	Direct line	01292 513648
	E-mail	aa-uhb.ceo@aapct.scot.nhs.uk

Dear Ruth,

Thank you for your response to my letter outlining the changes made to Chemotherapy SACT services in NHS Ayrshire and Arran and update on our current position. Please accept my apologies for the delay in my response to you. As you know we have been experiencing significant system pressures over recent months which have required my attention.

The May 2020 letter that you referred to reflects only a small part of our Chemotherapy Services and the interim changes to make sure our service was safe. As outlined in my previous correspondence, recent service changes have had to be made due to the COVID-19 pandemic response which go beyond the realms of what was discussed previously and have already been implemented.

A series of changes took place across Oncology services to both protect the vulnerable patient group and to support wider site / service COVID-19 plans. As a result, all inpatient Chemotherapy is delivered in Ward 3A University Hospital Crosshouse (UHC). All Tier 2 outpatient Systemic Anti-Cancer Therapy (SACT) is now delivered from one dedicated site at UHC - Ward 5E. Tier 3 outpatient SACT is delivered from a dedicated upgraded unit at Kyle, Ailsa Hospital, within University Hospital Ayr (UHA) grounds. We continue to deliver some Tier 3 in ward 5E UHC - for those for whom travel to Kyle Unit may be more difficult or impractical. Patients who are equidistant between Ailsa Hospital and University Hospital Crosshouse will be offered the opportunity to attend Kyle Chemotherapy Unit in Ailsa Hospital. Reflecting on these changes to our SACT delivery model, they clearly correlate with our pre-pandemic intentions and the requirements of the WOS SACT model.

In our correspondence in May 2020, it was agreed that we would not go out to consultation as this was not appropriate or best practice due to the pandemic.

Following the Chemotherapy Service Review in 2019, associated engagement and EQIA activity, it was recommended that our Tier 2 ward should be located at Crosshouse. It was also indicated in the recommendations that development of further Tier 3 delivery sites should be considered and the relocation of Station 15 to Kyle Unit is the first of these sites. Therefore, this does not differ from the proposal we developed previously and engaged with people on in early 2020.

Subsequently we are able to deliver an appropriate, safe and patient centred service model for our SACT delivery in Ayrshire and Arran which is to:

- develop a pathway of care for managing patients with COVID-19 alongside maintaining a level of service for other patients;

- continue to treat as many patients as possible as close to home as possible, where this can be done safely;
- provide a single dedicated inpatient ward delivering all inpatient chemotherapy;
- provide a dedicated unit for Tier 3 SACT delivery which is located out with the acute hospital and therefore much safer for patients and staff and provides better parking and accessibility.

Other significant changes to the way we deliver our service due to the pandemic have provided mitigating steps in relation to key points highlighted within the May 2020 letter. For example, patients now receive their initial assessment via Near Me or in person at the site closest to their home, where this can be done safely. Patient pathways, including the use of Near Me, have been redesigned to minimise clinical risk – and are additionally helping to minimise travel, parking and access issues for patients. This has helped to mitigate these issues which were all raised in our engagement with patients and the public in early 2020. The use of virtual visiting methods using iPads in our in-patient ward has also mitigated this anxiety raised during our earlier engagement.

As outlined in the Engagement and participation in service change and redesign in response to COVID-19 Guidance note - November 2021, the urgent changes we have had to implement for our chemotherapy services over the past 20 months as a direct result of COVID-19, are categorised as: “Changes that were introduced on a temporary basis and are now being considered as a longer term or permanent model for service delivery”.

Therefore we have followed the suggested 5 steps within this guidance to inform what engagement activities need to take place. Due to the pace of the required changes and COVID-19 restrictions, there was no scope to engage appropriately or meaningfully with patients or public initially. However we feel that the extensive engagement that was previously undertaken from January - March 2020 provided a meaningful opportunity for people and the feedback from this engagement exercise has been collated and used to inform service planning and current engagement activity.

We understand that service change proposals should be informed by patients’, service users’, carers’ and third sector groups’ lived experience. As such we feel we have engaged as appropriately as has been possible, with the ongoing restrictions and pressures due to the pandemic. Over the past 12 months we have engaged with patients and staff on both Tier 2 and Tier 3 sites to gather feedback and lived experience on these changes, as outlined in my previous correspondence. This has enabled us to gather valuable service user experience and evidence that supports the case for change.

As per your response, the Engagement EQIA was updated in 2020 to reflect the previous engagement exercise. However, an updated specific EQIA pertaining to these current service changes has since been produced. I attach this specific EQIA for this current proposal, along with the current informing and engaging plan.

In order to ensure that we continue to plan for the future recovery of our services we will continue with our engagement plan and intend to submit a proposal paper to our NHS Board in March 2022 to seek approval to make these changes permanent.

Yours sincerely

Hazel Borland

Professor Hazel Borland
Interim Chief Executive

Enc. Chemotherapy Services Engagement Plan 01.12.2021 EQIA - Redesign of Systemic Anti-Cancer Therapy (SACT) delivery

Healthcare Improvement Scotland | Community Engagement

By e-mail to:

Professor Hazel Borland
Interim Chief Executive
NHS Ayrshire & Arran
Chief Executive and Chair's Office
Eglinton House, Ailsa Hospital
Dalmellington Road, AYR KA6 6AB

23 December 2021

Dear Hazel

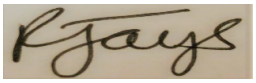
West of Scotland Systemic Anti-Cancer Therapy (SACT) model

Thank you for your letter of 10 December, with the additional information requested.
We understand the unique operational arrangements that have been required to be put in place in response to the COVID pandemic.
To ensure our advice on engagement and consultation continues to be robust and proportionate, our approach will be to consider each NHS Board's proposals on a case-by-case basis in line with national guidance and *Healthcare Improvement Scotland – Community Engagement*'s COVID-19 guidance note (November 2021).
Our next step is for these changes, developed in response to COVID, to be considered by our Service Change Sub-Committee and the Scottish Health Council Committee, which meet in January and February 2022 respectively. The committees will reconsider their view in light of the additional information you have provided and form a view about whether or not making these temporary changes a permanent service model continues to meet the threshold for major service change as already intimated in our letter of May 2020. We will inform you of the conclusions of these discussions as soon as is practically possible afterwards.
There are specific requirements set out in 'Planning with People' for those changes that are considered 'major' and this may inform your next steps e.g. governance and proportionality.
In the meantime, to ensure your engagement process is open, robust and meets with national guidance, we reiterate the recommendations made previously by us in our letter of May 2020:

- Involves people and communities in the engagement planning group (e.g. Chemotherapy Service Review Patient and Public Reference Group) to inform and provide support to the communications and engagement plan – this may include methods of engagement and the development/review of communication materials.
- Prepares and makes publicly available information that clearly sets out the reasons for change and describes the proposed/ interim model, benefits and potential constraints e.g. explain areas that you believe cannot be influenced and why. Information should make clear the process you have followed to date and how people's feedback from previous engagement exercises has been taken into account. You should also make clear how a decision will be made.
- Provides sufficient opportunities for people to ask questions and provide feedback on the proposed/ interim arrangements. This will also enable you to capture details and suggestions for potential improvement to the current interim arrangements.
- Makes the equality impact assessment publicly available and engages with people and communities on whether the proposed actions are sufficient in helping to mitigate potential adverse impacts e.g. transport and travel.

We note you plan to take an engagement report to your Board meeting in January 2022 – if this remains the timescale you are working to, we would be pleased if you would share our letter of May 2020 together with

this letter to ensure NHS Ayrshire and Arran's Board members are sighted on current discussions and timescales.
Please get in touch if you would like to discuss.
Kind regards



Ruth Jays, Director
Healthcare Improvement Scotland – Community Engagement

Healthcare Improvement Scotland | Community Engagement

Meeting:	Service Change Sub-Committee
Meeting date:	27 January 2022
Title:	NHS Ayrshire & Arran: Review of Chemotherapy (SACT) Services
Agenda item:	2.2
Responsible Executive/Non-Executive:	Ruth Jays, Director of Community Engagement
Report Author:	Louise Wheeler, Service Change Advisor

1 Purpose

To provide the Service Change Sub-Committee with an opportunity to discuss the recent proposed service changes by NHS Ayrshire and Arran in relation to the Review of Chemotherapy (SACT) services and make recommendations to the Scottish Health Council meeting in February 2022.

This is presented to the Committee for:

- Discussion and recommendations

This paper relates to:

- Proposed service changes

This aligns to the following HIS priorities(s):

- Access to care
- Safe, reliable and sustainable care

2 Report summary

This paper provides an SBAR on the Review of Chemotherapy (SACT) Services being undertaken by NHS Ayrshire & Arran. It presents the findings from HIS – Community Engagement and recommendations on the next steps.

3 National Guidance

3.1 Our deliberations are in line with current Planning with People guidance.

6 Recommendation

- **Service Change Sub-Committee are asked to make a decision regarding the proposed service changes and make recommendation(s) to Scottish Health Council.**

Healthcare Improvement Scotland | Community Engagement

SBAR- NHS Ayrshire and Arran: Review of Chemotherapy (SACT) services

Situation

NHS Ayrshire and Arran has made interim changes to its inpatient, day case and outpatient Chemotherapy (SACT) services in response to the COVID pandemic. These interim changes have been in place for around two years. It plans to present an engagement report to Board members in March 2022, with a proposal to make interim arrangements to the service model permanent.
On 10 December 2021, NHS Ayrshire and Arran shared the additional information previously requested by *Healthcare Improvement Scotland – Community Engagement*. The updated EQIA also included data on the number of patients affected by the proposals and the engagement and communications plan.
Scottish Health Council Service Change sub-committee members are asked to review and consider whether it feels substantive evidence has been provided, taking into account the wider context of the pandemic, to support a change in the view given in May 2020 on the impact of proposed change i.e. major, and expectations regarding next steps.

The Director of the Community Engagement Directorate wrote to NHS Ayrshire and Arran on 23 December 2021 (appendix 1) summarising engagement advice previously given (to further inform their draft engagement and communications plan) and outlining our governance process.

Background

Chemotherapy services have been under review in NHS Ayrshire and Arran since 2014.
During 2017-18 a new West of Scotland Regional Model was developed, supported by service user and carer engagement.

Tier 1 Cancer Centre, population 2.7 million, one for West of Scotland	• Complex treatments • Treatment for rare cancers • Chemoradiotherapy • Phase 1 and 2 clinical trials
Tier 2 Cancer Unit, population 300,000 to 600,000 4-5 in West of Scotland	• Multidisciplinary teams (consultant and Non-Medical Prescriber) • Treatment for main tumour types and some less common cancers • Long infusions (more than 4 hours) • Phase 3 clinical trials
Tier 3 outreach centres, population 150,000 to 300,000 10 to 15 in West of Scotland	• Nurse led service • Simple short infusions • Subcutaneous treatments • Supportive medicines (for example, bisphosphonates)
Community	• Dispensing of selected oral SACT • Primary care shared care • Delivery of supportive medicines • Community staff delivery

In 2020 NHS Ayrshire and Arran proposed and undertook a 2 month period of engagement with patients and the public on the following arrangement for Chemotherapy services, which would aim to align with the regional model.

- The Tier 2 cancer unit at University Hospital Crosshouse (also serving as a Tier 3 outreach facility for its local catchment area)
- Tier 3 outreach facility provided at University Hospital Ayr
- Eight inpatient chemotherapy beds transferred from University Hospital Ayr and consolidated at University Hospital Crosshouse

- Some specialist services and treatments may be repatriated from the Tier 1 regional cancer centre (in Glasgow) to NHS Ayrshire & Arran.

Based on the information provided, *Healthcare Improvement Scotland – Community Engagement* gave its view, in May 2020, that the proposed changes met the threshold for major service change and outlined next steps to be taken forward. However, due to the operational pressures created by the COVID pandemic, public consultation was not taken forward at that time.

Analysis

NHS Ayrshire and Arran has stated interim arrangements are wider than those proposed in Spring 2020: "*recent service changes have had to be made due to the COVID-19 pandemic response which go beyond the realms of what was discussed previously and have already been implemented*". However it also acknowledges "*these changes to our SACT delivery model, (they) clearly correlate with our pre-pandemic intentions and the requirements of the WOS SACT model*".
The sequence of changes made to chemotherapy services in response to the COVID pandemic, with a focus at University Hospital Ayr (UHA), is summarised in Appendix 1, page 20 of the EQIA papers.
Data is also included in the EQIA paper (pages 4-5) to show the number of people potentially impacted by the changes of where services are delivered from.
All patients receive their first two treatment cycles at University Hospital Crosshouse (UHC). If there is no adverse reaction, and it is safe to do so, the patient can receive further treatments at UHC or UHA.
Figures indicate that around 150-160 patients from the UHA catchment area will travel to UHC for SACT services per year, with each person requiring on average two trips over their treatment course (each patient receives on average 7.3 episodes of treatment). With regards to haematology and oncology inpatients, there are 3-4 patients a day at ward 3A UHC who would have previously been treated at UHA (it is not clear how many patients are treated per year).
NHS Ayrshire and Arran refers to its public engagement undertaken January-March 2020 and the key themes identified in the feedback from over 670 people. These themes were

1. Travel impact on patients: 70%
2. Parking: 1%
3. In-patient beds for chemotherapy and symptom management or end of life care: 1%
4. Relatives/carers: 1%
5. Relationships and clinical expertise: 7%
6. Other (e.g. communication and infrastructure): 14%

The Board considers that measures put in place help to mitigate against the main points of the Community Engagement Directorate letter (May 2020) including:

- patients receive their initial assessment via Near Me or in person at the site closest to their home, where this can be done safely
- patient pathways, including the use of Near Me, have been redesigned to minimise clinical risk – and additionally helping to minimise travel, parking and access issues for patients
- the use of virtual visiting methods using iPads in our in-patient ward

Since the public engagement activity (January-March 2020), NHS Ayrshire and Arran has surveyed over 150 patients in its outpatient and inpatient service areas over the past 18 months to gather their views on the interim service configurations. Feedback (particularly in relation to the person's overall experience and in comparison with previous cancer clinical settings attended) appears very positive.

The EQIA states that approximately 10% of patients attending chemotherapy services travel by public transport and these patients could be disproportionately disadvantaged in terms of increased travel to either site depending on where they live. To assist with chemotherapy patient access to the single Tier 2 site and to help mitigate against additional patient travel, NHS Ayrshire & Arran proposes:

- Providing a limited number of dedicated car parking spaces for use by volunteer driver services transporting patients to chemotherapy services.
- Ensuring patients are given information about access to Ayrshire Cancer charities that are committed to providing transport locally for people to attend appointments and treatment at both hospitals.

Given that the interim arrangements have been in place since March 2020, it is not clear if NHS Ayrshire and Arran has evaluated how effective these mitigating measures, especially with regards to travel and transport, have been in supporting patients to access care.

Recommendations

- Service change sub-committee members are asked to review the additional information provided and consider whether they feel this is sufficiently substantive to revisit the view given on 12 May 2020 (appendix 2) on major service change.
- The service change sub-committee to clearly articulate the reasons for how it has arrived at its view.
- Taking into account the current context, consider the engagement and communication actions previously identified by *Healthcare Improvement Scotland – Community Engagement* to ensure these fully meet expectations, in line with national guidance.
- Recommendation to be made to the Scottish Health Council meeting on 17 February 2022 for consideration and approval. Advise NHS Ayrshire and Arran of the outcome of the discussion.
- Agree that service change proposals by NHS Boards and Integration Authorities should be reviewed by the Community Engagement Directorate on a case-by-case basis taking into account Planning with People and our COVID guidance (November 2021).

EQUALITY IMPACT ASSESSMENT

This is a legal document stating you have fully considered the impact on the protected characteristics and is open to scrutiny by service users/external partners/Equality and Human Rights Commission

If you require advice on the completion of this EQIA, contact elaine.savory@aapct.scot.nhs.uk

'Policy' is used as a generic term covering policies, strategies, functions, service changes, guidance documents, other

Name of Policy	Redesign of Systemic Anti-Cancer Therapy (SACT) delivery in response to the COVID-19 pandemic		
Names and role of Review Team:	Peter MacLean, Clinical Director - Cancer Services / Consultant Haematologist Caroline Rennie, Macmillan Nurse Consultant Nicky Batty, MacMillan Practice Development Facilitator - Acute Cancer Seonaid Lewis, Engagement Manager Elaine Savory, Equality and Diversity Adviser	**Date(s) of assessment:**	Initial assessment - 21/10/21 The EQIA is updated on an ongoing basis.

SECTION ONE AIMS OF THE POLICY

1.1. **Is this a new or existing Policy :** New – temporary changes to service delivery due to the COVID-19 pandemic

Please state which: Policy ☐ **Strategy** ☐ **Function** ☐ **Service Change** ■ **Guidance** ☐ **Other** ☐

1.2. What is the scope of this EQIA?

NHS A&A wide ☐ **Service specific** ■ **Discipline specific** ☐ **Other (please detail)**

1.3a. What is the aim?

The aim of this service change is to provide a safe, high quality and risk stratified service for SACT delivery in Ayrshire and Arran due to the impact of the COVID-19 pandemic.
The aim is to safeguard patients receiving Systemic Anti-Cancer Therapy treatment and oncology staff during the COVID-19 pandemic and to identify the most appropriate model of service delivery to ensure a safe, high quality and risk stratified service moving forward.

1.3b. What is the objective?

During the initial pandemic response it was necessary to adapt very quickly and develop a pathway of care for managing patients with COVID-19 alongside maintaining a level of service for other patients. At this time the Lead Cancer Team were asked to review the delivery of Systemic Anti-Cancer Therapy

(SACT) and consider whether there were any alternative options that would ensure a high quality, risk stratified and safe service - and additionally to release in-patient bed space to be used for dedicated COVID-19 wards.

Following this review a series of environmental moves were implemented across Oncology services to both protect the vulnerable patient group and to support wider site / divisional COVID-19 plans. As a result, in a series of steps over several months, all inpatient activity and high risk (Tier 2) outpatient chemotherapy *(for the first 2 cycles, if no reactions they can continue at the patients local oncology unit i.e. Kyle Unit or ward 5E)* was moved from University Hospital Ayr (UHA) to University Hospital Crosshouse (UHC). Within UHC outpatient chemotherapy moved from ward 3C to ward 5E. With regard to UHA low risk (Tier 3) outpatient chemotherapy relocated from Station 15 (UHA) to Kyle Ward, Ailsa campus Ayr, while high risk outpatient chemotherapy (Tier2) was initially hosted within the Medical Day Unit (UHA) prior to transfer to ward 5E (UHC). (*Appendix one - relocations summary table)*

Within cancer services there are 3 tiers of treatment, as well as provision of inpatient service:

Tier 1: Highly specialised treatments that are provided on West of Scotland basis at the Beatson West of Scotland Cancer Centre
Tier 2: Higher risk of patient having adverse reaction, and in some cases longer duration of treatment. A typical regime is often Tier 2 for the first 2 cycles when the risk of reaction is highest. Tier 2 treatments are delivered on an acute hospital site with access to the full range or resuscitation and medical support services.
Tier 3: Lower risk treatments, with patients less likely to have adverse reaction. A patient is usually moved to Tier 3 if the first 2 treatments with a specific drug or regime have been uneventful at Tier 2. Tier 3 treatments can be delivered on a site where a more limited clinical support is available as they have been deemed low risk of adverse reaction.

The West of Scotland Cancer Network (WoSCAN) SACT future service delivery plan was endorsed by Boards within the network, including NHS Ayrshire and Arran. Our local strategy is to implement this plan within Ayrshire and Arran to support safe and effective care delivery for patients and staff, as close to home as possible, where this can be done safely. The plan is based upon a tiered model of care with one Tier 1 centre for the whole of West of Scotland region, Beatson West of Scotland Cancer Centre, one Tier 2 site within Ayrshire and Arran and as many Tier 3 sites as needed.
Although the Chemotherapy Service Review for future service delivery had been undertaken in 2019, the urgent changes to chemotherapy services that have been implemented over the past 18 months have taken place as a direct result of COVID-19 and as such are categorised as: *"Changes that were introduced on a temporary basis and are now being considered as a longer term or permanent model for service delivery" (https://www.hisengage.scot/media/1732/service-change-engagement-and-covid-guidance-note-jul20.pdf).* Any further developments or recommendations that had emerged from the review were paused due to the onset of the pandemic.

1.3c. What are the intended outcomes?

The intended outcome is to deliver the most appropriate, safe and patient centred service model for SACT delivery in Ayrshire and Arran.

- To develop a pathway of care for managing patients with COVID-19 alongside maintaining a level of service for other patients.
- To assess the impact and benefits of the service changes that have had to be implemented due to the COVID-19 pandemic.
- To continue to treat as many patients as possible as close to home as possible, where this can be done safely.
- A single dedicated inpatient ward delivering all inpatient chemotherapy - specialist oncology/haematology medical, nursing and pharmacy support.
- To consider making these temporary service changes, brought about by the pandemic, our permanent model for service delivery.
    - This should be applied in a proportionate and realistic way, recognising that temporary models may not always reflect the previous 'status quo' for the service and therefore there is a 'new starting position'.

During Covid-19 Phase 1, cancer services were reviewed based on the evidence around clinical risk within each area. Telephone consultations were introduced and are now the new norm, with face to face appointments in selected cases. Enhanced senior referral vetting was introduced to establish which patients required face to face review, with telephone consultations being the norm. Pre SACT clinical assessments were mostly transferred to telephone assessment, but where face to face review was needed this is still delivered on the Hospital site closest for the patient. Most chemotherapy and radiotherapy continued with enhanced precautions for vulnerable, shielding patients.

Current context

- Pre SACT assessment by phone or at closest Hospital site except where the pre-existing service was delivered from a single site.
- All Inpatient SACT delivered at UHC - Ward 3A
- First 2 cycles Tier 2 SACT delivered from one dedicated site at UHC - Ward 5E, if no reactions the patients can then be treated at their local oncology unit i.e. Kyle Unit or Ward 5E
- Tier 3 outpatient SACT delivered from an upgraded unit at Kyle Ward Ailsa campus, within UHA grounds.
- Continue to deliver some Tier 3 in ward 5E (UHC) - for those for whom travel to Kyle Ward may be more difficult or impractical, for example:
    - patients from Arran who travel by ferry to and from treatment in the same day
    - those living closer to UHC who would need to travel further to go to Kyle Ward, Ayr
- Patients who are equidistant between Ailsa Hospital and University Hospital Crosshouse will be offered the opportunity to attend Kyle Chemotherapy Day Case Unit in Ailsa Hospital.
- Telephone assessment and online electronic assessment (My Clinical Outcomes) are currently being used where appropriate to minimise travel for assessment - from the period May 2018 - June 2021, 116 haematology patients have completed 1, 384 electronic assessments.
- Patient pathways, including the use of Near Me / Attend Anywhere, have been redesigned to minimise clinical risk (*Near Me / Attend Anywhere is a safe and secure video calling platform that helps us to offer patients video call access to our services from wherever they are, without the need for travel)*. From the period May 2020 to May 2021, 163 Oncology Services Near Me appointments were undertaken with patients.
- Covid testing pathways in place for pre- in-patient admissions.

1.4. Who is this policy intended to benefit or affect? In what way? Who are the stakeholders?

Patients and their carers/families
Staff (Medical, Nursing, Pharmacy)
Laboratory Services
Supporting clinical services (Radiology, Cardiology, Renal, etc.)
Third Sector / Voluntary Organisations, for example Ayrshire Cancer Support
Supporting clinical services

The following information illustrates the number of patients impacted by these changes.
SACT data 01 January - 30 September 2021

- In the first 9 months of 2021 a total of **817** patients received at least one cycle of parenteral chemotherapy – that is either intravenous or subcutaneous – within a day unit in NHS Ayrshire and Arran. Collectively, these patients received 5978 episodes of treatment - an average of 7.3 each.

- Of the **276** patients from the catchment of Ayr Hospital, **81 (30%)** had at least one treatment at UHC over this period. Of the 1788 treatment episodes provided to these Ayr catchment patients however only **172 (10%)** were delivered at UHC. **This equates to just over 2 treatments at UHC for each Ayr catchment patient for whom this applies.**
- At the same time **132** patients from the UHC catchment area, had at least one treatment delivered at Ayr, with an average of 14% of treatment episodes for UHC catchment patients delivered at Ayr.
- For those **33** patients living equidistant between the 2 hospital sites, 80% of treatment episodes were delivered on the UHA site.

The above data confirms that prior to the transfer of Tier 2 chemo from UHA to UHC in October 2021, there was a significant pre-existing cross site transfer of SACT activity.
Over this period **39** patients received Tier 2 treatment within the Medical Day Unit at UHA, this would swell the number of patients potentially having treatment diverted to UHC from **81 to 120**, roughly a 50% increase.
From this data we would anticipate approximately **150 - 160** patients from the Ayr catchment will require to travel to UHC for SACT per year, with each patient requiring on average 2 such trips over the course of their treatment. This would account for approximately 15% of the total treatments delivered to this patient group.
There are on average **3 - 4** patients per day within the Haematology/Oncology in-patient ward at University Hospital Crosshouse who would previously have been treated within the Haematology/Oncology in-patient ward at University Hospital Ayr.

Of the total activity in 2021 58% of the overall treatment episodes are delivered in UHC and 41% in UHA. This is in keeping with the overall NHS Ayrshire and Arran population split.

Tier 2 and Tier 3 Risk Stratification

The Christie Model of SACT delivery (https://www.christie.nhs.uk/about-us/our-future/innovative-models-of-care) is a tried and tested way of delivering Tier 3 Chemotherapy in a local setting that does not require Acute support. It can be delivered in many settings with examples ranging from outreach community hubs, to Chemotherapy buses. The review group used the guidelines from the Christie model and expanded on these to include haematology regimens following the risk stratification principles when considering what might be possible for Tier 3 SACT delivery within Ayrshire and Arran context and available sites. It was agreed that Kyle ward, Ailsa campus Ayr would be a suitable Tier 3 site and that the Christie Model of SACT would be used initially - in the future new SACT regimens and non SACT therapies could potentially be added in a staged approach, following risk assessment and agreement by the relevant clinicians, as appropriate.

Key benefits of the Tier 2 relocation to Ward 5E (UHC)

- High risk chemotherapy regimens administered on an acute site with easy access to the oncology in-patient ward (ward 5E) where appropriate.
- Patients easily transferred to oncology in-patient ward or appropriate other ward where medical care required.
- Ward 5E separated from haematology out-patient area resulting in reduced footfall compared to the previous 3C location.
- Provides a spacious environment with access to multi-disciplinary team members.

Key benefits of the Tier 3 relocation to Kyle Unit

- Kyle ward provides a spacious environment with areas for multi-disciplinary team members and adjacent out-patient appointment facilities.

- Haematology and Oncology out-patients operating throughout the week.
- Situated out with the acute hospital environment - safer for patients and staff during the pandemic by not having to enter an acute hospital.
- Good parking and accessibility - e.g. easier for those patients for whom walking across UHC carpark and through large hospital building is a challenge.
- Patients easily transferred to UHA if they react to treatment or require medical care.
- Patients who are equidistant between Ailsa Hospital and University Hospital Crosshouse will be offered the opportunity to attend Kyle Unit in Ailsa Hospital.

1.5. How have the stakeholders been involved in the development of this policy?

- Local internal steering group has been established to plan and oversee the service model
- Internal engagement steering group has been established to co-ordinate engagement activity - to seek views and feedback on the changes and impact
- Patient and staff engagement has taken place during these changes to gather feedback on how this has impacted on patients and staff and seek views on the new service model (summarised in below table). This has enabled us to gather valuable service user experience and evidence that supports the case for change.

Timeline	Engagement Activity	Summary
Oct 2020	• A period of engagement took place with staff and patients to gather views and feedback on the relocation of Tier 3 service delivery from Station 15 (UHA) to Kyle Ward (Ailsa campus, Ayr)	• Questionnaire developed to seek views from patients and staff - *engagement opportunities and methods were somewhat restricted due to the pandemic.*
May / June 2021	• Further engagement exercise undertaken on the relocation of Tier 3 chemotherapy service delivery, to reflect current status. • Engagement with staff and patients to gather views and feedback on the relocation of Tier 2 services to University Hospital Crosshouse - this encompassed Wards 3A, which is a SACT delivery inpatient area, and 5E which provides Tier 2 and Tier 3 day case.	• Questionnaires were based on the previous questions used in 2020 to ensure consistency and enable us to compare and contrast. • In total across the three ward areas we received 150 completed patient questionnaires and 27 staff responses.

- An engagement exercise with patients and staff is underway (*Oct 2021*) to gather views and seek feedback to help inform NHS Ayrshire and Arran Board when considering the proposed service model - please see attached engagement plan. *(Appendix 2)*
- Engagement has taken place with third sector organisations who provide patient support and transport, to ensure that they are informed and involved in service planning and engagement.
- Extensive engagement with staff, patients, service users and the population of NHS Ayrshire & Arran took place January - March 2020 as part of the Chemotherapy Service Review for future service delivery - the outputs from this engagement exercise have been used to inform service planning and further engagement activity.

1.6 Examination of Available Data and Consultation - *Data could include: consultations, surveys, databases, focus groups, in-depth interviews, pilot projects, reviews of complaints made, user feedback, academic or professional publications, reports etc.)*

The decision to implement this service change has been driven by the need to provide a safe, high quality and risk stratified service for SACT delivery in Ayrshire and Arran in line with the impact of the COVID-19 pandemic. Consideration has also had to be given to ensuring appropriate accommodation provision for patients who are immune-compromised and therefore at a higher risk of implications of COVID-19.

Name any experts or relevant groups / bodies you should approach (or have approached) to explore their views on the issues.

**Information to be added by EQIA review team (November 2021)*

What do we know from existing in-house quantitative and qualitative data, research, consultations, focus groups and analysis?

**Summary to be added by Engagement Team (November 2021)*

**Information to be added from Chemotherapy Services Review engagement exercise (Jan-March 2020) and recent engagement linked to these current changes – (EQIA review team to action, November 2021)*

What do we know from existing external quantitative and qualitative data, research, consultations, focus groups and analysis?

**Information to be added from Chemotherapy Services Review (EQIA review team to action, November 2021)*

1.7. What resource implications are linked to this policy?

*A SACT service delivery and workforce resource paper is in the process of being finalised for discussion at Health Board level.

SECTION TWO IMPACT ASSESSMENT

Complete the following table, giving reasons or comments where:

The Programme could have a positive impact by contributing to the general duty by –

- **Eliminating unlawful discrimination**
- **Promoting equal opportunities**
- **Promoting relations within the equality group**

The Programme could have an adverse impact by disadvantaging any of the equality groups. Particular attention should be given to unlawful direct and indirect discrimination.

If any potential impact on any of these groups has been identified, please give details - including if impact is anticipated to be positive or negative. *(The Impact Assessment is currently under review and will remain a working document for the duration of the service modelling)*

If negative impacts are identified, the action plan template in Appendix C must be completed. *(under development - EQIA Review Team Dec 2021)*

	Positive impact	*Adverse impact*	*Neutral impact*	*Reason or comment for impact rating*
2.0 All patients during Covid-19	X	X		As a result of the pandemic, changes had to be made to the existing delivery of Chemotherapy services to ensure safe, person-centred care. All inpatient chemotherapy has been transferred to Ward 3A at University Hospital Crosshouse. The first 2 cycles of Tier 2 chemotherapy are delivered in ward 5E at UHC, following this if there have been no reactions the rest of the treatment can be delivered at the patient's local oncology unit i.e. Kyle Unit or Ward 5E. Whilst this may require extra travel for some families or carers, for others it does not. Due to the no visiting clause in response to the pandemic, there is no additional adverse impact on visitors having to travel at this time. For those patients in receipt of oral chemotherapy, a volunteer group was established and provided door to door delivery of all oral chemotherapy.

2.1. Age • Children and young people • Adults • Older People	X	X X X	X X X	Young people under the age of 16 will not be affected by this service change. Young people 16-25 will be given the choice of whether to attend Glasgow or local Tier 2 or Tier 3. Depending on the diagnosis, young people may require to continue to attend Glasgow. For those who have a choice, we would encourage the young acute leukemic patients to attend Glasgow for treatment. The centre is purpose built for teenage/young adult with targeted support groups and activities. The first 2 cycles of Tier 2 is now delivered from UHC, following this if there have been no reactions the rest of the treatment can be delivered at the patient's local oncology unit i.e. Kyle Unit or Ward 5E. This will have an adverse impact on travel and transport for those adults who live further away but not so for those within the UHC catchment. Those patients living in the remoter parts of the UHA catchment will be most impacted, as this will involve longer travel times. It is important to recognise that the primary purpose of designating a treatment Tier 3 is to allow treatment closer to home, however we do have to note that we are constrained in choice of location and that clinical safety must take priority over convenience. As tier 3 is currently delivered from both acute hospital sites, there is scope for some patients to be given the opportunity to attend Kyle Unit or Crosshouse, if this is equidistant for the patient, clinically appropriate and patient preference - thus mitigating adverse impact of further travel. For some older people, travelling for treatment could potentially result in individuals having to be transported using a local cancer charity/transport support provider and therefore at this current time there is no scope for an individual's partner or carer to travel with them due to COVID-19 related safety restrictions. However for some older patients who are able to transport themselves or live close to the relevant site, the impact remains neutral.

2.2. Disability (incl. physical/ sensory problems, learning difficulties, communication needs; cognitive impairment, mental health)		X		Patients with a physical disability who require travel support would need to use the Patient Transport service (provided by Scottish Ambulance Service). The service provided by Third Sector Cancer Support organisations cannot accommodate patients who require assistance to get in and out of the car, as this service is provided by volunteers. This could potentially increase the impact on the patient transport service in terms of travel time and capacity. Additionally due to the pandemic volunteer drivers are only allowed to transport one person in the vehicle per journey - so carers and family members would not be able to travel together with the patient. Telephone assessment and online electronic assessment (*My Clinical Outcomes*) and the use of Near Me / Attend Anywhere are currently being used where appropriate to minimise travel for assessment. However, it is recognised that patients with sensory or cognitive needs may not be able to utilise these services. Additionally this is also relies on patients having access to digital methods and appropriate Wi-Fi connection. Existing service provision for patients requiring communication support remains the same.
2.3. Gender Reassignment			X	The impact on gender reassignment patients is neutral.
2.4. Marriage and Civil partnership			X	The impact on marriage and civil partnership patients is neutral.
2.5. Pregnancy and Maternity		X	X	For patients who are pregnant / have very young babies there may be positive impact, as all Tier 2 is now delivered at UHC, where the Ayrshire Maternity Unit (AMU) and Inpatient Paediatric Unit (IPU) are also based. As described above (2.1) there is some choice of attending either acute site for Tier 3 treatment, so the impact would remain neutral.
2.6 Race/Ethnicity			X	The change to this service provision will have no differential impact on someone's race or ethnicity. Existing processes for supporting patients whose first language is not English would still be followed.
2.7 Religion/Faith			X	The change to this service provision will have no differential impact on someone's religious or faith beliefs. Chaplaincy services are available at both sites should any patients require access or support.

2.8 Sex (male/female)		X		A person's sex would have no specific impact due to the proposed service model however the impact on sex for the chemotherapy service provision falls in line with travel and transport implications. According to the 2019 Scottish Transport Statistics, 71% of households had a car or other motor vehicle. Car ownership is more common in: • Higher income households • Remote and rural areas (regardless of income) • Households with more people (e.g. families with children) However, driving is gendered. Simply having a car in a household does not mean that men and women use the car equally, even if both have a driving license. Only 64% of women (compared to 76% of men) have a full driving license. This means that women are more reliant on other modes of transport, particularly public transport. Therefore, there is the potential for travel to be more challenging for women. Mitigating actions are outlined in the provision of transport at section 5?
2.9 Sexual Orientation • Lesbians • Gay men • Bisexuals			X	The change to this service provision will have no differential impact on someone's sexual orientation.
2.10 Carers		X		Staff as carers could potentially be impacted upon in terms of caring responsibilities however this is not specifically due to the service changes. Carers could be adversely impacted if they need to use volunteer transport, as only the patient is able to travel due to current COVID-19 restrictions. The change in service does not affect this as the limitations are due to COVID restrictions.
2.10 Homeless			X	The impact of someone being homeless would be neutral.
2.12 Involved in criminal justice system	X			The local HMP is based on the outskirts of Kilmarnock and therefore, Crosshouse is closer should anyone within the prison require to undergo any treatment. If the individual is still undergoing treatment when they are liberated, travel to the relevant site may be required. However, this will depend on the need for Tier 2 or Tier 3 treatment.

2.13 Literacy			X	The impact of someone's literacy ability would be considered to ensure their understanding of the changes. Existing processes for supporting individuals would be followed.
2.14 Rural Areas	X X	X X	X	Rurality as a whole will have an impact on patient transport and travel time, as some parts of Ayrshire are remote and rural. Rurality affects all parts of Ayrshire with the proportion of the population defined as remote greatest in East Ayrshire and the only significant 'very remote' population being on Arran - therefore the proposal to deliver the first 2 cycles of tier 2 chemotherapy from UHC will have a positive impact for patients living within these locations. Following the first 2 cycles of treatment if there have been no reactions the rest of the treatment can be delivered at the patient's local oncology unit i.e. Kyle Unit or Ward 5E. For patients living in the south of South Ayrshire there will be additional travel required to access Tier 2 treatment at Crosshouse - (Ballantrae to Crosshouse is 48.8 miles which is an additional 15 miles from Ayr). However for other geographical areas, Crosshouse is a closer to home option - for example, patients travelling from the Isle of Arran. For Tier 3 treatment, equidistant patients have an opportunity to select the location closest to home.

2.15 Staff • Working conditions • Knowledge, skills and learning required • Location • Any other relevant factors	X X	X		There is an impact on nursing / clinical staff with the potential for some staff to have additional travel/travel time and also others to have reduced travel/travel time. However this will not be differential in relation to the proposed model of service delivery. Existing organisational change processes will be implemented to ensure staff are not financially adversely impacted, including excess travel costs which would be covered for a 4-year period. This is not an agreed model at present and cross cover is being provided on an adhoc basis. The current adhoc cross cover provides staff from Kyle Unit with opportunities to maintain their Tier 2 and in-patient SACT knowledge, skills and experience. Both Kyle Unit and Ward 5E are more spacious and comply with CEL30 (2012) guidance with regards to spacing between beds/chairs which provides a safer work environment for both patients and staff. The single Tier 2 site at UHC for the chemotherapy in-patient and assessment/ verification service may mean less travel time for some visiting oncologists who previously travelled to UHA. Both sites have pharmacy hubs within the oncology areas MDT now established on Microsoft Teams so can be accessed by staff working from home. Telephone prescribing clinics can be delivered by staff working from home.

2.16. What is the socio-economic impact of this policy / service change? (The Fairer Scotland Duty places responsibility on Health Boards to actively consider how they can reduce inequalities of outcomes caused by socio-economic disadvantage when making strategic decisions)				
	Positive	**Adverse**	**Neutral**	**Rationale/Evidence**
Low Income Poverty		X		We know that women and disabled people are particularly likely to experience poverty (Scottish Government, 2019), and that women and disabled people are less likely to drive and more likely to use buses (Transport Scotland, 2018).
Living in deprived areas		X		

Living in deprived communities of interest		X		Approximately 10% of patients attending chemotherapy services travel by public transport and these patients could be disproportionately disadvantaged in terms of increased travel to either site depending on where they live. To assist with chemotherapy patient access to the single Tier 2 site for chemotherapy in-patient and assessment/verification service and to help mitigate against additional patient travel, NHS Ayrshire & Arran is committed to: • Providing a limited number of dedicated car parking spaces for use by volunteer driver services transporting patients to chemotherapy services. • Ensuring patients are given information about access to Ayrshire Cancer charities that are committed to providing transport locally for people to attend appointments and treatment at both hospitals.
Employment (paid or unpaid)		X		

SECTION THREE	**CROSSCUTTING ISSUES**			
What impact will the proposal have on lifestyles? For example, will the changes affect:				
	Positive impact	*Adverse impact*	*No impact*	*Reason or comment for impact rating*
3.1 Diet and nutrition?			X	The change to this service provision will have no differential impact on exercise and physical activity.
3.2 Exercise and physical activity?			X	The change to this service provision will have no differential impact on substance use.
3.3 Substance use: tobacco, alcohol or drugs?			X	The change to this service provision will have no differential impact on risk taking behaviour.
3.4 Risk taking behaviour?			X	The change to this service provision will have no differential impact on risk taking behaviour.

SECTION FOUR	**CROSSCUTTING ISSUES**
Will the proposal have an impact on the physical environment? For example, will there be impacts on:	

	Positive impact	Adverse impact	No impact	Reason or comment for impact rating
4.1 Living conditions?			X	The change to this service provision will have no differential impact on an individual's living conditions.
4.2 Working conditions?	X			It is anticipated that working conditions will improve for staff as the aim is to provide specialist oncology/haematology medical, nursing and pharmacy support in the right place at the right time, and thus providing safe and effective care for patients.
4.3 Pollution or climate change?	X		X	There is limited impact on pollution or climate change for this proposal. For some people the travel distance will be reduced, whilst for others there may be additional travel. However, increased telephone assessment, online electronic assessment (My Clinical Outcomes) and Attend Anywhere helps mitigate against this for some patients.
Will the proposal affect access to and experience of services? For example:				
	Positive impact	Adverse impact	No impact	Reason or comment for impact rating
Health care	X	X		Having a single in-patient chemotherapy unit at UHC and the first two cycles of Tier 2 chemotherapy, has demonstrable advantages, such as: • Confidence and familiarity with new therapies Co-located services and adjacencies may have an adverse or positive impact: • Inpatient renal services available only on Crosshouse site • 24 hour laboratory services including blood transfusion only available on Crosshouse site. Ayr has reduced hours to access this service. • Interventional radiology is currently only provided on Ayr site.

Social Services				The current support provided by social services has the potential to affect some patients care packages should they require to travel additional distances for care. However, telephone assessment and online electronic assessment (My Clinical Outcomes) can mitigate against this for some patients. We are also mindful that across Ayrshire Wi-Fi connection is variable and therefore, this service may not be available for all. Also see narrative at section 1.2 in relation to ongoing improvement works across Ayrshire.
Education			X	There is no differential impact on education services for this service change.
Transport				This proposal may have an impact on transport needs dependent on the level of care and treatment required by individuals. It is anticipated that some of the impacts of transport will be mitigated through: • better education of the public of what support services are available • use of Tier 3 sites providing closer to home treatment • remote technology To assist with chemotherapy patient access to chemotherapy services and to help mitigate against additional patient travel, NHS Ayrshire & Arran is committed to: • Providing a limited number of dedicated car parking spaces for use by volunteer driver services transporting patients to chemotherapy services. • Ensuring patients are given information about access to Ayrshire cancer charities that are committed to providing transport locally for people to attend appointments and treatment at both hospitals. • Ensuring that public transport information is available from chemotherapy service reception areas. There will also be increased parking requirements. Finding ways to minimise the issue of parking and maximise the use of transport services will be considered further as part of this work. Improved service organisation allows people to plan their time better which may have an impact on travel arrangements locally for family/friends. Through the engagement work, transport and travel for families and carers is a recurring theme and if we move forward with this new model of care, we will consider what solutions can be put in place to minimise this impact.

Housing			X	There is no differential impact on housing services for this service change.

SECTION FIVE	**MONITORING** *(To be discussed and agreed by EQIA Review Team - Dec 2021)*
How will the outcomes be monitored?	
What monitoring arrangements are in place?	
Who will monitor?	
What criteria will you use to measure progress towards the outcomes?	

PUBLICATION

Public bodies covered by equalities legislation must be able to show that they have paid due regard to meeting the Public Sector Equality Duty (PSED). This should be set out clearly and accessibly, and signed off by an appropriate member of the organisation.

Once completed, send this completed EQIA to the **Equality & Diversity Adviser**

Authorised by		**Title**	
Signature		**Date**	

Identified Negative Impact Assessment Action Plan *(To be completed by EQIA Review Team - Nov 2021)*

Name of EQIA:	

Date	**Issue**	**Action Required**	**Lead (Name, title, and contact details)**	**Timescale**	**Resource Implications**	**Comments**

Further Notes:	

Signed:		Date:	

Appendix 1

Changes to Chemotherapy Services on University Hospital Ayr site due to COVID-19

January 2020 – status quo

Intensive Inpatient Chemotherapy	Non-Intensive Inpatient Chemotherapy	Tier 2 (High Risk) Day case Chemotherapy	Tier 3 (Low risk) Day case Chemotherapy	Chemotherapy Prescribing Clinics (Haematology)	Chemotherapy Prescribing Clinics (Oncology)
Station 15(IP)	Station 15(IP)	Station 15(DC)	Station 15(DC)	Station 15	Suites/ Ballochmyle

March 2020 – initial Covid contingency required Station 15 as Covid HDU ward

- Decision to transfer Intensive Chemotherapy to UHC

Intensive Inpatient Chemotherapy	Non-Intensive Inpatient Chemotherapy	Tier 2 (High Risk) Day case Chemotherapy	Tier 3 (Low risk) Day case Chemotherapy	Chemotherapy Prescribing Clinics (Haematology)	Chemotherapy Prescribing Clinics (Oncology)
Ward 3A UHC	Station 11	Medical Day Unit	Medical Day Unit	Ballochmyle	Suites/ Ballochmyle

July 2020 – recovery in Day case activity such that MDU no longer had capacity

- Ballochmyle Suite needed again for usual clinical activity
- Over this period a process of review examined alternative delivery sites including Kyle Unit, but at this point the cost of such a move was prohibitive

Intensive Inpatient Chemotherapy	Non-Intensive Inpatient Chemotherapy	Tier 2 (High Risk) Day case Chemotherapy	Tier 3 (Low risk) Day case Chemotherapy	Chemotherapy Prescribing Clinics (Haematology)	Chemotherapy Prescribing Clinics (Oncology)
Ward 3A UHC	Station 2 *	Station 11	Station 11	Station 11	Suites/ Ballochmyle

* Note - Station 2 accommodated non-intensive patients but was not a chemotherapy delivery area.

October 2020 – further inpatient pressures required the return of Station 11

- Station 2 also became an unsafe site for Haematology/Oncology inpatients in face of rising inpatient Covid burden. Decision made to transfer all inpatient Haem/Chemotherapy to UHC
- Kyle Unit quickly refurbished to a standard suitable for chemotherapy delivery
- Over a period of 6 weeks between mid Oct and early Dec 2020 low risk chemotherapy delivery was introduced to Kyle Unit under careful clinical guidance
- Haematology and Oncology teams able to relocate clinic activity to Kyle Unit

Intensive Inpatient Chemotherapy	Non-Intensive Inpatient Chemotherapy	Tier 2 (High Risk) Day case Chemotherapy	Tier 3 (Low risk) Day case Chemotherapy	Chemotherapy Prescribing Clinics (Haematology)	Chemotherapy Prescribing Clinics (Oncology)
Ward 3A UHC	Ward 3A UHC	Medical Day Unit	Kyle Unit	Kyle Unit	Kyle Unit

January 2021 – Tier 3 migration complete and decision made to plan for Tier 2 transfer to UHC.

September 2021 – Moved Tier 2 activity from MDU in UHA to 5E UHC.

Chemotherapy Services

- **Redesign of Systemic Anti-Cancer Treatment (SACT) delivery in response to the COVID-19 pandemic**

Engagement Plan 2021

Document Status:	Draft		Other key contacts
Version Number:	v0.02		Peter McLean, Consultant Haematologist
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Approved By:	Chemotherapy Planning & Oversights Group		Caroline Rennie, Macmillan Nurse Consultant
Date Effective From:	September 2021		
Review Frequency:	Ongoing		
Next Review Date:			

Approvals

Name & Title / Group:	Date:	Version:
Chemotherapy Planning & Oversights Group	01/12/21	0.02

Introduction

During the initial pandemic response it was necessary to adapt very quickly and develop a pathway of care for managing patients with COVID-19 alongside maintaining a level of service for other patients. At this time the Lead Cancer Team were asked to review chemotherapy delivery to consider whether there were any alternative options that would ensure a high quality, risk stratified and safe service.

Following this review a series of environmental moves were implemented across Oncology services to both protect the vulnerable patient group and to support wider site / divisional COVID-19 plans. As a result, in a series of steps over several months, all inpatient activity and high risk (Tier 2) outpatient chemotherapy was moved from University Hospital Ayr (UHA) to University Hospital Crosshouse (UHC). Within UHC outpatient chemotherapy moved from ward 3C to ward 5E. Low risk (Tier 3) outpatient chemotherapy was moved from Station 15 (UHA) to Kyle Ward, Ailsa campus Ayr, while high risk outpatient chemotherapy (Tier2) was initially hosted within the Medical Day Unit (UHA) prior to transfer to ward 5E (UHC).

As outlined in the *Engagement and participation in service change and redesign in response to COVID-19 Guidance note* - July 2020/*November 2021*, the urgent changes we have had to implement for our chemotherapy services over the past 18 months, as a direct result of COVID-19, are categorised as: "*Changes that were introduced on a temporary basis and are now being considered as a longer term or permanent model for service delivery*". We are now therefore now in a position to consider making these temporary changes our permanent model for service delivery. As such and in line with current national guidance, a period of informing and engagement will be undertaken to ensure that these service change proposals are informed by patients, staff and partner organisations.

This engagement plan outlines how we will engage with patients, staff and partner organisations, to gather views and feedback on the changes, proposed service model and the impact it has had on patients and staff.

The purpose of the engagement plan is to:

- ensure that patients, NHS staff and partner organisations are aware of the implemented changes and proposed service model;
- implement an effective and meaningful engagement process to enable patients, directly involved staff and partner organisations to share their views and feedback on the current service and proposed service model; and
- provide NHSAA Board with an engagement report to ensure that this service change proposal is informed by patients, directly involved staff and partner organisations.

Background

The West of Scotland Cancer Network (WoSCAN) Systemic Anti-Cancer Treatment (SACT) future service delivery plan was endorsed by the Boards within the network including NHS Ayrshire and Arran in 2017. Our local strategy is to implement this plan within Ayrshire and Arran to support safe and effective care delivery for patients and staff. The plan is based upon a tiered model of care with one Tier 1 centre for the whole of WoS region, currently Beatson WoS Cancer Centre, one Tier 2 site for Ayrshire and as many Tier 3 sites as required.

Following the Chemotherapy Service Review in 2019 and associated engagement in early 2020, it was proposed that our Tier 2 site should be at UHC. Additionally, it was recommended that development of further Tier 3 delivery sites should be considered. An extensive public engagement exercise was

undertaken from January to March 2020, which included focus groups, public information, discussions with patients and carers in clinical settings, local media coverage and an engagement survey. This exercise provided a meaningful opportunity for people to be involved and provide feedback and lived experience. However, any further development in the implementation of this model was paused in March 2020 due to the pandemic.
Due to the pace of the urgent changes to our SACT delivery, and associated restrictions on engagement methods due to the pandemic, there was no scope to engage appropriately or meaningfully with patients or public at that time. We therefore took the opportunity, when safe to do so, to gather views and feedback from patients and staff on the temporary changes that had been implemented, to enable us to consider and inform current practice and future service design.

Timeline	Engagement Activity	Summary
Oct 2020	• A period of engagement took place in with staff and patients to gather views and feedback on the relocation of Tier 3 service delivery from Station 15 (UHA) to Kyle Ward (Ailsa campus, Ayr)	• Questionnaire developed to seek views from patients and staff - *engagement opportunities and methods were somewhat restricted due to the pandemic.*
May / June 2021	• Further engagement exercise undertaken on the relocation of Tier 3 chemotherapy service delivery, to reflect current status. • Engagement with staff and patients to gather views and feedback on the relocation of Tier 2 services to University Hospital Crosshouse - this encompassed Wards 3A, which is a SACT delivery inpatient area, and 5E which provides Tier 2 and Tier 3 day case.	• Questionnaires were based on the previous questions used in 2020 to ensure consistency and enable us to compare and contrast. • In total across the three ward areas we received 150 completed patient questionnaires and 27 staff responses.

Chemotherapy Services Informing and Engagement Plan

The engagement plan sets out a clear timeline of activity from September 2021 - March 2022. Key to this is collaboration with oncology staff to plan and implement the engagement process. We will ensure that our engagement approaches are inclusive and utilise appropriate methods - as a minimum this will include patient feedback questionnaires for those currently using services, staff questionnaires and targeted engagement with Third Sector partners and organisations.

Key objectives:

- **Understanding impact**: Identify people who currently use the services and those who may have been undergoing treatment during the implementation of the changes and seek their views and lived experiences.
- **Communicating clearly:** Ensure that all informing and engaging communications are clear, transparent and accessible.
- **Engagement process:** Undertake meaningful and inclusive engagement using tailored approaches - this will include a blend of digital and face-to-face engagement, as appropriate.
    - Evaluate the engagement process and use this learning to inform current approaches and to enhance future engagement.

- **Using feedback:** Collate feedback from patients and staff on the service changes and produce a comprehensive engagement report which will be used to inform decision making on the proposed service model.
    - Provide appropriate feedback to staff and patients on the outcome of the engagement and impact of their involvement
    - Use to inform next steps and future service planning

Key stakeholders have been identified as:

- Patients and their family members / carers
- Directly involved staff (e.g. Medical, Nursing, Specialist, Pharmacy)
- Third Sector Partners / Organisations - (*Ayrshire Cancer Support, North Ayrshire Cancer Care, Irvine and Troon Cancer Care*)
- Patient Transport

Engagement Action Plan

Timeline	Activity	Summary	Responsibility	Notes/Update
By August 2021	Establish steering group to plan and oversee engagement.	• Identify key Oncology staff • Develop engagement plan ○ Learning from previous engagement • Prepare questionnaires • Undertake Equality Impact Assessment	Engagement Team	Engagement Steering Group Meetings: • 28/07/21 • 31/08/21 • 28/09/21
30/09/21	Meeting arranged with Staff Side to discuss upcoming staff engagement process.	Initial meeting took place with staff side to discuss approach and function of upcoming staff engagement process - *Claire Ritchie, Ewing Hope, Seonaid Lewis* in attendance.		Agreement to commence with staff engagement questionnaires.
11/10/21 - 04/11/21	**Patient engagement** • Questionnaires disseminated within each of the three ward areas to gather views and feedback from patients • Provide feedback on previous engagement	• Questions developed to gather experiences and views on current service delivery, impact on patients and staff and proposed service model. • Infographics produced to share feedback and information on previous engagement activity within ward areas. NHSAAA Kyle Ward Patient Survey - Oct NHSAAA Ward 3A Patient Survey - Oct NHSAAA Ward 5E Patient Survey - Oct DRAFT Kyle Ward - Patient Feedback Po	Engagement Team / Service Teams	Complete
15/10/21 - 01/11/21	**Staff engagement** • Inform and update directly involved staff on current position, timelines, Board proposal and upcoming engagement • Questionnaire disseminated to all directly involved staff	Engagement questionnaire circulated to core staff teams to seek feedback and views on proposed new service model - via hard copy and electronic link to complete online. • Circulated widely to include specialist nurses, visiting oncologists and pharmacy • Feedback from previous (May/June 2021) engagement made available and summary infographics produced. Staff questionnaire NHSAAA Chemotherapy Servi	Engagement Team / Service Teams	Complete

Timeline	Activity	Summary	Responsibility	Notes/Update
w/c 18/10/21	**Engage with Third Sector -** Community services and supports.	• Ensure third sector and voluntary groups are informed of the changes and proposed service model • Scope out engagement opportunities with third sector organisations • Discuss future engagement targeted around travel and transport	Seonaid Lewis	18/10/21 - Meeting took place with Sandra McCall, CEO Ayrshire Cancer Support - to inform on service model proposal, provide update on engagement process and discuss future engagement opportunities.
w/c 08/11/21	Collate and analyse engagement questionnaire responses. • Pull out key themes • Prepare information to feedback to those that participated - staff and patients	• 34 staff questionnaires and 118 patient questionnaires were completed in this latest **Ward 3A:** 7 staff 22 patients **Ward 5E:** 5 staff 68 patients **Kyle Unit:** 15 staff 28 patients 7 visiting / specialist staff	Engagement Team	Following this engagement activity and collation of questionnaire responses it was agreed to delay the Board proposal paper until early 2022 to allow more time to inform and engage with staff.
01/02/21	Chemotherapy Planning and Oversight Group meeting to review plan and discuss next steps: • Agree revised timelines • Scope out engagement sessions with core staff • Workforce paper to be reviewed and updated • Staff engagement materials to be developed • Provide update to directly involved staff on current position and revised timelines	Propose that further staff informing/engagement activity takes place early January 2022 to ensure directly involved staff are fully informed and involved on the service model and proposal to make current temporary service changes the permanent model for service delivery. Propose that an engagement summery paper will be presented to the Board in January 2022 for noting - setting out the engagement that has been undertaken to date and next steps. Followed by the new service model proposal paper in March 2022. Next steps: • Further informing and engagement with staff to be arranged - Team discussions required to provide further information for directly involved staff • Informing materials to be developed	Chemotherapy Oversights Group	Staff side representative invited to join the Oversights Group. Key actions from meeting: • Weekly group to be established to plan and oversee engagement and service planning • Seonaid to circulate staff questionnaire responses to Oversights Group to inform staff engagement discussion • Engagement Team to prepare patient engagement summary feedback and circulate to group • Update email to be circulated to all directly involved staff

Timeline	Activity	Summary	Responsibility	Notes/Update
December 2021	Provide feedback to staff from the October engagement exercise and update on outcome and next steps. Staff informing and further engagement to be arranged. • Information to be circulated to all directly involved staff • Set out plan for team discussions and information sessions with all directly involved staff Review and update Equality Impact Assessment (EQIA) and Fairer Scotland Duty assessment template	Infographics to be produced to share summary of October questionnaire responses with staff and patients. • Weekly steering group meetings to be arranged • Prepare engagement report and accompanying paper • Prepare patient feedback infographics to display in ward areas • EQIA review meeting to be arranged • Populate action plan template	Service Teams / Engagement Team Engagement Team EQIA Review Group	 Draft EQIA - Redesign of Systemi
By 12th Jan 2022	Finalise engagement report and accompanying paper to present at January Board meeting for noting.		Engagement Team	Board meeting - 31st Jan - submit papers by 12th
January 2022	Staff informing and engagement to take place	Further discussion required - outline to be confirmed	Service Teams / Engagement Team	
March 2022				Board meeting - 28th March - submit papers by 9th
April 2022				

Healthcare Improvement Scotland

Meeting:	**Scottish Health Council Committee**
Meeting date:	**17 February 2022**
Title:	**Guidance for Identifying Major Service Change**
Agenda item:	**4.1 (Reserved Business)**
Responsible Executive:	**Ruth Jays, Director**
Report Author:	**Jane Davies, Head of Engagement Programmes and Louise Wheeler, Service Change Advisor**

1 Purpose

To share with the committee proposed updated guidance for NHS Boards and Integration Joint Boards on identifying Major Service Change.

This is presented to the Committee for:

- Discussion and approval

This report relates to:

- Emerging issue

This aligns to the following HIS priorities(s):

- Access to care
- Safe, reliable and sustainable care

2 Report summary

2.1 This paper provides a brief overview on the review of the current guidance (developed in 2010), feedback from a small number of stakeholders on the current guidance, their suggestions for improvements and recommendations on the next steps. Proposed updated guidance is contained in appendix one.

2.2 Key points

- When an NHS Board is planning changes to or the redevelopment of services it may seek to establish whether the proposed change would meet the threshold for

'major'. This outcome has an impact on the proportionality and process of engagement.

- *Planning with People* describes the process for ascertaining a view on the impact of change i.e. whether it meets the threshold of major as:

  "*NHS Boards can designate proposals as major change themselves, as informed by the Healthcare Improvement Scotland - Community Engagement guidance, and then follow the process detailed below.*

  While Healthcare Improvement Scotland - Community Engagement can offer a view on the designation of specific proposals, if a final decision is required as to whether proposals should be considered major, this should be sought from the Scottish Government".

- This review of the Identifying Major Service Change guidance has involved:
  - Discussion and shared learning within the service change team
  - Updating the text to reflect the language and content of *Planning with People*
  - Including references to reflect the current operating context, for example Integrated Joint Boards, regional and national planning
  - Reviewing previous ~~-~~letters in which HIS-CE~~D~~ set out views on the status of a proposed service change and considering the frequency of issues used to determine whether a proposal met the threshold of major service change
  - Seeking feedback from four NHS boards on the revised draft Identifying Major Service Change guidance (2021). Three of the four NHS boards responded with feedback relating to timescales, subjectivity and process, and impacts of change on other NHS boards.

3 Risk Assessment/Management

There has previously been significant public and political interest in HIS-CE~~D~~'s view on whether a service change proposal meets the threshold for major service change. This view can sometimes be arrived at because although the proposal may not be viewed as 'major' by the board, the impact on some people and communities may be significant. Where a proposal has been determined as 'major' there will be specific requirements of the consultation process, which will be quality assured by HIS-CE and the NHS Board's final recommendation on the way forward will be subject to Ministerial approval. ~~By giving the view that a proposal is major, there are specific requirements on the consultation process, which will be quality assured by HIS-CE*D,* and Ministerial approval required.~~

4 Equality and Diversity

Two of the issues within the guidance which help to determine whether a proposal may meet the threshold for 'major' specifically in relation to equality and diversity are 'Impact on patients and carers', and 'Change in the accessibility of services'. The updated guidance

includes additional text advising that this should be informed by evidence from the equality impact assessment.

5 Route to the meeting

This approach and updated guidance has been considered by the Service Change sub-committee at its meeting on 28 January 2022.

6 Recommendations

1. Review, discuss and approve the updated Identifying Major Service Change guidance for publication (appendix 1)
2. HIS-CE~~D~~ to further develop their approach for giving a view on whether a proposed change meets the threshold for 'major service change'.

Healthcare Improvement Scotland | Community Engagement

Appendix 1

Guidance on Identifying Major Health Service Changes

Introduction

NHS Boards and Integration Joint Boards have a statutory duty[1],[2] to involve people and communities in the planning and development of care services, and in decisions that will significantly affect the operation of those services.

The Scottish Government and COSLA's *Planning with People*[3] guidance sets out how NHS Boards, Integration Joint Boards and Local Authorities should involve people and community groups throughout the development, planning and decision-making process for service change. This is particularly important when a proposed service change will have a major impact. There is a specific requirement for NHS Boards to formally consult on issues which are considered major service change. A full public consultation process will be required for major changes and the NHS Board's final recommendation on the way forward will be subject to Ministerial approval.

This guidance aims to provide NHS Boards with a framework that will assist them in identifying and designating proposals as major service changes themselves. Healthcare Improvement Scotland – Community Engagement (HIS-CE) can provide advice on using this guidance and also offer a view on the designation of specific proposals. If a final decision is required on whether the change proposals should be considered major, this should be sought from the Scottish Government.

NHS Boards' plans should take account of the time required by external bodies, for example Scottish Government, to provide a view on the impact of a proposed change and approval of the process and proposal.

While HIS-CE would not provide a view on whether a change was considered major when a decision had been made by an Integration Joint Board (IJB), t~~T~~his guidance can also be used by ~~Integration Joint Boards~~IJBs ~~to consider~~when considering the potential impact on people and communities of any proposed changes to delegated health services. ~~Healthcare Improvement Scotland – Community Engagement would not provide a view on whether a change was considered major when a decision had been made by the Integration Joint Board.~~

Where a proposed service change would impact on people and communities in another NHS Board area, the Boards concerned should work together throughout the process. The principles and good practice for effective engagement that are covered in *Planning with People* also apply to regional and national planning arrangements.

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[1] National Health Service Reform (Scotland) Act 2004, section 7

[2] Public Bodies (Joint Working) (Scotland) Act 2014 and Planning and delivering integrated health and social care: guidance

[3] Planning with People: Community Engagement and Participation Guidance (2021), Scottish Government and COSLA

There are factors that NHS Boards will consider relevant, and which provide significant drivers for change in care services, including workforce challenges and clinical standards. However, this ~~paper~~ guidance document concentrates on key issues that are relevant for identifying when a proposed service change might be classed as major, rather than on factors which are underlying drivers for the change proposal.

Issues to consider

The following issues should be considered when identifying whether a proposed service change should be regarded as major. They are intended simply to provide a framework for discussion. Please note that these issues are not ranked in order of importance. Some of the issues may appear to overlap, but each should be considered. Any evaluation as to what extent these issues apply will involve a level of subjectivity.

It is intended that NHS Boards and other stakeholders should consider each of the issues in the context of ~~the particular~~ local circumstances. **As a general rule, the more issues that apply, the more likely it is that a service change should be considered as major**. There are prompts under each of the issues. These are not intended to be ~~exhaustive~~exhaustive, and NHS Boards should consider what evidence they have from their engagement to date and whether they are at the right stage in the process to complete the major service change template.

1. Impact on patients and carers

- Consider the number of people that will be affected as a proportion of the local population, and assess the likely level of impact on patients, together with any consequential impact on their carers, for example length of hospital stay.
- Where it appears that a relatively small number of people ~~is~~ are affected, it may still be necessary to consider the level of impact on those individuals, particularly where their health needs are such that they are likely to require to continue to access the service over a longer period of time.
- The ~~particular impact~~impact of the proposed change on people ~~that~~ who may experience discrimination or social exclusion should also be taken into account.

This should be informed by evidence from the equality impact assessment of the proposals and engagement to date with people – for example communities, people with lived experience, staff.

2. Change in the accessibility of services

- Consider whether the proposed change involves relocation, reduction or withdrawal of a service.
- Consider whether the proposed change will result in the closure of a hospital or care facility
- Assess the likely impact of the proposed change in terms of transport (in relation to patients, carers, staff, goods / supplies).

This should be informed by evidence from the equality impact assessment of the proposals, any assessment of transport and access issues, and engagement to date with people – for example communities, people with lived experience, staff.

3. Emergency or unscheduled care services

- Consider whether the proposals involve, or are likely to have a significant impact on, emergency or unscheduled care services, such as Accident and Emergency, Out-of-Hours or maternity services.
- Assess the potential impact on the delivery of services provided by the Scottish Ambulance Service.

This should be informed by evidence from any assessment of transport and access issues and, if applicable, discussions with the Scottish Ambulance Service.

4. Public or political concern

- Assess the likelihood that the proposals will attract a substantial level of public interest or concern, whether across the local population, or amongst particular patient groups or third sector organisations.
- Take account of any views expressed by local health forums, local community groups, community councils or elected representatives.
- Consider any views reflected in the local media or on social media forums, for example, Facebook.
- Are there likely to be complex evidence issues that could be open to challenge or dispute?

This should be informed by evidence from engagement to date with people – for example communities, people with lived experience and staff, on the development of the proposals.

5. Conflict with national policy or professional recommendations

- Do the proposals run counter to national policy, for example, National Clinical Strategy for Scotland, which sets out plans for transformational change (the development of general practice and primary care, hospital networks to deliver services planned at a population level, and realistic medicine)?
- Do the proposals align with specialist clinical group recommendations, for example, National Maternity and Neo-Natal Review?

6. Change in the method of service delivery

- Are changes proposed in relation to practitioner roles?
- Might there be changes in settings, such as moving a service from a hospital to a community setting, or vice versa; or other changes in the care process, for example, moving to 'one stop clinics' for services which have traditionally been provided separately: or moving from an inpatient service to day case?
- Has the proposed change been demonstrated to work in other areas? Identify whether there are examples of working models elsewhere, which would help to inform discussions.

7. Financial implications

- Consider in broad terms the level of investment, or savings, associated with the proposed changes
- Consider assumptions around proposals to disinvest in services
- Take account of the implications for the NHS Board(s) involved and for other agencies e.g. Integration Joint Boards, local authorities.

8. Consequences for other services

- Assess whether the proposed local service change has emerged from a clinical model developed at a regional or national level.
- Consider any cumulative impacts the proposals could have on decisions about the development or location of other services, for example where there are public concerns on local hospital provision in the future.
- Consider how any vacated space may be used to support local people and the community
- Identify whether the proposals will impact on other NHS Boards and Integration Joint Board areas

If the proposals have emerged from a national or regional decision then there should be consideration of the feedback from any local equality impact assessment and engagement to date with people – for example communities, people with lived experience, staff.

Feedback and review

Healthcare Improvement Scotland – Community Engagement welcomes feedback from people who have used this guidance in order that we can assess whether it has been helpful in identifying major service changes. We intend to review this guidance one year after re-issue on the basis of feedback received to decide whether any changes are necessary. Please send your views to:

his.engageservicechange@nhs.scot