NHS Lothian Annual Delivery Plan 2024-25

This document is NHS Lothian's Annual Delivery Plan for the 2024-25 financial year.

A draft of this plan was presented to and agreed at the NHS Lothian Public Board Meeting in April 2024. It was finally agreed – unchanged - at the NHS Lothian Public Board Meeting in August 2024, following feedback from Scottish Government.

There is one formal appendix reflecting the planned care trajectories.

About NHS Lothian

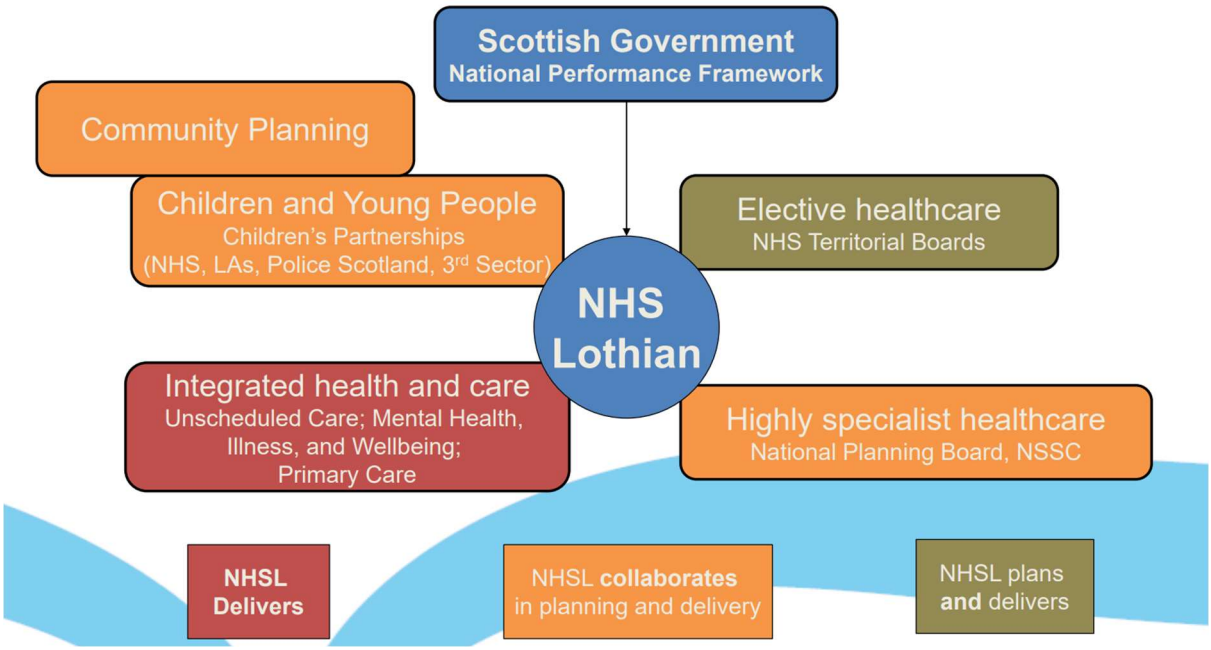
According to the National Health Service (Scotland) Act 1978, as amended, the purpose of NHS Lothian is to plan, commission and deliver healthcare services for the people of Lothian in order to:

- promote the improvement of physical and mental health;
- prevent, diagnose and treat illness

Under the 1978 Act, NHS Lothian is required to deliver its statutory responsibilities within the limits of annual revenue and capital resources allocated to it by Scottish Ministers.

NHS Lothian works closely with the public, its statutory partners, and non-governmental organisations to commission, plan, and deliver services to meet the needs of the population it serves. In particular, the organisation works with four Integration Authorities, known commonly as Integration Joint Boards (IJBs), and collectively these five organisations – East Lothian IJB, Edinburgh IJB, Midlothian IJB, NHS Lothian, and West Lothian IJB – are known as the Lothian Health and Care System (LHCS).

Figure 1, below, shows how NHSL interacts with other bodies for the key elements of its work.



The Lothians have had a rapidly growing population over the last 15 years, with the expectation that this growth will continue over the next ten. During this twenty-five year period, the population of the Lothians will have grown by 23%. It is projected that over the period to 2033 further growth represents 84% of Scotland's expected population growth during this latter period.

During that time, the organisation has expressed its concern that its funding from the Scottish Government has not kept pace with the growth in population. By NHSL's calculations, the gap between money received and money which should have been provided, according to the government's agreed formula, is in the region of £150m over 2012-2022. NHSL understands the

difficulties in shifting resources across as diverse a country as Scotland -that increasing resources for growing areas can only happen by taking from those which are not.

NHS Lothian has approximately 27,000 staff and serves the Lothian population of c. 916,000 people across a diverse geographic area. We also provide specialist services for regional partners, such as specialist cancer treatment, cardiac interventions, or major trauma, for other NHS Boards such as NHS Fife, NHS Borders, NHS Dumfries and Galloway, and NHS Forth Valley. In some cases we also provide specialist services for the whole of Scotland, for example renal transplantation, paediatric epilepsy surgery, or spinal deformity surgery.

NHS Lothian is therefore a complex organisation working within a complex system to deliver on its purpose and the outcomes the Scottish Government wishes to commission.

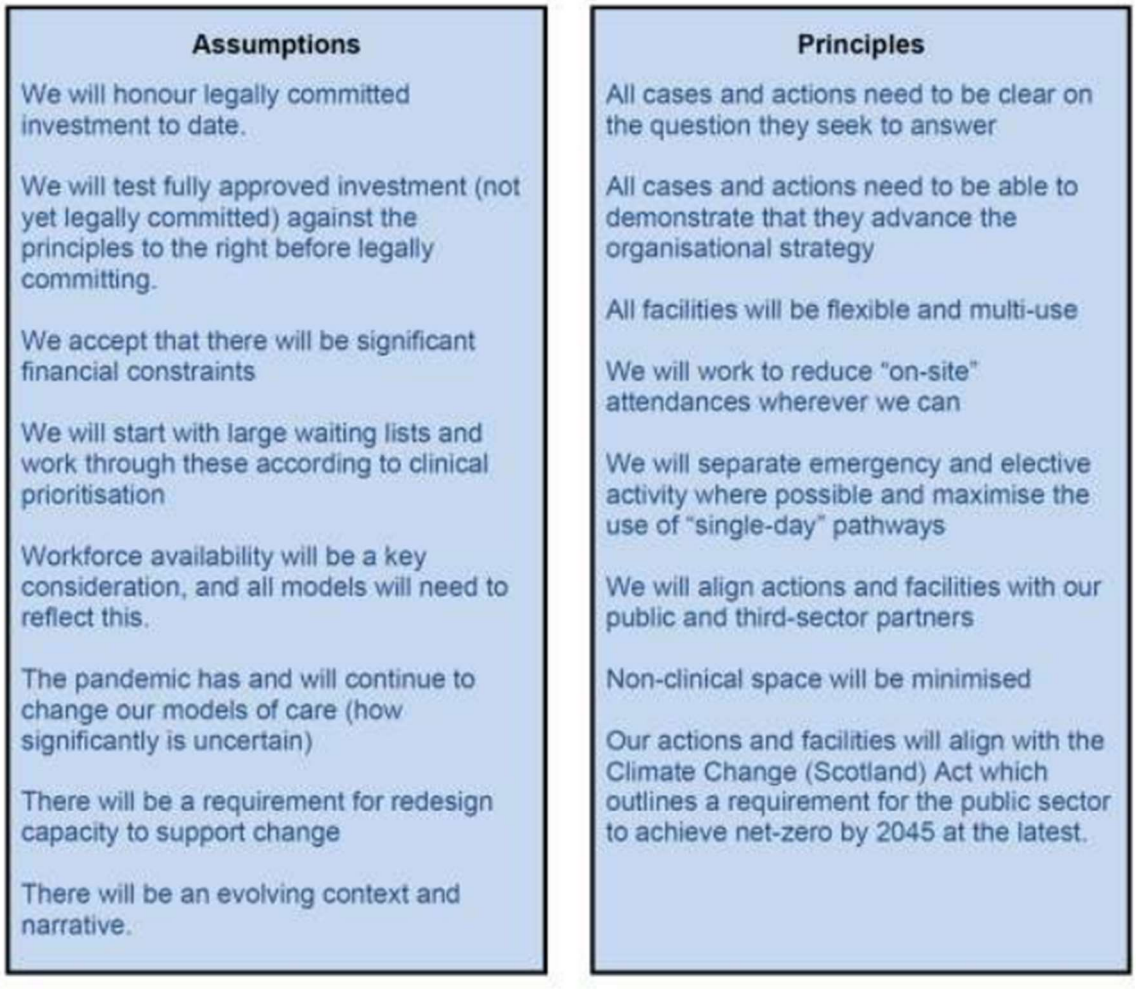
Strategic context

The LHCS adopted the Lothian Stategic Development Framework in June 2022 to guide its activities over the period to 2027-28. The LSDF is built around a vision, a series of principles and assumptions, and six pillars and can be found at Strategic Development Framework – Strategies (nhslothian.scot).

The LSDF Vision

- Citizens live longer, healthier lives, with better outcomes from the care and treatment we provide
- We connect health and social care services seamlessly, wrapping around the citizen in their home
- We improve performance across our system, with better experiences for citizens and those who work for and with us

Our principles and assumptions



NB – in 2024 we have augmented these principles and removed the reference to the COVID-19 pandemic.

Our pillars

- **Working to become an Anchor Institution** – *Being a good employer, a good neighbour, and a good consumer*
- **Children and Young People's Services -** *We see the provision of appropriate support, care, and treatment when required for children as the major investment we can make in the health of the Lothians.*
- **Mental Health, Illness, and Wellbeing** – *working to improve access to outpatient care, and changing our model of residential care so more people can live in their own homes*
- **Primary care services** – *being valued appropriately as one of the key elements in any community*
- **Unscheduled Care** – *working towards delivering the 4-hour Emergency Access Standard and an inpatient bed occupancy of 85%*
- **Scheduled Care** – *meeting prevailing national standards with a particular focus on care for those with cancer, or suspected cancer*

Across these six pillars we have five parameters which are both enablers and constraints for us, allowing us to maximise our resources and ensure that we have robust and reliable plans. These are

- **Revenue**
- **Workforce**
- **Capital**
- **Digital**
- **Environmental sustainability**

In keeping with our statutory requirements – and basic good practice – we place a high premium on our responsibilities in promoting equality and as an anti-racist organisation. We therefore run proposals through our standardised equality impact assessment process, and ensure that we publish an annual report on the LSDF and our progress against it.

Our arrangements for delivering the LSDF

We recognise that we work in a complex system with 5 key stakeholders. As noted in figure 1, above, we have a clear delineation of responsibilities for the key pillars of the LSDF. We therefore have a series of Programme Boards which govern each of our pillars and parameters, and which report into the NHSL Board through the Corporate Management Team and Strategy, Planning, and Performance Committee.

The Programme Boards for Unscheduled Care, Primary Care, and Mental Health, Illness, and Wellbeing (MHIWB) are collaborations between our four IJBs and NHSL, and are charged with planning and delivering the five-year plans for each parameter. The Unscheduled Care and MHIWB Programme Boards are chaired by IJB Chief Officers and have all four IJB Chief Officers as members.

The Programme Boards for Children and Young People, for Scheduled Care, and for Anchor Institutions, all sit within the boundaries of NHSL and are chaired by senior NHSL executives.

It is important, therefore, to remember that the actions and plans described in this document are collaborations in all senses with our partners. NHSL's Corporate Objectives flow from these pillars and parameters. The *LSDF Annual Report* for the 2022-2023 cycle is available at 9.-LSDF-Annual-Report-2022-23-FINAL-DRAFT.pdf (nhslothian.scot)

Financial context

NHS Lothian has a proud history of delivering financial balance in every year of its history.

This is ever more challenging year-on-year, especially given the context of demographic pressure and the 2024-25 financial settlement.

NHS Lothian is again expecting to deliver a balanced outturn in financial year 23/24, delivered without the requirement for additional financial support in the form of Brokerage from the Scottish Government (SG).

The table below sets out the prevailing position for this financial year and shows:-

- The underlying position in relation to NRAC parity across all fourteen territorial boards in 2023/24;
- The requirement for additional brokerage for some boards to achieve a balanced outturn by year end;
- The list of boards that expect to achieve financial balance in 23/24 without requiring additional borrowing in the form of brokerage, whilst also remaining behind NRAC parity:-

NHS Board	2024/25 Total Allocation £m	Distance from NRAC parity %	£m	Brokerage Likely Required to deliver breakeven 23/24	Achieved Balance 23/24 without Brokerage while 0.6% away from NRAC Parity	Achieved Balance 23/24 without Brokerage but better than 0.6% away from NRAC Parity (or above)
NHS Ayrshire & Arran	883.5	-0.6%	(5.30)	Yes		
NHS Borders	260.4	-0.6%	(1.56)	Yes		
NHS Dumfries & Galloway	364.7	1.1%	4.01	Yes		
NHS Fife	829.2	-0.6%	(4.98)	Yes		
NHS Forth Valley	658.9	-0.6%	(3.95)		Yes	
NHS Grampian	1176.4	-0.6%	(7.06)	Yes		
NHS Greater Glasgow & Clyde	2733.1	1.3%	35.53			Yes
NHS Highland	807.1	-0.6%	(4.84)	Yes		
NHS Lanarkshire	1489	-0.6%	(8.93)		Yes	
NHS Lothian	1825.5	-0.6%	(10.95)		Yes	
NHS Orkney	63.6	-0.6%	(0.38)	Yes		
NHS Shetland	62.4	1.9%	1.19			Yes
NHS Tayside	951.2	-0.3%	(2.85)	Yes		
NHS Western Isles	92.9	12.6%	11.71			Yes
Total	**12197.9**					

The table shows that Lothian is one of three territorial boards within Scotland that will achieve targets without brokerage, whilst remaining 0.6% behind NRAC parity.

In the latest budget communication on 19th December 2023 from the SG Director of Finance, boards received confirmation of key pieces of information incl. that there would be no further move towards NRAC parity funding, at this time, to reduce the 0.6% gap. NHS Lothian is continuing the dialogue with SG colleagues to review this at the earliest available opportunity. The ongoing impact of this shortfall for NHS Lothian is c£11m for 24/25, and cumulatively c£160m over the last decade.

As a result of the December budget announcement (where boards also received confirmation of a 0% budget uplift on revenue resources subject to final agreement of pay awards), NHS Lothian faces an unprecedented challenge moving into the new financial year to deliver a breakeven outturn for

2024/25. We have reported a gap in the financial plan for the new year of c£140m currently, before efficiency savings have been identified, contrasting with a starting plan financial gap of £52m in 23/24.

The overall gap that needs to be managed for 24/25 equates to approximately 7% of baseline budget. To address this we have split the challenge into two components:

1. Efficiency savings – an expectation remains that health boards will deliver 3% efficiency in 24/25. Delivering these reflects the maintenance of service delivery, but with reduced costs. With extant infrastructure to support, we will continue to work towards full delivery of this 3% target;

2. Cost Reduction – to close the remaining gap, a further 4% of cost reduction opportunities will be sought across a range of areas for 24/25. This will result in the delivery of lower costs but with the potential impact of **reduced service delivery** in order to reduce spend. Areas of focus include:-

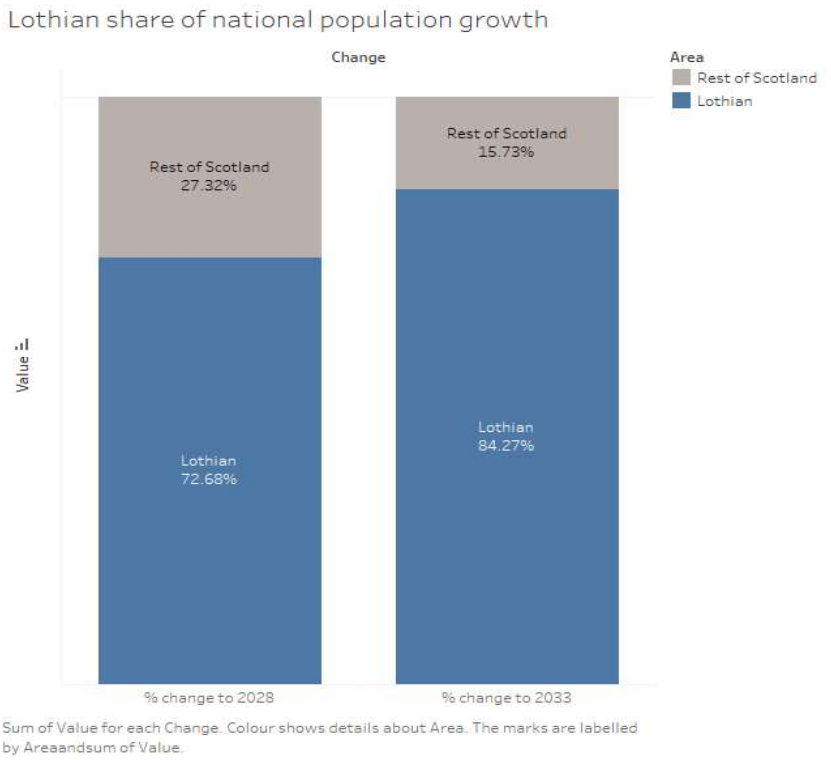
    i. Corporate Controls – including review of new allocations received;
    ii. Pause and Assess – to review current activity, capacity and options for cost reduction;
    iii. Non-pay – including further grip and control initiatives;
    iv. Other bridging actions – to introduce measures in the short term to slow and stop expenditure, or to realise additional income e.g. Asset sales.

We explicitly assume that given NHSL's relatively strong financial baseline, the actions we will have to take will be replicated in all other Boards, and indeed be taken further.

Future Demographic Growth Projections

Whilst 2024/25 presents significant challenge around the delivery of financial balance, we also recognise that demographic change will compound our challenge further.

The chart below highlights the relative growth in population within Lothian compared to growth across Scotland. It highlights that relative to the whole of Scotland, by 2028 Lothian will experience c73% of Scotland's total population growth, and by 2033 this will increase to c84%:



NHS Lothian has already seen a rapidly growing population over the last 15 years, with the additional growth over the next ten years likely to be as above – during this twenty-five year period, the population of the Lothians will have grown by **23%, while its NRAC share remains at 0.6% below NRAC parity.**

As well as contending with the NRAC parity shortfall over the past decade, this largest proportion of population growth will give rise to a disproportionate financial challenge.

This change needs to be considered in the context of ongoing NRAC parity discussions. At present, only two mainland territorial boards are ahead of NRAC parity. Over the next decade, this number will furthermore likely increase, as a result or by-product of relative population decline, leaving those boards remaining behind parity, resulting in NHS Lothian being **further disadvantaged.**

NHS Lothian has expressed its concern that its funding from the SG has not kept pace with the growth in population. By NHS Lothian's calculations, the gap between money received and money which should have been received, according to the government's agreed formula, is in the region of £160m over the last decade (as noted above). NHS Lothian understands the difficulties in shifting resources across Scotland – and that increasing resources for growing areas can only happen by taking from those which are not.

However, population growth in the Lothians has now reached a point where the board believes it is unable to fully carry one of its key statutory purposes, specifically regarding the diagnosis and treatment of illness - the organisation simply does not have enough physical capacity – space – to carry out all of the patient care it needs to deliver its **statutory responsibilities.**

This pressure will be worsened by the number of additional citizens requiring care, and the fact that the Lothians have, by Scottish standards, a relatively young population. As this population ages, the proportionate demand for care will increase.

Capital Investment in NHS Lothian

In addition to constraints applied to Revenue funding, the December letter also stated that capital funding beyond the formula allocation would not be available for a minimum of 2 years. A number of significant projects required to maintain and enhance capacity for NHS Lothian's future (REH, Primary Care schemes, PAEP, Lothian NTC, The Cancer Centre) will now be placed in abeyance **with immediate effect**. This also places a further strain on the formula funding available to support the existing estate, which will now need to be operable for a period longer than previously planned. Further detail on capital investment is provided later in this paper.

The SG funds capital projects over the value of £10m through direct allocations to boards, based on the case presented by each board. During the previous ten-year period NHS Lothian has received the following specific investment;

- £258m for the Royal Hospital for Children and Young People (a regional and national facility)
- £49m for phase 1 of the redeveloped Royal Edinburgh Hospital
- £70m for the redeveloped East Lothian Community Hospital
- £28m for new primary care facilities including the Wester Hailes Healthy Living Centre, Pennywell All Care Centre and Allermuir Health Centre
- £10m for Infrastructure work at the Western General Hospital
- £25m committed investment for the ongoing Oncology Enabling Project at the Western General Hospital
- **Totalling £440m, an average of £44m per year.**

While these are significant and very welcome investments, they are not on the same scale as investments seen by cities like Aberdeen and Glasgow, or boards like Shetland, Dumfries & Galloway, or Fife. And it is worth noting again that outwith the Lothians, and Fife, the population of Scotland is expected to shrink over the next ten years.

NHSL has undertaken intensive, system-wide planning, paying close and careful attention to the needs of its growing and aging population and to the condition of its infrastructure. The LSDF was supported by a clear capital plan for the next fifteen years, which mapped out the physical resources required, including;

- 33 new or replacement general practices
- A new, expanded, Edinburgh Cancer Centre to support the populations of the Borders, Dumfries and Galloway, Fife *and* the Lothians
- A National Treatment Centre at St John's Hospital, Livingston, to meet the First Minister's 2015 pledge to provide additional facilities to focus on scheduled diagnostics and treatment[1]
- Replacement facilities for people with learning disabilities, and mental illness, at the Royal Edinburgh Hospital, to replace the no-longer-suitable buildings there
- A replacement facility for the Princess Alexandra Eye Pavilion.

These investments combine *additional capacity* to treat patients, with *replacement* of old, outdated facilities where backlog maintenance, and fire safety works costs, are prohibitive.

[1] The First Minister's 2015 pledge was originally for a total of 6 facilities across the country, including one at St John's Hospital and one at the Royal Infirmary of Edinburgh.

These investments also support not just in the 'diagnose and treat' part of NHSL's purpose, but the 'prevent' element by:

- Putting nearly £3bn into the economy of the Lothians over a 5-10 year period, creating potentially thousands of new, skilled jobs;

- And supporting research and development industries working in partnership with higher education institutions to develop new treatments.

In a Scottish context, the Lothians, containing the capital city, are the **major growth area** for Scotland's economy. The economic health of the region therefore *drives* Scotland's wealth and tax base. There is a risk that the Lothians will *not* grow at the projected rate as people are put off moving to, or staying in the area due to a lack of access to healthcare. This will particularly impact on families.

It should be noted that the increase in the Lothians population over the last 15 years is the equivalent of 21 new general practices. The lack of capital availability means that the actual number opened is zero.

For clarity, our assumption is that, per previous correspondence and discussion with the Scottish Government, we will receive full funding for any and all RAAC issues which require amelioration. We have identified a significant requirement for this funding to support works in Ward 1 of the Western General Hospital, which provides the South-East of Scotland's Chemotherapy centre.

We will also have to progress our work with the PFI contract related to the Royal Infirmary of Edinburgh. Our work to date shows that we will have to choose a "least worst" option for this, and we will seek to engage fully with the Scottish Government and seek their support to resolve.

Decision-making for 2024-25

As noted above, the Board and the system remain committed to the LSDF as our collective direction of travel. However, it is important to recognise that the journey will take longer than originally anticipated.

It is also important to recognise that during the 2024-25 year our performance will deteriorate in a range of services. We have constructed a governance structure with direct and transparent linkages to our Board – and Boards – which allows us to be clear with the public and stakeholders what the financial challenge means for us.

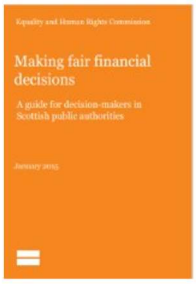
We have augmented our general principles described above with some specific principles for financial decision-making.

- All business units will need to focus on delivering a recurring 3% efficiency in cash terms
- The Corporate Management Team will be responsible for this process, and will present recommendations to the Board of NHS Lothian
- Wherever possible, we'll start with proposals that allow us to take forward a plan
- We will pull together a single financial plan for the whole of the organisation
- We will not start or develop services to meet national policy aims unless funding is clearly and transparently allocated from the Scottish Government, and implementation plans agreed by CMT
- We will make decisions as early as we possibly can in the process, so services have time to implement these
- We will use a standard risk management methodology to assess proposals for resource allocation
- We will continue to focus on the delivery of the LSDF, but accept that where we originally aimed to deliver within five years, this may now be ten years or longer
- CMT will maintain a register of services and service developments that it agrees will improve the quality of care NHSL provides, in line with the LSDF, but that it cannot as yet allocate resources to support implementation of as yet.
- We will work with other health boards to ensure cost reduction programmes minimise differential services across regions (ie post code lottery)
- We have statutory responsibilities around impact assessment and reducing inequalities and these must be part of decision-making.

We are also acutely conscious of our moral, ethical, and legal responsibilities with any and all proposals that we assess, and that these need to be assessed with due regard to principles of equality and equity. The following exhibits demonstrate our approach to this.

Financial improvement will require NHS Lothian to consider unpalatable options and proposals.
The full impact of and risks associated with these proposals need to be understood.

- Cost
- Environmental Sustainability
- **Equality**
- Patient Experience
- Population Health Outcomes
- Performance
- Quality
- Staff Experience
- Unintended Consequences



The public sector equality duty does not prevent you from making difficult decisions….nor does it stop you from making decisions which may affect one group more than another. The equality duty enables you to demonstrate that you are making financial decisions in a fair, transparent and accountable way, considering the needs and the rights of different members of your community.

Making fair financial decisions. A guide for decision-makers in Scottish Public Authorities
Equality and Human Rights Commission
January 2015

Principles

Equality, Fairer Scotland and Children's Rights Impact Assessments help us make good decisions, by making sure we check and develop our proposals so they:

- Do not result in unlawful discrimination
- Help to tackle inequalities and achieve greater equality for people experiencing disadvantage or with different needs
- Uphold and progress children and young people's rights

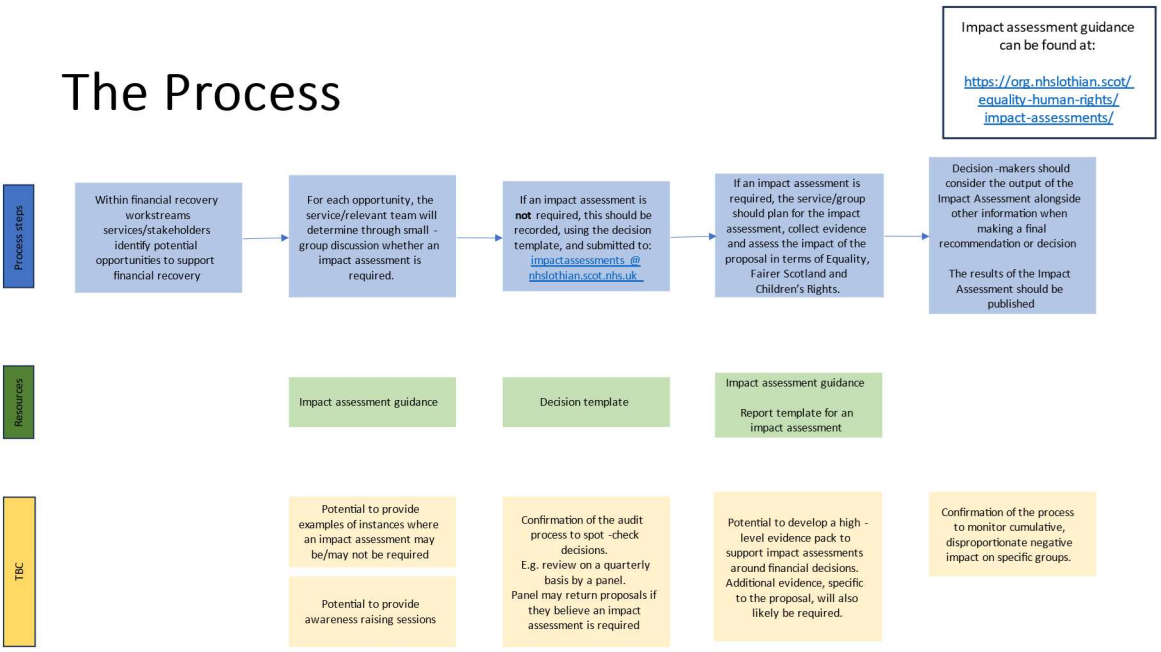
With regard to financial recovery, there is likely to be increased scrutiny of our decisions.
All decisions will be difficult and are likely to have consequences.
We need to monitor the actual impact of financial sustainability.

The role of Equality and Children's Rights Impact Assessment is to ensure that NHS Lothian does not unlawfully discriminate do not result in any unlawful discrimination and to allow us to consider how any individual and cumulative potential disproportionate negative impacts can be mitigated.

We will monitor Impact Assessments to identify and act on cumulative disproportionate negative impacts.

The lawfulness of decisions can be challenged by individuals or external organisations including regulators. If we have not undertaken an impact assessment, we may be asked to review our decision and carry out an Impact Assessment.

Existing NHSL Impact Assessment guidance continues to apply to financial decisions



The NHS Board is very clear on its responsibilities and each proposal will work to follow this process. We have already piloted this approach with regard to the distribution of technology to support people with type 1 diabetes mellitus.

NHS Lothian is a good performer in this area, with the second-highest rate of distribution of technology by population for adults and the third-highest for children. A working group has reviewed the evidence on the benefits of this technology, noting that 99% of the lifetime cost of this technology is over and above the purchase of the initial pump. Given severe financial constraints, LHCS reluctantly agreed that it would need to reduce the funding made available, and recognised that the evidence for providing technology to children and young people, and pregnant women, was of greater benefit than providing to older adults. A full equality impact assessment confirmed this outcome.

Other work to deliver financial sustainability

It is important to be transparent that meeting the financial challenge will also involve significant other changes to service provision.

In terms of sustainability of services we are aware that infrastructure failure at the Western General Hospital means that we will need to relocate the regional infectious diseases unit to elsewhere in the estate. This means, in turn, that we will lose up to 31 acute beds from the system.

We are also aware that the human and financial resource pressures on IJBs mean that they may have to carefully consider the configuration of services, and that we expect to see decisions made by IJBs to reconfigure.

We fully expect to dispose of some properties, to place caps on activity, and to carefully review service duplication. We will particularly examine where we are out of kilter with other health board areas, in having two inpatient units where others have only one.

How this Annual Delivery Plan is constructed

This ADP is a response to a commission from SGHSCD to lay out in detail our plans for the 2024-25 financial year and to lay out in headline our plans for thereafter.

The financial – both revenue and capital – is such that NHSL cannot be as clear as it would wish on the levels of activity and performance it will be able to deliver. It remains committed to the approach laid out in the LSDF, but increasingly sees this as a ten-year process, rather than a five-year one. It is therefore crucial to recognise these points.

The guidance provided by SGHSCD to Health Boards presents a strategic context and suite of priority areas underpinning recovery plans across NHS Scotland. These are;

1	Improved access to primary and community care to enable earlier intervention and more care to be delivered in the community
2	Urgent & Unscheduled Care - Provide the Right Care, in the Right Place, at the right time through early consultation, advice and access to alternative pathways, protecting inpatient capacity for those in greatest need
3	Improve the delivery of mental health support and services
4	Recovering and improving the delivery of planned care
5	Delivering the National Cancer Action Plan (Spring 2023-2026)
6	Enhance planning and delivery of the approach to health inequalities and improved population health
7	Take forward the actions in the Women's Health Plan and support good child and maternal health, so that all children in Scotland can have the best possible start in life.
8	Implementation of the Workforce Strategy
9	Optimise use of digital & data technologies in the design and delivery of health and care services for improved patient access and fast track the national adoption of proven innovations which could have a transformative impact on efficiency and patient outcomes
10	Climate Emergency and Environment

This ADP presents the actions we are undertaking across LHCS for 2024-25 in detail within this document against these ten recovery drivers. As we are unchanged in our approach for the medium term, we have placed our high-level plans in our Implementation Books, which are provided as appendices.

The significant caveat to this approach is that our plans for Scheduled Care (including Cancer), Unscheduled Care, MHIWB, and Primary Care, are all subject to a detailed process reviewing the affordability of the activity we expect to undertake. We intend this work to be completed and more detail available for the final version of this ADP, to be presented to NHS Lothian's Board in April. There are therefore some elements that are not finalised in this current version of the document.

Primary and Community Care

The planning and commissioning of Primary and Community Care services sits, by statute, with Integration Authorities. Delivery sits with NHS Boards, and in Lothian, we have expressed this through our Implementation Book for Primary Care

Our priorities in Primary and Community Care are;

a. Accessible primary medical services, both in and out of hours
b. Further development of local community pharmacy services in line with the Pharmaceutical Care Services Plan
c. Accessible primary dental services, both in and out of hours
d. Increased provision of community ophthalmic services
e. HSCP/board-wide infrastructure to deliver managed primary care services (note this priority supports delivery of above priorities and so some overlap)

ADP Priority Areas as per SG guidance:

Delivery of core primary care services

This will continue into 24/25 as per our strategic priority areas above. There are a number of key risks for NHS Lothian going into 24/25:

· Continued challenges with sustained closed GP practice lists, particularly in South-East Edinburgh. These challenges are largely due to increases in population. While patients are assigned to a practice this may be further from home than we would like, which potentially impacts patient access to the practice, increases the time required of the GP in case of a home visit causing wider practice capacity issues, and could cause challenges with the integration with other health and social care services which are locality based.

· Scale of population growth – current total Lothian patient list size is 1,020,000. This has risen from 864,000 in the last 15 years, an increase of 156,000 or 18%. That equates to approximately 21 additional practices (based on the Scottish 2023 average list size of 7,200). However there have been no new additional practices in Lothian and existing practices have grown their lists to accommodate population increases.

· There is now very limited flex to accommodate new population growth and with NRS projecting that 84% of Scotland's population growth will be in the Lothians in the next 10 years, additional general practice capacity – both infrastructure (premises) and workforce is essential.

· We have developed a Strategic Programme Initial Agreement for general practice infrastructure which sets out our prioritised list for capital investment. Seven of these priority areas have been assessed as 'Essential – Needed Now'. While we recognise the limited capital funding available, we are very constrained in options to manage the significant population growth without further investment. Work is being developed to seek to mitigate this risk in terms of exhausting all options with existing estate, exploring alternative delivery models and other potential opportunities and collaborations with other partners. We are excited by the potential for collaboration on primary care and community care that exists in a potential strategic partnership with Queen Margaret University. However, all of these 'plan B' options will require some form of investment to try to mitigate the risk this poses to short-medium term delivery of GMS.

· Of the top seven priority areas, five will be completely new practices. There is no national guidance or funding available to support the establishment of a new practice. Additionally, there is no additionality to the PCIP funding provided to allocate to these new practices. One of the priority areas, Maybury, is nearing completion through a CEC development, however we currently have no mechanism to allocate the fair PCIP share without an uplift on the PCIP allocation for new practices or removing funding from other practices.

· Additionally, there is insufficient funding provided to the board under PMS allocations to deliver GP entitlements set out in the SFE e.g. superannuation, locum cover for maternity and sickness etc which is causing a growing cost pressure. The Enhanced Services allocation continues to not be uplifted, and this annual, real terms, reduction in relative funding of remuneration for Enhanced Services threatens the future uptake of these services, for example delivery of Long-Acting Reversible Contraception (LARC) to deliver on the aims of the Women's Health Plan.

Ongoing delivery of Community Treatment and Care (CTAC) services, supporting more local access to a wider range of services

Our four HSCPs will continue to deliver CTAC services. However, they are unlikely to be able to support more local access to a wider range of services over 24/25. The direction from the GMS 2018 contract resulted in some areas like CTAC services, as well as vaccination and pharmacotherapy services, being removed from the GP contract and given to NHS boards, or their local delivery arms, HSCPs, to deliver. Therefore, as each individual practice is no longer responsible for community treatment and care services, and staff employed by the health board now undertake these services, local hubs have been created to provide the services. Unfortunately, this does mean that patients who used to receive these services at their local GP practice may now need to travel further to access the services.

There continue to be challenges with the 2018 GMS contract implementation. The lack of specification and detailed directions relating to CTAC and Pharmacotherapy services, and absence of updated premises directions including lack of progress with a national sub-lease template, is causing confusion of practice responsibilities, inequity across practices and cost pressures on boards. We believe to fully realise the aims of the 2018 GMS contract, including supporting more local access to a wider range of services via CTACs, we would need a significant increase in the current allocated level of funding.

Ensuring there is a sustainable Out of Hours service, utilising multi-disciplinary teams

Our GP Out-of-Hours service is currently delivering a good quality service and we expect this to continue into 24/25 as we have strengthened our demand and capacity service planning, and the management of patient flow across the service including additional co-ordination arrangements over our busiest public holiday periods. Our service is delivered by multi-disciplinary teams, however is predominantly delivered by GPs and Nurses. We have strengthened our nursing workforce plan, and we continue to explore opportunities for other professions to join our service where their skillsets add value to urgent primary medical care.

Our GP Out-of-Hours service will only remain sustainable if the Transforming Urgent Care / Ritchie funding continues on a recurrent basis.

Early detection and improved management of the key cardiovascular risk factor conditions, primarily diabetes, high blood pressure and high cholesterol

This is part of core GMS delivery. We will over 24/25 further review the opportunities to develop further 'care bundles' implemented through improvement activities for the highest risk groups.

- Delivery of sustained and improved equitable national access to NHS dentistry, setting out how they will assess and articulate local oral health needs, and engage with independent dental contractors and bodies corporates to ensure that patients receive the NHS oral health care they are entitled to.

The first stage of the dental contract reforms with the implementation of the revised Determination 1 in November 2023 are welcomed and have slowed the deregistration of NHS patients. We welcome continued focus on the next stage of the reforms to support our access to NHS dentistry challenges.

We have a local action plan that will continue into 24/25 that covers support for contractors in establishing new practices, development of a general dental services plan working across primary care contracts, public health and Public Dental Service (PDS) teams to set out the areas of need across Lothian so we can better target our interventions across the GDS and PDS, and sets out our collaborative approach across GDS, PDS and Hospital Dental Service (HDS). This includes reviewing and refining referral criteria for both the PDS and HDS, and ensuring all GDPs are aware of any changes. With the financial challenges we will be ensuring that only core NHS care is provided by the PDS and HDS, and this may result in some changes to referral pathways, for example acceptance onto the orthognathic pathway which involves extended orthodontic treatment and jaw surgery. Referrals to this pathway have been paused since July 2022 due to the backlog of patients in treatment and the risks of iatrogenic disease with prolonged wearing of orthodontic appliances, as the covid pandemic significantly affected surgical capacity for these procedures.

- Increasing delivery of hospital-based eyecare into a primary care setting where appropriate.

The Community Glaucoma Service is welcomed and is a priority within the primary care pillar of our Lothian Strategic Development Framework. However without funding to support the infrastructure required for an Electronic Patient Record that can be viewed across primary and secondary care, or concession on this point, this service is unlikely to be delivered in the near future.

The expansion of flow centre work is covered in our Unscheduled Care section.

See also – Primary Care Implementation Book

Unscheduled and urgent care

Our urgent and unscheduled care programme is owned by the Unscheduled Care Programme Board. Of all our programmes, it is probably the most complex and most complicated, and is a key focus for the entire LHCS.

There is considerable risk to the planning process due to both the constraints on funding within the NHS and also the constrained position for local authorities. This means that we cannot be sure that the same level of social care support, both preventative and rehabilitative, will be provided going forward. This is a headline statement which we will work through during the course of the 24-25 year, but it does compound the system risk.

A full review of our actions in 23-24 and an outline of all of our plans for USC are in the attached Implementation Book – Unscheduled Care.

The Unscheduled Care Programme

Unscheduled Care is one of our six key pillars of the LSDF. Planning and commissioning of these services sits, by statute, with Integration Authorities. In order to ensure that LHCS has a coherent approach to the challenges, our Unscheduled Care Programme Board brings together the Chief Officers of our four IJB partners, the Chief Officer of Acute Services, representatives of the medical and nursing directors, the Director of Strategic Planning, and the Chief Executive of NHSL. It is supported by an operational group.

The priorities for the Unscheduled Care Programme are;

- Meeting prevailing standards of emergency access
- Working towards an 85% bed occupancy across the system

To facilitate this, the Programme is broken down into three key priorities;

- Reducing attendances
- Reducing length of stay
- Reducing admissions

In addition, a dedicated programme of work supporting flow through the Royal Infirmary of Edinburgh Emergency Department is also in place and reflected in the Implementation Book.

Specific asks of Lothian in the Annual Delivery Plan guidance

Improve urgent care pathways in the community and links across primary and secondary care

AND

Ensuring patients receive the right care in the right place by optimising Flow Navigation Centres, signposting and scheduling of appointments to A&E where possible and increasing the routes for professional to professional advice and guidance with a specific focus on frailty pathways and care home support

These cut across both the “attendances” and “admissions” priorities.

Lothian has been successful in reducing the number of ED attendances from 288,440 in 2019 to 265,732 in 2023 a reduction of 7%. In addition, since the implementation of the signposting policy, we have succeeded in increasing the proportion of attendances redirected to 4% of the total.

We have been successful in our work with our Flow Centre, with just under 18% of primary care and Ambulance Service referrals redirected to an alternative to hospital. Over 30% of referrals from NHS24 and our minor injury units have been redirected to alternatives, too. We will continue to develop our work in this area during 2024/25 by transitioning from a Flow Centre to a Flow Navigation Centre, by;

- Developing and implementing the workforce model required to support transition
- Continuing to review urgent care clinical pathways to optimise flow and maximise alternatives to ED attendance
- To scope opportunities through use of virtual consultation, algorithms, technology to optimise referral flow and support triage / prof to prof advice.

All of these actions will clearly include specific focuses on the elderly and frail and on support for other vulnerable groups, such as those with chronic respiratory diseases.

In addition, we will implement the outcomes from our minor injury appraisal.

We will also take forward work between the flow navigation centre and the single points of contact in each health and social care partnership to map out how best these can complement each other going forward, providing easier access to the entire suite of services.

Improving access to Hospital at Home services across a range of pathways including OPAT, Respiratory, Older People, Paediatrics and Heart Failure

LHCS has had a significant increase in the provision of Hospital at Home (H@H) services over the last three years. A key part of this has been aligning core models across the four IJB areas, but there has also been an increase in the number of patients managed per month from 271 in September 2021 to 479 in January 2024. On average 130-140 patients are managed per day, with an average length of stay of 5.73. 30% of referrals to services are from Emergency Departments and acute wards.

The financial constraints facing the system mean that our Hospital at Home services will need to retract to a core service, and not provide additional services that have been develop on non-recurring monies in the last 12-18 months. This means that we will have to retract from 479 referrals per month to closer to 271 per month over the next 12 months.

Optimising assessment and care in Emergency Departments by improving access to 'same day' services, the use of early and effective triage, rapid decision-making and streaming to assessment areas.

The LHCS approach to what was previously known as Same-Day Emergency Care (SDEC) is now known as RACU. This has been a success in building relationships between primary and secondary care and in avoiding attendance at EDs. Over a 6-month period a total of 359 patients were diverted from the ED of the RIE, and seen at WGH on a planned basis instead.

We have developed a business case to further expand the WGH service and establish a sister unit at St John's Hospital, and our intention would be to take this forward. However, the financial position means that we are unable to guarantee that this will be taken forward.

Reducing the time people need to spend in hospital, increasing 1-3 day admissions and reducing delays over 14 days, by promoting early and effective discharge planning and robust and responsive operational management

Progress here for 2024-25 will be built on the same approach as outlined above, with a mix of discharging from EDs and medical units into H@H, where possible. However, we will also continue to accelerate on the Discharge without Delay (DwD) pilots undertaken across West Lothian and the Western General. The key impacts and actions in 23-24 were;

- In WLHSCP there has been a 30% reduction in ALOS on integrated discharge hub tracker comparing Dec 22 and Dec 23
- Across SJH there has been better coordinated discharges with an increase s in the number of discharges which has helped coordinate flow
- Within the WGH there has been a 50% reduction in bed occupancy by patients in delay from the first quarters of 2022 to 2023. Average LOS shortened by approximately 9 days (when comparing data from the end of Phase one with the previous year) and an increase discharge rate of 35%
- Local request for service (RFS) data at the WGH has shown a reduction in the 48-hour validation rule being applied
- The implementation of weekly, multi-disciplinary Long Length of Stay meetings across the 3 Acute Hospitals has shown a notable reduction in LoS
- There has strengthened collaborative working relationships between Health and Social Care teams across the system
- Detailed Phase 1 evaluation which has been widely shared at a local and national level

During 2024-25 we intend to;

Implement Phase 3 - Planned Date of Discharge – across identified wards within Acute and Community Hospitals:

Planned Date of Discharge – identify wards within Acute and Community Hospitals, develop improvement aim for high impact areas identified, align to ought to be LoS and utilising tools and resources developed in Phase 1:

- Develop spread plans to support implementation of Planned Date of Discharge – across Acute and Community Hospitals taking a QI approach with iterative implementation over 5 Phases.
- Support transition on Trak from Estimated Date of Discharge to Planned Date of Discharge
- Identify priority area/speciality for implementation PDD
- Identify improvement aim for Phase 3 using data to identify high impact areas
- Ensure PDD is aligned to ought to be LoS to support optimal flow
- Utilise tools developed through Phase 1 and 2 work
- Support the implementation of Criteria Lead Discharge
- Support implementation through ongoing ToC and PDSA cycles

In addition, we will continue to progress work on criteria-led discharge and recording of planned date of discharge on TRAK.

Reduce unscheduled admissions and keep people care for closer to home through reconfiguring existing resource to accelerate rapid assessment and evolve to implement Frailty Units

See above.

Royal Infirmary of Edinburgh Emergency Department challenges

In response to concerns regarding performance and quality in the ED of the RIE, as raised by HIS inspections and others, the organisation undertook an external review of the ED during 2023-24. This led to an intensive action plan and this continues with Executive Leadership Team and Board scrutiny of progress and performance. Example actions for the RIE include;

- **Continued implementation of the external review recommendations**
  - The RIE EAS board will continue to implement the external recommendations which focus upon enhancing and strengthening the form and function of ED and AMU at the RIE.
- **Specialty by Specialty Length of Stay Programme**
  - Target completion of first cycles of improvement : **June 24**
  - Each specialty will be tasked with reducing their length of stay to bring the RIE down to initially 90% occupancy.
  - PDD implementation will form the backbone of this workstream, although challenges to current practice, ensuring standardised practice to eliminate variation will also be required.
  - Teams will be supported through existing site leadership structure and QI support along with data analysis demonstrating where biggest gains can be made in high volume pathways, as well as specialty specific targets to bring in line with a) best national practice and b) site requirements
  -
- **Bed Reprofiling**
  - Target Completion: **July 24**
  - The site will seek to eradicate boarding by undertaking a bed reprofiling exercise to match demand with specialty capacity
  -
- **Continuous Flow // Flowthian 2.0 & Discharge Framework**
  - Target go live date: **Immediate post bed reprofiling**
  - Flowthian refined to ensure patients are moved from ED into AMU/ from AMU into downstream beds / (from ward arc into community-based settings utilising discharge framework) within set time markers

This will remain a key focus of our programme during 2024-25.

Mental Health, Illness, and Wellbeing

Governance and approach

The planning and commissioning of Mental Health, Illness, and Wellbeing (MHIWB) services is, in the main, delegated to Integration Authorities. The exceptions to this are medium-secure forensic services and services for children and young people.

Services for adults and older people, therefore, follow the same governance pattern as for unscheduled care and primary care, with LHCS having established a MHIWB Programme Board. This is chaired by an IJB Chief Officer, with the other three IJB Chief Officers, the Director of the Royal Edinburgh Hospital, the NHSL Director of Strategic Planning, and representatives of the Medical Director and Nurse Director all members. This group pushes forward the implementation of the MHIWB pillar of the LSDF.

For medium-secure forensic services and services for children and young people NHSL undertakes the planning and commissioning.

Actions

The MHIWB programme is focussed on;

- Delivering an agreed vision where people are only cared for in institutions where there is no alternative, with everyone entitled to a safe and homely environment
- Improving access to outpatient services in psychology
- Strengthening community services by shifting resources to follow patient flow
- Improving the mental health built environment

At the heart of this approach is a belief that people should only be institutions when they absolutely need to, combined with workforce planning data and intelligence which shows that we will not be able to continue with the model of care we currently have.

Clearly, the urgency to make this shift is even more crucial when our financial resources are so badly stretched, and when the resources available to IJBs are equally so.

Our main acute inpatient mental health and intellectual disabilities centre is the Royal Edinburgh Hospital. We are extremely disappointed to be told to stand down efforts to progress phases 2 and 3 of the project, which would have allowed us to move from outdated facilities into 21st-century units far better suited to modern care standards and expectations. We remain concerned about the safety of current facilities, and during 2023-24 needed to temporarily close part of our facilities at St John's Hospital to undertake urgent safety works. The constraints on funding for backlog maintenance and equipment have consequences for our programme of upkeep in older wards.

The major challenge for us on a day-to-day basis is ensuring appropriate flow through inpatient psychiatry units. We currently have additional beds open within the Royal Edinburgh Hospital which appear to be broadly the correct number in total, but these are under extreme pressure due to the demographic changes in the Lothians over the last 15 years. We see particular challenges with the number of code 100 delayed discharges and the number of delays in the Older People's Mental Health area.

We have established an intensive programme of works within the city of Edinburgh to push improvements in flow. This includes;

- Implementation of Discharge without Delay and PDD methodologies within the Royal Edinburgh Hospital
- Working through the implementation of Edinburgh IJB's Bed-Base Review. This requires clear bed capacity commissioning in Psychiatry of Old Age community beds and of specialist intensive care home capacity for dementia. This work is advancing but is at risk due to funding constraints in Edinburgh IJB
- Focusing in on code 100 delays and delays in rehabilitation, in order to anticipate difficulties and utilise dedicated social worker capacity

We anticipate a Direction from West Lothian IJB instructing NHSL to close beds in St John's Hospital which are no longer needed for West Lothian patients due to extensive redesign of that capacity.

In terms of outpatient services, we anticipate a significant slowdown in the rate of improvement in psychological therapies performance, due to reductions in non-recurring funding from SGHSCD. We will continue to apply rigorous focus on throughput and return ratios in particular, and will submit trajectories for performance improvement in the final version of this ADP, following the undertaking of a similar process to that in scheduled/planned care.

With regard to Forensic Mental Health services, we continue to participate positively in the work associated with the Barron Review, although we would wish greater clarity from SGHSCD on the specific next steps they would expect us to undertake. We have been clear that we cannot provide female high-secure capacity. We continue to be the lead health board for the development of the PREVENT and SOLS responses across the country. On SOLS, we remain of the opinion that there are excellent services in parts of the country, and will look to help build a supportive network in partnership with other Boards and stakeholders such as Police Scotland. On PREVENT, we have made recommendations to the Scottish Government on next steps and look forward to developing this work further in the coming year. We would also note that the lack of capital means we have very little capacity available for low-secure accommodation and that this raises a financial risk that NHSL – and all territorial Boards - will be fined.

Children's Services

Children's Services are commissioned and planned by NHS Lothian.

As with psychological therapies, we anticipate a slowing in the rate of performance improvement due to the reduction in non-recurring funding from the Scottish Government. We continue to utilise basic improvement methodologies as described for psychological therapies, and will submit a trajectory following the undertaken of a similar process to that as for scheduled/planned care.

We will continue to participate in the national commission for regional delivery of CAMHS unscheduled care services, noting that the commission for this could perhaps be clearer. We work closely with NHS Borders and NHS Fife in re specialist inpatient CAMHS services and so this is a natural set of developments for us.

We continue to work to develop a national service for children with both intellectual disabilities and mental health difficulties. Our original plan for a physical unit was included in our case for redevelopment of the Royal Edinburgh Hospital, and given the lack of capital available, we will be unable to progress a temporary inpatient unit. We remain enthusiastic to continue with the national consultation service for patients with these difficulties, a valuable resource for teams across the country, but need confirmation from SGHSCD that this will be funded from 1st July onwards.

Planned Care and Cancer

This section should be read in conjunction with our Planned Care Submission, appended

Scheduled (or planned) care is the area of healthcare which planning and commissioning has the greatest level of control over. It also tends to be the most expensive, given the level of equipment and staffing that is required to ensure that procedures can be undertaken.

In NHS Lothian, all planning and commissioning for planned care and cancer is undertaken by NHS Lothian through the Scheduled Care Recovery Board, chaired by the Chief Officer for Acute Services.

Our overall position for the 2024-25 financial year is that we will see a reduction in activity and a deterioration in an already challenged performance position. NHS Lothian will not fund flexible capacity through approaches such as waiting list initiatives or other non-core methods. NHS Lothian will also reduce its use of outside providers for procedures. This will include the Golden Jubilee National Hospital for orthopaedic procedures, due to costs. We will continue to use capacity in NHS Fife, the funding for which is already top-sliced from our financial allocation.

Our process for reaching this decision has been to firstly develop a set of guiding principles, including clinical prioritisation of available capacity, through 'Pause & Assess' capacity workstream and are included in figure 1. These were tested and supported by the Finance Improvement Group (FIG) 26 February 2024 and the CMT on 12 March 2024.

NHS Lothian is unable to commit additional investment until The Board forecasts a breakeven position at the end of March 2025. In recognition of the scale of the financial challenge, the pace required to support delivery of a balanced position for 24/25, and the known limitations to reduce expenditure and release funding, it was apparent previous investment plans for 24/25 were unaffordable and all uncommitted funding would need to pause in Q1 & 2 at least.

Uncommitted money in scheduled care equates to £8.6m. Whilst uncommitted, this is budget set aside for previously approved proposals, such as internal investments to improve service sustainability (where employment offers have not yet been made), Waiting List Initiatives (WLIs) and external capacity including Golden Jubilee University National Hospital (GJUNH). Table 1 below sets out the budget release available in scheduled care by pausing uncommitted investment for the full year.

Table 1: Proposed cash release in Scheduled Care

	£k 24/25 Expenditure Funding
Planned Care baseline allocation	10,500
Recurring GJUNH Core Budget	3,605
Budget sub total	14,105
Committed Funding from budget	5,504

Uncommitted funding released to NHSL financial Plan	8,601

There is full recognition pausing discretionary spend will result in pausing activity that The Board would otherwise prioritise, were there alternative levers to release cash & reduce costs.

Pausing previously supported proposals in Q1&2 is viewed as a necessary action to bridge the financial gap. The impact will be assessed and delivery against activity trajectories will be monitored with early escalation of non-compliance. In parallel, alternative options and opportunities to take forward previously approved proposals will be fully investigated e.g. improving productivity within current resources, realignment of current resources, eliminating waste, or delivery of cash release from other 4% workstreams, such as 'Stop & Assess' Treatment, Choices etc.

Over the last 5 weeks there has been rapid development of a robust tool which models trajectories for various investment scenarios. Support has been required from Lothian Analytical Services using Alteryx and Tableau software to deliver an ability to visualise impacts of changes in demand and capacity in response to any changes in investment.

As per previous years specialties submitted capacity plans for 24/25. Component parts of capacity were clearly identified allowing various investment scenarios to be modelled. On testing core capacity (assuming pausing of the uncommitted investment proposed above), the model forecasts the impact on performance.

This impact equates to a 59.4% increase in the size of the outpatient waiting list and a 13.4% increase in the size of the IPDC waiting list. It does, however, suggest a continued improvement in our Cancer Waiting Times performance.

Further interrogation of the nuances between waiting lists, particularly in complex specialities and sub-specialties, will be required. Development of the model will continue so it can be used as a tool to monitor delivery against agreed trajectories within NHS Lothian's ADP submission.

Phase 2

Phase 2 will include:

- Wider communication to acute teams – acute roadshows.

- Monitoring, through the Scheduled Care Delivery Board and Access Delivery Group, delivery of agreed trajectories within NHS Lothian ADP 24/25, in line with financial plan.

- Expanding service health checks and oversight of KPI/ CfSD delivery across scheduled care – maximising the use of our current resources / doing more with less.

- Assessing the impact of pausing investment on patient experience, outcomes, and equality with a focus on reducing inequalities.

- Ensuring mechanism for early escalation of noncompliance with agreed trajectories, KPIs, clinical prioritisation, or impact on equality.

- Realigning resources - if financial balance is to be achieved before NHS Lothian will commit additional investment, how we realign current resource to meet our clinical priorities or address

early escalation of the above will be critical. However, the effectiveness of this may be limited due to known constraints to moving resource between specialties and sub-specialties.

Risk mitigation

There is a risk more patients will come to harm due to a reduction in capacity leading to poorer clinical outcomes. To mitigate we will continue clinical review of waiting lists and referrals and prioritisation of USOC, urgent and clinically urgent returns.

As experienced during Covid there is a risk the proportion of urgent referrals or additions to waiting lists increase and this exceeds available capacity leading to increased risk of patient harm through delayed diagnosis & treatment. Clear message to clinical colleagues across the system regarding clinical prioritisation and referral / acceptance thresholds. Work with Stop & Assess Treatment.

There is a risk that core funded capacity will not deliver against agreed trajectories, because we are no longer able to backfill unavoidable workforce gaps, leading to pathway inefficiencies, a reduction in activity & productivity and worsening of performance.

There is a risk that core capacity is insufficient to meet demands for USOC, urgent and clinically urgent returns in some specialties/ subspecialties (including diagnostics) because of increased demand or reduced capacity, leading to delays in cancer diagnosis and/or cancer pathways. Close monitoring of urgent and USOC performance and early escalation to CMT where urgent realignment of resource is required recognising that due to insufficient funds it will be increasingly challenging to address deteriorating performance.

There is a risk that patients not referred to USOC or Urgent pathways but have cancer or require urgent care will wait even longer to be seen because there is less capacity for routine activity, leading to increased risk of patient harm through delayed diagnosis & treatment. Clear message to clinical colleagues across the system regarding clinical prioritisation and referral / acceptance thresholds. Clinical review of waiting lists and keeping in touch where deliverable and review of ACRT practice.

There is a risk patient complexity and the number of people with co-morbidities increases as more people in Lothian wait longer for the care they need, leading to additional pressure on our constrained resources, and poorer clinical outcomes and quality of life for individuals in Lothian. 5 Monitor and realign resources where possible however no additional funding available and restrictions in ability to reassign work and reduce workforce presents challenge.

There is a risk of increased demand for non-surgical pathways due to longer waits, leading to pressures elsewhere in scheduled care.

There is a risk of increased patient complaints and risk to staff safety and wellbeing relaying these communications to patients directly.

There is a risk other boards do not follow a similar financial approach (Reputational risk and access for patients in Lothian disadvantaged as capacity allocated to other Health Boards.)

There is a risk pausing investment, for an unconfirmed duration, will lead to less availability / more competition, leading to increased costs or no availability if the Board decides to reinvest later. (workforce & external capacity)

There is a risk that patients with protected characteristics will be disproportionately impacted by growing waiting lists and longer waiting times leading to a less equitable health system and increased detriment to the most vulnerable groups of the population.

Other actions

We will continue to work to isolate rehabilitation capacity and protect, in particular, access to elective orthopaedic inpatient capacity at the Royal Infirmary of Edinburgh, as part of a "hospital within a hospital" approach.

We are fully engaged with the Centre for Sustainable Delivery and will continue to utilise recommendations on reducing variation and heatmaps from CfSD to support maximising utilisation.

Cancer Care

All activity on the delivery of cancer care is through the Scheduled Care Recovery Board, and NHS Lothian is proud that it is both a tertiary treatment centre and has delivered good performance against the 31 and 62-day targets. We acknowledge that performance in colorectal and urology remains problematic, as is the case across Scotland.

We will continue to prioritise our work on cancer assessment, diagnosis, and treatment, and align capacity accordingly, and this applies to imaging and endoscopy in particular.

We have fully embraced the national framework for effective cancer management, with intensive work with national colleagues to deliver on this, and we will continue to do so.

We remain proud of our partnership with Maggie's Centres and continue to work to provide streamlined access to support and help for patients and families with cancer.

Clearly, our strategic intent with cancer services was to redesign services will delivering increased capacity over the next ten years through the development and delivery of the South-East Cancer Centre. Scottish Government funding decisions on capital mean that we will rethink this approach, while remaining absolutely committed to advancing the case for capital investment. The precarious position of our current buildings at the Western General has been highlighted by the discovery of RAAC in Ward 1, our chemotherapy outpatients suite.

We continue to provide support to other cancer centres in dealing with sustainability challenges and look forward to the progression of the national Oncology Transformation work.

Population Health

Health Inequalities and Population Health

Tackling local health inequalities (including racialised health inequalities) and reflecting population needs and local joint Strategic Needs Assessment

People's health, and inequalities in health between different population groups, are significantly shaped by their access to **money and resources**, **work**, **housing**, **transport**, the quality of their **neighbourhood and surroundings**, as well as **family, friends and community**.[i] Without these building blocks, it is harder for our population to live healthy lives. Although these determinants of health are largely shaped outside the Lothian health and care system, there are important roles for public health and strategic planning teams to engage with public, private and community and voluntary sector partners, in a place-based way, to ensure health is considered in wider policy making. NHS Lothian, as an anchor institution, is well placed to positively influence the social, economic and environmental conditions in local communities, thereby impacting on the wider determinants that influence health and wellbeing and ultimately preventing and reducing future ill health.

We have a strong commitment in our Equality and Human Rights Plan for 2023-2028 on addressing racism which will have an impact on racialised inequalities. Patients and staff will benefit from an approach that tackles barriers within our system that may contribute to disadvantage. So Lothian will structure its work across the following six priorities to advance equality and promote human rights throughout the organisation.

i. Equality and human rights are a central part of our planning, decision-making, delivery, and reporting.
ii. We are an anti-racist organisation, and our work helps to eliminate racism, remove racialised inequalities and reduce racial prejudice.
iii. We anticipate and meet the needs of disabled people so they can access services, employment opportunities and have better outcomes.
iv. We are gender inclusive, we do not discriminate on grounds of sex or gender identity and our work helps to tackle persistent gender inequalities.
v. We support people who use our mental health services and people with dementia to know about and claim their rights, and to make decisions about their care and treatment.
vi. We reap the benefits of equality and human rights education and training.

Supporting improved population health, with particular reference to smoking cessation and weight management

It is important to strike the right balance between individual and population approaches when planning actions to address healthy weight, in particular to disrupt the current upward trajectory for type 2 diabetes. Historically, public health actions, such as those to tackle obesity, have focused on individual-level changes to diet and physical activity, rather than the upstream actions required to alter structural and environmental determinants of health such as the content of or marketing of mass produced food. To focus purely on individual behaviour can widen inequalities and increase obesity-related stigma. Individual approaches should be seen as just one component of a whole system response that includes upstream initiatives to tackle 'obesogenic' environments. We have created a programme of work which takes a whole system approach to addressing these wider issues and in addition we will review our adult weight management services in order to increase capacity and effectiveness in this area.

The harms caused by smoking remain one of the largest preventable causes of ill-health and early death. As tobacco use remains heavily socially patterned, during 2024-25 we will continue to focus our Quit Your Way effort on achieving our target of 1,181 quits from the most deprived communities in Lothian. This Quit Your Way activity will include enhanced support for our community pharmacy cessation work. We also aim to implement our refreshed nicotine dependency pathway in hospitals and roll out a revised approach to smoking cessation support for pregnant women and their families.

If health outcomes are to improve in Lothian, there needs to be a strong focus on and investment in primary prevention; actions that improve the conditions in which people work, live and grow, delivered at both a whole population level and targeted at groups at highest risk.

A range of public health programme are already offered on a universal or targeted basis across Lothian. There is an opportunity to further explore how these offers are better linked to the scheduled or unscheduled care touch points that people already have with our services. This can be particularly important for population groups who may be more likely to present in an unscheduled way, as well as those who are supported by specialist services. We know that adjusting service provision proportionately for populations such as 'inclusion health groups'[2], is an evidence-based way to improve outcomes. This could involve improving the way that we assess, support and treat the holistic health and wellbeing needs of these individuals, including supporting access to income maximisation, immunisation, screening and other disease detection such as BBV testing, as well as emphasising the benefits of smoking cessation and other harm reduction activities, even if these are not directly linked to a person's presenting complaint.

[2]Inclusion health includes any population group that is socially excluded. This can include people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery, but can also include other socially excluded groups. There will be differences in needs within socially excluded groups (for example between men and women) and these differences must be understood and responded to appropriately. (Inclusion Health: applying All Our Health - GOV.UK (www.gov.uk))

- Public Health will continue to explore opportunities to strengthen preventative action across cardiovascular pathways, linking with colleagues in primary and secondary care to embed referral pathways for support to address risk factors, as well as considering health literacy and adherence to medication to optimise treatment of hypertension.
- Public Health will continue to provide leadership on tackling the obesogenic environment and supporting the delivery of a Whole System Approach (WSA) to type-2 diabetes, working with stakeholders from across the community planning partnership, to help to tackle the root causes of overweight and obesity[ii].
- The Maternal and Infant Nutrition service should continue to support breastfeeding initiation and continuation, and deliver and expand the HENRY programme, designed to increase staff knowledge, confidence and skills on health, exercise and family nutrition when working with families with young children in the most deprived areas.
- Obesity is impacted by weight stigma. Public Health will facilitate the development of a programme on how to have positive conversations with families about weight and to avoid weight bias.
- Improve the effectiveness and efficiency of child and adult weight management programmes across the obesity pathway, which are accessible to local populations and robustly evaluated.

How they will redirect wealth back into their local community to help address the wider determinants of health inequalities, through actions set out in their "Anchors Strategic Plan"

Our Anchors Strategic Plan is focused on three themes: workforce, spending and land and assets. Financial challenges mean that opportunities need to be scoped carefully but the importance of our commitment to being a good neighbour, good consumer and good employer remains central to the Board's ambitions. The Anchor Institution reporting metrics provide helpful baselines especially for our work around recruitment and local expenditure.

<u>Workforce</u>

- We are building on NHS Lothian's existing commitment to innovative and supported employment opportunities such as Modern Apprenticeships and supported placements. Our new Employability Strategy provides the platform for investigating new approaches to recruitment. We are developing a pilot programme looking at opportunities for how NHS work experience can be provided in conjunction with Local Employability Partnerships. We are keen to ensure that opportunities are targeted at population groups identified through child poverty work and other anti-poverty activity that our Partnership and Place teams engage with in CPP settings.

<u>Spending</u>

- We retain a commitment to developing our local supplier chain and looking at opportunities to increase opportunities for local companies to bid for contracts. We will continue to support (and expand if the opportunity is right) our hospital income maximisation service provided in conjunction with the NHS Lothian Charity.

Land and Assets

- We are working with other public sector partners to investigate whether there are partnership opportunities linked to an anchors approach to disposal of land and assets and longer-term development plans. We also hope to develop clear guidance for how our sites and facilities can be used for community use or benefit.

Commitment and contributions (leadership, funds, staffing and other resources) to Community Planning Partnerships (CPPs) to improve local outcomes agreed in Local Outcome Improvement Plans and Locality Plans.

NHS Lothian has public health (Partnership and Place) teams dedicated to each of the local authority areas in Lothian. These teams are each led by a Public Health Consultant. They have a remit to engage with partners to improve population health with a place-based approach. The priorities for the teams are

- Addressing inequalities by reducing poverty, including through community wealth building actions to mitigate the impacts of poverty
- Develop and strengthen place-based work supporting the development of healthy and safe communities
- Lead public health strategic input around place-based work to improve the health of children

The teams lead NHS Lothian's local work on child poverty action plans and contribute to a range of community planning activity. Each CPP Board is attended by either the Director of Public Health or the Deputy Director of Public Health. And senior public health staff are involved in CPP delivery and co-ordination groups and also lead work streams for LOIP priorities.

Women and children's health

Setting out how they will work with their local authorities to take forward the actions in their Local Child Poverty Action Report

In implementing the Anchor Institution approach particular focus is on ensuring that reducing child poverty and action on priority families (those most at risk of poverty) continues to be a priority for the Lothian health and care system working with our local authority and community and voluntary sector partners. This is part of an ongoing commitment to support Local Child Poverty Action Reports and includes measures to:

- Prioritise child poverty at senior level and include explicitly in strategic plans.
- Ensure reducing child poverty across priority groups is a priority outcome in anchor institution activity.
- Embed financial wellbeing pathways for pregnant women and families with children.
- Increase awareness and understanding across frontline health and social care staff, including how to act on child poverty in their roles.

- Continuing to influence in the partnership space to ensure prevention of poverty is a priority across community planning activity.

Women's health and children and young people

Women's Health

Our approach to Women's Health recognises that our Primary Care, MHIWB, Scheduled Care, and Unscheduled Care all pertain equally to Women. Our executive lead for the Women's Health Plan is Dona Milne, our Director of Public Health, with the strategic lead Rebecca Miller, Head of Strategy Development.

Our aim through our Women's Health Plan is to;

Ensure that women and girls in Lothian enjoy the best possible health throughout their lives, and that health outcomes are equitable across the population

An initial assessment of our position against the priorities, aims and actions of the SG Women's Health Plan highlighted many examples of excellent work across the Lothian Health & Care system to support women and girls to live well. We have sought to acknowledge these achievements in this plan. We have also identified areas for future focus, including some actions that reach beyond the first iteration of the SG Women's Health Plan and reflect the ideas and ambitions of our staff, partners and other stakeholders.

Priority 1: Ensuring access to healthcare for all women and girls

Alternatives to face-to-face appointments

A key area of focus within the SG Women's Health Plan is the provision of alternatives to face to face appointments, with a view to providing flexibility around work commitments and caring responsibilities. This theme was echoed by some respondents to the draft Lothian Strategic Development Framework and a wide range of engagement activity carried out by others, although the risks of "digital exclusion" have also been noted, and the need to offer a choice of access mechanisms when required.

We also know that many people, including young women, value alternative ways to make appointments or access healthcare. Online appointment booking is available for Sexual Health services in Lothian, for example, and asynchronous appointments are currently being piloted within some acute services.

Abortion Care

Demand for abortion services in Scotland rose by almost 19% between 2021 and 2022, with termination rates for those living in the most deprived areas now more than double those living in the least deprived areas. In Lothian, the abortion rate per 1,000 women aged 15-44, based on 2021 mid-year population estimates, varied by SIMD quintile as follows:

Quintile	SIMD 1 (Most deprived)	SIMD 2	SIMD 3	SIMD 4	SIMD 5 (Least deprived)
Rate per 1,000 women	23.3	18.5	14.8	14.2	11.0

**Source: PHS Termination of Pregnancy Statistics, Year ending December 2022*

In Lothian, for gestations less than twelve weeks, women are offered early medical abortion at home (EMAH) and can choose where and when to take abortion medications with remote nursing support, although women may have to travel significant distances to collect abortion medications. For gestations at 12-20 weeks, abortion is performed in secondary care hospitals. For gestations beyond 20 weeks, abortion care is currently provided in England.

We will continue to seek to ensure that women can access safe and timely abortion care in Lothian by monitoring demand and capacity, and continuing to review models of care. This will include consideration of alternative venues for collection of abortion medications, and ensuring consistent access to abortion care in terms of waiting times across Lothian.

Contraception Services

Long-Acting Reversible Contraception (LARC) is largely delivered in primary care, where a significant number of General Practitioners and Nurse Practitioners have been trained to fit LARC, and a Local Enhanced Service (LES) is in place. There are challenges with the current LES arrangements including increasing demand, a reduction in the number of trained practitioners who can fit LARC and accessing training.

The challenges in primary care have a knock-on impact on Lothian Sexual Health Services. Increasing capacity to provide LARC could impact other services or reduce capacity to provide training to other practitioners. 70% of appointments are available to be booked online. Appointments are often booked quickly on release and there is some evidence that women are finding it difficult to make an appointment, although it is difficult to measure unmet demand. Waiting times for complex LARC can be 3-4 months.

We will review provision and our service delivery model for provision of Long Acting Reversible Contraception, which a view to improving access.

Sexual Health Services

In Lothian, sexual health services are provided both centrally at the Chalmers Centre and in eight locality clinics across Lothian, in an effort to increase accessibility. There is some evidence that people in Lothian travel to clinics in different localities, to access appointments.

Outreach services are provided to saunas, substance misuse services and hostels via WISHES (Woman Inclusive Sexual Health Extended Service), to support vulnerable women to access sexual healthcare. Other outreach models have been piloted, including an “outreach bus” to provide services in areas of deprivation in Lothian (although this is not currently operating due to lack of funding), and provision of sexual health care within the Royal Edinburgh Hospital. Community midwifery services have started to provide contraception to women in the community, with a focus on vulnerable women including those with multiple complex needs including substance use.

Community Pharmacy

The Scottish Government Women’s Health Plan includes an action to: “Provide and promote a ‘Women’s Health’ Community Pharmacy service”. While it is anticipated that this action will be delivered at a national level, we have considered how this might be supported within Lothian.

There are 183 community pharmacies in Lothian, providing services within the local community without the need for an appointment. Community pharmacies work to a national service contract, which includes provision of sexual health services including emergency and bridging contraception, with some pharmacies providing additional services including a c-card condom service, where young

people can present the card at a pharmacy and receive free condoms. Several pharmacies also offer a service to supply treatment or patients who have tested positive for chlamydia, and one pharmacy in Lothian provides a designated safe space for women experiencing domestic violence.

Menopause Services

The Women's Health Plan is clear that those who need it should have access to specialist menopause services for advice and support. Across the UK, awareness of the impact of the menopause has increased, alongside increasing expectations of menopause care, including around the safety and efficacy of Hormone Replacement Therapy (HRT). We have seen increasing demand to both primary care and specialist menopause services in Lothian, challenging available capacity.

We will seek to review NHS Lothian's current offer for women who are experiencing menopause, including those experiencing POI, building upon positive work to date including the provision of information and advice for primary care colleagues and the development of nurse or AHP-led primary care menopause clinics. We will determine a future model of care that ensures women are effectively signposted to accessible and reliable patient information, and is cognisant of increasing demand and capacity challenges across the system.

Acute Gynaecology Services, including Endometriosis

Acute women's health services, including maternity, neonatology, fertility and gynaecology services, are provided from all of our main adult acute sites as well as in community settings with key bases at the Royal Infirmary of Edinburgh and St John's Hospital at Howden. Acute women's health services manage almost 237,000 patient contacts per year.

The Covid-19 pandemic exacerbated existing capacity and workforce challenges within acute gynaecology services, echoing the situation across the NHS. Many women experience long waits when seeking support for chronic gynaecological conditions. For example, the waiting time for surgical diagnosis of endometriosis via diagnostic laparoscopy is currently two years, and long waits for diagnosis can also affect treatment waiting times. Reducing waiting times would require additional capacity, including both staff and infrastructure, and waiting times across all acute services need to be considered as a whole. Waiting times recovery in Lothian is governed by the Scheduled Care Programme Board. As part of the annual review of the Scheduled Care Programme in 2023/24, we will review the status of waits for acute gynaecology services.

Women's Health Physiotherapy

Physiotherapists work to improve pelvic health of women focusing on how to help them achieve optimal relaxation, function and strength of pelvic floor muscles. Physiotherapists also have a preventive as well as treatment role during pregnancy.

The Royal College of Midwives and the Chartered Society of Physiotherapy released a joint statement on Pelvic Floor Muscle Exercises in 2020, with a view to improving health outcomes for women following pregnancy and birth[3]. We will consider whether and how these recommendations could be adopted within Lothian.

Access to community women's health physiotherapy can be inconsistent across Lothian and work is ongoing to review capacity and demand and redesign outpatient services across East Lothian, Edinburgh, Midlothian and West Lothian with a view to improving access.

[3] RCM/CSP Position Statement

Priority 2: Promote good women's health and prevent ill health for women and girls

Women and Girls are able to easily access good quality health information.

Women and girls need to be able to access high quality healthcare information. We recognise that lots of excellent information is already available across the health and care system and from our partners in the third sector. The Women's Health platform on NHS Inform provides a central platform for information on women's health and gives us the opportunity to work with others to provide information on a Once for Scotland basis. Other helpful sources of information in Lothian include:

- Lothian Sexual Health website, which maintains comprehensive information about sexual health, available services and invites online appointment booking: https://www.lothiansexualhealth.scot/
- the Diabetes Managed Clinical Network, which maintains a webpage with information for patients and carers including signposting to other resources from Diabetes UK and Edinburgh Diabetes: https://services.nhslothian.scot/diabetesservice/information-for-patients-and-carers/
- Exppect Edinburgh, which provides information for patients on endometriosis and pelvic pain, treatments, support groups and pain management: https://www.ed.ac.uk/centre-reproductive-health/exppect-endometriosis/information-for-patients
- The Adult Weight Management & Type 2 Diabetes Prevention Service provides information on a range of programmes to support weight management: https://services.nhslothian.scot/awmt2d/
- Healthy Respect provides information on sexual health and wellbeing for young people and the workforce who support them, including information on accessing sexual health services: https://www.healthyrespect.co.uk/

For people who use our services, the challenge may be in navigating to information from trusted sources, including information about how to access local healthcare services:

'Young women often felt frustrated that there was a lack of information upfront about how to access their local healthcare services. They talked about how different services have their own websites which can often be inaccessible and difficult to navigate' [4]

Reviewing how we provide and signpost to accessible information is likely to be a complex task involving multiple stakeholders but would also be of significant value to everyone living in Lothian.

[4] SYWS

Services are welcoming and women and girls feel safe when accessing health services.

Promoting good health and preventing ill health requires women and girls to feel safe when accessing healthcare information and advice, and welcome within all our services. The *Status of Young Women in Scotland* report found that ''young women and people of marginalised genders need to feel safe to access timely care. Especially in relation to abortion and reproductive services and gender-affirming healthcare' [5] There is also evidence that women and girls who have experienced gender-based violence may avoid some services.

It is anticipated that this work will learn from and build upon approaches that are already in place across the system, such as Spring in Midlothian.

Spring is a service for women in Midlothian who are involved with the Justice system or *at risk* of coming into contact with the Justice system. Spring welcomes women aged 18 years and over, with or without disability, of different ethnicity, religions and faiths, as well as women who identify as LGBTQIA. Often women Spring supports have experienced trauma, may be struggling with their mental health and/or substance use and may be in, or have been in, relationships where they are not safe.

The Spring service offers a twelve-week group work programme aimed at supporting women to better understand their life experiences, how these may have impacted upon them, and to support them to develop effective coping skills and strategies. The group also supports women to build confidence and self-esteem; to manage difficult emotions and stressful situations; and to improve their overall health and wellbeing. Women attending are supported by and have access to a range of different professionals including Social Workers, a registered Nurse and Occupational Therapist, alongside workers with backgrounds in mental health and gender-based violence.

The Spring service operates weekly in a central location, with support and refreshments provided in a women-only space.

Pre-pregnancy care

The Women's Health Plan seeks for all women to have easy access to info and advice they need to best prepare themselves for pregnancy, as 'planning for pregnancy and optimisation of health and lifestyle before pregnancy improves outcomes for both mother and baby' [6]. It is understood that a once-for-Scotland approach to pre-pregnancy care is intended, and that initial scoping work has identified priority areas for provision of information on NHS Inform.

Determining our approach to pre-pregnancy care is a key action within the Maternity, Children and Young People pillar of the LSDF. A pre-pregnancy care evaluation framework has been developed, and a gap analysis is underway to identify areas for action. We anticipate that our plans in this area will develop over the coming months.

Heart Health

'Heart disease remains the leading cause of death for women is Scotland, and is responsible for significant morbidity and reduced quality of life'.[7]

The challenges women face in maintaining heart health are made clear in the Women's Health Plan, with women presenting differently, symptoms under-investigated, less likely to access treatments

[5] SYWS
[6] WHP
[7] WHP

and likely to experience poorer outcomes. We will seek to ensure that referral guidance for primary care clinicians reflect sex-related differences in diagnosis, investigation or treatment.

There are also specific acute cardiac conditions that affect women more than men, including spontaneous cardiac artery dissection (SCAD) or angina without artery narrowing or stress cardiomyopathy. We welcome the recent establishment of a pilot national clinical service for patients with SCAD, based in Forth Valley.

Prior to the pandemic, very few women from black and ethnic minority groups would attend cardiac rehabilitation sessions in Lothian. The service has found that providing flexible options including NearMe and telephone consultations has supported increased attendance from these groups, as well as amongst women who have a caring role and are less willing to put their health needs first. We will continue to monitor the profile of those who attend cardiac rehabilitation sessions, to ensure that the service is appropriately reaching all women in Lothian.

Adopting a Life Course Approach

The women's health plan emphasises the importance of identifying opportunities to prevent disease and promote health at key life stages. The Royal College of Gynaecologists recognises in their report "Better for Women" that women have predictable long-term reproductive healthcare needs and more frequent interactions with health services than men. We will seek to identify opportunities to promote and protect health and wellbeing within different services and consider how best to adopt this life course approach, building on examples of practice such as routine enquiry or brief intervention.

Priority 3: Provide workforce support and information to promote positive patient experiences, staff equity and staff wellbeing

Staff feel confident and competent to use positive and appropriate language

One of the ways in which we can help people to feel safe and supported when they access our services is to ensure that our staff feel confident and competent to use positive and inclusive language. Our initial scoping work around the Women's Health Plan suggested that some staff feel they would benefit from education, information or resources to use appropriate language. This action links well with our Equality and Human Rights priorities, as set out in our Equalities and Human Rights Strategic Plan, and the work we intend to do to deliver our Equality Outcomes for 2023-25. We will seek to provide our staff with the information and resources they need.

Provide information on the Women's Health Plan, and opportunities for stakeholders to connect

Our work to date around the Women's Health Plan has highlighted the volume of interest there is in contributing to women's health across the health and care system. It is recognised that reducing avoidable health inequalities for women and girls and ensuring that women and girls enjoy good health with positive outcomes requires connection across the health and care system and beyond. We are keen to ensure that those working within Lothian who have an interest in women's health and the women's health plan are connected to ongoing work both locally and across Scotland. We will seek to maintain a network of local stakeholders and ensure that relevant information is shared with them. We will also support staff to link to national networks including the network of Menopause Specialists and the NHS Knowledge Network Women's Health Plan forum, to promote sharing of good practice.

Support Women who work for and with us to Work Well

NHS Lothian has established a number of staff networks with the aim of providing peer support, social events, networking and a point of contact on equality and diversity issues. The Women's Network supports and encourages members to come together to discuss experiences and is a safe place for women to talk about issues that are important to them. We will continue to support the NHSL Women's Network to continue to provide a safe place for women who work for and with us to talk about issues that are important to them.

Prior to 2023, a number of staff working across our sites and services were undertaking activities to support women who work for and with us to work well. This year, a Women's Health Group for staff has been established, to provide a strategic focus on supporting staff wellbeing issues, concerns and practical activities aligned with menopause, menstruation, breastfeeding and other women's health issues in the workplace. The group is chaired by our Work Well Specialist Lead, includes representatives from across the organisation and has developed a programme of short, medium and longer-term actions aimed at improving our support for staff. We will continue to take forward staff wellbeing issues and practical activities through this group.

Representation of women in the workforce

Ensuring adequate representation of women in the workforce is essential for promoting women's health and advancing gender equality. A diverse and inclusive workforce not only reflects a fair and just society but also contributes to improved decision-making, creativity and innovation.

NHS Lothian's *Gender Pay Gap Report*, published in April 2023, demonstrates an overall mean gender pay gap of 12.6% in favour of male staff, although this position has shortened from 15.99% in 2019 to 12.61% in 2023. The report notes that women are the dominant sex in all Agenda for Change pay bands, particularly at Bands 3-8a and also that:

- At Executive and Senior level, there is a mean gender pay gap of 6.9% in favour of men
- There is a mean gender pay gap of 9.8% in favour of men in Medical and Dental pay grades

The NHSL Advancing Equalities Action Plan for 2023 included an action to review the gender pay gap report, and develop an action plan to address any gaps identified.

The SG Women's Health Plan seeks to encourage increased representation of women clinicians by promoting diverse role models and encourage mentoring for trainees. In Lothian, we will seek to understand where women clinicians are under-represented, and work to understand why this is the case.

Maternity services

We have piloted continuity of care elements of the "Best Start" policy, and while there have been considerable successes, we do not have the workforce to be able to provide universal continuity of care in a safe and sustainable way until 2027 at the earliest. We have therefore pivoted our focus to be on the provision of continuity of care to the most disadvantaged communities, and we will continue to do this through the coming year. Where opportunities to spread this approach present themselves, we will pick these up if we can be assured they will be safe and sustainable. We believe this to be in the spirit of the "Best Start" recommendations and congruent with Safe Staffing legislation.

Neonatal service provision

NHS Lothian works closely with its regional partners (most pertinently Fife and Borders) to ensure that we already have a strong and robust model of neonatal care. As it stands, we are already closely aligned within this tripartite structure to the recommendations of the Best Start neonatology work. We continue to fine-tune this work regionally, with the regional working group chaired by the NHSL Chief Executive.

As part of this work it has become apparent that final implementation will depend on the agreements made in the North and West about patient flows. There is considerable flow from these areas into the Lothian neonatology service, and while we are happy to continue with this, clarity on particular commissioning requirements will be welcome.

Children's Services

We have continued to follow the Children and Young People's Implementation Book, which lays out the next four years of actions. This illustrates our commitment to four key priorities;

1. Improving maternal health and tackling poverty
2. Infant and Child health and wellbeing
3. Adolescent health and wellbeing
4. The Promise

These four priorities are shared with our statutory partners in the four Children's Partnership Plans we are signatories to.

We can confirm that we have plans in place to deliver child health reviews as required.

For actions on delivering on Local Child Poverty Action Report, please see pp32-33.

Paediatric Audiology

NHS Lothian was obviously at the heart of the Independent Review of Audiology, and has worked closely with SGHSCD throughout its programme of improvements arising from investigations. Our paediatric audiology action plan has already been shared with SGHSCD and progressed effectively, but more detailed discussions with SGHSCD would of course be welcome.

Implementation of Workforce Strategy

Governance and approach

Workforce is one of the five parameters for the LSDF. Our Workforce Development Board is chaired by the Director of Human Resources and Organisational Development and has senior leadership involvement across the gamut of NHS Lothian organisational units and staff groups.

Key priorities

Although it is not requested in the ADP guidance, it is pertinent to confirm that NHSL has arrangements in place to take forward the Cabinet Secretary mandate on the non-pay elements of the latest Agenda for Change pay agreement between the Scottish Government and staff representative unions. Per communications of 7th March, we will seek to implement further guidance from SGHSCD with all deliberate speed. For clarity, our assumption is that the implications of non-pay improvements will be fully-funded by the Scottish Government, in line with previous correspondence and public announcements. Phase 1 of this work will see staff in Finance, HR, and Strategic Planning move to 37-hour weeks from 1st April.

Since 2019, the Workforce in NHS Lothian has increased by 13%. Considering the current financial context, such workforce growth is financially unviable and therefore the extant 3-year Workforce Strategy will need to be altered in some areas. In essence, we will be required to reduce workforce costs and ensure optimisation of current workforce to ensure best value is achieved and patient and staff safety is maintained.

In terms of agency staffing use and the optimisation of staff bank arrangements, NHSL is proud of its current staff bank infrastructure, and we will continue to see these arrangements as core to our financial sustainability and the provision of safe care. The staff bank now covers the vast majority of all types of staff.

This robust staff bank infrastructures means that we are able to securely progress towards removing agency staffing. We have implemented additional senior checks on the use of agency staffing with all requests now vetted by one of our Nurse Director team – Director of Primary and Community Care Nursing, Director of Acute Services Nursing, Director of Mental Health Nursing, and Deputy Executive Nurse Director. This team also provides an out-of-hours on-call rota for urgent requests to be considered and appropriately overseen, with a “break glass” methodology in place to facilitate objective decision-making. The Executive Nurse Director presents a monthly report on progress to the Corporate Management Team and we have evidenced significant reductions at all sites. We will continue with this work.

Medical locums are not yet at this level of sophistication, but it is clear that the plans we have outlined for financial sustainability will reduce medical locum and non-core staffing spend as we go through the 24-25 financial year.

We continue to perform relatively well in a Scottish context for sickness absence with a well-described series of resources for staff and excellent staff-side engagement and support, and will continue with this. Clearly, however, much of our work will reach a natural limit of unavoidable illness absence, especially as the workforce ages.

Digital and innovation

Governance and approach

Our digital delivery board is the key vehicle for taking forward our digital agenda. This board is chaired by the Chief Executive and most members of our executive leadership team are also members of the delivery board. Digital remains a key part of our LSDF and as such the key document for reviewing plans remains the LSDF Implementation Book, which is appended. This shows how we intend to implement the national digital programmes and we will remain active in this area.

Our Board remains particularly interested in the digital and innovation agenda and we intend to run a development session for our Board in May on this very topic. Board members are also undertaking work with NES on their development in this area.

Concerns and risks

The most significant challenge to effective implementation of the digital agenda remains resource constraints. This is a twofold challenge across both revenue and capital funding.

Our revenue position is, as described in detail elsewhere, severely constrained. In the digital sphere, the switch to subscription rather than purchase models for software has increased pressure in those areas, with vendors increasing fees in very large increments.

Our capital position is also, as described above, severely constrained. The limiting of formula capital to £25m in turn limits our digital purchase budget, and in this year we anticipate a limit of £5m-£7m. This may seem to be a large figure, but for an organisation the size of NHSL this equates to somewhere in the region of 0.2% to 0.3% of our total budget. There is therefore an increased list of negative impacts on all aspects of our digital work, and in the last week we have seen a further reminder in Dumfries and Galloway of the risks that encapsulates.

Climate emergency

TO FOLLOW

[i] Evidence hub: What drives health inequalities? - The Health Foundation
[ii] Whole systems approaches to obesity and other complex public health challenges: a systematic review | BMC Public Health | Full Text (biomedcentral.com)