NHS Lothian Board

08 January 2020, 09:30 to 13:00
Scottish Health Service Centre, Crewe Road South, Edinburgh EH4 2LF

Agenda

Declaration of Interests

1. Declaration of Interests

Brian Houston

Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. It is also a member's duty under the Code of Conduct to ensure that changes in circumstances are reported within one month of them changing. Please notify changes to Georgia.Sherratt@nhslothian.scot.nhs.uk.

For further information around declarations of interest please refer to the code of conduct section of the Board Members' Handbook.

Items for Approval or Noting

2. Items proposed for Approval or Noting without further discussion

Decision

Brian Houston

2.1. Minutes of Previous Board Meeting held on 4 December 2019

For Approval

Brian Houston

2.1 04-12-19-Public.pdf (17 pages)

2.2. Appointment of Members to Committees

Brian Houston

2.2- 8 January 2020 Board - Committee Appointments (final 181219).pdf (2 pages)

2.3. Healthcare Governance Committee Minutes 10 September 2019

For Noting

Moira Whyte

10-09-19 HGC Signed Minutes.pdf (8 pages)

2.4. West Lothian IJB Minutes 10 September 2019

For Noting

Martin Hill

WLIJB minute Sept 19.pdf (6 pages)

Items for Discussion

3. Opportunity for committee chairs or IJB leads to highlight material items for awareness

Discussion

Brian Houston

4. NHS Lothian Recovery Plan Update

Appendix 2 - Waiting Times Improvement Plan
Appendix 3 - Mental Health and Learning Disability Update

Discussion

Pete Lock

4.1- Board Cover Recovery Plan Dec 2019 v2 (301219).pdf	(8 pages)
4.2- Board Paper_WTIP_Jan 20 - Final_Submitted.pdf	(17 pages)
4.3- App 3 - Men Health LD (231219).pdf	(13 pages)

5. Towards a System Transformation Plan

Alex McMahon

5.1- System Transformation Plan (public).pdf	(6 pages)
5.2- AOP 20-21 - AOP Letter and Guidance - November 19 FINAL.pdf	(18 pages)

6. Operational Performance throughout the Festive Period

This will be a verbal report

Discussion

Jacquie Campbell and David Small

7. RHCYP, DCN and CAMHS Update

Discussion

Susan Goldsmith

8. Future Board Meetings

- 12 February 2020 - Edinburgh Training Centre, 16 St Mary's Street
- 04 March 2020 - SHSC
- 08 April 2020 - SHSC
- 06 May 2020 - SHSC
- 24 June 2020 - SHSC
- 12 August 2020 - Edinburgh Training Centre, 16 St Mary's Street
- 02 September 2020 - SHSC
- 14 October 2020 - SHSC
- 07 November 2020 - SHSC
- 09 December 2020 - SHSC

Information

9. Any Other Business

Verbal

Brian Houston

10. Invoking of Standing Order 4.8 - Resolution to take items in closed session

Decision

Brian Houston

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 4 December 2019 in the Carrington Suite, Scottish Health Service Centre, Crewe Road South, Edinburgh, EH4 2LF.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mr M Ash; Mr M Connor; Dr P Donald; Cllr G Gordon; Ms C Hirst; Professor T Humphrey; Mr A McCann; Mr W McQueen; Mrs A Mitchell; Mr P Murray; Cllr F O'Donnell and Dr R Williams.

Executive Board Members: Mr T Davison (Chief Executive); Ms T Gillies (Executive Medical Director); Mrs S Goldsmith (Director of Finance); Professor A K McCallum (Director of Public Health & Health Policy) and Professor A McMahon (Executive Director, Nursing, Midwifery & AHPS – Executive Lead REAS & Prison Healthcare).

In Attendance: Dr E Bream (Consultant in Public Health and Quality Directorates Lead for Emergency Departments, Primary Care and Mental Health for Item 52); Mrs J Butler (Director of HR & OD); Ms J Campbell (Chief Officer, Acute Services); Ms E Johnstone (Quality and Safety Information Manager – Primary Care for Item 52); Mr P Lock (Director of Improvement); Dr N Maran (Consultant Anaesthetist and Associate Medical Director, Quality Improvement for Item 52); Dr R McGregor (Shadowing Ms T Gillies); Mr C Stirling (Site Director, Western General Hospital for Item 52); Dr S Watson (Chief Quality Officer) and Mr D Weir (Business Manager, Chairman, Chief Executive and Deputy Chief Executive's Office).

Apologies for absence were received from Mr J Crombie, Mr M Hill, Ms F Ireland, Mr A Joyce, Councillor J McGinty, Mrs J Mackay, Councillor D Milligan and Professor M Whyte.

Declaration of Financial and Non-Financial Interest

The Chairman reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. There were no declarations of interest.

Chairman's Welcome and Introduction

The Chairman welcomed members of the public and press to the Board meeting. In addition he welcomed Dr Richard McGregor advising that he would be shadowing Ms Gillies. He also welcomed Dr Elizabeth Bream, Dr Nikki Maran, Mr C Stirling and Ms E Johnstone to the meeting advising that they were in attendance to participate on the discussion around the NHS Lothian Quality Strategy: Annual Update Report 2018-2019.

50. Items for Approval

50.1 The Chairman sought and received the agreement of the Board to agree items 2.1 – 2.9. The following were approved.

50.2 Minutes of previous Board meeting held on 2 October 2019 – Approved.

50.3 Appointment of Members to Committees – The Board agreed to appoint Stanley Howard and Brian McGregor to the Pharmacy Practices Committee as lay members for the period 4 December 2019 to 3 December 2022. It was also agreed to reappoint Michael Ash as a voting member of Edinburgh Integration Joint Board for the period from 1 February to 31 July 2020. Finally it was agreed to appoint Professor Moira Whyte as a member of the Healthcare Governance Committee with immediate effect and as Chair of the Healthcare Governance Committee with effect from 1 February 2020.

50.4 Change to the Schedule of Board Meetings – the amended schedule of Board meetings was approved.

50.5 Review of Scheme of Delegation – the Board approved the Scheme of Delegation.

50.6 Audit & Risk Committee Minutes 17 June 2019 and 26 August 2019 – Noted.

50.7 Staff Governance Committee Minutes 31 July 2019 – Noted.

50.8 Finance & Resources Committee Minutes 25 September 2019 – Noted.

50.9 Midlothian Integration Joint Board Minutes 22 August 2019 and 12 September 2019 – Noted.

50.10 East Lothian Integration Joint Board Minutes 20 August 2019 and 11 September 2019 – Noted.

Items for Discussion

51. Opportunity for Committee Chairs or Integrated Joint Board (IJB) Leads to Highlight Material Issues for Awareness

51.1 Mr Ash commented that although the Minutes of the most recent meeting of the Audit & Risk Committee were not before the Board he felt it was important to advise of discussion around the internal audit report on the Quality directorate which had been circulated to the Board as part of the debate at the current meeting. He also advised of discussion around the need for internal audit reports once published and posted on the website to be transmitted to the relevant Board Governance Committee for awareness. He advised that these actions would be followed up.

52. NHS Lothian Quality Strategy: Annual Update Report 2018-2019

52.1 The Chairman welcomed and introduced Dr Watson and his colleagues advising that they would provide an update on the progress, current position and future intentions around the NHS Lothian Quality Strategy. The Board received a short video presentation consisting of enthusiastic participants in the Quality Programme.

52.2 The Board were reminded that in 2016 it had approved a prototyping programme about how to put quality and care at the heart of the organisation. It was noted that this had been progressed through networks involving a significant number of people and pathways aligning to areas of operational concern. The process had been progressed with a focus on normal business and making real change at ground level. Progress had been delivered through a core team of improvement advisers and a senior team to support local development, embedding quality into routine business and to coach people. The Board were advised that since the inception of the Quality Strategy that the landscape had changed and Lothian was now seen as a place to undertake the prototyping of national accreditation programmes. Dr Watson advised that all Executive Directors had actively played key roles in the development and introduction of the Quality Strategy and provided details of these to the Board.

52.3 The Board were advised that a key issue moving forward was how to resource the Quality Programme given that it did not have national funding. Dr Watson advised that the Director of Finance and her team had been helpful in resourcing the process with the input of the Sustainability and Values Group being welcomed. In order to develop the process the Executive Team had utilised a process of agile meetings to progress issues without the need for significant amounts of paper. Dr Watson commented that there was a need for this agility now to become balanced with a requirement to report progress to the Board and its sub-committees and secondary to the wider NHS Lothian organisation in order to share and celebrate achievements. The key work programmes were explained and categorised against the issues set out in the Quality Strategy. The Board noted that other organisations had been inspired by the Lothian approach.

52.4 Dr Watson advised that the pull on central resources was becoming an issue and that there was also a squeeze in the middle of the department which the Executive Team were aware of. He commented that it had been helpful that non-recurrent funding had been made recurrent and this provided security to the Directorate and its staff. The Board noted that work for the following year had been planned and aligned to the recovery actions particularly in respect of high volume clinical pathways where access was an issue i.e. orthopaedics, dermatology and child and adolescent mental health services (CAMHs). This work would be taken forward in conjunction with Health Improvement Scotland (HIS) as part of an accelerator programme with a view to spreading it to other Health Boards.

52.5 The Chairman echoed the points made by Dr Watson advising that at a previous NHS Board Chairs Group the virtues of the Lothian approach had been extolled in the presence of the Cabinet Secretary where it had been reported that NHS Lothian was a vanguard Board with details of the detailed progress having been reported.

52.6 The Board received a short video presentation covering activity at the Blackford Ward, Astley Ainslie Hospital, mental health project in respect of patient care and safety, CAMHs psychology as part of a HIS accelerator programme in respect of queuing methodology to reduce waiting times, orthopaedics around hip fracture care which had resulted in a reduced length of stay and the identification of “golden patients”, primary care and the benefits of sign-posting patients to appropriate services, frailty with a view to giving patients realistic care and reducing prescribing and inappropriate admissions, urology where QI had been used to improve waiting

times with a particular focus around flexible cystoscopy resulting in better access for patients. Finally an update was provided on the Western General Hospital where a site based approach had been adopted with a view to marrying the culture of the site to Quality Improvement. The approach had demonstrated a reduction in cardiac arrest rates as well as an increase in financial efficiency and productivity in a number of areas. It was noted that in infectious diseases work was underway to look at the rate of penicillin usage and the need to use the most cost effective drugs.

52.7 Dr Watson advised that the Quality Improvement Programme had strong links into the work being undertaken by the Director of Human Resources and Organisational Development around leadership.

52.8 The Chairman welcomed the comprehensive update and invited Board members to participate in a question and answer session.

52.9 Mr Murray advised that he had found the report and presentation to be interesting and helpful and commented that he recognised the value of continuous improvement. He commented however as a Board member that he would welcome a triangulation around how to attend to risks through the organisation in respect of clinical care and finance. He felt that the general improvement work needed to be referenced with a focus around issues like the treatment time guarantee report and issues around the 62 day wait for cancer. He commented that he had not seen these issues reflected and questioned whether this was a focus of attention in respect of the Quality Improvement work. He also felt that representation of the Board was an aspect that was missing from a strategic perspective.

52.10 Dr Watson commented in respect of clinical care aspects that all of the work had been commissioned through the Executive Team with a focus on areas of significant organisational challenge and provided examples of work undertaken in primary care and mental health. He advised in respect of how to join up the bright spots of work that this was a significant challenge that would be addressed and that NHS Lothian would be one of the first organisations to join up small dots into a wider perspective although there was currently no template on the shelf for undertaking this work. In terms of cancer the point was made that a number of people had been through the training programme although it was recognised that it was difficult to get people fully engaged when they were dealing with other infrastructure issues and this had been drawn to the attention of management and leadership. Dr Watson commented that work with colleagues in cancer would continue.

52.11 The Chief Executive commented in respect of 62 day cancer performance that the diagnostic pathway and in particular around endoscopy was a significant challenge and that progress was being made. He advised that the system was constantly striving through opportunities in innovation and research and development etc to focus on organisational challenges a lot of which was down to looking at capacity in the first instance. He commented that a twin track approach was needed as quality in itself would not fix the challenges facing the organisation and there would be a need to invest in capacity. Ms Campbell provided the Board with an update on work around urology and flexible cystoscopy advising that this linked to 62 day pathways and the waiting time. She commented that the focus of available capacity was used to treat urgent patients in the queue. An update was also provided on QI work in dermatology and HIS access collaboratives.

52.12 Mrs Hirst commented that the report was useful although she had a concern that it concentrated on a measurable matrix and that as a Board member she was interested in qualitative measures and the impact on patients particularly from a pre and post QI perspective. The point was made that the video presentation had touched on the benefits of the process for patients within the Blackford Pavilion at the Astley Ainslie Hospital and other areas. Professor McMahon commented that as part of the QI work undertaken to date there had been a focus on a patient experience questionnaire where positive outcomes and experiences had been reported. Mrs Hirst commented however that this type of information was not coming through in the narrative in the Board paper. Dr Maran acknowledged this point but assured the Board that all programmes as part of the planning phases included a focus on encouraging users to give their views about the service they received. She commented that all improvement work was focussed on the impact on patients and users. The Board were advised that the Programme Board in the acute sector was absolutely focussed on patient experience as part of the monitoring process which included receiving patient stories which were rich in detail. It was agreed that the issues raised by Mrs Hirst would be captured in future reports to the Board with it being noted that there was a need to also share this type of information in other public facing arenas.

52.13 Dr Watson in response to a question about how the Quality Programme dovetailed into the Sustainability and Values Group and whether a big project approach was adopted advised that the Project office approach worked well. He commented that the Quality agenda was a significant part of the Sustainability and Values Group and he felt that the support and challenge from the Group was positive. Dr Watson advised that discussions had been held about what project management needed to look like and the different skill sets required to support the process. He commented that in the early stages of the QI Programme that a different skill set from that adopted in project management was needed to deliver the programme. He commented now that QI had been embedded and that a programme of work had been developed there was now a need to adopt a more gateway type of approach and that he felt that processes were now becoming more aligned. Mr Connor advised that the issue was about making sure that projects were monitored and he felt that the utilisation of a Project office helped to weld together a more systematic approach. Mrs Goldsmith commented that she and colleagues recognised the input of QI into sustainability particularly in respect of increased efficiency and productivity. Prescribing was mooted as an example of joint work with it being noted that the Sustainability and Values process had supported this by providing a project manager who was part of the Academy as well as coaching people and developing networks. Dr Watson advised that now that Quality Improvement was becoming more embedded into business as usual that the previous agile approach now needed to be more formalised in terms of infrastructure.

52.14 Dr Donald questioned the position in respect of the use of measurement and impact tools around patient responses. Dr Watson advised that this was an area of constant challenge and that considerable work was undertaken to measure these types of issues although he was conscious there was a danger that the process could end up doing nothing but measuring. He advised that there was a lot of engagement with staff and that the impact of the QI process in terms of staff and patients was being measured. Dr Bream advised that she was looking at toolkits in

order to maximise the measurement benefit and that these were in the process of being developed. Dr Watson commented that he felt there was sometimes too much focus on measurement and that in some instances this could be challenging and off putting to participants. He commented however that measurement tools were in place for all of the 6 dimensions of quality and described the maturation approach that was being adopted. Dr Watson advised that there were a lot of matrixes in play although he was keen to ensure that outcomes were only measured once. Dr Maran advised that the acute quality programme had established outcome measures to track big issues in the programme and advised that every piece of improvement work was registered and followed a project template with clear aims and measures. Dr Watson commented that in Appendix 2 of the report that detail was provided around the impressive work undertaken around patient falls at the Western General Hospital.

52.15 Mr Stirling commented from his perspective the main challenge had been that initially there had been a broad base of enthusiastic people and that the key issue was to align this to the bigger picture. His focus had been on moving from enthusiastic amateur status to a more professional approach and that tools were married together for all significant projects with it being stressed that sometimes there was a need to disinvest from areas that were not adding value. He commented that new measurements were being developed and highlighted the "attend anywhere" initiative which resulted in significant reductions in patient miles and carbon footprint. Mr Stirling commented in respect of maturation spread for the Western General Hospital that the focus was on delivering outcomes and financial returns.

52.16 Dr Williams advised that he had welcomed the positive and reassuring presentation which was not often seen by Board members and this linked back to earlier debate around the Audit and Risk Committee observations. He suggested that there would be benefit in including a standard section in all Board and Board committee papers referencing quality work.

52.17 Professor Humphrey advised that she would also like to echo the positive comments made about the presentation and the progress of the Programme. She suggested that a key issue was about how to scale up the project to make it systemic in the organisation. She commented from her perspective as the Chair of the Healthcare Governance Committee that she did see evidence of the benefits of the Quality Improvement Programme albeit it was not specifically labelled as such. She suggested that there was a need to focus discussion at the Committee to highlight the important work that was being done in this area. Dr Watson advised that as work became more embedded in the fabric of the organisation then the quality logo would probably become less visible. He advised that he was conflicted about the use of branding as there was a possibility that this might disengage some people from the process. He commented however that he was determined to make the quality experience real at the front line and the band width to support this would be an issue. He commented that the internal audit work had been helpful and updated on plans to hold a Quality conference in 2020 to which each Board member would be invited to attend. He advised that he also intended to bring more regular monitoring papers to the Board and that he would welcome the input of Board members in developing the process moving forward.

52.18 Mrs Mitchell echoed the previous comments about the quality of the work and the outputs. She commented however that she was concerned about what was being done with the outputs and the need to train people in the methodology. She questioned where the outputs from the process were being shared. Dr Watson concurred that outputs were not being shared widely enough at the moment albeit good experiences were being publicised through clinical change forums on a local basis. In respect of training he commented that he felt that people had 100 seconds in each hour to participate in quality work it would be important to develop an efficient way of utilising this time with training needing to be relevant and proportionate. He advised that whole day training events were now being held and that this was an efficient way of engaging with people although it was important to recognise that people did not need to have "the badge" to be able to participate in quality improvement work. He advised in terms of scalability that 80% of GP practices in Lothian were actively engaged in the Quality Improvement Programme and were doing outstanding work. Ms Johnstone provided the Board with details of the sharing mechanisms undertaken through the primary care programme including the development of a network web page and the work with the clinical team to write up a clinical support document. Bowel screening was put forward as a good example of where a positive toolkit had been developed. Posters developed for conference events were made available on a virtual basis in order to demonstrate benefits and progress. Ms Johnstone advised that there was a strong focus on the virtual sharing of experiences and information. The Chairman advised that he had been unaware but pleasantly surprised to learn about the spread of the programme within primary care.

52.19 Councillor O'Donnell with respect to the GMS contract questioned how information was shared and the links with IJBs. She asked how quality was defined and how it was measured as well as how the patient experience sat within this. Dr Watson commented that in 2001 the Institute of Medicine had published a paper defining quality of health as being safe, timely, efficient, effective, equitable and patient centred. He advised that in NHS Lothian a further criteria had been added in respect of sustainability in relation to the environment. He commented that the primary care QI programme had been successful because of the good networking arrangements that had been put in place. Ms Gillies commented that the GMS Oversight Group which included IJB members was another way of ensuring that people were sighted on what was happening on the ground.

52.20 The Chief Executive commented that when the Quality Improvement initiative had first been established that the first phase had been to generate interest with the second phase being about sustaining and growing the process with the next steps of the forward programme needing to be considered as the third phase. He felt that the system should congratulate itself and feel good about what had been done to date commenting that in Lothian work was more complex and substantial than other Health Boards. He recognised however that this work was being taken forward using a small infrastructure and was dependent upon a small core of staff. He advised that as part of the previous external support team process lead by Sir Jim Mackay that he had been hugely impressed and congratulatory about the Lothian QI work in the Emergency Department and had intended to implement a similar approach within his own Trust. The Chief Executive commented that despite a lot of hard work there had been an increase of 6% in attendances at the Emergency Department. He advised that the challenge moving forward was to make Quality

part of the heart of the organisation and he felt that this was the fundamental challenge that needed to be addressed. He commented that only a small amount of money was being invested in innovation and robotics and that the future third phase of the QI Programme would require targeted investment in the infrastructure in order to support further progression and to ensure that the Programme did not go backwards as currently it was not possible to scale the process as quickly as he would have liked.

52.21 The Chairman thanked the Quality Team for the excellent update advising that he felt that the Board had received assurance around prioritisation, evaluation and measurement and the need to consider focussing moving forward on the patient outcome and experience. In terms of the points made about visibility and general awareness of reporting the need to spread awareness at Board level and wider into the organisation was recognised. The Chairman advised that he recognised the conflict between making the process more visible and embedding this in business as usual with the debate at the meeting reflecting where the organisation was on this journey.

52.22 The Chairman commented that it would be important to reflect on the proposal that quality should feature as a standard section on Board and Board Committee papers. He felt there was a need to move away from a silo approach and think about how aspects needed to link together.

52.23 The Board agreed the recommendations contained in the circulated paper.

53. NHS Lothian Recovery Plan Update

53.1 The Chairman commented that it was important to remind the Board that whilst addressing the recovery plan that the circulated paper subsumed issues around waiting times and the winter plan.

53.2 Mr Lock advised that the paper was intended as an update and would touch on the process and current position as well as how to progress other performance aspects. He advised that comments had been received from the Scottish Government on the reported plan. He advised the Board there was a factual inaccuracy in the paper in that the recovery plan had been submitted to the Scottish Government the previous Friday and that positive comments had been received on it. Mr Lock advised that he was keen for the project plan to go to the Scottish Government Oversight Board who would then decide where NHS Lothian sat in terms of the escalation framework with there being a possibility that this position would be reviewed downwards.

53.3 The Chief Executive advised that he and colleagues were in active dialogue about how to get into the de-escalation process and he felt that NHS Lothian was now in a more positive position in terms of meeting the criteria for this to happen. He commented however that unscheduled care continued to be a vulnerability albeit that dialog with the Scottish Government was now more positive.

53.4 Mr Lock advised that he felt that good progress was being made although there remained as reported by the Chief Executive significant risks around areas like unscheduled care. He provided a brief overview of progress being made. The

Board were advised in terms of outpatients and treatment time guarantees (TTG) that since September the numbers have reduced in line with trajectory. The Board were advised that a challenging plan for reduction in the second part of the year was in place and that good work was also underway in respect of 62 day cancer care waiting times with the October data providing confidence of sustained improvement.

53.5 Mrs Campbell advised that the circulated paper in respect of scheduled care had demonstrated that the outpatient position was showing signs of improvement and although the position was still above trajectory there was confidence around the actions deployed. In terms of the risk to delivery in December the focus was on exploring capacity at East Lothian in the new hospital. She advised that TTG continued to perform better than trajectory with there having been a positive reduction between September and October in terms of the number of patients waiting more than 12 weeks. The Board were advised that one of the recovery actions had been around the utilisation of 2 theatres at Forth Valley with it being advised that at this point in time the second theatre had not come on stream causing a risk to 550 cases with work being undertaken to consider how to mitigate this position. Mrs Campbell advised that another area of risk in respect of TTG was in respect of unscheduled care performance and as result of pressures a number of patients had been postponed specifically in orthopaedics at the Royal Infirmary of Edinburgh.

53.6 Mrs Campbell advised that the diagnostic and endoscopy position had improved and that there would be no patients waiting more than 12 weeks at the end of March 2020. She also updated the Board on the previously referenced flexible cystoscopy improvements. The Board were advised that a CT and MRI recovery action was in place involving a change in protocols and pathways particularly in respect of head injury and cardiology. The Board were advised in terms of the 62 day cancer target that there had been a 3.5% improvement between July and October 2019. A weekly monitoring group had been convened and had proved to be beneficial with this approach being expanded to cover lung cancer.

53.7 Mr McQueen questioned what impact the pension and taxation issues were having on the ability to run waiting list sessions given the dependency on these. Mrs Campbell advised that this was variable across services although it was clear that there had been a reduction in the number of consultants willing to undertake waiting list initiatives and this was a concern given it was an embedded part of the sustainability process. She commented in terms of job plan sessions that there was a need to quantify the position and that in contracts there was always a focus on out of hour services. Ms Gillies advised that as job plans developed the detail of issues like this would be brought back to the Board.

53.8 Mr Murray questioned the risk to patients of NHS Lothian not meeting the TTG guidance. It was pointed out that this depended on the specialty and was the reason why a clinical risk matrix had been deployed for use in areas of limited resource in order to ensure that the most needy patients were prioritised. The Board were reminded of the ‘keeping in touch’ approach and if during contact with patients their health status had changed then their position on the waiting list would be reassessed. It was noted that currently there were no outcome measures to demonstrate the effectiveness of this approach. Ms Gillies reassured the Board that the system would look at any known negative impacts and instigate an appropriate

investigation although she agreed that social personal and economic impacts were not captured. The Chief Executive commented that data was kept in respect of 'keeping in touch' contacts. It was agreed that the consequence of call back of patients needed escalated and that there was a need to record what had happened to those patients. Mr Murray commented that if NHS Lothian was held to account as a consequence of NRAC detriment then the impact of this needed to be evidenced. The Chief Executive commented that there was a recognition that resourcing needed to be addressed.

53.9 Dr Williams advised in respect of paragraph 3.6 in the paper in relation to CAMHS and psychological therapies that reference was made to the fact that once the backlog had been tackled that performance should return to target. He commented that a simple hyperlink to the paper to add in narrative around processes and outcome would be helpful as supporting information. Professor McMahon commented that it was intended to focus on CAMHS and psychological therapies at the January 2020 Board meeting and that this would demonstrate the improvements that had been made. Dr Watson commented that in 2020 as part of the active QI process that consideration would be given to looking at referral pathways and how to manage these.

53.10 Cllr O'Donnell sought an update on the role of the private sector and work in respect of quality improvement on patient journeys. She referred to the need to cancel orthopaedic appointments and questioned how the quality of external service providers would be monitored. The Board were advised that the external provider office had created a clinical and service specification which was utilised before engaging with either in service providers or external providers and that this included issues around the management of adverse events. Cllr O'Donnell questioned what processes were in place in terms of comments made about not being able to get patients home as quickly as would be desired. Mrs Campbell advised that the expectation would be that the same number of patients would be treated with consideration being given to the issues that were causing the delays with it being noted that the external provider office were very experienced in this area.

53.11 Mr Lock reiterated that unscheduled care remained the biggest point of risk and that there was a need to recognise the position at the Royal Infirmary of Edinburgh and the Western General Hospital with active consideration being given to reducing length of stay and how to get patients out of the hospital more quickly. He advised that a number of actions had been set out to address this position and that this was being taken forward as a priority on management time and attention. Mr Lock commented that it was important to mention that the delayed discharge position had slightly deteriorated in October although it was too early to tell whether this was a trend and there would be a need to see progress in this area. He advised that the key issue was how to improve throughput in the acute sector and that a number of system wide approaches were being considered. In particular a Royal Infirmary of Edinburgh Recovery Meeting had been established with Partnership engagement and in terms of capacity short term actions were being considered. The Board were advised that although the Royal Infirmary of Edinburgh was the largest site that all acute adult sites were full and therefore mutual aid was less available and was impacting on the number of patients waiting at the front door. The Board noted that the circulated paper detailed actions in place for patients fit for discharge and the processes to move them out of a hospital bed in order to be looked after more

appropriately. The focus was on getting patients discharged earlier in the day with a whole system approach with Partnership colleagues being adopted in respect of how to reduce the length of stay. Reference was made to the West Lothian Hospital at Home Team whose focus was on preventing patients presenting at the front door and also reaching in and pulling out patients to get discharged earlier. It was noted that the City of Edinburgh were also looking at exploring the Hospital at Home model to bridge gaps in packages of care using the Red Cross and investing in additional social work. The Board were advised that additional beds were being opened in East Lothian to provide step-down facilities in order to bring people out of the acute hospitals in order to maintain flow in the system.

53.12 The Chief Executive commented that currently there was a worrying tension at management level around the acute and Health & Social Care Partnerships particularly around the front door in respect of concerns around overcrowding. He commented that it was important that the Board recognised that when staff were working under significant pressure that there was a danger that behaviours could become compromised. He felt that there was a need to continue working with Edinburgh in respect of delayed discharge reductions as the current position equated to two wards at the Royal Infirmary of Edinburgh. The Chief Executive commented that the benefit of Mr Lock's engagement was his ability to look at the position on a whole system basis without having an operational management responsibility. He reiterated the earlier point that the earlier discharge of patients would make a significant difference to the current pressures being experienced in the acute sector. He felt that delayed discharges was the systems main achillies heel and needed to be addressed. He commented that NHS Lothian was not unique in this position as this was a central belt phenomenon although other Health Boards have lower rates of attendance. He advised that NHS Lothian was also an outlier in respect of 4 hour waits largely as a consequence of hospitals being full to capacity. The Chief Executive commented that he would like to pay tribute to the management staff at the Royal Infirmary of Edinburgh who were going beyond the call of duty and working stretched hours which was not a sustainable position moving forward. He commented however that an improving position had been evidenced over the previous few weeks.

53.13 Mr McCann advised that he was aware of the problems described and that the IJB had also discussed similar concerns. He questioned what should be done differently in respect of engagement between the Health Board, Council and IJB in terms of coming together more than was currently the case. The Chief Executive commented that the only way out of the current position was to improve performance and until that happened tensions would remain within the system with it being important to stress that overcrowding was a significant safety issue. He advised that there was a need for the City of Edinburgh to improve their delayed discharge position thereby allowing 50 beds to be freed up providing additional headroom within the acute sector. The approach adopted at the Royal Edinburgh Hospital was referenced with it being noted that this had made an improvement in bed occupancy from 105% down to 90% and had therefore reduced the temperature in the organisation. Mrs Goldsmith commented that she did not think that currently there was a consensus about the type of capacity and quantum needed to make a difference and that there was currently not a proper plan in place to get the system into a balance position. Mr Lock advised that this was part of his remit and that he intended to create integrated team working with a lot of the issues being about understanding current

restrictions on what people felt they were able to do. He advised that there were a number of good plans in existence within the City of Edinburgh.

53.14 Professor Humphrey commented that she also felt that unscheduled care was a priority and sought advice on how Board members could be assured that this was also a priority for the Health and Social Care Partnerships. She questioned whether comprehensive plans were in place to address what was a complex issue. She also questioned what evidence was available about actions that would make a difference and were worth scaling up and what steps were taken to step down workstreams that were not working. Ms Campbell advised that she and colleague were looking at multiple actions and considering how best to measure these as the system should not be cancelling elective programmes of work. She assured the Board that consideration was being given to how best to measure outcomes and what could be scaled up and also stopped.

53.15 Cllr Gordon commented that during these debates there was always reference made to issues around Edinburgh in respect of capacity and resource. He felt that there was a need to consider how to get the two organisations to work better together to address capacity issues and agree what plan of action could be put in place as it was important to recognise that Edinburgh did not have the resource available to open up facilities like satellite units. He felt that moving forward there was a need to be clear about the plan. The Chief Executive commented that the main challenge for colleagues in the council was that they needed to make choices about their priorities with it being noted that the City of Edinburgh was a significant outlier in delayed discharges and that in his view there was therefore a requirement for prioritisation around adult social care.

53.16 Mr Murray commented in respect of interactions with the IJBs that the best way to achieve this would be through the Strategic Planning process and interfaces with the Annual Operational Process (AOP) in terms of obtaining clarity about how interaction could be undertaken to deliver results. He felt that there was a need for IJB directions to align to collaboration work and that there was a need for interaction across the two systems. Professor McMahon commented that he felt that a key issue was about all parties using the same narrative at the same time and that there was a need to reflect on that. He advised that he felt that the creation of the Integrated Care Forum (ICF) provided an appropriate vehicle to get relevant people around the table albeit there was a need for more regular engagement. Mrs Goldsmith advised that one of the key reasons why the financial position was only reporting moderate assurance was because of the issues discussed with there being a need to provide resource to get additional capacity.

53.17 The Chairman commented that it was important to recognise the critical situation that the system was in. The Chief Executive advised that the system was in the middle of the budget setting process and it was unlikely that details of the health budget would be available before February 2020 although there was speculation in the system suggesting that there would be a reduction in Health and Social Care resource. He advised that when discussing these issues with Scottish Government colleagues that he was encouraging the adoption of a holistic Health and Social Care budget to counter the perception that health budgets were protected. Board members were advised that part of this process would be to encourage ring-fencing in order to give priority to adult social care budgets. Mrs Goldsmith advised that

section 95 finance officers had agreed to meet to discuss the financial position and the range of options.

53.18 The Chief Executive commented that the risk for the NHS Board in respect of the extant tensions was that it was the Health Board that got escalated in terms of the performance and not Councils and that the delayed discharge was a compromising factor in escalation. The Chairman commented that even if the NHS system had not been escalated in the performance framework that the issues would still be on the table to be addressed.

53.19 Cllr O'Donnell commented that the Chief Executives concerns were real and that she felt there was a need for political engagement over and above the current officer to officer approach.

53.20 The Chairman welcomed the useful discussion and commented that this only reinforced the decision to keep closer order regarding engagement around these issues through the move to monthly Board meetings.

53.21 The Board agreed the recommendations considered in the circulated paper.

54. RHCYP, DCN and CAMHS Update

54.1 The Chairman commented that for reasons of commercial and contractual issues there would be a further discussion on this item in the private session of the Board to be held immediately following the Public Board meeting.

54.2 Mrs Goldsmith advised that there had been considerable work undertaken over the previous few months with support from Ms Morgan the Senior Programme Director appointed by the Scottish Government and others in order to produce a clear programme of work and the delivery timescale to ensure that the new hospital could open safely. It was noted that the main issue of rectification remained around critical care ventilation and that the Board was also taking the opportunity to enhance ventilation in haematology / oncology and elements of fire safety. The other key outstanding issue was the design of the replacement air handling unit.

54.3 Mrs Goldsmith advised that the contractual mechanism for delivering these outstanding works was through the change process set out in a project agreement with IHSL. However the scale and nature of the works and the timescale to which they must be delivered meant that the normal change process would need to be adapted to allow progress to be made. The Board had entered into commercial discussions with IHSL which were in the process of being concluded. The principles of the approach had been agreed by the Oversight Board which had established a Commercial Sub-Group. The Finance and Resources Committee had also endorsed the approach being taken.

54.4 Mrs Goldsmith commented that at this stage the initial programme received from IHSL remained deliverable within the timelines announced by the Cabinet Secretary to move DCN in spring 2020 and RHSC in the autumn. The Board noted that considerable progress had already been made to address actions to support the existing Sciennes site and DCN at the Western General Hospital through the winter

period and beyond and these were detailed in the circulated paper. The Board were also advised of unannounced HEI inspection visits had taken place in October in both the Royal Hospital for Sick Children and DCN. Verbal feedback had been positive and the draft report was due on 4 December 2019 to be reviewed and signed off by NHS Lothian by 18 December 2019.

54.5 The Board noted that an Executive Steering Group currently continued to meet on a weekly basis with the Oversight Board now having moved to a 2 weekly frequency. There was therefore significant engagement in the process.

54.6 The Board noted that the Auditor General and the Board's External Auditor were preparing a section 22 report due for publication on the 18 December 2019. The Board had had an opportunity to review the draft for factual accuracy. The Auditor General would brief the Scottish Parliament's Public Audit and Post Legislative Scrutiny Committee on the section 22 report and the committee might decide to take evidence from the Board's Accountable Officer (Chief Executive). The date for this had yet to be agreed.

54.7 The Board noted that the Cabinet Secretary had confirmed the appointment of the Right Honourable Lord Brodie QC PC as Chair of the Public Enquiry into the matters of concern that had arisen at the Queen Elizabeth University Hospital campus - Glasgow and the Royal Hospital for Children and Young People – Edinburgh. The Cabinet Secretary would provide an update on the terms of reference and timescales of the enquiry in the New Year. Mrs Goldsmith advised that the Central Legal Office had appointed two solicitors to support this work and that senior and junior counsel would be appointed once the remit of Lord Brodie's work was finalised. In the meantime work was underway in order to concatenate relevant files and ensure these were fit for purpose for use by the enquiry.

54.8 The Director of Finance in response to a question from Mr McQueen in respect of the Auditor General section 22 report advised that she and the Chief Executive had had an opportunity to reflect on the report which they had felt was fair and balanced with some issues around nuances having been fed back. It was noted that the section 22 report raised issues for other parts of the NHS system other than just NHS Lothian.

54.9 Mrs Goldsmith commented in respect of a budget for the ongoing legal process that she was unclear about this at the moment and had discussed a joint approach with Glasgow. She advised that at the appropriate time she would bring forward an assessment of the financial quantum to both the Board and Finance and Resources Committee.

54.10 Mrs Mitchell questioned the risk profile around recruitment and the viability of recruitment to posts. Mrs Campbell advised that recruitment was challenging and was currently under review with efforts being made to make this as flexible as possible. Ms Gillies commented there were specific issues around maintaining the existing site particularly in respect of the parallel running of pharmacy services. An update on nursing recruitment was provided by Professor McMahon advising that different routes were being considered including the utilisation of modern apprenticeships.

54.11 At the suggestion of Mr Murray it was agreed that Mrs Goldsmith would pull together key themes discussed at previous meetings of the Scottish Parliament's Public Audit and Post legislative Scrutiny Committee and in the first instance refer this back to the Finance and Resources Committee.

54.12 Dr Williams commented on the key risks and noted that NHS Lothian had an action plan and that the Scottish Government Oversight Board was receiving regular progress reports from the Senior Programme Director. He questioned whether there was a parallel process for Board Committees to obtain the same advice. In terms of the public enquiry he advised that he had welcomed the fact that the Cabinet Secretary had said that she would seek patients comments in the development of the terms of reference although he felt that it was important that the Board would also be able to comment. Mrs Goldsmith advised that at this point she did not know whether the NHS Boards input would be sought. She advised that the Senior Project Director provided reports to the Executive Steering Group which to date had not yet reported through the NHS Boards Governance Committee's albeit the Finance and Resources Committee were updated on the commercial position. Dr Williams felt this was a slight disconnect. Mrs Goldsmith advised that she would include such information in future updates to the Finance and Resources Committee.

54.13 Mr Connor questioned in terms of the contractual position whether NHS Lothian would sign the contract and whether the Scottish Government were content with the contractual position that was being adopted. Mrs Goldsmith advised that issues were more explicit this time and that the paper to be discussed in the private session would also be submitted to the Oversight Board the following day and had been generated by work undertaken by the Commercial Sub-group which included representatives from the Scottish Government. It was noted that the Oversight Board also included representatives from the Scottish Government. It was noted that the Oversight Board would be asked to sign-off the private Board paper at their meeting the following day.

54.14 The Board considered and discussed the issues raised in the circulated report.

55. 2019/20 Financial Position and 2020/21 Financial Outlook

55.1 The Board accepted the circulated report as a source of significant assurance that the Finance and Resources Committee had considered the year to date and year end forecast position of NHS Lothian and the required actions to support breakeven and had accepted the moderte assurance currently provided on the achievement of breakeven by the yearend. Mrs Goldsmith advised that as previously reported that the uncertainly around performance and capacity issues meant that only moderate assurance could be taken at this stage.

55.2 The Board were advised that for the following financial year that finance colleagues were modelling a 3% pay uplift and that 2020/21 would be a more difficult financial year. The assessment for 2020/21 was that NHS Lothian would see a start position similar to that in previous years once recovery plans were in place. It was noted that if the financial uplift to NHS Lothian reduced to 2% then this would result in an additional gap of £15m. Discussion was also held about some of the consequentials

arising from the General Election. The Board noted the list of financial risks contained in the circulated paper.

55.3 The Board agreed the recommendations contained in the circulated paper.

56. Corporate Risk Register

56.1 Ms Gillies advised that the Corporate Risk Register which had been updated for quarter 2 included templates in the new format for the new risks; The Royal Hospital for Children and Young People and Department for Neurosciences and the lack of bed availability at the Royal Edinburgh Building. It was noted that the template for the new risk; the delivery of NHS level 3 recovery plans was currently being finalised.

56.2 The Board also noted that all of the actions required from the Internal Audit of Risk Management in February 2019 had been completed and agreed as closed. This had been evidenced through the process of developing the corporate risk register in the new format. The point was made in terms of unscheduled care that the report reflected that despite using all of the strategies to mitigate risk that these had had minimal impact.

56.3 Mr Murray applauded the revised report and asked if it would be possible for narrative in future iterations to separate out finance and care elements and provide examples of how care issues were being attended to. Ms Gillies commented in respect of specific issues around the Royal Hospital for Sick Children that the Executive Steering Group had put a lot of extra focus into improving facilities for staff and that this had also been considered by the Oversight Board. It was felt that the risk to the care of patients would be low. She pointed out however that infection risks could not regarded as negligible in the current environment and that work was under way to make the environment as safe as possible.

56.4 The Board agreed the recommendations contained in the circulated report.

57. Future Board Meetings

57.1 The dates of future Board meetings were agreed.

58. Invoking of Standard Order 4.8 – Resolution to Take Items in Closed Session

59.1 The Chairman sought permission to invoke Standing Order 4.8 to allow a meeting of Lothian NHS Board to be held in Private. The Board agreed to invoke Standing Order 4.8.

60. Date and Time of Next Meeting

60.1 The next meeting of Lothian NHS Board would be held at 9:30am on Wednesday 8 January 2020 at the Scottish Health Services Centre, Crewe Road, Edinburgh.

Chair's Signature……

Date……

Mr Brian Houston
Chair – Lothian NHS Board

NHS LOTHIAN

Board
8 January 2020

Chairman

APPOINTMENT OF MEMBERS TO COMMITTEES

1 Purpose of the Report

1.1 Lothian NHS Board's Standing Orders state that "The Board shall appoint all Committee members". This report has been presented to the Board so that it may consider the recommendations from the Chairman on committee appointments. Any member wishing additional information should contact the Chairman in advance of the meeting.

2 Recommendations

The Board is recommended to:

2.1 appoint Bill McQueen to the Strategic Planning Committee with immediate effect.

2.2 nominate Dr Patricia Donald as a voting member of East Lothian Integration Joint Board with effect from 1 February 2020 to 31 January 2023.

3 Discussion of Key Issues

Strategic Planning Committee

3.1 The terms of reference for this committee state that its membership includes representatives from the integration joint boards. Bill McQueen is now the vice-chair of West Lothian Integration Joint Board. It is recommended that the Board appoints Bill McQueen to the Strategic Planning Committee.

East Lothian Integration Joint Board

3.2 In light of other commitments, Professor Moira Whyte will be stepping down as a voting member. It is recommended that the Board nominate Dr Patricia Donald to replace her as a voting member of East Lothian Integration Joint Board.

4 Key Risks

4.1 A committee does not meet due to not achieving quorum, leading to a disruption and delay in the conduct of the Board's governance activities.

4.2 The Board does not make the most effective use of the knowledge, skills and experience of its membership, leading to the system of governance not being as efficient and effective as it could be.

5 Risk Register

5.1 This report attends to gaps in committee membership, and it is not anticipated that

there needs to be an entry on a risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 This report does not relate to a specific proposal which has an impact on an identifiable group of people.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 This report does not relate to the planning and development of specific health services, nor any decisions that would significantly affect groups of people. Consequently public involvement is not required.

8 Resource Implications

8.1 This report contains proposals on committee membership. It is probable that some of the members may require further training and development to support them in their new roles. This will be addressed as part of normal business within existing resources.

Alan Payne
Head of Corporate Governance
18 December 2019
alan.payne@nhslothian.scot.nhs.uk

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 9.00 on Tuesday 10 September 2019 in Meeting Room 8, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Professor T. Humphrey, Non-Executive Board Member (chair); Ms J. Clark, Partnership Representative; Dr P. Donald, Non-Executive Board Member; Ms W. Fairgreive, Partnership Representative; Ms C. Hirst, Non-Executive Board Member.

In Attendance: Ms C. Bebbington, Interim Head of Health, West Lothian Health and Social Care Partnership; Dr A. Coull, Consultant Physician (item 40.2); Ms J. Bennett, Associate Director of Quality Improvement and Safety; Ms J. Campbell, Chief Officer, Acute Services; Ms L. Cowan, Interim Chief Nurse, East Lothian Health and Social Care Partnership; Ms M. Cuthbert, Associate Director of Pharmacy, Acute Services; Ms T, Gillies, Medical Director; Professor A. McCallum, Director of Public Health and Health Policy; Ms A. MacDonald, Chief Officer, East Lothian HSCP; Professor A. McMahon, Executive Nurse Director; Ms J. Macrae, Associate Nurse Director, Edinburgh Health and Social Care Partnership; Ms J. Morrison, Head of Patient Experience; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Ms B. Pillath, Committee Administrator (minutes); Ms J. Proctor, Chief Officer, Edinburgh Health and Social Care Partnership; Mr A. Short, Chief Officer, Midlothian Health and Social Care Partnership; Mr D. Small, Director of Primary Care Services; Mr P. Wynne, Chief Nurse, Edinburgh Health and Social Care Partnership.

Apologies: Dr B. Cook, Medical Director, Acute Services; Mr J. Crombie, Deputy Chief Executive; Mr B. Houston, Board Chairman; Professor A. Timoney, Director of Pharmacy.

Chair's Welcome and Introductions

The Chair welcomed members to the meeting and members introduced themselves.

Members were reminded that they should declare any financial or non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. No interests were declared.

24. Minutes from Previous Meeting (9 July 2019)

24.1 The minutes from the meeting held on 9 July 2019 were approved as a correct record.

24.2 The updated cumulative action note had been previously circulated.

25. Patient story

25.1 Professor McMahon read out feedback from a patient who had an urgent referral from a GP to hospital due to suspected asthma. The experience was positive with staff courteous and organised with good communication, though the difficulty in sleeping in a 6 bed mixed ward due to noise and other confused patients was noted. Members noted that this was a frequent complaint.

26. Emerging Issues

26.1 Brexit Management

26.1.1 Professor McCallum gave a verbal update. A strategic group was meeting regularly and had identified risks of supply, workforce and continuity of service. Experts from NHS Lothian were feeding into national groups. Signifcicant risks had been identified in the worst case scenario and resilience responses were in place.

26.1.2 The Scottish Government was putting mitigations in place but details of these had not yet been finalised. Local, regional and national planning groups were seeking to coordinate management.

26.1.3 Integration Joint Boards were joining with Council and Lothian brexit planning meetings. Mr Short noted that auditors had identified a specific need for assurance in relation to recruitment and pharmaceutical supplies, so this work was being done.

26.2 Ophthalmology HSDU

36.2.1 Ms Gillies gave a verbal update. An Incident Management Team was in place following identification of debri in phacoemulsification equipment for treatment of cateracts. It was found that decontaimination instructions were not being fully implemented. New handsets had been purchased and a new decontamination regime was in place but debri continued to be found in equipment both at St John's Hospital and at the Eye Pavilion. The manufacturers were working with the team.

36.2.2 Some operations had been cancelled, but no infection had been found in patients. The situation was being monitored by the Incident Management Team.

36.3 Pathology

36.3.1 Ms Gillies gave a verbal update. To clear a backlog some blocks of samples had been sent away for processing, resulting in 70 samples being lost. 38 patients were affected, but no patients required an additional proceduer. Additional samples already received from some patients were processed.

36.3.2 A robust protocol for sample transfer had already been in place. Part of the improvement plan following the incident was to avoid sending samples away for processing by considering alternatives when there were high than usual numbers of samples to be processed.

37. Committee Effectiveness

37.1 Quality and Performance Improvement Report

37.1.1 Ms Bennett presented the previously circulated paper. It was agreed that the Acute Hospitals Committee would be removed from the list of Committees receiving assurance as this Committee had been disbanded. The performance in treatment time guarantee and 4 hour emergency access had been taken on as part of the remit for the Healthcare Governance Committee and would be covered as part of service reports.

38. Person Centred Care

38.1 East Lothian Health and Social Care Partnership

38.1.1 Ms MacDonald presented the previously circulated paper and noted the key risk as the primary care improvement plan.

38.1.2 It was noted that a further paper on actions taken regarding drug related deaths in all four partnerships would be brought to the next meeting. **AMcC**

38.1.3 It was agreed that a link to the Healthcare Governance Committee would be added to the Clinical Care Committee Terms of Reference, referring to annual reporting. This would apply to the equivalent Committees in all the Health and Social Care Partnerships. **Chief Officers**

38.1.4 The evaluation report of the Musselburgh Practice model would be circulated to members. **AMcD**

38.1.5 In response to a question about delivery of care in psychiatric mental health where there was a small isolated workforce and a high agency use, Ms McDonald advised that a mental health forum was being being considered for doctors to allow peer support and sharing of ideas. Mental health nursing staff were involved in the Quality Acadamy and had contact with other disciplines through this. The Learning Disabilities MCN also facilitated collaborative working. It was noted that as clinical directors for Health and Social Care Partnerships were GPs there needed to be other input from mental health experts. This was more easily done in partnership.

38.1.6 Members accepted the recommendations laid out in the paper and accepted moderate assurance.

38.2 Edinburgh Health and Social Care Partnership

38.2.1 A paper had been previously circulated and Ms Proctor gave a presentation. Improvements made to delayed discharge numbers by the home first programme were noted.

38.2.2 It was noted that MHRA would have new requirements for medical devices which would include items of equipment that were manufactured and adatpted at the SMART centre from next year and would require standard quality control and testing processes. Work was ongoing and this would be placed on the risk register.

38.2.3 It was noted that there needed to be identification and mitigation of risks and governance around regional services which had pathways in both Health Board(s) and Integration Joint Boards, for example SMART rehabilitation or gender assignment.

38.2.4 It was suggested that some services were commissioned by the Integration Joint Board where NHS Lothian had employer responsibilities, but for those services both commissioned and managed by the Integration Joint Board NHS Lothian needed governance oversight.

38.2.5 The integration schemes were to be reviewed over the next few years as part of the 5 year review so this would be an opportunity to make delegations and oversight of services more clear. The review would go to the Health Board, Integration Joint Boards and Councils before ministerial sign off and it was agreed that the Healthcare Governance Committee should be the Board Sub Committee responsible in NHS Lothian, and that a timeline for the review should be drawn up. **AMcM / Chief Officers**

38.2.6 It was suggested that the Healthcare Governance Committee should also report on relevant Acute services to the Integration Joint Boards and that this could be trialled with an individual paper first, for instance LUCS.

38.2.7 It was agreed that the report from the Joint Inspection of Older People's Services in Edinburgh would be brought to the Committee. **JP**

38.2.8 Members accepted the recommendations laid out in the paper and accepted moderate assurance.

38.3 Midlothian Health and Social Care Partnership

38.3.1 A paper had been previously circulated and Mr Short gave a presentation. A facilitied workforce planning session had taken place with the Director of Human Resources and the Chief Officers. Integration Joint Boards were represented on the NHS Lothian programme board for workforce. It was noted that in West Lothian representatives from NHS Lothian and West Lothian Council workforce planning were invited to the Health and Social Care Partnership workforce planning group.

38.3.2 Members accepted the recommendations laid out in the paper and accepted moderate assurance.

38.4 West Lothian Health and Social Care Partnership

38.4.1 A paper had been previously circulated and Ms Bebbington gave a presentation. It was noted that the models for mental health transformation were different in each Integration Joint Board. Outcome measures were needed to demonstrate improvement and evaluate the different models. In West Lothian this included working with analytical services to measure waiting times trends, continuity of care and complaints. There could also be an impact on recruitment and workforce.

38.4.2 Ms Gillies asked whether there were processes in place in all Integration Joint Boards for ensuring that patients who attended a number of different types of services in acute, primary care and third sector were considered in a multidisciplinary and holistic way, and that staff were trained to recognise and escalate needs of patients that were outwith their specialist area or individual service. This could be considered by the Primary Care Transformation Team around competency boundaries for different roles and escalation policies to link different services across partnerships. As a starting point Mr Wynne and Mr Small in discussion with Ms Gillies would develop a paper on the framework for different roles in the primary care standard for work previously done by GPs and now to be done by Allied Health Professionals. **TG / DS / PW**

38.4.3 Members accepted the recommendations laid out in the paper and accepted moderate assurance.

39. Safe Care

39.1 Safety of the Built Environment

39.1.1 Ms Gillies presented the previously circulated paper. It was noted that the Pan Lothian Infection Control Committee also had management oversight of water safety and infection control.

39.1.2 Members accepted the recommendations laid out in the paper and accepted moderate assurance.

39.2 Hospital Standard Mortality Rate

39.2.1 Ms Gillies presented the previously circulated report. A change in the model used for measurement meant that it was not possible to compare the measure with previous years. All three NHS Lothian acute sites were within the control limits for the Scottish Health Boards. Within Lothian this data was combined with data from other person centred care measures.

39.2.2 Members accepted limited assurance as processes had not yet been tested. A further report would be brought to the Committee in May 2020 where observed mortality rates would be compared to expected rates during increased admissions over winter period. **TG**

39.3 Safe Introduction of Robotic Surgical Platforms

39.3.1 Ms Gillies presented the previously circulated paper. There would be a further update at the meeting in May 2020 after six months' use of the equipment. **TG**

40. Effective Care

40.1 Dental Services

40.1.1 Professor McCallum presented the previously circulated paper. A regular process of dental practice inspections was now in place. A data dashboard was being developed which would allow the impact of this to be evaluated. Data currently held was transactional, CPD reports and inpectiotion reports and annual complaints data survey.

40.1.2 Members accepted limited assurance due to the lack of data to show improvements made. A further paper would be brought to the meeting in November 2019 with an evaluation of the data currently available. **DS / AMcC**

40.2 Stroke Care

40.2.1 Dr Coull presented the previously circulated paper. Ms Hirst noted that walkrounds at both St John's Hospital and Royal Infirmary stroke units were positive, and that there had been special praise for the important work done by the activities co-ordinator. although it was noted that this therapy was not available to patients at the weekends. Dr Coull agreed that weekend therapy would reduce length of stay and that this could offset additional cost of extending therapy to seven day working. Professor McMahon

noted that there was work ongoing regarding 7 day working for allied health professionals.

40.2.2 In order to improve stroke outreach to the Emergency Department at St John's Hospital and the Western General Hospital where there was a smaller number of stroke patients a stroke care bundle nurse had been implemented to check for stroke patients arriving in the Emergency Department to ensure a quicker bundle time. This was working well at St John's Hospital but had not been successful at the Western General Hospital; quality improvement work was in progress to find a solution.

40.2.3 It was noted that a lot of work had been done on stroke prevention including smoking cessation and obesity work, and this could be included in the next annual report.

40.2.4 Delayed discharge had previously been highlighted as a risk. Leads for stroke could not be identified in the Integration Joint Boards as roles were more generic, but the rehabilitation groups from each Board were now identifying any gaps in the service. Home First was being used at the Western General Hospital for Edinburgh patients and this could be rolled out.

40.2.5 Members accepted the recommendations laid out in the paper and accepted moderate assurance.

40.3 Safe and Effective Cancer Care

40.3.1 Ms Campbell presented the previously circulated paper. Members agreed that the update gave them confidence that risks were being managed, and accepted the recommendations laid out in the paper with moderate assurance.

40.4 GP Sustainability

40.4.1 Mr Small presented the previously circulated paper. The proposals for measuring the impact of the new GP contract at Board level were supported. This was important to establish whether the primary care service was sustainable under the new model. This would include measuring the impact on patients of the new GP contract in terms of access to GPs and continuity of care.

40.4.2 A single meeting had taken place with members of the GP Sub Committee where coordination with the data group had been agreed to consider the resource required for regular data submission.

40.4.3 It was noted that a national committee was in place but each health board was developing separate measures. The local group would remain sited on national discussions.

40.4.4 It was noted that some measures could be taken from GP involvement in quality improvement projects collecting data on patient safety, patient experience, and outcomes. 104 GP practices in NHS Lothian were involved in quality improvement work.

40.4.5 Members accepted the recommendations laid out in the paper. A further update would be given at the next meeting in November 2019. **DS**

40.5 Edinburgh Primary Care – 2C Practices

40.5.1 This item was deferred for discussion at the next meeting as no-one was available to present it. **JP**

40.6 Measuring Success: Dementia Care in Lothian

40.6.1 Professor McMahon presented the previously circulated paper. Ms Bebbington noted that there were challenges around making a post diagnosis model for dementia care due to the different stages at which diagnosis could happen. Diagnosis could be early at a stage where patients were not yet ready to become a patient, or late where the early phases of support were no longer relevant.

40.6.2 The work currently being done by the Patient Outcomes Programme Board would give more system wide information but this was currently at an early stage. It was noted that this was also an opportunity to look at the community aspect of how people with dementia were living.

40.6.3 Members accepted the recommendations laid out in the paper and accepted limited assurance that systems were in place to collect data to monitor outcomes. A further update would be brought to the Committee in March 2020. **AMcM**

40. Exception Reporting Only

40.1 Healthcare Associated Infection Update

40.1.2 Members noted the previously circulated paper. Professor McMahon noted that the Department of Clinical Neurosciences and Ward 20 at the Western General Hospital remained under active surveillance and there had been no reports of *pseudomonas* for a number of months. The improvement work would now be carried out in stages as the whole ward could not be decanted due to the delay in opening the new Royal Hospital for Children and Young People.

Members noted the following previously circulated papers for information:

40.2 Quality Improvement Team Annual Report;
40.3 Sexual Health Blood Borne Virus Programme Board Annual Report;
40.4 Duty of Candour Report.

41. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

10.1 Clinical Management Group, 9 April, 14 May, 11 June, 9 July 2019;
10.2 Public Protection Action Group, 14 August 2019;
10.3 Organ Donation Sub Group, 27 June 2019;
10.4 Lothian Infection Control Advisory Committee, 11 June 2019.

42. Corporate Risk Register

42.1 Ms Bennett presented the previously circulated paper. Professor McMahon propsed that Royal Edinburgh Hospital capacity be added as a risk. A new nine bed ward had been opened and ward 17 at St John's Hospital was at full capacity and but there were still not enough beds to meet demand. More work on the recovery plan was ongoing. This was part of the recovery actions on performance escalation which was on the risk register, but it was agreed to recommend to the Board that this would be added as a new risk. **JB**

43. Date of Next Meeting

43.1 The next meeting of the Healthcare Governance Committee would take place at **9.00** on **Tuesday 12 November 2019** in **Meeting Room 8**, Fifth Floor, Waverley Gate.

44. Meeting Dates in 2020

44.1 Meetings would take place on the following dates in 2020:
- 14 January 2020;
- 10 March 2020;
- 12 May 2020;
- 14 July 2020;
- 8 September 2020;
- 10 November 2020.

Signed by the Chair on 12/11/2019

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within BLACKBURN PARTNERSHIP CENTRE, ASHGROVE, BLACKBURN, EH47 7LL , on 10 SEPTEMBER 2019.

Present

Voting Members – Martin Hill (Chair), Martin Connor, Andrew McGuire (substituting for George Paul), Dom McGuire, Bill McQueen and Damian Timson

Non-Voting Members – Jim Forrest, Jo MacPherson, Alan McCloskey, Martin Murray, Patrick Welsh and Rohana Wright

In attendance – Carol Bebbington (Interim Head of Health), Yvonne Lawton (Head of Strategic Planning and Performance) and James Millar (Standards Officer)

Apologies – Harry Cartmill, Elaine Duncan, Mairead Hughes, Alex Joyce, Caroline McDowall, George Paul and Ann Pike

Absent – David Huddlestone

1. ORDER OF BUSINESS

The Chair congratulated St John's Hospital on the revalidation of its Healthy Working Lives Gold award.

2. DECLARATIONS OF INTEREST

There were no declarations of interest made.

3. MINUTES

The Board approved the minute of its meeting held on 13 August 2019 as a correct record. The minute was thereafter signed by the Chair.

4. MINUTES FOR NOTING

The Board noted the minute of the meeting of the West Lothian Integration Joint Board Strategic Planning Group held on Thursday 1 August 2019.

5. MEMBERSHIP AND MEETING ARRANGEMENTS

The Clerk advised that there was nothing to report under this item.

6. AUDIT OF THE 2018/19 ANNUAL ACCOUNTS

The Board considered a report (copies of which had been circulated) by

the Chief Finance Officer advising members of the outcome of the 2018/19 Audit and providing a summary of the key points arising from the Auditors' (EY) Annual Report.

The report outlined EY's conclusions on their audit of the 2018/19 accounts. Both the Annual Audit Report (Appendix 1) and the Annual Accounts (Appendix 2) had been considered by the IJB Audit, Risk and Governance Committee on 4 September 2019, and the Committee had agreed to recommend to the Board that the annual accounts and the recommendations from management be accepted.

Key points in the EY's conclusions included: No audit adjustments were required; good quality draft financial statements and working papers; adequate core financial management arrangements; further partnership work required to meet IJB's financial plan; a sound basis for demonstrating good governance and transparency in IJB's operational activity; and that IJB's Annual Performance report was published in line with the requirements of the relevant legislation.

The wider scope audit considerations reflected EY's judgements and conclusions on the IJB's arrangements for financial management, financial sustainability, governance and transparency, and value for money. The context for the amber financial sustainability indicator was then discussed, and Board members commented that the result was as expected considering the current challenges the health sector was facing.

Risks in line with auditing standards were also noted; the annual audit report included an action plan with management responses to identified risks.

Board members acknowledged the hard work of the Chief Finance Officer and the team that had prepared the annual accounts and noted their thanks and appreciation to all involved.

It was recommended that the Board:

1. Consider the Auditors' 2018/19 Annual Audit Report including the management action plan;

2. Agree the audited 2018/19 Annual Accounts for signature; and

3. Note the Audit Risk and Governance Committee's recommendations for agreement, following the Committee's review of the Annual Accounts and Annual Audit report on 4 September 2019.

Decision

1. To approve the terms of the report.

2. To record thanks to the Chief Finance Officer, management and team involved in the production of the annual accounts for achieving a clean set of accounts and therefore providing the Board a strong foundation for further progress.

7. IJB FINANCE UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on the 2019/20 budget forecast position for the IJB delegated health and social care functions.

The report indicated that an overspend of £926,000, which related to Health functions, was forecast against IJB delegated functions. Appendix 1 provided further detail on the forecast position shown.

Further work was progressing as part of the ongoing monitoring based on the approved West Lothian Integration Scheme to mitigate the pressures within the Health budget, and it was noted that the level of budget funding would continue to move throughout the year as a result of additional funding awarded during the year. A summary of key risks and service pressures was shown in Appendix 2.

The overall forecast position for the IJB took account of the position on savings, which stood at £5.372 million and which monitoring indicated would be substantially achieved. Appendix 3 provided further detail on the areas in which savings were being delivered.

It was clarified during discussion that figures were seasonally adjusted for the varying trends at different times of the year. Members also requested an update on budget efficiency and staffing and recruitment issues.

It was recommended that the Board:

1. Note the forecast outturn for 2019/20 in respect of IJB Delegated functions taking account of saving assumptions;

2. Note that further action was required by partner bodies in partnership with the IJB to manage within the 2019/20 budget;

3. Note the forecast outturn for 2019/20 in respect of IJB Delegated functions taking account of saving assumptions; and

4. Note that further updates on pressures identified would be reported to future Board meetings.

Decision

1. To approve the terms of the report.

2. To agree that a report would be produced for the next Board meeting providing an update on budget efficiency and on staffing and recruitment issues.

8. LOCAL CODE OF CORPORATE GOVERNANCE

The Board considered a report (copies of which had been circulated) by

the Standards Officer reviewing the Board's Local Code of Corporate Governance and considering recommendations by the Audit Risk & Governance Committee concerning the Code and the process by which it was compiled and applied.

The Code had been approved in May 2018 and was first used for 2017/18. The Code was updated for 2018/19 to ensure that the information it contained was comprehensive and up to date; the updated Code could be found in Appendix 1. It was proposed that arrangements continue with regard to consideration of governance issues and interim reports. It was also proposed that further standards to cover gaps were added to the Code, and that the Board delegate authority to the Director to add and update standards.

It was recommended that the Board:

1. Note the completed Local Code of Corporate Governance for 2018/19 as reported to Audit Risk & Governance Committee on 5 June 2019;

2. Note that the Code should be reviewed before the end of 2019 as was agreed when the Code was adopted and used for the first time in 2017/18;

3. Consider and review the Code and in particular to agree the recommendations made by Audit Risk & Governance Committee, as follows:

a) To agree to add the proposed new standards in relation to care governance arrangements, and liaison and planning arrangements with partner bodies

b) To continue the practice of monitoring progress on governance issues and populating the Code through the integrated senior management team

c) To continue the practice of reporting on an interim basis to the committee on progress against governance issues;

4. Agree that the Code should be formally reviewed again in two years' time; and

5. Delegate authority to the Director to add new standards to the Code where required, and to update existing standards where there are changes to legislation or terminology.

Further to the recommendations in the report, members suggested that the proposed delegated authority to the Director should cover minor changes, while matters of significance should continue to be reported back to the Board.

Decision

To approve the terms of the report subject to the following amendment to

recommendation 5:

To add that matters of significance would continue to be reported back to the IJB; and to specify that delegated authority in the recommendation referred to 'minor' changes in terminology or legislation and guidance.

9. NHS LOTHIAN ESCALATION

The Board considered a report (copies of which had been circulated) by the Director providing an update on the decision by the Director-General Health and Social Care and Chief Executive of NHS Scotland (the DG) that had concluded, on the advice of the Health and Social Care Management Board, that NHS Lothian had now been placed at level 3 of the NHS Board Performance Escalation Framework. The report also set out the proposed approach within NHS Lothian and West Lothian to support the delivery of recovery plans.

The report recalled that the DG had written to the NHS Lothian Chief Executive on 12 July to advise that NHS Lothian would now be placed at level 3 of the NHS Board Performance Escalation Framework (Appendix 1). A number of challenging areas where further improvement was required in the context of a challenging financial environment were listed.

The NHS Lothian Corporate Management Team had taken a collaborative, whole-system approach to consider what improvement support was required. As a result, an Oversight Group had been formed to maintain regular contact with NHS Lothian Chief Executive and lead Directors and to deliver a satisfactory Recovery Plan, with a demonstration of progress, against each of the escalated issues by the end of October. It was noted that ongoing updates on progress against delivery of the recovery plans would be reported to future IJB meetings.

A Lothian Integrated Care Forum had also been established to bring together the four IJBs, four Councils and NHS Lothian colleagues to consider issues across the system and provide an opportunity to accelerate systemic and sustainable improvement and transformation of services. Membership of the Forum was then discussed.

It was recommended that the Board:

1. Note the placing of NHS Lothian Board at level 3 of the NHS Board Performance Escalation Framework;

2. Note and support the whole-system collaborative approach involving NHS Lothian and the four Integration Joint Boards, with support from the Council areas, to develop and implement a recovery plan; and

3. Agree to receive future updates on progress being made on the delivery of the recovery plans.

Decision

To approve the terms of the report.

10. SELF-EVALUATION IMPROVEMENT PLAN

The Board considered a report (copies of which had been circulated) by the Director informing members of the submission of the improvement plan for West Lothian based on self-evaluation of progress with integration.

Following consultation with IJB, council and health board, an improvement plan had been submitted to the Scottish Government by the required deadline. It was noted that the points raised at the August IJB meeting had been considered and incorporated in the plan.

It was recommended that the Board:

1. Note the final version of the improvement plan produced following discussion at the previous meeting of the Board; and

2. Note submission of the plan to the Scottish Government by the required date.

Decision

To approve the terms of the report.

11. WORKPLAN AND LIST OF CYCLICAL REPORTS

The workplan for upcoming meetings and a list of reports that the Board considered on a cyclical basis were presented.

Decision

To note the workplan and list of cyclical reports.

12. CLOSING REMARKS

In closing the meeting, the Chair on behalf of the Board thanked the Director for his valuable contribution to the IJB and wished him well in his retirement.

The Director then thanked IJB members and officers for their hard work and wished them well for the future.

NHS LOTHIAN

Board Meeting
8th January 2020

Director of Improvement

LOTHIAN RECOVERY PLAN UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress in relation to the ongoing Lothian Performance Recovery Programme following the Scottish Government's escalation of NHS Lothian to Level 3 (significant variation from plan) of the Scottish Government Performance Escalation Framework. As part of the escalation process the Scottish Government require a formal Recovery Plan with clear milestones to be developed. The responsibility for developing this plan has resided with NHS Lothian with oversight provided by a Director within the Scottish Government.

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

2 Recommendations

2.1 To note the progress in the development of the whole system Lothian Performance Recovery Programme and delivery of core performance targets. In particular, the plans and actions in place within the Mental Health and Learning Disability Recovery Programme set out in Appendix 3.

2.2 The Board is asked to review the risk related to the Recovery Programme (4820) and agree to its risk score of 12 (High), and accept this report as a source of moderate assurance that there are adequate improvement plans are in place to manage the risk.

3 Discussion of Key Issues

3.1 A system wide Recovery Plan was submitted to the Scottish Government at the end of November 2019 setting out an integrated approach to improving performance across a range of performance indicators. We are now awaiting a formal communication from the Scottish Government regarding next steps with the next meeting scheduled for the 23 January 2020.

3.2 In the meantime, the Recovery Programme team, working with colleagues from across the health and care system are continuing to put in place appropriate programme infrastructure to manage and monitor system performance. Weekly operational recovery meetings are progressing in a number of areas and the newly constituted Mental Health and Learning Disability, and Unscheduled Care Programme Boards will commence from January 2020.

3.3 Appendix 1 sets out the proposed Corporate Risk Register entry for the Recovery Programme and associated mitigating actions. Having reviewed the risk it is proposed that the assurance level in relation to the Recovery Programme is moderate given plans that have been put in place, and the risk score has been set at High (12) on the basis of applying the methodology in the risk management procedure.

3.4 The remainder of this paper provides an update on performance against each of the core targets included within the scope of the Recovery Plan as of November 2019. Some of these data are still provisional but provide an indication of performance trends along with the accompanying narrative.

Table 1. Core Recovery Plan Metrics

Metric		Nov 2019p	Oct 2019	Oct 2018	Change	Target
Delayed Discharges	Standard	197	211	356	-44.7%	200 (Dec 19)
	Standard & Complex	228	242	379	-39.8%	-
4 Hour ED Waiting Time		81.5%	86.4%	89.2%	-8.6%	95%
Outpatient >12 week waiting time		23,181	24,201	26,069	-11.1%	16,151*
Treatment Time Guarantee		2,530	2,563	2,157	17.3%	2,472*
Cancer Waiting Times (62 day target)		80.8%	78.9%	80.0%	-	95%
Mental Health & Learning Disability Bed occupancy		87.3%	88.0%	99.8%	-12.5%	85-90%
CAHMS >18 week target		48.3%	52.1%	61.3%	-21.2%	90%
Psychological Therapies > 18 week target		79.9%	76.3%	73.1%	9.3%	90%
Paediatrics and St John's		4 days a week 24x7	4 days a week 24x7	Closed to inpatients	-	7 days a week 24x7

p some November 2019 is provisional management information and may be subject to small variation.
* 2019/20 AOP Trajectory at year end
* Green denotes an improvement, red deterioration, and amber no change since Oct 2018

3.5 The table illustrates that whilst performance has improved across a number of metrics over the past year, it is still significantly below Government targets in a number of areas with particular concern in relation to the 4 Hour ED access standard.

3.6 The 62 day Cancer Waiting Time target, whilst broadly unchanged in November is expected to improve following actions put in place to improve colorectal and prostate cancer pathways. These actions have focused on ensuring earlier diagnosis and reducing the decision to treat backlog, for example, the number of patients at risk of breaching the 62 day target within the next 14 days reduced from 311 to 179 over the course of November. These metrics indicate that progress is being made to reduce the backlog of patients and this will continue to be the focus of the team in the weekly multidisciplinary cancer huddles. As noted last month, these expected improvements have been reflected in a revised year-end performance forecast, with the AOP position for the 62 Cancer Waiting Times increasing from 84% to 88%. The 31 day Cancer Waiting Time target remains in line with the Government target at circa 95%.

3.7 The total number of outpatient 12 week waits have reduced further in November to under although this is now slightly behind trajectory[1]. Further 'see and treat' capacity increases are planned for the final quarter of 2019/20 taking advantage of the East Lothian Community Hospital and other external facilities. These actions will continue to reduce the number of over 12 week outpatient waits. However, it will be challenging to meet the large planned outpatient reductions set out in the AOP in the final quarter of 2019/20. Performance against TTG is ahead of trajectory and has remained relatively static over the month, although this may come under pressure in the coming months if elective activity is cancelled due to bed pressures. A number of day case and orthopaedic surgical sessions have already been cancelled at the Royal Infirmary. Appendix 2 provides further details within the Waiting Time Improvement Plan.

3.8 Performance in relation to the CAHMS and Psychological Therapies 18 week target has remained relatively consistent in the last month, albeit below the Government standard. Acute adult mental health bed occupancy has been maintained within an appropriate target range over the past month. Waiting list trajectory planning is currently underway as part of the annual AOP process and illustrates that recovery measures put in place will significantly reduce the number of patients waiting over 18 weeks for treatment. Initial forecasts indicate that this reduction should be sufficient to move CAMHS performance back to target by December 2020 although there remain a number of risks to delivery. Based on these forecasts it has become clear that further action within Psychological Therapies will be required to meet the access standard by December 2020 although performance will be maintained at current levels during the period. Further details are set out in Appendix 3 within the Mental Health and Learning Disability Recovery Programme Update paper.

3.9 Sustained increases in attendance at EDs have been experienced across the three adult acute sites across the 2019 calendar year. This increase in attendance combined with an increasing acuity of patient and high occupancy across the three sites has contributed to a deteriorating four hour emergency access standard performance. These challenges are not unique to Lothian and similar patterns are occurring across Scotland.

3.10 Performance in November has reduced further despite efforts to improve staffing in the out of hour period and a continued focus on flow across sites. Across all sites for November performance was 81.5%. However, this does not reflect the variation that occurs on a daily basis. One of the focuses of the unscheduled care recovery programme will be to better understand this variation (for example is it due to patient acuity, increased resuscitation demand, capacity, clustering of demand, etc) and support more reliable performance.

3.11 In addition, 12 hour waits increased over the last week of November, whilst this reduced again in early December, these have again increased largely due to bed pressures. Each acute site continues to focus on early discharge of patients as well as effective use of the observation units, with the WGH putting steps in place to ensure the PACA (Post Assessment Care Area) unit is able to be bedded in times of significant demand and can remain in use for patients who require further treatment or diagnostic results but do not need admission. Each Health and Social Care Partnership have also increased capacity within community services to offer greater alternatives to admission

[1] As members will be aware, in November 2019 waiting time information for outpatients at the Dental institute was moved from their stand-alone system onto Trak. The over 12 week position described, sourced from ISD's Waiting Time National Data Warehouse, is estimated to be an understatement of the position by a few hundred patients. Data validation work continues to progress in this area and is anticipated to be concluded in the new year. When that is completed the provisional figure provided here will be revisited.

as well as care support for patients ready for discharge. Additional investment from winter funding has been made available with services increasing capacity over January to March to meet demand. This includes the opening additional beds in East Lothian Community Hospital to reduce delays and support flow at the RIE. Ten beds were opened at short notice with plans to increase this further during the winter period.

3.12 Significant clinical and managerial attention is being focused on this issue, both looking to progress short term options as well as looking at improving performance at a system-level. Weekly unscheduled care recovery programme meetings have been established, which have initially focussed on the RIE with representation from the HSCPs and the acute site to support a collaborative whole system approach and have now also begun with WGH. The focus remains on reducing occupancy at the sites through reducing lengths of stay and earlier discharge planning, while also providing greater alternatives to admission to reduce activity at the front door and progress will be reviewed on a weekly basis.

3.13 Each HSCP has made significant progress in reducing the number of unplanned OBDs lost to delayed discharges. The number of delayed discharges has decreased slightly over the month and is back below 200 for standard delays.

4 Key Risks

4.1 The key risks associated with delivery of the Recovery Plan are similar to those outlined in the 2019/20 Annual Operational Plan. They relate to the need for recurring, long term investment plans, a sustainable workforce and robust approaches to managing future demographic demand. In the short term, there are also risks associated with the winter period and tight budget settlements in social care.

5 Risk Register

5.1 The Corporate Risk Register has been updated to reflect the risks specifically associated with the Recovery Programme with reference to a number of linked risks (see Appendix 1). The Risk Register will be subject to ongoing review and update by the Recovery Programme team.

6 Impact on Inequality, Including Health Inequalities

6.1 An integrated impact assessment associated with the Recovery Plan has not been undertaken. Following approval of NHS Lothian's 2019/20 AOP, communication was sent to responsible directors where new services, redesign of services and new strategies/plans are referenced to allow NHS Lothian's lead on Equalities and Human Rights to follow up and review whether the necessary integrated impact assessments have been completed as appropriate. The final Recovery Plan submission will also be forwarded for information.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 NHS Lothian Directors, IJB Chief Officers and their teams have supported the development of the Recovery Plan. Due to the timelines associated with the development of the Recovery Plan, public engagement and consultation relating to the contents of the plan will not have been undertaken.

8 Resource Implications

8.1 Recovery Plan discussions will continue with the Scottish Government to clarify any further investment to support performance improvement and will continue as planning commences for the 2020/21 AOP.

8.2 The Scottish Government have identified resources to support the Recovery Programme and this has been allocated to create additional programme infrastructure. During December, Anne Lavery joined the team as the new Head of Access and the final team member will join in early January 2020 providing additional capacity modelling skills to support the development of scheduled care trajectories.

Appendix 1. Corporate Risk Register Entry (4820)
Appendix 2. Waiting Times Improvement Paper
Appendix 3. Mental Health and Learning Disability Recovery Plans

Peter Lock
Director of Improvement
23 December 2019

Appendix 1. Risk 4820 - Delivery of level 3 recovery plans

Corporate Objective	Risk Description	Linked Key Risks	Controls	Key Measures	Updates
Improve Quality, Safety and Patient Experience	There is a risk that the Board does not deliver NHS Lothian's Level 3 Recovery Plans to agreed timescale impacting on patient experience and outcome of care.	(3203) 4-hour target (organisational) (4688) Patient safety - RIE ED (3211) – Access to treatment (organisational) (4191) – Access to treatment (patient) (4921) REB inpatient beds (4813) RHCYP and DCN (3726) – Timely discharge **Associated Plans** • Recovery plan • Financial plans • Underpinning plans for all associated linked key risks **Assurance Committees** • Assurance of this risk is reserved to the Board	**Governance and management** Routine reporting to every Board meeting. Assurance levels provided by relevant committees for linked risks are also provided to the Board through reporting of the corporate risk register to every Board meeting. Fortnightly reporting to Scot Gov oversight group. These arrangements are underpinned by robust reporting for each of the 6 challenging service area work streams: • Scheduled care & cancer programme delivery Board (chair: acute services Chief Operating Officer) • Unscheduled care & delayed discharge programme Board (Chair: IJB Chief Officer) Supported by unscheduled care committee • Mental Health & learning disabilities Programme Board (Chair: IJB Chief Officer) - weekly operational meeting • Paediatric programme Board (chair: Board non-exec director);	Core recovery plan metrics are in place and monitored by the Board: • Delayed discharges • 4 hour ED waiting time • Outpatient >12 week waiting time • Treatment time guarantee • Cancer waiting times (62 day target) • Mental health and learning disability bed occupancy • CAMHS>18 week target • Psychological therapies > 18 week target • Paediatrics and St Johns	• Assurance level to be agreed by the Board

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Corporate Objective	Risk Description	Linked Key Risks	Controls	Key Measures	Updates
		Grading • Very High 20	RHCYP/DCN oversight Board The Strategic planning committee and Finance and Resources committee also receive and respond to regular reports. In addition, the sub-committees of the Board receive reports on the relevant individual linked key risks and provide appropriate assurance levels. **Plans** A Director of Improvement has been appointed and a formal recovery plan has been developed and submitted to Scot Gov early December – currently awaiting sign-off. The Integrated care forum (4 IJBs, 4 councils and NHS Lothian) provides a forum to ensure a whole system approach and collaborative working. **Scheduled care/Cancer waiting times** A Programme Director and infrastructure to support delivery is in place. Projects in place include: • Additional, non-recurring investment for outpatients and TTG • Plans for elective centre at St Johns **Unscheduled care/delayed discharge** Programme Director in place with internal and external improvement support in place. Key work includes: • additional investment to address		

Corporate Objective	Risk Description	Linked Key Risks	Controls	Key Measures	Updates
			4EAS • Resign of services at front door RIE • New models of care such as Hospital at home • Range of work within HSCPs to increase community capacity **Mental Health** Number of short term actions in place including 13 additional beds in REH and completion of anti-ligature works at St John's. Longer term plans in place for improvement including: • adult mental health pathway • development of Home First approach • access to CAMHs and psychological therapies **Policies** National policies and targets provide a framework for improvements in delivery of these services. **Adequacy of Controls** An adequate framework of controls and governance arrangements is in place and operating as intended. Hence, the adequacy of controls is satisfactory.		

NHS LOTHIAN

NHS Lothian Board Meeting
8 January 2020

Chief Officer, Acute Services

WAITING TIMES IMPROVEMENT PLAN
RECOVERY & SUSTAINABILITY

1 Purpose of the Report

1.1 The purpose of this report is:

1.2 To update the Board in relation to NHS Lothian's progress towards delivery of the national Waiting Times Improvement Plan (WTIP), in terms of short-term Recovery, and planned Sustainability.

1.3 To provide detail of performance against agreed 2019/20 trajectories for Scheduled Care standards: New Outpatients; Treatment Time Guarantee (TTG); Diagnostic key tests; 31 and 62 Day Pathway Cancer patients.

1.4 To update on availability and utilisation of resources to support delivery of the plan.

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

2 Recommendations

Board Members are recommended to;

2.1 **Note** current performance against agreed AOP trajectories as outlined in Appendix 1.

2.2 **Acknowledge** that 62% of patients were waiting 12 weeks or less for a new outpatient appointment in October 2019, and that 74% of patients were seen within the 12 Week Treatment Time Guarantee.

2.3 **Recognise** that Cancer 31 day performance for November 2019 was 95.2% - better than trajectory of 94.8%. 62 day performance whilst 80.8% against a trajectory of 84.0%, has improved month on month since July (5.4% improvement).

2.4 **Acknowledge** that TTG performance has remained better than trajectory since May 2019, including provisional November figures.

2.5 **Recognise** that due to changes in demand/capacity for a number of services since AOP trajectory submission that the December 2019 milestone is at risk for outpatients. Data is being reviewed on an ongoing basis, and remedial actions actively explored to bring outpatient performance back within AOP milestones. Provisional November performance suggests a further improvement of over 1,000 since October but is subject to validation.

2.6 **Acknowledge** that there is a new risk to OP performance associated with EDI transferring on to TRAK due to data quality issues.

3 Discussion of Key Issues

3.1 Current Performance 2019/20

3.1.1 Performance is discussed below against trajectories for Scheduled Care standards submitted within the NHS Lothian Annual Operational Plan (AOP). A summary of current performance is also attached as **Appendix 1.**

3.2 Outpatients

3.2.1 Validated MMI performance for October was 701 over AOP trajectory (please see Appendix 1 and Chart 1 below), however, performance improved by more than 1,300 from September to October.

3.2.2 Provisional figures for November suggest that the number of patients waiting over 12 weeks will reduce further, and by more than 1,000 from the October improvement. These figures are subject to validation.

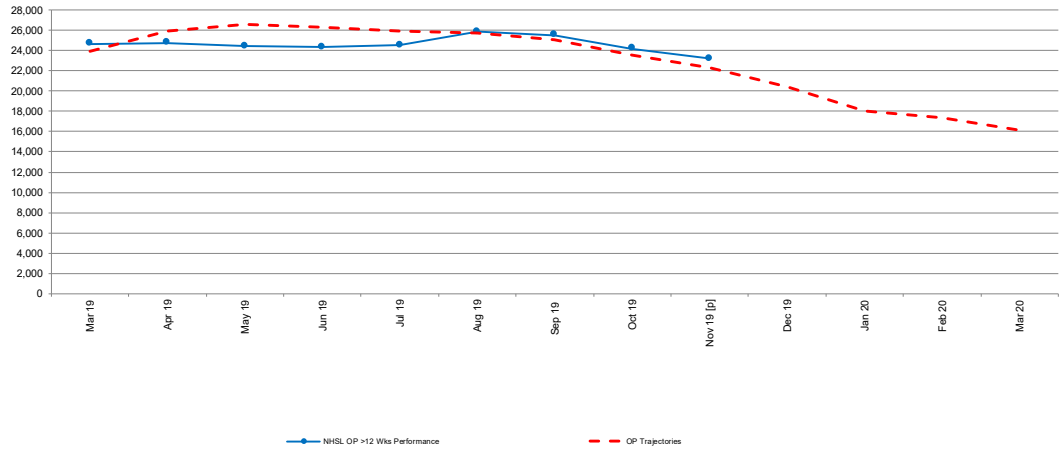
3.2.3 Dermatology has shown improved overall performance to date. Dermatology MMI performance was 6,242 in April 2019 and 5,213 for Oct 2019. Un-validated figures for November indicate performance of circa 4,800. This is based on increased internal workforce, redesign and investment in private sector.

3.2.4 Endoscopy > 6 week breach numbers have almost halved since the beginning of the year, although overall Gastroenterology Diagnostics performance is above trajectory for November. Please see Section 3.4.

Table 1 – New Outpatients waiting in excess of 12 weeks as at 27th Dec 2019 – incl. provisional Nov forecast

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Mar-20
AOP Trajectory	24,933	26,552	25,269	25,964	25,760	25,051	23,500	22,293	20,393	16,151
Actual/ *Forecast* Performance	24,775	24,425	24,307	24,502	25,851	25,529	24,201	*23,181*		

Chart 1 – New OP waiting in excess of 12 Weeks (ongoing waits) *versus* AOP Trajectory – incl. provisional Nov forecast [p]



3.2.5 The last half of 2019/20 requires a significant reduction in the number of patients waiting longer than 12 weeks, in line with our AOP trajectory commitment to reach 16,151 patients waiting over 12 weeks by March 2020. This constitutes a reduction of approximately a third against current position.

3.2.6 Several specialties have reported challenges in meeting trajectory capacity assumptions, due to workforce issues (including inability to recruit, and pension changes impacting reduction in waiting list initiative uptake), as well as increases in demand over and above levels declared within AOP plans (ENT demand increased by 10% for 2019/20 Q1 and 2, compared with the previous year). Indicative figures for Orthopaedics, Paediatric ENT and Urology suggest that they maybe furthest from Trajectory for December 2019, and Adult and Paediatric ENT are currently furthest from Trajectory for March 2020.

3.2.7 In terms of reduction in waiting list initiatives specifically, work undertaken at mid-year indicates that there has been an 11% reduction in WLI activity against original plans. Most significant impact has been seen in Colorectal, Urology, ENT and General Surgery.

3.2.8 **Mitigating Actions**

3.2.9 Mitigating actions include work ongoing to ensure all relevant data housekeeping; expand use of external providers; utilisation of East Lothian Community Hospital and temporary capacity at Leith Community Treatment Centre (LCTC), for Dermatology throughout January. This capacity is only available until the end of January as the upgraded endoscopy suite is then due to reopen.

3.2.10 In the context of tightening trajectory commitments performance visits are being undertaken. These are to ensure and to quantify where possible all opportunities yielded from Patient Focussed Booking (PFB), Patient Initiated Follow-Up (PIFU), Keeping in Touch (KIT), Virtual Clinics, Active list housekeeping and Clinical Validation. The Head of Access Anne Lavery is now in post and will support this work as an early priority.

3.2.11 Capacity at East Lothian Community Hospital (ELCH) will be extended to March 2020 primarily for services that do not convert to TTG.

3.2.12 Waiting List Initiatives (WLIs) are being undertaken where possible and requests are being made for additional external provider capacity. As stated above WLI uptake continues to reduce due to pension and tax regulatory changes. Recently announced temporary

government measures around pensions may alleviate the current impact.

3.2.13 Significant progress has been made against since April 2019 in terms of Long Waits (>78 Weeks) for Gastroenterology, Endoscopy and Dermatology, which Figure 1 below demonstrates. These three services also have high volumes of urgent patients, so capacity has been balanced to meet this urgent need and to reduce excessively long waits.

Figure 1

3.2.14 Paediatric OP performance carries pressures within a number of specialties due to vacancies/limited recruitment/reliance on waiting list initiatives. Recruitment of nursing staff to support weekend clinics on a regular basis is being implemented.

3.3 **Inpatients & Day Cases**

3.3.1 Validated TTG MMI performance figures for October 2019 indicate continued achievement of AOP Trajectory as per Table and Chart 2 below. Please see Appendix 1 for detail.

3.3.2 Provisional figures for November suggest that performance will improve by more than 30, further to October.

3.3.3 Ophthalmology MMI for October 19 was 88, against an AOP trajectory commitment of 0. Decontamination issues in Ophthalmology have resulted in cancellations and delays in lists at PAEP and SJH since August 2019. There have been no further incidents since end October. However, further challenges with non-functioning lifts on the site has impacted upon planned theatre activity on the site.

3.3.4 Risks to TTG delivery include reliance on NHS Forth Valley capacity which is now projecting a 550 patient shortfall (from planned 1,000 additional cases by end March 2020.) Options to secure additional capacity to mitigate this shortfall were examined in discussion with GJNH but was confirmed that no additional capacity is available for Orthopaedics through the independent sector.

3.3.5 Furthermore, the impact of unscheduled care on the elective programme, especially at RIE is placing a risk to TTG delivery in the months ahead. Since 1st November there have been 93 elective cancellations due to bed availability. Of these, 74 were Orthopaedics at an

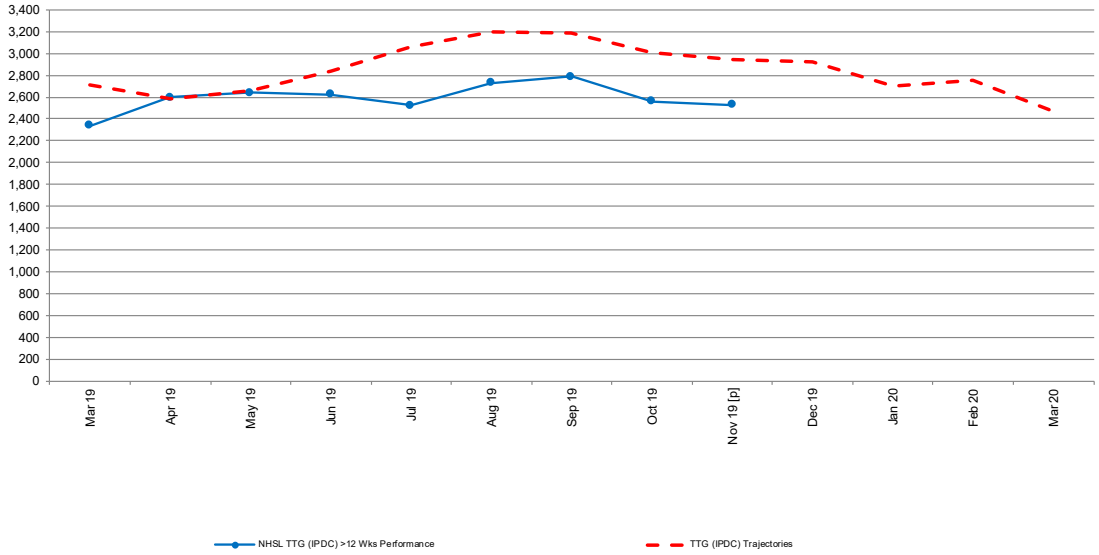
average rate of 15 cancellations per week. To date 24 cancellations have had a direct impact on TTG.

3.3.6 Mitigating actions include focus on increasing patient throughput via initiatives within the Theatres Improvement Programme; further capacity to be sought within the independent sector as outlined above and contingency plans being developed for Ophthalmology, which has been impacted on by contamination concerns and lift failure. Provisional Theatre utilisation performance for November is 90% for uptake of sessions, and 72% for over-all utilisation.

Table 2 – Inpatients/Day Cases waiting in excess of 12 weeks as at 27th Dec 2019 – incl. provisional Nov forecast

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Mar-20
AOP Trajectory	2,586	2,658	2,839	3,055	3,198	3,190	3.011	2,947	2,922	2,472
Actual/*Forecast* Performance	2,597	2,642	2,622	2,526	2,727	2,788	2,563	*2,530*		

Chart 2 – Inpatient and Day Case waits over 12 Weeks (ongoing) versus AOP Trajectory - incl. provisional Nov forecast [p]



3.4 Diagnostics

3.4.1 The DMMI Diagnostics >6 Week standard covers two key areas of Diagnostics - Gastroenterology (incl. Endoscopy and Urology), and Radiology - for which reporting is required for four separate performance metrics each. Please see Appendix 1 for figures.

Endoscopy

3.4.2 Gastroenterology trajectories have not been met for November as a result of reduced capacity for Endoscopy. The service had planned to deliver 20-25% additional activity this year via internal efficiencies and utilisation of the Vanguard Unit and external providers. However, the refurbishment of LCTC and lack of locums available to cover Vanguard, arising from sickness and compassionate leave, have impacted performance. One locum is currently returning on a phased basis. Further mitigations are in place and improvement should be seen by early next financial year, providing LCTC opens as planned, and work

is underway to ensure that this happens. For validated figures please see Appendix 1.

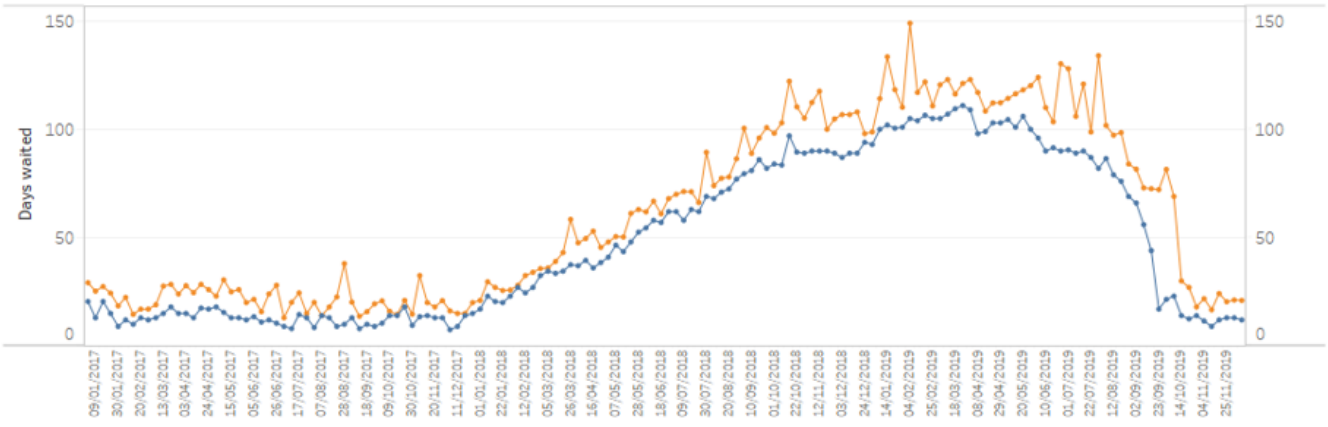
3.4.3 Attempts to recruit to Nurse Endoscopist posts have so far received no applicants, but these posts be re-advertised in January 2020. Approval has also been received to recruit two consultants – one advertised initially as a fixed term post at WGH received no applicants, but will be re-offered as a permanent post. The second post is for RIE and again no suitable applicants were received, however a retired General Medicine consultant from SJH has been appointed to a 12 month fixed term post, covering 4 sessions per week; two in Vanguard and two at additional Trans-Nasal Endoscopy (TNE) sessions. The additional Nurse Endoscopists are required to provide support for this work.

3.4.4 Once LCTC is open it will provide threefold gains – increased TNEs will provide 150 extra slots per month; the redesign of lists on the three major sites as a result of additional TNE capacity which will increase colonoscopy slots, and increase PFB to its previous levels. These levels will be provision of no less than 120 contact letters for Upper Endoscopy as well as 120 for Lower Colonoscopy. New PFB queues will also be introduced.

3.4.5 Endoscopy risks include lack of locum support for the Vanguard unit as above; loss of capacity at LCTC while upgrade works are taking place (November 2019 – January 2020 incl.), increased activity from GI additional capacity and increased pressure to reduce waiting times for USOC. Support of cancer pathways for Colorectal could also redirect capacity previously identified for longer waits.

3.4.6 The service has however been achieving the national target for Bowel Screening of 31 days since October 2019, following introduction of Nurse Triage in April to mitigate the impact of a change in national guidelines – please see Chart 3 below:-

Chart 3 – Endoscopy New OP Referrals to All Sites – Days Waited and Median Wait



Key:-

90th percentile days waited
Median days waited

3.4.7 Band 3 Pre-Assessment support has also been recruited to telephone patients in advance of appointments to allow them to prepare, and for waiting times adjustments to be made in line with Cancer Tracking Guidelines, if required. This should bring down time to pre-

assessment to under 5 days, compared with the current situation of 7 days or more. This post will also support Cancer Tracker colleagues.

3.4.8 As well as additional capacity as outlined above, mitigations include daily management of different queues to align capacity and demand as clinically appropriate; and the implementation of nationally agreed surveillance protocols to help alleviate some of the pressures in these queues. Active triage and management of repeat queues has also significantly reduced longest waits.

Radiology

3.4.9 The main pressures within Radiology CT have arisen from delays to the move to RHCYP/ DCN; staff issues including vacancy, maternity leave, and the introduction of a new rota to comply with major trauma centre.

3.4.10 This new rota ensures that a CT radiographer is available on site overnight/ at weekends instead of being on call. This been required to manage front door CT demand and to avoid waiting for a Radiographer to come to site. These factors have all impacted on service ability to resource regular weekend work on a second CT scanner, as more staff are now working weekends meaning that they are less likely to volunteer on additional weekends.

3.4.11 Overall capacity for OP CT and MRI at RIE is being reviewed for options to increase OP capacity required to meet WLI OP demand. CT will be a challenge as NHS Lothian replaces the two RIE scanners in the first half of 2020.

3.4.12 Actions to reduce current RIE CT waiting times include transferring patients to DCN on an ongoing basis, staffing weekend CT sessions at RIE throughout November and until replacement project commences, and utilisation of third party provision for one weekend per month.

3.4.13 CT coronary angiography (CTCA) will continue at CRIC until both CT scanners are replaced and Cardiology are reviewing options to reduce demand and source external provision if available.

3.4.14 The possibility of sourcing an additional CT scanner to offset downtime caused by the scanner replacement programme (up to 180 slots per week) and potentially offer additional capacity is also being explored.

3.4.15 Additional risks include demand increase in unscheduled care pathways over the winter period. Also, additional demand arising from Medinet clinics. External capacity is being sourced to address both. The impact of Cancer waiting times is unpredictable, but service colleagues are working closely with the cancer team to identify mitigating actions, for example, introducing a one stop clinic for urology. Full DCAQ is also underway.

3.4.16 In considering MRI, the replaced scanner at RIE is now fully operational, but the impact of downtime is still evident. Full capacity should be achieved in line with plan. Additional internal sessions and additional activity by University will provide an improved position.

3.4.17 Approximately 70 patients are scanned at GJNH from West Lothian and a recent shortage

of reporting capacity recently has resulted in a 6 week delay from scan to report. This has directly impacted NHSL waiting times, but the position has now improved to 4 weeks.

3.4.18 Mitigation of MRI risks include maximisation of external provision from TEC and use of the mobile MRI scanner based at DCN, extra internal sessions where possible, including four additional days at Midlothian in December, and a pan-Lothian approach to patient allocation and appointment.

3.4.19 Ultrasound has recently performed above trajectory as a result of short term sickness of a specialist Radiologist. A high level of Sonographer sickness has resulted in some cancelled lists pre-Christmas, and this combined with Specialist Radiologist leave over the festive period could result in up to 30 patients tripping 6 weeks at end of December. This will however, be recovered to zero by end of Feb.

3.5 **Cancer**

3.5.1 Cancer performance remains an area of significant risk, particularly in terms of the 62 day standard, where validated November performance remains 3.2 percentage points worse than Trajectory (please see Appendix 1). Colorectal and Urology (Prostate) performance remain areas of concern though Melanoma and Upper GI have shown improvement. Significant reductions in waits have been made within some elements of the Colorectal pathway since mid-September.

3.5.2 Challenges with respect to workforce continue with one Colorectal surgeon being on a phased return after prolonged leave, in addition to an on-going capacity gap of three consultants, as identified in the sustainability plan submitted earlier in the year.

3.5.3 The absence of a Urology surgeon due to sickness, and extended waits for Uro-Oncology OP assessment have contributed to delays across the Urology 62 day pathway.

3.5.4 Mitigating actions include weekly reporting to the Scottish Government: restructuring of cancer tracking processes in preparation for the revised reporting schedule; establishment of a Cancer huddle to improve grip and control, escalation; communication across cancer pathways with the ultimate goal of improving 62 day performance, and regular review of Colorectal and Urology action plans in conjunction with the Chief Officer and at the WTIP Board.

3.5.5 Action plans have now also been developed for Melanoma and Lung, further to detailed pathway analysis, and these were reviewed at initial meetings on 18th December. This work will be extended to all reported tumour groups in the forthcoming period.

3.6 **Edinburgh Dental Institute (EDI)**

3.6.1 The waiting list and appointments from the Edinburgh Dental Institute were moved onto Trak on 18th November. Complete reporting will commence once the migrated data has been checked and necessary corrections made.

3.6.2 Indicative November >12 week breach figures are higher than anticipated, but data cleaning is underway. There was also a reduction in clinic capacity both before and after the move to Trak to allow for appropriate training of approximately 300 staff which may

have impacted reporting.

3.6.3 Data validation work continues to progress in this area and is anticipated to be concluded in the New Year. When that is completed EDI figures will be revisited.

3.7 **Scheduled Care Recovery Programme**

3.7.1 The WTIP Programme Board continues to oversee the programme of work across current recovery phase, implementation of WTIP end March 2021 and long term sustainability actions. The Head of Access, Anne Lavery commenced in post early December.

3.8 **Available Resources**

3.8.1 NHS Lothian was successful in securing £125,000 for HIS/NES/IHI/Access Collaborative support for quality improvement within CAMHS, Dermatology and Urology services have now met with the funders. This work is to demonstrate that deployment of QI methodology will improve performance. Urology is focussing on their high volume general Urology pathway and Dermatology on looking at their triage process to identify opportunities to reduce demand and manage demand effectively.

3.9 **Short Stay Elective Centre**

3.9.1 The outline business case for the Short Stay Elective Centre cost reduction analysis has been completed and approved by the November meetings of the Lothian Capital Investment Group and the Finance & Resource Committee. The request to government not outlines indicative cost of £70.9m which will now be progressed through the Capital Investment Group.

3.10 **Local Access Collaborative**

3.10.1 NHS Lothian will establish a Local Access Collaborative in the New Year. This group will oversee the programme of work in line with the national Access Collaborative and manage the transition from the extant Modern Outpatient Programme to the emerging Modernising Patient Pathways Programme.

4 Key Risks

4.1 NHS Lothian's WTIP Programme Board has established a risk register which details the specific risks associated with individual service plans, as well as those applicable to the overall Recovery and Sustainability plan.

4.2 Scheduled Care risks are also captured within an NHS Lothian Clinical Risk Matrix, updated monthly within this paper. Clinical risks as at 27th December 2019 were scored and ranked as below:-

OP Specialty	No. of weeks 9 out of every 10 patients had been seen within, in the quarter ending Nov 2019 - for adults unless otherwise specified	No. of patients waiting over waiting time standard as at 27/12/2019. Standard is 12 weeks for all but GI and Urology Diagnostics*, which have a six week standard.	Risk Rating			
			Risk based on current length of wait for 90% of patients (1-5)	Probability of clinical risk (e.g. cancer) (1-5)	Risk based on number of patients waiting over the waiting time standard (1-5)	Risk score (from highest, descending) (1-125)
GI Diagnostics*	61	1,699	4	5	4	
Dermatology	62	4,098	4	4	4	
Urology	40	1,810	3	4	4	
Colorectal	36	1,578	3	4	4	
Gastroenterology	45	1,108	3	5	3	
ENT (paed)	35	594	3	3	3	
ENT (adult)	39	1,293	3	2	4	
Ophthalmology	38	2,961	3	2	4	
Orthopaedics	37	2,172	3	2	4	
Neurosurgery	46	410	3	3	2	
General Surgery (paed)	27	293	3	3	2	
Gynaecology	15	253	2	4	2	
General Surgery (adult)	12	33	2	3	2	
Urology Diagnostics*	18	327	2	3	2	
Vascular	15	120	2	3	2	
Gastroenterology (paed)	51	2	4	1	1	

4.3 The number of patients waiting more than 12 weeks for a new outpatient appointment for Dermatology has improved by more than 900 since last reporting, and for Adult ENT, by 455. General Surgery (adult) figures have reduced by more than 50% to 33.

4.4 Paediatric Gastroenterology is included for the second time in the table above, as a result of the number of patients having completed waits in the quarter ending Oct 2019 exceeding 50. A Paediatric GI Consultant has been recruited as part of our sustainable investment and starts in March 20. The number of breaches has also decreased from 7 to 2.

5 Risk Register

5.1 Improved performance for patients waiting over 12 weeks for both an Outpatient appointment or an Inpatient/Day case procedure should reduce the risk levels for both corporate risk IDs 4191 (*Risk that patients will wait longer than described in the relevant national standard and the associated clinical risk*), and 3211 (*That NHS Lothian will fail to achieve waiting times targets for inpatient / day case and outpatient appointments).*

6 Impact on Inequality, Including Health Inequalities

6.1 Actions to deliver the Waiting List Improvement Plan will be assessed to identify direct impact on health inequalities.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 Actions to deliver the Waiting List Improvement Plan will have appropriate impact assessments and required consultations undertaken.

8 Resource Implications

8.1 Resource impact as detailed within body of the paper.

Jacquie Campbell
Chief Officer, Acute
Services
30/12/2019

List of Appendices

Appendix 1 - Scheduled Care Performance

Appendix 1: Scheduled Care Performance

Below is a summary of current performance against trajectories.

OP Performance against Trajectory

The 2019/20 outpatient trajectory and associated performance is detailed below. Performance is expressed in terms of number of patients waiting over 12 weeks for a new outpatient appointment.

	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19 *[p]*	Dec 19	Jan 20	Feb 20	Mar 20
NHSL OP >12 Wks Performance	**24,669**	**24,755**	**24,425**	**24,307**	**24,502**	**25,851**	**25,529**	**24,201**	*23,181*				
OP Trajectories	23,930	25,933	26,552	26,269	25,964	25,760	25,051	23,500	22,293	20,393	18,048	17,332	16,151
Difference	739	-1,178	-2,127	-1,962	-1,462	91	478	701	888				
% of patients waiting 12 weeks or less for a new outpatient appointment	**64.5%**	**64.9%**	**64.6%**	**64.0%**	**64.6%**	**62.8%**	**62.5%**	**62.0%**	tbc				

Please note that data provided above is management information and so may differ from published statistics

IPDC Performance against Trajectory

The 2019/20 IPDC trajectory and associated performance is detailed below. Performance is expressed in terms of number of patients waiting over 12 weeks for an Inpatient or Day case procedure.

	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19 *[p]*	Dec 19	Jan 20	Feb 20	Mar 20
NHSL TTG (IPDC) >12 Wks Performance	**2,340**	**2,597**	**2,642**	**2,622**	**2,526**	**2,727**	**2,788**	**2,563**	*2,530*				
TTG (IPDC) Trajectories	2,707	2,586	2,658	2,839	3,055	3,198	3,190	3,011	2,947	2,922	2,699	2,758	2,472
Difference	-367	11	-16	-217	-529	-471	-402	-448	-417				
% Patients Seen Within 12 Week Treatment Time Guarantee	**73.6%**	**78.4%**	**75.3%**	**74.7%**	**76.6%**	**75.2%**	**74.2%**	**73.5%**	tbc				

Please note that data provided above is management information and so may differ from published statistics
Ongoing Waits

Gastroenterology Diagnostic Performance against Trajectory

The 2019/20 Gastroenterology diagnostic trajectory and associated performance is detailed below. Performance is expressed in terms of number of patients waiting over 6 weeks for a diagnostic procedure.

	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Upper Endoscopy patients waiting over 6 wks	1,427	1,117	759	625	565	504	374	452	585				
Colonoscopy patients waiting over 6 wks	1,129	1,024	1,002	933	753	683	521	701	815				
Flexible Sigmoidoscopy (Lower Endoscopy) patients waiting over 6 wks	785	713	469	340	282	282	297	279	299				
Gastroenterology Performance	3,341	2,854	2,230	1,898	1,600	1,469	1,192	1,432	1,699				
Gastroenterology >6 Week Trajectory	2,901	2,260	2,196	2,034	1,844	1,719	1,794	1,619	1,444	1,269	1,094	919	744
Difference	440	594	34	-136	-244	-250	-602	-187	255				

Urology Diagnostic Performance against Trajectory

The 2019/20 Urology diagnostic trajectory and associated performance is detailed below. Performance is expressed in terms of number of patients waiting over 6 weeks for a diagnostic procedure.

	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Flexible Cystoscopy (Urology Performance)	349	394	370	323	271	292	340	317	327				
Urology >6 Week Trajectory	0	435	395	385	415	445	395	345	295	245	195	145	95
Difference	349	-41	-25	-62	-144	-153	-55	-28	32				

Radiology Diagnostic Performance against Trajectory

The 2019/20 Radiology trajectories and associated performance is detailed below. Performance is expressed in terms of number of patients waiting over 6 weeks for a Radiology scan.

Specialty Radiology - CT Lothian	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
CT Performance	32	63	101	101	97	98	112	108	85				
Trajectory >6 weeks	8	50	80	100	80	60	40	20	0	0	0	0	0
Difference	24	13	21	1	17	38	72	88	85				

Specialty Radiology - MRI Lothian	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
MRI Performance	103	137	114	87	194	204	260	393	446				
Trajectory >6 weeks	0	200	250	150	250	200	150	50	0	0	0	0	0
Difference	103	-63	-136	-63	-56	4	110	343	446				

Specialty Radiology - General Ultrasound (not Vasc)	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Ultrasound Performance	6	12	4	3	4	4	2	20	40				
Trajectory >6 weeks	10	10	20	10	0	0	0	0	0	0	0	0	0
Difference	-4	2	-16	-7	4	4	2	20	40				

Specialty Radiology - Barium Studies	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Barium Performance	0	1	1	0	0	0	2	0	0				
Trajectory >6 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0
Difference	0	1	1	0	0	0	2	0	0				

Specialty Radiology - Vascular Labs	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Vascular Labs Performance	95	23	5	11	5	3	5	29	*				
Trajectory >6 weeks	-	-	-	-	-	-	-	-	-	-	-	-	-
Difference	-	-	-	-	-	-	-	-	-	-	-	-	-

*Vascular Labs performance for Nov 19 not yet available

Cancer Performance The following tables details 31 and 62 day cancer performance against trajectory

31 Day performance

	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Urological	94.5%	86.4%	92.9%	91.2%	81.7%	86.4%	92.2%	89.4%	85.9%				
Colorectal (screened excluded)	85.7%	82.9%	76.7%	78.3%	73.3%	78.1%	88.6%	90.3%	83.3%				
Colorectal (screened only)	100.0%	100.0%	55.6%	100.0%	87.5%	20.0%	83.3%	72.2%	77.8%				
Melanoma	91.7%	100.0%	100.0%	95.7%	100.0%	88.9%	100.0%	93.8%	97.9%				
Breast (screened excluded)	98.1%	97.1%	97.5%	97.5%	100.0%	100.0%	100.0%	100.0%	98.1%				
Breast (screened only)	100.0%	78.1%	91.1%	95.1%	97.1%	100.0%	100.0%	96.6%	97.7%				
Cervical (screened excluded)	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Cervical (screened only)	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	n/a	100.0%	n/a				
Head & Neck	100.0%	100.0%	100.0%	100.0%	93.1%	100.0%	100.0%	100.0%	100.0%				
Lung	93.2%	95.2%	100.0%	93.9%	98.6%	94.9%	94.9%	98.5%	100.0%				
Lymphoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				
Ovarian	100.0%	66.7%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%				
Upper Gastro-Intestinal (GI)	97.7%	96.4%	95.1%	100.0%	100.0%	97.3%	100.0%	100.0%	100.0%				
All Cancer Types	95.3%	91.1%	93.9%	94.5%	92.2%	92.2%	96.2%	94.3%	95.2%				
All Cancer Types Trajectory	92.9%	92.6%	92.8%	92.5%	94.7%	94.4%	93.7%	94.7%	94.8%	94.8%	94.6%	95.1%	94.9%
Difference	2.4%	-1.5%	1.1%	2.0%	-2.5%	-2.2%	2.5%	-0.4%	0.4%				

62 Day performance

	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Urological	50.0%	51.4%	45.2%	51.7%	61.3%	48.8%	47.8%	77.1%	50.0%				
Colorectal (screened excluded)	55.6%	37.5%	61.9%	41.7%	55.0%	54.5%	38.1%	61.1%	60.0%				
Colorectal (screened only)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	5.9%	22.2%				
Melanoma	80.0%	75.0%	72.2%	82.4%	90.9%	66.7%	94.8%	89.7%	93.6%				
Breast (screened excluded)	90.6%	95.7%	73.9%	84.0%	75.9%	95.8%	92.9%	95.7%	85.3%				
Breast (screened only)	100.0%	97.1%	95.7%	97.7%	90.2%	100.0%	97.2%	97.0%	95.8%				
Cervical (screened excluded)	100.0%	0.0%	100.0%	100.0%	75.0%	100.0%	100.0%	25.0%	0.0%				
Cervical (screened only)	100.0%	0.0%	n/a	0.0%	n/a	0.0%	n/a	0.0%	n/a				
Head & Neck	100.0%	100.0%	88.9%	100.0%	73.3%	88.9%	100.0%	91.7%	100.0%				
Lung	92.9%	90.5%	76.2%	93.3%	90.5%	82.1%	83.3%	82.4%	87.5%				
Lymphoma	100.0%	66.7%	100.0%	75.0%	50.0%	100.0%	83.3%	100.0%	66.7%				
Ovarian	100.0%	0.0%	40.0%	75.0%	100.0%	100.0%	33.3%	100.0%	100.0%				
Upper Gastro-Intestinal (GI)	90.5%	100.0%	90.9%	100.0%	92.3%	94.7%	94.7%	92.9%	93.1%				
All Cancer Types	79.3%	74.3%	70.6%	78.0%	75.4%	75.8%	78.5%	78.9%	80.8%				
All Cancer Types Trajectory	89.5%	78.0%	81.8%	81.5%	82.8%	84.2%	81.2%	82.1%	84.0%	84.1%	84.1%	88.1%	88.3%
Difference	-10.2%	-3.7%	-11.2%	-3.5%	-7.4%	-8.4%	-2.7%	-3.2%	-3.2%				

NHS LOTHIAN

Board Meeting
8th January 2019

Executive Director, Nursing, Midwifery and Allied Healthcare Professionals and REAS Director of Improvement

LOTHIAN RECOVERY PLAN
MENTAL HEALTH AND LEARNING DISABILITY UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress in relation to the ongoing Lothian Performance Recovery Programme. This paper provides an overview of activities and actions undertaken in relation to the Mental Health and Learning Disability areas of escalation focusing specifically on adult acute bed occupancy as well as CAMHS and Psychological Therapies access targets.

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

2 Recommendations

2.1 To note the progress in the delivery against the Recovery Plan.

2.2 Acknowledge current performance against Government targets for CAMHS and Psychological Therapies is 48.4% and 79.9% respectively.

3 Discussion of Key Issues

3.1 The Lothian system has faced a number of significant performance challenges relating to the provision of mental health and learning disabilities services during 2019. In particular, there has been a shortage of inpatient bed capacity for adult mental health patients at the Royal Edinburgh, where patients were on occasion having to sleep on sofa beds and mattresses due to bed occupancy rates exceeding 100%. In addition, performance against the waiting time standards for both Psychological Therapies (PT) and Child and Adolescent Mental Health Services (CAMHS) outpatients was below trajectory and significantly adrift of the required 90% of patients seen within 18 weeks.

3.2 In this paper we provide an overview of performance in each of these three areas as well as plans over the next few months to maintain and improve performance as well as setting out indicative performance trajectories for 2020/21.

3.3 These plans have been put in place by a new management team in the Royal Edinburgh Hospital including a new site Director, Director of Psychology and General Manager for the CAMHS service with support of the four Partnerships. In addition, a weekly cross system Operational Recovery Group has been established to provide enhanced delivery assurance and this will report into the Mental Health and Learning Disabilities Programme Board chaired by the Chief Officer of Edinburgh City.

Adult Mental Health Bed Occupancy

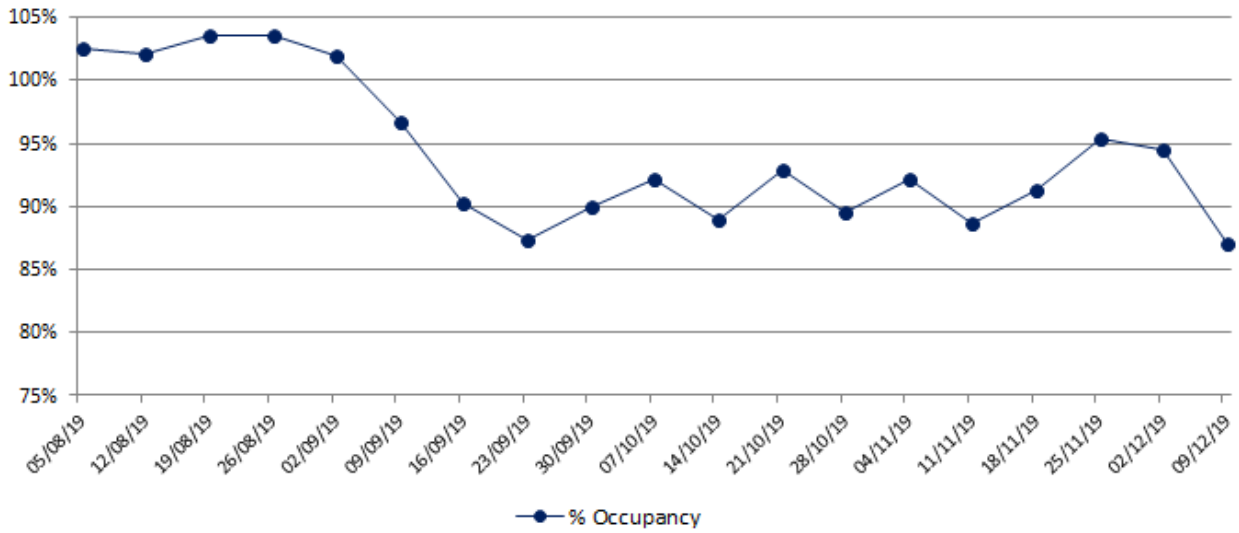
3.4 The immediate plan for adult mental health capacity focussed on reducing the occupancy level of inpatient beds at the Royal Edinburgh Hospital (REH). Throughout September and October occupancy rates have reduced to between 85-90%, and there has not been any patients without an appropriate bed since late August, as against 3 in July and 13 in early to mid-August.

3.5 In late November and into December, bed occupancy increased slightly, partly due to the site taking on additional out of area patients due to available capacity and delays in the finding alternative community accommodation for patients in psychiatry of old age beds, however, it is now back down into the target range.

3.6 This has been achieved by opening an additional 9 adult mental health beds temporarily within the system, as well as implementing a series of internal process improvement measures in the REH which have facilitated the discharge of patients and improved the flow within the hospital. These include establishing enhanced discharge procedures at Royal Edinburgh with daily rapid rundown meetings and daily 'MATT' meetings with an improved focus on safe discharge to free up bed capacity.

3.7 The commissioning of additional care places in the community should be sufficient to support the reduction in delays from older peoples' wards. Additional community places for patients leaving rehabilitation combined with the actions detailed above should sustain the reduction in acute bed shortages and provide some breathing space for the re-profiling of the total bed stock.

Figure 1. Bed occupancy profile August to December 2019
(% Occupancy, Adult Acute Wards, Royal Edinburgh Hospital)

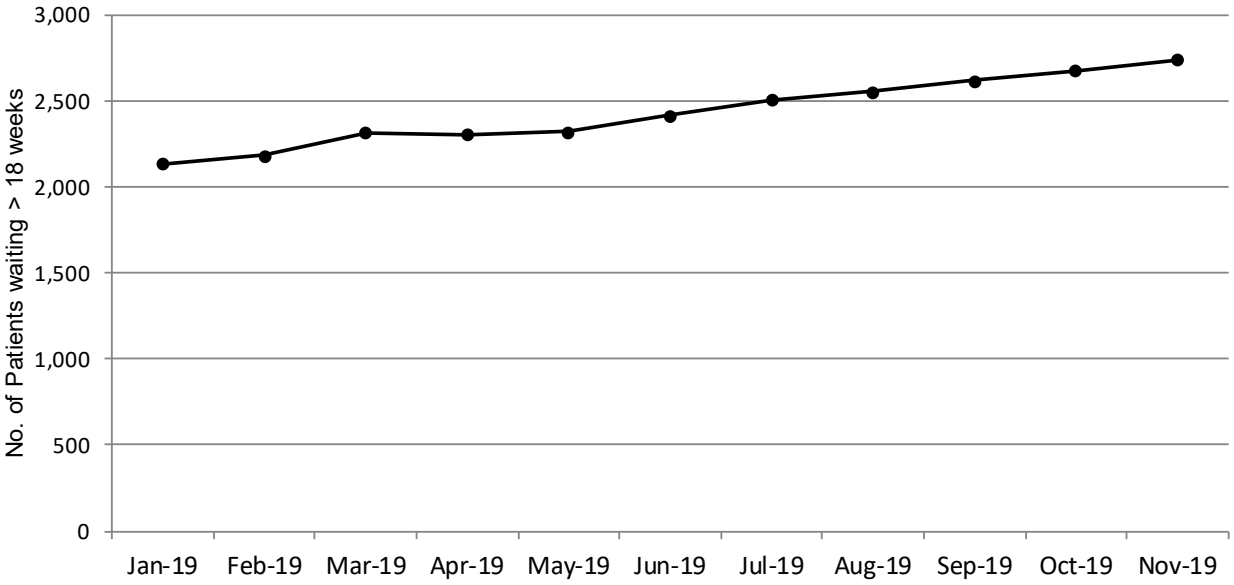


3.8 Further work is underway to address the medium term bed requirements across Lothian to provide whole system sustainability across primary, community, social care and the acute sector. This work is reviewing the current inpatient mental health and learning disabilities service model, including demand, capacity, utilisation, length of stay, throughput and the configuration of the bed base, and how this aligns with future redevelopment plans at the Royal Edinburgh site. This work will take a whole system approach to capacity, taking into account community models to ensure the acute bed base is optimised. This work will report into the newly established Programme Board with initial findings expected in March 2020.

Psychological Therapies

3.9 Performance in relation to Psychological Therapies 18 week target has steadily deteriorated over the past few months with the adult treatment list increasing by 30-40 patients per month. The number of people waiting on this list was 2,743 at the end of November 2019 with performance against the 18 week standard currently at 79.9%.

Figure 2. Psychological Therapies Waiting List January to November 2019
(Patients waiting over 18 weeks)



3.10 The largest and most significant component of the waiting list relates to general adult services, with over 2,100 patients waiting over 18 weeks. The long waits are concentrated in Mid and West Lothian, the four locality teams in Edinburgh City as well as the Group Therapy service. Historical trends indicate that the increase in the waiting list for first treatment relates to a capacity gap rather than an increase in referrals which have remained flat over the past 18 months. The remaining over 18 week waits are in specialist adult services such as, learning disabilities, psychotherapy, clinical health psychology, neuropsychology and guided self-help. The number of people waiting for these services has been relatively constant over the last year, with the exception of the Cullen Eating Disorders Service. There are intervention plans for each of these services in place currently to reduce the waiting times further.

3.11 To address these issues, the Lothian system is investing in additional short term capacity to tackle the longest waits, is implementing a number of changes in Standard Operating Policies (SOPs) and is taking part in a number of initiatives to extend the use of a computer based Cognitive Behavioural Therapy (cCBT) and other CBT digital services.

3.12 Recruitment to the service is ongoing, 4.2 WTE staff have had offers of employment in December and further interviews are scheduled in January 2020 with the first new joiners expected to start in early spring time. For Edinburgh City the aim is to recruit 16 WTE into the service on 18 month contracts with a focus on those waiting the longest. The team will consist of psychologists and administration staff. The management team are currently looking for suitable clinical office space and accommodation for the team to be based. Midlothian will recruit 4 WTE additional staff to address their waiting list and discussions are ongoing about additional temporary posts in West Lothian.

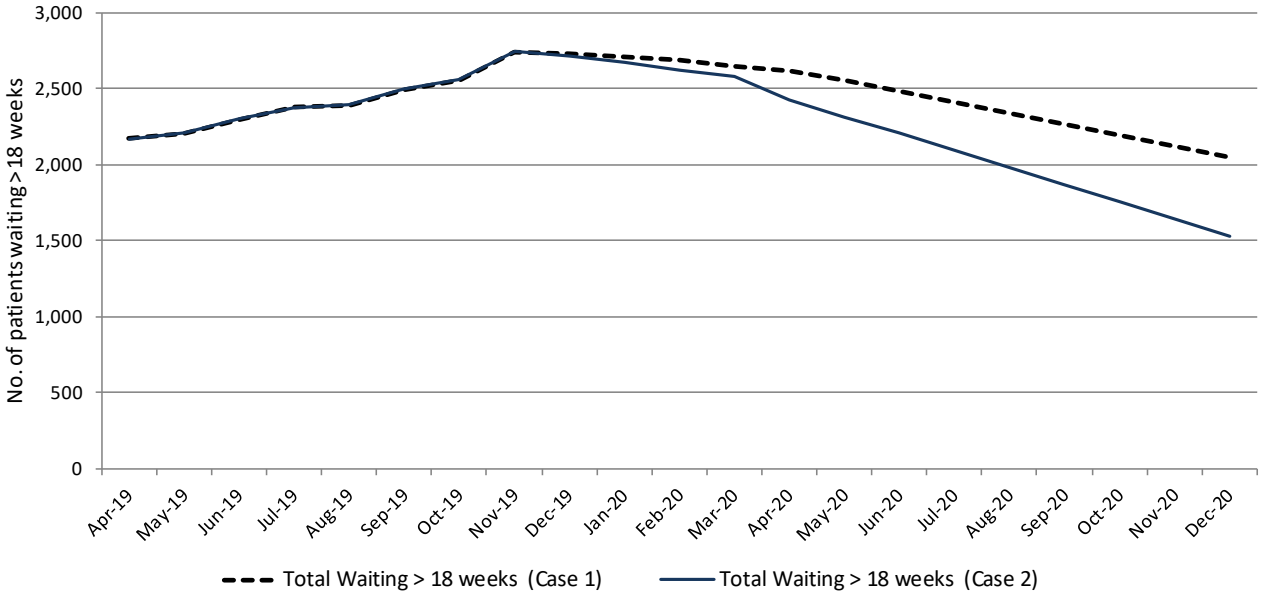
3.13 In parallel, a number of changes to SOPs have been proposed with the aim of increasing capacity for seeing new patients and tackling the waiting list deficit. Introducing these will be critical to ensuring a sustained increase in capacity. These measures include:

- introducing Patient focused Booking (PfB) for treatment appointments to reduce non-attendance rates as well as reducing the number of Patient Tracking Lists to ensure that those who have been waiting longest are treated first. The centralised additional administrative capacity will be used to support this approach;
- a review of the Edinburgh Group therapy service and how onward referrals are managed;
- reviewing job plans and caseloads for new and existing staff to ensure that there is consistency of availability of new treatment slots, combined with the patient focused booking system
- reviewing patients with long follow up rates, so that patient's with a treatment package reaching 20 consultations is subject to review; and
- undertaking an exercise to validate the waiting list, particularly those who will have been waiting five months or more to check the accuracy of the patients contact details and to ascertain whether treatment is still required.

3.14 The aim of these policy changes is to balance the needs of those in treatment with those still waiting to be seen, ensuring patients receive high quality treatment and maximising available capacity. The introduction of these polices will involve a change in how existing teams work, and a phased implementation plan across Lothian is currently being developed with each Partnership. The aim is to introduce these changes in West Lothian in January, and then roll out across the rest of the Partnership areas. A large staff engagement event is scheduled for 15 January 2020 when these and other issues will be communicated more widely across the service. Annex 1 sets out in further detail and the plans in place to deliver from November 2019 to April 2020.

3.15 Figure 3 illustrates how the improvement programme will impact on long patient waits.

Figure 3. Psychological Therapies Indicative Waiting List Trajectory
(Patients waiting over 18 weeks)



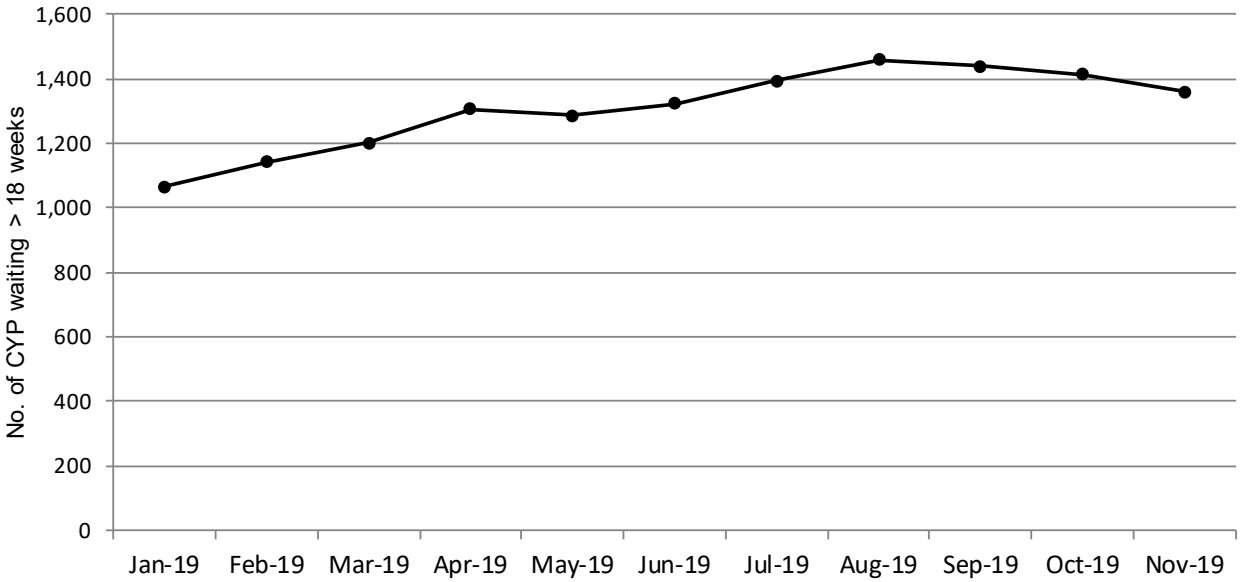
3.16 Due to current uncertainties around the recruitment profile for the service and timing of other changes two scenarios have been illustrated (high and low cases). It is estimated that the measures outlined above will significantly reduce those waiting over 18 weeks by the end of December 2020 (over a thousand patients). However, current projections illustrate the entire waiting list backlog may not be cleared by December 2020 and it could take a further nine plus months to bring performance back to the 90% target unless further measures are put in place. Whilst the backlog is being addressed it is projected that performance will remain at between 75-80% against the access standard.

3.17 Further work is ongoing to refine these trajectories and consider what further service redesign may be required to bring waiting lists to a more sustainable position. One of the key proposals is the extension of computerised CBT and other innovative computer accessible treatment approaches, although Lothian is already one of the highest adopters of cCBT in Scotland which may limit future uptake. The final submission of 2020/21 waiting list trajectories to the Scottish Government is scheduled for the end of March 2020 as part of the Annual Operating Plan which provides time to address these issues. A number of risks to the delivery of these plans are described in section 4.

Child & Adolescent Mental Health Service (CAMHS)

3.18 Performance in relation to the CAMHS 18 week target has remained weak over the past year, with the performance in November at 48.4% well below the 90% Government target. The number of patients waiting for treatment stands at over 1,300.

Figure 4. CAMHS Waiting List January to November 2019
(Patients waiting over 18 weeks)



3.19 The distribution of the long waits by team is set out in the table below, illustrating that all teams are struggling to meet the access standard. In addition, there are over 150 patients waiting over 18 weeks for the ADHD service. Historical trends indicate that the increase in the waiting list for first treatment relates to a capacity gap rather than an increase in referrals which have remained flat over the past 18 months.

Table 1. CAMHS Waiting List by Team (end November 2019)

Team	Service Wait Type	No. Waiting	No. <= 18 weeks (adjusted waits)	No. > 18 weeks (adjusted waits)
CAMHS - East Lothian	Treatment	139	34	105
CAMHS Midlothian	Treatment	279	32	247
CAMHS North Edinburgh	Treatment	329	71	258
CAMHS South Edinburgh	Treatment	348	65	283
CAMHS - West Lothian	Treatment	282	60	222
	Total	**1377**	**262**	**1115**

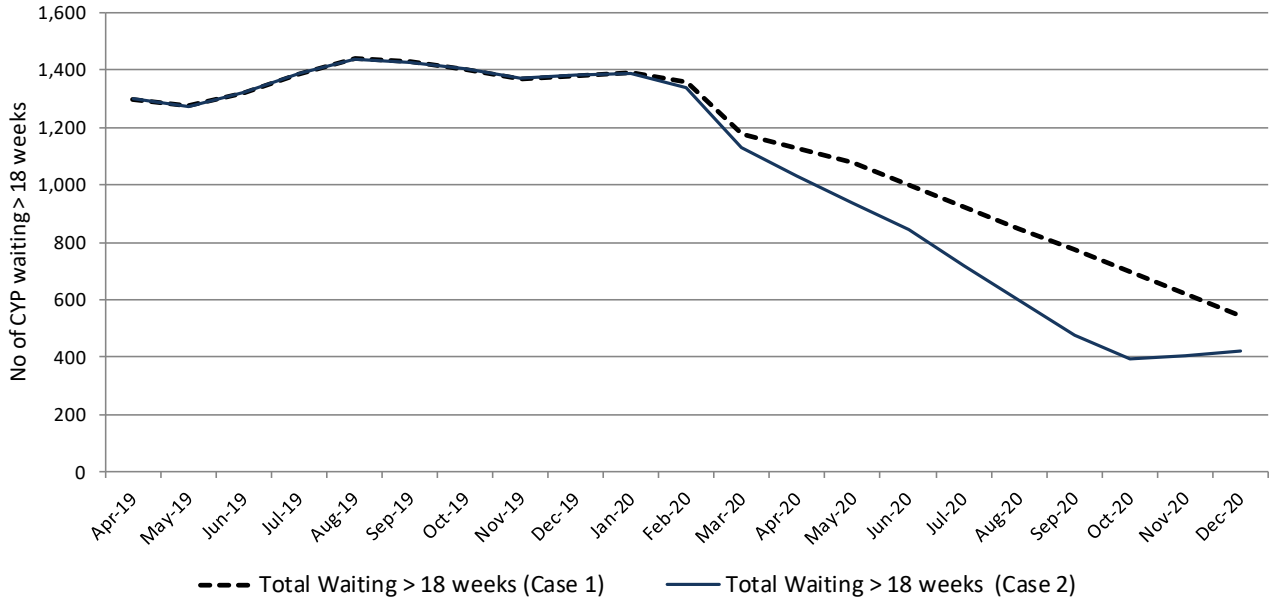
3.20 Within CAMHS, the plan over the next 12 months is to focus on increasing capacity across all areas, whilst also putting in place short term improvement measures related to Standard Operating Policies for waiting list and capacity management. These will be implemented on a phased basis. A number of long term improvement initiatives have also been identified and will ensure all new and adopted practices are sustainably embed into the vision and future direction of CAMHS. Planning for this will be firmed up in due course.

3.21 Recruitment to the service is ongoing with the first new joiners in post in November. In total, it is expected that an additional 21 WTE psychology, administration and OT support staff will be in post by January 2020 with a further 20 WTE by the end of March 2020. In addition, CAHMs will review current service management and unscheduled care capacity. These additional resources will be embedded across existing teams with all teams focused on tackling the waiting list backlog.

3.22 The service will adopt the NHS Lothian Waiting Times SOP and will implement changes within the service over the next few months. These are similar to those agreed within Adult Psychological Therapies and will be implemented with support from the Director of Psychology. They will cover issues such as Patient focused Booking (PfB), reviewing job plans and caseloads for new and existing staff to ensure there are sufficient new treatment slots, reviewing patients with long follow up rates as well as undertaking a programme to validate the waiting list to check whether those with very long waits still require treatment. Annex 2 sets out in further detail and the plans in place to deliver from November 2019 to December 2020.

3.23 Figure 5 illustrates how the improvement programme will impact on long patient waits. Due to current uncertainties around the recruitment profile for the service and timing of other changes two scenarios are illustrated (a high and low case estimate of patients waiting over 18 weeks are illustrated)

Figure 5. CAMHS Indicative Waiting List Trajectory
(Patients waiting over 18 weeks)



3.24 The figure illustrates that waiting list numbers will be reduced significantly over the next year. In the short term, as the waiting list backlog is addressed performance against the 18 week target will fall further, but will move back to target by December 2020 once the backlog is tackled under the first scenario. Under the second scenario it is projected that it will take an additional three months to clear the backlog. Further work is ongoing to refine these trajectories with a final submission required to the Scottish Government as part of the Annual Operating Plan at the end of March 2020. A number of risks to the delivery of these plans remain and are described in the section below.

4 Key Risks

4.1 A number of risks to delivery remain across the Mental Health recovery plan. In relation to acute adult mental health beds, the main risk relates to increased admissions pushing occupancy rates higher. At present this has been manageable but occupancy rates remain tight and it will be important to maintain performance as medium to long term changes in the bed base are introduced.

4.2 The main risk to both the Psychological Therapy and CAMHS plans relates to the ability to recruit staff on a timely basis. Current indications are promising, and there is believed to be capacity in the jobs market with a number of newly qualified graduates in the Edinburgh area especially for the permanent posts, however, there is less clarity about the likelihood of filling all of the fixed term posts given the competitive staffing context. Another risk relates to how changes in processes and policies are managed to ensure staff are engaged and connected rather than leading to dissatisfaction and resistance. The aim is to ensure all changes are jointly agreed with clinical leads in each area and are widely communicated.

4.3 In the medium term, it will be important to ensure that investment in additional capacity is sustainable, and in particular support a broader range of mental health services ensuring those in most need access specialist health service provision. Further redesign of services and use of innovative delivery methods such as cCBT will also need to be considered further especially if referral volumes increase further.

5 Risk Register

5.1 The Corporate Risk Register is currently being updated to reflect the risks specifically associated with the Recovery Programme. The Risk Register will be subject to ongoing review and update by the newly established Recovery Programme team.

6 Impact on Inequality, Including Health Inequalities

6.1 An integrated impact assessment associated with the Mental Health Recovery Plan has not been undertaken. Following approval of individual components of the Recovery Plan communication will be sent to responsible directors where new services, redesign of services and new strategies/plans are referenced to allow NHS Lothian's lead on Equalities and Human Rights to follow up and review whether the necessary integrated impact assessments have been completed as appropriate.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 NHS Lothian Directors, IJB Chief Officers and their teams have supported the development of the Mental Health Recovery Plan. Due to the timelines associated with the development of the Recovery Plan, public engagement and consultation relating to the contents of the plan will not have been undertaken.

8 Resource Implications

8.1 NHS Lothian has earmarked a £3m recurrent investment in CAMHS services and £0.95m non-recurrent investment in Psychological Therapies to support the implementation of the Recovery Programme. Additional staffing resources has also been committed within the Royal Edinburgh Hospital to open additional beds with the use of temporary bank and agency staffing. Costs are estimated to be in the region of £1m for the additional beds. Planning is underway to develop a more sustainable model of bed provision.

Annex 1. Psychological Therapies: Key Actions and Programme Plan
Annex 2. CAMHS: Key Actions and Programme Plan

Peter Lock
Director of Improvement

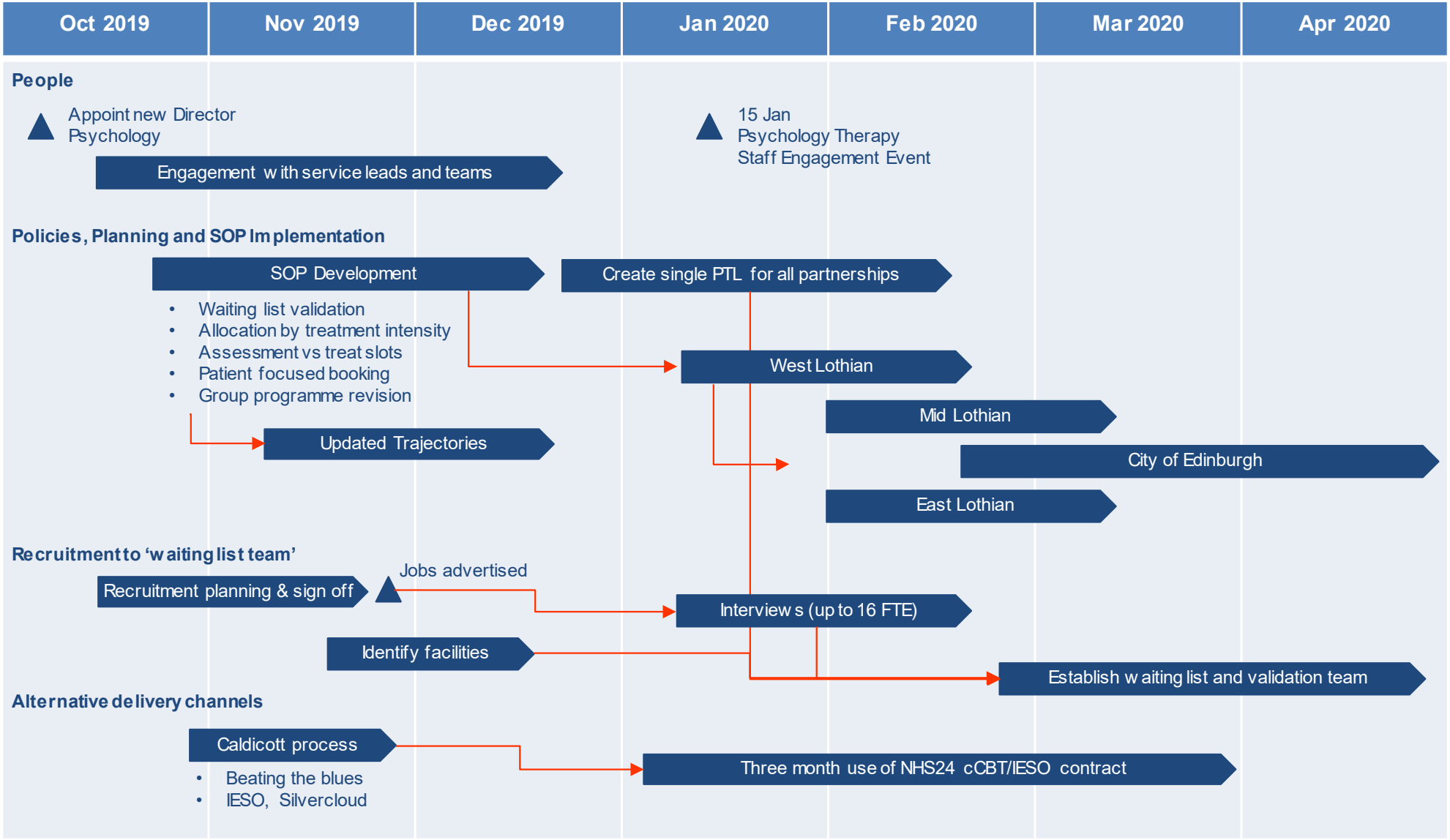
Alex McMahon
Executive Director, Nursing, Midwifery and Allied Healthcare Professionals and REAS

20 December 2019

Annex 1. Psychological Therapies. Key Actions and Programme Plan

#	Description	Milestone	Owner	Impact	Risk Status
PT1	Team leadership and staff engagement regarding proposed changes in SOPs and model of service delivery	Ongoing & 15 Jan 2020	Belinda	-	On track
PT2	SOP development and key changes to delivery in six main areas: 1) waiting list validation 2) review of assessment slots and reuse for treatment 3) patient focused booking for treatment 4) review of the group programme and onward referrals 5) creation of a single PTL in Edinburgh so the central waiting list team target the longest waits 6) allocation by treatment intensity not therapy for all waiting lists.	Nov – Dec 2019	Belinda	-	In progress
PT3	Implementation of SOPs and key changes in West Lothian with revised job plans for the existing team	Early Jan 2020	Belinda/ WL	Increased new slots	Dependency on local buy in and job planning processes
PT4	Implementation of SOPs and key changes in Mid and East Lothian with revised job plans for the existing team	End Jan 2020	Belinda/ EL/ML	Increased new slots	
PT5	Implementation of SOPs in Edinburgh City with revised job plans for the existing teams working sector by sector using one treatment waiting list	Mid Feb 2020	Belinda/ Mike	Increased new slots	
PT6	Recruitment of additional psychology staff and admin support. 16 FTE posts to be advertised in Edinburgh and 4 in Mid Lothian.	End Nov – Jan 2020	Belinda	-	Ability to recruit fix term posts
PT7	Establish short term waiting list team 1) admin support to validate waiting list based on new SOP 2) treatment capacity for longest waits. Suitable office, clinic space required.	Commence Feb/Mar 2020 and ramp up	Belinda	15% reduction in waiting list from validation estimated	Dependency on successful recruitment
PT8	Finalise Caldicott approval for cCBT & IESO in Lothian. This should provide sufficient time for a cohort to finish treatment from Jan – March 2020 before existing NHS24 licence agreements and funding expires. We understand these agreements are likely to continue (but funding route is less clear)	Jan – March 2020	Belinda, Alex	Capacity for ~500 referrals	Caldicott delays

Psychological Therapies Programme Plan

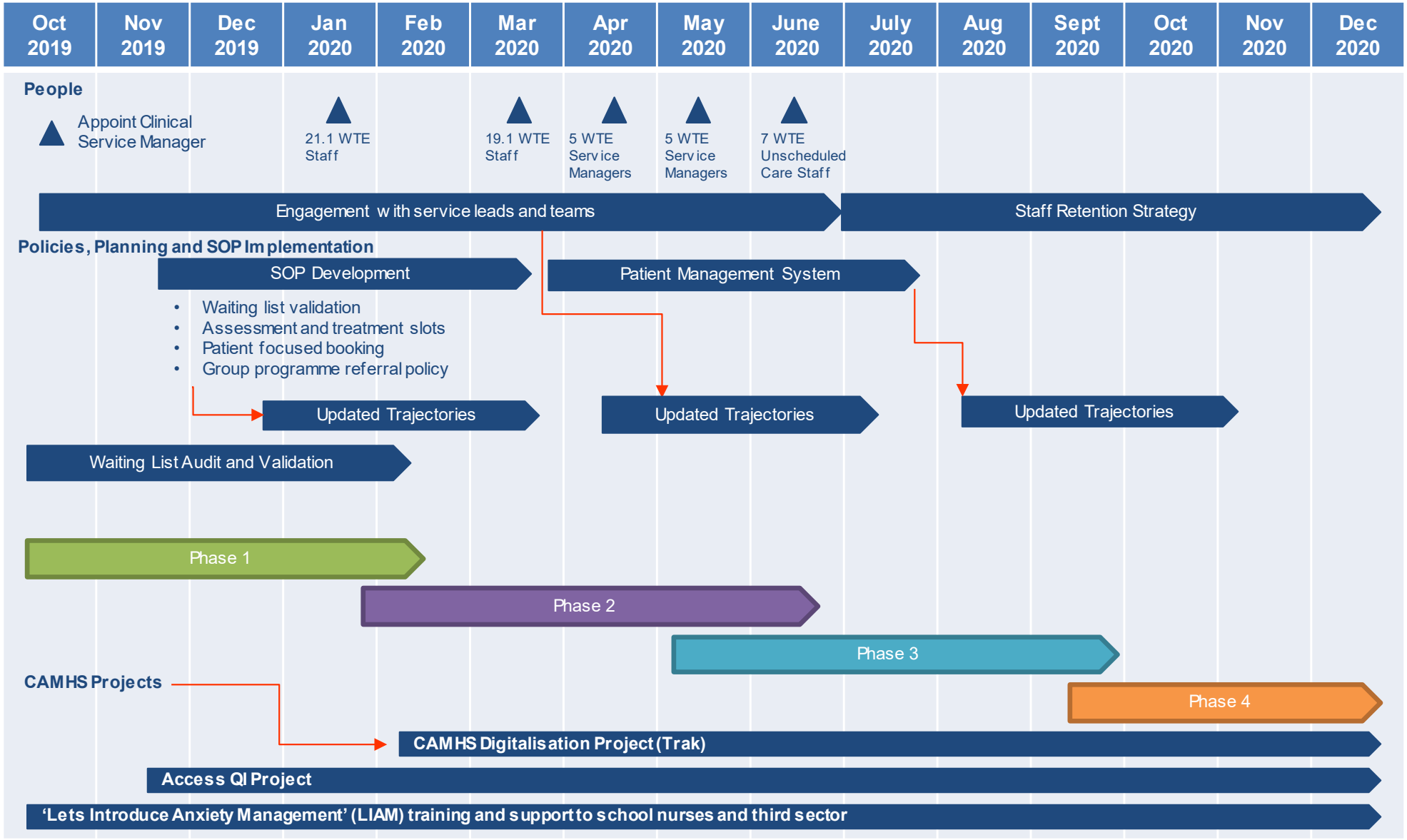


Annex 2. CAMHS. Key Actions and Programme Plan

#	Key Action Description	Milestone	Owner	Impact	Risk Status
1	Complete waiting list audit and validation for >18 weeks	January 2020	David	15- 20% reduction in waiting list from validation.	On Track
2	Recruitment of additional psychology, administration and OT support (21.0 WTE). In post.	January 2020	David	>400 children and young people from the >18 weeks waiting list	On Track
3	Recruitment of CAMHS Project Manager (1.0 WTE)	January 2020	David	Successful delivery of all associated projects	On Track
4	Recruitment remaining additional psychology, administration and OT support (19.08 WTE). In post.	March 2020	David	>380 children and young people from the >18 weeks waiting list	Dependency on successful recruitment
5	Recruitment of Service Manager for all CAMHS teams/areas (5.0 WTE)	April 2020	David	10% increased new slots	On track
6	**SOP development in four main areas**: 1) waiting list validation 2) review of assessment and treatment slots 3) patient focused booking 4) review of the referral policy, post group treatment to reduce internal referrals. Standardised practices and policies across all Lothian teams.	March 2020	David/Belinda	9% increased new slots*	Dependent on local buy in
7	Developing unscheduled care capacity (7.0 WTE). Reduce the number of routine and urgent referrals to outpatient team.	April 2020	David	A&E 4 hour target Reduction in tier 3 referrals	Dependency on successful recruitment
8	Developing and imbedding non-medical prescribing (nurses and pharmacists) or GPwSI capacity. - 95% of long-term case holding in the service was a result of the need to monitor and review medication.	May 2020	David	TBC% Increased new slots	Dependency on successful recruitment

#	Key Action Description	Milestone	Owner	Impact	Risk Status
9	**Completion of Phase 2**: Stakeholder engagement/ mapping Forming a greater understanding of our service from a stakeholders perspective.	June 2020	David	Health System Methodology	On Track
10	**Completion of Phase 3:** Developing a Vision, Purpose and Direction Defined pathways Defined service provision Shared understanding of the role of CAMHS	September 2020	David	*	On Track
11	Develop and implement a patient management system that accurately balances the needs of both the service and patient group.	November 2020	David	Treatment slot quotas Accurately calculate DCAQ	On Track
12	Access QI Project. Using QI methodology to improve access and shorten waits in East Lothian. Generic Pathway.	November 2020	CAMHS QIT	TBC	On Track
13	**Phase 4**: Build an internal and external campaign around CAMHS (and partners) with accompanying communication strategy.	December 2020	David	*	Dependent on Internal and External Stakeholders
14	Support community capacity to promote mental health and wellbeing e.g. Lets Introduce Anxiety Management' (LIAM) training and support to school nurses and third sector	Ongoing	CAMHS SMT	*	
15	**CAMHS Digitalisation Project (Trak)** Develop and implement a project plan for using TRAK patient information system to its full potential (Progress Notes [Paper-lite day to day]; Using TRAK for Clinic Letters [not Word]; Using TRAK App / W-List letters; Use of TRAK letters; Clinic templates; Outcoming)	Mid Feb 2020 (Start) June 2021 (Finish)	Dr Rob Waller/ David	TBC. Will have considerable positive impact on efficiency. Need to quantify.	On track

CAMHS Programme Plan



NHS LOTHIAN

Board Meeting
8th January 2019

Executive Director Nursing, Midwifery, AHPs

TOWARDS A SYSTEM TRANSFORMATION PLAN

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board notes and approves the approach being taken to develop a Lothian System Transformation Plan, including the modified "Annual Operational Plan" and Recovery and Improvement Plan.

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

2 Recommendations

2.1 The Board is asked to **note**;

- The proposal on how the organisation will develop the Lothian System Transformation Plan to encompass the various parts of our strategic planning and implementation landscape (paras 3.1-3.22)
- The guidance to NHS Boards on development of revised "Annual Operational Plans", and the role that NHSL has played in the development of same (para 3.23-3.30);
- The outline of this "Annual Operational Plan", and the process for refining;
- The discussions at December's Strategic Planning Committee

3 Discussion of Key Issues

3.1 NHS Lothian (NHSL) has a busy strategic landscape to navigate. Paragraphs 3.4-3.18 outline this as concisely as possible. The key proposition within this paper, however, is to create a tool to help stakeholders understand how the organisation sees this landscape and the actions it is taking to help re-shape this environment.

3.2 The key part of any strategy is the effective execution of its propositions, through tactical and operational approaches. With this in mind, a System Transformation Plan would bring together the visioning documents the organisation is working to convert into action – broadly, those within the *Our Health, Our Care, Our Future* family and the Strategic Plans produced by our Integration Joint Board partners – together with our revised "annual operational plan" and our recovery and improvement plan.

3.3 Simply put, the organisation should be able to see where all of its efforts are supporting delivery of its key strategic objectives. Where these efforts are delivering these, this work should be supported and redoubled. Where work is not focussed on these objectives, the organisation needs to understand whether it wishes to alter its objectives, or to cease the efforts and redirect energy and resources. Clearer linkages to operational and improvement plans should help Board members and managers, as well as other stakeholders, be clearer on where the organisation is adding value.

3.4 Taken together, a System Transformation Plan will show;

- **Strategic-level work** – *Our Health, Our Care, Our Future; The Lothian Hospitals Plan;* IJB Strategic Plans
- **Tactical-level work** – as summarised in revised Annual Operational Plans, including the Strategic Financial Plan, the Workforce Plan, etc
- **Operational-level work** – such as the Recovery and Improvement Plans

Or, to borrow a historical allusion – to win the peace, to win the war, and to win the battles, respectively.

3.5 This initiative and approach would directly address concerns expressed by Board members that some elements of the organisational approach feel poorly expressed or "bitty", as well as more clearly identify where more work needs to be done.

Our Health, Our Care, Our Future

3.6 NHS Lothian has an extant strategy, *Our Health, Our Care, Our Future* ("*OHOCOF"*) which was published in 2014 and runs to 2024. *OHOCOF* laid down the strategic direction for NHSL and identified some key planning assumptions to underpin how NHSL would go forward – for example, that the organisation would consolidate all acute activities onto the four major campuses, that the organisation would be at the forefront of integration, that the organisation was fully committed to reshaping the workforce, and was committed to a strong and sustainable primary care sector.

3.7 *OHOCOF* was written in such a way as to require NHSL to undertake further work to develop the proposals for integrated systems (as outlined by the schemes of establishment for IJBs) and the acute sector (*The Lothian Hospitals Plan)*. It was intended that the Strategic Plans of the Integration Joint Boards would either build upon, or replace, the propositions outlined for integrated services such as primary care and mental health as outlined in *OHOCOF.*

3.8 Work on a successor to *OHOCOF* will commence in 2022, in order that it can be appropriately developed and consulted on ahead of publication. This assumes, however, that the logic and propositions contained within *OHOCOF* still apply and that progress is being made towards them. The organisation has not, as yet, undertaken this detailed review, both to ensure that work is heading in the right direction, and to identify where the landscape has changed enough to alter this direction, either now or for the next strategic plan.

3.9 To be clear, it is believed that *OHOCOF* does still stand as a basis for the organisation to go forward, but it is appropriate to review this proposition at this point.

Integration Joint Board Strategic Plans

3.10 NHSL outlined its commitment to integrating services in *OHOCOF*, and while advancing propositions for the services which were to be integrated, was careful to be cognisant that these new organisations would develop their own direction of travel, and would express this through their Strategic Plans as they were refreshed every three years, and indeed through the issuance of Directions from each IJB.

3.11 It would be fair to describe the experience of these Strategic Plans and Directions as being a work in progress, which is entirely understandable given the significance of the changes brought about by the integration approach and that these are entirely new organisations and new governance structures.

3.12 This being said, these are key documents which dictate at least part of the future of NHSL, and it does appear that the "work in progress" summary also applies to how NHSL has dealt with IJB Strategic Plans and Directions.

The Lothian Hospitals Plan

3.13 The *Lothian Hospitals Plan (LHP)* was developed in 2016 and approved by NHS Lothian in early 2017. It laid out a strategic headline for each of the four major acute sites and provides a "docking point" for our 4 IJB partners to see what NHSL's plans are for these sites, and therefore to outline a basis for discussion on the development of services within the "set-aside".

3.14 The LHP also been a key staging point in the development of the Lothian Capital Plan, with its underpinning prioritisation process both supporting and supported by the clarity the LHP offers.

3.15 It is absolutely acknowledged that the LHP can be interpreted as being focussed on buildings and capital spend. While this may appear to be the case, LHP was driven by the need to clarify service models for sustainable delivery, and, where this delivery was not possible, to flag the need for further work, new models, and choices to be made within the organisation about how to deliver the vision.

Regional and National Work

3.16 Alongside this triumvirate of key strategic documents for the organisation sit the regional and national pieces of work such as the National Health and Social Care Delivery Plan and its regional expressions. The work contained within these finds its expression both within the day-to-day work of the organisation and of its partners. The most recent change of Cabinet Secretary brought with it a renewed focus on the delivery of Mental Health, Scheduled Care, and Unscheduled Care.

The underpinning tactical and operational delivery

3.16 NHSL has a range of initiatives in what can be described as a "tactical" space, where medium (of around a 3 year) timescale work is taking place. This range includes the Workforce Plan, the Strategic Financial Plan, the Capital Plan, the Quality Strategy, the Waiting Times Improvement Plan, and other key initiatives.

3.17 At an operational (around a year's horizon) level, the day-to-day work of the organisation can be summarised around the Recovery and Improvement plan, as well as the broader range of operational work in acute services, REAS, corporate services, public health, and the Health and Social Care Partnerships.

3.18 In addition, NHSL has its summarising piece of work representing annual corporate objectives ("Our Priorities") that is for discussion at the December 2019 meeting of SPC.

The need for review

3.19 As suggested at para 3.8, this is an appropriate time to review *OHOCOF* and the underpinning to it. To support this, Strategic Planning Committee agreed that a small team be established to undertake this review and feed back within 3 months to the Strategic Planning Committee.

3.20 This team, as agreed by Strategic Planning Committee, would include two non-executive members of the Board (ideally, with one holding a senior position in an IJB), the Director of Strategic Planning, and an IJB Chief Officer. Strategic Planning Committee agreed that Brian Houston and Peter Murray would join this team.

3.21 The remit of this team is to;

- Review *OHOCOF* and identify where there is evidence of **good** progress, **limited** progress, and **no** progress (remove from plan) on each of the propositions;
- Review *LHP* and the IJB Strategic Plans and identify progress on these, and make recommendations as to key areas for review in the forthcoming review of IJB Schemes of Establishment;
- Identify where organisational initiatives are adding to the effort to deliver *OHOCOF*, and, if appropriate, identify where there need to be additions to the *OHOCOF*.

3.22 This work would inform two significant pieces of work for the coming financial year – the embedding of the new approach to "annual operational plans" and the review of IJB schemes of establishment, and can provide recommendations as to where the latter could be more effectively drawn.

The revised approach to "Annual Operational Plans"

3.23 Annual Operational Plans (AOPs) constitute the annual "contract" between NHS Boards and their stakeholders, specifically but not solely the Scottish Government.

3.24 The guidance underpinning these documents was revised for the 2019-20 financial year and this led to a more concentrated focus on operational priorities in Mental Health, Scheduled Care, and Unscheduled Care. For a range of reasons, this process proved unsatisfactory to Boards across the country and to the Scottish Government.

3.25 For the 2020-21 year, the Scottish Government has engaged in what appears to be a meaningful and open way with Board representatives, and has worked closely with the national Directors of Planning Group to try to reshape these documents into more functional pieces of work which have a longer timescale and a more dynamic process of development.

3.26 Specifically, this work has identified some key representative actions which are expected within the new "AOPs";

- That these should take a longer timescale, incorporating the next three years as a minimum, and show the strategic, tactical, and operational timescales;
- That these should more explicitly tie in to IJB Strategic Plans;
- That these should show the full breadth of the Board's activities;
- That these should build on the flexibility brought in with the national Medium-Term Financial Framework;
- That these should show where there are clear ties to the AOPs of other Boards, either as work in development, or as work in place.

3.27 The guidance supporting this work is attached at appendix 1.

3.28 Although the timescales for this year's submission round have been extended versus 2019-20's, there is an understanding that it is likely that fully embedding this approach may take more than one cycle – as an example, further guidance was received on 13th December, which was also the initial deadline for first submission. A first progress update is required with SGHSCD on 20th December 2019 and as of the writing of this paper this is being worked on by an Editorial Board chaired by the Director of Strategic Planning and with input from across the organisation and its IJB partners. A draft will be circulated to SPC members as soon as it is ready.

3.29 The revised AOP will include;

- A introductory section on the strategic objectives and framework for the organisation;
- A broader section on the tactical stages the organisation is taking to meet the strategic objectives;
- A detailed series of sections on key operational deliverables (such as scheduled care and cancer waiting times) showing the fine detail of delivery.

To give an example of how this should flow, the following summarises one element of scheduled care and cancer waiting times;

NHSL has been challenged in delivering the treatment time guarantee consistently and sustainably, due to a lack of physical capacity and appropriate, recurringly-funded, staffing. This challenge is also, in part, due to the growth of demand across Lothian as the population both grows and ages. Some of our physical facilities are also in need to expansion and refurbishment. Within OHOCOF, we have described this as providing the right care in the right place at the right time.

To deliver this sustainable model of care, we will work with our partners at the Scottish Government to deliver on the ministerial commitment to provide elective care centres across the country. We have developed a business case to construct a new Short-Stay Elective Centre on the St John's Hospital campus. The current estimated cost of this centre is just over £70m.

This model will be centred on providing care for patients receiving procedures where the estimated length of stay will be less than 48 hours, in the specialties of gynaecology, orthopaedics, general surgery, colorectal surgery, and urology. This model will also facilitate the development of a centre of excellence in both teaching and delivery of rapid-turnaround patient-centred care, with high levels of resource utilisation and efficiency delivered in a safe, specially-designed and purpose-built facility.

The benefits of this model to patients will be a reduction in waiting times, quicker turnaround in hospital, and a new and innovative facility. For staff, this will allow greater subspecialisation and flexible working, with new skills and a chance to be part of a genuinely cutting-edge model of patient care. This centre will also provide a boost to the economy of West Lothian and should reassure the local population of how serious NHSL is about sustaining and developing St John's Hospital.

The additional benefit to this piece of work is that it will free theatres up at both the Western General and Royal Infirmary. These provide additional capacity for cancer waiting times surgery on both sites, as well as more complex orthopaedic procedures. Again, the benefits for patients will be reduced waiting times, and more sustainable delivery.

In the short-term, our Waiting Times Improvement Plan governs our efforts to commission external capacity, to improve efficiency and utilisation, and to work with our general practice services to ensure that the appropriate level of priority is given to every patient. To support this NHSL is investing £9m of resource in this work, with similar levels of investment from the Scottish Government.

In addition, the AOP will have read-across to the AOPs for both NHS24 (regarding return outpatients capacity) and the Scottish Ambulance Service (regarding further spread of operational changes made by SAS in the Musselburgh Primary Care model, which will also be in the NHS 24 document)

3.30 A final draft of the revised AOP will be brought to the NHSL Board towards the end of this financial year for approval.

3.31 A version of this paper was presented to Strategic Planning Committee on 19th December 2019 and was endorsed.

4 Key Risks

4.1 The risks associated with this work are all incorporated in the underpinning pieces of work. There is a risk that the review of the current strategic landscape leads to us bringing forward the development of a replacement strategy, but this would be a positive development if indeed it was required.

5 Risk Register

5.1 All risks are captured already on the risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 Impacts on inequality will be captured in the constituent pieces of work.

7 Duty to Inform, Engage and Consult People who use our Services

7.1 If the review of the strategic landscape made changes to our strategies necessary, these would be consulted upon. A Strategic Transformation Plan would assist in explaining to stakeholders where the organisation is on its journey and how the various pieces of work fit together.

8. Resource implications

8.1 The resource implications are not considered significant at this point.

Colin Briggs
Director of Strategic Planning
17th December 2019
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List of Appendices

Appendix 1: Annual Operational Plan 2020/21 (Scottish Government, 6 November 2019)

Health Performance and Delivery Directorate
Chief Performance Officer, NHSScotland and
Director
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T: 0131-244 2480

NHS Chief Executives
NHS Directors of Finance
Integration Authority Chief Officers
Integration Authority Chief Finance Officers

cc NHS Board Chairs
IJB Chairs

6 November 2019

Dear Colleague

ANNUAL OPERATIONAL PLAN 2020/21

Annual Operational Plans (AOPs), which are now going into their third year, are intended to provide Scottish Government with confirmation that NHS Boards and their partners have plans in place to demonstrate how they will continue to deliver safe and accessible treatment and care and fully deliver Ministerial priorities.

The plans will continue to represent the agreement that sets out how NHS Boards will deliver the Cabinet Secretary's priorities on waiting times improvement; investment in mental health; service transformation and contribute to the delivery of greater progress and pace in the integration of Health and Social Care.

National NHS Boards are requested to agreed with their own SG Sponsor Team which elements of the attached guidelines are relevant for inclusion in their own AOP.

Strategic Context

Boards are also expected to clearly set out in their AOP how their activities are expected to contribute to:

- delivering the Medium Term Financial Framework, published in October 2018;
- the relevant health and social care commitments contained in 'Protecting Scotland's Future: The Government's Programme for Scotland 2019-20';
- Scottish Government's National Performance Framework.

The AOPs must be clearly set in the context of the local Integration Authorities' strategic commissioning plans, and should reflect the key contextual aspects of ongoing work on service transformation, regional planning, workforce planning and financial planning. The wide range of quality improvement and collaborative work that is underway in Scotland also forms part of the context. The relevant activities being undertaken as part of the Boards' overall improvement programmes should be reflected or summarised in the AOP.

Requirements of the Annual Operational Plan

While the current (2019/20) AOPs have been accepted as primarily single year plans, for 2020/21 and beyond the system will move to a three year rolling planning cycle, updated annually.

This three year planning cycle is expected to enable NHS Boards to clearly demonstrate what they are doing, in conjunction with their partners, to increase the pace and scale of reform across the health and social care system, with an expectation that those things that will make the greatest difference are positioned at the heart of Boards' transformation programmes.

The expectation is that for the first year (2020/21), planned actions and programmes of activity will be absolutely firm and aligned to budgets while accepting that, for future years, specific programmes of work may still be developing. However, the AOPs are expected to make clear links between all actions or activities and the outcomes they are expected to deliver.

The AOPs should also set out in detail how the Board will achieve and maintain the expected levels of operational performance, particularly with regard to waiting times – with specific detail and trajectories required in relation to the first year of the Plans. Feedback from the Indicative Improvement Plans should support this process. These AOPs should factor in anticipated levels of seasonal variation in demand and capacity across the health and social care system. For the first time we expect that Winter Plans (for the 2020/21 year) will be submitted as a core part of the AOP. This will allow early consideration of investment requirements by the partners involved across the integrated system.

There are also a number of new headings which have been added to the guidelines, including Population Health and Digital and eHealth, recognising the increasing importance of these areas in an integrated health and care system.

Timetable for Submission

This is expected to be an iterative process with the initial drafts of the AOPs to be shared with Scottish Government by **Friday 13 December 2019**. Scottish Government will be engaging with Boards to provide feedback and support throughout January and February 2020. The final draft AOPs are expected to be submitted by the end of February with final feedback by the end of March. At that point, arrangements should be put in place to ensure this final draft is taken through the appropriate governance processes prior to formal sign off. As part of the engagement process, Scottish Government will agree waiting times investment plans with Boards during December and January.

AOPs will be formalised between NHS Boards and Scottish Government, with the DG Health and Social Care and each Board Chief Executive signing off Board plans as the performance agreement for 2020/21 and future years.

Further guidelines to support the development of the AOPs, along with templates for completion, are attached to this letter. We will write to you again in the next few weeks to provide further details of the specific arrangements for the submission, assessment and sign off for this year's AOPs and Financial Plans.

In the meantime, if you have any queries or concerns please contact Gary Mortimer up until 2 December 2019 (gary.mortimer@nhs.net) or Yvonne Summers from 2 December onwards (yvonne.summers@gov.scot).

Yours sincerely

JOHN CONNAGHAN CBE
Chief Performance Officer, NHSScotland
and Director of Delivery and Resilience

CHRISTINE MCLAUGHLIN
Chief Finance Officer, NHSScotland
and Director of Health Finance,
Corporate Governance and Value

ANNUAL OPERATIONAL PLANS - GUIDELINES

Sections

1. Elective Care
2. Cancer
3. Unscheduled Care
4. Mental Health
5. Integration & Primary Care
6. Healthcare Associated Infection
7. Population Health
8. Finance
9. Workforce
10. Digital and eHealth
11. National Boards
12. Other Key Aspects of Operational Delivery

1. Elective Care

Context

The Waiting Times Improvement Plan sets out expected levels of elective performance. Through to Spring 2021 the Waiting Times Improvement Plan (WTIP) will make an immediate and sustainable (2020/21 and beyond) improvement in the experience of patients waiting to be seen or treated. There is a focus on improvements for patients whose treatment is urgent, who have a suspicion of cancer, and those who have waited the longest for an appointment. Delivery of the WTIP will require boards to effectively eliminate waits over 52 weeks by March 2020.

Requirements

Each Board's AOP will clearly quantify the outpatient, diagnostic and inpatient/day case Treatment Time Guarantee (TTG) activity required during 2020/21 to deliver the expected levels of elective performance. This will include a breakdown of required activity by key speciality or sub-speciality. The required levels of activity will need to take explicit account of conversion from outpatients to diagnostics and treatment, and should specify the activity expected to be delivered for neighbouring Boards.

NHS Boards are expected to summarise how additional outpatient, diagnostic and TTG activity will be delivered, including increasing core capacity, use of the new elective centres, as well as waiting times initiatives to address one-off backlog issues. The use of the independent sector will be structured and prioritised on a limited basis and plans should demonstrate how Boards will transition from short term initiatives to longer terms sustainable solutions, including reducing the use of the independent sector.

Plans should also include reference to any agreements in place with the Golden Jubilee that are intended to support the delivery of Waiting Times Improvement Plans targets.

The AOP should include how the Board is delivering improved elective activity using proven methodology and implementation of Access Collaborative programmes. It is expected that each NHS Board will clearly state the future ambitions of the Board in the implementation of the Access Collaborative programme in order to sustainably balance demand and capacity.

Boards should explore how changes in demand through redesign can be achieved to enable the redirection of capacity to improve access times eg through national improvement programmes such as the Scottish Access Collaborative, Modernising Patient Pathways or Access QI. Such expected activity offsets should be described in full to allow discussion of the likelihood of expected impact. These improvements can include reduction in face to face appointments (provided any alternative activity is accounted for), reduction in procedures or diagnostic tests from new clinical models or pathways or any increase in capacity from new workforce models.

Scottish Government will agree the level of financial support available to Boards on a recurring and non-recurring basis as part of the delivery planning for the WTIP for 2020/21. Boards are expected, however, to utilise the full extent of their core funding in pursuit of Scottish Government priorities. The intention is to agree a balanced plan for 2020/21 and beyond with each NHS Board. Any investment from Scottish Government will be linked to additionality in 2020/21, over and above 2019/20 core activity.

Moving beyond 2020/21, outline outpatient, diagnostic and TTG plans for 2021/22 and 2022/23 must also be included in the AOP. It is important the plan demonstrates how the Board will transition from short term initiatives to longer terms sustainable solutions beyond 2020/21.

Reducing the Longest Waits

Reduction of the longest waiting patients remains a priority in line with the Waiting Times Improvement Plan milestone dates. NHS Boards should progressively reduce the longest waits to achieve no person waiting longer than 12 weeks by March 2021.

AOP should contain detail of how the following milestones are to be achieved;

- No patient waiting more than 52 weeks by 31 March 2020 for first outpatient appointment or inpatient day / daycase treatment,
- No patient waiting more than 26 weeks by 30 September 2020 for first outpatient appointment or inpatient / daycase treatment.
- All patients seen or treated within 12 weeks by March 2021.

To aid future planning and consideration of capacity, demand and activity, a specific performance trajectory template and sub-speciality template are provided to accompany the plan narrative (see Annex 1).

2. Cancer waiting times

Context

Achievement of cancer waiting times standards remains a priority and NHS Boards are expected to deliver 95% performance for the 62 day and 31 day standards as set out in the Waiting Times Improvement Plan. Delivery of these standards requires the whole system to work together including both primary and secondary care.

Requirements

NHS Boards should detail within the AOP how the Framework for Effective Cancer Management will be embedded across cancer services and detail the additional outpatient,

diagnostic, oncology and surgical capacity that will be required to deliver and maintain the cancer waiting times standards. The AOP should have a focus on and provide detail of the additional activity required to treat those cancer patients who have already breached the standards and the proposals for securing that activity in 2020/21, as well as describing longer term service improvement initiatives.

The anticipated impacts of these initiatives on operational capacity should be specified in the outline plans for 2022/22 and 2022/23. The template attached at Annex 2 allows Boards to detail the expected activity required to deliver the cancer waiting times standards.

3. Unscheduled Care

Context

NHS Boards are expected to deliver the 4 hour A&E Target of 95% - working towards the 98% standard to ensure that patients receive the most appropriate assessment, treatment, support and services at the right time, in the right place by the right person. Although the standard is measured in the Accident & Emergency Department, it requires the whole NHS system to work together effectively. Therefore we would expect the plan to clearly set out how partners from across the health and social care system will work collaboratively to deliver efficient emergency and urgent care.

Requirements

The AOP will describe the improvements that NHS Boards and their partners will deliver in 2020/21 and the following two years against each of the 6 Essential Actions (6EA) including: robust escalation to reduce crowding and exit block; balancing capacity and demand through timely in-patient discharge across seven days to eliminate boarding; and to reduce unnecessary attendances and length of stay. We also expect NHS Boards and partners to provide reassurance that recommendations from Scottish Government Reviews such as 'Improving Health and Social Care Service Resilience over Public Holidays' are implemented and how these actions, along with the 6EA, will be embedded in everyday 'business as usual' practices beyond 2020/21. Progress against these actions will be monitored through the established monthly Programme Management Action Plan process.

Working closely with Integration Authorities and primary care partners we expect plans to demonstrate a collaborative approach to planning and actions that are being put in place to address current and emerging issues that are impacting on health and social care services in order to deliver an efficient and safe service for the future.

As indicated in the covering letter, it is the intention to consider the detailed Winter Plans as part of the AOP. Consequently, it is expected that the AOPs will include confirmation that Board plans take adequate account of anticipated patterns of seasonal variation in demand and capacity and have in place appropriate resilience arrangements to ensure business continuity in the face of exceptional events and circumstances. As part of the AOP sign off process, we intend to provide confirmation of recurring funding for winter plans from 2020/21 onwards. This will not negate the requirement for Boards to plan for winter annually. Funding continuity will depend on the submission confirmed in AOPs on an annual basis.

4. Mental Health

Context

Our ten-year Mental Health Strategy set out our ambition for mental health. Our ambition reflects the need for a whole-system approach to mental health, taking a partnership approach.

The arrangements to deliver Mental Health Services vary across the country. NHS Boards and Integration Authorities both have a role in delivering high quality services and must focus their efforts to ensure the successful delivery of the Mental Health Strategy in an operational context. The key areas of focus are as follows:

- Improving support during pregnancy and after birth;
- Reforming children and young people's mental health services;
- Improving specialist services for children and young people and adults;
- taking a 21st century approach to adult mental health;
- respecting, protecting and fulfilling rights; and
- making suicide prevention everybody's business.

For Child and Adolescent Mental Health Services (CAMHS) and Psychological Therapies, the standard is that 90% of patients should be seen within 18 weeks from the point of referral to treatment. These standards are currently being met by very few NHS Boards across Scotland and many people are waiting too long for treatment. In 'Better Mental Health in Scotland', the Minister for Mental Health set out the Government's clear expectation that these standards will be met. In addition, Ministers also expect NHS Boards to tackle long waits for treatment.

The target for waiting times for all presentations at Emergency Departments (EDs) is for 95% of people to be seen, treated, admitted or discharged within 4 hours. Individuals presenting with mental health problems are twice as likely to breach the four-hour access target as those with any other type of presentation and reason for breach is more often related to wait for first assessment or wait for a mental health specialist, as opposed to wait for a bed which is more common in the case of other ED presentations.

Requirements

In the previous round of AOPs, NHS Boards were required to provide a realistic trajectory to reach the standards for CAMHS, Psychological Therapies and presentations at ED by December 2020**.** NHS Boards should now review these trajectories and complete the template attached at Annex 3, setting out the actions that will be taken each quarter to deliver the trajectories; the expected impact of these actions on progress towards the standards; and any associated dependencies and risks.

In addition, the AOP should make clear how the NHS Board plans to reduce the number of long waits for CAMHS and Psychological Therapies and complete the trajectory in the template to demonstrate how these will be reduced each quarter.

There are a range of factors that may have an impact on progress towards the standards, and on tackling long waits, and these should be taken into account in the calculation of trajectories and set out in the template. For instance: the use of the increased resources available for Mental Health through the commitment to real term increases on existing spending levels by Boards and Integrated Authorities; the range of commitments and

associated funding set out in the two most recent Programme for Government documents, and other resources such as the commitment to recruit 800 additional mental health professionals which formed Action 15 of the Government's Mental Health Strategy.

Action 13 of the Mental Health Strategy highlights the unnecessary delays experienced by this group of patients in accessing unscheduled care and aims to streamline their care pathways irrespective of the mental health problem; this Action links in closely with Actions 14 and 15. From the latter viewpoint, NHS Boards are expected to link in with their local unscheduled care data analysts when considering deployment of mental health practitioners along the unscheduled care pathway to ensure resource matches demand.

Whilst we anticipate that in the refreshed trajectories the expected performance in any quarter may vary from the original trajectories submitted last April, **the expectation however remains that standards will be met by December 2020.** Future allocations of funding to support access will have performance conditions attached.

In addition to the above, we require the AOP to set out how the following additional priorities will be addressed:

a) National service specification for CAMHS

As well as describing improvement work to achieve the trajectories for the CAMHS standards, NHS Boards are asked to set out how they will implement the national service specification for CAMHS to be published by the end of this year as part of the work of the Children and Young People's Mental Health and Wellbeing Programme Board.

Each Board's AOP should include a clear statement of intent to implement the national service specification for CAMHS, along with the contact details of a designated Board lead for implementation.

b) Suicide Prevention

Ensuring staff receive appropriate training in this area is essential to support delivery of safe and effective person-centred care. Whilst acknowledging the ongoing efforts to ensure this happens, Scotland's Suicide Prevention Action Plan *Every Life Matters* includes a Ministerial commitment that NHS staff undertake Mental Health and Suicide Prevention Training. It has been a requirement to include this training as an essential element of Workforce Development Plans since June 2019.

We require that each Board's AOP includes a clear statement setting out its commitment to training, an update on progress to date and details of how the Board's workforce development plan will ensure rollout of the training to all staff. Details of a designated Board lead for implementation should also be included.

c) Secure Provision

The AOP should provide details of current bed provision and known demand for medium and low secure beds, Psychiatric Intensive Care Units and other acute mental health inpatient services as relevant. Plans for addressing any unmet demand in year should be included.

5. Integration and Primary Care

Context

Integration Authorities are responsible, as a minimum, for all adult social care, all primary and community healthcare, and some unscheduled inpatient care, for adults. Operational management of unscheduled care waiting times sits with NHS Boards, working with the local Integration Authorities. AOPs should reflect and take into account the directions produced by Integration Authorities for NHS Boards and Councils in relation to provision of services.

Inpatient adult services included in Integration Authorities' responsibilities are A&E, general medicine, geriatric medicine, rehabilitation medicine, psychiatry of learning disability, palliative care, GP beds, addictions and substance misuse, and mental health services apart from secure forensic beds.

Some Integration Authorities are responsible for additional inpatient services, and some are also responsible for children's health and social care services and criminal justice social work.

The 'Review of Progress with Integration of Health and Social Care' that was published by the Ministerial Strategic Group for Health and Community Care (MSG) in February 2019 outlined 25 practical proposals for NHS Boards, Local Authorities and Integration Authorities, working with key partners including the third and independent sectors, to increase the pace and effectiveness of integration by February 2020. Extensive work has been underway to address all of the proposals and the Review Leadership Group continues to meet every 6 weeks to oversee progress.

Attention should be paid to particular proposals that require local action, including that NHS Boards and Local Authorities must ensure that Chief Officers and Chief Finance Officers are effectively supported and empowered to act on behalf of the Integration Authority, and that effective support is provided for strategic planning and commissioning – including staffing and resourcing requirements.

The MSG review report contained an expectation that Integration Authorities, Health Boards and Local Authorities would collectively evaluate their current position in relation to the proposals. An overview analysis of the self-evaluation responses, presented to the Review Leadership Group and the MSG, highlighted that there is a wide range of work underway within and across local systems, with considerable variance in where local systems had evaluated themselves in progressing the delivery of integration.

The self-evaluations also highlighted that there are opportunities for local learning and adoption of good practice. Local systems have developed improvement action plans to ensure this work is taken forward in a systematic way and at pace. It is vital that NHS Boards continue to collaborate effectively with Local Authorities and Integration Authorities to ensure these improvements are delivered and to drive the necessary change, particularly in agreeing budgets for IJBs and ensuring that set aside is operating as per legislative requirements. Improvement support and shared learning with a number of local systems is augmenting this local endeavour, led by David Williams in his role as Director of Delivery, Health and Social Care Integration.

NHS Boards, in partnership with the Local Authorities and Integration Authorities, must fully implement the delegated hospital budget and set aside budget requirements of the legislation, in line with the statutory guidance published in June 2015. The Scottish

Government Medium Term Financial Framework includes an assumption of efficiencies from reduced variation in hospital care coupled with 50% reinvestment in the community to sustain improvement. Ensuring the set aside arrangements are working effectively will be key to delivering this commitment.

Requirements

It is also important for NHS Boards to ensure that current primary care services remain safe and sustainable, both in and out of hours. NHS Boards should set out in their AOP how they intend to work with Integration Authorities to ensure that primary care services continue to be provided to all patients in their area.

As part of this, Boards should show strong evidence of strategic planning for all the enablers of an effective primary care services such as workforce, premises and digital infrastructure.

Workforce planning will be key as the recruitment and retention of GPs and the wider multi-disciplinary team is needed to deliver effective primary care redesign. It is important that NHS Boards work with Integration Authorities to plan the workforce needed to deliver primary care services relative to local population need, and ensure that workforce recruitment does not destabilise the wider system. This work will be underpinned by robust analysis strengthened by updated and refined workforce planning guidance for workforce planners in NHS Boards and Integration Authorities.

Effective physical and digital infrastructure planning is also vital for the long-term sustainability of primary care. Territorial Health Boards are required to “provide, maintain and where necessary, upgrade any integrated information management and technology systems used by the (GP) contractors for provision of services under the (GP) contract”. GPs usually provide their own premises and are reimbursed by Heath Boards under the Premises Directions. Under the Directions, Health Boards must have in place a plan for the provision of approariate premises to support the provision of Primary Medical Services. The AOP should confirm that a plan has been approved by the Board in consultation with the local Area Medical Committee. The plan should be updated annually and be consistent with the Health Board’s wider Asset Management Strategy.

GMS Contract Implementation

As one of the four signatories to the Memorandum of Understanding (MoU) supporting implementation of the 2018 General Medical Services Contract, NHS Boards are expected to work with Integration Authorities to deliver service redesign as set out within in the MoU.

Integration Authorities have Primary Care Improvement Plans (PCIPs) agreed with the local GP profession. These PCIPs set out how service redesign will be prioritised and delivered by April 2021. Second iterations of these plans have been submitted to the Scottish Government with the final iteration due in 2020. Alongside this, six monthly implementation trackers will be completed and shared with Scottish Government to monitor progress. It will be important for NHS Boards to be involved in this process as they provide many of the enablers required to deliver these plans, and will need to contribute to ensure progress is being made.

For 2021/22 and 2022/23 NHS Boards will want to set out arrangements for continued sustainable support of the redesigned services as well as any remedial action required should Primary Care Improvement Plans not be fully implemented by March 2021. NHS Boards will also wish to consider how GPs can be supported in terms of their leadership role

as an Expert Medical Generalist. Attention should also be given to enablers for primary care - such as premises and IT - and how these can be further developed both in light of the new model of multi-disciplinary team working and the overall sustainability of general practice.

Out of Hours

For out of hours, NHS Boards should set out what they are doing to secure the out of hours workforce, reflecting on whether there is sufficient workforce in service to meet its needs and what plans there may be in place with regard to the recruitment of salaried GPs. The AOP should also capture the number of GP training practices that are taking part in the new scheme, what it the Board is doing to support them and whether they are planning to bid for the GP out of hours fellowships. In addition, the AOP should set out what the out of hours nursing workforce looks like (referencing any ANP recruitment and training programmes) and also the wider multi-disciplinary team (to include AHPs and paramedics).

NHS Boards should set out their plans to ensure that health and social care pathways can be properly accessed by NHS 24, SAS and GP practices as appropriate, indicating when and where these pathways are available. NHS Boards should also indicate what they are doing by way of building up pathways and/or filling known gaps.

6. Healthcare Associated Infection

Context

Reducing Healthcare Associated Infection (HCAI) remains a key priority for Scottish Ministers and NHS Boards are expected to continue working towards reductions in HCAI and appropriate antimicrobial prescribing. We ask for your continued support and cooperation in complying with the mandatory HCAI and antimicrobial resistance (AMR) policy, monitoring and reporting requirements set out in DL (2015) 19.

Requirements

Infection prevention and control measures are of critical importance in relation to patient safety and NHS Boards should demonstrate any actions they propose to take over the plan period to meet the HCAI standards and antimicrobial prescribing indicators as part of their AOP submission.

Specific aspects to be covered in the AOP include:

- Confirmation of compliance with the Healthcare Improvement Scotland standards for HCAI;
- Confirmation of compliance with DL(2015) 19, including the forthcoming revised version, which will confirm the mandatory HCAI and AMR policy requirements that must be adopted and implemented in all NHS healthcare settings and are deemed best practice (where relevant) in all non NHS healthcare settings;
- Confirmation of compliance with Scottish Health Technical Memorandum 03-01 and 04-01, which deal with ventilation and water respectively, for healthcare premises;
- Confirmation of compliance with HAI-Scribe for all refurbishment and new build projects within the Board.

7. Population Health

Context

The successful delivery of Ministerial priorities on a sustainable basis will require significant effort to be devoted to to improving and protecting population health. The Scottish Government's 2020 Vision is that everyone is able to live longer healthier lives at home, or in a homely setting and that we will have a healthcare system where there is a focus on prevention, anticipation and supported self-management.

Prevention should be defined in broad terms as activity that maintains positive outcomes and breaks cycles of negative outcomes, helping to tackle persistent inequalities for people and communities.

Requirements

In this initial round of three year AOPs we would expect to see an increased emphasis on preventative action, early intervention and self-management approaches; and improved links to other planning cycles – particularly with Integration Authorities and Community Planning Partnerships in the first instance.

Traditionally, prevention is defined under the following three levels:

- Primary investment to stop a problem arising in the first place and/or modifying the social or physical environment. E.g. effective use of vaccinations, support to improve the environment of the whole population.
- Secondary to identify a problem at a very early stage to minimise harm. E.g. those at risk of obesity, alcohol or substance misuse. The focus being on at-risk groups.
- Tertiary to identify and to stop a problem becoming worse. E.g. effective use of national screening programmes as a means to identify conditions at an earlier stage.

We would therefore expect AOPs to reflect a focus on prevention by demonstrating action planned or in hand to address primary, secondary and tertiary preventative activity recognising that not everything will be in the Board's complete control. In preparing AOPs Boards are also asked to include:

- A detailed demonstration of how the Public Health Priorities are being implemented and measured locally;
- Explain how Boards will work with the new Public Health Body, Public Health Scotland;
- Demonstrate engagement with Community Planning Partnerships and other relevant multi-agency Partnerships; providing specific examples where engagement have resulted in the co-production and/or co-delivery of public health related activities. This may, for example, include cross-cutting activities that involve education, justice, transport, housing, the environment, social security, and culture;
- Explain how social prescribing is being used to reduce demand on acute, primary care and community services.

It will be important that Boards understand the healthy life expectancy and level of health inequality within their geographical area as well as seeking to influence the wider system to encourage others to support this preventative agenda. We would expect each Boards AOP to reflect this and outline the action to improve these measures.

8. Finance

Context

As outlined in the Medium Term Health and Social Care Financial Framework (MTFF), published in October 2018, the new planning and performance cycle requires NHS Boards to deliver financial break-even over a fixed three year period. Previously issued guidance on the new three year planning and performance cycle is provided in the paper issued as Annex 4.

Requirements

Boards should submit their financial plans covering all three financial years from 2020/21 using the template and associated guidance also issued with this letter (Annexes 5 and 6).

As in 2019-20, the supporting narrative should include:

- The improvements that the additional funding for waiting times improvement (elective, cancer and diagnostics) and mental health will deliver;
- The financial planning assumptions about the balance of spend, specifically progress in shifting in the balance of spend to mental health and to primary, community and social care; and
- how your Board is contributing to the five areas of reform set out in the MTFF.

Based on review of 2019-20 AOP submissions; we specifically request that:

- All three financial years (2020-23) are reported;
- AOPs set out the savings required to deliver breakeven - specifically the steps being taken to deliver these savings and the Board's assessment of likelihood of achievement. This should include a statement on the risks to achieving financial balance and the mitigating actions that are being taken. The AOP should also include detail as to how the Board will reduce the reliance on non-recurring savings over this period;
- AOPs set out clearer linkages between financial and performance assumptions and evidence use of sensitivity analysis in terms of financial planning.

Boards should submit their infrastructure plans covering all three financial years from 2020/21. These plans should set out your planned expenditure in each year and which projects have a confirmed funding source.

The NHS National Infrastructure Board will shortly undertake a review of all capital plans, with a view to developing a prioritised list of projects to take to Ministers for approval. While this process will take some time to develop, it will be important to get an early sight on what capital investment projects are being considered.

In addition to three year plans we also require:

- An analysis of the high and significant backlog in your Board and the mitigation to address these risks;
- An assessment of the risks associated with equipment replacement and your plans to mitigate; and
- An analysis by year of the proposed use of your CRL allocation to reducing backlog maintenance and replace essential equipment replacement.

9. Workforce

Context

It is essential that NHS Boards ensure that workforce planning activities are aligned with strategic, financial and business planning processes as in doing so, this will ensure that:

- safe and effective services continue to be delivered by preventing workforce shortfalls;
- health and social care providers are able to respond to future service user needs;
- efficiency across the workforce, prevents over and undersupply of staff and supports flexible deployment of resources;
- Supply at national, regional and local levels are aligned to meet demand;
- Changes in the workforce are managed more strategically;
- workforce skills gaps are identified at an early stage promotes succession planning;
- appropriate talent management and people development strategies are in place;
- turnover is reduced by supporting the retention of key skills within the workforce;
- workforce learning and education needs are understood.

New guidance will be circulated later this year setting out a new three-year workforce planning cycle, with NHS Boards and Integration Authorities (through HSCPs) publishing their first 3 year workforce plans by 31 March 2021. A period of adjustment will be required to ensure there is time to develop the first iteration of these new three year workforce plans.

In the intervening years between these three year workforce plans, an *Annual Workforce Planning Reporting Template* will be developed, including workforce planning information that is appropriately concise while still adding value to national, regional and local workforce planning activity.

The Health and Care (Staffing) (Scotland) Act received royal assent on 6 June 2019 and the Scottish Government is working with Boards to support their preparation for compliance with the legislation.

Upon commencement of the legislation Boards will need to have systems in place to:

- ensure the common staffing method is embedded in practice. This will include development of and co-ordination of implementation of an annual plan to ensure all workload workforce tools are applied within nationally agreed timescales;
- ensure a consistent approach to analysis of workload and workforce information, quality measures and local context to inform staffing requirements across the NHS Board;
- ensure a consistent approach to risk identification, escalation and prioritisation on a NHS Board wide basis;
- ensure a consistent approach to seeking and having regard to clinical advice in relation to staffing;
- utilise data to identify service redesign and role development opportunities and to predict future service and nursing and midwifery workforce requirements in the NHS Board;
- ensure appropriate training and education programmes are delivered on workload and workforce planning across the NHS Board;
- ensure provision of expert clinical advice in workload and workforce planning and support and facilitate teams to review workforce information in order to inform service redesign, development of roles, to ensure that services and workforce are responsive to the needs of patients; and

- monitoring and reporting of high cost agency use across the Board.

Requirements

As part of their AOP submission Boards should demonstrate actions they propose to take in 2020/21 to ensure they are prepared for compliance with the above Act.

In terms of the content of the AOPs, NHS Boards should also clearly set out the work they are involved in over the three year period to ensure that they and their partners have the 'right people in the right place at the right time'.

Within the AOPs NHS Boards should:

- Outline the anticipated changes to the size and structure of the NHS Board workforce which includes the identification of any specific local labour market issues and "hard to fill posts";
- Identify actions being taken to mitigate any identified areas of workforce pressure through improvements in productivity (e.g. introduction of new technologies aimed at increasing clinical capacity);
- Outline the expected workforce impacts of any service redesign activities aimed at increasing efficiency through improved patient pathways:
- Describe the workforce requirements arising from the development of joint service/shared service models with local authorities through Health and Social Care Partnerships and service commissioning with other providers in the third and independent sectors;
- Detail any job redesign approaches to improve service delivery capacity, specifically around the development of enhanced or advanced practice roles to address identified workforce pressures (e.g. Long Term Medical Consultant vacancies);
- Note the use of modern apprenticeships or other programmes being used as a mechanism to introduce additional workforce capacity.

10. Digital Health & Care

Context

Scotland's Digital Health & Care Strategy sets out a clear ambition for the role of digital in empowering and enabling our citizens. Published jointly with COSLA, it establishes a strong focus on supporting the delivery of integrated care across the twin aims of empowering citizens and putting in place the necessary enabling infrastructure.

Requirements

Within that context, we are clear that both staff and citizens should have the digital capability to access, update and meaningfully use relevant health *and* social care information from wherever they are, regardless of organisational boundaries. This includes having access to the necessary tools, products and smart devices to effectively manage their care responsibilities, access services and have the necessary skills and training to do so. This means that Health Boards must work with their Local Authority and Integration Authority partners, along with national partners such as National Services Scotland (NSS), National Education for Scotland (NES) and the Local Government Digital Office, to realise this ambition.

Whilst the Strategy makes it clear that more digital products and systems should be developed/implemented 'once' across Scotland, rather than multiple times locally, and that in doing so consideration should be given to the National Digital Platform, we recognise that this is not always possible or desirable. Therefore, there is an expectation that NHS Boards set out the critical contribution of digital to the successful delivery of their AOPs and related plans within their AOP, along with an articulation of the national and local dimension.

This, alongside digital maturity work already completed by NHS Boards and their partners, will enable them to be in a stronger position when developing their spending plans for digital, based on guidance that will be issued separately for digital health & care. Scottish Government release of funding for Digital Health & Care will be predicated against the receipt of, and agreement on, NHS Board plans to meet national expectations.

11. National Boards

It is acknowledged that not all elements of the guidance set out above, or indeed all Ministerial priorities, may apply to the National NHS Boards. There may also be alternative or additional priority areas that specific National Boards may wish to include in their AOP. These should be discussed and agreed with individual sponsor teams within Scottish Government as a first point of contact.

It is also recognised that the expectations regarding timescales and processes set out in the guidance may pose particular challenges for some of the National NHS Boards. Should there be a requirement for greatler flexibility, for example in relation to the scope or content of early versions or progress updates to be shared with Scottish Government, this should also be agreed and confirmed in writing with Sponsor Teams.

Where Boards already have an agreed overarching strategy in place, Scottish Government aims to support Boards to evolve their AOP so it becomes a three year forward looking Transformational AOP. As for all NHS Boards the AOP should be aligned to the National Performance Framework, Ministerial Priorities and Programme for Government outcomes, and clearly related back to the individual NHS Board's overarching strategy.

12. Other Key Aspects of Operational Delivery

Stroke Pathways

Over the past 10 years, the number of people in Scotland dying from stroke has decreased by 42%. This is significant progress but we want to strive for even better outcomes. That is why the Programme for Government 2019-20 includes specific commitments in relation to stroke. In the coming year, we will develop a programme to improve stroke pathways and services, including prevention, treatment and care. We will review and improve the current stroke care bundle to improve outcomes for patients.

There is also a specific commitment to begin work to scope out and define what a progressive stroke unit looks like, and we expect Boards to share examples of good practice within current stroke services.

Person Centred Visiting

The Programme for Government 2018/19 contained the commitment to support improvements to person-centred visiting in our NHS, so that patients can be with the

important people in their lives while in hospital, by ensuring flexible visiting will be in place across NHS Scotland by 2020. We would like to confirm how NHS Boards have built on the introduction of person-centred visiting to support a culture of family presence and involvement across all in-patient areas and would welcome examples of good practice.

A person-centred approach to visiting is underpinned by the following characteristics:

- a conversation, supported by a reliable process, for the person receiving care to designate those people that matter most to them;
- a conversation with the person about how they would like those that matter most to be involved in their care, and
- the absence of set visiting times.

Eyecare

For eyecare, the AOPs should set out Board plans to deliver the following:

Territorial NHS Boards

- ensuring sufficient allocation of resource to IM&T facilitator support for NHS community eyecare services.
- shifting more eyecare services from the hospital eye service to community optometry.
- the national Eyecare Integration Programme target of at least 90% of all patient referrals submitted by community optometrists to the hospital eye service being made in each Board via SCI Gateway.

NHS Education for Scotland

- supporting more optometrists becoming independent prescribers.
- providing accredited postgraduate training for the optometry profession to enable them to manage stable glaucoma and treated ocular hypertension patients in the community.
- providing mandatory annual training for optometrists and ophthalmic medical practitioners providing General Ophthalmic Services in Scotland.

NHS National Services Scotland

- updating existing electronic payment systems to support planned policy reforms to General Ophthalmic Services and optical vouchers.
- providing community optometrists with an alternative way of accessing electronic NHS systems, once the current VPN token system ends.
- providing all optometrists, ophthalmic medical practitioners, dispensing opticians and optometry practices with NHS mail accounts, prior to the rollout of Office 365 across NHS Scotland.
- ensuring that the new National Primary Care Clinician Database system: (a) is sufficiently interlinked with existing systems (both internal and external to the Board's own system infrastructure) to realise operational efficiency improvements and enhanced quality and accuracy in workforce data for each NHS contractor group; (b) has appropriate change control procedures in place to support future amendments to the system.
- providing access to Emergency Care Summary information for independent prescribing optometrists.

Oral Health and Wellbeing

Improvements in oral health are a Ministerial priority, aspects of which form part of the formal Programme for Government. The impact of a healthy mouth on general health is significant,

and is far wider than simple oral hygiene. In children it can mean the difference between regular attendance at school or not, their social skills and future socio-economic resilience. For older people, poor oral health can affect their ability to eat, to speak and to socialise and thus their overall wellbeing.

The Oral Health Improvement Plan (Scottish Government, January 2018) sets out Scotland's change programme for oral health and dentistry. In keeping with national policy direction, the blueprint focuses on prevention, shifting the balance of care, reducing oral health inequalities, and meeting the oral health needs of an aging population. Boards should use this Plan as the basis for their own planning, setting out how they are working with Integration Authorities in this context with clear actions, objectives and outcomes towards improved oral health and wellbeing.

Domiciliary Care for people living in a Care Home Setting

Arrangements for dentists with Enhanced Skills have been introduced through early adopter cohorts. Boards should now set out clear plans for implementation across all their Care Homes, to include strategic mapping of local requirements and the methodology for comprehensive roll out - training sufficient numbers, processes for allocation, partnership working with Care Homes, shared care with the Public Dental Service, and links with the wider multi-disciplinary team, including 'Caring for Smiles.'

A New Model of Care for Adult Oral Health Care

Whilst NHS primary care dentistry is, at present, largely about restorative services, the Oral Health Improvement Plan envisions the delivery of a prevention-focused system for adult NHS dental patients. Boards should consider how they will engage with patients across both primary and secondary care dentistry to enhance their understanding of the risk assessment, clinical pathways and review appointment frequency, putting the patient at the centre of the decision making process.

Reducing Oral Health Inequalities

Despite overall improvements in the oral health of the population, there is still significant adverse impact from poor oral health amongst those living in our most disadvantaged communities. The main reason for child admission to hospital is for tooth extraction under general anaesthetic (GA), and the incidence of tooth decay is higher for children living in areas of multiple deprivation than for those living in more affluent areas. AOPs should describe proactive ways in which support is being provided for people living in these communities to improve oral health, to reduce the level of paediatric GAs and long waiting times for tooth extraction.

e-Dental Development Programme

Effective physical and digital infrastructure planning is vital for the long-term sustainability of dental care. e-Dental priorities identified include, for example, access to the Emergency Care Summary (ECS) for Domiciliary Care Dentists; integration of Dental Software Systems with other parts of NHS Scotland IT infrastructure, plus the IT infrastructure for the New Model of Adult Oral Health Care. Territorial Health Boards are asked to take cognisance of these consideration in their planning process