BOARD MEETING

DATE: **WEDNESDAY 3 OCTOBER 2018**

TIME: **9:30 A.M. - 12:30 P.M.**

VENUE: **SCOTTISH HEALTH SERVICE CENTRE**
CREWE ROAD SOUTH EDINBURGH EH4 2LF

Members are reminded that they 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 any changes in circumstances are reported within one month of them changing. Please notify any changes to Georgia.Sherratt@nhslothian.scot.nhs.uk

AGENDA

Agenda Item		Lead Member	
	Welcome to Members of the Public and the Press		
	Apologies for Absence		
1.	**Items for Approval**		
1.1.	Minutes of Previous Board Meeting held on 1 August 2018	**BH**	*
1.2.	Running Action Note	**BH**	*
1.3.	Corporate Risk Register	**TG**	*
1.3.1	Risk Management Policy and Procedure	**TG**	*
1.4.	Review of the Board's Standing Orders	**BH**	*
1.5.	Appointment of Members to Committees	**BH**	*
1.6.	Royal Edinburgh Hospital	**AMcM**	*
1.7.	Staff Governance Committee Minutes 24 July 2018	**AM**	*
1.8.	Audit & Risk Committee Minutes 27 August 2018	**MA**	*
1.9.	Acute Hospitals Committee Minutes 21 August 2018	**AM**	*
1.10.	Strategic Planning Committee Minutes 9 August 2018	**AMcM**	*
1.11.	Healthcare Governance Committee Minutes 10 July 2018	**TH**	*
1.12.	Finance & Resources Committee Minutes of 25 July 2018	**MH**	*
1.13.	Midlothian Integration Joint Board Minutes of 3 May & 7 June 2018	**CJ**	*
1.14.	East Lothian Integration Joint Board Minutes 28 June 2018	**PM**	*
1.15.	West Lothian Integration Joint Board Minutes of 26 June 2018	**MH**	*
2.	**Items for Discussion** (subject to review of the items for approval)		
2.1.	Financial Position to August 2018 and Year End Forecast	**SG**	*
2.2.	Quality and Performance Improvement	**SW**	*
2.3.	Emergency Access Standard: Performance & Improvement Actions	**JCam/JC**	*
3.	**Invoking of Standing Order 4.8 - Resolution to take items in closed session**	**BH**	**v**

***** = paper attached # = to follow **v** = verbal report **p** = presentation ® = restricted

For further information please contact Chris Graham, ✉ chris.graham@nhslothian.scot.nhs.uk

PRIVATE SESSION

4.	**Minutes of the Previous Private Meeting held on 1 August 2018**	**BH**	**®**
5.	**Matters Arising from Previous Meetings**	**BH**	**v**
6.	**RHCYP/DCN Project Potential Final Agreement**	**SG**	**v**
7.	**The Governance of the NHS in Scotland**	**TD**	*****
8.	**Any Other Competent Business**	**BH**	**v**

Board Meetings in 2018

5 December	Scottish Health Service Centre

Board Meetings in 2019

6 February	Scottish Health Service Centre
3 April	Scottish Health Service Centre
26 June*	Scottish Health Service Centre
7 August	Scottish Health Service Centre
2 October	Scottish Health Service Centre
4 December	Scottish Health Service Centre

Development Sessions in 2018

7 November	NINE, Life Sciences Innovation Centre, Edinburgh Bioquarter

Development Sessions in 2019

9 January	Scottish Health Service Centre
6 March	Scottish Health Service Centre
1 May	Scottish Health Service Centre
3 July	Scottish Health Service Centre
4 September	Scottish Health Service Centre
6 November	Scottish Health Service Centre

DRAFT

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 1 August 2018 at the Scottish Health Service Centre, Crewe Road South, Edinburgh, EH4 2LF.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mr M Hill (Vice-Chair); Mr M Connor; Mrs C Hirst; Professor T Humphrey; Mr A McCann; Cllr J McGinty; Mrs A Mitchell; Mr P Murray (until 11.50am); Mr B McQueen; Ms F Ireland; Mr A Joyce; Cllr F O'Donnell; Professor M Whyte; Dr R Williams and Dr P Donald.

Executive and Corporate Directors: Mrs J Butler (Director of Human Resources and Organisational Development); Ms J Campbell (Chief Officer of Acute Services); Mr J Crombie (Interim Chief Executive); 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: Ms J Mackay (Director of Communications & Public Engagement), Mr C Marriott (Deputy Director of Finance), Mr A Jackson (Assistant Director of Healthcare Planning)(Item 26), Dr J Hopton (Programme Director, Facilities)(Item 30), Ms J Morrison (Head of Patient Experience)(Item 31) and Mr C Graham (Secretariat Manager, Corporate Governance Team).

Apologies for absence were received from Mr T Davison, Cllr D Milligan, Cllr I Campbell, Mr M Ash, Miss T Gillies, Mrs S Goldsmith and Dr S Watson.

Chairman's Introductory Comments

The Chairman welcomed members of the public and press to the meeting.

Changes in Board Membership

The Chairman welcomed Dr Patricia Donald and Dr Richard Williams who were attending their first Board Meeting.

Declaration of Financial and Non-Financial Interest

The Chairman reminded members 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. The Vice Chair declared an interest in Item 30 as a SEPA Board Member and Miss Ireland declared an interest in item 32 as she had operational responsibility for volunteering.

25. Items for Approval

25.1 The Chairman sought and received the approval of the Board to approve items 1.1 – 1.10. The following were approved:-

25.1.1 Minutes of the Previous Board Meeting held on 27 June 2018 – Approved.

25.1.2 Running Action Note – Approved.

25.1.3 Corporate Risk Register – Approved.

25.1.4 Appointment of Members to Committees - The Board agreed to:

- Appoint Fiona Ireland as the Chair of the Dental Appeals Panel with immediate effect.
- Re-nominate Alex Joyce to continue as a voting member of the Midlothian Integration Joint Board with effect from 20 August 2018.
- Nominate Dr Richard Williams to replace Alex Joyce as a voting member of City of Edinburgh Integration Joint Board with effect from 1 August 2018.
- Re-nominate Alex Joyce to continue as a voting member of the West Lothian Integration Joint Board with effect from 20 October 2018.
- Appoint Dr Richard Williams as a member and chair of the Acute Hospitals Committee with immediate effect.
- Appoint Dr Patricia Donald as a member of the Healthcare Governance Committee with immediate effect.
- Re-appoint Caroline Myles as the registered nurse non-voting member of the Midlothian Integration Joint Board with effect from the day after when her current appointment ends (20 August 2018).
- Re-appoint Mairead Hughes as the registered nurse non-voting member of the West Lothian Integration Joint Board with effect from the day after when her current appointment ends (20 October 2018).
- Re-appoint Dr Andrew Coull as the '*registered medical practitioner who is not providing primary medical services*' non-voting member of the Edinburgh Integration Joint Board with immediate effect.
- Re-appoint Dr Ian McKay as the '*registered medical practitioner whose name is on a list of primary medical services performers*' non-voting member of the Edinburgh Integration Joint Board with immediate effect.
- Appoint Dr Nik Hirani as the '*registered medical practitioner who is not providing primary medical services*' non-voting member of the Midlothian Integration Joint
- Board with immediate effect.
- Re-appoint Dr Hamish Reid as the '*registered medical practitioner whose name is on a list of primary medical services performers*' non-voting member of the Midlothian Integration Joint Board with effect from the day after when his current appointment ends (20 August 2018).

25.1.5 Staff Governance Committee Minutes 30 May 2018 – Endorsed.

25.1.6 Audit & Risk Committee Minutes 18 June 2018 – Endorsed.

25.1.7 Acute Hospitals Committee Minutes 19 June 2018 – Endorsed.

25.1.8 Strategic Planning Committee Minutes 7 June 2018 – Endorsed.

25.1.9 Edinburgh Integration Joint Board Minutes 18 May 2018 - Endorsed

25.1.10 East Lothian Integration Joint Board Minutes 26 April & 24 May 2018 – Endorsed.

26. Quality & Performance Improvement

26.1 Mr Jackson provided an update on the most recently available information on NHS Lothian's position against a range of quality and performance improvement measures.

26.2 The Board acknowledged that performance on 14 measures considered across the Board, including those relating to the Hospital Scorecard, are currently met with 19 not met. It was noted that it was not possible to assess performance on dementia post diagnostic support or complaints stage 1 or 2.

26.3 Mr Jackson reported that governance committees were continuing with the enhanced programme of assurance agreed, with a provisional timetable for remaining measures now outlined. To date, 34 measures have been considered with significant, moderate, limited and no assurance reached on 8, 13, 12 and 1 instances respectively.

26.4 There was discussion on the 4 hour standard. Members noted that since the board meeting the acute hospitals committee had agreed it was appropriate to split assurance levels in relation to the standard. The performance assurance level had been agreed as moderate and assurance in relation to process had been agreed as limited assurance.

26.5 The Vice Chair commented that whilst the nature of the report as an overview or monitoring paper was valuable, the part that was missing was provision of the idea of trends and whether these were improving or not. Would it be possible to have information to show improving or worsening trends to allow the Board to focus on areas that need it. Mr Jackson stated that he would be content to look at adding in an indication of previous reporting into future iterations of the paper.

26.6 Mr McCann referred to the repository data in particular the 62 day cancer numbers across various specialities and suggested that greater narrative around trend would also be helpful.

26.7 Mr McQueen asked about NHS Lothian performance against other health boards in Scotland. There was discussion on the gradient of different socio-economic groups. Professor McCallum explained that Lothian was the only Board to have a programme designed to reduce overall avoidable delays in the pathway for diagnosis and treatment of cancer, funding initiatives designed to address socio-economic differences.

26.8 Mrs Hirst commented that it was positive to see in reference to quality and performance measures and standards rather than targets.

26.9 The Board considered whether consideration by committee is merited for any of 4 areas yet to be granted a level of assurance since the process' inception. A further 2 have not been reconsidered since 2016.

26.10 Mr Jackson made the point that a number of these had been scheduled for committee consideration over coming months. The Board recognised that these areas had not yet been considered but were included in appropriate committee work plans.

27. Involvement of Non Executive Board Members in the Oversight of the Emergency Access Standard

27.1 The Chairman reminded members that at the NHS Board meeting of 27 June 2018, the Board had considered the emergency access standard and the Academy of Medical Royal Colleges' report arising from its review into that subject. The Board had also debated the appointment of non-executives to groups which management had established within NHS Lothian to oversee the various issues.

27.2 At the 27 June meeting the Chairman had commented that he would finalise the position in respect of the Access and Governance Committee (A&GC) and the Emergency Access Standard Improvement Programme Board (EASIP) Chair out with the meeting and advise Board members of the outcome of his deliberations. The Chairman and executive management team had now given this matter further consideration and the report now sets out the issues and makes recommendations as to the way forward, recognising the distinction between the functions of governance and management.

27.3 The Board noted sections 3.5 to 3.7 of the report explaining the nature of A&GC and EASIB and their roles. The conclusion was that these were effectively management committees and as such it would not be appropriate to appoint a non-executive to chair them. However it would be appropriate to have non-executive representation on the groups providing input and that given the overlap between the two groups, the same non-executive would be appropriate. It was noted that this way forward had stepped away from the recommendations of the external review.

27.4 There was discussion on the report from Academy Royal Colleges and the request inviting the Board to consider if they wanted any independent validation of the way the 4 hour target was now being counted. It was likely that officers would come back to follow up on this at some point. Mr Crombie stated that in discussion with the audit and risk committee chair it had been agreed to consider and cover external validation at a likely milestone such as Month 6.

27.5 The Board agreed to appoint Mr Peter Murray as a non-executive Board representative member on the Access & Governance Committee and the Emergency Access Standard Improvement Board.

27.6 The Board also agreed that the Information Governance Sub-Committee was the appropriate body to exercise governance oversight of the quality and reliability of waiting times data.

28. East Region Short Stay Elective Centre (SSEC), St John's Hospital Livingston

28.1 Mr Crombie introduced the report providing the Board with the Initial agreement (IA) for a Short Stay Elective Centre at St John's Hospital, which had been submitted to the Finance & Resources Committee (25 July 2018) and had been commended to the Board for onward submission to the Scottish Government Capital Investment Group.

28.2 Mrs Campbell reported on the national programme for short stay elective centres. £200M capital was to be provided to build a network of elective centres to cope with anticipated demand growth at a national level. The IA proposes a capital cost for the East Region of £67M against to £200M nationally, with revenue of £27M which was being talked about as part of revenue stream discussion at the national forum. Enabling projects were currently looking at releasing capacity to cope with a growth in complex cases along with the development of opportunities with clinical colleagues.

28.3 There was discussion on the East Region's overarching ability to deal with elective patients. Mrs Campbell added that colleagues from Borders and Fife believed they would not need to use the short stay unit. Similar regional support would be required for the Princess Alexandra Eye Pavilion but such capital programmes would be separate requests to the £200M national pot.

28.4 Having the short stay elective centre at St John's Hospital would allow highly complex orthopaedics cases to remain at the Royal Infirmary of Edinburgh which already had the required orthopaedic specific theatres. Mr Crombie added that the development of the elective centre at St John's Hospital demonstrated the Board's continued commitment to the site.

28.5 There was discussion on the key risks of the programme at this time. It was noted that nationally, all current capital bids put forward exceeded the £200M by £80M. There were also concerns around workforce provision given all elective centres were currently planned to open at the same time.

28.6 Mrs Campbell gave more explanation around plans to address workforce requirements. Work on the workforce pipeline was ongoing with experts. The Operating Department Practitioners (ODPs) programme would be starting in January 2019. It was noted that as a board and a region there had been recent success in recruiting key surgical colleagues. Mr McCann questioned if the plans for achieving delivery would be realistic given current shortages with specialties. Professor McMahon stated that there would need to be a review of theatre workforce in totality and that this would take time to complete, there would need to be parallel working and planning and professional groups such as advanced nurse practitioners and ODPs would need to grow quickly enough to meet timelines.

28.7 Professor Humphrey highlighted the fact that although the proposal was not yet approved there was a need to flag workforce and forward planning concerns to the Scottish Government as the intake numbers for next year's adult student nurses were about to be confirmed which may put the required workforce a year behind already. Mrs Butler commented that part of the challenge was the funding stream

behind the proposals. It was noted that clarity around capital funding was expected at the end of September 2018, there was no revenue stream timeline yet.

28.8 Dr Williams raised the impact that there would be on the primary care workforce and the impact travelling to the new elective centre would have on primary care, with work having to be picked up should patients be unwilling to travel to St John's Hospital. Professor McCallum added that it was important to address this and the modernising primary care piece as well to remain as an employer of choice.

28.9 Mr Connor stated that, as the new chair of the St John's Stakeholder Group, he welcomed the IA. However from a practical point of view car parking at St John's remained a very real challenge and would only worsen when a regional centre was introduced unless this was addressed. Mrs Campbell confirmed that this was a well recognised concern and was being picked up as part of the St John's Hospital Master Plan.

28.10 Cllr McGinty echoed the expressed views around workforce, travel and parking challenges and asked if there was a public consultation aspect as part of the plan. The proposed communication engagement plan by the Scottish Health Council planned for September 2019 appeared to be happening too late. Earlier consultation was helpful as part of planning. Mrs Campbell agreed to revisit the public consultation timeline again and would follow up with Cllr McGinty on this point.

28.11 Cllr McGinty also asked about volumes of work at St John's Hospital. Given the current mix of work, specialties and range of services there and knock on effect or reshuffle of services for St John's or other sites should be communicated as earlier as possible. Mrs Campbell confirmed that there was no intention to displace any services already on the St John's Site. It was hoped the elective centre would enhance and benefit the site.

28.12 Mrs Hirst raised concern around health and social inequalities in relation to physically travelling to St John's Hospital and hoped this would be looked at in considerable detail. Mrs Campbell stated that this would be looked at and a similar model to that used for Golden Jubilee transport was being considered but at a local level.

28.13 Mr Crombie reminded members that the IA is used as a short introduction of concept, drivers and ambitions. The IA would be dwarfed by the Outline Business Care process which would go into full detail. The Board had spent significant time today reviewing and understanding deficits in capacity. The intention had been to bring the IA to the Board to outline the vision and first steps of a sustainable solution for Lothian and the region.

28.14 The Board agreed to accept significant assurance that the content of this proposal had been developed as part of the Acute Services workstream of the East Region Health & Social Care Delivery Plan, which had the full participation of Borders, Fife, and Lothian.

28.15 The Board also accepted the commendation of the IA from the Finance & Resources Committee and noted the anticipated submission of the IA to an extraordinary meeting of the Scottish Government Capital Investment Group at the end of

September 2018. Mr Crombie would bring progress updates back to the Board as appropriate.

28.16 The Board noted that the issues raised around workforce, revenue stream, travel, access and public engagement would be considered further by colleagues and reported back on at a future board meeting.

29. Financial Position to June 2018

29.1 Mr Marriott updated the Board on the financial position at Period 3 based on the latest financial information.

29.2 The Board noted the improvement in overspend position which had been reassessed against GP prescribing, meaning the starting deficit had been adjusted from £5M to £1M. There continued to be pressures in specific areas, namely, junior doctors, supplementary nurse staffing, acute prescribing and pay awards.

29.3 The Board accepted significant assurance that the Finance & Resources Committee had received and accepted a report setting out the financial position at month 3 of NHS Lothian with detail on the relevant issues. The Board also accepted that limited assurance remains in place at this stage for the achievement of breakeven by the year end, based on the month 3 position and noted that F&R Committee had also accepted this level of assurance.

30. Climate Change and SDAP Report

30.1 Mr Crombie introduced the report recommending that the Board note the content of and endorse the mandatory Climate Change Report for 2016 to 2017 and the Sustainable Development Action SDAP 2017-2018.

30.2 Mr Crombie explained that the paper described in detail NHS Lothian's approach to climate change and also a complex series of nationally deployed initiatives.

30.3 The Vice Chair made a point of information for members that today was earth overshoot day. This was the day when the earth used up its budget of natural resources until the end of year. Scotland currently was consuming three planets worth of resources. Whilst the report complied with requirements set down for the public sector, the Vice Chair questioned if as a Board this went far enough. Given the Board's focus on quality improvement could more be done to fundamentally improve transformation of services? This needed to be a larger part of the Board's core business and not just a tick box exercise to comply with Scottish Government requirements.

30.4 The Chair stated that before considering the Vice Chair's higher level points and further debate to address these high level points, the Board first had to consider the report and whether or not to accept the recommendations outlined for the report and plan.

30.5 There was discussion on key risks, mandatory targets, omissions associated with Golden Jubilee transport, PFI procurement process and energy consumption.

30.6 Mr Crombie invited Dr J Hopton who was in attendance in the public gallery to contribute to the debate on the Climate Change and SDAP Report

30.7 Dr Hopton explained that Golden Jubilee transport was one of the most significant contributors to the Board's carbon footprint along with pharmacy waste and that there were a range of difficulties involved in taking forward climate change challenges.

30.8 There was further discussion around other areas such as use of taxis, ethical implications, the development of true innovation into future plans for current and new buildings when considering environmental impact and the integration of the climate change agenda into everything the Board does.

30.9 Dr Hopton welcomed the helpful discussion and confirmed that the priorities for 2019 would include focus on pharmaceutical waste and community engagement to look at reducing costs and impact.

30.10 There Board considered the best way to take this forward and whether there was an appropriate opportunity to use a future development session or Strategic Planning Committee session. The Chair stated that this totality approach played into strategic planning of the future. Mr Murray added that at the last development session focus had been on using community planning resource in a more effective way. Dr Williams stated that this was something for the Finance & Resources Committee to take forward and provide assurance to the Board that there was a plan in place.

30.11 The Vice Chair added that Finance & Resources had a real role to play in driving the agenda for improvement and development forward with limited funding. There was a need to develop a mindset where climate change and all other implications were viewed as core Board business.

30.12 The Board agreed to endorse the mandatory Climate Change Report (16-17) and the NHS Lothian Sustainable Development Action Plan (17-18).

31. Patient Experience

31.1 Professor McMahon introduced the report on the range of work across complaints & feedback and patient experience activities across NHS Lothian in respect of the Annual Report. In particular the Business Case that was approved by the Corporate Management Team in June 2018 that supports the redesign and implementation of the revised complaints handling procedure.

31.2 Prof McMahon invited Ms J Morrison who was in attendance in the public gallery to contribute to the debate on Patient Experience.

31.3 There was discussion on the publication of the annual report and the significant work undertaken in dealing complaints and learning from patient feedback. The Board noted that there were nine new KPIs being reported on nationally and that there had been an improvement in the relationship with the Scottish Ombudsman in relation to dealing complaints and a reduction in the Ombudsman overturning complaints.

31.4 The Board also noted the work undertaken to look at the infrastructure to support complaints and the capacity and expertise within team with the expanded role now covering prisons.

31.5 There was further discussion on reviewing and learning from complaints, including patient experience feedback. It was noted that most acute wards used care assurance standards and not tell us 10 things and this approach had been previously agreed. In relation to tell us 10 things it was acknowledged that most complaints were about noise at night and food. It was important to look at how to address these repeated issues and not just accept them as old faithfuls. Care Opinion was the national system which was also used and overall postings on the system were positive. People generally felt cared for compassionately and in a meaningful way.

31.6 The Board also considered the complaints and feedback process for primary care. Ms Morrison reported that primary care independent contractors used a survey monkey approach which was held and owned locally. This feedback was then reported back to the Board and IJBs through the annual report.

31.7 Professor McMahon outlined other vehicles that can be used in relation to complaints and feedback including use of the QI programme, Clinical Change sessions and internal audit reviews which gave staff opportunity to learn from.

31.8 Mr McCann stated that this was an interesting and useful paper, patient opinion information was valuable. Although some results were positive, the 'Staff took account of what mattered to you' was at 0.9%. Whilst this seemed low it was still a lot of people when considering the overall number of patients seen. Professor McMahon commented that moving forward, going back to patients and asking for opinion would be an important part of the process.

31.9 Dr Donald asked if there was feedback to the public on how to get the best out of the NHS. Professor McMahon stated that this was a good point which needed to be picked up and thought about as currently this was not done.

31.10 Miss Ireland added that the Care Assurance Standards Programme discussed at the Corporate Management Team had also been discussed by the Area Clinical Forum and the importance of not putting funding into silos had been recognised. The opportunity to extend this work across the workforce to link into the excellence in care programme should be considered.

31.11 The Chair welcomed the report and commented that a lot of work had been undertaken over the last two years. This had been a monumental task with culture, process and staffing aspects and Ms Morrison and her team deserved a great deal of credit for this progress. Professor McMahon added that the next phase would be to expand the base of feedback data to drive forward the business and quality programme.

31.12 The Board agreed to note the Patient Experience Annual Report 2017/8 that had been signed off by the Healthcare Governance Committee. The Board also endorsed the ongoing work undertaken with particular reference to the implementation of the new Complaints Handling Procedure from 1 April 2017.

31.13 The Board supported the next steps of the complaints and feedback Business Case and the range of work being done to support the patient experience agenda via Tell Us Ten Things, Care Opinion and the Care Assurance Standards.

32. Refreshed Strategic Vision for Volunteering across Lothian (2018-2023)

32.1 Professor McMahon introduced the report seeking the Board's endorsement of the new strategic plan for volunteering across NHS Lothian 2018-23 which has been developed and consulted upon over the last 18 months.

32.2 Miss Ireland gave some background on volunteering and the development of the strategy. In terms of the strategy volunteers are defined as someone that gives their time freely and willingly. There were around 700 volunteers in Lothian covering approximately 40 different roles from ward helpers to volunteer gardeners.

32.3 There was discussion on funding for youth volunteering, employability and supporting people. From a governance point of view having Healthcare Governance Committee oversight with annual report was felt appropriate.

32.4 Miss Ireland commented that this was an exciting strategy and a different, much more proactive approach for NHS Lothian. There was also the opportunity for a future employment pipeline within services given links with modern apprenticeships and Project Search. It was important to note that volunteers are supplementary to and not replacing workforce.

32.5 Mr Murray welcomed the strategy and asked if there was an intention to proactively seek people with learning disabilities to volunteer. Professor McMahon stated that there no boundaries to who could volunteer. Mr Murray suggested that there be a larger statement on this within the strategy. Mrs Butler added that the strategy linked directly to the Project Search work, recruiting people with learning disabilities.

32.6 Mr Murray also commented that there was a paid employee within Edinburgh Health and Social Care Partnership for volunteering and that this resource should be made Lothian wide and accessible to all partnerships. Professor McMahon confirmed that there was an intention to work with all partnerships and use resources across all areas not just individual partnerships. Mr McCann added that having previously volunteered within NHS Lothian he was pleased to see a stronger emphasis on a personally rewarding experience for volunteers.

32.7 Professor Whyte stated that from a medical school point of view the prioritisation of people from disadvantaged backgrounds having access to volunteering and opportunities was welcomed and there was already good work in partnership on this.

32.8 The Board agreed to approve the refreshed strategic vision of volunteering across Lothian (2018- 2023).

33. Unscheduled Care Performance

33.1 Mrs Campbell reported on the current performance across the adult acute hospitals and outlined actions being taken to mitigate areas of concern.

33.2 Mrs Campbell highlighted that it was clear to see that the 4 hour performance standard remained a challenge for the Board. It was noted that the standard was 95% that should be achieved and for June 2018 this was sitting at 83%. It was noted that the Royal Infirmary of Edinburgh remained the biggest pressure for NHS Lothian and was the slowest recovering of all the adult acute sites.

33.3 There was discussion on the total number of attendances, improvements in patients waiting 8-12 hours for a bed, the number of unscheduled admissions, and the number of delayed discharges across adult acute sites and winter planning.

33.4 In relation to winter planning it was noted that this had started earlier. This year there was a refreshed approach with prioritised bids against funding from the Scottish Government. It was noted that there had been 80 bids against expected funding of £3M. Recommendations would be brought to the Unscheduled Care Committee to try and avoid bed based solutions.

33.5 Dr Donald pointed out that winter planning was very much a GP area as well and had to be a whole system approach. Consideration had to be given to how members of the public could be better signposted away from A&E and how patients could be supported to stay in the community and not be admitted.

33.6 There was also discussion on annual front door attendance numbers and the upwards trend of people turning up who could have been signposted elsewhere. Mrs Campbell commented that this was a national trend and was likely to continue to increase along with population if nothing was done. The key was how to safely support people out with attending A&E.

33.7 Dr Williams stated that the paper clarified that the challenge was at the back door and getting patients out of hospital. If there was new additional money for winter planning, investment had to be into getting people home and remaining in the community.

33.8 Mr Crombie added that there were constraints around non recurring money and the late notification of winter allocation given the time taken for recruitment and arranging of resources. Health and Social Care Partnerships were also central to defining and devising infrastructure to get people home quickly.

33.9 Mrs Hirst commented on the transport issues around getting people home as well as people having the appropriate support at home. There was discussion around the development of short stay observation units to help alleviate pressures. Mrs Campbell confirmed that progressing this was being looked at.

33.10 The Committee requested that future papers show the trajectory towards 4 hour standard compliance and that there be more consistency with the colour coding of graphs in the paper.

33.11 The Board noted the performance detailed in the report and accepted moderate assurance that mechanisms were in place across all three adult acute sites to monitor performance against unscheduled care and to support staff to design and implement a comprehensive programme of improvement actions.

33.12 The Board also noted the actions being taken to respond to the challenges associated with unscheduled care as outlined in the paper and accepted moderate assurance that the Unscheduled Care Committee was developing a robust winter strategy in response to learning from previous winter initiatives, as well as supporting new initiatives to continuously improve the winter planning processes.

34. Any Other Competent Business

34.1 There was no other business.

35. Board Development Session

35.1 The Board noted that the next Board Development session would be held on **12 September 2018 at the Scottish Health Services Centre, Crewe Road, Edinburgh.**

36. Date and Time of Next Meeting

36.1 The next meeting of Lothian NHS Board would be held at **9:30am on Wednesday 3 October 2018 at the Scottish Health Services Centre, Crewe Road, Edinburgh.**

37. Invoking of Standing Order 4.8

37.1 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.

LOTHIAN NHS BOARD

RUNNING ACTION NOTE

FOR THE MEETING OF 3 OCTOBER 2018

Action Required	Lead	Due Date	Action Taken	Outcome
Review of the Standing Orders – The Chairman commented that Councillor McGinty had raised a valid issue about the Review of the Standing Orders and it was proposed to remove and defer this paper until the next Board meeting. In the meantime Councillor McGinty and Mr Ash would resolve the outstanding issue.	**MA/JM**	**03/10/18**	**Item 1.4 on Agenda for October meeting.**	
East Region Short Stay Elective Centre (SSEC), St John's Hospital Livingston - The Board noted that the issues raised around workforce, revenue stream, travel, access and public engagement would be considered further by colleagues and reported back on at a future board meeting.	**JCAM**	**TBC**		

1.3

NHS LOTHIAN

Board
3 October 2018

Medical Director

NHS LOTHIAN CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to set out NHS Lothian's Corporate Risk Register for assurance.

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

2 Recommendations

The Board is recommended to:

2.1 Accept significant assurance that the current Corporate Risk Register contains all appropriate risks, which are contained in section 3.2 and set out in detail in Appendix 1.

2.2 Accept that as a system of control, the Governance committees of the Board assess the levels of assurance provided with respect to plans in place to mitigate the risks pertinent to the committee.

2.3 Note the review of NHS Lothian's Risk Register within the context of the Board's May 2018 workshop and feedback from committee members with respect to single system approach to risk through the Audit & Risk Committee.

3 Discussion of Key Issues

3.1 As part of our systematic review process, the risk registers are updated on Datix on a quarterly basis at a corporate and an operational level. Risks are given an individual score out of 25; based on the 5 by 5 Australian/New Zealand risk scoring matrix used; 1 being the lowest level and 25 being the highest. The low, medium, high and very high scoring system currently used, is based on the same risk scoring matrix, remains unchanged.

3.2 There are currently 14 risks in total in Quarter 1; the 6 risks at Very High 20 are set out below.

1. The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge
2. Achieving the 4-Hour Emergency Care standard

3. Timely Discharge of Inpatients
4. General Practice Sustainability
5. Access to Treatment (organisational risk)
6. Access to Treatment (patient risk)

3.2.1 The Board and Governance committees of the Board need to assure themselves that adequate improvement plans are in place to attend to the corporate risks pertinent to the committee. These plans are set out in the Quality & Performance paper presented to the Board and papers are considered at the relevant governance committees. Governance Committees continue to seek assurance on risks pertinent to the committee and level of assurance along with the summary of risks and grading is set out below in Table 1.

3.2.2 If you have an electronic version of this report, links to each risk in Appendix 1 have been embedded in the below table (please click on individual Datix risk number in the table).

Table 1

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018
3600	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. **(Finance & Resources Committee)**	July 2018 F&R considered the revised risk and accepted limited assurance.	High 12	Very High 20	Very High 20	Very High 20	Very High 20
3203	Unscheduled Care: 4 hour Performance **(Acute Services Committee)**	In November 2017, Acute Services Committee continued to accept moderate assurance.	High 10	Very High 20	Very High 20	Very High 20	Very High 20
3726	Timely Discharge of Inpatients (Previously Unscheduled Care: Delayed Discharge) **(HCG Committee)**	November 2017 HCG continued to accept limited assurance.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3829	GP Workforce Sustainability **(HCG Committee)**	September 2017 HCG continued to accept limited assurance, but more confident that the plans in place will mitigate this risk over time and asked for regular updates.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3211	Access to Treatment – Organisation Risk (Previously Achievement of National Waiting Times) **(Acute Services Committee)**	July 2017. Limited Assurance. The Committee was impressed with the work in progress but also disappointed that performance remained of concern with the volume of patients waiting over 12 weeks. Recognition that systems of control were in place was accepted.	High 12	Very High 20	Very High 20	Very High 20	Very High 20

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018
4191	Access to Treatment Risk – Patient (New Risk May 17) **(Acute Services Committee)**	HCG January 2018 HCG – moderate assurance.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
3454	Management of Complaints and Feedback **(HCG Committee)**	November 2017 HCG considered and moderate assurance accepted.	High 12	High 16	High 16	High 16	High 16
1076	Healthcare Associated Infection **(HCG Committee)**	May 2018 - Overall moderate assurance due to SAB infections, but significant with respect to CDI HEAT target achievement.	High 12	⇩ Medium 9	Medium 9	Medium 9	Medium 9
3480	Management of Deteriorating Patients in Acute Inpatients **(HCG Committee & Acute Services Committee)**	Progress update to January 2018 HCG – moderate assurance.	High 16	High 16	High 16	High 16	High 16
3527	Medical Workforce Sustainability **(Staff Governance Committee)**	October 2017 meeting continued to accept moderate assurance.	High 16	High 16	High 16	High 16	High 16
3189	Facilities Fit for Purpose (accepted back on the Corporate Risk Register October 2015) **(Finance & Resources Committee)**	Finance & Resources Committee Jan 2018 - moderate assurance received.	High 15	High 16	High 16	High 16	High 16
3455	Management of Violence & Aggression. (Reported at H&S Committee, **via Staff Governance Committee**)	Staff Governance in considered in July 2017 and accepted limited assurance.	Medium 9	High 15	High 15	High 15	High 15
3828	Nursing Workforce – Safe Staffing Levels **(Staff Governance Committee)**	March 2017 Moderate assurance that systems are in place to manage this risk as and this risk will be regularly reviewed particularly with respect to District nursing. Staff Governance in October 2017 considered a paper on this risk and continues to accept moderate assurance.	High 12	Medium 9	Medium 9	Medium 9	Medium 9
3328	Roadways/ Traffic Management (Risk placed back on the Corporate Risk	Staff Governance Committee, October 2017 continued to accept moderate assurance.	High 12	High 12	High 12	High 12	High 12

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Jul-Sep 2017	Oct-Dec 2017	Jan-Mar 2018	Apr-Jun 2018
	Register December 2015) (Reported at H&S Committee, **via Staff Governance Committee**)						

3.3 **Testing of Strategic Framework**

When testing the strategic framework for risk as agreed by the June 2018 Audit & Risk Committee, a number of questions arose linked to a discussion around a whole system approach to risk which need to be clarified prior to further testing of the framework. These include:-

1. What is the definition of the risk
2. Who owns the risk and provides assurance
3. What plans are in place to proactively and/or reactively manage the risk and do they address key aspects of the strategic framework
4. What impact do the plans have on mitigating the risk.

As an illustration of the above, the current Delayed Discharge risk was reviewed.

3.3.1 <u>What is the definition of the risk</u>

The risk is currently expressed as:

'There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.'

When considering this risk from a problem definition perspective and taking into consideration the current controls, it is suggested that the risk may be better expressed as:

'There is a risk that constraints on Health & Social Care capacity and current models of care, could result in people being cared for in an inappropriate setting leading to poor experience and outcome of care.'

3.3.2 <u>Who owns the risk</u>

Currently this risk is owned by the Deputy Chief Executive and assurance is sought by the Healthcare Governance Committee.

Areas for consideration are:-

- Who owns the plan(s) in place proactively and/or reactively to manage this risk
- Who manages delivery of the plans
- Who should be providing assurance and to whom at the planning and delivery level

3.3.3 What plans are in place

It is currently unclear in our current risk template, the plans in place to proactively and/or reactively manage this risk and who is accountable for the plans. It is these plans (IJB strategic plans and delivery for HSCPs and Acute services) that would require assessment against the proposed strategic risk framework, for example do the plans demonstrate:-

- New models of Health and Social Care
- The ability to improve and understand
- Establishing positive working relationships
- Active public and patient engagement.

3.3.4 Impact of the plans

The impact of these plans would also benefit from a set of key measures which would indicate if the risk is being managed.

3.3.5 As part of providing a more holistic approach to risk, a new template was recommended to the August 2018 Audit & Risk Committee that sets associated risks, plans and balanced set of key measures to illustrate the impact of plans to mitigate the risk for testing (see Table 2 below).

The Board is to note that the Audit & Risk Committee in August 2018 approved the testing of this template and within it the proposed strategic risk framework starting with the risk as set out above.

Table 2

Corporate Objective	Risk Description	Linked Key Risk	Controls	Key Measures	Updates
Improve patient pathway and shift the balance of care	There is a risk that constraints on Health & Social Care capacity and current models of care, result in people being cared for in an inappropriate setting leading to poor experience and outcome of care	• Finance • General Practice Sustainability • Nursing Workforce (District Nursing) • Access to Treatment **Associated Strategic Plans** • IJB strategic plans / HSCP delivery plans • Winter plans • GMS improvement plans	**Current controls which will need to be updated:-** **HSCP/IJB** A range of management/governance controls are in place for Unscheduled Care notably: Integrated Joint Boards will report via the Deputy Chief Executive to Scottish Government on the delivery of key targets which include Delayed Discharges and actions in response to performance. Delayed discharges are examined and addressed through a range of mechanisms by IJBs which include: • Performance Management. Each Partnership has a trajectory relating to DD performance and these are reported through the Deputy Chief Executive • Oversight of specific programmes established to mitigate this risk for example Edinburgh Flow Board and/or Strategic Plan Programme Board (East Lothian) **Acute Services** NHS Lothian Board (bi monthly) oversee performance and the strategic direction for Delayed Discharges across the Lothian Board area. The bi-monthly Acute Hospitals Committee as well as formal SMT and SMG meetings. Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (data analysis from EDISON	**Potential Measures:-** • Delayed Discharges • Unscheduled avoidable admissions, including readmissions • Number of care home beds • Number of restricted care home beds • Number waiting for assessment by social care • Unnecessary attendance and referrals to outpatients • Number of people dying in a hospital setting • 4-Hour emergency standard • GP restricted lists	

4 Key Risks

4.1 The risk register process fails to identify, control or escalate risks that could have a significant impact on NHS Lothian.

5 Risk Register

5.1 Not applicable.

6 Impact on Health Inequalities

6.1 The findings of the Equality Diversity Impact Assessment are that although the production of the Corporate Risk Register updates, do not have any direct impact on health inequalities, each of the component risk areas within the document contain elements of the processes established to deliver NHS Lothian's corporate objectives in this area.

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

7.1 This paper does not consider developing, planning and/or designing services, policies and strategies, with the exception of the Risk Management Policy and Procedure which required stakeholder engagement (see 3.4).

8 Resource Implications

8.1 The resource implications are directly related to the actions required against each risk.

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11 September 2018
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List of Appendices

Appendix 1: Summary of Corporate Risk Register

Corporate Risk Register

Appendix 1

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3600	3: Secure Value & Financial Sustainability	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	There is a risk that the Board does not systematically and robustly respond to the financial challenge to achieve its strategic plan. This could be due to a combination of: uncertainty about the level of resource availability in future years, the known demographic pressure which brings major potential service costs and increasing costs of new treatment options, e.g. new drugs, leading to a reduction in the scale or quality of services. NOTE: During the last few years, NHS Lothian has been reliant on non-recurring efficiency savings, which has exacerbated the requirement to implement plans which produce recurring savings.	The Board has established a financial governance framework and systems of financial control. Finance and Resources Committee provides oversight and assurance to the Board. Quarterly review meetings take place, where acute services COO, site/service directors in acute, REAS and joint directors in Primary Care are required to update the Director of Finance on their current financial position including achieve delivery of efficiency schemes. Rationale for Adequacy of Control: A combination of uncertainty about the level of resource availability in future years combined with known demographic pressure which brings major potential service costs, requires a significant service redesign response. The extent of this is not yet known, nor tested.	Risk reviewed for period April to June 2018 <u>Update 31 July 2018</u> At the 23 May Finance & Resources Committee: The Committee acknowledged that NHS Lothian had achieved its financial targets for the year 2017/18, subject to external audit review. The Committee noted that the 2018/19 Financial Plan had now been approved by the Board and there would be a 2018/19 Financial Plan brought to the July F&R Meeting. And at the 25 July 2018 Finance & Resources Committee it was asked to: Consider the financial position as at June 2018 which reports a deficit of £2.5m, and incorporating three months of the £10.8m reserves identified in the Financial Plan; • Accept that a limited assurance on achieving a breakeven outturn remains in place after the first three months of the 2018/19 financial year. Strategic Financial Plan The Finance & Resource Committee were keen to ensure it focuses on medium and long term sustainability plans. The Chairman is setting up a new Futures Group working to the Strategic Planning Group. The outputs from this work will require to be included within the Strategic Financial Plan. Risk Grade/Rating remains Very High 20	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	Very High 20	Medium 6	Director of Finance	Deputy Director of Finance	Finance & Resource Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3203	2: Improve the quality and safety of health care	Unscheduled Care: 4 hour Performance	There is a risk that NHS Lothian will fail to meet the 4 hour performance target for unscheduled care which could mean that patients fail to receive appropriate care, due to volume and complexity of patients, staffing, lack and availability of beds, lack of flow leading to a delay to first assessment, a delay in diagnosis and therefore in treatment for patients and a reputational risk for the organisation.	A range of governance controls are in place for Unscheduled Care notably: <u>Board</u> Monthly NHS Lothian Board oversee performance and the strategic direction for Unscheduled Care across the NHS Lothian Board area. NHS Lothian's Winter Planning Project Board is now established as NHS Lothian Unscheduled Care Committee in collaboration with the Integrated Joint Boards to promote sustainability of good performance all year round. The Unscheduled Care Programme Group chaired by West Lothian HSCP joint director meet on a monthly basis, monitoring performance reporting and unscheduled attendances. Winter Preparedness is on the Agenda of the Unscheduled Care Committee seasonally, however notable improvements through planning will be embedded as systems to promote sustainable access performance and mitigate risk. The winter planning process has started earlier this year, with agreement in place on schemes to be funded, and sites are now progressing to implementation. The approved Winter Plan outlined the approach to supporting performance over the winter period and beyond. This reflected a number of actions namely: • Winter Readiness plans established for each site • Plans focused on discharge capacity as well as bed capacity for 2017-18 and is starting to plan for winter 18-19 • Clear measures in terms of escalation procedures • Measures to counter any demand unmatched to support winter and patient flow • A focus on DD and POC to ensure sustainable performance throughout the winter period liaising closely with IJB partner organisations including - Weekly teleconference with IJBs - Trajectories in place to support reduction in DD for each partnership - Agreed data set to assist with developing a wider capacity plan across all health & social care partnerships	Risk Reviewed for period April – June 2018 Risk reviewed and approved by Acute Services Committee in November 2017 accepted Moderate Assurance Updates highlighted below Risk Grade/Rating remains Very High/20 Through the Unscheduled Care Committee work continues in line with the Scottish Governments 6 Essential Actions initiative. Each site is taking forward a set of actions to support a step change in performance. Priority interventions are focussing on: • Clinical Leadership • Escalation procedures • Site safety and flow huddles • Workforce capacity • Basic Building blocks models • Proactive discharge • Flow through ED/ Acute Receiving • Smooth admission/ discharge profiling • Effective capacity and Demand models being developed re in /out , BBB methodology • Patients not beds principle • Daily Dynamic Discharge/check, chase, challenge methodology rolled out across the acute sites • Plan to roll out across the whole system and partnerships campuses <u>The regular quarterly report on 6EA progress is due to be submitted to the Scottish Government at the end of August 2018. Periodic updates are provided to the unscheduled care committee meeting by the service improvement leads.</u> <u>As per SG guidance, regional plans have been developed (currently in draft form) which underline actions that are due to be implemented to deliver 4 hour emergency access standard. These are due for finalisation by mid July with implementation thereafter.</u>	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Jim Crombie	Jacquie Campbell (NHSL) / Jim Forrest (W/Lothian IJB)	Acute Services Committee

				A number of performance metrics are considered and reviewed weekly, including: - 4 hour Emergency Care Standard and performance against trajectory - 8 and 12 hour breaches - Attendance and admissions - Delayed Discharge (see Corporate Risk ID 3726) - Boarding of Patients - Length of Stay (LOS) - Cancellation of Elective Procedures - Finance - Adherence to national guidance/ recommendations (what Scottish Government expect for the money received) Funding from the Scottish Government is allocated against whole system bids. This includes testing and evaluating ways of working against flow, near patient testing and diagnosis at the front door. <u>Acute Services</u> -The bi-monthly Acute Hospitals Committee review and respond to plans and performance. - Frontline updates to acute services monthly CMG and SMT - Weekly briefings to the Scottish Government on performance across the 4 main acute sites (RHSC, RIE, WGH, SJ H - RIE Service Improvement Managers and Data Analysts are now in place on each site and in Outpatients services to analyse real time data to inform improvement work.						

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates/Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3726	2: Improve the quality and safety of health care	Timely Discharges of Inpatients	There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.	A range of management/governance controls are in place for Unscheduled Care notably: NHS Lothian Board (bi monthly) oversee performance and the strategic direction for Delayed Discharges across the Lothian Board area. The bi-monthly Acute Hospitals Committee as well as formal SMT and SMG meetings. Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (data analysis from EDISON NHS Lothian's Winter Planning Project Board is now established as the NHSL Unscheduled Care Committee in collaboration with the Integrated Joint Boards Integrated Joint Boards will report via the Deputy Chief Executive to Scottish Government on the delivery of key targets which include Delayed Discharges and actions in response to performance. Delayed discharges are examined and addressed through a range of mechanisms by IJBs which include: • Performance Management. Each Partnership has a trajectory relating to DD performance and these are reported through the Deputy Chief Executive • Oversight of specific programmes established to mitigate this risk for example Edinburgh Flow Board and/or Strategic Plan Programme Board (East Lothian)	Risk reviewed for period April to June 2018 Reviewed by HCG in November 2017 and continued to accept limited assurance. Update August 2018 Risk Grade/Rating remains Very High/20 Action to help tackle DD across NHS Lothian include: • Criteria led discharge pilots • Locality based services/discharge hubs developed to support pulling patients out • Evidence based dynamic discharge at each adult site • Unscheduled Care Committee Refresh • Pilots that are underway to support focus on DD include: • Stroke rehab pathway with early supported discharge model(to complete rehab at home) • Intermediate care beds in Care home – evaluation of bed utilisation, turnover and readmission rates • Investment in flow centre for West Lothian commencing 30th July • Length of Stay Improvement Board has been founded with the aim of reducing the site's length of stay • The Winter Planning Board / NHS Lothian Unscheduled Care committee are overseeing the necessary actions in support of sustained performance during the winter period and beyond. o Unscheduled Care Committee has already engaged with wider health and care personnel to complete and return bids for winter investment. o Earlier release of funds to be made available by Scottish Government which will be invested in areas which will see greatest impact based on winter 2018 de-brief process. The Winter planning process has started earlier this year with a refreshed approach to developing the winter strategy. The approved approach includes: • Table top exercise, with open discussion against each bids and apply a weightings framework to each bid against a criteria of: o Links with 6EA Programme; o Ministerial Steering Group Indicators o Areas of greatest impact. • Application of live weightings to create a prioritised list of winter bids that fit within financial; constraints/unscheduled care winter funding for 2018-2019; • Link with Resilience planning work streams. • Trajectories are in place for each partnership and these are being monitored to support capacity to meet demand. • Health and social care partnerships are fully engaged in winter planning process through the unscheduled care committee and local planning workshops and working collaboratively to mitigate risk to patients due to poor performance.	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Medium 9	Deputy Chief Executive	Director of West Lothian H&SCP/Chief Operating Officer (Acting)	Acute Hospitals Committee in partnership with IJBs

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3829	2: Improve the quality and safety of health care	GP Workforce Sustainability	There is a risk that the Board will be unable to meets its duty to provide access to primary medical services for its population due to increasing population with multiple needs combined with difficulties in recruiting and retaining general practitioners, other staff and premises difficulties (e.g. leases). This may affect: • ability of practices to accept new patients (restricted lists); • patients not being able to register with the practice of their choice; • ability to cover planned or unplanned absence from practice; ability to safely cover care homes; difficulties in one practice may impact on neighbouring practices/populations, occur at short notice with the result that practices are unable to provide services in their current form to existing patients; • other parts of the health and social care system e.g. secondary care, referrals, costs As a result of these pressures practices may choose to return their GMS contracts to the NHS Board who may in turn not be able to either secure an new 17j practice or successfully fill practice vacancies or recruit sufficient medical staff to run the practice under 2c (direct provision) arrangements. Practices can be affected by changes or instability at very short notice.	Governance and performance monitoring • Regular updates reported to Healthcare Governance Committee. • NHS Lothian Board Strategic plan. • HSCP Primary Care Transformation and Primary Care Improvement Plans. • Reports to Board and Strategic Planning Committee. • Establishment of the implementation structure for the new GMS contract – GMS Oversight Group - which will oversee implementation of local plans and measure associated improvement across NHS Lothian. • The risk is highlighted on all HSCP risk registers with local controls and actions in place and on the East Lothian IJB risk register as host IJB for the Primary Care Contractor Organisation (PCCO). Core prevention and detection controls • PCCO maintain a list of restrictions to identify potential and actual pressures on the system which is shared with HSCPs and taken to the Primary Care Joint Management Group (PCJMG). • PCJMG review the position monthly with practices experiencing most difficulties by way of reports from Partnerships to ensure a consistent approach across the HSCPs and advise on contractual implications. • Ability to assign patients to alternative practices through Practitioner Services Division (PSD). • "Buddy practices" through business continuity arrangements can assist with cover for short-term difficulties. Rationale for Adequacy of Controls - remains inadequate as HSCP transformational plans are still at developmental stage and GP retention and recruitment is a national issue (see Medical workforce risk. Risk grading therefore remains very high/20).	Risk reviewed for period Jan to March 2018 Risk reviewed at Primary Care Joint Management Group on 14/09/17 and 10.05.18. Update: June 2018 Noted that improvement in primary care sustainability is a process that will take up to three years Healthcare Governance Committee received reports in September 2017, January and March 2018 which again confirm limited assurance. 2018 GMS contract has been approved by the profession and will be implemented over the next three years overseen by the GMS Contract Oversight Group. All HSCPs developing Primary Care Improvement Plans for submission to Scottish Government by 1 July 2018. • NHS Lothian investment of £5m over three years from 2017/18 and national funding of 4.8m in 18/19 with further increases in the next three years to address the key pressures are reflected in HSCP improvement plans for Primary Care Transformation to increase provision of clinical pharmacist posts in General Practice, meet same day demand, remove vaccinations from practices, establish community treatment clinics, provide additional non-medical workforce in primary care and community link workers • Further work on GP recruitment including: ➢ Testing the recruitment market (using Google clicks or a social media campaign to identify where GPs might come from before running a more visible, targeted campaign to recruit) ➢ Promotion of Edinburgh and Lothians as good place to work ➢ Provision of local contacts to discuss job opportunities ➢ GP practice recruitment micro site Position on golden hellos reviewed and updated - discretionary applications to be considered on a case by case basis.	Inadequate; control is not designed to properly manage the risk and further controls and measures are required.	Very High 20	High 16	Medical Director	Joint Director, East Lothian H&SCP	Healthcare Governance Committee

					Examples across Lothian of actions contributing towards stability: East Lothian Care Home Team and CWIC service Midlothian MSK posts and Mental Health support West Lothian use of paramedics for home visiting and signposting training for practice staff Edinburgh transformation and stability injections and community link workers Funding support to ensure new capacity for housing developments in Midlothian, Edinburgh and East Lothian. Interest free loans under new premises code being made available to practices who own their own premises in order to alleviate risk to current partners and attract new partners.					

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3211	2. Improve patient pathways and shift the balance of care	Access to Treatment Risk – Organisation Risk (Previously Achievement of National Waiting Times)	There is a risk that NHS Lothian will fail to achieve waiting times targets for inpatient / day case and outpatient appointments, including the overall Referral To Treatment target, due to a combination of demand significantly exceeding capacity for specific specialties and suboptimal use of available capacity, resulting in compromised patient safety and potential reputational damage. Bowel screening Service pressure is a new addition to this register. Due to a change in the test that took place in October 2017 this service has seen its numbers requiring urgent scope rise each month and has now doubled. All Health Boards across Scotland are experiencing the same pressure	Governance & performance monitoring • Weekly Acute Services Senior Management Group (SMG) meeting • Monthly Acute Services Senior Management Team meeting- monthly outturn and forecast position • Performance reporting at Corporate Management Team (CMT) • NHS Lothian Board Performance Reporting • Performance Reporting and Assurance to Acute Hospital Committee • Monthly access and Governance Committee, to ensure compliance with Board SOPs relating to waiting times. Core prevention and detection controls • Establishment of the Delivering for Patients Group to monitor performance and work with individual specialties to delivery efficiency improvements against key performance indicators on a quarterly basis • Scope for improvement identified with recommendations made to specialties e.g. target of 10% DNA rate; theatre session used target of 81 %, cancellation rate 8.9%; for every 10 PAs recommendation of 6 DCCs directly attributed to clinic or theatre. • Increase in staffing on a temporary basis in Bowel screening is planned to carry out pre-assessment at the same stage as before the increase. Increase the (currently) small number of scopers who are qualified to carry out bowel screening scopes. Rational for adequacy of controls Some controls are in place and additional controls currently being designed and as such, overall control is inadequate. Controls and actions are now being reviewed quarterly at Acute SMT to ensure any areas of concern are highlighted and actioned. Risk remains high while demand continues to exceed available capacity.	Risk reviewed for period April – June 2018 Reviewed by AHC in July 2017 and accepted limited assurance. Update August 2018 description and controls updated Ongoing Actions • Weekly Acute SMG monitors TTG, RTT, long waits, cancer performance, theatre performance and recovery options on a weekly basis, with monthly deep dives into theatre and cancer performance. • Monthly Acute SMT has sight of Access & Governance minutes, to monitor ongoing actions and escalate as appropriate. • Performance is also reported to, and monitored by, Acute CMT. • Performance is also monitored by the Board and Acute Hospitals Committee, using the Quality & Performance report, which is also reviewed at Acute SMT. Additional Actions • Implementation of a Theatres Improvement Programme – a significant programme with multiple work streams (Pre-assessment, HSDU, Booking and Scheduling, Workforce) to improve theatre efficiency. • Establishment of an Outpatient Programme Board that focuses on demand management, clinic optimisation and modernisation. • Service improvement work is being supported by the DfP quarterly reviews, which in turn are supported by more regular meetings with service management teams and clinicians to develop and implement improvement ideas, and to facilitate links to the Outpatients and Theatre improvement programmes. Running action notes are kept at each service meeting, and regularly reviewed by service management teams and the DfP core group. Risk Grade/Rating is Very High/20	Inadequate – control not designed to properly manage risk; further controls required	Very High 20	Medium 4	Deputy Chief Executive	Chief Operating Officer (Acting)	Acute Services Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
4191	2. Improve patient pathways and shift the balance of care	Access to Treatment Risk - Patient	There is a risk that patients will wait longer than described in the relevant national standard due to demand exceeding capacity for in-patient / day case outpatient services and endoscopic procedures within specific specialties. Bowel screening Service pressure is a new addition to this register. Due to a change in the test that took place in October 2017 this service has seen its numbers requiring urgent scope rise each month and has now doubled. All Health Boards across Scotland are experiencing the same pressure Clinical risk is identified in two dimensions: 1) the probability that due to length of wait the patient's condition deteriorates; 2) the probability that due to the length of wait significant diagnosis is delayed.	• Service developed trajectories, that are used to monitor performance, early indications of pressures, and opportunities to improve efficiencies/productivity. • A re-invigorated Delivering for Patients (DfP) programme provides a framework for learning and sharing good practice through a programme of quarterly reviews. • New referrals are clinically triaged, a process which categorises patients as Urgent Suspicion of Cancer (USOC), Urgent or Routine. Within each of these categories, patients are triaged into the most appropriate sub-specialty queue, each of which is associated with a different level of clinical risk. Long wait surveillance endoscopies are also clinically triaged to identify any patients that require expedition. • Increase in staffing on a temporary basis in Bowel screening is planned to carry out pre-assessment at the same stage as before the increase. Increase the (currently) small number of scopers who are qualified to carry out bowel screening scopes. • A revised communications strategy has been established to ensure that both patients and referrers are appropriately informed of the length of waits. • If the patient's condition changes, referrals can be escalated by the GP by re-referring under a higher category of urgency. There is an expectation that the GP would communicate this to the patient at the time of re-referral. • Specific controls are in place for patients referred with a suspicion of cancer. Trackers are employed to follow patients through their cancer pathways, with reporting tools and processes in place which trigger action to investigate / escalate if patients are highlighted as potentially breaching their 31-day and / or 62-day targets. Trackers undergo ongoing training, and have access to clear escalation guidance on how to deal with (potential) breachers.	Risk reviewed for period April to June 2018 Reviewed by HCG in November 2017 – accepted moderate assurance. Update Aug 2018 – reviewed and description and controls updated Ongoing Actions • DfP quarterly reviews are supported by more regular meetings with service management teams and clinicians to develop and implement improvement ideas, and to facilitate links to the Outpatients and Theatre improvement programmes. Running action notes are kept at each service meeting, and regularly reviewed by service management teams and the DfP core group. • Significant redesign and improvement work is being undertaken through the Outpatient Programme Board and through the Theatre Improvement Programme Board, to help mitigate some of the increasing waiting time pressures and clinical risks. • Revised communications strategy includes an "added to outpatient waiting list" letter, which informs patients that their referral has been received, and that some service waits are above the 12-week standard. Current waiting times are also published on *RefHelp*, making them available to GPs at the time of referral. It has been agreed (March 2017) that a link to *RefHelp* waiting time information will be included in letters to patients, allowing them to check service waiting times regularly. There has also been the implementation of a Keep in Touch initiative (Dec 2017) which is a co-ordinated process whereby all long wait patients are called or lettered by a member of clerical staff. This process has clinical endorsement. This is to ensure they are aware they are still on the list and will receive an appointment at the earliest opportunity. This also allows any patients who feel their symptoms are worsening to be escalated for clinical review to the CSM. It also results in a greater efficiencies as patients often advise they no longer require or have had a procedure already and so are removed from the list. This then allows a slot to be used for another patient. • Keep In Touch is continuing with a focus on the longest waits for outpatient and endoscopy with the aim to contact every long waiting patient.	Inadequate – control not designed to properly manage risk; further controls required	Very High 20	Medium 4	Deputy Chief Executive	Chief Operating Officer (Acting)	Acute Services Committee

				Rationale for adequacy of controls Some controls are in place and additional controls currently being designed and as such, overall control is inadequate. Controls and actions are now being reviewed quarterly at Acute CMG to ensure any areas of concern are highlighted and actioned. Risk remains high while demand continues to exceed available capacity.	• Information on the projected length of wait throughout a patient's pathway is communicated clearly to patients at clinical appointments throughout their cancer journey. <u>Additional Actions</u> • There are some ongoing issues with resilience with regard to cross-cover among trackers during periods of absence and / or annual leave and these are being addressed robustly with, in the first instance, an in-depth review of current cancer tracking arrangements. • Executive Medical Director and Interim Chief Officer have developed risk matrix for specialties under waiting time pressures, and will work with NHS Grampian to develop a clinician led framework for risk analysis to help prioritise resources. Risk is very high while demand exceeds available capacity and as such Risk Grade/Rating is Very High/20					

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3454	2: Improve the quality and safety of health care	Management of Complaints and Feedback	There is a risk that learning from complaints and feedback is not effective due to lack of reliable implementation of processes (for management of complaints and feedback) leading to the quality of patient experience being compromised and adverse effect on public confidence and expectation of our services. It is also acknowledged that a number of other corporate risks impact on this risk such as the processes and experience of unscheduled care, patient safety, primary care and waiting times.	Governance and performance monitoring • Routine reporting of complaints and patient experience to every Board meeting • Regular reports to the Healthcare Governance Committee - complaints and patient experience reports. • Additional reports are submitted to the Audit and Risk Committee • Monthly quality and performance reporting arrangements include complaints and patient experience • Internal Audit 'Management of Complaints & Feedback'. Core prevention and detection • The complaints improvement project board, chaired by the Executive Nurse Director oversees implementation of the new complaints handling model for management and learning from complaints as part of a wider improvement project to improve patient experience • Feedback and improvement quality assurance working group meets monthly, chaired by Non-executive Director and is overseeing implementation of the SPSP action plan • Corporate Management Team and Executive Nurse Directors group review and respond to weekly/monthly reports Complaints management information available on DATIX dashboard at all levels enabling management teams to monitor and take appropriate action. Weekly performance reports on complaints shared with clinical teams. Patient experience data is fed back on a monthly basis at service and site level to inform improvement planning and is available via Tableau Dashboard. Rationale for inadequate controls: Governance processes and improvement plans are in place but yet to be fully implemented.	Risk Reviewed for period April to June 2018 Update August 2018 A new complaints handling procedure was implemented 1 April 2017 which introduced a 3-stage approach: 1) front line resolution, 2) Investigation and 3) SPSO. • Complaints Improvement Project Board now in place chaired by the Executive Nurse Director and a refreshed membership has been agreed. • Stakeholder engagement from across the organisation continues and full Business Case went to June CMT. Additional funding confirmed to implement the new delivery model (Hybrid Model). • An implementation plan is being developed and paper went to Workforce Organisational Change Group for their July meeting to restructure the Patient Experience Team. • A number of teams across the organisation are assisting with complaints data collection to support the new CHP. • Feedback & Improvement Quality Assurance Working Group meet bi-monthly chaired by Non Executive and has overseen the implementation of SPSO action plan which is now completed. Have reviewed its terms of reference. • Patient Experience Annual Report was presented at the August 2018 NHS Lothian Board Meeting and was positively received. • Bi-annual meetings with the new Ombudsman agreed and positive meeting took place in April 2018. • Combined complaints and patient experience report continues to receive moderate assurance by the HCG committee – May 2018. • Internal Audit review of complaints completely and draft report available. • Ongoing support, training and awareness raising within services to increase confidence and capability in managing complaints • Work ongoing to support the complaints and feedback systems within the 2 prisons encouraging early resolution / Stage 1. • Services are being supported to test a range of approaches including Care Opinion, Tell us 10 Things and Care Assurance Standards • Tell us Ten things questionnaire has been aligned with "5 must dos with me" and is being tested in 3 acute sites with adults and an amended version with children and young people Risk Grade / Rating is High / 16 Rationale for this – moderate assurance given at Nov 2017, March 2018 & July HCG committees. SPSO cases have increased due to SPSO improving their backlog – currently 62 (07.08.18) Complaints Improvement Project Board in place. Blended approach to patient feedback (TTT, Care Opinion & CAS)	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 16	Medium 6	Executive Director Nursing, Midwifery & AHP's	Head of Patient Experience	Healthcare Governance Committee

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1076	2: Improve the quality and safety of health care	Healthcare Associated Infection	There is a risk of patients developing an infection as a consequence of healthcare interventions because of inadequate implementation of HAI prevention measures leading to increased morbidity and mortality and further treatment requirements, including potential extended stay in hospital.	<u>Governance & Performance Monitoring</u> There is a comprehensive reporting and monitoring of system in place both at Board and operational level directing action as required. • Bi-monthly board papers • The NHS Lothian Infection Committee (LICC) reports to the Board through Healthcare Governance Committee. • Lothian Infection Control Advisory Committee (LICAC) receives reports from this committee, public health, facilities on environmental aspects of infection control and advices actions. • Sites have established local monitoring/reporting either as standalone infection control committees or as part of agenda in site management meetings reporting through Pan Lothian ICC • In addition to LICAC and local committees, Infection Prevention and Control report routinely at a senior management level to CMG and. & Director of Nursing Group <u>Core prevention & detection controls</u> Strategy/Training Overarching HAI Education Framework developed in collaboration with Workforce Planning & Development which is currently under review. Corporate Induction and mandatory update programme for Infection Prevention and Control training is in place for all staff and compliance is reported through Tableau. Additional, specialised modules are also available through LearnPro for relevant staff. Local and ad hoc sessions are provided often in response to events/incidents. IPCNs work collaboratively with clinical and non clinical services to communicate risk, support improvement and escalate concerns as appropriate. ICT IT systems are in place to allow IPCNs to monitor incidence, trends and patterns of HAI within their geographical region. Monthly reports with progress made against local delivery plan KPI's and are shared with clinical teams and senior management and are widely available on the Intranet. Clinical teams undertake local audits for compliance against SICPs and their data is published within QIDS. A Problem Assessment Group (PAG) or Incident Management Team (IMT) is convened to investigate and manage any significant event or outbreak. These are reported to the Local ICC and LICAC for shared learning and any system wide actions. SAE reviews are undertaken for CDI and SAB related deaths by services with support of IPCNs. Surveillance Enhanced surveillance is carried out for all SAB, CDI and *E-coli bacteraemia cases*. Monthly case review of all SAB and CDI carried out to determine key issues/learning opportunities. ICNet is a software system which imports positive results and also has an alert set to notify team of increased incidence. These are reported to the local ICC's for discussions on how to reduce them. Mandatory surveillance is undertaken for Surgical Site Infections within Obstetrics for C Section and Orthopaedics for Hip Arthroplasty. NHS Lothian is currently not compliant with mandatory surveillance reporting for Colorectal or Major Vascular surgeries due to lack of resource to support this activity in the short term. Reporting capabilities/IT requirements fully tested and ready to commence data submission. Re-provision of staffing budget provided 1.5 WTE band 2 support workers to assist in surveillance activity in	Risk reviewed for period April – June 2018 Risk and Controls Reviewed July 2018 Risk Grade/Rating remains Medium 9 based on the current performance for LDP <u>Risk owned by HAI Executive Lead. This role transferred from the Executive Medical Director to the Executive Nurse Director in April 2018. Risk owner updated as Prof Alex McMahon.</u> Current reporting and governance arrangements for HSCP's are being reviewed. <u>HSCP infection control committee have now met and approved terms of reference.</u> NHS Lothian deferred data collection and submission for mandatory colorectal and major vascular surgical site infection surveillance (commencing April 2017) pending the approval of funding for 2 WTE surveillance nurses. <u>Both posts have successfully been appointed and data submission is anticipated for Quarter 2 July –Sept 2018.</u> Progress in moving to reporting HAI through Tableaux Dashboards has stalled due to resource/ workload issues within informatics teams. <u>LDP targets for CDI were met (and exceeded) to end 2017.</u> <u>LDP targets for SAB were not met to end 2017, but remain within control limits and are not statistically different to other Boards performance</u> The new NES SICEP (Standard Infection Control Education Pathway) which replaces the Cleanliness Champion Programme has been reviewed in conjunction with NHS Lothian Education and other key stakeholders. It has been agreed that the complexity of the programme and volume of content would increase the risk of non-compliance with mandatory education. Local scenario based educational resources which map to the NES learning outcomes are now in development with ambition to <u>launch Summer 2018</u>. <u>SICPs compliance >90% reported for NHS Lothian. Potential for improvement to existing audit tools and processes identified. Work to revise this will commence Summer 2018 with support from HPS and Senior Management.</u>	Adequate but partially effective; control is properly designed but not being implemented properly	Medium 9	Medium 4	Tracey Gillies	Fiona Cameron	Healthcare Governance Committee

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				anticipation of Colorectal/Vascular surveillance coming on line, however there remained a gap in resource and workload. Where SSI or alert organism surveillance indicates a data exceedance there are processes in place for investigation. The Antimicrobial Management Team is responsible for the review and development of the Antimicrobial Prescribing Guidelines and provide oversight of antimicrobial use, compliance with guidelines and report findings to clinical teams to help drive improvement. Summary Reports are also provided to Clinical Management Team. Decontamination Responsibility for operational aspects of decontamination of reusable medical devises is with Facilities. There is a Decontamination Project Board, chaired by the Director of Public Health, which consider capital projects and wider strategic objectives – limited monitoring function Progress/monitoring of actions associated with endoscopy, reusable surgical, dental and podiatry equipment is via the operational group which has been established to support local delivery and is chaired by Service Director, DATCC. The decontamination lead provides updates to Lothian ICC and LICAC. The physical condition of building and capacity is struggling to maintain levels of provision for service demands, There is person dependant expertise through the decontamination lead nurse and without a business continuity plan this service could be at significant risk. Estate/ Care Facilities There are a number of aging properties within NHS Lothian built environment that do not meet current standards and are continuing to decline such as Edington Cottage Hospital , PAEP and recognition that within economic climate, prioritisation of works means some areas that are no longer fit for purpose will continue to pose a risk. PCT, facilities and clinical teams working collaboratively to implement current national standards and guidance in new builds, refurbishments and maintenance programmes - Healthcare Associated Infection System for Controlling Risk in the Built Environment (HAI SCRIBE).						

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3480	Improve the quality and safety of health care	Management of Deteriorating Patients	There is a risk that NHS Lothian does not reliably manage deteriorating patients in adult acute inpatient settings leading to potential harm and poor patient/family experience	• The Quality Report, reported to the Board monthly, contains a range of measures that impact and relate to management of deteriorating patients • Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical adverse event reporting and response. • The Patient Safety Programme reports to relevant governance committees of the Board setting out compliance with process and outcome safety indicators and includes external monitoring. • Adverse Event Management Policy and Procedure. • Quality of care reviews which include patient safety issues is subject to internal audit and compliance with recommendations, and is reported via Audit & Risk Committee and HCG Committee when appropriate. • Patient safety walkrounds to gain an understanding of safety culture and work taking place at service level. Also now in general practice. • Charge Nurse Ward Round and Patient Centred Audit put in place as Quality Assurance Mechanisms to validate self reporting of patient safety data • Quarterly visit by HIS to discuss progress actions and Quarterly submission of data. • Access to national outcome data by Board which enables boards to see whether they are outliers and escalate concern and risk as appropriate • Adverse Event Improvement Plan in place monitored via HCG • Site Based Quarterly Reports including Patient Safety Data (QIDS) sent monthly. •Live data at ward level	Risk reviewed for Period Jan – March 2018 Approved at September 2017 HCG Committee. • As part of the Quality and Performance reporting the issue of meeting the 50% reduction in Cardiac Arrests by January 2016 was considered. Lothian has achieved 8% with the 4 major sites above Scottish rate • A HIS visit has taken place, plans are in place and monitored through the service supported by QIST and reviewed by HIS. Plan progressing well. The risk is not related to quality of care but about data reporting • The HCG committee have approved a review of the management of deteriorating patients in March 2017 with an improvement plan based on finding going to the 11th July 2017 meeting. The review provided significant assurance with respect to the robustness of the review and areas for improvement. The HCG Committee accepted limited assurance that a potential impact on cardiac arrest rates will follow from the improvement plan, since the elements of it are as yet untested in Lothian at scale. • Implementation plan developed results of this fed back to individual service areas to inform improvement planning. Progress to go back to HCG in January 18 and regular monitoring through Quality and Performance Report. • Progress updated provided to HCG in January improvement in outcomes observed will re-assess risk when improvement has been sustained. Moderate Assurance Accepted • A detailed Acute Hospital Management of Deteriorating Patients plan is being drawn up to be reported at the October 18 AHC Risk grade/rating remains High/16 based on unmet actions for key safety priorities	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 6	Medical Director	Associate Director for Quality Improvement & Safety	Healthcare Governance Committee

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3527	3: Secure value and financial sustainability	Medical Workforce Sustainability	There is a risk that the availability of medical staffing will not be adequate to provide a safe and sustainable service to all patients because of the inability to recruit and increase in activity resulting in the diverting of available staff to urgent and emergency care. Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics & Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology	<u>Governance & Performing Monitoring</u> • A report is taken to the Staff Governance Committee when required, providing an update of the actions taken to minimise medical workforce risks in order to support service sustainability and address capacity issues within priority areas. • A Lothian Workforce Planning & Development Board has been established to coordinate work within all professional groups including the medical workforce. <u>Core prevention and detection controls</u> • Medical workforce risk assessment tool is available and implemented across all specialties. The assessments are fed back to local Clinical Directors and their Clinical Management Teams. They use these to inform their own service/workforce plans to minimise risk. • For the risks that require a Board or Regional response the findings are fed back to the SEAT Regional Medical Workforce Group and feed into the national medical workforce planning processes co-ordinated by NES/SG. A recent update paper was taken to the Staff Governance Committee providing a detailed up date and the current risk rating was supported. There was moderate assurance that all reasonable steps are being taken to address the risks.	Risk Reviewed for period April to June 2018 October 2017 Staff Governance Committee accepted moderate assurance. <u>Update May 2018 – No change at present update will follow next Staff Governance Meeting</u> A recent review of trained doctor establishments show significant improvements in recruitment from 2 years ago with an overall establishment gap of 4.3% from 4.9% in March 2015 and is relatively stable. There remain challenges in particular at the St John's site within General Medicine(7.6wte), there also remain gaps. There has however been recruitment to 2wte Ophthalmology posts with successful candidates taking up posts in June/July. Recruitment to 8wte posts to provide additional capacity at both RHSC and St John's sites in line with the recommendations of RCPCH review has been partially successful with 6wte successfully appointed, there remains however 2wte vacancies. For those specialities at high risk, local workforce plans and solutions which minimise risk have been developed and are monitored closely through existing management structures. Vacancies in 'hard to recruit' specialties regularly reviewed and different ways explored of delivering services where there are persistent gaps e.g. psychiatry and paediatrics. Ongoing implementation of risk assessment tools used to inform local workforce plans and solutions which minimise risk and are monitored closely through existing management structures. An updated paper has been written for the October staff governance committee highlighting the relatively strong position in relation to recruitment overall. The committee was asked to note that the level risk had not changed substantially since the last update and to accept a moderate level of assurance that the controls in place mitigate any risks to patient safety related to this. However given that there is not a generalised problem with recruitment for trained and training grade doctors there is a need to reconsider the risk contained on the risk register to ensure that it better reflects that only a small number of specialties would be regarded as having a high level of risk with a significantly lower level of risk across specialties in general. This review will be carried out by Medical Director. Risk Grade/Rating remains High/16	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Low 2	Medical Director	Head of Workforce Planning	Staff Governance Committee

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3189	3. Secure Value of Financial Sustainability	Facilities Fit for Purpose	There is a risk that NHS Lothian is unable to deliver an efficient healthcare service because of unsuitable accommodation and clinical environments leading to potential delays in patient care and threatening patient and staff safety.	A stringent Governance Process and structure for reporting of Backlog Maintenance (BLM) has been implemented as follows: o Property & Asset Management Strategy (PAMS) Group o Capital Steering Group o Lothian Capital Investment Group (LCIG) o Finance & Resources Committee o Scottish Government through the annual Property & Asset Management Strategy To ensure accurate reporting the Board has implemented the following controls: • Ensure that 20% of the Board's estate is surveyed annually for physical condition and statutory compliance by the surveyors appointed by Scottish Government. • Review the outcome of surveys with the Operational Hard FM Managers and review and assess risks in accordance with the operational use of the properties to ensure priorities are addressed. • Recurring capital funding approved of £2.5m to undertake priority works (high and significant areas) • Capital Investment Plan which addresses refurbishment and re-provision of premises, linked to the Estate Rationalisation Programme includes the termination of leases and disposal of properties no longer fit for purpose. • The Procurement Framework has been implemented that allows issues identified to be rectified without the need for lengthy tendering exercises	Risk Reviewed for period – April to June 2018 Finance & Resources reviewed in Jan 2018 accepted moderate assurance. Update August 2018 Action undertaken 2017/18 • Review of Risks and programme of works resulted in BLM exposure as of May 2018 2was £44.6m a reduction of £9.2m from previous year • At May 2018 the high risk exposure was - £0.84m and significant risk being £27.2m. It is anticipated that the Board will be in a position to reduce the high and significant risks over this financial year. • BLM programme of works for 2018/19 was endorsed by the July LCIG meeting. The programme will address fire precaution works across all sites, mechanical and electrical plant replacement, legionella, building fabric (external cladding and window replacement), external grounds maintenance (car park upgrades) • Hospital closures (Corstorphine Hospital, Royal Victoria, Edenhall) and the disposal of 63 Morningside Drive, in addition the expiry of leases (Pentland House)has reduced backlog maintenance exposure further • Future programmes of work will be developed and financial models/scenarios will be prepared using the capital planning tool. The F&R Committee considered a detailed report in November 2017 and were updated in January 2018. The following conclusions were noted: • The committee agreed to support the current programme of works proposed this financial year and to support the proposal that the Facilities Directorate set up a multi-disciplinary group as described. • The Committee agreed to take significant assurance that Management have calculated the BLM in line with NHS Scotland's requirements and BLM remained a priority for Facilities and that high priority items are being undertaken within the funding currently allocated. This aligns with the Board's commitment to prioritise patient safety in particular. • Furthermore the Committee agreed to accept the limited assurance that the Board can achieve an adequate reduction in the high and significant risks within BLM with the current level of funding by 2020 (the Scottish Government's objective). Risk Grade/Rating remains High 16	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 4	Jim Crombie	George Curley	Finance & Resources Committee

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3455	2: Improve the quality and safety of health care	Management of Violence & Aggression	There is a risk of Corporate Prosecution by HSE under the Corporate Homicide Act or the H&S at Work Act Section 2, 3 and 33 or any relevant H&S regulations If the risk from violence and aggression adverse events are not adequately controlled. Highest risk would be under H&S at Work Act Section 2 and 3. If we harm our staff (2) or visitors to our sites (3). There is also a statutory requirement to provide an absolute duty of care regarding NHS Lothian staff safety and well being.	•Closed loop Health & safety management system in place. •Robust H&S Committee structure. •Violence & Aggression related policies and procedures in place (attached document). •Competent specialist V&A and H&S advice in place. Robust Occupational Health Services. Learning lessons through adverse event investigation. • The Interim Director of Occupational Health & Safety delivers an annual report to the NHSL H&S Committee with specific actions related to controlling violence & aggression risk within these reports. ROSPA QSA Audit complete and action plan in place. NHS Lothian Health and Safety Strategic Plan endorsed. Specific actions related to controlling violence & aggression risk are contained within these reports.	Risk reviewed for period April-June 2017. (As per Quarterly Review – under review) A review has been commissioned by the Executive Lead. The purpose of the review is to ensure NHS Lothian's approach to the management of violence and aggression is appropriate and effective. Where improvements in approach or resource are required these will be highlighted. Risk Grade/Rating remains High/15 whilst the review is taking place. The review will inform the risk exposure to the Board.	Adequate but partially effective; control is properly designed but not being implemented properly	High 15	Medium 6	Medical Director	Head of Health & Safety	Staff Governance Committee

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3828	3. Improve Quality, Safety and Experience Across the Organisation	Nurse Workforce – Safe Staffing Levels	There is a risk that safe nurse staffing levels are not maintained as a consequence of additional activity, patient acuity and / or inability to recruit to specific posts, the subsequently high use of supplementary staffing to counteract shortfalls potentially leading to compromise of safe patient care impacting on length of stay and patient experience.	<u>Governance & Performance Monitoring</u>
				• Two Nursing and Midwifery Workforce meetings are being held (one for in patient areas and one for community nursing) alternate months. These provide a delivery function and monitor progress against agreed actions. The governance arrangements are through the Safe Staffing Group which reports to Staff Governance Committee
				• Professional governance is through monthly review at the Nurse Directors Committee with Associate Nurse Directors & Chief Nurses.
				
				<u>Core Prevention and Detection Controls</u>
				• Recruitment Group, Safe Staffing and Nursing Workforce Groups to plan requirements
				• The agency embargo remains with every use of agency subject to scrutiny by a senior nurse.
				• Recruitment meetings to oversee the implementation of the recruitment plan are being held monthly
				• Use of tools to ensure safe staffing levels:
				  • A calendar to ensure the annual use of the nationally accredited workload and workforce tools is in place to ascertain required establishment levels
				  • eRostering and SafeCare Live tools are being rolled out to all nursing and midwifery teams, community teams and departments to provide real time information for local decision making around the deployment of the available staffing.
				• Datix reports are escalated on a weekly basis for reports of staffing issues/shortages these are reviewed by the senior management team at the PSEAG. The supplementary staffing and rostering detail is annotated with this information to provide context and enable risk to be understood.
				• Tableau Dashboard in place provides data overview of staffing at all levels.
				• <u>Tableau Dashboard for eRostering KPIs</u>
				• Detailed analysis of staffing demand and supply, together with SAE and complaints data at ward level in acute sites to enable senior managers to pinpoint actions to areas of greatest need.
					<u>Risk Reviewed for period April 2018 to June 2018</u>
					Last reviewed at Staff Governance Committee Oct 2017 accepted Moderate Assurance
					
					<u>UPDATE – August 2018</u>
					The focus of recruitment activity are plans in place to reduce the establishment gap in the speciality areas that were harbouring a high vacancy rate.
					
					<u>ACTIONS</u>
					<u>National posts have been appointed to, to support the development of the NMWW tools and funding has been advised but not received to enable Board to appoint to fixed term senior nursing posts to support the completion of the workforce tools and analysis of the data.</u>
					
					<u>The adult in patient NMWWP tools have been analysed, the mental health and learning disability tools have been run and are being analysed and the other specialities are scheduled. A Board wide report is being prepared pending completion of all tools.</u>
					
					<u>The national contract for agency supply is being retendered. The terms of the new contract will make agency work an attractive option over bank work.</u>
					
					<u>The Programme Board for the Regional approach has been established and the Project Manager has been appointed.</u>
					
					<u>The Open Days across the Acute sites and for Edinburgh H&SCP have recruited large numbers of new staff. Attendance at the Belfast event has yet to deliver appointments but there was considerable interest in Lothian and London Sept 2018 event in planning.</u>
					
					<u>"Meeting the Challenge" Workshops for Charge Nurses and Staff Nurses have been held in locations across the organisation and continue for a further 2 months</u>
					
					<u>Excellence in Care leadership programme redesigned to include a full day on the NMWW tools.</u>
					
					St John's have established rotational posts for Staff Nurses being recruited.
						Satisfactory; controls adequately designed to manage risk and working as intended	Medium 9	Low 2	Executive Director Nursing, Midwivery & AHP's	Assistant Director - Nursing Workforce & Business Support	Healthcare Governance Committee

					A Return to Practice programme has been agreed with a HEI supplier which will offer a local opportunity for nurses and midwives that have had a career break and lost NMC registration. It is still hoped this will commence in 2018 and will include a payment to applicants at band 2 for the duration of the programme (using existing vacancy) The MA programme is underway with 2 cohorts recruited to for RIE and WGH and a third cohort of applications planned for the community hospitals Draft risk assessment and guidelines for the use of 1:1 specialling are being tested in 4 pilot wards (evidence of reduced reliance on 1:1 in early phase of testing) The use of SafeCare live continues to be reviewed and optimised as a quality improvement test of change.. The eRostering and SafeCare live tools roll out is 84% complete with 8878 nursing staff, on 362 rosters actively using eRostering. Trend KPIs have been produced and circulated to CNMgrs./ Service managers every 4 weeks, and the dashboard has been developed to provide easily accessible data customised to the clinical area. Risk Grade/Rating remains: Medium/9						

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates/Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3328	1:Improving the Quality and Safety of Healthcare	Roadways / Traffic Management	There is a risk of injury to staff, patients and the public from ineffective traffic management as a result of inappropriate segregation across NHS Lothian sites leading to loss of life or significant injury	A stringent Governance Process and structure for reporting has been implemented as follows: o Site specific Traffic Management Groups o Reported in Facilities H&S quarterly reports o Reported to Health & Safety Corporate group via Facilities Health & Safety Group o Reported to Staff Governance via Health & Safety Committee • Escalation process in place through the Governance process should congestion become an issue on any site. Governance process is - Local Traffic Management Groups to Facilities Quarterly Reports, Facilities Health & Safety Group (also reported to Facilities Heads of Service) Overarching Health & safety Group • Traffic surveys have been conducted across all hospital sites, and action plans have been prepared and subject to regular review • The commission of Independent expert reviews of road infrastructures on high traffic high inpatient sites • Action plans have been developed across all sites by the Local Site Traffic Management Groups and high risk items approved subject to funding. • Additional dedicated car park personnel in high volume traffic sites has been implemented • A policy for reversing has been implemented across all sites, which includes – all NHS L vehicles have been fitted with reversing cameras and audible alarms, no reversing unless with the assistance of Banksman • Risk assessments and procedures are developed and regularly reviewed where risks have been identified, and a more task specific process has been developed. • Work Place Transport Policy available and reviewed within agreed timescales.	Risk reviewed for period April - June 2018 Reviewed and approved at October 2017 Staff Governance Committee - accepted moderate assurance. <u>Update – August 2018</u> The Pan Lothian TM Plan is being updated monthly and tabled quarterly at each Heads of Service Meeting. This details the risks, controls and further actions required at each site. Applications have been submitted to extend the TRO at the REH and introduce a TRO at the AAH, these works have now been completed. The resurfacing of car park P (main visitors car park is now complete and is now in operation. This will now provide additional traffic management controls due to the relining of spaces etc.. It is proposed to fund additional resurfacing of car park A during 2017/18 through the Backlog Maintenance Programme. The alterations to the road layout adjacent to Turner House (WGH) have now been completed. (which was considered as the highest risk on the WGH site). These works will reduce the speed of traffic movement on this part of the site.. Cycle path works have now been completed Traffic Management works at Whitburn HC have been stopped until land ownership issues have been resolved. Traffic Management works at Liberton, PAEP and MCH have been completed. <u>Traffic management works at REH Phase 1 including road lining and signage works completed.</u> <u>Capital application submitted for areas of high risk Funding of £200k has provisionally been agreed to fund the applications for the WGH and St John's Hospital</u> <u>The Goodison Structural and Civil Engineers Report is now available which provides recommendations on improvements required to the road network required to accommodate RHSC/DCN coming on site.</u> Risk grade/rating remains unchanged - High/12	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 12	Medium 8	Jim Crombie	George Curley	Staff Governance Committee

NHS LOTHIAN

1.3.1

Board
3 October 2018

Medical Director

RISK MANAGEMENT POLICY

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approve the refreshed Risk Management policy. The Board's Standing Orders provide that the approval of the Board's Risk Management Policy is a matter that is reserved to the Board.

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

2 Recommendations

2.1 Accept the recommendation of the Audit & Risk Committee to approve the refreshed Risk Management Policy with immediate effect.

3 Discussion of Key Issues

3.1 The Audit & Risk Committee accepted the refreshed Risk Management Policy at its meeting on 27 August 2018 and agreed to recommend to the Board for approval.

3.2 The Risk Management Policy and associated Procedure have been refreshed in line with the requirements of the NHS Lothian procedure for the development of policies and procedures. The Policy approval group has reviewed both documents and has confirmed compliance with the four main approval criteria:

- A clear need is identified
- Prepared in line with the requirements of the Procedure for the Development of NHS Lothian Policies and Procedures
- Stakeholders are engaged and consulted in the development process
- Policy Implementation and Communications Plan is credible and robust

3.3 The risk appetite statement has been removed from the documents as discussed at the Board risk management workshop in May and agreed by the Audit & Risk committee at the June 2018 meeting. Otherwise, there is no fundamental change to policy and the format now complies with the new requirements (see Appendix 1).

4 Key Risks

4.1 There are no risks identified from this paper.

5 Risk Register

5.1 There are no implications for the Corporate Risk Register arising from this paper. Successful implementation of the policy and procedure will ensure that risk is managed appropriately throughout NHS Lothian.

6 Impact on Inequality, Including Health Inequalities

6.1 Not applicable to this paper.

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

7.1 Not applicable to this paper.

8 Resource Implications

8.1 There are no additional resource implications arising from this paper.

Jo Bennett
Associate Director for Quality Improvement and Safety
19 September 2018
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Revised Risk Management Policy and Procedure 2018

Risk Management Policy

Title: **Risk Management Policy**			
Date effective from:	Click here to enter a date.	**Review date:**	Click here to enter a date.
Approved by:			
Approval Date:	Click here to enter a date.		
Author/s:	Quality & Safety Assurance Lead		
Policy Owner:	Associate Director for Quality Improvement & Safety		
Executive Lead:	NHS Lothian Medical Director		
Target Audience:	Managers / All NHSL Staff		
Supersedes:	Risk Management Policy v1.0 (June 2012)		
Keywords (min. 5):	Risk, Risk Management, Residual Risk, Governance, Register		

Version Control

Date	Author	Version/Page	Reason for change
June 2012	Quality and Safety Assurance Lead	1.0	
May 2018	Quality & Safety Assurance Lead	1.1	Under review
June 2018	Quality & Safety Assurance Lead	2.0	Review approved - *TBC*

RISK MANAGEMENT POLICY

1 EXECUTIVE SUMMARY

1.1 Key Messages

Whatever you may be trying to achieve there will always be some risk. Risk creates uncertainty, and if we do not actively manage risk, could lead to us not achieving our goals and objectives, such as safe and effective care.

To increase our chances of success, we should:

- Be very clear what we are trying to achieve, and purposely set out the objectives.
- Identify the risks to those objectives. Risks should always be related to objectives, as this allows us to properly assess them and consider how important they are in terms of their threat to success.
- Put in place measures and take appropriate action to manage the risks.

This Risk Management Policy has been produced to embed a consistent approach to risk management across the NHS Lothian.

1.2 Implementation

The Board shall have a record of its risks and the Corporate Management Team is responsible for directing this policy through operational management structures. All senior management teams must ensure that:

- There is a process to systematically consider the relevance and management of existing and new risks in their area of responsibility
- All departments within their area effectively implement this policy.
- That all employees are clear of their roles and responsibilities in regard to implementing this policy.

2 Why do we have this Policy?

2.1 Lothian NHS Board (the "Board") exists to carry out NHS functions and services as directed by the Scottish Government. The Board will develop strategies and set objectives in order for it deliver its purposes and intended outcomes.

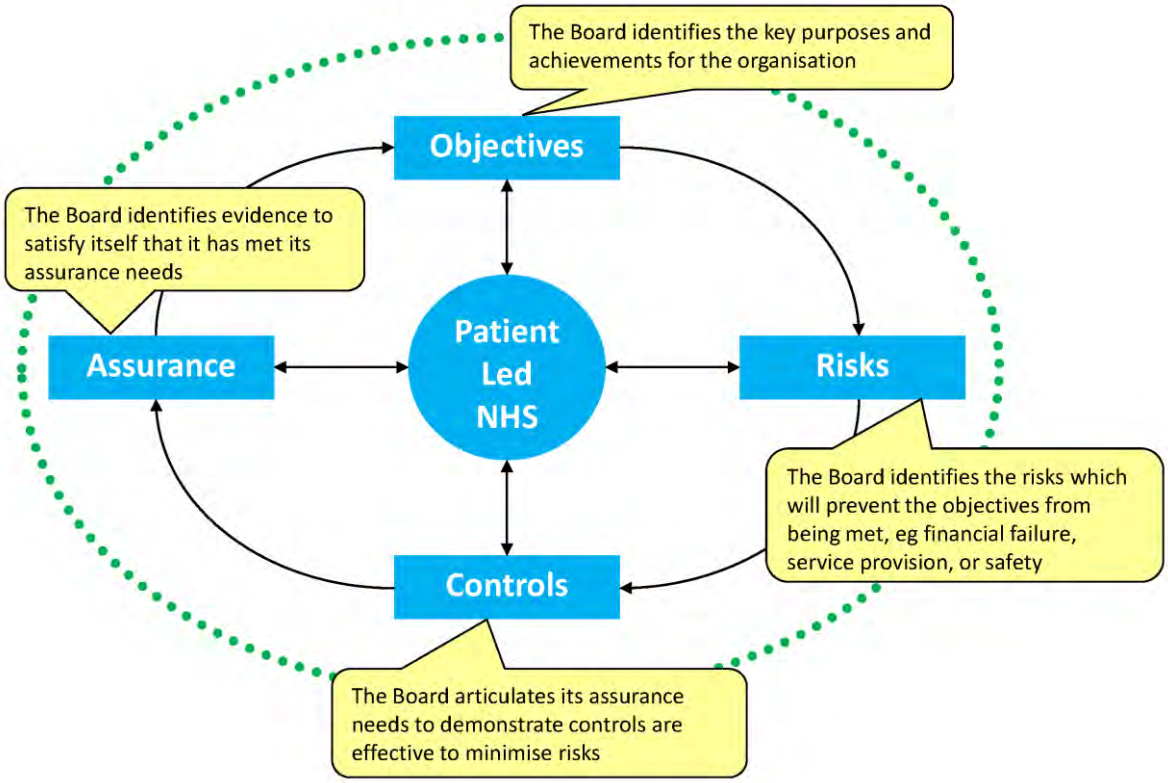
2.2 Whatever you may be trying to achieve there will always be some risk. Risk creates uncertainty, and if we do not actively manage risk, could lead to us not achieving our goals and objectives, such as safe and effective care.

To increase our chances of success, we should:

- Be very clear what we are trying to achieve, and purposely set out the objectives.
- Identify the risks to those objectives. Risks should always be related to objectives, as this allows us to properly assess them and consider how important they are in terms of their threat to success.
- Put in place measures and take appropriate action to manage the risks.

This Risk Management Policy has been produced to embed a consistent approach to risk management across the NHS Lothian.

2.3 The following diagram, taken from the guidance on Corporate Governance and Assurance, illustrates the general concept:



Source: adapted by NHS Lothian from Health Care Standards Unit, as referred to in the Oxford University Hospitals Foundation NHS Trust Assurance Strategy (September 2015)

3 Policy Statement

3.1 The Board will have a systematic approach to the management of risk in all of its functions and services. As part of this approach, the Board expects employees to give greater priority to managing and reducing risks associated with the safety of people, the experience of people who receive care, and the delivery of effective care.

3.2 The Audit & Risk Committee shall seek assurance that:

- There is a comprehensive risk management system in place to identify, assess, manage and monitor risk at all levels of the organisation.

- There is appropriate ownership of risk in the organisation, and that there is an effective culture of risk management.

In order to discharge its advisory role to the Board and Accountable Officer, and to inform its assessment on the state of corporate governance, internal control and risk management, the Committee shall:

- At each meeting, review a report summarising any significant changes to the Board's corporate risk register, and what plans are in place to manage them. The Committee may also elect to occasionally receive information on significant risks held on other risk registers held in the organisation.

- Assess whether the Corporate Risk Register is an appropriate reflection of the key risks to the Board, so as to advise the Board.

- Consider the impact of changes to the risk register on the assurance needs of the Board and the Accountable Officer, and communicate any issues when required.

- Reflect on the assurances that have been received to date, and identify whether entries on the Board's risk management system requires to be updated.

- Receive an annual report on risk management, confirming whether or not there have been adequate and effective risk management arrangements throughout the year, and highlighting any material areas of risk.

3.3 Whilst the Committee shall seek assurance on the overall system of risk management for all risks and risks pertinent to its core functions, the Board's Healthcare Governance Committee shall provide particular oversight to clinical risks and all matters relating to the Board's legal duty to monitor and improve the quality

of health care which it provides (Reference: S12H of National Health Service (Scotland) Act 1978).

3.4 The Healthcare Governance Committee shall also provide oversight to the Board's responsibilities for information governance, through the Information Governance Sub-Committee.

3.5 The Staff Governance Committee shall have particular oversight of risks relating to the Board's legal duty in relation to the governance of staff. (Reference: S12I of National Health Service (Scotland) Act 1978).

3.6 All of the committees shall use the standard levels of assurance (Significant, Moderate, Limited, None, Not Assessed Yet) in the course of discharging its remit.

4 DEFINITIONS

4.1 **Risk** is uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. It is the combination of the likelihood and impact of the risk materialising.

4.2 **Risk should always be related to some objective or purpose. A statement of risk should always contain:**

1. The cause of the impact on the objective, AND
2. The impact on the objective (i.e. the consequence of the risk)

4.3 **Risk Management** is a process which helps the whole organisation to identify areas that require attention and remedial action. It can be defined as the processes involved in managing those risks, including:

- Identifying
- assessing and judging risks
- assigning ownership for the management of the risk
- taking actions to mitigate or anticipate them
- monitoring and review progress

4.4 The **risk register** is a record of the risks identified, the assessment of them, the controls in place to manage them and any additional actions planned to improve controls to manage them. There should be risk registers at all levels of the organisation.

4.5 An **internal control** is measure put in place with the aim to mitigate risk. Internal controls will constrain risks but are unlikely to eliminate them entirely and every control will come at some type of cost.

4.6 When designing systems of control, the investment in controls should be in proportion to the risk, e.g. when trying to avoid the most extreme of undesirable

outcomes such the loss of human life, the associated systems of control have to be forensically designed and effectively implemented. One should expect to undertake a higher degree of effort to reach a "significant" level of assurance for these areas.

4.7 **Inherent risk** can be defined as the exposure arising from a specific risk before any action is taken to manage it i.e. there are no controls in place

4.8 **Residual risk** - the exposure arising from a specific risk after action has been taken to manage it and making the assumption that the action is effective i.e. controls are in place and are operated as intended

4.9 **Risk escalation** is the process of communicating a risk across up, down or across the organisation to ensure that is managed effectively

4.10 **Risk tolerance** – the boundaries of risks judged to be justifiable and which the Board is prepared to accept or be exposed to at any point in time. This will typically be expressed in quantifiable measures that will be monitored.

5 IMPLEMENTATION AND ROLES AND RESPONSIBILITIES

5.1 Chief Executive

5.1.1 The Chief Executive is the Accountable Officer for NHS Lothian, and as such is legally responsible for ensuring that risks are identified, that their significance is assessed and that systems appropriate to the risks are in place in all relevant areas to manage them.

5.1.2 For the purpose of the role of Accountable Officer, the Chief Executive shall require assurance from the executive directors that risks are being managed. The Chief Executive shall also take independent assurance from the Audit and Risk Committee as to the robustness of the risk management arrangements throughout the Board.

5.2 Medical Director

5.2.1 The Medical Director is the lead executive director for the Board's risk management arrangements, and has delegated responsibility for leading on their development and implementation.

5.3 Associate Director for Quality Improvement & Safety

5.3.1 The Associate Medical Director for Quality Improvement & Safety promotes arrangements for risk management, including maintenance of materials to support the process, and support for operational management teams including training. This includes preparation of an annual report on risk management and periodic reporting to the Board and others as required.

5.4 Managers of Functions and Services

Managers must ensure that within their area of responsibility:

- risk is effectively identified and managed, including, but not limited to ensuring that this policy and other arrangements put in place are followed
- they ensure all local efforts taken to mitigate the risk have been exhausted prior to escalation.

5.5 All Staff

All staff are responsible for:

- continually considering the potential risks
- identifying risks
- taking quick and appropriate action to escalate any risk they have identified

6 Associated Procedures & Guidelines

6.1 Implementation of this policy is predominantly achieved by recording the risk management information in the risk register module on DATIX. Following NHS Lothian policies, procedures, guidance and systems on all matters is in itself a 'key' to controlling risk. All NHS Lothian policies, procedures, guidance and systems are designed to achieve the aims and objectives of the subject matter. This Risk Management Policy and its associated procedures should assist in managing the risks that arise from these activities. Details of the processes are set out in the **Risk Management procedure** (link to be added) and supporting guidance documents.

7 Evidence Base

The principles of this policy and procedure are based upon recognised good practice in risk management, as set out in the following publications:
The Orange Book *Management of Risk - Principles and Concepts published by HM Treasury 2004.*
Institute of Risk Management: A Risk Management Standard © IRM: 2002
Scottish Government Memorandum to Accountable Officers for Parts of the Scottish Administration November 2010
The Scottish Public Finance Manual
Scottish Government's Audit & Assurance Handbook (April 18)

8 REVIEW OF THIS POLICY

The Responsible Officer will continually keep this policy under review with a formal review every 3 years.

Risk Management Operational Procedure

Title: Risk Management Operational Procedure			
Date effective from:	Click here to enter a date.	**Review date:**	Click here to enter a date.
Approved by:			
Approval Date:	Click here to enter a date.		
Author/s:	Quality & Safety Assurance Lead		
Policy Owner:	Associate Director for Quality Improvement & Safety		
Executive Lead:	NHS Lothian Medical Director		
Target Audience:	Managers / All NHSL Staff		
Supersedes:	Risk Management Operational Procedure v1.0 (June 2012)		
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June 2012	Associate Director of Quality & Safety	1.0	
May 2018	Quality & Safety Assurance Lead	1.1	Under review
June 2018	Quality & Safety Assurance Lead	2.0	Review approved - *TBC*

Contents

1. Executive Summary

1.1 This procedure has been prepared to support the implementation of the NHS Lothian Risk Management policy (***link to be added***), and ensure consistency of approach in operational risk management.

1.2 **Risk** is uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. It is the combination of the likelihood and impact of the risk materialising.

1.3 Risk should always be related to some objective or purpose. A statement of risk should always contain:

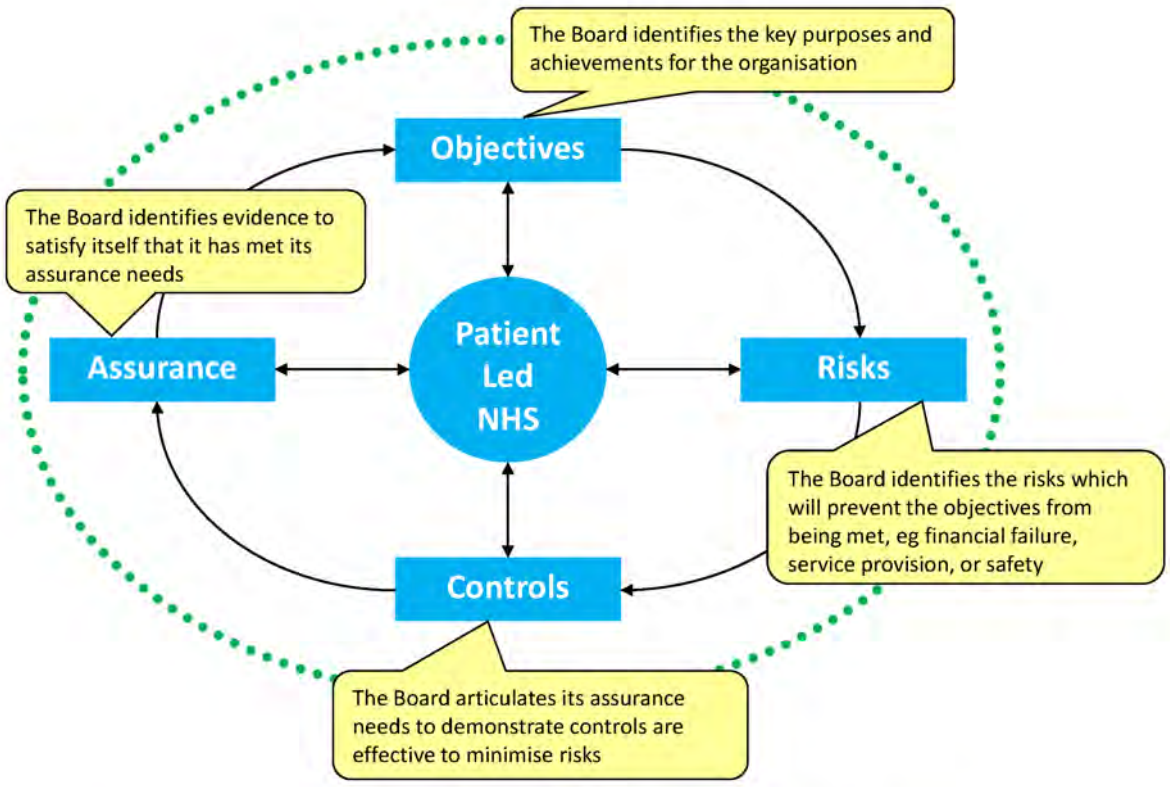
1. The cause of the impact on the objective , AND
2. The impact to the objective (i.e. the consequence of the risk)

1.4 **Residual risk** is the exposure arising from a specific risk after action has been taken to manage it.

1.5 A risk register is simply an explicit record of identified residual risk, which should be used by management to take appropriate action to mitigate that risk.

1.6 The diagram below gives a high level view of the system of corporate governance, and the part that risk management plays in it.

Figure 1 – Overall System of Corporate Governance



Source: adapted by NHS Lothian from Health Care Standards Unit, as referred to in the Oxford University Hospitals Foundation NHS Trust Assurance Strategy (September 2015)

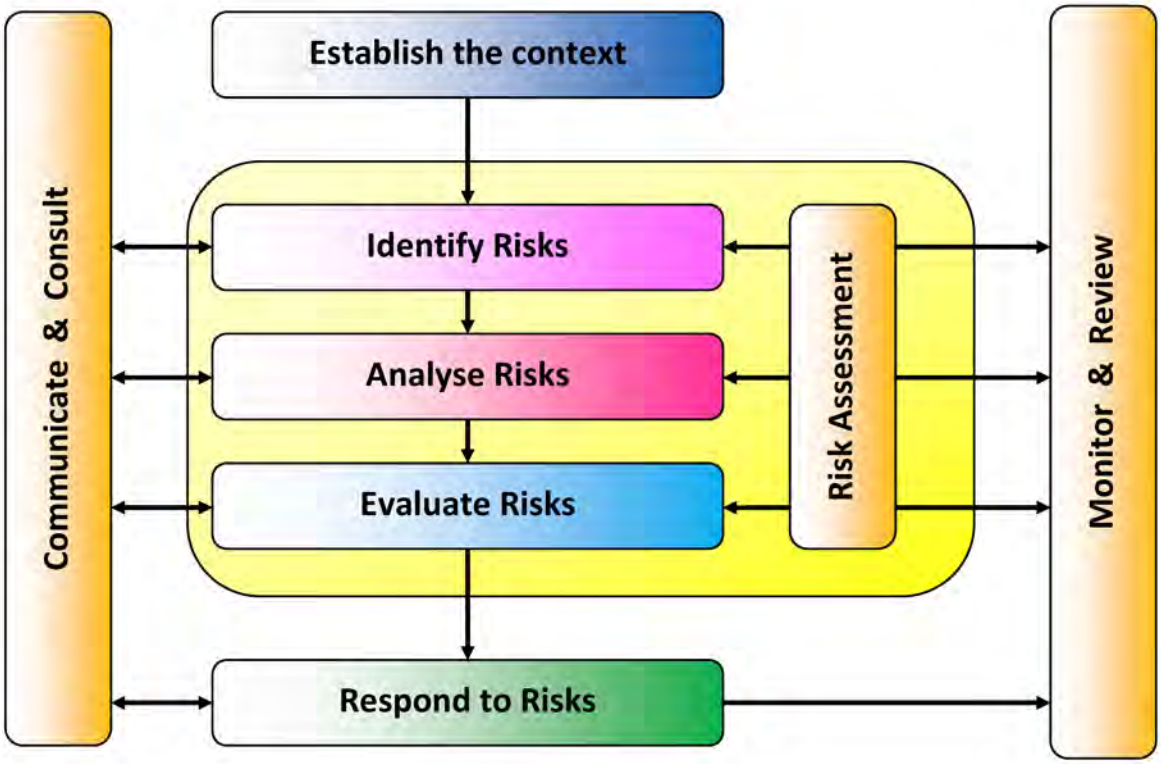
1.7 If the systems of assurance within the organisation are designed properly, they can add value by reducing bureaucracy, and allowing the Board and senior management to confidently focus on the key matters which do require attention.

1.8 The design of the systems of assurance should reflect the strategic aim of making NHS Lothian a more data driven organisation.

1.9 You can find further information on corporate governance and assurance, and other information on the wider system of governance in the Board Members' Handbook on the Board's website.

The steps to identify and respond to risks are summarised at Figure 2 below:

Figure 2 – The risk management process



1.10 When a risk has been identified, action must be taken to respond to it. The four options are:

1. **Treat:** Eliminate the risk completely, or reduce it to the point where the risk is at an acceptable level.

2. **Tolerate:** Where the risk is unavoidable, formally conclude that the risk is of a type that any further action would be disproportionate to the level of risk exposure, and that the risk is therefore at an acceptable level.

3. **Transfer the Risk** e.g. insurance cover.

4. **Terminate the Activity** from which the risk derives.

1.11 An **internal control** is a measure put in place with the aim to mitigate risk. Internal controls will constrain risks but are unlikely to eliminate them entirely and every control will come at some type of cost. Management are expected to design and implement systems of internal control, and this procedure includes further detail on this subject.

2. Who is responsible for managing risk?

2.1 The simple answer is everyone. Every person through their daily duties contributes to the management of risks which are relevant to their activities.

2.2 The Board and its committees are not involved in operational management and delivery, but exercise oversight of the system of risk management in the organisation and receiving reasonable assurance that the system supports the implementation of the Risk Management Policy. The Board and its committees require assurance from management (and other sources) in order to carry out their role in corporate governance.

2.3 Managers are responsible for managing risk and developing and implementing the detailed systems of internal control in their areas of responsibility. This effort should be aimed at delivering the Board's strategic objectives and improvement. If risks can be and are efficiently and effectively managed at a local level, it is less likely that more significant risks will develop throughout the organisation. Consequently management need to assure themselves that those systems of internal control and risk management are operating as intended. If they successfully do so, they can efficiently provide assurance to a committee and the Board as and when required.

2.4 Risks should be managed at the lowest level possible in the organisation. The identification of and response to risk, and the development, maintenance and use of a local risk register should be a team effort. However one person will be accountable at each level of the organisation for the co-ordination of the associated risk register.

2.5 The NHS Lothian Quality Improvement Team supports the whole organisation to develop and implement the system of risk management.

2.6 Two key roles within the process of risk management are the risk owner and the risk handler.

2.7 A Risk Owner is the named director or manager with overall responsibility for a particular risk – albeit the management of the risk may be passed to another person (Risk Handler).

2.8 The Risk Owner has overall responsibility for ensuring that:

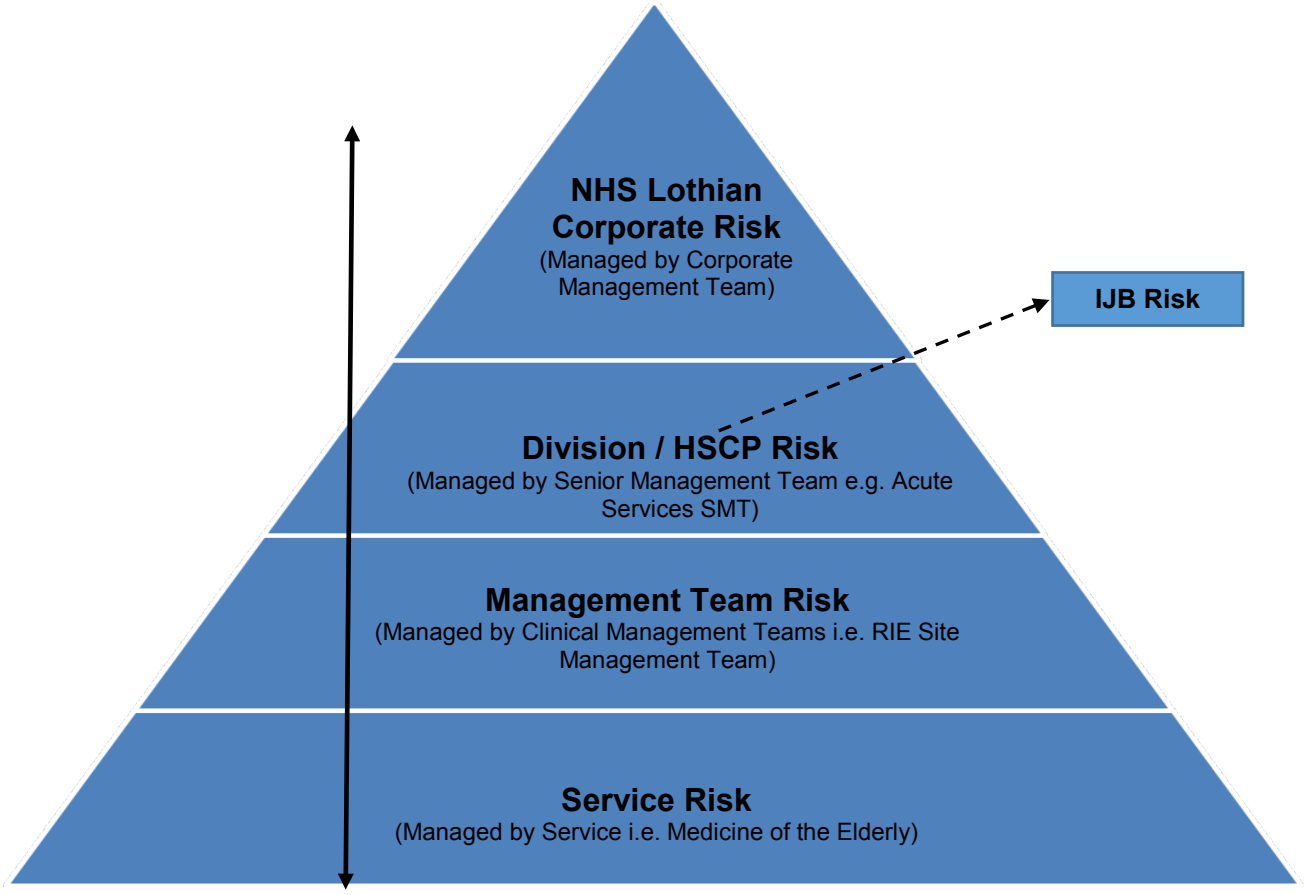
- risks are managed and analysed in accordance with the Risk Management policy and procedures
- risks and their supporting action plans are evaluated/reviewed in a regular and timely manner and that progress against action plans is maintained to support the management of risks
- he or she is assured that adequate and effective systems of internal control are in place
- provide a report on the management of a risk, should a management team or a Board committee require

2.9 The Risk Handler typically undertakes the detailed work on the particular risk, and reports to the Risk Owner on that work.

3. The Risk Register Hierarchy

3.1 Risk registers exist at all levels of the organisation (see Figure 3) and should be recorded on the Risk Management Information System (Datix), where all the information required for a risk assessment can be entered (see Guidance on Recording and Reviewing Risks on Datix). As the management of any risk should be undertaken at the most devolved level in the organisation. To allow this, risks should be properly recognised, and expressed in terms that are of relevance to that part of the organisation:

Figure 3 **Risk Register Hierarchy**

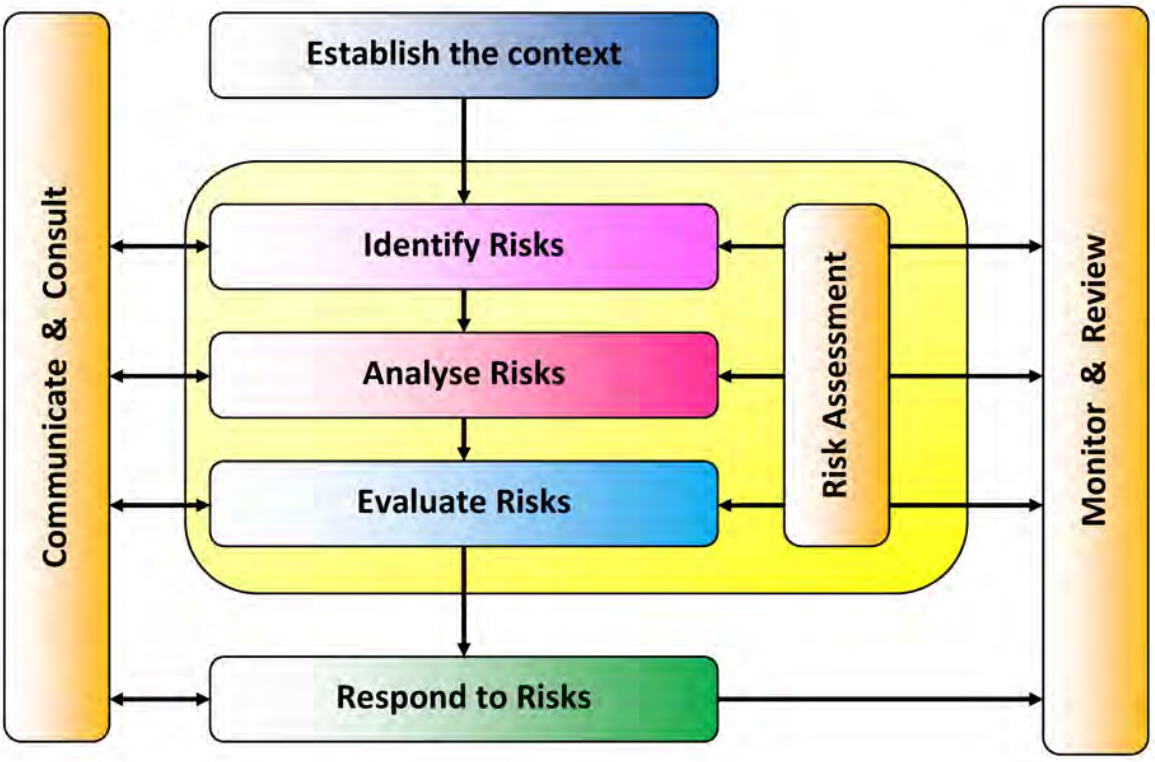


3.2 Ward/Department Risk Assessments link to risk assessment form: General Risk Assessment Form may be held in Ward/Departmental Health, Safety and Risk Folders rather than on Datix. For further advice please refer to the NHS Lothian Health & Safety intranet pages.

3.3 The Corporate Risk Register contains strategic risks which compromise the delivery of NHS Lothian objectives as well as operational risks which cannot be managed at a lower level and/or have an impact across the system.

3.4 We should ensure that the risks are in the right level to be managed appropriately and effectively. Escalation can be up or down. Please refer to NHS Lothian's Risk Escalation Flowchart.

4. Risk Register Process



Establish the context

4.1 Risks may be generated through a range of mechanisms, though will ultimately relate either directly or indirectly to the achievement of NHS Lothian objectives, objectives specifically defined for your service, or area of responsibility. Risks may relate to a specific objective or may be generic, for example, related to patient safety, quality, and experience which will affect delivery of a number of objectives.

Risk Assessment → **Identify Risks**

4.2 It is essential that all risks are clearly defined. If you define your risks properly, you will have a better understanding of what they are, and more likely to identify appropriate actions that will be successfully attend to those risks.

4.3 **How to express a risk**

A risk should have two elements:

1) **What can happen** <u>which will have an impact on an objective or assurance need</u> (the cause)

2) The **impact on the objective or assurance need** (the consequence)..

What you should **not** do when expressing risk is:

a) Stating risks which are simply the converse of the objectives.
b) Stating impacts which may arise as risks themselves.

Illustration

Objective: to travel by train from A to B for a meeting at a certain time	
Failure to get to from A to B in time for the meeting.	X This is simply the converse of the objective.
Being late and missing the meeting.	X This is a statement of the impact of the risk, not the risk itself.
There is no buffet on the train so I get hungry	X This does not affect the achievement of the objective.
Missing the train causes me to be late and miss the meeting.	✓ This is a risk which can be controlled by getting to the station in plenty of time.
Severe weather prevents the train from running and me from getting to the meeting.	✓ This is a risk which cannot be controlled; however, you can make a contingency plan. You could alternatively "terminate the activity" and not make the journey and instead use tele- or video-conferencing.

Source: Adapted from HM Treasury: The Orange Book –Management of Risk – Principles and Concepts (October 2004)

A helpful discipline in articulating a risk is to think of three elements:

'There is a risk that ....'
What event could happen that creates uncertainty as to the achievement of the stated objective or assurance need?

'Because ...'

Why/and/or how could the event occur? The risk will often occur because something changes e.g. a new target, a new piece of legislation, a gap in assurance identified by a committee or performance below expectation highlighted through the performance management system

'Leading to ...'
What would the consequence be if the event occurred?

Specific Examples of Risks for the NHS

There is a risk that the Board has to reduce or cease certain services in order to live within resources **because** our overall costs in providing services are increasing at a faster rate than growth in our income, **which can lead to** poorer health outcomes

There is a risk that smokers who do wish to quit are unaware of the support that is available to them, **because of** ineffective communication of services **leading to** low uptake and successful quits.

There is a risk that prospective mothers are not aware of the benefits of breastfeeding, **because** of inadequate funding of resources for promotion, **leading to** the rate of breastfeeding being lower than it could be, and missed opportunity for positive health outcomes.

There is a risk that surgical services are unable to staff the on-call rota **because** there is a shortage of surgeons **leading to** poor patient experience and increased waiting times with potential deterioration in conditions, as well as unsustainable extra workload for the surgeons.

There is a risk that the Board does not treat patients in a timely manner **due to** a combination of demand significantly exceeding capacity for specific specialties and suboptimal use of available capacity, **leading** to compromised patient safety.

4.4 Risk identification should be a team effort. It is good practice to purposely identify risks which will impact on a number of objectives or assurance needs. Its potential impact may vary in relation to different objectives. (It is possible that a single treatment may adequately address the risk in relation to more than one objective).

4.5 Once you have created a list of risks, review them and look for some which may state similar risks, or may need reworded.

4.6 Finally, decide, what is the main objective or assurance need that will be compromised should the risk materialise? This function provides the organisation with the opportunity to group risks against specific objectives and assess what risks are likely to impede their delivery.

4.7 **Identify the System of Internal Control**

For each identified risk you should be aiming to have assurance that that internal controls are in place and operating effectively so that the associated objective(s)/ assurance needs are being achieved.

You have to identify what controls are in place.

There are four types of internal controls:

1.	**DIRECTIVE** These are designed to ensure a particular outcome is achieved. Directive controls are typically expressed in a policy or procedure, describing broadly set out what is required to happen. They are not in themselves effective in managing risk and providing assurance unless there is a corresponding suite of preventative and detective controls in place.

Examples:

- Require staff to wear protective equipment when doing certain tasks.
- Require staff to have completed a qualification or have cleared a check before being employed
- Require staff to have completed a particular training before being allowed to carry out a particular activity without supervision.

2. PREVENTATIVE

Preventative controls are designed to prevent undesirable outcomes. They are measures which design out risk and, if they operate correctly, should ensure that the right thing does happen. This is the strongest type of internal control.

Examples:

- Upon appointment the employee is automatically issued with the required protective equipment. There is a supervisory check to ensure the equipment is available for use before an activity, and the activity will not start unless this is the case.
- An employee is required to provide documentary evidence of qualifications before a job offer can be made.
- A PVG check must be undertaken before a job offer can be made.
- A person (who is independent from the person who approved an order) has to confirm that the goods or services have definitely been received before any payment is made to the supplier.

3. DETECTIVE

Detective controls will alert management to when an undesirable outcome has happened. As they only operate after the event, they are not as useful at managing risk as preventative controls.

Examples:

- A system of spot observation checks can confirm whether or not employees are indeed using their protective equipment in practice.
- All employees are required to and know how to report all adverse events.
- A monthly check against the NMC database will identify whether current employees have up-to-date registration.
- A stock check will identify whether we have all the stock that we think we should through our stock records.

Managers are advised to explore opportunities to use the reporting capability within existing systems as these can automatically provide information that will allow you to monitor the operation of key controls, e.g. Tableau, finance reports, TRAK, Empower, DATIX.

4. CORRECTIVE

These are measures that can be put in place to correct undesirable outcomes after they have happened. They provide a way to allow for some recovery of any loss or damage.

Examples:

- The design of terms within a contract to allow for the recovery of any overpayments.
- The use of insurance policies that will provide compensation should certain insured events happen.
- The development of business continuity plans and disaster recovery plans, to help the organisation respond to an event that it could not control.

4.8 The next stage is to evaluate the controls so that you can identify any unmanaged risk. To do this, you must consider the adequacy of the controls that are already in place either to reduce the likelihood of the risk materialising or to reduce the impact if it does materialise. For each risk, select from the list below how best to describe the adequacy of controls.

Satisfactory	**The control is adequately designed to manage the risk, and the system is operating as intended** E.g. the Board has a procedure on how to use infusion pumps, and staff are aware of it and have had the necessary training. Departments conduct compliance audits to confirm the infusion pumps are being properly used in practice, and the results are positive. There are no reported incidents of the use of infusion pumps leading to harm.
Adequate but partially effective	**The control is adequately designed to manage the risk, but it is not being implemented properly** e.g. The Board has a procedure on how to use infusion pumps, however there is evidence that staff are not aware of it, and/ or are not consistently applying it in practice. The evidence may have been identified through observation, audit, or reported incidents, The causes of this could be that there is no consistent effort made to make staff aware of the procedure, or train them. There could be a training programme in place, but staff are not participating in the training for a variety of reasons.
Inadequate	**The control is not designed to properly manage the risk, and further controls and measures are required** E.g. Employees in the department have different levels of understanding as to how to use an infusion pump. Training on infusion pumps depends on who manages the member of staff, and

	there are no guidelines or procedures available for people to refer to. The department has no knowledge as to whether infusion pumps are being used correctly.
Unknown	**The details of the system of internal control are not known at this time, and further work is required to identify what the current situation is, and whether or not there are any controls in place.** Although a specific team or department has identified the risk, controls may be outwith their management sphere.

Risk Assessment → **Evaluate Risks**

4.9 Once you have established the adequacy of controls, apply a risk grade.

The grading tool used in NHS Lothian measures risks according to the following formula:

Likelihood x Impact = Risk

This is done by considering the likelihood of the risk and the most likely consequence (bearing in mind the controls that are in place). Each description of likelihood and consequence has an assigned line on the risk matrix. The risk grade is given taking account of the controls and other preventative measures that are in place and provides you with the **residual** or current risk grade. Please refer to NHS Lothian Risk Matrices.

The resulting value will inform prioritisation and place the risk into one of 4 categories:

Risk Grade		Risk Level
Very High	Red	20-25
High	Amber	10-16
Medium	Yellow	4-9
Low	Green	1-3

4.10 When evaluating the risks it is important to also think about and record the target risk grading that you wish to set for the risk – this is the level of risk that the organisation will deem acceptable.

NB If a risk has been identified with an extreme impact but a rare likelihood of happening, this could be a business continuity risk and should be escalated to the attention of the Resilience Team rather than being recorded on the risk register.

Respond to Risks

4.11 Now that the risk has been identified and analysed, any gaps or opportunities for improvement in the adequacy of controls should be addressed through an action plan. Action must be taken to either:

	PROCESS	TREATMENT
Tolerate	The current risk is either acceptable or tolerable i.e. the risk is currently managed sufficiently	Periodically reassess to ensure the risk and controls have not changed
Treat	The level of current risk is not tolerable, it is too high. Additional action should be taken to reduce the likelihood and/or impact of the risk occurring	Consider which additional controls are required to better manage the risk. The cost and effectiveness of additional controls should be balanced against the potential consequences of the risk crystallising
Transfer	Management of the risk should be either be fully transferred e.g. to an insurer	Identify how the risk can be transferred. Consider the consequences of transferring the risk to a third party and what new risks may arise
Terminate	Consider whether this risk can be eliminated by ceasing to carry out the activity	If the underlying activity giving risk to the risk cannot be terminated then apply the action suggested for **Treat**

4.12 All actions should be **SMART**, ie:

- **Specific** – target a specific aspect for improvement/action
- **Measurable** – quantify or at least suggest an indicator of progress
- **Assigned** – specify who will make it happen
- **Realistic** – ensure that it can realistically be achieved, given available resources
- **Time Bound** – specify when the result(s) can be achieved.

4.13 Actions should be reviewed regularly and updates provided. They should detail progress against agreed actions to date. If there is a failure to make progress on an action, consider if there are any new actions required.

4.14 When an action is completed, it will become a control and the controls should be updated to reflect this.

Monitor & Review

4.15 A review of the risk register should be carried out by relevant manager (see Section 2 for Roles and Responsibilities) at least every 3 months at the appropriate level, although individual risks, depending on their grade, may be reviewed more frequently. New risks and escalation of risks should be considered at this point.

The main elements when reviewing a risk are:

- Cause of risk
- Controls in place and have any actions resulted in new controls
- Adequacy of controls
- Risk grade and level
- Action plan to address any gaps in adequacy of control
- Escalation

Refer to Level of Risk and Review for further information regarding review of risk.

4.16 It may be necessary to escalate the risk to a higher level of management if:

- all local actions required to reduce the risk have been exhausted at your level of management, e.g. you do not have the necessary resources or authority
- controls are maximum and agreement is required regarding acceptance of the residual risk.

Note that by escalating a risk:

- its description may change ie the same risk may be described and assessed differently, according to differing objectives and perspectives at different management levels.

Please refer to the NHS Lothian's Risk Escalation Flowchart

4.17 A risk may have been managed to a reasonable/tolerable level but because the cause is still present, the risk should not be closed. It should be reviewed regularly to consider:

- Whether there are any new innovations or reasonable newly available actions to further mitigate the risk
- If the controls are effective, due consideration being given to other data such as incidents, complaints, concerns, claims
- If the existing risk assessment requires a review.

In such instances, one action, for example to carry out a review of the 3 bullet points given above, in 3 months is sufficient.

Closing risks

4.18 A risk can be closed in the following circumstances:

- The situation or set of circumstances that gave rise to the risk being recorded is totally removed. An example could be a piece of outdated equipment that presented a level of risk has been replaced or a particular procedure is no longer carried out.
- The controls and preventative measures enable the risk to be graded medium or low and there is sufficient assurance regarding the effectiveness of the controls.

4.19 It **may not** be appropriate to close a risk in the following circumstance:

- The organisation has deemed that the controls and preventative measures will be tolerated, but the risk grade remains high or very high. These risks should be reviewed as on a regular basis to monitor effectiveness of controls.

Communicate & Consult

4.20 The Board or Senior Management Team should be periodically informed of the key risks of the organisation and to factor this into its decision making.

4.21 A report of residual risk informs the Board, or other management team. It provides them with:

- The opportunity to consider the adequacy and effectiveness of the controls and assurances identified in the risk register. This should include measures to address gaps in controls and assurances to identify any further measures NHS Lothian should take to manage its key risks.

4.22 The Quality Improvement Support Team supports the Corporate Management Team with the quarterly updates of the Corporate Risk Register which is approved by the CMT prior to submitting to the Audit & Risk Committee and the Board.

4.23 All the senior management teams must have an explicit process in place for managing and reviewing risks within their own area (see example Acute Services Process).

4.24 A standard risk register report template should be used when reporting risks to committees and groups.

5. Training & Support

5.1 The NHS Lothian Quality Improvement Support Team provides training and support on developing and maintaining a Risk Register on DATIX which includes running workshops for management teams if requested.

5.2 For DATIX training and support contact: Datix Helpdesk – datixhelp@nhslothian.scot.nhs.uk Ext 88561

5.3 The Health & Safety Department provide Risk Assessment training on task based or environmental based risks.

6. Governance and Reporting Arrangements

6.1 Each senior management team requires to have explicit processes in place for regular reporting and review of risk registers (see example Acute Services Process)

6.2 The Corporate Risk Register is reported at every Board and Audit and Risk Committee

6.3 Every 6 months Divisional High / Very High risks are reported to the Audit and Risk Committee.

6.4 All risks will be included in the papers relating to the business of the particular Board committee e.g. Healthcare Governance, Staff Governance, Performance and Resource.

7. Review of Procedure

The procedure will be continuously reviewed by the Quality Improvement Support Team with a formal review carried out every 3 years.

NHS LOTHIAN

Audit & Risk Committee
3 October 2018

Director of Finance

REVIEW OF THE BOARD'S STANDING ORDERS

1 Purpose of the Report

1.1 The Board has reserved the approval of its Standing Orders to itself. There is an opportunity to simplify the Standing Orders by removing the existing provisions for members to raise motions. The Board is not obliged to have these provisions. Additionally a few minor amendments are proposed to reflect the appointment of the Head of Corporate Governance and the creation of the Board Members' Handbook on the Board's website.

1.2 The Audit & Risk Committee has previously reviewed and recommended proposed revisions to the Standing Orders to the Board to attend to this matter. Following the Board meeting of 27 June 2018, the Chair of the Audit & Risk Committee met with Councillor McGinty to find a resolution to the remaining issues.

1.3 The Audit & Risk Committee considered the amendments which arose from this discussion on 27 August 2018, and agreed to recommend the Standing Orders to the Board.

1.4 Following the Audit & Risk Committee meeting, the Head of Corporate Governance identified the need to make some further amendments to Section 6 (Matters Reserved to the Board). These are minor reflecting changes to the language now used in community planning, and the replacement of the term 'Local Delivery Plan'. Additionally the Board members have previously agreed not to use a risk appetite, and this is reflected in the draft revised Risk Management Policy. Accordingly the reference to risk appetite has been removed.

1.5 Any member wishing additional information should contact the Director of Finance in advance of the meeting.

2 Recommendations

The Board is asked to:

2.1 Approve the proposed revised Standing Orders with immediate effect.

3 Discussion of Key Issues

3.1 The outstanding issue related to the ability of any Board member to effectively challenge proposals and recommendations within reports, as part of the Board's decision-making process. There was also a view that it would be helpful if the

extent of any support for an alternative view was formally determined and recorded.

3.2 The provisions for decision-making had already been strengthened and reflected in earlier drafts (paragraphs 5.16- 5.19 of the Standing Orders refer). Additionally paragraphs 4.3 and 4.4 add measures for any Board member to propose an item of business for the Board agenda.

3.3 The updated proposal (at Appendix 1) has new amendments at paragraph 5.20, so that if approved it will be:

'*Where the Chair concludes that there is not a consensus on the Board's position on the item and/ or what it wishes to do, then he or she will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on*.'

3.4 The effect of these amendments is that the decision as to whether or not a matter is put to a vote, is not at the sole discretion of the Board Chair. If at least two Board members ask for a vote, then there shall be a vote.

3.5 The Audit & Risk Committee confirmed on 27 August 2018 that it supported these amendments.

4 Key Risks

4.1 The Standing Orders are not consistent with how the Board works, leading to lack of clarity for Board members, which in turn negatively impacts on their engagement in Board business.

5 Risk Register

5.1 This is not on a risk register as the proposed amendment should attend to the issue.

6 Impact on Inequality, Including Health Inequalities

6.1 This report addresses an administrative matter with no impact on a specified group of individuals.

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 health services, nor any decisions that would significantly affect people.

8 Resource Implications

8.1 There are no resource implications arising from these proposals.

Alan Payne,
Head of Corporate Governance
29 August 2018
alan.payne@nhslothian.scot.nhs.uk

NHS LOTHIAN
STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF LOTHIAN NHS BOARD

1 General

1.1 These Standing Orders for regulation of the conduct and proceedings of Lothian NHS Board, the common name for Lothian Health Board, [the Board] and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension and disqualification of members in line with the above regulations. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

1.3 Board members are required to subscribe to and comply with the NHS Lothian Code of Conduct ~~(Appendix 6 to the Standing Orders)~~ which is made under the Ethical Standards in Public Life etc (Scotland) Act 2000.

1.4 Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.5 Any one or more of these Standing Orders may be varied or revoked at a meeting of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment.

1.6 The ~~Corporate Services Manager~~Head of Corporate Governance shall provide a copy of these Standing Orders to all members of the Board on appointment. A copy shall also be held on the Board's ~~intranet~~ internet site ~~at -~~ ~~CORPORATE > POLICIES > NHS LOTHIAN STANDING ORDERS PACK~~ Board Members Handbook

2 Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board.

3 Vice-Chair

3.1 The Board shall appoint a Board member to be Vice-Chair. A member who is an employee of a Board is disqualified from being Vice-Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice Chair may at any time resign from that office by giving notice in writing to the Chair, and the Board may appoint another member as Vice-Chair.

3.3 Where the Chair has died, ceased to hold office, or is unable to perform his or her duties due to illness, absence from Scotland or for any other reason, the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board and references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to the Vice-Chair.

4 Calling and Notice of Board Meetings

4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least six times in the year and will annually approve a forward schedule of meeting dates.

4.2 The Chair will determine the final agenda for all Board meetings, and no business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member which meeting the item will be discussed.

4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.

4.~~2~~5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that~~.~~ ~~However~~ no business shall be transacted at the meeting other than that specified in the requisition.

4.~~3~~6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be delivered to every member (e.g. sent by email) or sent by post to the usual place of residence of such members so as to be available to them at least three clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point. The Board may exceptionally convene a meeting at shorter notice only if all members agree.

4.~~4~~7 With regard to calculating clear days for the purpose of notice under 4.~~3~~ 6 and 4.~~6~~9, the period of notice excludes the day the notice is sent out and the day of the meeting itself. Working days and weekend days are counted. e.g. If a notice is sent out on Friday for a meeting to be held on the following Tuesday, three clear days notice will have been given.

4.~~5~~8 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.~~6~~9 Board meetings shall be held in public. The ~~Corporate Services Manager~~Head of Corporate Governance shall place a public notice of the time and place of the meeting at the Board's offices at least three clear days before the meeting is held. If the meeting is held at shorter notice (see 4.~~3~~6) then the public notice shall be placed at the same time that the shorter notice is served. The notice and the meeting papers shall also be placed on the Board's website.

4.7 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting. However the Chair has the right to adjourn a meeting in the event of disorderly conduct or other misbehaviour at the meeting.

4.8 The Board may ~~pass a resolution~~agree to meet in private in order to consider certain items of business. The Board may decide to do so on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation.
- The business relates to the commercial interests of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information, and requires to be discussed in private in order to uphold the Data Protection Principles.

- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

4.9 The minutes of the meeting will reflect the reason(s) why the Board resolved to meet in private.

5 Conduct of Meetings

Authority of the Chair

5.1 The Chair shall preside at every meeting of the Board. The Vice-Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of a Board to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the Committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video-conferencing, teleconferencing.

5.4 In the event that a~~A~~ny member who disregards the authority of the Chair, obstructs the meeting, or conducts himself/herself offensively ~~shall be suspended for the remainder of the meeting, if a motion (which shall be determined without discussion) for his/her suspension is carried~~the Chair may propose to the Board that the member be suspended for the remainder of the meeting. Where the Board elects to agree with the proposal, the member is ~~Any person so~~ suspended and shall leave the meeting immediately and shall not return without the consent of the ~~meeting~~Board. If a person so suspended refuses to leave when required by the Chair to do so, the Chair will adjourn the meeting until such time as the person leaves.

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least five non-executive Board members. Two of the five should also not be employees of a Board. The quorum for committees will be set out in their terms of reference, however it can never be less than two Board members.

5.6 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close. The Chair shall provide a report to the next meeting of the Board in the event of quorum not being reached.

5.7 In determining whether or not quorum is present the Chair must consider the effect any declared interests.

5.8 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.

5.9 Paragraph 5.8 will not apply where a member's interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to effect any influence in the consideration or discussion of any question with respect to that contract or matter.

5.10 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by a decision of the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.11 Paragraphs 5.7-5.10 equally apply to members of any Board committees, whether or not they are also members of the Board, e.g. stakeholder representatives.

Adjournment

5.12 If it is necessary or expedient to do so for any reason, a meeting may be adjourned to another day, time and place. A meeting of the Board, or of a committee of the Board, may be adjourned by ~~a motion, which shall be moved and seconded and be put to the meeting without discussion~~the Chair until such .

~~If such a motion is carried, the meeting shall be adjourned to such~~ day, time and place as ~~may be specified in the motion~~the Chair may specify.

Business of the Meeting

The Agenda

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, he or she must make a request to the Chair ideally in advance of the day of the meeting and certainly before ~~at~~ the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting. ~~No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency. Any request for the consideration of an additional item of business must be raised at the start of the meeting and the majority of members present must agree to the item being included on the agenda.~~

5.14 For Board meetings only, the Chair may propose within the notice of the meeting "items for approval" and "items for discussion". The items for approval are not discussed at the meeting, but rather the members agree that the content and recommendations of the papers for such items are accepted, and that the minutes of the meeting should reflect this. The Board must approve the proposal as to which items should be in the "items for approval" section of the agenda. Any member (for any reason) may request that any item or items be removed from the "items for approval" section. If such a request is received, the Chair shall either move the item to the "items for discussion" section, or remove it from the agenda altogether.

5.15 The Chair may change the running order of items for discussion on the agenda at the meeting.

Decision-Making

5.1~~5~~ 6The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. All members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.

5.17 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.

Comment [AP1]: This is a lift from Scottish Government's guidance On Board (March 2017): http://www.gov.scot/Publications/2017/03/9182/27

5.18 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.

5.19 The Board may reach consensus on an item of business without taking a formal vote, and this will be normally what happens where consensus has been reached.

~~The Board may reach consensus on an item of business without taking a formal vote.~~

5.20 ~~-~~Where the Chair concludes that there is not a consensus on the Board's position on the item and/ or what it wishes to do, then he or she will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

Comment [AP2]: This is a new sentence which has been added to the version presented to the Board in June 2018.

Comment [AP3]: These introductory words have been edited to improve the flow of the paragraph, so as to accommodate the preceding amendment.

5.21 Where a vote is taken, every question at a meeting shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote. The Chair may determine the method for taking the vote, which may ~~A vote may~~ be ~~taken by members~~ by a show of hands, or by ballot, or any other method ~~determined by the Chair~~the Chair determines.

~~5.16 Any member may move a motion or an amendment to a motion (a "motion"), and it is expected that members will notify the Chair in advance of the meeting. The Chair may require the motion to be reduced to writing. The member who moved the motion may speak to it. However, another member must second the motion before there is any further debate on it.~~

~~5.17 Any member may second the motion and may reserve his/her speech for a later period of the debate.~~

~~5.18 Once a motion has been seconded it shall not be withdrawn without the leave of the Board.~~

~~5.19 After debate, the mover of any original motion shall have the right to reply. In replying he/she shall not introduce any new matter, but shall confine himself/herself strictly to answering previous observations, and, immediately after his/her reply, the question shall be put by the Chair without further debate.~~

~~5.20 When more than one amendment is proposed, the Chair of the meeting shall decide the order in which amendments are put to the vote. All amendments carried shall be incorporated in the original motion which shall be put to the meeting as a substantive motion.~~

~~5.21 A motion to adjourn any debate on any question or for the closure of a debate shall be moved and seconded and put to the meeting without discussion. Unless otherwise specified in the motion, an adjournment of any debate shall be to the next meeting.~~

Minutes

5.22 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded. The names of other persons in attendance shall also be recorded.

5.23 The ~~Corporate Services Manager~~Head of Corporate Governance (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall receive and review the minutes at the following meeting.

6 Matters Reserved for the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at a NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board.

Standing Orders

6.3 The Board shall approve its Standing Orders.

Committees

6.4 The Board shall approve the establishment of, and terms of reference of all of its committees.

6.5 The Board shall appoint all committee members.

Values

6.6 The Board shall approve organisational values.

Strategic Planning

6.7 The Board shall approve all strategies for all the functions that it has planning responsibility for. This is subject to any provisions for major service change which require Ministerial approval.

6.8 The Board shall review and approve the NHS Lothian contribution to Community Planning Partnerships through the associated ~~Single Outcome Agreements~~improvement plans.

6.9 The Board shall approve the ~~Local Delivery~~Annual Operational Plan for submission to the Scottish Government for its approval.

6.10 The Board shall approve its Corporate Objectives.

Risk Management

~~6.11 The Board shall define its risk appetite and associated risk tolerance levels.~~

6.~~12~~11 The Board shall approve its Risk Management Policy.

Health & Safety

6.~~13~~12 The Board shall approve its Health & Safety Policy.

Finance

6.~~14~~13 The Board shall approve its financial plan for the forthcoming year, and the opening revenue and capital budgets.

6.~~15~~14 The Board shall approve Standing Financial Instructions and a Scheme of Delegation.

6.~~16~~15 The Board shall approve its annual accounts and report.

Capital – Acquisitions and Disposals

6.~~17~~16 The Board shall comply with the Scottish Capital Investment Manual. The Board shall review and approve any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval.

Other Organisational Policy

6.~~18~~17 The Board shall approve the arrangements for the approval of all other policies.

Performance Management

6.~~19~~18 The Board shall approve the content, format, and frequency of performance reporting to the Board.

Criminal Prosecution/ Civil Litigation

6.~~20~~19 The Board will approve its system for responding to any civil actions raised against the Board. The Board will approve its system for responding to any occasion where the Board is being investigated and / or prosecuted for a criminal or regulatory offence. Within these systems the Board may delegate some decision making to one or more executive Board members.

Other Items of Business

6.~~21~~20 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g. the Integration Plans for a local authority area.

6.~~22~~21 The Board itself may resolve that other items of business be presented to it for approval.

7 Delegation of Authority by the Board

7.1 Except for the Matters Reserved to the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions and the Scheme of Delegation.

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair's action should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in ~~sections 24 and 39 of~~ the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself. The Board may withdraw any previous act of delegation to allow this.

8 Board Members – Ethical Conduct

8.1 Members have a personal responsibility to comply with the Lothian NHS Board Code of Conduct for Board Members. The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached

their Code of Conduct. The ~~Corporate Services Manager~~ Business Manager (Chair, Chief Executive and Deputy Chief Executive's Office) shall maintain the Lothian NHS Board Register of Interests. When a member needs to update or amend his or her entry in the Register, he or she must notify the ~~Corporate Services Manager~~ Business Manager (Chair, Chief Executive and Deputy Chief Executive's Office)of the need to change the entry within one month after the date the matter required to be registered.

8.2 The ~~Corporate Services Manager~~ Business Manager (Chair, Chief Executive and Deputy Chief Executive's Office)shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.

8.3 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.8 & 5.9 of these Standing Orders, and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

8.4 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.

8.5 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the ~~Corporate Services Manager~~ Business Manager (Chair, Chief Executive and Deputy Chief Executive's Office)who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website.

9 Common Seal and Execution of Documents

9.1 The ~~Corporate Services Manager~~Head of Corporate Governance is responsible for the safe custody of the common seal of the Board, and for maintaining a register of the use of the seal.

9.2 Any document or proceeding requiring authentication by the Board by affixation of its Common Seal shall be subscribed by three Board members. Normally the Chair and the Director of Finance will be subscribers.

9.3 Where a document requires for the purpose of any enactment or rule of law relating to the authentication of documents under the Law of Scotland, or otherwise requires to be authenticated on behalf of the Board it shall be signed by an Executive Member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the provisions of the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by

the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

9.4 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.

9.5 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

10 Committees

10.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. The Board shall appoint the chairs of these committees. The Board shall approve the terms of reference and membership of the committees and shall review these as and when required.

10.2 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed

10.3 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a Committee member who is also a non-executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

10.4 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings. The general exception is that committee meetings shall not be held in public and committee papers shall not be placed on the Board's website.

10.5 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time, and shall call a meeting when requested to do so by the Board.

10.6 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of Lothian NHS Board and is not to be counted when determining the committee's quorum.

~~List of Appendices~~

~~Appendix 1 - Committees and Sub-Committees~~
~~Appendix 2 - Terms of Reference for Committees and Sub-Committees~~
~~Appendix 3 - Standing Financial Instructions~~
~~Appendix 4 - Scheme of Delegation~~
~~Appendix 5 - SEAT Framework of Governance~~
~~Appendix 6 - Code of Conduct for Board Members~~
~~Appendix 7 - Freedom of Information Code of Practice~~

NHS LOTHIAN

Board
3 October 2018

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 as the Vice-Chair of the Pharmacy Practices Committee with immediate effect, replacing Councillor Derek Milligan.

2.2 Re-nominate Martin Hill to continue as a voting member of the West Lothian Integration Joint Board (and the lead voting member for Lothian NHS Board), to take effect once his current term ends (2 December 2018).

2.3 Endorse the re-appointment of Dr Elaine Duncan as the ''*registered medical practitioner whose name is on a list of primary medical services performers*' non-voting member of the West Lothian Integration Joint Board with effect from when her previous term ended (21 September 2018).

2.4 Appoint Dr Rohana Wright as the '*registered medical practitioner who is not providing primary medical services*' non-voting member of the West Lothian Integration Joint Board with immediate effect.

3 Discussion of Key Issues

Pharmacy Practices Committee

3.1 The Board is required to have this committee by the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 (as amended). The Regulations require the chair to be someone who is a Board member and not be, nor previously have been (nor an employee of) a doctor, dentist, ophthalmic optician or pharmacist. The Regulations also allow a deputy for any committee position to be appointed.

3.2 In the interests of ensuring continuity of the Committee's business, it is recommended that the Board appoint Bill McQueen as the vice-chair of the Pharmacy Practices Committee. Mr McQueen will replace Councillor Milligan as the vice-chair.

Integration Joint Boards

3.3 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 (as amended) determines the membership of integration joint boards. The NHS Board has to nominate its voting members, and it also has to appoint a person to the following non-voting positions:

'(f) a registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;

(g) a registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract; and

(h) a registered medical practitioner employed by the Health Board and not providing primary medical services.'

3.4 The Order provides that the term of office for members of integration joint boards is not to exceed 3 years (this does not apply to the Chief Officer, Chief Finance Officer, and the Chief Social Work Officer). At the end of a term of office, the member may be re-appointed for a further term of office. The integration joint boards in Lothian started to meet in the summer of 2015, and consequently there is a need to review the appointments of those who were members at that time and still are.

3.5 The Board made several appointments on 1 August to attend to this subject. This report makes further recommendations for positions which need to be filled.

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
2 October 2018
alan.payne@luht.scot.nhs.uk

NHS LOTHIAN

1.6

Board meeting

3rd October 2018

Executive Nurse Director

ROYAL EDINBURGH HOSPITAL

1 Purpose of the Report

1.1 The purpose of this report is to inform the Board of NHS Lothian ("The Board") of the operational and strategic actions being taken to sustain services at the Royal Edinburgh Hospital ("REH").

2 Recommendations

1.2 The Board is recommended to;

- Note the operational steps being taken to sustain REH services (paragraphs 3.4-3.12);
- Take **moderate** assurance that appropriate actions are being deployed in this context;
- Note the steps being taken to deliver phase 2 of the REH Campus Masterplan, including the requirement that the 4 Integration Joint Boards (IJBs) provide commissioning guidance to support (paragraphs 3.13-3.19);
- Take **significant** assurance that appropriate actions are being deployed in this context

3 Discussion of Key Issues

Background

3.1 REH is described in the Board's *Lothian Hospitals Plan* as;

"Edinburgh's inpatient centre for highly specialist mental health and learning disability services, incorporating regional and national services"

3.2 The strategic planning and commissioning of the majority of services provided at REH are delegated to NHSL's 4 partner IJBs. The management of the acute services provided from REH is on a "hosted" basis, with the Royal Edinburgh and Associated Services ("REAS") management team reporting through the Executive Nurse Director, who is NHSL's *de facto* "Chief Officer". The Executive Nurse Director also chairs the Royal Edinburgh Masterplanning Group and is the senior responsible officer for the development of the site.

3.3 The effective functioning of REH is dependent not only on the effective operation of the services themselves, but the effective deployment of actions in community services, managed by the four Health and Social Care Partnerships ("HSCPs").

Operational issues – mental health services

3.4 Over the last two years, the effective operation of REH services has come under increasing strain, in much the same way as the acute physical services operating from the Royal Infirmary of Edinburgh, the Western General Hospital, and St John's

Hospital, have. Increasing demand combined with constraints on other parts of the health and social care system has led to a higher than acceptable level of delayed discharges in the system, with concomitant impacts on the quality of care provided to patients, both in terms of the negative impact of staying longer than clinically necessary, and in terms of access to beds. There has been a particularly challenging position within the boundaries of the City of Edinburgh.

3.5 Board members will recall the significant challenges in delivering flow through the system to support the occupation of the reduced bed base in phase 1 of the new Royal Edinburgh Building, which opened over summer 2017. Additional care home placements and community services were appropriately commissioned but were delayed in their coming on-stream, and there has been continuing pressure to appropriately maintain this level of capacity.

3.6 Over summer 2018, the issues with flow within Edinburgh became particularly acute, with bed occupancy frequently exceeding 100%, with additional beds in suboptimal settings opened to support patients, and with some patients who required repatriation to REH being delayed in other places. This picture reflected, to an extent, a national pressure on acute (beds for patients under the age of 65) mental health beds in particular.

3.7 Consultant psychiatrists identified, in particular, a pressure in discharging from the rehabilitation service, for patients who have a longer stay and who need to reduce their dependency on services gradually. This, in turn, prevents appropriate flow out of the acute service and into rehabilitation.

3.8 As at 10th September 2018, the breakdown of delayed discharges within the REH for Edinburgh patients was as shown in table 1, below;

Service area	**Type of delay**	**Number of patients delayed**
Adult acute	Requiring care home bed for dementia, age under 65	3
Rehabilitation	Package of care +/- rehousing	6
	Adults with incapacity	2
Older People	Requiring care home bed for dementia	6
	Adults with incapacity	3
	Assessment	2
All areas	**TOTAL**	**22**

3.9 The Edinburgh IJB has a current level of 214 community places to support people with severe and enduring mental health needs that mean they need supported living and housing arrangements. This is being added to with opening of a further 16 beds in St Stephen's Court, funded by the Edinburgh IJB, and which will, by the end of November 2018, provide a further 16 places to support the rehabilitation flow. As at 17th September 2018, 12 of these places had been allocated.

3.10 To support this transition, Edinburgh IJB has also agreed to fund an additional 9 beds within REH, in a reopened ward.

3.11 Considerable work is also ongoing within REH and within Edinburgh to support flow;

- Quality Improvement Work within REH to optimise length of stay and quality of care;
- Additional time for consultant leadership in this area;
- The appointment of a Senior Charge Nurse to focus on this area across REH;
- The establishment of a daily Multi-Agency Triage Team (MATT) between REH staff and Edinburgh HSCP staff, to troubleshoot and ensure effective flow;
- The establishment of the Edinburgh Delayed Discharge Oversight Group, chaired by the Joint Director for the Edinburgh HSCP, which is providing oversight for the Edinburgh Delayed Discharge Action Plan and Trajectory;
- Investment by NHSL in supporting community capacity within Edinburgh, expected to realise between 170 and 180 additional packages of care across all settings;

3.12 These actions are in progress at the moment, and it is too early to tell whether these are as effective as they need to be. The financial implications of opening additional beds are well understood. What is clear from this process is, however, is that REH and community services have been slowly strengthening relationships and that this is positive for the future.

Operational issues – learning disabilities

3.13 REH also houses NHSL's inpatient beds for patients with complex learning disabilities who are in the assessment and treatment phase of their care. Board members will be aware of the transformation of care for people with learning disabilities over the last 30 years, and in this context the direction of travel is well understood and described.

3.14 People leaving inpatient care in this context tend to move to new homes with very large packages of care, the planning for which take considerable time. More than 85% of care for people with learning disabilities is undertaken, in the community, by third sector providers. In the vast majority of cases these services function very well and provide a very good quality of care and of life for the people accessing these services.

3.15 The flipside to this is that a breakdown in package provision can be very difficult to manage, and across the whole of Lothian over the last 12 months the service within REH has reported an increasing fragility of some community services, with unplanned admissions being reported. This places increasing pressure on inpatient services, as patients have very long lengths of stay.

3.16 The 4 partnerships all have plans developed to progress the discharging of patients who no longer require inpatient care. Edinburgh, for example, currently has 10 patients delayed in their discharge, and has plans to reduce this number modestly before Christmas, before reducing to zero during 2019. This very long timescale is due to the need for providers to build new facilities to accommodate patients and provide them with new, purpose-built, homes.

Development of phase 2 of the Royal Edinburgh Hospital Masterplan

3.17 NHSL's extant Strategic Plan, *Our Health, Our Care, Our Future* emphasised the need to redevelop the Royal Edinburgh Hospital and to provide healthcare facilities more appropriate for the requirements of 21st century healthcare.

3.18 Phase 1 of the Royal Edinburgh Building opened in summer 2017 and provided new accommodation for the Robert Fergusson Unit, acute adult mental health, and older people's mental health.

3.19 Phase 2 covers adult rehabilitation, low secure, and learning disability services as well as infrastructure and facilities management facilities on the site. As noted in paragraph 3.2, the strategic planning and commissioning of these services is delegated to IJBs.

3.20 The 4 IJBs working with NHSL are therefore required to design future-state services which balance acute bed-based requirements with community services. NHSL has been in intensive discussions with all 4 of these IJBs on this topic, with a timescale for IJBs to confirm their final commissioning "bed number" for the turn of the year, in order to ensure that the timescale for business case can be met.

3.21 Technical workstreams are already underway, and an Initial Agreement covering all phases of the REH Masterplan has been developed. As the future development of the campus will be procured through the hub framework Hub SE has been appointed to support NHSL's Project Team to update the Development Control Plan.

3.22 The work on agreeing the bed model for phase 2 has been progressing over the last 12 months. This led to agreement by the 4 IJBs of their own bed numbers, and notification to NHSL's Finance and Resources Committee in May 2018 of their assent to move to the next stage of development, with a requirement from the 4 IJBs that a discrepancy between the number of beds proposed by NHSL and that proposed by the 4 IJBs be resolved before moving on to the next stage. This work is ongoing and the discrepancy is being resolved through a series of workshops across the system and within the 4 IJB areas. This is a complex and complicated process, as resources released by a reconfiguration of the bed model will support additional community services, which in turn need to be deliverable and robust in order to sustain this bed model on an ongoing basis.

3.23 One topic which has been apparent during the process to develop the bed model is that there is, currently, no overarching bringing together of the plans each of the 4 IJBs and NHS Lothian has for mental health and learning disability services. IJBs hold the statutory responsibility for planning and commissioning of these services, so Board members who also hold IJB memberships may wish to consider this point and agree a way forward.

3.24 The proposed timescales for phase 2 going forward, assuming overlapping IJB, NHSL and Government workflows, are:

- September 2018: Appoint Hub SE to support planning through Strategic Services
- December 2018: issue New Project Request to appoint Hub SE for Phase 2
- April 2019: Outline Business Case completion
- December 2019: Full Business Case completion
- February 2020: Financial Close
- March 2020: Construction Commencement
- March 2022: Construction Completion

4.1 **Key risks**

4.2 There is a risk that insufficient flow through the system leads to suboptimal patient care, and this applies to both current and future states.

4.3 There is a risk that poor planning leads to delays in agreeing the business case, or inefficient models of care, leading to financial inefficiencies.

5. Risk Register

5.1 There are no specific implications for the risk register, although the issues described herein also impact on other risks within the Board's risk register.

6. Impact on Inequality, Including Health Inequalities

6.1 Integrated Impact Assessments will be carried out at each stage of planning and commissioning services.

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

7.1 Appropriate arrangements are in place to consult service users on both the IJB and NHS Board sides throughout the process. In particular, the REH Patient Council are key stakeholders in all activities.

7. Resource implications

7.1 The capital implications of the new REH are to be confirmed but are built into the NHSL capital plan.

7.2 The revenue implications of the work described above falls into the set-aside budget held by IJBs. As an example, the Edinburgh IJB has invested £918,000 on a recurring basis in the St Stephen's Court service described at paragraph 3.9.

7.3 There are significant pressures on nursing budgets at REH associated with additional beds being open and increased dependency of, in particular, learning disability patients.

Colin Briggs
Director of Strategic Planning
17th September 2018

DRAFT

1.7

NHS LOTHIAN

STAFF GOVERNANCE COMMITTEE

Minutes of a Meeting of the Staff Governance Committee held at 9:30am on Wednesday 24 July 2018 in Meeting Room 8&9, Fifth Floor, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mrs A. Mitchell (Chair); Mr B. Houston; Mr A. Joyce; Mrs. J Butler; Professor A. McMahon; Ms H. Fitzgerald; Mr S. McLaughlin and Miss T. Gillies (from 9.50am).

In Attendance: Mrs R. Kelly, Deputy Director of HR, NHS Lothian; Mr G. Curley, Director of Operations – Facilities (Item 25.1.1); Dr A. Leckie, Director, Lothian Occupational Health & Safety Services (Item 26.3); Mr C. Stirling, Site Director WGH; Ms J. Gaskell, Head of Employee Relations - CH(C)Ps (Item 25.5); Ms S. Sloan, Lead Practitioner Clinical Leadership (Item 28.1); Mr D. Richardson, Lead Health & Safety Adviser (Item 25.4); Professor A. McCallum, Director of Public Health and Health Policy (from 10.45am) and Mr C. Graham, Secretariat Manager.

Apologies for Absence were received from Professor T. Humphrey; Cllr D. Milligan; Cllr J. McGinty; Mr J. Crombie; Ms J. Campbell and Ms J. Mackay.

Declaration of Financial and Non-Financial Interest

The Chair 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.

22. Values Cards – Short Exercise

22.1 Mrs Butler introduced the exercise using the values cards which is being undertaken before each meeting.

23. Minutes of the Previous Meeting

23.1 The Minutes and Action Note of the Staff Governance Committee Meeting held on 30 May 2018 were approved as a correct record.

24. Matters Arising

24.1 The Committee noted that most items on the action note were either complete or covered elsewhere on the agenda. In relation to Modern Apprentices and Early Careers it was agreed to keep this on the action note and for Amanda Langsley to confirm what a realistic timeframe for the action would be.

AL

25. Assurance and Scrutiny

25.1 Corporate Risk Register

25.1.1 3328 Roadways/Traffic Management – Mr Curley introduced the report updating the Committee on progress with managing the risks associated with roadways and traffic management. Mr Curley reported that this was one of a number of papers that had now been brought to the Staff Governance Committee. As outlined at previous meetings there was a difference in the overall management of traffic between the RIE site and the rest of NHS Lothian. Therefore moving forward it was proposed to bring two separate papers – one for the RIE site and one for the rest of NHS Lothian

25.1.1.1 The Chair thanked Mr Curley for the paper which has now been seen by the Committee many times in its current form. Moving forward it would be good to see a more proactive approach to new ways of undertaking traffic management and providing assurance.

25.1.1.2 Miss Gillies added that from the health and safety committee's point of view there was support for separating into two papers to make sure the correct levels of assurance are reported and to allow focus on future work at the RIE site.

25.1.1.3 The Committee accepted the proposed moderate assurance and agreed to endorse progress to date and supported the direction of travel on future recommendations to improve capability and deal with significant risk.

25.1.1.4 The Committee also supported actions being taken at the RIE campus site to influence the external contractor to introduce improvements and endorsed the Facilities Directorate assessment that roadways and traffic management remains a high risk throughout the estate, in particular for the major hospital sites. It was acknowledged that as the availability of capital funding reduces the ability to implement engineered designed solutions could diminish, therefore the risk rating may be unlikely to change in the immediate future.

25.1.1.5 Finally the Committee noted that a paper outlining concerns around prioritisation of funding for this risk had gone to the finance and resources committee in January 2018, where it had been agreed for this to remain a priority.

Mr Curley left the meeting.

25.1.2 3455 - Management of Violence and Aggression - Professor McMahon updated the committee on recommendations and actions being implemented to support and improve the current level of support to staff on Violence and Aggression (V&A) management. Professor McMahon highlighted a number of key issues around staff V&A encounters; DATIX reporting of incidents; staff training and training DNA rates.

25.1.2.1 Professor McMahon also reported on updates to the action plan following submission to a previous Staff Governance Committee meeting. The Committee noted the developments around quality improvement; purple packs review; Identicom system for community based staff and review of staff training policy for restraining patients when aggressive which had been raised with Healthcare Governance Committee.

25.1.2.2 The Chair asked about improvement work at the Islay and Harris units within the Royal Edinburgh Hospital. Professor McMahon explained that there had been significant redesign of the units including introduction of single rooms and courtyard areas and communal areas. Professor McMahon added that staff perception and knowledge of patients within these units was invaluable when it came to recognising V&A triggers and knowing when to intervene and diffuse situations.

25.1.2.3 The Committee noted the figures provided, showing investment in the units. Mr McLaughlin pointed out that the figures provided were from 2013/14 and that these had now probably changed as there was the same investment in both units now with staff arrangements now targeted around patients needs. The Chair requested that comparison figures be brought back to a future meeting.

AMcM

25.1.2.4 A paper on the review of V&A training and Restraint Training will be on the agenda for the next meeting. This paper would also be going through Healthcare Governance Committee.

25.1.2.5 The Committee accepted the moderate assurance level regarding the implementation of the actions and a significant level of assurance in relation to the process, however the issue with training DNAs was noted. The Committee also noted steps being taken to review the organisations approach to the management of V&A and strengthening of organisational assurance.

25.1.3 3527 – Medical Workforce Sustainability – Miss Gillies reminded the Committee that at the previous meeting there had been discussion on the importance of long term strategies around taking forward recruitment and retention and the move towards a regional employer model for Doctors and Dentists in training.

25.1.3.1 Miss Gillies reported that in relation to new foundation year 1 doctors, 40% were from the University of Edinburgh and 60% from other UK medical schools, this was a healthy balance, bringing in people with experience of different healthcare settings. The Committee noted that from August 2018 all doctors being employed with NHS Lothian will have training placements within the Lothians, Fife and Borders, as part of the NHS Education Scotland training scheme and speciality programmes. There would be a reduction from 14 employers to 5 as part of the implementation of the regional employer model.

25.1.3.2 Miss Gillies pointed out that there was a perception that foundation doctors did not see organisation processes as important to them, however they were still employees and it was important to provide a safe and appropriate working environment. Having to change employer every year had not been helpful and this new approach should make working in Scotland a much more positive experience. It would also hopefully increase desire amongst the doctors to come back and work for NHS Lothian in future substantive posts.

25.1.3.3 Mrs Kelly added that doctors in training had previously missed out on benefits other staff received through having just one employer for example – cycle to work and childcare benefits. Now with this new consistent and more efficient approach they would have access to such benefits and consideration was also being given to rolling out iMatter to this staff group, however this would be part of national discussions.

25.1.3.4 There was discussion on the new Chief Registrar roles for each acute site. The Chief Registrar would be part of the integrated site management team on each site and would be part of leading projects across sites. Miss Gillies stated that these posts would be important to each site with slight differences from the junior doctors' perspective around actions to involve them. This approach was being modelled on the College of Physicians of London programme. It was agreed that an update would come back to the Staff Governance Committee in 6 months time and Miss Gillies would pick up important priorities with each of the site directors out with the meeting.

TG

25.1.4 3828 – Nurse Workforce – Safe Staffing Levels – Professor McMahon gave an update on the legislation being laid before parliament. Evidence to the Health and Sport Committee and the Finance Committee was due by September 2018 and the Board's response to the parliament finance committee would focus on the costs of implementing the safe staffing legislation. The Board was also working with others across Scotland to ensure consistency of responses whilst highlighting local challenges. The legislation principles were expected in summer 2019 with the full legislation being published in 2020.

25.1.4.1 Professor McMahon also reported on the continued site specific recruitment and the re-running of staffing workforce tools to clarify requirements ahead of the legislation coming into full effect. There are also a series of workshops currently running entitled 'Meeting the Challenge' to engage nurse managers in a number of issues such as effective rostering, management of annual leave and sickness and budgeting.

25.1.4.2 It was noted that the safe staffing legislation would have an effect across every area and could have significant financial impact for any Board to work through. It was important that appropriate mitigating actions were identified as part of planning arrangements.

25.1.4.3 Professor McMahon stated that there would be a plan for managing the implementation of safe staffing going forward and this would be taken to the Corporate Management Team and the to the Board. The Committee noted that the Executive Nurse Director would be the accountable officer for this work and would be working with the other Scottish Nurse Directors on building a robust system.

25.1.4.4 The Chair stated that there was a lot of complex work to go through ahead of the implementation of the legislation in 18 months time. The Lothian vacancy rate of 5-6% was noted as good against the rest of Scotland but it was important not to become complacent. There were also other elements to be mindful of such as the potential impacts from special class status and Brexit. It was recognised that there would be a large communication piece to discuss with staff on what this means for them and the process for support locally.

25.1.4.5 The Chair requested that for the next update to the Committee there should be a paper setting out the process and when it was planned to have this finished and the plan for taking this through operational management and board governance processes. The paper should also address concerns around competition for staff in relation to the care home setting.

AMcM

25.2 Staff Governance Workplan 2018/19 – The Committee approved the updated 2018/19 workplan. It was noted that the workplan continued to be based around the 5 priorities for action contained within the Everyone Matters: 2020 Workforce Vision. The workplan kept a track of issues which the Committee were covering at each of their meetings. Mrs Butler pointed out that Occupational Health would now be added into the workplan following today's meeting.

JB/RK

25.3 Staff Governance Statement of Assurance Need – The Committee confirmed the statement of assurance need. It was noted that the statement would be updated after each meeting and these additions would formulate part of the annual report at the end of the year. The Chair requested that a column be added into the statement to detail when items will be considered by the Comittee so this could be married up to the Committee's Workplan. Mrs Kelly would take this forward.

RK

25.4 Health and Safety Assurance Update – Miss Gillies and Mr Richardson provided the health and safety assurance update to the Committee. The update gave detail on the risk assurance levels for the Q4 health and safety prioritised risk topics, covering Slips, Trips and Falls, Stress Management and local Adverse Event Management (including RIDDORs) which had been submitted to the NHS Lothian Health and Safety Committee from all local area health and safety groups. The report also provided an update on current "Clinical Sharps" within NHS Lothian, setting out how this topic is being managed.

25.4.1 The Committee noted that this new approach to assurance had been well received by the Health and Safety Committee and hoped that it addressed concerns previously raised by the Staff Governance Committee.

25.4.2 The Chair stated that there had been a large amount of work undertaken and the report now provided a substantial, more meaningful improvement in provision of assurance and evidence base. Mr Richardson added that this approach would make a huge difference to the reporting structure and was an evolving process as part of building an action plan and framework to provide and address assurance levels.

25.4.3 The Committee noted the appended 29 May 2018 draft NHS Lothian Health and Safety Committee minutes. In particular page 3, Section 2.6 relating to overall assurance levels for Q4 2017-18 which collated current assurance returns for the particular risk topics discussed at the Health and Safety Committee. It was noted that the no proposed overall assurance levels for the three risks had been agreed due to the lack of sufficient evidenced returns from the thirteen local health and safety groups.

25.4.4 The Committee acknowledged that the NHS Lothian Health and Safety committee had now given clear instruction to the local health and safety groups that future evidenced assurance levels must be agreed by involving the whole committee membership, particularly staff side and health and safety advisor colleagues so that appropriate documented evidence can be provided and reviewed as part of the decision making process. This approach will commence for Q1 topics which will be reportable to the NHS Lothian Health and Safety Committee meeting on 28th August 2018.

Mr Richardson left the meeting at 11.15am

25.5 Sickness Absence Update – Ms Gaskell introduced the report updating the Committee on actions being taken in 2018/19 to address sickness absence levels in NHS Lothian. It was noted that the annual pattern for sickness absence had remained the same over the previous three years.

25.5.1 Ms Gaskell reported that there had been some fluctuation in short term sickness absence however longer term levels remained stable. There had been focus on the reasons for absence and these remained unchanged, continuing to be cough / cold / flu and GI problems for short term absence and anxiety / stress/ depression and MSK problems for long term.

25.5.2 In terms of job families and absences, of the 4 large job families the biggest absences are in Nursing and Midwifery Bands 5+, with approx 7000 wte however this performance had improved over the last 12 months. A&C had maintained its performance and N&M Bands 1-4 and Support Services had a marginally increased sickness absence. Ms Gaskell also reported on the workforce age profile. It was noted that this was weighted towards the over 50 age range, where there had been a higher absence rate than those under 50.

25.5.3 In the NHS Scotland context, the Committee noted that NHS Lothian maintained its position as the third best performing large Board in Scotland and was below the NHS Scotland average every month of 17/18. It was however noted that none of the 5 large Boards had met the NHS Scotland target of 4%. There was further work needed around health and wellbeing with a focus on culture and staff experience.

25.5.4 Ms Gaskell also reported on information sharing and the development of dashboards which managers are continuing to find useful. There continued to be Courage to Manage and Absence Management training run throughout the year for new managers and those requiring refresher training.

25.5.5 The Chair stated that it was good to see threads coming together in what was a very full paper, it was also good to see improvement within the unknown cause category with this category now being used less frequently. The Chair asked what other boards may be doing differently to Lothian. It was noted that some boards still rely on linking absence to conduct policies which Lothian did not as this was out with the PIN standard.

25.5.6 Mr Joyce made the point that nationally it would be a challenge to meet the 4% absence target as NHS staff are advised not to come into work when sick particularly where this could be a risk to colleagues or patients.

25.5.7 The Committee accepted significant assurance that systems and processes are in place to assist managers in addressing absence management and limited assurance that the extant 4% NHS Scotland standard will be achieved.

25.5.8 The Committee also noted the work undertaken by the Human Resources and Occupational Health Services to support managers with absence management. For the next 6 month update the Committee requested that some examples of new initiatives along with outcomes be outlined.

JB

Ms Gaskell left the meeting

26. Healthy Organisational Culture

26.1 iMatter – Mrs Kelly reported on the Key Performance Indicators (KPIs), in relation to iMatter for 2018. The overall NHS Lothian KPI for 2018 was noted at 63% across the Board, with 65% receiving team reports. The Employee Engagement Index (EEI) Score was 78. It was noted that cohorts 2,3,4 were still to conclude

26.1.1 The Committee noted the current position with Corporate Services and REAS having now completed a full cycle into action plans. The 2017 and 2018 position showed an increase in conversion of team reports to action plans and a decline in conversion rates in REAS.

26.1.2 Mrs Kelly also reported on work being done around conversions including meeting with management teams about what needs to be done. It was noted that St John's Hospital had not received a report on this occasion but this was not unexpected given the leadership changes.

26.1.3 The Chair requested that for the next update there be a summary of actions taken to encourage conversion of team reports into action plans and more about initiatives being carried out.

26.1.4 The Committee accepted significant assurance that staff in Cohort 1 had engaged in the iMatter process and the majority of teams in most areas had now completed action plans. Mrs Butler advised that she was following up with those areas in cohort 1 that had a low conversion rate. Significant assurance was also taken that staff in Cohorts 2 and 3 had completed their questionnaire, generating a Team Report in the majority of the areas;

26.1.5 The limited assurance around the conversion of team reports into action plans for Cohorts 2 and 3 was also accepted.

26.2 Whistleblowing Monitoring Report

Mr Houston took over as Chair for this item.

26.2.1 Mrs Kelly updated the Committee on recent actions that had been taken in relation to whistleblowing and shared the monitoring data for the whistleblowing cases that had been raised within NHS Lothian for the period October 2016 to 17 July 2018.

26.2.2 Mrs Kelly confirmed the number of case, 23 since recording started. Currently for this year there were 8 lives cases, 4 carried over from last year. There was discussion on the half day training sessions planned; the proposed Speak Up campaign, differences between whistleblowing, grievance and staff complaints and the possible new standards around the timeframe for investigating a proposed whistleblowing claim similar to the timeframe already in place for dealing with patient complaints. More detail around the Speak up campaign would be brought to the October meeting.

JB/RK

26.2.3 The Committee accepted moderate assurance based on the information contained in the paper that systems and processes are in place to help to create a climate in NHS Lothian which ensures employees have absolute confidence in the fairness and objectivity of the procedures through which their concerns are raised and are assured that concerns raised will be acted upon.

Mrs Mitchell thanked Mr Houston and took back the Chair.

26.3 Occupational Health Annual Report 2017/18 – This Item was taken first on the agenda. The Committee received the 2017/18 Annual Report for the NHS Lothian Occupational Health department. It was agreed to accept the departmental objectives and assurances in the report for the services delivered which were occupational health physiotherapy, manual handling service, occupational health and staff counselling. The Committee supported the retention of the same departmental objectives for year 2018/19 and also supported the intention to deliver services aimed at the prevention of mental ill health and protection of staff from mental ill health.

26.3.1 Dr Leckie then gave a presentation highlighting aspects of the annual report and looking at services provided and assurance levels; any gaps in services and future plans for services. The presentation covered seeking feedback on the direction for the department; departmental objectives; prevention of harm to, and protection and improvement of the health of the NHS Lothian workforce; improving the quality and safety of LOHSS healthcare; securing value and financial sustainability for LOHSS and delivering actions to enable change.

Miss Gillies joined the meeting at 9.50am

26.3.2 The Chair thanked Dr Leckie for a very comprehensive paper and helpful presentation picking out key areas. There was discussion on work around needle stick injuries and safer sharps. Dr Leckie outlined areas to focus on including prevention, organisational factors, influencing views on work, more control, change shifts, changing perceptions of work and changing culture.

26.3.3 The Chair stated that it was important that Dr Leckie was asking for guidance on where to focus attention. Mrs Butler added that the HR/OD team were working closely with Dr Leckie around staff engagement and a delivery plan.

Dr Leckie left the meeting.

26.4 Equality and Diversity Monitoring Report - Mrs Kelly presented the Equality and Diversity Monitoring Report for 2017-18 to the Committee. The Committee noted that it was planned to look next year to extend reporting. It was agreed that a progress report should come back to the Committee in 6 months for other protected characteristics to help provide trends and information in relation to areas such as gender, race, disability and age. Mrs Kelly stated that an exercise would be launched shortly to improve reporting on the protected characteristics of staff. It was noted that picking up on nationality would help with work around Brexit. Work with LGBT, BME and disabled staff was also underway, with the first disability network workshop having been held. There will also be a submission made to the Stonewall Equality Workforce index outlining work done so far with LGBT staff.

26.4.1 The Committee noted the content of the Equality and Diversity Monitoring Report for 2017-18 and accepted moderate assurance that systems and processes were in place to ensure that this information about staff was captured. The Committee also took limited assurance that information was currently being used in a meaningful way to improve the experience for all staff regardless of ethnic background, gender, disability and age but recognised that work had already commenced in this area to consider and address some of the potential issues.

27. Sustainable Workforce

27.1 Workforce Report – The Committee noted the updated Workforce Report for July 2018 and the actions being taken to address some of the issues raised in the Report.

28. Effective Leadership and Management

28.1 Leadership and Management Development Framework - Mrs Sloan reported on the impact of the Leadership and Management Development Framework (LMDF) to date, since introduction in August 2017.

28.1.1 There was discussion on the current, second version of the LMDF which is in use. There had been some changes made to the second version however focus remained on the dissemination of the Framework. Work with the communications team and involvement with Project Lift remained ongoing.

28.1.2 There was also discussion on structured evaluation and extra cost involved. Mrs Sloan pointed out that practitioners deliver a lot of evidence and evaluation every time programmes are delivered. Some larger programmes have a more developed, robust evaluation. The challenge with the LMDF remained evidencing the 'so what' aspect. Work was underway to make corporate and clinical programme evaluation more meaningful.

Mr Stirling left the meeting at 12.10pm

28.1.3 Mrs Butler added that there is a resourcing issue associated with programme activation but that the intention was to create a business support post, which would help with this.

28.1.4 The Committee supported the on-going evaluation of the LMDF to inform the development of the evolving framework for all staff at all levels of the workforce.

28.1.5 The Committee accepted that at this stage it would be resource intensive to undertake detailed quantitative evaluation and therefore the approach to evaluation would be primarily qualitative. The positive feedback to date on the framework and actions being taking to improve reach were also accepted.

28.2 Project Lift - Mrs Butler updated the Committee on Project Lift, which is NHS Scotland's approach to leadership development and talent management and the implications this may have for the Board.

28.2.1 Mrs Butler gave some background on Project Lift what was a collaboration between the Scottish Government, NHS Education for Scotland, the Golden Jubilee Hospital and National Services Scotland. This followed on from the publication of the May 2017 overview paper – "Executive Level Leadership and Talent Management in NHS Scotland". The overall intention would be to ensure:

- a 'Once for Scotland' approach to Leadership and Talent Management in NHSScotland;
- that NHS leaders live by, and demonstrate, our shared values with and for patients, service users and staff;
- that chief executive and executive director posts have four appointable candidates coming through the new approach; and
- that NHSScotland is regarded as an exemplar employer – attracting, developing and retaining its leadership cohort.

28.2.2 The Committee noted the new approach to the values based recruitment for Executive Level Leaders in NHS Scotland and the emerging work of Project Lift to ensure that the Board is developing the current leaders and those for the future. Mrs Butler would bring a further update to the Committee in 6 months time.

JB

Miss Gillies left the meeting at 12:20pm

29. For Information and Noting

29.1 The Committee noted the following items:

- Lothian Partnership Forum Minutes 26 June 2018
- Staff Engagement and Experience Project Board Minutes 30 April 2018

30. Any Other Business

30.1 There was no other business

31. Date of Next Meeting

31.1 It was noted that the next meeting of the committee would be held on Tuesday 24 October 2018 at 9.30am in meeting rooms 8&9, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

32. 2019 Meeting Dates

30 January 2019	27 March 2019	29 May 2019
31 July 2019	30 October 2019	

NHS LOTHIAN

AUDIT AND RISK COMMITTEE

Minutes of the Audit and Risk Committee Meeting held at 9.00 am on Monday, 27 August 2018 in Meeting Room 8 & 9, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present:
Mr M Ash (Chair), Non-Executive Board Member; Mr B McQueen, Non-Executive Board Member; Mr P. Murray, Non-Executive Board Member; Mr M Connor Non-Executive Board Member.

In Attendance:
Ms J Brown, Chief Internal Auditor; Mr C Brown, Scott Moncrieff; Ms J Bennett (Associate Director for Quality Improvement & Safety); Dr B Cook (Medical Director – Acute Services); Mr J Crombie, Interim Chief Executive; Ms M Cuthbert (Associate Director of Pharmacy Acute & SCAN); Ms S. Goldsmith, Director of Finance; Mr B. Houston, Board Chairman; Ms A Langsley (Training Manager); Ms B Livingston, Finance Manager – Corporate Reporting; Professor A McMahon, Executive Director Nursing, Midwifery & AHPs; Mr A Payne, Head of Corporate Governance; Ms M Pringle (Chief Finance Officer, Edinburgh IJB); Professor A Timoney (Director of Pharmacy); Dr S. Watson, Chief Quality Officer and Miss L Baird, Committee Administrator.

Apologies:
Councillor J McGinty.

The Chair 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. The Chair declared an interest in the Edinburgh IJB paper as a member of the Edinburgh Integration Joint Board (IJB) and the IJB Audit Committee.

23. Minutes of the previous meeting held on 18 June 2018.

23.1 The minutes of the meeting held on 18 June 2018 were accepted as an accurate record.

24. Running Action Note

24.1 Acute Hospitals Committee – The Committee noted that the action was complete.

24.2 Risk Management – Members agreed to pick up actions against the risk register under item 3.1 of the agenda.

24.3 Internal Audit Progress Report (February 2018) – the Chief Internal Auditors Group would meet early October to discuss the audit approach to homecare; a more detailed update was anticipated following the meeting.

24.4 Follow-Up of Management Actions (June 2018) – Members noted that Professor McCallum would bring forward a report to respond to a supplementary question on lessons learned from business continuity and resilience systems to the Committee on 26 November.

24.5 2017/18 Annual Report from the Finance and Resources Committee – Ms Goldsmith assured the Committee that links were being made against financial strategy and the priorities of the Board. This would be seen in the proposed Q1 Review scheduled for discussion at the September Finance and Resources Committee. The Q1 Review would ensure clear choices between financial strategy and performance.

24.6 The Committee accepted the running action note.

24.7 Update on the Actions from Internal Audit: Consultant Job Planning – Dr Cook spoke to the report. He highlighted the considerable effort than been put into the completion of job plans; 759 (85%) job plans were complete and progress since the production of the paper saw that figure rise to over 90%.

24.7.1 Ms Brown advised that she was content with the progress against the management actions and the evidence in place to close of the actions.

24.7.2 Members noted that 100% was not a realistic or achievable target given staff turnover, maternity, paternity and long term sick leave in NHS Lothian.

24.7.3 Dr Cook advised that the benefit associated with the completion of job plans was a heightened awareness of capacity within each service where there was previously none. A failure to complete job plans can also have a negative impact on morale, should there be a variation of workload amongst members of a team. In Dr Cook's opinion completing job plans would not only be beneficial for staff but also patients where capacity met demand.

24.7.4 Members discussed the mandatory process and previous non-compliance to the process. They questioned what expectations were places on staff to complete job plans. Dr Cook advised the members that all consultants were expected to complete a job plan. He anticipated that by 2019/2020 discussions would be more straight forward and in line with service requirements rather than a reiteration of areas of existing agreement.

24.7.5 The Committee took moderate assurance from the attached actions as evidence that actions identified had been completed, and will contribute to the usefulness of job planning as a tool to ensure that consultant time and expertise was directed towards activities that meet the board's strategic and operational priorities.

24.7.6 The Committee agreed to accept the report.

24.8 Pharmacy Losses and Gains 2017-18 – Ms Cuthbert spoke to the report noting the key issues and provided assurance that pharmacy stock was effectively managed, losses were minimised, and that management had reviewed the accounting practice, taken the advice of the external auditor, and had agreed a new approach which would be applied for 2018/19 and subsequent years.

24.8.1 Members were advised that excluding the fridge incident at the RIE, financial stock loss within the financial year would have been £205k which would equate to 0.2% of the total stock well within the key performance indicator of <0.4%.

24.8.2 Ms Cuthbert drew the Committees attention to the benchmarking report and noted that NHS Lothian was the third largest organisation that participated in the benchmarking exercise. Based on hospital beds, NHS Lothian's medicines cost per 100 beds was below the UK and Scottish average. Work to learn from colleagues within other organisations to mitigate future incidents was in progress.

24.8.3 Members accepted that some errors were attributed to the human aspect of the system. Given the complexity and nature of the systems in place some human error was inevitable; these would be dealt with on a continuous basis to ensure that errors were investigated in a timeous manner and recorded appropriately.

24.8.4 Ms Cuthbert advised that the procedure detailed for fridges on wards later on the agenda would have no bearing or impact on the outcome of the fridge incident and the losses seen within the central pharmacy. Central Store policy called for a higher level of scrutiny of the fridge sheets. Future occurrences would be mitigated by removing the human aspect of the system and the implementation of an automated text being sent to the Pharmacist on call.

24.8.5 Mr Crombie advised the Committee that access to medicines and workforce planning following Brexit would be pursed at a national level.

24.8.6 The Committee agreed to accept the report as a source of significant assurance that there was an adequate & effective system of control in place, with standard processes in place, to minimise loss of medicines within the pharmacy service accredited to ISO9001 (2015) standards.

24.8.7 The Committee agreed to accept that the NHS Lothian Pharmacy service met the key performance indicator of less than 0.4% of stock loss from total annual stock turnover with the fridge incident excluded.

Mr Houston entered the meeting.

24.8.8 The Committee agreed to accept the report as a source of significant assurance that management had reviewed the accounting practice, taken the advice of the external auditor, and had agreed a new approach which will be applied for 2018/19 and subsequent years.

25 Risk Management (Assurance)

25.1 Risk Register - Ms Bennett spoke to the report drawing out the key points within the report. She drew the Committees attention to the review of the strategic framework and the first test against the strategic framework related to delayed discharges.

25.1.1 Members noted the importance of the delayed discharges review, in identifying what is the definition of the risk was, who owned the risk and provides assurance, what plans were in place to proactively and/or reactively manage the risk and do they address key aspects of the strategic framework and what impact do the plans have on mitigating the risk. It was anticipated that reviewing risks in such a way would give a rounded view on risk.

25.1.2 There was some discussion on how to best communicate the outcome of the review to the Governance Committees and partners to ensure cooperation over the respective parts of each risk. Members agreed that IJB directions needed to feature as part of the revised approach. It was imperative that the risks were not seen as health centric and solely lead by the Board. It is essential to find a way for organisations to work together in a meaningful way, so as to address fundamental risks.

JBenn

25.1.4 Mr Ash commented that there needs to be a process to share this work with the integration joint boards and their audit committees.

Dr Cook left the meeting.

25.1.5 Members agreed that it was important that the complexity of the arrangements for integration to not be a barrier to progress. Members proposed that a report go to the Board in December 2018 and a further development session on risk be added to the diary as part of a yearly review on risk. Mr Houston advised that he would prefer for there to be a report to the Board, rather than a development session. Feedback would be seen in the running action note relating to the wider issues of engagement, followed by a revised paper would be brought back to the Audit and Risk Committee following discussions at the Board in December.

J Benn/ BH

25.1.6 Mr McQueen raised specific concerns on the action that proposed; The Board and Governance committees of the Board need to assure themselves that adequate improvement plans were in place to attend to the corporate risks pertinent to the committee. These plans are set out in the Quality & Performance paper presented to the Board and papers are considered at the relevant governance committees. Governance Committees continue to seek assurance on risks pertinent to the committee and level of assurance along with the summary of risks and grading was set out below in Table 1. He advised that he was unclear what mechanism was in place to draw member's attention to the necessary risks so as to discharge the duties required on himself as a Board member. The Chair advised that there was regular oversight of risks through the risk register and the quality and performance paper to the Board, noting that the Audit and Risk Committee had the opportunity to dig into risk when concerns were raised and has done so in the past.

25.1.7 There was some discussion on how risk was linked to management actions within internal audits. Ms Brown agreed to consider how this could be best highlighted in internal audit reports.

JBr

25.1.8 The Audit and Risk Committee agreed to:

- Accept significant assurance that the current Corporate Risk Register contains all appropriate risks, which are contained in section 3.2 and set out in detail in Appendix 1.
- accept that as a system of control, the Governance committees of the Board assess the levels of assurance provided with respect to plans in place to mitigate the risks pertinent to the Committee
- Accept the refreshed Risk Management Policy and recommend to the Board for approval.
- Accept the recommendation to review further NHS Lothian's Risk Register within the context of the Board's May 2018 workshop and feedback from committee members with respect to single system approach to risk.

26. Internal Audit (Assurance)

26.1 Internal Audit Progress Report (August 2018) – The previously circulated report was noted. Ms Brown reported that since the June meeting 7 reports had been

finalised. There were no concerns related to the progress of internal audits to date.

26.1.1 The Committee accepted the Internal Audit Progress Report August 2018.

26.2 Reports with all control objectives have significant assurance (August 2018) – Ms Brown spoke to the report. She noted that the two report covered big topics under a limited scope that focused on processes. The two reports were titled 'Healthcare Governance – Governance Arrangements in place over Child Protection Services' and 'East Lothian – Delayed Discharges'. .

26.2.1 The Committee accepted the reports with all control objectives that have significant assurance.

Mr Crombie left the meeting.

26.3 Complaints Management (June 2018) - Ms Brown noted that there had been a significant work done to tighten up the process surrounding complaints. She drew the Committees attention to the limited assurance provided in respect of lessons learnt and how they were cascaded through the organisation.

26.3.1 Professor McMahon commented that it was not the responsibility of the central complaints team to disseminate learning; he proposed that the responsibility should sit with the organisation within the management line.

26.3.2 Members noted the work of the Feedback and Improvement Quality Assurance Working Group over the last 2 years in light of concerns raised by the SPSO and the meeting in September dedicated to discussing feeding back learning through the organisation.

26.3.3 Mr Houston supported Professor McMahon's response, advising that it was imperative that as an organisation the Board must drive forward improvement on the back of data collated. As an organisation we need to improve how we generate lessons learned from all feedback. It was for the CMT and the Chief Executive to consider how the organisation moves into the feedback arena. In his opinion the primary vehicle would be the quality programme.

Mr Connor highlighted that lessons can be learned at three distinct levels. There are lessons for specific areas, lessons which can be shared and used by other operational areas, and strategic/ cultural lessons which should be built into the organisation's overall approach to quality.

26.3.4 Mr Ash suggested that there needs to be an executive lead for organisational learning.

26.3.5 The Committee agreed to accept the report on complaints management.

Mr Houston left the meeting.

Ms Pringle entered the meeting.

26.4 Edinburgh IJB – Performance Target Data (May 2018) – Ms Brown spoke to the report drawing the Committee's attention to two areas where no assurance had

been given. She highlighted that timescales and performance objectives had not been clearly stated for all directions, reporting arrangements for directions had not always been stated and performance information was not always reported to committee with the required frequency. A key challenge is aligning performance data back to the original IJB directions.

26.4.1 Ms Pringle noted that the management response recognised the findings within the internal audit report but acknowledged the newness of the directions within the IJB and the work required to make process more robust and smarter. Moving forward the IJB would review the governance surrounding the directions how it and its sub-Committees get assurance and report against key directions.

26.4.2 It was noted that directions were brought forward in June 2015 and may not be considered new. However, members recognised the volume of directions was an issue, and that there has been limited guidance on directions. Members welcomed work to streamline directions so that they become more measurable. Ms Pringle acknowledged that Edinburgh IJB had used directions as a strategic plan 'work plan', which on reflection had not been an effective approach.

26.4.3 Mr McQueen advised of a recent seminar at the West Lothian IJB on directions. Lessons from the seminar were that:

- Directions should be set for what you wish to achieve and be high level with clear performance systems.
- The approach was that of Commissioner/ Provider allowing the IJB to have clear procurement processes with a clear expectation of return for the money ensuring success and improvement.
- Infrastructure and processes were essential to support the disbursement of resources.

26.4.4 The Committee recognised that it was perhaps irrelevant, from a learning perspective, that this particular audit was carried out in Edinburgh. Integration joint boards are different and approach directions in different ways, however they could all learn from this audit. The organisation needs to be assured that there is an infrastructure in place to facilitate a robust system for IJB directions, and monitoring of the same. Mr McQueen highlighted a risk as to whether the analytical services function has the capacity to provide the performance information that IJBs may require. .

26.4.5 Members expected that the issues raised by the Committee would feature in the Audit Scotland report following their review. Members anticipate sight of the report and outcomes detailed within.

26.4.6 Ms Goldsmith highlighted that it was important that performance metrics did link to strategic objectives, such as shifting the balance of care. She also highlighted that if IJB directions are unclear, then the NHS Board does have a valid and significant interest in this.

26.4.7 Mr Ash highlighted that the audit report did concentrate on directions to the NHS Board, however presumably the same issues apply to the IJB directions to the local authority. He proposed that learning from the report should be shared with the other IJBs. Ms Pringle noted that sharing lessons learnt could be done through the standard mechanisms.

26.4.8 There was a brief debate surrounding who had commissioned the audit and whether it was appropriate to ask for an update from the Chief Officer. The

Committee noted that the audit was carried out by the Chief Internal Auditor of NHS Lothian and though the resources had been delegated to the IJB reporting lines ultimately lay within the Board. The Chair requested that process should not get in the way of the issues and proposed that it would be in the best interest of both the IJB and the Board to ensure that there was oversight of actions.

26.4.9 The Chair referred to the process within the NHS Lothian assurance framework for when no assurance is provided. The following next steps were agreed:

- The Chair would refer the report to the Chief Officer of Edinburgh IJB, and request an update from her for the next Audit & Risk Committee meeting which is on 26 November. He will liaise with Ms Pringle on the form of words for that request.
- The Chair would also refer the report to the Chief Executive and the Deputy Chief Executive, so that the report may be considered with by the IJB Chief Officers group. **MA**

26.4.10 Ms Pringle was invited to provide a form of words in respect of the request made to Chief Officer. **MP**

26.4.11 The Committee accepted the report on the Edinburgh IJB – Performance Target Data.

Ms Pringle left the meeting.

26.5 Mandatory Training – Members noted the 3 key findings and the expectation from the Board that 80% of its employees complete mandatory training. It was noted that with the creation of the Mandatory Education & Training Policy and launch of the Tableau Workforce dashboards, an effective control framework was in place for the provision of mandatory training to staff and how this was monitored and reported.

26.5.1 Ms Langsley advised that the new policy proposes that 100% of available staff must complete mandatory training. In addition there would be an expectation on those unavailable to complete mandatory training on return to work within a given timeframe.

26.5.2 There was some discussion on increasing the Board's expectations for compliance with mandatory training. The report highlighted that currently the target is for 80% of employees to have completed their mandatory training, and the management response stated that 100% was unrealistic and unachievable. . The Committee was informed that that mandatory training was an area of focus for the Staff Governance Committee and with the implementation of TURAS it was expected that review processes and compliance would be improved.

26.5.3 Professor McMahon advised that revalidation was a 3 year process and there were other process and arrangement in place to release time for staff to complete mandatory training.

26.5.4 The Committee remained concerned with the principle of having a 80% target for something that is classified as 'mandatory' for all employees. The Committee requested that Ms Langsley refer the Committee's concerns on the compliance rate to the Staff Governance Committee, to re-consider the options available to increase the uptake, and provide feedback through the Audit & Risk Committee's running action note.

AL

Ms Langsley left the meeting.

26.6 Medicines Management on Wards (June 2018) – Professor Timoney acknowledged the recommendations detailed within the report and drew attention to the proposed work with nursing to resolve them.

26.6.1 Members noted that while the Safe Use of Medicines Policy & Procedures set out clear instructions for managing medicines, the requirements of the Policy & Procedures were not always being followed across wards. Professor Timoney reported that she would work with nursing to ensure that compliance to policy and procedures was acknowledged and taken forward.

26.6.2 There was a brief discussion surrounding the duty to report the loss of controlled drugs. Members noted that such matters would be addressed by the Local Intelligence Network and the reporting of such losses would be picked up by Area Drug and Therapeutic Committee and reported to the Board through the Healthcare Governance Committee.

26.6.3 The Committee agreed to accept the report on medicine management on the wards.

Professor Timoney left the meeting.

26.7 Use of Nursing and Midwifery Workload and Workforce Planning Tools – Ms Brown spoke to the previously circulated report. She noted that the area under review comprised five control objectives, of which one received Limited Assurance and four received Moderate Assurance. She acknowledged that one aspect of the recommendations (IT infrastructure) may not be within NHS Lothian's gift.

26.7.1 Professor McMahon welcomed the timing of the audit aligning with the safe staffing legislation. He reported that there would be focus on raising awareness and developing better tools and the outputs. There would be a series of workshops to support staff in the use of tools and the confidence to challenge the outcomes. There would be a strategic approach to training, moving up the management line to ensure that there were no excuses for non-compliance.

26.7.2 Professor McMahon advised that the national Government posts would only be funded to the end of the financial year. He noted that there had been no previous investment and as a result Boards were playing catch up. It was hoped that the Government posts would provide the necessary expertise within the service to sustain future training for staff.

26.7.3 The Committee agreed to accept the recommendations and the actions in place to resolve them.

26.8 Follow-Up of Management Actions Report (August 2018) – the Committee accepted the report on the Follow-Up pf Management Actions.

27. Counter Fraud (Assurance)

27.1 Counter Fraud Activity – Ms Livingston spoke to the previously circulated report. She noted that there had not been much activity since the previous meeting.

27.1.1 There was some discussion on the consistency of detail within the report; Members felt that cases closed, closed, fraud not found, footnotes and actions resulting from decisions taken were not clear within the report. Ms Livingstone and Mrs Goldsmith agreed to work with Mr Old to resolve issues surrounding the format of the update to the Committee, to improve the clarity of the report.

BL/SG/JO

27.1.2 Members were advised that the Fraud Liaison Officers were the conduit between the Board and counter fraud services. It was their responsibility to pass on concerns and matters that required to be escalated to the Police.

27.1.3 The Committee accepted the report as a briefing on the current status of counter fraud activity. The Committee agreed that the report provided a significant level of assurance that all cases of suspected fraud are accounted for and appropriate action was taken.

28. General Corporate Governance (Assurance)

28.1 Scottish Government Audit and Assurance Committee Handbook – Mr Brown presented the report for information, noting that NHS Lothian was further ahead than some of their counterparts.

Professor McMahon left the meeting.

Dr Watson entered the meeting.

28.1.1 Members agreed that Mr Payne should reflect on how best to implement the changes proposed within the document and bring a report to the November meeting.

AP

28.1.2 The Committee agreed to accept the briefing on the Scottish Government Audit and Assurance Committee Handbook.

28.2 Review of the Standing Orders – The Committee reviewed the proposed revised Standing Orders, and recommended them to the Board for its approval.

28.3 Update on the Access and Governance Committee – Members received a summary of the conversations at the Corporate Management Team. Mr Payne informed the committee that the Board had agreed at its August meeting that the Information Governance Sub-Committee was the appropriate governance committee to oversee matters relating to data quality and management.

28.3.1 Dr Watson spoke to the report. He highlighted that the key developments were:

- Increased senior management attendance, and the Board had appointed a non-executive to the membership of the Access & Governance Committee.
- Improved clarity through the development of a Risk Register.
- The development of the governance framework that flags up high risks and a timeframe to address them.

28.3.2 The remit and the resource required to address the identified risks and expansion of the framework was discussed. This would be a mixture of staffing and system development but would vary dependant on risk. It was acknowledged that there was a large step up in the work for Analytical Services in monitoring waiting times g overnance and it was likely additional resources would be required there.

28.3.4 Dr Watson noted that those risks that remain on the agenda but there was possibly no solution contribute to the limited level of assurance provided within the report. He noted that it would not be possible to provide a higher level of assurance at this stage given the 'unknown' areas. He questioned whether the Access and Governance Committee was the right vehicle to address waiting times issues if problems remain unsolved.

28.3.5 The Committee sought a report for the November meeting detailing further assurances. If the Audit & Risk Committee could receive moderate assurance, then it would consider transferring the oversight of data quality and management to the Information Governance Sub-Committee.

28.3.6 The Committee agreed to:

- Accept the summary of issues presented for Corporate Management Team consideration and the reasons for 'limited' level of assurance.
- Support the attendance of a Non-Executive Director at Access & Governance meetings.
- Request an update from the Corporate Management Team following deliberations in October seeking a further level of assurance and whether in fact Access and Governance was the correct route.

29. Any Other Competent Business

29.1 There were no other items of competent business.

30 Date of Next Meeting

30.1 The next meeting of the Audit and Risk Committee would take place at **9.00** on **Monday 26 November 2018** in **Meeting Room 8&9, Fifth Floor, Waverley Gate**.

NHS LOTHIAN

ACUTE HOSPITALS COMMITTEE

Minutes of the meeting of the Acute Hospitals Committee held at 14:00 on Tuesday 21 August 2018 in Meeting Room 8, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Dr R. Williams, Non Executive Board Member (chair); Mr A. Joyce, Employee Director, Non Executive Board Member; Ms A. Mitchell, Non Executive Board Member.

In Attendance: Ms J. Campbell, Chief Officer, Acute Services; Ms A. Cunningham, Divisional Business Manager, Acute Services; Dr E. Doyle, Associate Divisional Medical Director, Royal Hospital for Sick Children (5.1); Mr A. Jackson, Associate Director Strategic Planning; Ms R. Kelly, Deputy Director of Human Resources; Mr C. Marriott, Deputy Director of Finance; Mr M. Pearson, General Manager, Surgical Services Directorate (item 5.2); Ms B. Pillath, Committee Administrator (minutes); Mr A. Tyrothoulakis, Site Director, St John's Hospital (item 4.1).

Apologies: Ms S. Ballard Smith, Nurse Director, Acute Services; Dr B. Cook, Medical Director, Acute Services; Ms T. Gillies, Medical Director; Professor A. McMahon, Nurse Director; Councillor F. O'Donnell, Non Executive Board Member.

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.

1. Minutes from Previous Meeting (19 June 2018)

1.1 The minutes from the meeting on 19 June 2018 were approved as a correct record.

2. Matters Arising

2.1 Acute Hospitals Committee Workshop Outcomes

2.1.1 The summary from the workshop which took place on 1 June 2018 had been previously circulated. Following discussion at the workshop it had been agreed that the Committee should continue as a distinct Board committee and not become a sub committee of the Healthcare Governance Committee but with a review of the Terms of Reference. It was agreed that as part of the work plan for the Committee each acute director would be scheduled to present their service overview each year. It was also agreed that the Acute Services risk register would be considered at each meeting and used to inform areas for attention.

2.1.2 Dr Doyle noted that the planned opportunity for service updates was welcome as it allowed positive areas to be presented as well as being asked for assurance where problems had arisen.

2.1.3 It was noted that the remit and workplan would be important to ensure that specific areas were covered that were not covered elsewhere. There also needed to be a working relationship with Health and Social Care Partnerships, not a separation of issues which were related.

2.1.4 Members accepted the recommendations laid out in the paper.

3. Fiscal Governance

3.1 Financial Performance

3.1.1 Mr Marriott presented the previously circulated paper and explained that a different approach was being taken this year by considering both the financial gap and the care gap and thinking about the resources needed to reduce the care deficit. There would be open discussion with the Board about whether to increase the financial deficit or to improve performance.

3.1.2 It was noted that penalty payments were still being made due to non compliance with junior doctor rotas. Ms Campbell advised that there had been a significant reduction in non compliant rotas since the introduction of new rostering software which allowed reaction to non compliance and showed when areas were being monitored. Junior doctors were now being informed at induction the working conditions expected so that compliant rotas could become routine.

3.1.3 Mr Marriott advised that national comparisons were difficult as it was not possible to get more detail than overall figures for other Boards, not specified to acute services.

3.1.4 Members accepted the recommendations laid out in the paper. It was requested that the next update include what the waiting list initiative payments and private sector had delivered in terms of improved access, and for a level of assurance to be stated on delivery of recovery plans. **CM**

4. Performance Assurance

4.1 Diagnostic Waiting Times

4.1.1 The Chair welcomed Mr Tyrothoulakis to the meeting and he presented the previously circulated paper.

4.1.2 With reference to item 4.1.4 in the paper, there was a question as to whether the reduction in routine screenings was causing the increase in referrals for urgent suspicion of cancer as GPs tried to avoid the long waiting list for patients. Mr Tyrothoulakis advised that a triage process meant that urgent referrals were considered and downgraded if appropriate, but very few were downgraded and GPs were rightly concerned that formerly routine patients could become urgent during the long wait.

4.1.3 Ms Campbell also noted that the increase in urgent referrals could reflect the improvement in early detection of cancer due to positive results of screening. Some national work was in progress on bowel screening to identify whether this was the case.

4.1.4 Mr Tyrothoulakis reported that of those patients waiting over 26 weeks for routine screening, half had been waiting over 52 weeks. All resources were being used to screen urgent referrals.

4.1.5 The sustainability action plan was being updated to show when with actions in place to reduce the waiting list it was expected that this would become sustainable. The first stage was to reach a position where demand for routine screening could be met within a month, then to identify resources for clearing the backlog of cases. The original plan was for 3 years and identified a requirement of £10 million. This was being updated to reflect the higher demand and the importance of surveillance.

4.1.6 Mr Tyrothoulakis noted that a workstream was considering how improving technology could help meet demand, including artificial intelligence surveillance using triggers. Mr Marriott suggested that work was needed to encourage development in this area as there needed to be a change in process rather than just more money to solve the capacity demand discrepancy.

4.1.7 Members accepted the recommendations laid out in the paper and accepted limited assurance that the improvement plan would lead to compliance with the standard. The sustainability plan would be brought to the meeting once updated, and more information about the clinical review of patients on the waiting list was requested. **AT**

4.2 <u>4 Hour Performance</u>

4.2.1 Ms Campbell presented the previously circulated paper. There was high pressure on acute sites with large numbers of patients arriving at front door areas in short periods of time.

4.2.2 There was a question about governance and oversight of Integration Joint Board and Acute Services decision making in interrelated areas, and the differing priorities of the two areas where decisions would affect one another. Ms Campbell advised that the Unscheduled Care Committee made system wide decisions but these had to be approved by 5 governance boards.

4.2.3 It was noted that a major problem was delayed discharge and this was dependent on decisions made in Health and Social Care Partnerships. Ms Campbell advised that there were some improvements that could be made in acute services, and that an unusually high volume of high acuity patients at the front door was also contributing to the problem.

4.2.4 It was advised that some hospital at home services were in place and that this was being developed including one which the City of Edinburgh Council had agreed to continue funding. Members asked for more information on this including timescales at the next update.

4.2.5 Ms Campbell added that there had been sustained improvement in four hour performance in all areas except the Royal Infirmary of Edinburgh, but that more improvement was needed.

4.2.6 Members accepted the recommendations laid out in the paper and were happy that the paper was based on data and showed risks, actions and impact of actions. Limited assurance that the current performance would meet the national 4 hour access standard, moderate assurance that there was monitoring of performance in place, and significant assurance that there was a system in place to test and evaluate the impact of improvement work. It was suggested that the Integration Joint Boards should report to the Healthcare Governance Committee on their plans to reduce delayed discharges. **RW**

4.3 Quality and Performance Improvement Report

4.3.1 Mr Jackson presented the previously circulated paper. The HSMR standard was noted as having not been assessed. It was thought that this had been covered in a previous paper and this would be checked. **BP**

4.3.2 Stroke services had not been assessed since 2016 although it had been considered at the Healthcare Governance Committee since. An update would be added to the agenda for the next meeting. **TG**

4.3.3 Members requested that the recommendations in the paper be tailored specifically to the Acute Hospitals Committee in the next update. **AJ**

5. Clinical Governance

5.1 Paediatric Programme Board Update

5.1.1 The Chair welcomed Dr Doyle to the meeting and he presented the previously circulated paper. The Cabinet Secretary had requested an update by 31 August 2018 on the commitment to the nurse practitioner model. This new position still allowed the commitment to a 24/7 paediatric inpatient unit at St John's Hospital.

5.1.2 In response to a question about ensuring safety for patients under the proposed model, Dr Doyle advised that there was rigorous training and professional accountability for advanced nurse practitioners. The model of a middle grade practitioner with a consultant on call for supervision was established and used throughout Scotland. The model was also used at Royal Hospital for Sick Children out of hours with one advanced nurse practitioner. A middle grade ST3 doctor would be at an equivalent level to an advanced nurse practitioner and this level of doctor would normally be resident on call with on call consultant supervision. The new model at St John's would be a mix of doctors and advanced nurse practitioners with a shift of the focus to nurses.

5.1.3 It was expected to take 2-3 years to reach the proposed position. There was currently one advanced nurse practitioner employed at this level, 2 would have completed

training in one year and there were another 2 new applicants. There was already more experience of this in the neonatal unit.

5.1.4 In the meantime there would be a period where patients would continue to be admitted from St John's Hospital to the Royal Hospital for Sick Children. Dr Doyle noted that the paediatric unit had always been a low acuity ward with a low threshold for transfer of patients out. The number of transfers had increased since the inpatient area had been closed and this was being discussed regularly with the Scottish Ambulance Service to reduce delays.

5.1.5 Members accepted the recommendations laid out in the paper and requested that at the next update there would be more detail on timing and experience of the model proposed, and of interim processes to reduce delays on transfer to the RHSC. **ED**

5.1.6 It was agreed that Ms Campbell would send a response to the Cabinet Secretary that the Acute Hospitals Committee was supportive of the development of the plan proposed and that this would be further considered by the Board at its next meeting in October 2018.

5.2 Vascular Laboratory Update

5.2.1 The Chair welcomed Mr Pearson to the meeting and he presented the previously circulated paper. It was noted that as cover for maternity leave had not been secured at the time of writing the paper, limited assurance had been offered; since then cover had been confirmed so significant assurance was now offered that there would be no routine waits over 6 weeks by the end of September 2018.

5.2.2 It was noted that the service remained vulnerable to staff long term leave or sickness. Mr Pearson advised that there had been a proposal to recruit a stenographer to cover some of the work to reduce pressure on the specialist healthcare scientists who were more difficult to recruit.

5.2.3 Members accepted the recommendations laid out in the paper and accepted significant assurance.

6. Corporate Governance

6.1 Winter Planning

6.1.1 Ms Campbell presented the previously circulated paper. There was a question about whether a higher staff uptake of influenza was reflected in reduced staff absences. Staff absences were monitored but it was not clear if there was any relation. NHS Fife had done a successful vaccination campaign last year which had increased uptake and NHS Lothian would follow their example.

6.1.2 Members accepted the recommendations laid out in the paper and accepted moderate assurance. It was agreed that when this update was taken to the Board there would be more detail on the impacts of actions taken and what actions had been effective in the past. **JC**

7. Minutes for Information

Members noted the previously circulated minutes from the following meeting for information:

7.1 Healthcare Governance Committee, 10 July 2018;
7.2 Health and Safety Committee, 29 May 2018.

8. Date of Next Meeting

8.1 The next meeting of the Acute Hospitals Committee would take place at **14.00** on **Tuesday 16 October 2018** in **Meeting Room 8**, Second Floor, Waverley Gate.

8.2 Meetings in 2018 would take place on the following dates:
- Tuesday 11 December 2018.

STRATEGIC PLANNING COMMITTEE

Minutes of the meeting of the Strategic Planning Committee held at 9.30 on Thursday 9 August 2018 in Meeting Room 8, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr M. Hill, Non-Executive Board Member (acting chair); Mr M. Ash, Non-Executive Board Member; Ms S. Goldsmith, Finance Director; Ms C. Hirst, Non-Executive Board Member; Ms F. Ireland, Non-Executive Board Member; Professor A. McCallum, Director of Public Health and Health Policy; Mr A. McCann, Non-Executive Board Member; Professor A. McMahon, Nurse Director; Mr P. Murray, Non-Executive Board Member.

In Attendance: Ms J. Anderson, Partnership Representative; Mr C. Briggs, Director of Strategic Planning; Mr J. Crombie, Interim Chief Executive; Dr D. Milne, Consultant in Public Health Medicine; Ms B. Pillath, Committee Administrator (minutes); Mr A. Short, Mr A. Short, Chief Officer, Midlothian Health and Social Care Partnership; Mr D. Small, Director of Primary Care Service.

Apologies: Ms J. Campbell, Chief Officer, Acute Services; Mr B. Houston, Board Chairman (chair); Ms T. Gillies, Medical Director; Professor T. Humphrey, Non-Executive Board Member; Ms J. Mackay, Director of Communications.

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.

1. Minutes and Actions from Previous Meeting (12 April 2018)

1.1 The minutes from the meeting held on 7 June 2018 were approved as a correct record.

2. The People's Health

2.1 Community Planning – Workshop Session

2.1.1 A workshop session was held.

3. Integration

3.1 Reprovision of Belhaven Hospital, Edington Hospital, Abbey Care Home and Eskgreen Care Home

3.1.1 Mr Small presented the previously circulated paper. A presentation had been given to this Committee on the reprovision in February 2018 prior to a paper being submitted to the Integration Joint Board. A consultation was carried out between March and June 2018. This paper would be submitted to the Integration Joint Board on 23

August 2018 and there would be a parallel process between NHS Lothian Board and East Lothian Council to progress the Business Case. The plan was in the strategic assessment stage but a lot of background work had been done and it was expected that the Business Case would be submitted in October 2018.

3.1.2 Mr Small noted that there could be a capital request on Lothian for facilities and medical services but this was not clear yet and would become more defined at the stage following discussion at the Board. Ms Goldsmith noted that this was not currently on the capital funding priorities list and there was no funding planned. The current assumption was that the funding would be revenue contributions from the sites rather than capital. Ms Goldsmith noted that funding would also be expected from East Lothian Council and it was agreed that this should be made explicit.

3.1.3 It was noted that East Lothian Council, the Integration Joint Board and NHS Lothian all needed to agree each stage of the plan. The Strategic Planning Committee was being asked to support the proposal that community hospitals should be reconfigured into extra care housing. The reduction in bed numbers at Belhaven hospital had already taken place and there were currently 91 beds. With the extra care housing model there would be 200 beds.

3.1.4 Mr Small noted that extra capacity was also needed for the GP Practice in North Berwick. Currently Edington Hospital provided minor injuries services for 15,000 patients per year. This was not sustainable and would not be provided as part of extra care housing. A separate review was recommended.

3.1.5 Members accepted the recommendations laid out in the paper, noting the current position regarding capital planning and recognising that there should also be financial contributions from East Lothian Council. There would be a separate review of the minor injuries unit. Members commended this forward looking proposal.

3.2 Gamechanger

3.2.1 Mr Crombie presented the previously circulated paper. There had been an agreement with Hibernian Football Club that a more formal analysis of the benefits of the programme would be carried out which could be used as a formal proposal to engagement with Government ministers. This would be in the form of an Initial Agreement.

3.2.2 Dr Milne raised some concerns regarding the evidence base for the gamechanger approach. Review of use of the health check approach in other areas over 9 years had shown no improvement in reducing inequalities. NHS England were continuing to provide national health checks but this was not thought to be an evidence based cost effective intervention.

3.2.3 Dr Milne noted that the literature did not cover the social benefits of the approach and the opportunity for engaging with individual people that might arise from this approach and it was noted that the third sector did this well and NHS Lothian could support rather than lead this. Mr Briggs noted that the project would provide a health and social care space and an opportunity for partnership working where different interventions could be used, and developing a model for future partnership working.

3.2.4 It was agreed that although there was a lack of evidence for the health checks, the evidence for social aspects including reducing social isolation should be researched before investment agreed.

3.2.5 The replacement of the Brunton Practice was a separate issue which was already on the capital plan and it was agreed that this needed to be considered separately even if it was part of the same Initial Assessment.

3.2.6 Mr Crombie noted that there was a wider interest among other local football clubs to become involved in health and social care initiatives and this was being discussed between the club chief executives. The driver for this project was the chief executive of Hibernian Football Club.

3.2.7 Members agreed to support further work to develop the proposal including an Initial Assessment.

4. Lothian Hospitals Plan

4.1 Royal Edinburgh Hospital Update

4.1.1 Professor McMahon gave a verbal update. The Royal Edinburgh Hospital was currently over 100% capacity with additional beds being made up in shared areas within wards; this was unsustainable in terms of patient safety and staffing. The Scottish Government and the Mental Welfare Commission had been informed and staff were aware that there was an action plan in place to redress this. There had been a meeting with the Scottish Government as the national direction was for reduction of beds in mental health services.

4.1.2 Rehabilitation was also pressured but there was a plan in place for 15 more beds. In older peoples services the pressure was delayed discharges and community capacity was being considered. Learning disability services currently had unfunded beds open. Adult services currently had 6 patients waiting for admission, 3 in the community and 3 in acute hospitals.

4.1.3 A workshop would take place the following week to discuss phase 2 of the reprovision based on the learning from phase 1. There would be a focus on mental health services at the next Healthcare Governance Committee meeting in September 2018. The Mental Welfare Commission had a visit scheduled the following week and the sustained pressures would be discussed. The focus would be to take action quickly to reduce pressure.

4.1.4 Mr Crombie advised that Edinburgh Integration Joint Board and improving community capacity was important. A group had been established to consider the wider issue of delayed discharge across the system and a senior manager had been identified to take this forward.

4.1.5 It was noted that there needed to be consideration of whether the clinical model was the most appropriate and efficient, but that short term resolution was needed first before any system redesign. The Healthcare Governance Committee would oversee

an ongoing enquiry which would include whether reducing bed numbers as part of the Royal Edinburgh Hospital reprovision was the right thing to do and what model should be used in the medium and long term.

4.1.6 It was noted that there were a number of groups working on different aspects of mental health services and delayed discharges and they needed to be working together.

4.1.7 Members accepted that there was engagement with key stakeholders to resolve the issues. A paper would be brought to the Committee at the next meeting in October 2018 to review progress made.

5. Any Other Business

5.1 Health and Social Care Partnerships Review

5.1.1 Mr Crombie advised that Audit Scotland was due to publish a review of health and social care integration and outcomes in the next few months. This would be an opportunity to discuss with the Chief Officers how the partnerships were working and to consider further improvements which could be made.

6. Date of Next Meeting

6.1 The next meeting of this group would take place at **9.30** on **Thursday 11 October 2018** in **Meeting Room 8**, second floor, Waverley Gate.

6.2 Further meetings in 2018 would take place on the following dates:
- Thursday 6 December 2018.

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 9.00 on Tuesday 10 July 2018 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; Ms W. Fairgrieve, Partnership Representative; Ms N. Gormley, Patient and Public Representative; Ms C. Hirst, Non-Executive Board Member; Ms F. Ireland, Non-Executive Board Member; Mr A. Joyce, Employee Director, Non-Executive Board Member; Mr A. Sharp, Patient and Public Representative.

In Attendance: Ms J. Bennett, Associate Director of Quality Improvement and Safety; Ms J. Campbell, Chief Officer, Acute Services; Mr J. Crombie, Deputy Chief Executive; Ms T. Gillies, Medical Director; Professor A. McCallum, Director of Public Health and Health Policy; Professor A. McMahon, Executive Nurse Director; Ms J. Morrison, Head of Patient Experience; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Ms B. Pillath, Committee Administrator (minutes); Mr D. Small, Director of Primary Care Services; Professor A. Timoney, Director of Pharmacy; Mr P. Wynne, Chief Nurse, Edinburgh Health and Social Care Partnership.

Apologies: Dr B. Cook, Medical Director, Acute Services; Mr J. Forrest, Chief Officer, West Lothian Health and Social Care Partnership.

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.

9. Patient Story

9.1 Ms Gormley read out feedback from a patient who required multiple surgeries after a road traffic accident and community based care. Communication and involvement in the care plan were complimented but there was some feedback about staffing issues while in hospital and nursing staff not having the time to give attention when needed.

10. Minutes from Previous Meeting (8 May 2018)

10.1 The minutes from the meeting held on 8 May 2018 were approved as a correct record.

10.2 The updated cumulative Committee action note had been previously circulated.

11. Emerging Issues

11.1 Gosport Memorial Hospital Review

11.1.1 Ms Gillies advised that the recently published report from the Gosport Memorial Hospital Review gave an analysis of events over 20 years and revealed individual and systemic failures regarding opiate management in elderly patients. The review took place following a complaint from the family of one of the patients affected. Failings were found in the investigations carried out by Police, General Medical Council and Nursing and Midwifery Council as well as the institution itself. There was evidence that 450 patients died sooner due to inappropriate use of pain medication.

11.1.2 This was relevant to prescribing of pain medication in all areas. A summary document was being prepared looking at how the recommendations made in the review could apply in Lothian. This would be included in the papers at the next Healthcare Governance Committee. **TG**

12. Committee Effectiveness

12.1 Healthcare Governance Assurance

12.1.1 Ms Bennett gave a presentation on gaining assurance from papers presented to the Committee and measures that could be considered to give evidence of the quality of the service. Key questions to be considered were: analysis of the scope and definition of systems; escalation processes; concerns or risks in services; priorities for improvement and information being considered to inform actions taken; external reporting where relevant.

12.2 Quality and Performance Improvement Report

12.2.1 Ms Bennett presented the previously circulated paper. It was noted that smoking cessation should be considered at the next meeting as a level of assurance was outstanding for this year. **AMcC**

12.2.2 Ms Gillies agreed to bring a report for the next meeting on areas of the Health and Safety report` that were relevant to this Committee including clinical governance and performance. **TG**

12.3 Risk Register

12.3.1 Ms Bennett presented the previously circulated paper. A Board workshop had recently been held on risk it was agreed that strategic risks would be separated from escalated risks and questions to ask when considering risks were discussed. It was agreed at the workshop that that 'risk appetite' would be removed from analysis because of the complexity and different levels of control in managing risk appetite which was a concept designed for use in private financial institutions where there was more control over risk.

12.3.2 It was noted that the risk register paper gave the context in which the papers on the agenx9da could be considered in terms of clinical governance risk and performance and the impact on patients, giving background information which would allow members to request more detail in areas required.

12.4 Medicines Governance

12.4.1 Professor Timoney gave a presentation which members were to consider using the questions for assurance previously discussed.

12.4.2 It was noted that following the UK exit from the EU there would be less ability to be involved in European medicines safety organisations and that Scotland and the UK were too small for separate processes to be set up effectively so it was likely that there would be continued input into the MHRA.

12.4.3 It was noted that medicines costs were 15% of NHS Lothian's budget. The spend in primary care was higher than in secondary care but secondary care spend had increased due to increase in the cost of drugs.

12.4.4 In response to a question about clinician compliance with medicines policies Professor Timoney advised that a system had been introduced which could measure compliance with the Formulary which was currently 82%; this was high as it included specialist areas which used non Formulary drugs. Currently there was no patient level data to show whether patients were receiving the correct prescriptions but hospital electronic prescribing systems when in place would allow this. In the meantime the clinical pharmacy team advised and monitored prescribing in their areas. Students were doing baseline measurements so that the impact of the hospital prescribing system could be measured when in place.

12.4.5 In response to a question about external review of medicines governance, Professor Timoney advised that medicines were included in the HIS Older People in Acute Care inspections, controlled drugs were overseen by HIS, and reviews had been requested from the Health and Sport Committee at least once a year in recent years.

12.4.6 Professor Timoney advised that the different needs of different areas were accommodated in the medicines governance processes, as each area had a separate medicines Committee sitting under the ADTC with experts from the area to consider relevant issues.The key risk was lack of assurance around governance of medicines prescribing and administration for inpatients until the electronic prescribing system was implemented. It was agreed that the pharmacy team would consider how the Committee could be assured through audit and include this in the next Annual Report. **AT**

13. Person Centred Care

13.1 Patient Experience and Feedback

13.1.1 Ms Morrison presented the previously circulated paper. The process for stage 2 complaints being managed in the service was being developed including training for clinical areas on how to do the investigation and working to improve the relationship with services. It was an important that there was a partnership approach between the complaints team and the service. There would also be evaluation and review of the quality of the investigation and response as improvements could be made.

13.1.2 It was noted that learning from complaints was important but that it needed to be recognised that system and cultural issues influenced the choices made by staff and there needed to be a focus here.

13.1.3 An internal audit had recently been carried out which showed that the system was generally working well. The report would be brought to the next meeting. **AMcM**

13.1.4 Stage 1 complaints were to be resolved at the service level within 5 days. These were less complex complaints and this should be possible following training and increasing confidence of staff. There were 20 days for responses to more complex complaints. The new system to be put in place should drive improvement in 5 day responses; the Corporate Management Team had approved the business case for the process and the new structure was to be in place by March 2019 following recruitment.

13.1.5 It was agreed that significant progress had been made in the last two years and the team was in a much better place due to the hard work of the team. The relationship with the Ombudsman had also improved. The next stage following this would be actively get more patient feedback and allow it to drive improvements in the service.

13.1.6 Members approved the recommendations laid out in the paper and asked that thanks would be passed on to the Patient Experience Team for their hard work and the progress made.

14. Safe Care

14.1 External Review of Community Perinatal Service

14.1.1 Professor McMahon spoke to the previously circulated paper. The review had been commissioned following the death of a baby in 2016 whose mother was under the care of the service. The report had been received in May 2018 and had been shared with staff and with the Procurator Fiscal.

14.1.2 A new lead consultant and charge nurse had been appointed to the team and their leadership would be key to implementing the recommendations made. The key risks raised were funding and the impact on staff of the incident and investigations following. There had been a gap in leadership which had been unsettling for staff but it was hoped that this would be resolved going forward. It was recognised that there was a scarcity of skills in this area and it was important that the resource was developed in the future and that resources were used in the best way.

14.1.3 Members accepted the recommendations laid out in the paper and accepted limited assurance but noted that a lot of work had been done. An update would be brought back to the Committee in January 2019 and presented by members of the service. **AMcM**

14.2 Smoke Free Prisons

14.2.1 Professor McMahon gave a verbal update. Prisons were to be smoke free by November 2018. 70-80% of prisoners were smokers. The prisoner population was 700 at HMP Addiewell and 900 at HMP Edinburgh. This would be positive for

prisoner and staff health and many prisoners wanted to stop smoking. Nicotine replacement therapy was expected to cost £160,000; no extra funding was being provided for this. Training and awareness for prisoners was planned and there was a plan for helping prisoners to continue to be non smoking when integrated back into the community.

14.2.2 Professor McCallum advised that other European countries had already implemented smoke free prisons. Research indicated that approximately 10% of prisoners take up the offer of nicotine replacement and smoking cessation support. The remainder would either stop smoking without help, or choose to use electronic cigarettes. No increase in violence was indicated in these studies although other behaviour including trading products was noted.

14.2.3 The uptake of smoking cessation support and any incidents would be monitored locally, and there would also be a national evaluation following implementation. An update paper would be brought to the Committee at the meeting in January 2019.

14.3 Scottish Patient Safety Programme Walkrounds

14.3.1 Ms Gillies presented the previously circulated paper. There would be a review of the purpose of the walkround with a view to focus more on quality measures including staff experience.

14.3.2 Members accepted the recommendations laid out in the paper and accepted limited assurance as a change had been proposed and the current process needed to be updated. Progress would be reported in the Scottish Patients Safety Programme Annual Report.

14.4 Infection Outbreak, Ellen's Glen

14.4.1 Mr Wynne presented the previously circulated paper. It was noted that the vacancy and absence levels in the team contributed to this incident and that this should be monitored in order to prevent incidents similar to this. Mr Wynne noted that there had been difficulty recruiting mental health nurses but that more general nurses should be recruited to improve the skill mix. There was an opportunity to improve the skill mix in these areas with the introduction of registered general nurse training which would train nurses to look after all patients. Those who had received the new training would start to be available in five years' time.

14.4.2 Professor McMahon noted that consideration was being given as to how to better support small hospitals and respond to warning signs such as vacancy rate, bank staff levels and absence levels. The Chief Nurses had agreed to put a peer review system in place for clinical nurse managers.

14.4.3 Mr Wynne noted that staff in the unit were keen to make the required changes and worked well with the infection control team to resolve the incident once it had been escalated. There had been a delay in recognising and escalating the situation although individual patient's symptoms were managed.

14.4.4 Ms Bennett noted that the Excellence in Care programme would help to make data on complaints, infection rates, vacancy rates, absence rates, staff turnover and other measures available to a charge nurse so that instability that could lead to incidents could be escalated and resolved early.

14.4.5 Members accepted the recommendations laid out in the paper and accepted moderate assurance that an action plan was in place.

15. Effective Care

15.1 Health and Social Care Partnership GP Improvement Plans

15.1.1 Mr Small gave a presentation. He advised that the new GMS contract had followed wide engagement with an opportunity for all practices to provide feedback, and the profession had voted in favour of the contract overall. GPs had presented each GP improvement plan at the GP Sub Committee for review and there was enthusiasm for making improvements in the areas highlighted. Actions needed to follow to maintain optimism.

15.1.2 The impact of contractual changes on patients and how it would improve care and access needed to be articulated and communicated to patients.

15.2.3 It was important that nurses and other practice workers employed by the health board were supported and their reporting structures clarified.

15.2.4 Professor Timoney noted that pharmacists were positive about the change but that there were risks around workforce as recruiting to practices could destabilise hospital or community pharmacy.

15.2.5 Integration Joint Boards would oversee the implementation of the improvement plans, but clinical governance issues would be reported to the Healthcare Governance Committee. Measures for assurance were still to be defined. These would be focused on access and quality of service. Transformation must be central to improving sustainability of the service.

15.2.6 A paper would be presented to the next meeting giving a more developed proposal of outcomes for consideration. **DS**

16. Exception Reporting Only

Members noted the following previously circulated papers for information:

16.1 Voluntary Services Annual Update;
16.2 Primary Care Dental Services;
16.3 Blood Transfusion Annual Report.

17. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

17.1 Clinical Management Group, 10 April 2018, 8 May 2018;
17.2 Area Drug and Therapeutics Committee, 13 April 2018;
17.3 Lothian Infection Control Advisory Committee, 5 June 2018;
17.4 Acute Hospitals Committee, 17 April 2018;
17.5 Feedback and Improvement Quality Assurance Working Group, 29 May 2018;
17.6 Health and Safety Committee, 21 February 2018, 29 May 2018;
17.7 Public Protection Action Group, 2 May 2018;
17.8 Policy Approval Group, 30 January 2018, 27 March 2018.

18. Date of Next Meeting

18.1 The next meeting of the Healthcare Governance Committee would take place at **9.00** on **Tuesday 11 September 2018** in **Meeting Room 8**, Fifth Floor, Waverley Gate.

18.2 Further meetings would take place on the following dates in 2018:
- 13 November 2018.

DRAFT

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9:30am on Wednesday 25 July 2018 in Meeting Room 8&9, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr M. Hill (Chair), Mr B. Houston, Mr B. McQueen, Mr P. Murray, Mr A. McCann, Cllr Ian Campbell and Miss T. Gillies (until 12.10pm).

In Attendance: Mr C Marriott, Deputy Director of Finance, Mr C Briggs, Director of Strategic Planning, Mr I Graham, Director of Capital Planning and Projects, Mr I Robertson, Head of eHealth Operations and Infrastructure (Item 10.2), Mr M Pryor, Asset Development Director (Item 10.1), Mr G. Curley, Director of Operations-Facilities (Item 10.4), Dr J. Hopton, (Item 10.4), Mr Charlie Halpin, Senior Project Manager Sustainable & Technical Development (Item 10.4), Mr A. Tyrothoulakis, Site Director St John's Hospital, Mr C. Briggs, Director of Strategic Planning (until 10.20am), Mr C. Stirling, Hospital Director Western General Hospital and Mr C. Graham, Secretariat Manager (Minutes).

Apologies: Mr J. Crombie, Mrs S. Goldsmith, Mr T. Davison, Ms J. Campbell, Professor M. Whyte, Professor A. McMahon, Ms J. Proctor and Ms A. MacDonald.

The Chair welcomed members to the meeting, in particular Cllr Ian Campbell who was attending his first meeting as a member of the Committee.

The Chair also apologised for the tardiness of the papers being issued. There would be discussion on the Committee's views of papers at the end of the meeting.

Declaration of Financial and Non-Financial Interest

The Chair invited members to 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. Cllr Campbell, the Chair, Mr McCann and Mr Murray all made declarations in relation to 9.3.

7 Minutes from Previous Meeting (23 May 2018)

7.1 The minutes from the meeting held on 23 May 2018 were approved as a correct record.

8 Committee Business

8.1 Running Action Note – The Committee agreed the action note and noted the following:

- **Assurance Report on the Procurement Systems** – Mr Marriott to bring an update on further work on collaborations at regional level.

CM

- **Clinical Information System Critical Care NHS Lothian Initial Agreement** - Miss Gillies reported that the timescale for intensive care expansion had been held back by uncertainty around the new RHSC move date. This action remained outstanding and Miss Gillies would follow up on this.

TG

9 Revenue

9.1 Financial Position to 30 June 2018 and 2018/19 Financial Plan - Mr Marriott provided an overview of the financial position at period 3 based on the latest financial information.

9.1.1 The Committee noted the month 3 position, showing a £2.5M overspent to date. Mr Marriott made the point that in comparison to the opening forecast financial plan defict of £21.5M the Board was in a better position than expected. There was discussion on areas of current pressures including pay pressures and nursing staff and junior doctors pay. There had been areas of improvement for example GP prescribing and income which had assisted in improving the monthly results.

9.1.2 There was more detailed discussion around the medical and nursing pay overspends and how this was being managed. Mr Marriott explained that in relation to junior doctors large steps forward were being made with the management of locums. Within nursing and in discussion with Professor McMahon, a number of initiatives had been introduced such as e-rostering and a sustained movement to have more staff in post rather than bank or agency use. It was noted that the strategic financial plan contained more detail around sustainability and value.

9.1.3 There was also discussion on drug costs, development of new drugs and political changes making access to new drugs more difficult to manage.

9.1.4 Mr McCann asked if nursing and medical wages were over month by month and were there issues with incorrect forecasting or were budgets realistic in the first place. Mr Marriott commented that NHS Lothian was no different to any other Board with these challenges around sustainability of uplift levels and how this limits the setting of budgets. The Chair reminded the Committee that overall funding to NHS Lothian remained below the Scotland average, with a gap still to be made up and on that basis budgets remained insufficient.

9.1.5 The Committee noted the financial position as at June 2018 reporting a deficit of £2.5m and incorporating three months of the £10.8m reserves identified in the Financial Plan. The Committee accepted the limited assurance on achieving a breakeven outturn after the first three months of the 2018/19 financial year.

9.2 Development of the NHS Lothian Financial Strategy – Mr Marriott explained that this was the third paper in the development of the strategy. The Committee had previously received updates in November 2017 and March 2018. The March 2018 update had set out progress made in developing a structured approach to supporting implementation, concluding that the Committee could only take limited assurance that there was a reliable framework in place to deliver future financial sustainability. Committee members requested that the developing financial strategy should be a standing agenda item.

9.2.1 Mr Marriott reported that the strategy remained dynamic and evolving with the tiered approach to delivering financial sustainability improving due to the evidence being picked up in the four tiers of the pyramid. There was also evidence of progress in individual areas, in line with the wider corporate strategy - Our Health, Our Care, Our Future.

9.2.2 There was discussion on the work around financial sustainability, good financial governance, financial recovery, business units' best practice, best use of data for improvement opportunities, support for financial training, difficult choices and values based assessment.

9.2.3 The Committee noted that further iterations of the strategy along with any key risks for exploration would be brought forward through F&R, CMT and Business Units. The Chair stated this was a very rich paper with a lot lying behind it and it would be useful to have a more descriptive paper at a future meeting.

9.2.4 The Committee agreed that the development of a logical structure was excellent however it was important to note that at the end of the day the top of the pyramid remained unknown territory. There was still a big gap and thought was needed to how to address this. Mr Marriott added that there was also focus at the bottom of the pyramid where it was not always about cash but about the creation of capacity.

9.2.5 The Committee also discussed regional and national planning efforts. It was noted that whilst regional planning in the East had been better there was still a long way to go with the development of solutions.

9.2.6 The Chair stated that the NHS Lothian Financial Strategy would remain a standing item and from a broader point of view should set out development going forward including how transformation would be dealt with and where ideas generated. There was a role for the Committee and the Strategic Planning Committee to take in moving transformational change forward.

9.2.7 The Committee noted that over the last year or so the NHS Lothian Strategic Planning Committee had been looking at reshaping and redesigning its role and what this would mean for strategic planning. At the moment this comprised a fairly mechanistic set of plans. Since publication of Our Health, Our Care, Our Future the purpose of the strategic planning committee had become less clear.

9.2.8 Mr Houston explained the plans for the strategic planning committee to have oversight and stewardship of Our Health, Our Care, Our Future. Over the last couple of months there had been an idea to create a futures group or think tank sitting above the Strategic Planning Committee but with a direct feed into the four community planning partnerships. This remained to be developed further and would go back to SPC, F&R and the Board.

9.2.9 The Chair stated that this work was an important part of the Committee's role. The Committee noted the development of the arrangements to deliver financial sustainability through the application of the framework and the underpinning infrastructure, including engagement with IJBs.

9.3 **Commercial in Confidence:** Additional Investment in Community Care Services in Edinburgh – Mr Briggs introduced the report seeking the Committee's approval for an additional allocation to the Edinburgh Integration Joint Board of £4m to support the transformational development of community care services.

9.3.1 The Committee (F&R) noted the progress made by the Edinburgh Integration Joint Board (EIJB) and Health and Social Care Partnership (EHSCP) over the last 9 months and noted the analysis of what is required to deliver the next steps in the transformational change programme for Edinburgh

9.3.2 The Committee approved the additional allocation to EIJB of up to £4m to support this transformational shift by investing in community care services, with the precise mechanism being agreed between the Interim Chief Executive, Director of Finance, and the Chief Officer of EIJB;

9.3.3 The Committee requested that a further report outlining details of impact analysis be prepared for the next F&R meeting.

9.4 2018/19 Annual Operational Plan (AOP): Access Funding to Support Additional Capacity – Mr Tyrothoulakis introduced the report recommending that the Committee review and authorise the 2018-19 Scottish Government funding allocation for Acute Elective Access and be aware of the current impact associated with Scottish Government 2016-2020 Mental Health Access funds.

9.4.1 Mr Tyrothoulakis reported that the draft AOP had been submitted to the Scottish Government in February 2018. The allocation of £7.4M non recurring was confirmed at the end of May 2018. It was noted that £943k of commitments had been identified against the non recurring allocation. The Committee noted that a clinical risk matrix was being used to identify main priority areas for additional funding, as shown in the paper, and that an additional capacity board had been established.

9.4.2 There was discussion on the AOP. The Chair asked Mr Tyrothoulakis for confirmation that the AOP had been through the Board and Scottish Government process and that there was an awareness that the sum allocated was significantly below that required to return waiting times to the March 2017 level. Mr Tyrothoulakis confirmed that this was the case. It was noted that delivery at this level could be a high risk approach and funding should not sit in isolation of the primary care improvement plans. There needed to be communication of these concerns and more joined up thinking about using funding across all IJBs.

9.4.3 The Committee expressed further concern at the deliverability of the spending that it was being asked to approve along with receiving assurance that appropriate consideration had been given to the third sector including mental health.

9.4.4 The Committee agreed the allocation of funding as outlined in the table within the report, enabling the acute service operational teams to progress implementation plans to increase local capacity. However the Committee also agreed that there were concerns here which needed to be highlighted to the Board through a short, but transparent paper.

AT/JCam

10 Capital

10.1 **Commercial in Confidence:** Business Case to support the proposed commercial agreement on the completion of the Royal Hospital for Children & Young People and Department of Clinical Neurosciences

10.1.1 Mr I Graham referred to the report recommending that the Committee agreed to support a proposed commercial agreement between the Board and IHSL to resolve disputed issues and to effect the completion and handover of the new RHSC/DCN facility.

10.1.2 The Committee agreed the proposed way forward and agreed to a) the provision of a working capital loan or capital injection to IHSL to fund the completion of works that have been subject to dispute and b) to obtain early access to the facility to allow commissioning to commence and to pay IHSL a 'rental fee' during this period. The Committee's agreement was conditional upon formal approval of the capital contribution from the Scottish Government.

10.2 Unified Communications Business Case Update - The Committee agreed to support and approve the Benefits Plan omitted from the previously submitted full business case pack. The Committee also noted the range and nature of benefits which could be delivered in the future should further investment be made available to exploit the full capabilities of the new technologies deployed as part of the Unified Communications implementation. The Committee also noted the comparative costs from the preferred supplier and the supplier next in line.

10.3 Inclusive Homelessness Service at Panmure - Mr Briggs outlined the report asking the Committee to approve the Business Case for the creation of a new operational base for the Inclusive Homelessness Service (IHS) in a setting that will enable the co-location of NHS Lothian, Edinburgh Council and third sector agencies that are working together to serve the target population. It was noted that the Business Case had been approved by the Edinburgh Integration Joint Board (EIJB) on 18 May 2018 and by NHS Lothian Capital Investment Group (LCIG) on 30 May 2018.

10.3.1 Mr Murray commented that this approach made perfect sense. The Committee recognised that the specific arrangements that have been devised for the occupancy of Panmure would not be viewed as a precedent for future Edinburgh HSCP services that are hosted in NHS Lothian or Edinburgh Council properties.

10.3.2 Mr Murray asked about wider access by those homeless out with Edinburgh and whether this would be likely. Mr Briggs stated that his understanding was that the

access practice was hosted by Edinburgh on behalf of all four partnerships and anyone coming to the service would be supported.

10.3.3 The Committee agreed to:

- approve the selection of the Council owned property that previously served as Panmure St Anne's school as the preferred operational base for the IHS
- approve the accompanying Business Case and the capital funding of £2.98 million from NHS Lothian for the re-fit of Panmure St Anne's
- NHS Lothian entering into a lease for the Panmure property for a rent of £1 per annum for 30 years and contribute a further £86K annually towards the total £106K of premises costs for the building.

10.4 Initial Agreement - Western General Hospital Energy Infrastructure - Mr Curley introduced the draft Initial Agreement for Energy and Infrastructure at the WGH. Mr Curley outlined the proposal along with the four options and costs associated with each of these. The plan was to introduce reliability, sustainability and flexibility for the WGH infrastructure moving forward. The Committee noted that that the requirement to address energy infrastructure on the WGH site had been recognised as the number one priority in the Board's capital prioritisation process, approved in May 2018.

10.4.1 There was discussion around carbon emissions. Mr Curley pointed out that a significant proportion of NHS Lothian's emissions come from the WGH site and that this proposal along with work at St John's Hospital would lead to a significant reduction. The WGH scheme would save around 10 thousand tonnes of emissions and this could be increased further. Mr Curley confirmed that an application for matched funding to the Low Carbon Infrastructure Transition Programme had not been successful. Formal feedback on the reasons for this was awaited however it was noted that in the context of the programme there was focus on district heating type systems and local authorities or areas as a whole and not individual developments.

10.4.2 There was also discussion on the use of carbon certificates and the EU hospital carbon trading scheme which targeted CO2 emissions and the fines and high reputational damage around exceeding these targets. The Committee noted that this work would tie into key master planning developments and there was the opportunity to start work on the energy project as the existing contract ends in 2020.

10.4.3 The Chair stated that this appeared to be a great scheme and looked forward to the realisation of revenue savings over and above the contribution making NHS Lothian more environmentally sustainable.

10.4.4 The Committee endorsed working towards submission of the Initial Agreement to the Scottish Government Health and Social Care Division (SGHSCD) Capital Investment Group on the 15 August 2018. The challenging governance and approvals process deadlines which will need to be met to achieve success with this submission were noted.

10.4.5 The Committee approved the draft Initial Agreement to allow further rapid development, noting the recommendation to consider three viable options at Outline Business Case (OBC), with the Centralised Energy Centre as the preferred option. The Committee also confirmed that the approval of capital funded resources required to deliver an OBC be agreed by the Lothian Capital Investment Group, within its delegated limited of £1m and taking cognisance of overall project requirements on the WGH site.

10.5 Initial Agreement – Elective Diagnostic and Treatment Centre - Mr Tyrothoulakis introduced the report inviting the committee to review and recommend the Initial Agreement for a Short Stay Elective Centre to the Board for submission to the Scottish Government (SG) Capital Investment Group (CIG) for their approval.

10.5.1 Mr Tyrothoulakis reminded the Committee of the First Minister's 2015 commitment to develop six centres in Scotland, three in the North, one in the West and two centres in the East, at Livingston and Edinburgh.

10.5.2 There was discussion on the investment elements of the proposal, future proofing and repatriation of patients to Lothian from the Golden Jubilee Hospital. The separate business case for Fife elective activity and decoupling of Borders work from the Lothian proposal was also mentioned. Mr Murray asked that reference to paragraph at 3.2 of the report on revenue consequences be added to minute our anticipation that these would be met centrally.

10.5.3 The Committee accepted significant assurance that the content of the proposal had been developed as part of the Acute Services workstream of the East Region Health & Social Care Delivery Plan (EHSCDP), which has had the full participation of Borders, Fife, and Lothian. It was noted that this additional capital availability was over and above the capital pipeline associated with formula funding. The Committee assumed that the revenue consequences of these centres would be provided by the Scottish Government.

10.5.4 The Committee commended the Initial Agreement for a Short Stay Elective Centre to the Board for submission to the Scottish Government Capital Investment Group.

10.6 Property and Asset Management Investment Programme - Mr I Graham provided the Committee with an update on the status of the Property and Asset Management Investment Programme (PAMIP) and sought approvals on matters of asset management and performance.

10.6.1 There was discussion on the risk matrix outlined at Appendix 3 of the paper and the reference to minimal public interest. It was noted that given the onset of primary care improvement plans there may be greater public interest in spending at that level. Mr I Graham stated that developments with primary care were being monitored and that work tended to be part of projects anyway instead of an additional layer. The Committee would continue to test this with reporting schemes back to F&R to ensure the correct level of spending is set.

10.6.2 The Chair thanked Mr Graham and the Capital Planning and Projects team for the well set out information in the paper and welcomed the clear, informative executive summary that had accompanied the report.

10.6.3 The Committee accepted the assurance levels and recommendations in the paper, namely to:

- note the forecast over commitment of the 2018/19 PAMIP
- accept moderate assurance around the programme delivery in year;
- accept significant assurance over the procedures for verification of assets

- approve the refreshed Property and Asset Management Strategy (PAMS) for formal submission to the Scottish Government and subsequent publication
- endorse the approach to relocation of inpatient services currently based at Liberton Hospital to the Jardine building on the Royal Edinburgh Campus
- accept moderate assurance around the delivery of proposed disposals and securing capital;
- approve the proposal to declare Clermiston Clinic as surplus
- confirm the suitability of the draft reporting framework to provide appropriate levels of assurance to the Committee.

11 Any Other Competent Business

11.1 Agenda Papers - The Committee requested that executive colleagues undertake more work at summarising papers coming to the Committee to reduce the load as well as to remove unnecessary replication and repetition. It was agreed that at today's meeting there had been some good and some not so good examples of reports. It was suggested that there may need to be further consideration given to the reporting template used and The Convention of Scottish Local Authorities (COSLA) was given as a good example for papers.

12 Date of Next Meetings

19 September 2018 21 November 2018

13 2019 Dates

23 January 2019
20 March 2019
22 May 2019
24 July 2019
25 September 2019
27 November 2019

Midlothian Integration Joint Board

Date	Time	Venue
Thursday 3rd May 2018	2.00pm	Conference Room, Melville Housing, The Corn Exchange, 200 High Street, Dalkeith, EH22 1AZ.

Present (voting members):

Angus McCann (Chair)	Cllr Jim Muirhead
Tracey Gilles	Cllr Catherine Johnstone
Alex Joyce	Cllr Pauline Winchester
Alison McCallum	Cllr Margot Russell (substitute for Cllr Derek Milligan)

Present (non voting members):

Allister Short (Chief Officer)	Alison White (Chief Social Work Officer)
David King (Chief Finance Officer)	Caroline Myles (Chief Nurse)
Fiona Huffer (Head of Dietetics)	Wanda Fairgrieve (Staff side representative)
Pam Russell (User/Carer)	Marlene Gill (User/Carer)
Ewan Aitken (Third Sector)	

In attendance:

Morag Barrow (Head of Primary Care and Older Peoples Services)	Jamie Megaw (Strategic Programme Manager)
Chris Lawson (Risk Manager)	Tom Welsh (Integration Manager)
Claire Flanagan (NHS Lothian)	Karen Ozden (NHS Lothian)
Dr Cat Harley (Scottish Clinical Leadership Fellow)	Mike Broadway (Clerk)

Apologies:

Cllr Derek Milligan	Aileen Currie (Staff side representative)
Hamish Reid (GP/Clinical Director)	Keith Chapman (User/Carer)

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1. Welcome and introductions

The Chief Officer, Allister Short, welcomed everyone to this Meeting of the Midlothian Integration Joint Board and introduced Angus McCann who had been nominated by NHS Lothian as a voting Board member and Chair of the Midlothian Integration Joint Board.

The Board endorsed NHS Lothian's nomination, following which Angus assumed the Chair for the remainder of the meeting, and there was around of introductions.

2. Order of Business

The order of business was confirmed as outlined in the agenda that had been previously circulated.

3. Declarations of interest

No declarations of interest were received.

4. Minutes of Previous Meetings

4.1 The Minutes of Meeting of the Midlothian Integration Joint Board held on 29 March 2018 were submitted and approved as a correct record.

4.2 The Minutes of Meeting of the MIJB Audit and Risk Committee held on 14 December 2017 were submitted and noted.

5. Public Reports

Report No.	Report Title	Presented by:
5.1	Royal Edinburgh Hospital	Claire Flanagan/Karen Ozden

Executive Summary of Report
The purpose of this report was to seek the support of the Midlothian Integration Joint Board (MIJB) for the bed numbers and financial assumptions for Phase 2 of the Royal Edinburgh Hospital (REH) re-provision thereby allowing the Outline Business Case (OBC) to progress. The report explained that Phase 2 of the REH re-provision programme was to provide facilities for patients with Learning Disabilities and who required low secure mental health care and complex longer term psychiatric rehabilitation. It also included the re-provision of the Ritson Clinic which provided inpatient detoxification for patients with substance misuse and the new Facilities Management building for the REH campus. Potential benefits included:-

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- Provision of services locally without the need for patients, relatives or staff to travel to other parts of the UK for many years.
- Provision of inpatient services that are fit for purpose in modern facilities in Morningside, a community with many assets.
- An expansion of provision in the community.
- Significantly better use of available resources.
- Provision of facilities management and infrastructure improvements that both futures proof the site for utilities and enable Phase 3 to proceed without disruption to clinical services.

Summary of discussion

The Board, having heard from the Claire Flanagan/Karen Ozden, who responded to Members questions, considered the proposals at length, of particular interest was the discussions regarding proportionality of bed numbers and arising therefrom the need for transparency in the event that there was to be a move away from the use of historic financial models. It was acknowledged that for this reason, it was important that as the OBC progressed and as the allocation formula for hosted services was reviewed during 2018/19, that each IJB had the opportunity to review and approve the final models used in the OBC.

Decision

The Board:

- **Agreed to the proposed Midlothian bed numbers in Phase 2.**
- **Agreed in principle to a bed risk share model with other IJBs in order to progress the business case and ensure Midlothian patients have continued access to specialist services.**
- **Agreed that the financial model would be revisited as part of the work towards the new IJB NRAC financial allocation model and that the final financial model for the OBC should be presented to the IJB.**

Action

Chief Officer

Report No.	Report Title	Presented by:
5.2	Risk Management and Risk Appetite	David King

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Executive Summary of Report
With reference to paragraph 5.1 of the Minutes of MIJB Audit and Risk Committee held on 29 March 2018, there was submitted a report presenting for the Board's consideration and approval an approach to the recognition of risks to support the successful operation of the MIJB,. The approach was supported by the Audit and Risk Committee. The report advised Members that as the MIJB was not an operational delivery unit it was not in a position to manage operational risks. The delivery of the functions delegated to the MIJB were carried out under the auspices of one or other of the partners (NHS Lothian and Midlothian Council) and each of these partners had its own governance process, statutory responsibilities for service delivery, audit and risk committees and risk registers. The MIJB's risk register (and risk management process) required to focus on recognising the risks to the MIJB's own business, which was principally the preparation and delivery of the Strategic Plan. The MIJB should only consider 'operational' risks, being the risks managed by the partners, in instances where these risks were so significant that they would impact on the MIJB's Strategic Plan.

Summary of discussion
The Committee, having heard from the Chief Finance Officer, who responded to Members question and comments, welcomed the proposed approach to the recognition of risk, and acknowledged that it made sense for the MIJB to focus on recognising the risks to its own business.

Decision
• **To approve the proposed approach to risk management and risk appetite detailed in the report; and** • **To, otherwise, note the report.**

Action
Chief Finance Officer/Risk Manager

Report No.	Report Title	Presented by:
5.3	Risk Register	Chris Lawson

Executive Summary of Report
With reference to paragraph 5.1 of the Minutes of MIJB Audit and Risk Committee held on 29 March 2018, there was submitted a report setting out the current version of the MIJB's risk register and highlighting risks of major concern.

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Summary of discussion
The Committee, having heard from the Risk Manager, discussed the Risk Register; a copy of which was appended to the report. It was felt that the inclusion of a key to explain the symbols and notations used in the register would be a welcome addition. With regards the contents of the register itself, it was felt they were a good reflection of the risks/opportunities currently facing the MIJB.

Decision
• **To confirm that the risks contained in the report reflected the current risks/opportunities facing the MIJB; and** • **To, otherwise, note the report.**

Action
Risk Manager

Report No.	Report Title	Presented by:
5.4	Delayed Discharge	Morag Barrow

Executive Summary of Report
With reference to paragraph 5.7 of the Minutes of the MIJB held on 29 March 2018, there was submitted a further report highlighting the continuing challenges within Midlothian in addressing delayed discharge, setting out the actions that were being taken to ensure patients were discharged at the earliest opportunity in their care pathway and ongoing work on admission avoidance. The report advised that the Midlothian Partnership had consistently been a good performer in addressing delayed discharge and ensuring that patients were discharged in a timely manner to an appropriate setting. Over the previous 12 months, this performance had deteriorated as a result of a number of factors, details of which had previously been presented to the MIJB. The report also set out a range of actions that were either now in place or being implemented to improve performance in relation to timely support for patients being discharged from hospital.

Summary of discussion
The Board, having heard from the Head of Primary Care and Older Peoples Services, discussed the series of actions that had been progressed to support discharge, the ongoing work on admission avoidance and the challenges that had impacted on this work. Consideration was also given to possible ways this work could be further improved with better interagency dialogue being suggested as one possible way of improving outcomes.

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Decision
After further discussion, the Board, having acknowledged the complexities involved: • **Noted the current admission profile and corresponding delayed discharge performance in Midlothian; and** • **Noted and expressed support for the detailed actions in place to address and reduce the number of patients who were delayed in hospital.**

Action
Chief Officer

Report No.	Report Title	Presented by:
5.5	2018-19 Delivery Plan for Health and Social Care	Tom Welsh

Executive Summary of Report
This report introduced and sought approval of the 2018-19 Delivery Plan for Health and Social Care. The Plan was based upon the Strategic Plan 2016-19 providing an update on progress in 2017-18 and the key actions planned for 2018-19. It was a wide-ranging document that covered all the main aspects of the delivery of health and social care in Midlothian. It also highlighted the need to focus upon those areas in particular need of transformation either for budgetary reasons or to address current areas of service pressure, namely:- • Reshape Primary Care • Develop a coherent approach to Out of Hours services • Reduce use of Unscheduled Care in Acute Hospitals • Reduce expenditure on Prescribing • Reshape Learning Disability services • Review and redesign Carers' services • Develop a Care Home strategy • Implement new approaches to Care at Home • Shift the balance of care in Mental Health services • Strengthen prevention and recovery in Criminal Justice • Implement a new Public Engagement Strategy • Design and implement a Prevention Strategy

Summary of discussion
Having heard from the Integration Manager, who responded to Members questions and comments, the Board welcomed the development of a Delivery Plan for Health

and Social Care and acknowledged the importance of the transformation process in changing the way in which services were delivered. The monitoring and evaluation of the implementation of the Plan and the transformation process itself to ensure that change was delivered were viewed as a critical part of this overall process.

Decision

The Board:

- **Approved the 2018-19 Delivery Plan, a copy of which was appended to the report;**
- **Agreed that the Strategic Planning Group should oversee the implementation of the Plan; and**
- **Noted that updates would be reported to the MIJB as required.**

Action

Chief Officer/Integration Manager

Report No.	Report Title	Presented by:
5.6	Measuring Performance Under Integration	Jamie Megaw

Executive Summary of Report

With reference to (i) paragraph 5.5 of the Meeting of 20 April 2017 and (ii) paragraph 5.5 of the Meeting of 29 March 2018, there was submitted a report updating the Board on performance and improvement towards achieving the Local Improvement Goals set by the IJB based on the indicators that the Ministerial Strategic Group for Health and Community Care had agreed in December 2016.

The report also included information on performance as a rate of the population. This information was not routinely available for all the IJB's Local Improvement Goals but had been provided by ISD Scotland from the LIST team for A&E activity, unplanned admissions and unplanned occupied bed days. The data presented was for 'all ages' which was different to the IJB's own Local Improvement Goals.

Summary of discussion

Having heard from the Strategic Programme Manager, who responded to Members' questions and comments, the Board in discussing the usefulness of the data acknowledged that in terms of the improvement goals set by the MIJB these were based on the indicators that the Ministerial Strategic Group for Health and Community Care had agreed, over which the Board had no control. The Board welcomed the addition of the information on performance as a rate of the population.

Midlothian Integration Joint Board

Thursday 3 May 2018

Decision
After further discussion, the Board:- • **Noted the performance across the improvement goals; and** • **Noted the information on the ranking of Midlothian IJB against other IJBs and the rate against the population which had been included for some indicators.**

Action
Chief Officer

Report No.	Report Title	Presented by:
5.7	Primary Care Improvement Plan	Jamie Megaw

Executive Summary of Report

This report updated the Board on progress in developing the Midlothian Primary Care Improvement Plan (PCIP).

The report explained that the 2018 General Medical Services Contract and associated Memorandum of Understanding required IJBs and HSCPs to develop a Primary Care Improvement Plan to cover a three-year period from April 2018. The key requirements of the Plan being:

- To be developed collaboratively with HSCPs, GPs, NHS Boards and the key stakeholders;
- To detail and plan the implementation of services and functions listed as key priorities under Section G, with reference to agreed milestones over a 3 year time period;
- To give projected timescales and arrangements for delivering the commitments and outcomes in the priority areas under Section G and in particular to include intended timescales for the transfer of existing contractual responsibility for service delivery from GPs.
- To provide detail on available resources and spending plans (including workforce and infrastructure);
- To outline how the MDT will be developed at practice and cluster level to deliver primary care services in the context of the GMS contract.
- Initial agreement for the Primary Care Improvement Plan secured by 1 July 2018.

The current version of the Midlothian Primary Care Improvement Plan was appended to the report. This was not the final version and further consultation with the IJB, General Practices and other key stakeholders would inform the final version, which would be presented to a future meeting of the Board.

Midlothian Integration Joint Board

Thursday 3 May 2018

Summary of discussion
The Board, having heard from the Strategic Programme Manager, who responded to Members' questions and comments, welcomed the development of the plan.

Decision
After further discussion, the Board: • **Noted the progress and emerging content and direction described in the draft Primary Care Improvement Plan;** • **Agreed that any detailed comments be fed back to the Strategic Programme Manager; and** • **Noted that a final version of the PCIP would be presented to a Special MIJB in June for approval prior to submission to the Lothian GP Sub-Committee for approval.**

Action
Chief Officer/Strategic Programme Manage

Report No.	Report Title	Presented by:
5.8	Appointment of Chief Finance Officer	Allister Short

Executive Summary of Report
With reference to paragraph 4.4 of the Minutes of 20 August 2015, there was submitted a report which set out the process that would be used to appoint the Chief Finance Officer (Section 95 Officer) for the Midlothian Integration Joint Board. The report advised that, following confirmation from the current Chief Finance Officer of his intention to retire, it was proposed after review, that the existing arrangement on a permanent or secondment basis should form the basis for filling the Chief Financial Officer (Section 95 Officer) post. This would provide an opportunity from one of the three parties (NHS Lothian, Midlothian Council, East Lothian Council) to be Chief Finance Officer (Section 95 Officer) for both IJBs and to have an operational remit in one of the parties.

Summary of discussion
The Board, having heard from the Chief Officer, discussed the proposed arrangements and the success of the current working arrangements.

Decision
The Board:

Midlothian Integration Joint Board

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- **Noted that the current Chief Finance Officer, David King had confirmed his intention to retire in October 2018; and**
- **Agreed the proposals for the Chief Finance Officer (Section 95 Officer) recruitment.**

Action
Chief Officer

Report No.	Report Title	Presented by:
5.9	Chief Officer's Report	Allister Short

Executive Summary of Report

This report provided a summary of the key issues which had arisen over the past month in health and social care, highlighting in particular key activities, as well as future key developments.

The report also advised that as the next formal IJB meeting was not due to be held until 23 August 2018, it was proposed to hold a formal IJB meeting on 7 June in place of the planned development session. This would enable the Primary Care Implementation Plan which was a key area of work that would require discussion, agreement and formal sign-off by the IJB prior to submission in July to be progressed, amongst other things.

Summary of discussion

Having heard from the Chief Officer, who responded to Members questions, the Board welcomed the update on the planned opening of the new Medical Practice in Newtongrange, again emphasised the importance of learning lessons from the less than favourable inspection report received by Springfield Bank, and acknowledged the importance of the practice boundary review.

Decision

The Board:

- **Noted the issues and updates raised in the report; and**
- **Noted and approved the Development Session scheduled for Thursday 7 June being changed to a Special Meeting of the Midlothian Integrated Joint Board.**

Action
Chief Officer/Clerk

Midlothian Integration Joint Board

Thursday 3 May 2018

Report No.	Report Title	Presented by:
5.10	Review of the Standing Orders of the Midlothian Integration Joint Board	Allister Short

Executive Summary of Report

With reference to paragraph 4.1 of the Minutes of 20 August 2015, there was submitted a report seeking approval of proposed changes to the MIJB's Standing Orders; and seeking, in line with what was considered good governance practice, authority to establish a review process for Standing Orders..

The report explained that the proposed changes to the MIJB's Standing Orders took account of:-

- adjustments requested by the MIJB at its' meeting on 20 August 2015
- changes as a result of the Public Bodies (Joint Working) (Integration Joint Boards and Integration Joint Monitoring Committees) (Scotland) Amendment (No. 2) Order 2015;
- provision for the inclusion of the terms of reference for the Audit & Risk Committee;
- amended governance to ensure that substitutes on the MIJB are aware of their duties under the Code of Conduct; and
- provision to allow urgent decisions to be taken.

A copy of the MIJB's Standing Orders showing the proposed adjustments as tracked changes was appended to the report.

Decision

The Board, having heard from both the Chief Officer and the Clerk:

- **Approved the proposed changes to the Standing Orders of the Midlothian Integration Joint Board; and**
- **Approved the proposed review process for Standing Orders.**

Action

Chief Officer/Clerk

Report No.	Report Title	Presented by:
5.11	Delegation of Powers to Officers	Allister Short

Executive Summary of Report

This report invited the Board to consider and approve a list of powers and responsibilities to be delegated by the Board to its officers, as part of the review of the Board's meeting governance arrangements.

Midlothian Integration Joint Board

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The report explained that the Scheme of Delegation was not intended to replace, duplicate or repeat the role descriptions of each of the officer posts, nor was it designed to be an exhaustive list of things that officers could do on behalf of the Board. The Scheme simply sought to set out the scope and rules for decisions being taken by officers on behalf of the Board as part of the governance framework for efficient, effective and accountable decision-making by the Board, its committees and its officers. A copy of the proposed Scheme was appended to this report

Summary of discussion

Having heard from the Chief Officer, and the Clerk who advised in addition that rather then bring every single minor or administrative change, for example when new legislation was introduced or terminology changed, or the Board made a new delegation or amended an existing delegation, to the Board authority was being sought for the Chief Officer to amend and re-publish the Scheme, which would be checked annually and reviewed every three years.

Decision

The Board:

- **Approved the proposed Scheme of Delegations as detailed in the Appendix to the report;**
- **Delegated to the Chief Officer the powers to make administrative changes to the Scheme as required from time to time, and to amend and re-publish the Scheme as and when required by further delegations authorised by the Board;**
- **Agreed that the Scheme should be comprehensively reviewed every three years; and**
- **Noted that the approved Scheme would be published alongside the Board's Standing Orders in order to provide an open and transparent set of decision-making rules and procedures.**

Action

Chief Officer/Chief Finance Officer

Report No.	Report Title	Presented by:
5.12	Proposed Midlothian IJB Meeting Schedule and Development Workshop Dates for 2018/19	Allister Short

Executive Summary of Report

The purpose of this report was to set the dates for the Board and Development Workshops for the Midlothian Integration Joint Board and for the meetings of the Audit & Risk Committee, for 2018/19 as prescribed by Midlothian Integration Joint Board Standing Orders 5.2.

Midlothian Integration Joint Board

Thursday 3 May 2018

Summary of discussion
Having heard from the Chief Officer, the Board considered the proposed dates for 2018/19 it being noted that some fine tuning may be required, particularly with regards the timings of the Special Board and Audit and Risk Committee meetings scheduled for 7 June 2018.

Decision
The Board agreed, that subject to resolution of the above, to: • **Approved the schedule of meetings of the Midlothian Integration Joint Board;** • **Approved the schedule of meetings of the Midlothian Integration Joint Board Audit and Risk Committee;** • **Approved the schedule of Development Workshops for the Midlothian Integration Joint Board;** • **Approved the schedule of Joint Special Midlothian Integration Joint Board/Development Workshops all as outlined in the report; and** • **Noted the approach for service visits for the Midlothian Integration Joint Board.**

Action
All Members to Note

6. Private Reports

No private business to be discussed at this meeting.

7. Any other business

No additional business had been notified to the Chair in advance

8. Date of next meeting

The next meetings of the Midlothian Integration Joint Board would be held on:

• Thursday 6th June 2018 *	2pm	Special Midlothian Integration Joint Board
• Thursday 23rd August 2018	2pm	Midlothian Integration Joint Board
• Thursday 13th September 2018	2pm	Joint Special Midlothian Integration Joint Board/Development Session

* Please note carefully that this date will now be a formal Board meeting.

The meeting terminated at 3.50 pm.

Midlothian Integration Joint Board

Thursday 3 May 2018

Appendix

(relative to paragraph 5.12)

Midlothian Integration Joint Board
Meeting Schedule and Development Workshops
Dates 2018-19

Board Meetings

- Thursday 23rd August 2018, 2 pm
- Thursday 11th October 2018, 2pm
- Thursday 13th December 2018, 2pm
- Thursday 14th February 2019, 2pm
- Thursday 11th April 2019, 2pm
- Thursday 13th June 2019, 2pm
- Thursday 22nd August 2019, 2 pm
- Thursday 10th October 2019, 2pm
- Thursday 12th December 2019, 2pm

Development Workshops

- *Thursday 7th June 2018, 2pm (already approved)
- Thursday 15th November 2018, 2pm
- Thursday 17th January 2019, 2pm
- Thursday 16th May 2019, 2pm
- Thursday 14th November 2019, 2pm

Joint Special Board Meeting/Development Workshops

- Thursday 13th September 2018, 2pm – Annual Accounts
- Thursday 14th March 2019, 2pm – Budget/Directions
- Thursday 12th September 2019, 2pm – Annual Accounts

Service Visits

- Further service visits will be scheduled as required or at the request of members of the Midlothian Integration Joint Board.

Midlothian Integration Joint Board
Audit and Risk Committee
Meeting Schedule 2018-19

Meetings

- Thursday 7th June 2018, 2pm
- Thursday 6th September 2018, 2pm
- Thursday 6th December 2018, 2pm
- Thursday 7th March 2019, 2pm
- Thursday 6th June 2019, 2pm
- Thursday 5th September 2019, 2pm
- Thursday 5th December 2019, 2pm

Minute of Special Meeting

Special Meeting of Midlothian Integration Joint Board

Date	Time	Venue
Thursday 7 June 2018	2.30pm	Conference Room, Melville Housing, The Corn Exchange, 200 High Street, Dalkeith, EH22 1AZ.

Present (voting members):

Angus McCann (Chair)	Cllr Derek Milligan (Vice-Chair)
Alex Joyce	Cllr Jim Muirhead
Alison McCallum	Cllr Pauline Winchester
Martin Connor (substitute for Tracey Gilles)	Cllr Kenneth Baird (substitute for Cllr Catherine Johnstone)

Present (non voting members):

Allister Short (Chief Officer)	David King (Chief Finance Officer)
Hamish Reid (GP/Clinical Director)	Wanda Fairgrieve (Staff side representative)
Fiona Huffer (Head of Dietetics)	Pam Russell (User/Carer)
Keith Chapman (User/Carer)	George Wilson (Third Sector)

In attendance:

Morag Barrow (Head of Primary Care and Older Peoples Services)	Jamie Megaw (Strategic Programme Manager)
Mike Broadway (Clerk)	

Apologies:

Tracey Gillies	Cllr Catherine Johnstone
Alison White (Chief Social Work Officer)	Caroline Myles (Chief Nurse)
Aileen Currie (Staff side representative)	Ewan Aitken (Third Sector)

Midlothian Integration Joint Board

Thursday 7 June 2018

1. Welcome and introductions

The Chair, Angus McCann, welcomed everyone to this Special Meeting of the Midlothian Integration Joint Board, following which there was around of introductions.

2. Order of Business

The order of business was confirmed as outlined in the agenda that had been previously circulated.

3. Declarations of interest

No formal declarations of interest were received, however, Keith Chapman advised for the record that he was a member of Alzheimer Scotland, which may impact on his participation on items relating to dementia.

4. Public Reports

Report No.	Report Title	Presented by:
4.1	Financial Out-Turn 2017/18	David King

Executive Summary of Report

The purpose of this report was to set out the MIJB's out-turn position for 2017/18 based on the information provided by Midlothian Council and NHS Lothian regarding the actual expenditure that would be charged against the IJB's budgets for the 12 months ended 31 March 2018.

The report explained that the MIJB was underspent for the 2017/18 financial year. This was an improved financial position from that reported to the MIJB at its December 2017 meeting. This underspend would allow the MIJB to create a reserve and carry these unused funds forward into future years. Although the MIJB did not have a reserve in its own books at the end of 2016/17, Midlothian Council had carried forward c. £1.2m of funds on the MIJB's behalf. An element of those funds had been used to support the financial position in the current year along with holding back new funding in 2017/18 to offset the projected overspend as far as possible. The use of these funds masks a continuing underlying and significant overspend in social care and does not alter the continuing need for transformation to more affordable models of care

Summary of discussion

The Board, having heard from the Chief Finance Officer, discussed the reasons behind the underspend, acknowledging that whilst beneficial from a Midlothian perspective it gave rise to pressures elsewhere in the system and that ultimately what was required was for the transformation process to successfully deliver more affordable models of care. In this regard, the Chief Officer confirmed that it was hoped to utilise some of the underspent money to assist in that process.

Midlothian Integration Joint Board

Thursday 7 June 2018

Decision

The Board agreed to:-

a) **Accept the charges (service delivery costs) for 2017/18 from the partners (Midlothian Council and NHS Lothian);**

b) **Note the year-end position for 2017/18, this position being unaudited;**

c) **Note the creation of a reserve for the MIJB; and**

d) **Support the proposals for the utilisation of the reserve as detailed in the report.**

Action

Chief Finance Officer/Chief Officer

Report No.	Report Title	Presented by:
4.2	Update on 2018/19 Financial Assurance	David King

Executive Summary of Report

The purpose of this report was to update the MIJB on the financial assurance for the MIJB's 2018/19 budget which was presented to the MIJB at its March 2018 meeting, specifically it considered the formal budget proposition that was made by NHS Lothian in April 2018.

The report explained that at its March 2018 meeting the MIJB considered its financial assurance for 2018/19, that is it examined the budget propositions from its partners and applied its two tests – that of fairness and adequacy. At that date a formal offer had been made (and accepted) by Midlothian Council however an indicative position for NHS Lothian was considered based on the NHS Lothian financial plan that had been presented to NHSL Finance and Resources Committee at its January 2018 meeting. The MIJB agreed to accept the NHSL indicative position on the basis that NHS Lothian provided further information on the plans underway to deliver financial balance within the Set Aside budgets and that the final offer was not materially different from the indicative position. A final offer has now been received from NHS Lothian and this paper considers that offer.

Summary of discussion

Having heard from the Chief Finance Officer, the Board discussed the formal budget proposition received from NHS Lothian, which complied with the tests of 'fairness' and 'adequacy' applied to any budgetary proposition received by the MIJB. In response to Members' comments, it was acknowledged that whilst budgetary pressures inevitably would remain, there was some additional monies that still had to filter through the system that should assist the likely financial position.

Midlothian Integration Joint Board

Thursday 7 June 2018

Decision
After further discussion, the Board agreed to • **Accept the NHS Lothian 2018/19 budget proposition;** • **Request further information by August laying out plans to bring the Set Aside services back into a break-even position;** • **Note the revised indicative financial pressures for 2018/19; and** • **Note that a further report on the development and the current shape of the MIJB's financial plan would be brought to the MIJB's September meeting.**

Action
Chief Finance Officer

Report No.	Report Title	Presented by:
4.3	Midlothian Primary Care Improvement Plan	Jamie Megaw

Executive Summary of Report
The purpose of this report was to present the Midlothian Primary Care Improvement Plan (PCIP) for approval by the MIJB. The report explained that the 2018 General Medical Services Contract and associated Memorandum of Understanding (MoU) required IJBs and HSCPs to develop a Primary Care Improvement Plan to cover a three-year period from April 2018. Initial agreement for the Primary Care Improvement Plan (PCIP) from the GP-Sub Committed was required before 1 July 2018. Assuming that both the MIJB and the GP-Sub Committee supported the PCIP then the Midlothian HSCP, working with key stakeholders including General Practice would move into an engagement and implementation phase following the timelines set out in the PCIP. The Plan and its implementation would transform how care was provided in Midlothian over the next three years. A copy of the Midlothian PCIP was appended to the report.

Summary of discussion
The Board, having heard from both the Strategic Programme Manager and the Chief Officer discussed the Midlothian Primary Care Improvement Plan (PCIP). Whilst it was acknowledged that the overall policy direction of developing a multi-disciplinary team approach within primary and community care supported the Midlothian IJB Strategic Plan and would contribute to the wider aim of shifting the balance of care from secondary care to community settings, concerns remained about issues such as, the shortage of GPs, workloads, restricted practice lists, and the use of new technology. It being accepted that these and other related issues would require to be addressed as the PCIP developed and move into a phase of stakeholder engagement and involvement and implementation of the Plan following initial approval by the MIJB and the GP-Sub Committee.

Midlothian Integration Joint Board

Thursday 7 June 2018

Decision
The Board agreed after further discussion to approve the Midlothian Primary Care Improvement Plan for submission to the Lothian GP-Sub Committee on 11th June 2018.

Action
Chief Officer/Strategic Programme Manager

Report No.	Report Title	Presented by:
4.4	Workforce Planning	Allister Short

Executive Summary of Report
The purpose of this report was to inform MIJB of the progress made over the past six months in Workforce Planning across the Midlothian Health and Social Care Partnership. The report reminded Members that the MIJB had agreed a framework for Workforce Planning in October 2017. This had provided a foundation for each service area to shape their workforce for the future, taking account of transformational change, resulting in new models of care and the increasing need to maximise on the effective use of resources. The report, in addition, outlined the proposed plan for workforce action planning in other key service areas.

Summary of discussion
Having heard from the Chief Officer, the Board discussed the importance of good Workforce Planning in helping to successfully deliver organisational change and new models of care, which were both integral elements of the MIJB's Strategic Plan. In response to Members' comments, the Chief Officer confirmed that there had been consultation with service users as part of the change process but as always there was certainly scope for more, he suggested that this, together with more detailed information on connections with NHS Lothian, Midlothian Council, pan-Lothian, Regional and National Workforce Planning developments, and how the challenge of ensuring staff had sufficient 'time' was being addressed could be picked up in the next update.

Decision
After further discussion , the Board agreed to:- • **Note the progress to date;** • **Support the plans for future work; and** • **Receive a further report in 3 months to provide assurance that workforce planning was progressing with positive effect.**

Midlothian Integration Joint Board

Thursday 7 June 2018

Action
Chief Officer

Report No.	Report Title	Presented by:
4.5	Development of Midlothian IJB's Strategic Plan 2019-22	Allister Short

Executive Summary of Report
The purpose of this report was to explain proposals to develop Midlothian IJB's second Strategic Plan covering the period 2019-22. The report explained that the Strategic Plan would explain how the MIJB intended to use its resources to improve the health and wellbeing of the people of Midlothian. The redesign of health and social care should be based on a good understanding of the needs of the local population. In addition, the success of the Plan required the support and active contribution of all stakeholders including staff, voluntary organisations, unpaid carers, patients, service users and the public. In order to achieve this there was a need to begin the process of developing the 2019-22 Strategic Plan now. This report laid out a proposed timetable for its development

Summary of discussion
The Board, having heard from the Chief Officer, discussed how Board Members could become involved in the development of the Strategic Plan. In addition, and in response to Members' comments, the Chief Officer confirmed that it was intended to produce an easy read version and that the Plan would be the subject of equalities impact and joint needs assessments.

Decision
The Board agreed to:- • **Note and approve the timetable for the development of the next strategic plan.** • **Approve the role and contribution of MIJB members to the development of the plan.**

Action
Chief Officer

Report No.	Report Title	Presented by:
4.6	Chief Officer's Report	Allister Short

Midlothian Integration Joint Board

Thursday 7 June 2018

Executive Summary of Report
This report provided a summary of the key issues which had arisen over the past month in health and social care, highlighting in particular service pressures as well as recent and future service developments. The report also advised that due to the timescales associated with producing the financial accounts by each of the Partners, it had not been possible to prepare the draft MIJB annual accounts for consideration at this meeting of the MIJB. Given that a draft of the annual accounts required to be published by the end of June, the MIJB was asked to agree that the draft accounts were submitted for approval at the MIJB Audit & Risk Committee meeting on 20 June 2018.

Summary of discussion
Having heard from the Chief Officer, who responded to Members questions, the Board welcomed the planned development of a business case to request capital funding to enable the reprovisioning of Highbank Intermediate Care Facility, were pleased to learn of the success of the recent Voluntary Sector Summit and of plans for a follow-up event, and acknowledged the challenges being experienced in the timeous production of both the Annual Report and draft Annual Accounts.

Decision
The Board: • **Noted the issues and updates raised in the report; and** • **Agreed that the draft MIJB annual accounts be submitted to the Audit & Risk Committee meeting on 20 June 2018 for consideration/approval.**

Action
Chief Officer/Chief Finance Officer

5. Private Reports

No private business to be discussed at this meeting.

6. Any other business

No additional business had been notified to the Chair in advance.

7. Date of next meeting

The next meeting of the Midlothian Integration Joint Board would be held on:

• Thursday 23rd August 2018	2pm	Midlothian Integration Joint Board
• Thursday 13th September 2018	2pm	Special Midlothian Integration Joint Board/Development Workshop

The meeting terminated at 3.47pm.

East Lothian
Integration Joint Board

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 28 JUNE 2018
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON

Voting Members Present:
Mr P Murray (Chair)
Councillor S Akhtar
Ms F Ireland
Councillor S Kempson
Councillor F O'Donnell
Prof M Whyte (Items 1 – 10)

Non-voting Members Present:
Ms F Duncan
Dr R Fairclough (Items 3 – 14)
Ms E Johnston
Mr D King
Mrs M McKay
Dr M Flynn (*substitute)

Officers from NHS Lothian/East Lothian Council:
Mr P Currie
Ms J Odgen-Smith

Clerk:
Ms F Currie

Apologies:
Councillor S Currie
Ms A MacDonald
Ms M McNeill
Mr T Miller
Mr D Small
Dr J Turvill*

Declarations of Interest:
None

1. MINUTES OF THE EAST LOTHIAN INTEGRATION JOINT BOARD MEETING OF 24 MAY 2018 (FOR APPROVAL)

The minutes of the East Lothian Integration Joint Board meeting of 24 May 2018 were approved.

2. MATTERS ARISING FROM THE MINUTES OF THE MEETING ON 24 MAY 2018

The following matters arising from the minutes of 24 May were discussed:

Replacement of the Chief Officer – the Chair advised members that Alison MacDonald had been appointed to replace David Small on an interim basis. Her appointment would take effect from 2 July and last between 6 and 9 months.

In response to questions from Margaret McKay and Elaine Johnston, the Chair explained that the decision to appoint an interim had been made by the Chief Executives of East Lothian Council and NHS Lothian and reflected their intention to review the job description for the post before appointing a permanent replacement. He confirmed that arrangements to fill Ms MacDonald's current post were being considered.

3. CHAIR'S REPORT

The Chair reported on two meetings he had attended earlier in the week. Firstly, the IJB Chairs and Vice Chairs Network meeting which had involved speakers from NHS Scotland, CoSLA, the Scottish Government and Audit Scotland. He said that 15 IJBs had been represented and the presentations had covered a range of topics; with two key themes being the use of Directions and more effective use of IT and data sharing. The Chair suggested that these topics be discussed at the IJB's October meeting.

The Chair had also attended the NHS Lothian Board meeting which had included a discussion on the recently published report from the fora on unscheduled care. He said that this report had implications for the work of the IJB and he would circulate an electronic copy to members as soon as it became available.

The Chair also referred to the recent Care Inspectorate report on Drummore Nursing Home. He said he was disappointed with the findings and that care should be of a much higher standard than that described in the report. He also said that the IJB should take every opportunity to comment on care and standards and to encourage the expectation that concerns raised by staff or families would be addressed.

Mrs McKay said that she had made some observations to the Chair previously. Councillor Fiona O'Donnell advised that she had recently received a complaint regarding the transfer of a patient from Liberton to Drummore.

Dr Morgan Flynn referred to a nursing home in another area where a specialist team had been placed in the home for a few months to make the necessary improvements

The Chair thanked members for their input but said that he did not want to enter into a detailed discussion at today's meeting. He would instead raise the matter with the Chief Officer.

4. NHS HEALTHCARE GOVERNANCE COMMITTEE (VERBAL)

Fiona Ireland reported on the meeting of 8 May at which the Committee had considered the Care Inspectorate report on Belhaven Care Home. She said that the Committee had taken significant assurance that the Action Plan would be delivered, along with a review of the healthcare model.

Councillor O'Donnell asked if there had been any discussion or awareness of problems prior to the inspection. Ms Ireland said that there had been internal feedback and discussion regarding whistleblowing. There was also an internal inspection regime and nursing peer reviews.

Fiona Duncan commented that Belhaven was an interesting site as it included a care home and a hospital. She said that care home staff and nursing staff had very different ways of thinking and working and placing nursing staff in a care home was not the way to resolve issues. This was recognised in the inspection report and she hoped that the service review would provide a positive way forward. She made the point that hospital was very different from a care home; a care home was a home rather than a place of clinical treatment.

The Chair acknowledged this important point and said that it was incumbent on the IJB to encourage positive workforce development where all roles were valued and the staff understood their responsibilities.

5. AUDIT & RISK COMMITTEE (VERBAL)

Margaret McKay reported on the Committee's meeting earlier that day. She outlined the findings of the internal audit report on delayed discharges which she said had provided strong assurance that the processes and monitoring arrangements were working effectively. The only recommendation had been to ensure that the IJB received an update on delayed discharge statistics at each meeting. Mrs McKay also reported the findings of the internal audit report on risk management. This had identified some room for improvement around the monitoring of risks through the risk register and had noted that the risk management strategy and policy had yet to be approved by the IJB. However, this last point was being rectified at today's meeting.

Mrs McKay advised members that one of the key themes of discussion for the last few meetings of the Committee had been the crossover between strategic and operational risks and how best to record and monitor these. It was recognised that the IJB had no mechanism for ensuring regular reporting and monitoring on the delivery of Directions. Although the partners were the bodies responsible for delivering Directions, any failures would impact the IJB's ability to achieve its strategic goals. The Committee had therefore agreed that 'Performance on Directions' should be added to the IJB's risk register.

The Chair concurred with Mrs McKay and noted that at the recent NHS Lothian Board meeting they had discussed their annual operating plan and the requirement for a contribution from the Health & Social Care Partnership. He suggested that the IJB should be asking for all relevant Directions to be included in the plan. Although NHS Lothian were the delivery body, he said it was crucial for the IJB to have oversight of these actions.

Mrs McKay reported that the Committee had discussed issues such as participation and engagement and how to track outcomes and receive feedback in a number of

areas. The IJB needed to ensure that they had the necessary mechanisms in place to identify and address problems that could affect the delivery of Directions.

The Chair observed that the Committee appeared to be on a good footing and would provide a useful scrutiny function going forward.

Councillor Shamin Akhtar asked about actions required in relation to processes, following the internal audit report on Delayed Discharges. Mrs McKay said that it had been clear in the report that the processes were robust but that the IJB needed to consider what was preventing them from reducing delays further, for example, access to services.

6. FINANCIAL UPDATE 2018/19

The Chief Finance Officer had submitted a report to the IJB providing an initial review of the financial position for 2018/19 and reflecting on further developments of the IJB's financial plan.

Mr King presented the report outlining the position as at the year-end for 2017/18 and how this affected the opening position for 2018/19. He advised that NHS Lothian had provided a year-to-date position for month two and a year-end forecast. These figures had demonstrated the ongoing pressures within hosted and set aside budgets and the IJB would continue to discuss actions with NHS Lothian. He said that the Council had been had not, at this time, struck a month 2 position. However, he hoped that the Quarter 1 figures for both the Council and NHS Lothian would be available in time for him to present them to the IJB at its August meeting.

Mr King also reported on his meetings with officers within NHS Lothian and East Lothian Council and the agreements reached regarding closer oversight, as well as principles and strategy for future financial planning.

Decision

The IJB agreed to:

(i) Note the update on the 2018/19 projected financial position; and
(ii) Support further developments of the IJB's financial plan.

7. 2017/18 ANNUAL ACCOUNTS

The Chief Finance Officer had submitted a report to the IJB presenting the IJB's draft (unaudited) Annual Accounts for 2017/18.

Mr King presented the report summarising the key elements of the annual accounts and indicating that the management commentary had been expanded to provide more information on the work of the IJB.

Mr King advised members of one amendment, following a suggestion from Councillor O'Donnell that an example of prevention work be included in the text. On page 10 of the accounts, point no. 3, a sentence would be added stating: "For example this approach is delivered through the link workers project in partnership with the third sector and is emphasised further in the Primary Care Improvement Programme."

The Chair asked members if they were content with the proposed addition. The members agreed.

Mrs McKay said it was worth noting that 2017/18 was the second year running that the IJB had needed additional support from the partners to break even. The Chair acknowledged the point and Mr King advised that this had been included in the management commentary.

Decision

The IJB agreed that the draft annual accounts, as amended, could be published and presented for audit.

8. RISK MANAGEMENT STRATEGY AND POLICY

The Chief Finance Officer had submitted a report to the IJB laying out its risk management strategy and risk management policy.

Mr King presented the report explaining the background to the development of the strategy and policy. He indicated that the revised draft had been presented to the Audit & Risk Committee who had recommended its approval by the IJB.

The Chair made some comments on the draft policy and strategy in relation to avoiding duplication of effort between the IJB and its partners; the role of Directions in linking strategic and operational risks; and the inclusion of NHS Lothian's unified assurance methodology as part of the IJB's risk management processes.

Decision

The IJB agreed:

(i) the draft risk management strategy; and
(ii) the draft risk management policy.

9. PRIMARY CARE IMPROVEMENT PLAN

The Chief Officer had submitted a report to the IJB presenting the East Lothian Primary Care Improvement Plan (PCIP) which is required as part of the process of delivering the new General Medical Services (GMS) contract for GPs across Scotland.

Paul Currie presented the report summarising the background to the GMS contract and the requirement for the PCIP. He explained that, as well as delivering the GMS contract, the PCIP was also required to develop priority areas of service redesign including vaccinations, community treatment and care services, community mental health and community link workers.

Mr Currie outlined the consultation process involved in the development of the PCIP and said that the three month timescale for development and approval had proved challenging. He advised that the PCIP had been approved by the Lothian GP Sub Committee on 11 June 2018 and, if approved by the IJB, it would be submitted to the Scottish Government on 2 July. The next stage would be to prepare an implementation plan to deliver the PCIP and this would be the subject of further consultations. He added that an Integrated Impact Assessment had been carried out and its findings would also be taken into account.

Mr King provided a summary of the resources connected with the PCIP and the monies which would be made available to IJBs over the next two years. He also confirmed that

discussions had yet to take place on funding some aspects of the work, such as changing vaccination delivery.

In response to questions from members, Mr King provided further advice on aspects of the funding arrangements and East Lothian's share of the resources provided by the Scottish Government. He acknowledged that the whole contract was very ambitious and that further discussions on priorities and funding would be required in later years.

Responding to further questions he confirmed that resources for mental health services were included within the Primary Care Transformation Fund but that the total amount available had not been broken down.

Mr Currie explained that Link workers had been included in the PCIP because they provided important support to primary care workers. He advised that he would be working with STRiVE and others as part of the engagement on the implementation plan. He said that part of the purpose of the PCIP was to encourage GPs and others to look at new ways of working, to consider whether premises remain fit for purpose, and to promote supported self-care and management of long-term conditions such as diabetes.

Councillor O'Donnell commented on the need to consider alternative providers for the community Link Worker provision and mentioned the Citizens Advice Bureau (CAB) as a previous provider.

On the issue of premises, the Chair indicated that any proposals which required additional funding would need to be brought forward at an early stage as NHS Lothian set their capital investment budget for a five year period.

Richard Fairclough said that, as a GP working in a large urban practice, he welcomed the PCIP. He believed that it was coming at a time when there were huge challenges in primary care and he welcomed the shift in focus to a model of multi-disciplinary led care. He noted that the level of engagement had varied in different areas and that the compatibility of the PCIP with the GP contract would require to be kept under review. He stated that there needed to be an equitable delivery of services across East Lothian but he acknowledged the funding challenges and emphasised the importance of assessing need. He also recognised the challenges of an increasing population; recruitment of GPs and other allied health professionals and gaps in the skills sets of existing staff. However, he welcomed the support the PCIP gave to the delivery of urgent care and in drawing the focus away from GPs to allow them to concentrate on the delivery of quality, long-term care.

Dr Flynn commented that the East Lothian PCIP was more integrated than those of other areas and had GP services tailored into it. He commended the team who had developed the PCIP despite the huge pressure of a three month timeframe. He referred to the recent situation in Musselburgh and the need to target resources in a more focused way. He also expressed concern about the lack of sufficient allied health professionals to deliver the PCIP and whether it would be possible to recruit the numbers of staff required. Nonetheless, he believed that the PCIP represented a positive attempt to address these issues.

The Chair said that concerns about the ability to meet the personnel requirements within the PCIP would be recorded in the minutes.

Ms Johnston observed that there was a difference between consulting and engaging and that it was important to start having conversations at an early stage. She referred to a very useful meeting she had had recently with Third Sector colleagues and said that this was an area where they could get involved in engaging with the public. She

also reminded members of the need to think beyond GP surgeries to other places where primary care services were available and to consider the role of these services in prevention work. Lastly, she suggested that if the IJB was to review its Strategic Plan by March 2019 then the engagement work needed to begin now.

Councillor O'Donnell reflected on Dr Fairclough's point about equity of resources across the county. She said that it was important to consider the full range of need within each area as there would be variations which would affect the level of services and resources required. She also raised some concerns about the lack of uptake of CMS prescribing.

Dr Flynn outlined the background of CMS prescribing and his experiences in North Berwick. He said that it had been seen as a bit of a cumbersome process but that it was designed to benefit GPs and practices were being asked to increase their use of the service. Dr Fairclough added that pharmacy support would be very helpful in the setting up stage.

Jane Ogden-Smith advised that, in addition to the consultations carried out, work on the PCIP had been informed by feedback from previous engagement activities such as the 'Big Conversation' events.

Mrs McKay said that she was very excited by the PCIP. However, there was a general lack of awareness within the general public of the services that were already available. As well as a plan for engagement, she stressed the need for a campaign to encourage a change in the mindset of the public. She added that the Scottish Government should consider a national campaign to encourage people to think differently about the services they required.

The Chair said he intended to raise the need for a national campaign at the next Ministerial Strategy Group meeting.

Dr Fairclough, Councillor O'Donnell and Councillor Kempson also agreed that there was a need to educate the public to think differently about primary care services.

Ms Ogden-Smith indicated that work was already underway and that one suggestion had been to develop a video which could be shown in surgeries. She added that this could be done locally and designed to show patients how to access specific services. The Chair considered this to be an excellent way forward.

Ms Ireland said she was hugely supportive of the PCIP and the integrated way in which it had been developed. She said that the key would be how to link this in with the workforce plan.

The Chair brought the discussion to a close. He noted that the positive comments on the PCIP and, although there had been issues around the level of engagement during the initial stages, this would be addressed during the next stage of the process.

Decision

The IJB agreed to:

(i) note the requirement for the IJB to work with partners to support introduction of a new General Medical Services (GMS) contract for GPs;

(ii) note the work over recent months to engage with a wide range of stakeholders in the development and finalisation of an East Lothian Primary Care Improvement Plan;

(iii) note the intention of the Improvement Plan to develop the professions within the multidisciplinary primary care team to expand their roles and to direct workload from GPs in practices;

(iv) note East Lothian's progress to date in developing the Collaborative Working for Immediate Care (CWIC) Team and the Care Home Team to deliver new and innovative primary care services;

(v) approve the East Lothian Primary Care Improvement Plan which will form the basis of work to further develop primary care services and to deliver the GMS contract requirements in the next three years.

10. PERFORMANCE AGAINST NATIONAL INDICATORS FOR 2017/18

The Chief Officer had submitted a report informing the IJB of the East Lothian Health and Social Care Partnership's (HSCP) performance in 2017-18 against the agreed suite of national indicators.

Mr Currie presented the report outlining the background to the survey and taking members through the individual results for each of the indicators. He said that this followed on from previous performance reports presented to the IJB and represented a mixed picture of results. He reminded members that this was based on performance in 2016/17 and a response level equivalent to 1% of the population.

The Chair added that it was important to bear in mind the difference between results based on perception and those based on fact. Although overall the results read badly when compared to peer IJBs, he believed that the key issues could be addressed by educating the public about services and through the use of Directions.

Councillor Kempson observed that individuals who have complaints are generally more likely to return surveys than those who are content with the service.

Mrs McKay also questioned the validity of the sample but stated that if levels of satisfaction had gone down from last year then that was an issue; the IJB needed to understand why things had changed.

Ms Odgen-Smith explained the timing of the survey may have affected responses as it had coincided with significant events such as the closure of a GP practice and worry over the reprovision of Belhaven and other sites.

Dr Flynn and Dr Fairclough commented on the expectations of patients and their perception of how changes to services will impact on them. Dr Fairclough added that negative media is always more prevalent than positive messages and this needed to be addressed.

Ms Duncan commented that the results seemed skewed and a whole population demographic appeared to be missing.

In response to questions from Ms Johnston, Ms Ogden-Smith advised that the survey was sent to a random sample of residents and she provided examples of other surveys undertaken which included some similar questions.

The Chair concluded that although they could not dismiss the results, it would be useful to understand more about the methodology and to cross reference the results with other survey information.

Decision

The IJB agreed to:

(i) note that as previously agreed trend data had been developed for the national indicators to better present performance changes over time and to make interpretation easier compared to 'snapshot' data;
(ii) note that the East Lothian HSCP Data Performance Group had brought together individuals from East Lothian and NHS Lothian to develop performance monitoring and reporting approaches;
(iii) discuss the 2017-18 performance set out in the report which follow and note changes compared to performance in 2016-17 and in previous years.

11. MEMBERSHIP OF THE IJB AND THE AUDIT & RISK COMMITTEE

The Chief Officer had submitted a report informing the IJB of the renomination of members by NHS Lothian, the GP Forum and the NHS Lothian staff unions and to provide an update on progress with the selection of permanent replacements for the roles of independent sector and carers' representatives on the IJB.

The report also sought approval for a change of membership on the Audit & Risk Committee.

Mr King presented the report outlining the background and proposed actions in relation to recruitment of new independent sector and carers' representatives. The Chair added that during selection they needed to ensure that the representatives had a broad view of their sector rather than a singular focus.

Councillor O'Donnell asked about the balance of NHS and Council members on the Audit & Risk Committee. She offered to remove herself from the membership if the 3:2 split was likely to cause any difficulty.

The Chair agreed to discuss the situation with the NHS Lothian Board and feedback to the IJB. He indicated that his preference would be for 2 members from each partner. In the meantime, he invited members to agree the recommendations as set out in the report.

Decision

The IJB agreed to:

(i) note the renomination of Alex Joyce, Alison MacDonald, Jon Turvill, Andrew Flapan, Thomas Miller and Richard Fairclough as voting and non-voting members of the IJB for the maximum three year term;
(ii) note the actions underway to select permanent replacements for the roles of independent sector and carers' representatives on the IJB; and
(iii) approve the appointment of Councillor Susan Kempson as member and chair of the Audit & Risk Committee, in place of Margaret McKay.

12. APPOINTMENT OF AN INTERIM CHIEF OFFICER

The Chief Officer had submitted a report asking the IJB to consider and approve the appointment of the Chief Officer of the IJB on an interim basis.

Mr King presented the report asking members to approve the interim appointment.

Decision

The IJB approved the recommendation made by the Appointment Committee as to the appointment of a Chief Officer, on an interim basis for 6 months.

13. IJB MEETING DATES FOR 2018/19

The Chief Officer had submitted a report setting the dates of meetings of the IJB for 2018/19.

The Chair presented the report inviting members to agree the proposed dates as outlined.

Decision

The IJB approved the dates for meetings during session 2018/19, including development sessions, as set out in the report.

SUMMARY OF PROCEEDINGS – EXEMPT INFORMATION
The Integration Joint Board unanimously agreed to exclude the public from the following business containing exempt information by virtue of Paragraph 5.9.1 of its Standing Orders (the Integration Joint Board is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation).

Minutes of other Groups of Relevance to the IJB (for noting):

- **MELDAP Strategic Group – 5 December 2017**

The IJB agreed to note the minutes of the meeting of the MELDAP Strategic Group on 5 December 2017.

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 26 JUNE 2018.

Present –

Voting Members – Martin Hill, Harry Cartmill, Martin Connor, George Paul, Bill McQueen and Damian Timson.

Non-Voting Members – Ian Buchanan, Carol Bebbington, Elaine Duncan, Jim Forrest, Jane Kellock, Bridget Meisak and Patrick Welsh

Apologies – Marion Barton, Jane Houston, Mairead Hughes, Alex Joyce, Mary-Denise McKernan and Martin Murray

Absent – Dave King (Voting Member)

1. DECLARATIONS OF INTEREST

No declarations of interest were made.

2. MINUTE

The Board confirmed the Minute of its meeting held on 1 May 2018.

3. RISK MANAGEMENT POLICY AND STRATEGY

The Board considered a report (copies of which had been circulated) by the Director advising of the revised Risk Management Policy and Risk Management Strategy, copies of which was attached to the report at Appendix 1.

The report recalled that the IJB approved the Risk Management Policy and Risk Management Strategy in March 2017. An audit of the IJB's risk management arrangements was included in the IJB's 2017-18 internal audit plan; this was subsequently conducted by Falkirk Council's internal audit service.

The resultant internal audit plan was submitted to the IJB Audit Risk and Governance Committee on 28 March 2018. The report concluded that substantial assurance could be provided in relation to risk management arrangements. This meant that the auditors considered that "largely satisfactory control and governance systems were in place". A small number of recommendations were made.

One of the auditor recommendations was that the strategy and remit of the Audit, Risk and Governance Committee should match. The committee agreed and recommended to the IJB that the committee's remit be adjusted accordingly. That was done by the IJB on 1 May 2018.

The report then provided a summary of the other recommendations made and how the strategy had been updated accordingly.

It was recommended that the IJB approves the revised Risk Management Policy and Risk Management Strategy.

Decision

To approve the revised Risk Management Policy and Risk Management Strategy.

4. PRESENTION ON RISK MANAGEMENT

The Board was advised that as part of the internal audit of the IJB carried out by Falkirk Council's Internal Audit Service one of the recommendations was that the IJB Risk Manager provides the IJB with further training on the subject of Risk Management. Therefore the following presentation fulfilled that requirement.

The IJB Risk Manager then provided the Board with an overview of those risks that had been identified for the IJB and the methodology used to identify those risks, including the use of a Risk Matrix.

The IJB maintained a risk register, as did both the health and council sides and these covered operational risks. The risks identified for the IJB were:- Strategic Planning/Directions; Performance Management; Funding; and Governance. The Risk Manager then explored each of these risks in more detail. He also highlighted those risks that had been identified as being "high" for the IJB; these being Sustainability of Primary Care; Delayed Discharge; Inadequate Funding; and Workforce Planning.

The IJB Risk Manager then explained the process which was followed for reviewing those identified risks and included reports bimonthly to the Senior Management Team, quarterly reports to the IJB Audit, Governance and Risk Committee, however those high risks would now be reported to every meeting; and an annual report to the IJB.

A discussion then ensued amongst the board members regarding those identified risks and the mitigating measures that had been put in place in relation to them. It was noted that further work continued to be done particularly in relation to those areas in the control of the IJB, in particular Primary Care and Delayed Discharge. A discussion was also had with regards to other risks to the IJB which had not been identified; a number of suggestions were made including homelessness and engagement.

The Chair thanked the Risk Manager for the very informative presentation and for the contributions made by members.

Decision

To note the contents of the presentation.

5. INTERNAL AUDIT ANNUAL REPORT

The Board considered a report (copies of which had been circulated) by the Internal Auditor advising of the Internal Audit Annual Report for 2017-18.

The Local Authority Accounts (Scotland) Regulations 2014 required the IJB or a relevant committee to conduct, at least once in each financial year, a review of the effectiveness of the IJB's system of internal control. The system of internal control could be defined by those policies, procedures and arrangements which were put in place by the management of the organisation to ensure that it met it objectives.

The Public Sector Internal Audit Standards (PSIAS) required the IJB's Internal Auditor to submit an annual report timed to support the annual governance statement. This was required to include :-

- An opinion on the overall adequacy and effectiveness of the IJB's framework of governance, risk management and control;
- A summary of the audit work from which the opinion was derived;
- A statement of conformance with the PSIAS and the results of the internal audit quality assurance and improvement process

The report attached to the report at Appendix 1 fulfilled the requirements of the PSIAS and also assisted the IJB in discharging its requirement to review the system on internal control.

The IJB was also asked to note that the Internal Audit had concluded that the IJB's framework of governance, risk management and control required improvement. This included improved performance management and a workforce plan.

A follow-up of audit workforce planning was due to be submitted to the IJB Audit, Risk and Governance Committee in December 2018.

It was recommended that :-

1. The IJB considers the internal audit annual report for 2017-18 and the Internal Auditors opinion on the IJB's framework of governance, risk management and control; and
2. Notes that the internal audit annual report would be submitted to the IJB's Audit, Risk and Governance Committee on 27 June 2018 for further consideration.

Decision

To note the terms of the report

6. CONSIDERATION OF 2017/18 ANNUAL ACCOUNTS (UNAUDITED)

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer asking the Board to consider the unaudited 2017-18 Annual Accounts of the West Lothian Integration Board (IJB).

The report recalled that the Public Bodies (Joint Working) (Scotland) Act 2014 specified that IJB's should be treated as if they were bodies falling within Section 106 of the Local Government (Scotland) Act 1973. This required annual accounts to be prepared within the reporting requirements specified in the relevant legislation and regulations.

The Local Authority Accounts (Scotland) Regulations 2014 required the unaudited annual accounts to be submitted to the appointed auditor no later than 30 June each year. Prior to the submission, the Regulations required that the unaudited accounts be considered by the Board or a committee whose remit included audit or governance.

The Annual Accounts attached to the report at Appendix 1 detailed the IJB's financial position for 2017-18 taking account of health and social care functions and resources which had been delegated to the IJB. The accounts also included a Management Commentary setting out the purpose and strategic aims of the IJB and the key messages on the IJB's planning and performance for year 2017-18.

Letters of assurance were also appended to the report from the council's Head of Finance and Property Services and NHS Lothian's Director of Finance. These letters set out confirmation of the income and expenditure included in partner financial ledgers that related to IJB delegated functions; this had also been included in the IJB's unaudited accounts.

Legislation also required the Board to approve an annual governance statement whose purpose was to give assurance and demonstrate to service users, the West Lothian community and other stakeholders, that the Board operated and carried out its statutory duties in accordance with the law and in accordance with the principles and standards of good corporate governance.

Once approved the annual governance statement must be signed by the Chair and the Director and then incorporated into the unaudited accounts before submission to the Board's external auditors. The draft annual governance statement was attached to the report as an appendix, starting at page 15.

The procedure agreed by the Board would now require the unaudited accounts and annual governance statement to be referred to the Audit, Governance and Risk Committee for further review and consideration.

It was recommended that the Board :-

1. Considers the overall 2017-18 Annual Accounts prior to submission to Ernst and Young (EY) for audit;

2. Agrees the letters provided by NHS Lothian and West Lothian Council along with partner financial ledger reports used throughout the year, provided assurance of the year end spend and funding contained in the unaudited accounts;

3. Approves the draft governance statement for inclusion in the unaudited 2017-18 annual accounts submitted to EY;

4. Authorises the Director to make minor alternations that may be required to the annual governance statement prior to its submission with the accounts; and

5. Refers the unaudited accounts and governance statement to the Audit, Risk and Governance Committee for its consideration.

Decision

To approve the recommendations of the report.

7. MENTAL WELFARE COMMISSION: 'THE RIGHT TO ADVOCACY' PROJECT

The Board considered a report (copies of which had been circulated) by the Director advising of the recommendations made by the Mental Welfare Commission for Scotland on how NHS Boards and local authorities were discharging their statutory duties to secure independent advocacy services.

The report recalled that in 2015 the Mental Welfare Commission was given new responsibilities to oversee how NHS Board and local authorities were discharging their statutory duties under the Mental Health (Care and Treatment) (Scotland) Act 2003 to secure independent advocacy services to everyone with a mental disorder who required them.

The commission carried out its first biennial survey about advocacy planning and had published a report “The Right to Advocacy”; this was available online via a link provided for in the report.

West Lothian commissioned services for independent advocacy was provided by the Mental Health Advocacy Project (MHAP) and EARS Advocacy.

The principle issues highlighted in the report related to variable planning and provision of advocacy services across Scotland and a lack of clarity in some areas on where responsibilities lay for preparation of strategic advocacy plans. The report particularly identified a lack of clarity on provision of services for children and young people with mental illness or learning disability other than those who were looked after.

The report made four recommendations, details of which were attached to the report at Appendix 1, for NHS Chief Executives and HSCP Chief Officers. West Lothian responses to these recommendations along with

supporting commentary were also contained in Appendix 1.

The report also made specific recommendations about advocacy services for children and young people. However as these services did not form part of the IJB's responsibilities and other governance arrangements were in place for children's services these were not dealt with in the report.

The Mental Welfare Commission had set a deadline of 30 June 2018 for responses to its recommendations.

It was recommended that the Board :-

1. Notes its responsibility for planning integrated arrangements for strategic planning and for the delivery of services;

2. Reviews the recommendations made by the Mental Welfare Commission in respect if NHS Chief Executives and HSCP Chief Officers regarding independent advocacy services;

3. Reviews the responses regarding the recommendations;

4. Confirms that it was satisfied that the responses addressed the recommendations; and

5. Advises the Commission by the deadline of 30 June 2018 that it had reviewed the recommendations and was satisfied that local responses were in place to address the recommendations.

Decision

To approve the recommendations of the report

8. REVIEW OF STRATEGIC PLAN - CONSULTATION

The Board considered a report (copies of which had been circulated) by the Director providing an update on the review of the IJB Strategic Plan and seek approval for the proposed approach to consultation. It was noted that the consultation document had been tabled earlier in the meeting.

The existing Strategic Plan 2016-2026 was developed during 2015-16 with engagement of stakeholders through the Strategic Planning Group. The Strategic Plan 2016-2026 was then approved by the IJB at its meeting on 31 March 2016.

Following the annual review of the Strategic Plan the IJB agreed at their 13 March 2018 meeting that a replacement Strategic Plan would be developed to take account of new legislation, national contract changes, market & workforce factors to drive forward transformational change in health and social care aligned to the medium term financial plan.

The Public Bodies (Joint Working) (Scotland) Act placed a duty on the Board to consult stakeholders in the preparation, publication and review of

the Strategic Plan. Therefore the consultation on the replacement Strategic Plan would cover a wide range of stakeholders, including health and social care professionals, providers of health and social care, users of health and social care and their carers. Every house in West Lothian would also be reached through the council's Bulletin publication.

The document would set out the IJB's challenges along with its key priorities under the National Health and Wellbeing Outcomes. It would also ask Stakeholders to say if they agreed with those priorities and if not, what they thought the priorities should be. Those challenges were summarised in the report along with the priorities which covered Tackling Health Inequalities; Prevention & Early Intervention; Integrated & Co-ordinated Care, Managing our Resources Effectively; and Transformational Change.

It was proposed that the consultation would launch with the delivery of the Bulletin, in week commencing 13 August 2018 for a period of 8 weeks. The document would also be disseminated to all relevant stakeholders including hard to reach groups.

A draft Strategic Plan would also be considered by the Strategic Planning Group before approval was sought at the 21 November 2018 meeting of the IJB. The draft Strategic Plan would then go out for consultation and any feedback would be incorporated into the document before it returned to the Strategic Planning Group and then onto the IJB for final approval in January 2019.

The IJB was recommended to :-

1. Note that the Integration Joint Board agreed at their meeting in March 2018 that a replacement plan was required to drive forward the transformational change required in health and social care;

2. Note the requirement to consult stakeholders on the Strategic Plan;

3. Agree the proposed timescales for consultation; and

4. Agreed the proposed consultation document

Decision

1. To approve the recommendations of the report;

2. To agree that the consultation would take place over a three month period and would be posted online and be promoted through the use of social media; and

3. To agree the content of the consultation document subject to it including additional information on the role of the IJB.

9. ADULTS' MENTAL HEALTH COMMISSIONING PLAN

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

the Director providing an update on the strategic commissioning priorities outlined in the Strategic Commissioning Plan for Adults' Mental Health 2016 to 2019.

The Adults' Mental Health Commissioning Plan was approved by the IJB on 18 October 2017. The plan set out the strategic ambitions, priorities and the next steps for delivering integrated health, social care, support and other services in West Lothian for adults with mental health problems, their families and carers.

Progress had been made across a number of priorities outlined in the plan and included the re-design of mental health services being moved forward across a wide and varied range of work streams.

The review of Supported Accommodation and Outreach Support had also led to changes in contractual arrangements. A clear vision of how the support needs of the care groups were to be met in the future was developed; the vision was to help people in the care group's move towards independence by providing progressive, person-centred Supported Living Services.

The provision of information about services and support for adults with mental health problems had also been strengthened. This was had been through the on-going development of Westspace, an online source of mental health and wellbeing information.

The IJB was asked to note the contents of the report and the progress made in respect of each of the commissioning priorities as outlined in Appendix 1 attached to the report.

Decision

To note the contents of the report

10. UPDATE LEARNING DISABILITY COMMISSIONING PLAN

The Board considered a report (copies of which had been circulated) by the Director providing an update on the strategic commissioning priorities outlined in the Strategic Commissioning Plan for Adults with a Learning Disability 2016-2019.

The Learning Disability Commissioning Plan was approved by the IJB on 18 October 2017. The plan set out the strategic ambitions, priorities and next steps for delivering integrated health, social care, support and other services in West Lothian for adults with a learning disability and autism, their families and carers.

The Board were advised that good progress continued to be made across the range of priorities outlined in the plan. Work also continued on the modernisation and redesign programme for learning disability services across the Lothian's which would see a shift in the balance of care from hospital to community settings throughout Lothian by 2020.

The relocation of NHS Lothian's Community Learning Disability Team to Arrochar House had been a particularly positive development and a very effective model of joint working was now emerging. Now co-located with the learning disability social work teams, the move had allowed greater scope for partnership working and improved communication.

The report concluded that the council's Transforming Your Council programme would focus on the development of core and cluster residential facilities for adults with learning disabilities which had been identified as a priority in the commissioning plan.

The Board was asked to note the contents of the report and the progress made in respect of each of the commissioning priorities outlined in Appendix 1 attached to the report.

Decision

To note the contents of the report

11. PHYSICAL DISABILITY STRATEGIC COMMISSIONING PLAN - UPDATE - REPORT BY DIRECTOR (HEREWITH).

The Board considered a report (copies of which had been circulated) by the Director providing an update on the Physical Disability Strategic Commissioning Plan, which included progress in relation to projected timescales.

At the meeting of 31 October 2017 the IJB noted the contents of the report on the Physical Disability Commissioning Plan for Adults with a Physical Disability. An update was then provided on 5 December 2017.

Attached to the report at Appendix 1 were details of progress against the Action Plan for the period up to 29 May 2018.

The Board was asked to note the progress against areas of development to 29 May 2018.

Decision

To note the contents of the report

12. UPDATE OLDER PEOPLES COMMISSIONING PLAN

The Board considered a report (copies of which had been circulated) by the Director providing an update on progress in relation to the Older Peoples Commissioning Plan and projected timescales

At the meeting of 29 November 2016 the IJB approved the areas for development detailed in the Older Peoples Commissioning Plan.

Attached to the report at Appendix 1 were details of progress against the

Action Plan for the period up to 27 March 2018.

The Board was asked to note the progress against areas of development to 27 March 2018.

Decision

To note the contents of the report

13. IJB FINANCIAL PLAN

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on the 2018-19 budget and to set out an indicative five year financial plan covering the period 2018-19 to 2022-2023.

The Board were advised that since the last budget was presented to the IJB on 13 March 2018 there had been further refinement of the overall NHS Lothian budget and the report provided an update on the financial resources position based on the NHS Lothian 2018-19 Financial Plan approved by NHS Lothian Health Board on 4 April 2018. In addition the report set out an initial five year financial plan for IJB delegated functions based on a joint working approach across the IJB, West Lothian Council and NHS Lothian.

The NHS Lothian Director of Finance, in his letter dated 26 April 2018, confirmed that there would be an updated allocation of £157.691m to the IJB. This included baseline Social Care Fund monies of £9.990m which in line with previous years was included in the council's social care budget for the purposes of the IJB. Therefore taking this into account the Health budget contribution was £147.701m. Taking into account this revised funding the budget gap as a percentage of the total budget was 1.3% and largely related to acute set aside function.

It was important to note that the level of budget funding would continue to move throughout the year as a result of additional funding awarded during the year. For example additional Alcohol and Drug funding was anticipated from the Scottish Government which would impact favourably on the resources available to the IJB's.

As previously reported to the Board, the council's budget contribution to the IJB was approved by Council on 13 February 2018. While the council's budget contribution of £72.839m represented a balanced budget position, significant increase in demand would require close monitoring during 2018-19.

Work on monitoring the forecast 2018-19 outturn position against IJB budget resources was undertaken on an operational basis by NHS Lothian and West Lothian Council and reported to the Chief Finance Officer. A full monitoring exercise would be undertaken by the end of Quarter 1 to establish a forecast outturn position for 2018-19 and this would be reported to the next Board meeting

With regards to a draft five year financial plan, in line with the Board's agreed approach to IJB financial planning, budget plans had and continued to be developed across health and social care functions and officers supporting the IJB were at the forefront of ensuring overall health and social care considerations were taken into account in partner financial planning.

The indicative five year plan was outlined in a table in the report. This showed budget resources increasing on an annual basis. Based on current planning assumptions over the five year period, IJB resources were estimated to increase by over £13m (from £220.540m in 2018-19 to £233.664m in 2022-23). A second table in the report summarised the estimated budget gap over the five years and the measures identified to date to help control within estimated available funding. Based on the latest planning assumptions and taking account of estimated increases in funding there was an estimated budget gap of £18.160m against social care functions and £16.364m against health functions.

At this stage £21.2m of budget savings had been identified towards the estimated gap, details of which were set out in Appendix 3 of the report. Of the savings identified, £16.7m related to social care. Savings of £4.488m had also been identified in health functions with further work progressing on health savings through the development of broader programmes as part of the Lothian Sustainability and Value work streams.

The Chief Finance Officer continued by explaining some of the key risks and uncertainties over the next five years including Scottish Government funding and staff costs, details of which were summarised in the report.

It was important that the financial planning context set out in the report was taken account of in the development of the refreshed strategic plan and strategic commissioning plans. A key aspect of delivering health and social care services would be having appropriate strategic plans that reflected medium term changes to care demands and service provision, and the prioritisation of funding to maximise performance and achievement of health and social care outcomes for the population of West Lothian.

It was recommended that that IJB :-

1. Notes the update financial contribution received from NHS Lothian in respect of 20018-19 IJB delegated functions;

2. Agrees that Directions were updated and re-issued by the IJB Chief Officer to NHS Lothian taking account of the updated 2018-19 budget resources advised;

3. Notes that monitoring of financial performance would be ongoing during the year and updates provided to each Board meeting; and

4. Notes the indicative five year financial plan fir IJB delegated resources and supports the ongoing development of medium term financial planning.

Decision

1. To approve the terms of the report; and

2. To agree that Board members would undertake a further discussion at the forthcoming away day on the time span that Directions were in place in light of ongoing budget updates and fluctuations.

14. PERFORMANCE REPORT

The Board considered a report (copies of which had been circulated) by the Director presenting the most up-to-date performance against health and social care integration indicators and the measures within the Balanced Scorecard and to also outline the Annual Performance Report.

The report recalled that the Scottish Government had developed a core suite of 23 integration indicators to demonstrate progress in achievement of the nine national health and wellbeing outcomes. Attached to the report at Appendix 1 was the summary of performance with comparison to previous years and the Scottish average.

Appendix 2 attached to the report was the Balanced Scorecard which had been update with available data. The scorecard had been rag-rated using a traffic light system for illustrating progress against expected performance.

The Ministerial Steering Group (MSG) had defined a further set of indicators for measuring the impact of integration of health and social care. These integration indicators focused on individuals' experience of care and high level indicators of how care was being delivered, for example emergency admissions, delayed discharge and where the last six months of life was being spent. These indicators had been updated with performance to end of March 2018 and these were provided for in Appendix 3 attached to the report.

The Board continued to be advised that performance in respect of delayed discharges continued to be challenging with the main contributing factors being Care at Home and care home capacity. Daily multidisciplinary meetings had been established to support discharge planning. Additionally the rehabilitation pathway was being reviewed to streamline activity and support a discharge to assess model, building on a successful project in stroke pathways. The care home contract was also due for renewal in 2019 and preparations were underway with procurement on the tendering process.

The IJB was required to publish an Annual Performance Report by the end of July 2018. The report was currently being prepared and would focus on performance in relation to the health and wellbeing outcomes and highlight progress in the delivery of the transformational change programmes and the key priorities being taken forward.

The Integration Joint Board was asked to :-

1. Note the contents of the report;

2. Note that the most up-to-date performance against key integration indicators and within the balanced scorecard;

3. Consider the current performance against the previously agreed targets and whether the local targets as set continued to be realistic and appropriate; and

4. Note that the Annual Performance Report was being prepared for publication by 31 July 2018 and agree approval by the Chief Officer prior to publication.

Decision

1. To approve the terms of the report;

2. To agree to delegate authority to the Chief Officer to sign-off the Annual Performance Report once it was finalised; and

3. To agree that future Performance Reports would include more contextual information in relation to the Health and Care Survey Experience.

15. PRIMARY CARE REPORT

The Board considered a report (copies of which had been circulated) by the Director providing an update on the Primary Care Summit held on 16 May 2018 and the draft Primary Care Implementation Plan in support of the GMS Contract.

The Board were advised that in recent years General Practice had been under increasing pressure due to increasing volume and complexity of workload and challenging workforce availability. The 2018 GMS Contract therefore presented an opportunity to stabilise and develop Primary Care services to create a sound basis for the future.

Implementation of the contract would take place over three years starting from April 2018 and would be undertaken through collaborative working between Health and Social Care Partnerships, Health Boards and the GP Sub-Committee of Local Medical Committees, who the involvement of ensured that the focus was maintained firmly on the needs of the General Practice as well as the wider Primary Care community.

The West Lothian Primary Care Implementation and Improvement Plan 2018-2021, attached to the report at Appendix 1, described those aspects of the new contract development that fall within the remit of West Lothian Health and Social Care Partnership. It reflected ongoing programmes of support and development in primary care along with new initiatives identified through discussion with GP clusters, other local GP's and West

Lothian practice managers.

The West Lothian Primary Care Summit held on 16 May 2018 afforded the opportunity for representatives from GP practices, community services, Board members and other stakeholders to hear about some of the initiatives already in progress to support GP practices; these included the MSK project; signposting; care homes and anticipatory care planning; and paramedic home visiting service.

The summit attendees considered the proposed West Lothian Primary Care Implementation and Improvement Plan 2018 which was positively received and supported. The plan was also considered and approved by the Local Medical Committee on 11 June 2018.

The Board continued to be advised that the West Lothian GMS base funding had been uplifted through application of the national formula and Practices had been informed whether their income had remained stable or had been uplifted. Details of the funding for West Lothian HSCP was summarised in the report.

In the initial year of funding the funding would be issued in two tranches starting with an allocation of 70% of the funding in June 2018. A high level report on how spending had been profiled would be submitted to the Scottish Government by the start of September and subject to confirmation that the HSCP could spend the full 100% allocation in-year, the remaining 30% of funding would be allocated in November 2018.

Spending plans were in development and would take account of the requirements of the funding allocated by the Scottish Government.

The Integration Joint Board was asked to :-

1. Note the contents of the report;

2. Note the output of the recent Primary Care Summit; and

3. Consider the draft Primary Care Implementation and Improvement Plan and support its implementation.

Decision

1. To note the contents of the report; and

2. To support draft Primary Care Implementation and Improvement Plan and support its implementation.

16. WORKPLAN

A copy of the workplan had been circulated

Decision

To note the contents of the workplan

NHS LOTHIAN

2.1

Board Meeting
3 October 2018

Director of Finance

FINANCIAL POSITION TO AUGUST 2018 AND YEAR END FORECAST

1 Purpose of the Report

1.1 This paper provides an update to the Board on NHS Lothian's year end forecast position considered by the Finance and Resources (F&R) Committee at its meeting on the 19th September.

1.2 The paper sets out the following:

- Summary Information on the year to date financial position and the year end forecast;
- Assurance that processes are in place to oversee and take forward the achievement of financial balance in 2017/18;
- The next steps in supporting the achievement of a breakeven outturn in-year.

1.3 Any member wishing additional information on the detail of this paper should contact the Executive Lead prior to the meeting.

2 Recommendations

2.1 The Board is recommended to:

- **Accept** this report as a summary briefing on the current financial position and year end financial forecast;
- **Accept** this report as a source of significant assurance that the F&R Committee has received a report which sets out the financial position at month 5 and a current estimate of a £1.4m year end overspend, with detail on the relevant issues and required actions to achieve a balanced outturn, and;
- **Accept** that **limited assurance** for the achievement of breakeven by the year end is given by the F&R Committee.

3 Discussion of Key Issues

3.1 The F&R Committee received a paper on the Period 5 financial position and the year end outturn projection for 2018/19 at its meeting of the 19th September. The paper set out the areas of movement in the Quarter 1 forecast position of £1.4m overspend compared to that assumed in the Financial Plan of £21.5m, as shown in Table 1.

Table 1: Closing the Financial Plan Gap

	£k
18/19 Financial Plan Gap	**(21,475)**
Improvement In Operational position	
- Acute Services Division	6,982
- Corporate Services	1,734
- Prescribing improvement in forecast	5,700
- Strategic including R&D	2,425
- Various offsets	1,309
Increase in availability of reserves in Fin Plan	727
In Year Flexibility	
- Additional prior year benefit	2,100
- Benefits from prior year accounting adjustments	1,776
- Slippage in opening of RHSC	2,000
- Edinburgh IJB support	(4,000)
- Other identified commitments	(2,348)
- Other in year benefits including VAT recovery	1,659
18/19 Year End Forecast	**(1,411)**

3.2 The paper also highlighted an in year overspend at Month 5 of £4.2m and the main drivers for this overspend. Further detail on the financial position and the Q1 forecast by Business Unit is provided in Table 2 below.

Table 2 – NHS Lothian year-to-date overspend and year-end forecast

	Financial Plan 2018/19 £k	Q1 Year End Forecast Variance £k	Movement from 18/19 Financial Plan £k	Month 5 YTD Position £k
Acute Services Division	**(23,447)**	**(16,465)**	**6,982**	**(7,624)**
REAS	(1,510)	(2,534)	(1,024)	(1,052)
Edinburgh Partnership	(4,441)	(2,390)	2,051	(2,011)
East Lothian Partnership	(576)	869	1,445	235
Directorate of Primary Care	(252)	(431)	(179)	(95)
Midlothian Partnership	(691)	878	1,568	136
West Lothian Partnership	(1,259)	686	1,945	738
Facilities And Consort	69	356	287	(937)
Corporate Services	**(846)**	**887**	**1,734**	**1,145**
Inc + Assoc Hlthcare Purchases	883	1,799	916	782
Research & Teaching	(1,823)	(787)	1,036	(284)
Strategic Services	2,284	3,673	1,389	(448)
Operational Position	**(31,608)**	**(13,458)**	**18,150**	**(9,415)**
Reserves	10,133	10,860	727	4,525
Additional Flexibility	0	7,535	7,535	637
Edinburgh IJB Support	0	(4,000)	(4,000)	
Other Identified Commitments		(2,348)	(2,348)	
NHS Lothian Position	**(21,475)**	**(1,411)**	**20,064**	**(4,253)**

3.3 The F&R Committee considered the issues within the forecast and were able to acknowledge the actions being progressed to achieve breakeven in 2018/19. Actions being progressed to reduce the year-end deficit include:

- Opportunities are being explored within the property and asset management budgets;
- One-off benefits generated as a result in delays in agreed developments;
- Non-recurrent cost reduction initiatives generated through business units.

3.4 The Committee agreed that it could only give limited assurance at this point that the Board will achieve a breakeven outturn in 2018/19.

3.5 The actions identified above aim to support the achievement of financial balance for 2018/19. However these do not address the issues of achieving recurrent financial sustainability in future years.

3.6 The Committee also discussed the impact of NHS Lothian's financial position on the IJBs' ability to achieve a breakeven outturn this year. NHS Lothian has commissioned work on the issue, which would be an agenda item considered at the next F&R meeting.

3.7 The financial forecast provides an estimate of a year-end outturn position based on delivering activity at current levels. Further work is required to determine the financial consequences of meeting specific targets beyond finance. The Executive Team will review the opportunities to address some of the performance issues relating to patient care. This may bring a degree of financial risk.

3.8 The next stages of supporting the achievement of financial balance include the following steps:

- Ongoing monthly monitoring and reporting of the financial position;
- Follow up meetings with business units as part of the Quarter 2 review to agree further actions to control and reduce spend;
- An update report to the F&R committee at its November meeting on the progress made to achieving in year financial balance, and a report on the five year financial outlook;
- A follow up report to the Board at its December meeting setting out the F&R committee's consideration of the financial position for 2018/19 and beyond.

4 Key Risks

4.1 The F&R Committee also considered the risks that may impact on financial performance throughout the year. Table 3 presents the risk schedule was shared with the Committee.

Table 3 – Risks to achieving year end financial balance

Key Assumptions / Risks	Risk rating	Impact / Description
Integration	High Risk	The forecast is based on the assumption that any flexibility from NHS resources at an IJB level will stay within Lothian. The IJBs may wish to consider other options for utilising any flexible resource
Delayed Discharge	High Risk	There is a requirement to manage the volume of delayed discharges - the forecast does not consider any further deterioration in this area.
Winter Costs	High Risk	The risk remains whether sufficient additional resources are available to meet the pressures from anticipated winter demand
New GP Contract	Medium Risk	No additional costs of the new GP contract eg immunisation, GMS premises have been included in the financial forecast. These will need to be reviewed and potentially included in later updates.
GP Prescribing	Medium Risk	The financial forecast has been reviewed in line with current unit cost and activity, this could change during the year and this will be reviewed on a monthly basis
Acute Medicines	Medium Risk	There is a risk that the level of growth exceeds that estimate in the Forecast. The impact of any additional growth or additional spend on high cost drugs remains an unresolved issue.
Changes to pay T&Cs and backdated pay claims	Medium Risk	The impact of the 18/19 pay award has been modelled and included in the current forecast, there is a risk that the actual costs materialise at a higher level than that anticipated. NHSL no longer has a provision for backdated pay claims,
SGHD Allocations	High Risk	The forecast includes a substantial level of additional Scottish Government funding pay awards and previously separately funded programmes and initiatives. Any change from the funding level assumed will have an impact on the forecast.
Capital Programme	Medium Risk	The revenue consequences of the ongoing capital programme are an issue for several areas and in particular facilities. Estimates have been included in the forecast based on the current information, but these may change as the year
Waiting Times	High Risk	There requires to be continued management of the financial exposure on elective capacity pressures. The risk is that the current investment plans are revised to improve performance.
Doctors in Training	Low Risk	Changes to the Doctors in Training contracts and single employer status may bring financial risks which have not been included in the forecast. The ongoing current level of overspend on Doctors in Training has however been included.
Payment as if at Work	Medium Risk	An estimate of the additional cost for 18/19 has been included in the forecast, the actual cost will be unknown until the final agreement is reached nationally.
Availability of trained staff	Medium Risk	The availability of trained staff has resulted in supply issues which has seen an increased use in agency staff and the associated costs. To maintain the current forecast the use of agency needs to be held static or reduce.
Capital Receipts	Medium Risk	The year end forecast is dependant on a substantial level of capital receipt in 18/19.
Mental Health	High Risk	The continuing demand for mental health services and the impact of the smoking ban in prisons will be greater than the additional SG funding provided. Some provision for additional costs have been included in the forecast but this could be
Impact of Regional and National Developments	Medium Risk	Development or changes to Regional & National services may have a knock on affect to NHS Lothian with reduced income recovery but continued costs.
Brexit	Low Risk	No additional costs for Brexit preparations have been built into the plan, at present they have not been quantified, however they will need to be considered as part of the longer term financial outlook currently being prepared
Utilisation of Primary Care Investment Fund	Medium Risk	Expectation of GPs that Primary Care Improvement Fund will flow directly practices rather than for NHSL to use to develop of Primary Care Health teams to support the GP practices.
Safe Staffing	High Risk	The impact of the Safe Staffing requirements are still being quantified and costed and have therefore not been included in the forecast. At present there are no obvious source of funding to meet additional costs and presents a risk. This will

4.2 It was recognised by the Committee that those risks set out were consistent with those previously reported.

5 Risk Register

5.1 The corporate risk register includes the following risk:

Risk 3600 - The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. ***(Finance & Resources Committee)***

5.2 The contents of this report is aligned to the above risk. At this stage there is no further requirement to add to this risk.

6 Impact on Inequality, Including Health Inequalities

6.1 There are no new implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

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

7.1 The implementation of the financial plan and the delivery of a breakeven outturn may require service changes. As this particular paper does not relate to the planning and development of specific health services there was no requirement to involve the public in its preparation. Any future service changes that are made as a result of the issues raised in this paper will be required to adhere to the Board's legal duty to encourage public involvement.

8 Resource Implications

8.1 There are no resource implications arising specifically from this report.

Susan Goldsmith
Director of Finance
19th September 2018
susan.goldsmith@nhslothian.scot.nhs.uk

NHS LOTHIAN

2.2

Board Meeting
3rd October 2018

Chief Quality Officer

QUALITY AND PERFORMANCE IMPROVEMENT

1 Purpose of the Report

1.1 This report provides an update on the most recently available information on NHS Lothian's position against a range of quality and performance improvement measures.

1.2 Any member wishing additional information on a particular measure should contact the specific lead director identified, having accessed to self-service pack initially. Matters relating to the monitoring and assurance process should be directed towards the Chief Quality Officer.

2 Recommendations

2.1 The Board is invited to:

2.1.1 Acknowledge that target performance levels on 14 measures are currently met with 19 not met. This situation is unaltered since the Board's last meeting. 3 are not able to be assessed;

2.1.2 Note that 4 areas yet to reviewed by Board Committees are planned to be considered by the Committees in their coming meetings; and

2.1.3 Acknowledge that across the measures considered, assurance of significant, moderate, limited and none has been reached in 9, 12, 12 and 1 instances respectively.

3 Recent Performance and Assurance

3.1 NHS Lothian Board asked its Committees to assess 34 quality and performance measures[1]. This report updates the Board on the measures' status.

3.2 The overall position on performance is unchanged from the last report. 14 met the expected standard, whilst 19 did not. Performance could not be judged in three instances, due to work awaiting completion nationally. Those are Dementia Post-Diagnostic Support and Complaints, both stage 1 and 2.

3.3 Committees have assessed all but 4 of the areas since the process was introduced at the end of 2016. Those outstanding, relating to smoking cessation, primary care

[1] One measure (diagnostics) has been split into 3 different assurance discussion. Therefore 34 measures involve 36 outcomes.

access (2 measures) and HSMR, are to be examined in the coming scheduled meetings of relevant committees.

Table A – Assessed Levels of Assurance

			Assurance Level				
			To be Reviewed	None	Limited	Moderate	Significant
Board	Met	14	2	-	-	5	7
	Not Met	19	2	-	12	5	2
	TBC	3	-	1	-	2	-
Acute Hospitals Committee*	Met	9	1	-	-	1	7
	Not Met	9	-	-	8	2	1
Healthcare Governance Committee	Met	5	1	-	-	4	-
	Not Met	9	2	-	4	2	1
	TBC	3	-	1	-	2	-
Staff Governance Committee	Met	-	-	-	-	-	-
	Not Met	1	-	-	-	1	-

* As the diagnostic measure has been split into 3, Acute Hospitals awards 20 levels of assurance across 18 measures.

3.4 Of those areas assessed, assurance has been determined as significant, moderate, limited and no assurance in 9, 12, 12 and 1 instances respectively. This is a change from the previous position due reassessment of the measure for Diagnostics (Vascular Labs) by the Acute Hospitals Committee in August. Significant assurance was awarded.

4 2018/19 Quality and Performance Improvement Reporting Process

4.1 Committee members will be aware over recent months a lighter reporting approach was been piloted.

4.2 Following feedback received through the surveymonkey questionnaire earlier this summer, these changes are now made permanent and further steps, proposed previously, now taken.

4.3 These latest changes are customisation of reports provided to the specific board committees and the provision of the dashboard in lieu of the excel pack previously circulated alongside this paper.

4.4 A hyperlink to the dashboard remains available on request.

Table 1: Summary of Latest Reported Position

Measure[1]	Quality Domain[2]	Type[3]	Assurance Committee	Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/ Standard[4]	Trend[5]	Published NHS Lothian vs. Scotland[6]	Date of Published NHS Lothian vs. Scotland[7]	Target/Standard	Latest Performance	Reporting Date	Lead
Cardiac Arrest (per 1,000 discharges)	Safe	Quality	Acute Hospitals (AHC)	Limited	Aug 17	Not Met	No Change	Not Applicable	Not Applicable	0.95 per 1,000 discharges (median)	1.76 (median)	Aug 18 (Mthly)	TG
Falls With Harm (per 1,000 occupied bed days)		Quality	Healthcare Governance (HGC)	Moderate	Mar-18	Met		Not Applicable	Not Applicable	0.31 per 1,000 occupied bed days (median)	0.25 (median)	Aug 18 (Mthly)	TG
Healthcare Acquired Infection - CDI (rate per 1,000 bed days, aged 15+)		LDP	HGC	Moderate	Mar 18	Met		Worse	Mar 18 (Quarterly)	0.32 (max) (<=262)	0.26 (rate) 84 (incidences)	Aug 18 (Mthly)	TG
Healthcare Acquired Infection - SAB (rate per 1,000 acute bed days)		LDP	HGC	Moderate	Mar 18	Not Met	No Change	Better	Mar 18 (Quarterly)	0.24 (max) (<=184)	0.30 (rate) 95 (incidences)	Aug 18 (Mthly)	TG
Hospital Standardised Mortality Ratios (HSMR) (within limits)		Quality	AHC	To be reviewed	TBC	Met		Not Applicable	Not Applicable	1 All sites within HS Limits	NHS L 0.87 / RIE 0.91 / SJH 0.80 / WGH 0.76	Mar 18 (Qtrly)	TG
48 Hour GP Access – access to healthcare prof	Timely	LDP	HGC	To be reviewed	TBC	Met		Equal	Mar-18	90% (min)	93.0%	Mar 18	DS
48 Hour GP Access – GP appt		LDP	HGC	To be reviewed	TBC	Not Met	Deteriorating	Worse	Mar-18	90% (min)	65.0%	Mar 18	DS
Four hour Unscheduled Care (% <=4 hrs)		LDP	AHC	Limited	Aug 18	Not Met	Deteriorating	Worse	Jul 18 (Monthly)	95.0% stretch to 98.0%	84.5%	Aug 18 (Mthly)	JC
Alcohol Brief Interventions (ABIs) (Number)		LDP	HGC	Moderate	Mar-18	Met		Better	Mar-18	9,738 (Annual) 2,435 (per Quarter)	4,031	Jun 18 (Qtrly)	AMcM
CAMHs[8] (<=18 wks)		LDP	HGC	Limited	Mar 18	Not Met	Improving	Worse	Jun 18 (Quarterly)	90.0% (min)	64.7%	Aug 18 (Mthly)	AMcM
Cancer (<=31-day) (% treated)		LDP	AHC	Limited	Nov 17	Not Met	Improving	Worse	Jun 18 (Quarterly)	95.0% (min)	92.3%	Jul 18 (Mthly)	JC
Cancer (<=62-day) (% treated)		LDP	AHC	Limited	Nov 17	Not Met	Improving	Worse	Jun 18 (Quarterly)	95.0% (min)	83.9%	Jul 18 (Mthly)	JC
Diagnostics (<=6 wks) - Gastroenterology/ Urology Diagnostics			AHC	Limited	Aug 18	Not Met							
Diagnostics (<=6 wks) - Radiology/Imaging			AHC	Significant	May 17	Not Met	Improving	Worse	Jun 18 (At month end)	0 (max)	4,556	Aug 18 (Mthly)	JC
Diagnostics (<=6 wks) – Vascular Labs			AHC	Limited	Aug-18	Not Met							
Drug & Alcohol Waiting Times (% <=3 wks) - Edinburgh IJB		LDP	HGC	Limited	Sep 17	Not Met	Improving	Worse	Jun 18 (Quarterly)	90.0% (min)	84.1%	Jun 18 (Qtrly)	JP
Drug & Alcohol Waiting Times (% <=3 wks) - Midlothian & East Lothian IJB		LDP											EM/DS
Drug & Alcohol Waiting Times (% <=3 wks) - West Lothian IJB		LDP											JF
IPDC Treatment Time Guarantee (<=12 wks)		LDP	AHC	Moderate	May 17	Not Met	Improving	Better	Jun 18 (Quarterly)	0 (max)	80.3% 2,110	Aug 18 (Mthly)	JC
IVF (% <=12 months)		LDP	AHC	Significant	Apr 18	Met		Equal	Jun 18 (Quarterly)	90.0% (min)	100.0%	Jul 18 (Mthly)	JC
Outpatients (<=12 weeks)		LDP	AHC	Moderate	May 17	Not Met	Deteriorating	Worse	Jun 18 (at month	95.0% (min)	62.7% 25,110	Aug 18 (Mthly)	JC
Psychological Therapies (% <=18 wks)		LDP	HGC	Limited	Sep 17	Not Met	Improving	Worse	Jun 18 (Quarterly)	90.0% (min)	69.5%	Aug 18 (Mthly)	JF
Referral to Treatment (% <=18 wks)		LDP	AHC	Limited	Feb 17	Not Met	Deteriorating	Worse	Jun 18 (Monthly)	90.0% (min)	73.3%	Aug 18 (Mthly)	JC
Stroke Bundle (% receiving)		Quality	AHC	Moderate	Nov 16	Met	Improving	Not Applicable	Not Applicable	80.0% (min)	81.5%	Jun 18 (Mthly)	JC
Planned Repeat Surveillance Endoscopy (past due date)			AHC	Limited	Aug 18	Not Met	Deteriorating	Not Applicable	Not Applicable	0 (max)	4,227	Aug 18 (Mthly)	JC
Delayed Discharges (>3 days) – East Lothian IJB	Effective		HGC	Limited	Sep 17	Not Met	Deteriorating	Worse	Jul 18 (Monthly)	0 (max)	291	Aug 18 (Mthly)	DS
Delayed Discharges (>3 days) – Edinburgh IJB													JP
Delayed Discharges (>3 days) – Midlothian IJB													EM
Delayed Discharges (>3 days) – West Lothian IJB													JF
Hospital Scorecard – Standardised Surgical Readmission rate within 7 days	Efficient	Quality	AHC	Significant	Feb 18	Met		Not Applicable	Not Applicable	All NHS L Sites (RIE; SJH & WGH), Within Hospital Scorecard Limits	NHS L 27.25 / RIE 33.48 / SJH 24.69 / WGH 24.04	Dec-17 (Qtrly)	TG
Hospital Scorecard – Standardised Surgical Readmission rate within 28 days		Quality	AHC	Significant	Feb 18	Met					NHS L 47.66 / RIE 60.39 / SJH 37.32 / WGH 47.93		TG
Hospital Scorecard – Standardised Medical Readmission rate within 7 days		Quality	AHC	Significant	Feb 18	Met					NHS L 56.83 / RIE 58.11 / SJH 63.74 / WGH 65.81		TG
Hospital Scorecard – Standardised Medical Readmission rate within 28 days		Quality	AHC	Significant	Feb 18	Met					NHS L 123.35 / RIE 132.10 / SJH 130.10 / WGH 123.22		TG
Hospital Scorecard – Average Surgical Length of Stay - Adjusted		Quality	AHC	Significant	Feb 18	Met					NHS L 0.96 / RIE 0.94 / SJH 0.86 / WGH 1.03		TG
Hospital Scorecard – Average Medical Length of Stay - Adjusted		Quality	AHC	Significant	Feb 18	Met					NHS L 1.15 / RIE 0.86 / SJH 1.38 / WGH 1.42		TG
Staff Sickness Absence Levels (<=4%)		LDP	Staff Governance	Moderate	Mar 17	Not Met	Deteriorating	Better	Mar-18	4.0% (max)	4.84%	Jul 18 (Mthly)	JB
Early Access to Antenatal Care (% <=12 wks)	Equitable	LDP	HGC	Moderate	Mar-18	Met		Better	Mar-17	80.0% min for each SIMD[9] quintil	88.3%	Jul 18 (Mthly)	AMcM
Smoking Cessation (quits)		LDP	HGC	To be reviewed	To be reviewed	Not Met	Improving	Worse	Mar-17	403.98 (min for this quarter)	235	Mar 18 (Qtrly)	AKM
Complaints - Stage 1 (%<=5-day)[10]	Person-Centred	Quality	HGC	Moderate	Nov 17	TBC	Improving	TBC	TBC	TBC[10]	67.3%	May 18 (Mthly)	AMcM
Complaints - Stage 2 (%<=20-day)[10]		Quality	HGC	Moderate	Nov 17	TBC	Improving	TBC	TBC	TBC[10]	61.6%	May 18 (Mthly)	AMcM
Detect Cancer Early (% diagnosed)		LDP	HGC	Significant	Nov 16	Not Met	Improving	Better	2016 & 2017 (Combined Calendar Years)	29.0% (min)	27.0%	2016 & 2017 (Combined Calendar Years)	AKM
Dementia – East Lothian IJB[11]		LDP	HGC	None	Mar 18	TBC	Not Applicable	Part 1: Worse / Part 2: Worse	2015/16	TBC[11] (exptd diag rate + 1 Year (min) PDS)	Part 1: 40.1% / Part 2: 75.6%	2015/16	DS
Dementia – Edinburgh IJB[11]		LDP											JP
Dementia – Midlothian IJB[11]		LDP											EM
Dementia – West Lothian IJB[11]		LDP											JF
Patient Experience (9.0/10 – Overall Experience)		Quality	HGC	Moderate	Nov 17	Not Met	Improving	Not Applicable	Not Applicable	9 (out of 10)	8.90	May 18 (Mthly)	AMcM

Notes
1. Much of this reporting uses management information and is therefore subject to change;
2. 6 Domains of Healthcare Quality http://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/create/sixdomains.html
3. This describes the standard type – 'LDP' target/standards are Local Delivery Plan (previously HEAT), target/standards; Quality standards were originally reported under a separate Quality Paper.
4. Performance Against Target/Standard – describes where Latest Performance meets or does not meet Target.
5. Trend - describes Improvement, No Change or Deterioration for Latest Performance, where Performance Against Target/Standard is 'Not Met', against an average of the last two relevant reported data points. Cardiac Arrest and HAI measures (as applicable) use HIS run chart assessment to ascertain trend. (Black cells indicate that a Standard is 'Met' so a Trend is not available).
6. Published NHS Lothian vs. Scotland – describes most recent published Lothian position against the most recent (directly comparable) published Scotland position to comply with Official Statistics' requirements - either for rates (incl. %) or against NRAC share. These may refer to different time periods than Latest Performance.
7. Date of Published NHS Lothian vs. Scotland – describes most recent published Lothian position against the most recent (directly comparable) published Scotland position to comply with Official Statistics' requirements - either for rates (incl. %) or against NRAC share. These may refer to different time periods than Latest Performance.
8. Abbreviations – CAMHS - Child and Adolescent Mental Health Services; CDI- Clostridium difficile Infection; SAB Staphylococcus aureus Bacteraemia; IPDC – Inpatient and Day-case; IVF – In Vitro Fertilisation
9. SIMD - Scottish Index of Multiple Deprivation, http://www.gov.scot/Topics/Statistics/SIMD
10. From the start of April 2017 there has been a national change on assessment of the complaints process. As no historical data is available for the proposed metrics, data will only be available covering April onward. Furthermore as a new measure, there will be an absence of comparative data initially in order to consider performance against that elsewhere.
11. ISD have stated in their publication of 24/01/17 "there is no specific threshold or target in which NHS Boards are expected to be attaining to as the PDS services are still within their infancy and it is anticipated there is likely further developments required". No further update was mentioned in the publication of 06/02/18.
http://www.isdscotland.org/Health-Topics/Mental-Health/Publications/2017-01-24/2017-01-24-DementiaPDS-Summary.pdf?

5 Risk Register

5.1 Not applicable.

6 Impact on Inequality, including Health Inequalities

6.1 The production of this update do not have any direct impact on health inequalities but consideration may be required elsewhere in the delivery of the actions identified.

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

7.1 As the paper summarises performance, no impact assessment or consultation is expected.

8 Resource Implications

8.1 The resource implications related to the assurance programme would be considered by Board Committees are consider items under the Programme of Assurance.

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Analytical Services
28th September 2018
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Appendices

Appendix 1 – Alignment of Measures to Board Committee

Appendix 2 – Adopted Assurance Gradings

Appendix 1 – Alignment of Measures to Board Committee

	Acute Hospitals	Healthcare Governance	Staff Governance
Effective		Delayed Discharges	
Efficient	*Hospital Length of Stay (2)* Hospital Readmission Rate (4)		*Staff Sickness Absence*
Equitable		*Early Access to Antenatal Care* Smoking Cessation	
Person-Centred		*Complaints (2)* Detecting Cancer Early *Dementia Post Diagnostic Support* Patient Experience	
Safe	*Cardiac Arrest Incidence* Hospital Standardised Mortality Ratio	*Falls with Harm* Healthcare Acquired Infection (2)	
Timely	*4 hr Unscheduled Care Wait* Cancer Waits (2) *Diagnostic Waits* Inpatient and Daycase Waits *IVF Waits* Outpatient Waits *Referral to Treatment Wait* Stroke Bundle Compliance *Surveillance Endoscopies Overdue*	*Access to General Practice (2)* Alcohol Brief Interventions *CAMHS Waits* Drug & Alcohol Waiting Time *Psychological Therapy Waits*	

Appendix 2 – Adopted Assurance Gradings

Definition	Most likely course of action by the Board or committee
LEVEL – SIGNIFICANT The Board can take reasonable assurance that the system of control achieves or will achieve the purpose that it is designed to deliver. There may be an insignificant amount of residual risk or none at all. Examples of when significant assurance can be taken are: • The purpose is quite narrowly defined, and it is relatively easy to be comprehensively assured. • There is little evidence of system failure and the system appears to be robust and sustainable. • The committee is provided with evidence from several different sources to support its conclusion.	If there are no issues at all, the Board or committee may not require a further report until the next scheduled periodic review of the subject, or if circumstances materially change. In the event of there being any residual actions to address, the Board or committee may ask for assurance that they have been completed at a later date agreed with the relevant director, or it may not require that assurance.
LEVEL – MODERATE The Board can take reasonable assurance that controls upon which the organisation relies to manage the risk(s) are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk. Moderate assurance can be taken where: • In most respects the "purpose" is being achieved. • There are some areas where further action is required, and the residual risk is greater than "insignificant". • Where the report includes a proposed remedial action plan, the committee considers it to be credible and acceptable	The Board or committee will ask the director to provide assurance at an agreed later date that the remedial actions have been completed. The timescale for this assurance will depend on the level of residual risk. If the actions arise from a review conducted by an independent source (e.g. internal audit, or an external regulator), the committee may prefer to take assurance from that source's follow-up process, rather than require the director to produce an additional report.
LEVEL – LIMITED The Board can take some assurance from the systems of control in place to manage the risk(s), but there remains a significant amount of residual risk which requires action to be taken. Examples of when limited assurance can be taken are: • There are known material weaknesses in key areas. • It is known that there will have to be changes to the system (e.g. due to a change in the law) and the impact has not b • een assessed and planned for. • The report has provided incomplete information, and not covered the whole purpose of the report. • The proposed action plan to address areas of identified residual risk is not comprehensive or credible or deliverable.	The Board or committee will ask the director to provide a further paper at its next meeting, and will monitor the situation until it is satisfied that the level of assurance has been improved.
LEVEL – NONE The Board cannot take any assurance from the information that has been provided. There remains a significant amount of residual risk.	The Board or committee will ask the director to provide a further paper at its next meeting, and will monitor the situation until it is satisfied that the level of assurance has been improved. Additionally the chair of the meeting will notify the Chief Executive of the issue.
NOT ASSESSED YET This simply means that the Board or committee has not received a report on the subject as yet. In order to cover all aspects of its remit, the Board or committee should agree a forward schedule of when reports on each subject should be received (perhaps within their statement of assurance needs), recognising the relative significance and risk of each subject.	

NHS LOTHIAN

2.3

Board Meeting
3rd October 2018

Chief Officer, Acute Services

UNSCHEDULED CARE PERFORMANCE AND IMPROVEMENT

1 Purpose of the Report

1.1 The purpose of this report is to;

- Update the Board on the current performance across the adult acute hospitals and to describe the actions being taken to mitigate areas of concern.
- Provide a summary of our process, progress and ongoing work to implement the recommendations arising from recent reviews into NHS Lothian's reporting of the 4 hour emergency care standard.

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

2 Recommendations

The Board is asked to:

2.1 **Note** the performance detailed in paragraphs 3.1 to 3.9.

2.2 **Accept** this report as a source of significant assurance that senior management have developed an appropriate set of oversight and governance groups to oversee the improvement required in line with the overarching improvement plan.

2.3 **Accept** this report as a source of moderate assurance that mechanisms are in place across all three adult acute sites to monitor performance against unscheduled care, and to support staff to design and implement a comprehensive programme of improvement actions.

2.4 **Accept** this report as a source of limited assurance that the improvement programmes developed will deliver the significant improvement in performance required within the short term.

2.5 **Note** the actions being undertaken in collaboration with the Scottish Government External Support Team.

3 Discussion of Key Issues

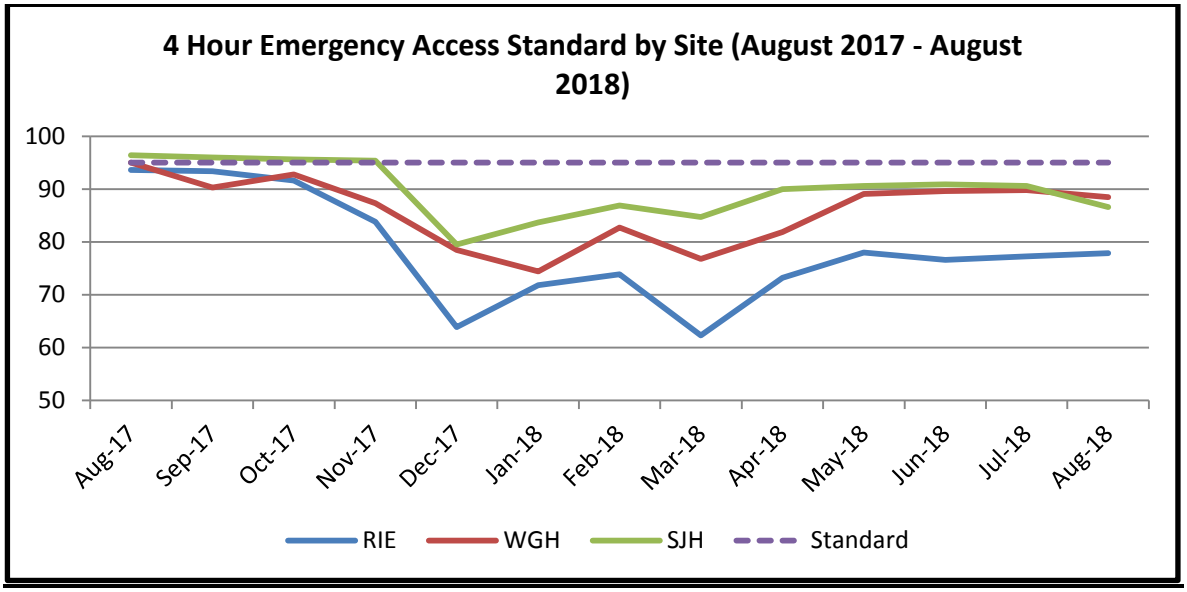
Unscheduled Care Performance January – August 2018

3.1 The 4-hour emergency access standard ("the standard") is a whole system measure; to either admit or provide definitive treatment and discharge for 95% of unscheduled care patients within 4-hours requires a collaborative approach from all parts of the health and social care system to provide patient flow.

3.2 NHS Lothian reported compliance to this standard of 82.3% for the month of August 2018. Exhibit 1a, below, demonstrates performance against the standard by Site

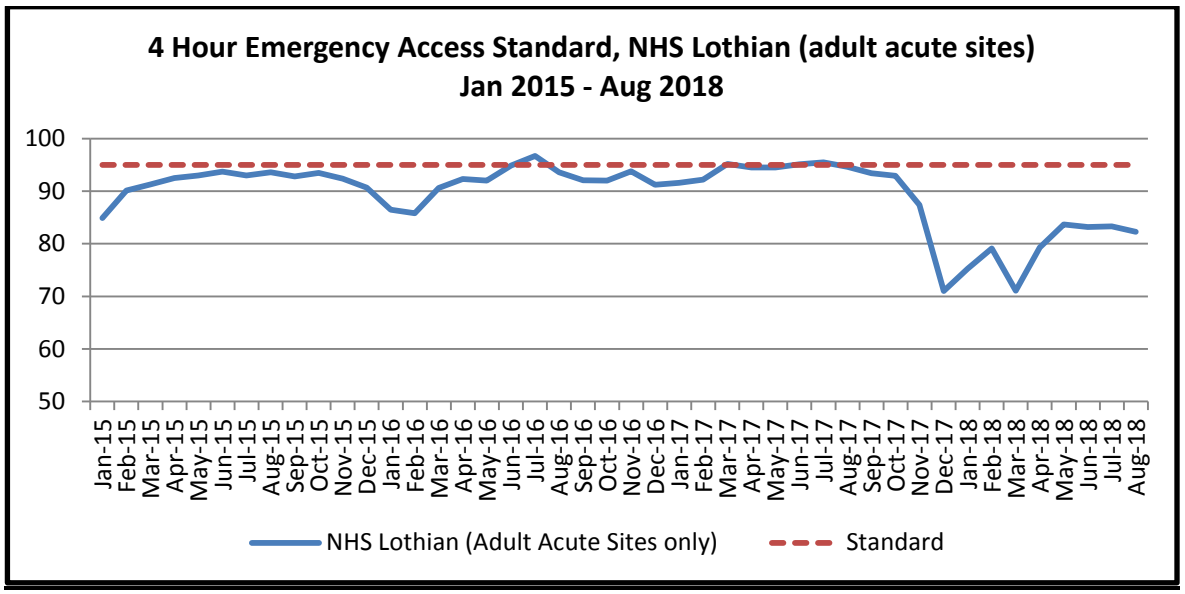
(August 2017 – August 2018). Exhibit 1b beneath shows compliance against this standard, NHS Lothian 2015 – 2018.

Exhibit 1a – Performance against the 4-hour emergency access standard by Site (June 2017 – July 2018),



As shown in Exhibit 1a above there has been improvement from both the RIE and WGH while performance at SJH has deteriorated during the last few months:

Exhibit 1b – Performance against the 4-hour emergency access standard, NHS Lothian (all adult sites) Jan 2015 - Aug 2018,

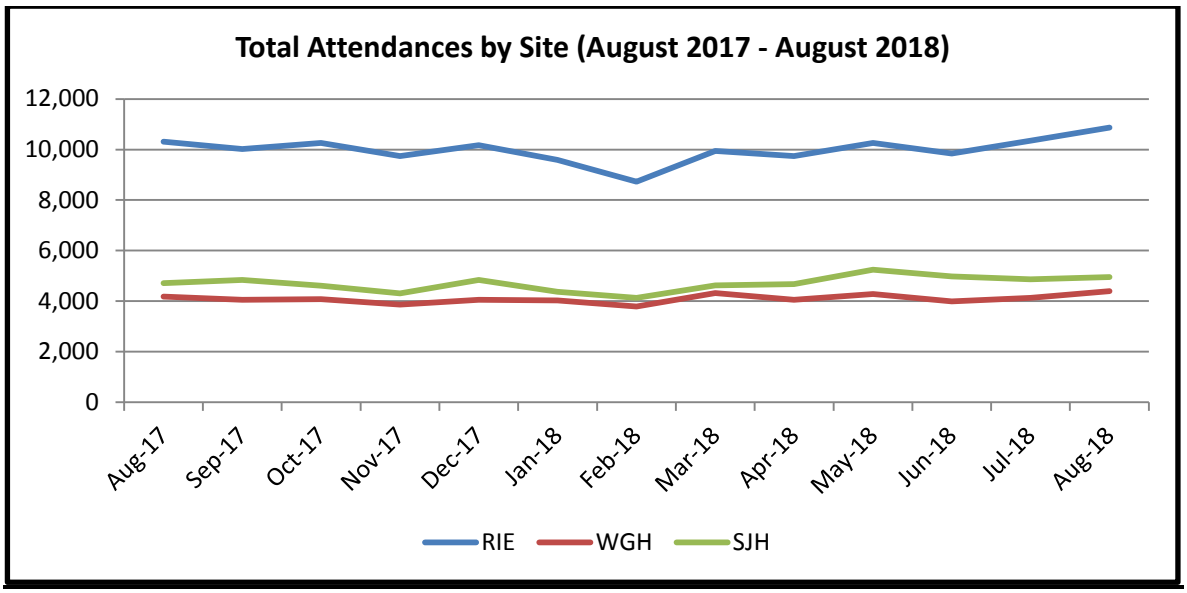


3.3 Performance against the 4-hour emergency access standard is influenced by a range of factors including, but not limited to;

- the volume of Emergency Department (ED) attendances,
- the pattern of arrival of ED attendances i.e. high volumes within a short period causing crowding,
- patient acuity,
- bed pressures, most acutely as a result of Delayed Discharges.

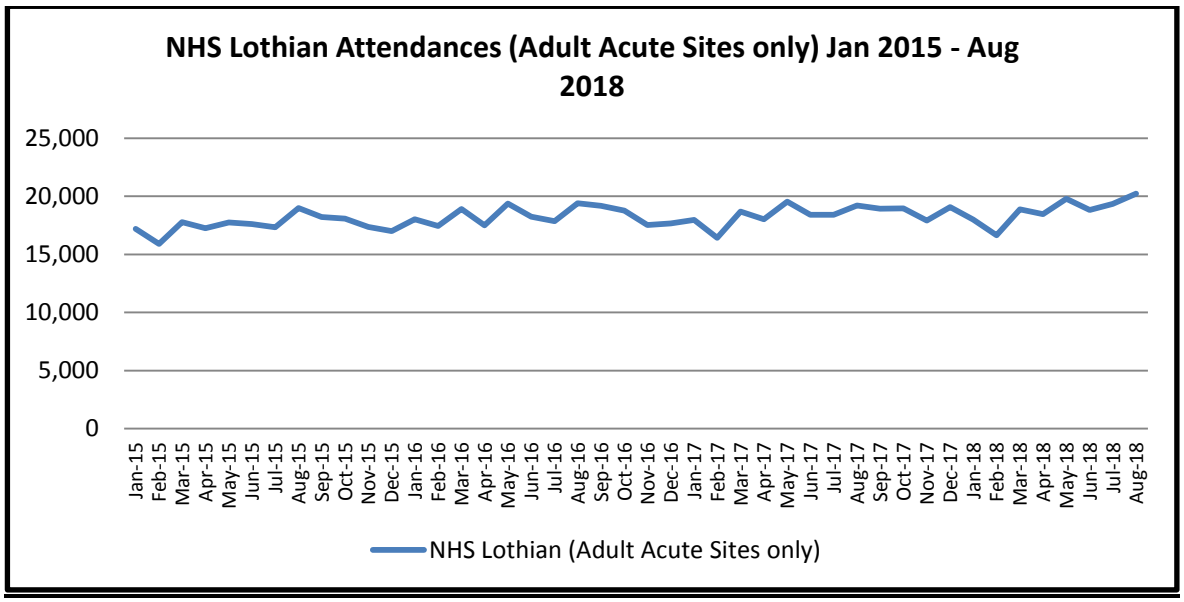
3.4 Exhibit 2a below, shows the number of total ED Attendances by Site (August 2017 – August 2018) while Exhibit 2b beneath shows Total ED Attendances, NHS Lothian (all adult sites) 2015 - 2018.

Exhibit 2a – Total ED Attendances by Site (June 2017 – June 2018),



As shown in Exhibit 2a/2b below above, attendances across Lothian have increased significantly from 17'991 (January 2018) to 20'222 (August 2018) which is a 12.4% increase.

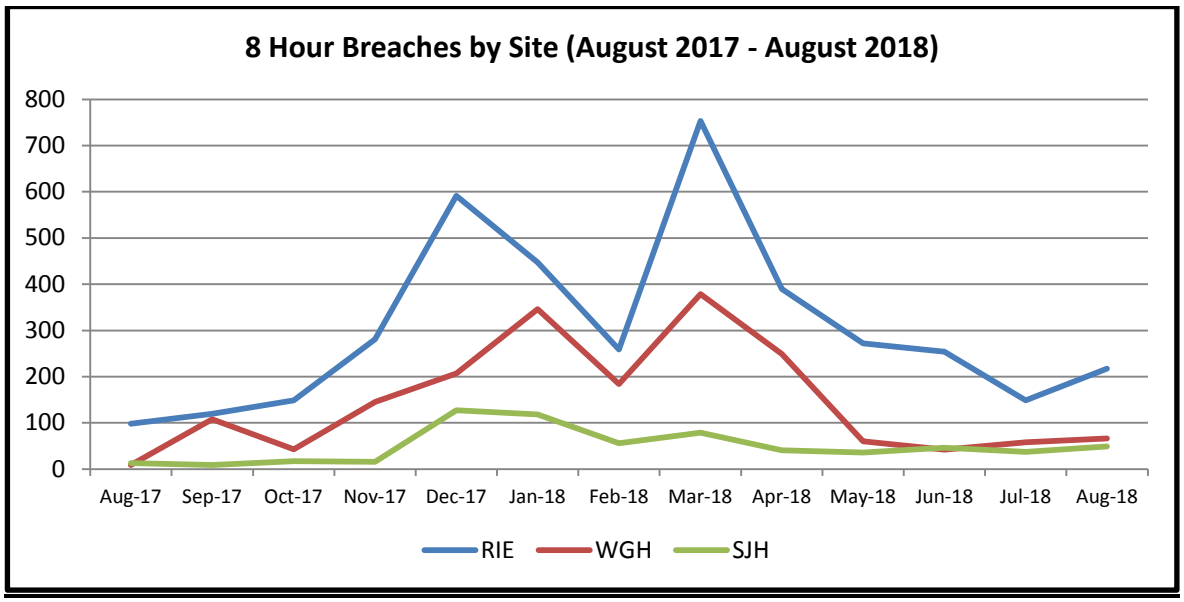
Exhibit 2b – Total ED Attendances, NHS Lothian (all adult sites) 2015 – 2018,



3.5 Exhibit 3a and 3b shows the impact of pressures that existed throughout the adult acute services by the number of 8 hour breaches throughout the year. These long waits have a direct impact on patient experience and safety, and add to ED crowding. As shown from the exhibits below there has been a significant improvement in

performance since January 2018. Exhibit 4a and 4b replicate this data across the 12 hour breaches marker.

Exhibit 3a - Total 8 Hour Breaches by Site (August 2017 – August 2018),



Breaching performance has improved since the peak in March 2017. This peak in February/March 2018 was attributed to a number of factors including but not limited to:

- Poor compliance against the 4 hour standard;
- High numbers of attendances;
- Standard winter pressures;
- Adverse weather.

Despite this, 8 hour breach performance has generally improved month across all adult sites.

Exhibit 3b – NHS Lothian Total 8 Hour Breaches (Adult Acute Sites only), Jan 2015 – August 2018),

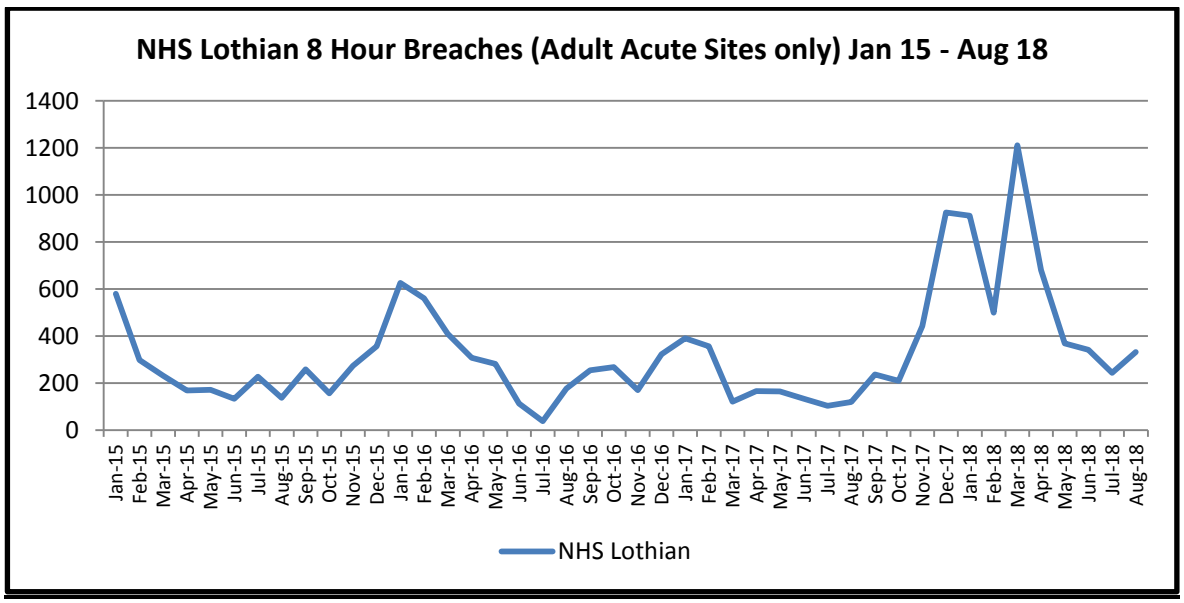
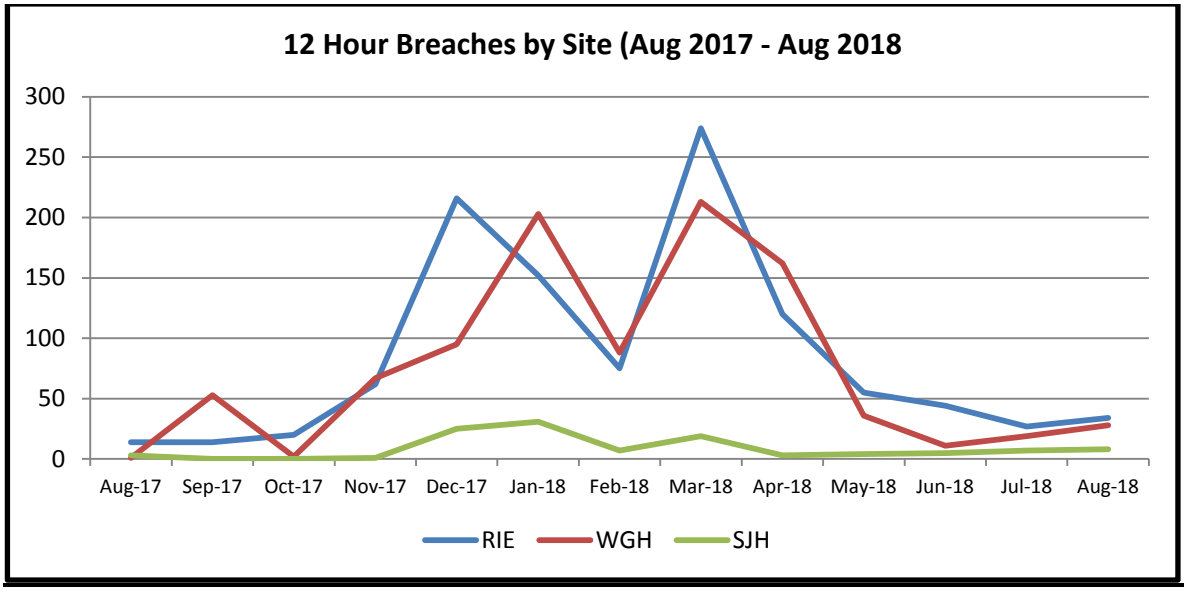
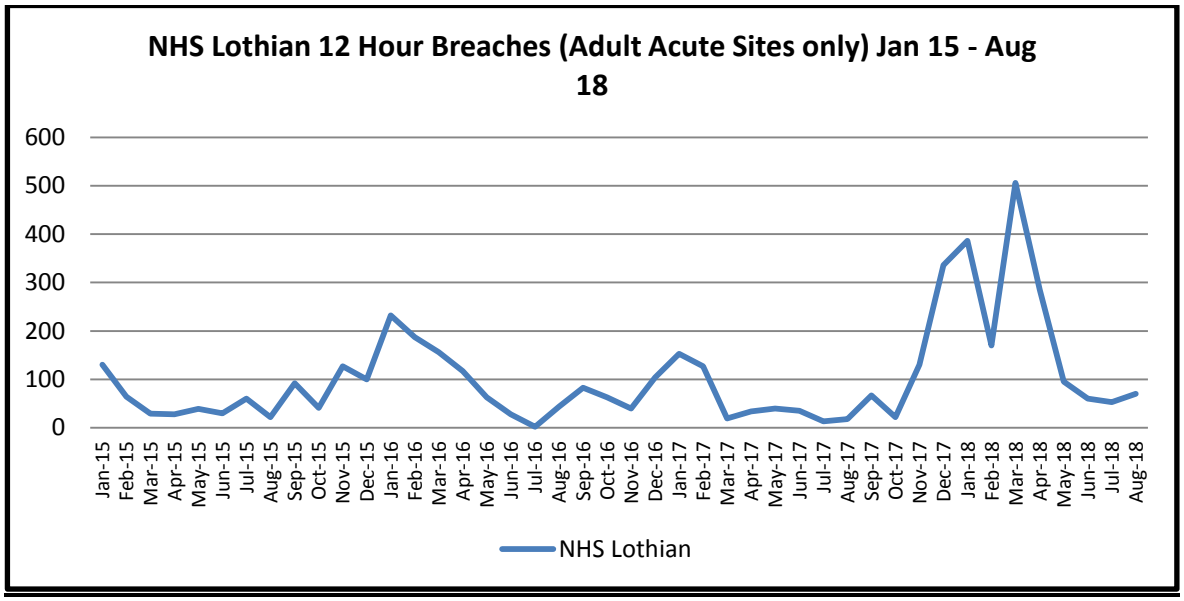


Exhibit 4a - Total 12 Hour Breaches by Site (August 2017 – August 2018),



12 hour breach performance has also improved in line with 8 hour breach performance across all adult sites.

Exhibit 4b – NHS Lothian Total 12 Hour Breaches (Adult Acute Sites only), Jan 2015 – August 2018),



3.6 Unscheduled admissions have stabilised as shown in Exhibit 5a and 5b.

Exhibit 5a – Total Number of Emergency Unplanned Admissions, by Site (August 2017 – August 2018),

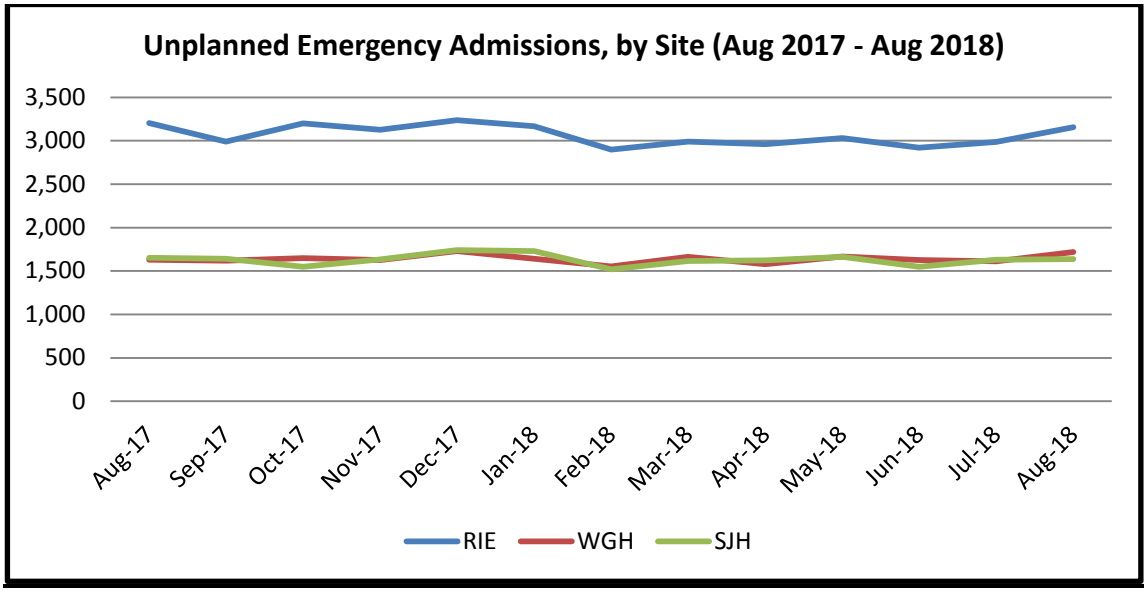
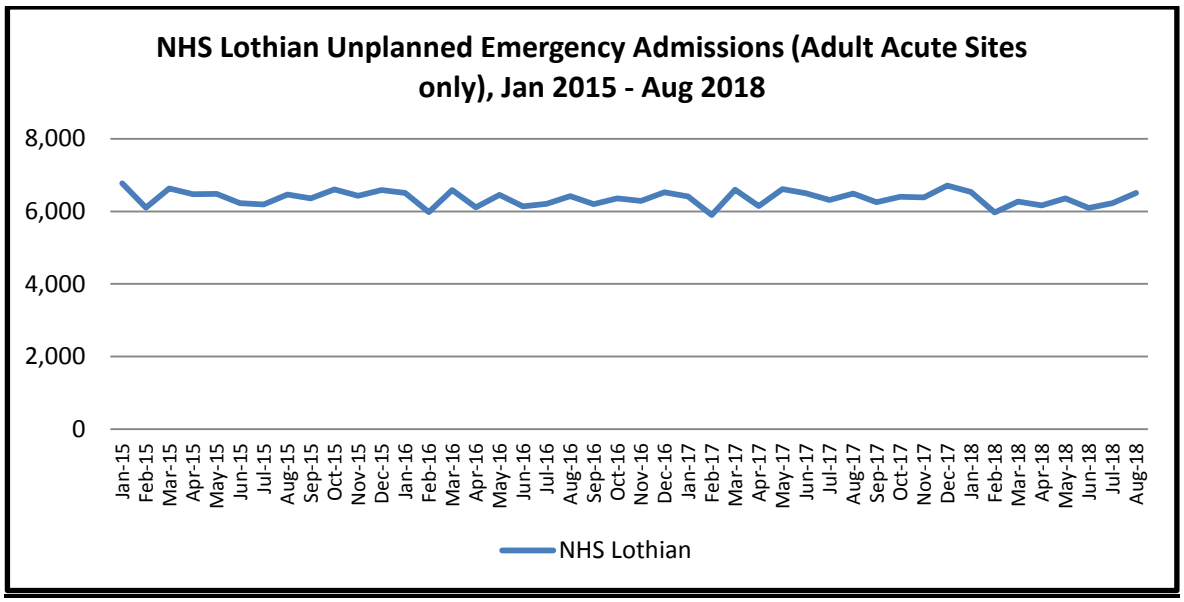
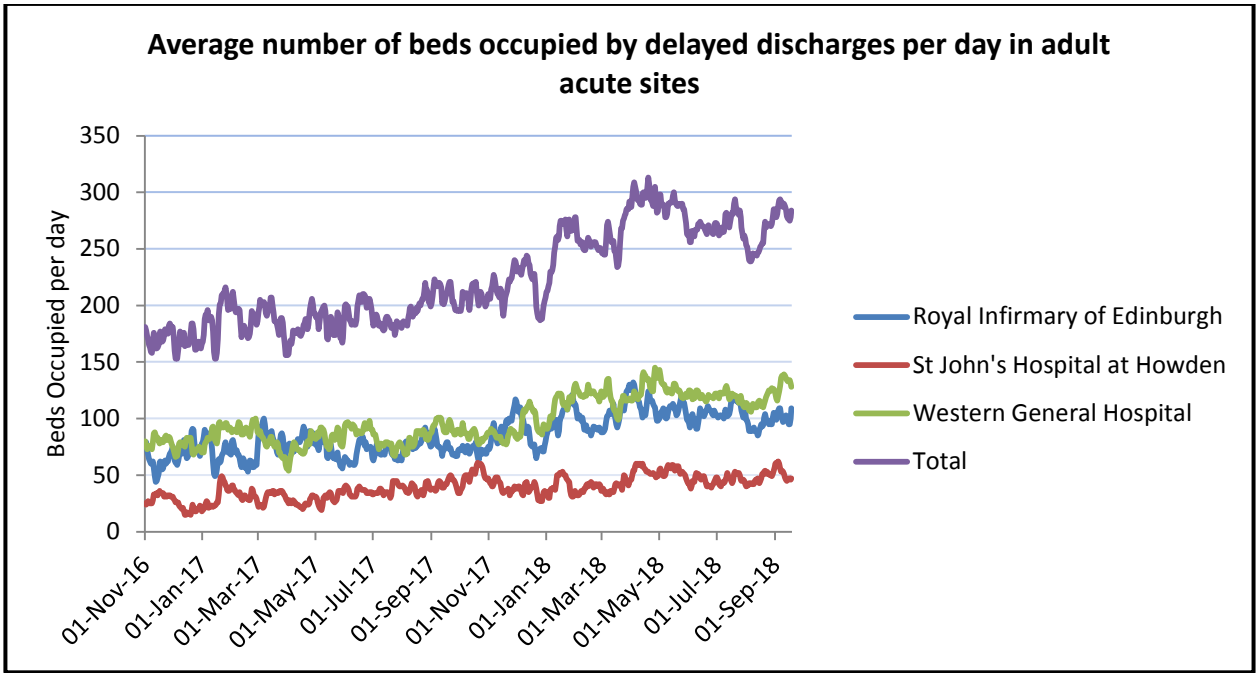


Exhibit 5b – Total Number of Emergency Unplanned Admissions by Site (Jan 2015 – August 2018),



3.7 There continues to be high levels of delayed discharges across all three adult sites. Exhibit 6a below shows the average daily number of bed occupied by delays on each adult acute site from November 2016 – YTD 2018 while 6b shows this performance by each H&SCP.

Exhibit 6a – Average Number of patients delayed in their discharge by site (November 2016 – September 2018)



3.8 The delayed discharges performance continues to cause significant difficulties in achieving sustainable flow across each acute site. Difficulties associated with accessing packages of care; Nursing Home positions and Guardianship all contributing to this performance. Similar issues were experienced in downstream community hospitals board where increasing numbers of delays reduced capacity.

Exhibit 6b – Delayed Discharge performance for April 17 – August 18 by H&SCP,

Table 1: Census Return Data - Total Delayed Discharges (incl Code 9s; excl. Code 100s)	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
City of Edinburgh (14)	215	201	187	161	173	216	186	204	191	253	245	286	240	233	222	250	246
East Lothian (12)	29	11	11	14	19	29	34	25	19	19	16	20	17	10	12	17	14
Midlothian (20)	34	38	37	25	19	30	33	41	35	33	24	29	37	48	36	38	28
West Lothian (31)	47	36	36	39	45	53	69	52	40	61	64	58	62	54	45	56	54
Total Delayed Discharges (inc. Code 9s, excl. Code 100s) (Total not sum of above - includes other HSCPs)	326	287	274	245	259	334	330	327	293	374	357	400	359	347	317	362	344

Improvement Actions

3.9 NHS Lothian rapidly responded to the output of the SAE, the internal audit, and The Academy of Medical Royal Colleges Report, and is steadfast in their determination to significantly improve and deliver sustainable and compliant service models and patient pathways. At Board level and at Acute and H&SCP level there are a number of initiatives and plans in place to implement the recommendations made by the recent reviews and respond to the challenges that are associated with unscheduled care performance. These actions are captured within a corporate level "Emergency Access Standard Improvement Plan" and each site has its own specific action plans based on this to address these issues locally. The key focus of these plans is ultimately to improve patient and staff experience and efforts have been concentrated on the rapid operational delivery of actions that are deliverable over the initial 6 month period.

3.10 The Academy's report groups recommendations under six themes;

1. Governance
2. Culture
3. Recording of the 4 hour standard and achieving sustained performance
4. NHS Lothian's Internal Audit Report, Significant Adverse Event (SAE) Process
5. Patient safety and quality of care
6. Staff and site leadership

3.11 Examples of work underway and a short summary of what has been achieved to are detailed below. For the purposes of this report, the themes of Culture and Staff and Site Leadership have been amalgamated due to the cross-over in actions.

Governance

3.12 In response to the Whistleblowing concerns and the subsequent SAE and NHS Lothian's Internal Audit, a 4 Hour Emergency Access Board (4EAS) was created to address the issues raised and the respond to the emerging recommendations. This Emergency Access Standard Improvement Board was a management meeting, not a governance committee, and was effectively a short-life working group which was designed to give the Chief Executive assurance that all the actions arising from the recent reviews, which were consolidated into a single Emergency Access Standard Improvement plan, were being addressed This was established 25th January 2018. This group has now been superseded by two groups detailed below.

3.13 A programme delivery group has been recently established to provide leadership, strategic advice and guidance for the delivery of the 4 Hour Emergency Access Standard (4EAS) Programme which includes, the short/mid-term improvements against quality and unscheduled care performance standards, the development of sustainable leadership capacity and capability as well as the implementation of the recommendations made by the Academy of Medical Royal Colleges and Faculties In Scotland report in April 2018. This ensures the focus is aligned to the operational delivery of the recommendations found within the 3 reports.

3.14 The programme delivery group will include, initially, the leadership team responsible for the delivery of localised actions to improve performance at the RIE. The leadership personnel from the RIE will be replaced by that of SJH when the focus of the support arrangements switches to this particular adult acute site. The RIE improvement framework is detailed as **Appendix 1**. A Scottish Government appointed Support Team has been assembled to enhance the efforts made by NHS Lothian across their improvement journey.

3.15 To complement the programme delivery group, a Governance Oversight Group, with representation from Non Executive team, has also been assembled to provide assurance to the Scottish Government in the following areas:

- The improvement of delivery against the short-term quality and performance standards.
- A plan for the future organisation and management of the 4 Hour Emergency Access Standard (4EAS) Programme which includes the implementation of the recommendations made by the Academy of Medical Royal Colleges and Faculties In Scotland report in April 2018.

3.16 The Terms of Reference for these two groups can be found as **Appendix 2 and 3**. Early engagement between the External Support Team and NHS Lothian has been constructive with a focus on the models of care within ED.

3.17 An over-arching improvement plan has been developed which compiles the actions and recommendations from the Internal Audit Review, Significant Adverse Event Process (SAE) and External Review. The plan will be subject to scrutiny by the Governance Oversight Group with a focus upon ensuring there is a robust and dynamic approach to evidence gathering to support closure of actions from the plan. The organigram below details the governance reporting structure now in place;

To date the following has been achieved within the theme of "governance";

- Created a 4 Hour Emergency Access Board (4EAS) Chaired by Deputy Chief Executive established 25th January 2018 ✓
- This group has since evolved into a Programme Delivery Group (Chaired by Deputy Chief Executive) and Governance Oversight Group (Chaired by Chief Executive) - both fortnightly ✓
- Non-Executive Board membership in place to support Governance Oversight Group ✓
- Over-arching improvement plan developed compiled from Internal Audit Review, Significant Adverse Event Process and External Review✓
- Site owned and developed plans aligned to overarching plan which will be reviewed for accuracy and completion by Governance Oversight Group through evidence gathering through repository. ✓
- Evidence repository created to manage information and data sources that can align with over-arching plan and signal completion. ✓
- The Board had a development session on 16 May 2018 which covered both unscheduled care and the general subject of risk management. ✓

Currently in progress

- Review of governance arrangements including evaluating roles and remit of Board Sub Committees.
- Continue to embed the Lothian procedures and processes for developing and approving policies, and the Policy Hub.

Recording of the 4 hour standard and achieving sustained performance

3.18 A Local Standard Operating Procedure (SOP) developed in line with national guidance (Dec 2017). Face to face and online training programmes have been rolled out (March 2018) with the majority of key staff having now been trained. A suite of dashboards created to monitor SOP compliance (Feb 2018) and a target audit tool has been developed (Aug 2018). All changes to the SOP will be subject to ongoing scrutiny and approval through Access and Governance Committee. There continues to be ongoing communication between NHS Lothian, Scottish Government and ISD to clarify guidance to support positive pathway developments across sites.

3.19 Tests of change are underway to improve flow throughout adult acute sites. Improvement frameworks have been devised to detail and predict the performance improvement of any change ideas. An example can be found as Appendix 1. Examples of tests of change at the RIE, the WGH and between the Flow Centre and SJH are detailed below.

RIE Test of Change

3.20 As of Tuesday 15th May, the process for booking a bed from ED at the RIE has changed. Previously, bed requests made by ED would go through the Capacity & Site team who would then contact the specific ward and confirm a bed. During this test of change, ED are contacting the wards directly to confirm when a bed is available against one of three responses;

- Bed is available and patient can move
- Bed will be available within the hour
- Bed will not be available within the hour

3.21 If it is the third option, the ward will escalate to the Capacity & Site team and work together to create capacity to accommodate the patient. The metrics employed to improve patient experience and unscheduled care performance includes:

- Activity;
- Breaches;
- Daily 4EAS compliance;
- Length of Stay;
- Time from bed request to ready (to reduce ED crowding);
- Time to care provider.

3.22 The exhibit below shows initial performance data resultant from this change;

	Tuesday 8th May	Tuesday 15th May	Tuesday 31st July	Tuesday 21st August
Overview				
Total Activity	364	341	303	351
Total Breaches	111	52	34	98
Daily Compliance	69.50%	84.80%	89.90%	72.10%
ED LOS				
LOS up to 3hrs	138 pts = 38%	184 pts = 54%	189 pts = 56%	157pts = 45%
Time from bed request to ready				
Up to 30mins	10 pts = 14%	42 pts = 64%	49 pts = 79%	25pts = 36%
Over 2hours	35 pts = 50%	3 pts = 5%	2 pts = 3%	19pts = 28%
Time to Care Provider				
Up to 60mins	101 pts = 33%	132 pts = 42%	145 pts = 47%	125pts = 39%
Over 90mins	156 pts = 51%	115 pts = 37%	107 pts = 35%	137pts = 42%

3.23 As shown above there have been incremental improvements across each metric since the change started although poorer performance was seen in August in line with increased attendances and admissions in the month of August 2018. This also evidences the significant correlation in performance with daily attendance figures and further underlines the need to reduce attendances at emergency departments.

WGH Tests of Change

3.24 The WGH are currently undertaking a number of small scale test of change initiatives which will be evaluated through analysis of changes in overall unscheduled care performance standards. These tests of changes are:

- The use of a complex discharge co-ordinator to work with localities/H&SCP and focus on increased length of stay patients. Impact is centred on length of stay improvements and details are currently being analysed – expected early October 2018.
- Establishment of a clinically led LOS Panel to review patients over 14 days and actions that can reduce overall LOS – this is currently being re-scoped with a focus on process and identification of a specific patient group – meeting scheduled for October 2018.

Flow Centre and SJH

3.25 Since 30th July 2018 the Flow Centre has been providing an urgent GP admissions service to West Lothian. Previously all GP urgent admissions to Primary Assessment Area (PAA) and Medical Admissions Unit (MAU) were managed by operating a bleep system 24 hours a day, taking clinical staff away from direct patient care. Patients were not booked directly into TRAK until they arrived and if a patient required transport, the GP had to arrange this separately with SAS emergency ambulance as the only option, with the associated delays for the patient.

3.26 Since the implementation of admissions through the Flow Centre, clinical and medical staff are be able to spend more time on direct clinical care with patients. Staff in MAU/ PAA/ ED all have live up to date information as to when the patient is due to arrive, and all GP urgent patients travelling on Flow Centre vehicles or low acuity PTS ambulances are collected within the requested time stratification and all within 4 hours reducing delays with emergency ambulances.

3.27 The activity curve for GP admissions has already started to flatten and the later peak in demand is earlier in the day. Currently the Flow Centre is taking 65% of all GP referrals and is working with GP practices to increase this number. The Flow Centre is also working with H&SCP colleagues to refer to alternatives to admission, to prevent unnecessary front door attendances.

To date the following has been achieved within the theme of "Recording of the 4 hour standard and achieving sustained performance";

- SOP developed based on national guidance ✓
- Training programmes rolled out to majority of staff ✓
- Suite of forensic dashboards created to monitor SOP compliance ✓
- Improvement frameworks devised and tests of change underway to improve unscheduled care performance ✓

NHS Lothian's internal audit report, significant adverse event (SAE) process

3.28 To date the following has been achieved within the theme of "NHS Lothian's internal audit report, significant adverse event (SAE) process";

- A single improvement approach has been developed encompassing recommendations from all three processes. ✓
- Enhanced Site based improvement approach aligned to 6 Themes, developed by the Scottish Academy review team and the site leadership team which will now include explicit roles and responsibilities for Site Directors, Associate Medical and Nurse Directors. ✓
- Monitoring of progress and implementation overseen by Board non-executive director with external and independent quality assurance support to the Board. ✓

Patient safety and quality of care

3.29 There is has been work to ensure the acute sites are focused on the 6 Essential Actions and that a culture of the right place, right time for patients and staff is the norm.

As a result each site has a 6 Essential Action Improvement Plan Developed by Quadrumvirate Team.

3.30 Boarding policies are currently being reviewed by medical leadership which includes focus upon patient safety and ensuring principles of Clinical Review and Safe Care are embedded. This was reviewed and presented at June SMT. Overarching principles to build capacity and minimise boarding to be presented at an upcoming Senior Management Team Meeting for discussion and action through sites.

3.31 Actions have been taken forward to improve the access to and quality of unscheduled care. This includes testing and evaluating actions that contribute to reducing number of attendances at emergency departments and reduce crowding. Examples of such are developing an ambulatory care clinic at the RIE and implementing length of stay programmes of work to reduce length of stay where clinically appropriate and in collaboration with Health and Social Care Partnerships a reduction in overall length of stay.

3.32 Additionally acute sites have implemented site specific Patient Safety Experience Action Groups (PSAEG) in August 2018. Membership includes Senior Medical, Nursing and Managerial Leadership.

SJH Front Door Redesign

3.33 The Emergency Department at SJH provides a 24/7 unscheduled care service. Last year (2017) just over 55,000 patients were assessed and treated in the department. The department manages on average between 150 and just over 200 presentations per day. Attendances have increased by 14.5% since 2008 (47,927) compared to 2018 (54,868). This change has been amplified by increasing complexity and acuity of patients presenting to the ED as well as increasing presence of patients 65+ y/o. The increase in attendances, compared with current capacity has resulted in an increase in the episodes of ED crowding. Risks associated with crowding include the following in the following publication RCEM, 2015.

3.34 The problem with a lack of available beds in MAU is threefold; 1) this leads to patients who need to go to MAU remain within ED, which is adding unnecessary delay to the patient journey. 2) this causes delays for other patients who are awaiting cubicles within ED directly contributing to first assessment breaches; 3) the impact of not having an available bed in MAU is that patients identified as requiring a bed for medical assessment cannot be directly admitted and are redirected to ED until a bed in MAU is available.

3.35 A comparison with the RIE ED indicates that proportionally the SJH ED is working with a deficit of 6 cubicles in comparison to the RIE ED. The RIE ED has 35 cubicles along with 4 resus bed spaces and deals with an activity of 118,894 presenters 2017/2018 in comparison to 12 cubicles plus 3 resus at SJH with 54,868 presenters. However, comparison in this way assumes that the footprint at the RIE is adequate to meet activity and critically this is not the case. Overcrowding is an issue at the RIE ED too and a piece of work is required to benchmark activity and footprint across the UK to support future ED capacity modelling in Lothian

3.36 In line with the Lothian Capital Prioritisation Process a phased programme is being developed by the SJH team to re-design the front door to address the problems associated with capacity and overcrowding. Currently a clinical model is being developed on which the physical footprint will be built upon. The general principles and requirements of the ED are categorised as:

- Patients should receive safe and effective care in a safe environment that protects their privacy and dignity;
- Clinical areas should enable patients to retain dignity and privacy and limit the incidence of sensitive conversations overheard by other patients and staff;
- Patients should be cared for in an area where clinical staff can monitor patients.
- The ED can be disorientating. It should be easier for patients to locate the department and for patients and staff to understand the 'pathway' through the ED department.
- There should be an adequate area for Multidisciplinary teams / clinical discussion and handover.
- Storage/Equipment – adequate space for equipment in the department which is accessible, easy to locate and clearly organised.
- The physicality of the department should mirror the patient journey from the front door through to discharge.

RIE Front door Redesign

3.37 A proposed front door redesign at the RIE is currently being scoped against a feasibility and strategic assessment. The Strategic Assessment for this piece of work will be discussed with the External Support Team for input and will be progressed by the leadership team at the RIE with targeted support from the programme delivery group.

3.38 The front door of the RIE is currently undergoing a feasibility study to understand if the department could be segmented to improve patient flow and performance across the site. The following options are being scoped and considered:

- Introduction of a Short Stay Observation Unit;
- Introduction of a GP Assessment Area;
- A dedicated Minor Injuries Unit, accommodated outwith the existing Emergency Department;
- Expansion of the current Ambulatory Emergency Care Unit;
- Redesign of the current footprint within the Emergency Department

3.39 The findings from the feasibility study and accompanying strategic assessment are due to considered and published by the RIE team in October 2018 and thereafter appropriate governance arrangements, and engagement will take place to progress plans.

3.40 It is proposed that a new service would be created within the existing footprint of the RIE site. This would provide a separate flow from the main ED for patients who have been referred from primary care. These patients would be comprised from current triage category number 9 (TC9) – GP referrals and would be appropriate for safe consultation from this area. This area would provide a safe, purpose built facility for patients to have access to consultant led assessment, diagnosis and treatment. These patients would be either discharged home or admitted into the main arc of the RIE but bypass the need to be admitted or triaged through ED.

3.41 Additional pathways are in the process of being finalised and approved. This would lead to an expansion of the service, incorporating surgical patients and pathways still operating out of the Surgical Observation Unit (SOU). Currently, the patients within these pathways breach their 4-hour standard as clinical exceptions or treatment end waits. These breaches can account for 30% of the total breach reasons between January and July 2018 on-site with a proportion of these patients under the ambulatory care pathways. Focusing on just the surgical pathways, once these have been

approved and implemented. There is a potential for a 60% performance improvement within SOU (467 breaches out of 745 relating to treatment end waits. The Ambulatory Care Clinic has 2 trolleys and 1 seated space in which to review patients this capacity is able to review up to 15 patients per day. The relocation of this service will allow the introduction of additional pathways therefore able to review more patients, reduce overcrowding within the ED and lead to a better experience for both patients and staff.

3.42 With the expansion of both the medical and surgical pathways, the team expect to see a 2% overall performance improvement; with 1% coming from the medical pathways and 1% from the surgical pathways based on the number of the breaches recorded that would have been suitable for this service.

3.43 Within Exam at the RIE, there is now a dedicated minor injuries space where all category 7 (minor injury) patients are reviewed. Along with its own dedicated cubicles, this service streamlines their patients with their own dedicated staff of ANPs to ensure patients are treated in a timely manner. By streamlining these patients, it reduces the overall number of patients within the department and reduces first assessment delays at the same time. Improvement work is still ongoing within this area and the team is currently adjusting its staffing model to ensure there is enough staff during the evening when the presentation profile peaks and where we would record first assessment delays.

3.44 It is worth noting that escalations are regularly distributed from the ED team to the Senior Management Team to raise any first assessment delays. The current text escalation includes the following;

- Time to first assessment;
- Number of patients awaiting assessment;
- Actions taken to address issue;
- Reference escalation status (green/amber/red);
- Detail impact of crowding on assessment.

To date the following has been achieved within the theme of "Patient safety and quality of care";

- Acute sites have implemented site specific Patient Safety Experience Action Groups (PSAEG) in August 2018. ✓
- Each site has a 6 Essential Action Improvement Plan Developed by Quadrumvirate Team. ✓

Currently in progress;

- Models of care within ED being evaluated
- Boarding policies are currently being reviewed by medical leadership
- Currently being considered through a feasibility study and strategic assessment are the opportunities regarding;
    - Introduction of a Short Stay Observation Unit – A test of change is planned October 2018, trialling base from AMU as short stay observation unit to evaluate flow and crowding and quantify patient volumes.
      Introduction of a GP Assessment Area;
    - A dedicated Minor Injuries Unit, accommodated out with the existing Emergency Department – Test of Change since June 2018, trailing of isolation of minor injuries patients to achieve 100% compliance.
    - Expansion of the current Ambulatory Emergency Care Unit.

Staff Experience and Leadership

3.45 The Staff Experience Group continues to inform and oversee the implementation of the Organisational Development (OD) Programme and accompanying staff experience improvements that were derived out of the external review and reports into the Programme Delivery Group. The Staff Experience group is chaired by the Director of HR and OD and is Partnership based. Alongside this programme of work is a wider corporate programme to improve staff engagement and experience which is overseen by the NHS Lothian Staff Experience and Engagement Programme Board, which reports directly into the Staff Governance Committee.

Site OD Plans

3.46 Each adult acute site has a local OD Plan which is based on a collaboration model and has been co-created by the Site Leadership Teams, with senior OD practitioner input (each site has a dedicated OD lead to advise, support and facilitate the local programme of work). Site specific OD plans span a number of themes, looking at 'soft' and 'hard' factors. A range of OD interventions have already taken place across the sites ranging from 1:1 coaching, group sessions with leadership teams and mutli-professional groups. Key areas of work have included, working relationships, building capacity and resilience, medical leadership and communications, with a focus on quality and patient safety. The current plans for each site, as updated during September are shown in **Appendix 4**:

Leadership Support and Development;

Embedding Executive Leadership into Operational Solution Delivery

3.47 From October an Executive Director will be allocated to each of the 3 adult acute sites to provide enabling support to the Site Director and their teams. The Site Director remains in charge of the site day to day. The role of the Executive Director is to guide, mentor, facilitate the fast-tracking of solutions and provide executive level sponsorship for improvement ideas and tests of change which lead to performance improvement.

Site Leadership Arrangements

3.48 There is a review underway lead by the Chief Officer, Acute, supported by the Director of HR & OD and the Executive Medical Director, to identify how to strengthen the triumvirate and site medical leadership in particular. The initial focus has been on the role of the Associate Nurse Directors (AND) and Associate Medical Directors (AMD), with an initial desktop review of job descriptions, moving to a review of the "As Is " arrangements to determine if there are opportunities to strengthen and improve the current working arrangements. It is anticipated that this work should be concluded by early November.

3.49 An example of an early outcome from this work is the decision to strengthen the leadership capacity at St John's Hospital by releasing the AMD from their combined leadership role for pan-Lothian Outpatient Services to concentrate solely on their AMD role at St John's. It has also been agreed to recruit to an additional General Manager and Clinical Service Manager for the site to strengthen the leadership arrangements within unscheduled care.

3.50 The external review raised concerns about the engagement and availability of medical leaders (principally AMDs) and actions have been developed to clarify their role and contribution to issues on the site as they occur. The Executive Medical Director is

therefore leading a specific piece of work to review the site medical leadership arrangements.

3.51 A workshop is proposed to agree and work through the detail of expectations of the AMDs from each other and the Site Directors as they work to address deliver of unscheduled care at each site and in particular to address the contribution of medical leadership to the challenges faced on a day to day basis. These include (but are not limited to)

- Pressures around boarding
- Insufficient capacity for elective or critical care flow
- Balance of work and expectations of support for teams under pressure- e.g. when respiratory patient numbers are very high, how do others on the site support

3.52 A short survey will be sent to AMDs to seek their thoughts about where they contribute and add most value. A facilitated work shop with AMDs and Site Directors will be held 6 November. This will also be informed by other models and will provide the opportunity to consider these and ensure that a model that fits Lothian's needs and purposes is in place.

3.53 A externally facilitated team session on 25th October with the Acute Site and Service Directors to explore working relationships, team dynamics and resilience.

Leadership Development Activity

3.54 In support of the Site OD plans and the review of leadership arrangements, leadership development support has been prioritised for the Acute Adult sites to help re-build confidence and resilience, specifically:

- Playing to Your Strengths: brief "assets" based leadership development intervention, drawing attention to people's strengths and resilience so that they can leverage these and lead effectively in times of change
- Courage to Manage: Equipping leaders at all levels with the theory and practice to approach difficult conversations with honesty, benevolence and courage.
- Thrive: An empowering programme which challenges limiting beliefs and unhelpful thinking styles and helps to build resilience.
- Joy in Work: improving joy in work and reducing burnout by building on "what matters to you?" conversations, empowering and enabling leaders at all levels to better understand the barriers to joy in work ("stones in my shoes") and co-create meaningful strategies to address them.

Review of Bullying and Harassment Policy

3.55 At its September meeting the HR Policy Group reviewed the Prevention of Bullying and Harassment Policy against the Partnership Information Network (PIN) guideline. The group confirmed that the policy was PIN compliant but wished to take the opportunity to refresh the policy to make more explicit links with organisational values and to emphasise the options for informal resolution, including mediation. The updated policy will be issued during October.

3.56 Awareness raising and building confidence that concerns will be handled appropriately remains a work in progress and links to the 'Speak Up' initiative referred to below.

Whistleblowing

3.57 The Board's Non-Executive Whistleblowing Champion has regular oversight of whistleblowing complaints, through a process of monthly and real time monitoring and scrutiny. Standing item on the Staff Governance Committee, with emerging themes and issues identified and where it is deemed necessary issues will be raised with the full Board. Whistlebowing Champion also has an established feedback mechanism to learn from Whistleblowers experiences. There is extensive information and guidance on HR online (online portal for staff and managers).

3.58 Good systems and processes in place, evidenced by other Boards seeking to learn from our approach. There is still work to be done in shifting the culture to ensure that staff feel safe to speak up about issues of patient safety and malpractice (in the 2017 Dignity at Work Survey, 69% of respondents indicated that they felt safe to speak up).

3.59 Following publication of the external report our time and attention has been focused on learning from others, most notably the guardian approach in NHS England. A short life working group is currently scoping and developing our approach to raising awareness and building staff confidence to raise concerns. Our focus is on creating a network of speak up advocates and a speak up campaign.

Staff Engagement and Experience Development Framework

3.60 Alongside the recommendations from the External Review, the Boards Staff Engagement and Experience Programme Board has been developing a framework for all staff at all levels in response to iMatter feedback and other information we have received from staff. The Framework is a roadmap that sets out key commitments and ambitions. It covers everything from focusing on staff's health and wellbeing, embedding our values, improving communication, celebrating and recognising success and more. The framework is in the process of being launched across the organisation.

3.61 One of the early outputs from this work will be a toolkit for managers to help embed values across our organisation.

To date the following has been achieved within the theme of "Staff Experience and Leadership";

- EAS Staff Experience Improvement Group established March 2018 ✓
- Robust communications plan for release of report ✓
- OD programmes in place for 3 adult acute sites and the site and capacity team ✓
- Revised leadership arrangements for the Site and Capacity team with effect from 31st July✓
- Prevention of Bullying and Harassment Policy reviewed by partnership based HR Policy Group and confirmed as PIN compliant (but taking the opportunity to strengthen references to organisational values and informal resolution)✓
- Review of AMD and AND job descriptions ✓
- Agreement to strengthen site leadership arrangements for St John's, with additional AMD support on site, additional General Manager and Clinical Service Manager Posts ✓
- Scoping of speak up campaign and approach to how we encourage staff to raise concerns safely, including session with Guardian from NHS Trust in Cumbria and information sourced from Guys and St Thomas' ✓

Currently in progress;

- Ongoing implementation of OD Plans
- 'Deep dive' into to dignity at work survey and iMatter responses at SJH and co-create improvements/solutions to problems and barriers
- Development of 'Speak Up' campaign and network of speak up advocates
- Launch of NHS Lothian Staff Engagement and Experience Development Framework
- Development of managers toolkit to help embed organisational values
- Review of site medical leadership
- Review of site triumvirate arrangements
- Improving inter-site working relationships
- Refreshed Prevention of Bullying and Harassment Policy to be launched
- Paper to Board Staff Governance Committee in October to formally review actions against the action plan and establish if any further or different actions are required.

HSCP Improvement Actions

3.62 HSCPs play a key role in maintaining and improving patient flow throughout acute hospitals. Both promoting admission avoidance and supporting timely discharge are key priorities and some examples of work being undertaken in these fields are detailed below. These tests of change and improvement plans are subject to review and outputs will be scrutinised thought the performance meetings held between the Deputy Chief Executive and HSCPs leadership teams.

Midlothian

3.63 In Midlothian there have been a number of schemes that are currently at start up phase to support admission avoidance and improve flow management. There have been appointments to additional roles such as a Flow Manager and Tracker roles while an additional service manager has been appointed for Intermediate care. All roles are due to start at the beginning of October 2018. In addition to this beds at Midlothian Community Hospital have been evaluated with 5 beds reallocated to support acute flow.

3.64 Recruitment is underway to expand CRT capacity by 50% which will improve the management of patients living with CRT in Midlothian. The improved operation is due to go live from 1st December with further evaluation expected in early 2018. A further test of change is also underway with external care providers to increase carer capacity by 360 hours a week from November 2018 to ensure that the backlog going into winter is minimised. Evaluation of this test of change is also expected early 2019.

3.65 In addition to the quadrumvirate team, the General Managers and Associate Medical Directors at the RIE are working together with the Midlothian H&SCP strategic planning group. This is in an effort to participate in collaborative, solution focused meetings which agree joint objectives for service provision taking into account current unscheduled care performance and specific barriers to service delivery.

East Lothian

3.66 East Lothian has recently established the START service (Short Term Assessment and Rehab Team). This is an integrated team including Health and Social Care OT's and

PT's. In a targeted test of change area (Tranent, Prestonpans and Port Seton GP surgeries) these professionals are providing intense rehab to patients – facilitating discharge and prevention of admission.

3.67 The Discharge to Assess (D2A) team within the START test of change areas attend these GP surgeries weekly to discuss patients whom START are supporting following discharge home. The criteria has been extended to accept urgent referrals to prevent admission in an acute setting.

3.68 The D2A team conduct weekly in-reach to several clinical areas within the RIE – MoE, Orthopaedics and Stroke. This involves the team emailing lists to the OT/PT staff in these areas on a weekly basis, identifying the East Lothian inpatients. The in reach sessions are conducted to discuss each patient, and where appropriate, patients can be assessed. The team has been effective in identifying patients appropriate for D2A where the clinician may have not considered the service, facilitated the referral at an earlier stage, and taking referral details. In addition, the team assist in identifying appropriate places for patients in the acute setting to be transferred to a step down facility.

Edinburgh

3.69 Edinburgh IJB (EIJB) has agreed a plan for the short, medium and longer term in relation to addressing its significant challenges which relate to delays in the discharge of people from an acute facility, as well as address the equally important challenge of ensuring sufficient community capacity to maintain people's independence at home or in a homely setting.

3.70 There are a wide range of actions being undertaken in relation to the IJB's agreed plan which aim to address these challenges and these will continue to develop and be tested. Work in this area includes:

- A single hub placed within the 4 Localities with consistent processes and accountability to a single Manager.
- Roll of the Multi Agency Triage Team (MATT) model to REAS to create whole system flow, reduce length of stay, prevent admissions and support discharge earlier in the pathway.
- Evolving inclusive Multi-Agency Triage Teams with greater engagement from Acute sites in each Locality meeting daily to address flow, prevent admissions or ensure timely discharge following treatment where possible,;
- A consistent approach to SDS options while in hospital , with hospital assessors initiating the discussion.
- Development of a realistic care model.
- Third sector involvement in prevention admission and timely discharge with the support of wider community resources;
- A Hospital at Home model in place with a proposal to widen across the city.
- Creating care home capacity- through commissioning and review of the in-house capacity so that patients with specialist dementia and care home needs can be met.

3.71 In addition, the new leadership team have recently put in place a Delayed Discharge Oversight Group – Chaired by the Chief Officer – which will review current actions, including conscience of the work currently being undertaken by Carnall Fararr, and set

out a detailed Action Plan. This group is well attended and has representation from acute, localities, data intelligence and the Scottish Government. This will be taken to the IJB for approval and actions, resources and impact will be reported into the IJB structure. The Oversight Group draws on operational experience from across the H&SCP, Acute Hospitals and REAS as well as drawing on health and care intelligence data to support decision making. This group is moving at a pace, an example of this is the REAS MATT which is a collaborative approach focused on planning around hospital and community flow to prevent admissions and support discharges early.

3.72 Moreover, a Delayed Discharge lead has been put in place by the Partnership to lead delivery of the actions and wider resources relating to this will also be scoped. A significant issue in relation to the East H&SCP's performance is a well known challenge of availability of care at home capacity within the care at home market, recognising this the partnership has in place a Sustainable Community Support Programme which has undertaken analysis of the care at home market and its potential to grow capacity to meet more demand. The additional funding being made available to the H&SCP by the City of Edinburgh Council, NHS Lothian and the IJB will fund this as part of the wider package of measures highlighted elsewhere. The Partnership has set a clear action plan and trajectory for over the next year which addresses the high numbers of delays. This has been shared with the Corporate Management Team and the Joint Performance group with NHS Lothian and City of Edinburgh Council.

West Lothian

3.73 West Lothian HSCP have been working to address Unscheduled Care challenges through it's Frailty transformational change programme.

3.74 Recognised areas of challenge are:

- Timely Multi Agency Clinical Decision Making – At each stage of acute pathway 'decide to admit' rather than 'admit to decide'
- To commence discharge planning within 24 hrs within hospital admission
- Streamline internal processes to move to safe effective discharge planning
- Increased Community capacity to reduce the level of delayed discharges

3.75 Within the programme specific areas of multi-agency development have been explored and this has now evolved into 4 project key work streams;

1 Optimising Flow

3.76 Central to this project is the phased introduction of a real time pan Lothian Flow Centre - which commenced at the end of July - with a function of directing and diverting patient to the right acute and community pathways when presenting an urgent unscheduled deterioration of their health in the community. This function will play a pivotal role in managing the unscheduled care demand across the acute and community system.

3.77 The Optimise flow project is also supporting an 18 month National Collaborative Frailty initiative (WL has been chosen as one of 5 pilot sites) at the front door which is about screening and initiation of comprehensive geriatric assessments with emphasis on minimising unnecessary length of stay and transfers of care within the acute Frailty pathway. Frailty pathway 'Value stream' mapping was commenced in early August and is being evaluated by the Senior Acute team to determine the opportunities for changing in practice/ process and optimising bed utilisation. One of the key deliverables will be managing demand in the acute setting particularly as we approach winter. Consideration is being given to delivering a front door Frailty model to manage and

whether it is possible to stem the demand into the acute sector to allow for flow and minimise a person become more.

In Summary:

- Establishment if WL Flow Centre
- Alternatives to admission, pathways & processes
- Acute flow links to iHub & enhancement of frailty team
- Boarding Policy and Bed Utilisation

2 Integrated Discharge Planning Hub

3.78 The objective of this project is to introduce a multi -agency Health and Social discharge planning care hub within St John's Hospital with developed 'Early supported discharge to assess' pathways and processes into the community but also linked to a Community Health and Social Single point of Access and associated locality based health and social teams and the primary care practices.

3.79 Work is underway to prepare a minor works options appraisal to develop the multi agency hub in order to go live between the end of Oct and Mid-Nov. The aim is to have a discharge planning team that co-locates/links health and social partner organisations, Carer, 3rd sector and voluntary and housing. In supporting this vision, a bid has been submitted for national funding to embed a Carer role within the hub under section 28 of the Carers act for a 6 month period to measure the impact on the discharge process and capacity. In addition, active engagement with the 3rd sector is underway.

- In Summary:
- Effective discharge planning implemented within 24 hours of admission
- Multiagency integrated discharge hub : co located
- Agreed and documented Safe For Transfer Criteria and Risk Assessment (Acute/Community)

3 Home First

3.80 This project is prioritising the alignment of pathways and processes of Community health and social care services through a community 'Single point of Contact' triage and signposting people to the right care at the right time. The role of developing 'home first' in providing the ability to manage personalised care as appropriate; short term intervention (Proactive Admission Avoidance) and (Early supported discharge to assess) thus optimising a person's independence in their home, managing ongoing health needs and minimise the need for unnecessary hospital admissions and reliance on longer term care.

3.81 Pivotal to this project is the building of sustainable pathways with the voluntary and 3rd to build resilience within prevention and self-help and both reduce/prolong the number of people having critical and substantial social care needs. The programme has identified a need to build a rehabilitation model/pathway that spans across, primary, community and the acute setting with the ability to access both short, long term rehabilitation and re-ablement intervention and deliver care closer to home, where ever possible.

- In Summary:
- Integrated Home First Teams
- Discharge to Assess pathways
- Single Point of Access for community services
- Technology Enabled Care & Home Safety
- Redesign Care at Home Contract

4 Intermediate Care

3.82 This project work stream will lead the development of an 'Intermediate care bed based' service and associated medical staffing model to create capacity and flexibility in providing shorter stay 'step-up' and 'step-down' and specialised beds in the community to optimising opportunities to convalesce and rehabilitate people where possible thus reducing length of stay into longer-term care bed-based Configuration and Management – Community based services, bringing together health and social care professionals to support short-term needs both medical/clinical and care needs. These beds will support intensive rehabilitation, sub- acute care, recovery and crisis care: 'Step-up' and 'Step-down'.

- In Summary:
- Develop Intermediate Step Up and Step Down Care
- Specialised Beds/ provision for under 65s
- Demand and capacity modelling
- ACP and Case Management

4 Key Risks

4.1 Failure to meet the 4 hour standard leads to poor patient and staff experience, including overcrowding in emergency departments, long waits and patients boarded out with required speciality.

4.2 There is a risk that failing to start the process of winter planning in a timely manner will leave the board unable to respond to peaks in demand.

4.3 There is a risk that community infrastructure cannot meet demand resulting in continued reliance on bed based models, with associated risk to site flow, ED crowding and staffing.

4.4 There is a risk that high levels of delayed discharges remain impacting on the elective programme, with patient surgery being postponed during the 2018/2019 winter months will have an adverse impact on TTG performance.

5 Risk Register

5.1 The Acute and Corporate Risk Register contain risks attributed to "A&E four hour performance" and Timely Discharge of Inpatients. Both have been categorised as very high risks.

6 Impact on Inequality, Including Health Inequalities

6.1 This paper does not include any strategic or policy changes which might impact unfairly on different sectors of the wider community served by NHS Lothian however a comprehensive integrated impact assessment will be undertaken prior to Winter 2018/2019 delivery.

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

7.1 This paper does not propose any strategic or policy changes.

8 Resource Implications

8.1 There are no resource implications associated with this paper.

Jacquie Campbell
Chief Officer, Acute Services
21/09/2018

Appendix 1 – RIE Improvement Framework
Appendix 2 – Draft Terms of Reference – Programme Delivery Group
Appendix 3 – Draft Terms of Reference – Governance Oversight Group
Appendix 4 – Site OD Improvement Plans

NHS Lothian 4 Hour Emergency Access Standard Programme

Programme Delivery Group – 'Part 1'

TERMS OF REFERENCE

Purpose:

The role of the Programme Delivery Group is to provide leadership, strategic advice and guidance for the delivery of the 4 Hour Emergency Access Standard (4EAS) Programme which includes, the short/mid-term improvements against quality and unscheduled care performance standards, the development of sustainable leadership capacity and capability as well as the implementation of the recommendations made by the Academy of Medical Royal Colleges and Faculties In Scotland report in April 2018. It will ensure that the proposals and plans, developed by local Project Groups, fit together in a cohesive whole and can result in the best configuration of service and delivery of healthcare within available resource for the population of NHS Lothian.

Responsibilities:

The Programme Delivery Group will be responsible for:

Developing, testing and supporting site and divisional teams to implement impactful actions which explicitly deliver;

- The implementation of the recommendations made by the Academy of Medical Royal Colleges and Faculties In Scotland report in April 2018 under 6 themes:
  - Governance
  - Leadership
  - Unscheduled Care Performance
  - NHS Lothian's Internal Audit Report, Significant Adverse event (SAE) Process
  - Patient Safety and Quality of Care
  - Patient and Staff Experience
- Short term and sustainable long term improvements against agreed quality and performance standards.
- Sustainable leadership capacity and capability to ensure transparency, compliance and sustainable impact on workforce and patient experience.

The developing will include;

- Effective and targeted collaboration, and engagement with Executive and operational teams at a site and system level.
- Preparing and refining the site specific improvement plans.
- Authorise rapid improvement actions effectively against the over-arching project plan to deliver outputs.

- Establishing sufficiently effective Programme Management Office arrangements to support the programme.

The timetabling will include;

- Ensuring all aspects of the action plan have a clear timeline/schedule to deliver against with explicit accountable leadership for each element.
- Ensure the critical path of the programme is understood and that both critical path and the work areas' timetables are cohesive/aligned.
- Ensure that enabling activities e.g. expert assistance, planned engagement work with communities, joint development events etc. are arranged well in advance to support the programme.

The coordinating will include;

- Use suite of reference points (e.g. report of Academy of Medical Royal Colleges and Faculties In Scotland April 2018) to support prioritisation and modelling for the future as well as input from External Support Team.
- Ensuring that the overall service model is coherent and deliverable utilising evidence and clear/cohesive forward assumptions.
- Ensuring detailed analysis is undertaken to demonstrate the sustainability of the overall service models proposed as a "whole system".

The assuring will include;

- Ensuring each work area and the programme overall identifies current issues and potential risks to be escalated and made visible within the programme as appropriate.
- Ensuring that mitigation of these is achieved so that the programme is successful.
- Providing a robust evidence base and where required independent clinical validation for the models being proposed
- Ensuring an agreed structure and reporting mechanism is in place to provide assurance to the governance oversight group and to External Support Team governance arrangements.

Membership:

It is important that the scope of the Programme includes, initially, the leadership team responsible for the delivery of localised actions to improve performance at the RIE. The leadership personnel from the RIE will be replaced by that of SJH when the focus of the support arrangements switches to this particular adult acute site.

In attendance (TBC)

- Tim Davison Chief Executive
- Jim Crombie (Chair) Deputy Chief Executive

- Jacquie Campbell — Chief Officer, Acute Services
- Janis Butler — Director of Human Resources and OD
- Tracey Gillies — Executive Medical Director
- Bhav Joshi — Strategic Programme Lead – Unscheduled Care
- Chris Graham — Secretariat Support
- Lyn MacDonald — Site Director RIE
- Jacquie Macrae — Associate Nurse Director
- Janice Alexander — General Manager Medicine
- Gill Clarke — Clinical Service Manager ED
- Chris Connolly — Clinical Nurse Manager ED
- Sara Robinson — Clinical Director ED
- Brian Cook — Medical Director
- Andrew Flapan — Associate Medical Director RIE

Programme Delivery Group Support:

The Programme Delivery Group will be supported by Programme Management (Bhav Joshi).

Frequency

Fortnightly

Quorum
Each member or deputy to be in attendance

Review Date
The role of the Group will be reviewed March 2019

NHS Lothian 4 Hour Emergency Access Standard Programme

Governance Oversight Group – 'Part 2'

TERMS OF REFERENCE

Purpose

The role of the Governance Oversight Group is to provide assurance to the Scottish Government in the following areas:

- The improvement of delivery against the short-term quality and performance standards
- A plan for the future organisation and management of the 4 Hour Emergency Access Standard (4EAS) Programme which includes the implementation of the recommendations made by the Academy of Medical Royal Colleges and Faculties In Scotland report in April 2018.

Via the Programme Chair the Governance Oversight Group are accountable to the Audit and Risk Committee for NHS Lothian and Scottish Government for the successful development and implementation of the report by the Academy of Medical Royal Colleges and Faculties In Scotland in June 2018 under 6 themes:

- Governance
- Leadership
- Unscheduled Care Performance
- NHS Lothian's Internal Audit Report, Significant Adverse event (SAE) Process
- Patient Safety and Quality of Care
- Patient and Staff Experience

Responsibilities

The Governance Oversight Group will be responsible for:

- Maintaining a strategic overview of the Programme and implementation of the recommendations
- Providing programme leadership
- Ensuring 'sign-off' against the over-arching action plan and scrutiny of accompanying evidence.
- Providing strategic decision making guidance on direction, pace, resourcing and variance against plan
- Holding to account the Programme Delivery Group
- Recommending strategic decisions as appropriate to NHS Lothian and Scottish Government
- Direct interface with External Support Group and associated governance framework.

Membership

The Chief Executive of NHS Lothian will chair the Programme Board. It is important that the scope of the Programme includes all major stakeholders across the full range of health and care services across NHS Lothian.

In attendance (TBC)

• Tim Davison (Chair)	Chief Executive
• Jim Crombie	Deputy Chief Executive
• Peter Murray	Non Executive Lead
• Jacquie Campbell	Chief Officer, Acute Services
• Janis Butler	Director of Human Resources and OD
• Simon Watson	Chief Quality Officer
• Alex McMahon	Director of Nursing, Midwifery & AHP's
• Tracey Gillies	Executive Medical Director
• Alex Joyce	Employee Director
• Bhav Joshi	Strategic Programme Lead – Unscheduled Care
• Chris Graham	Secretariat Support

Frequency

Fortnightly.

Quorum

Each member or a deputy to be present at each meeting

Review Date

The role of the Group will be reviewed March 2019

APPENDIX 4 – SITE OD PLANS

St John's Hospital

	What	Who	When
1	Emergency Medicine: *Build and supporting the ED Triumvirate.* • Appoint and allow new leadership team to embed. Identify with their input initiatives to be progressed and mode of delivery that would allow staff to access these • Introduce regular interface with site management team to improve lines of communications and ensure ED triumvirate team is involved in and informed of any development • Promote paired learning and building understanding of each other's roles and responsibilities. Shadowing opportunities for consultants with general managers. *Building the relationships and resilience for the wider ED front Line teams.* • Improve the educational experience of junior doctors, 'courage to manage' sessions for the professional groups, 'Thrive' sessions for the senior nursing group, engaging the 'Joy in Work' programme across the department. *Improve ED staff experience* • Progress the ED Redesign programme that will ensure that we have a fit for purpose working environment for patients and staff • Improve understanding of recruitment and retention feedback, imatters feedback, what matters to you feedback and general staff engagement through team meetings and away days and enact on issues identified ('you said, we did') • Use Quality Improvement forums to showcase SJH quality work	Site Director, AMD, AND, Core MEDAS Team	Ongoing
2	Site Management Teams *Build resilience within the wider site management team.* Key activities: • Senior Management Team development sessions x2 have taken place with third meeting to be organised in early 2019 (focus on teamwork, communication, roles and responsibilities, resilience) • Case prepared to increase capacity for the management team with introduction of new posts • Dedicated core management weekly conversation cycle including monthly extended management team meeting, and SPSP shadowing walkabouts in wards and depts to promote frequent personal contact. • Coaching in place for members of the Triumvirate team and other senior managers • CNM and SCN development programmes in place • Healthy Working Lives core programme of activities across all wards and departments in line with the site's Gold Standard • Update and implements actions from the site's Staff Governance Plan • Review Site Safety Huddle and request feedback from attendees and peers from the other acute sites to deliver improvements	Site Director and teams	Ongoing
3	Work on inter-site improvement activities: • Thresholds/triggers for cross site diversion of activity • Develop a daily management conversation on system capacity and flow which feels safe and constructive • Definitions for Medically Fit for Discharge • Ambulatory care • Minor Injuries/Flow 1 cross site support • NHS 24 flow and interface with the Flow Centre • Work on Carnell Farrar (note the activities above form part of site 6EA activity but the process of joint site working, establishment of joint and equitable success criteria, communication and experience of teams represent the OD element relevant to this plan rather than the tasks themselves)	Site Director and teams	30 November

4	Review job descriptions for ED Nurse in Charge, ED Flow Coordinator and MAU coordinator role	AND	31 December
5	Continue to support S&C releasing time from non value added tasks to spend more time on wards (improved S&C staff satisfaction and iMatters/Engagement scores evidenced) and support new S&C management structure/processes pan-Lothian as required	Site Director, S&C	30 November
6	<u>Medical leadership</u> Increase dedicated medical leadership on site with the repatriation of the AMD for Medicine from OAS Review Site AMD/ CD/ CL arrangements for the Front Door (including the AMD for Surgery role) Continue to engage with wider NHS L review/discussion about medical leadership	 Site Director and AMD Site Director. Acute MD, AMD Site Director, S Edgar, AMDs	 28th September 30 October Ongoing

Western General Hospital

	What	Who	When
1	Conclude roles/responsibilities work for S&C and MAU team	Site Director, S&C, MAU	5 October
2	Undertake roles/responsibilities work for S&C and SAU team	Site Director, S&C, SAU	30 November
3	Continue to support S&C releasing time from non value added tasks to spend more time on wards (improved S&C staff satisfaction and iMatters/Engagement scores evidenced) and support new S&C management structure/processes pan-Lothian as required	Site Director, S&C	30 November
4	Work on inter-site improvement activities: • Thresholds/triggers for cross site diversion of activity • Definitions for Medically Fit for Discharge) • Ambulatory care • Minor Injuries/Flow 1 cross site support (note the activities above form part of site 6EA activity but the process of joint site working, establishment of joint and equitable success criteria, communication and experience of teams represent the OD element relevant to this plan rather than the tasks themselves)	Site Directors and teams	ongoing
5	<u>Medical leadership</u> Conclude role descriptor on UC leadership role for Medicine AMD with increased clarity that this role leads for site on Unscheduled care. Continue to work with tailored support for other CD's/Clinical leads on their own personal development programme Continue to engage with wider NHS L review/discussion about medical leadership	Site Director and AMD, GM for Medicine Site Director, S Edgar, ML, SS, AMDs	30 November ongoing

Royal Infirmary of Edinburgh

	What	Who	When
1	<u>Emergency Medicine:</u> <u>*Build and supporting the ED Triumvirate.*</u> Key actions include coaching support, regular leadership team conversations, and regular interface with core management team. Clarity around lines of communication with the purpose of the triumvirate all being cited on actions and future developments and a common purpose. <u>*Building the core team triumvirate and working relationships with the ED triumvirate.*</u> This includes promotion of paired learning and building understanding of each other's roles and responsibilities. Shadowing opportunities for consultants with general managers. <u>*Building the relationships and resilience for the wider ED front Line teams.*</u> This includes improving the educational experience of junior doctors, 'courage to manage' sessions for the professional groups, 'Thrive' sessions for the senior nursing group, engaging the 'Joy in Work' programme across the department.	Site Director, Core MEDAS Team	Ongoing

	Improve ED staff experience through a better understanding of recruitment and retention feedback, imatters feedback, what matters to you feedback and general staff engagement through team meetings and development sessions. *Promote valued communication and teamwork* across professional groups and inter professional groups to ensure time is used wisely and key conversations have time to happen. This includes having IT solutions to ensure team are engaged and at same time maintain work/life balance.		
2	Site Management Teams *Build resilience within the wider site management team.* Key activities: • Dedicated core management weekly conversation cycle including monthly extended management team meeting, and SPSP shadowing walkabouts in wards and depts to promote frequent personal contact. • CNM development programme in place and access to dedicated coaching for all CNMs. • Clinical Services Managers forum in place and building courage to have difficult conversations across teams and services. • Healthy Working Lives core programme of activities across all wards and departments.	Site Director and teams	Ongoing
3	Work on inter-site improvement activities: • Thresholds/triggers for cross site diversion of activity • Develop a daily management conversation on system capacity and flow which feels safe and constructive • Definitions for Medically Fit for Discharge • Ambulatory care • Minor Injuries/Flow 1 cross site support • NHS 24 flow and interface with the Flow Centre • Work on Carnell Farrar (note the activities above form part of site 6EA activity but the process of joint site working, establishment of joint and equitable success criteria, communication and experience of teams represent the OD element relevant to this plan rather than the tasks themselves)	Site Director and teams	30 November
4	Conclude roles/responsibilities work for S&C and front door teams including ED, AMU and SOU.	Site Director, S&C, ED/AMU	5 October
5	Continue to support S&C releasing time from non value added tasks to spend more time on wards (improved S&C staff satisfaction and iMatters/Engagement scores evidenced) and support new S&C management structure/processes pan-Lothian as required	Site Director, S&C	30 November
6	Medical leadership: Conclude role descriptor on UC leadership role for Site AMD with increased clarity that this role leads for site on Unscheduled care. Continue to work with tailored support for other CD's/Clinical leads on their own personal development programme Continue to engage with wider NHS L review/discussion about medical leadership	Site Director and AMD Site Director, S Edgar, AMDs	30 November ongoing

The Pan-Lothian Site and Capacity Team also has an OD plan and has undertaken 4 team development sessions to date, linking in and across the adult acute sites as appropriate. Single line management structure for the team, through the Diagnostics, Anaesthetics Theatres and Critical Care Directorate was achieved in July. A key feature of the plan is to promote value add communications and create development opportunities which offer mutual understanding of the respective roles within Site and Capacity and ED & ward teams.