

## BOARD MEETING

DATE: WEDNESDAY 4 APRIL 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 to the Business Manager within one month of them changing.*

### AGENDA

<u>Item</u>	<u>Lead</u>
Welcome to Members of the Public and the Press	
Apologies for Absence	
<b>1. Items for Approval</b>	
1.1. Minutes of the Previous Board Meeting held on 7 February 2018	MH *
1.2. Running Action Note	MH *
1.3. Corporate Risk Register	TG *
1.4. Appointment of Members to Committees	MH *
1.5. NHS Lothian Reference Committee Terms of Reference	AKM *
1.6. Staff Governance Committee Minutes 31 January	AM *
1.7. Finance & Resources Committee Minutes 23 January; 7 March & 21 March 2018	MH *
1.8. Audit & Risk Committee Minutes 26 February	MA *
1.9. Healthcare Governance Committee Minutes 16 January	TH *
1.10. Strategic Planning Committee Minutes 8 February	AMcM *
1.11. Edinburgh Integration Joint Board Minutes 15 December 17; 26 January	CH *
1.12. West Lothian Integration Joint Board Minutes 23 January	MH *
1.13. Midlothian Integration Joint Board Minutes 11 January	DM *
1.14. East Lothian Integration Joint Board Minutes 21 December 2017	PM *
<b>2. Bio Quarter Business Case</b>	JC p
<i>Mr Hugh Edmiston and Professor Jonathan Seckl, University of Edinburgh attending</i>	
<b>3. Items for Discussion</b> (subject to review of items for approval)	
3.1. Unscheduled Care: Current Pressures	JCam *
3.2. Financial Position to February 2018 and Year End Forecast	SG *
3.3. Financial Plan	SG *
3.4. Corporate Parenting	AMcM *
3.5. Best Start Maternity Strategy	AMcM *
3.6. Quality and Performance Improvement	SW *
<b>4. Development of Mental Health, Learning Disabilities &amp; Older People Services</b>	AMcM p

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|---|-----------|----------|
| <b>5. Invoking of Standing Order 4.8 - Resolution to take items in closed session</b> | <b>MH</b> | <b>v</b> |
| <b>6. Minutes of the Previous Private Meeting held on 7 February 2018</b>             | <b>MH</b> | <b>®</b> |
| <b>7. Matters Arising from Previous Meetings</b>                                      | <b>MH</b> | <b>v</b> |
| <b>8. RHSC/DCN Commercial Issues</b>  | <b>SG</b> | <b>v</b> |
| <br>  |           |          |
| <b>9. Any Other Competent Business</b>  | <b>MH</b> | <b>v</b> |

**Board Meetings in 2018**

27 June \* Scottish Health Service Centre  
 1 August Scottish Health Service Centre  
 3 October Scottish Health Service Centre  
 5 December Scottish Health Service Centre

**Development Sessions in 2018**

16 May Scottish Health Service Centre  
 18 July Scottish Health Service Centre  
 12 September Scottish Health Service Centre  
 7 November Scottish Health Service Centre

*\* Annual Accounts Meeting*

## LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 7 February 2018 in the Carrington Suite, Scottish Health Service Centre, Crewe Road South, Edinburgh, EH4 2LF.

### Present:

**Non-Executive Board Members:** Mr M Hill (Chair); Mr M Ash; Mr M Connor; Ms C Hirst; Professor T Humphrey; Mr A McCann; Cllr J McGinty; Cllr D Milligan; Mrs A Mitchell; Mr P Murray; Mr W McQueen; Mr J Oates; Professor M Whyte and Dr R Williams.

**Executive and Corporate Directors:** Mrs J Butler (Director of Human Resources and Organisational Development); Mr J Crombie (Deputy Chief Executive); Mr T Davison (Chief Executive); Miss T Gillies (Medical Director); Mrs S Goldsmith (Director of Finance); Professor A K McCallum (Director of Public Health & Health Policy); Professor A McMahon (Executive Director, Nursing, Midwifery & AHPS – Executive Lead REAS & Prison Healthcare) and Dr S Watson (Chief Quality Officer).

**In Attendance:** Dr J Goodhart (shadowing Dr S Watson); Ms J Mackay (Director of Communications); Mr D A Small (Chief Officer, East Lothian Integration Joint Board); Dr Rosemary Millar (Shadowing Professor A K McCallum) and Mr D Weir (Business Manager, Chairman, Chief Executive & Deputy Chief Executive's Office).

Apologies for absence were received from Mrs J Campbell, Mr B Houston, Mrs F Ireland, Cllr F O'Donnell and Ms L Williams.

### Welcome and Introduction

The Vice Chair advised that the Chairman had sent his apologies as he was unwell and it had been agreed that he would Chair the current Board meeting in his absence.

### Mrs K Blair Condolences

The Vice Chair advised that it was with regret that he had to report on the untimely death of Mrs Kay Blair who had been unwell for some time. However her untimely passing had still come as a shock to her family, friends and colleagues. He commented that Mrs Blair had been a very loyal and devoted member of the Lothian NHS Board and other Boards related to NHS business as well as other parts of the public sector.

The Vice Chair advised that Mrs Blair had also served on the Royal Hospital for Sick Children Trust Board in the 1990s and had joined NHS Lothian Board in 2012. She also served on the Board of NHS24. The Vice Chair advised that the Board Chairman had written a letter to Mrs Blair's husband on behalf of the Board the contents of which were read to the meeting.

The Board observed a period of 1 minutes silence in memory of Mrs Blair.

## **Valedictory Comments**

The Vice Chair advised that this would be Dr Williams last Board meeting as his term of office ended on 28 February 2018. He advised that Dr Williams had served on the Lothian NHS Board in a stakeholder capacity over the past 8 years. He had represented this stakeholder interest in a robust and professional fashion and this has been appreciated particularly at a time when there had been few voices around the Board table in respect of the primary care agenda. The Vice Chairman advised that the Board would miss Dr Williams' friendship and support.

The Board noted that this would also have been Ms L Williams last formal meeting as she had stood down with effect from the end of March 2018 as her family were relocating out with the Lothian area. The Board noted that Ms Williams had joined the Lothian NHS Board 2 years previously and had served on the West Lothian Integration Joint Board (IJB). The Board thanked her for her service over this period.

## **Welcome and Introduction**

The Vice Chairman welcomed members of the public and press to the Board meeting. He also welcomed Mr Bill McQueen to his first meeting as a Non Executive Board member.

The Vice Chairman also welcomed Ms Judith Mackay the newly appointed Director of Communications to the Board meeting. The Board were advised that Mr D A Small would attend part of the Public Board meeting and along with the Medical Director would speak to agenda item 2.4 'The 2018 General Medical Services Contract in Scotland'.

The Vice Chairman also advised that Dr S Watson had a new member of his team shadowing him. Dr Jamie Goodhart who was a Clinical Quality Fellow was attending the Board meeting as part of his orientation.

The Vice Chairman advised that the Board Development Session on 7 March had been slightly expanded and would now run from 0900 – 1300. The topics were 1 – the regional delivery plan, and 2 – corporate objectives/ risk register and operational plan. It had been agreed that the Board should not lose the Mental Health / Learning Disabilities / Older People Work Session and this would be covered at the end of the open part of the 4 April Board meeting with a presentation.

## **Declaration of Financial and Non-Financial Interest**

The Vice 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. There were no declarations of interest.

## 48. Items for Approval

- 48.1 The Chairman sought and received the approval of the Board to accept and agree the following recommendations contained in the previously circulated "For Approval" paper without further discussion with the exception of agenda item 1.4 'Review of the Boards Standing Orders' which would be discussed in the main body of the meeting at the request of Cllr J McGinty. The following were approved: -
- 48.2 Minutes of the previous Board meeting held on 6 December 2017 - Approved.
- 48.3 Running Action Note – Approved.
- 48.4 NHS Lothian Corporate Risk Register – The Board acknowledged that the corporate risks were undergoing review to improve the expression of risk, controls and actions. The Board also acknowledged that the Healthcare Governance Committee in November 2017 had reduced the Healthcare Associated Infection risk to medium due to current performance. The Board accepted significant assurance that the current Corporate Risk Register contained all appropriate risks which were contained in section 3.2 and set out in detail in appendix 1. The Board further accepted that as a system of control the Governance Committees assessed the levels of assurance provided with respect to plans in place to mitigate the risks pertinent to the committee.
- 48.5 Appointment of Members to Committees – The Board agreed to appoint Mr B McQueen to the Finance and Resources Committee with immediate effect, to appoint Cllr D Milligan to the Remuneration Committee with effect from 1 April, to nominate Mr B McQueen as a member of the West Lothian Integration Joint Board with effect from 1 April 2018. To appoint Professor T Humphrey to the Edinburgh Integrated Children's Services Board with immediate effect and to appoint Mr J Niven, Mr K Kirkwood and Ms J Stirrat as lay members of the Pharmacy Practices Committee.
- 48.6 East Calder Health Centre – The Board noted that the Strategic Assessment and Initial Agreement had been reviewed by the Lothian Capital Investment Group on 13 December 2017 and by the Finance and Resources Committee on 23 January 2018 who were supportive of this being progressed to the Board for approval. The additional information requested in relation to resources, prioritisation and governance had been incorporated.
- 48.7 The Board reviewed the Strategic Assessment and Initial Agreement and recommended it to the Scottish Government Capital Investment Group for its review and approval with confirmation of the Boards support as the capital cost for the preferred option was above the NHS Lothian delegated limit of £5m.
- 48.8 Strategic Assessment and Initial Agreement for Hospital Electronic Prescribing and Medicines Administration (HEPMA) – The Board reviewed the Strategic Assessment and Initial Agreement and agreed to refer them to the Scottish Government with confirmation of its support and the capital costs for the preferred option as above the NHS Lothian delegated limit of £2m for IM & T schemes. The Board supported the proposed timescales for development of an outline business case.

- 48.9 Lothian Health Board Carbon and Energy Fund Project Full Business Case – The Board approved the full business case for submission to the Scottish Government Capital Investment Group and reviewed and endorsed the following minute prepared by legal advisors.
- 48.10 The Board received a paper on 7 February 2018 from the Deputy Chief Executive advising that the relevant documentation relating to a project for the re-provision of energy and energy management facilities at St John's Hospital, Livingston (the "Project") was nearly complete. The Board is asked to approve the Full Business Case on 7 February 2018. It was noted that, in order for the new energy and energy management facilities to be made available to St John's Hospital, Livingston (the "Hospital Site"), the Board was required to enter into certain contractual and legal documents with Vital Energi Solutions Limited and Vital Holdings Limited, including amongst others:
- A project agreement between the Board and Vital Energi Solutions Limited for the re-provision of energy and energy management facilities at the Hospital Site (the "Project Agreement");
  - A parent company guarantee to be granted by Vital Holdings Limited in favour of the Board;
  - A certificate confirming that Vital Energi Solutions Limited is permitted to commence construction and/or installation works at the Hospital Site; and
  - An agreement for the application of insurance proceeds between the Board, Vital Energi Solutions Limited and an account bank designated for such purpose, (together, the "documents").
- 48.11 It was noted that the paper referred to above confirmed that the Documents will be prepared in a manner consistent with the full business case associated with the Project. It was further noted that the Documents will oblige the Board to make certain payments to Vital Energi Solutions Limited in accordance with the Project Agreement. Annex 1 to these minutes contains the certificate requiring specimen signatures of the persons approved to execute the Documents on behalf of the Board.
- 48.12 It was confirmed that the Board has satisfied itself (through the receipt of legal advice or otherwise) that:
- The Board has the power and authority to enter into the Project;
  - The proposed financial arrangements in respect of the Project are intra vires; and
  - The Board has full capacity and power to enter, and has taken all necessary actions to authorise such entry, into the Documents and each other document required to be entered into on behalf of the Board in connection with the implementation of the Project.
- 48.13 It was confirmed that the Project is within the Board's power and authority, and that the associated full business case had been prepared in accordance with and complies with the Board's Code of Corporate Governance comprising the Board's Standing Orders and Standing Financial Instructions. It was confirmed that by virtue of the Board's Standing Orders and Standing Financial Instructions, the Chief Executive and Director of Finance both have delegated authority to execute and deliver each of the Documents on behalf of the Board, and each other document or

notice required to be executed or signed on behalf of the Board in connection with implementation of the Project.

48.14 It was resolved, subject to the Board obtaining funding approval from the Capital Investment Group, that:

1. Subject to such amendments as the Chief Executive and/or Director of Finance may in his/her absolute discretion deem necessary or desirable) each of the documents (other than the certificate of commencement referred to above) be executed on behalf of the Board and that the same be delivered, and that the certificate of commencement referred to above be executed on behalf of the Board, and that (as determined by the Board's Chief Executive or Director of Finance) the same be delivered.
2. The Chief Executive and Director of Finance be severally authorised to sign or execute on behalf of the Board (subject to such amendments as the Chief Executive or the Director of Finance may in his/her absolute discretion deem necessary or desirable) all other documents and to do all other acts and things as the Chief Executive and Director of Finance may consider necessary or desirable in connection with implementation of the Project.
3. The Board Chairman or another authorised officer of the Board be authorised to complete and sign a certificate of specimen signatures in the form appended to these minutes as Annex 1, and that the same be delivered; and
4. Either of the persons referred to in (2) above, the Board Secretary or another authorised officer of the Board be authorised to deliver to Vital Energi Solutions Limited a certified copy of the Board's Code of Corporate Governance comprising the Board's Standing Orders and Standing Financial Instructions.

48.15 It was confirmed that, subject to receiving funding approval from the Capital Investment Group, each of the Documents, and each other document required to be executed or signed in connection with implementation of the Project, would (once amended as considered necessary by the Chief Executive or Director of Finance and validly executed on behalf of each relevant party thereto) bind the Board, Vital Energi Solutions Limited and each other party to those agreements or other documents for the performance of the obligations stated in those agreements or other documents.

48.16 Audit and Risk Committee Minutes 4 December 2017 – Endorsed.

48.17 Acute Hospital Committee Minutes 7 November 2017 – Endorsed.

48.18 Healthcare Governance Committee Minutes of 14 November 2017 – Endorsed.

48.19 Strategic Planning Committee Minutes of 12 October 2017 & 14 December 2017 – Endorsed.

48.20 Edinburgh Integration Joint Board Minutes of 17 November 2017 – Endorsed.

48.21 West Lothian Integration Joint Board Minutes of 5 December 2017 – Endorsed.

48.22 Midlothian Integration Joint Board Minutes of 5 October & 7 December 2017 – Endorsed.

48.23 East Lothian Integration Joint Board Minutes of 24 October 2017 – Endorsed.

### **Items for Discussion**

#### **49. Review of the Boards Standing Orders**

49.1 Cllr McGinty commented that he had some concerns around the proposed standing orders particularly in respect of issues around collective responsibility, voting and the inability to make motions and therefore exercise appropriate challenge. He felt there was a need to clarify what the process for challenge would be and how this would take place. The proposed standing orders were not clear on how a vote would be triggered and the process for this. He stressed he was not against revising the standing orders if this was legitimate for the running of Board business. He felt however that the paper required work around the voting process in respect of movers and seconders of motions and that there was a need for more clarity around consensus and the ability to have disagreement.

49.2 The Vice Chair reflected on the matter around challenge commenting that this was important and that culturally this was exercised differently within NHS Boards and Local Government in terms of their proceedings. He reminded colleagues that the Board Chair invited challenge at meetings and that the formalities around how these were achieved happened as seamlessly as possible without resort to formal processes. This would be a key difference between the culture in the NHS environment and Local Authorities.

49.3 Mr Ash as Chair of the Audit and Risk Committee advised that the standing orders had been discussed although not in significant detail. The Board Chairman would decide how a majority view was arrived at. Mr Ash commented however that if there was a feeling that more work was required around the proposed revisions to the standing orders that he was happy to take this back to the Audit and Risk Committee and consult more widely to include seeking Cllr McGinty's views around his concerns.

49.4 Cllr Milligan commented that he understood the points being made and suggested there was still a requirement for a motion to address routine issues of business like the requirement to disbar people from the meeting.

49.5 Mr Ash advised that the Audit and Risk Committee would consult Council and other colleagues and bring back a revised paper to a future Board meeting.

#### **50. Unscheduled Care Current Pressures**

50.1 The Deputy Chief Executive commented that this report followed on from previous briefings and that this issue now featured highly on the Board corporate risk register. He commented that the intention of his report was to provide the Board with an update on progress over the previous few weeks and to provide reassurance around continued action. The Board were advised that pressures were being experienced not only in the acute hospitals but across the whole system including primary care



and this period of duress had been evident since early December and continued. The Board were advised that the position in respect of 8 and 12 hour wait breaches was showing a deteriorating position when compared against the same period the previous year. The delayed discharge position continued to result in sustained pressure in acute beds and that the use of occupied bed days for this reason had shown a significant increase in December 2017 against the December 2016 position. This was in particular characterised through difficulties in achieving flow of patients through the acute sector.

- 50.2 The Deputy Chief Executive advised that the paper also detailed the actions taken to support the team and the provision of safe effective care. The Board were advised that despite the plethora of management actions that were being taken that the system was not showing any signs of recovery at present. The position had been escalated with whole system daily teleconferencing being undertaken to remove bottlenecks and streamline actions. Despite this and the resilience of teams across the system the delayed discharge position remained stubborn and difficult to improve on. The Deputy Chief Executive advised that he had as part of a further escalation process made contact with Integration Joint Board Chairs and Chief Officers noting their commitment but seeking their oversight and involvement in the ambition to improve the position. The impact on the 4 hour accident and emergency target was significant with the January position reporting 76% against a target of 95%. This represented a significant reduction in performance in an area that was regarded as providing a barometer of acute hospital functioning. The Board noted that the contribution of IJBs had been commendable and significant although it had been interesting that the solutions proposed had all been bed base and not community focussed. The ability to identify extra at home services had been significantly comprised across the system leading to a reduction in support to people requiring to be discharged. There would be a need to look at this further in a more formal review of performance.
- 50.3 The Vice Chair commented that as the Chair of the West Lothian Integration Joint Board the letter from the Deputy Chief Executive signposting the requirement for further discussions had been received to a timescale that had allowed the position to be rapidly discussed at the Integration Joint Board. He hoped that the other Integration Joint Board Chair's had been likewise able to engage around solutions. It was noted however that the key issue remained the inability to flex care home capacity.
- 50.4 Mrs Mitchell commented that the pressure on staff and carers through this period had been intense and they should be congratulated for their amazing resilience. She commented on the issues around patient safety and the impacts of boarding on the internal machinations of the system. The Deputy Chief Executive advised that through the Patient Safety Experience and Action Group (PSEAG) that work was being undertaken to look at how to measure the impact given that there had been an increase in boarding areas in acute adult sites which brought with it an inherent risk. He commented that as a consequence of the 12 hour wait target that often decisions were taken to admit patients to achieve targets. It was noted that during the current period of pressure that often inpatient beds were being created in areas not designated for inpatients. PSEAG had agreed to look at patient indicator engagement impacts and this would include consideration of serious adverse event cases, infection control issues and complaints in order to ascertain whether steps

taken had resulted in adverse impacts. He commented that currently this information was not available although it was in the process of being identified.

- 50.5 Cllr Milligan questioned whether any pre-discussions had been held in respect of the winter plan in advance of the actual winter period and whether consideration had been given around aspects of the plan that had worked and other aspects that had been less successful. The Deputy Chief Executive commented that Integration Joint Boards and partnerships had extensive engagement in the process. The Unscheduled Care Committee met monthly Chaired by the Chief Officer of West Lothian Health and Social Care Partnership which brought other IJB, acute and other partnership people together to gear up and plan for the winter period. This process culminated in the production of a winter plan which looked at current financial availability and additional non recurrent resources using experience gained in previous years with an example of an increased deployment of staff being demonstrated as a key success factor from the previous year. The Board noted that normally the Unscheduled Care Committee managed the winter the process but the pressures evident during the current winter period had required this process to be escalated.
- 50.6 The point was made about whether additional information was available around front door activity and the extent to which adverse weather led to additional pressure. In terms of business continuity the question was raised about whether community planning structures were able to cope with the current level of pressure. Mr Murray commented that there was a need to be sure of a collective approach around business continuity in a way that joined up issues like delayed discharges between NHS Lothian and Local Authorities. The Board were advised that a process of engagement was being undertaken through the office of Dr Andrew Coull in order to ensure as much use as possible was made of the hospital at home model. Mr Murray commented that he would also welcome evidence of sources of funding to expand teams from an IJB perspective.
- 50.7 Mr McCann also paid tribute to the dedication of staff and commented that given the communications and letter received by IJBs from the Deputy Chief Executive that it was clear people understood the issues. He commented however that escalation was not addressing the fundamental problem and the key consideration was what could be done differently from the past.
- 50.8 Dr Williams advised that by coincidence, 2 of the recent patient stories read out at Healthcare Governance Committee (HGC) concerned patients with delayed discharges. The committee recently reviewed its contribution to the delayed discharges issue, and felt that as the data was analysed at numerous other committees, HGC should focus on the impact on patient mortality and morbidity. He commented that at the recent Edinburgh IJB meeting, it was agreed that current measures were simply not impacting on delayed discharge numbers, and the executives had been asked to outline their 'Plan B'. He questioned whether the philosophy of contracting out community care services was appropriate, and whether it would be more efficient and cost effective to bring them back "in house"
- 50.9 The Deputy Chief Executive commented that a financial debrief would be undertaken which would summarise all actions taken and give a view to an impact assessment of areas of success and failure. He commented that in respect of the

strategic ambition to improve the provision of care at home to allow people to lead independent lives that currently the system did not have vehicles to deliver this and that when the organisation moved into winter there was evidence that existing providers of care packages were struggling or failing to deliver on their commitment. This was further compounded by the fact that the ability to attract new providers was not available. The Deputy Chief Executive commented that a major issue over the coming few months would be what actions could be taken to increase the flow process and whether the ability to deliver at home care was deliverable as currently there was evidence that the Lothian position in this area was compromised. He commented that once options were available there would be a requirement to seek resources to implement these. The Deputy Chief Executive advised that when the vehicle to provide community care failed that this increased anxiety including in the acute sector. In that regard he commented that there was a need to create credible and sustainable alternatives.

- 50.10 The Director of Finance advised that the set a-side budget was not yet making a difference in shifting the balance of care. The level of delayed discharges had risen from around 50 in the past to the current level of around 550. She felt there was a need to look at financial and other planning over a 3-5 year time frame and set out the resources available via routes like the primary care contract and the transformation fund. She commented that even if additional resource was provided the system would still not be able to deliver as the capacity was not available and there was therefore a need to be thoughtful about how to spend financial resources. The Director of Finance felt there was a need for different thinking about how to shift the balance of care.
- 50.11 The Chief Executive commented that a key issue that needed to be discussed was the cancelation of elective activity with over 400 elective cases having been cancelled over a 3 week period in January 2018. This had real consequences for patients and families some of whom were awaiting major procedures. It also had a negative impact on the use of resources as the health system was paying for procedures twice. He commented that this was a difficult area and that decisions were needed around financial priorities and Lothian links to the regional strategy which he was leading. The Board were advised that the Scottish Government had earmarked a £126m transformation fund with the intention being that this would grow over the lifetime of the current Scottish Parliament to a figure in excess of £200m. The purpose of this fund would be to plan for transformation including social care alternatives to current service provision. The fund would also be used to deliver improvements in elective waiting times in hospitals and also to fund some capital investment. The Chief Executive commented therefore that there was a need to move into the prioritisation process both from the perspective of NHS Lothian and also regionally.
- 50.12 The Chief Executive commented in respect of elective provision that NHS Lothian had received an additional allocation of £7m over and above its core budget in order to mitigate some of the forecast deterioration by the end of March 2017. He advised that 15,000 outpatients were breaching with the projection being that this would rise to 40,000 by the end of May 2018 if no additional actions were taken. He commented in respect of the £7m for the year end the system was targeting the position whereby the projected 40,000 cases would be reduced down to 25,000 breaches. The Board noted in terms of the Treatment Time Guarantee (TTG) that

the projection was that 400 patients would be impacted upon with the position deteriorating with a tabletop exercise having identified that to get people treated in the private sector would cost in excess of £30m.

- 50.13 The Board noted that the 4 IJBs and NHS Lothian would be part of regional discussions about best to deploy their share of the transformation funds. Part of this discussion should be around moving elective activity in to social care in order to reduce cancellations. The Board were advised that the key issue in Lothian was the inability to move patients out of the hospital environment once they had been admitted.
- 50.14 The Chief Executive commented that if the financial plan prioritised on community provision then this would only be credible if IJB were able to commission activity which they currently could not do. There would be a need for IJBs to deliver services to reduce pressure at the front door and that the IJB confidence to do this would feature as part of the NHS Lothian and regional planning process.
- 50.15 The point was made that in future papers it would be helpful if the Scottish context could be included along with details of anything that was particularly different between NHS Lothian and other Boards.
- 50.16 In terms of front door activity the question was raised whether all attendees needed to be there and whether more could be done around prevention. It was suggested that it would be important not to lose the focus on providing care at home and in a homely setting for patients. Ms Hirst commented that it would also be useful to consider getting people to come together to receive their treatment when this was appropriate. There was a view expressed about the need to provide better support for unpaid carers.
- 50.17 Professor Humphrey commented that she did not feel there was enough confidence about the prevention agenda and that there was a need to focus on how to prevent scheduled admissions and to ensure appropriate service based interventions. In terms of workforce it was suggested that going forward there was a need to maintain and build resilience as a lot of what had been discussed and being proposed depended on the availability of staff.
- 50.18 Mr Murray commented that a lot of the issues went beyond NHS Lothian and that not all solutions were within its control for example housing provision. He commented that there had been a recent increase in hospital at home provision in East Lothian and that there had been 30 applications for 6 staff posts.
- 50.19 Cllr Henderson commented that he had welcomed the opportunity to meet with the Deputy Chief Executive and the Chief Officer and he was happy to continue with such engagement. He advised that he and the Medical Director had visited the Royal Infirmary of Edinburgh in mid December where it had been clear that demand at the front door was in excess of what staff had anticipated and was leading to cancelled operations. He advised that following the visit he had asked Local Authority colleagues to look at how they could assist the position with it having been noted that 500 falls and other weather related issues had caused an increase at Accident and Emergency. He commented that there would be benefit in working across Local Authorities to undertake public awareness campaigns and to be

smarter in developing community activity to help people to cope with the additional risks generated as part winter.

- 50.20 Cllr Henderson commented in respect of the care at home issue that there was a need to address this. He advised that the Edinburgh contractual arrangements were not delivering. Discussions were ongoing with private providers but a key issue was around the difficulty being experienced in training and recruiting staff with there being a need to consider how this position had occurred. He commented there was a need to bring stability to this area through longer term contracting. The Board were advised that within Edinburgh a pilot project had commenced at the Royal Infirmary of Edinburgh with a private provider at no cost to the Local Authority or the NHS.
- 50.21 The Chief Quality Officer advised that data was available in respect of slips on ice and links to falls and that if the coding of emergency department data was looked at this could also identify issues like alcohol misuse related admissions. He advised that the adoption of the quality approach allowed issues to be tested. He advised that use of the safety climate looked at escalation and allowed opportunities to develop tangible tools.
- 50.22 The Deputy Chief Executive commented that the debate had been incredibly helpful and that the process had demonstrated whole system involvement and ownership. He commented that there was significant further work to be undertaken and this would be brought forward as part of the next paper. He commented that there was a need to keep visibility high in this area.
- 50.23 The Chief Executive advised that a national winter debriefing session would be held in March to look at lessons and that this information would be shared once available.
- 50.24 The Chief Executive advised in respect of the external review process being undertaken by Professor Bell from the Scottish Academy of Medical Royal Colleges that this was not yet complete with a further visit being scheduled to interview staff at the Royal Infirmary of Edinburgh on 16 February 2018 and the Western General Hospital the following week. The Chief Executive commented that it had been planned to bring an update report to the current Board meeting but the timelines around the review process had meant that this had not been possible. He advised that it was intended to bring an update report to the April Board meeting with it being noted that dependant on timescales the Scottish Government might decide to issue the report into the public domain before the 4 April Board meeting. In the event that this happened Board members would be kept updated.
- 50.25 The Board agreed the recommendations in the circulated paper and noted that continued visible and escalating work would continue in order to find sustainable solutions.
- 51. Financial Position to December 2017 Year End Forecast and Financial Outlook 2018/19**
- 51.1 The Director of Finance tabled an update paper and advised on the approach taken around the financial plan for 2018/19 following on from the Scottish Government budget. It was noted that this position had been discussed by the Finance and

Resources Committee at its meeting in January 2018. The month 9 financial outturn was still predicting a breakeven position at the year end with there having been a steady improvement in financial performance over the previous few months largely due to one off benefits, improved operational performance and less pressure in medicines in respect of primary care volumes and also hospital usage. The Board were advised however that there were a number of new drugs about to be introduced therefore it was unlikely that the reduction in the acute spend would be sustainable throughout the course of 2018/19. The Board noted that improvement in the forecast outturn position to deliver financial balance was largely due to a reduction in the national CNORIS charges and additional non recurrent funding from the national PPRS scheme. The Director of Finance advised that the additional non recurrent funding received from the Scottish Government to support activity should be sufficient to cover the additional costs of extra beds over the winter period.

51.2 The Board were advised that the 2018/19 financial report represented a high level position in respect of cost forecasts for the period. It was noted that separate allocations would be made to Local Authorities in respect of social care funding. The Board noted that broadly speaking the financial position was at the same point as in the previous year with a current gap of £28m being anticipated although this might increase dependant on pay rise levels. The Board were advised that there was a possibility that additional resources would be made available after the pay review body outcomes had concluded. Once a clearer understanding around the financial consequentials was known additional funding might be transferred which would reduce the financial gap.

51.3 The Director of Finance commented that the key issue during 2018 based on previous performance was that year end financial balance would be achieved. A key issue however would be the impact on performance and achieving this and discussion would be held at the Strategic Planning Committee the following day in respect of modelling around treatment time guarantee (TTG) and other targets that were not currently being met with these needing to be part of the operational plan to be submitted to the Scottish Government later in the year.

51.4 The Vice Chairman commented that the report represented a relatively positive position for the current year although a key issue was around the degree of uncertainty for the follow and subsequent years.

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

## **52. Quality and Performance Improvement**

52.1 The Chief Quality Officer advised that the circulated paper set out performance against a basket of key indicators including local patient safety issues. He advised that some Board members had tested accessing the dashboard indicators and that a web based solution would be looked at by the analytical services department.

52.2 The Boards attention was drawn in particular to performance around the 4 hour emergency access target and the cardiac arrest position. The Board noted that the challenges around achieving the 4 hour emergency access standard had already been discussed. It was noted that data was being looked at over the previous 2 years to allow a comparison of performance over the respective period. Early

indications were that current performance was not because of recent waiting times protocol issues but was reflective of a system under extreme pressure.

- 52.3 The cardiac arrest position was showing improvement over previous years although there had been a spike in the last quarter although it was important to recognise that the position was not that different from previous years.
- 52.4 The Board expressed a desire to align data to real life patient stories in order to back up the position reported in the Board paper. It was noted that this approach would link with ongoing quality work. This request would be incorporated into future Board papers.
- 52.5 The Board agreed that the performance report and process was developing well with there being a lot data now available through hyperlinks. Mr McCann noted that there remained 17 areas that had not been assessed for assurance and questioned what the process would be for achieving that. The Chief Quality Officer advised that part of the assurance process would be through the revised role of Board Committees which would lead to all measures being addressed in a scheduled way. It was not possible at this stage to provide a timeline for the completion of the 17 areas identified. The Chairman commented that it would be pertinent to remit this question back to the Board Committees and for them to reflect on appropriate timelines.
- 52.6 Mr Ash commented in order for the Audit and Risk Committee to provide Board assurance it required to obtain input from various other committees. This would require them to update on progress and if areas and aspects had not been considered to provide an indication of why and when. It was anticipated that there would be a significant reduction in the number of areas requiring to go through the assurance process in the near future.
- 52.7 Mr McCann questioned in respect of the 4 hour performance position and the external review whether there was evidence of staff behaviours changing. The Deputy Chief Executive reminded the Board that part of the action planning process included having local discussions with people on the ground. The behavioural impact was yet to be defined and would be part of the organisational development programme to support people.
- 52.8 The Board agreed the recommendations contained in the circulated paper and noted that Board Committees would look at the outstanding areas requiring assessment.

### **53. The 2018 General Medical Services Contract in Scotland**

- 53.1 The Vice Chair welcomed Mr Small to the meeting advised that he and the Executive Medical Director would speak to the circulated paper.
- 53.2 The Executive Medical Director advised that she was particularly pleased to be able to bring this item to the Board for discussion prior to Dr Williams demitting office as she was keen to secure his views and comments. The Board noted that the new GMS contract was long awaited and was broadly welcome although some strongly felt concerns had been raised. The new GMS contract had been developed following extensive consultation to address pressures in primary care and to give local scope to provide solutions. It was noted that a primary care summit event had

been held the previous week and had been attended by a small number of Board members. The summit had been intended to allow Health and Social Care Partnerships and Integration Joint Boards to discuss their priorities around the implementation of the new contract.

- 53.3 Mr Small commented that the implementation of the GMS contract would result in key roles for Health and Social Care Partnerships and Integration Joint Boards as well as NHS Lothian and the GP Sub-committee. He commented that the key elements of the GMS contract were around the changing role for general practitioners who would now have the restricted role of expert medical generalists. There was a need for further clarification around the new contract which would result in a reduced workload in respect of protocols and risks. It was noted that Health and Social Care Partnerships were required to produce development plans by July 2018 to reduce workload and this would include the identification of new ways of dealing with demand and the development of community treatment as well as the transfer of responsibility for vaccines from general practice to Health Boards. The Board noted that the new contract would also mean that NHS Lothian would assume more responsibility for staff and would have responsibility for GP premises. Significant work was already underway in this regard by the Health and Social Care Partnerships.
- 53.4 The Board noted that £23m had been identified to be used in 2018/19 to fund all practices up to the level of the formula. Practices currently earning more than this were being protected. The Board noted that the premises code essentially set out a programme that aimed over time to remove the need for GPs to own their own premises or lease from private landlords. These responsibilities would shift to NHS Boards. £40m had been set aside for the next 4 years to provide interest free loans to resolve premise issues that were affecting practice sustainability.
- 53.5 The Board noted that the Health and Social Care Partnerships needed to prioritise up to £5m of support to practices and in order to undertake this there would be a need for local engagement. The GP Sub-committee would have a key role in the development of the Lothian plan prior to it being submitted to the Scottish Government. It was noted as a result of NHS Lothian having 4 Integration Joint Boards and Health and Social Care Partnerships that there was a need for engagement across NHS Lothian and this would require coordination and leadership to develop. It was for this reason that the Transformation Oversight Group proposal had been developed with membership reflecting NHS Lothian, the Health and Social Care Partnerships and the GP Sub-committee. The Oversight Group would be co-chaired by the 3 key partners. It was proposed to appoint a fixed term Director of Primary Care Contract Implementation to reflect the complicated requirements around the implementation of the GMS contract particularly in terms of workforce issues.
- 53.6 The Board noted given the complexities around the new GMS contract that the Board's corporate risk register would need to be reviewed and that the Healthcare Governance Committee would take an overview of progress. Mr Small detailed the risk around the implementation of the contract to the Board again focussing on workforce, quality and value issues around GP premises. It was noted that GP out of hours services would now be provided on an opt-in basis and there was a risk of creating a disconnection between in-hours and out of hours provisions.



- 53.7 The Executive Medical Director commented that the new GMS contract presented a good opportunity for primary care and agreed with Mr Small that it would require a lot of co-ordination to support the development of workforce and the roles that they would need to move in to. A key issue would be to ensure that the implementation process delivered a safe way of delivering patient care as well as improving access to patients in the most appropriate place.
- 53.8 The Vice Chair commented that he also agreed that the new contract would afford exciting opportunities to primary care. He commented that he had attended the primary care summit the previous week and he felt this would be a good start point to start to scope issues needing to be addressed. He commented however that a mature implementation plan would not be available by summer 2018.
- 53.9 Mr Murray commented that he had also attended the Primary Care Summit the previous week. He commented in respect of the interest free element of the £40m that he would be intrigued to see how capital would be spent. The importance of primary care and the Board liaising around future property models would be important. The Musselburgh model was a good example for roll out. The Director of Finance outlined the role that the Lothian Capital Investment Group would have in the process and the need to triangulate with IJB priorities. There would be a need for transparent engagement with IJBs around the forward capital programme.
- 53.10 The point was made that the paper before the Board was light in detailing the benefits of the new contract for patients and there was a need to clarify this. The Executive Medical Director commented that this was a fair challenge and a similar question had been raised at the Primary Care Summit Meeting. She advised that demonstration of patient benefit would be a crucial part of the successful implementation of the new contract. It would be important that patients were not expected to navigate through new systems. A proper benefits realisation process would be needed.
- 53.11 Mr McQueen commented on the tight timescale for the production of the four plans and questioned how much work had been done around risk. He also questioned whether the plan would be fixed or exist over a wider review period. He questioned whether decisions around GP premises would be delegated to Health Boards and if so whether decisions would be taken by individuals or Board Committees.
- 53.12 Mr Small advised that the plans would need to be live documents given that the July timescale was very tight and there were two stages to the contract. The Director of Finance advised that premises would fall under the remit of the Finance and Resources Committee and would be wedded to the formal capital plan and asset management plan.
- 53.13 Mr Hirst commented that the new contract provided opportunities to be more creative around the management and maintenance of premises and to use other agencies that had specific expertise in this area. She also commented that there was a need to consider the benefits of linking up with partners in the community to work with NHS Lothian.

- 53.14 The Board noted that the Finance and Resources Committee had discussed the issue around the Board requiring to take responsibility for GP practices and the need to direct work on behalf of all stakeholders. The point was made that the person appointed to the Implementation Director role would require to have a clear management line. The point was made that there would be a need to have clarity around the financial implications of the transfer of vaccination services away from GPs to NHS Lothian. The Chief Executive commented that when the job description for the Director level post had been developed a key decision had been around the accountability requiring to be through multiple stakeholders but with the management reporting line being directly into the Chief Executive of NHS Lothian who would set objectives on behalf of multiple stakeholders.
- 53.15 Mrs Mitchell in respect of the timeline for implementation questioned what would happen in the event that detailed implementation plans were not available and asked whether it was intended that this process should be managed within an existing budget or whether additional resource would be made available. She commented in terms of human resources that it would not be possible to rob Peter to pay Paul and stressed that there was also a need to recognise the lead time required to train specialist staff. She commented that it would be important to quickly clarify how finances would be monitored and managed. The Director of Finance commented that at the moment attempts were being made to obtain clarity around finances. She reminded colleagues that NHS Lothian was committed to providing an additional £5m of resource to primary care with £2m already having been committed to fund shifting the balance of care. The development of a financial framework between NHS Lothian and the Scottish Government was under consideration.
- 53.16 The Vice Chair commented in terms of the questions raised by Mr McQueen that it was not yet clear where specific responsibilities would sit. He commented that there were wider issues around the implementation plan with it not yet being clear where governance sat in that respect. Mr Small commented that the Healthcare Governance Committee had been appointed as the lead Board governance vehicle. The Executive Medical Director commented that there would be a need to work through issues like workforce and to be clear where governance sat. The Board were advised by the Director of Human Resources and Organisational Development that work was at the early stages around risk profiling workforce issues like training and the need to take account of change as well as considering the risk to other parts of the organisation through the drift of staff in to primary care settings. The Chief Executive commented that health visiting was a particular pressure point in terms of recruitment and the age profile of existing staff.
- 53.17 The Chief Executive commented in terms of health visiting that this was only a delegated function in two of the Integration Joint Board and that there would requirement to have a health visiting work plan coordinated across Lothian. He commented in terms of the new GP contract that there would be a need to think about the development of a Single Governance Oversight Group. The Chief Executive was of the view that currently there was no neutral governance committee for issues around the GMS contract other than the Board itself particularly given the importance of the transition.
- 53.18 The Board were advised that IT failings were a key theme of concern emerging from GP practices and the ability to support this in future would be important given the

fact that staff coming to work in practices would need to share data and information. Mr Ash commented that in terms of governance that there was an issue about whether this should be kept at Board level or undertaken through a coordinating committee. In any event he felt that there would be a need for Non Executive input and quality reporting back to the Board. He commented that currently the governance lead was the Healthcare Governance Committee although he suggested that a sub-group could be established to give this work the degree of prominence it required. The Chairman commented that there was a need to take away and consider and clarify issues around where the governance around the GMS contract would sit.

- 53.19 Cllr Milligan commented that he welcomed the report and the introduction of the new GMS contract as the current position was not sustainable. He commented from a layman's perspective that there was a need to ensure that housing and other development bills did not just land with the Health Board and that developers should contribute to the capital costs of GP premises etc. He commented that there was also a need to streamline processes around issues like the awarding of licences to people wishing to operate pharmacies in local areas. The Chairman commented that these were important points. He commented that Local Authorities took different positions in respect of developers contributing to infrastructure.
- 53.20 Dr Williams commented that the paper and debate represented a good summary of the contract which attempted to respond to a profession in crisis and the increase in workload of GPs. The response had been to focus on recruiting new GPs and excepting other staff to take on some of the former duties of GPs. He commented that only 40% of GPs had voted in respect of the contract with around 75% of this number having been supportive. An issue of concern was that the profession was split between remote and inner city GPs in respect of favouring the new contract. GPs had pointed out their disappointment that no mention had been made of patients in the new contract. There were concerns about losing aspects of continuity of care as the GP would no longer be the first point of contact therefore moving away from the cradle to grave concept of the role of the GP which had been a bedrock of the NHS.
- 53.21 Dr Williams reminded the Board that Lothian GPs were the most cost effective prescribers in Scotland. There was a danger if prescribing was opened up to other staff groups that this might lead to increased prescribing costs and a narrowing of the Lothian benefits. Dr Williams stressed the need to be aware of other unintended consequences of the move away from the GP being the first point of contact, as evidence shows GPs to be very good "gatekeepers", and the risk of increased referrals, admissions and costs was very real and needed to be considered when forward planning. In his own opinion, the new contract was a clear step towards a salaried service (which he believed was the best model), and again thought will need to be given to the implications and implementation of this in due course.
- 53.22 The Board agreed the recommendations contained in the circulated paper with the proviso that the model of implementation around Government arrangements needed further discussion.

## **54. GMC Review of Medical Education in NHS Lothian**

- 54.1 The Executive Medical Director advised that the purpose of the report before the Board was to update Board Members on the General Medical Council (GMC) review of medical education in NHS Lothian; to revisit the outputs and themes from the Board Development Session in July 2017 which had focussed on undergraduate and post graduate medical education and to outline proposals for further development of NHS Lothian as a high quality clinical education provider.
- 54.2 The Board were advised that the GMC report would not be in the public domain until the end of April. The report would be unique in that it would contain no recommendations from the visit and it was important to take heart from this given issues around paediatrics and cancer within the system. The Board noted the Multidisciplinary approach being taken to Care of the Elderly services and the supporting strategy.
- 54.3 Professor Whyte commented that the University of Edinburgh had been part of the same process with the output in respect of the Medical School also having been positive. She thanked the Executive Medical Director and the Chief Quality Officer for their assistance during the review process.
- 54.4 The point was made that whilst the GMC report was positive it would be important to pick up and address the themes raised at the Board Development Session and not reflected in the GMC report. The Executive Medical Director advised that she was thoughtful about how to progress these issues and this would probably be done on a site by site basis with regular feedback being provided in conjunction with NHS Education for Scotland.
- 54.5 The Executive Medical Director in response to a question advised that in the fullness of time the Lothian Teaching and Training Management Group would be Multidisciplinary in its membership. It was reported that on a site by site basis information would be pulled together on the quality of training and issues of concern for inclusion in the development plan.
- 54.6 The Executive Medical Director advised that the above issue had not been specifically discussed during the GMC visit. Issues around the move to a Single Regulatory System were discussed. The Chairman commented that in Lothian there was an aim for a more multidisciplinary approach to training with appropriate governance being a key part of the process.
- 54.7 The Board agreed the recommendations contained in the circulated paper.

## **55. Edinburgh Cancer Centre Reprovision programme**

- 55.1 The Deputy Chief Executive commented that the Board paper had been long heralded and was the correct response to address the condition of property at the Western General Hospital for the provision of cancer services to patients. The paper described the approach taken by leadership in oncology to look at the modernisation of service provision. The production of the paper represented a complicated journey the details of which were documented in the report. The Deputy Chief Executive had been heartened at the level of engagement in the process including from members

of the public in discussing what the new facility would provide. There had also been a stakeholder relationship with sister Health Boards as well as at regional and national level.

55.2 The Deputy Chief Executive laid out the key milestones to October 2019 in respect of delivering an initial agreement to the Scottish Government for approval. The Government approval process was also explained.

55.3 Mr Ash commented that he supported the paper.

55.4 In respect of the proposal that the Foundation Trustees should take a lead on funding for the new Edinburgh Cancer Centre it was agreed that this needed further consideration. The Director of Finance advised that this issue had been discussed by the Foundation Trustees with it being noted that there were already a number of areas where donations were made by the public for example in breast cancer and cardiology. There had been a desire to develop a more consolidated approach to fundraising. It was agreed at the suggestion of the Chair that there would be opportunities through Trustees meetings to discuss this position in more detail. Mr Ash advised that he would seek assurance that any fundraising activity did not divert resources away from the core responsibilities of the Board.

55.5 It was noted that following a decision by the IJB in East Lothian around ward 2 at Belhaven Hospital that a crowd funding initiative had been started. It was recognised that whilst there was no locus to stop this that the Foundation had been concerned about the competitive element. Mr Murray suggested that if the paper was approved it would be important to engage with partners and stakeholders as soon as possible.

55.6 The Deputy Chief Executive in respect of reprovision proposals advised that there would be a need to look at how oncology services were provided in the future. The new clinical lead had ideas around this. Any future build requirement might be considerably different from that currently in place.

55.7 Dr Williams reflected back on his previous comments about changes around service delivery. He commented that going forward there would be a need for continual engagement with primary care and that currently the Programme Board did not reflect this. The Deputy Chief Executive confirmed that primary care would be fully engaged moving forward.

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

## **56. Next Board Development Session**

56.1 The Board noted that the next Board Development Session would be held on Wednesday 7 March 2018 at 9am at the Scottish Health Service Centre, Crewe Road, Edinburgh, EH4 2LF.

## **57. Date and Time of Next Meeting**

57.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 4 April 2018 at the Scottish Health Services Centre, Crewe Road, Edinburgh.

**58. Invoking of Standing Order 4.8**

- 58.1 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

1.2

RUNNING ACTION NOTE

FOR THE MEETING OF 4 APRIL 2018

Action Required	Lead	Due Date	Action Taken	Outcome
<b>Emergency Access Standard – Review of Performance Reporting Compliance</b> The Board were advised that the external review led by Professor Derek Bell would no doubt provide additional learning and cause for further reflection on next steps and this report would be brought back to the Board at the next meeting in February.	JC	07/02/18	<i>Considered at February Board</i>	<b>Final Review Report was not available</b>
<b>Unscheduled Care Current Pressures</b> The Chief Executive advised in respect of the external review process being undertaken by Professor Bell from the Scottish Academy of Medical Royal Colleges that this was not yet complete with a further visit being scheduled to interview staff at the Royal Infirmary of Edinburgh on 16 February 2018 and the Western General Hospital the following week. The Chief Executive commented that it had been planned to bring an update report to the current Board meeting but the timelines around the review process had meant that this had not been possible. He advised that it was intended to bring an update report to the April Board meeting with it being noted that dependant on timescales the Scottish Government might decide to issue the report into the public domain before the 4 April Board meeting. In the event that this happened Board members would be kept updated.	JC	04/04/18	<i>Unscheduled Care Performance on April Agenda</i>	
<b>Paediatric Programme Board Update</b> The options for the future for clinical model would be developed through this process then risk assessed with realistic timelines being detailed and would form the basis of a report that would be submitted to the Board in April 2018.	JC/MH	04/04/18	<i>Follow up workshop was cancelled due to snow.</i>	<b>Ongoing</b>
<b>Review of the Boards Standing Orders</b> Mr Ash advised that the Audit and Risk Committee would consult Council and other colleagues and bring back a revised paper to a future Board meeting.	MA	<b>To be confirmed</b>	<i>Being considered at the 23 April Audit and Risk Committee.</i>	<b>To come to 27 June Board Mtg</b>

## 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.
- 1.2 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 Acknowledge the corporate risks have undergone a review to improve the expression of risk, controls and actions.
- 2.2 Acknowledge the Committee in November 2017 reduced the Healthcare Associated Infection risk to Medium due to current performance.
- 2.3 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 (updates are in bold).
- 2.4 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.
- 2.5 Note the focus of the Board's May 2018 development workshop based on the outcome of the November 2017 workshop.

### 3 Discussion of Key Issues

- 3.1 The Board has approved a number of changes to the risk register as initiated as part of the risk review process. A number of risks have been under significant review and/or change.

These include:-

- Approving an additional patient focused access to treatment risk
- Change in title from 'Achievement of National Waiting Times' to 'Access to Treatment (Organisation Risk)'. Strengthening of controls within the current performance and raising this risk from High 16 to Very High 20, given the current performance
- Change in title from 'Unscheduled Care: Delayed Discharges' to 'Timely Discharge of Inpatients', as this title is more illustrative of the risk



- Review the Management of Complaints risk and reduced in severity from Very High to High, due to current performance and future plans
- Healthcare Associated Infection risk has been reviewed and the risk has been reduced in severity from High to Medium due to current performance at the request of the Healthcare Governance Committee.

The corporate risks have undergone a review with one exception – Violence & Aggression risk which is under review. The aim of the review was to improve clarity of expression of risks, controls and actions to maximise effectiveness of the process which was an Audit & Risk Committee agreed risk management objective for 2017/18.

3.2 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.

3.3 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)

\* Out with risk appetite as illustrated in Table 3.

3.3.1 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.

3.3.2 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).

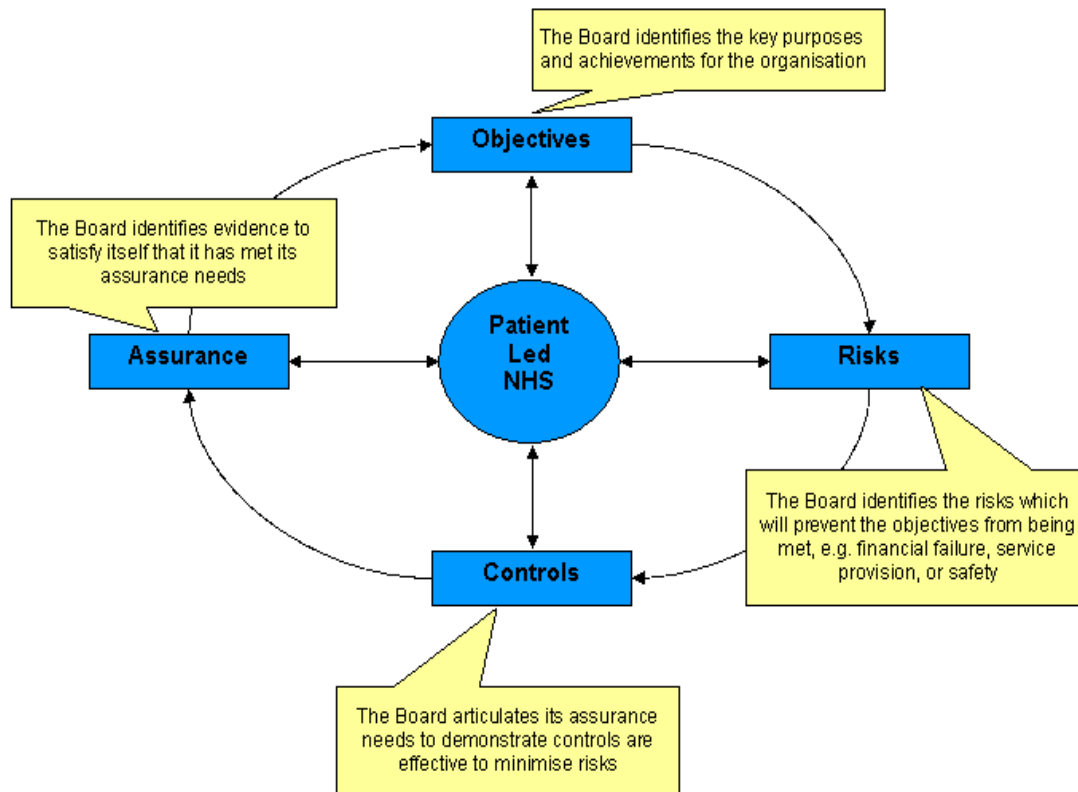
Table 1

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017
<a href="#">3600</a>	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. <b>(Finance &amp; Resources Committee)</b>	March 2017 Limited assurance with respect to financial balance 2017/18. July F&R considered the revised risk and accepted limited assurance.	High 12	Very High 20	Very High 20	Very High 20	Very High 20
<a href="#">3203</a>	Unscheduled Care: 4 hour Performance <b>(Acute Services Committee)</b> (Set out in Quality & Performance Improvement Report)	February 2017 Moderate Assurance; Members approved the recommendations laid out in the paper and accepted moderate assurance, but asked for more detail in the next paper on the greater impact of the measures taken to manage unscheduled care. Paper received and moderate assurance accepted due to performance over the last 4 quarters. 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
<a href="#">3726</a>	Timely Discharge of Inpatients (Previously Unscheduled Care: Delayed Discharge) <b>(HCG Committee)</b> (Set out in Quality & Performance Improvement Report)	January 2017 Limited assurance. No clear improvement plans in place to mitigate the risk. A plan was presented to the September 2017 HCG committee who accepted limited assurance and ask for regular updates from the Chief Officers. November HCG continued to accept limited assurance.	Very High 20	Very High 20	Very High 20	Very High 20	Very High 20
<a href="#">3829</a>	GP Workforce Sustainability <b>(HCG Committee)</b>	March 2017. Limited assurance. No clear improvement plans in place at March 2017. Plans presented in May 2017. 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
<a href="#">3211</a>	Access to Treatment – Organisation Risk (Previously Achievement of National Waiting Times) <b>(Acute Services Committee)</b> (Set out in Quality &	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	High 12	↑ Very High 20	Very High 20	Very High 20	Very High 20

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017
	Performance Improvement Report)	systems of control were in place was accepted.					
<a href="#">4191</a>	Access to Treatment Risk – Patient (New Risk May 17) (Acute Services Committee)	Considered at HCG July 2017. Continues to be limited assurance and update to come regularly.	Very High 20		Very High 20	Very High 20	Very High 20
<a href="#">3454</a>	Management of Complaints and Feedback (HCG Committee) (Set out in Quality & Performance Improvement Report)	July 2017. Moderate assurance with respect to a plan being in place, but need assurance that the plan will lead to an improvement and asked for an update every 2 <sup>nd</sup> meeting. November 2017 HCG considered and moderate assurance accepted.	High 12	Very High 20	High 16	High 16	High 16
<a href="#">1076</a>	Healthcare Associated Infection (HCG Committee) (Set out in Quality & Performance Improvement Report)	July 2017. Overall moderate assurance due to SAB infections, but significant with respect to CDI HEAT target achievement. Committee asked for the risk grading to be reviewed in light of current performance. Incorporated into the Risk Review process. Risk reviewed and grading reduced and approved at November 2017 HCG due to current performance.	High 12	High 16	High 16	Medium 9	Medium 9
<a href="#">3480</a>	New Title - Management of Deteriorating Patients in Acute Inpatients (previously Delivery of SPSP Work Programme) (HCG Committee & Acute Services Committee) (Set out in Quality & Performance Improvement Report)	July 2017 Significant assurance received for Patient Safety Programme with the exception of the management of deteriorating patients. Committee in March. Review presented to HCG July 2017. Significant assurance re robustness of the review, limited as actions agreed that will lead to an improvement as changes not tested at scale. Progress update to January 2018 HCG – will review risk grading should improvement in as outcomes are improving but need sustained outcomes.	High 16	High 16	High 16	High 16	High 16
<a href="#">3527</a>	Medical Workforce Sustainability (Staff Governance Committee)	March 2017 Moderate Assurance that all reasonable steps are being taken to address the risks. Paper requested for 26 <sup>th</sup> July meeting. Risk considered in paper at October 2017 meeting and continues to accept moderate assurance.	High 16	High 16	High 16	High 16	High 16

Datix ID	Risk Title	Assurance Review Date	Initial Risk Level	Jan-Mar 2017	Apr-Jun 2017	Jul-Sep 2017	Oct-Dec 2017
<a href="#">3189</a>	Facilities Fit for Purpose (accepted back on the Corporate Risk Register October 2015) <b>(Finance &amp; Resources Committee)</b>	Updated risk reviewed and approved at Finance & Resources Committee Jan 2018. Moderate assurance received.	High 15	High 16	High 16	High 16	High 16
<a href="#">3455</a>	Management of Violence & Aggression. (Reported at H&S Committee, <b>via Staff Governance Committee</b> )	March 2017 Limited Assurance. Pending the review of the management of violence and aggression commissioned by Medical Director. Findings of review to be considered by Staff Governance on 26 <sup>th</sup> July 2017 and inform the management of this risk.	Medium 9	High 15	High 15	High 15	High 15
<a href="#">3828</a>	Nursing Workforce – Safe Staffing Levels <b>(Staff Governance Committee)</b>	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
<a href="#">3328</a>	Roadways/ Traffic Management (Risk placed back on the Corporate Risk Register December 2015) (Reported at H&S Committee, <b>via Staff Governance Committee</b> )	March 2017 Moderate Assurance that issues are regularly reviewed, managed and improvements developed as supported by recent audits. Further report requested for 26 <sup>th</sup> July meeting. Staff Governance Committee considered report at October 2017 meeting and continues to accept moderate assurance.	High 12	High 12	High 12	High 12	High 12

3.4 Since mid-2016/17 NHS Lothian has been using standard levels of assurance in its system of governance, and the Corporate Governance Manager has prepared some internal guidance on Corporate Governance and Assurance set out below and assurance levels are now routinely being used in governance committees.



**Source:** Health Care Standards Unit, as referred to in the [Oxford University Hospitals Foundation NHS Trust Assurance Strategy](#) (September 2015)

3.5 The Audit & Risk Committee has raised a challenge to explore the mechanisms by which the Board's Corporate Objectives inform NHS Lothian's Risk Profile and support the achievement of the Board's Corporate Objectives.

In response, a workshop was convened for 30<sup>th</sup> November 2017 with the members of the Audit & Risk Committee and the Chairs of the other governance committees. The session reflected on the 2017/18 Corporate Objectives and identified key risks to delivery of those objectives and the impact of these risks. The outcome of the workshop is summarised below and is set out in more detail in Appendix 2.

Using the Corporate Objectives as the vehicle for generating risks has shown that there are a number of potential strategic risks that are not captured on NHS Lothian's Corporate Risk Register:-

- Realising New Models of Health & Social Care
- Ability to Improve and Innovate
- Establishing Positive Working Relationships
- Active Public and Patient Engagement

Some current risks would also appear to be barometers/measures of strategic risks rather than a risk in themselves. For example, the current 4-hour Standard and Delayed Discharge risks are system measures related to our ability to identify and implement new models of care. There is an opportunity to further develop and refine the above areas in the Board's May 2018 workshop.

### 3.6 Risk Appetite Reporting Framework

NHS Lothian's Risk Appetite Statement is:-

“NHS Lothian operates within a low overall risk appetite range. The Board's lowest risk appetite relates to patient and staff safety, experience and delivery of effective care. The Board tolerates a marginally higher risk appetite towards delivery of corporate objectives including clinical strategies, finance and health improvement.”

Risk Appetite relates to the level of risk the Board is willing to accept to achieve its corporate objectives and measures has been identified as set out in Table 3 to provide a mechanism for assessing the delivery of these objectives. Green denotes Appetite met, Amber denotes Tolerance met but not Appetite and Red denotes Tolerance not met.

**Table 3**

	Current Status	Current Position	Data Report
<b>Corporate Objective 3 – Improve Quality, Safety &amp; Experience Across the Organisation (LDP 2016-17 - 2.3 Deliver Safe Care) Low Risk Appetite</b>			
<ul style="list-style-type: none"> <li>Scotland target to reduce acute hospital mortality ratios by 10% with a tolerance of 15-20% by Dec 2018<sup>1</sup> All sites within HS limits &amp; &lt;=1</li> </ul>	Green	0.83	Quality & Performance Improvement Report (HCG Committee)
<ul style="list-style-type: none"> <li>Achieve 95% harm free care with a tolerance of 93-95% by Dec 2015</li> </ul>	Green	99.9%	Patient Safety Programme Annual Report (Jan 2017) (HCG Committee)
<ul style="list-style-type: none"> <li>Achieve 184 or fewer SAB by March 2018 with a tolerance of 95% against target. n=193 to 184</li> </ul>	Green	192	Quality & Performance Improvement Report (HCG Committee)
<ul style="list-style-type: none"> <li>Achieve 262 or fewer C.Diff by March 2018 with a tolerance of 95% against target. n=275 to 262</li> </ul>	Green	170	Quality & Performance Improvement Report (HCG Committee)
<ul style="list-style-type: none"> <li>Reduce falls with harm by 20% with a tolerance of 15-20% by March 2017</li> </ul>	Green	53%	Quality & Performance Improvement Report (HCG Committee)
<b>Corporate Objective 3 – Improve Quality, Safety &amp; Experience Across the Organisation (LDP 2016-17 - 2.4 Deliver Person-centred Care) Low Risk Appetite</b>			
<ul style="list-style-type: none"> <li>Patients would rate out of 10 their care experience as 9, with a tolerance of 8.5</li> </ul>	Amber	8.50	Quality & Performance Improvement Report (HCG Committee)
<ul style="list-style-type: none"> <li>90% of staff would recommend NHS Lothian as a good/very good place to work by Dec 2015 with a tolerance of 93-95%</li> </ul>	Red	74%	iMatters first report. Frequency of reporting to be confirmed. (Staff Governance Committee)
<ul style="list-style-type: none"> <li>Staff absence below 4% with a 5% tolerance (4.2%)</li> </ul>	Red	6.03%	Quality & Performance Improvement Report (Staff Governance Committee)
<b>Corporate Objective 3 – Improve Quality, Safety &amp; Experience Across the Organisation (LDP 2016-17 - 2.7 Scheduled Care &amp; Waiting Times) Low Risk Appetite</b>			
<ul style="list-style-type: none"> <li>90% of patients of planned/elective patients commence treatment</li> </ul>	Red	74.5%	Quality & Performance Improvement Report

<sup>1</sup> This is a Scotland-wide target which NHS Lothian will contribute to.

	Current Status	Current Position	Data Report
within 18 weeks with a tolerance of 85-90%			(Acute Hospitals Committee)
<ul style="list-style-type: none"> <li>95% of patients have a 62-day cancer referral to treatment with a tolerance of 90-95%</li> </ul>	Red	89.4%	Quality & Performance Improvement Report (Acute Hospitals Committee)
<b>Corporate Objective 3 – Improve Quality, Safety &amp; Experience Across the Organisation (LDP 2016-17 - 2.8 Appropriate Unscheduled Care) Low Risk Appetite</b>			
<ul style="list-style-type: none"> <li>98% of patients are waiting less than 4 hours from arrival to admission by Sept 2014 with tolerance of 93-98%</li> </ul>	Red	82.3%	Quality & Performance Improvement Report (Acute Hospitals Committee)
<ul style="list-style-type: none"> <li>No patients will wait more than 14 days to be discharged by April 2015 with an appetite of 14 days, and a tolerance of 15 days*</li> </ul>	Red	270	Quality & Performance Improvement Report (HCG Committee)
<ul style="list-style-type: none"> <li>No of all patients admitted to hospital with an initial diagnosis of stroke should receive the appropriate elements of the stroke care bundle, with an appetite of 80% and a tolerance of 75%.</li> </ul>	Red	73%	Quality & Performance Improvement Report for management actions (Acute Hospitals Committee)
<b>Corporate Objective 1 – Protect &amp; Improve the Health of the Population. Medium Risk Appetite</b>			
<ul style="list-style-type: none"> <li>Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% SIMD areas, with a 10% tolerance (36-40%). (Target = 293 minimum per quarter).</li> </ul>	Red	243	Quality & Performance Improvement Report (HCG Committee)
<ul style="list-style-type: none"> <li>At least 80% of women in each SIMD percentile will be booked for antenatal care by 12<sup>th</sup> week of gestation, with a 10% tolerance (69.3-77%)</li> </ul>	Green	Lowest SIMD is SIMD 4 – 88.2%	Quality & Performance Improvement Report (HCG Committee)
<b>Corporate Objective 5 – Achieve Greater Financial Sustainability &amp; Value (LDP 2016-17 – 3.1 Financial Planning) Medium Risk Appetite</b>			
<ul style="list-style-type: none"> <li>In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5%</li> </ul>	Green	£1,575k underspend at period 10 equating to 1.1%	Period 10 Finance Report (Finance & Resources Committee)
<ul style="list-style-type: none"> <li>For the year to date, the overspend against the total core budget for the year to date is not more than 0.1%</li> </ul>	Red	£3,381k overspend for the year-to-date, equating to 0.3%	Period 10 Finance Report (Finance & Resources Committee)

\* Note: There is now a national target for Delayed Discharges with patients waiting no more than 72 hours to be discharged. The above Delayed Discharge targets will be replaced with the 72 hour target once they have been met.

3.6.1 The above table reporting would suggest NHS Lothian is outwith risk appetite on corporate objectives where low risk appetite with respect to Patient/Staff Experience and Access to Treatment, and medium appetite with respect to Finance. It should be noted the improvements in Safe Care.

#### **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.

#### **8 Resource Implications**

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

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12 March 2018

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#### **List of Appendices**

Appendix 1: Summary of Corporate Risk Register

Appendix 2: Output from Risk Workshop, November 2017

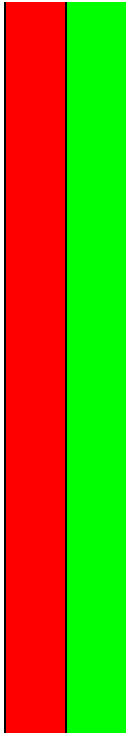


# Corporate Risk Register

# 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.	<p>There is a risk that the Board does not systematically and robustly respond to the financial challenge to achieve its strategic plan.</p> <p>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.</p> <p><b>NOTE:</b> 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.</p>	<p>The Board has established a financial governance framework and systems of financial control. Finance and Resources Committee provides oversight and assurance to the Board.</p> <p>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.</p> <p><b>Rationale for Adequacy of Control:</b> 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.</p>	<p>Risk reviewed for period Oct – Dec 2017</p> <p><u>Update 6 March 18</u></p> <p><u>At the 23 January Finance &amp; Resources Committee it was acknowledged that, based on date to December, NHS Lothian can now provide significant assurance on the achievement of financial balance by the 2017/18 year end.</u></p> <p><u>Based on current information, NHS Lothian is not able to provide any assurance at this stage, on its ability to deliver a balanced financial position in 2018/19. N.B. a Financial Balance Risk matrix was included in this paper.</u></p> <p>The medium term financial plan will have a renewed focus on the national opportunities identified via the national Value and Sustainability work streams. The positive impact on finance from the Quality initiatives work on reducing unwarranted variation and waste will also be reflected in the plan.</p> <p>The Board has agreed to produce a medium term strategic financial plan, with the specific aim of identifying a plan for the Board to return to recurring financial balance.</p> <p>The National Health and Social Care Delivery Plan has requested that Regional service models are enhanced to support delivery of recurring financial balance. The Board is committed to working with regional partners to deliver this aim.</p> <p>Risk Grade/Rating remains Very High 20</p>	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.	<p>A range of governance controls are in place for Unscheduled Care notably:</p> <p><b>Board</b> Monthly NHS Lothian Board oversee performance and the strategic direction for Unscheduled Care across the NHS Lothian Board area.</p> <p>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 weekly basis, monitoring performance reporting and unscheduled attendances.</p> <p>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.</p> <p>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.</p> <p>The approved Winter Plan outlined the approach to supporting performance over the winter period and beyond. This reflected a number of actions namely:</p> <ul style="list-style-type: none"> <li>• Winter Readiness plans established for each site</li> <li>• Plans focused on discharge capacity as well as bed capacity for 2017-18</li> <li>• Clear measures in terms of escalation procedures</li> <li>• Measures to counter any demand unmatched to support winter and patient flow</li> <li>• A focus on DD and POC to ensure sustainable performance throughout the winter period liaising closely with IJB partner organisations including <ul style="list-style-type: none"> <li>- Weekly teleconference with IJBs</li> <li>- Trajectories in place to support reduction in DD for each partnership</li> <li>- Agreed data set to assist with developing a wider capacity plan across all health &amp; social care partnerships</li> </ul> </li> </ul> <p>A number of performance metrics are considered and reviewed weekly, including:</p>	<p><b>Risk Reviewed for period Oct – Dec 2017</b></p> <p>Risk reviewed and approved by Acute Services Committee in November 2017 accepted Moderate Assurance</p> <p>Updates highlighted below Risk Grade/Rating remains Very High/20</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Clinical Leadership</li> <li>• Escalation procedures</li> <li>• Site safety and flow huddles</li> <li>• Workforce capacity</li> <li>• Basic Building blocks models</li> <li>• Proactive discharge</li> <li>• Flow through ED/ Acute Receiving</li> <li>• Smooth admission/ discharge profiling</li> <li>• Effective capacity and Demand models being developed re in /out , BBB methodology</li> <li>• Patients not beds principle</li> <li>• Daily Dynamic Discharge/check, chase, challenge methodology rolled out across the acute sites</li> <li>• Plan to roll out across the whole system and partnerships campuses</li> </ul> <p>The regular quarterly report on 6EA progress is due to be submitted to the Scottish Government at the end of October.</p> <p><b>Updates – 13<sup>th</sup> February 2018</b></p> <p><u>In response a whistle blowing event an interim standard operating procedure for 4 hours, aligned to national guidance was implemented November 2017.</u></p> <p><u>In response to the deterioration in NHSL performance a schedule of improvement work was developed in line with the 6EA framework. Including</u></p> <ul style="list-style-type: none"> <li>• <u>Training and development programme for staff in the application of the interim SOP, including the development of a learn pro module</u></li> <li>• <u>Development of a performance dashboard</u></li> <li>• <u>Governance reporting procedure established via NHSL Audit and risk committee</u></li> <li>• <u>SAE completed to determine the root cause of the of the previous internal SOP development and implementation</u></li> <li>• <u>Review of role and responsibilities of the Site and Capacity</u></li> </ul>	<p>Adequate but partially effective; control is properly designed but not being implemented properly</p>	Very High 20	Low 1	Jim Crombie	Jacque Campbell (NHSL) / Jim Forrest (W/Lothian IJB)	Acute Services Committee

				<p>- 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)</p> <p>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.</p> <p><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)</p> <p>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.</p>	<p><u>Team in delivering the 4 hour standard</u></p> <ul style="list-style-type: none"> <li>• <u>Improved leadership visibility will be supported by leadership walk rounds</u></li> <li>• <u>In conjunction with the Site Director facilitate senior leadership development events focusing on setting priorities and expectations in terms of behaviours and working together, and across the organisation</u></li> <li>• <u>Organisation development support has been secured and a programme of work identified to improve staff experience and relationships with management. Front, back door, site and capacity, and leadership teams are planned to come together and reflect and recall experience in terms of processes, behaviours, communications and, how these can work better together.</u>  <u>Staff will be offered supportive one to one conversations to understand what matters to them, what's working well and what would make a difference to make it even better, using an appreciate enquiry approach.</u></li> </ul> <p><u>Debrief from winter is planned for March 2018 NHS Lothian achieved target of 81.4% performance for the period from 1/11/17 – 31.01.18</u></p>					
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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.	<p>A range of <b>management/governance</b> controls are in place for Unscheduled Care notably:</p> <p>NHS Lothian Board (bi monthly) oversee performance and the strategic direction for Delayed Discharges across the Lothian Board area.</p> <p>The bi-monthly Acute Hospitals Committee as well as formal SMT and SMG meetings.</p> <p>Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (data analysis from EDISON)</p> <p>NHS Lothian's Winter Planning Project Board is now established as the NHSL Unscheduled Care Committee in collaboration with the Integrated Joint Boards</p> <p>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.</p> <p>Delayed discharges are examined and addressed through a range of mechanisms by IJBs which include:</p> <ul style="list-style-type: none"> <li>• Performance Management. Each Partnership has a trajectory relating to DD performance and these are reported through the Deputy Chief Executive</li> <li>• Oversight of specific programmes established to mitigate this risk for example Edinburgh Flow Board and/or Strategic Plan Programme Board (East Lothian)</li> </ul>	<p>Risk reviewed for period Oct-Dec 2017 Reviewed by HCG in November 2017 and continued to accept limited assurance.</p> <p><b>Update 12 March 2018</b></p> <p>Risk Grade/Rating remains Very High/20 Action to help tackle DD across NHS Lothian include:</p> <ul style="list-style-type: none"> <li>• Criteria led discharge pilots</li> <li>• Downstream hospitals to have admission and discharge quotas similar to main acute sites.</li> <li>• A capacity and demand exercise is being implemented re hours of care at home required across the City of Edinburgh and other councils</li> <li>• Locality based Services (hubs) being developed to support pulling patients out of hospital and promoting prevention of admission and reducing delayed discharges</li> <li>• Evidence Based Daily Dynamic Discharge is rolled out across the whole system in collaboration with Scottish Government Improvement Team</li> <li>• <b><u>Band 3 District Nursing team support to work with Care at Home team to boost POC capacity throughout Midlothian</u></b></li> <li>• <b><u>Short term "boarding" has been identified for safe and appropriate Delayed patients into local care homes.</u></b></li> <li>• <b><u>Liberton Ward 5 &amp; 6 beds occupied with Ward 8 will be populated from Monday 12/3 to add additional capacity.</u></b></li> <li>• Additional capacity to support weekend discharge (diagnostic, pharmacy, AHPs, transport etc)</li> <li>• Twice daily Teleconference to plan and match transfer of care to right place for patients</li> <li>• Joint Venture with CEC to create additional models of interim care capacity –Gylemuir/Liberton</li> <li>• Discharge Hubs in the Royal Infirmary of Edinburgh, the Western General Hospital and St John's Hospital</li> </ul> <p>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. Lothian's approved Winter Plan sets out the key requirements in supporting service delivery and access performance during winter and beyond. Actions include:</p> <ul style="list-style-type: none"> <li>• Development of robust site winter readiness plans</li> <li>• Focus on Capacity and Demand in relation to beds and hours or care requirements</li> <li>• Clear measures in terms of escalation procedures</li> <li>• Counter any demand as a result of the extended 4 day break during the festive period.</li> <li>• Focus on DD and POC liaising with IJB Partner organisations to support patient flow and sustainable performance throughout the winter period.</li> <li>• Agreed Trajectories in place for each partnership and being monitored to support capacity to meet demand</li> <li>• <b><u>Allocation of a member of In reach team to work in a Flow manager role to provide overview of all related admission/discharge activity for Midlothian patients.</u></b></li> <li>• <b><u>Re- examination of all POC referrals from hospital to see whether patients can be discharged with a smaller POC.</u></b></li> <li>• <b><u>Daily review of all clients on delayed discharge list by senior managers and daily discharge hub established.</u></b></li> </ul>	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	<p>There is a risk that the Board will be unable to meet its duty to provide access to primary medical services for its population due to increasing population combined with difficulties in recruiting and retaining general practitioners, other staff and premises difficulties (e.g. leases). This may affect:</p> <ul style="list-style-type: none"> <li>ability of practices to accept new patients (restricted lists);</li> <li>patients not being able to register with the practice of their choice;</li> <li>ability to cover planned or unplanned absence from practice;</li> <li>ability to safely cover care homes; and 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;</li> <li>other parts of the health and social care system e.g. secondary care, referrals, costs</li> </ul> <p>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 successfully fill practice vacancies or recruit sufficient medical staff to run the practice under 2c (direct provision) arrangements</p>	<p><b>Governance and performance monitoring</b></p> <ul style="list-style-type: none"> <li>Regular updates reported to Healthcare Governance Committee</li> <li>NHS Lothian Board Strategic plan, HSCP primary care transformation plans and reports to Board and Strategic Planning Committee.</li> <li>Establishment of the Primary Care Investment and Re-design Board which will oversee implementation of local plans and measure associated improvement across NHS Lothian.</li> <li>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)</li> </ul> <p><b>Core prevention and detection controls</b></p> <ul style="list-style-type: none"> <li>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) monthly.</li> <li>PCJMG review the position monthly with practices experiencing most difficulties to ensure a consistent approach across the HSCPs and advise on contractual implications.</li> <li>Ability to assign patients to alternative practices through Practitioner Services Division (PSD).</li> <li>"Buddy practices" through business continuity arrangements can assist with cover for short-term difficulties.</li> </ul> <p><b>Rationale for Adequacy of Controls - remains inadequate</b> 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).</p>	<p>Risk reviewed for period October to December 2017</p> <p>Risk reviewed at Primary Care Joint Management Group on 14/09/17.</p> <p>Position on golden hellos reviewed and updated - discretionary applications to be considered on a case by case basis.</p> <p>Healthcare Governance Committee received reports in September 2017 and <b>January 2018 which again confirmed limited assurance. A further update will be provided for the March meeting.</b></p> <p><b>2018 GMS contract has been approved by the profession and will be implemented from 1 April 2018.</b></p> <ul style="list-style-type: none"> <li>All HSCPs developing transformational plans for Primary Care based on agreed, joint priorities and a second Lothian-wide Primary Care summit was held on 4 May and reported to May HCG. <b>A further Primary Care summit will be held on 1 February 2018.</b></li> <li>NHS Lothian proposed investment of £5m over three years from 2017/18 to address the key pressures are reflected in HSCP integration plans along with the additional national funding in 2017/18 for Primary Care Transformation, funding to increase provision of clinical pharmacist posts in General Practice to provide alternatives to GP consultations for medicines and prescribing related issues.</li> <li>Further work on GP recruitment including: <ul style="list-style-type: none"> <li>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)</li> <li>Promotion of Edinburgh and Lothians as good place to work</li> <li>Provision of local contacts to discuss job opportunities</li> <li>GP practice recruitment micro site</li> </ul> </li> </ul>	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

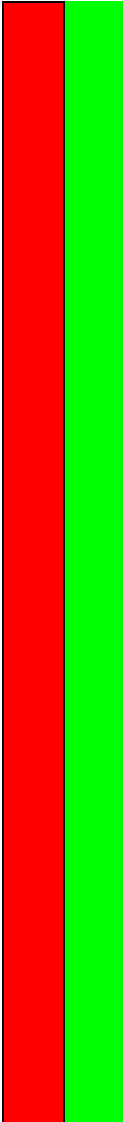
ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates / Actions	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3211	2. Improve patient pathways and shift the balance of care	Access to Treatment Risk – Organisation Risk (Previously Achievement of National Waiting Times)	<p>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 specialities and suboptimal use of available capacity, resulting in compromised patient safety and potential reputational damage.</p>	<p>Governance &amp; performance monitoring</p> <ul style="list-style-type: none"> <li>Weekly Acute Services Senior Management Group (SMG) meeting</li> <li>Monthly Acute Services Senior Management Team meeting- monthly outturn and forecast position</li> <li>Performance reporting at Corporate Management Team (CMT)</li> <li>NHS Lothian Board Performance Reporting</li> <li>Performance Reporting and Assurance to Acute Hospital Committee</li> <li>Monthly access and Governance Committee, to ensure compliance with Board SOPs relating to waiting times.</li> </ul> <p>Core prevention and detection controls</p> <ul style="list-style-type: none"> <li>Establishment of the Delivering for Patients Group to monitor performance and work with individual specialities to delivery efficiency improvements against key performance indicators on a quarterly basis</li> <li>Scope for improvement identified with recommendations made to specialities 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.</li> </ul> <p><b>Rational for adequacy of controls</b> 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.</p>	<p>Risk reviewed for period Oct-Dec 2017 Reviewed by AHC in July 2017 and accepted limited assurance.</p> <p>Update 12 March 2018</p> <p><b>Ongoing Actions</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>Monthly Acute SMT has sight of Access &amp; Governance minutes, to monitor ongoing actions and escalate as appropriate.</li> <li>Performance is also reported to, and monitored by, Acute CMT.</li> <li>Performance is also monitored by the Board and Acute Hospitals Committee, using the Quality &amp; Performance report, which is also reviewed at Acute SMT.</li> </ul> <p><b>Additional Actions</b></p> <ul style="list-style-type: none"> <li>Implementation of a Theatres Improvement Programme – a significant programme with multiple work streams (Pre-assessment, HSDU, Booking and Scheduling, Workforce) to improve theatre efficiency.</li> <li>Establishment of an Outpatient Programme Board that focuses on demand management, clinic optimisation and modernisation.</li> <li><u>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.</u></li> </ul> <p>Risk Grade/Rating is Very High/20</p>	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	<p>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 and outpatient services within specific specialities.</p> <p>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.</p>	<ul style="list-style-type: none"> <li>Service developed trajectories, that are used to monitor performance, early indications of pressures, and opportunities to improve efficiencies/productivity.</li> <li>A re-invigorated Delivering for Patients (DfP) programme provides a framework for learning and sharing good practice through a programme of quarterly reviews.</li> <li>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. <b><u>Long wait surveillance endoscopies are also clinically triaged to identify any patients that require expedition.</u></b></li> <li>A revised communications strategy has been established to ensure that both patients and referrers are appropriately informed of the length of waits.</li> <li>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.</li> <li>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.</li> </ul> <p><b>Rational for adequacy of controls</b>            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.</p>	<p>Risk Reviewed for period Oct-Dec 2017 Reviewed by HCG in November 2017 – accepted moderate assurance.</p> <p>Update 12 March 2018</p> <p><b>Ongoing Actions</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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 <i>RefHelp</i>, making them available to GPs at the time of referral. It has been agreed (March 2017) that a link to <i>RefHelp</i> waiting time information will be included in letters to patients, allowing them to check service waiting times regularly. <b><u>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.</u></b></li> <li><b><u>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.</u></b></li> <li>Information on the projected length of wait throughout a patient's pathway is communicated clearly to patients at clinical appointments throughout their cancer journey.</li> </ul>	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

**Additional Actions**

- 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





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
3454	2: Improve the quality and safety of health care	Management of Complaints and Feedback	<p>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.</p> <p>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.</p>	<p><u>Governance and performance monitoring</u></p> <ul style="list-style-type: none"> <li>Routine reporting of complaints and patient experience to every Board meeting</li> <li>Regular reports to the Healthcare Governance Committee - complaints and patient experience reports.</li> <li>Additional reports are submitted to the Audit and Risk Committee</li> <li>Monthly quality and performance reporting arrangements include complaints and patient experience</li> <li>Internal Audit 'Management of Complaints &amp; Feedback'.</li> </ul> <p><u>Core prevention and detection</u></p> <ul style="list-style-type: none"> <li>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</li> <li>Feedback and improvement quality assurance working group meets monthly, chaired by Non-executive Director and is overseeing implementation of the SPSP action plan</li> <li>Corporate Management Team and Executive Nurse Directors group review and respond to weekly/monthly reports</li> </ul> <p>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.</p> <p>Rationale for inadequate controls: Governance processes and improvement plans are in place but yet to be fully implemented.</p>	<p><b>Risk Reviewed for period Oct - Dec 2017</b> 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.</p> <ul style="list-style-type: none"> <li>Complaints Improvement Project Board now in place chaired by the Executive Nurse Director.</li> <li><u>Stakeholder engagement from across the organisation continues and paper went to Jan CMT with further update in Mar CMT on the new delivery model (Hybrid Model) to support the new CHP.</u></li> <li><u>A number of teams across the organisation are assisting with complaints data collection to support the new CHP.</u></li> <li>Feedback &amp; Improvement Quality Assurance Working Group meet monthly chaired by Non Executive and has overseen the implementation of SPSO action plan. <u>Now reviewing its terms of reference to extend remit.</u></li> <li><u>Bi-annual meetings with the new Ombudsman agreed and next meeting will take place in Feb 2018.</u></li> <li>Complaints and patient experience reports was given moderate assurance by the HCG committee – May 2017 and <u>agreement given in Nov to combine these two papers, moderate assurance continues.</u></li> <li><u>Internal Audit review of complaints currently in place and due to report by April / May 2018.</u></li> <li><u>Letter from Chair of GP Sub Committee and Head of Patient Experience sent to independent contractors.</u></li> <li>Ongoing support, training and awareness raising within services to increase confidence and capability in managing complaints</li> <li>Work ongoing to support the complaints and feedback systems within the 2 prisons encouraging early resolution.</li> <li>Services are being supported to test a range of approaches including Care Opinion, Tell us 10 Things and Care Assurance Standards</li> <li>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</li> </ul> <p>Risk Grade / Rating is High / 16 Rationale for this – moderate assurance given at July 2017 HCG committee. Performance improved 11 out of the last 12 months (before the new CHP was implemented). SPSO cases reduced by half – currently 32 (02.10.17) Complaints Improvement Project Board in place. Blended approach to patient feedback (TTT, Care Opinion &amp; CAS)</p>	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	<p>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.</p>	<p><b>Governance &amp; Performance Monitoring</b>  There is a comprehensive reporting and monitoring of system in place both at Board and operational level directing action as required.</p> <ul style="list-style-type: none"> <li>• Bi-monthly board papers</li> <li>• The NHS Lothian Infection Committee (LICC) reports to the Board through Healthcare Governance Committee.</li> <li>• Lothian Infection Control Advisory Committee (LICAC) receives reports from this committee, public health, facilities on environmental aspects of infection control and advises actions.</li> <li>• 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</li> <li>• In addition to LICAC and local committees, Infection Prevention and Control report routinely at a senior management level to CMG and. &amp; Director of Nursing Group</li> </ul> <p><b>Core prevention &amp; detection controls</b>  <b>Strategy/Training</b>  Overarching HAI Education Framework developed in collaboration with Workforce Planning &amp; Development which is currently under review.</p> <p>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.</p> <p>IPCNs work collaboratively with clinical and non clinical services to communicate risk, support improvement and escalate concerns as appropriate.</p> <p><b>ICT</b>  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.</p> <p>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.</p> <p>SAE reviews are undertaken for CDI and SAB related deaths by services with support of IPCNs.</p> <p><b>Surveillance</b>  Enhanced surveillance is carried out for all SAB, CDI and <i>E-coli bacteraemia</i> 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.</p> <p>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 anticipation of Colorectal/Vascular surveillance coming on line, however there remained a gap in resource and workload.</p>	<p><b>Risk Reviewed March 2018</b></p> <p>Current reporting and governance arrangements for HSCP's are being reviewed.</p> <p>A review of the workload and annual work programme is ongoing as the service cannot sustain existing work streams and integrate the new work programmes into business as usual within the current workforce establishment. This is further complicated by recent changes in staffing and the subsequent ratio of trained staff to trainees. <b><u>Following a review of the existing mandatory surveillance activity NHS Lothian have advised Scottish Government that in the short term the additional SSI surveillance programmes for colorectal and vascular surgery are delayed. Funding has been provided for 2WTE Band 5 nurses to support the additional mandatory surveillance activities. It is anticipated with successful recruitment NHS Lothian should be able to submit data for Quarter 2 July-Sept 2018</u></b></p> <p>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. <b><u>Local educational resources which map to the NES learning outcomes are now in development with ambition to launch April 2018.</u></b></p> <p>Progress in moving to reporting HAI through Tableaux Dashboards has stalled due to resource/ workload issues within informatics teams</p> <p><b><u>Risk Grade/Rating remains Medium 9 based on the current performance for LDP. C Diff data shows sustained improvement against LDP targets.</u></b></p> <p><b><u>Refer to Facilities and DATCC risk register for information on business continuity and contingency plans for sterile services provision. Lifecycle and upgrade work planned for HSDU in 2018.</u></b></p>	Adequate but partially effective: control is properly designed but not being implemented properly	Medium 9	Medium 4	Tracey Gillies	Fiona Cameron	Healthcare Governance 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
				<p>Where SSI or alert organism surveillance indicates a data exceedance there are processes in place for investigation.</p> <p>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.</p> <p><b>Decontamination</b> Responsibility for operational aspects of decontamination of reusable medical devices 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.</p> <p><b>Estate/ Care Facilities</b> 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.</p> <p>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).</p>							

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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	<ul style="list-style-type: none"> <li>The Quality Report, reported to the Board monthly, contains a range of measures that impact and relate to management of deteriorating patients</li> <li>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.</li> <li>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.</li> <li>Adverse Event Management Policy and Procedure.</li> <li>Quality of care reviews which include patient safety issues is subject to internal audit and compliance with recommendations, and is reported via Audit &amp; Risk Committee and HCG Committee when appropriate.</li> <li>Patient safety walkrounds to gain an understanding of safety culture and work taking place at service level. Also now in general practice.</li> <li>Charge Nurse Ward Round and Patient Centred Audit put in place as Quality Assurance Mechanisms to validate self reporting of patient safety data</li> <li>Quarterly visit by HIS to discuss progress actions and Quarterly submission of data.</li> <li>Access to national outcome data by Board which enables boards to see whether they are outliers and escalate concern and risk as appropriate</li> <li>Adverse Event Improvement Plan in place monitored via HCG</li> <li>Site Based Quarterly Reports including Patient Safety Data (QIDS) sent monthly.</li> <li>Live data at ward level</li> </ul>	<p><b>Risk reviewed for October-December Period Approved at September 2017 HCG Committee.</b></p> <ul style="list-style-type: none"> <li>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</li> <li>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</li> <li>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 11<sup>th</sup> 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.</li> <li>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.</li> <li><b><u>Progress updated provided to HCG in January 18 improvement in outcomes observed will reassess risk when improvement has been sustained. Moderate Assurance Accepted</u></b></li> </ul> <p>Risk grade/rating remains High/16 based on unmet actions for key safety priorities</p>	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	<p>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.</p> <p>Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics &amp; Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology</p>	<p><b>Governance &amp; Performing Monitoring</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>A Lothian Workforce Planning &amp; Development Board has been established to coordinate work within all professional groups including the medical workforce.</li> </ul> <p><b>Core prevention and detection controls</b></p> <ul style="list-style-type: none"> <li>Medical workforce risk assessment tool is available and implemented across all specialities. 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.</li> <li>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.</li> </ul> <p>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.</p>	<p>Risk Reviewed for period Oct – Dec 17 October 2017 Staff Governance Committee accepted moderate assurance.</p> <p>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.</p> <p>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.</p> <p>Vacancies in 'hard to recruit' specialities regularly reviewed and different ways explored of delivering services where there are persistent gaps e.g. psychiatry and paediatrics.</p> <p>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.</p> <p><b><u>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 specialities would be regarded as having a high level of risk with a significantly lower level of risk across specialities in general. This review will be carried out by Medical Director.</u></b></p> <p>Risk Grade/Rating remains High/16</p>	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.	<p>A stringent Governance Process and structure for reporting of Backlog Maintenance (BLM) has been implemented as follows:</p> <ul style="list-style-type: none"> <li>o Property &amp; Asset Management Strategy (PAMS) Group</li> <li>o Capital Steering Group</li> <li>o Lothian Capital Investment Group (LCIG)</li> <li>o Finance &amp; Resources Committee</li> <li>o Scottish Government through the annual Property &amp; Asset Management Strategy</li> </ul> <p>To ensure accurate reporting the Board has implemented the following controls:</p> <ul style="list-style-type: none"> <li>• Ensure that 20% of the Board's estate is surveyed annually for physical condition and statutory compliance by the surveyors appointed by Scottish Government.</li> <li>• 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.</li> <li>• Recurring capital funding approved of £2.5m to undertake priority works (high and significant areas)</li> <li>• 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.</li> <li>• The Procurement Framework has been implemented that allows issues identified to be rectified without the need for lengthy tendering exercises</li> </ul>	<p>Risk Reviewed for period – Oct – December 2017 Finance &amp; Resources reviewed in Jan 2018 accepted moderate assurance.</p> <p>Action undertaken 2017/18</p> <ul style="list-style-type: none"> <li>• Review of Risks and programme of works resulted in BLM exposure of £53.8 a reduction of £5m from previous year</li> <li>• At the start of the financial year 2017/18 the position in high and significant risk exposure was - £1m and significant risk being £37.4. It is anticipated that the Board will be in a position to reduce the high and significant risks significantly over this financial year.</li> <li>• BLM programme of works for 2017/18 addressed 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)</li> <li>• The closure of Corstorphine Hospital, Royal Victoria, Edenhall, former Wester Hailes HC and sale of 4 residential care houses , in addition the expiry of leases has reduced backlog maintenance exposure.</li> <li>• Programme of works for 2018/19 currently being reviewed together with future programmes.</li> </ul> <p>The F&amp;R Committee considered a detailed report in November 2017 and the following conclusions were noted:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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).</li> </ul> <p>Risk Grade/Rating remains High 16</p>	Adequate but partially effective: control is properly designed but not being implemented properly	High 16	Medium 4	Jim Crombie	George Curley	Finance & Resources 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
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.	<ul style="list-style-type: none"> <li>•Closed loop Health &amp; safety management system in place.</li> <li>•Robust H&amp;S Committee structure.</li> <li>•Violence &amp; Aggression related policies and procedures in place (attached document).</li> <li>•Competent specialist V&amp;A and H&amp;S advice in place. Robust Occupational Health Services. Learning lessons through adverse event investigation.</li> <li>• The Interim Director of Occupational Health &amp; Safety delivers an annual report to the NHSL H&amp;S Committee with specific actions related to controlling violence &amp; aggression risk within these reports.</li> </ul> <p>ROSPA QSA Audit complete and action plan in place. NHS Lothian Health and Safety Strategic Plan endorsed. Specific actions related to controlling violence &amp; aggression risk are contained within these reports.</p>	<p><b>Risk Reviewed for Period April-June 2017. (As per Quarterly Review. Under review.)</b></p> <p>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.</p> <p>Risk Grade/Rating remains High/15 whilst the review is taking place. The review will inform the risk exposure to the Board.</p>	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

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
3828	3. Improve Quality, Safety and Experience Across the Organisation	Nurse Workforce – Safe Staffing Levels	<p>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.</p>	<p><b>Governance &amp; Performance Monitoring</b></p> <ul style="list-style-type: none"> <li>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</li> <li>Professional governance is through monthly review at the Nurse Directors Committee with Associate Nurse Directors &amp; Chief Nurses.</li> </ul> <p><b>Core Prevention and Detection Controls</b></p> <ul style="list-style-type: none"> <li>Recruitment Group, Safe Staffing and Nursing Workforce Groups to plan requirements</li> <li>The agency embargo remains with every use of agency subject to scrutiny by a senior nurse.</li> <li>Recruitment meetings to oversee the implementation of the recruitment plan are being held monthly</li> <li>Use of tools to ensure safe staffing levels: <ul style="list-style-type: none"> <li>A calendar to ensure the annual use of the nationally accredited workload and workforce tools is in place to ascertain required establishment levels</li> <li>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.</li> </ul> </li> <li>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.</li> <li>Tableau Dashboard in place provides data overview of staffing at all levels.</li> <li>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.</li> </ul>	<p>Risk Reviewed for period Oct 2017 to Jan 2018</p> <p>Reviewed at Staff Governance Committee Oct 2017 accepted Moderate Assurance</p> <p><b>UPDATE</b>  <u>The opening of unfunded capacity has stretched the available staffing despite the total in post being higher than previously. St John's has made use of agency supply to support the staffing position. WGH had a sudden increase in vacancy as an unintended consequence of the bed reprofiling. St John's Gynae ward is operating as a medical boarding area with an impact on new starts anticipating working in a gynae surgery ward opting not to take up post.</u></p> <p><u>There are 187wte MORE staff in the system substantively as at Dec 2017 compared to Dec 2016. The vacancy rate has been &lt;5% since September 2017.</u></p> <p><u>There remain pressures in the system, increased levels of sickness (6.7%) and higher maternity leave and "other leave" than the Predicted Absence Allowance provides for.</u></p> <p>The national work being taken forward to mitigate against agency in critical care and theatres has been abandoned in favour of a regional approach.</p> <p><b>ACTIONS</b>  <u>An East of Scotland approach to negotiating with the off contract agency suppliers has been initiated to try and improve supply and achieve a better rate to minimise the cost.</u></p> <p><u>There is initial supply from the new agency supplier on the market.</u></p> <p><u>The national contract for agency supply is being retendered. Work continues to deliver a regional bank arrangement.</u></p> <p>Recruitment open days for 2018 are in planning. A corporate approach is being proposed with all sites represented at all open days..</p> <p><u>Campaigns to encourage school age children to consider NHS roles for their careers are underway with visits and engagement across the education sector.</u></p> <p>Rotational posts are being configured to make Lothian a more attractive employer for new graduates.</p> <p>A Return to Practice programme is being developed with Edinburgh Napier University to offer a local opportunity for nurses and midwives that have had a career break and lost NMC registration. This will commence in Summer 2018.</p>	Satisfactory: controls adequately designed to manage risk and working as intended	Medium 9	Low 2	Executive Director Nursing, Midwifery & AHP's	Assistant Director - Nursing Workforce & Business Support	Healthcare Governance Committee



				<p>A programme of recruitment to modern apprenticeship (MA) schemes for nursing and midwifery is being established with an aim of recruiting 100 MAs in 2018/19</p> <p>Draft risk assessment and guidelines for the use of 1:1 specialising are being tested in 4 pilot wards (evidence of reduced reliance on 1:1 in early phase of testing)</p> <p>SafeCare live is being used in RIE, The next test of change is to use SafeCare live in the safety huddles.</p> <p>The eRostering and SafeCare live tools roll out is 60% complete with 256 rosters (6638 nursing staff) actively using eRostering.</p> <p>Trend KPIs are being produced and circulated to CNMgrs./ Service managers</p> <p>Risk Grade/Rating remains: Medium/9</p>									
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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	<p>A stringent Governance Process and structure for reporting has been implemented as follows:</p> <ul style="list-style-type: none"> <li>o Site specific Traffic Management Groups</li> <li>o Reported in Facilities H&amp;S quarterly reports</li> <li>o Reported to Health &amp; Safety Corporate group via Facilities Health &amp; Safety Group</li> <li>o Reported to Staff Governance via Health &amp; Safety Committee</li> </ul> <ul style="list-style-type: none"> <li>• 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 &amp; Safety Group (also reported to Facilities Heads of Service) Overarching Health &amp; safety Group</li> <li>• Traffic surveys have been conducted across all hospital sites, and action plans have been prepared and subject to regular review</li> <li>• The commission of Independent expert reviews of road infrastructures on high traffic high inpatient sites</li> <li>• Action plans have been developed across all sites by the Local Site Traffic Management Groups and high risk items approved subject to funding.</li> <li>• Additional dedicated car park personnel in high volume traffic sites has been implemented</li> <li>• 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</li> <li>• Risk assessments and procedures are developed and regularly reviewed where risks have been identified, and a more task specific process has been developed.</li> <li>• Work Place Transport Policy available and reviewed within agreed timescales.</li> </ul>	<p>Risk Reviewed for period Oct – Dec 2017</p> <p>Reviewed and approved at October 2017 Staff Governance Committee - accepted moderate assurance.</p> <p><u>Update – March 2018</u></p> <p><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.</u></p> <p><u>Applications have been submitted to extend the TRO at the REH and introduce a TRO at the AAH, these works have now been completed.</u></p> <p><u>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.</u></p> <p><u>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</u></p> <p><u>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></p> <p><u>Funding has been sought to undertake traffic management works at REH Phase 1 which will include road lining and signage.</u></p> <p><u>An independent audit of arrangements at the RIE has been undertaken and a report with recommendation is being discussed with an anticipated financial application.</u></p> <p>Risk grade/rating remains unchanged - High/12</p>	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

**Audit & Risk Committee – Risk Workshop, 30<sup>th</sup> November 2017**

**Reflections/Analysis**

Using the Corporate Objectives to inform NHS Lothian's Risk Profile resulted in the identification of potential risks that are currently not explicitly on the Corporate Risk Register. These risks are separate to the current Person-Centred risks (Management of Complaints) and Safe Care risks (Healthcare Associated Infections, Management of Violence & Aggression).

The new potential risks identified can be categorised/themed into four main areas:-

1. Realising new models of health and social care
2. Positive partnership working
3. Ability to improve and innovate
4. Active public and patient involvement.

These risks and associated factors are set out below in the Venn diagram which highlights the interrelated nature of these risks.

Realising New Models of Health and Social Care

This risk was woven through a number of the current corporate risks as illustrated by the notes of the workshop set out in Appendix 1. Many of the current risks on the risk register are measures/indicators of whether we are realising new models of Health and Social Care, for example, the 4-hour target and delayed discharges. Others are enablers/associated risks such as workforce sustainability, for both GP and nursing workforce particularly in Primary Care.

Positive Partnership Working

This is currently not explicitly on the Corporate Risk Register but is stated on H&SCP and IJB risk registers.

Ability to Improve and Innovate

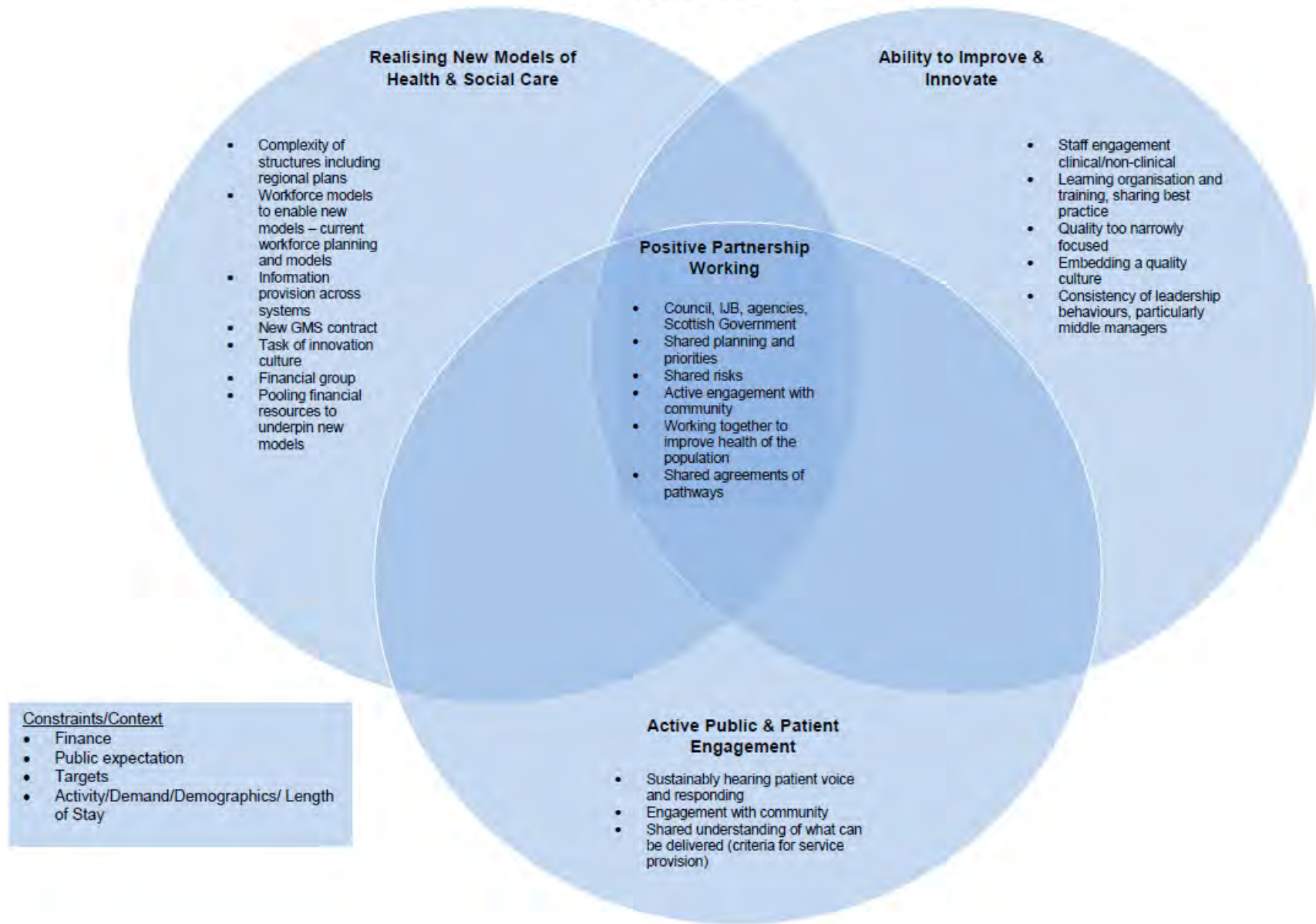
This risk is not on the Corporate Risk Register but is clearly set out as a business model for NHS Lothian through the development of NHS Lothian's Quality System and as such this may be seen as a risk in terms of not achieving this business model.

Active Public and Patient Involvement






This currently is not highlighted as a risk on the Corporate Risk Register and requires further articulation of this potential risk and mitigating actions.

This is also the case for all the above.

**NEW POTENTIAL KEY RISKS (THEMED)**








**No 1 – Protect & Improve the Health of the Nation**

						
Sub-heading	Risk	Negligible	Minor	Moderate	Major	Extreme
Resources	Insufficient resource.		1	2	3	1
	Stretched resources Primary Care!					
	Lack of financial resource at a community level.					
	Failure to invest ( <i>in</i> ) opportunities					
Partnership Working	Not able to deliver without key partners.		1			4
	Poor relationships with key partners, eg Education / 3 <sup>rd</sup> sector.					
Planning/Prioritisation	Changing demographics. Change required focus.			1	3	
	Lack of clarity about what priorities are.					
	Government priorities change the focus on a particular Health issue.					
	Confusing Government policies, requiring expert influence.					
	Wrong resource prioritisation.					
	1. Short-termism. 2. Lack of resource required. 3. Lack of national co- ordination.					
Societal/Cultural Norms	4. Inability to impact on cultural norms. 5. Failure of messaging to resonate.				3	1
	Ineffective engagement					

	with population.					
Impacts of Risks	↑Cancer ↑Respiratory ↑Winter					1
	Sustained provision of acute model.					

## No 2 – Improve Patient Pathways & Shift the Balance of Care

						
Sub-heading	Risk	Negligible	Minor	Moderate	Major	Extreme
	IJB Strategic Plan implementation				4	
	Complex structures – IJBs, Council Health					
	Affordable fit-for-purpose system infrastructure cannot be procured					
	Secure IT management systems. New regulations – hacking etc					
	Lack of shared agreement on pathway				1	
	10% reduction in unscheduled care – lack of alternative APPROPRIATE provision				1	
	New GMS contract					
	Quality Clusters identify need for more referrals & admissions					
	Innovation delivers need for more contact with healthcare sector					
Capacity	Insufficient capacity in acute sector					3
	Demand outstrips capacity					
	Insufficient capacity in community					
	Capacity issues in care sector					
	If beds are closed and resources are transferred, the risk of failure of community services is almost wholly left at the door of the acute hospitals					
	Market failure in social care					
Work force	Workforce sustainability					3
	Lack of staff to deliver palliative care					
	GPs reject new contract					
	ANPs do not reduce need for GPs					

	Increase capacity in adult social care [cross-refer to No 6]. New models of social care					
	Issue with Health & Social Care recruitment					
	Workforce recruitment. Availability/budget					
	GP vacancies					
	Brexit impinging on workforce					
	Failure to recruit social care staff					
	Attendances continue to rise because public does not think they are unnecessary					
	Failure to manage public expectation					3
	Do not clarify greatest need/criteria					
	Managing strategy/change requirement with target driven environment					
	Funding in real terms not increased					
	Release of funding to ↑ community care whilst delivering in acute with rising demand					
	Financial constraints					2
	Budget constraints					
	Council funding is inadequate for social care even if NHS transfers resource					
	↑ demand vs ↓ attendance					



## No 3 – Improve Quality, Safety & Experience across the Organisation

		●	●	●	●	●
Sub-heading	Risk	Negligible	Minor	Moderate	Major	Extreme
	Lack of clarity about how board gets assurance					
	<ol style="list-style-type: none"> <li>1. Quality too narrowly focussed</li> <li>2. Quality initiatives seen as elitist</li> <li>3. Embedding quality culture</li> </ol>					
	Quality focus directed wrongly					
	Quality seen as vanity projects			3	2	
	↑loss of resource efficiency ↑length of stay ↑readmission ↑late-stage cancer					
	Inability to deliver full potential of recovering patient					
	Lack of systematic approach to obtaining patient feedback					
	Failure of QA system to be sufficiently radical/transformational					
	Culture does not support quality approach in some parts of the organisation			1	2	
	Organisation focus remains: <ol style="list-style-type: none"> <li>1. Delivery of finance</li> <li>2. Delivery of targets</li> </ol> Missing the point!					
	↑harm to patients					
Staff Engagement	Poor staff engagement/buy-in					
	Lack of appropriate learning & training		1	2	4	
	Insufficient clinical engagement					
Innovation /	Failure to highlight Best Practice				2	2

Transformation Best Practice	Lack of aspiration and inspiration					
Quality/Safety experience	QA does not increase capability to manage services					
	QMS does not lead to measurable improvement in quality of care					
	Shared decision-making increases conflict between clinician & family or individual					
	No agreed way to reduce falls and maintain mobility					
	Increased awareness of sepsis lead to more antibiotic use – leads to ↑ in <i>c.diff</i> & antibiotic resistance					
	Increasing use of patient views leads to reduction in effectiveness of care					






## No 4 – Support the Engagement & Development of our Staff through Leadership & Behaviours

Sub-heading	Risk	Negligible	Minor	Moderate	Major	Extreme
		●	●	●	●	●
	Values not embedded				1	
	Staff don't engage				1	
	Failure to embed culture supporting innovation etc because of immediate 'pressures'					1
	There are insufficient people in workforce to fill plans					1
	Engage to innovate to support delivery of organisational objectives: <ul style="list-style-type: none"> <li>• No headroom</li> </ul>					
	Workforce planning capability			2	2	
	Capacity to succession-plan			2	2	
	Time constraints impinging on appraisal process			2	2	
	Sub-cultures / shadow culture					
	No effective way to address concerns raised by staff					
	Move from project to "everyday"					
	Experimentation causes diffusion of impact					
	Level of engagement				3	
	Provision of time/space/accountability to innovate at all levels				3	
	Meetings meetings meetings				3	
	Time. Visible consistent leadership				3	
	People don't like the leaders they see				3	
	Consistent behaviour visible at all levels				3	
	Engaging middle management				3	






## No 5 – Achieve Greater Financial Sustainability & Value

		●	●	●	●	●
Sub-heading	Risk	Negligible	Minor	Moderate	Major	Extreme
	Policy decisions made by government				1	
	Finance delivery care deficit					
New models & relationships	Failure to support innovation and redesign				1	4
	Poor engagement with key partners					
	Culture in health finance					
	Inability to employ financial muscle as collaborative					
	Relationships eg IJB: attitudes to responsibilities/confusion					
	Failure to deliver NRAC parity				3	
Ambitions/strategic thinking	Inability to bridge to new models				2	4
	Insufficiently ambitious around medium-term plans					
	Loss of robust financial management across organisation					
	Financial impact not viewed as a 'spending' problem					
	Financial settlements not used as an opportunity					

## No 6 – To work with Partner Boards to develop a Regional Health & Social Care Delivery Plan for the East of Scotland

						
Sub-heading	Risk	Negligible	Minor	Moderate	Major	Extreme
	Financial constraint					
	Perception of NHS Lothian takeover					
	Government expectations					5
	Moving plan 6 to implementation					
	Impact on local plans, and focus on priorities					
	Shifting resource as more to implement					
	Capacity to deliver on regional plans <u>and</u> board plans					
	Public expectations differ across areas and regions					
	Independent board structures				2	4
	Lack of agreement about critical issues across region					
	Regional partners					
	Differing priorities for health boards, IJBs and local authorities					
	Political divergence					
	No formal accountability of governance structures					
	Need to redefine wider partnerships CPP, IJB as well as Regional Health Boards.					1
	LOOK					

## Common Risks

						
Sub-heading	Risk	Negligible	Minor	Moderate	Major	Extreme
	Public & Scottish Government expectations lack clarity.					
	Criteria of Service Provision.					
	Models of Care: <ul style="list-style-type: none"> <li>• Innovation</li> <li>• Engagement</li> <li>• Staff models - workforce fit for purpose</li> </ul>					
	Finance to support new ways of working + sustainability <i>(of)</i> service					
	Staff engagement / leadership visibility: <ul style="list-style-type: none"> <li>• Middle management consistent behaviours.</li> </ul>					
	Partnerships/Relationships: <ul style="list-style-type: none"> <li>• Scottish Government</li> <li>• Council</li> <li>• Regional etc</li> </ul>					

## 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 Mr Bill McQueen to the Audit & Risk Committee with immediate effect.
- 2.2 Appoint Ms Aileen Fraser as lay member of the Pharmacy Practices Committee.
- 2.3 Appoint Caroline Wells as a non-contractor pharmacist member of the Pharmacy Practices Committee.
- 2.4 Appoint Fiona Ireland as a member and chair of the Organ Donation Sub-Group with immediate effect.
- 2.5 Appoint Martin Connor as a member of the St John's Hospital Stakeholder Group with immediate effect.
- 2.6 Nominate Angus McCann as a member of the Midlothian Integration Joint Board with immediate effect.
- 2.7 Agree that Angus McCann be designated as the lead NHS member on the Midlothian Integration Joint Board, and therefore assume the role of Chair of the Midlothian Integration Joint Board.

### 3 Discussion of Key Issues

- 3.1 Since the Board meeting of 7 February, Mr John Oates, Dr Richard Williams and Ms Lynsay Williams have left the Board. These departures create vacancies in the membership of the Board's committees and the integration joint boards.

#### Audit & Risk Committee

- 3.2 John Oates was a member of the Audit and Risk Committee, and it is recommended that Bill McQueen is appointed to that committee with immediate effect.

### Pharmacy Practices Committee

- 3.3 The NHS (Pharmaceutical Services) (Scotland) Regulations 2009 (as amended) require the Board to have a Pharmacy Practices Committee, and the Board has had this in place for a number of years. The Regulations prescribe the membership of the committee, and this includes three lay members (people who are not members of the Board, and also are not or have never been a doctor, dentist, ophthalmic optician, pharmacist, or an employee of one of these).
- 3.4 The Board appointed three lay members in February 2018. It is helpful to have a pool of members to draw from, however only three lay members will be used for any meeting. Ms Aileen Fraser has been approached and briefed regarding the role and responsibilities as lay member of the Pharmacy Practices Committee. The Board is recommended to appoint Ms Aileen Fraser to the committee.
- 3.5 The Board is also recommended to appoint Caroline Wells as a non-contractor pharmacist member of the Committee, so as to make it easier to convene meetings. Ms Wells has attended relevant training in another Board area.

### Organ Donation Sub-Group

- 3.6 Kay Blair was the NHS Board member on the Organ Donation Sub-Group, as well as its chair. It is recommended that Fiona Ireland is appointed to Sub-Group as the NHS Board member and chair with immediate effect.

### St John's Hospital Stakeholder Group

- 3.7 Lysay Williams was a member of this Group, and it is recommended that Martin Connor is appointed to this Group with immediate effect.

### Midlothian Integration Joint Board

- 3.8 John Oates was the lead NHS Board member on Midlothian Integration Joint Board, as well as its chair. It is recommended that Angus McCann is nominated a voting member of the Midlothian Integration Joint Board. It is further recommended that the Board agrees that Angus McCann is the lead NHS Board member on the Midlothian Integration Joint Board, and consequently will be the chair or vice-chair as per the rotation. NHS Lothian currently holds the right to chair the Midlothian Integration Joint Board.

## **4 Key Risks**

- 4.1 A committee does not meet due to not achieving quorum, leading to a disruption and delay in the conduct of the Board's governance activities.
- 4.2 The Board does not make the most effective use of the knowledge, skills and experience of its membership, leading to the system of governance not being as efficient and effective as it could be.

## **5 Risk Register**



5.1 This report attends to gaps in committee membership, and it is not anticipated that there needs to be an entry on a risk register.

## **6 Impact on Inequality, Including Health Inequalities**

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

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

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

## **8 Resource Implications**

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

Alan Payne  
Head of Corporate Governance  
26 March 2018  
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Director of Public Health and Health Policy

## **FAMILY HEALTH SERVICE PRACTITIONERS DISCIPLINARY PROCEDURES REFERENCE COMMITTEE**

### **1 Purpose of the Report**

- 1.1 The purpose of this report is to recommend that the Board approve an updated remit for the Board's Reference Committee.

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

### **2 Recommendations**

- 2.1 The Board is asked to approve an updated remit for the Board's Reference Committee.

### **3 Discussion of Key Issues**

- 3.1 The Board's Reference Committee will consider cases for family health service practitioners that may be required to be referred to a NHS Discipline Committee or the NHS Tribunal.
- 3.2 For General Dental Practitioners, Optometrists and Pharmacists, the Reference Committee will consider any referrals to the appropriate professional body (General Dental Council, General Optical Council and General Pharmaceutical Council).
- 3.3 Referrals of General Medical Practitioners to the General Medical Council are handled by the Board's Medical Director, given their role as the Board's Responsible Officer in relation to Revalidation.
- 3.4 The membership of the Reference Committee is a Board Member (currently the Director of Public Health and Health Policy) and a Non Executive Board member (currently Martin Connor). Should either be unavailable the Board's Chairman would be asked to appoint a substitute. The updated remit is attached at Appendix 1.

### **4 Key Risks**

- 4.1 There are no risks attached to the recommendation.

### **5 Risk Register**

- 5.1 There are no implications for the Corporate Risk Register.

### **6 Impact on Inequality, Including Health Inequalities**

- 6.1 An impact assessment has not been carried out.

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

- 7.1 This section is not applicable.

## **8 Resource Implications**

- 8.1 There may be resource implications in terms of staff time for case management and pulling together referrals together with CLO costs. These will vary on a case by case basis.

Alison McNeillage

Interim General Manager – Primary Care Contracts

13 March 2018

[Alison.McNeillage@nhslothian.scot.nhs.uk](mailto:Alison.McNeillage@nhslothian.scot.nhs.uk)

### **List of Appendices**

Appendix 1: Family Health Service Disciplinary Procedures – Reference Committee

## **APPENDIX 1 FAMILY HEALTH SERVICE PRACTITIONERS DISCIPLINARY PROCEDURES**

### **REFERENCE COMMITTEE**

#### **Remit:**

There shall be an established Reference Committee for disciplinary matters in relation to Family Health Service Practitioners in compliance with the terms of the National Health Service (Discipline Committees)(Scotland) Regulations 2006 as amended. The Reference Committee will exercise the Health Board's functions under these regulations with respect to the referral of disciplinary matters.

The Reference Committee will also consider any referrals to the NHS Tribunal under the National Health Service (Tribunal)(Scotland) Regulations 2004 as amended.

In relation to General Dental Practitioners, Optometrists and Pharmacists, the Reference Committee will consider any referrals to the appropriate professional body (General Dental Council, General Optical Council and General Pharmaceutical Council).

#### **Out of Scope:**

Referrals of General Medical Practitioners to the General Medical Council are handled by the Board's Medical Director, given their role as the Board's Responsible Officer in relation to Revalidation.

#### **Frequency of Meetings:**

As required.

#### **Membership:**

Non-Executive Board Member (Chair)  
Board Member (currently Director of Public Health and Health Policy)

#### **Quorum:**

No business shall be transacted at a meeting of the Committee unless a Non-Executive Director member and a Board Member for all cases in relation to Family Health Services which includes General Practitioners, Dental Practitioners, Optometrists and Pharmacists are present.

#### **Reporting Arrangements:**

The minutes of the Committee will be prepared following the Healthcare Improvement Scotland Guidance Paper on Data redaction and standardised adverse event review reports (December 2014). The Committee will report to the Board by means of submission of reports when required at the next available Board meeting.

March 2018

**STAFF GOVERNANCE COMMITTEE**

Minutes of a Meeting of the Staff Governance Committee held at 9:30am on Wednesday 31 January 2018 in Meeting Room 8&9, Fifth Floor, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

**Present:**

Mrs A. Mitchell (Chair); Cllr D. Milligan; Ms H. Fitzgerald; Mr S. McLaughlin; Mrs. J Butler; Miss T. Gillies; Professor A. McMahon; Professor T. Humphrey and Cllr J. McGinty.

**In Attendance:**

Ms J. Campbell, Chief Operating Officer; Mr J. Crombie, Deputy Chief Executive; Mrs R. Kelly, Associate Director of HR; Ms A. Langsley, Interim Head of Corporate Education & Employee Development; Ms K. Aitken, Organisational Development Consultant; Ms J. Gaskell, Head of Employee Relations - CH(C)Ps; Ms L. Guthrie, Lead Infection and Prevention Control Nurse and Mr C. Graham, Secretariat Manager.

Apologies for Absence were received from Mr B Houston and Mr A Joyce.

**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.

The Chair welcomed Professor Humphrey and Cllr McGinty to their first meeting as Committee members.

**36. Minutes of the Previous Meeting**

36.1 The Minutes and Action Note of the Staff Governance Committee Meeting held on 25 October 2017 were approved as a correct record.

**37. Matters Arising**

37.1 The Committee noted the completed actions and the items that were on the January agenda. The following actions were discussed:

- Leadership and Management Framework (LMF) - To be brought to the March Committee meeting.
- GMC visit to NHS Lothian - Miss Gillies reported that the formal report had not been received yet and could be another month to six weeks. The formal publication of the Scotland visit in its totality would be in April to coincide with the NES visit. Lothian would have its report before then. There was a paper going to the Board meeting next week and initial written feedback showed three actions for the RIE, some which related to longer term strategic work including the development of a multidisciplinary education strategy. There were no recommendations for the RHSC visit. Overall the visit to Lothian had been very positive.

- Whistleblowing Monitoring Report - Mr Crombie reported that since the last meeting two of these outstanding audit actions had been closed down and the timeframe for the third action in relation to overview had been extended to June 2018 by the Audit and Risk Committee. Mrs Butler confirmed that the Chair would have overview in her whistleblowing champion role and that the Audit and Risk Committee were sighted and monitoring the remaining work.

37.2 Staff Engagement and Experience Board Development Plan - Mrs Butler reported that it had been hoped to bring the plan to the meeting however the plan required to have appropriate staff side engagement before coming to the Committee. Therefore the plan would go to the February Lothian Partnership Forum and March Corporate Management Team meeting before the final draft plan then came to the Staff Governance Committee's March meeting.

## **38. Assurance and Scrutiny**

### **38.1 Corporate Risk Register**

38.1.1 3328 – Roadways/Traffic Management – Mr Crombie reported that a formal paper would be brought to the March meeting. There were no current issues, however it was noted that in relation to car parking at St John's Hospital additional options to support staff parking were now being looked at.

38.1.2 3455 – Management of Violence and Aggression - Professor McMahon introduced the update on the recommendations and actions being proposed to support and improve the current level of support to staff on violence and aggression management, given this has been flagged as a high risk on the corporate risk register for a number of years.

38.1.2.1 The Committee noted that a small group had reviewed current data to look at areas where violence and aggression was more common, the types of violence and aggression staff were exposed to, adherence to mandatory training and policies and the lone worker policy and management of this.

38.1.2.2 There was discussion on how the Lothian Health and Safety Committee and its new sub groups could help support staff and managers around the lone worker policy. It was noted that the procurement and monitoring of devices had been sitting with the training team, and this had been recognised as inappropriate and moved to procurement. Professor McMahon explained how lone worker devices were activated, monitored and tracked in practice. As part of the improvement piece there needed to be an understanding as to why staff were not activating the devices as the policy is to use the devices and this was not being adhered to.

38.1.2.3 Ms Fitzgerald asked how the Lone Working policy was linked up with Local Authority managers. Professor McMahon stated that he would be happy to pick this up with the IJB Chief Officers. It was recognised that some of actions would be immediate around the lone worker devices however areas such as governance issues may take some time to address.

38.1.2.4 Miss Gillies stated there was a clear analogy to draw here with falls in terms of number of incidents logged and the reporting culture. The paper gave a start at looking at root cause and beginning to address issues.

38.1.2.5 There was discussion on how training would be provided. Professor McMahon stated that the training team only consisted of 5 or 6 people working at sites rather

than a training centre. There needed to be more involvement through operational lines and governance required managers to take more responsibility. Feedback on the Purple Pack focus groups was that the groups were too long and take too much time to complete. It was noted that Ian Wilson and Julie Chalmers were working on improving the focus groups.

38.1.2.6 Cllr McGinty stated that it was reassuring to hear the detail around the structure and monitoring. The challenge was helping staff to understand their own personal safety, from previous experience this could be reinforced through constant repetition of the message and drip feeding of communication. The biggest pressure was when people become pressed and take risks.

**38.1.2.7 The Committee accepted the recommendations and actions currently being put in place to reduce risk and further improve violence and aggression management. The Committee would like to see the whole Health and Safety/Violence and Aggression piece married together as a standing item. The Committee confirmed the proposed limited assurance of the current position and moderate assurance that the action plan, if fully implemented, would provide a greater assurance regarding the reduction of risk.**

38.1.3 3527 – Medical Workforce Sustainability – Miss Gillies stated there was no change from the position reported at the last Committee meeting. There were current issues around psychology gaps in Midlothian and it was noted that recruitment was now complete and trainee numbers would come through in May or June.

38.1.4 3828 – Nurse Workforce – Safe Staffing Levels – Professor McMahon reported that there was to be a 10.8% increase in student intake numbers for 2018/19. The challenge was keeping staff and finding appropriate placements. Professor McMahon added that there was to be a return to practice programme run with Napier University later in the year and the apprenticeship routes remained through West Lothian and Edinburgh Colleges. There was also a sequence of recruitment days organised for all sites as well as events to allow school children to hear about nursing opportunities. Professor Humphrey added that work continued with accelerated programmes, looking to shorten programmes were appropriate and reducing courses from 3 years to 2 years + 1 semester.

38.1.4.1 The Committee noted that the current vacancy rate was at 5% and that agency staff had been required in December and January to ensure patient and staff safety. Staff bank continues to be used effectively.

38.2 Staff Governance Workplan – 2017/18 – Mrs Kelly reported that the intention of the workplan had been to ensure that by the end of the financial year all actions from Everyone Matters had been covered. The workplan is updated after each Staff Governance Committee meeting with the final actions from Everyone Matters item coming to the March meeting.

38.2.1 There was discussion on the plan for next year. Mrs Butler confirmed that the plan for the next two years would be based on Everyone Matters 2018-2020 which would be to tidy up items that had previously been embedded. The greatest challenge had been the embedding of iMatter and now the maintenance.

38.3 Staff Governance Statement of Assurance Need – Mrs Kelly reminded the Committee that this paper is provided for each meeting. It is used to record the level assurance received by the Committee for each item and is fed into the Committee’s Annual Report. This is updated after each meeting to confirm levels of assurance. The paperwork for the Annual Report will come to the Staff Governance Committee in May before then feeding into the Board Annual Report.

38.4 Staff Governance Standard Monitoring Framework 17/18 - Mrs Kelly reported that this was another element of the monitoring of the Staff Governance Standard. It had been anticipated there would be a new process this year, however the Scottish Government were still developing this which would mean another interim year. It was noted that in addition to sending in the return NHS Lothian would have the benefit of the Dignity at Work and iMatters survey. The Committee noted that there was an element for local partnership forums to contribute by providing examples around staff governance standards. The report would be pulled together for consideration at the Staff Governance Committee meeting in May.

### 39. Healthy Organisational Culture

39.1 iMatter Update – The Committee noted that full implementation of the iMatter Continuous Improvement Model had now been achieved and KPIs had now been identified. The Board Employee engagement score was 76% however the conversion rate for reports to action plans was low at only 27%. It was also noted that the anniversary cycles for corporate functions and public health were in process.

39.1.1 Mrs Butler pointed out that the report mentions additional organisational development resource for managers to work with teams and that online resource to support teams through action planning was underway. The key focus was on continuous improvement and effort was being put into building as much resource as possible to support managers and teams to raise the conversion rates of reports into action plans.

39.1.2 Mrs Butler added that the Dignity at Work survey response rate had been lower than anticipated as there had been technical issues with the system, which had led to significant periods where people were unable to access the survey; this had a significant impact for NHS Scotland. The results of the survey will be presented at the meeting in March 2018.

**39.1.3 The Committee took significant assurance that full implementation of iMatter was completed in December 2017, the date set by the Scottish Government. However the Committee noted its concern around the low conversion rates of reports into action plans.**

### 39.2 Whistleblowing Monitoring Report

*Prof Humphrey took over the Chair for this item.*

39.2.1 Mrs Kelly introduced the report on recent actions that have been taken in relation to whistleblowing and shared the monitoring data for the whistleblowing cases that have been raised within NHS Lothian for the period October 2016 to 19 January 2018.

39.2.2 The Committee noted that whistleblowing training for middle managers and staff side continued however attendance had been disappointing due to some last minute cancellations. The feedback from trainers and people who attended will be used to decide what further training will be scheduled beyond the end of March 2018.



- 39.2.3 Mrs Kelly informed the Committee that since the introduction of the monitoring returns in October 2016, 16 whistleblowing cases have been raised to date; these were subject to monthly discussions with Mrs Mitchell. HR Online had been developed to include letter templates and guidance on emerging themes and the differences between a grievance and whistleblowing.
- 39.2.4 The Committee noted that plans to appoint an Independent National Whistleblowing Officer for NHS Scotland were underway and there were ongoing consultation events at the moment to look at how that would work in practice. Once this was clearer further detail would come back to the Committee.
- 39.2.5 Professor Humphrey asked if trends showed an increase in whistleblowing over the years since monitoring began. Mrs Kelly stated that some months there may be a couple of cases and some months nothing. Mrs Butler added that that in the past it had been difficult to identify whistleblowing due to different routes and how these had been managed.
- 39.2.6 Mrs Mitchell gave feedback from a recent whistleblowing event that she had attended. The event had also been attended by current or previous whistleblowers and there had been discussion on the distinction between whistleblowing and grievance. It was noted that there was a misunderstanding of the whistleblowing champion role. The role was one of governance and scrutiny and the champion was not involved in the actual process. Mrs Kelly added that she would shortly be attending an event for people leading on whistleblowing in Boards. It was also noted that Mrs Mitchell had taken a couple of concluded cases and asked whistleblowers if they would be happy to meet to give feedback on the whole process to help improve in closing the loop of the continuous process.
- 39.2.7 Cllr McGinty asked if there was any further update with the Academy of Royal Colleges Investigation into the St John's Hospital issue. Mrs Butler stated that the report was still awaited and Mr Crombie added there would be a meeting with clinical staff on 16 February. It was noted that the Derek Bell report had been delayed and was also awaited.
- 39.2.8 There was further discussion on encouraging staff to speak up earlier, the limitations around investigations when whistleblowers are anonymous and the number of outcomes which are not upheld or any action taken.
- 39.2.9 The Committee agreed to take 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.**

*The Chair returned to Mrs Mitchell.*

- 39.3 Sickness Absence Update - Ms Gaskell introduced the report providing the Committee with an update on the arrangements in place to assist with the management of short term sickness absence.
- 39.3.1 The performance highlighted in the paper was noted, with running average being around 3.52%. The paper was an update from the report previously received in May 2017.

- 39.3.2 Ms Gaskell stated that over the last three years there had been a slight improvement in the overall absence rate, however short term absence had increased. In particular there was an increase within nursing and midwifery, absences within facilities was reducing. The Committee noted that compared to other health boards long term absence rates were lower and short term were about in line with others.
- 39.3.3 Ms Gaskell reported that since the previous report in May 2017, work on improving dashboard information had continued. Three dashboards had now been developed and two were being well used for easy access to ward and department level data. The financial information dashboard was not being used a lot and it was felt this may be complicated to look at and understand, there would be a view taken at the end of this May as to whether or not to continue with the financial information dashboard.
- 39.3.4 Ms Gaskell also reported on current work on unknown causes and reasons for absence. This was to allow more support around staff health and wellbeing moving forward. The Lothian Partnership Forum had recently considered a health and wellbeing staff engagement paper and it was hoped to use the healthy working lives framework to progress this and to make the information available online.
- 39.3.5 The Chair thanked Ms Gaskell for a clear and comprehensive paper on the raft of activity undertaken. However there remained a concern around providing Board significant assurance on a target which cannot be achieved. Mrs Butler clarified that this was not a target, but a HEAT standard which had never been achieved anywhere in NHS Scotland. NHS Lothian remained consistently below the Scottish average sickness absence rate.
- 39.3.6 The Committee discussed planning of systems, cultural change and health promotion required with an ageing workforce.
- 39.3.7 Mrs Butler stated that this work was the start of a journey which would take time to introduce systems and processes and it was important to be alert to where things were working and how to share these across the organisation.
- 39.3.8 The Committee noted the tools being developed and the work undertaken by the Human Resources and Occupational Health Services to support line managers with absence management, in particular short term absence.
- 39.3.9 The Committee agreed to take significant assurance that systems and processes are in place to assist managers to address short term absence. However only moderate assurance could be taken in relation to assurance to the Board given the non compliance with the HEAT Standard.**
- 39.4 Health and Safety Update – Miss Gillies reported that for the March Staff Governance Committee meeting a written update would be provided showing each considered risk at local level and a summary position. This would allow a more informed view to be provided for appropriate Assurance. The work of the new Health and Safety groups would commence with a focus on violence and aggression as previously covered. It was hoped to get to a place of local ownership for health and safety, with committees feeding in improvement actions locally which could then be collated by the main committee and fed back to Staff Governance Committee.
- 39.5 Mandatory Training Compliance – Healthcare Associated Infection – Ms Guthrie and Ms Langsley gave an update on the current position with mandatory Healthcare Associated Infection (HAI) education.

39.5.1 The Committee noted that the current compliant rate was 70%, however the compliance target was 80%. It had been agreed to progress with a new resource for mandatory compliance which was on track for delivery in March 2018.

39.5.2 It was recognised that the current education provision for mandatory HAI training was not fit for purpose and the NES SIPCEP (Scottish Infection Prevention & Control Education Pathway) modules do not meet NHS Lothian's mandatory requirements. NHS Lothian's Infection Control and Prevention Team have implemented a plan to develop a new video and scenario based learning resource. As an interim measure, the existing NHS Borders module had been adapted to address staff feedback on the assessment which had been felt to be too onerous and in depth.

39.5.3 The Committee noted that Facilities were an outlier at the moment and it was planned to roll out a DVD approach to address this as had been done for other aspects of mandatory compliance.

39.5.4 Ms Fitzgerald stated that having 30% of staff across the Board not complying was an area of great concern and the trends did not seem to be improving.

**39.5.5 The Committee agreed to take a limited level of assurance that management actions will be implemented that will improve both the staff experience of, and compliance with mandatory HAI education. A progress report will be provided to the committee in March 2018.**

39.6 Mandatory Training Compliance – Public Protection – Ms Langsley reported that the current compliance rate was 75.8%, a large part of the low organisational compliance was down to Facilities. This was being addressed with the DVD approach which would be launching shortly. It was hoped to have achieved the 80% compliance target by the end of April 2018.

**39.6.1 The Committee agreed to take a moderate level of assurance that management actions will be implemented that will improve compliance with mandatory Public Protection education. It was noted that a further progress report would be provided to the committee in March 2018.**

## **40. Sustainable Workforce**

40.1 Workforce Report – The Committee noted the updated Workforce Report for January 2018 and the actions being taken to address some of the issues raised in the Report, much of which had already been covered previously in the meeting.

40.2 Workforce Planning and Development Programme Board Update - Mrs Butler introduced the report presenting the NHS Lothian Workforce Plan for 2017-19. The Committee noted that this had been drafted in line with the extant national guidance. Improved guidance was expected in spring and this would include the integrated work and future shape and direction of services. Mrs Butler stated that the intention moving forward would be to have a regional level workforce plan, not Board level. It was noted that there was a requirement to publish the workforce plan online and that the Programme Board would provide updates to the Staff Governance Committee as appropriate.

40.2.1 Mrs Butler added that she was on the regional workforce planning group and the Board had good links with the regional work as she was the Regional Lead for Human Resources and Professor McMahon was the Regional Lead for Nursing.

## **41. Capable Workforce**

41.1 TURAS Appraisal – Mrs Butler reported on the current position with Turas Appraisal transition & implementation.

41.1.1 The Committee noted that all arrangements for transition to TURAS at national and local level were on schedule. There were no anticipated issues with the planned implementation by the 1<sup>st</sup> April 2018.

**41.1.2 The Committee agreed to take a moderate level of assurance that management actions are in place to effectively implement Turas Appraisal in NHS Lothian.**

41.2 Report from the Nursing and Midwifery Council (NMC) Visit to Napier University - Professor McMahon reported that NHS Lothian and Edinburgh Napier University had been privileged to recently host a very positive visit from the NMC. The NMC had met with students at Napier and three service areas from NHS Lothian. The NMC had been interested in hearing about standards of nursing and midwifery, experiences of students and joined up working.

41.2.1 Professor Humphrey added that the NMC as an organisation are located primarily in London and that the governance committee's visit had been the first and only trip to Scotland. The Staff Governance Committee noted that correspondence following the visit had been positive and the Committee praised those involved for their good work.

41.2 Everyone Matters – Working Across Organisational Boundaries - Ms Aitken gave a presentation on the Team Development Toolkit being used by NHS Lothian and the four Health and Social Care Partnerships.

41.2.1 The presentation covered some of the initiatives involved in working across boundaries as well as the modules included within the toolkit:

- Culture, Vision & Values
- Roles & Responsibilities
- Communication & Collaboration
- Change & Transition
- Innovation & Risk taking
- Monitoring progress
- Leadership

41.2.2 Ms Aitken also covered leadership development; staff engagement; HR&OD networks and groups; workforce planning; service development; common skills passport; modern apprenticeships; young person's network and corporate education around regional working.

41.2.3 Miss Gillies added that this work aligned with discussions held at the recent primary care summit on the new GP contract, where the GP is described as a multidisciplinary team leader. Miss Gillies would take this forward with Ms Aitken out with the meeting.

## **42. For Information and Noting**

42.1 The Committee noted the following items:

- Health and Safety Committee Minutes – 28/11/2017
- Lothian Partnership Forum Minutes – 28/11/2017
- Staff Engagement and Experience Project Board Minutes – 02/10/2017
- Workforce Planning and Development Programme Board Minutes – 06/11/2017
- Remuneration Committee Open Minute 12/12/2017

**43. Any Other Business**

43.1 There was no other business

**44. Date of Next Meeting**

44.1 It was noted that the next meeting of the committee would be held on Wednesday 21 March 2018 at 9.30am in meeting rooms 8&9, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

**35. 2018 Meeting Dates**

- 30 May 2018
- 24 July 2018
- 24 October 2018

DRAFT

## FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9:30am on Tuesday 23 January 2018 in Meeting Room 8&9, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

**Present:** Mr M. Hill, Non-Executive Board Member (Chair), Mr P. Murray, Non-Executive Board Member, Cllr R Henderson, Non-Executive Board Member, Mr A. McCann, Non-Executive Board Member, Ms L. Williams, Non-Executive Board Member (teleconference), Mrs S. Goldsmith, Director of Finance and Professor A. McMahon, Executive Director, Nursing, Midwifery & AHPS – Executive Lead REAS & Prison Healthcare.

In Attendance: Mr C. Marriott, Deputy Director of Finance, Ms J. Campbell, Chief Officer, Acute Services, Mr I. Graham, Director of Capital Planning and Projects, Mrs M. Barton, Head of Health, West Lothian CHCP (Item 37.3), Mr G. Curley, Director of Operations – Facilities (Items 36.3 & 37.1), Mr A. Milne, Project Director Hub Major Initiatives – REH (Item 37.5), Professor A. Timoney (Items 36.2 & 37.4), Mr A. Payne, Head of Corporate Governance and Mr C. Graham, Secretariat Manager (Minutes).

Apologies for absence were received from Mr B. Houston, Mr T. Davison, Professor M. White, Professor A. McCallum, Mr J. Crombie, Miss T. Gillies and Ms K. Blair.

*The Chair reported that Ms Blair would be stepping down from the Board for health reasons. The Committee recognised her contribution to the work of the Committee and the Board over the years and wished her well.*

### 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. The Chair mentioned his role on the West Lothian IJB with reference to consideration of the East Calder item at 37.3. The Chair determined that he did not think this caused a conflict and this did not raise cause for concern.*

### 34 Minutes from Previous Meeting (15 November 2017)

34.1 The minutes from the meeting held on 15 November 2017 were approved as a correct record.

### 35 Matters Arising

35.1 Running Action Note – The Committee were content to note the actions being taken and the outcomes at the present time. The action note was agreed.

## 36 Revenue

- 36.1 2017/18 Financial Position and Year-End Forecast - Mr Marriott gave an overview of the financial position at Period 9 and an updated year end forecast. It was noted that this was a positive report with the month 9 results posting a £800k underspend.
- 36.1.1 There was discussion on medical and nurse staffing, the cost of discretionary points, GP prescribing overspend and the improvement with the junior doctors' position was noted. The issue of the balance between the Board and IJBs break even position was also mentioned.
- 36.1.2 Mr Murray asked for further detail around Legacy LRP and what this would mean in practice. Mr Marriott stated that there was an expectation for business units to operate against a break even forecast and delivery of efficiency was part of that. Non delivery of legacy LRP was part of the forecast. Evidence would be looked for of a 3% delivery moving forward and there would be a series of meeting with operational units regarding this. Both legacy LRP and financial recovery plans would be dealt with as one and would be simplified into one target. In future budgets would be fixed and costs managed down to that budget.
- 36.1.3 Mr McCann stated that he was pleased to see the significant assurance recommendation and noted that the savings being achieved was largely down to finance pushing for these. Mrs Goldsmith confirmed that this was the case across the system with financial savings being driven by business partners and the finance department. One of the key components of the quality work was around the delivery of financial stability.
- 36.1.4 Mr McCann added that trimming at individual budgets was not what was needed, there needed to be more of a whole structural change. The Chair pointed out that there had been a lot of work around nursing staffing from a strategic approach. This had been a good model with a mix of strategic and local unit delivery. Professor McMahon confirmed that this model had been effective to date however it did not take away responsibility and ownership at a local level.
- 36.1.5 The Committee noted the year-to-date financial position at Period 9 showing an overspend of £4.95M, with an in-month underspend for December of £814k and accepted the significant assurance provided for the achievement of financial balance by the yearend.**
- 36.2 Prescribing Quality and Efficiency Programme - Professor Timoney reported on the work underway to formalise a systematic programme of work regarding the quality and efficiency of prescribing in NHS Lothian.
- 36.2.1 The Chair stated that this was an important paper and it was reassuring to know that appropriate arrangements would be in place along with the proper scrutiny.
- 36.2.2 Mr Murray asked if this area of work would be part of the regional working approach. Professor Timoney confirmed that there had been frustrations trying to undertake this work at national level however it remained on the agenda for the East coast Directors of Pharmacy meetings and there was still work to do in order to receive true clinical

engagement. There was also a need to improve the completeness and accuracy of data being obtained.

**36.2.3 The Committee agreed to endorse the proposed approach to develop a Prescribing Quality and Efficiency Programme and agreed that the additional staff support as requested to support this.**

36.3 Review of the “Facilities Fit for Purpose” Risk - Mr Curley reported that the paper provided assurance around the management of the backlog maintenance process.

36.3.1 There was discussion around risk 3189 on the corporate risk register, whole investment framework capability, the ability to meet the Scottish Government requirement to remove backlog maintenance by 2020 and additional investment for backlog maintenance.

36.3.2 There were two typographical errors noted in the risk 3189 entry which would be corrected for the Corporate Risk Register paper which is submitted to the Board. These were the reference to Finance and Review instead of Finance and Resources and a misspelling of ‘situation’.

**36.3.3 The Committee felt this was a well explained paper and agreed to note content paper and accepted the recommendations. The significant assurance that the entry on the Corporate Risk Register for risk 3189 is up-to-date was accepted as was the moderate assurance of an adequate improvement plan being in place to manage risk 3189.**

36.4 2018/19 Financial Outlook - Mrs Goldsmith introduced the report providing an update on the draft Financial Outlook for 2018/19 and a summary for the next five years.

36.4.1 The Committee noted that the report covered the issues which need to be considered to achieve financial sustainability in the next financial year and beyond. Mrs Goldsmith described the development of the financial strategy; the ongoing work around quality and what shifting the balance would look like along with one off allocations and primary care allocations and what these would look like when mapped out for Lothian. It was noted that the paper did not cover any scenario planning which would be required as part of the LDP. Mrs Goldsmith stated that the Scottish Government had requested that some modelling around activity and cost be undertaken.

36.4.2 There was discussion on cost pressures, nonrecurring funding costs, potential funding and new expenditure for 2018/19, including pay uplift which could be an average of 2.8% across the system. It was noted that clarity on what was happening with doctors was still required.

36.4.3 The Chair thanked Mrs Goldsmith for the update and there was further discussion around financial assumptions and the TTG position in line with Scottish Government expectations and what it would take to achieve better than that expectation. Ms Campbell stated that work on a costed proposal to get to a balanced position had been undertaken within endoscopy. It was acknowledged that the acute areas were volatile and development of the workforce profile was key. The Committee felt it was important to consider these assumptions further. Mrs Goldsmith stated that a further report would



come back to the Committee in March; however in the meantime there was work for the Strategic Planning Committee to consider.

36.4.4 Ms Campbell added that there needed to be a whole system approach to this work, not just acute. This was part of wider community provision. It was noted that the non recurring element would grow next year and this provided less flexibility to manage any gap.

**36.4.5 The Committee recognised that this work is focussing largely on the next financial year, developing a model to take forward over the next 5 years. The Committee would like to see more around assumptions and scenarios that this should lead towards with the assistance of the Strategic Planning Committee and this should come back to the next Finance and Resources meeting.**

**36.4.6 The Committee agreed to accept the recommendations, endorsing the proposals in relation to the application of resources whilst acknowledging that based on information currently available no assurance could be given at this stage of the delivery of a balanced financial position in 2018/19. The Committee noted that a further report would be come back to the March meeting and a report would also be taken to the February Strategic Planning Committee.**

## **37 Capital**

37.1 St John's Hospital Boiler Case Replacement Full Business Case - Mr Curley gave a brief overview of the business case which was with the Committee for endorsement ahead of going for full Board approval. It was noted that LCIG had agreed the business case at its last meeting with a view to a contract being awarded in March 2018.

37.1.1 There was discussion on the robustness of the procurement process, resilience, reduction of backlog maintenance, anticipated savings and efficiencies, insurance liability, carbon footprint reduction, laundry impact and the future development of the Western General Hospital using a similar approach.

**37.1.2 The Committee were content to recommend the Full Business Case to the Board for full approval. The Board would then be able to submit the Business Case to the Scottish Government with confirmation of its support.**

37.2 Property Transactions Programme 2016-2018: Estates Rationalisation Mrs Goldsmith updated Committee Members on the specific actions taken to rationalise NHS Lothian's estate during 2017/18 in support of the Board's Asset Management Strategy.

37.2.1 Mrs Goldsmith reported that there was a lot of activity currently taking place. It was noted that Bangour Village Hospital had now been sold and missives concluded. There were some difficulties with the sale of the Edenhall site given location and difficulties with the sale of Springwell House which would be escalated with Edinburgh IJB. It was also noted that the lease for Pentland House had now ended.

**37.2.2 The Committee accepted the proposed significant assurance level confirming that this aspect of the Board's property portfolio is being appropriately progressed and managed, in accordance with the Board's five year property**

**rationalisation programme as described in the Property Asset Management Strategy (PAMS) 2017, and is aligned to the clinical plan.**

37.3 Strategic Assessment and Initial Agreement for the East Calder Health Centre - The Committee reviewed the Strategic Assessment and Initial Agreement for the East Calder Health Centre and agreed:

- To note that the West Lothian IJB approved the priority for development of new health centre premises in East Calder to increase physical capacity for primary care and community service provision on 14<sup>th</sup> March 2017 and subsequently approved this Initial Agreement on 26<sup>th</sup> September 2017.
- To note the priority for investment supports the HSCP /IJB Primary Care Improvement Plan and takes account of need to sustain general practice and addresses the significant planned population growth and the need to provide fit for purpose premises for the provision of primary medical services.
- To note that LCIG reviewed the Strategic Assessment and Initial Agreement on 13 December 2017, and supported it being referred to the Finance & Resources Committee. LCIG requested that additional information in relation to resources, prioritisation and governance be incorporated into the Initial Agreement, and this has been done.
- To recommend the Strategic Assessment and Initial Agreement to the Board for its review and approval, so that the Board may thereafter submit the case to the Scottish Government with confirmation of its support, as the capital cost for the preferred option is above the NHS Lothian delegated limit of £5m.

37.4 Strategic Assessment and Initial Agreement Hospital Electronic Prescribing and Medicines Administration - Professor Timoney reported that the Scottish Government had agreed to implement HEPMA for Boards across Scotland. It was noted that three boards had already implemented this. The automatic electronic system would mean a transformational change for NHS Lothian and there were challenges around putting this in place. The system would take 2 years to fully implement.

37.4.1 There was discussion around procurement and a regional approach. It was noted that Lothian would be sharing both teams and learning with NHS Borders and NHS Fife.

37.4.2 The Committee noted frustration at the difficulties around development of a regional approach and suggested that the development of the Outline Business Case (OBC) should reflect as much commonality at the regional level as possible given forward patient flow.

**37.4.3 The Committee agreed to support the proposed timescales for development of an OBC and recommended that the Strategic Assessment and Initial Agreement now be submitted to the Board for its review and approval, so that the Board may then submit the case to the Scottish Government with confirmation of its support. It was noted that the capital cost for the preferred option was above the NHS Lothian delegated limit of £2m for IM&T schemes.**

- 37.5 Royal Edinburgh Hospital – Phase 2 and 3 Update - Professor McMahon and Mr Milne updated the Committee on the current status of Phase 2 and Phase 3 of the Royal Edinburgh Campus Masterplan development, the work required to inform an Outline Business Case (OBC) and the proposed timescales.
- 37.5.1 Professor McMahon reported that there had been a lot of work recently around the rehabilitation elements at Astley Ainslie Hospital and Learning Disabilities beds. There was further discussion to be had around secure and complex care needs. There was a proposal to rephase Phase 2 of the project.
- 37.5.2 The Committee noted the tabled diagrams of what the proposed re-phasing would mean in terms of the development. There was discussion on the impact rephrasing would have for the Astley Ainslie Hospital site. The Chair confirmed that by using the Jardine Clinic this would allow a complete move off the Liberton site for disposal and the Astley Ainslie Hospital work would now happen in Phase 3 in 2024.
- 37.5.3 The Committee noted the development of the clinical modelling for Integrated Rehabilitation Services and outpatient functions and that this would be delivered as a separate business case in Phase 3 of the development.
- 37.5.4 The Committee accepted the proposed significant assurance level and agreed the project phasing should be adjusted to deliver Facilities Management, Grade 6 Mental Health and Learning Disabilities as the next phase of development of the Royal Edinburgh campus (Phase 2).**
- 37.5.5 The Committee also agreed to the preparation of a business case to test the use of the Jardine Clinic for Liberton decant allowing 60 patients to transfer to the REH site and facilitate the closure of the Liberton Hospital site in 2018.**
- 37.6 Property and Asset Management Investment Programme - Mr I Graham reported on the current status of the Property and Asset Management Investment Programme. There was discussion on the business case for the new Edinburgh Cancer Centre and the prioritisation and levels of reporting for assurance purposes required against individual projects or programmes. Mr I Graham also gave the following updates:
- RHSC and DCN - Currently discussing with independent tester outcome of review of all independent reports received.
  - Primary Care Estate – Work on risks and impact ongoing following BMA vote. GMS Contract implications awaited.
  - PAEP – Ms Campbell reported that at LCIG in December the PAEP re-provision and design had been presented. There had been discussion and questions on why PAEP will not be regional. There remained an issue to resolve between Lothian ophthalmic activity and the Golden Jubilee. This would be considered again by LCIG at their next meeting.
  - Carillion Construction Company – Mr I Graham confirmed that NHS Lothian had no contractual arrangements with this company.
- 37.6.1 The Committee accepted the proposed moderate assurance level of programme delivery in year whilst noting the progress made against the agreed 2017/18 investment programme.**

**38 Any Other Competent Business**

38.1 Meeting Arrangements - Mr McCann suggested that better use of videoconference technology could be made to save those providing short updates to the Committee having to travel or wait.

**39 Date of Next Meeting**

39.1 The next meeting of the Finance and Resources Committee would take place at 9.30 on **Wednesday 21 March 2018** in Meeting Room 8&9, Fifth Floor, Waverley Gate.

**39.2 2018 meeting dates:**

23 May 2018

19 September 2018

25 July 2018

21 November 2018

## **DRAFT**

### **FINANCE AND RESOURCES COMMITTEE**

#### **EXTRAORDINARY MEETING**

Minutes of the Extraordinary meeting of the Finance and Resources Committee held at 1:00pm on Wednesday 7 March 2018 in Meeting Room 2.2, Edinburgh Training and Conference Venue, 16 St Mary's Street, Edinburgh EH1 1SU.

**Present:** Mr M. Hill, Non-Executive Board Member (Chair), Mr T. Davison, Chief Executive, Mr P. Murray, Non-Executive Board Member, Cllr R Henderson, Non-Executive Board Member, Mr A. McCann, Non-Executive Board Member, Ms L. Williams, Non-Executive Board Member (teleconference), Mrs S. Goldsmith, Director of Finance Professor A. McMahon, Executive Nurse Director, Mr J.Crombie, Deputy Chief Executive, Miss T. Gillies, Executive Medical Director and Ms J. Campbell, Chief Officer, Acute Hospital Services.

**In Attendance:** Ms J. McKay, Partner MacRoberts LLP, Mr I. Graham, Director of Capital Planning and Projects, Mr B. Currie, Project Director - RHSC / DCN and Mr C. Graham, Secretariat Manager (Minutes).

#### **Introduction**

The Chair explained that this extraordinary meeting had been called to discuss a single item agenda relating to the current issues relating to the new RHSC/DCN Build.

#### **40 RHSC/DCN Commercial Issues**

The Committee discussed the paper setting out the current position on negotiations with Multiplex, facilitated by Board members of IHSL (the Special Purpose Vehicle), and the options available to the Board to resolve the residual key issue of ventilation. The Board's legal advisers, Macroberts, were in attendance and a briefing note had been provided to assist in the facilitation of the discussion.

The Committee agreed to the recommendations as outlined, namely:-

- NHS Lothian to write to IHSL providing them with a copy of NHS Lothian's QC's Opinion and asking them to confirm their own position within 7 days and warning them that Court action will be pursued against them if they fail to do so.
- NHS Lothian to raise a Court action to force IHSL to design the ventilation to achieve balanced / negative pressure relative to the adjacent corridor in the relevant 20 multi-bedrooms in accordance with their contractual obligations.
- To ensure compliance with the existing contractual arrangements, NHS Lothian to seek an order from the Court that a ventilation design that achieves balanced / negative pressure relative to the adjacent corridor is submitted for review by IHSL / Multiplex pursuant to the review procedure in the Project Agreement within 15 days.
- Once the design is produced by IHSL / Multiplex pursuant to the Court order it is reviewed by NHS Lothian pursuant to the contractual arrangements.
- Once the design has been reviewed, IHSL (and Multiplex) will be obliged pursuant to the Project Agreement to construct that design. If they refuse to do so NHS Lothian could return to Court for an order to force them to do so.

The Committee also agreed the following:

- That NHS Lothian's decision should not be currently shared until in possession of the view from the Scottish Government.
- There should now be the development of an urgent communications strategy to ensure the public are kept informed around NHS Lothian's position.
- In terms of Governance, the Board would be kept informed at the April Board meeting where this item would be discussed under matters arising in private session.

#### **41 Date of Next Meeting**

41.1 The next meeting of the Finance and Resources Committee would take place at 9.30 on **Wednesday 21 March 2018** in Meeting Room 8&9, Fifth Floor, Waverley Gate.

#### **42 2018 meeting dates:**

23 May 2018

19 September 2018

25 July 2018

21 November 2018

## **DRAFT**

### **FINANCE AND RESOURCES COMMITTEE**

Minutes of the meeting of the Finance and Resources Committee held at 9:30am on Wednesday 21 March 2018 in Meeting Room 8&9, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

**Present:** Mr M. Hill, Non-Executive Board Member (Chair), Mr A. McCann, Non-Executive Board Member, Cllr R. Henderson, Non-Executive Board Member, Mr B. McQueen, Non-Executive Board Member, Ms L. Williams, Non-Executive Board Member (teleconference) and Mrs S. Goldsmith, Director of Finance.

**In Attendance:** Mr J. Crombie, Deputy Chief Executive (Item 48.1), Mr G. Curley, Director of Operations Facilities (Item 48.1), Mr D. Hill, Product Specialist, Decontamination (Item 48.1), Mr I. Graham, Director of Capital Planning and Projects, Mr A. McCreadie, Head Of Management Accounts, Mr C. Stirling, Hospital Director, WGH, Mr A. Payne, Head of Corporate Governance and Mr C. Graham, Secretariat Manager (Minutes).

Apologies for absence were received from Mr B. Houston, Mr T. Davison, Mr P. Murray, Professor M. Whyte, Professor A. McCallum, Mr David Small, Ms J. Campbell, Miss T. Gillies and Professor A. McMahon

#### **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. No declarations were made.*

#### **43 Minutes from Previous Meeting (23 January 2018)**

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

#### **44 Minutes from Extraordinary Meeting (7 March 2018)**

44.1 The minutes from the extraordinary meeting held on 7 March 2018 were approved as a correct record.

#### **45 Committee Business**

45.1 Running Action Note – The Committee were content to note the actions being taken and the outcomes at the present time. The action note was agreed.

45.1.1 Royal Edinburgh Hospital – Cllr Henderson reported that the action in relation to Headway's future premises on the campus could now be closed as Headway had now secured alternative premises in the Craigmillar area of Edinburgh and would move there in July or August.

45.2 Results from the Members Survey – The Chair introduced the report providing feedback from the recent member survey. There was discussion on the range of responses and the relevance of the responses given the current turnover of the Committee

membership. The Committee noted that City of Edinburgh Council had also decided to replace Cllr Henderson on the Board with a SNP group colleague. Cllr Henderson would continue on the Board until the administration process was complete.

45.2.1 There was discussion on skills development for members and the need for more formal NHS specific finance training sessions. These sessions could be recorded and then shared and used on demand. The Chair added that there was a good case for NHS generic finance training as well as training tailored to a member's role on the F&R Committee.

45.2.2 Ms Williams suggested that timing of training could also be considered to give members time to absorb information and know what to ask. This would mean saving some training and not giving it all at once upfront.

45.2.3 Mr Payne stated that in terms of skills gap, once members clarified exactly what was being looked for then he could take this forward with finance colleagues and consider if training could be done in-house, nationally or both.

45.2.4 The Committee discussed the type of training needed to help members properly consider the papers and cases that are presented to F&R and how to ensure these fit in with the overall strategic aims of the organisation.

45.2.5 Mrs Goldsmith stated that our current focus was to progress Our Health, Our Care, Our Future strategic plan. However, most of the Board Members originally involved with this strategy had now left and current Board Members may not be as familiar with the strategy.

45.2.6 The Chair pointed out that there was a range of issues which need addressed and that he would be keen to have something coming back to the Committee fairly soon. Mr Payne would take this away for consideration. There may need to be a more detailed survey circulated on the issues members wish addressed. Mr McCann and Mr McQueen agreed to work with Mr Payne on ideas around appropriate members' development.

45.2.7 The Chair suggested a session following the next Committee meeting to start the process of addressing these issues and look to having the beginnings of a development session.

**45.2.8 The Committee agreed the following further actions:**

- **Mr Payne to resend the original members survey to Ms Williams for her additional reflections. Mr Payne also to consider if a second more detailed survey would be required.**
- **Mr Payne to take this away for consideration and work with Mr McCann and Mr McQueen on ideas around appropriate members' development.**
- **There would be a session at the end of the next Committee meeting to start the process of addressing some of these issues and look to having the beginnings of a development session.**

**AP/AMcC/BMcQ**



45.3 Lothian Capital Investment Group (LCIG) Terms of Reference - Mrs Goldsmith reported that the terms of reference of the Lothian Capital Investment Group had been reviewed in the light of recent developments, including increasing emphasis on regional activity and the establishment of the permanent Property and Asset Management Strategy Working Group.

45.3.1 LCIG had considered the terms of reference in January 2018 and the terms of reference had been further developed following discussion and advice from Mr Payne. The terms of reference were then supported by the Corporate Management Team on 12 March 2018.

**45.3.2 The Committee approved the terms of reference subject to the removal of people's names under the membership section.**

**45.3.3 The Committee requested that consideration be given to whether the level of delegated authority to LCIG (£0.5m per Section 2 of the Scheme of Delegation) is still appropriate as it had been at that level for many years. The Committee was also interested in whether this was comparable to other Boards. Mr Payne agreed to take this forward with finance colleagues.**

**AP**

#### **46 Report on the Royal Hospital for Children and Young People/Department of Clinical Neurosciences**

46.1 The Committee discussed the tabled paper. Mrs Goldsmith reminded the Committee of the actions agreed at the meeting on 7 March and gave an update on developments since the Extraordinary F&R Committee meeting held on 7 March 2018:

- The Committee previously approved the recommendation by The Director of Finance to raise a court action seeking an interim order to force IHS Lothian Ltd to design and install a compliant ventilation system to twenty number four bedded rooms with an air change rate of 6 ac/hour.
- A letter was issued to IHS Lothian Ltd from the Deputy Chief Executive on 13<sup>th</sup> March, 2018 requesting that IHS Lothian Ltd set out their position. If no response was received by Monday, 19<sup>th</sup> March, 2018 the Board would assume IHS Lothian Ltd share Multiplex's view and dispute the Board's position.
- IHS Lothian Ltd responded on the 19<sup>th</sup> March confirming that they agree with the position outlined in an accompanying letter from Multiplex and that Multiplex would defend the proceedings referred to in the Board's letter of 13<sup>th</sup> March in the name of Project Co [IHS Lothian Ltd].
- The Board have again written to IHS Lothian Ltd [Deputy Chief Executive's letter of 20<sup>th</sup> March, 2018] advising them that in the absence of any constructive and substantive response from IHS Lothian Ltd by 10am on Thursday 22 March the Board will instruct their solicitors to lodge the Summons with the Court.
- The Board have yet to receive any revised programme to completion and remain concerned as regards quality, workmanship and general lack of progress in relation to witnessing, testing and commissioning of MEP [Mechanical, Electrical and Plumbing] infrastructure in particular.

- 46.2 The Committee noted the Cabinet Secretary's scrutiny of NHS Lothian's approach and intention to complete the interim order; however the Committee felt this approach was necessary, proportionate and showed NHS Lothian's seriousness of intent.
- 46.3 Mrs Williams asked if there had been follow up work with other hospitals using the same technical specification to see what their contracts may state. Mr I Graham stated some technical verification and specifications had been received but no contract wording. It was noted that both Glasgow and Birmingham had endorsed NHS Lothian's use of their information.
- 46.4 The Chair thanked Mrs Goldsmith for briefing the Committee on the situation. The Committee noted with concern the situation as it was at the moment. It was noted that court action for an interim order in relation to Four Bedded Room Ventilation, if served, would be done on Monday 26th March and that there would be a robust communications strategy around this. In the meantime the Cabinet Secretary's concerns would be clarified and a response from IHSL in relation to mediated discussion remained awaited. The Committee acknowledged the Chief Executive's awareness of the current situation.**

SG

## **47 Revenue**

- 47.1 Public Sector Reform Act (Scotland) 2010 Disclosures – The Committee received the report outlining the proposed disclosures on the NHS Lothian website in relation to the Public Sector Reform Act. Mrs Goldsmith reported that the Board had an obligation to disclose this information and publish it on the website. It was noted that the information set out key areas of expenditure.
- 47.1.1 There was discussion on whether information could be published sooner as the information being disclosed related to 2016/17. The Committee also discussed the necessity for a communications strategy given the potentially sensitive nature of some of the information.
- 47.1.2 Mr McCann requested that consideration be given to changing the format of how the information around Public Relations spend was presented at the foot of page 2, under Section 31 Disclosures and if the 4 hour reference should be removed from page 7, given recently well publicised concerns around performance. Mr McCann also asked that the word 'staff' be inserted in the reference to high vacancy rate at the bottom of page 6.
- 47.1.3 The Committee agreed to endorse the proposed publication of the disclosure report on the NHS Lothian website subject to the minor amendments as outlined.**
- 47.2 2017/18 Financial Position and Year End Forecast - Mr McCreadie gave the Committee an overview of the financial position at Period 11 and an updated year end forecast. It was noted that this was part of the routine reporting of the out turn position for NHS Lothian and implications for IJBs performance as well as the year end forecast.

- 47.2.1 Mr McCreadie reported that up to January 2018 only limited assurance of achieving financial balance could be advised. This advice had been upgraded to a significant assurance position moving on from January. The month 11 position showed no issues likely to impact on the significant assurance provided to achieving year end financial balance.
- 47.2.2 There was discussion on potential areas of overspend including GP prescribing, legacy LRP and efficiencies. The Committee also discussed assumptions made on Scottish Government allocation levels through the year. Mr McCreadie outlined that there was ongoing dialogue through the year with the Scottish Government and this was a feature of the mechanism which NHS Lothian operates.
- 47.2.3 The Committee accepted the proposed significant assurance on the achievement of financial balance by the year end and approved the additional allocation of £7.599m to the IJB's to enable them to achieve a break even position against the health component of their budget.**
- 47.3 NHS Lothian Financial Strategy - The Committee received the report discussing the development of a strategic and tactical approach towards long-term financial sustainability. The Committee noted that a 'do nothing' approach would see the financial gap reaching £130m. This figure was consistent with work done on the national financial framework and regional level and was predicated on an assessment of future growth. The Chair made the point that the 'do nothing' approach would still require achievement of the savings programme. Mr McCreadie added that no additional savings assumptions had been made in this scenario and only known factors were accounted for.
- 47.3.1 It was recognised that a gap of 4-6% per year was too large to deal with using only programmes to deliver improvement. There needed to be transformational change at regional level and with IJBs. There were also difficult choices to be made at government level.
- 47.3.2 The paper represented a start to thinking about how we deliver NHS Lothian's part of the agenda in the crowded landscape and set out developmental thinking with a need for further discussion at Corporate Management Team level. There needs to be a mechanism to identify opportunities which support delivery of these, whilst providing the Finance and Resources Committee with the appropriate assurances.
- 47.3.3 The Chair asked members for views on the framework approach to dealing strategically with the financial situation moving forward over 5 years, using complex national and regional work with accountability also woven in through the IJBs and Government.
- 47.3.4 Mr McQueen stated that it was useful to raise Board Members' and Stakeholders' awareness of inevitable problems with a declining resource base. The process of thinking about different component parts was a useful discipline for leaders to see the complexities involved. It was also helpful to link the work to that of the region and produce a similar framework, looking further ahead than 5 years.
- 47.3.5 Mr McQueen added that in terms of establishment of a programme management office it was important to have the right skills and consistency of programme management and therefore having teams experienced in this work from the outset was crucial.

47.3.6 The Chair asked Mr Stirling for his views on service level programme management. Mr Stirling stated that there was a challenge at the moment to carve out time for meetings for this work. The Chair added that such a programme could not be delivered simply by relying on operational management and that time to do work and interface with change programmes was important.

**47.3.7 The Committee recognised this should be a standing agenda item and agreed to accept the Limited Assurance, requesting a further developed strategy comes back to the next meeting. This should explore the facilitation of ideas from a bottom up approach and consideration to look beyond 5 years. The Committee would also find some sort of 'Map' to navigate the cluttered landscape helpful.**

**SG**

47.4 Annual Operational Financial Plan - Mr McCreadie gave an update on the Annual Operational Financial Plan for 2018/19. This was a follow up paper to the one the Committee received at its January meeting.

47.4.1 The paper set out some of the core cost pressures and showed some in year flexibility and uplift following discussion with the Scottish Government. It was noted that for the third year in a row there remained a financial gap. There was discussion on a number of the key issues highlighted in the report including the City of Edinburgh Council care gap, anticipated additional costs of fully funded NHS pay awards and drug costs estimates.

47.4.2 Mr McCann asked about the ability to extract savings from the system and what would happen with the financial planning if this were to run out. Mr McCreadie stated that the challenge was becoming greater and that it would not be unreasonable to look at some non recurring financial strategy work alongside transformational change.

47.4.3 There was also discussion on bringing the operational plan back into balance and the challenge around unscheduled care and delayed discharges, particularly within City of Edinburgh. It was noted that the additional £4m to support social care in Edinburgh had been agreed in principle however this relied on visibility of a planned improvement in performance. Cllr Henderson confirmed this position and added that there remained ongoing issues around homecare.

**47.4.4 The Committee acknowledged that, based on information currently available, only limited assurance on the ability to deliver a balanced financial position in 2018/19 could be taken. The Committee also endorsed that the Annual Operating Financial Plan for 2018/19 be presented to the Board for approval and submission to the Scottish Government. The need for consideration of the impact of the financial position on the Board's wider performance responsibilities was also recognised.**

47.5 Payment Verification in Primary Care Financial Year 2016/17 – Mr McCreadie reported that review of the paper related to a core part of the Committee’s duties.

**47.5.1 The Committee agreed the significant assurance level requested and accepted that the report confirmed that payments made to family health services practitioners were appropriate as follows:**

- **General Medical Practitioners**  
Quarters ending 30 September 2016, 31 December 2016 and 31 March 2017
- **General Dental Practitioners**  
Quarters ending 30 September 2016, 31 December 2016 and 31 March 2017
- **Community Pharmacists**  
Quarters ending 30 June 2016, 30 September 2016, 31 December 2016 and 31 March 2017
- **Optometrists**  
Quarters ending 30 September 2016, 31 December 2016 and 31 March 2017

47.6 Review of the System of Charging Overseas Patients - Mr McCreadie provided the Committee with an overview and assurance of the systems in place for the charging of overseas patients.

**47.6.1 The Committee accepted the proposed significant assurance that based on the current systems in place the Scottish Government guidelines are being implemented in full.**

## **48 Capital**

48.1 Initial Agreement for the Tracking and Traceability of Re-Usable Medical Equipment – Mr Crombie introduced the paper requesting approval for progression to a full business case and the appointment of a preferred bidder for a tracking and traceability system for reusable medical devices. This will provide a Radio-frequency identification (*RFID*) tracking infrastructure that can be used for other categories of equipment and has the potential to integrate with theatre planning and delivery.

48.1.1 Mr Crombie explained to the Committee that this issue had been subject to review by a number of fora across NHS Lothian over the last 3 or 4 years. The procurement exercise around this had been a complex one. The Initial Agreement sets out what is to be achieved and the product to be delivered. The Lothian Capital Investment Group (LCIG) had agreed capital to take forward, however the quantum of costs means that the Finance and Resources Committee needs to approve this to provide the appropriate governance and oversight.

48.1.2 Mr Crombie added that a number of organisational stakeholders had been engaged with this process which was being driven by Facilities. Support had also been received from the Service Director DATCC and Acute Division Senior Management Team.

48.1.3 The Chair asked about how realisable savings were likely to be as result of this. Mr Crombie stated that the true impact was unknown, estimated numbers had been derived using a number of manual exercises and corporate risk were aware of this.

48.1.4 The Committee considered the RFID technology and how much infrastructure this project would establish to allow subsequent projects to progress. It was noted that there was already medical physics engagement and pumps and other equipment could adopt the same approach to tracking. Mr Curley added that a prerequisite of the procurement process for the system had been the ability to interface with a number of other systems within NHS Lothian. Moving forward there would be pilots set up in other areas to get further data to assist embedding of other systems.

**48.1.5 The Committee discussed proof of concept and transfer of risk. It was agreed that the onus to provide proof of concept should sit with the supplier as a mandatory requirement. Currently if the concept was proved not to work at this stage, this could affect the Board contractually. The cost and risk should be with the supplier as they were likely to get further business down the line from the other Health Boards, if the system worked. Mr Crombie agreed to explore this further and would then confirm this in the Business Case.**

JC

48.1.6 There was also discussion on the tendering exercise and whether there only being 1 compliant bid told anything of the specification being sought and the confidence around this. Mr Curley stated that the tendering process had shown that there had been a difficulty in understanding the scope involved. It had been the intention to look at this work on the national level for all health boards however the appetite from national procurement to take this forward had not been forthcoming.

48.1.7 Whilst the proposed system had not been seen in a similar specification in a similar environment it had undergone a rigorous testing process and was installed by the Belgian vendor Aaxis, in many European hospitals. Mr McQueen asked if it would not be expected to see the system in operation on sites or to have robust references from sites using it. Mr Curley stated that today was about progression to full OBC. The Chair suggested that time could be saved by checking these things upfront.

**48.1.8 The Committee endorsed the Initial Agreement and Strategic Assessment and agreed that this should now progress to a full business case to be presented to the Committee in June 2018. This was subject to the caveat around proof of concept.**

48.2 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).

48.2.1 Mr I Graham stated that the process of updating how the information was presented to the Committee remained ongoing and would be implemented for the report to the May meeting.

48.2.2 The Committee noted the prioritisation list in the paper and also work that had been undertaken with the Lothian Capital Investment Group including the St John's Hospital Boiler Business Case. It was noted that the Royal Edinburgh Hospital would be the next big Business Case coming through to the Committee; this was with the IJBs at the moment. It was also noted that the risk assessment work around the code of practice was taking significant effort.

48.2.3 Mr I Graham reported that the East Lothian Community Hospital had been completed on 23 February and that the First Minister had visited that morning. However the Pennywell and Blackburn openings were still awaited. Disposals of Corstorphine, Edenhall, Hopetoun Haddington and RHSC were all progressing and planning around Liberton was ongoing.

48.2.4 Mr I Graham also reported that the Princess Alexandra Eye Pavilion was now considering supply chain partners and there were five interested investors. There had been a recent visit to the current eye pavilion which had helped the design team get an understanding of how the building needs to work. There was also discussion on delegated limits (£2.5m and £5m) and when these had last been reviewed.

48.2.5 The Chair informed the Committee that in the Board Chairman's absence he had attended the Edinburgh Partnership Board. What had come to light was the amount of assets and estate that all the various partners have. The Chair asked if there was a known formal process for disposals or if there was any dynamic work to compare notes on estates and look for opportunities. Mrs Goldsmith confirmed that there was ongoing work as part of the land proposition for Edinburgh. This would take a strategic view of the city and assets to help planning for public services. This would come back to the Committee in due course. It would also be hoped to roll this out for the rest of the Lothians.

**48.2.6 The Committee agreed to accept moderate assurance of the programme delivery in year.**

## **49 Any Other Competent Business**

### **49.1 Valedictory Comments**

49.1.1 The Chair advised that this would be Ms L Williams last meeting as she had stood down with effect from the end of March 2018 as her family were relocating out with the Lothian area. The Chair thanked Ms Williams for her contribution to the work of the Committee and also for her input into the work of the West Lothian IJB. The Committee wished Ms Williams all the best for the future.

## **50 Date of Next Meetings**

- 23 May 2018
- 25 July 2018
- 19 September 2018
- 21 November 2018

**AUDIT AND RISK COMMITTEE**

**Minutes of the Audit and Risk Committee Meeting held at 9.00 am on Monday, 26 February 2018 in Meeting Rooms 8&9, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.**

**Present:**

Mr M Ash (MA) (Chair), Non-Executive Board Member; Cllr J McGinty (JMcG) Non-Executive Board Member; Ms C. Hirst (CH), Non-Executive Board Member; Mr P. Murray (PM), Non-Executive Board Member and Mr M. Connor (MC) Non-Executive Board Member.

**In Attendance:**

Ms S Gibbs (SGi), Quality & Safety Assurance Lead; Ms J Brown (JBr), Chief Internal Auditor; Mr D Eardley (DE), Scott Moncrieff; Ms S. Goldsmith (SG), Director of Finance; Ms J Campbell, Chief Officer Acute Services; Mr C. Marriott (CM), Deputy Director of Finance; Mr J. Old (JO), Financial Controller; Dr S. Watson (SW), Chief Quality Officer and Mr C. Graham (CG), Secretariat Manager.

**Apologies:**

Mr T. Davison, Chief Executive; Mr J. Crombie, Deputy Chief Executive; Mr B. Houston, Board Chairman; Ms J. Bennett, Associate Director for Quality Improvement and Safety; Mr A. Payne, Head of Corporate Governance; Ms D Howard, Head of Financial Control; Mr C Brown, Scott Moncrieff and Professor A. McMahon, Executive Nurse Director.

*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. Nobody declared an interest.*

**34. Minutes of the Previous Meeting held on 4 December 2017**

34.1 The minutes of the meeting held on 4 December 2017 were accepted as an accurate record of the meeting.

**35. Running Action Note**

35.1 Performance against Risk Tolerance Measures – The Committee noted that this action was now complete. The Committee had held a risk workshop on 30 November 2017. The outcome from this workshop will inform a Board development session in 2018.

35.2 Comparison of the NHS Lothian risk register with that of other Boards - An update has been included in the Corporate Risk Register report (Item ??).

35.3 Acute Hospitals Committee Annual Report - Feedback/comment awaited from Acute Hospitals Committee

35.4 Quality of Communication – The Committee noted that the draft Internal Audit Plan for 2018/19 (Item ??) includes an audit on Complaints & Feedback which will attend to this point.



35.5 NHS Lothian's response to the CFS Presentation and recommendations - Mrs Goldsmith reported that this action was not part of the audit plan and that as an interim measure she was in discussions with Mr Old about undertaking a series of workshops as engagement across the system. Mr Old added that it was a case of identifying areas to target then set up the sessions.

35.5.1 The Committee accepted the verbal update and confirmed there was no need for a written report on this action next time. An assurance report would come to the Committee in due course.

35.6 Review of Board Standing Orders - The Chairman reported that the Head of Corporate Governance was working on a new version. The new version would come to the April Committee meeting and would be circulated to members ahead of this for advance input. Following this the revised standing orders would then go to the June Board meeting.

35.7 "Timely Discharge of Inpatients" (Risk ID 3726) - Mr Murray reported that a meeting to solely look at the effectiveness and efficiencies of hospital at home and acute had now been arranged.

## **36. Risk Management (Assurance)**

36.1 NHS Lothian Corporate Risk Register - Ms Gibbs covered the report setting out NHS Lothian's Corporate Risk Register for assurance.

36.1.1 Ms Gibbs reported that there was still work to do to complete the violence and aggression section. All risks were being reviewed and controls tightened up. The Committee noted that the HAI risks had reduced to medium assurance level.

36.1.2 The Committee noted that there would be a Board Development Session in May looking at risk management, building on the session held before Christmas. This risk appetite would also be revisited in May.

36.1.3 There was discussion on risk across NHS Lothian and the IJBs. It was noted that there had been a meeting in October 2017 to look at relationships, connections and synergies. It was recognised that there should be a more coordinated approach to mitigation of risk across the IJBs and NHS Lothian and it was important to get IJB/HSCPs and internal audit input into the May workshop. Mr Murray suggested that it may be useful to have the IJB Audit Committee Chairs attending along with the partnership directors to get as wide a view as possible.

36.1.4 The Chair suggested that some preliminary work could be undertaken around overlap with the IJB risk registers ahead of the May session. Ms Gibbs would feed this back to Ms Bennett. **SGi**

36.1.5 There was further discussion on risk appetite; the reporting framework; escalation of areas of concern to the Board and financial transparency. Mr Connor stated that there would always be unsolvable risks which were externally driven. Mrs Goldsmith added that the Board's Operational Plan link to risks and she was working with strategic planning colleagues on the Operational Plan.

- 36.1.6 The Committee accepted that the risk register contained all risks and a process was in place to provide assurance whilst acknowledging that the corporate risks had undergone a review to improve the expression of risk, controls and actions.**
- 37. Internal Audit (Assurance)**
- 37.1 Internal Audit Progress Report – February 2018 – Ms Brown gave an overview of internal audit activity since the December meeting, and confirmed the reviews planned for the coming quarter, identifying any changes to the original audit plan.
- 37.2 It was noted that there remained an outstanding draft report relating to data quality. Ms Brown clarified that this was a large area that was being looked at and that she would be meeting with the Executive Medical Director and the Chief Quality Officer shortly to finalise this. Ms Brown also confirmed that the Quality Improvement Strategy review would be moving to the first or second quarter of the 18/19 plan.
- 37.3 There was discussion around the home care services audit and it was noted that this was previously looked at in 2014/15. Ms Brown confirmed that this audit would be put on hold as the Edinburgh IJB were planning on undertaking similar work and this may impact on what NHS Lothian may want to focus on. It was suggested to wait and see what comes through from the Edinburgh IJB audit work and look to scheduling this into the 18-19 plan.
- 37.4 There was discussion on the potential opportunity for a cross organisation look at home care. **Ms Brown agreed to take this suggestion away and look at the practicalities involved in widening of scope and would come back and update the committee**
- 37.5 Ms Brown also reported on the stability of the Internal Audit team. It was noted that currently there was one vacancy and the team comprised two full time and one part time principle auditors. The team had been receiving part time assistance from two graduate finance trainees over the previous three months.
- 37.6 Mrs Goldsmith added that there had been discussion with NHS Borders on a shared audit system. It had been agreed that they would continue with their own audit arrangements for the next year then a shared system would be considered. There was also potential regional work impact to factor in.
- 37.7 The Committee accepted the contents of the Internal Audit progress report and approved the plan for the next quarter.**
- 37.2 Reports where all the control objectives have “Significant” assurance – Fixed Assets (January 2018) – The Committee accepted the report.
- 37.3 Follow-Up of Management Actions Report (February 2018) - The Committee accepted the report.
- 37.4 Internal Audit Plan 2018/19 - Ms Brown presented the draft plan for discussion and consideration. It was noted that the areas for review had been presented to the February Corporate Management Team meeting. There was discussion around policy framework work; impact of the new GP contract; the regional working agenda and home care. It was noted that this would require wider discussion with the Chief Officers and would need direct cooperation from Local Authority partners. **There was also discussion on the policy and procedure work undertaken by**

**the Head of Corporate Governance. Ms Brown would follow this up with Mrs Goldsmith outwith the meeting.**

**JBr/SG**

### **38. Counter Fraud Services (Assurance)**

38.1 Counter Fraud Activity – Mr Old gave an overview of the previously circulated report noting that as at beginning of February 2018, 1 referral and 3 operations were open.

38.1.1 In terms of how Lothian compared against other health boards. Lothian had made 15% referrals across NHS Scotland (55 for the first 9 months of last year), this was second highest behind NHS Greater Glasgow and Clyde. It was noted that the majority of referrals came back with no further management actions required.

38.1.2. Mr Old added that it was hoped that the presentation sessions would help make people more aware and could raise the potential for more referrals. There was the annual meeting of counter fraud soon and it was likely there would be a drop off in focus on smaller issues to allow concentrate on large issues.

### **39. External Audit (Assurance)**

39.1 External Audit Plan 2017/18 - Mr Eardley reported that the Plan was of similar format to previous years. There had been no major changes to standards or requirements. There was discussion on auditing of best value and value for money; the 4 hour access review process; scenario planning; financial management arrangements; engagement with IJB section 95 officers; assessment of risk; key audit risks and the implications of producing a financial plan which was not in balance.

39.2 Mr Eardley stated that the audit fee thjis year had been reduced by around £13k and confirmed there continued to be continuity within the audit team and that there were weekly meetings with NHS Lothian senior finance team to discuss any issues.

**39.3 The Committee accepted the External Audit Plan for 2017/18.**

### **40. Corporate Governance (Assurance / Decision)**

40.1 Access and Governance Committee Update – Dr Watson introduced the report informing the Committee of key developments in relation to the Access and Governance Committee (AGC).

40.1.1 The Committee noted that the AGC had now revised its Terms of Reference (ToR) as part of the Internal Audit Review of Emergency Access Standards and that there had been two meetings held under these new ToR. Dr Watson reported that the new more effective way of working was seeing the number of outstanding issues diminish quickly.

40.1.2 There was discussion on the assurance pathway for AGC. It was noted that a paper would go to the March Corporate Management Team meeting describing all activities undertaken by the AGC and including suggested risk ratings. It was proposed to bring a summary paper to the April Audit and Risk Committee for consideration and comment. The Chair stated that there should be a single assurance report from the Corporate Management Team and that the AGC

contribution should be part of that assurance.

40.1.3 The Committee asked for an update on the External Review being undertaken by Professor Derek Bell. Ms Campbell reported that at the moment the external review had finalized the last groups of staff engagement events. There had been two events at St John's Hospital, tow at the Royal Infirmary and one at the Western General Hospital. It was not planned to have any sessions at RHSC. It was hoped that the final report would be received middle to end of March 2018. A comprehensive report would come to the April Audit and Risk Committee.

**JCam/JC**

40.1.4 Ms Campbell added that the Deputy Chief Executive had established an improvement board to oversee improvement action and meeting timescales. In addition to this, the Director of HR&OD had established a staff engagement group which had a focus on the Organisational Development tie in and would report to the improvement board and the Corporate Management Team paper.

40.1.5 There was reference to the Internal Audit Plan and whether this should have a broad analysis of deployment and suitability of policies and procedures for NHS Lothian. There were a number of areas where policy failed to deploy as expected. The Chair suggested this be picked up under the Internal Audit Plan Item, ( , ). Mrs Goldsmith reported that the Head of Corporate Governance was leading on work on policy and procedure compliance and this work had been handed over to the Executive Nurse Director.

**40.1.6 The Committee received the revised Terms of Reference for the Access and Governance Committee, as had been requested at a previous Audit and Risk Committee meeting. The Committee also supported the proposed process to award the Access and Governance Committee assurance ratings.**

#### **41. Any Other Competent Business**

41.1 There was no other business.

#### **42. Date of Next Meeting**

42.1 The next meeting of the Audit and Risk Committee would take place at 9.00 on Monday 23 April 2018 in Meeting Rooms 8&9, 5<sup>th</sup> Floor, Waverley Gate.

## HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 9.00 on Tuesday 16 January 2018 in Meeting Room 8, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

**Present:** Dr R. Williams, Non-Executive Board Member (chair); Ms W. Fairgrieve, Partnership Representative; Ms C. Hirst, Non-Executive Board Member; Ms T. Humphrey, Non-Executive Board Member; Ms F. Ireland, Non-Executive Board Member; Mr A. Joyce, Employee Director, Non-Executive Board Member; Mr J. Oates, Non-Executive Board Member; Mr A. Sharp, Patient and Public Representative.

**In Attendance:** Ms M. Barton, Head of Health, West Lothian Health and Social Care Partnership; 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; Mr A. Jackson, Assistant Director of Healthcare Planning; Mr R. Mackie, Information Analyst; Professor A. McCallum, Director of Public Health and Health Policy; Ms J. Morrison, Head of Patient Experience; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Ms B. Pillath, Committee Administrator (minutes); 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 T. Davison, Chief Executive; Ms P. Eccles, Partnership Representative; Mr J. Forrest, Chief Officer, West Lothian Health and Social Care Partnership; Ms N. Gormley, Patient and Public Representative; Mr B. Houston, Chairman, NHS Lothian; Professor A. McMahon, Executive Nurse Director; Mr D. Small, Chief Officer, East Lothian Health and Social Care Partnership.

### Chair's Welcome and Introductions

*Dr Williams 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.*

#### 40. Patient Story

40.1 Mr Sharp read out the transcript from an interview with a patient who had received surgery in the Western General Hospital which highlighted communication problems between medical staff and the patient and showed that patient centred care was important. Ms Gillies agreed to pick up with surgical wards the need for proper communication to ensure patients understood what was happening.

#### 41. Minutes from Previous Meeting (14 November 2017)

41.1 The minutes from the meeting held on 14 November 2017 were approved as a correct record.

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

## **42. Emerging Issues**

### **42.1 Unscheduled Care Situation**

42.1.1 Mr Crombie gave a verbal update. The NHS in the UK was under significant pressure. There had been 10,000 front door attendances in NHS Lothian so far in January 2018. Capacity was being increased by using non inpatient areas. This came with increased risk but was being closely monitored. Staff in all areas had been extremely resilient and many were working beyond what was expected of them. No adverse events had been identified and the response to the problem had been a good example of whole system working.

42.1.2 Mr Crombie was chairing a daily conference call which included all Integration Joint Board officers who were working to make available services in the community which would reduce admissions, and to allow inpatients to be discharged safely.

42.1.3 A number of inpatient elective and day surgery elective operations had been cancelled to improve capacity. A group led Ms Gillies had developed a clinical prioritization process to aid decision making on cancellations. Any cancellation had an adverse effect on patients and their families psychologically.

42.1.4 There was no sign of the position changing in the near future and it was expected that this would not be a one off event and there would need to be more sustainable investment in community services. There would be a review of the situation and response.

42.1.5 Members expressed their appreciation of the exemplary work of staff in the wards, on behalf of the Board.

42.1.6 The Communications team was involved in the daily conference call and was working to balance the negative media reports with positive stories about what was being done to mitigate the risks. There had been a large number of positive patient contacts about the minor injuries unit through social media.

42.1.7 The Chief Executives group was considering any learning from the responses of other Boards to the situation, as all Boards were affected, including small Boards.

42.1.8 A paper would be submitted to the next meeting giving assurance against the risks associated with cancellation of elective operations, with patients admitted, and with whole system pressures.

**JCr**

## **43. Committee Effectiveness**

### **43.1 Corporate Risk Register**

43.1.1 Ms Bennett spoke to the previously circulated paper. Members accepted the recommendations laid out.

## 43.2 Quality and Performance Improvement Report

- 43.2.1 Ms Bennett spoke to the previously circulated paper. All the areas highlighted as outwith expected performance had had associated items discussed on the agendas of recent meetings, or would be on the agenda at future meetings. There had been an agreement not to use the GP Access targets for discussion as the data was out of date. Falls was included in the Patient Safety Annual Report. There had not been a report on smoking cessation recently, but Professor McCallum advised that new strategies were being developed which may include new performance measures, and that the Committee would be kept updated.
- 43.2.2 Ms Morrison noted that the Information Services Division no longer asked for complaints figures to be reported to them and that reporting systems could change in future but were being continued in the meantime internally.
- 43.2.3 Mr Jackson advised that the Scottish Government had confirmed that performance targets would remain the same for the year 2018/19.

## 44. **Person Centred Culture**

### 44.1 Spiritual Care and Bereavement

- 44.1.1 Ms Ireland spoke to the previously circulated paper which set out the reorganisation of the service. A settling in process was to be expected following this, but a future update would be needed to consider whether the capacity of the service was adequate to meet demand. **AMcM**

## 45. **Safe Care**

### 45.1 Patient Safety Programme Annual Report

- 45.1.1 Ms Gillies spoke to the previously circulated paper. Ms Hirst noted that the SPSP executive visits to clinical areas were crucial for understanding what was happening, and suggested that Integration Joint Board Members could also be invited to visits to outpatient areas as this was the interface between community and acute care. It was agreed that this would be arranged.
- 45.1.2 It was noted that SPSP data would be reported internally only and scrutinised at the Healthcare Governance Committee. Outcome measures reflected process measures so gave an indication to clinical teams as to whether processes needed review. Some areas had external oversight, for instance PVC and hand hygiene measured were examined by the Healthcare Environment Inspectorate, and ICU measures by the Scottish Intensive Care Society Audit Group. The purpose of collecting the data was to use it to make improvements.
- 45.1.3 Ms Bennett noted that pressure ulcer management had been a problem but improvement was now being seen which needed to be sustained. There had been a sustained improvement in falls management.

45.1.4 Members accepted the recommendations laid out in the paper and noted the significant improvements in areas where there had previously been concern. In addition to the assurance recommended in the paper, Members took significant assurance that patient safety was embedded in the culture of NHS Lothian.

#### 45.2 Child and Adult Mental Health Service (CAMHS) Waiting Times

45.2.1 Ms McKigen spoke to the previously circulated paper to which there was an update as the Corporate Management Team had agreed the previous day to renew funding from April 2018, and had asked that the Children's Partnerships continue the posts outlined in item 2.3 of the paper in the short term.

45.2.2 There was discussion about appropriate recommendations for an assurance committee which should look at risks and plans to mitigate these; the papers submitted to the Committee should recognise the governance risks and challenges.

45.2.3 Risks described in this paper were the intermittent funding situation which did not encourage sustainable services, that plans to reduce waiting times had not been successful and that there was no assurance that the plans now in place would make positive improvements despite the focus and hard work put in. Although it was not in the Committee's remit to approve funding, Members noted that there was no assurance that the demand for the service could be met without sustainable additional funding.

45.2.4 Mr Crombie noted that the discussion at the Corporate Management Team was that there had been too much focus on the specific waiting times target and there needed to be further consideration of how other services could be used to improve the position.

45.2.5 A further update paper was requested for the next meeting.

**AMcM**

#### 45.3 Management of clinical risk to patients on waiting list

45.3.1 Ms Campbell spoke to the previously circulated paper. Ms Morrison noted that waiting times was the second highest theme for complaints contacts and that the plan to maintain contact with patients on the waiting list was very positive from a patient perspective.

45.3.2 Resourcing of the hub for contacting patients and for receiving calls from patients had improved with staff now working evenings and weekends when patients were more likely to be able to answer calls. This was currently being supported by non-recurrent access funds from the Scottish Government. Ways to create a sustainable service were under review.

45.3.3 The clinical risk matrix developed for decision making about triage of patients on the waiting list had been shared by the Scottish Government with other Boards as an example of good practice.

45.3.4 Ms Campbell advised that this was expected to be the situation for the foreseeable future as there was no funding or capacity to make sustainable improvements to



reduce waiting times, so the measures described and tested needed to be made part of mainstream business.

45.3.5 Members noted that clear plans were in place to address clinical risks identified, and accepted moderate assurance.

#### 45.4 Alcohol and Drug Partnerships actions to mitigate the impact of changes

45.4.1 Ms McKigen spoke to the previously circulated paper. It was noted that the governance structure of the Alcohol and Drug Partnerships was unclear as there was accountability to local authorities, Integration Joint Boards and Community Planning Partnerships. For the purposes of the Health Board assurance was needed on mitigation of clinical risk.

45.4.2 Members noted that Integration Joint Boards were making decisions about funding the Alcohol and Drug Partnerships which meant the Healthcare Governance Committee was unable to give assurance that safe effective and equitable care was being provided.

45.4.3 Mr Oates noted that the ability to plan ahead was important and the short term decisions on funding made it particularly difficult on an operation level to mitigate the risks identified.

45.4.4 Members accepted the recommendations laid out in the paper and accepted limited assurance that actions were in place to mitigate risks.

#### 45.5 Public Protection Team Update

45.5.1 Ms McKigen spoke to the previously circulated paper. Members accepted the recommendations laid out.

### **46. Effective Care**

#### 46.1 Mental Welfare Commission Perinatal Report and Service Review

46.1.1 Ms McKigen spoke to the previously circulated paper. Ms Gillies noted that the family were expecting to receive the review report. The report was in two parts; the first part had been completed but the second part was delayed. It was not considered appropriate to give the first part to the family until the second part was complete, but it would be helpful if the first part could be sent to the fiscal's office to show that progress had been made. The family were being kept aware of the reason for delay.

46.1.2 Members noted that the delays were outwith the team's control but that the most of the actions from the review had been completed and the others were being worked on. The recommendations laid out in the paper were accepted with limited assurance was accepted in terms of the second half of the report, but accepting that the reasons for this had been explained. Members commended the hard work of the team in completing the actions.

#### 46.2 GP and Primary Care Sustainability

- 46.2.1 Members noted the previously circulated paper for information. Mr Small was not available to present. A further update would be given at the next meeting. **DS**

#### **47. Exception Reporting Only**

Members noted the following previously circulated papers for information:

- 47.1 Organ Donation Annual Report;
- 47.2 Tissue Viability Annual Report;
- 47.3 Pregnancy and New Born Screening Annual Report;
- 47.4 Research and Development Annual Report;
- 47.5 Resilience Annual Update.

#### **48. Other Minutes: Exception Reporting Only**

Members noted the previously circulated minutes from the following meetings:

- 48.1 Area Drug and Therapeutics Committee, 6 October 2017, 1 December 2017;
- 48.2 Clinical Management Group, 10 October 2017;
- 48.3 Lothian Infection Control Advisory Committee, 5 December 2017;
- 48.4 Public Protection Action Group, 22 November 2017;
- 48.5 Acute Hospitals Committee, 7 November 2017;
- 48.6 Organ Donation Sub Group, 23 November 2017;
- 48.7 Clinical Policy Documentation and Patient Information Group, 4 July 2017;
- 48.8 Information Governance Assurance Board, 25 October 2017.

#### **49. Date of Next Meeting**

- 49.1 The next meeting of the Healthcare Governance Committee would take place at **9.00** on **Tuesday 13 March 2018** in **Meeting Room 8**, Fifth Floor, Waverley Gate.
- 49.2 Further meetings would take place on the following dates in 2018:
  - 8 May 2018;
  - 10 July 2018;
  - 11 September 2018;
  - 13 November 2018.

DRAFT

## STRATEGIC PLANNING COMMITTEE

Minutes of the meeting of the Strategic Planning Committee held at 9.30 on Thursday 8 February 2018 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

**Present:** Professor A. McMahon, Nurse Director (chair); Mr M. Ash, Non-Executive Board Member; Mr T. Davison, Chief Executive; Ms T. Gillies, Medical Director; Ms S. Goldsmith, Finance Director; Professor T. Humphrey, Non-Executive Board Member; Mr A. Joyce, Employee Director, Non-Executive Board Member; Mr A. McCann, Non-Executive Board Member; Mr P. Murray, Non-Executive Board Member.

**In Attendance:** Mr C. Briggs, Strategic Planning Director; Ms J. Butler, Director of Human Resources; Ms J. Campbell, Chief Officer, Acute Services; Mr B. Dickie, Project Officer, Strategic Planning Committee (item 7.2); Ms S. Egan, Associate Director, Strategic Planning; Mr M. Higgins, Senior Health Policy Officer, Public Health and Health Policy; Mr C. Marriott, Deputy Director of Finance; Dr D. Milne, Consultant in Public Health; Ms N. Paul, Business Manager (observing); Ms B. Pillath, Committee Administrator (minutes); Mr A. Short, Chief Officer, Midlothian Health and Social Care Partnership.

**Apologies:** Mr J. Crombie, Deputy Chief Executive; Ms F. Ireland, Non-Executive Board Member; Professor M. Whyte, Non-Executive Board Member.

*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 (14 December 2017)**

1.1 The minutes from the meeting held on 14 December 2017 were approved as a correct record.

### **2. The People's Health**

#### **2.1 Best Start**

2.1.1 Ms Egan spoke to the previously circulated paper. The Maternity and Neonatal Strategy had been signed off by the Programme Board and the financial plan would be complete by the date of the strategy being submitted to Lothian Board in April 2018.

2.1.2 In response to a question about recruitment of midwives into new supernumerary posts if investment were agreed, Professor McMahon advised that options would be considered by the Programme Board but that as there was little flexibility in the workforce for backfill of posts so it was possible that there would be a move straight

to the new model rather than using supernumerary posts. Staff were enthusiastic about the strategy and they needed to be involved in decisions made.

- 2.1.3 Health visitors would also be involved in the new model and it was important not to disrupt the work done in the last few years to stabilise the health visiting workforce.
- 2.1.4 Professor Humphrey suggested using tests of change and to target enthusiastic teams but also start where the biggest impact was expected; research showed that the continuity of care reduces inequalities most in areas with the highest numbers of vulnerable people.
- 2.1.5 Ms Hirst suggested that there should be more emphasis on the systemic learning; the influence of the system on individuals and the learning from this which was being explored as part of the 'being open' work.
- 2.1.6 Mr Murray noted that the Scottish Government required this model to be put in place and suggested that funding for this could be requested. It was assumed that the new model would cost more than the current model; prioritisation within and between would be required including consideration of risks and mitigation.
- 2.1.7 Professor Humphrey advised that the Scottish Government were considering some input to help earlier adopters of the strategy, including a toolkit and perhaps some workforce work.
- 2.1.8 It was noted that the strategy envisaged a team based approach which was more robust than a single midwife for each patient.
- 2.1.9 Mr Murray suggested that a paragraph be added into the report describing any dialogue and engagement with partnership representatives before the strategy was submitted to the Board and this was agreed. **AMcM**
- 2.1.10 Members accepted the recommendations laid out in the paper.

## 2.2 Community Planning

- 2.2.1 The Chair welcomed Mr Higgins to the meeting and he spoke to the previously circulated paper. Mr Short noted that the original draft of this process had been implemented 9 years ago; some areas were working well and there had been improvement in the areas of housing and employability. There was a need for NHS Lothian to maximise opportunities and drive agendas at community planning groups more than currently to tackle inequalities of health, learning and income. This should be focussed on areas that would make the biggest impact on the population, for instance improving learning opportunities for young people and creating apprenticeships in health and social care areas could improve outcomes for young people and also improve our workforce.
- 2.2.2 It was noted that when community planning had been discussed at Integration Joint Boards there was currently no collective NHS Lothian view to represent. NHS Lothian was involved in four community planning partnerships; it was suggested that a focus on one with priorities which match NHS Lothian's would have a bigger impact and

help drive the agenda. A more detailed conversation was needed on what the key priorities were in each partnership so that decisions on investment could be made.

2.2.3 It was suggested that community planning partnerships would be a good forum for discussion of agreements about sale of our assets to the Councils on favourable terms in return for their use for something mutually beneficial.

2.2.4 There was currently one executive director and one non-executive board member on each community partnership but they were currently in a representative role and were not influencing and bringing ideas. The representatives on each partnership needed to work together to consider what priorities should be driven forward in each partnership. Dr Milne agreed to take this forward and bring an update to the next meeting.

**DM**

### **3. Pan Lothian Business**

#### **3.1 Financial Strategy**

3.1.1 Ms Goldsmith gave a presentation. The financial plan would be discussed at the Finance and Resources Committee. The purpose of the presentation was to make members aware of the situation so that decisions could be made at the Board about priorities.

3.1.2 It was noted that for the first time the Scottish Government were providing additional funding to help meet performance targets; this was as a result of pressure from the Chief Executives of all Boards. Mr Davison noted that no Board in Scotland was currently meeting the waiting times targets and there were 100 thousand patients in Scotland who were missing this guarantee. To return to the March 2017 position it was projected that £30 million per year would be required including the £7 million allocated, and that even if this funding were available there would not be the capacity or the private provider capacity to carry out the work. There were plans to create more capacity, for instance the new Eye Pavilion, but this would take four years to commission; in the meantime a four year contract with the private sector would be made to allow them to build up capacity.

3.1.3 It was noted that modelling for funding for shifting the balance of care only gave 1.5% improvement in the direction of primary care funding. To make it closer to 50/50 acute services and primary care either money would have to be taken from hospital services; or the Scottish Government would have to add funding for primary care. Given the current unscheduled care situation it was not possible to take money out of hospital services.

3.1.4 Ms Gillies suggested that articulation of how intervention in the community could impact and improve population health and reduce demand for hospital services could help prioritisation.

3.1.5 Ms Butler noted that there was more work to be done on workforce including the best ways to use the workforce available and the best ways of developing staff into the roles needed.

## **4. Integration**

### **4.1 Edinburgh Outline Strategic Commissioning Plans**

- 4.1.1 Mr Briggs spoke to the previously circulated paper. Members were encouraged to see that the plans had moved forward but noted that all resources were needed to meet urgent responsibilities and clear the backlog in the existing service, not leaving resources for investment in transformational change.
- 4.1.2 Mr Davison noted that due to the Council element Integration Joint Boards were in a better position to make their own priorities separate to Government priorities than Health Boards were, and they needed to be empowered to do this so that NHS Lothian could influence priorities.
- 4.1.3 Mr Briggs highlighted some good work that had taken place, for example Royal Edinburgh Hospital re-provision had led to transformational change in mental health planning by remodelling hospital and community bed numbers and alternative community accommodation.
- 4.1.4 Integration Joint Boards planned to consider areas that cover all partners, for instance housing and transport, so that they could make financial planning for priorities. Ms Hirst noted that the process of producing the plan had been positive in engaging different organisations including the third sector and demonstrating that there was a problem that could be solved.

### **4.2 Re-provision of Belhaven and Edington Hospitals**

- 4.2.1 The Chair welcomed Mr Dickie to the meeting and he gave a presentation. It was noted that following two engagement events the community were supportive of the proposals; this was a good position to start from but needed momentum.
- 4.2.2 The direction was for both the Health Board and the Council. Mr Small was presenting the plan to the Council that day. If agreed, the process for development was an options appraisal followed by a consultation as part of a business case. The community planning partnership would be given an opportunity to look at the options and make comments. There was an opportunity for the Integration Joint Boards to develop the strategy as this would not need cabinet secretary approval.
- 4.2.3 Ms Hirst noted that social housing providers should be involved as they had a long experience of providing similar models that were known to work.
- 4.2.4 Members were supportive of the early plans as described in the presentation.

## **5. The Lothian Hospitals Plan**

- 5.1 Professor McMahon gave a verbal update. It was proposed that phases 2 and 3 of the redevelopment would now be undertaken in reverse order due to better work progress in phase 3. This had been signed off by Edinburgh Integration Joint Board and dates would be set for East Lothian and Midlothian Integration Joint Boards to sign off by March 2018. The integrated rehabilitation at the Astley Ainslie Hospital

would be put back. The movement of Liberton Hospital beds to the Jardine Clinic at the Royal Edinburgh Hospital was supported by the Finance and Resources Committee and a business case would now be developed. The Scottish Government were also supportive of this.

## **5. Date of Next Meeting**

5.1 The next meeting of this group would take place at **9.30** on **Thursday 12 April 2018** in **Meeting Room 8**, second floor, Waverley Gate.

5.2 Further meetings in 2018 would take place on the following dates:

- Thursday 7 June 2018;
- Thursday 9 August 2018;
- Thursday 11 October 2018;
- Thursday 6 December 2018.

# Minutes

## Edinburgh Integration Joint Board

9:30 am, Friday 15 December 2017

Dean of Guild Court Room, City Chambers, Edinburgh

1.11

**Present:**

**Board Members:**

Councillor Ricky Henderson (Chair), Carolyn Hirst (Vice Chair), Shulah Allan, Michael Ash, Carl Bickler, Sandra Blake, Christine Farquhar, Alastair Gaw, Mark Grierson (substituting for Colin Briggs), Kirsten Hey, Councillor Derek Howie, Councillor Melanie Main, Michelle Miller, Moira Pringle, Councillor Alasdair Rankin, Ella Simpson, Councillor Susan Webber, Richard Williams and Pat Wynne.

**Officers:** Lesley Birrell, Wendy Dale, Gavin King, Angela Lindsay and Jamie Macrae.

**Apologies:** Colin Briggs, Andrew Coull and Alex Joyce.

### 1. Shulah Allan – Retirement

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The Chair recorded thanks to Shulah Allan for her commitment and valuable input and contribution to the work of the Joint Board since its inception and wished her well for her retirement.

### 2. Minutes

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#### Decision

To approve the minute of the Joint Board of 17 November 2017 as a correct record.

### 3. Sub-Group and Committee Minutes and Updates

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Updates were given on Sub-Group and Committee activity.

#### Decision

- 1) To note the minute of meeting of the Audit and Risk Committee of 1 December 2017.
- 2) To note that an update report was scheduled to be submitted to the next meeting of the Sub-Group on lessons learned and performance indicators aligned to Directions as part of the overall performance report.



- 3) To note that the minute of the Performance and Quality Sub-Group of 29 November 2017 would be submitted to the next meeting of the Joint Board on 26 January 2018.
- 4) To note that the minute of the Professional Advisory Group of 28 November 2017 would be submitted to the next meeting of the Joint Board on 26 January 2018.
- 5) To note the minute of meeting of the Strategic Planning Group of 3 November 2017.

#### **4. Rolling Actions Log**

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The Rolling Actions Log for 15 December 2017 was presented.

##### **Decision**

- 1) To agree to close Action 9 – Edinburgh Health and Social Care Partnership Statement of Intent.
- 2) To otherwise note the remaining outstanding actions.

(Reference – Rolling Actions Log 15 December 2017, submitted)

#### **5. Business Resilience Arrangements and Planning**

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The Edinburgh Health and Social Care Partnership was working towards embedding stronger business resilience practices throughout the organisation. Currently, the Partnership relied on two different business continuity models used by NHS Lothian and the Council.

It was proposed to integrate both business resilience plans to strengthen the Partnership's business continuity governance and reporting framework and to ensure that appropriate oversight, scrutiny and assurances were in place.

##### **Decision**

- 1) To note that currently there was no integrated approach to developing business resilience arrangements thus preventing the delivery of a clear and effective continuity plan.
- 2) To approve the Partnership's proposal to build on NHS Lothian's and the Council's resilience best practices to create a single coherent and easy to use plan for integrated services.
- 3) To note the intention to create, share and test plans with a view to providing a further update on progress at the meeting of the Joint Board on 18 May 2018.
- 4) To include further detail in the update report to the Joint Board on business resilience arrangements in respect of independent contractors and how these arrangements would be planned to link in with the localities.

(Reference – report by the IJB Interim Chief Officer, submitted)

## 6. Winter Plan 2017-2018

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The winter plan was the result of a collaborative approach to planning across local partners, building capacity for out-of-hours services, reducing unscheduled admissions to acute hospitals and supporting the early discharge of people who were admitted, if appropriate.

The winter plan also focused on addressing additional pressures, such as potential surges in admissions over the winter (particularly in relation to respiratory and circulatory conditions), incidence of norovirus and influenza, and seasonal business continuity challenges.

A summary was given of key areas of focus within the Plan and actions being taken in relation to critical areas outlined in the Scottish Government guidance.

### Decision

- 1) To note the progress with the winter planning for 2017-2018.
- 2) To approve the action plan set out at Appendix 1 of the report by the IJB Interim Chief Officer as far as it related to the issues under the authority of the Joint Board.
- 3) To issue a Direction to implement the Winter Plan in order to achieve the outcomes set out in the Plan with performance, evaluation and lessons learned being monitored and reported back to a future meeting of the Joint Board.

(Reference – report by the IJB Interim Chief Officer, submitted)

## 7. Whole System Delays – Recent Trends

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An overview was provided of performance in managing hospital discharge against Scottish Government targets. It was acknowledged that performance and delays across the system continued to be extremely challenging.

### Decision

- 1) To note that the current pressures and delays across the system, including delayed discharge and people waiting for assessment continued to be a challenge.
- 2) To acknowledge the range of actions being taken to address these pressures, including securing additional resources in the short term to resolve the current backlog of assessments and people waiting for discharge.
- 3) To welcome the introduction of monthly performance scrutiny meetings in each locality.

(References – Integration Joint Board 17 November 2017 (item 7); report by the IJB Interim Chief Officer, submitted)

## 8. Financial Performance and Outlook

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An update was provided on the financial position at the seven month stage of 2017/18 and the forecast year end position. An initial indication of the scale of the financial challenge facing the Joint Board over the five year period to 2022/23 was also reported.

Additional funding for local authorities had been announced by the Scottish Government as part of the spending plans for 2018/19 for the following key areas – primary care, mental health and social care.

### Decision

- 1) To note that delegated services were reporting an overspend of £4.0m for the first seven months of 2017/18 which was projected to rise to £7.1m by the end of the financial year without any further action.
- 2) To acknowledge that ongoing actions were being progressed to reduce the predicted in-year deficit to achieve a year-end balanced position, and to note that only limited assurance could be given of the achievement of break even at this time.
- 3) To acknowledge the initial financial outlook for the next five years.
- 4) To support the development of an underpinning financial strategy.
- 5) To note that the five year forecast would require to be adjusted in light of the Scottish Government's draft spending plans for 2018/19 announced on 14 December 2017.

(References – Integration Joint Board 17 November 2017 (item 10); report by the IJB Interim Chief Finance Officer, submitted.)

## 9. Health and Social Care improvement Programme and Short Term Resource Implications

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The Joint Board had approved the Edinburgh Health and Social Care Partnership's Statement of Intent setting out the seven key areas requiring intensive remedial action for all health and social care services in the City. Actions had been grouped into a comprehensive improvement programme with associated resource implications.

The Statement of Intent included an undertaking that the Health and Social Care Partnership would produce outline strategic commissioning plans for older people, mental health, disabilities and primary care. These would be submitted to the Joint Board for approval in early 2018.

Performance information would be reported to the Joint Board via the Performance and Quality Sub-Group and as part of the whole system reporting structure. The Savings Governance Board had been re-established to bring additional rigour to the savings that needed to be delivered. Workstream leads provided updates every two weeks on reducing costs and innovative ways of providing more capacity within the same resources.

## **Decision**

- 1) To approve the short term resource allocation detailed in paragraphs 27 to 29 of the report by the IJB Interim Chief Officer.
- 2) To approve the comprehensive improvement programme for the Health and Social Care Partnership, set out in full at Appendix 1, and in summary at Appendix 2 of the report.
- 3) To note the arrangements to co-ordinate the staffing resources to balance local knowledge and flexibility/speed of recruitment.
- 4) To note that a Direction would be drafted in relation to re-prioritisation of resource allocation to allow implementation of the short-term actions described in paragraphs 27 to 29 of the report.

(References – Integration Joint Board 17 November 2017 (item 8); report by the IJB Interim Chief Officer, submitted.)

## **10. Joint Board Membership and Appointments to Committees and Sub-Groups**

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NHS Lothian and the City of Edinburgh Council had identified replacement voting members to fill vacancies on the Joint Board as a result of resignations. The Joint Board was also asked to note the change to its non-voting members due to recent interim appointments.

Approval was also sought for the appointment of members to vacancies on the Audit and Risk Committee and the Performance and Quality Sub-Group.

## **Decision**

- 1) To note that NHS Lothian agreed, at its meeting on 4 October 2017, to nominate Angus McCann as a voting member on the Joint Board in place of Shulah Allan (resigned), effective from 1 January 2018.
- 2) To note that the Council agreed, at its meeting on 24 August 2017, to appoint Councillor Melanie Main as a voting member on the Joint Board in place of Councillor Claire Miller.
- 3) To note that Dr Richard Williams had intimated his intention to step down from the Joint Board in early 2018 and that NHS Lothian, at their meeting on 6 December 2017, had appointed Martin Hill to replace Dr Richard Williams on the Joint Board with effect from 1 March 2018.
- 4) To note the requirement to undertake a recruitment process to fill the two service user non-voting vacant positions on the Joint Board.
- 5) To note the appointment of Michelle Miller and Alistair Gaw as non-voting members on the Joint Board in their capacity as Interim IJB Chief Officer and Interim Chief Social Work Officer respectively.

- 6) To note the resignation of George Walker as an additional non-voting member of the Joint Board and to agree not to re-appoint a replacement additional member.
- 8) To delegate authority to the IJB Interim Chief Officer, in consultation with the Chair and Vice-Chair, to review the membership of the Audit and Risk Committee and the role description and specification for the Audit and Risk Committee Chair and report back to the Joint Board.
- 9) To delegate authority to the IJB Interim Chief Officer, in consultation with the Chair and Vice-Chair, to review the membership of the Performance and Quality Sub-Group and the role description and specification for the Performance and Quality Sub-Group Chair and report back to the Joint Board.

(Reference – report by the IJB Interim Chief Officer, submitted)

## **11. Recruitment of Citizen Members**

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The Joint Board had previously agreed to appoint two service users and two unpaid carers to be members of the Board. The two service user positions on the Board were currently vacant.

It was proposed to establish a short life working group to review the role and specification for citizen members of the Board along with the appointments process with a view to making recommendations to the Board in January 2018.

### **Decision**

- 1) To note the requirement to appoint two citizens of Edinburgh who use health and social care services to membership of the Joint Board.
- 2) To establish a short life working group as set out in paragraph 8 of the report by the IJB Interim Chief Officer, to review the role description and specification for the service user/unpaid carer Board members along with the advertisement and recruitment pack and report back to the Joint Board with recommendations in January 2018.
- 3) To delegate authority to the IJB Interim Chief Officer, in consultation with the Chair and Vice-Chair, to review the recruitment pack and selection arrangements and report back to the Joint Board.

(Reference – report by the IJB Interim Chief Officer, submitted)

# Item 4.1 Minutes

## Edinburgh Integration Joint Board

**9:30 am, Friday 26 January 2018**

Dean of Guild Court Room, City Chambers, Edinburgh

**Present:**

**Board Members:**

Councillor Ricky Henderson (Chair), Carolyn Hirst (Vice Chair), Michael Ash, Carl Bickler, Colin Briggs, Wanda Fairgrieve, Christine Farquhar, Councillor Derek Howie, Ian McKay, Michelle Miller, Moira Pringle, Councillor Alasdair Rankin, Ella Simpson, Councillor Susan Webber, Richard Williams and Pat Wynne.

**Officers:** Lesley Birrell, Wendy Dale, Ann Duff, Jamie Macrae.

**Apologies:** Colin Beck, Sandra Blake, Andrew Coull, Alistair Gaw, Kirsten Hey and Councillor Melanie Main.

### 1. **Dr Richard Williams**

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The Chair recorded thanks to Dr Richard Williams for his commitment and valuable input and contribution to the work of the Joint Board since its inception and wished him well for the future.

### 2. **Minutes**

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#### **Decision**

To approve the minute of the Joint Board of 15 December 2017 as a correct record.

### 3. **Sub-Group Minutes**

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Updates were given on Sub-Group and Committee activity.

#### **Decision**

- 1) To note the minute of meeting of the Professional Advisory Group of 28 December 2017.
- 2) To note the minute of meeting of the Performance and Quality Sub-Group of 29 November 2017.
- 3) To note the minute of meeting of the Strategic Planning Group of 1 December 2017.

- 4) To amend item 1, decision 2) of the minute of the meeting of the Strategic Planning Group of 12 January 2018 to clarify that night time payments related to paid carers and not unpaid carers; to otherwise note the minute of meeting.

#### 4. Rolling Actions Log

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The Rolling Actions Log for 26 January 2018 was presented.

In response to a question from Councillor Webber regarding an update on the Winter Plan 2017-2018, members were advised that a report detailing full monitoring information on the performance, evaluation and lessons learned would be submitted to a future meeting of the Joint Board.

##### Decision

- 1) To agree to close Action 1 – Communications and Engagement Strategy 2016-2019.
- 2) To agree to close Action 14 – Recruitment of Citizen Members.
- 3) To otherwise note the remaining outstanding actions.

(Reference – Rolling Actions Log 26 January 2018, submitted)

#### 5. Outline Strategic Commissioning Plans for Learning Disability, Mental Health and Older People

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The draft Outline Strategic Commissioning Plans for learning disabilities, mental health and older people were presented. The Plans outlined the headline issues and proposed strategic direction in each area and the key actions to be taken to address these. Covered within all the Plans were prevention, different levels of care for different levels of need, community services and bed-based services. Included were some propositions based on capacity and demand modelling.

The Strategic Planning Group had considered the draft plans at their meeting on 12 January 2018 and, whilst endorsing the content and direction of travel in the plans, requested an opportunity to bring all of the work back for the Joint Board to consider in the round. This would allow for outline financial frameworks to be developed in respect of each of the plans to highlight choices that needed to be made about the use of resources going forward.

##### Decision

- 1) To note that the draft outline strategic commissioning plans for learning disabilities, mental health and older people had been considered by the Strategic Planning Group on 12 January 2018.
- 2) To note that the Strategic Planning Group recognised that good progress had been made in the development of the plans and agreed that these could be used as working documents for sharing with stakeholders. The Strategic Planning Group noted that the drafts were in different formats and that aligning these along with the forthcoming outline strategic commissioning plans for primary care and physical disabilities as well as consideration of the cross-cutting themes was required.

- 3) To approve the summaries of the outline strategic plans for learning disabilities, mental health and older people as set out in Appendices 1, 2 and 3 as the means of communicating progress to date and action plans for the next 12 months.
- 4) To agree to use the Joint Board development session scheduled for 27 April 2018 to provide members with the opportunity to consider the draft final outline strategic plans, including cross cutting themes, in detail prior to approval at a future formal meeting of the Joint Board.
- 5) To agree to extend funding to EVOC and Scottish Care to support the development and implementation of the strategic commissioning plan for older people as set out in paragraph 13 of the report by the IJB Interim Chief Officer.
- 6) To note the timetable for the ongoing development of the strategic commissioning plans set out in paragraph 14 of the report by the IJB Interim Chief Officer.

(References – Integration Joint Board 17 November 2017 (item 6); report by the IJB Interim Chief Officer, submitted)

### **Declaration of Interest**

Christine Farquhar declared a non-financial interest in the above item as the Chair of Upward Mobility.

## **6. Financial Position and Budget Forecast**

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The IJB Interim Chief Finance Officer provided a verbal update on the financial position of the Joint Board and the budget forecast.

There was no material change from the position reported to the Joint Board in December 2017. NHS Lothian and the City of Edinburgh Council were updating financial plans following the draft spending plans announced by the Scottish Government on 14 December 2017.

Additional funding for local authorities had been announced by the Scottish Government as part of the spending plans for 2018/19 for the following key areas – primary care, mental health and social care.

Both organisations recognised the challenges faced by the Joint Board particularly in respect of delayed discharges and the size of waiting lists. Senior management teams were working on savings and recovery programmes to address the significant savings requirements.

### **Decision**

- 1) To note the update.
- 2) To agree that a further report would be submitted to the next meeting of the Joint Board on 2 March 2018.



## 7. Primary Care South East Edinburgh (Outer Area) Strategic Assessment

---

Approval was sought for the South East Edinburgh (Outer Area) Strategic Assessment. The strategic assessment had been produced in consultation with key stakeholders.

The Strategic Planning Group had considered the strategic assessment at its meeting on 3 November 2017 and had agreed to recommend that the Joint Board approve the strategic assessment for submission to the NHS Lothian Capital Investment Group for consideration as part of the NHS Lothian prioritisation process for capital allocations.

### Decision

- 1) To note that the South East had been identified as a priority area for investment in the Population Growth and Primary Care Premises Assessment 2016-2026 which was supported by the Joint Board on 22 September 2017.
- 2) To note that a strategic assessment was the first part of the Scottish Capital Investment Manual (SCIM) guidelines with which health boards must comply to inform the Scottish Government of an intended investment proposal.
- 3) To note the South East Edinburgh (Outer Area) Strategic Assessment set out in Appendix 1 of the report by the IJB Interim Chief Officer had been produced following a workshop with relevant stakeholders.
- 4) To accept the recommendation of the Strategic Planning Group that the Joint Board submit the South East Edinburgh (Outer Area) Strategic Assessment to the NHS Lothian Capital Investment Group (LCIG) for consideration as part of the NHS Lothian prioritisation process for capital allocations.

(References – Integration Joint Board 17 November 2017 (item 7); report by the IJB Interim Chief Officer, submitted)

## 8. Outstanding Directions

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The Joint Board had previously agreed to ask the Council to roll forward a number of grants due to expire on 31 March 2018 for a further year to 31 March 2019. The Council had also been asked to extend the contract with Edinburgh Voluntary Organisations Council (EVOC) to provide infrastructure support to the third sector for the same period of time.

This would allow time for the various grant programmes to be reviewed in collaboration with stakeholders and allow EVOC to support and facilitate collaboration on the review of grants across the third sector and the development of the market shaping strategy.

### Decision

To approve the Directions relating to the roll forward of grants and extension of the contract with EVOC for a further 12 months as set out in appendices 1 and 2 of the report by the IJB Interim Chief Officer.

(References – Integration Joint Board 22 September 2017 (item 11) and 15 December 2017 (item 9); report by the IJB Interim Chief Officer, submitted)

### **Declaration of Interests**

Ella Simpson declared a financial interest in the above item as an employee of Edinburgh Volunteer Organisations Council.

## **9. Edinburgh Alcohol and Drug Partnership Funding – Review of Service Changes Impact**

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An update was provided of progress being made in implementing the Edinburgh Alcohol and Drug Partnership’s agreed savings plan and the impact in each of the five areas of change.

### **Decision**

- 1) To note the progress against each action in the savings plan.
- 2) That a briefing note be prepared for Joint Board members setting out the broader challenges and information on approaches taken by the other Lothian Integration Joint Boards and the impact of service review, redesign and efficiencies in each area of change.

(References – Integration Joint Board 28 April (item 2); report by the IJB Interim Chief Officer, submitted)

## **10. Recruitment of Service User Members to the Integration Joint Board**

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The Joint Board had previously agreed to delegate authority to the IJB Interim Chief Officer, in consultation with the Chair and Vice-Chair to review the recruitment pack and selection arrangements and report back to the Joint Board.

A short life working group was established and met to review the role and specification for citizen members of the Board along with the appointments process.

Approval was sought for the revised documentation, advertising and recruitment process.

### **Decision**

- 1) To agree the proposed role description for service user members of the Joint Board set out on pages 3, 4 and 5 of Appendix 1 of the report by the IJB Interim Chief Officer.
- 2) To agree the recruitment pack set out in Appendix 1 of the report.
- 3) To agree that the vacancies should be advertised for a period of six weeks as set out in paragraph 8 of the report.
- 4) To agree that the interview panel comprise the Vice-Chair of the Joint Board, one non-voting member of the Joint Board and two officers from the Health and Social Care Partnership.

(References – Integration Joint Board 15 December 2017 (item 11); report by the IJB Interim Chief Officer, submitted)

## **11. Edinburgh Health and Social Care Partnership Communications Action Plan**

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The Joint Board had approved the Edinburgh Health and Social Care Partnership's communications and engagement plan 2016-19 at its meeting on 13 May 2016. The plan set out the principles and protocols for communication and stakeholder engagement activity.

An action plan had been developed in response to the priorities for the next twelve months including:

- Leadership visibility
- Communicating and engaging with staff
- Engaging the public in key decisions and service development
- Engaging key stakeholders and service providers in key decisions and service development

The Strategic Planning Group had also agreed to consider feedback from the workshop on communications and engagement at their meeting on 9 March 2018.

### **Decision**

- 1) To agree the Partnership's approach and action plan for the next twelve months.
- 2) To note that a separate engagement / communication plan for the Joint Board would be presented for consideration and agreement within six months.

(References – Integration Joint Board 13 May 2016 (item 11); report by the IJB Interim Chief Officer, submitted)

## **12. Whole System Delays – Recent Trends**

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An overview was provided of performance in managing hospital discharge against Scottish Government targets, trends across the wider system, identified pressures and challenges and improvement activities. It was acknowledged that performance and delays across the whole system continued to be extremely challenging.

The following issues were raised and discussed:

- important to establish a timeframe for bringing together all the work and different dependencies to set out how the Joint Board intended to address issues going forward
- the Joint Board needed to know what transformation would look like and the expectations around a realistic budget
- need to have an understanding of care at home partner providers in terms of the commissioning process and any business cases that have not been successful
- vital to get the strategic commissioning plans in place

## **Decision**

- 1) To note the ongoing pressures and delays across the system including delayed discharge and people waiting for a package of care.
- 2) To note the range of actions being taken to address these pressures including securing additional resources in the short term to resolve the current backlog of assessments and people waiting for discharge.
- 3) To note the introduction of monthly performance scrutiny meetings in each locality to facilitate senior management scrutiny of key performance, finance and equality issues.
- 4) To note that a further report setting out the underlying longer term strategy, improvement plan, projects and actions would be submitted to a future meeting of the Joint Board.

(References – Integration Joint Board 15 December 2017 (item 7); report by the IJB Interim Chief Officer, submitted)

### **13. Review of Professional and Clinical Governance in the Health and Social Care Partnership and Membership of the Integration Joint Board**

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The Edinburgh Health and Social Care Partnership planned to review the locality structure implemented during 2017 to ensure arrangements for effective professional and clinical governance were sufficient and fit for purpose.

It was proposed that the officer appointed to act as the lead allied health professional for the Partnership be invited to become a non-voting member of the Integration Joint Board.

## **Decision**

- 1) To note the Partnership's intention to carry out a review of the current management structure limited in scope to testing whether professional assurance and clinical oversight of service delivery were sufficiently robust.
- 2) To agree to the allied health professional lead for the Partnership being invited to sit as a non-voting member on the Integration Joint Board.

(Reference – report by the IJB Interim Chief Officer, submitted)



## West Lothian Integration Joint Board 23 January 2018

### ACTION NOTE

A meeting of the West Lothian Integration Joint Board was held on 23 January 2018. The items for action and the allocation of that action are listed below.

Present –

Voting Members – Martin Hill, Harry Cartmill, Martin Connor, Alex Joyce, Dave King, George Paul and Damian Timson.

Non-Voting Members – Ian Buchanan, Carol Bebbington Jim Forrest, Mairead Hughes, Jane Houston, Jane Kellock, James McCallum, Bridget Meisak and Patrick Welsh

Apologies – Lynsay Williams , Elaine Duncan and Mary-Denise McKernan.

If you have any comments or questions, please contact Anne Higgins as soon as possible on 01506 281601.

Item	Title	Decision	Action
001	Apologies for Absence	Lynsay Williams, Elaine Duncan and Mary-Denise McKernan	N/a
002	Declarations of Interest - Members should declare any financial and non-financial interests they have in the items of business for consideration at the meeting, identifying the relevant agenda item and the nature of their interest.	None	N/a
003	Order of Business, including notice of urgent business and declarations of interest in any urgent business	N/a	N/a
004	Confirm Draft Minute of Meeting of West Lothian Integration Joint Board held on Tuesday 05 December 2017 (herewith)	Minute approved	N/a

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<p><b>005</b></p>	<p>Scottish Draft Budget 2018 - Report by Chief Finance Officer (herewith)</p>	<ol style="list-style-type: none"> <li>1. To note the issue of the Scottish Draft Budget 2018/19, which included departmental spending plans for 2018/19;</li> <li>2. To note the key economic and financial implications at a Scottish public sector wide level resulting from the Draft budget.</li> <li>3. To note the initial funding implications for Local Government and Health Boards resulting from the draft 2018/19 Scottish budget.</li> <li>4. To agree that based on further confirmation on budget implications for the IJB, an update on the 2018/19 budget for IJB functions along with an update on the IJBs medium term financial plan should be presented to the Board Development Session on 19 February 2018 and to the next meeting of the IJB.</li> <li>5. In relation to the Scottish Government's plans to introduce Minimum Unit Pricing for alcohol on 1 May 2018, it was agreed that the Director considers writing to the Scottish Government on behalf of the IJB making a suggestion about the extra revenue raised from minimum pricing of alcohol.</li> </ol>	<p>Patrick Welsh</p>
<p><b>006</b></p>	<p>The 2018 General Medical Services Contract in Scotland - Report by Chief Officer (herewith)</p>	<ol style="list-style-type: none"> <li>1. To note the key content in the proposals for the new General Medical Services Contract in Scotland.</li> <li>2. To note the timescale for voting and if approved for implementation.</li> <li>3. To note the proposed model for implementation as outlined in the report.</li> <li>4. To support plans for a Primary Care Summit to be held in May to support the development of West Lothian Primary Care Improvement Plan.</li> </ol>	<p>Jim Forrest/ Carol Bebbington</p>

<p><b>007</b></p>	<p>Workforce Development Plan 2018 - Report by Director (herewith)</p>	<ol style="list-style-type: none"> <li>1. To note the content of the report and its attachment.</li> <li>2. To support the key objectives of effective workforce planning described in the report and Plan.</li> <li>3. To note the key themes and recommendations emerging from the recently published National Health and Social Care Workforce Plan (Parts 1 and 2) and note that further recommendations would be forthcoming from Part 3 which was due to be published early 2018.</li> <li>4. To note the framework provided a foundation for the continuous work required in response to changing priorities, national and local drivers and challenges.</li> <li>5. To support the framework within the plan and associated actions.</li> <li>6. To support the stakeholder event planned in January 2018 and note that the output of this would further inform the development of the plan.</li> <li>7. To note the revised timescale for finalisation of the Workforce Plan taking account of the publication of national guidance.</li> <li>8. To agree a suggestion by the Head of Health that a report examining sickness absence be brought to a future meeting of the IJB.</li> </ol>	<p>Jim Forrest/ Marion Barton/ Carol Bebbington</p>
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<p><b>008</b></p>	<p>Community Care Eligibility Criteria (Non-Residential Services) - Report by Director (herewith)</p>	<ol style="list-style-type: none"> <li>1. To note the Scottish Government Guidance on the National Standard Eligibility Criteria and Waiting Times for Free Personal and Nursing Care, September 2009, as the established framework to determine who should receive specific public funding to address their support need.</li> <li>2. To note that the threshold for funded support for social care needs was now set at substantial for the vast majority of Scottish local authorities.</li> <li>3. To note that West Lothian Council included a saving proposal for 2018/19 to 2022/23 directly linked to setting eligibility criteria at substantial and above in its Transforming Your Council consultation in 2017.</li> <li>4. To agree to set the eligibility threshold for which direct funded support for non-residential adult social care to the level of substantial and above, taking account of increasing demand and financial constraints.</li> <li>5. To note that the council would consider the saving proposal at its budget setting meeting and that the outcome would be reported to the IJB on 13 March when it set its Directions for 2018/19.</li> <li>6. To note that work was progressing on reviewing and updating the assessment processes within the council to take account of the proposed change to the eligibility threshold for funded social care support to be introduced from 1 April 2018.</li> </ol>	<p>Jim Forrest/ Lorna Kemp</p>
<p><b>009</b></p>	<p>West Lothian Eligibility Criteria for Carer Support - Report by Director (herewith)</p>	<ol style="list-style-type: none"> <li>1. To note the IJB's duties in relation to setting eligibility criteria for carer support.</li> <li>2. To note the IJB's duties in relation to setting eligibility criteria for carer support where functions are delegated.</li> <li>3. To note the draft eligibility criteria.</li> <li>4. To note that a consultation was underway with carers and representatives of carers on the proposed eligibility criteria.</li> <li>5. To agree that a further report be brought to the IJB on 13 March 2018 following the council's consultation period to approve the eligibility criteria for adult carers who provide unpaid care for adults.</li> </ol>	<p>Jim Forrest/ Lorna Kemp</p>



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<p><b>010</b></p>	<p>MSG Indicators - Report by Director (herewith)</p>	<ol style="list-style-type: none"> <li>1. To note the requirements of the Ministerial Strategic Group for Health and Community Care (MSG).</li> <li>2. To note the progress against the 6 key indicators in 2016/17.</li> <li>3. To note that officers would check the figure shown (50.9%) for “reduction in GLS bed days in 1<sup>st</sup> quarter compared to same quarter in 2015/16” and to include a note as appropriate against this data.</li> <li>4. To support the proposed objectives for 2018/19 which were to be returned to the MSG by 31 January 2018.</li> <li>5. To note advice by the Director concerning the the number of “Delayed Discharges” over December and January and the action being taken by management team and staff to manage demand for hospital beds.</li> </ol>	<p>Jim Forrest/ Carol Bebbington</p>
<p><b>011</b></p>	<p>NHS Lothian Budget and Cost Allocation Model for Integrated Joint Boards - Report by Chief Finance Officer (herewith)</p>	<ol style="list-style-type: none"> <li>1. To note that NHS Lothian Finance and Resources Committee had agreed that the IJB budget setting model should be explored further using NRAC as the basis of resource allocation and patient level data as the basis for allocating costs.</li> <li>2. To note the proposed changes to modelling and allocating budget and costs that were intended to reflect more fairly the resources delegated to and utilised by each IJB.</li> <li>3. To note that further work was ongoing to progress the revised budget setting model and it was proposed that any changes to the budget model and associated implications would need to be considered and agreed by IJBs.</li> </ol>	<p>Patrick Welsh</p>
<p><b>012</b></p>	<p>IJB Finance Update - Report by Chief Finance Officer (herewith)</p>	<ol style="list-style-type: none"> <li>1. To note the forecast outturn for 2017/18 in respect of IJB Delegated functions taking account of saving assumptions.</li> <li>2. To note that further management action was required by Partner bodies in partnership with the IJB to manage the 2017/18 budget pressures.</li> <li>3. To note the key risks associated with the 2017/18 forecast position.</li> </ol>	<p>Patrick Welsh</p>

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<p><b>013</b></p>	<p>IJB Development Session - Report by Director (herewith)</p>	<ol style="list-style-type: none"> <li>1. To note the contents of the report.</li> <li>2. To acknowledge the challenges being faced in delivery of health and social care that were driving the need for change.</li> <li>3. To consider a review of the membership of the Board and SPG to ensure appropriate and adequate representation and support wider stakeholder engagement in development and delivery of the Health and Social Care Delivery Plan.</li> <li>4. To support review of criteria and thresholds for service provision taking account of statutory responsibilities.</li> <li>5. To support review of early intervention and preventative approaches to inform priorities for Strategic Plan.</li> <li>6. To support the development of more detailed and explicit Directions to support service redesign and transformational change programmes.</li> <li>7. To note the proposed planning cycle and agree schedule for delivery.</li> <li>8. In response to a question raised, the Board noted that the SPG had been given an update relating to slippage in Phase 1 engagement on the Locality Plan.</li> </ol>	<p>Jim Forrest/ Carol Bebbington</p>
<p><b>014</b></p>	<p>Workplan (herewith)</p>	<p>To note the Workplan</p>	<p>Anne Higgins</p>

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 23 JANUARY 2018.

Present –

Voting Members – Martin Hill, Harry Cartmill, Martin Connor, Alex Joyce, Dave King, George Paul, Damlan Timson.

Non-Voting Members – Ian Buchanan, Jim Forrest, Mairead Hughes, Jane Houston, Jane Kellock, James McCallum, Budget Meisak and Patrick Welsh.

Apologies – Lynsay Williams (Voting Member) and Elaine Duncan and Mary-Denise McKernan (Non Voting Member).

In Attendance – Marion Barton (Head of Health), Carol Bebbington (Senior Manager, Primary Care and Business Support), James Millar (Standards Officer), Loma Kemp (Executive Project Officer).

1. DECLARATIONS OF INTEREST

There were no declarations of interest made.

2. MINUTE

The West Lothian Integration Joint Board approved the minute of its meeting held on 5 December 2017.

3. SCOTTISH DRAFT BUDGET 2018 - REPORT BY CHIEF FINANCE OFFICER

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update in relation to the Scottish Draft Budget presented to the Scottish Parliament on 14 December 2017.

The Board was informed that the Cabinet Secretary for Finance and the Constitution had announced the Scottish Draft Budget 2018/19. In overall terms Scotland's total proposed spending plans, as set out in the draft Budget 2018/19, amounted to £40,639 million, an increase of £1,261 million compared to the Scottish Budget 2017/18, and as updated for the Budget (Scotland) Act 2017 Amendment Regulations 2017. The allocations per portfolio were set out in a table within the report.

The report went on to set out the position in relation to Scottish Income Tax Rates.

In relation to public sector pay awards, it was noted that the cap had been lifted and replaced for 2018/19 with a 3% minimum increase for

employees earning less than £30,000 per annum. For staff earning between £30,000 and £80,000 per annum, a pay award of 2% was proposed. It was further proposed that public sector staff earning £80,000 or more would have their 2018/19 pay award capped at a maximum of £1,600. This only applied to staff under the Scottish Government's remit, subject to consultation with Independent Review Bodies. Additional funding for pay via UK consequentials were still to be determined. In terms of Local Government, trade unions had recently submitted a pay claim for 2018/19. The key element of which was a flat rate of £1,500 increase or a 6.5% increase, whichever was greater for staff.

The report provided commentary in relation to the implications for Local Government and West Lothian Council, together with Chief Finance Officer's assessment of the implications for NHS Boards/NHS Lothian.

The Chief Finance Officer recommended that the Board:-

1. Note the issue of the Scottish Draft Budget 2018/19, which included departmental spending plans for 2018/19.
2. Note the key economic and financial implications at a Scottish public sector wide level resulting from the Draft Budget.
3. Note the initial funding implications for Local Government and Health Boards resulting from the draft 2018/19 Scottish budget.
4. Agree that based on further confirmation on budget implications for the IJB, an update on the 2018/19 budget for IJB functions along with an update on the IJBs medium term financial plan should be presented to the Board Development Session on 19 February 2018.

#### Decision

1. To note the terms of the report and
2. To agree the terms of recommendation 4 and that, in addition, a report be brought to the next meeting of the Board.

#### 4. THE 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND

The Board considered a report (copies of which had been circulated) by the Chief Officer providing the Board with a brief summary of the 2018 General Medical Services Contract proposals with timescales and a proposal for implementation arrangements.

The Board was informed that the Scottish Government and the Scottish General Practitioners' Committee of the British Medical Association had agreed the proposed terms of the 2018 General Medical Services contract offer (Blue Book), a copy of which was attached as Appendix 3 to the report. A brief initial summary of the sections of the Blue Book was attached as Appendix 2 to the report.

Appendix 1 to the report was a proposed structural approach to the implementation of the contract. It summarised the roles of the parts of the system.

The report provided links to the following documents:-

Appendix 4 – A draft Memorandum of Understanding (MOU) between the Integration Authorities (IA), the Scottish General Practitioners' Committee (SGPC) of the British Medical Association (BMA), NHS Boards and the Scottish Government.

Appendix 5 – A national code for GP Premises setting out the Scottish Government's plan to facilitate the shift to a model which did not entail GPs providing their practice premises.

It was noted that overall the Scottish Government had committed at least £250m over the coming four years to the implementation of the contract. The financial offer to GPs was to be set out in two phases with a vote on each.

A Primary Summit would be held in May to support the development of West Lothian's Primary Care Improvement Plan

Going forward, the IJB would be responsible for local engagement and the NHS Board for Lothian wide engagement.

The Board was asked to:

- Note the key content in the proposals for the new General Medical Services Contract in Scotland.
- Note the timescale for voting and if approved for implementation.
- Support the proposed model for implementation.
- Support 2<sup>nd</sup> Primary Care Summit to be held in May 208 to develop the Primary Care Improvement Plan.

During discussion, it was acknowledged that much of the details had yet to come forward. The SPG had discussed the matter at its January meeting and had agreed that more discussion was required in relation to the proposed implementation structure.

#### Decision

1. To note the terms of the report.
2. To note the proposed model for implantation as outlined in the report.
3. To support plans for a Primary Care Summit to be held in May to support the development of West Lothian Primary Care Improvement Plan.

## 5. WORFORCE DEVELOPMENT PLAN 2018

The Board considered a report (copies of which had been circulated) by the Director updating the IJB of progress made in relation to the development of the West Lothian Workforce Development Plan.

The report provided the following appendices:-

Appendix 1 – West Lothian HSCP Draft Workforce Development Plan

Appendix 2 – Flash Report from Stakeholder Engagement September 2017.

The report provided background information relating to the National Health and Social Care Workforce Plan. The report noted that Part 2 of the Plan outlined key recommendations from engagement between Scottish Government, COSLA and other key partners involved in the delivery of social care in Scotland and built on the framework for improving workforce planning across NHS Scotland contained within Part 1.

Delivery of these recommendations and improved national and local workforce planning across the health and social care sector could only be delivered through extensive partnership working across these sectors. This meant, in particular, working with the organisations that commissioned and provided services and/or their representative bodies.

The development of the first draft of the Workforce Plan was an iterative process and required further work to fully understand the shape and dimension of the future workforce and to incorporate the national guidance and recommendations as outlined in the report.

A further stakeholder event was planned for 26 January 2018 to focus on the recommendations, build on the learning from the initial event held in September 2017 and enable a detailed action plan to be developed.

It was noted that the 2018 GMS Contract in Scotland indicated the likely workforce changes required ahead of the published guidance. In light of the recently and soon to be published national guidance and GMS Contract in addition to existing workforce knowledge, it was necessary to revise the schedule for finalisation of the workforce plan to late 2018. Officers would continue to develop the draft plan as outlined in the report and would bring this back to the SPG and IJB for discussion and approval.

Finally, the report provided details of engagement and consultation undertaken in the development of the plan.

The Board was asked to:

- Note the content of the report and its attachment
- Support the key objectives of effective workforce planning

described in the report and Plan

- Note the key themes and recommendations emerging from the recently published National Health and social care Workforce Plan (Parts 1 and 2) and note that further recommendations would be forthcoming from Part 3 which was due to be published early 2018.
- Note this framework provided a foundation for the continuous work required in response to changing priorities, national and local drivers and challenges.
- Support the framework within the plan and associated actions.
- Support the stakeholder event planned in January 2018 and note that the output of this would further inform the development of the plan.
- Note the revised timescale for finalisation of the Workforce Plan taking account of the publication of national guidance.

There followed a discussion around some of the issues highlighted in the report. The Head of Health made a suggestion that a report examining sickness absence be brought to a future meeting of the IJB.

#### Decision

1. To note the terms of the report and to agree the recommendations contained in Section B of the report.
2. To agree that a report examining sickness absence be brought to a future meeting of the IJB.

#### 6. COMMUNITY CARE ELIGIBILITY CRITERIA (NON-RESIDENTIAL SERVICES)

The Board considered a report (copies of which had been circulated) by the Director providing details of the proposed approach for a change to the criteria for eligibility for non-residential Community Care services for adults and older people; and seeking agreement that this change was required in order to manage demand within future available resources.

The report explained that, under Section 12 of the Social Work (Scotland) Act 1968, local authorities had a duty to assess any adult who might need community care services. This was a two stage process involving firstly an assessment of the adult's needs and, secondly, a decision on whether those needs required the provision of community care services. To ensure a fair and consistent process, local authorities set out how eligibility would be determined through the setting of eligibility criteria for receiving care.

The current mechanism for taking account of resource availability for care needs was through applying eligibility criteria in accordance with the Scottish Government Guidance on the National Standard Eligibility

**Criteria.** This was a framework that prioritised risk and care needs into four bands. These were Critical, Substantial, Moderate and Low.

As part of the council's Transforming Your Council consultation in 2017, a draft saving proposal of £8.8 million, over the five year period 2018/19 to 2022/23, was included in relation to changing the assessment criteria for adults. This largely related to changing the threshold at which care would be provided to substantial and critical need. This would bring the council into line with the vast majority of Scottish councils who had already set the eligibility threshold at the substantial level or above. Appendix 1 to the report provided information relating to all Scottish councils.

The Director reported that social care was experiencing unprecedented growth in demand and increase in costs. West Lothian had the fastest growing elderly population in Scotland and was also facing an increase in the population. A table within the report illustrated the percentage growth in expenditure in social care client groups over the previous three years.

The Board was informed that eligibility criteria for adults had to be set under the parameters of s12A of the Social Work (Scotland) Act 1968 – duty to assess. This was a delegated function to the IJB and, therefore, the IJB was required to agree to any proposed change in eligibility thresholds before the council set its budget for 2018/19 and agree its medium term financial plan.

The Director concluded that the current provision of funded support to those with moderate care needs was not sustainable based on increasing demands and constrained funding resources. The eligibility level at which care was provided was the main driver of social care costs and the vast majority of councils already only provided direct funded care to clients assessed as having substantial or critical needs. Based on this, draft savings had been proposed in relation to eligibility but the IJB was required to agree there was a need to change the eligibility threshold to allow for these savings to be implemented.

West Lothian Council would consider the saving proposal at its budget setting meeting and the outcome would be reported to the IJB on 13 March when it set its Directions to the council and the health board for 2018/19.

It was recommended that the Board:

1. To note the Scottish Government Guidance on the National Standard Eligibility Criteria and Waiting Times for Free Personal and Nursing Care, September 2009, as the established framework to determine who should receive specific public funding to address their support need.
2. To note that the threshold for funded support for social care needs was now set at substantial for the vast majority of Scottish local authorities.
3. To note that West Lothian Council included a saving proposal for 2018/19 to 2022/23 directly linked to setting eligibility criteria at



substantial and above in its Transforming Your Council consultation in 2017.

4. To agree to set the eligibility threshold for which direct funded support for non-residential adult social care to the level of substantial and above, taking account of increasing demand and financial constraints.
5. To note that the council would consider the saving proposal at its budget setting meeting and that the outcome would be reported to the IJB on 13 March when it set its Directions for 2018/19.
6. To note that work was progressing on reviewing and updating the assessment processes within the council to take account of the proposed change to the eligibility threshold for funded social care support to be introduced from 1 April 2018.

#### Decision

1. To note the terms of the report and
2. To agree to set the eligibility threshold for which direct funded support for non-residential adult social care to the level of substantial and above, taking account of increasing demand and financial constraints.

#### 7. WEST LOTHIAN ELIGIBILITY CRITERIA FOR CARER SUPPORT

The Board considered a report (copies of which had been circulated) by the Director informing the Board of its duties under the Carers (Scotland) Act 2016 in relation to setting eligibility criteria for carer support and consulting carers and representatives of carers on the proposed eligibility criteria; and to present the draft eligibility criteria for consideration.

The Board was informed that the Carers (Scotland) Act 2016 came into effect on 1 April 2018. The Act detailed the advice, information and support which carers were entitled to in order to support them in their caring role enabling them to maintain their health and well-being and to have a life alongside caring.

From 1 April 2018, the council must:

- Identify the support needs of carers
- Prepare an adult carer support plan or a young carer statement if someone asks for one
- Provide support to carers based on local eligibility criteria
- Involve carers in planning services
- Establish information and advice services for carers

The health service must:

- Involve carers in the hospital discharge planning of the people they cared for
- Partnerships must also prepare a local Carers; Strategy and a Short Breaks Services Statement.

The council had developed draft local eligibility criteria to determine what type of support carers would be offered. The draft West Lothian eligibility criteria for unpaid carers were based on the National Carer Organisations best practice framework as included in statutory guidance and consider:

- The impact of caring on the carer
- The level of need for support
- The thresholds to be met to be eligible for support.

The draft criteria were attached as Appendix 1 to the report.

The Director concluded that both the IJB and the council had a duty to set eligibility for carer support ahead of the Carers (Scotland) Act 2016 coming into effect in April 2018. For adult carers, this duty rested with the West Lothian IJB but the statutory guidance recommended that joint criteria were appropriate.

A council consultation on the draft eligibility criteria was ongoing, after which, it was proposed that a further report was presented to Council Executive on 6 March 2018 to approve the eligibility criteria in relation to young carers and carers of children with additional care needs. The same eligibility criteria would be presented to the West Lothian IJB for approval on 13 March 2018, in relation to adult carers.

It was recommended that the Board:

1. Note the IJB's duties in relation to setting eligibility criteria for carer support.
2. Note the IJB's duties in relation to setting eligibility criteria for carer support where functions were delegated.
3. Note the draft eligibility criteria.
4. Note that a consultation was underway with carers and representatives of carers on the proposed eligibility criteria; and
5. Agree a further report on 13 March 2018 following the council's consultation period to approve the eligibility criteria for adult carers who provided unpaid care for adults.

### Decision

To note the terms of the report and to agree that a further report be brought to the Board on 13 March 2018 following the council's

consultation period to approve the eligibility criteria for adult carers who provided unpaid care for adults.

## 8. MSG INDICATORS

The Board considered a report (copies of which had been circulated) by the Chief Officer providing a summary of the progress to date made against the six Ministerial Strategic Group Indicators for Health and Community Care and the proposed objectives for 2018/19.

The Board was informed that the Integration Authority was asked to provide an update overview of local objectives and ambitions relating to the following six indicators for 2018/19 by 31 January 2018 as follows:-

1. Number of emergency admission into Acute (SMR01) specialties.
2. Number of unscheduled hospital bed days, with separate objectives for Acute (SMR01), Geriatric Long Stay (SMR01E) and Mental Health (SMR04) specialties.
3. Number of A&E attendances and the percentage of patients seen with 4 hours.
4. Number of delayed discharge bed days. An objective could be provided to cover all reasons for delay or separate objectives for each reason type i.e Health and Social Care, Patient/Carer/Family Related, Code 9.
5. Percentage of last 6 months of life spent in the community.
6. Percentage of population residing in non hospital setting for all adults and 75+. A suggested further breakdown would be: care home, at home (supported) and at home (unsupported).

Appendix 1 to the report provided the proposed summary and objectives for West Lothian. Once approved by the IJB these would be returned to the Scottish Government by 31 January 2018.

It was recommended that the Board:

- Note the requirements on the Ministerial Strategic Group for Health and Community Care (MSG).
- Note the progress against the 6 key indicators in 2016/17.
- Support the proposed objectives for 2018/19 which were to be returned to the MSG by 31 January 2018.

During discussion, officers undertook to check the figure shown (50.9%) for "reduction in GLS bed days in 1<sup>st</sup> quarter compared to same quarter in 2015/16" and to include a note as appropriate against this data.

At this point in the meeting, the Director provided a verbal update

concerning the number of Delayed Discharges over December and January and the action being taken by management team and staff to manage demand for hospital beds.

#### Decision

1. To note the terms of the report; and
2. To support the proposed objectives for 2018/19 which were to be returned to the MSG by 31 January 2018.

#### 9. NHS Lothian Budget and Cost Allocation Model for Integrated Joint Boards

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on work agreed by NHS Lothian to explore the modification of the budget setting model for functions delegated to Lothian Integrated Joint Boards.

The Chief Finance Officer advised that a report on the proposal to update the IJB budget and cost allocation model for Health functions had been agreed by NHS Lothian Finance and Resources (F&R) Committee on 15 November 2017 and it was intended that a further update on progress would be provided to F&R in early 2018.

The report contained details of the current allocation model for health functions delegated to the IJB, together with the proposed new approach to budget and cost allocation. The proposal was summarised as follows:-

**Budgets** – The allocation model would be revised to recognise proportionate shares of the total resource included within delegated functions. This would result in an NRAC share of Core, Hosted and Set Aside budgets being allocated to each IJB.

**Costs** – Patient level data would be used to create a new proxy for resource utilisation where possible. Costs associated with a specialty would be split across each IJB based on an appropriate usage related weighting, such as occupied bed days for a ward cost. It was recognised that patient level data might not be available across all services, and where this was unavailable an agreement to use NRAC to split actual cost would be pursued as an interim measure.

The Chief Finance Officer considered that allocating costs to an IJB on the basis of usage would reflect the use of services from the relevant population and would allow a better understanding of how resources should be deployed in the future.

It was noted that, following agreement by the F&R Committee and support from each IJB, a number of strands of work were proposed to be progressed. These were:-

- Application and review of NRAC shares to overall delegated (and agreed) budgets.

- Application of Patient level data to delegated costs to provide an updated share of resources.
- Agreement on the arrangements for monitoring performance.
- Agreement with IJBs on any interim arrangements required to mitigate against turbulence created from the new model;
- Agreement on the protocols for budget reallocation based on IJB requirements.

Finally the report provided a summary of West Lothian IJB considerations and potential implications.

It was recommended that the Board:

1. Note that NHS Lothian Finance and Resources Committee had agreed that the IJB budget setting model should be explored further using NRAC as the basis of resource allocation and patient level data as the basis for allocating costs.
2. Note the proposed changes to modelling and allocating budget and costs that were intended to reflect more fairly the resources delegated to and utilised by each IJB.
3. Note that further work was ongoing to progress the revised budget setting model and it was proposed that any changes to the budget model and associated implications would need to be considered and agreed by IJBs.

#### Decision

To note the terms of the report.

#### 10. IJB FINANCE UPDATE

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on the 2017/18 budget position for the IJB delegated health and social care functions, including an update on key risk areas.

The forecast position in the report reflected the most recent NHS and council outturn position. West Lothian Council was forecasting an overall breakeven budget position for 2017/18 while NHS Lothian was forecasting an overspend of £1.102 million. Further detail on the forecast position was contained in Appendix 1 to the report.

The position took account of a number of significant pressures across both West Lothian Council and NHS Lothian such as prescribing, junior medical staff costs and the cost of care home placements for older people. It was important that plans were put in place to address the areas of overspend part of prioritising and planning future resource use.

Management actions were being progressed within the West Lothian Health Social Care Partnership and at a wider NHS Lothian level to manage spend within available resources. A summary of the key risks and service pressures along with actions being progressed to mitigate the risks had been identified as well as a review of in year and future year strategic risks. These were attached at Appendix 2 to the report.

The report provided commentary on the quarter 3 budget monitoring exercise.

It was recommended that the IJB:

- Note the forecast outturn for 2017/18 in respect of IJB Delegated functions taking account of saving assumptions.
- Note that further management action was required by Partner bodies in partnership with the IJB to manage the 2017/18 budget pressures.
- Note the key risks associated with the 2017/18 forecast position.

#### Decision

To note the terms of the report.

### 11. IJB DEVELOPMENT SESSION

The Board considered a report (copies of which had been circulated) by the Chief Officer providing a brief summary of the IJB Development Day on 30 November 2017 and outlining proposed development plan with timescales.

The report recalled that the IJB had held a development event on 30 November 2017 to discuss the financial context and to consider the impact the financial challenges would have on the delivery of health and social care and what needed to be included in the Strategic Plan, Commissioning Plans and Directions to NHS Lothian and West Lothian Council.

It was noted that brief presentations had been given on:-

- Members Code of Conduct
- The Financial Context and Planning 2018/19
- Strategic Planning and Commissioning

It was noted that there were current issues in relation to market capacity affecting health and social care provision both in hospital and community with a large proportion of delayed discharges due to lack of capacity in care at home and care home provision.

The increasing population, especially amongst the over 65s would place a greater demand on services. At the same time, the economic constraints would mean that this demand needed to be prioritised and managed within constrained resources. This challenging environment, as well as advances in technology, would mean that the way services were currently delivered would need to change.

The report went on to provide commentary on Transformational Change, Enabling Change, Realistic Medicine and Directions.

The report also provided an Appendix setting out a proposed schedule for development and delivery of the revised plans.

In response to a question raised, the Board was informed that the Strategic Planning Group had been given an update relating to slippage in Phase1 engagement on the Locality Plan.

It was recommended that the Board:-

1. Note the contents of the report.
2. Acknowledge the challenges being faced in delivery of health and social care that were driving the need for change.
3. Consider a review of the membership of the Board and SPG to ensure appropriate and adequate representation and support wider stakeholder engagement in development and delivery of the Health and Social Care Delivery Plan.
4. Support review of criteria and thresholds for service provision taking account of statutory responsibilities.
5. Support review of early intervention and preventative approaches to inform priorities for Strategic Plan.
6. Support the development of more detailed and explicit Directions to support service redesign and transformational change programmes.
7. Consider the proposed planning cycle and agree schedule for delivery.

#### Decision

To note the terms of the report and to approve the recommendations set out in Section B of the report.

## 12. WORKPLAN

A copy of the Workplan had been circulated for information.

#### Decision

To note the Workplan.





# 1.13

## Midlothian Integration Joint Board

Date	Time	Venue
Thursday 11 <sup>th</sup> January 2018	2.00pm	Conference Room, Melville Housing, The Corn Exchange, 200 High Street, Dalkeith, EH22 1AZ.

### Present (voting members):

Cllr Catherine Johnstone	John Oates (Chair)
Cllr Jim Muirhead	Tracey Gilles
Cllr Margot Russell (substitute for Cllr Derek Milligan)	Alison McCallum

### 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)	Patsy Eccles (Staff side representative)
Keith Chapman (User/Carer)	Pam Russell (User/Carer)
Ewan Aitken (Third Sector)	

### In attendance:

Tom Welsh (Integration Manager)	Morag Barrow (Head of Primary Care & Older People's Services)
Mike Broadway (Clerk)	Rosie Miller

### Apologies:

Cllr Derek Milligan	Cllr Pauline Winchester
Alex Joyce	Cllr Janet Lay-Douglas (substitute for Cllr Pauline Winchester)
Hamish Reid (GP/Clinical Director)	Aileen Currie (Staff side representative)

# Midlothian Integration Joint Board

Thursday 11 January 2018

## 1. Welcome and introductions

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The Chair, John Oates, opened the meeting by expressing the Boards condolences to the family, friends and colleagues of Midlothian Councils' Provost, Councillor Adam Montgomery, who had passed away follow a short illness.

He then went on to welcome everyone to this Meeting of the Midlothian Integration Joint Board, in particular Morag Barrow, the newly appointed Head of Primary Care & Older People's Services and Councillor Margot Russell (who was substituting for Councillor Derek Milligan), following which there was a round of introductions.

## 2. Order of Business

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The order of business was adjusted as follows - Agenda Item No 5.9 - Achieving Financial Balance in the IJB, would be taken along with Agenda Item No 5.2 - IJB 3 Three Year Financial Strategy as the first items of business. This would then be followed by Agenda Item No 5.8 - IJB Property Strategy, after that the remaining items would follow the running order as printed in the agenda.

## 3. Declarations of interest

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No declarations of interest were received.

## 4. Minutes of Previous Meetings

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- 4.1 The Minutes of Meeting of the Midlothian Integration Joint Board held on 7 December 2017 were submitted and approved.
- 4.2 The Minutes of Meeting of the MIJB Audit and Risk Committee held on 5 October 2017 were submitted and noted.
- 4.3 Arising therefrom, and in response to questions regarding how progress in the actioning of decisions made by the Board was monitored, and the governance arrangements for the Audit and Risk Committee, the Board noted that any recommendations made by the Audit and Risk Committee would be fed into the Board either through the minutes, or by way of a formal report, if this was more appropriate. With regards the monitoring of the actioning of decisions, there was no formal mechanisms currently in place, it was the responsibility of individual officers to ensure that the necessary agreed actions were timeously carried out.

## 5. Public Reports

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Report No.	Report Title	Presented by:
5.9	Achieving Financial Balance in the IJB	Allister Short

# Midlothian Integration Joint Board

Thursday 11 January 2018

## Executive Summary of Report

This paper set out the current challenges to achieving financial balance in 2018/19 for Midlothian IJB and set out some initial proposals for delivering efficiencies in support of a balanced budget. The report noted the challenging position and acknowledged that the scale, pace and quantum of savings that was required went beyond what had been achieved in previous years within the Partner organisations.

The report also highlighted that whilst the high-level areas for transformational change within Midlothian and acute services detailed in the report would provide savings, there remained a projected budget gap of £1m on the required levels of efficiencies within Midlothian to achieve financial balance and further work would be necessary to provide a detailed breakdown on the proposed high-level savings. A full report would be brought to the Midlothian IJB meeting in March 2018. This would also have the details of the revised settlement from Midlothian Council and NHS Lothian, which may impact on the overall budget position for the MIJB.

## Summary of discussion

The Chief Officer in presenting the report highlighted that there was a need to remain focused on the overall aim of Integration and to deliver new models of care that better supported the population of Midlothian and improved outcomes. There was also a need to ensure that data was used to drive forward service improvements and to benchmark activity both internally and externally to better understand the capacity and capability for change. Additionally, it was important that there was engagement with both the public and the voluntary sector, which was an area that it was acknowledged still required more work.

The Board, in discussing the budgetary pressures, welcomed the ongoing dialogue with NHS Lothian and Midlothian Council seeking ways to address the current position, expressed some reservations about the prospect of potentially introducing charging for some services, particularly in terms of the impact this might have, and emphasised the importance of getting the public engagement process right.

## Decision

### The Board:

- **Noted the projected deficit of the 'do nothing' option as a result of the growth and demand pressures across health and social care;**
- **Noted that the current projections are based on information provided by Midlothian Council and NHS Lothian in advance of the Scottish Government's announcement of their financial settlement for 2018/19;**
- **Noted the options available to the MIJB and the proposed high-level areas for transformational change and disinvestment to achieve financial balance;**
- **Noted the need for greater public engagement and welcomed plans to report on this in more detail to the March 2018 MIJB meeting; and**

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- **Agreed to receive detailed information on all efficiency programmes at the March 2018 meeting of the MIJB.**

## Action

Chief Officer/Chief Finance Officer

Report No.	Report Title	Presented by:
5.2	IJB – Outline Three Year Financial Plan - 2018/19, 2019/20 and 2020/21	David King

## Executive Summary of Report

With reference to paragraph 5.1 of the Meeting of 24 August 2017, there was submitted a report which further developed the MIJB's financial strategy and provided a high level outline of the MIJB's three year financial plan that had been prepared to support the Strategic Plan.

The report advised that the multi-year outline financial plan started to lay out both the financial challenges and how these might be resolved over the next three years, and how the MIJB intended to use the financial resources available to deliver its Strategic Plan. This outline financial plan was presented both to inform the MIJB's partners of the MIJB's plans in financial terms and also to stimulate discussion around the solutions presented. It was important to note that the plan did not differentiate between which partner would deliver services, it simply took the totality of the resource available to the MIJB and employed that resource to deliver the functions delegated to the MIJB expressed in terms of 'programmes'

There were three appendices attached to this report:-

- An revision of the MIJB's financial strategy;
- An outline financial plan for the next three financial years; and
- NHS Lothian's most recent proposal on the revised MIJB budget setting process.

## Summary of discussion

Having heard from the Chief Finance Officer, who responded to Members questions/comments regarding underspends and links to community planning, the Board welcomed the ongoing development of the financial planning model and highlighted the importance of the transformation process in changing the way in which services were delivered.

## Decision

**The Board:**

- **Supported the financial strategy;**

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- Supported the financial planning model; and
- Supported the continued development of the financial planning model.

## Action

Chief Officer/Chief Finance Officer

Report No.	Report Title	Presented by:
5.8	Midlothian IJB Property Strategy	Tom Welsh

## Executive Summary of Report

This report explained the case for the MIJB developing a strategy for its future property requirements. Whilst the MIJB did not have any direct control over capital or housing revenue budgets it needed to be in a position to give clear advice to Midlothian Council and NHS Lothian about investments required to enable the MIJB to fulfil its objectives regarding the delivery of health and social care. A copy of the proposed Property Strategy was appended to the report.

The report also provided an overview of current properties in use by the local Health and Social Care Partnership and an indication of the future requirements including special needs housing.

## Summary of discussion

Having heard from the Integration Manager, the Board welcomed the development of a property strategy which it was felt would offer an opportunity to input into the forward planning for facilities such as Health Centres, Dental Practices and specialist needs housing in Midlothian.

## Decision

### The Board:

- **Noted this first version of a MIJB Property Strategy;**
- **Agreed that the issues raised in this Strategy be discussed within the relevant forums in Midlothian Council and NHS Lothian; and**
- **Agreed that a more developed Property Strategy be presented at a future meeting of the MIJB no later than early June 2017.**

## Action

Chief Officer

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Report No.	Report Title	Presented by:
5.1	Measuring Performance Under Integration	Allister Short/Tracey Gillies

## Executive Summary of Report

With reference to paragraph 5.5 of the Meeting of 20 April 2017, there was submitted a report updating the Board on performance and improvement towards achieving the Local Improvement Goals.

## Summary of discussion

The Chief Officer provided a brief introduction to the report, following which Tracey Gillies, Medical Director, NHS Lothian updated the Board on current pressures within acute services, which had seen a steep rise in admissions.

The Board, in discussing the pressures within acute, acknowledged the particular challenges which it presented, and the work that was going on to address these pressures.

Thereafter, the progress that had been made generally was considered, along with the emerging challenges that remained to be addressed. The need to continue to challenge existing ways of delivering health and care services, and the importance of ensuring that any changes were proportionate and maximised outcomes within the resources available were acknowledged, it being accepted that a balance need to be struck between what could be achieved in the community; through community facilities such as the Community Hospital; and via acute hospital provision, as each was seen as having a role to play in the process of change.

## Decision

**After further discussion, the Board:-**

- **Noted the performance across the improvement goals;**
- **Noted the particular pressures currently being experienced with acute services;**
- **Noted the positive impact that stopping the use of Liberton Hospital had had on the overall unscheduled occupied bed days; and**
- **Noted the improvement in A&E 4 hour performance for people who were subsequently admitted into hospital.**

## Action

Chief Officer

Report No.	Report Title	Presented by:
5.3	The General Medical Services Contract in Scotland	Allister Short

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## Executive Summary of Report

The purpose of this report was to provide the Board with a summary of the new General Medical Services (GMS) Contract proposals and timescales, and a proposal for implementation arrangements.

The report explained that the contract was part of the Scottish Government's plans to transform primary care services in Scotland.

## Summary of discussion

Having heard from the Chief Officer, the Board discussed the likely impact of the key principles contained in the proposals, and also the proposed structural approach to the implementation of the contract.

## Decision

### The Board:

- **Noted the key content in the proposals for the new General Medical Services Contract in Scotland;**
- **Noted that a poll of the profession will inform a vote on the contract proposals, the outcome of which would be known on 18 January 2018; and**
- **Agreed to support the model for implementation as set out in the report.**

## Action

Chief Officer

Report No.	Report Title	Presented by:
5.4	Carers (Scotland) Act 2016	Allister Short

## Executive Summary of Report

The paper sets out the requirements for the need to review the Midlothian Integration Scheme as a result of the Carers (Scotland) Act 2016.

The report explained that given that the Integration scheme was submitted less than 3 years ago, the main purpose of the review would be to focus on the legislative changes brought about by the new Act rather than a systematic review of the Integration scheme itself. In line with previous arrangements, the review would be subject to public consultation and governance sign-off by each Partner.

## Summary of discussion

The Board, having heard from the Chief Officer, who responded to Members' questions, discussed the prospective timescale for the review, expressing support for the review focusing on the changes required as a result of the new legislation.

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## Decision

### The Board:

- **Noted the requirement to review the Integration scheme as a result of the Carers (Scotland) Act 2016 coming in to force on 1 April 2018, which places some new duties on Integration Joint Boards, for both adult and children's services;**
- **Noted that NHS Lothian has since written to the Chief Executive of Midlothian Council setting out the intention to work collectively to review the Integration scheme;**
- **Agreed that the focus of the review should be on the required adjustments arising from the Carers Act; and**
- **Noted and agreed that the request asking for the revised Integration schemes being presented back to Scottish Government by 2 March 2018 is not achievable and that NHS Lothian will advise Scottish Government accordingly of an appropriate timeline.**

## Action

Chief Officer

Report No.	Report Title	Presented by:
5.5	Regional Planning – Health & Social Care Delivery	Allister Short

## Executive Summary of Report

The purpose of this paper was to update the Board on the progress being made in developing a regional plan for health and social care in the East region of Scotland and to seek agreement to support a regionalised approach to diabetes prevention.

The report advised that the outline Regional Plan was due to be presented to Scottish Government shortly and further reports on progress on the regional plan would be presented to future meetings of the MIJB. The proposed regional partnership approach to diabetes prevention has been developed by the Chief Executive's from Scottish Borders Council and NHS Borders; a detailed copy of the proposals was attached as an appendix to the report.

## Summary of discussion

The Board, having heard from the Chief Officer discussed the excellent work which had already been started on addressing and preventing diabetes, with a local partnership having already been established ensuring that Midlothian was well placed to contribute and influence the proposed Partnership as well as benefitting at a local level.



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## Decision

### The Board:

- **Noted the progress to date on developing and implementing the Health & Social Care Delivery Plan in the East region in relation to primary, community and social care;**
- **Noted the work being done, led by Scottish Borders, to establish an East of Scotland Diabetes Prevention Partnership; and**
- **Agreed that Midlothian IJB supports the establishment of a regional approach to the Diabetes Prevention Partnership and to confirm our commitment to being involved in this Partnership.**

## Action

Chief Officer

Report No.	Report Title	Presented by:
5.6	Community Payback Order Annual Report 2016/17	Alison White

## Executive Summary of Report

The purpose of this report was to bring to the IJB's attention the Community Payback Order (CPO) Annual Report 2016/17; a copy of which was appended to the report.

## Summary of discussion

The Board, having heard from the Chief Social Work Officer discussed the excellent work undertaken by the Criminal Justice team in Midlothian.

## Decision

### The Board:

- **Noted the content of the Community Payback Order Annual Report 2016/17.**

## Action

Chief Officer

Report No.	Report Title	Presented by:
5.7	Chief Officer's Report	Allister Short

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## 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 service developments.

The report highlighted in particular the work that had been undertaken in partnership with all Practice in Midlothian to review practice boundaries to ensure almost universal coverage of at least 2 Practices covering every area of Midlothian, which was good for patient choice but also means that Practices were not stretched too thinly.

## Decision

**The Board, having heard from the Chief Officer:**

- **Noted the issues and updates raised in the report.**

## Action

Chief Officer

## 6. Any other business

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No additional business had been notified to the Chair in advance.

## 7. Date of next meeting

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The next meeting of the Midlothian Integration Joint Board would be held on:

- Thursday 8<sup>th</sup> February 2018      2pm    Development Workshop
- Thursday 1<sup>st</sup> March 2018      2pm    **Midlothian Integration Joint Board**

The meeting terminated at 4.17 pm.



**MINUTES OF THE MEETING OF THE  
EAST LoTHIAN INTEGRATION JOINT BOARD**

**THURSDAY 21 DECEMBER 2017  
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON**

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**Voting Members Present:**

Mr P Murray (Chair)  
Councillor S Akhtar  
Councillor S Currie  
Councillor S Kempson  
Councillor F O'Donnell  
Ms F Ireland  
Mr A Joyce  
Ms M Whyte

**Non-voting Members Present:**

Ms F Duncan  
Dr M Flynn  
Ms E Johnston  
Mr D King  
Ms A MacDonald  
Mrs M McKay  
Mr T Miller  
Ms S Saunders  
Mr D Small  
Mr A Wilson

**ELC/NHS Officers Present:**

Ms J Ogden-Smith  
Mr P Currie

**Visitors:**

Mr D Melly, Audit Scotland

**Clerk:**

Ms F Currie

**Apologies:**

Dr R Fairclough  
Dr A Flapan  
Ms M McNeill

**Declarations of Interest:**

None

## **1. MINUTES OF THE MEETING OF THE EAST LoTHIAN INTEGRATION JOINT BOARD ON 26 OCTOBER 2017**

The minutes of the meeting on 26 October 2017 were agreed, subject to an amendment on page 8 - the summary of the private discussion. (Further detail is provided at the end of these minutes.)

## **2. MATTERS ARISING FROM THE MINUTES OF 26 OCTOBER 2017**

**(Item 4) Carers Strategy** – Councillor Shamin Akhtar asked for an update on progress. David Small advised that work was underway and that the Strategy should in place by the end of the financial year. Jane Ogden-Smith added that the consultation would be available on the Council's website (Consultation Hub) until the end of the month. Margaret McKay observed that the membership of the working group had fluctuated which had slowed things down. She said that it was important to involve those out with the voluntary sector and she suggested that it might be possible to develop policies out with the formal meeting structure.

**(Item 6) Financial Position** – Councillor Fiona O'Donnell asked if it would be possible for members to receive information on how spending relates to individual Directions. Mr Small indicated that the Directions link directly to the IJB's budget and the monies provided by the two Partners. He said that the paper at Item 8 on the Agenda would provide more information on the current position.

Councillor O'Donnell commented that if the IJB had a budget overspend then it was not spending the amounts originally set for the delivery of its Directions. Having access to this information would allow members to understand where exactly the IJB was overspending.

David King acknowledged these comments and accepted that he did not always bring all of the detailed figures to the IJB. However, he advised that there would be a finance development session in January 2018 which would allow discussion on this and other matters. The Chair thanked Councillor O'Donnell and confirmed that action would be taken to address this issue.

**(Item 3) Engagement Strategy** – Mr Small reported that officers had been looking at the South Lanarkshire model and how this might be structured for East Lothian. He said that a draft would be prepared and presented to a future meeting of the IJB.

**(Item 5) Performance Reporting** – Mr Small reminded the IJB that at the last meeting it had been agreed that further information on satisfaction levels would be circulated to members. Paul Currie confirmed that this had been done

**(Item 5) Scottish Government Data Group** – Mr Currie said that the Group had met and was looking at improving reporting, analysis and dissemination techniques.

**Delayed Discharges** – Mr Small advised that the census figure for November was 17 and that good progress was being made. He praised Alison MacDonald and her team for their efforts.

### **3. CHAIR'S REPORT (VERBAL)**

The Chair said that he and Councillor O'Donnell had attended a meeting for Chairs and Vice Chairs of IJBs to discuss the issue of finance. Details of the outcome of this meeting had been circulated to members.

In addition, he had attended a meeting of the Belhaven Forum, but would provide more details of this under item 6, and the newly instituted North Berwick Forum. He reported that the group in North Berwick had made an encouraging start with a good dialogue opening up between the various parties. Mr Small agreed that the discussion had been very positive and added that the next meeting would consider the issue of care homes.

Councillor O'Donnell reported on the Musselburgh Forum meeting and the group's desire to be involved and engaged in the process.

The Chair also reported on his attendance at the recent Audit & Risk Committee meeting and advised that the Internal Audit Strategy report would be brought to the next IJB meeting.

Lastly, the Chair said he had met with the other Lothian IJB Chairs to look at how they could work together more effectively. The example they considered was Hospital to Home and the potential efficiencies that could be made across the system.

### **4. NHS HEALTHCARE GOVERNANCE COMMITTEE (VERBAL)**

Fiona Ireland advised that the East Lothian IJB had been the first to bring a paper to the Committee describing governance arrangements for the IJB. The Committee was particularly interested in the care element and asked that the paper be brought back when this had been further developed.

Alison MacDonald added that there had been discussion around the overlap with other Lothian IJBs, who each have responsibilities for clinical governance, and how to identify a collective framework.

### **5. EAST Lothian COUNCIL POLICY & PERFORMANCE REVIEW COMMITTEE AND AUDIT & GOVERNANCE COMMITTEE (VERBAL)**

Mr Small reported that there had not been a meeting of the Council's Policy & Performance Review Committee since the last IJB. However, the Audit & Governance Committee had met in November and had considered the Health & Social Care Partnership Risk Register. Mr Small said that this Risk Register had also been mentioned at the Audit & Risk Committee meeting earlier in the month and it had been agreed that a development session would be arranged.

### **6. OPTIONS FOR FUTURE PROVISION OF WARD 2 BELHAVEN HOSPITAL**

The Chief Officer had submitted a report for the IJB to consider the options for the future provision of the 12 beds currently provided within Ward 2 of Belhaven Hospital in order to address current unacceptable risks to patients and staff arising from the layout and environment of the ward.

The Chair provided clarification of Option No. 5, which had been developed following the views expressed at the Belhaven Forum meeting on 28 November 2017. This information had been circulated but when it was clear that it did not meet with the approval of members on the Forum it had been withdrawn. The Chair also outlined the procedure for dealing with this item of business. He said that Ms MacDonald would introduce the report and take questions from members. This would be followed by a statement from Stephen Bunyan, longstanding member of the Belhaven Forum and comments from IJB members.

Ms MacDonald presented the report going over the background and proposed options in some detail. She added that in response to a request from one of the members she had prepared some additional information regarding bed numbers. She circulated a paper copy of the information and outlined the key figures.

A lengthy debate followed during which Ms MacDonald answered questions regarding previous investment in Ward 2, implications for the loss of beds and the capacity of other services to provide alternatives, the impact on patients and the proposed transition arrangements. Ms MacDonald also provided information on how the options would impact on the provision of other services such as palliative care, and on future proposals for improvements and expansion of care at home.

Mr Bunyan reported that the Forum had discussed all of the proposed options for Ward 2 at their meeting on 28 November and he highlighted a number of points which had been identified by the members. Concerns had centred on the impact of losing 12 beds and the potential transport difficulties for families in travelling further afield to visit relatives. However, some members had favoured the idea of moving to alternative forms of care – either at home or in other facilities across the county. Whatever option was chosen members were very keen to ensure that transition arrangements were clear and were handled sensitively. Mr Bunyan advised that while the Forum members had failed to reach a consensus view on their preferred option, they had agreed that Ward 2 was no longer fit for purpose and that something needed to be done to address this urgently.

The Chair thanked Mr Bunyan for his comments and acknowledged that it was an almost impossible task to get consensus from such a variety of views. He added that the Forum members had had every opportunity to submit their views in advance of this meeting and that officers had been as transparent as possible.

Alex Joyce thanked Ms MacDonald for her report. He was of the view that NHS Lothian were unlikely to agree to fund the full refurbishment of Ward 2. He referred to the assurances given on bed capacity through alternative care home provision and Hospital to Home services and, while he accepted that there were still some concerns, he considered that Option 3 was the best way forward.

Ms Ireland acknowledged the contribution of staff in the hospital who had continued to deliver high quality care in a difficult environment. She said it was very important to provide care which was fit for purpose and to take a productive and planned approach to services. She stated that the only solution which was fit for purpose was Option 3.

Councillor Susan Kempson appreciated the attachment to Ward 2 within the community and that people may see this as the thin end of the wedge. However, she observed that closure had been on the horizon for a while and that Option 3 did not mean the loss of clinical activities but rather their provision elsewhere. She said that there would be additional benefits from the provision of a community hub in the Ward 2 building and that

this would also provide an opportunity to assess health and social care requirements for future increases in population.

Thomas Miller agreed that Ward 2 was no longer fit for purpose, however, he reminded members that work was currently being done on the preprovision of Abbey, Belhaven, Eddington and Esk Green and he questioned whether today's decision was premature.

Mrs McKay observed that whenever a move might be problematic or risky carers would always be concerned about the potential impact on their relatives. She noted that whatever option was chosen it would involve moving patients and this risk could not be avoided. She concluded that what was most important was how any move was managed and working with patients and carers to achieve the best outcome.

Councillor O'Donnell thanked those who had commented and those who had e-mailed her with their views. She said that one of the main concerns was on the potential loss of bed capacity. However, she said she was reassured that there were options for people not from Dunbar to move closer to their homes. She believed that dignity, respect and choice were at the heart of good care and that the current ward environment compromised that, regardless of the efforts of staff. She concluded that in her view Option 3 was the right way forward. She was reassured that work on delayed discharges was going well and that this would continue. She also reiterated Mrs McKay's point on the importance of engagement with patients and carers.

Councillor Stuart Currie wanted to know how the situation in Ward 2 had been allowed to get to this point. He noted from the report that although some of the work required was substantial, other issues were minor and he wanted to know why these had not been addressed sooner. He believed that there had been no substantial investment in the work as there had been no interest in securing a long-term future for the ward. His concern was that once beds were lost they could not be brought back and whatever the option agreed today, there would be a loss of beds. He acknowledged the views expressed but referred to the example in Musselburgh where the community had waited 5 years for a new care home to be built. He concluded that, although not perfect, Option 4 was the best way forward.

Councillor Akhtar echoed Mr Bunyan's point that the ward was no longer fit for purpose and she said she felt reassured by the information provided within the report that option 3 would provide the required capacity while allowing the hospital to continue its three main support functions. She viewed this solution as a proactive way to achieve improved and increased access to care at home and she underlined the importance of staff working closely with families during the transition period.

Ms Ireland referred to previous discussions within the IJB about improvement and transformation of services. She observed that this was the first opportunity for the IJB to genuinely transform care for people in East Lothian.

The Chair drew the discussion to a close. He echoed Ms Ireland's last point and moved to the approval of the recommendations. The members agreed unanimously to support recommendations (i) and (iii).

The Chair agreed to a request from Councillor Currie that the vote on recommendation (ii) would be taken by a show of hands:

For: 7

Against: 1

Abstentions: 0

## **Decision**

The IJB agreed to:

- i) Discuss the options for future provision of Ward 2 at Belhaven Hospital
- ii) Support the delivery of the recommended Option No. 3, as described in the report
- iii) Note the engagement with representatives of the Dunbar area and the Belhaven Forum.

Councillor Currie asked that it be formally recorded that, in relation to recommendation (ii), he had supported Option No. 4.

## **7. THE 2018 GENERAL MEDICAL SERVICES CONTRACT IN SCOTLAND**

The Chief Officer had submitted a report to provide the IJB with a brief summary of the 2018 General Medical Services Contract proposals and timescales and a proposal for implementation arrangements.

Mr Small presented the report advising members that the new contract proposed a major change to general practice. He referred them to the details of the proposals set out in the report and outlined one or two of the key changes. He said that the proposals were supported by the Scottish Government and the British Medical Association (BMA) and would be voted on by GPs in January 2018. He also indicated that while the NHS would take the lead in negotiations, GPs from East Lothian had been involved in discussions at sub-committee and forum level and there was a proposal to establish a Lothian General Medical Services Oversight Group.

In response to questions from members, Mr Small advised that if the new contract was not approved then then current arrangements would remain in place. Dr Morgan Flynn explained that the GP vote would take place in two stages: the first stage would be in January 2018 and the second would take place 18 months later. Mr Small reiterated that this was a national agreement and that local issues such as future arrangements for services, premises, and interactions with other practitioners would be discussed and agreed at local level.

In response to further questions, Dr Flynn provided information on the practice funding formula, caps on patient registration and the need for modernisation of GP practices to make any new contract sustainable.

## **Decision**

The IJB agreed to:

- i) Note the key content in the proposals for the new general medical Services Contract in Scotland
- ii) Support the model for implementation.

## **8. FINANCE UPDATE – DECEMBER 2017**

The Chief Finance Officer had submitted a report laying out the current financial position for the IJB and the actions being taken by the management team.



Mr King presented the report outlining the current position. He advised that while NHS Lothian were forecasting a modest overspend in the set aside budget, there was likely to be a slight underspend elsewhere. East Lothian Council's most recent figures suggested there would be overspend in the social care budget. If this remained the case, then the IJB's budget would be overspent and it must prepare appropriate recovery plans. Mr King explained that discussions were ongoing with the partners and, in the meantime, the IJB needed to consider what other actions should be put in place.

Mr Small referred members to the information provided in the report on the existing efficiency plans. He indicated that a significant amount of savings were to be made in the second part of the year and, in the meantime, there had been slippage on delivery of efficiency savings in the first part of the year. Recovery plans had been drawn up but further action was needed. He drew member's attention to one option which was to use currently uncommitted MELDAP reserves.

Councillor O'Donnell expressed concern about the pressures facing the IJB in 2018/19 such as the rise in the living wage. She asked if any financial modelling had been done. Mr Small explained that growth could be modelled but it was not as easy to quantify some future costs such as those related to the implementation of the Carers Act.

Councillor O'Donnell also asked whether it would be possible for the IJB to use MELDAP reserves, specifically allocated by Government, to address pressures elsewhere. She added that the Council would want to know for the future is money ring-fenced to the IJB were not likely to remain ring-fenced.

Councillor Akhtar commented that MELDAP needed to take a long-term view and look at how this might impact its ability to deliver services. She emphasised the importance of continuing to support one of the most vulnerable groups in the community.

The Chair acknowledged these remarks and indicated that he was seeking clarification on whether the IJB would be able to utilise the MELDAP reserves.

Councillor Currie agreed that if the reserves were to be used elsewhere the IJB needed to know the impact on services. Referring to the recovery plans, he asked if there would be additional resources available similar to last year and, what would happen if there were no additional funds and the IJB failed to address the current year overspend.

Mr Small advised that there were no additional funds this year as the sum provide last year was non-recurring. He said that the IJB had to get to as close as possible to a break even position and then look at other options, e.g. the MELDAP reserves.

Mrs McKay referred to the number of young carers supporting their families where parents had drug and alcohol issues. She urged that this issue be addressed in terms of support for young carers. She said that the needs of children were often overlooked and that it would be a matter of concern if this issue was not being adequately addressed.

Sharon Saunders advised that any proposals for the use of MELDAP reserves would have to be discussed at its strategic planning group so that any impact on other long term plans could be properly considered. She also referred to the previous point raised regarding Government funding and MELDAP's own annual reporting on the use of its funding as further issues to be taken into account. She agreed that clarification was needed before any decision could be taken by the IJB.

## **Decision**

The IJB agreed to:

- i) Note the current position
- ii) Consider the recovery plans including an IJB directed recovery plan
- iii) Support the recovery plans.

The Chair requested that it be formally noted that he would write to the Council seeking clarification on whether the IJB could use the MELDAP reserve as part of its recovery plan. He also agreed to Councillor O'Donnell's request that a report would be brought back to the IJB with an impact assessment.

## **9. 2018/19 INITIAL FINANCIAL OUTLINE**

The Chief Finance Officer had submitted a report laying out a very high level expression of the potential financial challenges that the IJB will face based on the 'do nothing' option.

Mr King presented the report summarising the key points in relation to the process and timetable for receiving budget propositions from the Partners, the impact of the Scottish Government financial settlement and the likely financial pressures for 2018/19. He said that further detail and implications would be presented to members at a development session on 25 January 2018.

Mr Small outlined changes to the Council's budget-setting process for the coming year and said its budget should be agreed in February 2018. NHS Lothian should have a draft budget in place by February with final propositions to be agreed later in the year. He suggested that a development session on finance might take place in January. He reminded members that the Partners each had a legal obligation to produce a balanced budget and it would be important to consider how this would affect the IJB's delegated functions and forward plans.

Mr King added that the IJB would need to give consideration to how it negotiates with its Partners and to make a realistic assessment of the resources needed to implement its plan.

Councillor Currie referred to the discussion which took place at the Audit & Risk Committee and that if the IJB accepted the offer then it must also accept the efficiency savings and the fact that some things may not be possible. He asked whether the requests which CoSLA had made of the Scottish Government in relation to Health & Social Care were included in the figures.

The Chair stated that the IJB must ensure that any figures reflect its transformation ambition and the need to do things differently and that any decisions could be defended if challenged by the Scottish Government or others.

Councillor Currie observed that real transformation of services could not be achieved in the short-term.

Mr Small said that the Strategic Planning Group had discussed revised priorities and what the IJB might 'de-escalate' to live within current budgets but still improve services.

## **Decision**

The IJB agreed to note the contents of the report.

### **10. CHANGE TO THIRD SECTOR MEMBERSHIP OF THE EAST LOTHIAN INTEGRATION BOARD**

The Chief Officer had submitted a report informing members of a change to the Third Sector membership of the IJB.

The Chair welcomed Elaine Johnston as the new Third Sector representative, replacing Eliot Stark.

Ms Johnston introduced herself and reminded members of the new process to identify Third Sector delegates for all planning & strategic groups and the IJB. Shae said that this larger pool of delegates offered the opportunity for a wider representation, a broader view and more engaged discussion.

## **Decision**

The IJB agreed to note the change in membership.

### **11. THE ROLES OF MEMBERS OF THE IJB**

Mr Small reported that Marilyn McNeill had provided very helpful feedback based on the experiences of other IJBs and had put forward some suggestions regarding the induction process for members.

Mrs McKay advised that a meeting of Carer representatives from all IJBs had discussed and prepared a draft role description. This would be signed off in February 2018 and made available to all IJBs.

The Chair said that it was his and David Small's intention to formalise the role of IJB members. Mr Small added that they would take in account the feedback from Ms McNeill and Mrs McKay and he suggested that Ms Johnston may also provide input from a Third Sector perspective. Ms Johnston indicated that the Third Sector Alliance, the countrywide organisation, may provide useful some information

## **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 the Meeting of the East Lothian Integration Joint Board on 26 October 2017 (Amendment to Private Item or Business)**

The minutes of the meeting on 26 October 2017 were agreed, subject to an amendment to the summary of the private discussion.

Chief Officer, Acute Services

## UNSCHEDULED CARE: CURRENT PRESSURES

### 1 Purpose of the Report

- 1.1 The purpose of this report is to update the Board on the current unscheduled care pressures being faced across acute hospitals and to describe the actions being taken to mitigate these.

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

### 2 Recommendations

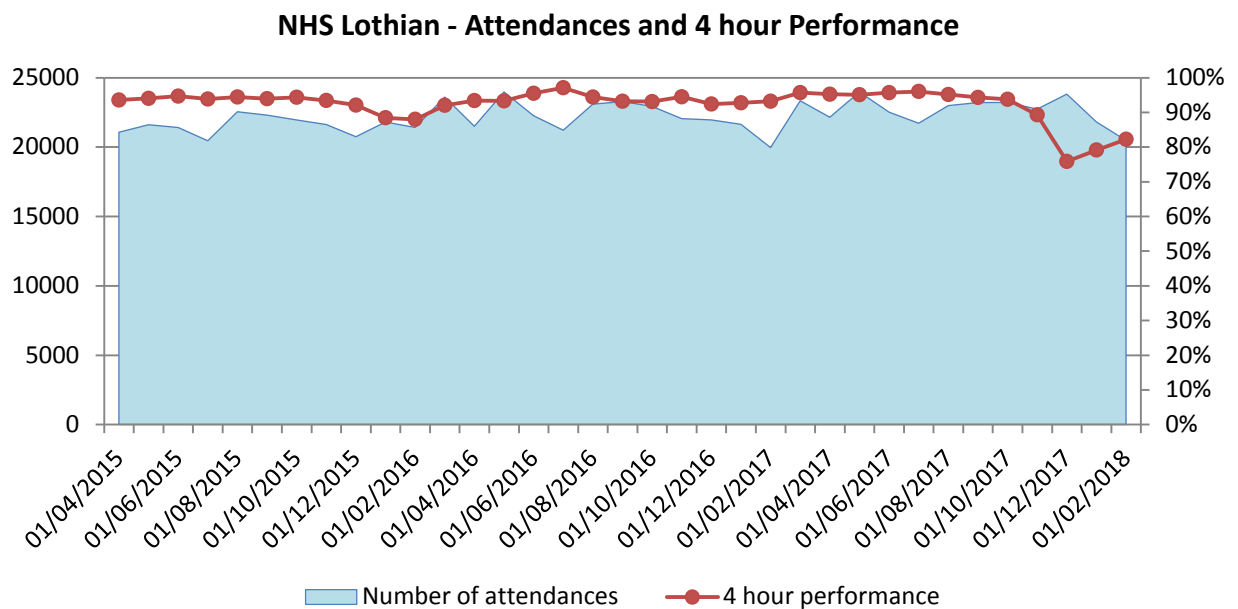
- 2.1 **Note** the pressures on the system detailed in sections 3.1 to 3.15.
- 2.2 **Endorse** actions taken to support patient and staff experience and to improve the current performance across the system.

### 3 Discussion of Key Issues

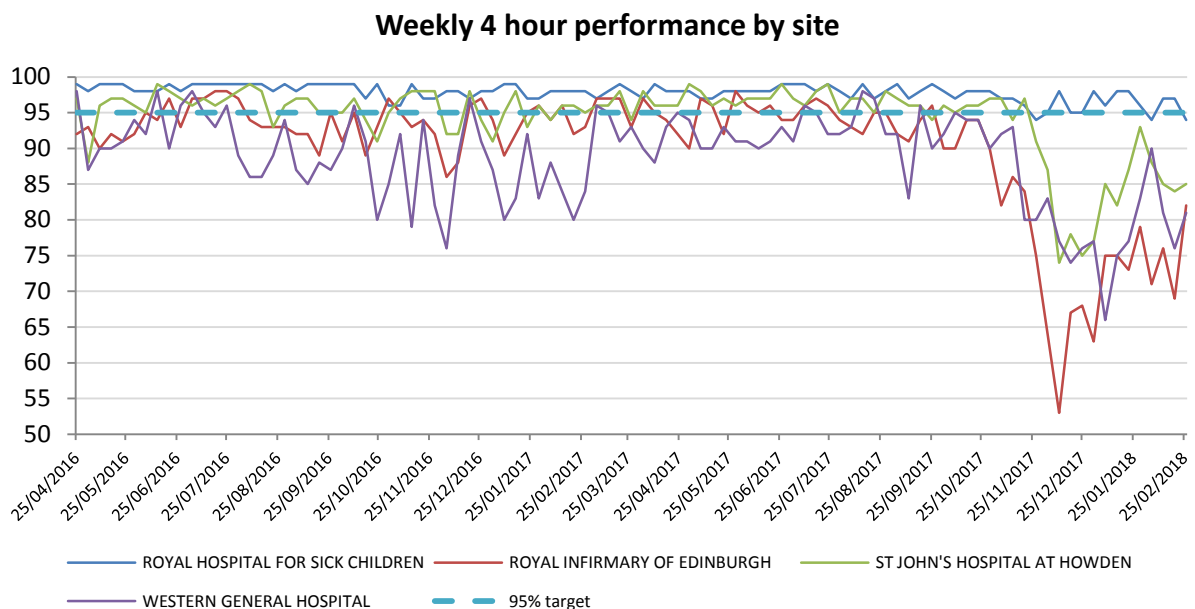
#### Current pressures and context

- 3.1 The 4-hour emergency access standard is a whole system measure; to either admit or provide definitive treatment and discharge for 95% (95% interim standard as milestone in achieving 98%) 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 with this standard of 76% for the month of December 2017, 79% for January 2018 and 82% for February 2018. Figure 1, below, demonstrates performance against the standard by month alongside total front door emergency attendances and figure 2 breaks the performance against the standard down by site.

**Figure 1 – Performance against the 4-hour emergency access standard, and total front door emergency attendances, NHS Lothian all sites.**



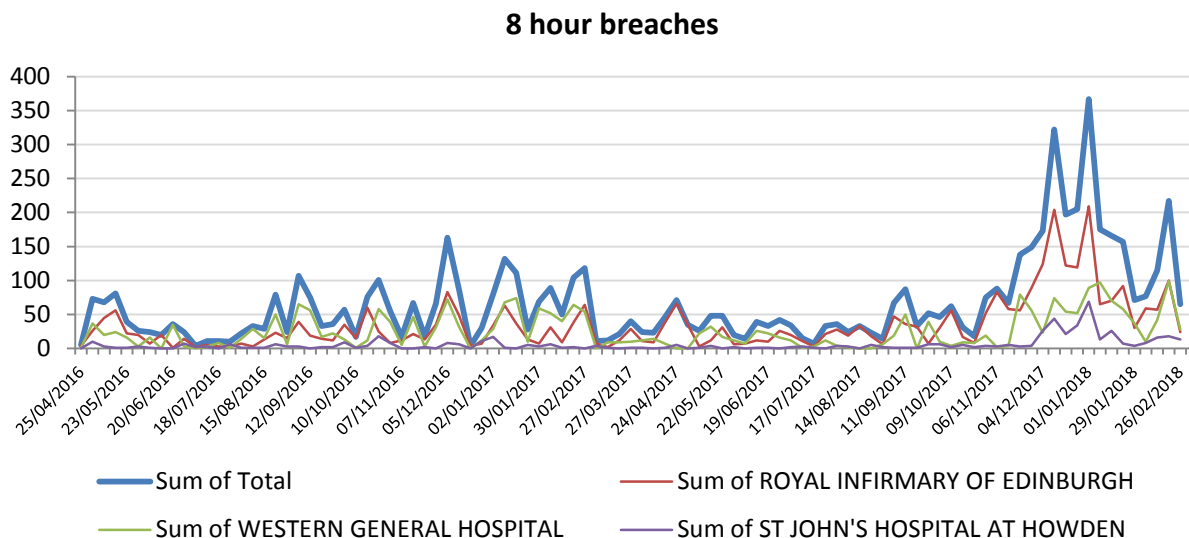
**Figure 2 – Performance against the 4-hour emergency access standard, all NHS Lothian sites.**



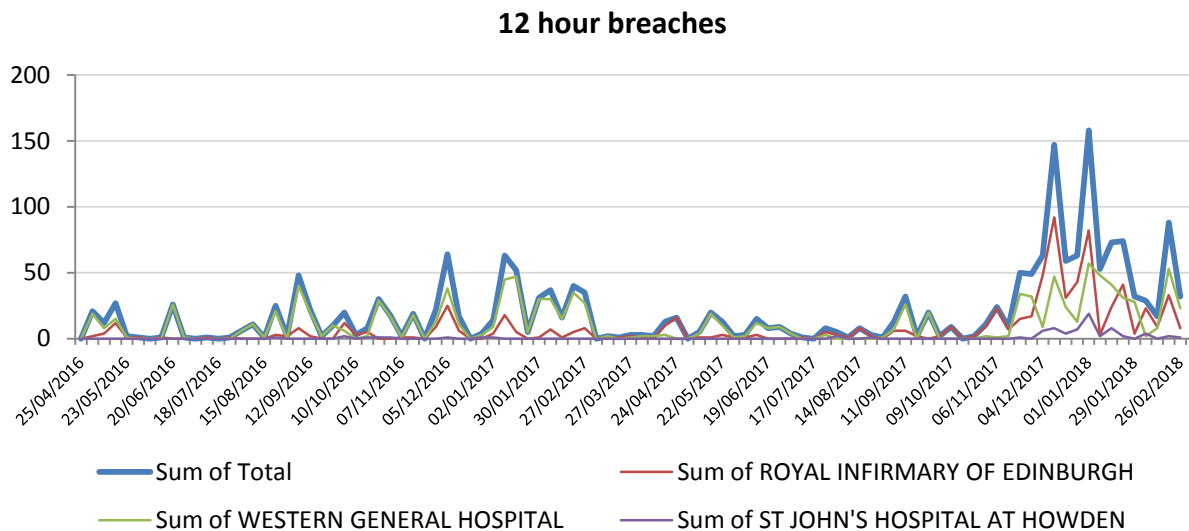
- 3.3 The 4-hour emergency access standard is a barometer of whole system pressures and is not an Emergency Department standard.
- 3.4 The performance against the 4-hour emergency access standard is influenced by a range of factors including, but not limited to, the volume of Emergency Department (ED) attendances, the arrival of ED attendances i.e high volumes within a short period causing crowding, patient acuity and bed pressures, including Delayed Discharges.
- 3.5 Figures 3 and 4 below show the impact of continued pressures that exist throughout adult acute services by the number of 8 hour and 12 hour breaches per week. These

long waits have a direct impact on patient experience and add to ED crowding. This data represents performance trends across the weeks of 25/04/2016 to 26/02/2018.

**Figure 3 – Number of 8 hour breaches across NHS Lothian adult sites per week**

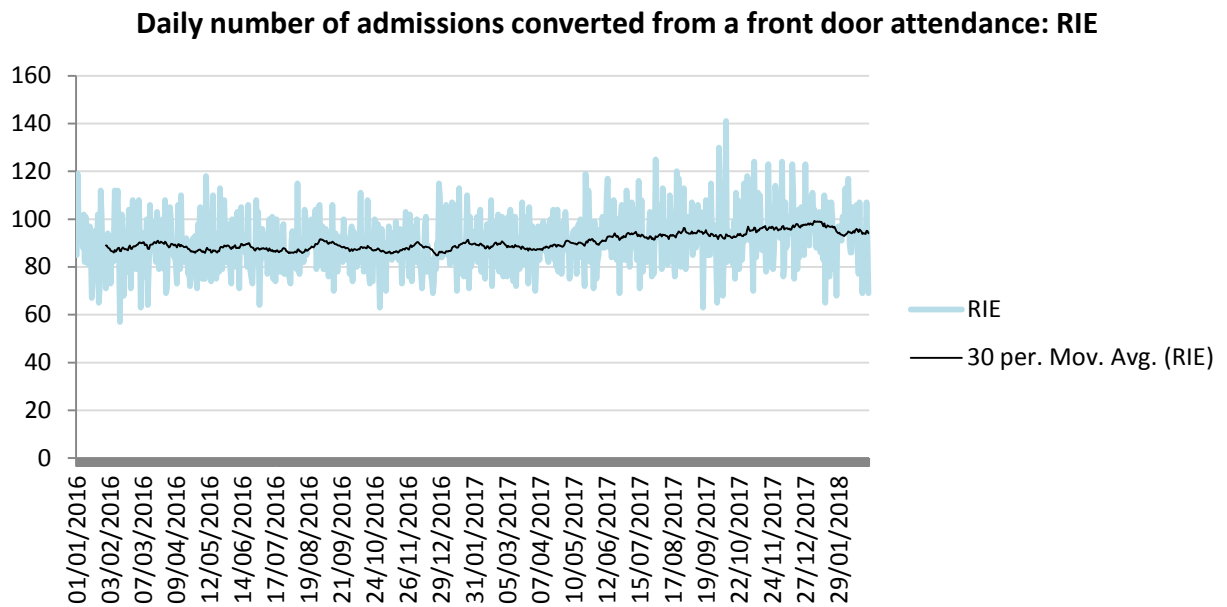


**Figure 4 – Number of 12 hour breaches across NHS Lothian adult sites per week**

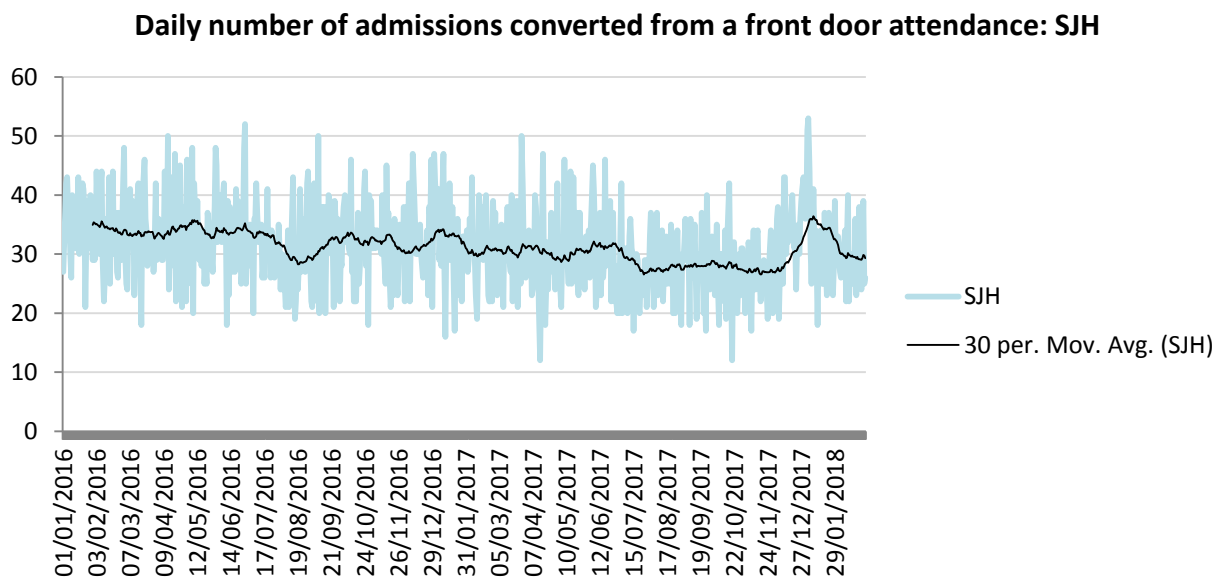


3.6 Both the RIE and SJH saw an increase (in the winter months) in the number of unplanned patients admitted who had originally attended the emergency departments. Figures 5 and 6 illustrate this increase.

**Figure 5 – RIE Number of daily admissions from front door attendances with 30 day rolling average trend.**



**Figure 6 – SJH Number of daily admissions from front door attendances with 30 day rolling average trend.**

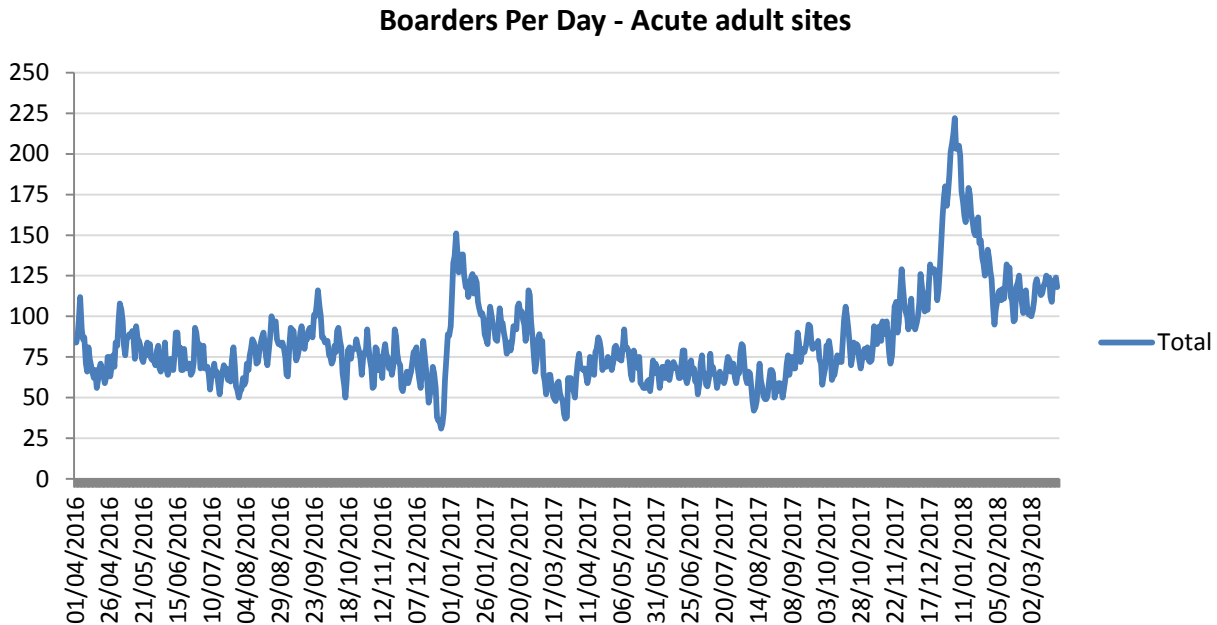


3.7 The number of patients boarded outwith their required speciality is another indicator of pressure on the system and can result in a longer length of stay for individual patients, therefore impacting on their experience, and frequently impacting on the elective programme. Figure 7 illustrates the significant increase in boarded patients over the 2017/18 winter period.

Caveats to note with this data:

- The current allocation of boarders appears to be an arbitrary and inconsistent process. Therefore, the purpose of this dashboard is to try and establish indicative trends of the volumes of boarders based on a consistent methodology.
- The patient must be under the care of an acute surgical or acute medical specialty\*
- The ward of the patient must be for the exclusive use of only an acute surgical or acute medical specialty
- The patient must be under the care of an acute surgical specialty in an exclusively acute medical ward OR the patient must be under the care of an acute medical specialty in an exclusively acute surgical ward
- Volumes of boarders are based on a 7:00am census point.
- \*Patients are classified as being part of a specialty group which determines whether a patient is a boarder. Full details of this underlying methodology are available on request.

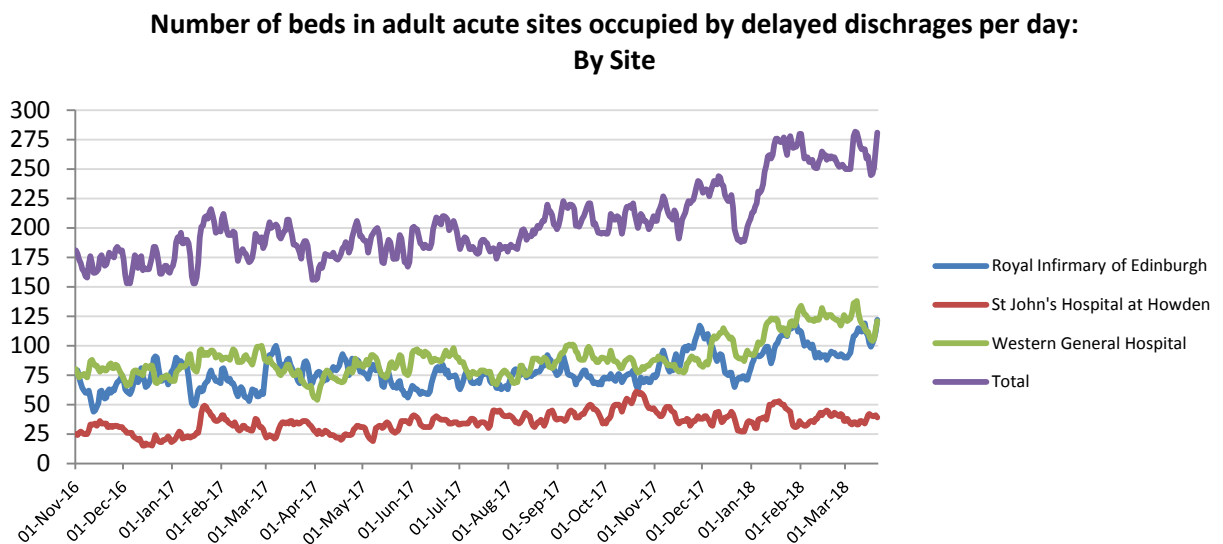
**Figure 7: Increase in boarders**



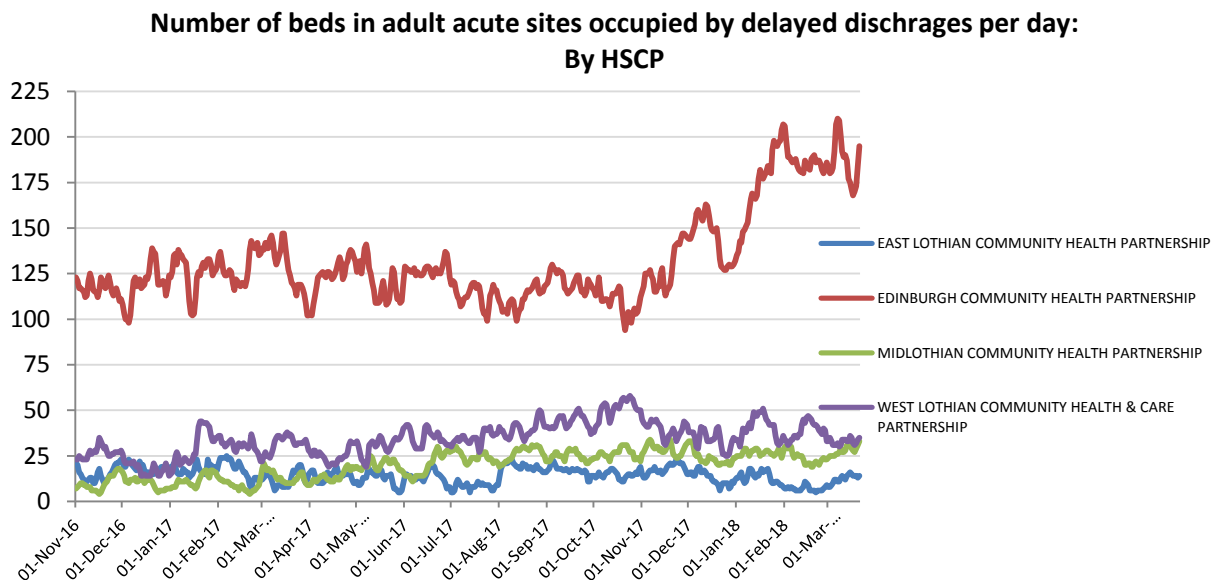
- 3.8 Delayed discharges represent poor experience for patients but also impact on patients needing to be admitted. This is a key measure of Integrated Joint Board performance, with the expectation being that no patients should be delayed for more than 3 days.
- 3.9 NHS Lothian’s four Health and Social Care Partnerships (HSCPs) have been regularly reporting that despite making clear improvement in the actual number of patients being discharged, this is in fact being offset by the number of patients being added to the delayed discharge list. Key issues in this respect include the ability to access community capacity including residential and nursing homes and social care support at home.
- 3.10 Figures 8 and 9 below detail the trend in the number of beds occupied by delayed discharges each day, by sites, and by HSCPs. This shows the already deteriorating performance significantly deteriorate further from January 2018 onward.



**Figure 8 – Daily number beds occupied by patients delayed in their discharge, by each adult acute site, NHS Lothian**



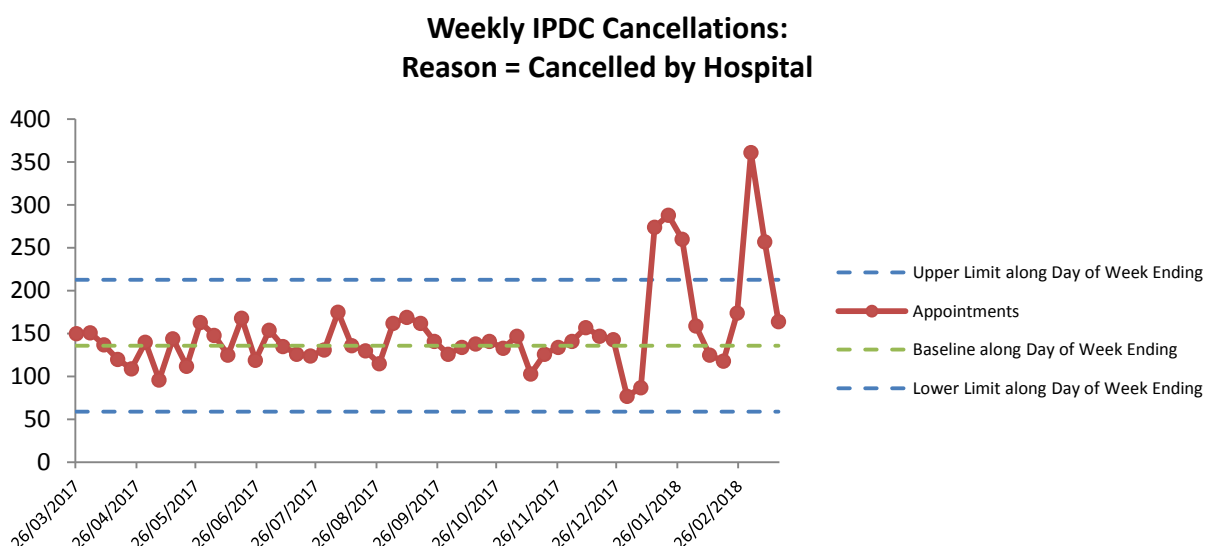
**Figure 9 – Daily number beds occupied by patients delayed in their discharge, by each HSCP**



- 3.11 The increased number of delayed discharges and the worsened starting point for winter 2017-18 resulted in an increased number of occupied beds due to delayed discharges, the impact of which has caused significant difficulties in achieving sustainable flow across each acute site.
- 3.12 In addition to the pressures above there has been a number of adverse weather warnings throughout the months of January and March which have further impacted on performance against the standard. South-East Scotland has, throughout this period, been subject to significant levels of snow, ice and other severe weather which increased pressure upon emergency departments and difficulty in discharging patients due to transport difficulties.

- 3.13 All acute adult sites have reported an impact resulting from influenza with the strain of influenza A (H3N2) among the most prevalent. This has impacted on site capacity and flow as a number of wards throughout acute have required to be closed/cohorted for safe containment of the infection. In addition a number of care homes were closed due to flu impacting on discharge rates.
- 3.14 The factors above have all contributed to a system that is under significant pressure this winter and this has been intensified by staff shortages across each site.
- 3.15 This pressure has had significant impacts on elective performance. Figure 10 details the impact that the winter pressures and adverse weather has had on the number of IPDC elective cancellations.

**Figure 10 – number elective IPDC cancellations per week (cancelled by hospital)**



**Actions to Mitigate Pressures**

- 3.16 For the 2017/2018 winter period, all sites have ensured business continuity plans for severe weather are in place and ensure the continuation of regular communication through established mechanisms (such as daily site huddles) with the addition of daily acute calls chaired by the Chief Officer (Acute Services)
- 3.17 Escalation policies with clear triggers to the Chief Officer (Acute Services) are in place detailing clear roles and responsibilities, with front door escalation plans being used daily to monitor activity and identify thresholds which, when breached, prompt appropriate responses.  
To manage safe patient flows through this challenging period, sites utilised the staff and skills across the hospitals including but not limited to:

- Site discharge hubs focus on care allocation, referrals to community services to proactively manage delayed discharges.
  - Focus upon working towards the social care standard to reduce delays.
  - Support by site service improvement team to cement Dynamic Daily Discharge processes to proactively promote discharge profile.
  - Delivery of 'hot clinics' and supported discharge.
  - The RIE extended their Ambulatory Care opening hours to ease pressure and congestion at ED Front Door.
  - Additional posts filled to support ED Flow Improvement and Criteria Led Discharge.
  - Additional weekend ED consultant shifts in position.
  - Additional unplanned winter beds opened on all three adult sites
  - Use of day surgery capacity to manage in-patient activity
- 3.18 A clinical risk categorisation was developed with Board Medical Director providing a consistent approach to the cancellation of elective procedure based on clinical risk.
- 3.19 To ensure visible leadership, senior manager presence across acute adult sites has been increased to include evening shifts to support out of hours support. This has been coupled with increased support from senior medical staff such as AMD's who are being deployed across wards at all sites to support with the decision making process in order to accelerate the discharge process.
- 3.20 Recognising the sustained compromise of acute care provision a further escalation was initiated by the Deputy Chief Executive. Whole system conference calls were implemented, during peak pressures post festive break, these include the five Chief Officers and/or their nominated deputies.
- 3.21 These teleconferences provided a platform for whole system review and a platform for joint action planning and projection of position for acute based/community constraints and on delayed discharges. These calls have also accommodated deep dive analysis of acute front door attendances, safety issues and impact briefings including elective cancellations, bed base expansions, risk increases as well as supporting thinking and actions to rapidly and safely increasing community care capacity.
- 3.22 This forum encouraged cross system support, sharing of effective actions and a focus to promote the fast decision making and leadership commitment to remove identified bottle necks.
- 3.23 Despite this significant leadership focus and collaborative working the acute operational position continued to be compromised. Recognising the continued and heightened risk across Acute sites the Deputy Chief Executive (DCE) initiated a further escalation and formally wrote to the four Lothian IJB Chairs & Chief Officers; Attached as Appendix 1. The DCE met with each leadership team individually to discuss the position, seek assurance re visibility of this extreme position within each IJB Board and sought additional ideas to support sustained improvement.

Outcome from this escalation included:

- Assurance this operational situation has been detailed to each IJB Board
- Recognition that care at home providers had not been a significant part of contingency capacity provision
- Review of additional actions including, additional discharge & admission prevention options

- Exploration of out of area care facilities
  - Additional capacity purchase options in care facilities
  - Use of test of change actions of improve capacity efficiency
  - Dedicated boarding teams, to optimise timely patient reviews, care plans and discharge.
- 3.24 A wide ranging public awareness campaign was launched in November to support winter messages and urged people in Lothian to make sure they sought the right care, at the right time, in the right place.
- 3.25 A bus advertising and poster campaign was launched, using graphics created in-house, to signpost people to their local pharmacy, GP, minor injuries clinic or the emergency department. It was supported by a social media advertising campaign.
- 3.26 As winter pressures increased in acute care, communications were also stepped up with the launch of a four-week radio advertising campaign and increased general social media messaging. The radio advert was designed to drive people, where appropriate, away from busy emergency departments to the Minor Injuries Clinic. Targeted and general social media messaging prove to be hugely successful and are reaching hundreds of thousands of people, telling them the importance of hand washing, the flu vaccination and the difference between a minor injury and an emergency and signposting to the minor injury unit.
- 3.27 The response to flu immunisation was comprehensive with 464 clinics held across hospital and primary care settings (roving vaccinations in wards and community hospitals and council premises are counted as a clinic hence the marked increase over last year's 180 clinics).
- 3.28 Data from 2016/17 across Scotland indicates a continuing fall in immunisation rates across risk groups however the Lothian uptake in over 65s is still very good at 74% and above Scottish average. This has been helped by a continuation of the programme to immunise housebound residents.
- 3.29 A daily situational report issued to executive management team, IJB Chief Officers and Chairs to maintain Board wide awareness and oversight.
- 3.30 In addressing patient experience and performance against the four-hour target at the RIE, a whole site approach has been instigated with a Length of Stay Programme Board has been established. Focused on the 'back door' of the hospital as opposed to the 'front door'. Patient flow will only be improved if the occupancy of the downstream wards can be reduced to a level that enables that flow to happen, and in order to achieve that, reductions in length of stay will be needed.
- 3.31 The main thrust of this work is improvement work, but data analysis will help this project by:
- Identifying those wards that are more 'instrumental' to patient flow than others
  - Identifying the levels of bed occupancy in each ward that are associated with good patient flow
  - Identifying and calculating the appropriate length of stay for each ward that is associated with the optimal levels of fullness
  - Helping to visualize the activity, length of stay and occupancy in the wards in ways that are meaningful and relevant to the staff working in those wards

- 3.32 The front door focus is on the development of a GP assessment unit and development of an ambulatory care unit. This work is focussed on how patients can be managed safely and compliantly out with the ED improving flow, waiting times and reducing crowding within the ED.
- 3.33 This work will include assessment of:
- Analysis of patient volumes
  - Sizing of a GP area and of an ambulatory care unit
  - Impact on department crowding
  - Impact on 4 hour performance

### **Actions to improve patient and staff experience**

- 3.34 The winter plan was centred around enhancing medical and nursing provision across sites to support the early review and care of patients. The enhanced earlier review of patients within the ED allowed patients to be discharged earlier from ED, or an earlier decision to admit, and also included an additional consultant at weekends. To support the wards there were dedicated boarding teams, or enhanced medical support who had responsibility for accessing boarders across the site, with a view to earlier decision making. Additional respiratory cover was already in place as part of winter planning, but additional rapid access clinic appointments were provided as an alternative to attending ED to assist with the high presentation of flu.
- 3.35 Daily huddles continue to support staff in managing whole site and system demand, take supportive action in relation to any risks escalated such as staffing pressures, also a forum to reinforce thank you and praise for staff flexibility, resilience and professionalism.
- 3.36 During peak in activity post festive period, Hospital at Night bolstered the rota by one Advanced Nurse Practitioner per shift for a 4 week period to support the medical assessment unit and backdoor activity, and Critical Care had an extra consultant on shift over two weekends, providing outreach ICU medical cover.
- 3.37 Increased transport across Lothian, supporting timely transfer or discharge. All admission transport triaged by SAS paramedic advisor to ensure appropriateness and timely arrival at front door. Implementation of direct booking to Ambulatory Care, WGH, which has increased capacity within service as it has released nursing time.

## **4 Key Risks**

- 4.1 Failure to meet the standard leads to poor care, including overcrowding in emergency departments and there is some published evidence that this is correlated with an increased prevalence of adverse clinical outcomes.
- 4.2 The elective programme continues to be impacted on, with patient surgery postponed, adding additional anxiety for individual patients. This will also have an adverse impact on TTG performance
- 4.3 There is a risk that continued pressure in the acute/community system may impact beyond the winter period and cause longer term delays.
- 4.4 There is a financial risk associated with needing to open additional capacity to keep the system safe.

## **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.

## **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 is potential resource implications if additional beds remain open beyond official winter period (End March)

Jacquie Campbell  
Chief Officer, Acute Services  
27 March 2018

Board Meeting  
4th April 2018

## Director of Finance

### FINANCIAL POSITION TO FEBRUARY 2018 AND YEAR END FORECAST

#### 1 Purpose of the Report

- 1.1 This paper provides an update to the Board on the financial position at Period 11 and an updated year end forecast.
- 1.2 Any member wishing additional information on the detail of this paper should contact the Director of Finance prior to the meeting.

#### 2 Recommendations

- 2.1 The Board is recommended to:
- **Accept** this report as a source of significant assurance that the Finance & Resources (F&R) Committee has considered and accepted the year to date and year end forecast position of NHS Lothian showing the achievement of breakeven by the year end;
  - **Endorse** the F&R Committee agreement to provide additional non recurring resource to the IJBs to ensure the health component of the budget breaks even in year.

#### 3 Discussion of Key Issues

- 3.1 The F&R Committee received a paper on the Period 11 financial position and the year end outturn projection for 2017/18 at its meeting on the 21<sup>st</sup> March. The F&R paper highlighted a year-to-date overspend of £1.25m and an anticipated year end achievement of breakeven. Further detail on the financial position is provided in table 1 below.

Table 1 – NHS Lothian year-to-date overspend and year-end forecast

	Forecast Variance @ Mth 8 £k	Month 11 YTD Position £k	Updated Forecast Variance @ Mth 11 £k
University Hosp Support Services	(12,485)	(9,390)	(12,821)
REAS	(1,051)	(967)	(935)
Edinburgh Partnership	(4,464)	(2,864)	(3,816)
East Lothian Partnership	400	292	506
Midlothian Partnership	98	113	144
West Lothian Partnership	1,133	876	844
Facilities And Consort	1,289	(1,566)	1,289
Corporate Services	1,288	2,128	1,816
Inc + Assoc Hlthcare Purchases	480	1,844	1,357
Research & Teaching	(1,405)	(959)	(1,405)
Strategic Services	7,366	1,512	8,170
Reserves & Flexibility	7,351	7,735	4,851
<b>NHS Lothian Position</b>	<b>0</b>	<b>(1,246)</b>	<b>0</b>

- 3.2 The F&R Committee was informed that the achievement of a balanced outturn for 2017/18 was largely achieved due to one off benefits and did not resolve the issue of recurrent financial sustainability in future years.
- 3.3 The F&R Committee agreed that it had significant assurance at this point that the Board is able to achieve a breakeven outturn in 2017/18.
- 3.4 Although year-end financial balance is now anticipated, work continues to ensure this is achieved, including ongoing monthly monitoring and reporting of the financial position. Quarter 3 review meetings have been undertaken with the business units focusing on further actions to control and reduce spend both in the current and future years.
- 3.5 The Committee recognised that, despite NHS Lothian anticipating financial balance, all four IJBs were forecasting a year end overspend. It was agreed additional resource would be made available to each IJB to ensure that the health component of the IJB budget is also in a balanced position at the year end.

#### **4 Key Risks**

- 4.1 As noted previously, significant assurance can be given to the Board on a breakeven outturn.
- 4.2 The key risks relating to the delivery of a breakeven position include:
- Delivery of Financial Recovery Plans by individual Business Units to the value required to meet the forecast delivery;
  - Major movements in current expenditure trends, in particular in relation to prescribing and supplementary staffing;

#### **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 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  
21st March 2018  
[susan.goldsmith@nhslothian.scot.nhs.uk](mailto:susan.goldsmith@nhslothian.scot.nhs.uk)

**Director of Finance****ANNUAL OPERATIONAL FINANCIAL PLAN****1 Purpose of the Report**

- 1.1 The Director of Finance, with the management team, has been developing the NHS Lothian Financial Plan for 2018/19 for approval by the Board. This is consistent with the Board's Standing Orders which state the requirement: "The Board shall approve its Financial Plan for the forthcoming financial year, and the opening revenue and capital budgets."
- 1.2 The development of the Financial Plan and longer term financial strategy to date has set out the extent of the financial challenge for 2018/19 and beyond. As a consequence, there are a range of issues that the Board require to consider.
- 1.3 This paper gives an update to the Board on the progress made towards reducing the level of the forecast gap in the Financial Plan for 2018/19, emphasising the issues arising and invites the Board to review the plan and agree the required next steps.
- 1.4 The Board also has a requirement to set budgets for the delegated functions of the IJBs for 2018/19. The outline plan presented at this stage will form the basis of a formal allocation of budgets to the IJBs.
- 1.5 Any member wishing additional information should contact the Executive Lead in advance of the meeting.

**2 Recommendations**

- 2.1 The Board is asked to:
  - **Approve** the Financial Plan for submission to the Scottish Government;
  - **Recognise** that, based on the latest information available, the Finance & Resources Committee can provide **limited assurance** that NHS Lothian is able to deliver a balanced Financial Plan for 2018/19;
  - **Consider** the impact of the financial performance on the Board's wider performance responsibilities which are being discussed with the Scottish Government through the wider Operational Plan.

**3 Discussion of Key Issues**

- 3.1 In February, the Board was presented with a paper which set out a total potential gap for next year of £27.8m. In the intervening period further refinement of the underlying baseline gap has been undertaken, along with an update of the additional 2018/19 costs and pressures and a review of available in year flexibility to support the position.

- 3.2 Incorporating these changes, the current shortfall for next year has reduced from £27.8m to £21.5m, a reduction of £6.3m on the previously presented plan. Table 1 gives the breakdown of the plan and recent movement, with further detail shown in Appendix 1 including where key movements have materialised. Appendix 2 shows the breakdown of the £21.5m gap across Business Units.
- 3.3 Discussions have concluded with the City of Edinburgh on the requirement to reduce the care gap which the IJB have identified. It has been agreed that the Board will match the £4m committed investment from the Council in the new financial year. The plan is that the stepped increase in funding will only be made available as performance improves against an agreed trajectory. This proposal has been included in the Annual Operational Plan which has been submitted to the Scottish Government.
- 3.4 Despite an inability to deliver a balanced plan for 2018/19 at this stage, limited assurance can be given on the achievement of a breakeven outturn next year, on the basis that imbalanced plans have been prepared in the last two years with a broadly similar level of gap, and breakeven has been achievable on both occasions.

**Table 1 – Financial Plan Summary Movements**

	NHS Lothian Total		
	Jan F&R	Mar F&R	Movement
	£k	£k	£k
Baseline Pressures	(52,267)	(53,945)	(1,677)
Projected Expenditure Uplifts & Commitments	(68,356)	(78,776)	(10,420)
<b>Projected Costs</b>	<b>(120,624)</b>	<b>(132,721)</b>	<b>(12,097)</b>
Total Additional Resources	72,328	83,575	11,247
Financial Recovery Plans	20,471	27,671	7,200
<b>Financial Outlook Gap</b>	<b>(27,824)</b>	<b>(21,475)</b>	<b>6,350</b>

- 3.5 The main changes to resources from the previously presented plan relates to £12.7m of additional SG funding (assumed from Barnett pay consequentials and included on SG advice) to fully fund the pay award for those staff on Agenda for Change pay scales. In addition, a further £7.2m of Financial Recovery Plans (FRPs) have been identified, discussed later in the paper.
- 3.6 Offsetting these are the increase in costs for the proposed AfC pay award, included in the Scottish Budget approved on 21<sup>st</sup> February, as well as further refinement of other costs.
- 3.7 As noted in table 1, NHS Lothian has an underlying carry forward recurring gap estimated at £53.9m. This is partially made up of £32.2m of cost pressures which were funded non-recurrently in 2017/18 and which require a funding solution moving into 2018/19. The elements funded non-recurrently in 2017/18 are shown in table 2. Further detail on the Plan for next year is provided by Business Unit in Appendix 2 with information on the costs and resources presented within this report.

**Table 2 – Prior Year Non Recurring Funding**

	18/19
	£k
FP 17/18 - Acute Pressures	(7,969)
FP 1718 - GP Prescribing	(8,588)
FP 1718 - PPRS	(5,120)
FP1718 - NDC/NSS Business cases	(552)
FP 1718 - Strategic & Income Pressures	(6,166)
Held in Reserves - in year flexibility in 17/18	(3,834)
<b>Prior Year Non Recurring Funding</b>	<b>(32,230)</b>

**Potential Funding Availability 2018/19**

- 3.8 The Scottish Budget, passed on February 21<sup>st</sup>, confirmed that NHS Lothian is to receive an uplift for 2018/19 of £29m. This comprises £20.3m of core uplift (representing 1.5% on baseline funding) and a further allocation of £8.7m for NRAC parity funding. All Scottish Boards underfunded to NRAC levels are now within 0.8% of parity based on 2017 census data.
- 3.9 In addition to the uplift agreed in the budget the Scottish Government is committed to funding the additional cost of the enhanced pay award for those staff on AFC pay scales. This has been estimated at an additional £12.73m of funding for Lothian and is included within the plan as an additional recurring source. An estimated £7.8m of recurring reserves and income uplift is also available to support the plan for 18/19, bringing the total recurrent sources to circa £50m.
- 3.10 In addition, there is a further circa £33m of non-recurrent funding that has been identified in-year to be used to support specific cost pressures in the Plan, bringing the total available resources to £83m.
- 3.11 The non-recurrent sources includes flexibility of £19m, based on current assumptions. This includes the following sources:
- Profit on disposal of Corstorphine - £5m;
  - Balance Sheet Provision Reviews - £6.3m;
  - Anticipated depreciation benefit - £2m;
  - Delay in opening of RHSC - £4.5m;
  - Additional PPRS funding received - £1.2m.
- 3.12 Table 3 shows the currently assumed additional resources for next year.

**Table 3 - Additional resources confirmed or anticipated**

	2018/19		
	Recurring	Non Recurring	Total
	£k	£k	£k
1.5% Base Uplift retained	20,300		20,300
Pay Consequentials	12,733		12,733
Additional NRAC	8,700		8,700
OHB Income	1,000		1,000
General Reserves	7,835		7,835
Additional DEL		5,000	5,000
Waiting Times		2,365	2,365
Additional Flexibility		19,000	19,000
PPRS		6,642	6,642
<b>Total Additional Resources</b>	<b>50,568</b>	<b>33,007</b>	<b>83,575</b>

## Application of Available Resources 2018/19

- 3.13 The total available resource of £83m has been applied across the organisation to meet specific pressures. Appendix 3 provides a summary of the source and application of available funds in 2018/19. Within this, there is currently £10.1m of resource which has not been allocated against specific cost pressures, most of which is non-recurrent flexibility, and is supporting the overall financial plan gap. Further discussion will be required to agree how this funding may be applied. Any commitment of this against new costs not included in the plan will result in an increase to the overall gap.
- 3.14 In prior years the Board has recognised the requirement to recurrently fund agreed pay awards in order to maintain the integrity of pay budgets. The agreed pay award based on the Scottish Government budget in February has been estimated at an additional cost of £24.7m for Lothian, and is fully funded in the Plan.

## Financial Recovery Plans

- 3.15 In addition to the refinement of costs and application of additional resources, Business Units have continued to develop Financial Recovery Plans (FRPs) which set out actions to try and bring each Business Unit back into financial balance.
- 3.16 Included in the Plan are FRPs totalling £27.7m, which brings the remaining gap on the Plan down to £21.5m. Of the £27.7m of plans identified, £10.6m are classed as one off and non-recurring in nature (for example property sales, including the current RHSC site). Table 4 below shows schemes by high level category and highlights the level of recurring savings been assumed from drugs and GP prescribing and the current costs of the workforce.

**Table 4 – Breakdown of Financial Recovery Plans**

	18/19 Recurring	18/19 Non Recurring	18/19 Total
	£k	£k	£k
Clinical Productivity	3,391	100	3,491
Drugs and Prescribing	6,637	0	6,637
Estates and Facilities	450	8,783	9,233
Procurement	1,919	0	1,919
Support Services	295	654	949
Workforce	4,361	1,081	5,442
<b>Grand Total</b>	<b>17,053</b>	<b>10,618</b>	<b>27,671</b>

- 3.17 The Financial Outlook is a key component of the Board's Local Delivery Plan (LDP), and the impact of the financial position for 18/19 will require to be considered in the context of the Board's performance as part of the LDP.
- 3.18 In relation to Access, an estimate of the investment required to return the Board to March 2017 performance levels has been prepared, and was included in the Annual Operational Plan discussed at the Board Development Session of the 7<sup>th</sup> of March. The current Operational Plan assumes no provision for performance improvement across the Board apart from the additional £2.4m investment for Waiting Times.

## **4 Risks and Assumptions**

- 4.1 Whilst every effort has been made to ensure all likely additional costs and national, regional and local priorities for investment have been incorporated into the financial plan at this time,

there remain a number of inherent uncertainties and associated risks. The financial planning process is an ongoing and iterative cycle, and it is not possible to fully identify all financial risks facing individual service areas, or the wider organisation at this stage. A draft Risk Matrix is provided in Appendix 4.

- 4.2 The Risk Matrix highlights Integration and Delayed Discharges as key risks for the Board, and this is recognised in the agreement to match fund £4m with Edinburgh Council, subject to performance improvement.
- 4.3 The Board have previously been briefed on the delay in delivery of the RHSC/DCN building. The Scottish Government have also been briefed and are aware of the inherent risk. Any further delay may impact on the asset sale from which profit is generated and included as a non recurring source in the current plan.
- 4.4 Work will continue to reduce the outstanding gap over the coming months. A number of key issues which may impact on the outturn value as shown include the following:
- GP Prescribing – An additional £2m has been set aside in the Financial Plan to support efficiency initiatives. The projected gap in the Plan from prescribing is circa £5m, and it is expected that that this investment will significantly reduce this gap. No value for efficiency is currently shown in the Plan from this initiative;
  - PPRS funding – the value in the Plan is based on funding anticipated up to the end of December, when the PPRS programme is due to conclude. However it is likely that a subsequent programme will be instigated from the start of the new calendar year which may yield further funding opportunities in the 18/19 financial year;
  - Efficiency Savings will continue to be explored, both at a local level within Business Units, but also through the development of broader programmes through the Sustainability and Value workstream;
  - Year end management may identify further flexibility that could be deployed in the new financial year.

## **5 Risk Register**

- 5.1 The Risk register will be considered as part of the conclusion of the financial planning process and any changes will be made at this point based on the outcome.

## **6 Impact on Inequality, Including Health Inequalities**

- 6.1 Any implications for health inequalities or general equality and diversity issues arising directly from agreement on the issues and recommendations in this paper may require to be impact assessed.

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

- 7.1 The financial planning process and development of efficiency plans will build on existing relationships across the organisation.

## **8 Resource Implications**

8.1 The resource implications are set out above.

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27<sup>th</sup> March 2018  
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### **Appendices**

Appendix 1 – 2018/19 Summary Financial Plan

Appendix 2 – Annual Operating Financial Plan 2018/19 by Business Unit

Appendix 3 – Source and Application Matrix

Appendix 4 - Annual Operating Financial Plan Risk Matrix

## Appendix 1 – 2018/19 Summary Financial Plan

	NHS Lothian Total		
	Jan F&R	Mar F&R	Movement
	£k	£k	£k
<b>Full Year Recurring Expenditure Budget</b>	<b>1,572,018</b>	<b>1,571,621</b>	<b>(397)</b>
<b>Baseline Pressures</b>	<b>(52,267)</b>	<b>(53,945)</b>	<b>(1,677)</b>
Projected Expenditure Uplifts & Commitments	(33,009)	(34,497)	(1,487)
Growth and Other Commitments	(19,088)	(26,116)	(7,028)
Policy Decisions	(5,247)	(6,981)	(1,734)
Strategic Investments	(7,124)	(7,249)	(125)
Essential Service Development	(3,888)	(3,933)	(45)
<b>Projected Expenditure Uplifts &amp; Commitments</b>	<b>(68,356)</b>	<b>(78,776)</b>	<b>(10,420)</b>
<i>Percentage of Recurring Budget</i>	<i>(4.3%)</i>	<i>(5.0%)</i>	
<b>Projected Costs</b>	<b>(120,624)</b>	<b>(132,721)</b>	<b>(12,097)</b>
<b>Recurring Resources</b>			
Base Uplift & Pay Consequentials	20,300	33,033	12,733
NRAC	8,700	8,700	0
Reserves	8,843	7,835	(1,008)
OHB Income	1,000	1,000	0
<b>Non Recurring Resources</b>			
Additional DEL	7,000	5,000	(2,000)
PPRS	5,120	6,642	1,522
Waiting Times	2,365	2,365	0
Flexibility	17,000	17,000	0
Delay in Capital Project	2,000	2,000	0
<b>Total Additional Resources</b>	<b>72,328</b>	<b>83,575</b>	<b>11,247</b>
<b>Financial Recovery Plans</b>	<b>20,471</b>	<b>27,671</b>	<b>7,200</b>
<b>Financial Outlook Gap</b>	<b>(27,824)</b>	<b>(21,475)</b>	<b>6,350</b>
<i>Percentage of Recurring Budget</i>	<i>(1.8%)</i>	<i>(1.4%)</i>	



## Appendix 2 – Annual Operating Financial Plan 2018/19 by Business Unit

	NHS Lothian	UHSS Total	Reas	East Lothian Partnership	Edinburgh Partnership	Mid Lothian Partnership	West Lothian Partnership	Facilities And Consort	Corporate Services	Strategic Services	Inc + Assoc Hlthcare Purchases	Research + Teaching	Reserves
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
<b>Full Year Recurring Expenditure Budget</b>	<b>1,571,621</b>	<b>655,667</b>	<b>75,903</b>	<b>73,019</b>	<b>299,469</b>	<b>63,316</b>	<b>130,023</b>	<b>147,855</b>	<b>83,517</b>	<b>14,270</b>	<b>9,178</b>	<b>(9,910)</b>	<b>29,314</b>
<b>Baseline Pressures</b>	<b>(53,945)</b>	<b>(29,006)</b>	<b>(1,021)</b>	<b>(1,258)</b>	<b>(5,606)</b>	<b>(1,066)</b>	<b>(2,377)</b>	<b>(6,041)</b>	<b>(778)</b>	<b>4,515</b>	<b>(5,099)</b>	<b>(1,822)</b>	<b>(4,386)</b>
Projected Expenditure Uplifts & Commitments	(34,497)	(16,783)	(2,097)	(1,118)	(3,061)	(686)	(1,500)	(4,447)	(2,116)	(51)	(183)	(1)	(2,452)
Growth and Other Commitments	(26,116)	(11,376)	(195)	(1,703)	(6,012)	(1,242)	(2,644)	0	(944)				(2,000)
Policy Decisions	(6,981)	(15)	(924)	(810)			(34)		(117)	(3,081)			(2,000)
Strategic Investments	(7,249)	(5,551)	(5)	(1)	(218)	(126)	(5)	(417)	74				(1,000)
Essential Service Development	(3,933)	(1,656)			(150)		(1,997)		(130)				
<b>Projected Expenditure Uplifts &amp; Commitments</b>	<b>(78,776)</b>	<b>(35,381)</b>	<b>(3,221)</b>	<b>(3,632)</b>	<b>(9,441)</b>	<b>(2,054)</b>	<b>(6,180)</b>	<b>(4,864)</b>	<b>(3,233)</b>	<b>(3,132)</b>	<b>(183)</b>	<b>(1)</b>	<b>(7,452)</b>
<i>Percentage of Recurring Budget</i>	<i>(5.0%)</i>	<i>(5.4%)</i>	<i>(4.2%)</i>	<i>(5.0%)</i>	<i>(3.2%)</i>	<i>(3.2%)</i>	<i>(4.8%)</i>	<i>(3.3%)</i>	<i>(3.9%)</i>	<i>(21.9%)</i>	<i>(2.0%)</i>	<i>0.0%</i>	<i>(25.4%)</i>
<b>Projected Costs</b>	<b>(132,721)</b>	<b>(64,387)</b>	<b>(4,242)</b>	<b>(4,890)</b>	<b>(15,047)</b>	<b>(3,120)</b>	<b>(8,557)</b>	<b>(10,905)</b>	<b>(4,011)</b>	<b>1,383</b>	<b>(5,283)</b>	<b>(1,823)</b>	<b>(11,839)</b>
<b>Recurring Resources</b>													
Base Uplift	0			1,880	2,098	1,352	3,258						(8,588)
Base Uplift & Pay Consequentials	33,033	13,007	1,708	834	1,881	456	1,213	1,702	1,802				10,431
NRAC	8,700	5,400									1,165		2,135
Reserves	7,835										4,001		3,834
OHB Income	1,000										1,000		
<b>Non Recurring Resources</b>													
Additional DEL	5,000	5,000											
PPRS	6,642	5,120											1,522
Waiting Times	2,365	2,365											
Flexibility	19,000	2,969		10	2,085	145	273		130	750			12,638
<b>Total Additional Resources</b>	<b>83,575</b>	<b>33,861</b>	<b>1,708</b>	<b>2,724</b>	<b>6,064</b>	<b>1,953</b>	<b>4,744</b>	<b>1,702</b>	<b>1,932</b>	<b>750</b>	<b>6,166</b>	<b>0</b>	<b>21,972</b>
<b>Financial Recovery Plans</b>	<b>27,671</b>	<b>7,143</b>	<b>987</b>	<b>1,385</b>	<b>4,606</b>	<b>478</b>	<b>2,468</b>	<b>9,208</b>	<b>1,397</b>				
<b>Financial Plan Gap</b>	<b>(21,475)</b>	<b>(23,383)</b>	<b>(1,547)</b>	<b>(781)</b>	<b>(4,377)</b>	<b>(689)</b>	<b>(1,345)</b>	<b>5</b>	<b>(683)</b>	<b>2,133</b>	<b>883</b>	<b>(1,823)</b>	<b>10,133</b>
<i>Percentage of Recurring Budget</i>	<i>(1.4%)</i>	<i>(3.6%)</i>	<i>(2.0%)</i>	<i>(1.1%)</i>	<i>(1.5%)</i>	<i>(1.1%)</i>	<i>(1.0%)</i>	<i>0.0%</i>	<i>(0.8%)</i>	<i>14.9%</i>	<i>9.6%</i>	<i>18.4%</i>	<i>34.6%</i>

### Appendix 3 – Source and Application Matrix

	Total £k	Recurring					Non Recurring Flex			
		Base Uplift £k	Additional NRAC £k	Pay Consequential Funding £k	Other Health Board Uplift £k	Reserves £k	Additional DEL £k	Additional Flexibility £k	Waiting Times £k	PPRS Funding £k
<b>Available Resources</b>	<b>83,575</b>	<b>20,300</b>	<b>8,700</b>	<b>12,733</b>	<b>1,000</b>	<b>7,835</b>	<b>5,000</b>	<b>19,000</b>	<b>2,365</b>	<b>6,642</b>
<b><i>Prior Year £32m pressures funded non recurrently</i></b>										
Acute Pressures	7,969						5,000	2,969		
GP Prescribing	8,588	8,588								
PPRS	5,120									5,120
NDC/NSS Business case 17/18	552		552							
Strategic & Income Pressures	6,166		1,165		1,000	4,001				
Held in Reserves	3,834					3,834				
	<b>32,230</b>	<b>8,588</b>	<b>1,717</b>	<b>0</b>	<b>1,000</b>	<b>7,835</b>	<b>5,000</b>	<b>2,969</b>	<b>0</b>	<b>5,120</b>
<b><i>2018/19 pressures</i></b>										
Pay Uplift	24,712	11,979		12,733						
PC Investment	2,000							2,000		
e-Health Investment	1,000							1,000		
eHealth Staffing Centralised Project	130							130		
CHAS payment	750							750		
Prescribing - 17/18 estimated overspend	2,513							2,513		
Efficiency initiatives GP prescribing	2,000							2,000		
RHSC Gap	5,400		5,400							
Waiting Times pressures	2,365								2,365	
NDC / NSS Business Case 18/19	342		342							
	<b>41,212</b>	<b>11,979</b>	<b>5,742</b>	<b>12,733</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>8,393</b>	<b>2,365</b>	<b>0</b>
<b>Total Applications</b>	<b>73,442</b>	<b>20,567</b>	<b>7,459</b>	<b>12,733</b>	<b>1,000</b>	<b>7,835</b>	<b>5,000</b>	<b>11,362</b>	<b>2,365</b>	<b>5,120</b>
<b>To Be Allocated</b>	<b>10,133</b>	<b>(267)</b>	<b>1,241</b>	<b>0</b>	<b>0</b>	<b>(0)</b>	<b>0</b>	<b>7,638</b>	<b>0</b>	<b>1,522</b>

## Appendix 4 - Financial Planning Risk Matrix

Key Assumptions / Risks	Risk rating	Impact
Integration	High Risk	The outlook has assumed that the additional resources passed to the IJBs in prior years from the Social Care Fund will create additional capacity and reduce the total level of Delayed Discharges in the Health System
Delayed Discharge	High Risk	Need to manage the volume of delayed discharges and the cost of new initiatives that will be required to deliver the required reductions.
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 ie immunisation, GMS premises have been included in the financial outlook
GP Prescribing	Medium Risk	A sustained level of ongoing growth and price increases have been included in the financial outlook, however there is the potential for increases to be greater than projected.
Pharmaceutical Price Regulation Scheme (PPRS)	Low Risk	The Pharmaceutical Price Regulation Scheme has provided a source of funding in previous year to offset the cost of approved IPTRs and New Medicines. At present the risk of not receiving any ongoing funding has assumed to be low.
Acute Medicines	Medium Risk	There is a risk that the level of growth exceeds the estimate contained in the Financial Outlook.
Changes to pay T&Cs and backdated pay claims	High Risk	Current indications are that the pay award for future years maybe higher than the 3%/2% included in the outlook. NHSL no longer has a provision for backdated pay claims, therefore any further claims will be an unplanned in year cost.
SGHD Allocations	High Risk	Availability of SGHD funding for previously separately funded programmes and initiatives.
Outcomes Framework	Medium Risk	The Financial Outlook assumes that plans are in place to reduce expenditure in line with reductions in ADP and Bundles Funding, however this has proved difficult over the last few years
Capital Programme	High Risk	NHSiL has an ambitious capital programme which requires significant resources in addition to those available to deliver. The revenue consequences of the programme are a significant pressure to the organisation.
Pay Consequential Funding	Medium Risk	Additional funding has been assumed to cover the cost of the additional cost of the pay award for AFC staffing. The risk is that the total additional funding assumed is more than the funding available to be distributed

## PART 9 CHILDREN AND YOUNG PEOPLE (SCOTLAND) 2014 ACT

### 1 Purpose of the Report

- 1.1 The purpose of this report is to update the Lothian NHS Board on progress in exercising their statutory Corporate Parenting duties as specified in [Part 9 of the Children and Young People \(Scotland\) Act 2014](#).

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

### 2 Recommendations

Lothian NHS Board are asked to

- 2.1 Endorse NHS Lothian's Vision and Priorities for Action as detailed within the Corporate Parenting Action Plan, 2017-2020, (Appendix 1) this having been approved by the Strategic Planning Committee on 14 December 2017.
- 2.2 Agree publication of the plan on the NHS Lothian Website.
- 2.3 Be assured that a progress report on the plan will be submitted to SG during June 2018.

### 3 Discussion of Key Issues

- 3.1 The Children and Young People (Scotland) Act 2014 was passed by the Scottish Parliament on 19 February 2014, and received Royal Assent on 27 March 2014. The legislation comprises a number of important interrelated legislative requirements including **Part 9, Corporate Parenting, that commenced April 2015**. The term Corporate Parent can be defined "as an organisation's performance of actions necessary to uphold the rights and safeguard the wellbeing of a *Looked after Child* (LAC) or *Care Leaver*". The legislation encourages preventative measures, rather than crises responses and is underpinned by the Scottish Government's commitment to the [United Nations Convention on the Rights of the Child 1989](#) (UNCRC), and the national children's services improvement programme, [Getting it Right](#) for Every Child (GIRFEC), the Act also establishes a new legal framework for service planning within which organisations particularly Local Authorities and NHS Boards (who have joint responsibility for producing and reporting on Children Service Plans) that must evidence organisations working collaboratively in support of children, young people and families.
- 3.2 All Public Bodies in Scotland who work directly or indirectly with *Looked after Children* and the *Care Leaver* population are Corporate Parents. Part 9 of the Act is supported by Statutory Guidance that provides corporate parents with information and advice and specifies the key corporate parenting responsibilities as follows:

- be alert to matters which, or which might, adversely affect the wellbeing of looked after children and young people to whom Part 9 of the Act applies – this covers children from birth to age 18 years as care leavers up until their 26<sup>th</sup> birthday if they choose ongoing support
- assess the holistic needs of those LAC children and young people for services within and provides appropriate response and support
- promote the rights and interests of those children and young people
- provide those children and young people with opportunities to participate in activities designed to promote their health and wellbeing
- take such action as it considers appropriate to help those children and young people - successful learning and positive destinations
- to access and provide opportunities, including employment opportunities
- to make use of services and access support from those services provided by the organisation
- take such other action as it considers appropriate for the purposes of improving the way in which it exercises its functions in relation to improving health and wellbeing for looked after children and young people.

3.3 The NHS Lothian self assessment evidenced that NHS Lothian is committed to Getting it Right for Every Child (GIRFEC) including those children and young people who are looked after and residing in, or being treated within, NHS Lothian services. As an organisation we provide inclusive children's services that promote the United Nations Convention *Rights of the Child* legislation and this is explicit within the NHS Lothian Children and Young People's Health and Wellbeing Strategy and the Corporate Parenting Action Plan and is cross referenced the four Lothian Local Authority Corporate Parenting Plans.

3.4 Since 2014 NHS Lothian has exercised their Corporate Parenting responsibilities with full support of the NHS Board. We have a notification of all *Looked after Children* system and process in place and have significantly invested in an augmented *Looked after Children's* specialist nursing team that provide comprehensive and specialist assessment including mental health screen, care planning and a system wide confidential alert system. However we have more to do particularly in relation to reaching the most vulnerable young people and ensuring uptake of, and access to, our services as well as improving our transition planning and referral to adult services. Supporting the older children and young people / care leavers is a key priority within the 2017-2020 Corporate Parenting Action Plan.

3.5 The Action Plan outlines our ambition and vision, our promise and commitment to achieving improved outcomes for all *Looked after Children and Young People* and describes how we will meet our duties and what wellbeing improvements we want to deliver between 2017-2020.

3.6 In terms of progress we have worked collaboratively with the four Lothian Local Authorities and other partners for over a decade and produced joint Community Planning Partnership (CPP) Corporate Parenting Plans including the recent production of East Lothian, Edinburgh, Midlothian and West Lothian (2017-20) Corporate Parenting Plans and there are agreed performance measures within all four joint plans. The NHS Lothian Corporate Parenting Plan builds on our wider prevention and early intervention programme as detailed within the four Lothian Children's Service and Corporate Parenting Plans but also addresses specific requirements for NHS Lothian.

- 3.7 The key health priorities within the first year of the Action Plan (2017-18) are to
- review the service model of health assessment and reviews for *Looked after Children* in light of the new Health Visiting and School Nursing pathways and future named person function
  - Improve the uptake of *Looked after Children and Young People* accepting a comprehensive health assessment and mental health screen
  - review our approach to supporting the mental health needs assessment and intervention for this group of children and young people using the child development framework to ensure the right tier of support and intervention is offered at the right time
  - explore and increase provision of opportunities for work experience, employment and mentoring within NHS Lothian for care experienced young people
- 3.8 Section 61 of Sc 9 of **the Act** states that a corporate parent must report on how it has exercised its corporate parenting responsibilities and that a Corporate Parenting Report should be submitted to SG on an annual basis and a full published report at least once every three years the first being due in April 2020. The report should be linked to the objectives and activities detailed in the plan, providing an analysis of progress and identifying any actions which could improve the way in which the corporate parent (or group of corporate parents) exercises its functions. As a minimum, every Corporate Parenting Report must include information on:
- How the corporate parent (or group of corporate parents) has exercised the duties set out in section 58 (the 'corporate parenting responsibilities')
  - How the corporate parent (or group of corporate parents) has fulfilled its functions in respect to planning, collaborative working with other corporate parents, preparing reports and, where relevant, providing information to Scottish Ministers and following directions issued by Scottish Ministers. These reports will be scrutinised by SG and published locally and nationally.
- 3.9 NHS Lothian performance and reporting will be led by the Maternal and Child Health Policy and Planning team in conjunction with the four Lothian Corporate Parenting Steering Groups within the Community Planning Partnerships. It is envisaged that the CPPs within Lothian will provide annual group corporate parenting progress reports with an overarching NHS Lothian report every 3 years.

## 4 Key Risks

- 4.1 There are no risks associated with this paper or the NHS Lothian Corporate Parenting Action Plan however self assessment highlights that as an organisation we need to widen corporate parenting awareness raising training and include as part of NHSL staff induction. Only then will we be able to assure the NHS Board of full compliance with the Part 9 (Corporate Parenting) of the Act requirements. This issue was discussed at Corporate Management Team in September 2017 and Strategic Planning Committee in December 2017 and discussions are on-going re how best to address this topic within Public Protection and GIRFEC mandatory training.

## **5 Risk Register**

5.1 As above but not recorded on the risk register as action underway.

## **6 Impact on Inequality, Including Health Inequalities**

6.1 Working collaboratively with our children, young people and their families together with statutory and third sector partners and local communities of interest will contribute significantly in ensuring that the health and wellbeing needs of individual *Looked after Children and Young People* are identified and that appropriate education, care and support plans are in place. This will contribute significantly to reducing health and social inequalities for individual children and young people.

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

7.1 NHS Lothian planning and operational services have and continue to be actively involved in participation work with the *Looked after Children* population together with partner agencies across the four Lothian Community Planning Partnerships (CPPs). As partners we engage and hear directly from our service managers and frontline practitioners about the challenges these young people face. Our programme lead for Mental Health organised and hosted a pan Lothian Mental Health and Young People “Open Space” event during 2017 and invited a cross section of *Looked after Young People* and previous care experienced young people the outputs and recommendations from this event are reflected within the Corporate Parenting Action Plan.

## **8 Resource Implications**

8.1 There is no new resource implications associated with this report.

Sally T Egan

Director & Child Health Commissioner

Maternal and Child Health Policy, Planning & Performance

20 March 2018

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## **List of Appendices**

Appendix 1: NHS Lothian Corporate Parenting Action Plan as approved by NHS Lothian Strategic Planning Committee on 14 December 2017



# NHS Lothian Corporate Parenting Action Plan 2017-2020





## What is Corporate Parenting?

Corporate Parenting is defined in the Children and Young People (Scotland) Act 2014 (The 'Act') as: 'the formal and local partnerships between all services responsible for working together to meet the needs of looked after children, young people and care leavers'. **Across Lothian there are 2,370 children who are looked after at home or away from home (July 2017).**

The East Lothian, City of Edinburgh, Midlothian, and West Lothian Corporate Parenting Plans identify this as including children, young people and care leavers who are:

- In residential care, including secure care
- In foster care
- In kinship care: who live with a family member other than a parent
- Looked after at home – with social work involvement
- Disabled and those who receive overnight respite
- Care leavers who were looked after on their 16<sup>th</sup> birthday (or subsequently) – with the responsibilities continuing to apply up to the age of 26 years



*All four share the aspiration to not only fulfil their statutory obligations under the 'Act' but to invest in these relationships.*

***We will work within the GIRFEC National Practice Model – Getting it right for every child***



*Our Key 'Corporate Parent' Leads committed to supporting you:*

Prof. Alex McMahon, Executive Lead for Corporate Parenting

Sally Egan, Child Health Commissioner and Director of Maternal and Child Health Policy, Planning & Performance

Anne Neilson, Director for Public Protection & LAC Specialist Nursing Services

## Corporate Parenting in Scotland – Our Duties

Part 9 of The Children and Young People (Scotland) Act 2014 (The Act) places a range of new duties on 18 public bodies including Health Boards to act in particular ways in support of certain children and young people. These duties commenced in April 2015.

Corporate parenting refers to an organisation's performance of actions necessary to uphold the rights and secure the wellbeing of a looked after child or care leaver, and through which their physical, emotional, spiritual, social and educational development is promoted, from infancy through to adulthood.

The Scottish Government believes corporate parenting is not just a responsibility but is also a real opportunity to improve the futures of looked after children and young people.

### **Section 59 of the Act sets out planning duties for corporate parenting:**

- 1. A corporate parent must prepare, keep under review, and publish a Corporate Parenting Plan. This must set out how the corporate parent proposes to fulfil its corporate parenting responsibilities (described in section 58 of the Act).**
- 2. A corporate parent, where appropriate, is to consult with other corporate parents before preparing or revising their corporate parenting plan.**
- 3. Corporate parents must also consult with such other persons as they consider appropriate. In every case the term 'appropriate person' would include the children and young people to whom Part 9 applies.**
- 4. Consult directly or indirectly with the eligible population: While it may not be possible or desirable for every corporate parent to consult with the eligible population directly, every corporate parenting plan should take account of their views and aspirations. Those corporate parents who do not engage with looked after children and care leavers directly should collaborate closely with corporate parents who do, or consult other organisations who can provide relevant information and insight.**

**Section 61 of the Act states that a corporate parent must report on how it has exercised its corporate parenting responsibilities: A Corporate Parenting Report should be published at least once every three years. The report should be linked to the objectives and activities detailed in the plan, providing an analysis of progress and identifying any actions which could improve the way in which the corporate parent (or group of corporate parents) exercises its functions.**

**At a minimum, every Corporate Parenting Report must include information on:**

- How the corporate parent (or group of corporate parents) has exercised the duties set out in section 58 (the 'corporate parenting responsibilities').**
- How the corporate parent (or group of corporate parents) has fulfilled its functions in respect to planning, collaborative working with other corporate parents, preparing reports and, where relevant, providing information to Scottish Ministers and following directions issued by Scottish Ministers.**

**As with the plan, the Corporate Parenting Report should be easily accessible to both the eligible population and general public. Accessibility relates to the availability of the document (e.g. published online), its format and language.**

**Section 60 of the Act requires all corporate parents to collaborate with each other:**

- 1. The Act requires all corporate parents to collaborate with each other, in so far as is reasonably practicable, when exercising their corporate parenting duties, where they consider that doing so would safeguard or promote the wellbeing of children and young people to whom Part 9 (Corporate Parenting) of the Act applies.**
- 2. Collaboration may involve (but is not restricted to): sharing information; providing advice or assistance; coordinating activities; sharing responsibility for action; funding activities jointly; exercising functions under this part jointly (e.g. publishing a joint plan or report).**
- 3. Section 60 does not prescribe the format of collaborative working. Ultimately it is the responsibility of each corporate parent to identify how and with whom they collaborate. Any collaboration should be recorded in the Corporate Parenting Report.**

**Section 58 of the Act sets out the ‘corporate parenting responsibilities’ and represents the core element of Part 9:**

**It is the duty of every corporate parent, in so far as consistent with the proper exercise of its other functions:**

- a. To be alert** to matters which, or which might, adversely affect the wellbeing of children and young people to whom this Part applies.
- b. To assess** the needs of those children and young people for services and support it provides.
- c. To promote** the interests of those children and young people.
- d. To seek to provide** those children and young people with **opportunities** to participate in activities designed to promote their wellbeing.
- e. To take such action** as it considers appropriate to help those children and young people:
  - i) To access** opportunities it provides in pursuance of paragraph (d).
  - ii) To make use of services, and access support, which it provides.**
- f. To take such other action** as it considers appropriate for the purposes of **improving** the way in which it exercises its functions in relation to those children and young people.

**Taken together these six duties provide an alternative definition of corporate parenting, and it is through a corporate parent’s efforts to fulfil these duties that they will uphold the rights and promote the wellbeing of looked after children and care leavers.**

# NHS Lothian

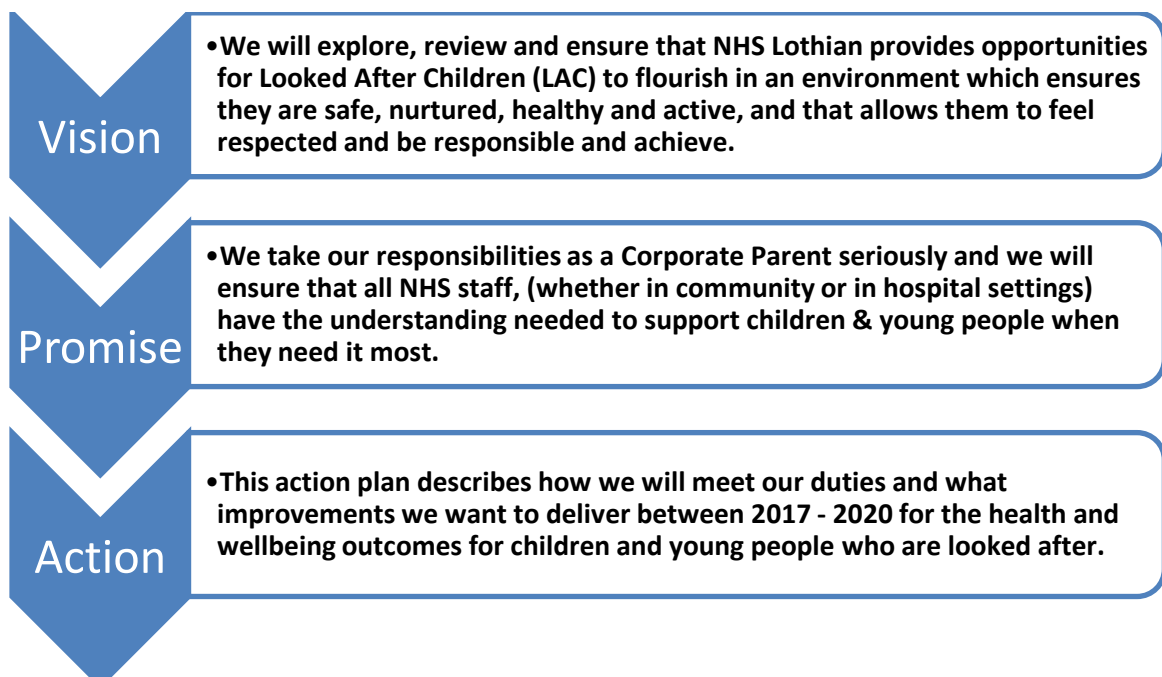
NHS Lothian provides healthcare to the entire Lothian population. We work in partnership across four Community Planning Partnerships. Each has their own Children’s Services Plans (part 3 of the Children and Young People (Scotland) Act 2014). The plans follow a 3 yearly planning cycle (current cycle 2017 -2020) and progress must be submitted to the Scottish Government on an annual basis. The needs of looked after children and young people are core within each plan and provide information on what each area is doing collectively. NHS Lothian is a statutory equal partner with all four councils, with legal duties to create the plans, ensure delivery and performance reporting

In addition to the four Children’s Services Plans, each corporate parent also has a corporate parenting plan. Whilst organisations such as Scottish Fire and Rescue and Skills Development Scotland are corporate parents, for the purpose of NHS Lothian’s role, our closest partners for collaboration under part 9 are: City of Edinburgh Council; East Lothian Council; Midlothian Council; and West Lothian Council.

NHS Lothian delivers services locally in the four areas of Lothian. NHS is a key contributor to the delivery of the local plans to improve care and outcomes for looked after children in our communities. The local plans can be accessed via the four council internet sites.

However, in addition to our contribution to local delivery, NHS Lothian has its unique contribution to play for Pan Lothian Health Services, and has actions which it must deliver as a single public service organisation. This plan focuses on this single agency contribution.

NHS care in Lothian is provided by staff directly employed by NHS Lothian but also via independent contractors such as GPs; dentists; and opticians. We will work with these partners to ensure that the necessary actions within this plan are delivered across Healthcare in Lothian.



## To Deliver Section 58

### – Our Key Responsibilities



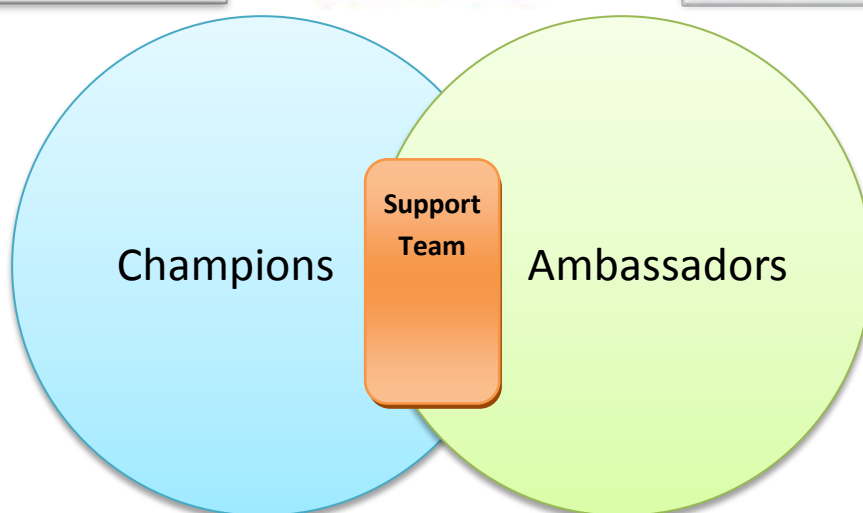
## Engaging with Looked After Children and Young People

Engaging with and listening to children and young people who are looked after/care leavers/care experienced young people is at the heart of improving our care and services. Our engagement with children who are looked after takes many forms:

- ❖ We see looked after children and young people one to one when we are providing healthcare.
- ❖ Looked after children and young people are involved in general engagement sessions we run with our community planning partners. An example of this is a range of sessions we ran within our Edinburgh Children's Partnership in 2017, after a successful bid to Scottish Government to involve children and young people in planning. These sessions were jointly run with our Edinburgh Partnership (NHS key partner) and the Children's Parliament. The output of these sessions was very illuminating and fun and can be found at <http://www.childrensparliament.org.uk/our-work/edinburgh-childrens-partnership/>.
- ❖ Via focus groups and interviews as part of children's services inspection. The recent inspection in West Lothian of integrated children's services involved listening directly to looked after children and asking directly if their needs are being met and how services are meeting their needs. The report is available on [2017 West Lothian C&YP services](#)

[inspection](#). In addition, West Lothian use 'Viewpoint' to ask questions based around the GIRFEC wellbeing indicators.

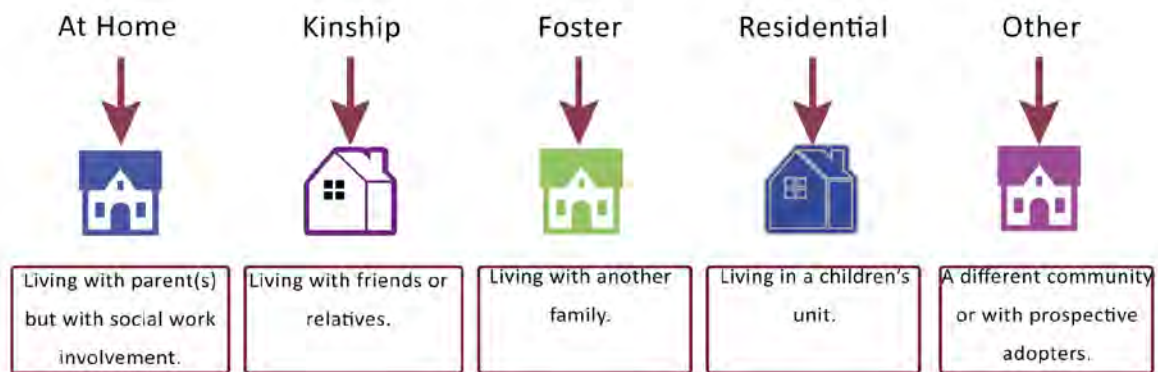
- ❖ Most importantly, we have a regular route to the views of our looked after children via our **Champions Boards in our Partnership Areas of Lothian**. The boards are supported by 'Who Cares? Scotland' and work on the following model:



- ❖ Within the model of Champions Boards, NHS Lothian senior staff are ambassadors and listen directly to children and young people. In addition, this joint work feeds into the local children's services partnerships, the local children's services plans and drives local services and improvements. The champions are supported to take on many roles, one of which is presenting and talking to agencies and service leads to help shape service improvement:
- ❖ **NHS Lothian 'Who Cares?' Event** for Executive and Non Executive Directors, Senior Managers and Senior Clinicians (December 2015) - At this event we explained the responsibilities of corporate parenting.
- ❖ **Are we listening and responding? 'Create Space'** (June 2017) – was designed to hear and discuss different perspectives on the mental health needs of looked after and accommodated children. The East Lothian champions spoke at this event and worked with 45 people from a variety of services.

## Meeting the Health & Wellbeing Needs of Looked After Children & Young People

We need to provide the right NHS services to children and young people wherever they are. We need our services to be responsive and person centred.



### We know that:

- ❖ Looked after children face challenges which many other children never experience.
- ❖ Many looked after children will have experienced trauma before coming into care, and This trauma often has a long term impact on their health and wellbeing.
- ❖ Positive experiences and successful long-term outcomes in life depend hugely on a child's physical, mental and emotional health (CELCIS - Centre for Excellence for Looked After Children in Scotland).
- ❖ The collective effort from agencies, carers, practitioners and professionals aim to make significant, long-term improvements in the health and wellbeing of looked after children, and encourage a deeper understanding of the multiple, complex health needs of children and families who have experienced trauma (CELCIS).  
The emotional and mental health needs of looked after children are significant. **Almost half of 5-17 year olds in care were diagnosed with a mental health disorder (Office of National Statistics 2004).**
- ❖ CELCIS have been undertaking work to consider the local and national picture for LAC/LAAC (Looked After Children/Looked After and Accommodated Children) in terms of mental health, health assessments and the provision available in different areas. They found:
  - That current practice and system response is problematic relating to meeting the health needs of looked after children.
  - There is considerable variability in how we meet the health & wellbeing needs of children and young people, as services look at individual health needs e.g. one practitioner deals with one part, and another service deals with another.
  - This leads to challenges with continuity of carer (from an NHS health professional perspective) and the building of trusted relationships.

- Tools for screening for needs (e.g. SDQ Strengths and Difficulties questionnaire), diagnosis and then meeting these health needs are variable across services.
  - The design of our offer of health services are often service led and limited due to our models and level of resource. For instance LAC nurses may carry out an initial health assessment with annual follow up. Therefore, this poses challenges again for continuity of care and meeting real time need.
  - Children and young people have also given mixed feedback about the experience of receiving a health assessment (the timing, the types of questions etc).
  - Children and young people may find it hard to articulate their problems as talking to someone they have just met is difficult.
- ❖ CELCIS promote working within a child development framework to look at the child at the centre. To do this we as corporate parents need to:
- understand the impact of early & cumulative adversity
  - work in a more integrated multiagency way
  - ensure the child is at the centre using the GIRFEC model
  - promote repair and recovery in the day to day
  - place an emphasis on building relationships and needs led care
  - Ensure the child's network of support is provided by competent and skilled practitioners

An example of how corporate parents can collaborate with each other to improve the outcomes for care experienced children and young people is the recent collaboration of the Champion's Board with Columba 1400 Leadership Academy. This consisted of 3 preparation sessions followed by a six day residential experience on Skye.

Young people were joined by key adults from various council departments and partner organisations with the aim to increase the levels of confidence, self-motivation, perseverance and resilience in these young people to enable them to realise their true potential in life, work and community.







## NHS Lothian Priority Actions for 2017 – 2020

The following pages describe our actions to fulfil our duties as a Corporate Parent under Part 9 of the Children and Young People (Scotland) 2014. To enable us to meet our section 58 actions, we wish to learn from the CELCIS findings on mental health and health assessments. We will listen to the feedback from the West Lothian inspection and our Champions Board surveys. **We have chosen the following priority actions for year 1 of this plan:**

1. **Review of service model of health assessment and reviews for looked after children** - In light of the new Health Visiting and School Nursing pathways and future named person function, we will explore our current model within this changing landscape.
2. **Increase the number of LAC children accepting a health assessment** - Whilst we are meeting the 4 week health assessment target (from when we are notified) for those who opt in for the assessment, we have not explored or met the health needs of those who did not opt in, or explored fully how to increase our reach. We will do this by working with children, young people and partners to increase understanding, knowledge and awareness of the health and wellbeing for LAC with the aim to increase uptake and improve early intervention and health outcomes.
3. **Review our approach to supporting the mental health needs of this group of children and young people using the child development framework as described above.** This will ensure that we identify the mental health needs and support Children & Young People to access the right tier of support and intervention required.
4. **Increase provision of opportunities for work experience, employment and mentoring within NHS Lothian, as explore and reduce barriers to these for care experienced young people**

## Lothian 2017-2020 Corporate Parenting Action Plan

<b><u>Sections 59 &amp; 60 &amp; 61 Actions:</u></b>	<b><i>Date to Achieve</i></b>	<b><i>Lead Group</i></b>	<b><i>Evidence We Have Delivered</i></b>
<b><i>1. To take corporate responsibility for delivering Part 9 of the Act.</i></b>	<b><i>12/10/17</i></b>	<b><i>SPC</i></b>	<b><i>Strategic Planning Committee (SPC) of NHSL Board approve plan</i></b>
<b><i>2. A corporate parent must prepare, keep under review, and publish a Corporate Parenting Plan.</i></b>	<b><i>31/10/17</i></b>	<b><i>SPC</i></b>	<b><i>Publication on NHSL website on submission of plan to Scottish Government</i></b>
<b><i>3. A corporate parent, where appropriate, is to consult with other corporate parents before preparing or revising their corporate parenting plan.</i></b>	<b><i>31/10/17</i></b>	<b><i>Maternity &amp; Children's Strategic Team (M&amp;CST)</i></b>	<b><i>NHS Lothian has collaborated with the multi-agency Corporate Parenting Strategic Groups of all four Partnership areas in Lothian. The membership of these groups consist of all agencies tasked with action under Section 9 of the 'Act'</i></b>
<b><i>4. Corporate parents must also consult with such other persons as they consider appropriate. In every case the term 'appropriate person' would include the children and young people to whom Part 9 applies.</i></b>	<b><i>31/10/17</i></b>	<b><i>M&amp;CST</i></b>	<b><i>We have consulted as described in the main narrative of this plan. In addition, we have taken account of:</i></b> <ul style="list-style-type: none"> <li><b><i>• analysis of national published statistics</i></b></li> <li><b><i>• detailed analysis of local data in relation to looked after children and young people in Lothian</i></b></li> <li><b><i>• other organisation's Corporate Parenting Plans</i></b></li> </ul>
<b><i>5. Consult directly or indirectly with the eligible population:</i></b> <b><i>5.1 To engage with children and young people, parents and carers in developing and delivering the strategy</i></b> <b><i>5.2 To support Access by developing knowledge of LAC/LAAC CYP engagement and experience of access to and use of NHS services.</i></b>	<b><i>31/10/17</i></b>	<b><i>M&amp;CST</i></b>	<b><i>We have consulted as described in the main narrative of this plan.</i></b>
<b><i>6. A Corporate Parenting Report (progress and outcomes) should be published at least once every three years.</i></b>	<b><i>April 2020</i></b>	<b><i>M&amp;CST</i></b>	<b><i>A corporate parenting report will be published in 2020.</i></b>
<b><i>7. The plan and future reports should be easily accessible to both the eligible population and general public. Accessibility relates to the availability of the document (e.g. published online), its format and language.</i></b>	<b><i>Nov 17</i></b>	<b><i>NHSL Comms. Dept&amp; M&amp;CST</i></b>	<b><i>The plan and future report of progress and outcomes will be published on NHS Lothian website.</i></b>
<b><i>8. All corporate parents to collaborate with each other – working together to deliver revised Corporate Parenting Plans at the 4 children's services partnership areas and Pan Lothian levels.</i></b>	<b><i>ongoing</i></b>	<b><i>M&amp;CST</i></b>	<b><i>Corporate Parenting is a standard steering group in each of the 4 children's services partnership areas, to which NHSL are an equal partner and will ensure that the NHSL corporate parenting duties are delivered in collaboration.</i></b>

<b>Section 58 Actions:</b>	<b>Date to Achieve</b>	<b>Lead Group</b>	<b>Evidence We Have Delivered</b>
<p><b>58a:</b> <i>To be alert to matters which, or which might, adversely affects the wellbeing of children and young people to whom this Part applies.</i></p> <p><b>Note:</b> <i>We must know who looked after children are and where they reside to ensure that wherever they interact with NHS services, that we are alert to their additional needs and vulnerabilities. Within our NHS Lothian electronic patient (child) health record electronic patient record (EPR) there is an alert that enables all practitioners who come in contact with the child / young person to be aware that this person is looked after; enabling practitioners to be vigilant and check the child or young person's EPR record for additional information.</i></p>			
<p>9. <i>To ensure processes are in place to record the LAC/LAAC status of children and young people which are consented, accurate, complete and timely.</i></p>	<p>June 18</p>	<p>Child Health Informatics Group</p>	<p>Systems and processes in place.</p>
<p>10. <i>Audit the use of this alert to ensure that it is being used routinely and guiding practice. Ensure that this transfers into other clinical IT systems up to age 26 yrs.</i></p>	<p>June 18</p>	<p>Child Health Informatics Group</p>	<p>Audit completed. Improvement plan from audit then actioned.</p>
<p>11. <i>Promote and develop age appropriate, compassionate and responsive services for all LAC/LACC children within CYP services but also ensure that adult services are responsive to the needs of age 26 – via health visiting services for 0-5 years, family nurses, school nurses, CAMHS services, AHP services, LAC nursing services, GP services, paediatric acute, adult mental health services, sexual health services by conducting a an awareness raising programme, training, and requesting that all operational services take consideration of service design and outcomes.</i></p>	<p>Sept 18</p>	<p>M&amp;CST</p>	<p><i>Each operational unit of NHSL delivery must demonstrate their consideration of LAC/LAAC/Through Care After Care (TCAC) service users in their service planning and delivery.</i></p> <p><i>Our Through Care and After Care Specialist Nursing Service will be strengthened and our range of adult health services will be responsive to the needs of young people up to age 26.</i></p>
<p>12. <i>To ensure robust governance and audit relating to age, gender, disability, religion, and interface between adult and children's services via disaggregation of data within PPAG reports.</i></p>	<p>Ongoing</p>	<p>PPAG tba</p>	<p><i>There will be no difference seen in our data for improvement relating to equality groupings.</i></p>

<b>Section 58 Actions:</b>	<b>Date to Achieve</b>	<b>Lead Group</b>	<b>Evidence We Have Delivered</b>
<p><b>58b:</b> To <u>assess</u> the needs of those children and young people for services and support it provides.</p>			
<p><b>Note:</b> All LAC/LAAC children are offered a comprehensive health assessment and a mental health screen by a Looked After Children's Nurse. Following assessment there will be ongoing referral of some children and young people to specialist services. We currently measure uptake of initial assessments, immunisation rates, referral to CAMHS, smoking cessation and other specialist services including dental services through a combination of extract from the child or young person's and the specialist LAC/LAAC assessment form and this forms our baseline.</p> <p>Whilst we are meeting the 4 week health assessment target (from when we are notified) for those who opt in for the assessment, we have not explored or met the health needs of those who did not opt in, or explored fully how to increase our reach.</p>			
<p><b>13. To undertake a review of our delivery model of CEL 16 health assessment delivery and LAC healthcare service to explore if redesign is required to increase reach and to ensure ongoing support for health needs is effective in improving outcomes.</b></p> <p>Part of this work will be to explore the joint working possibilities with other nursing groups e.g. health visitors, school nurses and to review the staffing levels within the LAC service, to ensure compliance with the 'Act', as the age of corporate responsibility has increased from 18 to 26 years for this special group of children.</p> <p>This work will also aim to improve the efficiency of notification of a child being looked after from social work service to our health service.</p>	<p>June 2018</p>	<p>LAC operational group and Maternity &amp; Children's Strategic Team</p>	<ul style="list-style-type: none"> <li>- Stretch aim to increase uptake to 100 % of LAC population by 2020.( from 75% to 85% in yr 1)</li> <li>- Qualitative feedback from Champions Boards and surveys that the assessment is supportive of their health needs.</li> <li>- Qualitative feedback from health professionals and Social Work colleagues - that health service support to children is well delivered.</li> <li>- That we have improved continuity of care to ensure that the health professional with the most consistent input to the child, young person or family carries out the assessment and ongoing support, with input from specialists as required.</li> <li>- There will be no delay in notification from Social Work/children's services in the 4 areas of Lothian.</li> </ul>

<b>Section 58 Actions:</b>	<b>Date to Achieve</b>	<b>Lead Group</b>	<b>Evidence We Have Delivered</b>
<b>14. To ensure up to date Child Health Plans exist for LAC/LAAC and that processes for communication with Named Persons are in place.</b>	<b>Sept 2018</b>	<b>LAC Operational Group and Maternity &amp; Children's Strategic Team</b>	<b>Annual audits of TRAK notes will show robust Child Health Plans following the practice development model. When parts 4 &amp; 5 of the 'Act' begin, ensure named person and statutory child's plans commence.</b>
<b>15. To reduce waiting times for CAMHS services and ensure capacity exists within CAMHS and adult mental health services to meet the mental health needs of LAC/LAAC children.</b>	<b>April 2018</b>	<b>LAC Operational Group/ Maternity &amp; Children's Strategic Team/Royal Edinburgh and Associated Services (REAS)</b>	<b>Referrals to the Mental Health Service for children and young people will be assessed in a timely and responsive manner. Referral and treatment times for LAC/LAAC will be assessed via PPAG and CAMHS reports.</b>
<b>16. To explore our approach to meeting the mental health needs of this group of children and young people – in line with the CELSIS child development frame. To ensure that we identify the mental health needs and explore the right tier of support and intervention required with the aim to provide continuity of carer. For this approach to be consistent with CELCIS child development approach and informed by trauma, loss, bereavement and ACE evidence base. This will include capacity building for staff, Children and Young People, Parents and Carers. The Mental Health and Wellbeing Framework can be used to guide actions</b>	<b>June 2018</b>	<b>LAC operational group/ Maternity &amp; Children's Strategic Team/REAS</b>	<b>The mental health needs of LAC/LAAC Children and young people will be met.</b>

<b>Action Required</b>	<b>Date to Achieve</b>	<b>Lead Group</b>	<b>Evidence We Have Delivered</b>
<b>58c: To promote the interests of those children &amp; young people</b>			
<b>17. To ensure that staff across the NHS Lothian are made aware of the legislation and their responsibilities within it, ACE agenda etc via spotlight reports, e-learning, presentations from Champions Boards (including the needs of care leavers).</b>	<b>Ongoing</b>	<b>PPAG Comms Team Training &amp; Development Team</b>	<b>- Staff and services will be fully responsive to the needs of LAC/LAAC wherever the care is needed.</b>
<b>18. To ensure all NHS staff, community and hospital, have the understanding needed to support CYP whenever and wherever they require NHS care via a tiered training and awareness programme (including the needs of care leavers). Make use of the advice and resources for corporate parents available from Who Cares? Scotland on the <a href="#">Corporate Parenting Learning Hub</a> and/or the CELCIS <a href="#">Corporate Parenting</a> website.</b>	<b>Ongoing</b>	<b>PPAG Training &amp; Development Team</b>	<b>Our Health Visiting Staff, Family Nurses and School Nurses undertake additional training in child protection, assessment using the national practice model and identification of the needs of LAC. In addition we have a specialist LAC service that encompasses specialist LAC Nurses and dedicated paediatricians and mental health workers. Staff and services will be fully responsive to the needs of LAC wherever the care is needed.</b>
<b>19. To bring Champions from the Champions Boards Pan Lothian into the NHSL Board to share their experiences.</b>	<b>Annual item</b>	<b>NHSL Board</b>	<b>-Board members feel fully engaged as corporate parents.</b>
<b>20. To work actively with Independent and Third Sector Providers: GPs, Dentists, Opticians, Voluntary Organisations, and contracted suppliers to ensure they understand and support CYP needs as action 16 &amp; 17.</b>	<b>Ongoing</b>	<b>PPAG Comms Team Training &amp; Development GP &amp; Primary Care Contracts Team</b>	<b>Primary care services will be fully responsive, sensitive and compassionate to the needs of LAC/LAAC. Service delivery will be adapted to meet the needs of these children and young people.</b>
<b>21. Ensure there is an understanding of the different developmental, gender, sexuality, disability, spiritual and cultural needs of LAC and their carers</b>	<b>Ongoing</b>	<b>LAC Operational Group</b>	<b>Staff will be trained and alert to the different needs of children in the LAC community</b>

<b>Action Required</b>	<b>Date to Achieve</b>	<b>Lead Group</b>	<b>Evidence We Have Delivered</b>
<b>58d:</b> To seek <u>to provide</u> those children and young people with <u>opportunities</u> to participate in activities designed to promote their wellbeing.			<b>Consultation with Children and Young People</b>
<p>22. Promote (with other community planning partners) opportunities for LAC to be involved in leisure, arts and sport opportunities which promote both positive physical and mental health and wellbeing</p> <p>NHSL actions will be the use of activities in mental health therapies and occupational therapy approaches and referring and signposting children to community opportunities.</p>	<b>Ongoing</b>	<b>Via 4 children's services partnerships and LAC Operational Group</b>	<b>Opportunities for children and young people to be involved in activities which are health and wellbeing enhancing.</b>
23. To explore opportunities and commit to support, training, mentoring and employment opportunities for LAC to be employed in NHS Lothian. Reduce barriers within processes to support care experienced young people work within NHS Lothian			<b>Stretch aim to be agreed with HR to ensure placements/apprenticeships/jobs for x number of LAC/carer leavers year who have been/are care experienced.</b>
<p><b>58e:</b> To take such <u>action</u> as it considers appropriate to help those children and young people:</p> <p>i) To access opportunities it provides in pursuance of paragraph (d)</p> <p>ii) To make use of services, and access support, which it provides</p> <p><b>58f:</b> To take such <u>other action</u> as it considers appropriate for the purposes of improving the way in which it exercises its functions in relation to those children and young people.</p>			<b>Note: Covered in Section 58b</b>
24. Explore areas for improvement to the processes for transition of young people into adult services	<b>Ongoing</b>	<b>Via 4 children's services partnerships</b>	<b>Audit of Transitions will show improvements</b>

**For Further Information on this plan, please contact the:**

**NHS Lothian Maternal and Child Health Planning, Policy and Performance Directorate on 0131 465  
5550**





**BEST START IN Lothian- Maternity and Neonatal Strategy 2018 - 2023**

**1 Purpose of the Report**

The purpose of this report is to brief the NHS Lothian Board on the development of the 'Best Start in Lothian - Maternity and Neonatal Strategy 2018 – 2023 (Appendix 1); that includes detailed actions to ensure synergy and compliance with Scottish Government 'The Best Start – Five Year Forward Plan for Maternity and Neonatal Care in Scotland' recommendations. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

**2 Recommendations**

- 2.1 The board are asked to consider the national direction of travel as specified within national 'The Best Start - A Five Year Forward Plan for Maternity and Neonatal Care in Scotland' (referred to as 'The Best Start') including the radical change and potential implications in delivering the revised service model.
- 2.2 The board are asked to approve the 'Best Start in Lothian - Maternity and Neonatal Strategy 2018 – 2023' to allow publication and continued implementation of the outline 2 year action plan (2017-2019) that commenced during the initial drafting in 2017 (Appendix 2). The strategy was approved by Strategic Planning Committee on 8<sup>th</sup> February 2018. The strategy has a separate two page executive summary for communication purposes (Appendix 3).
- 2.3 Acknowledge that NHS Lothian is confirmed by Scottish Government (SG) as one of five territorial Early Adopter Boards and be assured that an NHS Lothian Programme Board, chaired by the Executive Nurse Director, will oversee testing and implementation of 'The Best Start' recommendations. And that the Board Committee with primary oversight will be the Strategic Planning Committee, through which information is already flowing.
- 2.4 The board are asked to note that NHS Lothian are seeking financial support from SG to implement the test of the new model (see further section 4.4.2).

**3 Discussion of Key Issues**

**3.1 National Policy and Implementation**

- 3.1.1 In February 2015, the Minister for Public Health announced a national Review of Maternity and Neonatal Services in Scotland. A Review Group was established to examine choice, quality and safety and to make recommendations for a Scottish model of care.
- 3.1.2 'The Best Start' was published in January 2017 and the key changes were presented to NHS Lothian Strategic Planning Committee (SPC) in June 2017. This plan has 76 recommendations; within 7 areas of focus: continuity of carer; person-centred maternity and neonatal care; multi-professional team working; accessible

and appropriate local services; redesign of neonatal care; supporting the changes; and wider implications. <http://www.gov.scot/Publications/2017/01/7728>

- 3.1.3 To progress 'The Best Start' requirements a national implementation group was established in June 2017. Within the 76 recommendations 23 are deemed to be within the scope of local health boards to deliver. The remaining recommendations will require regional or national planning. In July 2017 all Boards completed a template measuring current position against these 23 recommendations.
- 3.1.4 Scottish Government wrote to all Health Boards mid August 2017 asking for expressions of interest in becoming an Early Adopter Board (EAB's). NHS Lothian submitted an expression of interest to Scottish Government and was confirmed as one of the 5 national EAB's in late September 2017.
- 3.1.5 On the publication of 'The Best Start', the SG expectation was that this national redesign was to be within the current NHS Board budgets and there has been no indication that this will change.
- 3.1.6 All EAB's have been given small Project Management funding of £50k.

## **3.2 Local Policy and Implementation**

- 3.2.1 NHS Lothian's previous Maternity and Neonatal Strategy and implementation plan 2009/10 – 2015, delivered on many service improvements in both clinical care and in capital planning investments.
- 3.2.2 The delay in the publication of the new national strategy led to an interim desk top review and extension of the NHS Lothian 2009/10 - 2015 strategy into 2017.
- 3.2.3 A Best Start Programme Board, Chaired by the Executive Nurse Director has been established to oversee strategy development and implementation and to provide governance to the Lothian EAB project.
- 3.2.4 The NHSL Best Start Programme Board will provide assurance to Healthcare Governance Committee or Strategic Planning Committee as appropriate (dependant on reporting and assurances required) and will also report progress to the NHSL Acute Services Committee.
- 3.2.5 The draft 'Best Start in Lothian - Maternity and Neonatal Strategy 2018 - 2023' sets the direction of travel for the modernisation of maternity and neonatal services in line with the 'The Best Start' national plan. The strategy has been designed to be public and service facing, with sections that can be read independently or collectively.

## **4. Key Risks**

### **4.1 Maternity Model**

- 4.1.1 The new model of maternity service care is a radical redesign of the whole system in Scotland.
- 4.1.2 On publication nationally in January 2017, SG stated that this was to be a cost neutral redesign of service. At that point in time, health boards and professional organisations such as the Royal College of Midwives, highlighted to SG that they did not believe the transformation from the existing models of care to the new best

start models of care to be cost neutral for services (at least in the short to medium term). In the long term, this may be the case, as similar to shifting the balance of care toward primary care we will be able to shift resources and see improving outcomes which lead to savings which can be reinvested in the system. However, in the testing and shifting the balance stage, new money is felt to be essential to bridge from the old to the new model. This will be discussed below in 4.4.

- 4.1.3 The national groups have not yet worked out the level of core hospital care that must remain in acute obstetric units for core hospital care to ensure a robust model which ensures patient safety and high quality care. (e.g. for elective and emergency caesarean sections, inductions of labour, high risk intrauterine transfers, premature births, high dependency care for mothers, neonatal care for babies etc).
- 4.1.4 At the testing phase, we cannot remove financial resource from our current hospital maternity service or reduce staffing in our units. Therefore to pilot the primary midwife and continuity of carer model as an EAB, we are requesting staff costs for 5 whole time equivalents (wte) band 6 midwives from SG. This request was submitted 20<sup>th</sup> March 2018 (Appendix 4).
- 4.1.5 All women will require continuity of midwifery care from a primary midwife who will provide antenatal, intra partum and post partum care. Caseloads will be capped at 35 women per WTE midwife caseload (at any time) and there will also be a primary obstetrician working around an aligned model of co-location and community hubs. This redesign will require extensive workforce and financial planning and will be part of the scoping and redesign tests of change within the EAB's. A technical resource group is currently scoping these implications.
- 4.1.6 At present our NHSL model of care is designed around settings rather than the woman. The new model will see the primary midwife following the woman through her care journey. Therefore, a large proportion of hospital midwifery workforce will need to be reconfigured into community teams and work in this new way. The community midwifery workforce will require a minimum of a threefold increase.

## **4.2 Neonatal Model**

- 4.2.1 The second largest implication for NHS Lothian relates to the move to five neonatal intensive care units for Scotland, progressing to three within five years. The new model will be:
  - Special Care Baby Units (SCBU). All neonatal units in Scotland will require to provide this level of care to their local population.
  - Local neonatal units – care for the majority of babies who need low-risk intensive care, high dependency care and special care, keeping the family together and as close to home as possible
  - Neonatal Intensive Care Units – three to five neonatal units in Scotland will have this designation, linked to the evidence that a small number of babies require highly specialist care and that most of these babies will require a relatively short period of this level before being transferred back to their local unit.
- 4.2.2 The neonatal intensive care unit at SCRH is a regional unit at present. There is physical capacity to increase the cot numbers within the current floor space, but there is no current staffing capacity to staff for these cots due to the national short staffing supply (financial and a national shortage of neonatal nurses); or any inpatient capacity in maternity beds or maternity staffing.

- 4.2.3 There are facilities for a small number of parents to stay in parent accommodation but no transitional care unit or model. This national change will require bed modelling and regional and national discussion as women at risk of giving birth to these very high risk babies will require intrauterine transfers, maternity care and neonatal care.

### **4.3 Workforce Organisational Change**

- 4.3.1 NHSL is the second largest health board in Scotland and as a tertiary centre of expertise we have a very large population to care for and a very large work force to reconfigure. This will require a large organisational change process and sensitive project management to ensure that this is a staged transformational process across the life span of the 5 years of the new strategy period.
- 4.3.2 Age of workforce: Within midwifery services there are 530.73 wte (652 head count) registered midwives/nurses and of these staff 32% are 50 year of age and over (of which 12% are 55 years and over). Impacting on this has been reduction in student midwives in recent years. This is now being addressed nationally and there is to be an increase in those training.
- 4.3.3 In neonatal nursing, there is a national shortage of specialised nurses. In Lothian, 24% of the nursing staff in neonatal are 50 years and over (11% of these being 55 and over).
- 4.3.4 The NHSL Best Start Programme Board, Women's Clinical Management Team and the NHSL EAB Project Team all have strong partnership and trade union representation alongside senior employee relations managers to ensure that the workforce changes required under the local implementation of this national model change, are fully considered and done in partnership with staff and in compliance with our organisational change policies and procedures.

### **4.4 Financial**

- 4.4.1 EAB's were asked to test parts of the model within their current financial budgets (separate to a £50,000 allocation for project management costs).
- 4.4.2 A financial appraisal of the testing costs has been carried out for the primary midwife model pilot and to create an 8 wte midwifery team. From existing resources, 3 wte staff can be seconded from existing community midwifery. Additional costs of £277,404 for 5 additional wte midwives and on costs have been requested from SG on 20<sup>th</sup> March 2018 (Appendix 4). A full service technical appraisal including workforce, financial and risk implications of a full scale redesign will be carried out to model how this transformational change can happen in staged process within existing financial envelope.

## **5 Risk Register**

- 5.1 No elements added to the corporate risk register at this point. As per Section 4, the new model of care and transformational change to service delivery are significant and will require extensive workforce and financial planning and risks assessed at all stages of the change process.

## 6 Impact on Inequality, Including Health Inequalities

- 6.1 An integrated impact assessment was carried out on 19<sup>th</sup> March 2018. The key findings were that the new model will reduce inequalities across populations and improve care and equality outcomes for service users. Challenges are anticipated around workforce impacts, such as changes to working patterns. There will be robust mechanisms put in place to mitigate these factors by close partnership working and by adherence to the organisational change policies and procedures.

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

- 7.1 As part of the national review, service user consultation was undertaken in Lothian, by the Scottish Health Council. This feedback has also fed into the development of the NHS Lothian 2018-23 strategy and a section on what we have heard from service users is included within. The Lothian Maternity Services Liaison Committee, which has a statutory role in representing all users of maternity services, is fully involved and has a seat on the new programme board.

## 8 Resource Implications

- 8.1 As per section 4, workforce and financial implications have been scoped for the pilot phase and the testing phase will allow further detailed analysis for the wider transformational change to enable us to more reliably predict the cost of the new model of care.
- 8.2 The previous non recurrent **Refreshed Maternity Framework** quality improvement national funding of £248,756 pa (Lothian share received since 2011) is not guaranteed beyond each financial year. This funding is currently within the outcomes framework bundle and fully utilised across a range of maternity operational improvement initiatives.
- 8.3 At this point there has not been any indication that Scottish Government will be allocating additional funding / bridging finance to Boards as part of the Best Start redesign of maternity and neonatal services in Scotland. However, as described in 4.4.2, we have asked for funding to be considered to deliver the pilot of the primary midwife, and have advised that without this, we will not be able to fund that part of the test from core services.

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### Appendices:

- Appendix 1 – NHS Lothian Draft Maternity and Neonatal Strategy 2018 – 2023  
Appendix 2 – NHS Lothian outline 2 year action plan (2017-2019)  
Appendix 3 - 2 page executive summary of strategy  
Appendix 4 - Letter to SG requesting further pilot funding



**Best Start in Lothian**  
**Maternity and Neonatal Strategy**  
**2018 - 2023**

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## **Foreword**

*Welcome to NHS Lothian's five year strategy for Maternity and Neonatal services across Lothian. This strategy sets the direction for the modernisation of our model of care in line with the Scottish five year strategy 'The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care' (Scottish Government January 2017).*

*Within Lothian, we care for between 9,000 and 10,000 births per year, caring throughout the antenatal period, labour and after each birth. We have a strong and proud tradition of being a leader in care and our centres provide regional and national expertise in obstetric and neonatal care.*

*In addition to caring for women, babies and their families within Lothian, we receive and care for women and babies from other health board areas who need intensive or specialised care.*

*Having a baby is the most special of periods in any family's life and we recognise that our care is very important, not only to ensure high quality and safe care but also to provide trusted relationships between families and health professionals to ensure our care is person-centred and supportive of people's individual needs.*

*The 'Best Start in Lothian –Maternity and Neonatal Strategy 2018 – 2023' mirrors the national strategy for Scotland within the context of Lothian.*

*We look forward to a five year period of significant focus, transformation and a new model of care which aims to place all our mothers and babies at the heart of service design.*

***Professor Alex McMahon  
Executive Director Nursing, Midwifery and  
Allied Healthcare Professionals***





# *Section 1*

## *Setting the Scene*



# 1. Setting the Scene

## The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care

On 20<sup>th</sup> of January 2017, the Scottish Government released the new five year strategy for Scotland [The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care](#), which sets out a vision for the future planning, design and safe delivery of high quality maternity and neonatal services in Scotland. It puts the family at the centre of decisions so that all women, babies and their families get the highest quality of care according to their needs. Jane Grant, Chief Executive, NHS Greater Glasgow and Clyde was appointed on 21 February 2017 to lead the implementation of the recommendations. The Minister for Public Health and Sport (Aileen Campbell) responded to the review in a [statement to Parliament](#) on 21 February and outlined her priorities for implementation.

*Extract from Ms Campbell's speech*

*'Every day, our maternity services deliver an excellent service to families across Scotland. In our maternity care experience survey, women reported over 90 percent satisfaction with the care that they had received. We also continue to reduce rates of maternal mortality, stillbirth and neonatal mortality in Scotland to record low levels. The number of neonatal deaths has reduced by 40% since 2007, which means that, in 2015, 76 more babies' lives were saved by the high-quality care that was provided by staff in neonatal units across Scotland. It also means that there were 76 fewer bereaved families. That improvement is a testament to the hard work of the staff who look after sick babies in Scotland. Our maternity system secures high satisfaction ratings among women and continues to improve care and outcomes for the sickest babies. We are in a position of strength, but we are not complacent and know that there is much that we can do to make further improvements. That desire to improve and transform in part inspired the review. The report is a landmark publication that represents a major opportunity to improve services even further, and its recommendations will transform service delivery in Scotland.'*

*For example, some women currently experience no continuity of maternity care and can see numerous different midwives and obstetricians throughout their care journey. That is not what women or staff want, and evidence tells us that it is not good for care. To give women and staff what they tell us they want – which the report describes as family-centred care – will require a radical shift in how we deliver care. There is no doubt that such a change will be challenging to deliver and, for many of our midwives and obstetricians, will represent a significant change in ways of working, but it will ensure better care.'*

# 1. Setting the Scene

## The Best Start Vision:



All mothers and babies are offered a truly family-centred, safe and compassionate approach to their care, recognising their own unique circumstances and preferences



Fathers, partners and other family members are actively encouraged and supported to become an integral part of all aspects of maternal and newborn care



Women experience real continuity of care and carer, across the whole maternity journey, with vulnerable families being offered any additional tailored support they may require



Services are redesigned using the best available evidence, to ensure optimal outcomes and sustainability, and maximise the opportunity to support normal birth processes and avoid unnecessary complications



Staff are empathetic, skilled and well supported to deliver high quality safe services, every time



Multi-professional team working is the norm with an open and honest team culture, with everyone's contribution being equally valued.

# 1. Setting the Scene

## Main recommendations of Best Start:

- **Continuity of carer**
  - From primary midwife and obstetrician through prenatal, intrapartum and postnatal care
  - Care co-located for the provision of community and hospital-based services
- **Person-centred maternity and neonatal care**
  - Relationship-based, personalised care
  - Aiming to keeping mums, babies and families together
  - Safe and family-centred neonatal care
- **Multidisciplinary team care**
  - Women receive the level of care they need
  - Clear referral pathways
- **Safe, high quality and accessible care**
  - Development of community hubs
  - Postnatal neonatal care
  - Specialist maternity and neonatal care co-located
  - Support for vulnerable women and improved perinatal mental health services
- **Neonatal care**
  - Three to five neonatal intensive care units should be the immediate model for Scotland, moving to three within five years
  - Development of a national model for 7 day neonatal community services
- **Transport**
  - Recommendations focused on safe and prompt transfer of neonates, and clear cot identification
- **Remote and Rural care**
  - Formalising support for additional skills and competencies in relation to remote and rural working
- **Workforce**
  - Workforce planning, and planning for training and education
- **IT and Quality improvement**
  - Development of quality improvement dashboards
  - Single maternity care system and electronic maternity record.

# 1. Setting the Scene

## **National Implementation Programme Board and Implementation Plan**

An Implementation Programme Board has been established and met for the first time on 9 June 2017, chaired by Jane Grant, Chief Executive of NHS Greater Glasgow and Clyde, with representation from across Scotland. The group have agreed which of the 76 recommendations require national, regional or local delivery. 23 of these 76 are deemed within the gift of local health boards to deliver via their own redesign and modernisation processes.

In addition, the Scottish Government wrote to Health Boards (17/8/17) asking for expressions of interest in becoming an Early Adopter Board (EAB). NHS Lothian expressed an interest and after submission of supplementary information (see additional document) the Scottish Government formally offered NHS Lothian a position as one of the 5 Early Adopter Boards (25/9/17).

### **Early Adopter Boards were asked to demonstrate:**

- Senior leadership support to ensure local leadership and governance
- Ability to undertake workforce planning to underpin the new models and ways of working
- Ability to support staff development and training as part of the change management process

- A willingness and ability to share learning throughout the process, and use this to support wider NHS implementation
- A willingness and ability to report data on a range of nationally agreed outcomes
- An organisational culture that can support and implement change, with planning anticipated towards the end of 2017 and implementation from the first half of 2018.

### **It is anticipated that Early Adopter Boards across Scotland, would lead the way in implementing:**

- Midwifery continuity of carer model for all women, including vulnerable women and families
- A new model for hospital-based maternity services, including postnatal neonatal care, and the associated core workforce
- Aligned and co-located midwifery and obstetric teams
- Enhanced roles for support workers in the community and in community hubs
- Community Hubs for the delivery of maternity care and, in time, neonatal outreach.

# 1. Setting the Scene

## The policy landscape shaping Best Start strategy and implementation:

*Within Scotland, the themes of Early Years and Supporting Children, Young People and Families are fundamental. The maternity and neonatal periods are the building blocks to make Scotland the best place to grow up.*

*Getting it right for the children of Scotland is the best prevention we can make within public life, as healthy, happy and achieving children grow up to be productive, healthy, happy adults.*

### **Getting it Right for Every Child (GIRFEC) and Children and Young People (Scotland) Act 2014**

Getting it right for every child is vital, and this starts from preconception onwards. In Scotland, Getting It Right for Every Child (GIRFEC) has been a national approach to children and young people services for 10 years, and moved into law under the Children and Young People (Scotland) Act 2014.

[The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care](#) starts the journey to Getting it Right for Every Child in Scotland. Midwives will link with health visitors in the antenatal period using the GIRFEC model and in preparation for handover to the health visitor in the postnatal period.

The new [Universal Pre-Birth to Preschool Pathway](#) for all of Scotland's children (delivered by health visitors and family nurses) commenced in Lothian from October 2016. This supports a holistic and person-centred model, where levels of support are tailored to each family's needs. Therefore the changes to the model of care under Best Start will dovetail into the Universal Pathway bringing supportive models of care from pre-birth through preschool.

# 1. Setting the Scene

## **Royal College of Midwives: 'Getting the Workforce Right'**

In 2016, the Royal College of Midwives launched 'Getting the Workforce Right'. Their report is reflected in the Best start recommendations from Scottish Government relating to continuity of midwifery care.

## **NICE Safe Staffing Guidelines NG4 2015**

In February 2015, The National Institute for Health and Care Excellence (NICE) published ['NICE Safe Staffing Guideline NG4 2015'](#) which set out recommendations for safe staffing in maternity settings. The report was published following high profile reports on failings in maternity care including the 'Kirkup Report on Morecambe Bay'. In response to the NICE report, the Royal College of Midwives (RCM) published ['RCM Guidance on Implementing the NICE Safe Staffing Guideline on Maternity Staffing in Maternity Settings'](#) which emphasises the importance of having the right number of staff available to care for mothers and babies and makes recommendations on clinical governance, transparency and continuity of care. The importance of a culture of mutual respect was highlighted as important to sustain effective working relationships.

## **Health and Social Care Delivery Plan (December 2016)**

This plan sets out the programme to further enhance health and social care services, which are systems that:

- Are integrated
- Focus on prevention, anticipation and supported self management.
- Take forward the recommendations from the 2015 Maternity and Neonatal Review.
- Will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting
- Focuses on care being provided to the highest standards of quality and safety, wherever the setting, with the person at the centre of all decisions
- Ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission

The plan focuses on three areas, referred to as the 'triple aim':  
*Better Care - Better Health - Better Value*

## **GP Contract and Scottish Government Primary Care Visions and Outcomes**

The role of the GP is transforming to become an 'Expert Medical Generalist' in the community, focusing on complex care; undifferentiated illness; and outcomes, quality and leadership – the way to make best use of GP skills. Other roles in primary care are evolving, such as advanced nurse practitioners, the role of pharmacists, paramedics, etc.

# 1. Setting the Scene

The role of the GP in maternity and neonatal care has reduced with past policy, with the clear role of midwives in community and linked geographical obstetricians. The GP role in complex care will continue for women who have long term conditions and ongoing medical needs throughout their pregnancy and beyond. The role of the health visitor as a primary care member will also support the joint working between maternity care and primary care.

**The World Health Organisation report on stillbirths and neonatal deaths (WHO 2016)** highlighted the importance of examining individual cases to identify underlying reasons for the deaths and provide opportunities to learn what is needed to prevent similar deaths. A full review is completed for every baby who dies in Lothian. A retrospective audit of a random selection of 16 stillbirth case reviews from 2015- 2017 across RIE and St John's maternity services was conducted in 2017 to ensure that the appropriate review process had taken place. In each case, the reviewers considered: whether multidisciplinary team review took place, whether the appropriate method was used, whether a significant adverse event review was done if needed, and the date at which the significant adverse event review took place. The reviewers concluded that there is a reliable and appropriate review process for significant adverse events and stillbirths within NHS Lothian Maternity Services.

## **The AFFIRM Study**

The AFFIRM study aims to reduce stillbirth by implementing and testing a package of care to recognise, assess and manage reduced fetal movement. It was launched in 2014 and has been rolled out across the UK at different time periods. Lothian was in the first cluster in early 2014.

For more information on stillbirths, see the birth outcomes section of the Additional Document: What do we know about Lothian ([ADD LINK](#))



### **Maternity and Children Quality Improvement Collaborative (MCQIC)**

*Building on the world-leading and recognised success of the Scottish Patient Safety Programme in NHS Scotland, we have an embedded improvement and patient safety programme for maternity services, neonatal services and paediatrics.*



### **Improvement Work in Lothian**

#### **Being Open Improvement Work**

A model of clinical communication training that enables staff to have effective, supportive discussions with families about adverse events and to involve families in the review process has been developed and tested in Lothian in response to the Lancet Executive Report (Heazall, 2016) that “Empathic behaviour in all encounters between bereaved parents and care providers can minimise additional emotional and psychological costs, both immediately after the stillbirth of a baby and in the longer term”.

The Being Open work is based on the National Patient Safety Agency (NPSA) framework – ‘Being Open, saying sorry when things go wrong’ (2009). It will also help meet most of the requirements for the Duty of Candour Act (2006) which will begin reporting in 2018. This process is now reliably embedded within Maternity Services and is being spread to other areas in a bid to implement it across all acute services.

## *Section 2*

# *Review of NHS Lothian Maternity Strategy 2009-2015: How did we do?*



## 2. Review of NHS Lothian Maternity Strategy 2009-2015

### **This section reports on our progress in the [‘NHS Lothian Maternity Plan 2009-2015’](#)**

In the period following the previous plan, we delivered many service improvements in care and facilities. We modernised the labour ward at St John’s Hospital (SJH), and neonatal units at SJH and the Royal Infirmary of Edinburgh’s Simpson Centre for Reproductive Health (SCRH). We opened the Birth Centre at SCRH. We also worked to improve the health of mothers and babies across Lothian and reduce inequalities.

Although there has been a period between the end of the last strategy and the beginning of our current strategy, work has continued in Lothian to achieve the strategic vision of the NHS Lothian Maternity Plan 2009-2015 while awaiting the Scottish Government’s ‘Best Start’ strategy.

To evaluate whether we have delivered what we planned in the NHS Lothian Maternity Plan 2009-2015, we look at how well we met some of the key objectives in Maternity Services Action Plan 2009-2015. For each objective listed below, we evaluate whether we achieved it and describe key achievements which helped deliver our aims.



**Interior View of Birth Centre at Simpson’s Centre for Reproductive Health**

## 2. Review of NHS Lothian Maternity Strategy 2009-2015

### Did we deliver on improving the health of mothers and babies in Lothian?

**1. What did we set out to do:** Implement agreed, evidence Based parenting frameworks

**Did we achieve it?** We are making progress across the Region and our key achievements are:

Bump Start Pregnancy Cafes

This work is done in partnership with the City of Edinburgh Council and uses the principles of the Baby Friendly Initiative to promote breastfeeding and attachment

Solihull Training

Support parents/children to promote healthy attachment

Sling Library with West Lothian Council

Using a sling or “baby wearing” promotes bonding and attachment between babies and parents

Training/Support of Sure Start

Promoting breastfeeding and weaning training, peer support

Triple P, Incredible Years, Dads2b parenting programmes



## 2. Review of NHS Lothian Maternity Strategy 2009-2015

**2. What we set out to do:** Establish Direct Booking Service to improve antenatal care

**Did we achieve it?** Yes, in 2010, NHS Lothian set up the direct booking service for pregnant women so that mothers can phone up and book appointments with midwives directly without having to go through their GP.

### Key achievements: Direct Booking Service

Our booking rates have improved each year since 2011. The Government target (**HEAT target**) is that 80% of women in each socio-economic group (SIMD quintile) will book for pregnancy care by the end of the 12<sup>th</sup> week of pregnancy.

### ANTENATAL BOOKING

*We have surpassed the HEAT target of 80% across all areas in Lothian since 2011.*

### Antenatal Booking by Lothian HSCP 2011 - 2017

	Edinburgh CHP	Midlothian CHP	West Lothian CHP	East Lothian CHP	Grand Total
2011	86.80%	88.99%	86.79%	86.78%	87.04%
2012	90.02%	91.88%	88.96%	91.31%	90.12%
2013	90.32%	92.35%	90.97%	91.14%	90.73%
2014	90.72%	92.60%	90.22%	91.22%	90.87%
2015	90.86%	93.34%	90.79%	94.19%	91.48%
2016	90.62%	94.48%	91.00%	92.98%	91.35%
2017	91.63%	96.08%	93.67%	93.89%	92.73%
<b>Grand Total</b>	<b>89.97%</b>	<b>92.43%</b>	<b>89.95%</b>	<b>91.32%</b>	<b>90.36%</b>

## 2. Review of NHS Lothian Maternity Strategy 2009-2015



**3. What we set out to do:** Achieve 44% of all women breastfeeding at 6 weeks by 2011.

**Did we achieve it?** Yes, in 2011/12, 49.1% of infants were breastfeeding at 6-8 weeks, in 2015/16, 52% of infants were breastfeeding at 6-8 weeks.

**4. What we set out to do:** To reduce the percentage of women who smoke during pregnancy from 29% >20%.

**Did we achieve it?** Yes, we achieved our goal and maintained this since 2011 for women in Edinburgh and East Lothian, and since 2015 for women in Midlothian and West Lothian.

**5. What we set out to do:** 'Stop for Life' campaign for pregnant women to be rolled out across Lothian.

**Did we achieve it?** 'Smokefree Lothian' (previously 'Stop for Life') provide smoking cessation and second hand smoke exposure advice to pregnant women across Lothian following CO reading at the booking visit. All acute sites are able to provide support to in patients as part of the Smoking Cessation Acute Services.

## 2. Review of NHS Lothian Maternity Strategy 2009-2015

NHS Lothian is a [UNICEF Baby Friendly Initiative](#) accredited health board. The Baby Friendly Initiative is a quality improvement programme that is designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support optimum health and development.



- The Simpson Centre for Reproductive Health (SCRH) and St John's Hospital are fully accredited Baby Friendly hospitals.

In the community, NHS Lothian achieved stage 2 accreditation in November 2016. This means that UNICEF has audited our community staff and has determined that they have been effectively trained in breastfeeding and relationship building. Lothian underwent stage 3 assessment in November 2016 and await formal notification of the result.

In recent years, there has been momentum to expand the Baby Friendly Standards to neonatal and special care baby units.

- The Neonatal Unit at SCRH and the Special Care Baby Unit at St John's have recently undergone their stage 1 assessment with UNICEF.

## 2. Review of NHS Lothian Maternity Strategy 2009-2015

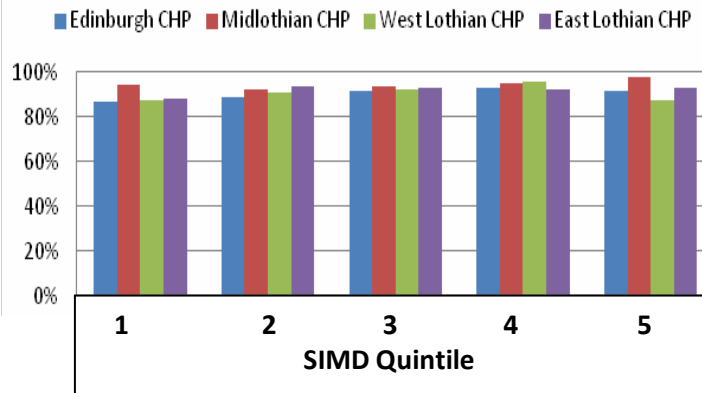
### Did we deliver on addressing Inequalities in Birth Outcomes?

#### 6. What we set out to do:

**Reduce Inequalities** to achieve the same outcomes for all mothers and babies, no matter where they come from, what their income is, what their age is and to develop partnerships with other statutory and voluntary services for vulnerable and disadvantaged families.

**Did we achieve it?** We have some positive achievements in this very complex area.

#### Jan - Dec 2016: Antenatal Bookings by 12 wks by SIMD



#### Key achievements: Reducing Inequalities

- We reached the Scottish Government target of 80% antenatal booking across socio-economic groups **Scottish Index of Multiple Deprivation (SIMD) quintiles**.  
We saved families £1,000s of pounds through the Pregnancy and Intervention Money Advice Project.
- We were the first test site in Scotland for the **Family Nurse Partnership (FNP)**, and Scottish Government continues to roll this out across Scotland.
- We worked in partnership to **deliver positive parenting programmes**. According to the UCL Institute for Health Equity report 'Local action on Health inequalities: Good Quality Parenting Programmes': 'the quality of parenting affects children's long-term physical, emotional, social and educational outcomes and therefore differences in parenting between social groups have implications for health inequalities.'



## 2. Review of NHS Lothian Maternity Strategy 2009-2015

### **Reducing Health Inequalities: The PIMAP project (Pregnancy and Intervention Money Advice Project)**

**PIMAP** was launched in West Lothian three years ago.

- It is a partnership project between Citizens Advice Bureau (CAB) Livingston and NHS Lothian. The aim of the project is to offer advice on a range of financial services to pregnant women, their families and those families with children under a year old. Topics include debt, benefits, housing issues, etc. The success of the project very quickly became apparent, saving families £1,000s of pounds. To date, the project has reached hundreds of families and their recruitment has expanded to the whole of West Lothian, the maternity ward at St John's Hospital and the dads2b group.



### **Reducing Health Inequalities: Family Nurse Partnership (FNP)**

- The FNP is a programme for first time young mums, aged 19 years or under.
- FNP has successfully been rolled out across our health board. FNP started in 2010 in Edinburgh city and was expanded to West Lothian in 2013, Midlothian in 2014 and East Lothian in 2016.
- 81% of our FNP clients in Lothian come from the two most deprived SIMD quintiles.

## 2. Review of NHS Lothian Maternity Strategy 2009-2015

### Did we deliver our improvements in services for Black and Ethnic Minority Women (BME)?

#### 7. What we set out to do: Improve services for Black and Ethnic Minority Women (BME)

**Did we achieve it?** We have made improvements in how widely available information is to women who do not have English as their first language. The [Maternity Services Liaison Committee](#) (MSLC) has been working with Health Scotland to make translated material more widely available and free to all health boards through the web2print service. This has allowed us to make overall progress to better serve the black and ethnic minority women of Lothian.

#### Key Achievements: Improving services for Black and Ethnic Minority Women (BME):

In June 2017, NHS Lothian launched our own in-house translation service. We are recruiting our own cohort of full-time interpreters and bank interpreters and will have access to an agency framework to cover the excess demand. NHS Lothian has a contract with [thebigword](#), a telephone interpreting service which is available 24/7 365 days a year with an average answering time of 40 seconds in Lothian in 2016. Our [Centralised Booking Service](#) is using 'The Big Word' to give ethnic minority mothers the choice to make their first appointment with the midwife. NHS Health Scotland resources are available in 9 different languages and formats and since February 2018 are available through web2print. This includes key publications such as 'You're Pregnant! – scans and tests', 'Your Baby- newborn tests', 'Childhood Immunisations', 'Off to a good start, Fun first foods'. Our Black and Ethnic Minority (BME) representatives in Lothian are working on 'Redesigning Health Information for Parents' with Health Scotland. This project has involved 4 ethnic minority focus groups with phase 1 completed. The MSLC are working with the NHS Inform website to decrease barriers to information for mothers who do not have English as their first language.

## 2. Review of NHS Lothian Maternity Strategy 2009-2015



### Did we deliver our staffing and capital investment outcomes?

**8. What did we set out to do:** Build midwife-led Birth Centre for up to 1,000 births at the SCRH site

**Did we achieve it?** The Birth Centre opened in 2010 and was designed to promote natural childbirth and encourage more beds to be open at SCRH. More than 1,000 babies have been delivered at the birthing centre each year since it opened.

**9. What we set out to do:** Strengthen neonatal services at St John's with neonatal nurse practitioners.

**Did we achieve it?** Yes, we have an advanced practitioner working in our St John's unit.



## 2. Review of NHS Lothian Maternity Strategy 2009-2015



**10. What did we set out to do:** Improve the accommodation for maternity services at St John's.  
**Did we achieve it?** The complete upgrade of the St John's Labour Ward was finished in 2014, along with a complete reconfiguration and upgrade of the Special Care Baby Unit (SCBU) at St John's.

### **The labour and SCBU units at St John's Hospital:**

- Underwent a multi-million pound upgrade to ensure they can meet demand and complexity of cases
- The Labour Ward now has 9 self-contained delivery suites with en-suite bathrooms
- Each room in the labour ward was fitted with a TV, bigger windows, birth balls and mats to help mums and dads stay comfortable
- The new Special Care Baby Unit (SCBU) provides 10 cots with modern clinical facilities for babies who require specialist care
- The design focuses on the provision of family-centred care with the inclusion of two bedrooms with en-suite facilities to allow parents to room in with their babies, a family room for use by parents and siblings with a small kitchen area and a counselling room allowing privacy

## 2. Review of NHS Lothian Maternity Strategy 2009-2015

### Did we deliver our service user involvement actions?



#### 11. What did we set out to do?

Increase the participation of service users in plans and decisions about the future development of the service.

#### Did we achieve it?

We collaborated with the Maternity Services Liaison Committee (MSLC) to increase the participation of mothers.

The MSLC is a committee which advises Lothian NHS Board on the care they provide to pregnant women and their partners and the parents of new babies and ensures that NHS Lothian takes into account the views of women and families using the service.

Membership of the MSLC includes: Service users, Operational Service Leads, Public Health, Primary Care, Local CPP representative, local university colleagues.

#### Key Achievements:

- ✓ Mothers' comments and suggestions for improvement for the postnatal wards in SCRH were reviewed and implemented through an MSLC working group.
- ✓ The MSLC relayed service user feedback about triage and helped make some changes to improve women's experience.
- ✓ The MSLC is currently working on the issue of consent and how to obtain meaningful consent.



## *Section 3*

*What do we know about?*

*3.1 Births in Lothian*

*3.2 Service User Views*

*3.3 Our Workforce*

## 3.1. What do we know about births in Lothian?

### Number of births in Lothian each year – local data 2010-2017

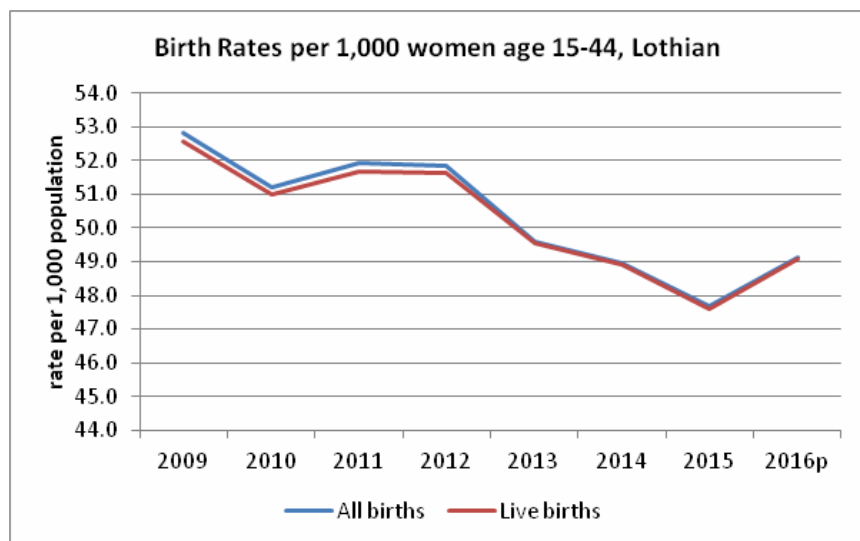
There have been around 9,500 births (range 9057-9909) each year in Lothian over the past 8 years.

2010	2011	2012	2013	2014	2015	2016	2017
9909	9829	9770	9582	9575	9320	9424	9057

Source: NHS Lothian TRAK System

The number of births (the number of women giving birth rather than the number of babies born) in 2017 shown above from local data is lower than in previous years. This reflects the national birth rate trend which is seen as decreasing in the Birth Trends (ISD) chart below. The 2017 local data on number of births is not yet published nationally and so is not included in the ISD Birth Trends chart.

### Birth Trends (ISD) – 2009-2016



Note:

This data from ISD relates to the birth rate per 1,000 women of childbearing age (age 15-44) in Lothian.

<https://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/2016-11-29/2016-11-29-Births-Report.pdf>

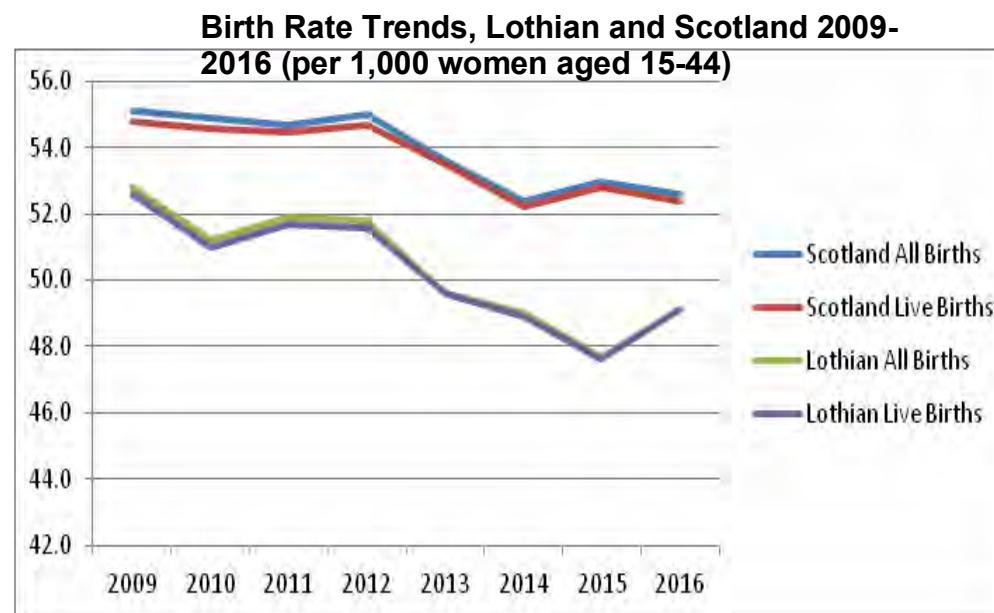
The majority of pregnancies in Lothian are singleton (one baby) with around 2.5% being twins or multiples in 2016, which is comparable to the Scottish rate of 2.8%.

## 3.1. What do we know about births in Lothian?

### Birth trend comparisons between Lothian and Scotland

Birth rates (live and all) are lower in Lothian than in Scotland but birth trends from 2009-2014 followed a similar pattern.

After a fall in births between 2012 and 2015, births have again increased to the current rate of 49.1/1000 women



<https://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/2016-11-29/2016-11-29-Births-Report.pdf>

### Population and Birth Trends Projections for Scotland and Lothian

Current Scottish population projections from National Records Scotland (NRS) provide an indication of the future size and age structure of Scotland's population based on a set of assumptions about future fertility, mortality and migration. The total population of Scotland is anticipated to rise from 5.40 million in 2016 to 5.69 million in 2041. The rise in population is driven by projected migration into Scotland both from the rest of the UK and from overseas, while the number of deaths is projected to exceed the number of births every year.

In the population projections, fertility is taken to mean the total number of children a woman would have, on average, at the end of her child bearing years. It is sometimes expressed as completed family size. The long term total fertility rate for Scotland is assumed to be 1.65. The number of births in Scotland is expected to decrease initially from its 2015-16 level of 55,300 to 53,400 in 2016-17 before increasing to a peak of 56,800 in 2022-23 before falling again to 55,000 by 2040-41.



## 3.1. What do we know about births in Lothian?

Birth trends for the lifespan of this strategy should see an increase of 6.4% from 2016/17 to 2022/23 numbers based on Scottish predictions, but then stabilise and fall slightly again towards 2040. However, using the national trend data may not fully capture the unique needs of Lothian. Consideration is required to the following population trends:

### % Change in Population between 2014 and 2039

	All Ages	Working Age	Children 0-15
Midlothian	+ 25.7%	+22%	+25%
East Lothian	+17.8%	+11%	+12%
Edinburgh City	+20.7%	+18%	+16%
West Lothian	+8.6%	+1%	-2%
NHS Lothian	+18.4%	+14%	+12%

[https://www.nrscotland.gov.uk/population-projections/2014-based data](https://www.nrscotland.gov.uk/population-projections/2014-based-data)

We know, therefore, that overall the population of Lothian is going up, and this is reflected in the working age and children, suggestive of families in the fertile range who may be users of maternity and neonatal services. In addition, we know of major house building in areas such as Midlothian which are attractive to young families. These elements suggest that the demand for our maternity services will rise in the life span of this strategy period from the population within Lothian.

However, we are seeing a much lower population rise in all ages in West Lothian, and especially in working age and children. Recent trends of through flow at St John's maternity unit mirror this trend. Following the Royal College of Obstetrics and Gynaecology peer review visit in 2015, a rezoning exercise was piloted to encourage women from the west corridor of Edinburgh to use the SJH facility to reduce demand on the SCRH units, but thus far this has not affected the usage across the 2 sites.

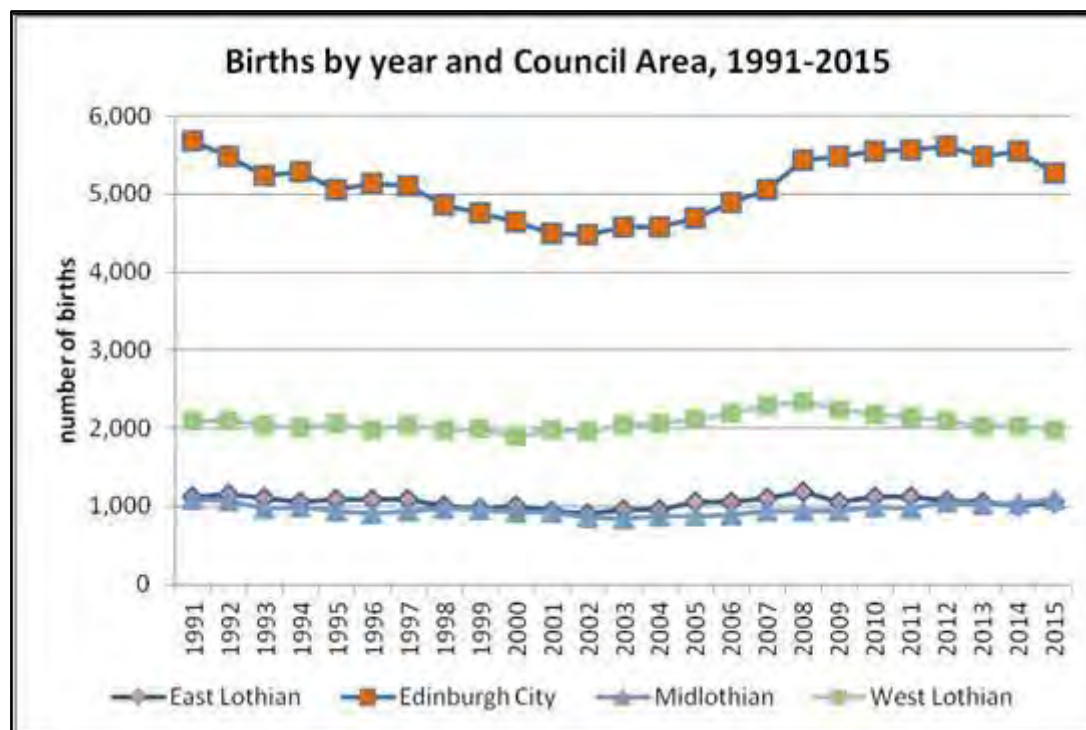
In addition, we anticipate higher usage from women and babies outwith Lothian who are transferred for specialised care at SCRH (see page 31).

Therefore, robust bed modeling and geographical care will be a key focus of the action plan for this strategy to ensure that the demand across Lothian is met in the new model of care.

## 3.1. What do we know about births in Lothian?

### Births Trends in Lothian by Council area (ISD)

<https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/births/births-time-series-data>



The City of Edinburgh birth rate has varied from 1991 to 2015 with a low of 4,477 in 2002 and a high of 5,671 in 1991. The number of births in Edinburgh has been more variable than other council areas over this time frame.

## 3.1. What do we know about births in Lothian?

**Births (Number of mothers giving birth) in Lothian from women who live outside of Lothian (Main other regions who regularly use the services) (Local Data)**

CHP	2015	2016	2017	Grand Total	Percentage of total deliveries 2015-2017
South Lanarkshire CHP	29	46	47	122	0.44%
Scottish Borders CHP	25	33	33	91	0.33%
Falkirk CHP	26	30	30	86	0.31%
North Lanarkshire CHP	19	13	20	52	0.19%
Dunfermline and West Fife CHP	19	12	12	43	0.15%
Kirkcaldy and Levenmouth CHP	9	3	4	16	0.06%
Other CHP	13	13	28	54	0.19%
Errors, Blanks, Unrecognised Postcodes	25	23	17	65	0.23%
<b>Grand Total</b>	<b>140</b>	<b>150</b>	<b>174</b>	<b>529</b>	<b>1.67%</b>

Source: NHS Lothian Trak System

This data provides us with a baseline of the areas in Scotland where women are transferred to Lothian as a specialist centre. Under the National Best Start vision and implementation plans, this number is anticipated to rise as intensive neonatal care providers are reduced to 5 units, then 3 units for Scotland. This will require increased intra-uterine transfers of mothers and care of these mothers and babies at birth and in neonatal intensive care areas.

## 3.1 What do we know about births in Lothian?

### Birth locations: consultant unit, birth centre, at home

The majority of births in NHS Lothian are in a consultant unit: 87.6% of the 75,570 births from 2009-2016. The NHS Lothian Maternity Plan 2009-2015 recommended a midwife-led Birth Centre for up to 1,000 births to be established at Simpson Centre for Reproductive Health (SCRH). The birthing centre opened in November 2010 and was designed to promote natural childbirth and encourage more beds to be open at SCRH. Since being fully opened, there have been more than 1,000 births in the centre each year, with 1,164 babies (12.4%) born there in 2016. The criteria for using the birth centre will be reviewed, during the lifespan of Best Start in Lothian 2018-2023 to be more inclusive, and to increase choice and numbers of mothers using the birth centre.

The home birth rate in Lothian (0.94% in 2015 and 2016) is in line with the Scottish average of 1%. Unplanned birth (BBAs – either unplanned at home or elsewhere) account for less than 1% of Lothian births.

DOD Year	BBA	Consultant Unit	Homebirth	Midwife Birth Centre	Not known
2010	77	9552	172	105	3
2011	77	8589	136	1023	4
2012	47	8030	116	1556	21
2013	81	8061	106	1312	22
2014	69	8128	90	1265	23
2015	67	7912	88	1235	18
2016	61	8077	89	1164	33
2017	73	7793	71	1100	20

### Assisted Conception Trends:

Data from the NHS Lothian Assisted Conception Unit Website indicates that 188 pregnancies were from in vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI) resulting in 142 live births in 2015 (see <http://www.nhslotian.scot.nhs.uk/Services/A-Z/EdinburghAssistedConceptionProgramme/Pages/Success-Rates.aspx>). There is no information on trends or how many women using the service are from NHS Lothian.

*For more information on our population, (NB: link will be uploaded once documents have been fully approved and are online)*



## 3.2. What do we know about service user views?

### 'Having a Baby in Scotland 2015: Listening to Mothers: Results for NHS Lothian

The following table lists the survey questions that had a high percentage of positive responses from mothers in Lothian. The questionnaire was sent to 690 women chosen at random, 298 responded, a 43% response rate. The number in column 3 indicates how Lothian compares with the rest of Scotland. (+ indicates better than Scottish average, - indicates lower than Scottish average)

For the full report, please see <http://www.gov.scot/Resource/0049/00490649.pdf>

Mothers' views about care...	Positive Scores	Compared to Scottish Average
Antenatal care...	89%	-3
During labour and birth...	92%	0
In hospital and after the birth...	87%	+2
At home after the birth...	90%	-1

In general, the quality of maternity care in Scotland is rated very highly by service users. Areas that could be improved were identified however and these helped form the foundations of the 'The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland'.

## 3.2. What do we know about service user views?



What areas for improvement were identified from the *'Having a Baby in Scotland'* survey which formed the foundations of 'The Best Start'

In the national survey, service users said they wanted:

- **Continuity of care and carer** – building relationships with staff and seeing the same person or team throughout their care, breastfeeding support, the opportunity for more partner support for bonding with their babies, and minimizing separation
- **More information and choice** – and better communication and consistent advice including the use of digital technology
- **Better emotional support** – for families with babies in neonatal care, and care for bereaved parents
- **More access** – to services locally, and support for parents of babies in neonatal units to stay with their babies

For more information about the views of our service users, (N.B. link to be uploaded once documents have been fully approved and are online)

## 3.3 What do we know about our workforce?

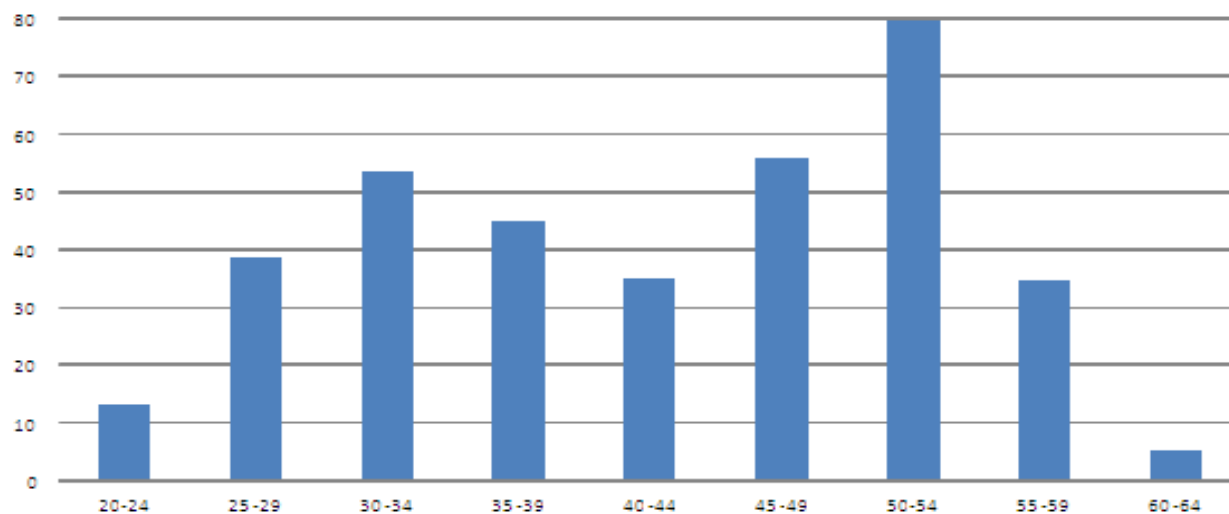
### Midwifery and Nursing Workforce:

We have 446 midwives (360.4wte) working in maternity services In Lothian. 33% of these midwives are 50 years and over age range, with 11.5% of these over 55 years.

- In Community Midwifery we have 127 midwives (97.46 whole time equivalents/wte) and 45% of these midwives are over 50 years of age.

In addition, there are 107 non registered staff (81.51 wte midwifery care assistants, healthcare support workers etc) and of these staff 46% are over 50 years of age.

The table below shows the age of our midwifery workforce. Most of our midwifery staff are in the 50-54 years age group and will soon be eligible for retirement. As a result, there is to be a Scotland-wide increase in 2016/17 to 191 midwifery students, up 4.9% from 2015/16.



Registered Midwife Age Profile December 2016



## 3.3 What do we know about our workforce?

### Neonatal Nursing

**'Neonatal Care in Scotland: A Quality Framework'** (The Quality Framework) was published in 2013 by the Scottish Government, and sets out the range of services required to ensure high-quality care is provided to babies born premature or sick, and their families.

The Quality Framework sets out the nurse-to-baby ratios which should be provided for babies receiving different levels of neonatal care. The recommendations are:

- *1 nurse available for every 4 babies requiring special care*
- *1 nurse available for every 2 babies requiring high dependency care*
- *1 nurse for every baby requiring intensive care*

All of these ratios are the minimum required to provide high quality care. Due to the individual care needs of each baby, some will need a higher nurse-to-baby ratio. Babies requiring intensive or high dependency care should be cared for by nurses who have completed accredited training in specialised neonatal care or who are undertaking this training and working under the supervision of a registered nurse who is qualified in specialty (QIS).

The Quality Framework sets out that a minimum of 70% of the registered nursing workforce establishment should hold an accredited post-registration qualification in specialised neonatal care. This standard is vitally important to ensure that a high proportion of the nurse workforce in each unit has proven competence in providing complex care to vulnerable babies.

Training a nurse to be qualified in a specialty takes about five years in total. This consists of a nursing degree (generally three years), and then a minimum of six months experience working in a neonatal unit to be eligible for the QIS training course. This post registration qualification then takes a further year to complete.

There are two neonatal units in NHS Lothian, one intensive care unit at the Royal Infirmary of Edinburgh and one local neonatal unit at St John's Hospital in Livingston. The funded nursing establishments in both units have been calculated according to the staffing

## 3.3 What do we know about our workforce?



Levels defined in the Quality Framework. However, maintaining nurse staffing levels and the appropriate skill mix for the caseload of babies is a challenge due to staff maternity leave, retirement and normal staff turnover rates. As a result, a rolling recruitment programme is in place to address this.

There are challenges around recruitment as there is a lack of neonatal nurses who are already 'qualified in specialty' to recruit to senior vacancies. This is a national issue and is not exclusive to NHS Lothian. Nursing staff are therefore supported 'in-house' to undertake training to become 'qualified in specialty' and approximately 8 staff are supported annually to complete the course.

At present, 73% of registered nursing staff in post at the RIE and 81% at St John's Hospital are qualified in specialty; this is above the recommended minimum of 70%. A further 4 staff at the RIE are due to complete training and a further 7 have recently commenced the course.

The Neonatal Unit at the RIE has a Community Outreach Service providing 6 day cover for follow up care in the community.

An Education Practitioner post has been developed for the Neonatal Service across Lothian to support the education and continuing professional development needs of the nursing team.

There is a well established team of 8 Advanced Neonatal Nurse Practitioners( ANNPs) who work across both sites on the junior and middle tier medical rotas. The long term vision is to have a team of 14 ANNPs to support the service.

In Lothian, 24% of the registered nursing staff in neonatal services are 50 years and over (11% of these being 55 and over). In special care, 25% are over 50 years (21% over 55) In the neonatal transport team, 38% are over 50 years (14% over 55 yrs)

## 3.3 What do we know about our workforce?

### Age Profile of NHS Lothian Neonatal and Obstetric Medical Workforce:

At the Simpson Centre for Reproductive Health (SCRH), 41% of our medical staff are over 50 years (18% over 55 years) and at St John's Hospital, 35% of our medical staff are over 50 years (6% over 55 years).

At SCRH, 57% of our neonatal staff are over 50 years (14% over 55 years).

### Neonatal Medical Workforce:

'The British Association of Perinatal Medicine (BAPM) Service Standards' set out guidelines for the minimum number of medical staff needed at each level of seniority. Medical staffing rotas should have a minimum of eight tier one (junior) staff members such as doctors new to the specialty and advanced neonatal nurse practitioners, eight tier two (middle grade) staff members such as specialty doctors and more experienced advanced neonatal nurse practitioners, and seven tier three (expert) staff members who are medical consultants.

The Quality Framework provides additional detail on how medical staffing rotas should be configured between each level of unit:

<b>Level one</b>	These units need 24 hour availability of a consultant paediatrician and out of hours cover is provided as part of a general paediatric service.
<b>Level two</b>	These units need 24 hour availability of a consultant paediatrician who has experience of and training in neonatal care. Out of hours cover can be provided by the general paediatric service. There should be 24 hour cover of resident experienced support with the ability to respond immediately to neonatal emergencies and 24 hour cover for provision of direct care with sole responsibility for the neonatal service. This can be a member of medical staff, an ANNP or a QIS nurse who has undertaken extended training.
<b>Level three</b>	These units must have 24 hour availability of a consultant neonatologist whose duties, including out of hours cover, are solely on the neonatal unit. There should be 24 hour cover of resident experienced support for sole cover of the neonatal service and associated emergencies, and 24 hour cover for provision of direct care with sole responsibility for the neonatal service; delivered by either a tier one doctor or ANNP.

## 3.3 What do we know about our workforce?

### **Neonatal Allied Health Professional workforce:**

The Neonatal Quality Framework sets out comprehensive guidelines for involving a range of allied health professionals in the neonatal team. There should be a dietitian, physiotherapist and/or occupational therapist, speech and language therapist and a clinical psychologist within the neonatal team. Level three units should also have access to a specialist neonatal pharmacist whose job plan contains identified and protected time for providing advice and support in neonatal pharmacy.

Both NHS Lothian units have access to a specialist neonatal pharmacist on site. The Unit at the Royal Infirmary of Edinburgh (RIE) has a dedicated neonatal physiotherapist. The service at St John's has access to a paediatric physiotherapist on site. Neither unit has a clinical psychologist, dietitian or speech and language therapist within the neonatal team, however both teams do have access to a dietitian and a speech and language therapist at the Royal Hospital for Sick Children (RHSC).

Both units have access to a Diana Children's Nurse to support palliative and end of life care. A Family Support Worker is based in the unit at the RIE one day a week to provide additional emotional support to families. Both posts are through partnership working with the Children's Hospice Association Scotland (CHAS).





## 4. Our Implementation Plan

In this next section, we will outline **our broad long term aims for implementing Best Start in Lothian** against the main recommendations of Best Start.

A baseline on our current position against the 23 recommendations that Scottish Government Best Start team believe can be implemented within local health boards without regional or national leadership or co-ordination (of the 76 national recommendations in Best Start) is available online at [\(NB: Link to be inserted once document is approved and online\)](#)

A two year action plan for 2017/2019 accompanies this strategy. [\(NB: Link to be inserted once document is approved and online\)](#)

A longer term action plan will be developed to work towards 2023, once the learning from the five Early Adopter Boards is analysed and recommendations for next steps made locally and nationally.

### What are we aiming for?

#### 1. Continuity of Carer

We will work as an early adopter pilot site from December 2017 to March 2019, testing the primary midwife caseload model in a community team within NHS Lothian. The learning from this will inform NHS Lothian's roll out of this model and inform the national implementation team to enhance national roll out.

#### 2. Person-centred care

Our aims will be to keep mums, babies and families together using a relationship based, personalised care model. This will include a safe and family-centred neonatal care model. As an early adopter board, we will test a model of transitional care to keep more babies together with their mums on postnatal wards. Moving forward, we will work in a regional and national model to review cot and bed numbers to ensure that we keep families with complex care needs together, e.g. to manage intrauterine transfers and care packages.

#### 3. Multi-disciplinary team care

We will work towards a model of community hub maternity care ensuring that midwives and obstetricians work within this geographical model. For women with increased medical needs, we will ensure that their hospital-based care still follows a relationship-based personalised model. We will work with national colleagues on the criteria for the "red" and "green" pathways and have clear Lothian care pathways for all women.

## 4. Our Implementation Plan

### 4. Safe, high quality and accessible care

We will continue to work to ensure a safe, high quality and accessible care model. This will include developments such as community hubs, specialist maternity and neonatal care co-location, support for vulnerable women, and improved perinatal mental health services. NHS Lothian hosts the East Scotland Mother and Baby Unit at St John's Hospital. In addition, NHS Lothian has a community perinatal mental health team who support Lothian women with known mental health conditions, co-ordinating care in pregnancy.

### 5. Neonatal Care

NHS Lothian, as a provider of national and regional neonatal intensive care, will work with the national implementation team on the plan to move to five intensive care units initially, with a further reduction to three.

### 6. Transport

We will work with the Scottish Ambulance Service to ensure that Best Start recommendations on transport support the needs of women and babies in Lothian.

### 7. Remote and Rural Care

NHS Lothian, as a tertiary expert provider of obstetric and neonatal care, will work with the national implementation team and neighbouring health boards with remote and rural needs.

### 8. Workforce

Analysis of workforce needs will be tested in the pilots within the early adopter board workstreams. This will include detailed analysis of the current workforce - whole time equivalent (wte) age, skills and competencies, contractual needs, and a strategic plan to develop the workforce required to deliver the full model of Best Start within the five year period.

To enable this to happen, we will deliver this closely with staff themselves, partnership forums, Trade Unions and Human Resources. The size of this service change for the workforce is significant and as such will require a step change and measured process. Partnership and Union representation from the Royal College of Midwives are present on both the project leadership teams and programme board, and will guide and assist the organisational change processes required.

# 4. Our Implementation Plan

## 9. Quality Improvement

NHS Lothian will work with the national implementation group on the development of the national dashboards and single maternity care system and electronic maternity record. NHS Lothian will continue to strive for service improvement using Maternity and Children Quality Improvement Collaborative (MCQIC) methodology and local quality improvement team action plans. MCCQIC is part of the wider NHS Scotland Patient Safety Programme.

NHS Lothian Maternity Services have recently re-launched their quality improvement programme and are setting their priorities for 2017-2018 in line with Health Improvement Scotland (HIS) requirements. The aims of this programme are to reduce avoidable harm in women and babies through reducing stillbirths and neonatal mortality.

Process measures to indicate improvements that affect this outcome are:

- Reducing severe postpartum haemorrhage (PPH)
- Increased cardiotocograph (CTG) education, escalation policy and its reliable implementation, documentation, stickers and "buddy reviews"
- Recognising the deteriorating mother with the use of the Maternity Early Warning Score (MEWS) and appropriate escalation
- Sepsis management and treatment using NHS Lothian's maternity criteria
- Improvements in VTE (venous thrombo embolism) risk assessment on booking
- A focus on smoking cessation and a tailored package of care
- Percentage of women with a documented discussion about fetal movement
- Increasing the percentage of normo-thermic babies at transfer from Labour ward
- A positive and pro-active safety culture with daily ward safety briefings, cross-site maternity capacity meetings (focus on safety), significant events debriefs (e.g. all PPHs > 2.5 litres, eclampsia), and structured handovers to aid effective communication
- Increase the percentage of women satisfied with their experience of maternity care. Maternity services are part of the NHS Lothian Programme of Executive Leadership Walk Rounds



## 4. Our Implementation Plan

### 10. Effective Use of Financial Resources

When Scottish Government launched the national Best Start Strategy, the vision was that the new models of care would be cost neutral to health boards in the long term, as money would move within the system to create the changes required. An example of this might be savings realised from reduced medical interventions in deliveries (e.g. induction of labour or caesarian section rates) which can be used to increase midwifery costs to enable the smaller caseloads required for the primary midwife model.

However, the existing model of care must run in tandem with the testing of the new model in various stages and therefore new costs are envisaged in the transitional period. The financial elements are part of the testing within the 5 Early Adopter Boards. The NHS Lothian Best Start project leadership team, Women's Clinical Management Team and the Best Start Programme Board will assess the steps required to achieve the expectations of delivering as an early adopter area against the current financial envelope. The two year action plan has financial planning within it and will explore what is deliverable within existing resources within NHS Lothian and in conjunction with any additional project funds that can be sourced from Scottish Government.

In the current model, hospital-based care accounts for £24.7 million and community based care (100% of community midwifery) is £5.3 million. In addition, women's support services, (administration, management etc) covers all areas of care and accounts for £0.7 million. The total budget for pregnancy, birth, postnatal and neonatal care for Lothian is £30.7 Million.

In the future model, hospital-based costs will partially transfer to a community-based model, and similar to the acute care/primary care transformation for all healthcare, the balance should shift. Core staffing in hospital intrapartum care will reduce as community midwifery teams take on primary midwife roles and care for more women in birth (either at home, in midwifery-led units and labour wards). For instance, community midwives currently have 100-120 women each at any time under their care. In the new model, the primary midwife will have 35 women on their caseload at any time (42 per annum), therefore we would need to increase our community midwife establishment threefold (as minimum) to meet the new caseload sizes. The resource is to come from hospital maternity care, by reducing the core establishment in areas such as intrapartum care (as you will need fewer midwives in labour ward, as community midwives will deliver babies in whatever setting is chosen/appropriate for the women in their caseload). As part of the 2 year action plan and piloting, we will assess these costs in detail and NHS Lothian will only be able to provide what is safe, effective and affordable within available resources.

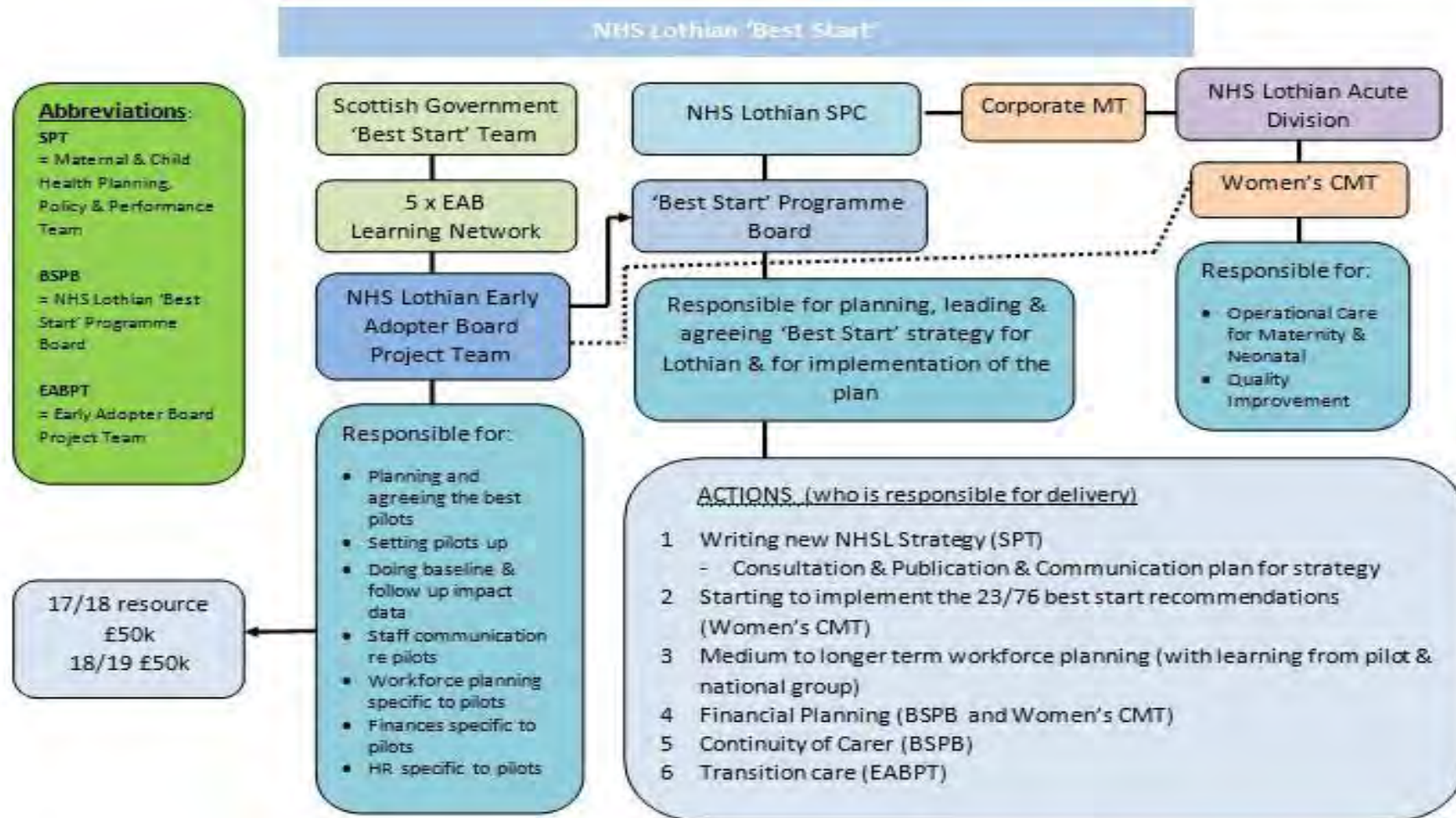
## 4. Our Implementation Plan

The current financial spend within Women's Services (Maternity and Neonatal) is displayed below:

Pan Lothian Community Midwifery £5.3m	RIE Wards 119 (Antenatal & Postnatal) & 211 (Postnatal) Inpatient Care £4.0m	RIE Labour Suite £4.0m	RIE Obstetrics Services Support & Running Costs £0.6m
RIE Medical Obstetric Staff £1.9m	Neonatal Unit £ 5.4m	RIE Neonatal Medical Staff £1.0m	RIE Pregnancy Support Centre £0.2m
SJH Labour Suite £2.1m	SJH Ward 11 (Antenatal & Inpatient Care) £1,.7m	SJH Outpatient Clinic £0.3m	SJH Ward 10 Day Assessment £0.3m
SJH Obstetrics Services Support & Running Costs £0.1m	SJH Pregnancy Support Unit £0.1m	SJH SCBU £1.0m	SJH Medical Obstetric Staff £0.7m
Lothian Birth Centre £1.2m	RIE Outpatient Department £0.4m	RIE Day Assessment £0.3m	RIE Fetal Medicine £0.1m

# 4. Our Implementation Plan

## Our Governance, Leadership and Delivery of this Strategy:



## 4. Our Implementation Plan

**If you wish to find out more about this strategy or the partner documents, please visit our NHS Lothian website**

<http://www.nhslothian.scot.nhs.uk/HealthInformation/Pregnancy/Pages/default.aspx>

**For Further Details from the National Team:**

**The National Report:**


<http://www.gov.scot/Publications/2017/01/7728>

**The Scottish Government Website for Best Start work:**

<https://beta.gov.scot/policies/maternal-and-child-health/improving-maternal-and-neonatal-care/>

**The Scottish Government Best Start on Twitter:**

@SGChildMaternal



***DRAFT Best Start in Lothian-  
Additional Document***

***2017-2019 Action Plan***

<b>2017/19 Action Plan</b>	<b>Date to achieve</b>	<b>Lead Groups</b>	<b>Evidence we have delivered</b>
<b>Baseline/Preparation Work</b>			
<b>1. To undertake a review of performance against the 2009-2015 NHSL maternity and neonatal strategy</b>	<b>06/18</b>	<b>Maternity and Children Strategy Team with Women's CMT</b>	<b>Contained within new strategy</b>
<b>2. To explore current population and service outcome data to identify areas of improvement to include within the new strategy</b>	<b>12/18</b>	<b>Best Start Programme Board (BSPB)</b>	<b>Clear improvement aims to be in the strategy and actions for the 5 year plan</b>
<b>3. To express interest in being an Early Adopter Board</b>	<b>08/17</b>	<b>Women's CMT</b>	<b>Submitted on deadline</b>
<b>4. To provide baseline information to SG on the 23 recommendations that out of the 76 can be initiated locally</b>	<b>08/17</b>	<b>Women's CMT</b>	<b>Submitted on deadline</b>
<b>Early Adopter Planning</b>			
<b>5. To plan EAB next steps with SG and other 4 Early Adopter Boards (EAB)</b>	<b>12/17</b>	<b>BSPB</b>	<b>To be agreed via Best Start Implementation Group and short life working group</b>
<b>6. Agree project management arrangements for the EAB work</b>	<b>11/17</b>	<b>BSPB</b>	<b>Project management has been agreed– Nov 2017</b>

<b>Workforce Preparation</b>			
<b>7. Agree scope of the Lothian EAB with SG</b>	<b>11/17</b>	<b>BSPB</b>	<b>Clearly defined Early Adopter Goals in collaboration with SG</b>
<b>8. Agree the test community midwifery teams to commence the testing of the enhanced primary midwifery caseload</b>	<b>04/18</b>	<b>BSPB</b>	<b>To be agreed via Best Start and short life working group</b>
<b>9. Agree the keeping mums and baby together testing required</b>	<b>03/18</b>	<b>BSPB</b>	<b>To be agreed via Programme Board and short life working group</b>
<b>10. Run midwifery continuity of carer test from May 18 to at least Dec 18 and to assess outcomes on an ongoing basis using improvement methodology</b>	<b>12/18</b>	<b>EABPT</b>	<b>Data from test cycles and difference against baseline. Staff feedback, service user feedback</b>
<b>11. Run tests on PN ward of keeping mums and babies together and reducing admission to NNU for low level SCBU needs</b>	<b>12/18</b>	<b>EABPT</b>	<b>Data from test cycles and difference against baseline. Staff feedback, service user feedback</b>
<b>12. Agree areas of the 76 recommendations that can be taken forward across services in parallel with pilot test</b>	<b>05/18</b>	<b>EABPT &amp; Women's CMT</b>	<b>Measurements against the 76 baselines</b>
<b>13. Consider geographical service usage and demand and consider routes to increasing usage of facilities and staff in West Lothian and SJH</b>	<b>07/18</b>	<b>Women's CMT EABPT</b>	<b>Birth trends and service statistics</b>
<b>14. Review birth centre criteria to reduce thresholds to women who can use facility</b>	<b>05/18</b>	<b>Women's CMT EABPT</b>	<b>Birth trends and service statistics</b>
<b>15. Engage workforce via local information sessions</b>	<b>02/17 ongoing</b>	<b>Women's CMT</b>	<b>This work is ongoing</b>
<b>16. Explore the workforce views on Best Start redesign via interviews and surveys by MW Consultant</b>	<b>10/17</b>	<b>Women's CMT</b>	<b>This work is ongoing</b>

<b>Communication</b>			
<b>17. Work with RCM and other trade union groups on regional and local work to ensure that we work in partnership to ensure that staff needs are considered fully in the testing and roll out periods of future models</b>	<b>At all times</b>	<b>Women's CMT; EABPT, BSPB</b>	<b>This is ongoing</b>
<b>18. Robust guidance from Employee Relations team in HR re workforce organizational change processes</b>	<b>At all times</b>	<b>Women's CMT; EABPT, BSPB</b>	<b>This is ongoing</b>
<b>Communication</b>			
<b>19. Commence a newsletter via the programme board</b>	<b>01/18</b>	<b>Women's CMT &amp; Mat Strat Team</b>	<b>First newsletter to be completed Jan 2018</b>
<b>20. Enhance the intranet site for staff to find information on the best start implementation</b>	<b>11/17</b>	<b>Women's CMT &amp; Mat Strat Team</b>	<b>Intranet site is live as of Nov 2017</b>
<b>21. Enhance the NHSL website maternity space to inform the public of the implementation phases and plan</b>	<b>02/18</b>	<b>Women's CMT &amp; Mat Strat Team</b>	<b>Best Start web page to be located on NHSL corporate server and to go live after update of corporate site (anticipated in spring 2018)</b>
<b>Financial Planning</b>			
<b>22. Financially appraise the cost of the piloting of midwifery model as an EAB and liaise with SG re this costing to explore investment</b>	<b>03/18</b>	<b>BSPB</b>	<b>Full financial appraisal by women's CMT finance team</b>
<b>23. Preliminary financial modeling of moving to full service new midwifery care model</b>	<b>04/18</b>	<b>BSPB</b>	<b>Full financial appraisal by women's CMT finance team</b>



# Best Start in Lothian Maternity and Neonatal Strategy 2018 - 2023

NHS Lothian’s five year strategy for Maternity and Neonatal services sets the direction for the modernisation of our model of care in line with the Scottish five year strategy [The Best Start: A Five Year Forward Plan for Maternity and Neonatal Care](#)

**Key Lothian Data:**

- 9,000 to 10,000 births per year
- 2 full maternity units at Simpson Centre for Reproductive Health (SCRH) at the Royal Infirmary and at St John’s Hospital (SJH) in West Lothian & 1 attached Midwifery Unit – Lothian Birth Centre at SCRH
- For neonatal and special care baby units, we have 39 cots: 9 intensive care, 8 high dependency care, and 22 special care on Simpson’s site and 10 cots: 2 HDU, and 8 special care at SCRH
- Low home birth rate at 0.96% and High caesarean section rate at 33%
- 27.2% induction of labour rate in 2016
- We care for women from other health board areas who transfer for specialist care for themselves or their babies
- 446 midwives (360.4 wte) working in maternity services in Lothian. 33% of these midwives are in the 50 years and over age range, with 11.5% of these over 55 years
- Our midwives are on contracts attached to settings – hospital or community
- 7.2% of births were preterm in 2016.



All mothers and babies are offered a truly family-centred, safe and compassionate approach to their care, recognising their own unique circumstances and preferences.



Fathers, partners and other family members are actively encouraged and supported to become an integral part of all aspects of maternal and newborn care.



Women experience real continuity of care and carer, across the whole maternity journey, with vulnerable families being offered any additional tailored support they may require.



Services are redesigned using the best available evidence, to ensure optimal outcomes and sustainability, and maximise the opportunity to support normal birth processes and avoid unnecessary complications.



Staff are empathetic, skilled and well supported to deliver high quality safe services, every time & multi-professional team working is the norm with an open and honest team culture, with everyone’s contribution being equally valued.



## What are we aiming for in Lothian?

- 1. Continuity of Carer - Primary Midwife Model (35 women on a midwife caseload at any one time)** - We will work as an early adopter pilot site to test the primary midwife caseload model in a community team within NHS Lothian. The learning from this will inform NHS Lothian's roll out of this model.
- 2. Person-centred Care** - Our aims will be to keep mums, babies and families together using a relationship based, personalised care model. This will include a safe and family centred postnatal/neonatal care model. As an early adopter board, we will test a model of transitional care to keep more babies together with their mums on postnatal wards and to shorten the length of stay in SCBU or NNU.
- 3. Multi-disciplinary team care** - We will work towards a model of community hub maternity care ensuring that midwives and obstetricians work within this geographical model. For women with increased medical needs, we will ensure that their hospital-based care still follows a relationship - based personalised model. We will work with national colleagues on the review of criteria for low and higher risk pathways.
- 4. Safe, high quality and accessible care** - We will continue to work to ensure a safe, high quality and accessible care model. including: community hubs, specialist maternity/ neonatal care co-location, support for vulnerable women, and improved perinatal mental health services
- 5. Neonatal Care** - NHS Lothian, as a provider of national and regional neonatal intensive care, will work with the national implementation team to review cot and bed numbers to support the national aim of moving to five then three intensive care units.
- 6. Transport** - We will work with the Scottish Ambulance Service on transport requirements to support the needs of women and babies in Lothian.
- 7. Remote and Rural Care** - NHS Lothian will work with the national implementation team on the needs within Lothian and in neighbouring areas.
- 8. Workforce** - We will carry out detailed analysis of our workforce to develop the new model required to deliver the Best Start. To enable this to happen, we will deliver this closely with staff themselves, partnership forums, Trade Unions and Human Resources. This size of this service change for the workforce is significant and as such will require a step change and measured process.
- 9. Quality Improvement** - NHS Lothian will work with national group on the development of the national dashboards and single maternity care system and electronic maternity record. NHS Lothian will continue to improve using current Quality Improvement Teams.
- 10. Effective Use of Financial Resources** – NHS Lothian will ensure that the services delivered are within existing financial resources.



Date 20 March 2018  
Your Ref  
Our Ref AMcM/JC/KL

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Dear Scottish Government Best Start Team,

### **NHS Lothian Early Adopter Board Financial Request**

As you are aware, the aim of early adopter board areas was to be at the forefront of implementation, leading the way across NHS Scotland with *regard to*:

- the midwifery continuity of carer model for all women, including vulnerable women and families;
- a new model for hospital based maternity services, including postnatal/neonatal care; and the associated core workforce;
- aligned and co-located midwifery and obstetric teams;
- enhanced roles for support workers in the community and in community hubs;
- Community Hubs for the delivery of maternity care and, in-time, neonatal outreach.

We have received funding for £50,000 to cover the equivalent of a band 7 local project manager post to support local planning. We attach our overall planning structure and project team membership.

At the launch of Best Start, health boards and professional organisations such as the Royal College of Midwives, highlighted to SG that they did not believe the transformation from the existing models of care to the new best start models of care to be cost neutral for services. In the long term, this may be the case, as similar to shifting the balance of care toward primary care we will be able to shift resources and see improving outcomes which lead to savings which can be reinvested in the system. However, in the testing and shifting the balance stage, new money is felt to be essential to bridge from the old to the new model.

The national implementation group and subgroups have not yet been able to work out the level of core hospital care that must remain for patient safety and acute care in obstetric units (for elective and emergency caesarean sections, inductions of labour, high risk intrauterine transfers, premature births, high dependency care for mothers, neonatal care for babies etc). At the testing phase, we cannot remove financial resource from our current hospital maternity service or reduce staffing in our units. Therefore to pilot the primary midwife and continuity of carer model we are requesting staff costs for 5 whole time equivalents (wte) band 6 midwives.

Our plan is to create a best start community midwifery team in Edinburgh, and for this team to consist of 8 wte midwives (to support one rostered on call per week per member of staff as at any time in a year you always have one member of staff on annual leave). We can move 3 of our existing community midwives into this team, and they would bring with them the starting caseloads of 280 women which would then be allocated on a 35 women to midwife ratio for the new model of care. The midwives would work in a team and provide the on-call for the labour care in the home/midwife led birth centre or labour ward, depending on the woman's preferences and needs.

SG were very keen for NHS Lothian to be one of the 5 EAB's as capital city and the only large city in the test group, with NHS Greater Glasgow and Clyde only testing in the Clyde area. Our health board were concerned about the financial constraints of being an EAB and have considered the financial option and we have come to the conclusion that we do not have any resource to fund the 5 wte posts within our existing budgets. We would like to start our pilot team in May/June if possible and would be very grateful if you could consider this request for funding.

**Our contribution to the overall EAB work is:**

3wte band 6 community midwives

Band 7 community team leader's time

Postnatal and neonatal midwifery, nursing and neonatology time to do the separate testing of keeping mums and babies together

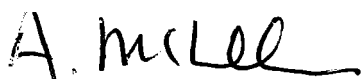
Best start wider programme team leadership and time

Executive Director and senior executive and management time for the Best Start Programme Board.

Our Request to SG is for additional 1 year funding for **£ 277,404 (see table attached)**

We look forward to hearing from you in due course, and should you wish to discuss this further by telephone or in person, please do not hesitate to contact myself.

Yours sincerely



ALEX MCMAHON  
Executive Nurse Director



JACQUIE CAMPBELL  
Chief Officer, Acute Services

## New Costs for Adding to NHS Lothian Contribution to the Primary Midwife/Continuity of Carer Test for Edinburgh

Category	Descriptor	Model	WTE	Cost	Assumptions
<i>Recurring Costs:</i>					
Midwifery	B6 Midwife	Hospital Backfill	5.00	263,580	Based on cost of backfilling RIE midwives on protected (current) earnings
Travel	Mileage			4,679	Based on current mileage + 40% additional for extra travel commitments
IT recurring				1,950	5 new maintenance transfers & 8 new data sims
Mobile phone recurring				750	5 new mobile phone contracts
<b>Annual Recurring Costs</b>				<b>270,959</b>	
<i>Setup Costs:</i>					
IT hardware	Laptop			5,400	5 new laptops
Mobile phones	Smartphone			1,045	5 new mobile phones
<b>Total Setup Costs</b>				<b>6,445</b>	
<b>Total Costs</b>				<b>277,404</b>	

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 performance on 13 measures considered across the Board, including those relating to the Hospital Scorecard, are currently met with 20 not met. It is not possible to assess performance on dementia post-diagnostic support or complaints stage 1 or 2; and
  - 2.1.2 Accept Board Committees are continuing with the enhanced programme of assurance agreed, with a provisional timetable for remaining measures outlined in this paper. To date, 21 measures have been considered with significant, moderate and limited assurance reached on 1, 11 and 9 instances respectively. On no occasion was 'no assurance' concluded.
  - 2.1.3 Consider whether consideration by committee is merited for any of 17 areas yet to be granted a level of assurance since the process' inception. A further 2 have not been reconsidered since 2016.

### 3 2018/19 Quality and Performance Improvement Process

- 3.1 In anticipation of the new financial year preparations are underway for a refresh of the process. Views of committee members are to be incorporated through a survey monkey questionnaire seeking views of the lighter approach trial (Table A). This is currently being piloted.
- 3.2 As in previous months an excel file has been circulated with the papers. A dashboard, at the development stage, can also be made available to members upon receipt of information governance paperwork.
- 3.3 As highlighted in previous reports, the Scottish Government Health Department and Board Chief Executives are currently engaged in the preparation of Annual Operational Plans and it is likely that the current standards will continue to be reported as part of the Q&PI process during the coming year. The status of these

and potentially additional measures will become clearer as discussions with Scottish Government progress.

**Table A – Summary of Lighter Approach Trial**

<b>Committee</b>	<b>Previous Approach</b>	<b>Lighter Approach</b>
Board	<ul style="list-style-type: none"> <li>• Overview for all measures</li> <li>• Assurance Summary</li> <li>• Proformas where not met</li> </ul>	<ul style="list-style-type: none"> <li>• Overview for all measures</li> <li>• Assurance Summary</li> <li>• <del>Proformas where not met</del></li> <li>• <u>Self-Service Pack</u></li> </ul>
Governance Committee	<ul style="list-style-type: none"> <li>• Overview for all measures</li> <li>• Assurance Summary</li> <li>• Detailed Measure Paper</li> <li>• Proformas where not met</li> </ul>	<ul style="list-style-type: none"> <li>• Overview for all measures</li> <li>• Assurance Summary</li> <li>• Detailed Measure Paper</li> <li>• <del>Proformas where not met</del></li> <li>• <u>Self-Service Pack</u></li> </ul>

#### **4 Recent Performance**

- 4.1 Against the measures considered, most recent information demonstrates that NHS Lothian met 13 of the 36 measures considered, whilst 20 were not met. As detailed above, it is not possible to make an assessment on Dementia Post-Diagnostic Support or Complaints Stage 1 or 2.
- 4.2 Board committees have been delegated the responsibility for seeking assurance for the measures contained in this report, seeking to conclude levels of assurance for those areas that they have examine, considering “*What assurance do you take that the actions described will deliver the outcomes you require within an acceptable timescale?*”
- 4.3 The assessments made to date are set out both in Table 1 21 have been considered with significant, moderate and limited assurance being reached on 1, 11 and 9 instances respectively. On no occasion was ‘no assurance’ concluded;
- 4.4 17 areas considered in the Q&PI process have not been assessed for assurance since its introduction. These are outlined below Table B. A further 2 were last assessed prior to 2017.
- 4.5 The delegation of measures to governance committee and detail behind assurance gradings are available in the appendix.

**Table B – Assessed Levels of Assurance**

			Assurance Level				
			Not yet assessed	None	Limited	Moderate	Significant
Board	Met	13	-	-	-	-	-
	Not Met	20	-	-	-	-	-
	TBC	3	-	-	-	-	-
Acute Hospitals Committee	Met	8	8	0	0	0	0
	Not Met	10*	2	0	5	5	0
Healthcare Governance Committee	Met	5	4	0	0	1	0
	Not Met	9	2	0	4	2	1
	TBC	3	1	0	0	2	0
Staff Governance Committee	Met	0	-	-	-	-	-
	Not Met	1	-	-	-	1	-

§ Those yet to be assessed are:

AHC – HSMR, Diagnostics Vascular Labs, IVF, Planned Repeat Surveillance Endoscopy and all Hospital Scorecard measures.

HGC – Falls With Harm, both 48 Hours GP Access measures, Alcohol Brief Interventions, Early Access to Antenatal Care, Smoking Cessation and Dementia.

\*The Diagnostic measure has been separated out in terms of assurance so although there are 8 measures not met the diagnostics has been split into 3.



**Table 1: Summary of Latest Reported Position**

Measure <sup>1</sup>	Healthcare Quality Domain <sup>2</sup>	Type <sup>3</sup>	Assurance Committee	Committee Assurance Level	Date Assurance Level Assigned	Performance Against Target/Standard <sup>4</sup>	Trend <sup>5</sup>	Published NHS Lothian vs. Scotland <sup>6</sup>	Date of Published NHS Lothian vs. Scotland <sup>7</sup>	Target/Standard	Latest Performance	Reporting Date	Lead Director	
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)	Feb 18 (Mthly)	TG	
Falls With Harm (per 1,000 occupied bed days)		Quality	Healthcare Governance (HGC)	To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Met		Not Applicable	Not Applicable	0.31 per 1,000 occupied bed days (median)	0.25 (median)	Feb 18 (Mthly)	TG	
Healthcare Acquired Infection - CDI (rate per 1,000 bed days, aged 15+)		LDP	HGC	Moderate	Jul 17	Met		Better	Sep 17 (Quarterly)	0.32 (max) (<=262)	0.23 (rate) 170 (incidences)	Feb 18 (Mthly)	TG	
Healthcare Acquired Infection - SAB (rate per 1,000 acute bed days)		LDP	HGC	Moderate	Jul 17	Not Met	No Change	Better	Sep 17 (Quarterly)	0.24 (max) (<=184)	0.27 (rate) 192 (incidences)	Feb 18 (Mthly)	TG	
Hospital Standardised Mortality Ratios (HSMR) (within limits)		Quality	AHC	TBC	TBC	Met		Not Applicable	Not Applicable	1 All sites within HS Limits	NHS L 0.83 RIE 0.82 SJH 0.74 WGH 0.68	Sep 17 (Qtrly)	TG	
48 Hour GP Access – access to healthcare prof	Timely	LDP	HGC	TBC	TBC	Met		Worse	2015/16	90% (min)	91.5%	2015/16	DS	
48 Hour GP Access – GP appt		LDP	HGC	TBC	TBC	Not Met	Deteriorating	Worse	2015/16	90% (min)	74.8%	2015/16	DS	
Four hour Unscheduled Care (% <=4 hrs)		LDP	AHC	Moderate	Feb 17	Not Met	Improving	Worse	Jan 18 (Monthly)	95.0% stretch to 98.0%	82.3%	Feb 18 (Mthly)	JC	
Alcohol Brief Interventions (ABIs) (Number)		LDP	HGC	To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Met		Better	2016/17	9,738 (Annual) 2,435 (per Quarter)	11,589	Dec 17 (Qtrly)	AMcM	
CAMHS <sup>8</sup> (<=18 wks)		LDP	HGC	Limited	Sep 17	Not Met	Deteriorating	Worse	Dec 18 (Quarterly)	90.0% (min)	62.9%	Feb 18 (Mthly)	AMcM	
Cancer (<=31-day) (% treated)		LDP	AHC	Limited	Nov 17	Not Met	Improving	Worse	Sep 17 (Quarterly)	95.0% (min)	92.9%	Feb 18 (Mthly)	JC	
Cancer (<=62-day) (% treated)		LDP	AHC	Limited	Nov 17	Not Met	Improving	Better	Sep 17 (Quarterly)	95.0% (min)	89.4%	Feb 18 (Mthly)	JC	
Diagnostics (<=6 wks) - Gastroenterology/ Urology Diagnostics			AHC	Limited	Aug 17	Not Met	Improving	Worse	Dec 17 (At month end)	0 (max)	3,623	Feb 18 (Mthly)	JC	
Diagnostics (<=6 wks) - Radiology/Imaging			AHC	Moderate	Mag 17									
Diagnostics (<=6 wks) – Vascular Labs			AHC	To be reviewed	To be reviewed									
Drug & Alcohol Waiting Times (% <=3 wks) - Edinburgh UB		LDP	HGC			Not Met	Deteriorating	Worse	Sep 17 (Quarterly)	90.0% (min)	80.8%	Sep 17 (Qtrly)	MM	
Drug & Alcohol Waiting Times (% <=3 wks) - Midlothian & East Lothian UB (MELDAP)		LDP	HGC	Limited	Sep 17	Not Met	Deteriorating	Worse	Sep 17 (Quarterly)	90.0% (min)		Sep 17 (Qtrly)	EM/DS	
Drug & Alcohol Waiting Times (% <=3 wks) - West Lothian UB		LDP	HGC										JF	
IPDC Treatment Time Guarantee (<=12 wks)		LDP	AHC	Moderate	Mag 17	Not Met	Deteriorating	Better	Dec 17 (Quarterly)	0 (max)	76.3% 2,181	Feb 18 (Mthly)	JC	
IVF (% <=12 months)		LDP	AHC	TBC	TBC	Met		Equal	Dec 17 (Quarterly)	90.0% (min)	100.0%	Feb 18 (Mthly)	JC	
Outpatients (<=12 weeks)		LDP	AHC	Moderate	Mag 17	Not Met	Improving	Worse	Dec 17 (at month end)	95.0% (min)	62.7% 22,864	Feb 18 (Mthly)	JC	
Psychological Therapies (% <=18 wks)		LDP	HGC	Limited	Sep 17	Not Met	Improving	Worse	Dec 17 (Quarterly)	90.0% (min)	76.9%	Feb 18 (Mthly)	JF	
Referral to Treatment (% <=18 wks)		LDP	AHC	Limited	Feb 17	Not Met	Deteriorating	Worse	Dec 17 (Monthly)	90.0% (min)	74.5%	Feb 18 (Mthly)	JC	
Stroke Bundle (% receiving)		Quality	AHC	Moderate	Nov 16	Not Met	Improving	Not Applicable	Not Applicable	80.0% (min)	73.0%	Jan 18 (Mthly)	JC	
Planned Repeat Surveillance Endoscopy (past due date)			AHC	To be reviewed	To be reviewed	Not Met	Improving	Not Applicable	Not Applicable	0 (max)	4,431	Feb 18 (Mthly)	JC	
Delayed Discharges (>3 days) – East Lothian UB	Effective		HGC										DS	
Delayed Discharges (>3 days) – Edinburgh UB			HGC	Limited	Sep 17	Not Met	Deteriorating	Worse	Jan 18 (Monthly)	0 (max)	270	Feb 18 (Mthly)	MM	
Delayed Discharges (>3 days) – Midlothian UB			HGC										EM	
Delayed Discharges (>3 days) – West Lothian UB			HGC										JF	
Hospital Scorecard – Standardised Surgical Readmission rate within 7 days	Efficient	Quality	AHC	TBC	TBC	Met		Not Applicable	Not Applicable	All NHS L Sites (RIE; SJH & WGH), Within Hospital Scorecard Limits	NHS L 27.79 RIE 31.52 SJH 26.65 WGH 28.68	Sep-17 (Qtrly)	TG	
Hospital Scorecard – Standardised Surgical Readmission rate within 28 days		Quality	AHC	TBC	TBC	Met					49.82 59.17 40.64 54.82		TG	
Hospital Scorecard – Standardised Medical Readmission rate within 7 days		Quality	AHC	TBC	TBC	Met					59.95 60.03 70.34 68.74		TG	
Hospital Scorecard – Standardised Medical Readmission rate within 28 days		Quality	AHC	TBC	TBC	Met					130.42 134.89 149.27 130.42		TG	
Hospital Scorecard – Average Surgical Length of Stay - Adjusted		Quality	AHC	TBC	TBC	Met					0.96 0.93 0.82 1.08		TG	
Hospital Scorecard – Average Medical Length of Stay - Adjusted		Quality	AHC	TBC	TBC	Met					1.11 0.86 1.29 1.35		TG	
Staff Sickness Absence Levels (<=4%)	LDP	Staff Governance	Moderate	Mar 17	Not Met	Deteriorating	Better	2016/17	4.0% (max)	6.03%	Jan 18 (Mthly)	JB		
Early Access to Antenatal Care (% <=12 wks)	Equitable	LDP	HGC	To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Met		Better	2015/16	80.0% min for each SIMD <sup>9</sup> quintile	88.2%	Jan 18 (Mthly)	AMcM	
Smoking Cessation (quits)		LDP	HGC	To be reviewed (was 'Met' at time of mtg)	To be reviewed (was 'Met' at time of mtg)	Not Met	Deteriorating	Worse	2016/17	404 (min for this quarter)	243	Sep 17 (Qtrly)	AKM	
Complaints - Stage 1 (%<=5-day)	Person-Centred	Quality	HGC	Moderate	Nov 17	TBC <sup>10</sup>	Improving	TBC	TBC	TBC <sup>10</sup>	90.4%	Dec 17 (Mthly)	AMcM	
Complaints - Stage 2 (%<=20-day)		Quality	HGC	Moderate	Nov 17	TBC <sup>10</sup>	Improving	TBC	TBC	TBC <sup>10</sup>	81.9%	Dec 17 (Mthly)	AMcM	
Detect Cancer Early (% diagnosed)		LDP	HGC	Significant	Nov 16	Not Met	Improving	Better	2014 & 2015 (Combined Calendar Years)	29.0% (min)	26.9%	2015 & 2016 (Combined Calendar Years)	AKM	
Dementia – East Lothian UB		LDP	HGC			TBC <sup>11</sup>							DS	
Dementia – Edinburgh UB	LDP	HGC	To be reviewed	To be reviewed	TBC <sup>11</sup>		Not Applicable	2015/16	TBC <sup>11</sup> (exptd diag rate + 1 Year (min) PDS)	Part 1: 40.1%	2015/16	MM		
Dementia – Midlothian UB	LDP	HGC			TBC <sup>11</sup>					Part 2: 75.6%		EM		
Dementia – West Lothian UB	LDP	HGC			TBC <sup>11</sup>							JF		
Patient Experience (9.0/10 – Overall Experience)	Quality	HGC	Moderate	Nov 17	Not Met	Deteriorating	Not Applicable	Not Applicable	9 (out of 10)	8.50	Dec 17 (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.nhs.uk/healthcare-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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23<sup>rd</sup> March 2018

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## **Appendices**

Appendix 1 – Alignment of Measures to Board Committee

Appendix 2 – Adopted Assurance Gradings

Appendix 3 – Technical Document

Appendix 4 - Quality & Performance Improvement Reporting Repository

## Appendix 1 – Alignment of Measures to Board Committee

	<b>Acute Hospitals</b>	<b>Healthcare Governance</b>	<b>Staff Governance</b>
<b>Effective</b>		Delayed Discharges	
<b>Efficient</b>	<i>Hospital Length of Stay (2)</i> Hospital Readmission Rate (4)		<i>Staff Sickness Absence</i>
<b>Equitable</b>		<i>Early Access to Antenatal Care</i> Smoking Cessation	
<b>Person-Centred</b>		<i>Complaints (2)</i> Detecting Cancer Early <i>Dementia Post Diagnostic Support</i> Patient Experience	
<b>Safe</b>	<i>Cardiac Arrest Incidence</i> Hospital Standardised Mortality Ratio	<i>Falls with Harm</i> Healthcare Acquired Infection (2)	
<b>Timely</b>	<i>4 hr Unscheduled Care Wait</i> Cancer Waits (2) <i>Diagnostic Waits</i> Inpatient and Daycase Waits <i>IVF Waits</i> Outpatient Waits <i>Referral to Treatment Wait</i> Stroke Bundle Compliance <i>Surveillance Endoscopies Overdue</i>	<i>Access to General Practice (2)</i> Alcohol Brief Interventions <i>CAMHS Waits</i> Drug & Alcohol Waiting Time <i>Psychological Therapy Waits</i>	

## Appendix 2 – Adopted Assurance Gradings

Definition	Most likely course of action by the Board or committee
<p><b>LEVEL – SIGNIFICANT</b></p> <p>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.</p> <p>Examples of when significant assurance can be taken are:</p> <ul style="list-style-type: none"> <li>• The purpose is quite narrowly defined, and it is relatively easy to be comprehensively assured.</li> <li>• There is little evidence of system failure and the system appears to be robust and sustainable.</li> <li>• The committee is provided with evidence from several different sources to support its conclusion.</li> </ul>	<p>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.</p> <p>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.</p>
<p><b>LEVEL – MODERATE</b></p> <p>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.</p> <p>Moderate assurance can be taken where:</p> <ul style="list-style-type: none"> <li>• In most respects the “purpose” is being achieved.</li> <li>• There are some areas where further action is required, and the residual risk is greater than “insignificant”.</li> <li>• Where the report includes a proposed remedial action plan, the committee considers it to be credible and acceptable</li> </ul>	<p>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.</p> <p>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.</p>
<p><b>LEVEL – LIMITED</b></p> <p>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.</p> <p>Examples of when limited assurance can be taken are:</p> <ul style="list-style-type: none"> <li>• There are known material weaknesses in key areas.</li> <li>• 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 been assessed and planned for.</li> <li>• The report has provided incomplete information, and not covered the whole purpose of the report.</li> <li>• The proposed action plan to address areas of identified residual risk is not comprehensive or credible or deliverable.</li> </ul>	<p>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.</p>
<p><b>LEVEL – NONE</b></p> <p>The Board cannot take any assurance from the information that has been provided. There remains a significant amount of residual risk.</p>	<p>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.</p> <p>Additionally the chair of the meeting will notify the Chief Executive of the issue.</p>
<p><b>NOT ASSESSED YET</b></p> <p>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.</p>	

Measure	Target/Standard
Smoking Cessation (quits)	NHS Boards to sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas (60% in the Island Boards).
Early Access to Antenatal Care (% booked)	Percentage of maternities booked for antenatal care within 12 completed weeks - the target is for 80% of women in each SIMD quintile to be booked within 12 weeks.
CAMHs (18 Weeks)	No child or young person will wait longer than 18 weeks from referral to treatment in a specialist CAMH service from December 2014. Following work on a tolerance level for CAMH services waiting times and engagement with NHS Boards and other stakeholders, the Scottish Government has determined that the target should be delivered for at least 90% of patients.
Psychological Therapies (18 Weeks)	The Scottish Government has set a target for the NHS in Scotland to deliver a maximum wait of 18 weeks from a patient's referral to treatment for Psychological Therapies from December 2014. Following work on a tolerance level for Psychological Therapies waiting times and engagement with NHS Boards and other stakeholders, the Scottish Government has determined that the Psychological Therapies target should be delivered for at least 90% of patients.
Delayed Discharges (over 3 days)	To minimise delayed discharges over 3 days, with a current national standard of none over 14 days.
Healthcare Acquired Infection - CDI (rate per 1,000 bed days, aged 15+)	NHS Boards' rate of Clostridium difficile infections (CDI) in patients aged 15 and over is 0.32 cases or less per 1,000 total occupied bed days.
Healthcare Acquired Infection - SAB (rate per 1,000 acute bed days)	NHS Boards' rate of Staphylococcus aureus Bacteraemia (including MRSA) (SAB) cases are 0.24 or less per 1,000 acute occupied bed days.
4-hour Unscheduled Care (% seen)	95% of patients are to wait no longer than 4 hours from arrival to admission, discharge or transfer for A&E treatment. NHS Boards are to work towards 98%.
Cancer (31-day) (% treated)	31-day target from decision to treat until first treatment for all cancers, no matter how patients were referred. For breast cancer, this replaced the previous 31-day diagnosis to treatment target.
Cancer (62-day) (% treated)	62-day target from receipt of referral to treatment for all cancers. This applies to each of the following groups: any patients urgently referred with a suspicion of cancer by their primary care clinician (for example GP) or dentist; any screened-positive patients who are referred through a national cancer screening programme (breast, colorectal or cervical); any direct referral to hospital (for example self-referral to A&E).
Stroke Bundle (% receiving)	The stroke bundle (percentage of initial stroke patients receiving appropriate bundle of care - Stroke Standard is 80%) covers four targets:- 1. Admission to the stroke unit on the day of admission, or the day following presentation at hospital (Stroke Standard is 90%); 2. Screening by a standardised assessment method to identify any difficulty swallowing safely due to low conscious level and/or the presence of signs of dysphagia within 4 hours of arrival at hospital (Stroke Standard is 100%); 3. CT/ MRI imaging within 24 hours of admission (Stroke Standard is 95%); and 4. Aspirin is given on the day of admission or the following day where haemorrhagic stroke has been excluded, or other contraindication, as specified in the national audit (Stroke Standard is 95%).
IPDC Treatment Time Guarantee (12 weeks)	From the 1 October 2012, the Patient Rights (Scotland) Act 2011 establishes a 12 week maximum waiting time for the treatment of all eligible patients due to receive planned treatment delivered on an inpatient or day case basis.
Outpatients (12 weeks)	From the 31 March 2010, no patient should wait longer than 12 weeks for a new outpatient appointment at a consultant-led clinic. This includes referrals from all sources.
Referral to Treatment (18 Weeks)	90% of planned/elective patients to commence treatment within 18 weeks of referral.
Diagnostics (6 weeks)	A six week maximum waiting time for eight key diagnostic tests (four for Endoscopy (a) & four for Radiology (b)) from 3 <sup>rd</sup> March 2009.
Surveillance Endoscopy (past due date)	No patient should wait past their planned review date for a surveillance endoscopy.
IVF (12 months)	The Scottish Government have set a target that at least 90% of eligible patients will commence IVF treatment within 12 months. This is due for delivery by 31 March 2015.
Drug & Alcohol Waiting Times (3 weeks)	The Scottish Government set a target that by June 2013, 90% of people who need help with their drug or alcohol problem will wait no longer than three weeks for treatment that supports their recovery. This was one of the national HEAT (Health improvement, Efficiency, Access, Treatment) targets, number A11. This target was achieved in June 2013 and has now become a Local Delivery Plan (LDP) standard - that clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%).
Detecting Cancer Early (% diagnosed)	Increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25 per cent.
Staff Sickness Absence Levels (<=4%)	4% Staff Hours or Less Lost to Sickness
Cardiac Arrest	50% reduction in Cardiac Arrests from the 2009 (Jan-Dec) baseline median of 1.91 to December 2019
Falls with Harm	"Harm" is Moderate, Major Harm or Death". Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level. 20% reduction in all inpatient falls with harm from 2010/11 (Apr-Mar) baseline median of 0.38. HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level 'warnings' for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.
Hospital Standardised Mortality Ratios (HSMR)	48 hour access or advance booking to an appropriate member of the GP team (90%) - Patients can speak with a doctor or nurse within 2 working days; or Patients are able to book an appointment 3 or more working days in advance.
48 Hour GP Access - access to healthcare profession; or GP appointment.	Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.
Alcohol Brief Interventions (ABIs)	This is the emergency readmissions to a surgical speciality within 7 days of discharge as a rate per 1000 total admissions to a surgical speciality
Hospital Scorecard - Standardised Surgical Readmission rate within 7 days	This measure has been standardised by age, sex and deprivation (SIMD 2009).
Hospital Scorecard - Standardised Surgical Readmission rate within 28 days	As for 7 day readmissions.
Hospital Scorecard - Standardised Medical Readmission rate within 7 days	This is the emergency readmissions to a medical speciality within 7 days as a rate per 1000 total admissions to a medical speciality. This measure has been standardised by age, sex and deprivation (SIMD 2009).
Hospital Scorecard - Standardised Medical Readmission rate within 28 days	As for 7 day readmissions.
Hospital Scorecard - Average Surgical Length of Stay - Adjusted	Ratio of 'observed' length of stay over 'expected' length of stay. This indicator is case mix adjusted by HRG* and speciality. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each speciality and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).
Hospital Scorecard - Average Medical Length of Stay - Adjusted	Ratio of observed length of stay over expected length of stay. This indicator is case mix adjusted by HRG* and speciality. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each speciality and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).
Complaints (Stage 1 & Stage 2)	Stage 1 - Early, local resolution - 5 working days. Stage 2 - For the complex, serious investigation - 20 working days. Target %s TBD.
Dementia	1. To deliver expected rates of dementia diagnosis; 2. All people newly diagnosed with dementia will have a minimum of a year's worth of post-diagnostic support coordinated by a link worker, including the building of a person-centred support plan.

N.b. Source for Current Data - with the exception of Dementia, Drug & Alcohol Waiting Times, DCE, 48 Hours, Hospital Scorecard & HSMR data for all of the measures reported is management information

\* HRG: Healthcare Resource Groups. These are standard grouping of clinically similar treatments that use common levels of healthcare resource. They are usually used to analyse and compare activity between organizations.